EVALUATING VA IT: SCHEDULING MODERNIZATION AND CHOICE CONSOLIDATION

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

JOINT WITH

SUBCOMMITTEE ON HEALTH

OF THE

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

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

THURSDAY, APRIL 14, 2016

Serial No. 114–63

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.fdsys.gov

U.S. GOVERNMENT PUBLISHING OFFICE
25–126 WASHINGTON : 2017

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
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Thursday, April 14, 2016

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

The Subcommittees met, pursuant to notice, at 10:03 a.m., in Room 334, Cannon House Office Building, Hon. Mike Coffman [Chairman of the Subcommittee] presiding.

Present: Representatives Coffman, Benishek, Lamborn, Bilirakis, Wenstrup, Kuster, Brownley, O'Rourke, Takano, Ruiz, and Walz.

OPENING STATEMENT OF CHAIRMAN MIKE COFFMAN

Mr. COFFMAN. Good morning. This hearing will come to order. I want to welcome everyone, especially our good friends from the Subcommittee on Health, to today's joint hearing regarding VA's health information technology.

Today we will examine the current state of key IT systems, and facilitate scheduling and community provider claims processing, or that—I am sorry, facilitate scheduling and community provider claims processing. And we will delve into VA's plan for modernizing them. The VHA and OI&T share responsibility for these systems.

We will also examine VHA's strategy for the IT systems that will be necessary to consolidate community care. My friend, Subcommittee on Health Chairman Dr. Benishek, has done extensive work on the consolidation issue. VHA released a draft request for proposal yesterday afternoon for the consolidated community care network, and we need to know the IT requirements.

Currently, VHA relies on the scheduling functions of VistA, the department's health information system, which was originally developed in the 1980s. Since late 2012, VA has been planning to procure commercial, state-of-the-art scheduling software. VA awarded a contract for this system, called the Medical Appointment Scheduling System, or MASS, in August 2015.

VA planned to conduct an initial pilot of MASS in Boise, Idaho, through 2016, but it was never started and activity on MASS has apparently been suspended. VA has simultaneously been developing an intermediate solution to improve VistA scheduling while MASS rolls out.

It consists of two parts: the VistA scheduling enhancement, or VSE; and a self-scheduling application called Veteran Appointment Request, or VAR. VSE gives VistA a modern look similar to a

Microsoft Outlook calendar. It replaces VistA's black and white command prompt interface. VA has described VAR as "limited."

Recently, VA determined that VSE and VAR appear to meet its scheduling needs and MASS is unnecessary. This decision is a dramatic about face. It means sticking with a government developed technology indefinitely. MASS has been stopped before, even its first pilot could be compared with VSE and VAR. The plan was to see what solution works best. It seems we will never know.

VA's claim processing system, called the Fee Basis Claims System, or FBCS, is also badly in need of modernization. VHA claims processors use it to receive, examine, and approve claims for reimbursement from community health care providers. The volume of claims is up dramatically since the Choice Act and the processors are overwhelmed.

On this Committee, we hear complaints from frustrated providers every day about not being paid, and VA lags far behind Medicare and TRICARE in processing claims. FBCS, as it exists now, has some fundamental limitations. Today, VHA has 34 groups of staff around the country processing claims manually on 34 disconnected FBCS databases.

Claims come in electronically and on paper. The paper claims don't enter the system at all until they are scanned, and GAO estimates scanning takes about two weeks. The electronic claims are immediately viewable and trackable, but there is no national view across the 34 locations of paper claims until they are actually approved for payment, and there is never a national view of paper claims that get denied. Claims information is too hard to find and they can get lost in the cracks.

VHA's manual processing takes too long. VHA's policy is to pay or reject 90 percent of claims within 30 days, and GAO found that VHA only meets this standard 66 percent of the time. Instead of manual processing, Medicare and TRICARE used auto-adjudication. Their systems automatically analyze claims for completeness and accuracy. FBCS can be upgraded to fix these problems.

An upgrade to make the paper claims more transparent has been available since May 2015. VA still hasn't tested it. An initial auto-adjudication upgrade could have been available this month, but it can't move until the earlier upgrade is implemented.

VA has a major decision to make about whether to upgrade FBCS now or to wait to put in a wholly different claims system as part of the consolidation plan. What is certain is we have a big claims paying problem right now, and payment delays chase away providers.

I now yield to Chairman Benishek for his opening statement.

OPENING STATEMENT OF CHAIRMAN DAN BENISHEK

Mr. BENISHEK. Thank you. Well, it is a pleasure to be here this morning with the Members of the Subcommittee on Health and our colleague from the Subcommittee on Oversight and Investigations.

Ensuring that the Department of Veteran Affairs is fully equipped with a modern, functional information technology system is a priority that we all share. Many of the deficiencies in the IT programs that underlie the VA health care system have already been laid out by Chairman Coffman, and I agree with his com-

ments regarding the urgent nature of the ongoing efforts to modernize the VA scheduling and claims processing.

We can't allow the failures that have characterized previous efforts in these two important areas to continue. We also can't continue to push decisions further down the road. Too often, IT projects have progressed to a critical decision point and then been abandoned in favor of another initiative or another plan. VA must realize that maintaining manual systems and deferring to archaic operating systems as a default cannot continue, we need a sense of urgency.

As Chairman Coffman noted, improving VA IT is also important to community care consolidation. Many of the key features of the VA's plan to consolidate community care under Choice will require a contemporary IT infrastructure to support them.

The VA has shared little information to date about what IT systems the VA intends to put in place to support community care consolidation, what those systems are going to cost, and when those systems will be up and running and ready to support the needs of veteran patients and the VA's community partners.

I hope the VA's prepared to provide that information today at the hearing. I am also interested in hearing today about how the Veterans Health Administration, managed by Dr. Shulkin, and the VA Office of Information Technology, managed by Ms. Council, are working together to build a modern IT program in the VA health care system that we need to serve our veterans.

The independent assessment of the VA health care system that was required by the Access, Choice, and Accountability Act found that the VHA and the OI&T did not collaborate effectively with respect to planning and executing IT strategies for managing and furnishing health care, and often disagreed on priorities for executing strategic plans.

I would venture to say that the disconnect is why so many previous health IT efforts have failed to achieve success. Ensuring appropriate coordination and communication between the VHA and OI&T is vital to moving the VA health care system toward the 21st century. I look forward to hearing some specifics from Dr. Shulkin and Ms. Council about how they are personally working together, side by side, to make these things happen.

So thank you all for being here this morning, and I will yield back to Chairman Coffman.

Mr. COFFMAN. Thank you, Dr. Benishek, for your remarks.

I now yield to Ranking Member Kuster for any opening remarks that she may have.

OPENING STATEMENT OF ANN KUSTER, RANKING MEMBER

Ms. KUSTER. Thank you very much, Chairman Coffman and Chairman Benishek, and I appreciate you taking the time for this hearing, it's an important one, and to my Ranking Member Brownley. We appreciate the opportunity to be with you all today.

The wait time crisis in Phoenix highlighted the VA's antiquated scheduling system and how difficult it was to use. And I have to say for many of us visiting VA facilities in our districts, we are having these same conversations.

VA has made a number of efforts over the last 15 years to modernize and improve its scheduling system. But as a result of the crisis, the Choice Act enacted by Congress last year mandated assessment of VA's health IT systems. And we know that modern IT systems and processes are critical to ensuring that patients receive quality coordinated care and that physicians and health care providers are not wasting their time for people who don't show up.

As we found after multiple hearings and assessments, VA's outdated and cumbersome patient scheduling system was a major contributor to patient access crisis, and remains a challenge.

VA's announcement in 2015 of a contract for commercial off-the-shelf solution to replace VA's scheduling system seemed like a promising response to the clear inadequacies of the current system, and we were all encouraged by that. There was concern that this would not be ready until 2017, but it was a promising step forward.

This five-year $624 million contract was awarded in 2015. But now, after VA has spent $27.5 million on a pilot project for the Medical Appointment Scheduling System, or MASS, as the Chair has pointed out, we are told that the project has been put on hold. At the same time, VA has continued with its own in-house initiative to update their scheduling system.

This seems like deja vu all over again to me. VA has already wasted 9 years, $127 million without an update to its scheduling system after finding a commercial product and abandoning that for an in-house solution that could not deliver an adequate update.

We cannot, and will not, let this happen again. And I can say that on a bipartisan basis, this is very frustrating for those of us who have been sitting here, and some of my colleagues much longer than I have.

I want to know what VA is doing to ensure that its scheduling system, EHR, and health care IT infrastructure are able to meet the current and future needs of our veterans. This means that VA must work toward developing a health care IT infrastructure that is interoperable with DoD. And I think some of us in the class of 2012 will remember, that was one of our very first hearings on this Committee was the frustration about the interoperability with the DoD, and the precious taxpayers that have been spent—taxpayer dollars that have been spent searching for a solution.

We need to ask, regarding VA health care and IT, how does this better enable the VA to do what it should be doing: serving our veterans, providing and coordinating health care for veterans all across our country. We need VA's businesses' processes to work so that community providers are able to treat veterans and receive prompt payment for providing care.

I continue to receive complaints from constituents in my district in New Hampshire that feel abandoned and forced to navigate their own care outside of the VA. I have community providers who have stopped participating in the Choice program because they are not paid on time, or the eligibility rules are simply too complex.

Our veterans deserve timely, high quality care. Health information technology has the potential to transform the VA into a leader in the delivery and coordination of health care, and a health care organization that leverages health technology to deliver the best

health care to our veterans. But VA needs to do its part to properly plan, implement, and oversee IT projects.

And I know that the two of you are relatively new to the organization, so we don't blame you for past faults. We certainly want to work with you going forward. But you need to understand that Congress cannot continue to give VA a blank check to spend on IT projects without results.

So I look forward to hearing from our witnesses on their suggestions and solutions. And I yield back. Thank you, Mr. Chairman.

Mr. COFFMAN. Thank you, Ranking Member Kuster.

I now yield to Subcommittee on Health, Ranking Member Brownley for any opening remarks she may have.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Mr. Chairman, and thank you, and Chairman Benishek, for bringing this hearing together, and I thank my Ranking Member Kuster for holding this hearing as well.

I will be brief because I think my colleagues have already laid out the issues that this Committee is concerned about. But I will say that our health Subcommittee has held a series of hearings on different aspects of the Choice program. We heard from VA on billing issues, eligibility, staffing, and provider networks, and most of them involved some component of technology that needed to be updated or fixed. It's fitting that we now hold a hearing on information technology and where the VA is going on this issue.

We know that, as the second largest Federal agency after the Department of Defense, VA runs the largest integrated health system in the country and is tasked with providing high quality, safe health care to eligible veterans. So we need, and our veterans need, a very strong and healthy IT program to deliver that kind of care. And I will look forward to the testimony this morning.

Mr. COFFMAN. Thank you, Congresswoman Brownley.

I ask that all Members waive their opening remarks as per this Committee's custom. With that, I invite the first and only panel to the witness table.

On the panel, we have the Honorable LaVerne Council, Assistant Secretary for Information and Technology and VA's Chief Information Officer. We have also the Honorable David Shulkin, Under Secretary for Health. They are accompanied by Dr. Alan Constantian, the VA's Deputy Chief Information Officer. I ask the witnesses to please stand and raise your right hand.

[Witnesses sworn.]

Mr. COFFMAN. Please be seated. And let the record reflect that all witnesses have answered in the affirmative.

Ms. Council, you are now recognized for five minutes.

STATEMENT OF DAVID SHULKIN M.D.

Dr. SHULKIN. Great. Good morning, Chairman Coffman, Chairman Benishek, Ranking Member Kuster, Ranking Member Brownley, and all Members of the Subcommittee. Thank you for the opportunity to discuss the progress being made by VHA and the Office of Information Technology, what we call OI&T, to provide veterans timely access to care. I do appreciate all the opening

statements. I think your candor and the issues that you want to discuss are exactly the issues that we think need to be discussed as well.

I'm pleased to be joined today, as the Chairman said, by the Honorable LaVerne Council, the VA's Chief Information Officer and Assistant Secretary for OI&T, and Alan Constantian, the Deputy Chief Information Officer for OI&T.

Ms. Council and I joined the VA at the same time, in July of last year. We went through the confirmation process together as partners. And during that process, we committed to continuing this partnership throughout the terms of our office. We began our work with one goal: to make VA work better for veterans. I'm proud to say that we are holding that commitment.

VA has a history of innovation that is deep and indelible, and we are proud to be part of it. The creation of the Veterans Health Information Systems and Technology Architecture, what we call VistA, is one of the flagship examples of that spirit.

Forty years ago, leaders of VHA recognized that technology in health care had reached a monument of mutual opportunity, a time when patients and clinical needs were growing more complex and IT capability was quickly improving; VistA was that result.

That initial visionary leadership, the recognition of a key moment in time, the collaborative partnership of the technologist, clinician, and the legislature led to the Nations first electronic health record and was the driver for today's health care environment.

But that was 40 years ago, and much has changed. The veteran, in 1975, had an average age of 46. Today, veterans average 60 years old. In 1975, we served 500,000 female veterans, today we serve over 2 million female veterans. In 1975, VA focused primarily on the physical needs of the average veteran, now we have an ever growing suite of comprehensive health care services such as prosthetics and mental health.

In 1975, VistA supported a handful of clinical processes, now it has over 200 applications, each having multiple processes, and there are over 130 different versions of VistA throughout VHA.

In 1975, the veteran was carrying a paper folded by hand between points of care. Today, the veteran is tech savvy, she has email, uses a cell phone, and wears a personal health tracker. As our veterans have changed, so has technology. We must keep pace and we must make the right decisions to do so.

We sit before you today with over 55 years of experience in transformational leadership. Today, we're bringing our years of industry experience and a sense of urgency, that Dr. Benishek called for, to our work at VA. As partners, we view every decision through that lens.

When Ms. Council and I arrived, the VistA evolution program was beginning its work on VistA 4. VistA 4 enables interoperability and focuses on care coordination, providing tools to better manage population health. Its development concludes in fiscal year 2018.

We sit before you 40 years after the creation of VistA and two years prior to its final development milestone, and want you to know we take our responsibility to do the right thing for veterans very seriously.

We want to be certain that continuous modernization of a 40-year-old electronic medical record is an appropriate decision, as well as our approach to modernizing scheduling. We are asking our teams very difficult questions every day.

Ms. Council demonstrated this commitment to asking difficult questions and taking difficult steps shortly after entering office. With the support of her team, she developed an actionable, far-reaching cyber security strategy and implementation plan for VA to Congress that was delivered in September of 2015 as promised.

VA, its core constituents, and external partners are all subject to a wide variety of cyber security threats. VA's enterprise cyber security strategy identifies key challenges and goals and is focused on building a comprehensive cyber security strategy that is aggressive, proactive, and addresses the unique needs of each of VA's business lines. This strategy is a major step forward in safeguarding veteran information and VA data with a complex environment, and we are proud of it.

Our approach to the Choice program, or care in the community, is an example of the success we can experience through a close partnership and critical evaluation. On October 30th of 2015, VA provided Congress with a plan to consolidate all VA's purchased care programs.

This transformation will require a stronger health IT platform that allows for bidirectional flow of information between providers and ensures continuity of patient care. The joint VHA and OI&T team are working to take on this issue, and meeting daily to ensure continuous progress and address obstacles. They are evaluating each health care and technology decision through a critical lens, ensuring we are making the right choices for the veterans and the taxpayers.

In all areas of our partnership, we must choose our path carefully and strategically as our work will lay the foundation for the next phase of VA's health care and technology environments. We are engaging industry leaders in technology and health care as well as domain knowledge for our teams to ensure that the path we choose is the right one.

As Ms. Council and I have the opportunity to evaluate more information from our health care technology initiatives, we gain more insight into which turn of the path will be the right one. We will share this vision with you this summer. We remain committed to making VA a better place for veterans, our employees, and taxpayers.

We appreciate the opportunity to appear before you today, and we'll be pleased to answer your questions at this time.

[THE PREPARED STATEMENT OF DR. DAVID SHULKIN APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you, Dr. Shulkin.

Ms. Council, do you have an opening statement?

[Inaudible.]

Mr. COFFMAN. Okay. Thank you, Dr. Shulkin. And the written statements of those who have just provided oral testimony will be entered into the hearing record. We will now proceed with questioning.

Ms. Council, what is VA's definition of sufficient capability in a scheduling system, and how did you determine VSE and VA—and how did you determine whether VSE and VAR met it?

Ms. COUNCIL. The requirements driven by the business in VSE and VOSVAR as well as the MASS decision were ones that were in place when we arrived. At the end of the day, we have a joint team led by business leaders as well as IT. The business leaders have really driven the requirements, and then the IT organization is responsible for creating the technology.

So we see it as one that would allow the veteran to get the demand met, and that we would have a clear understanding of the capacity to meet that demand.

Mr. COFFMAN. The plan was to pilot VSE and VAR alongside MASS and see which is the best solution. How did you rule out MASS—how did you rule MASS out before ever piloting it?

Dr. SHULKIN. Chairman, I would be glad to take that. We have not ruled out MASS, I want to be absolutely clear about that.

Here's the situation that we faced, and I appreciate that the frustration of Congress in this, and I appreciate the input that you will give us on this. But this is what made sense to us.

VSE is available today, right now, it's actually in the field being used. I agree with Ranking Member Kuster that the wait time crisis in 2014 was in part caused by an archaic scheduling system that is almost impossible to figure out. If you haven't seen it, this is our current scheduling system. It is DOS, it's what we used when computers first came out.

This is VSE. Okay? This is available right now, and this is in VAs today, in two VAs, soon to be eleven VAs with a national rollout in the next couple months. This makes scheduling errors a lot less likely to occur with this type of Microsoft Outlook type feel.

So let me just give you the numbers very quickly, why we put a pause on MASS, we did not cancel it at all. It is a contract that we can execute at any time. The entire VSE project, the national rollout, will cost taxpayers $6.4 million. It's available today; it will help veterans and schedulers today.

If we roll out MASS, which is an absolute option for us, the pilot alone will be $152 million. It will take us ten months to roll it out in three sites. The pilot, as you said Chairman, was to start in Boise, two other sites selected, three sites $152 million, ten months. And that's if VA stays on schedule with its pilots.

So we felt the very, very best decision for veterans and taxpayers—who we're trying to make these decisions for—was to roll out VSE because it's available today and we're going to get it all rolled out this summer, make a decision very, very quickly whether VSE meets all the needs for veterans and our employees and taxpayers, and if not, we'll proceed with MASS. We think that's a reasonable decision. If you have different thoughts on that, we're glad to hear it.

Mr. COFFMAN. Ms. Council, why hasn't VA implemented the FBCS upgrade to improve tracking of the paper claims?

Ms. COUNCIL. The requirements around paper claims are currently being developed with the care and the community team. We have the dollars, and the team is currently developing that capability.

Alan, do you have anything you want to add?

Mr. CONSTANTIAN. Only that we are—some of the VOCA funds that we have received, we are looking at the Fee Based Claim System and making the improvements that we see are most necessary in the short term.

Mr. COFFMAN. Okay. Ms. Council, what self-scheduling capability will VAR give veterans? How is it more limited compared to MASS?

Ms. COUNCIL. The best way I can explain MASS, MASS is a—is based on really capacity scheduling and work planning system within EPIC, so it's a much broader tool. It looks at everything, all your resources, your work flow, and everything, not just the schedule. And that's why it is a larger, more impactful set of solutions.

And VAR, is—which is the mobile device, which would allow the veterans to schedule, to cancel, for mental health as well as basic care, is currently also going through process. So DVAR is related to the mobile, VSE is the enhancements to VistA, and, of course, MASS includes not only scheduling, but the much broader workflow, capacity planning, and everything you need around BIZ, and DOCS, and Offices.

Dr. SHULKIN. I would just add, VA needs the ability to have veterans schedule appointments themselves. No question about it. That's what veterans want, and we want that for them. VAR, again, is available today. I spoke to a doctor last night who works at the Washington D.C. VA, and 25 of his patients at the Washington VA are using VAR.

So you can actually schedule mental health, primary care and cancel appointments on your mobile phone. It is planned to be rolled out to seven additional sites in the next month or two. So that is, again, an immediate solution. Whether MASS provides a better opportunity or not, I think we are going to decide that in the very near future, but our goal is to give veterans tools today because we still have an access crisis, and we have to act with the urgency that I think all of you have asked us to act with.

Mr. COFFMAN. Ranking Member Kuster, you are now recognized for five minutes.

Ms. KUSTER. Thank you very much, and thank you for helping us dive right into this. And as you can tell, we are not IT experts, so the acronyms can take us a minute.

I want to start, and I think I have asked some of you this before, but I just am curious. Couple years ago, I met with a company, the name of the company I believe is Zocdoc, do you know this story? So about efficiency because one of the things that we deal with—we want to serve the veterans and we are tasked with protecting the taxpayers, and the story that I hear over and over is veterans miss appointments because maybe they can't get a ride, maybe it is scheduled two months in advance and they don't get reminded, and this system is an IT system that improves efficiency by having reliable patients scheduled in the morning, less reliable patients in the afternoon, but you can double book in the afternoon so we don't have physicians waiting around for patients who don't show. Do you know about this? Have you talked to them? How could we speed this up? They could help you.

Dr. SHULKIN. First of all, I've known Zocdoc since they were little tiny start up in Manhattan in 2007. I can—

Ms. KUSTER. It just seems like one of those great ideas.

Dr. SHULKIN. No question about it. There are many, many commercial companies out there, Zocdoc clearly is a leader in that area, but I know this field extremely well. We need this capability, you are exactly right. This is what VAR was developed to do. Whether VAR meets all the requirements and whether we should abandon it and go with a commercial system, I think that we're open to that. What we don't want to do is start over when we have VAR that actually is ready to be put out into seven of our VAs—

Ms. KUSTER. So, and my time is limited I don't mean to be rude.

Dr. SHULKIN. Yes.

Ms. KUSTER. So VAR, you are in pilot right now for veterans to be able to self-schedule, and will that be tiered that way so it is done efficiently from the workflow end of things—from the VA end of things?

Dr. SHULKIN. It does not have all the features that you've talked about, about adding the ability to over book and capacity management. There may be some more features that may have what MASS has, and that's part of what we are going to evaluate. But what it begins to do is to let veterans schedule appointments themselves or cancel appointments themselves.

Ms. KUSTER. Which is also very important. My father-in-law used the VA, it is important to know when you can get a ride there, when it works for you. So, and then, I want to follow-up. So I am beginning to understand the big picture. MASS is a much bigger platform, it is going to be able to deal with the work processes, et cetera.

Can you give me a few specifics—two minutes and then lots of people are going to ask you the same question or more—what is the timing? What can we expect? And what is the cost? And we want to work with you, we want to solve this problem, we will go to our colleagues, Rs and Ds, and ask them for the funds, but we need some accountability.

Dr. SHULKIN. I will try to do it briefly and then ask Ms. Council if she wants to add anything. I think you mentioned this in your opening statement, the project cost for MASS is up to $624 million. The pilot alone for three sites would be $152 million. We have spent to date on MASS, in the planning, $11.8 million.

Ms. KUSTER. Okay.

Dr. SHULKIN. The entire cost for VSE, the alternative scheduling system, is $6.4 million.

Ms. KUSTER. Okay.

Dr. SHULKIN. The rollout for VSE would be over the summer to do a national rollout. The rollout for MASS would be a ten-month pilot at three sites—

Ms. KUSTER. Okay.

Dr. SHULKIN [continued]. —which we could start at any point if we want to. And then the rollout nationally beyond the three sites would be a much longer period of time. I don't have the exact, but I would guess it would be a year or greater.

Ms. KUSTER. Could we, my time is almost up, but it occurs to me, could we come and have a demonstration so that we could actually

understand? I mean, for the taxpayers, 6.4 million sounds better, but obviously it doesn't do the same thing, and we want long-term savings, long-term accessibility for physicians' capability for the whole system.

But the frustration we have is that we keep hearing about great systems and then we get halfway into it then it didn't work, so we gave that project up. And, you know, where I come from, 600 million that is a lot of money. That is a lot. So I am going to yield back, but I would love to—if we could work with the Committee to—

Dr. SHULKIN. We'd be glad to do that—

Ms. KUSTER [continued]. —schedule a demonstration so we have a better understanding.

Dr. SHULKIN. And what we're trying to say very transparently is, we think it's a lot of money too. We're trying to make the best decision for, exactly as you're saying, the veterans and the taxpayers, and everything's on the table. We'd be glad to show you this and get your thoughts on it. Anybody would be welcome.

Ms. KUSTER. That would be very helpful. Thank you. I yield back.

Mr. COFFMAN. Thank you, Ranking Member Kuster.

Dr. Benishek, you are now recognized for five minutes.

Mr. BENISHEK. Thank you, Mr. Chairman. Good morning. Ms. Council, in the past, you have testified that, thanks to a joint VA and DoD effort, we expect that interoperability will be certified with the DoD as defined by the 2014 National Defense Authorization Act eight months ahead of the December 2016 deadline. Well, that is where we are today. What is the story with that?

Ms. COUNCIL. We have an interoperability agreed to, we are interoperable with DoD on the JLV, that took place on April 8th. So DoD and VA have that handshake, and we are fully interoperable eight months ahead of schedule. In August—

Mr. BENISHEK. So if I go to the VA, then I can get the patient's DoD record for, not every veteran, but what is the story, how many veterans actually have access to the DoD if I walk into the VA?

Dr. SHULKIN. Yeah. So April 8th we've signed off on it, it is attested, we are interoperable. Today, 55,062 active users in VA and 60,000 users in the Department of Defense are able to do exactly what you're saying: able to get access to the records on any serviceman or member of the VA. And that number will grow to 120,000 during the course of this year of users.

Mr. BENISHEK. So VA personnel have access?

Dr. SHULKIN. 55,000 are using it today.

Mr. BENISHEK. How many veterans are in that?

Dr. SHULKIN. I actually do have that number. It is—let me get back to you, Dr. Benishek, with the exact number, but I was reviewing it last night, I think it's several hundred thousand veterans' records have already been accessed through the Joint Legacy Viewer.

Ms. COUNCIL. Exactly.

Mr. BENISHEK. Yeah. Well, that is the key issue, right?

Dr. SHULKIN. Yep. Oh, here—I'm sorry—what? 457,265 veterans are—oh, that's through the Health Information Exchange. Let me get you the exact number through the Joint Legacy Viewer.

Mr. BENISHEK. All right. Well, you understand the point I am trying to make is that so 60,000 VA employees have access, but are there, are we actually taking—is there a significant amount of veterans that we have access to those records? So that is a key issue. I would appreciate that.

The other issue that I am interested in, and it has already come up a little bit in testimony, is the self-scheduling piece. As you know, in the private sector, people schedule their own appointments. So you talked about it a little bit with an app, but that doesn't help most of the veterans that I deal with, because they can't figure out how to use an app on their phone, you know what I mean? That is just a limited amount of people I think. So what is the timeline for that, and how is that going to actually work for most people?

Dr. SHULKIN. Well, you're right, there are two ways to give veterans more control of the experience of scheduling appointments, which is what our goal is: to put health care back in the hands of the veterans. So there is the app, and increasingly more and more people are comfortable with smart phones, but even—the veteran population does lag behind the general population. So we have to wait until more people catch up on that.

The other way, of course, is the telephone. And this past week we announced something called the declaration of access that will put the decision about scheduling and canceling appointments into the hands of the veteran. We have a system right now that's very, what I call, paternalistic, which is called a recall system; we actually tell you when you're going to come for your appointment.

Mr. BENISHEK. No, no, I—

Dr. SHULKIN. We're going to stop that.

Mr. BENISHEK [continued]. I understand that problem. So is the eligibility going to be all figured out in advance then? Will the patient have an opportunity to schedule an appointment in their locale in the private sector or at the VA? Tell me how that's going to work.

Ms. COUNCIL. Actually, the largest users coming on JLV are actually the VBA in the benefit side so they can be ahead of the eligibility question. We only expected to have about 35,000 users of JLV, and we are actually—

Mr. BENISHEK. JLV, what's JLV again?

Ms. COUNCIL. The JLV is interoperability capabilities. So you can see—the Joint Legacy Viewer—so you can actually see the eligibility of the active duty soldier, and then, why they would be eligible as a veteran. It's really important that the—it's interesting that the VBA is really one of the bigger users now, and that's really helping to make this eligibility happen faster and much more accurately.

Mr. BENISHEK. I guess I don't quite understand that. But I want to follow-up with you later since I am out of time.

Mr. COFFMAN. Thank you, Dr. Benishek.

Ranking Member Brownley, you are now recognized for five minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman. I just wanted to go back to the Joint Legacy Viewer, and you said you were going to give us the number of veterans that are on there at this particular

point. But I am just curious to know, is it generally within the population of new veterans or is it, you know, veterans after 1975, or is it just a random number of veterans across the spectrum?

Ms. COUNCIL. No, it's not random at all. It is the holistic look at the DoD's—

Ms. BROWNLEY. No, no, no, I know, just in terms of the capability we have right now in terms of numbers of veterans, you know, within the system that users can actually see. So I am just wondering, is it sort of—did you start with the most current ones and go down a list or is it random across the board?

Ms. COUNCIL. No, it's not random. It's just taking the information that the DoD holds and actually finding that veteran and mapping it with the information that the VA has if they are coming into the VA. So it doesn't take it based on newest first or easiest first, it is the active duty records tied with the current state health records.

Ms. BROWNLEY. Right. But right now it is limited because it only has a current amount of veterans—

Dr. SHULKIN. Uh-uh.

Ms. BROWNLEY. No?

Dr. SHULKIN. No.

Ms. COUNCIL. No, no.

Ms. BROWNLEY. Okay. Then I am misunderstanding.

Ms. COUNCIL. No, I think what we're talking about are users. When we say users, those aren't actually patients, those are users, docs, the people that leverage information.

Ms. BROWNLEY. Okay. Okay.

Dr. SHULKIN. I did find the number I was looking for that Dr. Benishek asked for, which is that we just, last week, reached more than 1 million record lookups in the Joint Legacy Viewer.

Ms. BROWLEY. Okay.

Dr. SHULKIN. So those are veterans.

Ms. BROWNLEY. Okay. Very good. So on the scheduling piece, it—so for the Choice program then, veterans—will veterans be able to call the VA, find out if they're eligible, and then make an appointment with a community doctor? How will that work?

Dr. SHULKIN. Well, today—

Ms. BROWNLEY. I mean, because some of that problem—

Dr. SHULKIN. Yes.

Ms. BROWNLEY [continued]. —with the Choice program—

Dr. SHULKIN. Yes.

Ms. BROWNLEY [continued]. —is waiting for the VA to say whether you are eligible or not.

Dr. SHULKIN. Today, we follow the current rules of Choice—

Ms. BROWNLEY. Right.

Dr. SHULKIN [continued]. —which is to use the TPA—

Ms. BROWNLEY. Yep.

Dr. SHULKIN [continued]. —where you have to call and get—

Ms. BROWNLEY. But ultimately—

Dr. SHULKIN [continued]. —eligible through them.

Ms. BROWNLEY. But ultimately will we get to a place where the veteran knows he or she is eligible and can make the appointment with a community doctor?

Dr. SHULKIN. That's exactly our hope.

Ms. BROWNLEY. Very good. And so another question that I have. It seems as you lay it out, VSE versus MASS, it seems like you are making the right decision going down a path that is going to be veteran-centric, help the taxpayers, and a quicker timeframe. So that all, you know, that all sounds really good. My concern is, are we building that system on a sort of a weaker foundation, i.e. VistA, you know VistA was at one point in time way back when, you know, a state of the art system, it is no longer and so, as Ms. Kuster was asking, you know, the longer-term ramifications here are we building a network of strength that is going to sustain over a period of time and really make the VA veteran-centric, veteran friendly system?

Ms. COUNCIL. Chairman Brownley, actually Dr. Shulkin and myself had this conversation the end of last year and we decided that we needed to lay out a new strategy as it relates to EHR and what a great veteran experience health care system would look like because it is time.

The EHR today is really just the heartbeat of the organism, but it does not have everything that is needed to mandate and manage care in the community to deal with the needs of the female veteran, and also to support just the overall veteran experience and the clinical management.

I have given to Dr. Shulkin the recommendation around a state of the art, world-class system. He is evaluating it from a clinician's point of view, which is the appropriate thing to do, and that's what he's laying out is, the summer would be when we can unveil that as this is what we suggest that the VA does.

What I will tell you is, it is incredibly responsive, it is aligned with the world-class technology that everyone's seeing today, using today, and things like Facebook and Google and other capabilities. But it also is agile and it leverages what is called a FHIR capability, which is FAST HEALTH INTEROPERABILITY RESOURCES, which means we can bring things in, we can use them, we can change them, we can respond.

And so when he and I spoke about it, we sort of did the right leap and we said what we are going to do. We believe that VA is an innovator, we believe that VHA and health care should continue to be one, and we have provided innovative solution based on industry experts coming back and assessing it as that.

Ms. BROWNLEY. Thank you. I apologize, Mr. Chairman, and I yield back.

Mr. COFFMAN. Thank you, Ranking Member Brownley.

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

Mr. LAMBORN. Yeah. Thank you, Mr. Chairman, and thanks for having this hearing along with Dr. Benishek.

Ms. Council or Dr. Shulkin, I understand you are working on another contract to provide program integration support to the Choice consolidation, and it has IT and non-IT elements. Are you going to combine the IT work with the non-IT work or separate them?

Dr. SHULKIN. As you know, we have asked for the access to the 802 funds to be able to improve the Choice program. Of the $421 million that we have asked for to build the infrastructure for the new veterans Choice program, about $300 million is for IT and the

rest are non-IT costs. So they are essentially combined at this point into the combined $421.

Mr. LAMBORN. Okay. Okay, good. That was good for background. Ms. Council, your written testimony says "VA has obligated $510 million in development funds to build VistA capabilities since fiscal year 2014. VA has also obligated $151 million in IT sustained funds, and $110 million in VHA funds."

So with all that spending, what new capabilities does VistA have as a result of this money spent?

Ms. COUNCIL. From 2013 until now, enabling interoperability, doing the JLV, putting in what is called eHMP, which is our web capability, which is actually a long-term interoperability, fully interoperable with DoD solution, which we're moving to. So the JLV, the Joint Legacy Viewer, is part of the solution, eHMP is the web abled which moves you to a fully interoperable data set working with DHMSM (Defense Health Management Systems Modernization).

In addition, there have been clinical needs, lab needs, and different things like that implemented into VistA. Also stabilization. When you look at the sustainment costs, what you're really seeing there is the maintenance costs for the 130 different instances of it, keeping the data centers up, and all the equipment related to that. And that's what's in sustainment.

Mr. LAMBORN. All right. Dr. Shulkin, if a VA hospital is manipulating wait times, as we have seen with some of our OIG reports, how is a self-scheduling system like VAR going to put a stop to it? In other words, couldn't someone—and I hope this would never happen, but, like I say we have seen otherwise—couldn't someone just change the information in VAR on the back end?

Dr. SHULKIN. Your concern is one that we are very, very concerned about. We have 25,000 employees doing scheduling today. So that's a large system to have everybody doing it exactly right all the time.

There are two things that will help. Number one is VSE, this is the new scheduling system, and makes the likelihood of committing scheduling errors that we have been seeing less likely, because it's a—instead of that DOS system, it's a much more intuitive system that actually hard codes some of these decisions so you can't change them as easily.

The other is VAR, which is where the patient will schedule directly, would be very hard to change the data. Once the veteran—it's like a transaction in your bank account, you know, once the veteran pushes the button, it schedules it and it records it with an electronic, you know, digital print. So it would be much less likely that there'd be individual manipulations.

Mr. LAMBORN. Okay. Thank you. Mr. Chairman, thanks for having this hearing. I yield back.

Mr. COFFMAN. Thank you, Mr. Lamborn.

Mr. O'Rourke, you are now recognized for five minutes.

Mr. O'ROURKE. Thank you, Mr. Chairman. Secretary Shulkin, I really appreciated your opening comments and the harkening back to the spirit of innovation and leadership that allowed the VA to develop VistA and the Nation's first electronic health record in the first place. And in answer to some of my colleagues' questions, tak-

ing the long view on how we establish a base and a platform from which we can do great things again. I think that is the spirit that we need to approach this with.

And I know it is a real challenge because there are some basic questions of competency right now in the VA that are totally legitimate, and I think many of us and our constituents want to make sure that we at least reach competency but that cannot, be the goal, I mean, it has got to be excellence.

And I think in whatever the VA evolves into over the next 10, 20 years, the ability to schedule and expertly manage the patient's medical information, share it between the VA and DoD, and then VA and community providers, is critical.

And so I just want to make sure that we are approaching these challenges the same they did 40 years ago, let's find out whatever they were drinking back then and make sure we order a case of that for you and your team, approach this with that same vision towards innovating in medicine globally.

I mean, that is the VA's rightful role, and that is what we should expect for our veterans. And I really think your vision that you outlined with us in October, which focuses the VA on where it can truly excel, and then leverages capacity and competencies in the community that complement what the VA does is the way to get there. I think that allows you to focus on what you can do really well.

So, I wanted to make that statement to just compliment you on your approach. And really, my only concern is that you just started in July, and if conventional wisdom holds, you will leave at the end of this administration. It is my sincere wish, and I will do everything I can to make it happen, that our next President keeps this team in place so that we have the continuity and consistency to carry this out. I think that is really important.

What are the near-term milestones—and I know you have answered this question in different ways from different colleagues—what are the near-term milestones that will lay to rest any concerns we have about competency, and then also about executing a long-term vision that is going to allow the VA to develop excellence in this field? What should we be looking for in the next seven to eight months?

Dr. SHULKIN. Thank you, Congressman, for your comments.

Let me just make one historical correction to this. The truth is, the history of innovation with the EMR in VA was actually that the administration did everything they could to stop EMR. It was actually done by the people in the field who had to hide their efforts until an Under Secretary, Ken Kizer, actually said you're allowed to bring this out of the basement into the field.

So we're trying not to make that mistake. We're trying to actually innovate and to help the field actually give us the feedback so that we can do what you're asking us to do.

Mr. O'ROURKE. That is great.

Dr. SHULKIN. I think the short-term objectives that we have are really to focus on the veterans' needs. This is why when we're rolling out the VistA scheduling evolution, when we're rolling out the VAR, the self-scheduling application, our evaluation criteria are asking veterans did we meet their needs.

And so those are the short-term goals, and we should have this information very, very soon, this summer. As we're rolling out both VSE and VAR, we are doing constant evaluations asking our veterans are their needs being met in terms of access.

Mr. O'ROURKE. So the milestone measurement is determined by the veterans themselves?

Dr. SHULKIN. Yes.

Mr. O'ROURKE. And it is not the VA directly asking, or is it, that, or is there a third party whom we can trust that has got an objective distance from the VA to make sure that we are really getting the unvarnished truth about the success of this? That would be my preference.

Dr. SHULKIN. Yeah. Yeah. Yeah. And it's a little bit of both. The way that we're asking our veterans is actually several ways. One is, we use a standardized Federal government survey that is, in the government, called a CAHPS survey, which is done by every health care institution, that is done by a third party. So we hire a third party to administer that.

We also ask our veterans when they come to appointments, there's a kiosk, so we actually, in the kiosk ask them, how satisfied are you with the ability to get this appointment when you needed it? So they're entering that data.

Mr. O'ROURKE. And I will just say this real quickly as I wrap up. I think it is critical that we ask those veterans not physically in the VA because there are many who could not get an appointment, and we want to know about their experience just as much or maybe more so than we do about those who could get in.

And as you have heard me say countless times, especially when it comes to mental health because of the connection to veteran suicide, got to make sure that we know about their experience in being able to get an appointment, and then the VA honoring that appointment.

Dr. SHULKIN. And we generally get that feedback from you.

Mr. O'ROURKE. Thank you.

Dr. SHULKIN. Yeah.

Mr. O'ROURKE. I will yield back to the Chair. Thank you for your answers.

Mr. COFFMAN. Thank you, Mr. O'Rourke.

Ms. Walorski, you are now recognized for five minutes.

Ms. WALORSKI. Thank you, Mr. Chairman. Dr. Shulkin, you had already addressed, I think twice, on VSE and VAR the cost—the initial rollout cost and that kind of thing. Do you know what the lifestyle costs are to run those two programs?

Dr. SHULKIN. The sustainment costs?

Ms. WALORSKI. Yeah.

Dr. SHULKIN. I don't know that.

Mr. CONSTANTIAN. Well, there are no marginal additional sustainment costs in VSE. VSE is an augmentation of the VistA scheduling package, so the same funds that would go toward the support of the VistA scheduling package will be sufficient to support the enhanced VistA scheduling package with the VSE enhancements.

Ms. WALORSKI. Okay. And, you know, I am kind of asking that question because I am sitting here listening to this, I am cautiously

optimistic, and I appreciate what your team has done, I really do, because I think you have taken great steps forward.

And to kind of just echo some of the questions my colleagues had. You know, I haven't been here long, but in the four years that I have been here this issue with IT seems to be the one that continues to bounce back with some of the best efforts that have gone forward, and best trials, and then seems to bounce back, and all of a sudden—I will never forget the hearing where, you know, the VA was a billion dollars short and you needed that to go in the future.

So I am cautiously optimistic, but I—Ms. Council, in your written testimony, you say that "The JLV provides limited VA to DoD medical records sharing compared to the eHMP," you are working on now. Is it true in order to make eHMP work, you have to get rid of VistA's old user interface and implement a new one that integrates with the 'Net—with the Internet?

Ms. COUNCIL. You actually have to integrate it into the Web. And so you have to go through one at a time and lay that in—

Ms. WALORSKI. So you don't need to get rid of the old VistA program?

Ms. COUNCIL. No, it actually can still live.

Ms. WALORSKI. Okay. And then my final question, I think you may have answered this is, Ms. Council, OIT is strongly advocating Agile Software Development and Project Management, what specifically is OIT doing different now? VA's been talking about its leadership in Agile among agencies since 2014.

Ms. COUNCIL. Yeah. I'm excited about this. One of things that you should have received was the VIP Process, which is now standing up, that is our Enterprise Portfolio Management Office. That is our intake process. So if you look at PMAS and you compare it to what we're doing now with full Agile and VIP, we reduced the time that we were spending in document preparation by 88 percent.

We went from 55 documents to 6 plus available to operate. We are in a full Agile capability which means that you're following the 80/20 rule, which we will be able to produce in 70 percent faster time with better quality. We have the intake process which allows us to assess the business case. And if something does not have a viable business case, it will not get done.

Ms. WALORSKI. I don't want to interrupt, but let me just ask you this. So I really do think your presence to this conversation has been incredible. I really think you have brought this so much farther, so much quicker, than some of the folks have in the past. And so I really appreciate what you have done and how open you have been with our Committee.

And I guess, you know, from my perspective, and you know, we—-I really want this to work—

Ms. COUNCIL. Uh-huh.

Ms. WALORSKI [continued]. You know, I want the calls that we get in our office to decrease. I want our veterans to actually find a seamless, smooth transition, and I want this to work, you know, just as much as they do. And I am concerned, you know, as we talk about, you know, another rollout, another this, another that, and to echo what Congressman O'Rourke just said, is there a plan in

place, given the political realities of how this continuity often gets interrupted, is there a plan now, for example, that says no matter who is behind this seat, this is what is going to happen? That actually is a plan in place that really is not going to be changed in another, you know, another development program with another, you know, 20 million dollars or whatever? Is this going forward regardless?

Ms. COUNCIL. Yes, that was the main purpose of how the strategy was defined, because that was my biggest concern. I didn't want to spend the effort, either, and not see the team continue. So, you know, we've added an additional 11 new leaders within OI&T. We've added seven new senior leaders who will be out into the field.

Ms. WALORSKI. And let me just ask you about those leaders.

Ms. COUNCIL. Yeah.

Ms. WALORSKI. Are those leaders competent in the private sector, competent folks like when you came in, and you come in with all those competency and expert—are these the same kind of 11, or are these people that are just elevated inside the VA?

Ms. COUNCIL. No, these people are coming from outside in private industry as well as from other agencies. They're highly rated and we are very competitive. I am excited to say that when we look at, even our—actually, Dr. Constantian here is an account manager for VHA and that's why he's here. There are now standing account managers within OIT that didn't exist before, so that we actually have a head to head relationship with our business partners and having aggressive conversation about the work that we're doing, and how we're spending our dollars.

Ms. WALORSKI. I appreciate it. I am out of time. And I appreciate it, Mr. Chairman. I yield back.

Mr. COFFMAN. Dr. Ruiz, you are now recognized for five minutes.

Mr. RUIZ. Thank you, thank you. Last year in testimony to this Committee, Secretary McDonald said the following regarding the VA's accomplishment, quote, "We were the ones that discovered that aspirin was important for heart disease, first liver transplant, first implantable pacemaker. Last year, two VA doctors invented the shingles vaccine. That research is important for the American people, and I didn't even mention PTS or TBI or prosthetics, things we are known for."

So, Ms. Council and Dr. Shulkin, please explain why the VA is unable to develop or acquire the technology possessed by most modern health care systems and required to efficiently share health records and schedule appointments, yet can continue to make such progress in other areas of the Department. What are your logistical and political barriers?

Dr. SHULKIN. We appreciate the question and the recognition of VA's track record of innovation. VA is a leader in electronic medical records. There is no system that has the extensive experience with EHR than VA. I will tell you, I've spent my life practicing in the private sector. I've now practiced in the VA system. It's my first time using the EHR. And our clinicians really like the VistA EHR. What Ms. Council is saying is, and I think what Congresswoman Brownley was getting at is, the world has changed a lot. And is this 40-year-old EHR going to be the system that VA should stick

with for the next 20 years? And that's where Ms. Council is saying we owe it to veterans and to all of you to make sure that we believe that's the right answer, and that's where I—

Mr. RUIZ. I think you got to be careful with that notion, because health care information, diseases, recordkeeping changes, and it is flexible, so you can't make a guarantee that what we have now is going to last 15 years, because we don't want it to last 15 years. We want it to change with the ever needs of the patients and the community. And so you have got to, you know, manage some expectations that the information we get changes. So I don't, you know—if you say you are going to pick one, and then you are going to keep that same one for the next 15 years, then you are setting yourself up for failure. And you are also going to keep an archaic, 20 years from now, system in place just because you have committed to that.

Dr. SHULKIN. I think we're—I may not have been articulate enough, I think we're agreeing with that—

Mr. RUIZ. Okay.

Dr. SHULKIN [continued]. —which is saying today, VistA is actually 130 separate VistA systems, and new technology puts stuff in the cloud and makes it a singular system so you can be more agile and change it.

Mr. RUIZ. And I think one of the most important things you can do other than creating a more modern, flexible system that matches the needs of the patients and the doctors where you practice, in order to provide the best care, is to make it interoperable with the private sector, and in the private sector they are having difficulties in doing that themselves—

Dr. SHULKIN. Right.

Mr. RUIZ [continued]. —so it would be helpful if you could lead the charge to make sure that you do that, because, if I am an emergency physician, and I see a patient that is a veteran, and I can't get the last CAT scan to compare their abdominal CAT scan or I can't get their latest EKG, then I am limited in the decisions that require resources that I can make and more than not, because I care about the patient, I tend—you know, I will not take the risk for the patient, and I will do what I need to ensure that the patient is going to be healthy. And that means more cost, simply because I can't access a CAT scan or an EKG from another institution.

Ms. COUNCIL. Exactly. And so, Congressman, we assessed the solution that we've laid out, the one system, actually does that in the cloud using software as a service. It builds around, I have mentioned earlier, the FHIR concept, which is Fast Health Interoperability Resources, which allows you to pull those resources together, use that information, and redeploy it back out.

Mr. RUIZ. With the private sector, not within—

Ms. COUNCIL. Wholly with the private sector, and we believe that the VA should be the leader in this, as the largest health integrator, and actually drive that forward on an HL7 platform.

Mr. RUIZ. Thank you. I yield back my time.

Mr. COFFMAN. Thank you, Dr. Ruiz.

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

Mr. HUELSKAMP. Thank you, Mr. Chairman. Chairman, I appreciate this joint hearing on this topic, and I apologize for my tardiness.

I want to follow-up on just a few things, and I apologize if they have been covered before. But the strategic hold on the MASS system, can you describe that for me, if you haven't already for the full Committee, and I was kind of curious what a strategic hold is versus a non-strategic hold?

Dr. SHULKIN. I'd be glad to do that briefly, Congressman. We do have a contract with MASS and we could execute that at any point. We've decided since we have a system that's currently available, VSE, VistA Scheduling Enhancement, that is being rolled out as we speak to VAs, to roll that out because it's in the best decisions right now since it's available to veterans, and to taxpayers to do that. We will have that done over the summer and be able to evaluate did the VistA Scheduling Evolution meet the needs of veterans, and if not, then we'll proceed with a pilot for MASS, which would be a ten-month pilot at three sites at a cost of $152 million.

Mr. HUELSKAMP. So what have you spent on MASS already, and that is all on hold, and that—

Dr. SHULKIN. Yes.

Mr. HUELSKAMP [continued]. —if it doesn't go forward, we would lose all that—

Dr. SHULKIN. Yes, $11.8 million to date on MASS, already. The VistA Scheduling Enhancement total cost is 6.4 million.

Mr. HUELSKAMP. Yeah, and VistA, that is—you talk about rolling it out, it is still just pilot, correct? We are not rolling anything out, we are still testing it, beta testing it?

Dr. SHULKIN. Yes. Today, it's actually being used in two sites, in Asheville, North Carolina, and Salt Lake City. I have the user evaluations which I reviewed last night, which are tremendous in terms of its receptivity. It's planned to roll out to 11 more, or 11 total VAs by the end of this month or within six weeks, and then the national rollout.

Mr. HUELSKAMP. You mentioned Salt Lake City. I am looking at the testimony, I don't see that on the list of the—

Dr. SHULKIN. Yeah.

Mr. HUELSKAMP [continued]. —the VSE IOC sites?

Dr. SHULKIN. Yeah, I'll be glad to share—actually last night, I have it on me, I'll be glad to share the user feedback from Salt Lake City.

Mr. HUELSKAMP. Okay. How seriously did you consider a commercial alternative to the contract, which apparently strategic hold could be abandoning that work and doing it with VistA? Strategically, what did you consider on the commercial side, and I know Zocdoc was mentioned, I haven't used that. I was looking at it preparing for this hearing, but describe the process by which you decided not to use any commercial alternatives.

Dr. SHULKIN. Well, MASS is a commercial alternative. It's made by the Epic Company, which is a leader in health information systems. It was selected through a competitive process, and we do have an IDIQ contract with them that we could execute at any point.

Mr. HUELSKAMP. It is an operating system?

Dr. SHULKIN. Oh, yes.

Mr. HUELSKAMP. And so you spent how many dollars just to—

Dr. SHULKIN. Eleven point eight million.

Mr. HUELSKAMP. Did you ever use it as a pilot program—
Dr. SHULKIN. No.
Mr. HUELSKAMP [continued]. —or at least try it?
Dr. SHULKIN. Nope, the pilot program would be $152 million to implement because of all the interfaces and the spreads, so that's the decision which we're facing right now. We decided, you called it a strategic hold, is that it's in the best interest of taxpayers before we proceed with the $152 million, to see if VSE, which is in the field now being rolled out, meets the needs of veterans. If not, we can proceed with MASS.
Mr. HUELSKAMP. Still, maybe you can follow-up with something later if—went down the MASS road for a while and then apparently have abandoned it. Strategic hold is your name, not mine, and I am just trying to figure out how we got there. Now we are back on something that has, you know, been around for decades, and trying to make that work.
Another question, and more directly, or I guess more broadly on this, does anything in the Choice legislation or other current statutes require you to set up a system in which a contract or a third party or somebody other than the veteran can make their own appointment?
Ms. COUNCIL. Not that I'm aware of.
Dr. SHULKIN. I'm not aware of that in the legislation.
Mr. HUELSKAMP. So you are free to do that?
Dr. SHULKIN. Yes.
Mr. HUELSKAMP. And that is what bothers me more broadly, I think we are still—what I am seeing is just kind of this attempt at pushing through a model which doesn't work, in my opinion, in the 21st century. Maybe it works for a few folks. But it is also, for instance, we have got another system out there with many of the veterans who are in other systems. Many of them are in Medicare, and this is not the Medicare system at all. We don't require you to go through Medicare to make an appointment, but somehow it looks like the track is still push veterans through this system. Can you describe a little bit more why we still think we have got to push it through a system rather than letting, you know, something like a commercial term where you don't have to call the VA, you don't have to work through the contractor, you call the hospital and do like you do for Medicare.
Again, these veterans, many of them, go through the Medicare system. That was one of the concerns that the cost would be so great of Choice because folks would, yeah, abandon Medicare or other options because the VA system would work so well, and not quite happen that way. So but just, more description of that, I am concerned about still trying to put us in the same old model from 30 or 40 years ago, which I don't think fits our needs of veterans in this century.
Dr. SHULKIN. Yeah. VA has a long history of using care in the community for veterans. We've been doing this for a long time. You used to have a system, I think like you were describing, where veterans would seek care in the community, and we would go and schedule it, very similar to the way that you schedule with Medicare. The Choice legislation did require—

Mr. HUELSKAMP. If I interrupt, with Medicare, they don't schedule the appointment, do they?

Dr. SHULKIN. No, and so I think what you're describing now, where we're seeing so many complaints is the veteran needs to go to the TPA to access Choice. And so that has added a level of complexity. And this is where we've submitted legislation for your consideration to try to simplify and streamline these care in the community programs. Because we agree with you, it's too complex today.

Mr. HUELSKAMP. Yeah, that is why I asked first and this is—do we need any legislative changes to allow the veteran to make their choice directly, and I don't think so. But I appreciate that. With that, Mr. Chairman, I yield back.

Mr. COFFMAN. Thank you, Mr. Huelskamp.

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

Mr. TAKANO. Thank you, Mr. Chairman.

Is it Dr. Shulkin? There are some aspects to the legacy VistA system that you definitely want to see preserved and continued; am I understanding that correctly?

Dr. SHULKIN. I think there are many, many good things about the VistA system and VistA Evolution, which is the newer sort of what we call eHMP, it's the web-based version; it also has many, many great features. I think at the same time, what Ms. Council is saying is, is that she wants to make sure, and we're going to do this together, that this is the appropriate technology for the future of VA.

Mr. TAKANO. And you are going through that evaluation process now?

Dr. SHULKIN. Yes.

Ms. COUNCIL. Yes.

Mr. TAKANO. Okay. You know, I mean, I heard about the 130 separate systems, you are going to use the cloud, and try to get it all sorted together. And you are also looking at possibly a major replacement, or not. You are sort of trying to figure all of that out; is that correct?

Ms. COUNCIL. We actually have defined a new technical digital health platform for VHA. It's currently being looked at by the users, and I am currently looking for an ability to build the prototype, so that we can show it to you, but also, so that the users can play with it. It leverages EHR as a health record and does not have all that complexity that VistA has in it, and so we're agnostic as to which VHR, but it also is in the cloud, it's highly agile, and it's highly interoperable with care in the community, the DoD, and anyone else that we'd have to engage with on behalf of the veteran.

Mr. TAKANO. So that leads me to this next question. Dr. Shulkin, in your testimony you mentioned much of what, is it Dr. Council, or is it Ms. Council?

Ms. COUNCIL. It is sometimes, it depends on whatever you want—

Mr. TAKANO. That the VA plans to expand partnership with health information exchanges that are outside the VA—

Dr. SHULKIN. Uh-huh.

Mr. TAKANO [continued]. —or HIEs to improve access to health information between the VA and community providers. I want to

mention that we have a very, very successful HIE in the Inland Empire, the region of California that I represent and Dr. Ruiz represents, and we, actually by the end of the year, expect that health information exchange to include all of our hospitals in our region, a three million population strong, and we even—in other parts of southern California, other parts of California rather than start their own HIEs are actually leveraging off the work that our HIE has done. I understand it supports nine million patient files.

Dr. SHULKIN. Uh-huh.

Mr. TAKANO. And by the end of the year, it will include all the hospitals by the end of the year. How has the outreach to HIEs gone, and what challenges do you face as you look to form partnerships with HIEs such as the one I just described?

Dr. SHULKIN. Right. I completely agree with you, Congressman. When I was running hospitals prior to taking this position, I was participating in functional HIEs. So VA wants to be part of these regional HIEs. We currently are partners with 71 today, 71 HIEs active throughout the country. That's where it does impact 475,000 veterans today, where we're exchanging records with 713 hospitals as part of these 71 community partnerships. So we want to expand that. It's the future, and it's the only way that you're going to make community care and VA care work as an integrated network.

Mr. TAKANO. And what is your timeline for that? What is your timeline to get that done?

Dr. SHULKIN. It goes region by region, because as I said, some regions are really pushing it and others are a little bit slower to get there. But part of what we're doing with the revised care in the community program that Representative Huelskamp asked about, we are using the 421 million dollars to accelerate a VA portal into these HIEs.

Mr. TAKANO. And how—of the 77 that you already are doing partnerships with—

Dr. SHULKIN. Uh-huh.

Mr. TAKANO [continued]. —how meaningful is the interoperability?

Dr. SHULKIN. It's an exchange of documentation, an exchange of lab information, medical record information, it's what HIEs do. I mean, there's no—you don't enter new data into it, it's really read-only capabilities.

Mr. TAKANO. Okay. Thank you, Mr. Chairman. I yield back.

Mr. COFFMAN. Thank you, Mr. Takano.

Dr. Shulkin, using VAR, can the veterans actually see a calendar for available appointment slots?

Dr. SHULKIN. Yes, Mr. Chairman. In relatively limited today, primary care and mental health. But they can see what appointments are available to them so they select what's best for them.

Mr. COFFMAN. And what happens if the veteran requests say, three dates that are not available? What would occur in the system?

Dr. SHULKIN. I assume that if it's not working for them, because I would call that not working, I'd be frustrated. They have to pick up the phone and call.

But Alan, do you have a better answer?

Mr. CONSTANTIAN. If the three dates they selected with the VAR system were not available, they'd have to either pick up the phone, as Dr. Shulkin said, or make a subsequent request.

Mr. COFFMAN. So let me just say something. I think we are coming full circle on this, that we instituted a Choice Program because of problems in the VA scheduling system. Secretary McDonald was in Denver, Colorado last weekend, and his statement about the so-called quote-unquote scandal was that it was merely a lack of training of VA appointment personnel. I differ with that. I think it was fundamentally due to corruption, that they had manipulated the system in creating a secret list in order to get cash bonuses. And, you know, there is not even an acknowledgment of that. I think only six people out of what was a systemic problem were held accountable, that were responsible.

And so, I am very concerned about turning the—going full circle and giving it back to the people that created this problem, that caused us to enact the Choice Program. And where we have programs like Medicaid, Medicare, TRICARE, that, don't require that and so I just want to state my reservation about this. I think there are some other things that are being worked on that are very important. Obviously, I had a discussion about cyber security yesterday, and I was very disappointed in the answer that I received on that. But I just have—I think there is a cultural problem here that has not been resolved.

And, let's see. Ms. Brownley? You are now recognized for five minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman. I appreciate it.

I just wanted to follow-up on my line of questioning earlier with regards to, you know, the core VistA system, and it is my understanding that the independent assessment recommended the VA conduct a cost-benefit analysis between a commercial, off the shelf product and/or continuing the use of the VistA health record currently in use. So is the VA currently undergoing that, or what are we doing?

Ms. COUNCIL. We actually—

Ms. BROWNLEY. It sounds like you are thinking a lot about it—

Ms. COUNCIL. No, we actually have done the business case. The business case analysis was done last fall. Based upon that, we decided that the right thing to do is lay out the new digital health platform, because that's really what's needed for the future.

Ms. BROWNLEY. Uh-huh.

Ms. COUNCIL. If VHA is going to provide health care in the future and today, it needs to move into a digital platform, and that's what we have laid out. We're building the view for it, so people can see what we're talking about, and Dr. Shulkin is looking at it from a functional point of view and the user.

Ms. BROWNLEY. So when you say you have done a business analysis, that is not really a cost-benefit analysis, is it, or—

Ms. COUNCIL. The business case is a cost-benefit analysis—

Ms. BROWNLEY. Okay.

Ms. COUNCIL [continued]. —looking at the overall long-term ability to maintain it, what it would take if we wanted to change it, how could we get it onto an architecture that is more agreeable and agile so they can move and change as health care is changing.

Ms. BROWNLEY. Uh-huh.

Ms. COUNCIL. Also, how would we work with the care in the community, but fundamentally four core things need to be in a health care system. You need to have clinical management, you need to have hospital operations capability, you also need to have the veteran experience core to what we offer, and you have to have predictive analytics. We do not have that today with VistA, and so we decided to pull and build the new digital health platform to address it after reviewing that business case last fall.

Ms. BROWNLEY. Okay. Very good. And, you know, I would like to know more about the digital health platform and all of the different possibilities in terms of how it can support veterans and their needs.

I know I mentioned this to you in my office yesterday, and one of my frustrations, and I think probably all of us who sit here on the dais, their frustration is that we never—in terms of accountability, we never seem to have an agreed-upon matrix of what we are looking for, and let's just talk about scheduling and wait times is one of those metrics.

And so I'm just hoping that as we proceed in this system, that we all can agree on what we are looking for, and how we can hold you accountable and ourselves accountable for making sure that we are meeting the appropriate needs that we are looking for, because I think sometimes we have—you may be looking at something, and but we are looking for something else, and those two issues never seem to meet.

Ms. COUNCIL. And that's a core backbone of the new development, because you need analytics. That's what you really want to understand: how well things are performing, how well are we responding, and frankly, how well the diagnoses and what we decide to do for the veteran's actually working for that veteran. That is core to this system and it doesn't require human interface to get that information.

Ms. BROWNLEY. Well, and I think we need to have that discussion about what those—you know, what are we going to get from those analytics, and so that we all have sort of a common understanding of it.

And just one last, very quick question, you know I don't want to dwell on this, but we obviously have spent millions and billions of dollars on trying to make an IT system that works. And I guess my question is, of those millions and billions of dollars that we have spent, was any of that money, in essence sort of worthwhile in terms of what you are building on and trying to come to today?

Dr. SHULKIN. Yeah. First of all, you know, seeing patients in the system and using VistA, the country should be proud that we developed this system. Doesn't mean that it's going to be the system for the future, but it's working today, millions of veterans' lives depend upon it, and it helps VA provide better quality than the private sector in many, many measures that's consistently published in the best journals in America.

Secondly, VSE, which is the, I'm sorry, VistA Evolution, which is where this 510 million went to over the last couple years, is actually now being launched. April 5th it went into five sites. So you're finally seeing, with all these years in development, all that

money, it's actually now, just this April, being put into the system. It's going to be a major advance. So whether all of it was necessary, whether it could have been done more efficiently, I'm sure that it could have been done more efficiently, but absolutely not a waste, Congresswoman. It's here now.

Ms. BROWNLEY. Thank you very much and thank you all for your testimony. I yield back.

Mr. COFFMAN. Thank you, Ms. Brownley, Ranking Member Brownley.

Dr. Benishek, you are now recognized for five minutes.

Mr. BENISHEK. Thank you, Mr. Chairman.

I have got just a few more questions about where I was when I was asking the questions last time, and the DoD, VA interoperability now, so there was 55,000 VA people who are able to access both DoD and VA records of veterans. We are not sure the amount of veterans that they are actually able to access. Are these health—I wasn't sure because I think maybe you answered them in different ways—are these health professionals that have access to this, or are these veteran benefit people that have access?

Dr. SHULKIN. Both. Both.

Mr. BENISHEK. Both. So then what percentage of this and how many people are we talking about. 55,000, is that what percentage of that, is that ten percent of the system or—

Dr. SHULKIN. Well, of health professionals. You know, it may be as low as 20, 25 percent of the system.

Mr. BENISHEK. All right. Okay. That is kind of where I was going there.

Dr. SHULKIN. Yeah.

Mr. BENISHEK. So there is some definite work to be done there.

Dr. SHULKIN. Absolutely. Training, yes.

Mr. BENISHEK. So it is basically a training issue then, you think?

Dr. SHULKIN. It's primarily a training issue. You have to—it's not easy, at least not easy for me. You have to leave, you have to go out of a system—

Mr. BENISHEK. So by December you think we will have that better then, I mean, full up to speed then—

Dr. SHULKIN. Yeah.

Mr. BENISHEK [continued]. —Ms. Council?

Ms. COUNCIL. Yeah, it's an integration issue with VistA, and that's one of the reasons we need to get to a new digital health platform. Everything's separate, and that is the root of the issue.

Mr. BENISHEK. I want to ask another question, now this is still about this self-scheduling thing. So in the consolidation, we are not going to rely on the third party people to do the scheduling, or we don't know that yet? See, I have a problem if a veteran calls, I need an appointment, they get the appointment and then the eligibility and everything is figured out later? How is that going to actually work, Dr. Shulkin?

Dr. SHULKIN. Yeah. We know the current system isn't working the way it should for veterans. No disagreement there. So what we have proposed is a new streamlined system. We have actually released this week a draft RFP to the industry to seek industry partners who could help us do this better. We believe we're going—VA can't do this alone. I hear the skepticism. I don't think we're trying

to say that we should be doing this alone. So we are seeking—and the RFP will be released, a full one, later on this spring with a selection in the fall, for partners to help us do this better, because frankly this is what many managed care plans and other companies are doing much better than we are right now.

Mr. BENISHEK. All right. Okay.

Let me ask you another question now. There is this Fee Based Claim System, that is involved with paying providers in the community, and apparently the VA has this auto-adjudication update possibility to speed this along. Do you intend to make that happen, or, this is a problem with the payment issue?

Ms. COUNCIL. Yes, we do.

Mr. BENISHEK. What is the story there?

Ms. COUNCIL. Yes, we do. As part of the integration for community and care includes eligibility, referral authorizations, provider payments and customer service being tied into one service, so we can see that seamlessly, because it can't be done choppy like it is right now. Right now it's very human labor intensive.

Mr. BENISHEK. Is that something that is going to happen soon, or you have to wait until the whole integration is done, or, can it just be done now?

Ms. COUNCIL. No, I think what we needed were the requirements coming in from the business partners which we now have. We can make the changes and then upload that system.

Mr. BENISHEK. All right. Well, I have just got a few more minutes here, so I am just going to comment. And this has been an ongoing issue, and, you know, I appreciate your working on all these things. But it seems to me that in the private sector, many of this IT stuff is, you know, the problems are solved and then the system is improved on a constant basis rather than trying to develop a huge comprehensive fix. And then, you know, by the time the fix is actually figured out, it is obsolete, you know, so why isn't that more the way that we are doing this than what seems to be happening here?

Ms. COUNCIL. That is actually the way it should work. We have 365 data centers within the VA, 130 instances of VistA, and 834 custom systems. In addition, they're spread out across the 1,500 health systems, and it was built as it went. It looks nothing like what you would see in private industry, and fundamentally, what we're laying out is a digital health platform that will get us there. I hundred percent agree with you, you don't have to get a hundred percent of the solution in place to start. You could start with 20, 30, 40 percent and just get better over time. But that requires a standard platform, it requires one instance, one solution, and a process that everybody uses, and that was not how the VA was built.

Mr. BENISHEK. All right. I am out of time. Thank you, Mr. Chairman.

Mr. COFFMAN. Thank you, Dr. Benishek. And thank you to our witnesses, you are now excused.

I ask unanimous consent that all Members have five legislative days to revise and extend their remarks and include extraneous materials. Without objection, so ordered. I would like to once again

thank all of our witnesses and our audience members for joining us in today's discussion. With that, this hearing is adjourned.

[Whereupon, at 11:37 a.m., the Subcommittees were adjourned.]

A P P E N D I X

Prepared Statement of Dr. David Shulkin

Good afternoon, Chairman Benishek, Chairman Coffman, Ranking Member Brownley, Ranking Member Kuster, and Members of the Subcommittees. Thank you for the opportunity to discuss the progress that the Department of Veterans Affairs (VA) is making towards modernizing our information technology (IT) infrastructure to better serve our VA business partners and our Nation's Veterans. We will also discuss scheduling, claims processing and adjudication, and medical record sharing initiatives at the Department. In order to successfully carry out those initiatives and our consolidation of community care programs, in addition to the legislative authorities and resources identified in our October 30, 2015 report to Congress, VA will need a digital health platform and IT solutions that will meet the evolving needs of our Veterans, as well as support our streamlined business processes. We are accompanied today by Dr. Alan Constantian, Deputy Chief Information Officer in the Office of Information Technology (OI&T).

New VA IT Strategic Plan

OI&T is at a critical inflection point. Persistent internal challenges exist in delivering IT services, and external pressures are compelling us to change and adapt. Through the MyVA initiative, VA is modernizing its culture, processes, and capabilities to put Veterans first, and is giving our team the opportunity to make a real difference in Veterans' lives. This momentum is driving us to transform OI&T on behalf of our partners, our employees, and Veterans.

With this in mind, VA developed a new IT strategic plan. Our new vision is to become a world-class organization that collaborates with its business partners to provide a seamless, unified Veteran experience through the delivery of state-of-the-art technology. Our guiding principles are to be transparent, accountable, innovative, and team-oriented. To build trust, we are committed to measuring success, investing in the capabilities of our employees, and collaborating across VA.

We have created five new key functions to support VA's strategic objectives.

1.The Account Management function establishes a clear, consistent process for understanding and meeting the needs of our business partners and our customers.

2.The Enterprise Program Management Office (EPMO) function monitors key information to improve project execution and deliver better outcomes.

3.The Data Management function will ensure interoperability with our partners and protect Veteran data.

4.The Strategic Sourcing function will focus on knowledge sharing, best practices, and sharing insights on new technologies.

5.Finally, the Quality and Compliance function enables us to adhere to appropriate policies and standards to eliminate material weaknesses.

Building a strong team and ensuring that the mission continues past 2016 is vital to OI&T's transformation. IT is a field characterized by constant evolution. Veterans have earned the best care and benefits available which must be enabled by the best technological solutions and be empowered by the most skilled employee base. We must embrace creative staffing approaches and incentivize the best and brightest talent, both within and beyond the Federal government, to deliver world-class solutions.

However, talent management is not simply attracting the right people. It is retaining those with a passion and a commitment to our mission by fostering a compelling, rewarding environment. We are emphasizing our team's development as a key priority. The goals and milestones of our enterprise strategy will cascade throughout the team's performance plans at all levels. We are also customizing development and education programs, and by the end of 2017, VA will develop a meaningful employee career plan - a first in OI&T. Most importantly, we are leading talent development from the highest tiers of the OI&T team. We are evaluating

our leadership approach to ensure that we have the right leaders in the right positions. We are infusing new perspectives and skills by hiring new talent. OI&T has added 5 senior leaders in critical roles and will add 11 more in the next 90 days. This team will realize our strategies and carry out our mission now and into the future.

This transformation will be different because we have the key components for success. Over three phases of implementation, OI&T will stabilize and streamline core processes and platforms, eliminate material weaknesses, and institutionalize a new set of capabilities to drive improved outcomes.

Enterprise Program Management Office

EPMO is building our momentum in OI&T's transformation. EPMO hosts our biggest IT programs, including the Veterans Health Information Systems and Technology Architecture (VistA) Evolution, Interoperability, the Veterans Benefits Management System, and Medical Appointment Scheduling System (MASS). EPMO also supports the Federal Information Technology Acquisition Reform Act requirements.

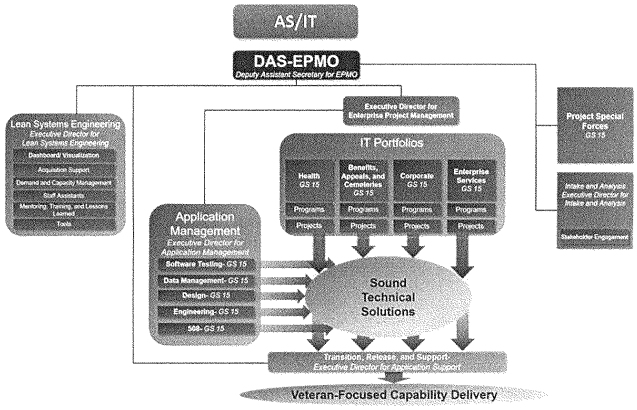

Fig. 1 - EPMO Organizational Chart

EPMO ensures alignment of program portfolios to strategic objectives and provides visibility and governance into the programs.

For enterprise initiatives, EPMO helps program and project teams to better develop execution plans, monitor progress, and report the status of these programs and projects. EPMO enables partnerships with IT architects for enterprise collaboration and serves as a program/project resource for the delivery of enterprise and cross-functional programs. This helps identify Shared Services Enterprise Programs and will help plan resource requirements with portfolios and architecture.

EPMO has already produced results. The Veteran-focused Integration Process (VIP) is a project-level based process that replaces the Program Management Accountability System (PMAS). VIP establishes a single release process with a predictable cadence that all VA organizations will follow by the end of 2016. It reduces overhead and eliminates redundancy in review, approval, and communication processes. These efficiencies include reducing the review process from 10 independent groups with

90 people to a single group of 30 people focused on ensuring that products meet specified, consistent criteria for release.

VIP focuses on doing rather than documenting, with a reduction of artifacts from more than 50 to just seven, plus the Authority to Operate, and the shift from a 6-month to a 3-month delivery cycle. Further, as a guarantee to our work, EPMO will ensure that product teams stay assigned to their projects for at least 90 days after the final deployment.

Enterprise Cybersecurity Strategy

OI&T is facing the ever-growing cyber threat head on. The first step in our transformation was addressing enterprise cyber security. We delivered an actionable, far-reaching, cybersecurity strategy and implementation plan for VA to Congress on September 28, 2015, as promised.

OI&T is committed to protecting all Veteran information and VA data and limiting access to only those with the proper authority. This commitment requires us to think enterprise-wide about security holistically. We have dual responsibility to store and protect Veterans records, and our strategy addresses both privacy and security. We designed our strategy to counter the spectrum of threat profiles through a multi-layered, in-depth defense model enabled through five strategic goals.

- **Protecting Veteran Information and VA Data:** We are strongly committed to protecting data. Our data security approach emphasizes in-depth defense, with multiple layers of protection around all Veteran and VA data.
- **Defending VA's Cyberspace Ecosystem:** Providing secure and resilient VA information systems technology, business applications, publically accessible platforms, and shared data networks is central to VA's ability to defend VA's cyberspace ecosystem. Addressing technology needs and operations that require protection, rapid response protocols, and efficient restoration techniques is core to effective defense.
- **Protecting VA Infrastructure and Assets:** Protecting VA infrastructure requires going beyond the VA-owned and VA-operated technology and systems within VA facilities to include the boundary environments that provide potential access and entry into VA by cyber adversaries.
- **Enabling Effective Operations:** Operating effectively within the cyber sphere requires improving governance and organizational alignment at enterprise, operational, and tactical levels (points of service interactions). This requires VA to integrate its cyberspace and security capabilities and outcomes within larger governance, business operation, and technology architecture frameworks.
- **Recruiting and Retaining a Talented Cybersecurity Workforce:** Strong cybersecurity requires building a workforce with talent in cybersecurity disciplines to implement and maintain the right processes, procedures, and tools.

VA's Enterprise Cybersecurity Strategy is a major step forward in VA's commitment to safeguarding Veteran information and VA data within a complex environment. The strategy establishes an ambitious yet carefully crafted approach to cybersecurity and privacy protections that enable VA to execute its mission of providing quality health care, benefits, and services to Veterans, while delivering on our promise to keep Veteran information and VA data safe and secure.

In addition, we have a large legacy issue that we need to address. VA is increasing our spending on security to $370 million, fully funding and fully resourcing our security capability for the first time. In addition, we are investing over $50 million to create a data-management backbone.

Scheduling

We recognize the urgent need for improvement in VA's appointment scheduling system. We are evaluating the Veteran Appointment Request (VAR) application and the VistA Scheduling Enhancement (VSE) through simultaneous pilot programs. We are also testing VAR at 2 facilities and VSE at 10 locations.

VSE updates the legacy command line scheduling application with a modern graphical user interface. This capability reduces the time it takes schedulers to enter new appointments, and makes it easier to see provider availability. VSE provides critical, near-term enhancements, including a graphical user interface, aggregated facility views, profile scheduling grids, single queues for appointment requests, and resource management reporting.

Our VSE Initial Operational Capability (IOC) sites are:

- Charles George VA Medical Center in Asheville, NC
- West Palm Beach VA Medical Center in Florida
- Chillicothe VA Medical Center in Chillicothe, OH
- VA Hudson Valley Health Care System in New York
- Louis Stokes Cleveland VA Medical Center in Cleveland, OH
- VA New York Harbor Health Care System in New York
- VA Salt Lake City Health Care System in Utah
- VA Southern Arizona Health Care System in Tucson, AZ
- James H. Quillen VA Medical Center in Mountain Home, TN
- Washington, DC VA Medical Center in Washington, DC

VAR allows Veterans to request primary care and mental health appointments as face-to-face, telephone, or video visits by specifying three desired appointment dates. The software allows established primary care patients to schedule and cancel primary care appointments directly with their already-assigned Patient Aligned Care Team provider.

VA schedulers tell us that they need a system focused purely on scheduling. VSE and VAR pilots are available now and show positive results in meeting the business requirements of our partners. In contrast, MASS includes additional features that add complexity, leading us to put MASS on a strategic hold while our VA team ensures that all requirements are met without undue processing difficulties.

VistA Evolution

VA is committed to the continued success of VistA, our electronic health record (EHR).

Current State of VistA Evolution

VistA Evolution is the joint VHA and OI&T program for improving the efficiency and quality of Veterans' health care by modernizing VA's health information systems, increasing data interoperability with the Department of Defense (DoD) and network care partners, and reducing the time it takes to deploy new health information management capabilities. We will complete the next iteration of the VistA Evolution Program-VistA 4-in fiscal year (FY) 2018, in accordance with the VistA Roadmap and VistA Lifecycle Cost Estimate. VistA 4 will bring improvements in efficiency and interoperability, and will continue VistA's award-winning legacy of providing a safe, efficient health care platform for providers and Veterans.

VA takes seriously its responsibility as a steward of taxpayer money. Our investments in VistA Evolution continue to make our Veterans' EHR system more capable and agile. VA has obligated approximately $510 million in development funds to build critical capabilities into VistA since FY 2014, when Congress first provided specific funding for the VistA Evolution program. VA has obligated $151 million in IT Sustainment funds and $110 million in VHA funds. The VHA funding supports the operational resources needed for requirements development, functional design, content generation, development, training, business process change, and evaluation of health IT systems.

It is important to note that VistA Evolution funding stretches beyond EHR modernization. VistA Evolution funds have enabled critical investments in systems and infrastructure, supporting interoperability, networking and infrastructure sustainment, continuation of legacy systems, and efforts-such as clinical terminology standardization-that are critical to the maintenance and deployment of the existing and future modernized VistA. This work was critical to maintaining our operational capability for VistA. These investments will also deliver value for Veterans and VA providers regardless of whether our path forward is to continue with VistA, a shift to a commercial EHR platform as DoD is doing, or some combination of both.

Interoperability Certification

At VA, we know that a Veteran's complete health history is critical to providing seamless, high-quality care and benefits. Interoperability is the foundation of this capability as it enables clinicians to provide Veterans with the most effective care and makes relevant clinical data available at the point of care. Access to accurate Veteran information is one of our core responsibilities. The Department is happy to report that, thanks to a joint VA and DoD effort, we expect that interoperability will be certified with DoD, as defined by the 2014 National Defense Authorization Act, 8 months ahead of the end of the December 2016 deadline.

For front-line health care teams, the most exciting products from VistA Evolution are the Joint Legacy Viewer (JLV) and the Enterprise Health Management Platform (eHMP).

Joint Legacy Viewer

JLV is the basis for achieving interoperability. JLV is a clinical application that provides an integrated, chronological display of health data from VA, DoD, and community health care partners in a common data viewer. It provides a Veteran-centric view of the Veteran's health record rather than a facility-centric view. JLV's user base has outpaced our projections. As of March 27, 2016, JLV had 55,607 VA users, and is adding thousands of new users in VA and DoD every week. JLV also provides a near real-time view of DoD and VA health care data to benefits administrators, which facilitates the processing of Veterans' claims. All Veterans Benefits Administration offices have access to JLV and can use it to expedite claims.

Enterprise Health Management Platform

JLV has been instrumental in connecting the VA and DoD health systems, but it does have limitations. We must do more to achieve data interoperability. eHMP will expand JLV's capabilities. eHMP is a modern, secure, configurable web-based

health information platform that will expand JLV's capabilities. eHMP is a major cornerstone of building VistA into a Generation 3 EHR, building on the capability for clinically actionable, patient-centric data pioneered by JLV. By August 2016, we will have a feed set up from VA to DoD through eHMP and the DoD Healthcare Medical System Modernization EHR. As the system matures, we will make it available to a broader base of clinicians. We will deploy eHMP with expanded capabilities in mid-2017. Clinicians will be able to write notes and order laboratory and radiology tests. During this deployment, eHMP will support tasking for team-based management and communication with improved communication and tracking. Instead of a static, "one-size-fits-all" desktop view, eHMP will allow clinicians to customize their workspaces to treat particular conditions more efficiently or best fit their clinical workflows.

Upon completion, eHMP will support the following capabilities:

- **Veteran-centric health care-**eHMP will allow clinicians to tailor care plans to specific clinical goals and help Veterans achieve their health care goals.
- **Team-based health care-**eHMP will provide an interoperable care plan in which clinical care team members, including the patient, will understand the goals of care and perform explicit tasks to execute the plan. eHMP will also monitor tasks that are not completed as specified and escalate them to the appropriate team.
- **Quality-driven health care-**eHMP will support the diffusion of best practices, including evidence-based clinical process standardization. eHMP will collect data on how clinicians address conditions and power analytics to generate new evidence for better care and best practices.
- **Improved access to health information-**when fully deployed, eHMP will allow clinicians to input new data directly into the system. eHMP will integrate health data from VA, DoD, and community care partners into a customizable interface that provides a holistic view of each Veteran's health records.

Fundamentally, this is about data, not software. Regardless of the software platform, we need to be able to access the right data at the right time. Health data interoperability with DoD and network providers is important-but it is equally important to understand that this is just one aspect of having a comprehensive profile to streamline and unify the Veteran experience.

Using eHMP as a tool, health care teams will better understand Veterans' needs, coordinate care plans, and optimize care intensity in VA and throughout the

high-performing network of care.

Looking to the Future

Modernization is a process, not an end, and the release of VistA 4 will not be the "end" of VA's EHR modernization. VistA 4 has always been scheduled to conclude in FY 2018, but there was always an intention to continue modernizing VA's EHR, beyond VistA 4, with more modern and flexible components.

Due to the expansion of care in the community, a rapidly growing number of women Veterans, and increased specialty care needs, the need for more agility in our EHR has never been greater. We are looking beyond what is delivered with VistA 4 in FY 2018, and we are evaluating options for the creation of a Digital Health Platform to ensure that we have the best strategic approach to modernizing our EHR for the next 25 years.

To prepare for this new era in connected health, VA is looking beyond the EHR to a digital health platform that can better support Veterans throughout the health continuum. These factors drive the need for continuous innovation and press us to plan further into the future.

Consolidation of Community Care

On October 30, 2015, VA provided Congress with a plan to consolidate all VA's purchased care programs. The plan included some aspects of the current Veterans Choice Program (VCP), established by section 101 of the Veteran's Choice Act, and incorporated additional elements designed to improve the underlying IT infrastructure and therefore, the delivery of community care. In this plan, VA identified several areas for needed IT solutions and improved IT infrastructure including care coordination, claims processing, and medical records management.

Care Coordination: Robust care coordination requires a strong health IT platform. VA's future health IT platform will perform the following functions: maintenance of care plans; a user-friendly interface for Veterans and caregivers to see their information; and accurate, timely information for providers. Patient-facing and telehealth technologies will allow Veterans to view their health data, care plan, and up-

date their health and medical needs. Providers will use VA's medical records exchange to support health information transactions, and care teams will use the platform to support Veterans in their health care experience.

Claims Processing: VA will pursue simplified processes as it implements industry best practices. VA will focus on standardizing business rules and logic to support claims processing and improving interfaces and coordination with dependent systems (e.g., Eligibility). This solution will require a scalable, flexible claims platform that supports emerging, value-based care models and streamlines data maintenance, storage, and retrieval. This new claims solution will be integrated with Veteran Eligibility Systems, Authorization Systems, and standardized fee schedules to support auto adjudication. Integration with fee schedules will support new payment models and enable better tracking and billing integration with other health insurance (OHI). VA will also integrate the claims processing system with patient information, increasing VA's ability to efficiently bill OHI.

Medical Records Management: As more Veterans receive care in the community, it is increasingly important to develop tools and solutions for easy access of health information between VA and community providers. To address this issue, VA will adopt a phased plan consistent with a systems approach to achieve a solution that is secure, efficient, effective, and standards based, using health information exchanges (HIEs). In the near-term, VA will focus on building upon current infrastructure to improve consistency, simplicity, and timeliness of information exchange. In the medium-term and long-term, VA plans to deploy a robust health information gateway and services, and share most clinical information through HIEs.

As described previously, we are further implementing the web-based JLV to offer a simple, complete, and easy-to-understand view of VA and DoD patient data. Second, VA plans to integrate existing exchange services to receive and store standards-based electronic documents, such as Continuity-of-Care Documents. This reduces the use of paper and builds on current VA investments. Third, VA plans to expand partnerships with HIEs and use direct secure email protocols. VA plans to continue to work with the critical Federal stakeholders to expand the usage of national standards for clinical terminology and data elements. As VA continues to evaluate the future solutions, VA will consider the needs of Veterans, community providers, and VA staff to ensure that any solution will support the future delivery of community care.

In the medium- and long-term, VA plans to create an electronic, secure, efficient, effective, and standards-based environment in compliance with relevant privacy laws affecting Veterans and their beneficiaries. VA plans to implement a health information gateway and associated services and share most clinical information through HIEs, when available. Currently, HIEs reach 40 percent of U.S. hospitals and serve approximately one third of the U.S. population.

Providers will be able to view, append, and share clinical and administrative information electronically through a VA health information gateway and associated services. Veteran clinical and administrative information will then be transferred back to VistA. VistA will incorporate an industry-leading information model, terminology normalization, knowledge enrichment, and search indexing for VA, Federal, and HIE partner sources. Available health information will drive enterprise-wide analytics efforts for process improvement.

Community Care IT Implementation Strategy

The New VCP will be implemented through a system of systems approach. A system-of-systems approach involves the design, deployment, and integration of metasystems that are themselves composed of complex systems, which are integrated to deliver the desired functionality and end-to-end user experience. Consistent with this approach, VA will begin by understanding the desired experience and required outcomes for Veterans, caregivers, VA staff, and community providers. VA will then examine all the components necessary to achieve the desired outcomes and understand how various component systems will integrate into the broader VA health care system and funding environment. To successfully implement this system-of-systems approach requires legislative changes, resources, and a budget.

Implementation of the system-of-systems approach will be executed through rapid cycle deployment using agile methodologies. This will allow VA to fix the most pressing issues with community care today, while making continuous updates to promote a learning health system that evolves with the needs of the Veteran population. This approach enables VA to implement an integrated system design that allows people, processes, facilities, equipment, and organizations to deliver high-quality, high-value care.

Based on preliminary analysis of Veteran needs and the desired Veteran experience, VA has determined that the component systems of the New VCP are: 1) Inte-

grated Customer Service Systems; 2) Integrated Care Coordination Systems; 3) Integrated Administrative Systems (Eligibility, Patient Referral, Authorization, and Billing and Reimbursement); 4) High-Performing Network Systems; and 5) Integrated Operations Systems (Enterprise Governance, Analytics, and Reporting).

In order to execute a program of this scope and scale, VA has outlined a transition plan consistent with the system-of-systems approach to sequence the design, development, and delivery of the New VCP. In developing the transition plan, VA considered recommendations from stakeholder feedback and the Independent Assessment Report. While the transition plan lays out a path forward for the program, the complexity of the change will require development of detailed implementation plans. In addition, any changes to the New VCP described in this plan, as a result of input from Congress or other stakeholders, will impact the activities described.

Transitions of this magnitude take years to design and implement; therefore, this plan is organized into three phases.

- Phase I can start immediately and will last 1 year, assuming available resources and required legislative and regulatory changes. This phase will focus on the development of minimum viable systems and processes that can meet critical Veteran needs without major changes to supporting technology or organizations.
- In Phase II, also lasting approximately 1 year, VA will enhance the changes implemented in Phase I through interfaced systems that will appear seamless to Veterans and community providers, but will largely continue to employ existing infrastructure and technology.
- Phase III will be a multi-year effort. In Phase III, VA will begin deploying an integrated system-of-systems approach that will support changes in Phases I and II and enable a seamless experience across VA and community care for all stakeholders. VA also will collect and analyze data on the progress and performance of the implementation to identify opportunities for continuous improvement.

Through all phases of the transition, VA will build a foundation for a health care system that can respond to the evolving needs of Veterans and the changing health care landscape at VA and in the community.

PHASE I: DEVELOP IMPLEMENTATION PLAN AND IMPLEMENT MINIMUM VIABLE SOLUTIONS AND PROCESSES

During Phase I, VA has begun to develop an implementation plan that articulates a clear path forward for each system component across the three phases. This will include decisions about long-term system changes and outcomes of make/buy analyses for clinical and administrative technology solutions and network development. Phase I will also include the implementation of minimum viable systems and processes for the Veteran, community provider, and VA staff experience. These systems will focus on improvements that can be executed without major changes to organizations or technology.

Phase II: Implement Interfaced Systems and Process Changes

During Phase II, VA will implement interfaced systems and associated processes that will enable a seamless experience for Veterans and community providers. Interfaces will employ existing resources and technology infrastructure, but will appear integrated to end users. VA will need support from Congress to ensure that this implementation takes place. Simultaneously, VA will continue to develop fully integrated solutions that will be deployed in Phase III.

Phase III: Deploy Integrated Systems, Operate High-Performing Network, and Make Data-Driven Improvements

During Phase III, VA will begin to deploy integrated systems, including process and organization changes that will enable a seamless Veteran, community provider, and VA staff experience. These systems will build on changes in Phases I and II and will support collection of quality, value, and performance data for continuous improvements. Similar to Phase II, VA will rely on Congress to support Phase III.

Conclusion

VA is at a historic crossroad and will need to make bold reforms that will shape how we deliver IT services and health care in the future, as well as improve the experiences of Veterans, community providers, and VA staff. Throughout this transformation, our number one priority has and will always be the Veteran-ensuring a safe and secure environment for their information and improving their experience is our goal.

Additionally, to make these reforms, as we have discussed in a series of hearings on the October 30, 2015, Consolidation of Care report, VA will need short- and long-term assistance with legislative authorities and resources. Transformation of VA's community care program will address gaps in Veterans' access to health care in a simple, streamlined, and effective manner. This transformation will take into account the interdependent nature of external and internal factors involved in VA's health care system.

As with all issues, VA strongly values the input and support of all its stakeholders. We realize the vital role they play in assisting us in providing timely, high-quality care to Veterans, and we look forward to continued open dialogue.

This concludes our testimony, and we are prepared to answer any questions you or other Members of the Committee may have.

Statements For The Record

THE AMERICAN LEGION

It is no simple task to reform the Information Technology (IT) enterprise of an organization the size of the Department of Veterans Affairs (VA). Compounding this challenge is the need to mesh reform with the larger goal of a national system in which health data flows seamlessly and securely, not only between Federal agencies, but between public and private health care systems too.

Chairmen Coffman and Benishek, Ranking Members McLane-Kuster and Brownley and distinguished members of the Subcommittees on Oversight And Investigations and Health, on behalf of National Commander Dale Barnett and The American Legion; the country's largest patriotic wartime service organization for veterans, comprising over 2 million members and serving every man and woman who has worn the uniform for this country; we welcome this opportunity to comment on "Evaluating VA Information Technology."

When a patient moves from one health system to another, there's no guarantee his or her electronic medical records are compatible with the new systems. This is an issue the nation is struggling with, both in the private and public sectors. Much attention has been given to the issue of examining the Departments of Defense (DOD) and Veterans Affairs information technology with an emphasis on the departments' efforts to develop and implement an interoperable electronic health record (EHR).

The 2008 National Defense Authorization Act (NDAA) directed DOD and VA to jointly develop and implement a "fully interoperable" EHR, creating an Interagency Program Office to facilitate and coordinate the Departments' efforts. In July 2015, DOD awarded a $4.3 billion contract to upgrade the Armed Forces Health Longitudinal Technology Application, while the VA continues to modernize and evolve its open-source platform, the Veterans Health Information Systems and Technology Architecture (VISTA). However, problems exist for the EHR platform. The EHR program has been listed on the GAO's high risk list for 2015. Additionally, recent inspectors general audits of both departments' Federal Information Security Management Act compliance identified weaknesses and deficiencies in cybersecurity.

Just last month, The American Legion submitted written testimony to the House Subcommittee On Information Technology, Committee On Oversight And Government Reform on "VA Cybersecurity And IT Oversight."[1] The hearing examined VA's implementation of the Federal Information Security Management Act and Federal Information Technology Acquisition Reform Act (FITARA), as well as specific IT investments, including the modernization of the VISTA system.[2]

VA is currently engaged in an effort to modernize VISTA. The centerpiece of VA's modernization program, referred to as VISTA Evolution, is an electronic health record (EHR) that should be interoperable with the Department of Defense, as well as private sector health care providers. The VA received an overall grade of 'C' on the Committee's 2015 FITARA Implementation Scorecard, with F's on both Data Center Consolidation and IT Portfolio Review Savings. Additionally, the VA Office of Inspector General has found repeat "material weaknesses" in the VA's cybersecurity posture.

In March of 2013, over a year before the scheduling wait time scandal in Phoenix, Arizona would open a wider window of scrutiny onto the entire VA healthcare system, The American Legion was raising concerns about problems with VA's sched-

[1] http://www.legion.org/legislative/testimony/231677/va-cybersecurity-and-it-oversight
[2] https://oversight.house.gov/hearing/va-cybersecurity-and-it-oversight/

uling software. In a hearing before this committee's Oversight and Investigation (O&I) Subcommittee, The American Legion sounded the alarm that contrary to reported numbers, veterans were waiting far longer for care and "figures are being manipulated by employees to look better, statistics such as VA's reported 94 percent of primary care appointments within the proper period, mean very little."[3]

A year after our testimony, VA found itself embroiled in the center of a nationwide scandal as concerns that advocates such as The American Legion had raised in the past became a staple of nightly news reports. At the heart of this scandal was the accusation that, exactly as The American Legion had predicted a year previous, figures were being manipulated to hide wait times through the use of offline, paper lists that avoided the public record of the computer scheduling software and its automatic tracking of wait times.

VA would see massive leadership change over the summer of 2014, but would still struggle with an IT plan to fix the problems.

In 2013 The American Legion noted a large portion of the problem was that previous attempts to replace the software had wasted money to no result and that there was not plan in place at the time to fix the problems. The American Legion stated:

As we are now a decade into the 21st Century, The American Legion believes that VA should also begin implementing 21st Century solutions to its problems. In 1998, GAO released a report that highlighted the excessive wait times experienced by veterans trying to schedule appointments, and recommended that VA replace its VistA scheduling system.[4] *To address the scheduling problem, the Veteran's Health Administration (VHA) solicited internal proposals from within VA to study and replace the VistA Scheduling System, with a Commercial Off-the-Shelf (COTS) software program. VA selected a system, and about 14 months into the project they significantly changed the scope of the project from a COTS solution to an in-house build of a scheduling application. After that, VHA ended up determining that it would not be able to implement any of the planned system's capabilities, and after spending an estimated $127 million over 9 years, The American Legion learned that VHA ended the entire Scheduling Replacement Project in September 2009.*[5] *We believe that this haphazard approach of fits and starts is crippling any hope of progress. It has now been over three years since VHA cancelled the Replacement Scheduling Application project, and as of today, The American Legion understands that there is still no workable solution to fixing VA's outdated and inefficient scheduling system.*

In the summer of 2014 VA announced plans to replace the software, going back to the original idea of Commercial Off the Shelf (COTS) software to accomplish that end. However, by September reports out of VA estimated the COTS plan would not roll out until 2020, over half a decade down the road.[6] VA would ultimately backtrack from this and revise that estimate down to 2017; however the move did little to ensure confidence in the ability to rectify the very real problems that the Phoenix scandal had highlighted.

Recent leadership changes, including the addition of Dr. David Shulkin as the Undersecretary for Health and LaVerne Council as VA's Assistant Secretary for Information and Technology and Chief Information Officer, have been promising moves and The American Legion has generally been impressed with the leadership team as they have worked to move forward on this issue.

While briefing VSOs on plans for future integration upgrades, VA shared ideas about a plan to move to an online scheduling system where veterans could schedule their own appointments. Because our Four Pillars include veterans issues as well as issues related to a strong national defense, The American Legion is well versed in both VA healthcare as well as TRICARE and military healthcare and was able to point out the many problems that arose when TRICARE implemented a similar scheduling system online.

Without scheduling personnel to oversee the process, and manage appointments, doctors' calendars rapidly overfill, clogging the system and making it impossible for patients to find time on the schedule. With a scheduling specialist available to determine what the type of appointments are and whether there can be multiple pa-

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[3] Testimony of Roscoe Butler, Waiting for Care: Examining Patient Wait Times at VA March 14, 2013

[4] U.S. Medicine Magazine, VA Leadership Lacks Confidence in New $145M Patient Scheduling System, May 2009

[5] GAO–10–579, Management Improvements Are Essential to VA's Second Effort to Replace Its Outpatient Scheduling System, May, 2010

[6] No New VA Patient Schedule System Until 2020 - Bob Brewin, NEXTGOV September 26, 2014

tients scheduled during certain time periods, the system is reduced to inelegant, brute force blocks of time, with little regard to whether doctors and support staff could handle different volumes of patients. This is just one example of how a strong and transparent partnership between VA and VSO stakeholders improves services to veterans.

We are hopeful that the dialogue with The American Legion and other groups will help guide VA moving forward with plans to reform the scheduling software. There were serious problems with the way VA had gone about business scheduling appointments for veterans. Under the old system, while veterans were left out on secret lists, few alarm bells were raised inside the system because employees had developed pencil and paper workarounds to the computer solutions VA had implemented. It took the combined pressure of groups like The American Legion and brave whistleblowers within VA who cared deeply about the safety of veterans to step forward and identify the problem.

We are now at a stage where VA is engaging with the very people whose membership utilize VA facilities across the country on a daily basis and are best in a position to identify problem areas. Hopefully VA is listening to these critical stakeholders.

New Veterans Choice Program

VA's current community care programs still utilize labor-intensive business processes that are too reliant upon manual data input, prone to errors and processing delays. The current system is a decentralized and highly manual process.[7] The New VCP plan proposes integrating most of VA's community care programs into one single program that would be seamless, transparent, and beneficial to enrolled veterans. The New VCP envisions a three-phased approach to implement these changes to support improved health care delivery for enrolled veterans.

The first phase will focus on the development of minimum viable systems and processes that can meet critical veteran needs without major changes to supporting technology or organizations. Phase II will consist of implementing interfaced systems and community care process changes. Finally, Phase III will include the deployment of integrated systems, maintenance and enhancement of the high-performing network, data-driven processes, and quality improvements.

To improve the accuracy of claims and reimbursement processing, the 2015 Independent Assessment Report recommended that VA employ industry standard automated solutions to bill claims for VA medical care (revenue) and pay claims for Non-VA Health Care (payment).[8] VA states its New VCP will focus on operational efficiencies, to include standardized billing and reimbursement, as well as geographically adjusted fee schedules that are tied to Medicare, as deemed appropriate. These foci will make it easier and more appealing for community health care providers to partner with VA.

The American Legion supports VA developing a 21st Century claims and reimbursement processing system that is rules-based, and to the extent possible, eliminates as much human intervention as possible. The system must eliminate the guess work out of the claims and reimbursement process and establish an error-free claims process that is responsive to veteran's needs.

Therefore, we are pleased to see that VA proposes to implement a claims solution which is able to auto-adjudicate a high percentage of claims, enabling VA to pay community health care providers promptly and correctly and to move to a standardized regional fee schedule, to the extent practicable for consistency in reimbursement.

Additionally VA proposes to simplify eligibility criteria so veterans can easily determine their options for community care, streamline the referral and authorization process to enable more timely access to community care, and standardize business processes to minimize administrative burden for community providers and VA staff. Improvements in how VA processes claims will enable VA to reimburse community providers in a timely and efficient fashion.

The American Legion understands VA's New VCP is a huge undertaking and understands the plan will take time to fully implement, particularly the IT component required to auto-adjudicate a high percentage of claims. However, we do not believe Congress should continue to provide VA an open check book without any assurance from VA that their IT plan will work. Congress must require VA to not only provide an IT plan, but provide some proof that the claim and reimbursement system will work. Too often Congress has authorized funding in support of process improvement

[7] Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care - Oct 2015

[8] VA Independent Assessment - Sept.2015

initiatives like CoreFLS, and VA's scheduling system, to name a few, without any deliverables, resulting in wasted tax payer dollars that can never be recovered. In these situations, the ones who are impacted are our nation's veterans who are calling out to Congress to fix the system.

An immediate remedy would be for VA to authorize payment for any Non-VA claim immediately upon receipt of a valid bill for health care services that a veteran receives. So, we were pleased to hear the recent VA announcement that the TPA's are now authorized to begin paying any Non-VA health care claim under the VCP without first obtaining the veterans medical record from the Non-VA health care provider. The American Legion applauds VA for initiating this action. This will prevent stories like the November 2015 Miami Herald article about Florida hospitals trying to get the Department of Veterans Affairs to pay about $134.4 million in outstanding claims for medical services they provided to veterans.[9] If it is determined VA overpaid for the care and services, cost recovery should occur after VA has verified the care and services provided to veterans receiving that health care. Of course, ensuring that records are ultimately returned to VA is very important and we look forward to hearing more about how VA plans to achieve this.

Finally, VA's IT systems need to be much more interoperable with the private sector, and veterans should be able to access their records from any setting. The overarching goal should be for the VA to use technology and health information to improve the health and well-being of veterans in ways that makes the information accessible when and where it matters most.

VA needs to develop a coordinated IT infrastructure for appointment scheduling, coding, billing, claims payment and other core VHA business processes, which include the automation of claims payment. This is essential to expanding veteran care with community providers. Billing and payment systems must be efficient.

The entire American healthcare economy is struggling to figure out ways to develop interoperable electronic healthcare records. If this nation is to have truly 21st century healthcare, this concept in both the public and private sector is essential. VA can take the lead in this field, as they have in so many fields of healthcare in providing true innovation. VA healthcare pioneered electronic healthcare records with VISTA. VA healthcare pioneered improvements in modern heart surgery, in the treatment of Posttraumatic Stress Disorder, and integrated care. There should be no reason they should not be trailblazers in this arena if properly supported.

Conclusion

The American Legion is deeply committed to working with VA to ensure that not only are these IT challenges worked out, but that any and all challenges are resolved to help protect the healthcare system designed specifically to service the unique needs and challenges of the veterans' population. Consistently, veterans speak highly of the high quality of care they receive when they can see their VA providers, and note how well VA understands their unique sacrifices and military culture when they are treating them. Therefore it is doubly important that we solve these challenges and make it easier for veterans to access the system best suited to treat them.

The American Legion thanks this committee for the opportunity to explain the position of the over 2 million veteran members of this organization. For additional information regarding this testimony, please contact Mr. Warren J. Goldstein at The American Legion's Legislative Division at (202) 861–2700 or wgoldstein@legion.org

[9] Florida Hospitals: VA owes $134 million in unpaid claims: Miami Herald; November 17, 2015