THE ROLE OF THE INTERAGENCY PROGRAM OFFICE IN VA ELECTRONIC HEALTH RECORD MODERNIZATION

HEARING

BEFORE THE

SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION

OF THE

COMMITTEE ON VETERANS' AFFAIRS
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CONTENTS

Thursday, September 13, 2018

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Thursday, September 13, 2018

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION
AND MEMORIAL AFFAIRS,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 2:00 p.m., in Room 334, Cannon House Office Building, Hon. Jim Banks [Chairman of the Subcommittee] presiding.

Present: Representatives Banks, Coffman, Bergman, Roe, Lamb, and Peters.

OPENING STATEMENT OF JIM BANKS, CHAIRMAN

Mr. BANKS. Good afternoon. The Subcommittee will come to order. Thank you all for being here today for the first hearing of the Subcommittee on Technology Modernization.

I would first like to thank Chairman Roe for entrusting me with this responsibility. I have spent much of the past 2 months studying VA's EHR modernization and the Military Health System GENESIS Program and meeting the people working on both of those efforts.

I never expected that electronic health records would be such a major part of my service in the House of Representatives. However, I do appreciate the central role they play in the quality of health care delivery to every servicemember, veteran, and practically every citizen in this country.

I am also well aware of the stakes. EHR modernization is inextricably linked to VA's ongoing reform efforts. If successful, it will be one of the lynchpins of a more responsive, agile, and efficient VA. If mismanaged, I fear a daunting and disappointing setback.

That is why this Subcommittee is so important. Very rarely has a body of the Congress been dedicated to oversight of one program from its inception. Far too often, we only take an interest in a government project when it has already become a public scandal. This time it must be much different.

I commit to digging into the details and asking the difficult questions. I commit to bringing the EHR modernization into public view. VA is asking veterans to invest their trust and all taxpayers to invest a huge amount of their dollars. The public deserves to know what is happening.

I would also like to thank Ranking Member Lamb for being my partner in this effort. We intend to set an example for how well bipartisan oversight can work, even in 2018, when we dispense with petty political games. Sometimes a big government bureaucracy is like a freight train lumbering down the tracks. The course may become dangerous, and the people driving the train may even realize it; but the track was expensive to set, and no one wants to alter it. Sometimes that train, that bureaucracy needs some external help to course correct. That is this Subcommittee's role.

VA's EHR modernization is still at the beginning of the beginning, but a great deal has happened since June 26, this Committee's last hearing on the subject. More is known now. We know there will be disputes within the VA and other agencies. We know leadership is crucial to resolve those disputes. We also know that EHR modernization must be people centric. The system must be designed from the bottom up and reflect what veterans and health care providers actually need.

We have learned so many lessons from MHS GENESIS' early mistakes. There is a great deal though that we still do not know. We do not know if in any significant level of detail what will happen and when in VA's EHR modernization. We do not know precisely how the Cerner Millennium system will be structured and configured.

The Department is still deep in its planning to flesh out its schedule and fill in those blanks. VistA, other systems, and VHA's processes are tightly interconnected. Once the changes begin, we do not know what disruptions may result. We also do not know what possibilities the future holds.

The EHR modernization promises native interoperability and data, reams of clinical data to make veterans health care more effective. It is important to take time and plan how to harness that. We are here today to discuss specifically the role of the Interagency Program Office. What is the IPO, and why does it matter?

VA's EHR modernization and the Defense Health Agency's MHS GENESIS Program must succeed together. That requires cooperation. There will be debates, sometimes disagreements, and decisions that must be made. There will be countless actions every single day which must be coordinated between the two programs.

Who makes sure all of that happens? Personalities will change, but what is the constant? Maybe the two agencies work together seamlessly at all times; maybe not. If not, Congress expects the IPO to bridge the gaps. Congress created the IPO in the 2008 NDAA to act as the single point of accountability for DoD and VA to rapidly develop and implement EHR systems or capabilities to achieve full interoperability—the single point of accountability.

The IPO has been many things over the past 10 years, a coordinating body for standards, the builder of an integrated EHR system, which was quickly abandoned, a contributor to the Joint Legacy Viewer, and the facilitator of interoperability when the two Departments decided to modernize their EHR systems separately.

But the IPO has never truly been the single point of accountability. After trying practically everything else under the sun over the past 10 years, VA and DoD have come to the last remaining,

hopefully best, solution to implement the same commercial EHR. This is exactly what the IPO was intended for.

The question is, though, after so many twists and turns over the years and the expansions and contractions of its mission, whether the IPO is up to the task. And if not, how do we make it up to the task?

With that, I yield to Ranking Member Lamb for his opening statement.

OPENING STATEMENT OF CONOR LAMB, RANKING MEMBER

Mr. LAMB. Thank you, Mr. Chairman.

I also would like to thank Chairman Banks and Dr. Roe as well for how well they have worked with me and my staff as we get started here.

To use Mr. Banks' analogy, my focus is on the passengers on that train. The veterans themselves have to remain our primary focus. They need to get where they are going in a timely and safe manner, and everything that we do here will be about making sure that their care is at the highest standard of health care worldwide, and that is what this project needs to serve.

So, along the way, we should do whatever it takes to get them to the destination, whether its change course or lighten the load or add additional fuel or hire new engineers. Whatever it is has to be on the table so that we can get the mission accomplished.

This Committee, in my brief experience in Congress, has lived up to its reputation as the last frontier of bipartisanship in Congress, and that is largely thanks, I think, to Dr. Roe's leadership. He has established a culture in this Committee that I am very proud to be part of, and I think that you will see that reflected in the work of this Subcommittee as well. So thank you very much to you, gentlemen.

I think that this project has great promise, and in addition to the care of our veterans, we need to focus on accountability. That is something that I have seen can be difficult to track in an agency as large and complex as VA, but I know we can do it, and I know there is some great people there trying to do the job.

I want to thank Mr. Windom for already meeting with my staff to lay out some of the organizational chart. And just like you would at the start of any military mission, I think part of our goal here today is to establish exactly who is accountable for what part of the mission and how quickly they will be able to get that done.

So, with that, I am ready to begin. Thank you, Mr. Chairman.

Mr. BANKS. Thank you, Ranking Member Lamb.

I now would like to welcome our first and only panel who are seated at the witness table. On the panel, we have the Director of the Interagency Program Office, Dr. Lauren Thompson, representing the Department of Defense. She is accompanied by the Deputy Director of the Interagency Program Office, Dr. Helga Rippen, representing the Department of Veterans Affairs.

We also have Mr. John Windom, the Acting Chief Health Information Officer and Program Executive Officer for the Office of EHR Modernization in the Department of Veterans Affairs.

Finally, we have Ms. Carol Harris, the Director of IT Acquisition Management Issues at the Government Accountability Office.

As will be the Subcommittee's practice, I ask the witnesses to please stand and raise your right hand.

[Witnesses sworn.]

Mr. BANKS. Thank you, and let the record reflect that all witnesses have answered in the affirmative. You may be seated.

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

STATEMENT OF LAUREN THOMPSON

Ms. THOMPSON. Chairman Roe, Chairman Banks, Ranking Member Lamb, and distinguished Members of the Subcommittee, thank you for the opportunity to testify before you today.

I'm honored to represent the Department of Defense as the Director of the DoD/VA Interagency Program Office. And I'm accompanied, as you mentioned, by Dr. Helga Rippen, the VA executive in our office as the Deputy Director of the Interagency Program Office.

The mission of the IPO is to lead and coordinate the adoption of and contribution to national health data standards to ensure interoperability across the DoD, the VA, and private-sector health care providers. The DoD and VA represent two of our Nation's largest health systems. Providing high-quality health care to servicemembers, veterans, and their families is one of the IPO's highest priorities, and health data interoperability is essential to improving the care delivered.

The IPO is a collaborative entity comprised of staff from both the DoD and the VA who have technical expertise in health data standards and interoperability. The IPO serves as a central resource for the DoD and VA monitoring industry best practices and providing technical guidance to facilitate health data exchange.

IPO team members work closely with the Office of the National Coordinator for Health Information Technology and the Department of Health and Human Services, as well as with standards development organization, such as Health Level-7 and others, to support the identification, implementation, and evolution of national standards associated with both the DoD and VA EHRs.

These activities are vital to providing the building blocks for interoperability across the Departments. In April 2016, the Departments with the IPO's support met the requirements of the fiscal year 2014 National Defense Authorization Act, certifying to Congress that their systems were interoperable with an integrated display of data.

Currently, the Departments share more than 1.5 million data elements daily. More than 415,000 DoD and VA clinicians are able to view real-time data of more than 16 million patients who have received care in the DoD and the VA through the Joint Legacy Viewer.

The IPO plays an important role in monitoring DoD and VA interoperability efforts as well. The IPO established a health data interoperability metrics dashboard to identify Department-specific targets for transactional metrics and trends, which are routinely shared with Congress.

The IPO has also implemented the recommendations of the Government Accountability Office regarding outcome-oriented metrics

to provide a basis for assessing and reporting on interoperability progress. We work collaboratively with the Departments on this.

The IPO also serves as a focal point for collaboration across DoD and VA in their EHR modernization efforts. The IPO has been actively supporting the Departments with the development of a governance process to enable them to make joint decisions regarding common aspects of EHR. The IPO will facilitate the governance process, provide expertise and guidance in implementing best practices, and capture artifacts needed for decision-making.

DoD and VA are working to further enhance interoperability through the implementation of the same electronic health record system. The IPO will continue to work with the Departments as well as the Office of the National Coordinator for Health Information Technology and industry partners to ensure that collectively we are advancing interoperability throughout the health care industry.

Enabling health information exchange and interoperability between EHR systems across DoD, VA, and private sector will serve as the foundation for patient-centric health care, seamless care transitions, and improved care for our servicemembers, veterans, and their families. The IPO remains committed to this mission.

Thank you for the opportunity to speak with you today. I am happy to answer any questions you may have regarding the IPO and ongoing work of the DoD and VA in regards to their modernization efforts. Thank you.

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

Mr. BANKS. Thank you, Dr. Thompson.

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

STATEMENT OF JOHN WINDOM

Mr. WINDOM. Good afternoon, Chairman Banks, Ranking Member Lamb, and distinguished Members of the Subcommittee.

Dr. Roe, good afternoon.

Thank you for the opportunity to testify on the VA's effort to modernize our electronic health record, commonly referred to as an EHR.

First, I want to take the time to personally thank each of the Members of the Subcommittee for your ongoing and really unwavering support EHRM. Without your support, VA would not be able to move forward on this critical initiative.

The Department is committed to providing the best care for our Nation's veterans, especially access to complete medical record. The new EHR system will improve access to quality care and enable the seamless transfer of health data as servicemembers transition from the Active Duty to veteran status.

On June 5, 2017, VA announced its decision to replace VistA, its legacy system, which is unsustainable and cannot deliver critical capabilities to meet the evolving needs of the health care market. Through this 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 utilizing a single common system.

The ultimate outcome of this initiative will enable the sharing of health information, improve care, delivery, and coordination, and provide clinicians with data and tools to support patient safety. VA took several additional steps to ensure this acquisition meets the needs of the veterans and the clinicians who care for our veterans while also being a good steward of the taxpayers' dollars by capitalizing on DoD synergies.

VA conducted an interoperability assessment and worked with leading health care organizations who recently implemented new EHR systems. These steps were critical in identifying and reducing potential gaps in VA's EHR contract.

On May 17, 2018, VA awarded a contract to Cerner to leverage an existing commercial solution to achieve interoperability within VA, between VA and DoD, and between VA and community care providers. This contract contains the necessary conditions fostering innovation and evolving commercial technologies.

VA also ordered the first three task orders that include project management, IOC site assessments, and data hosting. I want to highlight these important aspects of the EHR modernization effort, which will contribute to the overall success of the program.

First, VA's implementation strategy will take several years to deploy and will be an evolving process as technology advances. VA's approach involves deploying the solution at IOC sites to identify problems and correct them before deploying to additional sites. The IOC sites will further hone governance, configuration management, and solidify processes overall.

Secondly, VA has developed a change management strategy that involves users in the field earlier in the processes to determine their needs and quickly alleviate concerns. Furthermore, EHRM has established clinical councils that include nurses, doctors, and other end users from the field to support configuration of workflows.

Finally, VA and DoD are working closely together to advance transparency through governance from an interagency decision-making perspective through the DoD/VA Interagency Program Office. The Department's leadership, including myself, meets at least monthly to verify working group strategies and course correct if necessary.

By learning from DoD, VA will be able to proactively address challenges and further reduce potential risk at VA's IOC sites. As challenges arise throughout the deployment, VA will work urgently to mitigate the impact of veterans' health care.

We established a program office to provide oversight to the new EHR implementation. The office is staffed with the appropriate functional, technical, and subject-matter experts to enforce adherence to cost schedule and performance objectives, as well as quality objectives. This transformation will support the Department's effort to modernize the VA's health systems and ensure VA is a source of pride for our veterans, beneficiaries, employees, and taxpayers.

Mr. Chairman, this concludes my opening statements. I am happy to answer any questions that you or the Members of the Subcommittee may have, and, again, thank you for this opportunity.

Mr. BANKS. Thank you, Mr. Windom.

Ms. Harris, you are now recognized for 5 minutes.

STATEMENT OF CAROL HARRIS

Ms. HARRIS. Chairman Banks, Ranking Member Lamb, and Members of the Subcommittee, thank you for inviting us to testify today on DoD and VA's Interagency Program Office and its role in VA's Electronic Health Record Modernization Program. As requested, I'll briefly summarize our prior work on the establishment and evolution of the IPO over the last decade.

As you know, VA and DoD operate two of the Nation's largest health care systems, which provide coverage to millions of veterans and Active Duty servicemembers and their beneficiaries. Both Departments have long recognized the need for shared health information systems and capabilities, the benefits of which include making patient information more readily available and reducing medical mistakes. To this end, the IPO was established by law to act as a single point of accountability for DoD and VA system interoperability efforts.

Unfortunately, this office has not come close to fulfilling this objective. Between 2008 and 2010, we issued a series of reports detailing how VA and DoD have not yet fully executed their plan to set up the IPO. For example, key leadership positions were either vacant or being filled on an interim basis, and the office was not yet carrying out critical IT management responsibilities in the areas of performance measurement, project planning, and schedule.

Accordingly, we recommended, among other controls, the IPO develop a project plan and detailed integrated master schedule. And while the Departments agreed with the recommendation, their subsequent actions were incomplete and the IPO remained ineffectual.

In 2009, the IPO was rechartered and assigned responsibility for establishing a virtual lifetime electronic record for servicemembers and veterans. In February 2011, we reported that the office had not developed an improved integrated master schedule, master program plan, or performance metrics for this initiative. We noted if these deficiencies were not corrected, VA and DoD's ability to effectively deliver capabilities to support their joint health IT needs would be uncertain.

As such, we recommended that the Departments address these management weaknesses. The Departments agreed with the recommendation but did not take action, and thus, the IPO's ability to effectively deliver this initiative continues to be hampered.

In March 2011, the Secretaries of VA and DoD committed the two Departments to developing a common integrated electronic health record system. To oversee this new effort, in October 2011, the IPO was rechartered yet again to give it increased authority and expanded responsibilities for leading the integrated system effort.

However, in February 2013, VA and DoD abandoned their plans for the system. We reported on this decision and found that the Departments had not addressed management barriers for effective collaboration on their joint health IT efforts. Among other things, VA and DoD did not provide the IPO with controls over essential resources, such as funding and staffing.

In addition, the Departments diffuse their responsibility for achieving integrated health records, thus undermining the office's intended role as a single point of accountability. We recommended that the Departments ensure the IPO has authority over dedicated resources, developing interagency processes, and making decisions over the Departments' interoperability efforts. Again, the Departments agreed with the recommendation, but no action was taken.

In June 2017, the VA announced that it planned to acquire the same commercial electronic health record system that DoD has been acquiring. VA has since established a program management office and drafted high-level plans for governance of the electronic health record implementation.

Program officials have noted the governance bodies will not be finalized until next month, and the officials have not yet indicated what role, if any, the IPO is to have in the governance process. As such, we are recommending that VA clearly define the role and responsibilities of the IPO within the governance plans for acquisition of the new system.

Because the IPO has historically been ineffective in increasing interoperability and the VA has largely ignored our previous recommendations, the Department has made limited progress. In order for VA to successfully acquire the same system as DoD, the Department must expeditiously and effectively implement this recommendation.

That concludes my statement. I look forward to addressing your questions.

[THE PREPARED STATEMENT OF CAROL HARRIS APPEARS IN THE APPENDIX]

Mr. BANKS. Thank you, Ms. Harris.

The written statements of Dr. Thompson and Ms. Harris will be entered into the hearing record. Mr. Windom was unable to submit written testimony for this hearing.

We will now proceed to questioning, and I yield to myself to begin questioning.

To start with, Mr. Windom, I have to start by asking you about the leadership turnover in the Office of EHR Modernization. You might recall that this was my first question for the Full Committee's June EHR hearing, so I hope this isn't becoming a—somewhat of a pattern moving forward.

But in the immediate aftermath of Ms. Morris' resignation on August 24, you were appointed the Acting Chief Health Information Officer in her place. Our understanding at that time was VA intended to conduct a search to fill the position and that you would at some point return to your previous role as program executive officer. Has that changed?

Mr. WINDOM. Sir, the—I've been with the effort since its inception, including in uniform, as part of the drafting of the determination and findings that drove this process. So I've been with the VA for approximately 17 months in and out of uniform.

The departure of Genevieve Morris really impacted no continuity issues within our office. The Deputy Secretary, who recently has come on board and I've been interacting with daily, we're assessing

the overall organizational structure. From our perspective, we feel like we have no gaps in leadership.

We have the full support of VHA and OI&T in augmenting the present OEHRM, Office of Electronic Health Record Modernization, and therefore, we feel like we, at this point in time, have no gaps in leadership or in subject-matter expertise.

I'm more than—was more than involved in the day-to-day operations for the past 17 months even as Genevieve Morris assumed the helm for approximately 1 month. So, sir, I guess I would offer to you that we expect turnover—that's kind of the way things go, not only in the Federal space but in the normal commercial workspace—and that, you know, we wish Genevieve Morris the best.

And in the same vein, you know, our chief medical officer who departed, again, family wanted to be on the West Coast. We have Dr. Laura Kroupa who immediately stepped in from the CMIO role into the CMO role. She's been with us for 17 months, fully understands her requirements. Again, we kind of pride ourselves on no single points of failure, people being willing and ready to step up. So, sir, that's where—that would be what I offer as a response.

Mr. BANKS. Appreciate that.

Mr. Windom, as well, the Office of EHR Modernization has a chief medical officer position and a chief technology officer position, in other words, a physician executive and a general IT executive. Health informatics is somewhat different. It blends the two competencies. Do you believe it is valuable to have a health informaticist as the leader or one of the leaders at your office?

Mr. WINDOM. Yes, sir, absolutely. I think your—the term—the use of the word "leader" is the critical piece. I pride myself on knowing what I don't know and knowing what I do know. And we've got an incredible subject-matter base throughout the VA portfolio for me to access, including support contracts in Booz Allen Hamilton and other access to other consultants where we can draw on the expertise on a moment's notice.

Mr. BANKS. So, with that, is there anyone working in the Office of EHR Modernization who has managed an EHR implementation in a large health system to its completion?

Mr. WINDOM. Sir, the—we have subject-matter experts that are being provided to us by Booz Allen Hamilton as part of our support contract that are delivering who have done just what you've just—you've captured, which is work in EHR implementation from start to finish. And so I'm comfortable with the support we have from the commercial—

Mr. BANKS. So it's a yes?

Mr. WINDOM [continued].—environment. So that is a yes.

Mr. BANKS. Okay.

Mr. WINDOM. Do we have the expertise on the government side? I would offer limited.

Mr. BANKS. Okay. All right. Mr. Windom, your position in MHS GENESIS in the Defense Health Management System's Modernization Office was as the program manager. Is that correct?

Mr. WINDOM. Yes, sir, that's correct.

Mr. BANKS. Okay. And when did you hold that position?

Mr. WINDOM. I held it from October 2013 through—I departed in November/December of two thousand and—my years are running together. I'm getting older—2015, so approximately 3 years, sir.

Mr. BANKS. So what—what were—can you tell us then what were some of the other leadership positions at MHS GENESIS in addition to that one?

Mr. WINDOM. My primary position was the program manager, so I report—

Mr. BANKS. What were some other positions that existed?

Mr. WINDOM. I'm sorry, sir. Would you please repeat that?

Mr. BANKS. Within the organization.

Mr. WINDOM. Well, we've had chief engineer. We had system engineers. We've had testing leads, obviously a functional lead, chief medical officer. We had a, you know, a technical lead and a CIO/engineer, system engineer. We had no role called a CHIO, chief health informatics officer. That seems to be an evolving role in the commercial—

Mr. BANKS. All right. I don't mean to cut you off. Before I yield to the Ranking Member, do you believe the chief health information officer position is necessary and beneficial, yes or no?

Mr. WINDOM. I have been unable to find in any implementations in the commercial the naming of a chief health information officer. I find that that skill set is offered from our CMIO community and from our informatics community in general.

So, to answer to your question, I believe that the leadership role is the fundamental and most important element of this bringing together the requisite expertise to deliver to the mission.

Mr. BANKS. Thank you. My time has expired.

I yield to Ranking Member Lamb for his questions.

Mr. LAMB. Thank you, Mr. Chairman.

Mr. Windom, who do you believe is the person within VA who is primarily accountable for the success of this project?

Mr. WINDOM. Sir, my ego would say me, but reality is the DefSec, Mr. Jim Byrne. I report to him as mandated by, you know, the various elements of—from congressional mandates regarding who should oversee the funding of this project. So my ego, my accountability, in reality, his accountability, and I think that relationship is—supports that.

Mr. LAMB. Thank you.

Now, could you just tell me succinctly, what do you view as the role of the IPO when it comes to the actual successful implementation of this project?

Mr. WINDOM. The IPOs, sir, is—I think is a—the facilitator between DoD and VA. When I say that, I mean clearly DoD has a mission set of requirements. VA has a mission set of requirements. It's impossible as we execute our day-to-day operations to be absolutely aware of what's going on in the DoD portfolio, and I believe vice versa.

I think the importance of the IPO is that they do have the visibility under both portfolios and therefore can facilitate or bridge the gaps of understanding between the organizations and to ensure that we are aware and in tune as to what, if you will, are problems that are being countered, lessons learned being shared, things along that line. So I would offer a facilitator between the two orga-

nizations and support of overall success, mission success for both organizations.

Mr. LAMB. And so it sounds like you view it as—and this is just a yes-or-no question so I can move on. Do you view it mainly as their responsibility to provide information to you?

Mr. WINDOM. I believe it's not only information but also consult, guidance as appropriate, and also recommendations and, if you will, endorsement of good ideas, So the full spectrum, sir.

Mr. LAMB. Okay. Do you believe that the IPO has decision-making authority over you with respect to any aspect to this project?

Mr. WINDOM. I do not believe that.

Mr. LAMB. Okay. Thank you.

Dr. Thompson, same question for you. Can you just define for me very succinctly what you view the role of the IPO to be in this project?

Ms. THOMPSON. Thank you for the question, sir.

The IPO serves in a convening role, a coordinating role. We facilitate the information sharing from the experiences of the DoD's MHS GENESIS deployment at initial sites to the VA and conversely information from the VA as their program is being developed to share with the DoD.

We do, as I had indicated in my opening statement, we have been working in collaboration with both Departments, been developing a process for governing, how decisions will get made as they arise, where there are—when decisions need to be made regarding the common electronic health record that is able—that has evolved since the VA made their announcements to purchase the same system as the DoD.

Mr. LAMB. But do you think that you have the decision-making authority to establish how that governance structure looks, or would you agree with Mr. Windom that you're basically making recommendations to both entities?

Ms. THOMPSON. At this point in time, we make recommendations. We do not have the decision-making authority.

Mr. LAMB. Okay. Thank you.

Now, Ms. Harris, having heard both of those answers, can you fill us in in the time remaining, do you think that there's a further definition of IPO that needs to happen, or are there shortcomings in what we've heard here today?

Ms. HARRIS. Well, according to the law, the IPO is supposed to be the single point of accountability, so that would include responsibility, authority, and decision-making responsibilities. So I think that how they've responded is in conflict with the expectations set out by law.

Mr. LAMB. And would you agree that, as of right now, it appears that we lack a single accountable individual person or group who will be accountable for the joint success of this project, meaning the actual interoperability that we're trying to achieve between the two agencies?

Ms. HARRIS. That is correct, yes.

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

Mr. BANKS. Thank you. I now yield to the Full Committee Chairman of the House Veterans Affairs Committee, Dr. Phil Roe, for 5 minutes.

Mr. ROE. Thank you, Mr. Chairman.

I'm going to give a little history lesson here, and then we'll go with questions. I remember sitting here, and I think maybe Mr. Coffman was here, when we spent $1 billion of taxpayers' money to try to get VistA and AHLTA to speak to each other, and it was a failure. And I think that's—was astonishing to me that we could get rid of $1 billion and accomplish not anything.

That was several years ago when you all went through Mr.—when it went through the chronology as Ms. Thompson did. I don't want to do that again. I think Secretary Panetta and Shinseki sat right at that dais and said: We failed.

We then—I think the decision was made by the DoD and then our previous VA Secretary to move on and try to have the same system. I thought that was a good decision that was made.

One of the things that I want to get into, and I think it's very important what both the Ranking Member and the Chairman have said, is about who's in charge—you know, who's in charge of this thing. And I'm going to quote the Yogi Berra: If you don't know where you're going, you might end up someplace else.

And that's my fear that if we don't have somebody in charge, that that's going to happen. And so we need to establish that this—today when we leave here who can the Chairman and the Ranking Member contact when they need to know something about this program.

And I took the—I've implemented the electronic health record system, and it is difficult. And every VA hospital I go to, I try to explain to them that this—and talk to the people and to veterans that this is going to be hard and you've got to be patient with the providers and the hospital when this implementation takes place.

And I know from our visit out at Fairchild and Madigan—I know the Chairman has been out there—it was less than smooth, to be kind. And, Mr. Windom, you mentioned any time you put EHRs in, it slows you down. There's no question about it. I found myself sitting at 8 o'clock at night, 9 o'clock at night, entering data in the computer from my day's work, a really fun thing to be doing.

And I know you mentioned here that you would look at a hit of 10 percent. I think you're going to have to look, if you look at Madigan, a much bigger hit in productivity, and that has slowed them down initially 50 percent. And they had to hire a number of people to get up to speed.

And one of my concerns is, is all this at this 30,000-foot level is fine, but there's a nurse and a doctor and a health care people out there that are seeing a patient. And if they hit a blind canyon, what do they do? Because there's six other people waiting to see them right then.

And apparently what happened when DoD was putting this out, they had to call a number here in D.C., and, you know, it was 1-800, hold, and "We'll get back to you, and there are 1,000 people in front of you," and yet there's a provider out there that they were fearful that they would put inaccurate data in and so forth and actually harm patients.

Can we be assured that the training—and what I found out was—I didn't care about all that. What I cared about: Can I negotiate this electronic system and get this data in there accurately,

because after I'm long gone somebody is going to be looking at this data making clinical decisions based on the patient's well-being?

Can we be assured that there will be adequate—Cerner has been in our office. Can we be assured that there will be help there for those providers, and have we talked to those providers instead of putting a top-down approach? Have we found out what they want and what works at their hospital after this initial rollout? And, Dr. Thompson, you or Mr. Windom, either can take those questions.

Mr. WINDOM. Thank you, Dr. Roe.

The 10 percent number, I'm not sure. We have articulated, I think, at various aspects anywhere from 10 to 50 percent understanding that there are inefficiencies introduced by business transformations, and our job is to be preemptive and proactive.

And I think we are, with the support of VHA, in making sure that we have strategies that augment the workforces that are there as part of our implementation strategies. I think that's a key element, and we will continue to monitor those. I can—yes, sir.

Mr. ROE. No. I'll tell you what really—when I was at Fairchild, what really got me was they had taken a year to put 10,000 healthy people—and VA have healthy people. Most of them are not. And what—the data that was entered—was entered into the record was very basic data, and you had to use the Joint Legacy Viewer to get into the weeds.

And we need—in other words, we were going to have to run that system parallel until, I guess, for 70 years or 90 years until every veteran who went in there was gone. And then I thought: Well, that's a disaster. If we've got to run two systems to be able to have an EHR, that defeats the purpose of it.

So can we be assured that all of that data will be moved onto one system so that, at one point in time, we can cut the lights off on the old and be totally beholden to the new one with that data backed up and shared somewhere?

Mr. WINDOM. Yes, sir. It is our intent to migrate all data into the healthy intent platform that Cerner manages. We will have complete access to data and still own the data. So that's absolutely our strategy. I think you hit the nail on the head in a myriad of ways, and I think you hit the nail on the head when you said this is hard.

And so we are going to continue to leverage our partnership with DoD. We're going to continue to learn from that, and we're going to continue to do the absolute best we can not to impact that important care being delivered to our veterans.

So I can't disagree with any of your remarks, sir, other than we're learning by the day, and we're going to continue to develop our implementation and integration strategies to minimize that impact on our veterans and on the clinicians that serve our veterans. So—

Mr. ROE. I yield back, and hopefully, we'll have a second round.

Mr. BANKS. Thank you, Chairman Roe.

I now yield 5 minutes to Mr. Peters.

Mr. PETERS. Thank you, Mr. Chairman. I am glad that we're having our first Technology Modernization Subcommittee hearing today. And sorry I'm covering two hearings, so I didn't—I wasn't able to catch all the testimony. But I'm looking forward to working

with my colleagues here to make sure that veterans remain the priority throughout the project.

I served my first two terms on the Armed Services Committee. This is my third term, and I'm honored to serve on the Veterans Committee. One of the things I always wondered and laypeople always wondered was why you'd have two electronic health records for that set of people. Every single veteran comes from the Department of Defense. So we scratched our head about this, and we all understood there was kind of standoff between the DoD and the VA in terms of how they wanted to approach it.

So I recognize that the IPO, the Interagency Program Office, provides an important role in sharing information. But I think Mr. Lamb's questioning showed pretty clearly that there's really no one there to break the ties or resolve the differences. It seems to me that the same kinds of differences, whether they're cultural or historical, exist today as they did when I came in.

I guess my question for Ms. Thompson or Dr. Thompson is: You had mentioned that the IPO, the DoD, and the VA planned to set up governance bodies to oversee the effort. How would—what would those look like, and how would the bodies differ from the current process? And then I'm going to ask Ms. Harris to address the same issue, what you think it should look like. Dr. Thompson.

Ms. THOMPSON. Thank you for the question.

So, first, let me point out that there are existing joint governance bodies in place today, and we intend to use those bodies to the extent that we can. What we are proposing as new bodies are specific to making decisions about the configuration of the electronic health record that will be implemented at the sites in both Departments.

What we are proposing are three bodies, a joint functional governance board and a joint technical governance board and a joint decision-making board. The premise of the governance is that the decisions are made at the lowest level possible. We have clinicians working together side by side today, technical experts working side by side today to help determine the path forward and solve problems.

When they cannot agree, then only at that point would a decision be escalated to respectively either a functional governance board or technical governance board. And we fully believe that those bodies will be able to come to agreement, and only if they can't would those decisions then be escalated to a decision board which would be comprised of those in the Departments with the authority to make decisions regarding the configuration of the electronic health record.

Mr. PETERS. Ms. Harris.

Ms. HARRIS. Sir, I think, based on the IPO's past history, I think it's evident that they never had the clout to either mediate and resolve the issues between VA and DoD as it relates to interoperability. So I think when it comes to the law itself of having a single point of accountability, the IPO was never set up to succeed there because neither of the Departments were willing to relinquish control.

Mr. PETERS. Right.

Ms. HARRIS. I think in terms of what you would see in leading organizations,—what they have shown based on our past work is

that you have a single executive level entity that is the point of accountability, and it's just one body as opposed to multiple bodies, and it has to be at that executive level.

So that's something that we would expect to see, you know, moving forward when VA and DoD establish their joint governance. Certainly I would expect to see it at a minimum at the Deputy Secretary level, you know, VA's Deputy Secretary and his counterpart at the DoD leading this joint executive entity.

Mr. PETERS. Do you anticipate that the joint effort would actually have new decision-making authority that would bind both agencies?

Ms. HARRIS. That would—I mean, in order to be the single point of accountability, they would have to have decision-making authority in order to be able to arbitrate issues and make decisions so that if compromises are necessary—

Mr. PETERS. Yeah.

Ms. HARRIS [continued].—that they have the authority to make those decisions. That's essential.

Mr. PETERS. And is that something that we've seen in other agencies? Is there a model for this that we can borrow?

Ms. HARRIS. Unfortunately, we've never seen it work well when we've seen those joint collaborative efforts. I mean, there's a reason IT is difficult. And certainly, you know, when you're talking about the two largest health care networks in the Nation, I mean, it compounds that complexity. However, we—

Mr. PETERS. Well, I would just—I'm out of time, but I would just offer that either the President has to do this or the Congress has to do this, because I don't think this thing gets created without some action by us. And the only people—the only person that both agencies report to now is the President of the United States. And if—I think also Congress would have a role to create such an agency as well. So I think—I look forward to the current—the coming work. Thank you. I yield back.

Mr. BANKS. Thank you.

I now yield 5 minutes to Mr. Coffman.

Mr. COFFMAN. Thank you, Mr. Chairman.

Ms. Harris, from a Government Accountability Office standpoint, if you were to look at how we wasted $1 billion and got nowhere on this interoperability of health records, isn't it that you had two large Federal entities with neither—both considered to be coequals with neither one in charge and people in the middle, you know, trying to negotiate with them unsuccessfully, is that—does that characterize where we are—where we were?

Ms. HARRIS. Yes. I think that in the past situations what we've seen historically is that when everyone is responsible, no one's responsible. And so I think that's what has led us to where we are today since, you know, we've had these subsequent interoperability initiatives, including the integrated electronic health records initiative between DoD and VA, and unfortunately, because of the lack of collaboration on the part of both Departments, that's why we're here today.

Mr. COFFMAN. So now what we have going is creative, strengthen this IPO to hopefully move forward. I think you still have two big coequals out there. I'm not sure that the results are going to be dif-

ferent. Isn't it better—wouldn't it be better for—to make a decision, whether by the Congress of the United States or preferably the executive branch that would put one of these two players in charge to say either it is the DoD or VA, and the other player certainly is going to have input, but it's going to have to follow whatever—if DoD is the lead agency, then DoD is going write this thing, and VA is going to have to follow or vice versa.

But to have—I think to have the IPO with the expectation that these two big players—that life is going to be different, I'm not sure life is going to be different. And I worry that we're going to waste another $1 billion on this.

And so I would—I think to my colleagues, and would love to get your input on this, wouldn't it be better—I mean, if we look back, clearly—this would be—if either DoD or VA were in charge of this, and we're not coequals, I think this would be done by now. I don't think we waste $1 billion. I'd love your input on that.

Ms. HARRIS. Well, I think that—I think, number one, if the IPO continues the way that it is operating today, we are going to continue to have dysfunction in moving forward, and unfortunately, you know, we want to prevent that.

We have not done work on MHS GENESIS, so I can't speak to the DoD side, and so I wouldn't be able to weigh in on whether DoD or VA should be taking the lead. I think that's something that the Departments should discuss as they define the roles of joint governance moving forward for their two implementation efforts.

Again, I—perhaps Mr. Windom might have some perspectives as well, but I think that's something that the Departments have to negotiate amongst themselves.

Mr. COFFMAN. Mr. Windom.

Mr. WINDOM. Sir, I would offer that our governance is evolving. It's impossible to create a governance structure that can—handles all matters that may arise. As a matter of fact, we think we have a notional governance structure that is being tested through use cases as to how it would function and render decisions that you speak to. I think we are working through that process right now.

Again, the mission set went from a JOV-dominated element for interoperability to now two EHRs that are going to make us interoperable. That's a new mission set. That's a new oversight responsibility, and I think we're working through those challenges, sir. And I think we will have a governance structure that works. And as you know, any business transformation typically involves challenges with governance. So we will continue to work that, sir. We understand.

Mr. COFFMAN. So where I might disagree is you said we will have a—it will evolve, and we will have a governance structure that will work. And I think given the restraints that you're under, I think that that's pretty optimistic, and I think it's good. That's leadership on your part.

However, that still doesn't define the fact that we don't have a lead agency in charge. I still think there is a role for an—the IPO with the lead agency in charge. But I—you know, I think we owe it to the taxpayers, we owe it to our Active Duty and our veterans to get this right, and I believe that we've got to define that some-

body who's going to be the lead agency—one of these two that's going to be the lead agency here.

Mr. Chairman, I yield back.

Mr. BANKS. Thank you.

I now yield 5 minutes to General Bergman.

Mr. BERGMAN. Thank you, Mr. Chairman.

Thanks to everybody for being here.

Now, as I look at the timeline here on the documents presented, it kind of goes, you know, back to the future. In January 2008, when we, Congress, created the Interagency Program Office, I was still in command of the Marine Corps Reserve. And in April of 2009, when work on the virtual lifetime electronic record began, I was still in command. Okay.

So I didn't really think about it in that depth until we were sitting here today, and you look at how fast time flies. I'm not sure which goes faster, the time or the $1 billion out the door. Okay. The point is we cannot recover time ever. We as a Committee, we as a Congress could, you know, put more money into a program. We can always do that, but is that the right answer for this Committee, who you've heard said several different ways, works bipartisan. Are we throwing good money after the bad?

And I guess what I was, you know, hoping for is to hear some level of testimony that instills confidence in us that we're not writing one check after another and dropping it into a black hole because, in the end, what we're talking about is creating a health record when a young man or woman comes into the military and having it be their final health record, if you will, when they are at the end of their time on this Earth. I don't see it.

So, having said that, let's talk a little about—I'd like to hear from you as to some of the whys we're not. In fact, I took a note that, Mr. Windom, you said joint governance is evolving. Evolving, okay, there's a lot of things that evolve. Do you or any—would any of you at the table be willing to venture a statement, making a statement as to, are you satisfied with the rate of evolution? Anybody could answer.

Mr. WINDOM. Sir, I'm very satisfied with the rate of evolution. And this is why I say it's evolving, is that the as-is state of the enterprise within VA is different than the as-is state of the enterprise within DoD. We've acquired the same commercial electronic health record, and now we're understanding the gaps between how we sought to implement and how DoD is implementing.

And so those gaps have to be reconciled, and they have to be reconciled through governance. We've got site surveys that are ongoing that are discovering new things within the framework of the VA environment that have to be also taken into consideration.

Our job is to deliver more capabilities than is presently being delivered within the VA as is DoD's. We didn't buy a new system to implement the same thing. And so there is some cross-pollinization. There is some hard work that has to be done. There's some hard—

Mr. BERGMAN. Let me ask you a question—

Mr. WINDOM. Yes, sir.

Mr. BERGMAN [continued]. —because I don't want you to run out my time.

Mr. WINDOM. No. No problem, sir.

Mr. BERGMAN. Okay. And the point of this is we talk about vying—you know, you've got two big dogs vying for control, in some ways, of a project. What can Congress do—what can Congress do to set the stage for—I don't care if it's you agree in the joint governance that DoD is going to have it for the first year, and then you're going to do a handoff with a baton and hand it to the VA for the second year, don't care, because as we evolve, the situation is still there; people in positions change. Is there something that Congress or through the Veterans' Affairs Committee can actually do through legislative process to actually jump start this evolution?

Mr. WINDOM. Sir, I think you did jump start it when you provided $782 million in the year of execution, fiscal year 2018. And so we are very respectful of your investment in us. And so I think you have to let us—

Mr. BERGMAN. Are you guys going to be able to then as hopefully will—you know, most of us will be back here to look you in the eye a year from now and get accountability up, you know, update as far as the—where we are?

Mr. WINDOM. Sir, that's the only way I know how to do it. I spent 30 years in the military. Cost, schedule, performance objectives have been at the forefront of any program that I've worked in or led, and so I expect to be held to the same standard. So we look forward to giving you and presenting you with the data that supports our adherence and exceeding of cost, schedule, and performance objectives or rationale why we didn't. So we look forward to that scrutiny, sir.

Mr. BERGMAN. The point is I look forward to being here and whether it be in the Technology Committee or whether it be in the Oversight Investigation Committee—

Mr. WINDOM. Yes, sir.

Mr. BERGMAN [continued].—because we've got things moving to a small extent. And I see I'm over my time, and I yield back. But we need to keep the sense of urgency at all levels moving forward.

Mr. WINDOM. Yes, sir.

Mr. BERGMAN. Thank you, Mr. Chairman.

Mr. WINDOM. Thank you, sir.

Mr. BANKS. Thank you. We will now proceed to a second round of questioning, and I will begin.

Mr. Windom, this is a diagram—is it on the screen? Yes. Okay. This is a diagram from your office depicting VA's Committees, boards, and councils, and DoD's equivalents that oversee the EHR modernization. Can you please take a moment to explain what these are, what they do, and how they interact with each other?

Mr. WINDOM. Sir, I can't really see the screen, but I think I have the boxes memorized. So at the lower level we've got technical and functional governance boards. Again, Dr. Thompson mentioned for us governance to be successful, things have to be resolved at the lowest level. Okay.

If everything has to be elevated to an executive council or a government integration board, then we're really not succeeding. So really it's the clinicians talking to the clinicians, the technicians talking to the technicians. And you see, other than the names being changed, we pretty much mirror on the VA side what DoD is doing in the name of TSWGs and other things.

So really those four layers of governance that allow pass of resolution—thank you. Now I've got to put on my glasses. So the Steering Committee at the top is chaired by the DefSec. The Governance Integration Board, No. 2, is chaired by me, and it's bringing together the CMO and the CTO for elements that they were under—unable to adjudicate at the lower level. And then 3 and 4 reflect the functional and the technical governance board that I indicated chaired by the CMO and the CTO respectively. And then you have that lowest level of governance where we hope at the functional level and the technical level, which is No. 5, things are really being resolved. The more we have to elevate, the less we are succeeding.

Mr. WINDOM. There's absolutely no way. We will have thousands of governance elements, and I hope to having risen to block No. 1 only a handful for the executive levels like the DepSec and VHA and the CIO. Because, again, that is going to be a slower, arduous process where things can get resolved in block No. 5 at a more efficient—and those are the people that are being called upon to execute using the new HR, and so, sir, that's—an explanation of the left side.

Mr. BANKS. I need to move on.

Dr. Thompson, the middle of the diagram there's a box, marked, quote, "facilitated by IPO." Can you please explain what these boards are that the IPO facilitates, and how does your office do that?

Ms. THOMPSON. These are the three boards that I mentioned that are not in place yet but that we are proposing be put into place. A joint technical board, a joint functional board, and a joint decision board. The proposal is that the IPO serve as the executive secretariat for these boards as we serve in that capacity for other joint bodies. In that role, we would take responsibility for planning the meetings and developing the process and capturing decisions that are made at the meeting, ensuring that the artifacts are captured and that the decisions made at the meetings are communicated appropriately.

So, in effect, we would be managing the proceedings of these meetings, bringing together the appropriate people, the decision-makers.

Mr. BANKS. Could you elaborate on when they would be established?

Ms. THOMPSON. We are in the final stages of formalizing a proposal to our Joint Executive Committee, which is co-chaired by the Deputy Secretary of the VA and the Undersecretary for Personnel and Readiness. It is our hope to be able to bring that before them for consideration in the near future.

Mr. BANKS. What is the near future?

Ms. THOMPSON. Within the next few months.

Mr. BANKS. Okay.

Ms. Harris, the middle portion of this diagram, where the IPO coordinates between the DoD and VA, has existed for some time. Isn't that correct?

Ms. HARRIS. Yes, that's correct.

Mr. BANKS. Okay. How well, Ms. Harris, has this structure performed in the past and how well has the IPO been able to drive interoperability projects between the two Departments?

Ms. HARRIS. The IPO, based on history, has demonstrated they have not had the clout to be able to, again, mediate and resolve the issues between the two Departments. So the performance of the IPO has been relatively lackluster, but there is an important role for the IPO. I mean, they play a critical role in identifying interoperability standards, and they certainly have a role to play in measuring the progress and performance of interoperability between the two Departments. So certainly there is a role for the IPO to play.

However, you know, based on what we see here, I mean, they are not acting as the single point of accountability, again as called for by statute. So I think, you know, one of the things, going back to one of the earlier questions of what Congress could potentially do, one thought for consideration would be to relieve the IPO of the legislative requirement to act as a single point of accountability. I think that, again, when you look at leading organizations, that single point of accountability should be at the executive level.

And one of the things that strikes me, when you look at this org chart, I mean, you count the number of boxes. There are at least 16 boxes here, which shows that accountability has been so diffused so that when wheels fall off the bus, you can't point to a single entity who is responsible, and that is a problem. And so, again, focusing on a single point of accountability is critical in moving forward to make sure that interoperability is functional.

Mr. BANKS. Thank you.

My time is expired. I now yield 5 minutes to Ranking Member Lamb.

Mr. LAMB. Thank you, Mr. Chairman.

So, Dr. Thompson, the proposal that you've laid out of the three bodies, you used the term "executive secretariat." Do you agree with Ms. Harris that that is—that is inconsistent with the statutory mission of IPO being a single point of accountability? Do you agree that those two things are not consistent with each other?

Ms. THOMPSON. In practice today, we do not function as a single point of accountability. Our approach is to—is collaborative in nature, to convene the decisionmakers of the Departments and facilitate a decision in that way. And I do believe we've been very effective in doing that.

Mr. LAMB. Okay, so you do agree, then, that the way you're functioning today and the way you would function under this proposal would not be consistent with the statutory objective of being a single point of accountability?

Ms. THOMPSON. Not in regards to electronic health record modernization. We have served in that capacity in regards to moving forward interoperability in health data exchange.

Mr. LAMB. Would your office be capable of fulfilling the statutory mission if given something that it doesn't have right now?

Ms. THOMPSON. We would be more than willing to fulfill that role. We are not currently staffed or resourced to fulfill that function as I would envision it would need to be if we were to serve in that capacity.

Mr. LAMB. And what is it that you would need in order to serve in that capacity?

Ms. THOMPSON. We would likely need additional people to support the function.

Mr. LAMB. Okay. Any idea how many people?

Ms. THOMPSON. I would not want to take a guess at that. I'd be happy to take that for the record and get back to you.

Mr. LAMB. Okay, I would appreciate that.

Do you agree that, under the proposal you've discussed here, with the three bodies, it doesn't appear that in that proposal there is anyone who is an arbiter between DoD and VA. Is that right?

Ms. THOMPSON. There is not a single individual. Our approach is for all of these bodies to be co-chaired by a DoD and a VA decisionmaker.

Mr. LAMB. Right. But there would essentially be an even number of—of votes.

Ms. THOMPSON. There's not—

Mr. LAMB. And if it was 1 to 1—

Ms. THOMPSON. There's not an individual who is a tiebreaker.

Mr. LAMB. Right, okay.

Mr. Windom, are you aware of this proposal, of the three bodies?

Mr. WINDOM. Yes, sir, I am.

Mr. LAMB. Okay. Any thoughts on how that could work?

Mr. WINDOM. Sir, I believe that the use cases that we've been running through this process have been yielding successes. So, again, my commitment is: Extremely dynamic environment. We will continue to assess our governance structure to make it as efficient as we possibly can. And so, at this point in time, I would offer, I think, that is a very viable governance structure, sir.

Mr. LAMB. So, correct me if I'm wrong, I just want to sum it up. Do I have it right that your view is basically that this is kind of being worked out on the fly, day to day, through the testing and examinations that you guys are doing, and you're raising issues to DoD as they come up? Is that a fair way of saying it?

Mr. WINDOM. I would say, we started governance—this governance discussion well over—almost a year ago. And so as discoveries are made, this is being refined. Again, we're in—

Mr. LAMB. What is being refined, though? Because this proposal of the three bodies does not exist yet, as far as I can tell, so—

Mr. WINDOM. No. It—which is one of the refinements that have been made is the need for these three bodies as we adjudicate issues between DoD and VA.

Mr. LAMB. Right.

Mr. WINDOM. Again—

Mr. LAMB. But right now that is not happening in any formal way. That's kind of what I'm asking you. Seems like it's happening on—

Mr. WINDOM. Not in a formal way, you're correct, sir. It is. And I guess I want to make a comment about the GAO's comments and Ms. Harris' comment, is that there's 16 boxes on there because there are a myriad of mission sets, that there's no single body that is qualified from technical to clinical perspective. Our job is to manage those and have elevation opportunities through the give and through the executive council to resolve things that are unable to be resolved at the lowest level. What I can't impress upon the Committee enough is that governance has to be successful at the lowest

possible level. Things can't rise to the superior level on every matter.

Mr. LAMB. Thank you.

Mr. Chairman, I yield back.

Mr. BANKS. Thank you.

I yield 5 minutes to Dr. Roe.

Mr. ROE. Thank you, Mr. Chairman.

And a couple things, everyone—every Member on this dais has been in the military, and we all understand the command structure. I understand—and when I had my little two silver bars and then finally got a little—I would have to absolute him every time because he had three stars. I got that. There's nobody that we have as a three-star here.

And what I think Mr. Coffman is concerned with in his question, his concern is we're going to have another Denver fiasco if we don't have somebody that the buck stops here. And we had a $600 million project end up being a $2 billion project. This would be a $40 billion if we triple the cost of this thing. So that's why it is absolutely critical—and Ms. Harris has said over and over again—the private sector where I came from, whoever signed the check was in charge. They were the ones that were responsible, either to the shareholders or to the partners in the group to make those decisions.

And what I see coming here is we've got to get that worked out, whether it's someone from the executive branch or—and I would argue that the VA has different needs than the DoD does. Those are different systems. They serve different patients. And the VA system is gargantuan compared to what the DoD is doing. So I think that should be taken into consideration when you're working out this command or this guidance structure. So that's just my two cents' worth on that.

If we haven't learned anything today, I think we've learned that, that we're going to end up in a Denver if we don't decide—or somebody—where the buck stops.

And, Mr. Windom, I totally agree: Everything doesn't need to go to the boss. There needs to be somebody, like I said, at the provider side, to help them navigate this. They don't need to call you for that, to find out how to get this button punched to get there. So I got that. One of the things that I would like to know and I think it's critically important, clinically, that you said that you—Mr. Windom, you said it was your intent to get to a single system, but there was no commitment to that. Are we committed to get off the legacy system and into this one single system?

Mr. WINDOM. Sir, absolutely, committed.

Mr. ROE. Okay.

Mr. WINDOM. The pivot strategy is an important piece of this. Again, I think everyone knows that we have to run these systems in parallel for a period of time. My job is to drive down the amount of time we have to run these systems simultaneously. That's taxpayers' money being expended.

We want to move—IOC is critical. We're going to be assessing during IOC what things can be deployed sooner, what things can be deployed out of sequence, to facilitate turning things off, sir, as you're alluding to. Absolutely, we want to pivot from the existing

legacy systems to the new her, but we want to do it without disrupting care or introducing efficiency—inefficiencies in the care of veterans. So we have to be judicious.

Sir, I've heard you say a number of times, the schedule won't drive us. We have to do what's right. We have to be committed to our veterans every step of the way. And that's what we're going to deliver to you, is a pivot strategy and then execute to that strategy, that, in fact, takes care of our veterans.

Mr. ROE. Where I see the—this is just my view after listening to this today. Where I see the IPO as, is that when you go to Bremerton and Madigan and you find out that the pharmacy has been slowed up, and that that they can pass that—this is what happened when we rolled this out. This is what you shouldn't do, or this is what you should do to ramp up to avoid the slowdowns that occur. That—I don't think they need to be involved in every decision going on.

But somebody, just like when Dr. Shulkin said we're going to use the Cerner System, one person made that decision. It was a gigantic decision, but when he took advice from a lot of people—but one person had to sit down and sign his or her name to that document so they could get it done. And there needs to be a buck-stops-here person in this organization, I think, so that those things we learned in Spokane and Seattle, the IPO can pass all that information along very well.

But I don't think they need to be—they need to be a flow of information and best practices, not the person that says: Here, no, we're not going to do that.

And there needs to be that person out there, so that backstop out there somewhere.

I yield back.

Mr. BANKS. Mr. Coffman?

Mr. COFFMAN. Thank you, Mr. Chairman.

I just want to—I just don't think this is doable. I just—I think that we're going to undergo the same problem unless we change. And I get that we plussed up the IPO to try and make a difference. I just don't think it's going to make enough of a difference at the end of the day that we are going to be efficient in terms of resolving this issue of interoperability. I think we're going to waste more taxpayer dollars in getting to where we need to go.

I think from day 1, we made a terrible mistake, the prior administration and continued by this administration in not saying to both of these major players, the Department of Defense and the Department of Veterans Affairs, one of you is in charge, and the other one can have input, and the IPO can certainly serve as a vehicle for that input. But by not doing that, we've created this consensus situation where we hope that it's going to get done, but we don't know that it's going to get done.

So I would hope that this Committee would take a hard look at this organizational structure and say whether or not one of these two agencies ought to be in charge, ought to be the lead agency, and then let's move forward from there.

I yield back, Mr. Chairman.

Mr. BANKS. General Bergman?

Mr. BERGMAN. Thank you, Mr. Chairman.

Dr. Thompson, you used a phrase that sent chills up my spine when the question was asked, what do you need, and it was: more people.

Okay. You didn't know how many, that's okay. But there's a—at least when I was spending my time in DoD, the answer that sent chills up a lot of spines then was the answer to every problem was: Give us more people, more money, more time, and we'll get you a solution.

So, you know, the point is, I think we really, really, really—I don't care who does it—we need to get realistic with the fact that that is not an answer that is going to energize what it is we're trying to accomplish. Because when you add more people to a situation, you get a chart, an org chart, that, as we've already kind of alluded to here, does not feel like it reports to anybody, or anybody's in charge. And you spend—waste a lot of time with reorganizing ourselves just because there's been a little, you know, a little change.

But let me ask you a question. You know, the GAO had previously recommended that the IPO have authority over budget and staff, over interagency processes and over decision-making for interoperability in both Departments. VA and DoD accepted the recommendations but never really implemented them. We know that. It seems that the IPO itself is not able to implement such recommendations. Is it a lack of authority to exercise more authority? Who can implement whatever recommendations are out there?

Ms. THOMPSON. I joined the IPO in 2015. Those recommendations were made prior to my tenure with the IPO. So I can't speak specifically to the reasons why, at that time, those recommendations were not put into place. As we've been rechartered, we have a much smaller footprint, very much focused on health data standards and interoperability, and that's where we have been focused. If there's a decision made that the IPO should take on a different function, I think we would need to consider what it would take for us to perform that function.

I don't believe today we are configured to support a single point of accountability as is being suggested here today. We would be happy to step into that role. I don't believe we're positioned for it properly today.

Mr. BERGMAN. So let's say for the sake of discussion that we had folks like the Under Secretary of Defense for Acquisition, Technology, and Logistics, AT&L, and ultimately maybe the Secretary of Defense and maybe the Secretary of Veterans Affairs and the Deputy Secretary for Veterans Affairs, do you think if we got them in the room, knowing some of the personalities involved with that group, that they could come out with an org chart that would show responsibility for what actions? I mean, do we have to leave it to the heads to send a wire diagram down, or I mean, can that actually be done at your level in a prioritized manner?

Ms. THOMPSON. We would be happy to do that if that is asked of us.

Mr. BERGMAN. Okay, in other words, so if basically told to do something, you'll do it?

Ms. THOMPSON. Yes, sir.

Mr. BERGMAN. Okay, well, I guess we need to figure out—yeah, yeah. So—yeah. In fact, the doctor and I are practicing the vulcan mind meld here, because my next question was, Ms. Harris, what do you think?

Ms. HARRIS. As currently chartered and resourced, the office would not be able to function as an effective means for joint governance. So things would have to change, both in terms of staffing and resources.

However, in addition, I think the root cause of why the IPO has been ineffective over the past decade is because it has had no authority or influence over the actions of the large and powerful organizations within DoD and VA that have responsibility for the Departments' electronic health record programs.

Mr. BERGMAN. Okay, thank you.

And, Mr. Chairman, I'll yield back the rest of my time.

Mr. BANKS. Thank you.

I have one final brief question, which I will ask, and then I will defer to my colleagues on the Committee if they, too, might have a brief question before we conclude.

Dr. Thompson, I recently visited the Seattle VA Medical Center, as you already know. I learned that personnel there had not been able to visit the nearby military health system facilities where Cerner has been implemented. It is my understanding, though, that they will now be permitted to do that. Is that correct?

Ms. THOMPSON. Yes, that—that is correct.

Mr. BANKS. Okay, thank you.

Do any of my colleagues—Ranking Member Lamb? Dr. Roe?

Mr. ROE. One very quick.

Ms. Harris, as we discussed this governance structure, do you think there should be one person, one entity, where the buck stops?

Ms. HARRIS. Yes, sir.

Mr. ROE. Okay, thank you.

I yield back.

Mr. BANKS. Anybody else?

Okay. Well, thank you once again to our witnesses for your testimony. If there are no further questions, the panel is now excused.

This afternoon, we have heard a great deal about leadership and governance. The VA needs leaders to establish the governance, but the governance must be enduring because individual leaders will come and go. Unfortunately, we have seen far too much of that turnover in the early months of this program. The IPO, or the Interagency Program Office, is one of the few aspects of her modernization that is mandated by law. That means that it has a very important and permanent role to play in governance.

Most everyone here today agrees the IPO needs to do more. My hope is DoD and VA will hash out what that looks like and come to mutual agreement. I am willing to give them additional time to do that, but I will not wait forever. The key decisions that will determine her modernization's future and prospects for success are being made over the next several months. I am skeptical of Congress imposing solutions, but we also have to keep the train safe on the tracks.

Thank you to all of you again for your participation in today's hearing.

I'd also like to thank the staff for helping make this a very productive first hearing of this Subcommittee.

I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous material.

And, without objection, so ordered.

The hearing is now adjourned.

[Whereupon, at 3:22 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Dr. Lauren Thompson

Chairman Banks, Ranking Member Lamb, and distinguished Members of the Subcommittee, thank you for the opportunity to testify before you today. I am honored to represent the Department of Defense (DoD) as the Director of the DoD/Veterans Affairs (VA) Interagency Program Office (IPO).The mission of the DoD/VA IPO is to lead and coordinate the adoption of and contribution to national health data standards to ensure health data interoperability among DoD, VA, and private sector healthcare worldwide. To give you a bit of history about the IPO, 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 the VA and directed 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 DoD and VA to develop a single, jointly integrated electronic health record.

When the Departments decided to pursue the modernization of individual systems in 2014, the DoD decided to replace its older system by purchasing a new, commercial off-the-shelf solution and the VA decided to modernize its existing Veterans Health Information Systems and Technology Architecture (VistA) health information system. In December 2013, the IPO was rechartered 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 DoD and VA represent two of our nation's largest healthcare systems. Currently, the Departments share more than 1.5 million data elements daily, and more than 415,000 DoD and VA clinicians are able to view the real-time records of the more than 16 million patients who have received care from both Departments.

Providing high-quality healthcare 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. In April 2016 the Departments, with the IPO's help, met a requirement of the Fiscal Year 2014 NDAA, certifying to Congress that their systems are interoperable with an integrated display of data. While the Departments met the required objectives, interoperability is a spectrum wherein data sharing and functionality can continually improve.

The two Departments currently share health records through the Defense Medical Information Exchange (DMIX) program, which includes the Joint Legacy Viewer, a health information portal that aggregates data from across multiple data sources to provide read access to medical information across multiple government and commercial data sources. As a result, the Departments increased patient data accessed through Joint Legacy Viewer more than fivefold; including the over 1.5 million data elements shared daily between the DoD and VA combined.

COLLABORATIVE DATA STANDARDS

Today, working closely with the Office of the National Coordinator for Health Information Technology (ONC) and standards development organizations, the IPO supports the identification, implementation, and evolution of the national standards associated with both Departments' Electronic Health Records. These activities are vital to continue providing the building blocks necessary for the Departments to expand and improve their health data interoperability, both across the Departments and with private healthcare providers.

The IPO is a collaborative entity, comprised of approximately 30 staff members from both the DoD and VA who have technical expertise in health data standards and information sharing.

Assisting the Departments with their interoperability and Electronic Health Record modernization milestones, the IPO serves as a central resource for the DoD and VA as they develop, adopt, and update a technical framework that is clinically driven to align identified standards with approved use cases. To that end, the IPO monitors industry best practices and provides technical guidance to facilitate health data exchange between the Departments and with private healthcare providers. The IPO also serves as a conduit for the Departments' engagement with the Office of the National Coordinator for Health Information Technology and standards development organizations to facilitate knowledge sharing on a national level. The IPO is integrated into the Office of the National Coordinator for Health Information Technology's planning for a national health IT ecosystem and is a key contributor to the Office of the National Coordinator for Health Information Technology's Interoperability Standards Advisory, a process that identifies standards to advance nationwide Health IT interoperability.

METRICS MONITORING

The IPO also plays an important role in monitoring DoD and VA interoperability efforts.

Specifically, the IPO established a Health Data Interoperability Metrics Dashboard to identify Department-specific targets for transactional metrics and trends, routinely shared with Congress.

In addition to these efforts, and in conjunction with the Departments, the IPO implemented the Government Accountability Office's (GAO) recommendations that the DoD and VA adopt outcome-oriented metrics to provide a basis for assessing and reporting on the health data interoperability progress, which resulted in the DoD/VA IPO Health Outcome-Oriented Metrics Roadmap. The IPO continues to foster the development of metrics in collaboration with the Health Executive Committee's Health Data Sharing Business Line sub-workgroups, based on the Joint Interoperability Strategic Plan use cases, developing metrics for Separating Service Members and Integrated Disability Evaluation System, Patient Empowerment, Transitions of Care, and Population Health.

ELECTRONIC HEALTH RECORD COLLABORATION

In July 2015, the DoD awarded a contract to the Leidos Inc. to deliver a modern, secure, and connected Electronic Health Record. The Leidos Partnership for Defense Health team consists of four core partners, Leidos Inc., as the prime integrator, and three primary partners in Cerner Corporation, Accenture, and Henry Schein Inc. The commercial electronic health record system, MHS GENESIS, provides a state of the market commercial off the shelf solution.

Throughout 2017, the DoD achieved major milestones, deploying MHS GENESIS to Fairchild Air Force Base, Naval Health Clinic Oak Harbor, Naval Hospital Bremerton, and Madigan Army Medical Center, all in the state of Washington. The DoD plans to deploy MHS GENESIS to more than 9.4 million beneficiaries and 205,000 medical personnel and staff by the end of 2023.

In June 2017, VA announced its plans to adopt the same Electronic Health Record system as the DoD, and on May 17, 2018, VA signed a contract with Cerner Corporation. Both Departments using the same electronic health record system will ultimately result in a single software baseline and enable seamless care between them without the exchange and reconciliation of data between two separate systems. This decision will, over time, solve the problem of moving patient health record data between the Departments, as there will be a single, common clinical system. This decision is another step toward advancing Electronic Health Record adoption across the nation and is in the best interest of our service members, veterans, and their families.

The VA and DoD are committed to partnering in this effort and understand that the mutual success of this venture is dependent on the close coordination and communication between the two Departments. As a result, the IPO's role in facilitating collaboration between the DoD and VA is more vital than ever before. The IPO has been actively supporting the Departments with the development of a governance process to enable them to make joint decisions regarding common aspects of the Electronic Health Record solution. This process will involve multiple layers, from Department-level governance within the DoD and VA, to the interagency coordination and collaboration through working groups and committees that is already underway and facilitated by the IPO, to joint DoD/VA Electronic Health Record Mod-

ernization governance bodies. We expect these governance bodies to be in place by 2019.

The joint Electronic Health Record Modernization governance bodies will focus on adjudicating only those issues that cannot be agreed upon through the existing interagency structures. The IPO will support the governance process, host meetings, manage information collection, and communicate assessments, meeting materials, action items, and decisions. The IPO will provide expertise and guidance implementing best practices and ensure a common standard operating procedure for capturing the artifacts needed to support decision-making by the Electronic Health Record Modernization governance bodies. The IPO will also be responsible for managing, organizing, and communicating decisions made by the governance bodies. However, the IPO will not redefine Departmental processes or function as a decision authority.

CONCLUSION

The field of health data is constantly evolving. With the DoD and VA further enhancing interoperability through the implementation of the same Electronic Health Record, the IPO must continue collaboration with the Office of the National Coordinator for Health Information Technology and industry partners to ensure that the DoD and VA map their data to the latest national standards, and that the Office of the National Coordinator for Health Information Technology and the private sector can continue to learn from our experience.

The IPO is fully committed to assisting the DoD and VA as they continue their modernization.

Enabling health information exchange between systems in DoD, VA, and the private sector will serve as the foundation for a patient-centric healthcare experience, seamless care transitions, and improved care for our service members, veterans, and their families.

Again, thank you for this opportunity, and I look forward to your questions.

Prepared Statement of Carol C. Harris

ELECTRONIC HEALTH RECORDS

Clear Definition of the Interagency Program Office's Role in VA's New Modernization Effort Would Strengthen Accountability

Chairman Banks, Ranking Member Lamb, and Members of the Subcommittee:

Thank you for the opportunity to participate in today's hearing on the Department of Defense (DoD) and Department of Veterans Affairs (VA) Interagency Program Office and the office's role regarding VA's Electronic Health Record Modernization (EHRM) program. As you know, these departments operate two of the nation's largest health care systems, which provide coverage to millions of veterans and active duty service members and their beneficiaries. The use of information technology (IT) is crucial to helping the departments effectively serve the nation's veterans and, each year, the departments spend billions of dollars on information systems and assets.

Both VA and DoD have long recognized the importance of advancing the use of shared health information systems and capabilities to make patient information more readily available to their health care providers, reduce medical errors, and streamline administrative functions. Toward this end, the two departments have an extensive history of working to achieve shared health care resources.[1] Over many years, however, the departments have experienced challenges in managing a number of critical initiatives related to modernizing major systems. Such initiatives include modernizing VA's electronic health information system—the Veterans Health Information Systems and Technology Architecture (VistA).

To expedite the departments' efforts to exchange electronic health care information, Congress included in the National Defense Authorization Act for Fiscal Year 2008, provisions that required VA and DoD to jointly develop and implement electronic health record systems or capabilities and to accelerate the exchange of health

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

care information.[2] The act also required that these systems or capabilities be compliant with applicable interoperability[3] standards, implementation specifications, and certification criteria of the federal government.

Further, the act established a joint Interagency Program Office to act as a single point of accountability for the electronic health care exchange efforts. The office was given the function of implementing, by September 30, 2009, electronic health record systems or capabilities that would allow for full interoperability of personal health care information between the departments.

In addition, the act included a provision that GAO report on the progress that VA and DoD have made in achieving the goal of fully interoperable personal health care information. Our reports in response to this requirement included information on the departments' efforts to set up the joint Interagency Program Office.[4] We also subsequently produced reports that have discussed the Interagency Program Office in relation to VA's efforts to develop a lifetime electronic health record capability for servicemembers and veterans,[5] develop a joint electronic record capability with DoD[6], and promote increased electronic health record system interoperability.[7]

At your request, my testimony today summarizes findings from our prior work that examined the establishment and evolution of the Interagency Program Office over the last decade. The testimony also discusses the roles this office has played in VA's and DoD's efforts to increase interoperability and electronic health record capabilities, and any challenges the office has faced in doing so.

In developing this testimony, we relied on our previous reports and testimonies related to the Interagency Program Office, as well as VA's and DoD's electronic health record system programs and modernization efforts.[8] We also incorporated information on the departments' actions in response to recommendations we made in our previous reports. In addition, we discussed this testimony with the Executive Director of VA's EHRM office. The reports cited throughout this statement include detailed information on the scope and methodology of our prior reviews.

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Historically, patient health information has been scattered across paper records kept by many different caregivers in many different locations, making it difficult for a clinician to access all of a patient's health information at the time of care. Lacking access to these critical data, a clinician may be challenged in making the most in-

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

[3] According to the National Defense Authorization Act for Fiscal Year 2014, interoperability is the ability of different electronic health records systems or software to meaningfully exchange information in real time and provide useful results to one or more systems. See Pub. L. No. 113-66, Div. A, Title VII, § 713, 127 Stat. 672, 794-798 (Dec. 26, 2013).

[4] GAO, Electronic Health Records: DoD and VA Have Increased Their Sharing of Health Information, but More Work Remains, GAO-08-954 (Washington, D.C.: July 28, 2008); Electronic Health Records: DoD's and VA's Sharing of Information Could Benefit from Improved Management, GAO-09-268 (Washington, D.C.: Jan. 28, 2009); Electronic Health Records: DoD and VA Efforts to Achieve Full Interoperability Are Ongoing; Program Office Management Needs Improvement, GAO-09-775 (Washington, D.C.: July 28, 2009); and Electronic Health Records: DoD and VA Interoperability Efforts Are Ongoing; Program Office Needs to Implement Recommended Improvements, GAO-10-332 (Washington, D.C.: Jan. 28, 2010).

[5] GAO, Electronic Health Records: DoD and VA Should Remove Barriers and Improve Efforts to Meet Their Common System Needs, GAO-11-265 (Washington, D.C.: Feb. 2, 2011).

[6] GAO, Electronic Health Records: VA and DoD Need to Support Cost and Schedule Claims, Develop Interoperability Plans, and Improve Collaboration, GAO-14-302 (Washington, D.C.: Feb 27, 2014).

[7] GAO, Electronic Health Records: Outcome-Oriented Metrics and Goals Needed to Gauge DoD's and VA's Progress in Achieving Interoperability, GAO-15-530 (Washington, D.C.: Aug 13, 2015).

[8] GAO, VA IT Modernization: Preparations for Transitioning to a New Electronic Health Record System Are Ongoing, GAO-18-636T (Washington, D.C.: June 26, 2018); VA Health IT Modernization: Historical Perspective on Prior Contracts and Update on Plans for New Initiative, GAO-18-208 (Washington, D.C.: Jan. 18, 2018); Electronic Health Records: VA's Efforts Raise Concerns about Interoperability Goals and Measures, Duplication with DoD, and Future Plans, GAO-16-807T (Washington, D.C.: July 13, 2016); GAO-15-530; GAO-14-302; Electronic Health Records: Long History of Management Challenges Raises Concerns about VA's and DoD's New Approach to Sharing Health Information, GAO-13-413T (Washington, D.C.: Feb 27, 2013); GAO-11-265; GAO-10-332; GAO-09-775; GAO-09-268; and GAO-08-954.

formed decisions on treatment options, potentially putting the patient's health at risk.

The use of technology to electronically collect, store, retrieve, and transfer clinical, administrative, and financial health information has the potential to improve the quality and efficiency of health care. Electronic health records are particularly crucial for optimizing the health care provided to military personnel and veterans. While in active military status and later as veterans, many DoD and VA personnel, along with their family members, tend to be highly mobile and may have health records residing at multiple medical facilities within and outside the United States.

VA and DoD operate separate electronic health record systems that they rely on to create and manage patient health information. In particular, VA currently uses its integrated medical information system—VistA—which was developed in-house by the department's clinicians and IT personnel and has been in operation since the early 1980s.[9] Over the last several decades, VistA has evolved into a technically complex system comprised of about 170 modules that support health care delivery at 170 VA Medical Centers and over 1,200 outpatient sites. In addition, customization of VistA, such as changes to the modules by the various medical facilities, has resulted in about 130 versions of the system—referred to as instances.

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

In July 2015, DoD awarded a contract for a new commercial electronic health record system to be developed by the Cerner Corporation. Known as MHS GENESIS, this system is intended to replace DoD's existing AHLTA system. The transition to MHS GENESIS began in February 2017 and implementation is expected to be complete throughout the department in 2022.

Interoperability: An Overview

The sharing of health information among organizations is especially important because the health care system is highly fragmented, with care and services provided in multiple settings, such as physician offices and hospitals, that may not be able to coordinate patient medical care records. Thus, a means for sharing information among providers, such as between DoD's and VA's health care systems, is by achieving interoperability.

The Office of the National Coordinator for Health IT,[10] within the Department of Health and Human Services, has issued guidance,[11] describing interoperability as:

1.the ability of systems to exchange electronic health information and

2. the ability to use the electronic health information that has been exchanged from other systems without special effort on the part of the user.

Similarly, the National Defense Authorization Act for Fiscal Year 2014[12] defines interoperability, per its use in the provision governing VA's and DoD's electronic health records, as "the ability of different electronic health records systems or software to meaningfully exchange information in real time and provide useful results to one or more systems." Thus, in these contexts, interoperability allows patients' electronic health information to be available from provider to provider, regardless of where the information originated.

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[9] VistA began operation in 1983 as the Decentralized Hospital Computer Program. In 1996, the name of the system was changed to VistA.

[10] The Office of the National Coordinator for Health IT is responsible for overseeing the certification of electronic health record technology, including establishing technical standards and certification criteria for it. Additionally, the Office of the National Coordinator is charged with formulating the federal government's health IT strategy and coordinating related policies, programs, and investments.

[11] Office of the National Coordinator for Health IT, Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Final Version 1.0. The definition of interoperability used in the Roadmap is derived from the Institute of Electrical and Electronics Engineers definition of interoperability.

[12] Pub. L. No. 113-66, Div. A, Title VII, § 713, 127 Stat. 672, 794-798 (Dec. 26, 2013).

Achieving interoperability depends on, among other things, the use of agreed-upon health data standards [13] to ensure that information can be shared and used. If electronic health records conform to interoperability standards, they potentially can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization, thus providing patients and their caregivers the information needed for optimal care. Information that is electronically exchanged from one provider to another must adhere to the same standards in order to be interpreted and used in electronic health records, thereby permitting interoperability. [14]

In the health IT field, standards may govern areas ranging from technical issues, such as file types and interchange systems, to content issues, such as medical terminology. [15] On a national level, the Office of the National Coordinator has been assigned responsibility for identifying health data standards and technical specifications for electronic health record technology and overseeing the certification of this technology.

In addition to exchanging the information, systems must be able to use the information that is exchanged. Thus, if used in a way that improves providers' and patients' access to critical information, electronic health record technology has the potential to improve the quality of care that patients receive and to reduce health care costs. For example, with interoperability, medical providers have the ability to query data from other sources while managing chronically ill patients, regardless of geography or the network on which the data reside.

VA and DoD Have a Long History of Efforts to Achieve Electronic Health Record Interoperability

Since 1998, DoD and VA have relied on a patchwork of initiatives involving their health information systems to exchange information and increase electronic health record interoperability. These have included initiatives to share viewable data in existing (legacy) systems; link and share computable data between the departments' updated health data repositories; develop a virtual lifetime electronic health record to enable private sector interoperability; implement IT capabilities for the first joint federal health care center; and jointly develop a single integrated system. Table 1 provides a brief description of the history of these various initiatives.

[13] Health data standards are one component that can be used to facilitate health information exchange and interoperability. Such standards consist of languages and technical specifications that, when adopted by multiple entities, facilitate the exchange of health information. Health data standards include, for example, standardized language for prescriptions and for laboratory testing.

[14] GAO, Electronic Health Records: HHS Strategy to Address Information Exchange Challenges Lacks Specific Prioritized Actions and Milestones, GAO-14-242 (Washington, D.C.: Mar. 24, 2014); and Electronic Health Record Programs: Participation Has Increased, but Action Needed to Achieve Goals, Including Improved Quality of Care, GAO-14-207 (Washington, D.C.: Mar. 6, 2014).

[15] Developing, coordinating, and agreeing on standards are only parts of the processes involved in achieving interoperability for electronic health records systems or capabilities. In addition, specifications are needed for implementing the standards.

Table 1: History of Interoperability Initiatives between the Department of Veterans Affairs (VA) and the Department of Defense (DOD), 1998 through 2010

Interoperability initiative	Year initiative started	Description
Government Computer-Based Patient Record	1998	This interface was expected to compile requested patient health information in a temporary "virtual" record that could be displayed on a user's computer screen.
Federal Health Information Exchange	2002	The Government Computer-Based Patient Record initiative was narrowed in scope to focus on enabling DOD to electronically transfer service members' health information to VA upon their separation from active duty. The resulting initiative, completed in 2004, was renamed the Federal Health Information Exchange.
Bidirectional Health Information Exchange	2004	This exchange allowed clinicians at both departments viewable access to records on shared patients.
Clinical Data Repository/Health Data Repository Initiative	2004	This interface linked DOD's Clinical Data Repository and VA's Health Data Repository in order to achieve two-way exchange of health information between the departments' systems.
Virtual Lifetime Electronic Record	2009	To streamline the transition of electronic medical, benefits, and administrative information between the DOD and VA, this initiative enabled access to electronic records for service members as they transitioned from military to veteran status, and throughout their lives; it also expanded the departments' health information-sharing capabilities by enabling access to private-sector health data.
Joint Federal Health Care Center	2010	The Captain James A. Lovell Federal Health Care Center was a joint demonstration project to integrate DOD and VA facilities located in the North Chicago, Illinois, area. It was the first integrated federal health care center for use by beneficiaries of both departments, with an integrated DOD and VA workforce, a joint funding source, and a single line of governance.

Source: GAO summary of prior work and department documentation. | GAO-18-696T

In addition to the initiatives mentioned in table 1, DoD and VA previously responded to provisions in the National Defense Authorization Act for Fiscal Year 2008 directing the departments to jointly develop and implement fully interoperable electronic health record systems or capabilities in 2009.[16] The act also called for the departments to set up the Interagency Program Office to be a single point of accountability for their efforts to implement these systems or capabilities by the September 30, 2009, deadline.

The Interagency Program Office Has Not Functioned as the Single Point of Accountability for VA and DoD's Efforts to Increase Electronic Health Record Interoperability

The Interagency Program Office has been involved in the various approaches taken by VA and DoD to increase health information interoperability and modernize their respective electronic health record systems. These approaches have included development of the Virtual Lifetime Electronic Record (VLER) and a new, common integrated electronic health record (iEHR) system. However, although the Interagency Program Office has led efforts to identify data standards that are critical to interoperability between systems, the office has not been effectively positioned to be the single point of accountability as called for in the National Defense Authorization Act for Fiscal Year 2008. Moreover, the future role of the office with respect to VA's current electronic health record modernization program is uncertain.

The Interagency Program Office Became Operational, but Was Not Positioned to Be the Single Point of Accountability for Achieving Interoperability

Although VA and DoD took steps to set up the Interagency Program Office, the office was not positioned to be the single point of accountability for the departments' efforts to achieve electronic health record interoperability by September 30, 2009. When we first reported on its establishment in July 2008, VA and DoD's efforts to set up the office were still in their early stages.[17] Leadership positions in the office were not yet permanently filled, staffing was not complete, and facilities to house the office had not been designated. Further, the implementation plan for setting up the office was in draft and, although the plan included schedules and milestones, the dates for several activities (such as implementing a capability to share immunization records) had not yet been determined, even though all capabilities were to be achieved by September 2009.

We concluded that without a fully established program office and a finalized implementation plan with set milestones, the departments could be challenged in meeting the required date for achieving interoperability. Accordingly, we rec-

[16] Pub. L. No. 110-181, § 1635, 122 Stat. 3, 460-463 (2008).
[17] GAO-08-954.

ommended that the departments give priority to fully establishing the office by putting in place permanent leadership and staff, as well as finalizing the draft implementation plan. Both departments agreed with this recommendation.

We later reported in January 2009 that VA and DoD had continued to take steps to set up the Interagency Program Office.[18] For example, the departments had developed descriptions for key positions within the office. In addition, the departments had developed a document that depicted the Interagency Program Office's organizational structure; they also had approved a program office charter to describe, among other things, the mission and functions of the office.

However, we pointed out that VA and DoD had not yet fully executed their plan to set up the office. For example, among other activities, they had not filled key positions for the Director and Deputy Director, or for 22 of 30 other positions identified for the office.

Our report stressed that, in the continued absence of a fully established Interagency Program Office, the departments would remain ineffectively positioned to assure that interoperable electronic health records and capabilities would be achieved by the required date. Thus, we recommended that the departments develop results-oriented performance goals and measures to be used as the basis for reporting interoperability progress. VA and DoD agreed with our recommendation.

Nevertheless, in a subsequent July 2009 report, we noted that the Interagency Program Office was not effectively positioned to function as a single point of accountability for the implementation of fully interoperable electronic health record systems or capabilities between VA and DoD.[19] While the departments had made progress in setting up the office by hiring additional staff, they continued to fill key leadership positions on an interim basis. Further, while the office had begun to demonstrate responsibilities outlined in its charter, it was not yet fulfilling key IT management responsibilities in the areas of performance measurement (as we previously recommended), project planning, and scheduling, which were essential to establishing the office as a single point of accountability for the departments' interoperability efforts. Thus, we recommended that the departments improve the management of their interoperability efforts by developing a project plan and a complete and detailed integrated master schedule. VA and DoD stated that they agreed with this recommendation.

In our January 2010 final report in response to the National Defense Authorization Act for Fiscal Year 2008, we noted that VA and DoD officials believed they had satisfied the act's September 30, 2009, requirement for full interoperability by meeting specific interoperability-related objectives that the departments had established.[20] These objectives included: refine social history data, share physical exam data, and demonstrate initial document scanning between the departments.

Additionally, the departments had made progress in setting up their Interagency Program Office by hiring additional staff, including a permanent director. In addition, consistent with our recommendations in the three previously mentioned reports, the office had begun to demonstrate responsibilities outlined in its charter in the areas of scheduling, planning, and performance measurement.

Nevertheless, the office's efforts in these areas did not fully satisfy the recommendations and were incomplete. Specifically, the office did not have a schedule that included information about tasks, resource needs, or relationships between tasks associated with ongoing activities to increase interoperability. Also, key IT management responsibilities in the areas of planning and performance measurement remained incomplete. We reiterated that, by not having fulfilled key management responsibilities, as we had previously recommended, the Interagency Program Office continued to not be positioned to function as a single point of accountability for the delivery of the future interoperable capabilities that the departments were planning.

The Interagency Program Office Was to Be the Single Point of Accountability for Establishing a Lifetime Electronic Record for Servicemembers and Veterans, but VA and DoD Did Not Develop Complete Plans for the Effort

Although the Interagency Program Office charter named the office as the single point of accountability for the initiative, the office did not have key plans to define and guide the effort. In April 2009, the President announced that VA and DoD would work together to define and build VLER to streamline the transition of electronic medical, benefits, and administrative information between the two depart-

[18] GAO-09-268.
[19] GAO-09-775.
[20] GAO-10-332.

ments. VLER was intended to enable access to all electronic records for service members as they transition from military to veteran status, and throughout their lives. Further, the initiative was to expand the departments' health information sharing capabilities by enabling access to private sector health data.

Shortly after the April 2009 announcement, VA, DoD, and the Interagency Program Office began working to define and plan for the VLER initiative. Further, the office was rechartered in September 2009 and named as the single point of accountability for the coordination and oversight of jointly approved IT projects, data, and information sharing activities, including VLER.

In our February 2011 report on the departments' efforts to address their common health IT needs, we noted that, among other things, the Interagency Program Office had not developed an approved integrated master schedule, master program plan, or performance metrics for the VLER initiative, as outlined in the office's charter.[21] We noted that if the departments did not address these issues, their ability to effectively deliver capabilities to support their joint health IT needs would be uncertain. Thus, we recommended that the Secretaries of VA and DoD strengthen their efforts to establish VLER by developing plans that would include scope definition, cost and schedule estimation, and project plan documentation and approval. Although the departments stated they agreed with this recommendation, they did not implement it.

The Interagency Program Office Was Responsible for the Development of a Joint Electronic Health Record System for VA and DoD, but the Office Was Not Positioned for Effective Collaboration

The Interagency Program Office was assigned responsibility for the development of an electronic health record system that VA and DoD were to share. However, the departments did not provide the office with control over the resources (i.e., funds and staff) it needed to facilitate effective collaboration.

In March 2011, the Secretaries of VA and DoD committed the two departments to developing the iEHR system, and in May 2012 announced their goal of implementing it across the departments by 2017. To oversee this new effort, in October 2011, VA and DoD re-chartered the Interagency Program Office to give it increased authority, expanded responsibilities, and increased staffing levels for leading the integrated system effort. The new charter also gave the office responsibility for program planning and budgeting, acquisition and development, and implementation of clinical capabilities. However, in February 2013, the Secretaries of VA and DoD announced that they would not continue with their joint development of a single electronic health record system.

In February 2014, we reported on the departments' decision to abandon their plans for iEHR.[22] Specifically, we reported that VA and DoD had not addressed management barriers to effective collaboration on their joint health IT efforts. For example, the Interagency Program Office was intended to better position the departments to collaborate, but the departments had not implemented the office in a manner consistent with effective collaboration. Specifically, the Interagency Program Office lacked effective control over essential resources such as funding and staffing. In addition, decisions by the departments had diffused responsibility for achieving integrated health records, potentially undermining the office's intended role as the single point of accountability.

We concluded that providing the Interagency Program Office with control over essential resources and clearer lines of authority would better position it for effective collaboration. Further, we recommended that VA and DoD better position the office to function as the single point of accountability for achieving interoperability between the departments' electronic health record systems by ensuring that the office has authority (1) over dedicated resources (e.g., budget and staff), (2) to develop interagency processes, and (3) to make decisions over the departments' interoperability efforts. Although VA and DoD stated that they agreed with this recommendation, they did not implement it.

The Interagency Program Office Subsequently Took Steps to Improve Interoperability Measurement and Additional Actions Are Planned

In light of the departments' not having implemented a solution that allowed for seamless electronic sharing of medical health care data, the National Defense Authorization Act for Fiscal Year 2014 included requirements pertaining to the implementation, design, and planning for interoperability between VA and DoD's separate electronic health record systems. Among other things, the departments were each directed to (1) ensure that all health care data contained in VA's VistA and DoD's

[21] GAO-11-265.
[22] GAO-14-302.

AHLTA systems complied with national standards and were computable in real time by October 1, 2014, and (2) deploy modernized electronic health record software to support clinicians while ensuring full standards-based interoperability by December 31, 2016.

In August 2015, we reported that VA and DoD, with guidance from the Interagency Program Office, had taken actions to increase interoperability between their electronic health record systems.[23] Among other things, the departments had initiated work focused on near-term objectives, including standardizing their existing health data and making them viewable by both departments' clinicians in an integrated format. The departments also developed longer-term plans to modernize their respective electronic health record systems. For its part, the Interagency Program Office issued guidance outlining the technical approach for achieving interoperability between the departments' systems.

However, even with the actions taken, VA and DoD did not certify by the October 1, 2014, deadline established in the National Defense Authorization Act for Fiscal Year 2014 for compliance with national data standards that all health care data in their systems complied with national standards and were computable in real time.

We also reported that the departments' system modernization plans identified a number of key activities to be implemented beyond December 31, 2016—the deadline established in the act for the two departments to deploy modernized electronic health record software to support clinicians while ensuring full standards-based interoperability. Specifically, DoD had issued plans and announced the contract award for acquiring a modernized system to include interoperability capabilities across military operations. VA had issued plans describing an incremental approach to modernizing its existing electronic health records system. These plans—if implemented as described—indicated that deployment of the new systems with interoperability capabilities would not be completed across the departments until after 2018.

With regard to its role, the Interagency Program Office had taken steps to develop process metrics intended to monitor progress related to the data standardization and exchange of health information consistent with its responsibilities. For example, it had issued guidance that calls for tracking metrics, such as the percentage of data domains within the departments' current health information systems that are mapped to national standards.

However, the office had not yet specified outcome-oriented metrics and established related goals that are important to gauging the impact that interoperability capabilities have on improving health care services for shared patients. As a result, we recommended that VA and DoD, working with the Interagency Program Office, take actions to establish a time frame for identifying outcome-oriented metrics, define goals to provide a basis for assessing and reporting on the status of interoperability-related activities and the extent to which interoperability is being achieved by the departments' modernized electronic health record systems, and update Interagency Program Office guidance to reflect the metrics and goals identified.

Subsequently, we reported that VA and DoD had certified in April 2016 that all health care data in their systems complied with national standards and were computable in real time.[24] However, VA acknowledged that it did not expect to complete a number of key activities related to its electronic health record system until sometime after the December 31, 2016, statutory deadline for deploying modernized electronic health record software with interoperability.

Further, in following up on implementation of the recommendations in our August 2015 report, we found that VA, DoD, and the Interagency Program Office had addressed the recommendations in full by updating guidance to include goals and objectives and an approach to developing metrics that would improve the departments' ability to report on the status of interoperability activities.

The Interagency Program Office's Role in Governing VA's New Electronic Health Record System Acquisition Is Uncertain

In June 2017, the former VA Secretary announced a significant shift in the department's approach to modernizing the department's electronic health record system. Specifically, rather than continue to use VistA, the Secretary stated that the department planned to acquire the same Cerner electronic health record system that DoD has been acquiring.[25]

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[23] GAO-15-530.

[24] GAO-16-807T.

[25] In July 2015, DoD awarded a $4.3 billion contract for a commercial electronic health record system developed by Cerner, to be known as MHS GENESIS. The transition to the new system began in February 2017 in the Pacific Northwest region of the United States and is expected to be completed in 2022. The former Secretary of Veterans Affairs signed a ″Determination and

Accordingly, the department awarded a contract to Cerner in May 2018 for a maximum of $10 billion over 10 years. Cerner is to replace VistA with a commercial electronic health record system. This new system is to support a broad range of health care functions that include, for example, acute care, clinical decision support, dental care, and emergency medicine. When implemented, the new system will be expected to provide access to authoritative clinical data sources and become the authoritative source of clinical data to support improved health, patient safety, and quality of care provided by VA.

Deployment of the new electronic health record system at three initial sites is planned for within 18 months of October 1, 2018,[26] with a phased implementation of the remaining sites over the next decade. Each VA medical facility is expected to continue using VistA until the new system has been deployed at that location.

As we testified in June 2018, VA has taken steps to establish a program management office and has drafted a structure for technology, functional, and joint governance of the electronic health record implementation.[27] Specifically, in January 2018, the former VA Secretary established the Electronic Health Record Modernization (EHRM) program office that reports directly to the VA Deputy Secretary.

Further, VA has drafted a memorandum that describes the role of governance bodies within VA, as well as governance intended to facilitate coordination between the department and DoD. According to EHRM program documentation, VA is in the process of establishing a Functional Governance Board, a Technical Governance Board, and a Governance Integration Board comprised of program officials intended to provide guidance and coordinate with DoD, as appropriate. Further, a joint governance structure between VA and DoD has been proposed that would be expected to leverage existing joint governance facilitated by the Interagency Program Office.

Nevertheless, while VA's plans for governance of the EHRM program provide a framework for high-level oversight for program decisions moving forward, EHRM officials have noted that the governance bodies will not be finalized until October 2018. Accordingly, the officials have not yet indicated what role, if any, the Interagency Program Office is to have in the governance process.

Conclusions

The responsibilities of the Interagency Program Office have been intended to support the numerous approaches taken by VA and DoD to increase health information interoperability and modernize their respective electronic health record systems. Yet, while the office has led key efforts to identify data standards that are critical to interoperability between systems, the office has not been effectively positioned to be the single point of accountability originally described in the National Defense Authorization Act for Fiscal Year 2008. Further, the future role of the Interagency Program Office remains unclear despite the continuing need for VA and DoD to share the electronic health records of servicemembers and veterans. In particular, what role, if any, that the office is to have in VA's acquisition of the same electronic health record system that DoD is currently acquiring is uncertain.

Recommendation for Executive Action

We are making the following recommendation to VA:

The Secretary of Veterans Affairs should ensure that the role and responsibilities of the Interagency Program Office are clearly defined within the governance plans for acquisition of the department's new electronic health record system. (Recommendation 1)

Chairman Banks, Ranking Member Lamb, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staffs have any questions about this testimony, please contact Carol C. Harris, Director, Information Technology Acquisition Management Issues, at

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Findings,″ to justify use of the public interest exception to the requirement for full and open competition, and authorized VA to issue a solicitation directly to Cerner. A ″Determination and Findings″ means a special form of written approval by an authorized official that is required by statute or regulation as a prerequisite to taking certain contract actions. The ″Determination″ is a conclusion or decision supported by the ″Findings.″ The findings are statements of fact or rationale essential to support the determination and must cover each requirement of the statute or regulation. FAR, 48 C.F.R. § 1.701.

[26] The three initial deployment sites are the Mann-Grandstaff, American Lake, and Seattle VA Medical Centers.

[27] GAO-18-636T.

(202) 512–4456 or harriscc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony statement. GAO staff who made key contributions to this testimony are Mark Bird (Assistant Director), Jennifer Stavros-Turner (Analyst in Charge), Rebecca Eyler, Jacqueline Mai, Scott Pettis, and Charles Youman.

GAO HIGHLIGHTS

What GAO Found

Since its establishment in 2008, the Department of Defense (DoD) and Department of Veterans Affairs (VA) Interagency Program Office has been involved in various approaches to increase health information interoperability. However, the office has not been effectively positioned to function as the single point of accountability for the departments' electronic health record system interoperability efforts. For example,

- Between July 2008 and January 2010, GAO issued reports on VA's and DoD's efforts to set up the office, which highlighted steps the departments had taken, but also identified deficiencies, such as vacant leadership positions and a lack of necessary plans. GAO recommended that the departments improve management of their interoperability efforts by developing a project plan and results-oriented performance goals and measures.
- In April 2009, the Interagency Program Office was assigned responsibility for establishing a lifetime electronic record for servicemembers and veterans, called the Virtual Lifetime Electronic Record. GAO reported in February 2011 that, among other things, the office had not developed and approved an integrated master schedule, a master program plan, or performance metrics for the initiative, as outlined in the office's charter. Accordingly, GAO recommended that the departments correct these deficiencies to strengthen their efforts to establish the Virtual Lifetime Electronic Record.
- In March 2011, VA and DoD committed to jointly developing a new, common integrated electronic health record system and empowered the Interagency Program Office with increased authority, expanded responsibilities, and increased staffing levels for leading the integrated system effort. However, in February 2013, the departments abandoned their plan to develop the integrated system and stated that they would again pursue separate modernization efforts. In February 2014, GAO reported on this decision and recommended that VA and DoD take steps to better position the office to function as the single point of accountability for achieving interoperability between the departments' electronic health record systems.

VA and DoD stated that they agreed with the above GAO recommendations. However, in several cases the departments' subsequent actions were incomplete and did not fully address all recommendations.

In June 2017 VA announced that it planned to acquire the same electronic health record system that DoD has been acquiring. GAO testified in June 2018 that a governance structure had been proposed that would be expected to leverage existing joint governance facilitated by the Interagency Program Office. At that time, VA's program officials had stated that the department's governance plans for the new program were expected to be finalized in October 2018. However, the officials have not yet indicated what role, if any, the Interagency Program Office is to have in the governance process. Ensuring that the role and responsibilities of the office are clearly defined within these governance plans is essential to VA successfully acquiring and implementing the same system as DoD.

View GAO–18–696T. For more information, contact Carol C. Harris at (202) 512–4456 or harriscc@gao.gov.

Highlights of GAO–18–696T, a testimony before the Subcommittee on Technology Modernization, Committee on Veterans' Affairs, House of Representatives

ELECTRONIC HEALTH RECORDS

Clear Definition of the Interagency Program Office's Role in VA's New Modernization Effort Would Strengthen Accountability

Why GAO Did This Study

The National Defense Authorization Act for Fiscal Year 2008 included provisions that VA and DoD jointly develop and implement electronic health record systems or capabilities and accelerate the exchange of health care information. The act also required that these systems be compliant with applicable interoperability standards.

Further, the act established a joint Interagency Program Office to act as a single point of accountability for the efforts, with the function of implementing, by September 30, 2009, electronic health record systems that allow for full interoperability.

This testimony discusses GAO's previously reported findings on the establishment and evolution of the Interagency Program Office over the last decade. In developing this testimony, GAO summarized findings from its reports issued in 2008 through 2018, and information on the departments' actions in response to GAO's recommendations.

What GAO Recommends

GAO recommends that VA clearly define the role and responsibilities of the Interagency Program Office in the governance plans for acquisition of the department's new electronic health record system.