

IMPLEMENTATION OF ELECTRONIC HEALTH
RECORD SYSTEMS AT THE DEPARTMENT OF
VETERANS AFFAIRS (VA) AND THE DEPART-
MENT OF DEFENSE (DOD)

HEARING

BEFORE THE

SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION
OF THE

COMMITTEE ON VETERANS' AFFAIRS
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CONTENTS

Wednesday, June 12, 2019

	Page
Implementation Of Electronic Health Record Systems At The Department Of Veterans Affairs (VA) And The Department Of Defense (DoD)	1
OPENING STATEMENTS	
Honorable Susie Lee, Chairwoman	1
Honorable Jim Banks, Ranking Member	3
WITNESSES	
Mr. John Windom, Executive Director, Office of Electronic Health Record Modernization, Department of Veterans Affairs	4
Prepared Statement	31
Accompanied by:	
Dr. Laura Kroupa, Chief Medical Officer, Office of Electronic Health Record Modernization, Department of Veterans Affairs	
Mr. John Short, Chief Technical Officer, Office of Electronic Health Record Modernization, Department of Veterans Affairs	
Mr. William J. Tinston, Program Executive Officer, Defense Healthcare Man- agement Systems, Department of Defense	6
Prepared Statement	34
Accompanied by:	
Maj. Gen. Lee E. Payne, M.D., Assistant Director for Combat Support, Defense Health Agency, Department of Defense	
Dr. Lauren Thompson, Director, Interagency Program Office, Department of Defense, Department of Veterans Affairs	8
Prepared Statement	37

**IMPLEMENTATION OF ELECTRONIC HEALTH
RECORD SYSTEMS AT THE DEPARTMENT
OF VETERANS AFFAIRS (VA) AND THE DE-
PARTMENT OF DEFENSE (DOD)**

Wednesday, June 12, 2019

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

The Subcommittee met, pursuant to notice, at 10:19 a.m., in Room 210, House Visitors Center, Hon. Susie Lee presiding.

Present: Representatives Lee, Lamb, Cunningham, Banks, Watkins, and Roy.

Also Present: Representative Roe

OPENING STATEMENT OF SUSIE LEE, CHAIRWOMAN

Ms. LEE. Good morning. This hearing will come to order. I would like to welcome everyone.

And last week, the Subcommittee on Technology Modernization heard from the prime contractors on the programs to implement electronic health record systems at the Department of Defense and the Department of Veterans Affairs. Today, we continue oversight of these programs with testimony from the Departments accountable for their implementation.

In providing oversight, it is important that we have the proper time to review documents and receiving the DoD testimony at 10:30 p.m. last night certainly does not optimize our ability to do our job. Accountability, obviously, is a big part of this effort, perhaps the most important.

In the history of failed efforts to implement information technology throughout the Federal Government, more often than not, technology was not the problem; rather, it was a failure of leadership and management. The questions most often asked after failed technology implementations were: Who is in charge? Who is accountable to the taxpayers and Congress? And the answers often are a confusion of finger pointing and a leadership vacuum. And after every failed project, there are lessons learned and promises to do before.

Before us today, we have the leadership of the respective offices for VA's electronic health record modernization and the DoD's health care management system modernization. We also have the current director of the Interagency Program Office.

We are at a moment in time when critical decisions must be made in order to advance the implementation of this program, but

we are doing so without a fully functioning joint governance structure. For months, this Subcommittee has asked for a joint proposal to address the longstanding programs with the existing IPO, and as of March 1st, we now have the Federal electronic health record modernization program office, or FEHRM, and we will hear testimony about the initial organizational plans.

We have a one-page slide right here about a three-phased plan, but it is hard to find where the governance and accountability is in this plan. We are also missing a plan about staffing and resources. Based on the timeline for implementation, it appears that it will come too late to address the critical decisions that must be made now.

Further, I wonder whether the DoD and VA are invested in the idea of true joint governance and transparency since both declined to provide feedback on a potential legislative solution to finally create a single accountable joint-governance office with a role to promote and facilitate interoperability between the Departments for health records and beyond.

I hope I am wrong and that the VA and DoD do want a real solution in a functional governance structure. I would like to believe that after we made this investment, are prepared to spend at least \$16 billion in taxpayer money on modernizing health records for our servicemembers, veterans, and their families, that we are prepared to do this right.

Joint governance is not the only challenge DoD and the VA are facing now. The time for VA's first go-live is March 2020, and that is fast approaching. There are many key decisions and tasks that have yet to be completed. We are concerned that the VA has left itself with very little margin for error. There are many lessons to be learned from the Department of Defense, which now has its ongoing struggles, and I hope we will get some transparency about that today.

But my questions really come down to these: Why not spend the time to get the governance right? Why not take the time to get the infrastructure in place? And why not leave yourselves room to do the necessary testing and training to ensure a successful rollout?

This Subcommittee has been clear that we want to work with the VA, even if that means delay, as long as the VA is transparent and accountable. Why insist on leaving yourselves very little margin for error when history is not on your side for successful IT implementations. What is the VA doing to mitigate risk and ensure that the final product delivered to clinicians and veterans is the best it can possibly be, understanding that opportunities for improvement and innovation should be part of the management of the EHRM?

I would like to get these answers to these and other questions, and we are asking for transparency and accountability now to pave the way for implementation ahead and what we owe to our servicemembers and veterans.

I thank all the witnesses for being here and I look forward to their testimony. And I would like to now recognize my colleague, Ranking Member Jim Banks, for 5 minutes to deliver his opening remarks that he may have.

Mr. Banks?

OPENING STATEMENT OF JIM BANKS, RANKING MEMBER

Mr. BANKS. Thank you, Madam Chair.

I would like to begin by thanking our witnesses, are especially our DoD witnesses for appearing today. You do so voluntarily, and I sincerely appreciate it.

Anyone who watched our contractor hearing last week or any of our Subcommittee hearings know that we think that cooperation between DoD and VA on electronic health records is very important.

Lack of cooperation has been the graveyard of all of the previous efforts. I have no doubt that it is a high priority for each of you. Case in point, you have spent much of the last 9 months hammering out a joint-management structure. I want EHRM and MHS Genesis to succeed. I want to support your decisions.

But it is not reasonable to expect this Subcommittee to endorse decisions that we have scant details about; decisions that are the product of a secretive process. By all accounts, DoD and VA are getting close to standing up the Federal Electronic Health Record Modernization Program Management Office, the FEHRM, to jointly manage EHRM and MHS Genesis.

I understand the desire to make the agreement in private before disclosing anything. The problem is, though, there has been no agreement. Compromise has been elusive because the stakes were so high and both sides were apparently dug in so deeply.

My hope was, and still is, for this Committee and the Armed Service Committee, which I am also proud to serve on, to help mediate the situation. No one wanted the FEHRM to be stood up this late, but this is the reality. We are now 4 months out from the go-live dates for MHS Genesis wave 1 and 10 months out from the go-live date for VA's initial operating capability sites. The opportunity for the FEHRM to have impact is right now. It is time for a candid discussion of the Department's vision to integrate EHRM and MHS Genesis.

However, I am more interested in what the FEHRM will accomplish than how it will be structured, or which individuals will lead it. I expect it to solve real problems, or better yet, prevent them from happening in the first place.

Since taking on this assignment 1 year ago, I have seen and heard enough to have some serious concerns. VA and DoD are different animals. VHA and the military health system have cultures, priorities, organizational structures, and even missions that are quite different. I happen to believe that they should be more closely integrated in the future.

But if we force them into a one-size-fits-all solution now and ignore these realities, it may very well break them. Healthcare is a roughly ninety-billion-dollar enterprise in VA, and it is one of the 3 core missions of the Department. Military health care is a critical component of force readiness; both are personally important to me.

But electronic health records are simply not central to the DoD mission in the same way that they are to the VA mission. DoD is in a unique position with the creation of the Defense Health Agency and the consolidation of the military services treatment facilities into one organization.

I understand MHS Genesis is a critical element in accomplishing that, so preserving the schedule is paramount. I have also seen for myself that AHLTA and CHCS are incredibly difficult on popular EHR systems; on the other hand, while the structure of VA is not changing at all, the Department is implementing the MISSION Act and Community Care is growing in importance.

VA is not replacing VistA because it works poorly—in fact, some clinicians like it very much—VA is replacing Vista because it has fallen too far behind to meet the needs of the future. A single longitudinal DoD–VA health record would be a major accomplishment.

But as Dr. Roe can attest, any EHR implementation is disruptive, at best, and traumatic, at worst. In order for the cost and time and disruption to be worthwhile, VA also needs true interoperability with the community providers. Attaining that 9 years from now is simply not good enough.

I believe Congress has a duty to spell out its expectations and a time to make impact is right now. That is why I will be offering two amendments in the National Defense Authorization Markup Act that is going to occur today. The first puts in place requirements to ensure the FEHRM has qualified leadership. The second calls for DoD and VA to develop a comprehensive interoperability strategy to accomplish strategic goals and defines interoperability for the first time.

Unfortunately, the Armed Service Markup happens to be going on simultaneous with this hearing, and Madam Chair, with your forbearance, I have to be present there to advocate for these amendments. So, I will be heading back there, but I appreciate, once again, all of you being here today for this important discussion.

And with that, Madam Chair, I yield back.

Ms. LEE. Thank you, Mr. Banks.

I would now like to introduce our witnesses we have before the Subcommittee. First, we have John Windom, who is the Executive Director of the Office of Electronic Health Record Modernization at the Department of Veterans Affairs. Mr. Windom is accompanied by Dr. Laura Kroupa, Chief Medical Officer for OEHRM, and John Short, Chief Technical Officer for OEHRM.

William Tinston is the Program Executive Officer for the Defense Healthcare Management Systems at the Department of Defense. Mr. Tinston is accompanied by Major General Lee Payne, the Assistant Director For Combat Support at the Defense Health Agency.

And we have Dr. Lauren Thompson, who is the Director for the DoD–VA Interagency Program Office.

Welcome. We will now hear from the prepared statements from our panel Members. Your written statements, in full, will be included in the hearing record.

Without objection, Mr. Windom, you are recognized for 5 minutes.

STATEMENT OF JOHN WINDOM

Mr. WINDOM. Good morning, Madam Chair Lee, Ranking Member Banks, who just departed, Dr. Roe, Congressman Lamb, your

respective support staffs, good morning. Thank you for the opportunity.

I am accompanied by Dr. Kroupa, ma'am, as you mentioned, who is my chief medical officer; Mr. John Short, who is my chief technology and integration officer.

First, I want to take this opportunity to personally thank you and the Members of the Subcommittee for your unwavering support of the EHR modernization effort. Without your steadfast support, VA would not be able to deliver this critical capability in support of our veterans.

On June 5th, 2017, VA announced the decision to replace VistA, its existing legacy system, which is costly to sustain, and cannot deliver commercially available critical capabilities to meet the evolving needs of the health care market. Though the decision, VA is working to adopt the same EHR solution as the Department of Defense, allowing patient data to reside in a single hosting site, using a single common system.

This initiative will ultimately enable the seamless sharing of health information, deliver enhanced analytics, improve care delivery and coordination, and provide clinicians with the requisite data and tools to support patients safely.

On May 17th, 2018, VA awarded a contract to Cerner Corporation, leveraging an existing commercial off-the-shelf solution in pursuit of interoperability objectives within the VA, between VA and DoD, and with community providers. This contract contains the necessary conditions to foster innovation and keep pace with the evolving commercial technology.

To the end, OEHRM hosted an industry day on May 29th, 2019, with over 750 registered industry executives and leaders and over 450 companies in attendance. VA and OEHRM leadership presented a status update on EHRM modernization efforts, consistent—what are—and your demand for transparency.

In coordination with OEHRM, Cerner Corporation and Booz Allen Hamilton, our support contractor, informed attendees on the way to provide value-added programmatic support to the EHR modernization initiative.

Now, I want to highlight three important aspects of the EHR modernization effort which will contribute to the overall success of the program. First, given the size, scope, and complexity of the EHR modernization effort, VA plans to deploy its new EHR solution in slightly under 10 years. The plan will evolve as technology advances and efficiencies are further identified. VA's approach involves deploying a solution at initial operating capability sites in the Pacific Northwest to mitigate risk and to solidify processes, procedures, and allowing enterprise initiatives before deploying to additional sites. Additionally, the IOC sites will further hone governance, configuration management, and a myriad of other implementation and change management strategies we intend to employ.

VA targeted the Pacific Northwest Region based on DoD's deployment of the EHR solution. By deploying in the same region, VA will be able to immediately demonstrate interoperability and reduce potential risk at the VA sites.

Second, VA has involved and is instituting a changed management strategy that involves engaging users in the field early in the

process to determine their specific needs and quickly alleviate their concerns; furthermore, OEHRM established clinical councils that include nurses, doctors, and other end-users from the field to support assessments and configurations of workflows. These clinical councils meet during the 8 scheduled national workshops which educate this diverse frontline, clinical end-user community, enabling them to validate workflows, ensuring the new EHRM solution meets the VA's needs. To date, VA has completed 5 national workshops, with the remaining scheduled to occur throughout the remainder of the fiscal year.

Finally, VA and DoD currently work with the Interagency Program Office to facilitate governance, collaboration, and decision-making. To further promote a comprehensive, rapid, and agile decision-making authority in support of interoperability objectives, DoD and VA are co-developing a joint organizational/management structure.

To execute this strategy, DoD and VA proposed establishing a FEHRM, Federal Electronic Health Record Modernization Office, responsible for effectively adjudicating functional, technical, and programmatic decisions in support of DoD's and VA's integrated EHR solutions. This strategy will optimize the use of DoD and VA resources, while minimizing risks, promoting interoperability without compromising patients' safety.

As demonstrated by our efforts, it is clear that VA is committed to providing the best care to our Nation's veterans, including access to a single longitudinal electronic health record. The effort to support one of VA's top priorities to modernize the VA health care system and ensure VA remains a source of pride for our veterans, beneficiaries, employees, and the taxpayers.

Madam Chair, this concludes my opening remarks. I am happy to answer any questions that you or the Subcommittee may have. Thank you, again.

[THE PREPARED STATEMENT OF JOHN WINDOM APPEARS IN THE APPENDIX]

Ms. LEE. Thank you, Mr. Windom.

Mr. Tinston, you are now recognized for 5 minutes.

STATEMENT OF WILLIAM J. TINSTON

Mr. TINSTON. Madam Chair and distinguished Members of the Subcommittee, it is an honor to testify before you today. I represent the Department of Defense, as the program executive officer, Defense Healthcare Management Systems. Our mission is to transform the delivery of health care, advance data sharing through modernized electronic health records for servicemembers, veterans, and their families.

In July 2015, the DoD awarded a contract to the Leidos Partnership for Defense Health, to deliver a modern, interoperable EHR, designed to share data with our Federal and private sector partners. This modern, secure, connected EHR, known as MHS Genesis, provides a state-of-the-market, commercial, off-the-shelf solution, consisting of Cerner Millennium, and industry-leading EHR, and Henry Schein's Dentrix Enterprise, a best-of-breed dental module.

Deploying a capability of this magnitude requires extensive coordination and communication with our stakeholders and industry partners. It is a complex business. This is not simply an IT solution; it is a complex business transformation and leadership is key to its success. The right people must be in the right place to make decisions and deliver solutions.

MHS Genesis concluded its pilot deployment in January 2018. Our deployment to 4 sites, ranging in both size and capability, allowed us to observe the system, assess performance, and capture user feedback. We used this information to enhance system capabilities as we developed our strategy to deploy our next sites, starting in September of this year.

The VA's decision to implement the same EHR as the DoD and the United States Coast Guard will result in a single, common record, eliminating the need for interoperability with VA. The DoD understands this decision demands extensive collaboration and joint decision-making between the Departments, and is working daily to ensure efficient workflows and standardized processes.

Cybersecurity is one area of extensive collaboration and joint decision-making. The DoD sets the standard for cybersecurity and PEO DHMS invests time and resources to ensure the common system meets that second degree. Our cyber team is co-located with the commercial data center, which strengthens our Federal and commercial relationships and allows for continuous cyber monitoring. As a result of our efforts, the VA will leverage this cyber posture and actively participate in critical decisions required to protect the environment.

We also work closely with our VA partners to ensure we maintain system integrity. Recommendations for system enhancements are carefully evaluated by our joint workgroups to minimize program risks and impacts. For example, we recently agreed to accept a Cerner software upgrade, only a few weeks following our next site implementation. The timing of the upgrade address complexity and a risk to DoD's implementation, but it will ensure that VA meets its scheduled initial operational capability in March of 2020. Understanding this, we knew it was the right decision for the successful implementation for both Departments.

Another example of our collaborative efforts is continuity of operations. The Departments have agreed to a joint approach, which provides both, technical and programmatic efficiencies, and will focus on clinical continuity of operations and IT disaster recovery.

As a prior beneficiary and the son of a veteran, I am passionate about the mission and firmly believe we are on the right track to improve health care delivery for our servicemembers, veterans, and their families. Working with the VA, the Coast Guard, and our industry partners, I am confident this team is committed to the successful deployment of a modern EHR. We are making daily strides in the implementation of an enterprise solution that will not only advance care for our beneficiary and veteran communities, but will ultimately lead to a longitudinal record focused on the patient, not where care is delivered.

Thank you, again, for the opportunity to share our progress as we deliver a single, common record for servicemembers, veterans, and their families. I look forward to your questions.

[THE PREPARED STATEMENT OF WILLIAM J. TINSTON APPEARS IN THE APPENDIX]

Ms. LEE. Thank you, Mr. Tinston.

Dr. Thompson, you are now recognized for 5 minutes.

STATEMENT OF DR. LAUREN THOMPSON

Dr. THOMPSON. Chairwoman Lee, Ranking Member Banks, and distinguished Members of the Subcommittee, thank you for the opportunity to testify before you today. As the director of the Department of Defense-Department of Veterans Affairs Interagency Program Office, I am honored to be here.

The mission of the DoD-VA IPO is to advance data interoperability across DoD, VA, and with private-partner systems. Providing high-quality health care to servicemembers, veterans, and their families is the IPO's highest priority and health data interoperability is essential to improving the care delivered.

A key component of meeting the unique needs of our beneficiaries and ensuring they receive the best care possible is making certain that no matter their status, location, or provider, their health data is readily available and accurate, or in other words, ensuring health data interoperability.

DoD and VA represent two of the Nation's largest health care systems; together, the Departments serve over—million eligible beneficiaries, including servicemembers, veterans, and their families. Over 60 percent of the DoD and 30 percent of VA beneficiaries receive care from the private sector.

Currently, the Departments share more than 1.5 million data elements daily and more than 430,000 DoD and VA clinicians are able to view the real time records of more than 16 million patients who receive care from both Departments.

The fiscal year 2008 National Defense Authorization Act directed DoD and VA to develop and implement electronic health records systems or capabilities that allow for full interoperability of health care data between the DoD and VA, instructing the establishment of the IPO to guide both Departments in their efforts.

In January 2009, the IPO completed its first charter, aiding the Departments in attaining interoperable electronic health data.

In March 2011, the Secretary of Defense and Secretary of VA instructed the Departments to develop a single, integrated EHR.

In 2013, the Departments decided to pursue modernization of their respective EHR systems. In December 2013, the IPO was rechartered to lead the efforts of DoD and VA to implement national health data standards for interoperability and to establish, monitor, and approve clinical and technical standards for the integration of health data between the Departments and the private sector, in accordance with the 2014 NDAA and in compliance with the THHS, Office of the National Coordinator for Health IT's guidance on standards, interoperability for clinical records.

The IPO acts as the point of accountability for identifying, monitoring, and approving the clinical and technical data standards and profiles to ensure seamless integration of clinically relevant health data between the Departments and private-sector providers who treat DoD and VA beneficiaries.

In April 2016, the Departments, with the IPO's assistance, met a requirement of the fiscal year 2014 NDAA, certifying to Congress that their systems are interoperable with an integrated display of data through the Joint Legacy Viewer or JLV.

JLV integrates data from the clinical data repositories of both Departments, as well as data on beneficiary encounters with private providers who participate in national health information exchange. The IPO monitors the usage of JLV and other interoperability metrics across the Departments to track progress on data exchange and interoperability.

The IPO collaborates extensively with ONC, other government agencies, and industry-standards development organizations to advance the state of interoperability across the health industry.

In 2018, Secretaries Wilkie and Mattis issued a joint-commitment statement pledging to align strategies to implement an integrated EHR system. DoD and VA leaders chartered the Joint Electronic Health Record Modernization working group, referred to as the JEHRM, to develop recommendations for an optimal organization construct that would enable an agile, single-decision-making authority to efficiently adjudicate functional, technical, and programmatic interoperability issues while advancing unity, synergy, and efficiencies.

On March 1st, 2019, the joint VA–DoD executive leadership group approved a course of action, plan of action, and milestones, and implementation plan to establish the Federal Electronic Health Record Modernization program office, or the FEHRM, in a phased manner in order to minimize risk.

The FEHRM will provide a comprehensive, agile, and coordinated management authority to execute requirements necessary for a single, seamless, integrated EHR, and will serve as a single point of authority for the Departments' EHR modernization program decisions.

FEHRM leaders will have the authority to direct each Department to execute joint decisions for technical, programmatic, and functional functions under its purview and will provide oversight regarding required funding and policy, as necessary. This management model creates a centralized structure for interagency decisions related to EHR modernization, accountable to both, the VA and DoD deputy secretaries.

And interim FEHRM director and deputy director will be appointed to work with the implementation team in transitioning joint functions into the FEHRM once the FEHRM has an approved charter. The interim leaders will manage and execute joint, technical, programmatic, and functional requirements and synchronize strategies between the two Department EHR program offices to ensure single, seamlessly integrated EHR is implemented with minimal risk to cost, performance, and schedule. The interim leaders will remain in these roles until permanent FEHRM director and FEHRM deputy director are appointed.

The permanent director and deputy director will report equally to the Deputy Secretary of Defense and Deputy Secretary of Veterans Affairs.

The IPO will continue to support the Departments as it transitions to the FEHRM in implementing a single EHR system to en-

sure a seamless, patient-centric experience that will ultimately lead to improved care for our servicemembers and their families.

Thank you for the opportunity to speak with you today. I look forward to your questions.

[THE PREPARED STATEMENT OF DR. LAUREN THOMPSON APPEARS IN THE APPENDIX]

Ms. LEE. Thank you. I will now recognize myself for 5 minutes for questions.

Perhaps my first question is, why the name change? Why do we just not—I guess this is for Mr. Tinston and Mr. Windom—why do we just not continue with the IPO?

Mr. TINSTON. Well, I wasn't—ma'am, I wasn't here when the decision was made and the JEHRM working group was put in place. I understand why they changed it from JEHRM to FEHRM. It just seemed an odd name.

Ms. LEE. It is really confusing.

Mr. TINSTON. So, internally we talk about it sometimes as IPO 2.0 or joint program office, but I can't really explain why we went with FEHRM.

Ms. LEE. Okay.

Mr. WINDOM. Ma'am, I can tell you, as we migrated from the JEHRM to the FEHRM, only that the JEHRM has a connotation that did not reflect the clinical desires, and so in the Federal element reflected, I think, an overarching responsibility within the Federal space that encompassed DoD and VA. I think we are not hard and fast on any name, ma'am; we are just trying to be distinguished that we are doing something different than is perceived to be occurring now, hence, the name.

But I can tell you—Bill, I think I can speak for both of us—I don't think we have any—

Ms. LEE. No, I was just curious.

Mr. WINDOM [continued]. —issues.

Ms. LEE. Yes.

Mr. WINDOM. Yes, ma'am.

Ms. LEE. All right. Thank you.

Dr. Thompson, in your testimony you stated that FEHRM leaders will have the authority to direct the Department to execute decisions for technical, programmatic, and functional functions under its purview. And it sounds—based on that, it sounds like the FEHRM has the authority to direct the Departments to execute the decisions that have already been agreed to.

And I would like to know what is the FEHRM's role, related to the issues that the Departments fail to reach consensus on?

Dr. THOMPSON. The intention of the FEHRM is to be the deciding authority on issues.

Ms. LEE. Okay. Thank you.

What does that mean? Like, who all—can you explain that further.

Dr. THOMPSON. So, the director and deputy director of the FEHRM, who will be hired to report equally to the deputy secretaries of the DoD and the VA, will have the authority to make decisions, that will then be executed by the respective Departments.

Ms. LEE. Okay. Mr. Windom and Mr. Tinston based on the DoD and IPO testimony; it seems like this FEHRM is just getting operational. Have your respective agencies signed off on a charter, and is that charter operational, functional, and are there any establishing documents that you are able to share with us?

Mr. WINDOM. Ma'am, I would start by saying that the documents are in staffing, including the charter, as are the persons that will serve as the director and the deputy director.

The concept that Bill and I primarily worked out, this three-phase concept, is a concept that was imperative to establish because it balances where we feel the greatest risks are. And so, the three-phase concept is not to delay, but it is to support the proper, efficient, and timely movement of resources into the FEHRM to support the decision-making process without compromising the risks in our present portfolios. So, hence, the three-phase—the second phase would be in support of Dr. Kroupa's team solidifying workflows in alignment with DoD in that arena. And then the third phase would revolve around a critical milestone called IOC, Initial Operating Capabilities.

As you know, until we demonstrate that it works in an operational environment, it really does not make sense to move a resource until we solidify our strategies. So, we are being consistent with what I heard you say and others regarding accountability and regarding understanding that it is the end-users that will solidify our success. And so, taking into consideration those same end-users is what has driven our three-phase strategy.

Bill?

Mr. TINSTON. Well, I think Mr. Windom addressed very clearly that the charters and staffing and the Departments are considering their options for who the interim directors and intend to pursue permanent hires for the deputy and the director of the organization.

Ms. LEE. Is there a plan that can be shared with us on timing on all of this? On timing for the hiring and the resources that are being put behind this?

Mr. WINDOM. Ma'am, my understanding is that events are being coordinated, literally, as we speak, to come over and brief your respective staffs on the details, where Bill and I will be co-leading an organization that comes over and literally gives you those details. We will be prepared to do so and offer those details and also discussion points on whatever detail you would like, and your staff would like.

Ms. LEE. Can I expect that in the next week or two weeks?

Mr. WINDOM. Ma'am, I would like to kind of get with the DoD counterparts to really solidify that date, and we will gladly reach out to your staff, through our legislative affairs, to solidify that. I really wouldn't want to give you a date in the hearing and then—I haven't agreed to mutually with Bill.

Ms. LEE. Okay. I am over my time, so I yield and will recognize Dr. Roe.

Mr. ROE. Thank you, Madam Chair.

And just to start with grumbling a little bit, I don't like this room. We ought to have the next hearing in the Verizon Center. I feel like that is where I am.

And, two, I actually read this stuff, so I would appreciate you all getting this to me a little sooner so I can sit down and read it. And I was able to read a few pages before the hearing, so I have got the grumbling over.

There are huge challenges with this. Obviously, your organizational structure is one; you are dealing with two separate Departments. One of the reasons we are concerned here, I know Mr. Lamb and the Chairwoman was not here when DoD and VA spent a billion dollars to try to make AHLTA and VistA interoperative, and could not.

So, I think this is a step in the right direction. And I guess about 18 months ago, whenever it was, I went to Spokane and was able to be there at Fairchild and began to see the rollout, and it was a bumpy rollout. And it was not because effort was not there.

Look, I have saluted many generals. I didn't have near as much on my sleeve as General Payne, as you do. So, I know what they did, was they saluted and said, Yes, sir, we will try to get this job done.

The problem is that was a—when I saw that, I had implemented an electronic health record in own office with 70,000 charts in our practice. This was 10,000, basically, healthy people in a system that really didn't seem like it worked all that well. And I know that you had to use the legacy reader to get back and get any information.

And I guess my first question is, I know you, Dr. Payne, you are the champion for the providers. I do know that. Isn't that correct, you are the person that is looking after them, that is sitting down every day at the computer terminal?

General PAYNE. Yes, sir. That is correct.

Mr. ROE. And do you think that the MHS Genesis, as it exists at Madigan, Riverton, Oak Harbor, and Fairchild, are meeting the needs of the clinicians there now?

General PAYNE. Yes, sir. I do. I think we have made significant progress since you saw the record in 2017. We have made some significant advancements. We learned that network stability was really, really important and we requiring that well in advance of go-live now.

We also learned that connecting all of our medical devices was critical, and making sure those were all working and well-established. All the cybersecurity standards were met before we went live.

Mr. ROE. Well, I know that slowed—I know that the security issue was one of the things that held it up, and I think that is, hopefully, one of the lessons learned that DoD can pass to VA so they don't have to have the same problem that you had.

Are you rolling out—is what is in Spokane now the same as what you are going to roll out, I think it is in California and Idaho is the next rollout that DoD is doing; is that correct?

General PAYNE. Yes, sir. We start at Travis Air Force Base, Mountain Home, Monterey, and Lamar Naval Air Station.

Mr. ROE. When does that—when do you start standing that up?

General PAYNE. September.

Mr. ROE. Of this year?

General PAYNE. Yes, sir. It is right around the corner.

Mr. ROE. And will it be different than what you rolled out, or the same thing, that they have now in Riverton and Spokane?

General PAYNE. I would like to say that the record has been advanced markedly over the past 2 years. Number one, and one of the great things about having a commercial off-the-shelf product, is that we get regular updates, and we have taken those updates, we have integrated those across the system.

We have also configured the system in a significant amount over the past two years. During the stabilization and adoption period, we added, to correct a lot of the problems that we were seeing initially in the sites.

We have also, in the past year, conducted 14 sprint sessions that were led and directed by the clinicians at the IOC sites telling us where they thought they needed the most help. So, that has been really well received by the community.

Mr. ROE. Well, my concern when I looked at it was, as a clinician seeing patients. And I was reading, just, again, the guide in here, which I find hard to believe, but it says, for instance, we can monitor the time a provider spends documenting care outside of duty hours, and it was less than 3 percent.

General PAYNE. That is correct.

Mr. ROE. Unless they are not seeing many patients, it certainly has been our experience in the private world, I mean, you are spending—I just saw a doctor when I got on the airplane to fly up here at home, and he was lamenting how many hours that he had to spend in entering data, because he had a very busy primary care practice.

The other thing before my time expires is, I was reading that, are we going to run the VistA and AHLTA systems with the legacy reader throughout the full 10 years of this until it is fully implemented or do you turn the switch off in Spokane now, so that you can rely on—I have got the information that I need in front of me right now?

General PAYNE. We do turn off.

Bill, I don't know if you want to answer that, about the legacy system turn-offs? You are probably better than me to answer.

Mr. TINSTON. So, we run the JLV, the legacy viewer, while we are implementing the 23 sprints and getting to all the sites—and that is not 10 years; that is to 2023, when we get to all the military treatment facilities. JLV is actually embedded as a capability in the electronic health record that we are delivering so that we can get to have continued interoperability with the VA records, as the VA is bringing their records over to the Cerner solution. So, it will continue to be used and available, but it is what we are using for interoperability while we are in both environments.

Mr. ROE. Madam Chair, I hope we have a second round. I know I am over my time.

But, I mean, the idea is that we have the Cerner system off the shelf and you are running a parallel system with it. Are we going to continue doing that, because that is really a bureaucratic mess to keep up two systems?

I yield back.

Ms. LEE. Thank you, Dr. Roe.

I now recognize Mr. Lamb for 5 minutes.

Mr. LAMB. Thank you. And I want to thank Mr. Banks' thanks to the witnesses for appearing; we really do appreciate it.

Mr. Windom, if I could just start with you and make sure I understand kind of where we are today in the timeline of everything. You noted in your testimony the contract that we are dealing with between Cerner and VA is what is known as an indefinite delivery, indefinite quantity contract—do I have that right—and that was not competitively bid out in the market because Cerner was already involved with DoD and the Government wanted to continue with Cerner, right?

Mr. WINDOM. Sir, VA leadership endorsed what is called a determination and findings that allowed us to sole-source directly to Cerner Corporation, in support of interoperability objectives, which involved being on the same Cerner Millennium platform. So, that is what drove—so, a DNF drove the award of a sole-source contract.

Mr. LAMB. Right. Got it. Okay. So, that was never—it wasn't put out for bid; it was sort of falling in line with what DoD had already done?

Mr. WINDOM. Yes, sir. Correct.

Mr. LAMB. That makes sense.

Okay. So, under this type of contract, if the go-live at the initial sites does not happen in March 2020, is there any penalty in the contract for that? Like, will money that has been paid to them be recouped if it doesn't happen in March of 2020?

Mr. WINDOM. Sir, the question that you pose spawns a number of "it depends." We are committed to the milestone identified in March of 2020.

The IDIQ contract approach allows for flexibility, flexibility that may be needed due to variability that is introduced that we flat-out didn't know. As you know, we are doing current state reviews. Discoveries may be made, such that you need to build the rectification of those discoveries or problems into your schedule.

We maintain an integrated master schedule, and in understanding of our critical path, we would know clearly when something was introduced to our critical path. Right now, our critical path revolves around clinical workflows, as controlled by Dr. Kroupa, in making sure that end-users embrace the solution and are educated on the solution. But the bottom line is—

Mr. LAMB. Yeah, but that is not really my question, though—if I could just interrupt you—my question is more from—I understand that you are doing everything to stay on schedule.

Mr. WINDOM. Right.

Mr. LAMB. My question is, if something happens on Cerner's end and they just don't perform and March 1st of 2020 comes and they just don't go live—they are not ready—does the flexibility that you are referring to include the flexibility to impose any sort of penalty or sanction on them for not fulfilling that goal in the contract?

Mr. WINDOM. So, the simple answer, sir, is yes. This is a performance-based contract. If Cerner fails to deliver in accordance with the performance and terms and conditions of the contract, we can withhold money. That would be the simple answer.

Mr. LAMB. You can withhold future money?

Mr. WINDOM. We could withhold money. We wouldn't obligate additional money if we had yet to rectify the issue that may be at hand. So, that would not be good oversight on my part. So, sir, we could withhold money. We could withhold work, in support of rectifying whatever concerns that have been identified that may have caused our milestone to slip.

But, again, it depends. I don't want to say, because there are going to be discoveries that may spawn, potentially, a movement. But right now, we are tracking to our March 2020 go-live, so I don't really spend a lot of time, sir, speculating what may happen. I simply say if performance is breached—

Mr. LAMB. Again, I hate to cut you off, but you know that my time is limited.

Mr. WINDOM. Yes, sir.

Mr. LAMB. I am not asking you to speculate about what may happen. I am just asking basic questions about the terms of the contract.

And tell me if I am correct here, it sounds like what you are saying is that in your understanding of the contract, if Cerner does not perform on schedule, VA has the ability to withhold funding from them going forward, yes or no?

Mr. WINDOM. That is correct. Yes, sir.

Mr. LAMB. Okay. Now, Mr. Tinston or General Payne, whoever wants to answer this, when DoD went live at the initial sites and there were all the problems that people had, you know, people were getting the wrong prescription drugs filled and, you know, everything that was widely reported at that time, was there any taken by DoD against the makers of MHS Genesis for those failings?

Mr. TINSTON. Congressman, I wasn't a part of the program at that point. I know that the DoD took those issues very seriously. We paused the implementation. We went through, as General Payne described, the stabilization and adoption period, and then set to correcting those, improving the capability of the system, and then building a different strategy and a different approach to—

Mr. LAMB. Of course. I mean, you have to fix the actual product, and I can tell that is what you all are doing.

My question, though, is, we have contracted with someone to do this work, and was there any sanction or penalty imposed for that initial—

Mr. TINSTON. Congressman, I will have to get back to you on that. I am not positive.

Mr. LAMB. That's fine. Now, I take it from everyone—and I am basically out of time here—but Mr. Windom, you kind of referred to this, do you believe that as of today, Cerner is on schedule to do the initial rollout in March of 2020?

Mr. WINDOM. Yes, sir.

Mr. LAMB. Okay. And I just want you all to know that you use the terms—Mr. Windom said that we are looking to build an inter-agency program decision-making that was comprehensive, rapid, and agile. Mr. Tinston talked about being technically and programmatically efficient.

You should know that that is not how the contractors described the current situation, as it stands right now. They were with us last week. They said that decisions are slow.

When I asked them open-endedly, what is the number one thing you need to succeed? It is faster decision-making by the two Departments, which are two large Departments—I can understand how they would be slow—but that is what is driving our interest in a more efficient process that is implemented quickly.

So, with that, Madam Chairwoman, I yield back.

Ms. LEE. Thank you. I now recognize Mr. Watkins for 5 minutes.

Ms. LEE. Thank you.

I now recognize Mr. Watkins for 5 minutes.

Mr. WATKINS. Thank you, Madam Chair.

I represent Kansas' 2nd Congressional District, think small towns, rural communities, and that makes expanded community care programs so very important.

And so, Mr. Short, what systems and mechanisms do you have in place to assure that the exchange records with community providers runs smoothly?

Mr. SHORT. Sir, with our contract with the Cerner Corporation, we have their Health Information Exchange that they have used in many other partnerships that they have through community providers. The process we are working through right now is before we Go-Live in March for those processes and connections to be in place, so it will grow the connectivity and ability for VA to have community partner access data exchange at a greater level than we have ever had before.

Mr. WATKINS. That is good to hear. Thanks.

And, General Payne and Mr. Short, would it be fair to say that the considerations for that interoperability are different for the DoD as compared to the VA, and so the DoD is implementing systems for the first time while the VA is replacing systems. Would either of you care to comment on that difference?

General PAYNE. Just a clarifying question, sir. We are implementing systems for the first time. We have had, you know, AHLTA, CHCS for 30-plus years for our in-patient systems. I think what we are doing is taking multiple separate systems and bringing them together in an integrated system, which is a huge advantage for us.

Mr. SHORT. And, sir, I will add to that. Currently, today, DoD and VA both have an HIE, Health Information Exchange, that are much smaller than what Cerner is going to provide for us later in this year where DoD and VA will both be able to share the same Health Information Exchange.

As you know, VA has a lot of care on the outside with MISSION Act, community care, that has potential to grow. Obviously, DoD has been on record many times, they have a large portion of their care on the outside. So when Cerner launches that next year, both DoD and VA will have the ability to get a lot more records from the outside than we ever have.

Mr. WATKINS. And just as a clarification, General, what major systems or mechanisms do you have in place to exchange medical records with TRICARE providers?

General PAYNE. I will start and then I think Mr. Tinston might be able to add. We use joint legacy viewer today, I want to say the number is over 50 health care information exchanges we have established with the civilian community, and that is going to expand,

as Mr. Short pointed out. As we move into a Common Well into the future, there will be thousands of health information exchange. And we are exchanging information with both our civilian counterparts, as well as the VA, on a daily and hourly basis.

Mr. Tinston?

Mr. TINSTON. Well, the number is 59 HIEs that we are connected to right now. When we move to Common Well and when we are joining VA in the Cerner environment, we get the added advantage that any HIEs or networks that we are connected to that the VA connects to, we also get to share the advantage of that same connection, and vice versa.

Mr. WATKINS. Thank you, Madam Chair. I yield my time.

Ms. LEE. Thank you. I now recognize myself for 5 minutes.

I would like to focus a little bit about patient identification. As I understand it, the VA and the DoD have different patient identification standards, understandably, in their medical record number formats; we heard that there has been more than some conversations about standardizing them.

Mr. Short, what is the status of those conversations and have you been able to reach a consensus?

Mr. SHORT. Ma'am, DoD and VA work together to create what is called a Joint Patient Identity Management Service. We have taken the back-end systems that we have had connected for many years, we have enhanced and created some new business rules. The current connections that DoD has feeding MHS GENESIS, as they call it, the EHRM platform, we have taken that connection and made modifications to it.

As part of that, we have also had to make sure that every veteran had a unique identifier. DoD issues out an EDIPI identifier to all soldiers, sailors, airmen, Marines, but many veterans in the past didn't have those. So, as part of this, we also had those identifiers issued to all veterans that ever existed that we have a record of. They could have been a World War II veteran that passed away 30 years ago. If we have a record of them, they now have been issued this identifier.

We have completed that in the last couple of months. We are down to about three or 400 left that had to go through manual checks, because someone with a similar name had similar Social Security numbers and they have to manually double check those.

So that has been put together and in the next couple of months that will go into testing, so that service is together, that way we feed one system of one identity service to the common EHR. Since you have the same population or very similar populations, you needed a common interface for identity going to the system for patient safety. So we engineered that early on in the system, we have put it in place, and testing will start in a couple months.

Ms. LEE. Great, thank you.

Now that the MISSION Act has been implemented and more veterans are going to be receiving their care in the community, has there been any conversation around standardizing patient identifiers with the VA and community providers?

Mr. Short?

Mr. SHORT. I'm sorry, ma'am, I didn't know who the question was to. So we currently today, we work with the HIEs, as I men-

tioned earlier, the health information exchanges, and Cerner has Common Well, which General Payne mentioned. So currently today, when we send someone out in the community, we have the advantage, we have already identified them before we send them out, so that part is taken care of. When it is accepted, when the community partner accepts them, that our community partner exchanges that we work with validate those identities also.

So we have the advantage of we kind of manage that process—or don't kind of, we manage that process through the community care referral process. So, from that standpoint, we keep that. We have the Social Security number, as well as the Veteran identifier I mentioned earlier. We actually track a number of identifiers on everybody and we double check that inside the VA system, the Identity and Access Management Team under VA OI&T, they have a whole process where they use all—a large number of identifiers to validate those from the outside.

Ms. LEE. Okay, thank you.

After—I would like to now turn to some infrastructure questions and after the contract between VA and Cerner was signed last year, Cerner completed a current-state review. The reports generated indicated the obvious concerns with infrastructure, including insufficient network capability, outdated hardware, necessary facility modifications. Did the VA conduct their own assessment in concert with Cerner?

Mr. SHORT. Ma'am, the VA staff went with Cerner when they did their current-state review, so it was done in partnership along with our government and contract staff. And then, once that was completed, there was subsequent reviews done by VA OIT for the technical pieces of it and VHA facilities as well.

Ms. LEE. So I understand now that VA has plans with MITRE to perform an assessment as well; has that assessment been completed?

Mr. WINDOM. Ma'am, I know of no plans with MITRE to conduct a technical assessment. We are using a number of other entities, but MITRE has not been one. We have got MITRE personnel on our staff who participate in some of these assessments, but we have not contracted specifically with MITRE to go do these assessments.

Ms. LEE. Okay, so no MITRE request to do an assessment?

Mr. WINDOM. No, ma'am.

Ms. LEE. Have there been any updates made to these assessments?

Mr. WINDOM. Ma'am, I am going to defer to John Short, my CTIO, for that.

Mr. SHORT. Yes, ma'am. Cerner did their initial review, we had some feedback, we did our review and, as we completed that, Cerner updated those current-state reviews. And again, as I mentioned, OIT and VHA facilities also did those reviews. Since then, we had a meeting in the Pacific Northwest to go over all the facility work that needed to be done and put that all under plan and action.

Ms. LEE. Thank you.

I now recognize Dr. Roe.

Mr. ROE. Thank you, Madam Chair. A couple of quick questions.

Any concerns about the 10-year rollout, because technology changes so fast now, are we afraid—do you think that the rollout now is going to look like in 2019 like it is going to look in 2027 or '28? Are you going to be able to adapt and make those changes as inevitably technology will change?

Mr. WINDOM. Dr. Roe, I think you have highlighted an important element of the IDIQ contract, indefinite delivery, indefinite quantity, where we get to leverage the commercial advancements that Cerner undertakes in its commercial environment with our own portfolio without incurring additional expenses. So we expect to evolve with the commercial market; to stay current, we will evolve with the market. And technology, as you just highlighted, moves very quickly, so we intend to use things like cloud computing and APIs and things that may become the prevailing methodologies in the technological arena.

Mr. ROE. And, Mr. Tinston, I hope that the mentality to listen to providers in the MHS system about why they don't like it, I think we should, and not just reeducate them about what is good about it, but have these providers out there that can change it and make it a better system. Are you doing that? Have you all done that?

And, Dr. Payne, you also may want to jump in.

Mr. TINSTON. So the way the DoD has set the program up subsequent to the IOC sites, it is designed to do exactly that. I have a team of IT business system implementers who make sure the IT is right and make sure that it reflects what the medical facilities need, and the clinicians need, and then General Payne takes care of that. So we are two elements of getting this right and he works with the clinicians to make sure that on the implementation side we are doing the right thing.

Mr. ROE. What I found out in implementing an electronic health record was you had the IT people that didn't really know what we needed, so they put everything in there. And I know I would get a stack of paper this much and I am thinking somewhere in this pile of you know what there is some information I might be able to use if I can find it. And that was the frustration I had with it, because we have these cut-and-paste things that you end up with misinformation being in there and you never can get it out.

And so are you listening to providers to say, look, I need this amount of information in my little silo right here, I don't need every question that has ever been asked anybody in their life every time I see them, which is what these records did. And it wasn't—I don't think it was the IT folks' fault, I think they just didn't understand what was clinically important to me as a doctor.

General PAYNE. As I mentioned to you about our Sprint sessions, I think the front-line clinicians, we also have clinical communities that are working with the VA councils in configuring the record. One of the great things about MHS GENESIS is it is configurable; we can adjust the system. As a provider, you can adjust it to your likes and dislikes.

We are working—the other part I really like about this is we are part—we are not an isolated—just isolated in DoD, we are participating with the Cerner client universe. We visited the University of Missouri, the Tiger Institute, to see how they are operating. We

are about to go to Memorial Hermann Hospital in Texas to see how they are implementing MHS GENESIS, that is one of the safest hospital systems in the country. And we are also, our ophthalmologists are working with Cerner to help devise the ophthalmology workflows.

So I think this record gives us an opportunity we have never had before and, with our VA colleagues, I think there is a huge amount of power in that.

Mr. ROE. And this is just a question, Mr. Windom, I read this last night, I have no idea what it means. "VA is leveraging several efficiencies, including revised contract language to improve trouble ticket resolution based on DoD challenges."

Could you translate that into something English?

Mr. WINDOM. Yes, sir. Sir, that was pre-contract award, so there is no contract modification. Basically, our partners in DoD shared with us very forthright and honestly some of the challenges they were dealing with, with trouble ticket management in the Pacific Northwest, and we were able to add terms and conditions to our contract to facilitate a high level of performance and review by Cerner in adjudicating ours sooner rather than later. So, it really is just a lesson learned, sir.

Mr. ROE. Thank you.

Mr. WINDOM. I will be more clear next time.

Mr. ROE. Thank you. The last couple things. One is a big challenge, Dr. Thompson, you know this, across the country is interoperability. It is not DoD and VA; it is the private sector: how do we share information? And, unfortunately, a lot of people don't want to share information, because the information they have is power and they can leverage it for money. But it is critical for us to be able—as clinicians to be able to share clinical information across VA to the private—look, it does me no good to have a MISSION Act if I am sitting out here and I can't get any information from the VA. And, by the way, after I see the patient, if that information doesn't end up back at the VA, it doesn't do the patient any good.

I am going to leave one question, you can think about it, both of you, because my time is expired, but in this rollout, what is the major thing that keeps you up at night?

And I will end on that. I yield back.

Ms. LEE. Thank you, Dr. Roe.

I now recognize Mr. Lamb for 5 minutes.

Mr. LAMB. Thank you. And if you would like to answer Dr. Roe's question, that is I think a major question on all of our minds, just sort of a current assessment right now, what is our biggest obstacle? Mr. Windom, if we could start with you. Between now—let's say between now and March 2020, what is the biggest thing that keeps you up at night?

Mr. WINDOM. Sir, I have listened to this Committee and I have listened to the end users intently, and it is about user adoption. The technology will work, the technology will support, the embracing of the end user to our change management strategies, our education strategy, training strategy, that is our critical path element. So the critical path element keeps me up.

I think Dr. Kroupa and her team are doing a great job. I would like to pass the question over to her, if you don't mind—

Mr. LAMB. I appreciate that. I was—

Mr. WINDOM [continued]. —and—

Mr. LAMB. —going to move to her anyway.

Mr. WINDOM. —but that is what keeps me up.

Mr. LAMB. And, Dr. Kroupa, are you the one who oversees the 18 councils and the input from the clinicians?

Dr. KROUPA. Yes.

Mr. LAMB. Okay. So if you could just let me know sort of what is at the forefront of your mind, but also what are the most recent examples that you are hearing from them of issues?

Dr. KROUPA. I think that the biggest challenge for us in VA is, as has been mentioned, we are going from a CPR system, which people are very accustomed to, to a commercial system. So there has been a lot of education about what does that mean, how does the commercial system work, how do we even speak the same language as the commercial system.

I think we are now getting into a phase where the councils understand that. They are really hitting their stride in terms of understanding how the system works and are able to really see the places where we can accept commercial best practice and places where there are specialized things that VA needs to do for our patient population and for our mission.

Mr. LAMB. And what are some specific things that they have identified recently?

Dr. KROUPA. So there are some things, some basic things like service connection. No one else in the world cares about service connected veterans, except for VA. That is not something that is in the commercial system to start with. We have a lot of programs in VA that other commercial systems don't have. We do things with PTSD, with blind rehab, you know, a lot of comprehensive—

Mr. LAMB. No, I am sorry to interrupt. I understand why the VA system is different than the commercial clients. What I am asking is there a recent example you know of where a clinician has flagged for Cerner and for you this thing that you already have programmed will not work for me for this reason?

Dr. KROUPA. There has certainly been a—probably in every council, there is something that has been flagged that says we need development in this. We need configuration in this to make sure that it meets the VA standards.

Mr. LAMB. But do you know what those are?

Dr. KROUPA. There is a whole list of those. So those are all the things that we are working on now with Cerner to rectify.

Mr. LAMB. Okay. And is there a—is it planned in the schedule where before March 2020, some of these clinicians, either on the councils or otherwise, are actually going to go through like a dry run testing in front of the computer?

Dr. KROUPA. Yes.

Mr. LAMB. How is—can you tell me how that is scheduled?

Dr. KROUPA. Sure, sure. So part of the council process is that they validate their decisions from the last time around. So they are constantly validating and reviewing the decisions they made before they move forward with the next phase. Then we have an extensive

testing time frame. People from the council has already been identified that will be the testers. So that we will make sure that their intentions are met in the product when it is—before it is ready to go out. And then we will have extensive testing in Spokane and Seattle, including mock GoLives and a variety of validation events to make sure that it is ready to go.

Mr. LAMB. And do you know when that starts in relation to March of 2020?

Dr. KROUPA. The testing will start in November.

Mr. LAMB. Okay.

Dr. KROUPA. That is our current plan.

Mr. LAMB. Thank you. Mr. Windom, if you would, yes.

Mr. WINDOM. Mr. Lamb, may I add just real quickly is that we knew at the inception, there are certain capabilities that aren't delivered as part of the Cerner integrated solution. We knew that. Things like prosthetics, things like long term care. These are capabilities that will be interfaced with the existing system as Cerner and us, to be frank, walk through the coding process to actually integrate it into a solution. So no capabilities will be lost. We may interface in the interim and then replace the capability in the future as part of our overall implementation strategy.

Mr. LAMB. Right. No, I understand that in general terms. I guess, I think I am just a little bit surprised that nobody can name a specific instance of where an end user doctor said to you guys, "Hey, the program falls short in this area of something that I do and we need to get it fixed," and how it was fixed. It seems to me that is what you are describing that you want to be taking place, but I am just a little concerned that we don't have specific examples of that. And you can feel free to get back to us later. I understand we are putting you on the spot.

Madam Chairwoman, I yield back.

Ms. LEE. Thank you. I would now like to recognize Mr. Roy for 5 minutes.

Mr. ROY. I thank the Chairwoman. I appreciate you all being here and taking your time to address this Committee. And I apologize for missing the first part of it, so hopefully I won't repeat anything. We have got redundant duties in another Committee. Fortunately, this is a Committee where we actually, on a bipartisan basis, tend to try to do something productive. So I am glad you all are here.

Mr. Windom, I might start with you. I understand that the VA is pursuing a best of suite strategy with the Cerner contract and not a best of breed strategy. Could you please explain what that means to you and how you all decided to pursue that path?

Mr. WINDOM. Sir, a best of breed is an individual set of capabilities that are basically daisy chained together, where often the government becomes the integrator of those products. Where a best of suite is an integrated solution that is built, that is developed, that is coded to perform in an integrated fashion such that there is no integration requirement in between the individual components of the solution. And so AHLTA and CHCS on the DoD side, that is an example of two different products where the DoD is the integrator between the two. So that is how I would describe it to you, sir.

Best of breed is a set of solutions that are daisy chained together to deliver the requisite end state, where a best of suite is an integrated set of elements where the end state is delivered without the interactions in between each stage.

Mr. ROY. So quick question, quick follow up on that, though, isn't the risk sort of putting all of the eggs in one basket, versus having other alternatives and options we might be able to have? Especially with modern technology, with APIs and all of the different ways that we can, you know, integrate across platforms, is that not putting all the eggs in that one basket or no?

Mr. WINDOM. Sir, we have not restricted innovation in any way, shape, or form on even a best of suite platform. So if there is capabilities being delivered in the market that we, the VA, want to leverage, we have the ability to present that to Cerner Solutions set as a requirement in fulfillment of VA mission objectives and pursue integration of those, if you will, enhancements or improvements.

So a best of suite does not imply you can't inject new capability or innovation into the product line.

Mr. ROY. Well, on a follow up then, Mr. Tinston, I assume DoD also has a best of suite strategy; is that correct? And if so, could you please walk me through your thought process there?

Mr. TINSTON. We do, in fact, have a best of suite strategy. And the idea is that you get an integrated set of capabilities, as Mr. Windom said. There may be a best product in this area, but what works best in the combination of capabilities that we are delivering to clinicians and the patients. So—

Mr. ROY. Okay. Slightly—I would love to engage on that probably for hours, but in our limited time, Mr. Windom, back to you. How do you define vendor lock in as it pertains to electronic health records, and health IT companies? And what would it mean for the VA to become locked into a particular company?

Mr. WINDOM. Sir, very sensitive in not only my DoD life but now to restrictions on the use of intellectual property. You know, the open sourcing, the things that allow us, if you will, to inject capabilities and not be bound by a solution that we have contracted for. So the—having access to code, having access in an unrestricted way to bringing in the requisite solutions, whether it be apps, you know, applications that are now very prevalent, that is where I deem vendor lock is. And in our terms and conditions of our contract, we have greatly inhibited vendor lock by promoting Cerner opening up their gateway to allow better solutions, enhancements to the product line that they may not only want to incorporate on behalf of the VA before their commercial customers as well. So, sir, hopefully that gets to where you were looking for.

Mr. ROY. Well, on a more specific basis, does buying the Cerner Millennium EHR pose the risk of vendor lock in?

Mr. WINDOM. No, sir. The terms and conditions, again, we have got an innovation CLIN, contract line item number. We have got—again, I don't—this is a VA requirement. We drive the requirement. We drive the behavior of Cerner and performance of the terms and conditions of the contract. We have no desire to give up on the innovative talent that the VA brings to bear, nor the solutions that are being developed in the market today.

So we believe we have that relationship in the terms and conditions of our contract, and we will exercise it as necessary down the road to support, again, our veterans.

Mr. ROY. And relatedly, does the VA getting rid of its patient portal, My HealtheVet, and adopting Cerner's patient portal pose the risk of vendor lock in?

Mr. WINDOM. Sir, that is—I am going to defer that question to Dr. Kroupa, but that is not our strategy. So I am going to—we are not getting rid of our patient portal.

Mr. ROY. Okay.

Mr. WINDOM. We have a methodology that we are going to move forward with that leverages the qualities of both patient portals in our strategy. The key is that this is not a turnkey solution set. We can't just turn one thing off and turn something on. We know there are benefits in the way our system performs. It is not our intent at all to reduce the capabilities being provided to our veterans, but to enhance the capabilities.

So Dr. Kroupa, ma'am, did you want to touch on patient portal specifically?

Dr. KROUPA. Certainly, so we have done a side by side comparison of what the Cerner portal offers versus My HealtheVet. We are working on a strategy of how we can assure that the veteran experience is as close to the same across the country as we can make that. There will be some transition time, but we are basically working with Cerner to upgrade their portal to make sure that it offers the information and the ease of use of My HealtheVet.

So we are still working, outlining that strategy, but we are constantly working with Cerner to make sure that their product gets better to serve our veterans.

Mr. ROY. Madam Chair, I am a minute over my time. Thank you.

Ms. LEE. Thank you. The Subcommittee has copies of the current state reviews and we have received updates and we appreciate that very much. I just want to make sure that we have every infrastructure report. So besides the CSRs, is there any other analysis review about infrastructure readiness?

Mr. WINDOM. Ma'am, we have a joint infrastructure plan that was co-authored by the OI&T office, headed by the CIO and also John Short and our team. We gladly share that with you, because what we feel is that the synergy between OI&T and our office is essential. They are the managers of the network today. So we can provide that if you don't have that.

John, did you have any other documents that you are hiding from me?

Mr. SHORT. No, sir, not hiding documents, but OIT, as I mentioned, there was other reviews that were done and the Office of Information and Technology did create a report on Seattle, Spokane, American Lake—we can get that for you.

Ms. LEE. Can we get that? Thank you.

Mr. SHORT. Yes, ma'am.

Ms. LEE. In the past, you have indicated that you will have the infrastructure projects completed within six months of go live. And then you just stated that—I just want to ask for clarification, you are going to do testing in November. Do you need the full infra-

structure done for the testing? Are you going to sort of test modules while you are completing—like how does that timing work out?

Mr. WINDOM. Yes, ma'am, there is testing in the operational environment and testing outside. The testing outside of the operational environment does not require the infrastructure to be ready to go. We are sticking to our plan of the infrastructure will be ready six months prior to Go-Live. And so the testing environment that we build in support of testing in a non-operational environment is separate, with possibly some connections or interfaces.

John, did you want to touch on that anymore?

Mr. SHORT. Yes, ma'am. Just for clarification. The infrastructure needed for Go-Live will be ready in that time. But there is still some additional infrastructure work that will be completed later, not required for Go-Live, but for a better user experience overall, some of those things, but not necessarily for operation. But all of the ones necessary for testing onsite, necessary for operations onsite, will be done in time.

Ms. LEE. Do you worry that if you implement the infrastructure for operation, but it is not optimal and ultimately, you said the thing that keeps you up at night is the end user experience, and so if you don't have the proper infrastructure in place, you actually set yourself back.

Mr. WINDOM. Ma'am, I think you are right on point. It goes hand in hand. What we do is we build plans to support being ready as intended. We would owe you that transparency to your staff if we are not meeting what we think our objectives are in support of that.

I have indicated quite a few times that IOC is a period of time, initial operating capability. What is available at Go-Live, we will continue to update the infrastructure to deliver capabilities throughout the IOC process, which is a period of time, vice a single point in time. So I wanted to make sure that was understood.

And then obviously tech refreshes will be ongoing to support the system operating at the optimal level. As you know, we are going to be running VistA and Cerner in parallel for a while. And so we know that the infrastructure will not run better with two systems, but we intend to—so we intend to make the appropriate and prioritize decisions on infrastructure upgrades.

Ms. LEE. So what is your timeline on just beginning the infrastructure construction at IOC sites and the ordering of the hardware?

Mr. SHORT. Ma'am, a lot of that is already taking place. Some devices will be arriving soon. Some cabling has been done. Wireless infrastructure has been replaced at one facility. So all the work is actually ongoing already. We can provide you a full schedule, ma'am.

Mr. WINDOM. Yes, and ma'am, we would gladly provide you a full schedule so you can see all of the spreadsheets that are being worked. We are leveraging—this is where I compliment the CIO and the OIT. We are leveraging their contracts to the maximum extent possible. I mean, we are talking about commodity type hardware that they already procure, that we are simply being able to leverage their vehicles for efficiencies on our side.

So that is actually a time saving mechanism that is giving us schedule back that we appreciate the CIO support in.

Ms. LEE. Good to hear. Thank you. I now recognize Dr. Roe for 5 minutes.

Mr. ROE. I thank the Chair very much. And we here on this Committee are here to try to help roll this out, not get in the way. But I would like to be invited to one of your sites, with no Power Point presentations, and so I could just sit down with nurses, and doctors, and other people using this system and actually see how it works. I, personally, would like to do that.

And to Mr. Roy's question, to follow up on what he was doing, and I guess anybody can get this here, what other functions will this system do? I mean, is it going to—are you going to be able to contract with it, schedule with it, appointments, what else is the Cerner system capable of?

Dr. KROUPA. So this is really very a full set of capabilities that we have bought from Cerner. So it will have the electronic health record, the clinical portions of that. It will have the revenue cycle side of things, so scheduling appointments, registration, billing, those types of things. It will have—we have HealtheIntent, which is the data analytics section—

Mr. ROE. Did you say it would be able to do billing also?

Dr. KROUPA. It will be part of the billing process, yes. We have HealtheIntent, which is the data warehouse side of that, where we will be able to do reporting and analytics. It has extensive management modules, so that it will help clinical managers understand the flow through clinics, the—as you mentioned, the time that providers use on the system. So we will be able to say that this particular provider is having trouble getting through this order set and we need to go help and train them, and help them understand the system better. So it has an extensive suite of both management and clinical uses.

Mr. ROE. Well, this is a—look, this is a monstrous undertaking that you all are doing, both of you. And there are going to be some bumps in the road. There is no question about that. So please just share them with us. Look, I have been down that road, know how it is. It is disruptive to the practice and the clinicians. So if you run across things like that, don't sweep them under the rug. Come to this Subcommittee and let us know about it. We are here to try to help you, provide what you need to get your job done.

And I think it is one of the most important projects that is going on now. At the end of the day, it is not about technology, it is about patient care. It is about going into the room and seeing a patient with their ailment, and providing the absolute best quality of care we can do. It is not about—nobody cares about Wi-Fi and 5G and all of that. They just want to get well when they come see me. They don't care how they do it or come see the doctor. That is what you do and what I do when we go in.

But our job is to make sure all of that other stuff works so we can do that. So I would encourage you to be as forthright with us as you can be. Mr. Windom or Mr. Tinston, either one, it doesn't matter, or both of you can answer this, but who decides, or have you all decided who is going to lead the firm? Has that decision been made and who made it?

Mr. TINSTON. To my knowledge, Congressman, that decision has not been made. So I think the two departments are in discussions about who is going to be the interim leadership, the interim director and the interim deputy director for the firm, and then they are going to pursue permanent hires in the future.

Mr. ROE. Okay. So that hadn't been made yet. Lastly, and I will finish up and yield back my time, you have been very—thank you all. It has been a very good hearing. Do you see, Mr. Windom, any delays that could happen right now? Looking out your windshield, do you see anything that would hold you up, because if you do, to me, that is fine, if you just—if it takes another month or two, I would rather have you get it right then get it quick and get it wrong.

Mr. WINDOM. Yes, sir. And you have been clear, sir, in a number of hearings and we appreciate that support. I will tell you March 2020 is where we are tracking for Go-Live. I keep pointing to the clinical decision-making process that Dr. Kroupa leads. It is about when they are ready. When they are ready is when we will go deploy this thing.

And so we have got our last workshop, I think, in September and we will be looking toward where we are in aligning the workflows with DoD being involved in those. And I think we, obviously, would owe you an interaction to say, "Sir, here is where we are in the workflows." But I view that as our critical path item. And as you know about the integrative master schedule process, my critical path—we can work a myriad of things in collateral and parallel, and we are doing that. So that critical path element for me is the clinicians and their embracing of the solution coming forward.

So I will—can I come back and see you in November?

Mr. ROE. Absolutely.

Mr. WINDOM. Yes, sir. Okay.

Mr. ROE. I hope so. I hope I am here in November. One last question. When will you know it is interoperable? When will a—because we are going to have folks separating from the military during this time and they are going to be leaving? When will we know you can punch a button and move that medical record over from DoD to VA?

Mr. WINDOM. I think, and I will defer to John after I make just two remarks, is that, sir, I think that is one of the benefits of us being in the Pacific Northwest simultaneously with the Department of Defense is that you should be able to walk from Madigan—after Go-Live, you should be able to walk from Madigan and into American Lake and to Seattle Medical Center, and to Mann-Grandstaff, and you ought to be able to bring up each other's records. That is where we are striving, what we are striving for. Let me turn this over—

Mr. ROE. Yes, I should be able to make a three foot putt, but I can't a lot of times and so—

Mr. WINDOM. Well, so that is what our testing is going to be in support of. That is what our strategy is going to be in support of. And we will welcome you out there for the Go-Live session to prove that to you.

Mr. ROE. When will that be?

Mr. WINDOM." Yes, sir.

Mr. ROE. When will that be?

Mr. WINDOM. March of 2020, sir.

Mr. ROE. March of 2020?

Mr. WINDOM. Yes, sir.

Mr. ROE. I yield back. Thank you.

Ms. LEE. Thank you, Dr. Roe. I now recognize Mr. Roy.

Mr. ROY. Thank you, Madam Chairwoman. Just to follow up with a few more questions. I started with Mr. Windom. Does using Cerner's HealtheIntent product as the repository for all veteran health data pose the risk of vendor lock in, just continuing the conversation about lock in?

Mr. WINDOM. Sir, we selected a solution to benefit the veterans and the active duty servicemembers. So the vendor lock thing, I don't know enough about the inter-workings of HealtheIntent to be able to give you, and so if you don't mind, I will take the look up—

Mr. ROY. Okay.

Mr. WINDOM[continued]. —and I will defer to John and Dr. Kroupa for maybe their assessment of the product.

Mr. SHORT. Sir, when we were negotiating the contract, we required Cerner, upon VA's request, to extract the data from Millennium and HealtheIntent into the form and structure that we require it in. So if in the future we decided to go somewhere else, we could have the data extracted to go somewhere else. And obviously that would be a whole effort in itself. But we do have that ability, so it is not locked into their system.

Mr. ROY. Okay. And relatedly, you know, in general terms, I just want to go back to Mr. Tinston. I understand DoD plans to buy HealtheIntent but has not done it yet and is vendor lock in a consideration in this decision?

Mr. TINSTON. So we are, in fact, we have a joint team with the VA for the implementation of HealtheIntent. We are setting up the environments now. I am not worried about lock in with HealtheIntent. As John Short just mentioned, the data is not Cerner's, but importantly with HealtheIntent, it is a set of capabilities built on other products, some of them even open source products that are not Cerner exclusive products. So I don't see a risk of vendor lock in here.

Mr. ROY. So just to clarify, you know, the questions that I am asking about vendor lock in are not meant to be critical of Cerner or anything along those lines. You know, I think, you know, obviously, one of the leading companies out in the industry. It is meant to just focus in on some of the concerns that we might have. This project is very large and difficult, and we want to complete the basics before turning attention to other stuff.

But I believe innovation is really important. And as I know, I think all of you do, believe it or not, I have a masters in Management Information Systems from my previous life, which was in 1995, so it is about as useful as, you know, having a putter in my hand right now.

But I do care about these issues and think about them, at least analytically, in the way that I would when I was in that realm of my life. So the question I would have here that I am trying to understand is how we are getting the kind of competition and innovation that needs to continue through this process, right? And par-

ticularly for veterans, I know I hear in my district all the time about their concerns, about under choice and mission, being able to go access private sector health care and having trouble doing so, and trying to make sure that we have got the best health records to make that process as smooth as possible.

So one question here, Mr. Windom, is do you know what Cerner's market share is now?

Mr. WINDOM. I do not, sir.

Mr. ROY. Okay. My basic understanding is it would sort of be in the upper 20s or something in that zip code of the market and then do—I assume the answer will be no, but do you know what the market share would be if the military health system and VA both finish implementing Cerner nationwide? Do you have an estimate of what that market share might look like?

Mr. WINDOM. I do not, sir.

Mr. ROY. Okay. We have some rough estimates that that might put it in the sort of mid to upper 30s. And again, nothing inherently wrong with that per se. We have got a lot of industries where there is some significant market dominance. I think it is just a question that should influence at least some of our thinking about making sure that there is the kind of innovation that is necessary. And you know, we are not talking about monopoly here, obviously, but we are talking about concerns about making sure there is continued innovation.

So this seems to have been one of VA's considerations when it negotiated the contract with Cerner. And so I want to ask you one question. The contract says VA will have access to Cerner's data architecture, not just the data in the system, which VA should already own. VA hailed this as a big victory when the contract was signed. What is Cerner doing differently to give VA this access and how is VA using it?

Mr. SHORT. Sir, on the access to the data models and the, so what we have done already, data migration is the main area where this hits first. And that is—and there is many elements to data migration, many steps. So when we did this, we had to map Vista data to the HealtheIntent data model, which CMO staff did with—Dr. Kroupa's staff did with Cerner. And then they had to be mapped to the Millennium data model so Cerner can move that data.

So the first steps that have been done, and now Cerner is taking the next steps over the next couple of months to move that into the HealtheIntent model and to the Millennium model. And by having access to the data models to be able to map that, we can actually make use of all of VA's Legacy data and Vista back to 1981 so it can be used by DoD and VA.

Mr. ROY. Anybody else have any other, anything to add to that? Okay. Well, okay. Well, thank you, Madam Chairwoman.

Ms. LEE. Thank you. Well, this wraps it up. I just want to thank you all for your time today and your testimony. Certainly, we understand how incredibly complex and important this project is and the opportunity to improve care for not only our active servicemembers, but our veterans. And, certainly, the example that Mr. Tinston provided with the nursing, rapid response that helped save a life is obviously what we look for as the future of this project

and the great opportunity we have, not just within the VA and the Department of Defense, but for health care, not just across this country, but throughout the world. So, not a small undertaking.

You know, last week—I just want to reiterate this—last week, the contractors said that their single greatest risk to their success was the timing and their ability to make decisions. And, you know, we had the IPO and now—then it was the JEHRM and now it is the FEHRM. But still, today, my understanding from the questions that were answered today, that this is really just still a concept and not an actionable plan, at this point.

And then, layered on top of that, we have the IDIQ contract which, you know, according to Mr. Windom, you have clear responsibilities that are Cerner's versus yours. So, we are happy to hear that you are confident you are on schedule for the March 2020 roll-out.

So, my concern is as we get closer and closer and if we start to miss deadlines, there is going to be a clear decision point when we want to understand who is responsible. And without a clear plan on this FEHRM, and I am going to reiterate that again, it really puts us and the taxpayers at risk. Because, you know, there is going to be a point where Cerner is going to say, No, it is your fault. We are going to say, No, it is your fault.

That is why it is so important that we have this governance structure in place, so we can understand, and we have one point of decision-making and one point that can say, this is what happened. And we are either going to hold Cerner accountable or we are going to hold ourselves accountable.

And, clearly, especially as Dr. Roe said, you know, we know this is an undertaking and when we come up to bumps in the road, we would rather than understand them than find out about them after the fact.

And so, I just need to close this out by reiterating, as soon as we can see the actionable plan on the FEHRM, it will give us a lot more clarity and comfort as we move forward and work together with you to try to meet the March 2020 rollout.

So, best of luck. Continue the great work. Thank you all for your service to our country and our veterans and our active military members, and we look forward to continuing the conversation. Thank you.

Oh, Members, before we end, will have 5 legislative days to revise and extend their remarks and include extraneous material. This hearing is now adjourned.

[Whereupon, at 11:51 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of John H. Windom

Good morning Chairwoman Lee, Ranking Member Banks, and distinguished Members of the Subcommittee. Thank you for the opportunity to testify today in support of the VA initiative to modernize its electronic health record (EHR) through the acquisition and deployment of the Cerner Millennium (Cerner) EHR solution. I am accompanied today by Dr. Laura Kroupa, Chief Medical Officer for the Office of Electronic Health Record Modernization (OEHRM), and Mr. John Short, OEHRM Technology and Integration Officer.

My thanks to Congress, and specifically this Subcommittee, for your continued support and shared commitment for the program's success. Because of your unwavering support, VA has stayed on track for implementation, enabling us to continue our mission of improving health care delivery to our Nation's Veterans being a responsible steward of taxpayer dollars.

Background

On May 17, 2018, VA awarded an Indefinite Delivery/Indefinite Quantity (ID/IQ) EHR contract to Cerner. Given the complexity of the environment, VA has awarded this ID/IQ to provide maximum flexibility and the necessary structure to control cost. Through this acquisition, VA will adopt the same EHR solution as the Department of Defense (DoD). The solution allows patient data to reside in a single hosting site using a single common system to enable the sharing of health information; improve care delivery and coordination; and provide clinicians with data and tools that support patient safety. VA believes that implementing a single EHR solution will allow for seamless care for our Nation's Servicemembers and Veterans. Since contract award, VA has accomplished several key events outlined below.

Task Orders

As mentioned earlier, VA awarded the Cerner contract on May 17, 2018. VA also awarded the first three Task Orders (TO), which are project management, Initial Operating Capabilities (IOC) site assessments, and data hosting. In September 2018, VA awarded three TOs for Data Migration and Enterprise Interface Development, and Functional Baseline Design and Development and IOC Deployment. VA leverages the ID/IQ contract structure awarding firm-fixed-price TOs as requirements are validated. This strategy affords VA the flexibility to moderate work and modify implementation and deployment plans efficiently. Since contract award, VA has awarded additional TO's to begin activities around data migration and IOC deployment. Additional details about the TOs are as follows:

- **TO 1 - EHRM Project Management, Planning Strategy, and Pre-IOC:** Cerner will provide project management, planning, strategy, and pre-IOC build support. More specifically, the scope of services included in this task order are project management; enterprise management; functional management; technical management; enterprise design and build activities; and pre-IOC infrastructure build and testing.
- **TO 2 - EHRM Site Assessments - Veterans Integrated Service Network (VISN) 20:** Cerner will conduct facility assessments, to prepare for the commercial EHR implementation, for the following Veterans Integrated Service Network 20 IOC sites: Mann-Grandstaff VA Medical Center (VAMC) in Spokane Washington; the Seattle, Washington VAMC; and the American Lake VAMC in Tacoma, Washington. Cerner will also provide VA with a comprehensive current-state assessment to inform site-specific implementation activities and task order-specific pricing adjustments.
- **Task Order 3 - EHRM Hosting:** Cerner is funded to deliver a comprehensive EHRM hosting solution and start associated services to include hosting for EHRM applications, application services, and supporting EHRM data.

- **Task Order 4 - Data Migration and Enterprise Interface Development:** Cerner will provide data migration planning refinement, analysis, development, testing, and execution. Cerner will support enterprise interface planning refinement, design, development, testing, and deployment. Cerner will provide a commercially available registry selected by VA for IOC as well as details and updates on the progress of IOC data migration and enterprise interface development.
- **Task Order 5 - Functional Baseline Design and Development:** Cerner will provide project management, workflow, training, change management, and EHRM stakeholder communication.
- **Task Order 6 - IOC Deployment:** Cerner will provide project management; IOC planning and deployment; test and evaluation; pre-deployment training; go-live readiness assessment, deployment, and release; go-live event; post-production health check and deployment completion; post-deployment support; and continued deployment decision support.
- **Task Order 7 - Technical Baseline:** Cerner will provide project management; adherence to enterprise technical plans and strategies; technical training plans and materials; technical and functional analysis; system integration; Health Information Exchange/Veteran Health Information Exchange modification; forward-deployed hardware; VA-specific functionality integration; and additional technical support.
- **Task Order 8 - Additional Interface Development for IOC:** Cerner will provide additional interface development, testing, and execution in support of interfaces required for VA's IOC sites. These tasks include interface development, integration, testing, deployment, sustainment, and maintaining the EHR Master System Integration list.

Current State Review

In July 2018, VA and Cerner conducted a Current State Review at VA's IOC sites to gain an understanding of the sites' specific as-is state, and how it aligns with the Cerner commercial standards to implement the proposed to-be state. The team conducted organizational reviews around people, processes, and technology. They observed and captured current state workflows; identified areas that will affect value achievement and present risk to the project; identified benefits from software being deployed; and identified any scope items that need to be addressed.

VA reviewed final reports analyzing the Current State Review in October 2018 and discovered there are infrastructure readiness areas that are in better condition than initially forecasted and areas that require slightly more investment due to aging infrastructure. However, there were no unexpected major needs or significant deviations from the current projected spend plan.

Model Validation Event

In September 2018, VA held its Model Validation Event, where VA's EHR Council met with Cerner to begin the national and local workflow development process for VA's new EHR solution. There was a series of working sessions designed to examine Cerner's commercial recommended workflows and evaluate the current workflows used at VAMCs. This allows VA to configure the workflows to best meet the needs of our Veterans, while also implementing commercial best practices.

Because of Model Validation, VA planned eight national workshops to educate diverse clinical end-users and validate workflows to ensure VA's new EHR solution meets the Department's needs. During the events, VA collaborates with front-line clinicians across VA's enterprise to validate workflows ensuring VA's new EHR solution meets the Department's needs. To date, VA has completed five national Workshops. The remaining workshops are scheduled to occur throughout the rest of this fiscal year.

Cerner Baseline Review

VA is committed to aligning its workflows closely with commercial best practices. As such, VA commissioned Cerner to complete a baseline assessment of how closely DoD's Military Health System GENESIS aligns with these practices. In September 2018, Cerner presented the results of the assessment. VA learned that DoD has a high adoption of recommendations and system configuration, which are generally in alignment with commercial best practices.

Organizational Structure and Strategic Alignment with DoD

On June 25, 2018, VA established OEHRM to ensure that we successfully prepare for, deploy, and maintain the new EHR solution and the health information technology (IT) tools dependent upon it. OEHRM reports directly to VA Deputy Sec-

retary and works in close coordination with the Veterans Health Administration and Office of Information Technology.

I currently serve as the program's Executive Director and have supported this effort at a leadership-level since its inception. Prior to joining VA, I served as the Program Manager for the Defense Health Management Systems Modernization, the organization which competitively and successfully acquired the Cerner EHR solution on behalf of DoD.

To ensure appropriate VA and DoD coordination, we emphasize transparency within and across VA through integrated governance and open decision-making. The OEHRM governance structure has been established and is operational, consisting of technical and functional boards that will work to mitigate any potential risks to the EHRM program. The structure and process of the boards are designed to facilitate efficient and effective decision-making and the adjudication of risks to facilitate rapid implementation of recommended changes.

At an inter-agency level, the Departments are committed to instituting an optimal organizational design that prioritizes accountability and effectiveness, while continuing to advance unity, synergy, and efficiencies between VA and DoD. The Departments have instituted an inter-agency working group, facilitated by the Inter-agency Program Office, to review use-cases and collaborate on best practices for business, functional, and IT workflows, with an emphasis on ensuring that interoperability objectives are achieved between the two agencies. VA's and DoD's leadership meet regularly to verify the working group's strategy and course correct when necessary. By learning from DoD, VA will be able to address challenges proactively and reduce potential risks at VA's IOC sites. As challenges arise throughout the deployment, VA will mitigate adverse effects to Veterans' health care.

Federal Electronic Health Record Modernization

DoD and VA are developing a Federal Electronic Health Record Modernization (FEHRM) joint governance strategy to further promote rapid and agile decision-making. This structure will maximize DoD and VA resources, minimize EHR deployment and change management risks, and promote interoperability through coordinated clinical and business workflows, data management, and technology solutions while ensuring patient safety. The FEHRM program office will be responsible for effectively adjudicating functional, technical, and programmatic decisions in support of DoD and VA's integrated EHR solutions. DoD and VA will jointly present the final construct of the plan to Congress, including our implementation, phase execution, and leadership plans.

Implementation Planning and Strategy

It will take OEHRM several years to fully implement VA's new EHR solution and the program will continue to evolve as technological advances are made. The new EHR solution will be designed to accommodate various aspects of health care delivery that are unique to Veterans and VA, while bringing industry best practices to improve VA care for Veterans. Most medical centers should not expect immediate major changes to their EHR systems.

VA's approach involves deploying the EHR solution at IOC sites to identify challenges and correct them. With this IOC site approach, VA will hone governance, identify efficient strategies, and reduce risk to the portfolio by solidifying workflows and detecting course correction opportunities prior to the deployment at additional sites. As mentioned, VA and Cerner have conducted Current-State Reviews for VA's IOC sites. These site assessments include a current-state technical and clinical operations review and the validation of the facility capabilities list. VA started the go-live clock for the IOC sites, as planned, on October 1, 2018.

Further, VA is continuing to work proactively with DoD and experts from the private sector to reduce potential risks during the deployment of VA's new EHR by leveraging DoD's lessons learned from its IOC sites. Most recently, on May 29, 2019, VA held an Industry Day with over 750 registered industry executives and leaders. OEHRM presented a status update on the program. Cerner and Booz Allen Hamilton joined OEHRM to inform eligible vendors on ways to potentially provide contracting and subcontracting support to the EHRM effort.

VA is leveraging several efficiencies including revised contract language to improve trouble ticket resolution based on DoD challenges; optimal VA EHRM governance structure; fully resourced program management office with highly qualified clinical and technical oversight expertise; effective change management strategy; and using Cerner Corporation as a developer and integrator consistent with commercial best practices.

During the multi-year transition effort, VA will continue to use Veterans Information System and Technology Architecture and related clinical systems until all leg-

acy VA EHR modules are replaced by the Cerner solution. For the purposes of ensuring uninterrupted health care delivery, existing systems will run concurrently with the deployment of Cerner's platform while we transition each facility. During the transition, VA will ensure a seamless transition of care. A continued investment in legacy VA EHR systems will ensure patient safety, security, and a working functional system for all VA health care professionals.

Change Management and Workflow Councils

Because the program's success will rely heavily on effective user-adoption, VA is deploying a comprehensive change management strategy to support the transformation to VA's new EHR solution. The strategy includes providing the necessary training to end-users: VAMC leadership, managers, supervisors, and clinicians. In addition, there will be on-going communications regarding deployment schedule and anticipated changes to end-user's day-to-day activities and processes. VA will also work with affected stakeholders to identify and resolve any outstanding employee resistance and any additional reinforcement that is needed.

VA has established 18 EHR Councils (EHRC) to support the development of national standardized clinical and business workflows for VA's new EHR solution. The Councils represent each of the functional areas of the EHR solution, including behavioral health, pharmacy, ambulatory, dentistry, and business operations. VA understands that to meet the program's goals we must engage frontline staff and clinicians. Therefore, the composition of the EHRCs will continue to be about 60 percent clinicians from the field who provide care for Veterans, and 40 percent from VA Central Office. As VA implements its new EHR solution across the enterprise, certain Council memberships will evolve to align with contemporaneous implementation locations. While deploying in a particular VISN, the needs of Veterans and clinicians in that particular VISN will be incorporated into national workflows.

Funding

With the support of Congress, OEHRM has not experienced funding shortfalls that would impact the success of the EHRM initiative. Additionally, OEHRM appreciates Congress for providing the program with three-year funding availability. This flexibility in funding execution is critical, as it allows OEHRM to fund key operations on a timeline that aligns with a successful implementation.

OEHRM's enacted fiscal year (FY) 2019 budget has allowed the program to continue the preparation of VA's EHR solution at VA's three IOC sites. VA's FY 2020 budget request of \$1.6 billion would provide the necessary resources for the post Go-Live activities of the IOC sites, the in-process deployment of seven sites, 18 new site assessments, and 12 site transitions scheduled to begin in 2020.

OEHRM reviews its lifecycle cost estimate at least once per month to reflect actual execution and to fulfill its programmatic oversight responsibilities. OEHRM will continue to provide Congress with regular updates to ensure that the program is fully funded and to support our commitment to transparency.

Conclusion

Again, the EHRM effort will enable VA to provide the high-quality care and benefits that our Nation's Veterans deserve. VA will continue to keep Congress informed of milestones as they occur. Madam Chair, Ranking Member, and Members of the Subcommittee, thank you for the opportunity to testify before the Subcommittee today to discuss one of VA's top priorities. I am happy to respond to any questions that you may have.

Prepared Statement of William J. Tinston

Chairwoman Lee, Ranking Member Banks, and distinguished members of the Subcommittee, it is an honor to testify before you today. We represent the Department of Defense (DoD) as the Program Executive Officer and the Military Health System (MHS) Electronic Health Record (EHR) System Functional Champion responsible for modernizing the military's EHR and developing one EHR with the Department of Veterans Affairs (VA), which is also interoperable with private sector providers.

The mission of the Program Executive Office, Defense Healthcare Management Systems (PEO DHMS) is to transform the delivery of health care and advance data sharing through a modernized EHR for servicemembers, retirees, and their families. As the information technology acquisition provider and part of the Defense Health Agency, we support the Quadruple Aim: improved readiness, better health, better

care, and lower cost; specifically committing to three equally important objectives: deploy a single, common inpatient and outpatient EHR, eliminating the need for interoperability with the VA; improve data sharing with our private sector health care partners; and successfully transform the delivery of health care in the MHS through advanced tools that provide beneficiaries more control over their health care.

In July 2015, the DoD competitively awarded a contract to the Leidos Partnership for Defense Health (LPDH) to deliver a modern, interoperable EHR capable of complying with DoD's high cyber security standards without compromising performance and designed to share data with our Federal and private sector partners regardless of their operational platform. This modern, secure, connected EHR, MHS GENESIS, provides a state of the market commercial off the shelf solution consisting, at its core, of Cerner Millennium, an industry-leading EHR, and Henry Schein's Dentrix Enterprise, a best of breed dental module.

Delivering a capability of this magnitude is a monumental challenge and the DoD recognizes this. The deployment and implementation of MHS GENESIS is a complex business transformation that requires extensive coordination and communication with stakeholders and partners. Understanding the importance, the DoD worked directly with the functional and technical communities to capture requirements and standardize workflows, minimizing variation and increasing the capabilities available via an enterprise system.

MHS GENESIS deployed to its pilot sites in 2017, beginning with Fairchild Air Force Base in February. Naval Hospital Bremerton and Naval Health Clinic Oak Harbor followed in the summer and our pilot officially concluded in January 2018 at Madigan Army Medical Center. These four pilot sites continue to use MHS GENESIS today and are safely delivering, managing, and documenting health care daily - completing more than 100,000 patient encounters each month.

Lessons Learned

Deploying to the pilot sites provided an opportunity to observe the system and capture user feedback, the intended purpose of a pilot. No system is flawless, and deploying to a small clinic, progressing to a larger hospital allowed us to assess system performance at various levels of capability.

In January 2018, PEO DHMS, along with the Defense Health Agency, implemented an eight week stabilization and adoption period to optimize MHS GENESIS, with a specific focus on improving network stability and medical device interfaces, governance, training, change management, and adoption of workflows.

As with any transition, leadership is key. Ensuring the right people are in place to make decisions significantly impacts a successful site deployment. Understanding this, DHA established a clear, agile, and accountable management structure to provide guidance and policy for effective enterprise decisions. Further, DHA implemented processes to ensure network stabilization and medical device configuration prior to MHS GENESIS Go-Live.

To address the change management and training challenges, we implemented three fundamental adjustments to the MHS GENESIS training strategy: functionally led workflow adoption; role based training configuration; and implementation of a peer expert training program.

Going forward, MHS GENESIS will deploy using a Wave approach. This deployment strategy allows optimal use of lessons learned to enhance our efforts as we proceed through enterprise-wide deployment.

Progress and Patient Safety Enhancements

Statistics revealed significant progress in 2018, ultimately improving patient care. For example, we avoided nearly 2,500 duplicate lab orders. Further, through new and effective decision support tools, MHS GENESIS equips our clinicians with the right tools and resources to evaluate a patient's status and quickly determine the best solution.

Recently at Madigan Army Medical Center, the MHS GENESIS inpatient nursing management module alerted the staff to an emergent patient situation. The nurses responded to the patient's bedside, identified the distressed patient, and activated the rapid response team. The patient immediately transferred to the cardiac catheterization lab and received a life-saving procedure. This example illustrates the new record's improved capabilities over our legacy systems. There are markedly improved tools within MHS GENESIS to monitor care and measure improvement as well as monitor care to the individual provider. For instance, we can monitor the time a provider spends documenting care outside of duty hours (current less than 3% of the time). This allows us to identify providers experiencing challenges and focus our training efforts in this area. Further, with our VA partners, we are now

connected to a wide range of commercial partners across the globe, who are collectively dedicated to improving care and interoperability within the DoD, VA, and the nation.

Joint Engagement

The VA's decision to implement the same EHR as the DoD and the United States Coast Guard (USCG) will result in a single, common record enabling more efficient, highly reliable, safe, and quality care, ultimately protecting our most important asset - our people. The DoD does not take this lightly, and understands this decision comes with the practicality of implementation. A single, common record requires extensive collaboration and joint decision making to ensure efficient workflows and standardized processes.

Federal Electronic Health Record Modernization Working Group

On September 28, 2018, the Secretaries of Defense and Veterans Affairs signed a Joint Commitment Statement pledging to align VA and DoD strategies to implement an interoperable EHR system. In response to this commitment, the DoD and VA evaluated program dependencies such as infrastructure, incorporation of clinical and business processes, and other requirements from the functional, technical, and programmatic communities. DoD and VA leadership determined the optimal and lowest risk alternative is to re-charter the DoD/VA IPO into the Federal Electronic Health Record Modernization (FEHRM) Program Office. The FEHRM, which will incorporate key members of the IPO as well as DoD and VA program office staff, will provide a more comprehensive, agile, and coordinated management authority to execute requirements necessary for a single, seamless integrated EHR.

Another example, of the DoD and VA currently collaborating and sharing best practices via joint workshops which focus on system standardization and configuration versus customization.

Specifically, the clinical nursing workshop recently completed an extensive process optimization review, identifying and agreeing to more than 2,300 workflow process optimizations, reducing nurse charting by 70%. This significant time savings provides more time for our priority - the patient. A DoD clinical nurse at one of our pilot sites highlights the improvements provided via MHS GENESIS and our commitment to collaboration with the VA in the quote below.

“Modernization of the DoD Electronic Health Record was a necessity. MHS GENESIS became our opportunity. It shined a light onto the Military Health System, illuminating the best practices throughout the MHS and identifying areas in need of improvement. It caused us to breakdown not only the barriers between services and the barriers between the DoD and the VA, but also the barriers between all specialists within a hospital's or clinic's care continuum. Never before have I seen nurses, physicians, surgeons, and transfusion technicians sit side-by-side and collaborate as intensely as I witness daily with MHS GENESIS. Every day, multi-disciplinary teams work across the pilot sites and the country to bring timely, relevant, evidenced-based practice to MHS GENESIS. This is more than an Electronic Health Record; it is a collaborative health record serving our nation's Service Members, Veterans, and beneficiaries. There is much work to be done to deploy and optimize MHS GENESIS, but it has been a great leap forward in support of the health care of this deserving population.”

Joint Solutions

Cybersecurity, the foundation of a joint solution, demands practical implementation. The DoD sets the standard for cybersecurity, and we invested significant time and resources to satisfy those requirements. By co-locating personnel at one commercial DoD/VA data center, our people assist with continuous cyber monitoring and are engaged in maintaining cyber integrity. Further, this strengthens the collaborative Federal and commercial relationship, encouraging the VA to leverage these capabilities and actively participate in critical activities to uphold the DoD cybersecurity standards. The continuous collaborative cyber work will not only benefit DoD and VA users, but it will contribute to the development of national standards, raising the bar for protecting the patient health information.

Further, the DoD and VA established workgroups which consists of cross-organizational representatives who resolve technical challenges and establish new processes to identify enterprise solutions and opportunities for both Departments to leverage. They work together to minimize the impact to both Department's schedules and ensure the most efficient use of program resources. For example, the DoD agreed to accept a Cerner software upgrade only a few weeks following its Wave 1 Go-Live to ensure VA fields its desired baseline solution to meet its scheduled Ini-

tial Operational Capability Go-Live in March of 2020. The timing of the upgrade adds complexity and risks to DoD's Wave 1, but it is the right decision for the DoD and VA's successful implementation.

Patient Centered Delivery

Patient centered delivery relies on the continued advancement of system capabilities, while maintaining system integrity and patient data throughout the life of the patient. To support this effort, the DoD and VA agreed to the joint execution of HealthIntent, a data warehouse and analytics platform which captures all patient data and migrates it into a single, common record that stays with the patient throughout their lifetime. Once executed, the Departments agreed to numerous decisions, including a joint URL which required collaborative decision making.

Continuous delivery demands established processes to address system enhancements and maintain the integrity of the system baseline and the hosting environment. Recognizing the significance, the DoD and VA established a joint decision making process to evaluate any request that would modify the technology solution, ensuring the practical implementation of an enterprise solution.

Conclusion

MHS GENESIS is on track for full deployment by the end of calendar year 2023. In December 2018, the DoD EHR Defense Acquisition Board met, and the Assistant Secretary of Defense for Acquisition affirmed MHS GENESIS met the criteria for approved deployment to Waves 1–6 beginning with Wave 1 in September 2019. The DoD and VA remain committed to continued communication and collaboration to ensure the successful implementation of a single, common record throughout the MHS, the USCG, and the VA.

Prepared Statement of Dr. Lauren Thompson

Chairwoman Lee, Ranking Member Banks, and distinguished members of the subcommittee, thank you for the opportunity to testify before you today. As the Director of the Department of Defense/Department of Veterans Affairs Interagency Program Office (IPO), I am honored to be here today. The mission of the DoD/VA IPO is to advance data interoperability across DoD, VA, and other partner systems. Providing high-quality health care to service members, veterans, and their families is one of the IPO's highest priorities, and health data interoperability is essential to improving the care delivered. A key component meeting the unique needs of our beneficiaries and ensuring they receive the best care possible, is making certain that no matter their status, location, or provider, their health data is readily available and accurate, or in other words ensuring health data interoperability—the ability of two or more systems or components to exchange information and to use the information that has been exchanged in a meaningful way.

The DoD and VA represent two of our nation's largest health care systems. Together, the Departments represent over 30 million eligible beneficiaries including service members, veterans, and their families. A significant amount of their care is provided via the private sector, providing more than 60 percent of DoD care and 30 percent for the VA. Currently, the Departments share more than 1.5 million data elements daily, and more than 430,000 DoD and VA clinicians are able to view the real-time records of the more than 16 million patients who receive care from both Departments.

The Fiscal Year 2008 National Defense Authorization Act (NDAA) directed the DoD and VA to develop and implement electronic health record (EHR) systems or capabilities that allow for full interoperability of personal health care information between the DoD and VA, instructing the establishment of the IPO to guide both Departments in their efforts. In January 2009, the IPO completed its first charter, sharing its mission and functions with respect to attaining interoperable electronic health data. In March 2011, both Secretaries of Defense and VA instructed the Departments to develop a single, jointly integrated EHR. In 2013, the Departments decided to pursue modernization of their respective EHR systems instead. In December 2013, the IPO was re-chartered to lead the efforts of the DoD and VA to implement national health data standards for interoperability and to establish, monitor, and approve clinical and technical standards for the integration of health data between both Departments and the private sector.

INTEROPERABILITY AND DATA SHARING

The IPO's goal is to support interoperability of clinically relevant health data in accordance with the FY 2014 NDAA, and in compliance with The Office of the National Coordinator for Health IT's (ONC) guidance on standards and interoperability for clinical records. Specifically, the IPO is chartered to jointly oversee and monitor the efforts of the DoD and VA in implementing national health data standards and act as the point of accountability for identifying, monitoring, and approving the clinical and technical data standards and profiles to ensure seamless integration of clinically relevant health data between the Departments and private sector providers who treat DoD and VA beneficiaries.

In April 2016, the Departments, with the IPO's assistance, met a requirement of the Fiscal Year 2014 NDAA, certifying to Congress that their systems are interoperable with an integrated display of data through the Joint Legacy Viewer, or JLV. JLV integrates data from the clinical data repositories of both Departments, as well as data on beneficiary encounters with private providers who participate in national health information exchange networks. The Departments also share documents and images with each other and private providers through DoD and VA data exchange and access services. The IPO monitors the usage of JLV and other interoperability metrics across the Departments to track progress on health data exchange and interoperability.

The IPO also serves a convening function, facilitating functional and technical discussions across the Departments and interoperability information exchange forums with industry. As executive secretary to the DoD/VA Interagency IT Steering Committee, a joint CIO-led body, the IPO works to ensure DoD and VA's technical alignment, planning, and implementation oversight of technical infrastructure and enterprise solutions meet the business needs of joint activities.

The IPO collaborates extensively with ONC, other government agencies, and standards development organizations to advance the state of interoperability across the health industry. IPO staff participate in ONC work groups, and IPO and ONC leaders meet regularly to discuss current interoperability initiatives and future collaboration opportunities to support national interoperability efforts.

FEDERAL ELECTRONIC HEALTH RECORD MODERNIZATION PROGRAM OFFICE

In 2018, Secretaries Wilkie and Mattis issued a Joint Commitment Statement pledging to align strategies to implement an integrated EHR system. DoD and VA leaders chartered the Joint Electronic Health Record Modernization Working Group, referred to as the JEHRM, to develop recommendations for an optimal organizational construct that would enable an agile, single decision-making authority to efficiently adjudicate functional, technical, and programmatic interoperability issues while advancing unity, synergy, and efficiencies.

On March 1, 2019, the joint VA/DoD Executive Leadership Group approved a course of action, plan of action and milestones, and implementation plan to establish the Federal Electronic Health Record Modernization Program Office, or the FEHRM, in a phased manner in order to minimize risk. Leveraging the existing 2008 and 2014 NDAA Statute, the IPO will be re-chartered into the FEHRM and will provide a comprehensive, agile, and coordinated management authority to execute requirements necessary for a single, seamless integrated EHR and will serve as a single point of authority for Department's EHR modernization program decisions. FEHRM leaders will have the authority to direct each Department to execute joint decisions for technical, programmatic, and functional functions under its purview and will provide oversight regarding required funding and policy as necessary. This management model creates a centralized structure for interagency decisions related to EHR modernization, accountable to both the VA and the DoD Deputy Secretaries.

An interim FEHRM Director and Deputy Director will be appointed to work with the implementation team in transitioning joint functions into the FEHRM once the FEHRM has an approved charter. The interim leaders will manage and execute joint technical, programmatic, and functional requirements and synchronize strategies between the two Department EHR program offices to ensure the single, seamlessly integrated EHR is implemented with minimal risks to cost, performance, and schedule. The interim leaders will remain in these roles until the permanent FEHRM Director and FEHRM Deputy Director are appointed.

The permanent Director and the Deputy Director will report to the Deputy Secretary of Defense and Deputy Secretary of Veterans Affairs.

CONCLUSION

The IPO will continue to support the Departments in implementing a single EHR system to ensure a seamless patient-centric health care experience that will ultimately lead to improved care for our service members, veterans, and their families.

Enhancing interoperability with private providers who provide care to DoD and VA beneficiaries will be of the utmost importance during this process to ensure the availability of a complete and comprehensive longitudinal health record.

We will continue our collaboration with ONC and industry partners to ensure the DoD and VA are employing the most current industry standards, and our industry partners are able to learn from our experiences.

Thank you for the opportunity to speak with you today. I look forward to your questions.

