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ELECTRONIC HEALTH RECORDS

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

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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 care information.² The act also required that these systems or capabilities be compliant with applicable

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

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

interoperability³ 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

³According 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).

⁴GAO, *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).

⁵GAO, *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).

⁶GAO, *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).

⁷GAO, *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).

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

⁸GAO, *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.

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.

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

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.

¹⁰The 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.

¹¹Office 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.

¹²Pub. 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 standards¹³ 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.

¹³Health 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.

¹⁴GAO, *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).

¹⁵Developing, 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.

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.

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

¹⁶Pub. L. No. 110-181, § 1635, 122 Stat. 3, 460-463 (2008).

¹⁷GAO-08-954.

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 recommended 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

¹⁸GAO-09-268.

¹⁹GAO-09-775.

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.

²⁰GAO-10-332.

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 departments. 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.

²¹[GAO-11-265](#).

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

²²GAO-14-302.

(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 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

²³GAO-15-530.

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

²⁴GAO-16-807T.

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

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.

²⁵In 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 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.

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

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

²⁷GAO-18-636T.

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)

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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 (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.