VA ELECTRONIC HEALTH RECORD MODERNIZATION: GET WELL SOON?

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

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C O N T E N T S

THURSDAY, SEPTEMBER 14, 2023

Page

OPENING STATEMENTS

The Honorable Mike Bost, Chairman 1
The Honorable Mark Takano, Ranking Member 2

WITNESSES

PANEL 1

Mr. Neil Evans, M.D., Acting Program Executive Director, Electronic Health Record Modernization Integration Office, U.S. Department of Veterans Affairs 4
Mr. Robert Fischer, M.D., Director, Mann-Grandstaff (Spokane, Washington) VA Medical Center, U.S. Department of Veterans Affairs 6
Mr. Scott Kelter, Director, Jonathan M. Wright (Walla Walla, Washington) VA Medical Center, U.S. Department of Veterans Affairs 6
Ms. Meredith Allison Arensman, M.D., Chief of Staff, Chalmers P. Wylie (Columbus, Ohio) VA Ambulatory Care Center, U.S. Department of Veterans Affairs 7
Ms. Thandiwe Nelson-Brooks, Associate Director, Roseburg, Oregon VA Medical Center, U.S. Department of Veterans Affairs 8

APPENDIX

PREPARED STATEMENT OF WITNESS

Mr. Neil Evans, M.D., Prepared Statement 45

STATEMENT FOR THE RECORD

Ms. Teresa D. Boyd, D.O. 51

VA ELECTRONIC HEALTH RECORD MODERNIZATION: GET WELL SOON?

THURSDAY, SEPTEMBER 14, 2023

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

The committee met, pursuant to notice, at 10:31 a.m., in room 360, Cannon House Office Building, Hon. Mike Bost (chairman of the committee) presiding.

Present: Representatives Bost, Radewagen, Bergman, Mace, Rosendale, Miller-Meeks, Murphy, Franklin, Van Orden, Luttrell, Ciscomani, Crane, Kiggans, Takano, Brownley, Pappas, Mrvan, Cherfilus-McCormick, Deluzio, McGarvey, Ramirez, Landsman, and Budzinski.

Also present: Representative McMorris-Rodgers.

OPENING STATEMENT OF MIKE BOST, CHAIRMAN

The CHAIRMAN. Good morning, everyone. The committee will come to order, and I want to welcome our witnesses. I also want to ask unanimous consent that Representative McMorris-Rodgers, and Newhouse, and Schrier be able to participate in today's questioning. Hearing no objections, we will proceed.

The Cerner Electronic Health Record (EHR) went live in Spokane, Washington nearly 3 years ago. It then went live in Walla Walla, Columbus, and Roseburg about 2–1/2 years ago. Things still are not right with these medical centers and their clinics. When I went to Walla Walla and Columbus last year, there were still struggles to get back to normal. The number of appointments was still cut back, the employees were furious, and the veterans were confused.

I understand these facilities have managed to get close to normal patient volumes by adding a whole lot more staff. That is more people to do the same amount of work. We still can not trust Oracle Cerner EHR to be safe and accurate. VA employees are being forced to doublecheck everything. Those extra employees cost us a lot of money.

The staff costs, reduced collections, and higher community care costs have put some of the medical centers in permanent budget deficits. This is outrageous and a terrible situation. I do not know how anyone with a share of judgment could call EHR a success. A parade of VA and Cerner executives repeatedly tried to tell us how great it was over and over and over again, and it just was not. We kept seeing it.

I want to tell you that the problems that came to us did not just come to one side of the aisle. Both Republicans and Democrats have agreed we see this problem, and we have tried desperately to get it fixed. The problem became overwhelming when Secretary McDonough finally did the right thing in April and declared an indefinite pause. This is a pause I had been calling for since 2021 because our staffs, as I said, on both sides of the aisle, had been watching and seeing things go south.

Now, the VA is in a reset where Dr. Evans has to figure out how to fix up a broken system. Dr. Evans, I do not envy your task at all. Your punch list has got to be a mile long. Not only does the EHR have a lot of built-in problems, VA created new problems in trying to customize it as well. VA leaders are going to have to make hard decisions they have been avoiding, and veterans care depends on it.

Unfortunately, the previous directors of the project wasted far too much money. They spent over 50 percent of the budget and only completed about 3 percent of the rollout. This is a deep hole to climb out of. If you are able to pull it off, we are going to see the improvement in these medical centers. I am not going to accept anything less.

Under no circumstances should VA deploy the Oracle Cerner's EHR elsewhere until these facilities have made and are made whole. Now that is the test. Congress has been letting VA grade its own test for too long. We were far too hands off at the beginning of this project. When setting our goals and when they really mattered, we kept our hands off, but we are not keeping our hands off anymore. We need to establish a clear in what our expectations are so that everyone knows and understands where we want to go. I want to thank the Ranking Member Takano for working with me over the last few months to refine the EHR reset legislation. I also want to thank Senator Tester and Senator Moran for collaborating with us. Now, our staffs are going to be working together to hammer out an agreement. It is simple. The project has to deliver results or end.

We cannot allow it to stumble along and spend more money and more time and not get the results we need. We are going to find a solution that gives veterans the level of service that they have earned and does right by the VA staff. Now, that is my commitment. Ranking Member Takano, I now recognize you for your opening statement.

OPENING STATEMENT OF MARK TAKANO, RANKING MEMBER

Mr. TAKANO. Well, thank you, Mr. Chairman. Thank you to the witnesses for being here today to discuss this critical project at the Department of Veterans Affairs. I want to start off by welcoming Dr. Evans. This is the first time that we have had you before our committee and before the full committee since you assumed leadership of the Electronic Health Record Modernization (EHRM) program. Welcome, Dr. Evans. The program needs strong and stable leadership, and I am optimistic that you are the person for the job. I am optimistic, as well, that we are going to be working together with you to ensure that the EHRM gets back on track.

Like most committee members, I was supportive of VA's announcement of a reset of the EHRM program and the decision to delay any further go-lives while VA and Oracle fix the issues at the five sites currently live on the Cerner system. I am concerned, though, to hear that VA is moving forward with the program at the Lovell Federal Healthcare Center. While I understand that Department of Defense (DoD) needs to go live at the Lovell facility to complete its program, I think it is risky to deploy a system that has been so problematic at a facility that is very different from any other facility in VA or DoD. We cannot allow DoD to pressure VA into going live prematurely just so that DoD can reach its goals. This program cannot afford another failed go live.

I am glad to see witnesses from most of the live sites today. I am hoping to hear about their perceptions about progress with the system. The frontline staff at these facilities have borne the brunt of the struggles with this program. We owe it to them to ensure that their feedback is being taken into consideration at this reset, as this reset moves forward.

VA has a major task ahead of it to change the hearts and minds of staff about the benefits and potential success of the program. I hope that the program office is taking its obligations to the frontline staff seriously. I am also very concerned that it appears that VA is too busy treating the symptoms of this program to think strategically about preventing these issues from resurfacing at the next facilities to go live. I share Ranking Member Cherfilus-McCormick's belief that VA must focus on developing a baseline EHR that minimizes deviations as the program moves forward.

I also believe that VA needs a robust governance structure to ensure that any changes made to the baseline are absolutely necessary and are in the best interest of veterans. Constant change requests have and will continue to have major impacts on the cost and timeline of the project and will force staff at the active sites to continually adjust their workflows. Because of this and my concerns about the future of the program, I am pleased that Chairman Bost and I have been working together to draft the House's version of the EHR Reset Act, building on the great work from Chairman Tester in the Senate.

We have spent a considerable amount of time discussing the struggles with the program, and now we need legislative action to force some of the structural and accountability measures that are necessary to get this program on track. It cannot be understated how big this problem is, both in terms of cost and scale, but a modern EHR is necessary if we want VA to be able to provide world class healthcare and for its providers and veterans to be able to access new healthcare technology.

It is clear that we need to give VA and Congress more tools to manage and oversee this program. I look forward to continuing to work with my House and Senate colleagues to ensure that we get this bill finalized and enacted into law as soon as possible. I thank you, Mr. Chairman, and I yield back.

The CHAIRMAN. Thank you, Ranking Member Takano. I now will introduce the witnesses. First, we have Dr. Neil Evans, the Acting Executive Director of EHRM Integration Office. We also have Dr. Robert Fischer, who is the Director of the Spokane Medical Center,

Mr. Scott Kelter, Director of Walla Walla Medical Center, Dr. Allison Arensman, Chief of Staff for the Columbus Ambulatory Care Center, and Ms. Thandiwe Nelson-Brooks, Associate Director of the Roseburg Medical Center. If each of you can rise and raise your right hand, please.

[Witnesses sworn]

The witnesses have all responded in the affirmative, and let the record reflect as such. Dr. Evans, you are now recognized for 5 minutes for your opening statement.

STATEMENT OF NEIL EVANS

Dr. EVANS. Thank you very much. Good morning, Chairman Bost, Ranking Member Takano, and all distinguished members of this committee. Thank you for this opportunity to testify. As you have just heard, accompanying me today are the leaders of our facilities, Mr. Scott Kelter, Medical Center Director of the Jonathan M. Wainwright Memorial VA Medical Center in Walla Walla, Dr. Rob Fischer, Medical Center Director of the Mann-Grandstaff VA Medical Center in Spokane, Washington, Ms. Thandiwe Nelson-Brooks, Associate Director of the Roseburg VA Health Care System, and Dr. Allison Arensman, Chief of Staff of the VA Central Ohio Health Care System in Columbus.

I am very grateful that they have been able to travel to join us today. Local medical center and Veterans Integrated Services Network (VISN) leadership, and for that matter, VA frontline staff and clinicians, are the most important members of our community when it comes to successfully implementing a new electronic health record in VA, and their perspectives are critical.

First, I would like to take a step back. As you are aware and just heard, VA needs to modernize its electronic health record system, and the Department remains steadfast in its commitment to doing so. The replacement of VA's EHR is one of the most complex health IT projects ever undertaken. The project will impact more than 300,000 VA employees and more than 100,000 trainees who will 1 day use the new system every year, and more than 7 million veterans whose care will be orchestrated and documented within the system every year.

I should emphasize that this is more, much more than just a technology project. The EHR change, by its very nature, requires VA to revisit, reconsider, and where possible, standardize clinical processes and workflows. Electronic health records profoundly impact operations, including how care is delivered in the modern healthcare system, how providers access the information that they need, how instructions for care, also known as orders, are transmitted and received within the hospital, how highly complex care is organized in our intensive care units (ICUs), how surgeries are successfully planned and completed, how prescriptions are ordered and delivered. Getting this right requires a massive team effort across the VA enterprise, attention to detail, effective communication, and consistent execution.

In fact, as has already been mentioned, the suite of technologies that make up a modern electronic health record are just part of a larger ecosystem of technologies needed by VA to enhance the quality and safety of healthcare delivery. It is this entire suite of tech-

nologies, both the Federal EHR and other critical health information technologies that need to be modernized and integrated effectively to simplify the healthcare experience for veterans and VA staff and to enhance standardization across VA's enterprise.

As you are aware, VA is implementing the very same electronic health record solution as the Department of Defense, U.S. Coast Guard, and National Oceanic and Atmospheric Administration (NOAA). This system is often referred to as the Federal EHR.

DoD completed their deployment in the Continental United States, and they are still going to go live at the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois, as well as their outside of the Continental United States sites. Together, we are planning an implementation of the record in North Chicago with a go-live currently planned in spring of 2024. In VA, the Federal EHR is in use at five VA medical centers, 22 community-based outpatient centers, and 52 remote sites such as call centers and telehealth hubs that support the facilities led by the individuals to my left.

We have been listening to veterans, clinicians, and frontline leaders such as my colleagues here at this table. In doing so, it became clear that the Federal EHR was not and is not meeting expectations. Therefore, in April 2023, VA announced a program reset, halting work on future deployments except for the Lovell Federal Health Care Center. As a result, we are now focusing on delivering the improvements needed for our current system users, while also preparing the enterprise for future deployment successes. Staff productivity levels, revenue collections, technical system performance, user adoption and satisfaction, and more require dedicated attention and positive improvements before deployments resume at full pace.

VA has organized its work during this program reset into 3-month increments, and just completed its first increment on August 31. Initial efforts focused on planning and making necessary system configuration changes, improving the technical stability of the system, enhancing user support and ticket management, addressing communications within VA, and developing a larger cohort of VA experts who can support the new system in the years to come.

I suspect you will hear from my colleagues that some of the necessary improvements they have been asking for are starting to be seen, but that there is still much to be done before we will be ready to publish a new schedule and proceed with deployments across the rest of the VA healthcare system. I am appreciative of the frontline leaders you see represented here. As I mentioned earlier, switching to a new EHR requires resiliency and demands a lot from staff. Frontline leaders such as my colleagues here are the cornerstone of any successful transition and are best equipped to support and lead staff through the process. Their remarks will follow, and I look forward to hearing those.

[THE PREPARED STATEMENT OF NEIL EVANS APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Dr. Evans. The written statement of Dr. Evans will be entered into the hearing record. Dr. Fischer, you are now recognized for 2 minutes for your opening remarks.

STATEMENT OF ROBERT FISCHER

Dr. FISCHER. Good morning, Chairman Bost, Ranking Member Takano, and distinguished members of the committee. We are approaching the 3-year implementation anniversary of the Oracle Cerner electronic health record at Mann-Grandstaff VA Medical Center in Spokane, Washington and our clinics in Wenatchee, Washington, Coeur d'Alene and Sandpoint, Idaho, and Libby, Montana.

I would like to take this opportunity to recognize the extraordinary efforts and dedication of our employees. In January 2020, during intense preparations to go live with the Cerner EHR, COVID–19 hit the West Coast of the United States. In April, our staff evacuated 41 patients testing positive for COVID–19 from our local Washington State Veterans Home to Mann-Grandstaff for enhanced acute care that unquestionably saved many lives. Mann-Grandstaff went live with Cerner in October of that year, 2 months before the country experienced its historic peak in COVID–19 hospitalizations.

Since implementation, our employees have recorded, investigated, and mitigated over 1,600 Oracle Cerner related patient safety events. They reviewed for potential intervention and mitigation more than 28,000 medical orders that populated the electronic health record queues when they did not execute successfully as anticipated. Our staff has entered 15,000 break-fix incident tickets and 3,000 change requests since initial implementation. They have been engaged in continuous EHR process improvement through collaboration with peers, facility teams, risk management, patient safety, VISN 20, other live sites, VA Central Office, and Oracle Cerner.

The diligence and resilience and often bravery of our staff in transitioning to a challenging new electronic health record during a deadly worldwide pandemic is absolutely nothing short of extraordinary. Their continued engagement in identifying gaps in training and functionality over the last 3 years is a testament to the high quality of our staff and their dedication to veterans' health. On behalf of the men and women of Mann-Grandstaff VA Medical Center, please accept our gratitude for your continued support of veterans and our employees who serve them and have gone way above and beyond. Thank you very much.

The CHAIRMAN. Thank you, Doctor. Mr. Kelter, you are now recognized for 2 minutes for your opening remarks.

STATEMENT OF SCOTT KELTER

Mr. KELTER. Thank you and good morning, Chairman, Bost, Ranking Member Takano, and distinguished members of the committee. Thank you for your engagement in the EHR modernization process and your commitment to veterans. Having now used the Cerner Millennium EHR for 18 months, the VA Medical Center in Walla Walla, Washington is recovering toward our pre-Cerner productivity, but is still not as efficient as we were prior to Cerner go-live in 2022. Clinical staff are working long days but are making improvements in efficiency and productivity.

From 2022 to 2023, primary care providers' time per patient in the medical record decreased by 10 percent, and they are seeing 24

percent more patients. Patient satisfaction with their appointment date and time also improved 7 percent throughout 2023. At VA Walla Walla, we added a modest number of permanent staff, 4 percent of our total staffing, to meet the demands of utilizing the Cerner Millennium Platform, including nurses, pharmacy staff, charge analysts, health informaticists, and an additional patient safety manager. Along with additional support from our network and the National EHRM Supplemental Staffing Unit, this has been sufficient to continue operations, but VA delivered care remains at 80 percent of our pre-Cerner levels. The number of Cerner related patient safety reports submitted by staff has declined by 73 percent from the initial spike after go-live, but remains 38 percent above pre-Cerner levels while staff still utilize workarounds outside of the software's designed workflow to complete tasks.

We are pleased with the intent of this reset, enabling VA and Oracle Cerner to fix issues in the EHR, redirecting resources from deployment to work on optimizing the EHR at medical centers where it is currently in use. Veterans deserve the very best healthcare, and we are committed to delivering that for them. I am optimistic about the eventual success of a modernized EHR within the Veterans Health Administration. I look forward to any questions you have.

The CHAIRMAN. Thank you, Mr. Kelter. Dr. Arensman, you are now recognized for 2 minutes.

STATEMENT OF ALLISON ARENSMAN

Dr. ARENSMAN. Chairman Bost, Ranking Member, Takano, distinguished congresspeople, thank you for the opportunity to address the current State of the VA healthcare system in Central Ohio. I am a physician and the chief of staff, and I am here to represent our hardworking, resilient, and incredibly dedicated team and the amazing veterans, many such as yourself, that we serve.

The past 2 years have been incredibly challenging. We are proud that we developed an extensive preparatory plan. We increased our staffing. We set aggressive goals to try to reach our pre-deployment productivity and access. We have unfortunately found that the new electronic health records has largely provided no meaningful improvements in safety, efficiency, or communication.

Our clinicians are exhausted, sometimes tearful, and frankly, distressed that they are not able to provide the level of care that they could in 2019. Imagine being a doctor in Columbus and receiving a critical message about a patient you have never seen, who is admitted to a Department of Defense site thousands of miles away because his provider has a similar name. Imagine being an optometrist and finding an eyeglass prescription that has your signature that you know you never signed. Imagine being a social worker and being unable to print a transfer summary for a patient that is decompensating and needs a higher level of care. These are not possibilities. It has been the reality for our team in Columbus.

While our productivity is nearing what it was pre-deployment, it remains 84 percent of what it was pre-pandemic. Our collections are down 48 percent. Joint patient safety reporting is nearly threefold what it was before we went live, with over 70 percent of events

attributed to the electronic health record. Our staff have spent over 8,000 hours on clinical lookbacks since go-live.

Despite these challenges, our staff continues to persevere, working longer hours and manually completing workarounds to protect veterans every day. We are proud of our innovative culture in Columbus. We are concerned that the current strategies and product are not yet adequate nor scalable. We understand we can not flip the switch and go back to the Legacy system, although there are days that would be our preference. We hope for a dynamic, intuitive, and adaptable system that meets the unique needs of veterans. This will take time, resources, and a commitment for all our stakeholders. Thank you.

The CHAIRMAN. Thank you, Doctor. Ms. Nelson-Brooks, you are recognized for 2 minutes of your opening statement.

STATEMENT OF THANDIWE NELSON-BROOKS

Ms. NELSON-BROOKS. Thank you. Chairman Bost, Ranking Member Takano, and distinguished members of the committee, thank you for the opportunity to speak today. The Roseburg VA is a rural facility comprised of five sites of care serving more than 36,000 veterans in Southern Oregon and Northern California. On June 11, 2022, the Roseburg VA made the switch from the Legacy system to the new EHR. Under ideal conditions, implementing a new medical record system is challenging. For a facility challenged with delivering care in a rural setting, the transition to the new EHR was difficult.

Post go-live, we saw increases in wait times, turnover of staff, and a decrease in patient satisfaction scores. In a survey of Roseburg VA staff conducted last April, 86 percent strongly disagreed with future deployments of the EHR in its current state, as it does not increase efficiency, improve patient safety, or meet expectations. I am happy to provide the committee with specific examples. However, these issues were elevated to leadership within the Department who heard the concerns of staff, deferred to their expertise, and implemented the reset. We applaud their commitment to getting it right, but it is not right yet, and our facility has adapted to ensure we continue to deliver safe, quality care.

Since go-live, our facility has increased staffing, supported frontline staff, and expanded care models. Fifteen months in, we have seen improvements in staff level of comfort in the new EHR. Prescription fill times have decreased and productivity has increased but has not returned to baseline. We are moving in the right direction. However, the system in its current state is not ready for additional deployments.

We are optimistic and committed to enhancing the system. In sum, our employees are the backbone of the organization. Their reluctance to simplify illustrates their commitment to our high reliability principles and the delivery of safe, effective quality care. Thank you to the committee for your advocacy on behalf of our veterans.

The CHAIRMAN. Thank you, Ms. Nelson-Brooks. Before we go further on to questions, at the VA's request, I would like to enter into the record for the hearing statement of Dr. Teresa Boyd, the Director of VISN 20.

Without objection, so entered.

Now, we are going to go to questions. Before I go to questions, I want to make one statement to each one of you. Please deliver the message back to your employees that we know they are doing the best they possibly can in a very, very hard time in their careers, and we want to get this right.

I will go to questions first. Dr. Arensman, what impact has Cerner's EHR had on the delivery of care to veterans, especially how many veterans you can treat in a day, and how has your team dealt with that?

Dr. ARENSMAN. Thank you for the question. Initially, it had quite an impact on the number of patients we could treat a day. The answer is somewhat diverse depending on what service we are considering. We were able to regain our productivity in our surgical clinics by August. We went live in April of last year.

In other places, we still have not quite reached what our productivity was before, particularly in primary care. The gains have been much more incremental and the slope much more shallow. We are approaching about 80 percent to 85 percent in some of those services.

The Chairman. Can you also let me know about the system downtime? Oracle and Dr. Evans' teams are reporting dramatic improvements. Are your staff seeing dramatic improvements?

Dr. ARENSMAN. Is that question for me as well?

The CHAIRMAN. Yes, please.

Dr. ARENSMAN. Thank you. We have seen over the past 6 months, there have been fewer total downtimes, so total outages. Our staff still is seeing at least once a month incidents that leads to having to go to downtime procedures. Functionally for those trying to take care of patients when they need to put pen to paper, that has still happened. It actually happened two times in the past 2 weeks.

The CHAIRMAN. Okay. I am going to stay with you for all my questions and then I think others will be going to the others.

Dr. ARENSMAN. Yes, sir.

The CHAIRMAN. Is your facility running better than it was before the Cerner EHR was implemented?

Dr. ARENSMAN. Operationally, I think our facility is running quite well. I would say that operating with the Cerner record has posed new and interesting challenges and we have had to dedicate resources that otherwise would have been dedicated to strategies to improve care.

The CHAIRMAN. Well, it sounds like you have done what you could do to make what you have been handed work to the best of your ability. Some of the big improvements will be beyond your control because it is going to be Cerner that has got to come in and right the wrong. In the current situation, is it a band-aid or is it sustainable? If it is not sustainable, how long is it sustainable?

Dr. ARENSMAN. I am sorry, can you clarify the question?

The CHAIRMAN. Basically where you are fixing now, are you going to be able to keep it together or is it going to have to be changed tremendously?

Dr. ARENSMAN. It is a great question. We are taking care of the veterans in Central Ohio and I think we are doing an amazing job.

At what cost? It is cost a tremendous amount in terms of additional staff, in terms of additional overtime, and in terms of, I think a degree of moral distress among our providers.

The CHAIRMAN. This is not on my questions, but it is on my mind, okay? Right now, we are turning up the The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act. Your workload is going to get a lot bigger. Are you going to be able to handle the workload that we are sending to you through the PACT Act with the system and the situation that we are with right now?

Dr. ARENSMAN. I have a bit of good news in that Columbus is really leading our region and I think our Nation in how we have addressed patients with toxic exposure screenings. We have no patients that are waiting for their follow-up exams for toxic exposure screening. I agree, if it increases our enrollments, it will be a challenge in the future.

The CHAIRMAN. Let me tell you that we want to thank you for being here today. I want to say thank you for you and your staff. Like I said, I know we are going to have a whole lot of other people that need to ask questions here, so I am going to yield to the ranking member so we can go on with the rest of questions.

Mr. TAKANO. Thank you, Chairman Bost. Yesterday, we received the quarterly patient safety data that was mandated by Representative Frank Mrvan's EHR Transparency Act in the last Congress. I have to say I was alarmed to see that there are quite a few of the reports from our facilities on patients. What is alarming is that we are seeing a few reports of facilities receiving reports on patients at other facilities.

I thought that VA told us over a year ago that this issue had been fixed. Now, Dr. Arensman, you mentioned this particular issue in your opening statement. Can you give us an indication of how often this situation is occurring where facilities are receiving reports on patients at other facilities?

Dr. ARENSMAN. Thank you. I believe I mentioned in my opening statement that there was an increase in patient safety reports. I have heard that occasionally they have been sent to erroneous sites. I do not have the documentation as I do not actually have access to that system. It is a highly protected system given the obvious privacy concerns for anyone involved.

I can say that there have been an increase in patient safety reports. I want to be clear, this is something we often celebrate and I think of as a good thing, because these are things that are recognized as dangers to patients. It does not necessarily mean there has been a catastrophic event. It means that something has been recognized as a potential patient safety concern. For a high reliability organization, we want people to speak up, and we encourage them to speak up. While it is concerning and while it is frustrating to me that we are spending a lot of time addressing these, I am proud of our staff, and I think that it is potentially a benefit.

Mr. TAKANO. Excuse me, Dr. Arensman. What I am talking about are patient messages.

Dr. ARENSMAN. Oh, sorry. Okay.

Mr. TAKANO. Patient messages. What specifically we are concerned about is facilities receiving reports on patients at other facilities.

Dr. ARENSMAN. Thank you for that clarification.

Mr. TAKANO. Okay, great.

Dr. ARENSMAN. So——

Mr. TAKANO. I mean, can you comment on how frequently this is occurring?

Dr. ARENSMAN. I hear about it happening on a weekly basis.

Mr. TAKANO. On a weekly basis? Okay. Dr. Evans, can you shed light on why this continues to be a problem?

Dr. EVANS. I think of course, we do not want to ever see that happen. We want care to be—we want orders and messages to be delivered to the right recipient at the right facility. As we are deploying an enterprise EHR, that is a single enterprise EHR with the Department of Defense, Coast Guard, NOAA, and VA, we are moving into a very different paradigm than VA has been used to, where care was constrained within the local Veterans Health Information Systems and Technology Architecture (VistA) instance.

We spend a lot of time working on optimizing the configurations of the record to try to make it such that that does not happen, that messages are not going to the wrong facility or wrong individual. It is a focus area of some of the configuration changes that we are doing in the reset. This is in some forms, there are real significant advantages to having an enterprise electronic health record, a single electronic health record that works for the entire VA healthcare system.

We will be able to better share resources between our facilities. We will be able to deliver telehealth care, provide support from tele-ICU physicians to facilities all across the country with less burden. There is an advantage. That advantage comes with a corresponding risk. That risk is that we now have to function as a healthcare system with over 300,000 employees at the end of this in the same system.

We are working on how do we mitigate that risk, how do we prevent that? I think there is been improvement, but we are not where we need to be, obviously, based on what you just heard from Dr. Arensman.

Mr. TAKANO. Well, Dr. Evans, can you assure me that VA and Oracle Cerner, they are looking at a way to fix this problem?

Dr. EVANS. Yes, to address this problem, absolutely.

Mr. TAKANO. Well, great. Well, you know, I just want to again, really thank Mr. Mrvan for the EHR Transparency Act. It is giving us already it is paying dividends in terms of giving us important reporting and enabling us to do better congressional oversight. I certainly hope we do get this issue fixed. I yield back, Mr. Chairman.

The CHAIRMAN. The gentleman, yields back. Thank you, ranking member. Representative Radewagen, you are now recognized.

Ms. RADEWAGEN. Talofa lava. I want to thank Chairman Bost and Ranking Member Takano for holding this hearing today, and I thank the witnesses for being here. Mr. Kelter, how long did it take after Cerner was implemented at your facility for patient volumes to go back to 80 percent of normal? Please answer that in

terms of primary care and specialties. I understand some of your departments are very large, while some are very small.

Mr. KELTER. Similar to what Dr. Arensman described, our specialty care was fairly quick to recover and the record did not affect their throughput very much. Our pharmacy almost—I am sorry—our laboratory service almost immediately saw benefits to the system. In fact, our laboratory service is more productive and the system has made them more efficient.

Primary care, as one of our largest departments, has had a very, also similar to Columbus, has had a slow slope. It took several months to—we started very slow with just a couple of patients a day as physicians and other members of the team learned the record. Incrementally grew from two to four to six to eight to 10 patients a day. It really has been—it probably took about a year before they were at the level, about the level that they are at now.

Ms. RADEWAGEN. Okay. Mr. Kelter, how have your wait times been impacted and how much more care are you sending out to the community compared to before Cerner?

Mr. KELTER. The wait times initially increased significantly. Our patient care going out to the community was nearly double for some period of time. Our community care office is pretty much caught back up to the consult volume that we were at prior to when those consults built up in the Cerner go-live timeframe. Part of that has been due to the system itself and the efficiencies of the system, and part of that has been due to staffing variabilities that are unrelated to Cerner.

Again, it has taken through a variety of factors, again a little bit over a year to catch up and get back to that as well as those departments, both the primary care department and our community care coordination department, quite a bit of work, not only in staffing, but in developing their own processes and working through those things to improve. They have worked extremely hard to get to where we are and also to help break those barriers to make it easier and to share those lessons forward to other sites to make it easier for sites that will deploy after us.

Ms. RADEWAGEN. How many more staff have you needed to hire since you got Cerner and what areas have you hired them in?

Mr. KELTER. We have increased staff in our community care department specifically to help with the coordination of consults. We have added a patient safety manager. We have gone from one to two patient safety managers. We have increased some of our essentially the equivalent of one primary care team. Some of those increases are coupled with the normal recruitment challenges that we have as well. Increasing the authorization does not necessarily mean a rapid——

Ms. RADEWAGEN. Yes.

Mr. KELTER [continuing]. increase in staff.

Ms. RADEWAGEN. How about your medical collections, the copays and insurance payments? How has Cerner affected them?

Mr. KELTER. We have had a very limited ability to do third-party collections, and our collections have been significantly decreased. We have very little revenue to show, and that is done through a third-party billing office. That is not done at the Medical Center. That is done at the network level.

Ms. RADEWAGEN. You are here to speak for your staff. How do they feel about the Cerner system? What are they saying in surveys and to you directly?

Mr. KELTER. The majority of staff are still frustrated at the amount of time. For many it is essentially the process time and the number of clicks to get through a process where something might have taken six to 10 clicks before and now takes 30 to 50. The process time for many things is still double or triple what it was.

Ms. RADEWAGEN. I see. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. The gentlewoman yields back. Representative Mrvan, you are recognized.

Mr. MRVAN. My question is that commonality is the challenges that you are facing and we can not go back in time. If you could each just give me a little bit of perspective, if you think it is the capacity of the new system, if it was training, just very simply, what do you think led us to get to this point that you are before Congress because of the slow rollout and the risk that it provides?

Dr. EVANS. I suspect you are interested in the perspective from the medical center leadership?

Mr. MRVAN. Correct.

Ms. NELSON-BROOKS. Thank you for the question. It is a rather complicated question. I think that there are a number of facets that are involved in what is led us to this point. The training that our staff initially received from Cerner was not what we expected and did not adequately prepare staff to be able to function effectively and efficiently in the medical record system.

In addition to that, there were specific things that were not included in the medical record to take into account some of the complexities of care that the VA delivers. Cerner is a commercial off the shelf product not designed for the VA and does not take into account specific programs such as our Caregiver Support, our Homeless Program, and other programs along those lines. Similarly with DoD, we are very different.

Then last, what I would say is that each medical center is different and is unique, and their capacity to handle change of this scale is very individualized.

Mr. MRVAN. Can I hone-in on that? Can you tell me what you mean by the capacity of each individual organization and just kind of explain just a moment of that?

Ms. NELSON-BROOKS. Absolutely. The Roseburg VA is very rural. As a rural site, we are challenged with recruitment and retention of staff. We currently have a 40 percent vacancy rate in our primary care providers. Our position is very different from Columbus, where Columbus may not have been struggling with high vacancy rates in primary care and mental health.

In addition to that, as a facility, we have had turnover in our leadership team. I am new to the Roseburg VA, having been there less than 2 years, and the new medical center director who really wanted to be here but could not be here today, began in April. As a facility, we have experienced turnover in our leadership team.

Mr. MRVAN. Thank you. Anyone else?

Dr. FISCHER. I would say one of the root causes is related to Oracle Cerner's lack of appreciation for the complexity of VA oper-

ations when we began this journey. I would also say that their training——

Mr. MRVAN. Can I ask? So——

Dr. FISCHER. Sure.

Mr. MRVAN [continuing]. just to interrupt, I am going to follow up on that. We have transitioned from Cerner to Oracle. Consistently as chairman of Technology Modernization last year, there has been an absence of you sitting at the table trying to give your opinion. Has Oracle changed that? Have you had an opportunity or has Oracle changed your input into these situations?

Dr. FISCHER. I think that is an excellent question, sir. Do not forget, we are in a reset period now, and so the conditions and the environment has changed. Now we are starting to rev up meetings with both Electronic Health Record Modernization Integration Office (EHRM-IO) and Oracle Cerner, which is a consequence of this reset. It will be hard to say today what a month from now will look like when we are more into normal operations. Improvements are being made, and I suspect we will get more and more engagement from Oracle Cerner.

Mr. MRVAN. Thank you. Dr. Evans, you talked about the ecosystem of technology that goes into the support, or I interpret it as support into the electronic medical records. Can you define what you mean by that?

Dr. EVANS. Sure. I think sometimes we think together that changing the EHR from VistA Computerized Patient Record System (CPRS), which we have been using in VA and are still successfully using in much of VA, to the Federal EHR, the Oracle record, is the sum total of what we need to modernize health information technologies to support a modern VA.

The EHR in many ways serves as the equivalent of the operating system of a health information technology ecosystem. There are other critical applications, telehealth applications, connected to, you know, the bedside monitors that are in an intensive care unit, you know, measuring real time Electrocardiograms (EKGs) or telemetry, new clinical decision support applications.

Mr. MRVAN. Does the new system not include those systems? Are they not working in conjunction with each other?

Dr. EVANS. I think in my opening statement when I mentioned that, I think in part, part of the promise of a modern commercial electronic health record is that we will more easily be able to integrate and deliver connected technologies that will enhance the function of the electronic health record. We currently have many interfaced technologies supporting the medical centers that you see represented at my left. I do not think that that is a problem. I was characterizing that as an important part of the overall modernization journey that we are on. We are modernizing the EHR as well as the rest of our health information technologies that support and work in an integrated fashion with that electronic health record.

Mr. MRVAN. Thank you. With that, I yield back.

The CHAIRMAN. General Bergman, you are recognized.

Mr. BERGMAN. Thank you, Mr. Chairman. Listening to the testimony and the questions reminds me of an old saying about trying to fit a square peg into a round hole. I would suggest to you, the round hole is how the VA medical system has been delivering serv-

ices to the veterans. The square peg is the new EHR. Okay? Now, you got two choices. You got a square peg, a new system, and you got the existing ways you are doing business, the round hole.

The question is, how do you make the two fit, because they have to fit. Anytime, to use the square peg as the example, if you start shaving it to fit the round hole, you are going to cutoff some of your capabilities and make the whole system not work. That is just how that evolution works.

Dr. Evans, just a thought here, because I heard you say in your opening testimony, where possible, standardize, and then you went on from there. Standardization is the key to controlling costs, standardizing care for everyone, ultimately standardizing the ability of your physicians and providers to actually do their job, and ultimately the long-term success of the new, you know, if you will, enterprise system. When it comes to the standardization, I ask anybody here to provide comment, how are you working to standardize roles and clinical processes at the sites rather than try to make the EHR system work for your existing processes? Anybody want to offer comment?

Dr. EVANS. Yes, I will start and then I would love to hear some thoughts from those to my left. First of all, I completely agree and I would argue that we have a square peg and many round holes, not just a square peg and a single round hole. And——

Mr. BERGMAN. VA is the round hole.

Dr. EVANS. Correct. If we are trying to put a square peg, a single enterprise electronic health record, we are having to fit it to workflows, which may not be the same at 165 different medical centers.

Mr. BERGMAN. I am going to just interject for a second here because in a former life, I was a commercial airline pilot, and we had 4,000 pilots on our seniority list. We all did things the same way, regardless of what aircraft we were flying. There was a little nuance in checklists and operation. Tell me again why it is going to be so different across the VA in other words.

Dr. EVANS. I am not. I am saying that we need to standardize. I fully agree with you that in order for us to successfully deliver an enterprise electronic health record, one of the significant tasks in front of us as part of this reset is standardizing how we deliver care, whether that be primary care——

Mr. BERGMAN. What is——

Dr. EVANS [continuing]. whether that——

Mr. BERGMAN [continuing]. the standardization, I would guess, is in the ball is in your court on that, because you are the providers. All this is, is a tool, if you will.

Dr. EVANS. Correct.

Mr. BERGMAN. Right? We can eat up all the time here. Anybody else want to make any comments on the standardization as you try to move forward, in number one, upping in the quality of the healthcare, and the timeliness, and all of that across the entire system, but the challenges you have in standardizing? Anybody?

Mr. KELTER. Sir, as we learn new things about the medical record, the Cerner Millennium product, and we continue to learn more things about it every month, across the live sites, we have a network.

Mr. BERGMAN. When you learn new things, what then is the way of sharing the new things so that a, you know, a brush fire does not become a forest fire in this case? What is the mechanism that the VA is using to communicate across and to work with Oracle to iron out the inevitable kinks in installing a new system?

Mr. KELTER. We have frequent recurring meetings across the five live sites, primarily within VISN 20 and including VISN 10, as well as frequent recurring meetings with Cerner executives. Each time we discover something, our immediate question is, what are the other sites doing? How do we share what we have learned? How do we determine what is the best way to approach that and then engage EHRM-IO and Oracle Cerner with that solution?

Mr. BERGMAN. Okay. Thank you. Mr. Chairman, I see my time is up. I yield back.

The CHAIRMAN. Thank you. Representative Brownley.

Ms. BROWNLEY. Thank you, Mr. Chairman. Just to piggyback on this conversation, it seems as though getting standardization across the VA is a task, an objective that I am not sure is possible to achieve, honestly. I mean, since, you know, we have said—I have been on this committee for 10 years, and we have always said, if you have seen one VA, you have seen one VA. Each medical center has a lot of autonomy. I just do not know. To me, that is like the biggest cultural shift that could possibly occur within the VA is to gain standardization. It makes me worried that that is an essential key to making this all work. I am not going to ask a question around that. I am going to move on.

The EHR has been deployed in the Coast Guard and NOAA, it sounds like successfully, understanding that there probably is standardization, you know, across those entities. The DoD has done half of their facilities have deployed the EHR. I guess it sounds to me that in all of those locations, you are having success. Is it just the standardization? Is that the key essential difference between VA not having success and they having success?

Dr. EVANS. That is a good question. The DoD is, I think, over 90 percent complete. The only sites that they have not deployed are outside of the Continental United States and the Captain James A. Lovell Federal Health Care Center in North Chicago.

I think there are several factors. Again, we are different healthcare systems, but healthcare is healthcare. You know, one of the challenges that you face in deploying an electronic health record is the tension between needing to deploy the health record and needing to optimize it such that it is fit for purpose for how you deliver care in your healthcare system. I think DoD was probably further along in the standardization journey than we were when they started. They were moving from an electronic health record where I do not know that there was as much autonomy locally and nor was there as much sort of satisfaction with the EHR that they were moving from to the new EHR. I do think that a commitment to a baseline, here is how the record will be configured and how we need to move forward, was a part of the success story for those three health systems that you mentioned.

I think, however, when you deploy an electronic health record you are never done. There is always a tension between pushing forward with the deployment but doing the optimization. It is really,

as part of this reset, we are choosing rightfully so, absolutely have to, to get some of that optimization work done now to take the time to do that so that we can deploy a more standardized EHR that will meet the needs of our facilities moving forward.

Ms. BROWNLEY. Thank you for that. I assume that the deployment of those three organizations, they did that on budget, did not have any cost overruns in order to do it?

Dr. EVANS. Coast Guard and NOAA are very small organizations, and their deployments were supported by the DoD. The DoD took a very, very similar pause, reset. They did not call it a reset, but what we are in the middle of. Interestingly, when they came out of that, they were able, they addressed many of the same challenges, standardizing, deciding what the baseline is, fixing issues around training, revisiting their deployment methodology. As they came out of their pause, they were able to accelerate their deployments. They revisited the structure by which how they went live. I can not comment exactly on where they are with regard to their budget, but they did pick up speed by spending the time to do things during an equivalent of a reset. By doing those things right, it actually helped them on the back end.

Ms. BROWNLEY. I guess there is hope——

Dr. EVANS. I——

Ms. BROWNLEY [continuing]. that the same thing can happen within the VA. I appreciate your honesty in your written testimony that, you know, you do not have a firm timeline for the completion of the project. I appreciate that very, very much. There have been many who say it is going to take more than 10 years. I am wondering if you have any sense of where we might be without making a hard commitment.

Dr. EVANS. I think, as I just mentioned, I think this is actually an important part of the reset. Part of the reset as we move toward thinking about restart needs to be because we have promised that we will publish a schedule that we can stand behind at the end of reset. There is a lot of analysis that needs to go into understanding what that is and to, frankly, develop a schedule in partnership with our field leadership that makes sense.

Should we be going live concurrently at medical centers that share resources and refer between each other? How do we want to revisit what that schedule looks like? That work is ongoing right now to analyze what the constraints are to develop a new schedule. We want to do this right. I feel an urgency. It is hard for me to commit to say where this is going to fit from a timeline. That is work that we need to do as part of the reset. I look forward to continuing conversations with this committee on that topic.

Ms. BROWNLEY. Thank you very much. I yield back, Mr. Chairman.

The CHAIRMAN. Thank you. Mr. Rosendale.

Mr. ROSENDALE. Thank you very much, Mr. Chair, and thank you to all the witnesses for coming here to D.C. to testify and answer questions. I have made it my mission to provide proper oversight of the Oracle Cerner electronic health record system, ensure that veterans are not being put in harm's way, and that taxpayers do not continue to waste billions of dollars, billions of dollars. Dr.

Fischer, are you able to treat as many veterans today as you were before the Cerner system was introduced?

Dr. FISCHER. No, sir.

Mr. ROSENDALE. Okay. If so, when do you anticipate that you would be able to return to that level? Any estimate?

Dr. FISCHER. I am optimistic that with Dr. Evans and the efforts of the Agency focused on improvement, once that gains appreciable traction, then I would expect we will therefore gain more productivity.

Mr. ROSENDALE. We can not estimate.

Dr. FISCHER. It would be difficult for me to estimate.

Mr. ROSENDALE. Okay. Dr. Fischer, I understand you have added about 20 percent more staff to treat the same number of patients, or as you say, a lower number of patients. Please help me to understand where the additional staff are working and why the Cerner EHR created the need for them?

Dr. FISCHER. Well, overall, we have added 20 percent more staff and 15 percent more clinical providers. I have not broken it down by specific departments. We have added to safety. We have added to quality. We have tripled our informatics staff. We have more administrative staff. Where we can——

Mr. ROSENDALE. All of this improvement in addition to staffing, and yet your client treatment, the number of patients that you are treating is going down.

Dr. FISCHER. Well, it is not going down. It is simply not increasing at a great rate. We are about 70 percent of efficiency from prior to go-live. A year ago, we were at 50 percent. We are seeing slow and incremental improvements, but we have told our staff to move at the speed of safety, and I believe that is what they are doing.

Mr. ROSENDALE. What is the sum total of additional expenses due to staffing or investments that have been measured since the introduction of Cerner?

Dr. FISCHER. The annual rate for roughly 200 more staff is in the multimillion-dollar range, sir.

Mr. ROSENDALE. Did Cerner cover any of that additional expense?

Dr. FISCHER. I do not know what the source is. I believe Veterans Affairs Central Office (VACO) covered those expenses, sir, central office.

Mr. ROSENDALE. That is coming out of Veterans Affairs budget.

Dr. FISCHER. That is my understanding.

Mr. ROSENDALE. Okay. Earlier this year, you were projecting about a $35 million deficit. There was a public controversy about whether the VISN was going to withdraw the funding that allows you to balance your budget, forcing you to lay staff off. Secretary McDonough even had to intervene and pledge support. Was your budget problem resolved? If so, how?

Dr. FISCHER. It was resolved. The VISN and VACO covered a $27 million deficit. We had some supplementary funding because of difficulty with third-party payers. We have got some activation funds for leases we are about to execute. Yes, the deficit was covered in total, and it always is every year.

Mr. ROSENDALE. Let me make sure I understand. Oracle Cerner is continuing to receive their full payments, billions of dollars'

worth of payments, and we are running budget problems at the facility. Even though Oracle-Cerner is not providing the work that they contracted for and is continuing to be paid, and it is costing additional expense at the medical facility, they are staying whole and the taxpayers are paying additional money for the additional staff. Is that fairly accurate?

Dr. FISCHER. I think that is fair.

Mr. ROSENDALE. Mr. Chair, I yield back.

The CHAIRMAN. Thank you. The gentleman yields back, Mrs. Ramirez.

Ms. RAMIREZ. Thank you, Chairman Bost and Ranking Member Takano. I want to also thank every witness that is here today. I am one of the newer members in the committee. I have appreciated really learning from my colleagues here, and certainly, I know that this has been a hearing we have had before.

The contract with Oracle Cerner and its implementation, the challenges really get us to the system of our root problem. I think it is deeper. I think we know that there have been failures at every level, unfortunately, in the VA, regarding veterans and healthcare and medical records.

I recently, during August district work period convened a series of roundtables that brought together veterans from all over my district, from DuPage to Chicago. I asked the veterans, tell me what you are experiencing, what are the problems you are seeing, and what are the possible solutions that you think we should be implementing? Unsurprisingly, a disproportionate amount of their feedback was related to healthcare. The veterans I heard from shared their concerns, including that veterans were outright denied healthcare, expressing that the VA healthcare system needs to be better for veterans in general, and that the VA cannot successfully transfer medical records between the Department of Defense and the VA. I must have heard that at least 10 times.

This signals to me that what we have in place for veterans is failing at multiple levels. It is not just the electronic health medical record modernization that is failing, but the entire healthcare system at the VA still needs some significant improvements. My hope is that as we continue to provide oversight of our electronic health record modernization efforts, that we come together to address the root causes in the VA healthcare system and what they are facing.

Dr. Evans, I would like to get clarity on your efforts to improve the health records. I would ask you can you tell me a little bit of how you are soliciting feedback to improve the EHRM efforts? The second part to that question would be what groups are you engaging in and how are you deciding to engage these groups?

Dr. EVANS. An excellent question, and I appreciate your comments. I have been a primary care provider in VA for 22 years and still see patients every week. I am incredibly proud of our healthcare system and agree with you that we need to be responsive to the veterans who are seeking care from us. I will also say that when I started 22 years ago at the VA oftentimes, I could not find records from the DoD. With the Joint Longitudinal Viewer, I cannot remember a time in the last, probably 5 to 10 years, that I could not find a piece of information from the Department of Defense that I needed to take care of a patient. We are sharing

records between the DoD and all VA sites, and it is visible in the Joint Longitudinal Viewer.

Now, we sometimes run into trouble where somebody does not actually know where to look for that. That is something we continue to work to improve to make sure that all of our staff are available, that are aware that that information is available. It is available. It will be even more available and even easier to access as we deploy the Federal EHR, a single record between DoD and VA.

Ms. RAMIREZ. Dr. Evans——

Dr. EVANS. On the topic of your question——

Ms. RAMIREZ [continuing]. my time is running out though, so I would love to hear. I think it is important for the veterans to hear how you are soliciting some of that feedback.

Dr. EVANS. Absolutely, absolutely. With regard to soliciting feedback, we do a regular survey of Federal EHR users, and by that, I mean staff. It is a standard set of survey questions that are provided and actually used across the healthcare industry by they are called the Kent Gale, Leonard Black, Adam Gale, and Scott Holbrook (KLAS), K-L-A-S, questions. That is one way we are seeking feedback.

We are also regularly engaged with end users of the system as we are resolving problems and getting input from folks in the field. Specifically for veterans, we regularly survey veterans about their satisfaction through a survey called the SHEP Survey, Survey of Healthcare Experience of Patients, and through our Veterans Signals (V Signals) platform. After clinic visits, we send satisfaction surveys and we read and pay attention to that feedback, including when there are suggestions about how we should improve our electronic health systems.

Ms. RAMIREZ. Thank you, Dr. Evans. I know I am running out of time. Just a quick yes or no question. This is about oversight of the system improvements. It is imperative that there is a third party that can objectively provide some of that feedback. Is there any third-party organization providing oversight or plans to contract with a third-party organization? That is a yes or no.

Dr. EVANS. There is work that is happening at the enterprise level around contract validation and verification from independent parties, yes.

Ms. RAMIREZ. Thank you, Chairman. I yield back. Thank you, Dr. Evans.

The CHAIRMAN. Dr. Miller-Meeks, you are recognized.

Ms. MILLER-MEEKS. Thank you, Mr. Chair. I would like to thank the committee and of the witnesses for appearing before us today. Let me say that I have provided care as a physician and a nurse when I was both active duty and then as a volunteer in our VA hospitals and institutions. Our VA in Iowa City provides some of the best care around. I have also had the opportunity, I am so ancient, that have gone from paper records to electronic health records and certainly know of its main dysfunction, which is a reduction in productivity and a reduction in the interaction and face to face interaction of providers with their patients.

Having said that, and having been through transitions from one type of EHR to another when it is necessary to be system wide,

even though I am a specialist ophthalmologist which another EHR would be much more adapted to my use, I know how difficult it can be in order to institute EHR throughout a system, and especially one as vast as the VA system, the VA healthcare system. However, the rollout was in five VA medical centers and there had already been experience with an electronic health record system. This is for all of our medical leaders here. Has your facility's overall experience with the Oracle Cerner electronic health record changed over time? As you have realized improvements, how many of those were due to the system itself improving versus measures you and your staff did in order to adapt the system to you? Then second follow-up question is, having been both in the military and the VA, is it really that critical that we have the same system through both active duty military medical and VA?

Mr. KELTER. Thank you for that. I would also to your comment about going from paper records to an electronic health system, I have had providers who did the same speculate that it is probably a more difficult conversion in a large scale from one electronic medical record to another than it was going from paper to electronic. I would say in the last year and a half, our satisfaction, and our ability to use the platform to do what we need to do has improved. It has been based on both of those factors, both the changes that have been made along the way. It is very heartening for staff to be able to see changes that occurred because of something that they recommended or asked for in terms of a configuration change. As well as the ongoing efforts to learn how to use it better to engage in how to optimize their own workflows and to see those changes in, you know, maybe going from 47 minutes to complete a task down to 42. Optimally, we would still like to see it at half of that time, but to see those changes and improvements over time.

Ms. MILLER-MEEKS. That is the problem we have had all along with EHRs. That is you are adapting your workflow to an electronic health record and electronic system rather than the electronic system being designed around your work, which is why productivity is reduced. When productivity is reduced, guess what? We are delivering less care to fewer veterans. With that, I know I asked you all to comment, but my time is running out, so I am going to yield back.

The CHAIRMAN. Representative Budzinski, you are recognized for 5 minutes.

Ms. BUDZINSKI. Thank you, Mr. Chairman, and thank you to the panelists for being here today. I had some questions specifically around some of the challenges and how this has impacted rural healthcare. I appreciated that Ms. Nelson-Brooks mentioned that obviously she services a medical center in a rural community and some of the unique challenges around interoperability with the new EHR system. I wanted to maybe start out by asking Dr. Evans a question related to this topic. Has anyone done an evaluation at any of those rural sites to determine if or how much the system is improving communication between the VA and community care?

Dr. EVANS. First of all, the importance of our delivering care in rural parts of our country is absolutely critical. I do not think—and I think I would be interested in Ms. Nelson-Brooks' opinion on this—I do not think that the technology itself is appreciably dif-

ferent with regard to interfacing with community care, that is, the electronic connections to get a referral sent to a community care provider.

There are differences around the sufficiency of the community care network in rural America and how we manage, you know, the capacity to deliver care to veterans in those communities. I do not think the technology should be a barrier. Do you have any further thoughts on that?

Ms. NELSON-BROOKS. Thank you. I agree with Dr. Evans. I do not think that there is anything within the medical record itself that has improved communication between our facility and our community care providers.

Ms. BUDZINSKI. Okay. Maybe I can now switch to a different topic around veteran mental health and suicide prevention, which are two topics that have become very extremely important to me. I have heard from some VA staff at the first go-live sites that there were a lot of issues with Cerner when it comes to the behavioral health and case management applications. Maybe this is a question for the medical center directors, and maybe I could start again with you, Ms. Nelson-Brooks. What progress has been made to improve these functions?

Ms. NELSON-BROOKS. Immediately post go-live, we had challenges with high-risk flags not being visible in the medical record. Those have since been fixed, as well as some additional changes that were made. I am not able to fully explain all of the changes that were made, but what I can tell you is that as a facility, we have seen marked improvement in our Charm One metric, which we had not seen the year prior. Charm One has to do with suicide prevention and our case management activities around suicide prevention. We have seen improvement there.

Ms. BUDZINSKI. Is there any area in particular that there has not been improvement that we should be working toward improvement on, if you could speak to that?

Ms. NELSON-BROOKS. Specifically in mental health?

Ms. BUDZINSKI. Mm-hmm, yes.

Ms. NELSON-BROOKS. None that I am aware of, but I will yield to my colleagues to see if they can add anything additional.

Dr. ARENSMAN. Thanks for the question. I was walking around the veteran memorials last night and thinking a lot about the mental health and all the things we try to do to help our veterans and sometimes going above and beyond what they can expect in the community in terms of their care. We have had some challenges, I think, particularly with relation to care plans. Sometimes it is as simple as having enough space to put in enough information for an accurate care plan. That is something that I am told is being worked on. We had some significant challenge with long acting injectables, which are the drugs that patients who have psychoses need to take because they are not good at necessarily taking their oral medications. This has been something that we have seen an improvement in since go-live.

Ms. BUDZINSKI. That is great. Would anyone like to add anything else? Okay, thank you very much. I yield back, Mr. Chairman.

The CHAIRMAN. The gentlewoman yields back. Dr. Murphy, you are recognized.

Mr. MURPHY. Thank you, Mr. Chairman, and thank you all for coming today. I will try to make these very quick and brief. I actually still use a medical record system I have for, I guess, 20 years now. Yes, I was a dinosaur and used paper system, and there were a lot of things that were actually good. Electronic medical record system came in, number one for billing. That was the primary source. number two was for order entry because they thought there were too many errors going on in prescription writing, et cetera. Come to find out, yes, errors are still occurring at the exact same rate. There are different errors when you click the wrong click to get in.

Also, it was reportability of the electronic medical record, and that is an absolute, in my opinion, the best whole thing. The fact that I still see VA patients and I can not get records from a VA is inexcusable. I am almost ineffable about your comment, Mr. Kelter, that it is 30 to 50 clicks to complete a task. Thirty to 50 clicks to complete a task that is unconscionable. That is unconscionable. Mr. Evans—or, Dr. Evans, did you say it might be 10 years until this problem is fixed?

Dr. EVANS. No, I did not. That specific question was around how long it was going to take us to complete the deployment from when this project began 5–1/2 years ago, whether we would complete the deployment within the 10-year cycle that was originally proposed.

Mr. MURPHY. All right, well, let me ask you this, if you will, are you happy with the support that Oracle has provided you for Cerner? My understanding, a comment made in another committee the other day that Oracle did not think it was a big deal. Is that correct or not correct? Are you happy? You say, hey, I am having this problem, can you come fix it? Are they there that day, the next day? What has been their response rate?

Dr. EVANS. Yes. I mean, they are highly responsive and motivated to move this forward. You know, I think one of the things that we have identified as a critical part of our moving forward with the reset is, I mean, Oracle will do what we ask them. We need to be able to ask them to do things in a way that delivers the kind of experience that is not 30 clicks. Some of that requires internal expertise within VA with regard to informatics, partnering with their team to deliver a better experience.

Mr. MURPHY. All right, so that is where my problem, the key error is. They are asking you to create your own medical record system with their expertise. Instead of them bringing a product to you that you can then conform to the VA. You should be able to, within just a few clicks, if somebody shows up at a VA from literally across the country, access their medical record, be able to read everything that they have done, and move on. You should also have a medical record that if somebody goes out into the community that they should be able to access.

I would consider this—I have not been in the military. It has just not been my bailiwick. I have been a surgeon for 30-plus years. I would consider this an absolute failure. If you have an error rate that is higher now, an inefficiency rate higher now, 5 years, 5 years afterwards, it is an absolute failure. If this were out in the private community, that company, the cord would have been cut and moved on.

Cerner now, and I am just going to be very plain with this, Cerner is losing market share in large systems. It may be gaining some in smaller systems. The last time I checked, the VA system is the largest in the country. My recommendation, I will be very plain and simple with it, I think Cerner has failed you. I think it will continue to fail you. I believe you ought to cut the cord and go to another, larger system.

There are systems. I use a system now that I was not happy with at first, but it is seamless, and I can go to another institution, boom, I can find their record. I think this is an absolute failure. I think it is putting lipstick on a pig and pouring millions, if not billions of dollars into a system that is not providing the best care for veterans, period. I think you can keep working this system and milking it and milking it. This is not a good system for the VA Healthcare Center.

I am incredulous that 5 years out, it seems like there is even more problems than there were to begin with. That 5 years out, you are still having to bring people and basically rebuild a system from the beginning. That is not what the electronic medical record is supposed to be.

Yes, we know there will be inefficiencies compared to being able to write something on a piece of paper and send it out. That is well documented, and I think it is accepted at this point in time. The fact that you can not do that now, 5 years out and efficiency is down 40 percent still, is inexcusable, absolutely inexcusable. There should be, in my opinion, another system. There are other systems out there that are much better, in my opinion, that could well translate to the needs of the veteran and the VA. With that, Mr. Chairman, I will yield back.

The CHAIRMAN. Thank you. The gentleman yields back. Representative Cherfilus-McCormick.

Ms. CHERFILUS-MCCORMICK. Thank you so much, Mr. Chairman, for having this hearing, and also, Ranking Member Takano. I wanted to go back to the standardization issue, since it seems that standardization is intimately tied to the success of the EHR. Dr. Evans, in your testimony, you mentioned that one focus of the VA's EHR reset is to improve the Federal EHR baseline. What progress have you made on the baseline EHR?

Dr. EVANS. Again, this does get to the point of standardization. We are currently working through items that have been identified by end users at our live sites and making those configuration changes. I think what you heard is we are trying—not just trying—we are doing that in a way that is standardized across the five sites. There are capabilities where we may need to revisit some of the original decisions around what the baseline of the EHR looks like and possibly simplify that in order to move closer to a model approach, a recommended ideal approach for the configuration, and that work is ongoing in the next several months.

Ms. CHERFILUS-MCCORMICK. Specifically, what I was asking is how are you measuring progress and success of the work that you have been doing to move toward standardization and also the baseline? How are you measuring that? Have you seen any improvement with what you have been doing so far?

Dr. EVANS. Yes, I do not know that I have an answer to how we are measuring it, other than we are working to compare how the VA has configured its record or how this particular record is configured with what Oracle recommends as its ideal baseline. We are doing that work right now to compare the configurations to see whether there are lessons learned where we can move toward a more standardized and optimized configuration.

Ms. CHERFILUS-MCCORMICK. I am assuming that the Federal baseline is different from the VA's baseline. Where are you at in the establishment of the VA's enterprise wide EHR workflow baseline?

Dr. EVANS. There are a couple things that matter from a baseline perspective. There is a baseline around what are the interfacing systems that we can support at baseline? When we deploy the electronic health record, what Intravenous Line (IV) pumps, what bedside monitors can we support, what other applications that connect to the EHR are part of the approved baseline? We have made considerable progress on essentially identifying what is that baseline of connected technologies. That will save us money over time by minimizing interface cost requirements. We are also working on the baseline of the configuration as part of our overall standardization effort as was just mentioned.

Ms. CHERFILUS-MCCORMICK. I am very concerned that the VA appears to be focusing only on the first five sites, which I agree must be fixed, but it is not thinking strategically about the rest of the go-lives. I am afraid that we are going to continue to have problems in VA and VA does not focus on standardization needs in order to roll the system out in future sites. What steps are you taking to actually consider not just the five that you have rolled out, but the ones that you are going to be rolling out in the future?

Dr. EVANS. Sure. In our improvement efforts, we bring together not just representatives of the five sites, but the clinical councils, as well as the clinical program offices. The clinical councils are groups of individuals who understand the healthcare delivery in their lane, whatever that might be, ambulatory care, virtual care, surgery, who are spending time making recommendations and support for how the EHR should be configured. The program offices are responsible for the national delivery of that type of care. We bring program office representation and council representation to these decisions so that when we are making a decision about how to configure things for one of the five live sites, we are doing so in a way that will meet the needs of the entire enterprise.

Ms. CHERFILUS-MCCORMICK. I still have concerns about the systems in place to measure success because you can create these different practices and plans, but how do we know that it is actually going to manifest itself into a successful system? Also, looking at feasibility, have you been looking at the feasibility of having that standardization in that baseline? Do you have these systems in place? I have not really heard of systems of measuring success and feasibility.

Dr. EVANS. We do have success criteria for the reset that we are developing and already measuring parts of these. I would start by saying that at the core, the system has to be rock solid from a technical perspective: up, available, with high performance for a user.

There is nothing more frustrating than trying to log into a system and it is not working. It has to work from a technical perspective.

There is the technical metrics. We are looking at user satisfaction and user adoption. The Oracle record has tools that we do not have available to us in CPRS VistA that can allow us to look at individual users' use of the system and identify folks who are struggling or places where workflows are inefficient. There are others that we are measuring. I know we are running out of time. Looking at individual users, understanding the technical behavior, looking at productivity, as you have heard, looking at revenue collections are areas where we are measuring metrics to demonstrate that we are improving.

Ms. CHERFILUS-MCCORMICK. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you. Mrs. Kiggans.

Ms. KIGGANS. Thank you, Mr. Chair. I just wanted to piggyback off of Dr. Murphy's comments, and he is no longer here. You can be very forthright. Just if you could each go down the row and just respond to what he said about, you know, is this system failing you and should we be pursuing another direction? Just curious.

Dr. EVANS. The one comment I would like to make is that—and I will answer your question—the Joint Health Information Exchange has been one of the successful parts of this project that we have delivered. VA and DoD are now exchanging data on three health information exchanges. Data is exchanged with more than 90 percent of U.S. hospitals. I actually rarely walk to the fax machine anymore. I can find the record from community providers. I think I just wanted to make that point.

Second, as I mentioned earlier on, we are committed to moving forward. We have invested a significant amount in the success of this project. I think we are beginning to see improvements as a result of the reset. It is slow and incremental, and we expect it, and frankly, it must accelerate. I still believe that we should proceed forward.

Ms. KIGGANS. Okay. Thank you.

Mr. KELTER. The interoperability of healthcare systems between our medical center, other VA medical centers, other agencies, and private sector is extremely important. As we heard the ability to if one of my patients is being seen in Spokane and then needs to go to a private hospital in Spokane, and then is going to come back to my medical center, I want my providers to be able to access all that information immediately. That integration is extremely important. I think the systems are moving in the direction that that will be achieved. We are not there yet, but I think we have the capacity within the current system to get there.

Ms. KIGGANS. Good. Thank you.

Dr. FISCHER. Good morning.

Ms. KIGGANS. Good morning.

Dr. FISCHER. I believe the ability to successfully implement this record in a level one facility will be very informative and telling. I think until we have reached this point, we certainly support the Secretary and the Undersecretary of Health's vision for a new electronic health record.

Ms. KIGGANS. Thank you.

Ms. NELSON-BROOKS. Thank you. The system as it exists now is currently not meeting our needs. Having said that, there have been marked improvements in specific areas. One area for our facility is the ability for our pharmacy technicians to be able to refill prescriptions in Medication Manager Retail (MMR), which takes some of that responsibility off of our pharmacists. In addition to that, in lab, they have been able to identify a number of efficiencies as well. Manifests are better, as is the chain of custody. The lab add on process is much more efficient. It is easier to see who placed a point of care test and tests that are sent out are available a lot sooner.

While we are not where we need to be, we believe that, you know, VA central office has made the right decision to commit to getting this right at the sites where the system currently exists.

Ms. KIGGANS. Thank you.

Dr. ARENSMAN. Thanks for that question. I think, to be fair to the majority of my staff, they would say that the current system is not yet meeting their needs. They would say there needs to be major changes, not just in terms of incremental gains, but really human-centered design to make this an efficient and usable system for the future of the VA.

Ms. KIGGANS. Do you think that that will be possible with this system, that we can get there?

Dr. ARENSMAN. I hope so. I think we need to see a change in the slope of improvements in order to think that that would be the case.

Ms. KIGGANS. Thank you very much for your responses. A couple of you did talk about compatibility just with outside providers. I represent Virginia's second District, so Hampton Roads, one of the largest veteran populations and active-duty military. I am also a primary care provider, nurse practitioner. For me, the frustration with dealing with the VA, there was no compatibility. We pretty much wrote you off if you were a VA patient and our primary care patient. We relied on your word of mouth. Tell us what happened at the VA. What meds are you on over there?

That is wrong. I can only imagine the errors that stemmed from those conversations. Also, being a provider who has sat through two different electronic charting implementations at nursing home facilities, you know, I remember the company coming and just sitting with us and really, one on one, you know, what is right, what is wrong about this EHR.

I think, Mr. Kelter, you talked about the process with the staff for configuration changes. What does that look like? Does Oracle sit with the staff? Is there a form they fill out? Do they have written documentation that they write on? What does that process look like?

Mr. KELTER. Sure, both of those happen. We have Cerner staff at our medical center on a weekly basis. Our staff do have the opportunity to sit elbow to elbow with them and walk through some things, explore their understanding of how the system works, and could it be done differently. The formal request for a change, it is through an electronic ticketing system where they can request a configuration change.

Ms. KIGGANS. I have other questions, but I am out of time, so I will yield back. Thank you.

The CHAIRMAN. Representative Franklin.

Mr. FRANKLIN. Thank you, Mr. Chairman, and thank you, panel, for being here today. I appreciate your time. This to me is the quality of panel and the makeup that we should have had yesterday in a similar hearing we had in Military Contruction-Veterans Affairs (MilCon-VA). Dr. Evans, you were there, but the directors were not. I am really glad you all are here today to join us.

Yesterday in that hearing, it was on the same topic, electronic health records, we were joined by Mr. Sicilia, who is the executive vice president of Oracle and I presume is responsible for the rollout of the system here. I want to quote a little bit and I want to get into a little bit on training. I should apologize up front, I have been bouncing between hearings, so if you have shared any of this, I apologize. Would love to kind of get it all encapsulated here.

On the topic of training, he said, I still struggle with the idea that we have to put people through extensive classroom training to learn to use the system. You do not have to learn to use many IT systems these days. It should be fairly intuitive to be able to pick up a system and use it. That kind of stunned me that he would say that. In the corporate world, I rolled out a few IT systems over the years. While nothing on a scale of what you all are trying to do and I am not trying to underestimate going through it because it is a pretty colossal task. I would like to know, and I am curious to know, you know, is he out of touch with what you all are experiencing? We do know from initial reports of the Mann-Grandstaff rollout that the VA acknowledged the Cerner system created unacceptable levels of productivity losses, patient safety risks, and staff burnout. Some of you had alluded to that earlier. I would love to hear from the staff directors your feedback, what you have received from your staffs on the ease of the system to use and the training they have received in order to complete their tasks. We do not have a whole lot of time, but if you would kind of be mindful. Yes, Mr. Kelter, if you could start but be mindful of your other three cohorts there, I would love to hear from them too.

Mr. KELTER. Thank you. I would agree that a well-designed intuitive system should not require a lot of training. This system does require quite a bit for the nuances and the differences and some of the things that might not be so intuitive for staff to learn.

Mr. FRANKLIN. Well, I guess, so a question, a real quick follow up there then. Is it designed properly if we have some of these steps? I understand there are going to be some specialized things in there, but if some of these steps take as many as 30 to 60 clicks to complete, is that properly designed, in your opinion? Should anything require that that is supposed to be—automation is theoretically supposed to make our lives easier and more accurate, but as we are seeing bear out, that does not seem to be the case. Is it a design flaw then, or is it a training issue?

Mr. KELTER. I think some of it is design. I think some of it is configuration. For example, if we could set up the system instead of presenting all of the possible options, some fields are more customizable than others. If we could limit the options that are immediately presented to the ones most likely to be used, that would

make it less likely for somebody to make an error. Maybe my top five comes up instead of the 2,000 possible choices.

Mr. FRANKLIN. Okay. Dr. Fischer.

Dr. FISCHER. Mr. Franklin, as you were mentioning Mr. Sicilia, I was thinking to myself, was that an aspirational comment about use of the electronic health record? I do not believe the Cerner record as it exists today is intuitive. I think the training, according to feedback from my staff as recently as last week, is that training is generally considered to be poor.

Mr. FRANKLIN. Thank you.

Ms. NELSON-BROOKS. I would agree with Dr. Fischer. Staff do not believe that the system is intuitive, nor is it easy to use. In addition to that, training was subpar. I think, as Dr. Arensman mentioned, it lacks that human-centered design component.

Dr. ARENSMAN. I agree with my VA colleagues. I do not think the system in its current state is one that is intuitive. I would love to get to a point where it may not be as easy as my 4-year-old trying to work my iPhone, which she does quite well, but to see a system where we can have a trainee, we have a lot of medical trainees rotate through VA medical centers, and we can not spend a week of their training teaching them how to use the electronic medical record. They need to be in the operating room. They need to be seeing patients and able to intuitively do their work.

Mr. FRANKLIN. During this reset period, is your feedback and input being solicited to help improve the training in the rollout? Or is it just being sort of an edict handed down from on high?

Dr. ARENSMAN. Our training—sorry—our input is being solicited. I think the reset is really just starting. The feedback for the training in particular, I would have to defer to Dr. Evans for the plans for that.

Mr. FRANKLIN. Well, I see my time is up, Mr. Chairman.

The CHAIRMAN. Representative Van Orden.

Mr. VAN ORDEN. Thank you, Mr. Chairman. I just want to go back to something earlier. It was a question that was asked to you, Dr. Fischer, by my colleague, Mr. Rosendale. He asked you if the VA—or excuse me—that Oracle, and everybody is still getting paid even though they are not doing anything. You said, I think that is fair.

I looked up fair, and it says, open to legitimate pursuit, attack, or ridicule. That is what is going down now. That is a yes or no question, sir. Is Oracle still getting paid? We are pushing $49.8 billion over the lifecycle of this. Is Oracle getting paid? Yes or no? I do not want any other words. One or the other, sir.

Dr. FISCHER. I apologize. It is not a yes or no question, in my opinion.

Mr. VAN ORDEN. Okay, then it is——

Dr. FISCHER. I do not know what——

Mr. VAN ORDEN. No, we are not doing that.

Dr. FISCHER. Fine.

Mr. VAN ORDEN. I am not doing that.

Dr. FISCHER. Understood.

Mr. VAN ORDEN. That is a yes or no question, and you know it. This is absurd. I live in a really small town, and we have an independent, nonprofit hospital that is doing everything that appar-

ently you can not to the tune of $49.8 billion over the lifecycle. Unacceptable. Just not.

I want it to be clear that you are not doing anything new or novel. How many hospitals, Dr. Evans, are in the United States of America? How about a guess?

Dr. EVANS. I do not know the answer to that.

Mr. VAN ORDEN. Okay. Yes.

Dr. EVANS. Several thousand.

Mr. VAN ORDEN. Check me out, the next biggest town up the river from me, you can call 911 from a farm in the middle of rural Wisconsin, and before you are at the emergency room, they have the appropriate bed for you waiting for you in rural Wisconsin. I just I am beside myself. Dr. Evans, where do you get your healthcare?

Dr. EVANS. That is a good question. My wife reminds me regularly that I need to get a primary care provider.

Mr. VAN ORDEN. Okay, great. Where do you get your healthcare, man? This is not a funny ha-ha thing. Where? I mean, is it the VA?

Dr. EVANS. I do not get my healthcare at the VA.

Mr. VAN ORDEN. Mr. Kelter, where do you get your health care? Is it the VA?

Mr. KELTER. It is.

Mr. VAN ORDEN. Okay. Where?

Mr. KELTER. Walla Walla, Washington.

Mr. VAN ORDEN. Okay, right on. How about you, Mr. Fischer?

DR. FISCHER. In the community.

Mr. VAN ORDEN. Okay. Ms. Nelson.

Ms. NELSON-BROOKS. In the community.

Mr. VAN ORDEN. Doctor.

Dr. ARENSMAN. I am not a veteran, so not eligible for VA care.

Mr. VAN ORDEN. Okay, so, we got one person. Where did you serve?

Mr. KELTER. I was active-duty Air Force for 10 years and reserve for 20 years.

Mr. VAN ORDEN. Right on, excellent. Okay. Is your healthcare good at the VA?

Mr. KELTER. It is.

Mr. VAN ORDEN. Okay. So is mine. I want to make sure you understand this across the board. I get all my healthcare at the VA, and I am very proud of my staff. I go to Tomah Health System, La Crosse, to do that. I have to do some community care if it is unavailable. This is not on them. It is on you. Dr.—Mr. Evans—Dr. Evans, that is Dr., D-R-M-D, correct? Not PhD?

Dr. EVANS. Correct.

Mr. VAN ORDEN. Okay. You have been onboard for quite a while, right?

Dr. EVANS. Six months.

Mr. VAN ORDEN. That is your bio. Do not tell me 6 months, man. In 2018, the VA awarded a sole source contract for this stuff. Did you have any participation in those negotiations at all?

Dr. EVANS. No.

Mr. VAN ORDEN. Okay. Then you guys scrubbed the program. You picked up the mantle here as interim director in 2019. Then in 2023, I think it was March, you guys renegotiate, did your reset,

right? This is as successful as the Russian reset, by the way. This was all thrown out and something else was picked up. You were the interim director. Did you have any participation in those negotiations when you renegotiated this stuff with Oracle? Did you? I will remind you that that man swore you in, and you are under the potential threat of—you are under the oath, and if this is not accurate, you will be held liable for perjury. Did you help negotiate these contracts, the new ones?

Dr. EVANS. I need to clarify that question. First of all, in 2019, I was the Interim Director of the Federal Electronic Health Record Modernization Office.

Mr. VAN ORDEN. Senior Advisor at the Federal Electronic Health Record Modernization Program Office, leading efforts to implement single common Federal electronic health record at Department of Defense.

Dr. EVANS. Which is a joint office between the VA and the DoD.

Mr. VAN ORDEN. All right, dude. Hey, you know what, director is a director. Did you have any participation in the renegotiation of these billion-dollar contracts that are failing, yes or no?

Dr. EVANS. Are you talking about in May when we negotiated with Oracle?

Mr. VAN ORDEN. You negotiated with Oracle. Have you been—have you participated between these private for-profit entities? Have you participated in negotiating these contracts?

Dr. EVANS. We awarded—so, the contract was awarded in 2018, as you mentioned.

Mr. VAN ORDEN. I know.

Dr. EVANS. It was a 5-year contract——

Mr. VAN ORDEN. Yes.

Dr. EVANS [continuing]. with a 5-year option period.

Mr. VAN ORDEN. May 16, 2023. Did you participate in these negotiations?

Dr. EVANS. I was not actively participating in negotiations, but as the senior leader, I was involved with the decisions on where that ended.

Mr. VAN ORDEN. All right. I want to talk to you later.

Dr. EVANS. Okay.

Mr. VAN ORDEN. I want dates and times because we are talking $49.8 billion and it is working worse than before. That is unacceptable. I suggest, Mr. Evans—Dr. Evans, you listen to your wife, get a primary care physician, see if we can get a waiver, so you are seen at the VA. You do not have a dog in this fight. That is wrong.

With that, sir, I am sorry for going over time.

The CHAIRMAN. Representative Mace.

Ms. MACE. Thank you, Mr. Chairman. I want to thank our witnesses for being here with us this afternoon and answering our questions. I am going to dive right in. Dr. Evans, I will start with you. The VA serves our veterans, veterans who understand and have lived their lives within the context of a chain of command following orders. Why does the VA not think they need to follow suit in terms of implementing a standardization?

The second or upcoming phase of the reset seems to be the place where the current live sites will see the most benefit. Can you give us an update on the work expected in this next phase and how you

are working with both site and VISN leadership to deliver improvements to the system?

Dr. EVANS. On your first question, I think there is recognition within the healthcare system about the importance of standardization in order to successfully implement the EHR. I think that recognition is at the leadership level. I was heartened. I was at a field informatics conference a few months ago where the informatics leaders, frankly, from the five sites, stood up and talked about how much they understood the importance of standardization. I think there is an understanding that we need to do that. Doing it is the challenge that we are in now.

Ms. MACE. When will the VA start making standardization decisions?

Dr. EVANS. We are currently making those.

Ms. MACE. Mm-hmm. How is the VA going to shift this culture of standardization, you know, across the board? I mean, the DoD has done it, but the DoD has a very cohesive there is a chain of command. You know, it is unilateral across the board. The VA seems to, you know, there is a lot of it seems like infighting or people that want to do their own thing and not go along with a national standard. How long do you think will take the VA to accept this shift and a change in the way you look at it?

Dr. EVANS. Yes, you know, I bring it up a notch. I think what people want is the electronic health record to work for them. People do not resist standardization, if the way we are standardizing makes sense, is intuitive, and works as part of clinical care delivery. And so, in part, we——

Ms. MACE. Does the VA, I mean, have culpability I mean, is the VA responsible for where we are today, yes, or no?

Dr. EVANS. I mean, I think, look, we have——

Ms. MACE. Does the VA accept any responsibility with where we are today with the implementation of this?

Dr. EVANS. Of course we are a part of this, right? We are implementing the record. The decisions that we have made to date are done as part of a partnership in moving forward, right? This is where I mentioned earlier, one of the things that we need to do and we know we need to do, is build the expertise of the VA workforce. Change does not happen to an organization, an organization leads through change.

Ms. MACE. In moving from 130 systems and processes to one, governance will play a central part, and that is not an easy feat. The VA must take a more aggressive role in change management for the good of the 171 Veterans Administration Medical Centers (VAMCs) within it and the 9 million veterans enrolled in the system. What kind of governance mechanisms will you rely on to get to a standard product and processes and then be able to maintain it?

Dr. EVANS. Yes. In part and related to your earlier question about what are we doing at this phase of the reset, this is actually part of the work that we are doing. We have identified an initial set of items that we need to fix, and we are working through that list. In part, that is not just about fixing the items, but it is about solidifying the governance structure, about how we will efficiently make those decisions about the changes we need to make and the

standardization. We call it the rapid EHRM baseline improvement. We use that word rapid because we are looking to not just establish strong governance around decision-making, but also efficient governance.

Ms. MACE. I would love to see efficiency at the VA. I hope you make good on that promise. Understanding within the enterprise system, all of that, and the challenges ahead in terms of a national standard and adhering to a standard for the betterment of the VA, will each of you commit to a national standard so we can move this thing forward and get it done with? Yes or no? Dr. Evans?

Dr. EVANS. Yes.

Ms. MACE. Mr. Kelter.

Mr. KELTER. Yes.

Ms. MACE. Dr. Fischer.

Dr. FISCHER. Yes.

Ms. MACE. Ms. Nelson-Brooks.

Ms. NELSON-BROOKS. Yes.

Dr. ARENSMAN. I would like to qualify that it needs to be a standard we can validate that we can meet the needs of our veterans.

Ms. MACE. It is yes or no question. This is not an argument.

Dr. ARENSMAN. Well——

Ms. MACE. We have 9 million veterans enrolled in this system, and I am trying to have a constructive conversation about how we move forward and not be an asshole when I am in this room, because it is just too important to members of my family and to millions of vets across the country who are enrolled. Either you can be a team player or not. If you are not going to be, I would find a new job. Thank you, Mr. Chairman, and I yield back.

The CHAIRMAN. Mr. Luttrell.

Mr. LUTTRELL. Dr. Evans, in the past 5 years, what is the roundabout dollar amount that we have spent on this program to date?

Dr. EVANS. At this point, we spend money in support of——

Mr. LUTTRELL. Just give me a good round number. I do not have that much time.

Dr. EVANS. A good round number would be on the EHR itself we have expended $3.5 billion, on infrastructure, $2.1 billion.

Mr. LUTTRELL. Okay. Roughly around $5 billion for five hospitals. Do the five hospitals communicate well, or are they siloed?

Dr. ARENSMAN. We are able to see the record for the entire five hospitals that are live.

Mr. LUTTRELL. If you needed to talk to Ms. Nelson, you could do that——

Dr. ARENSMAN. I could.

Mr. LUTTRELL [continuing]. effectively.

Dr. ARENSMAN. I could.

Mr. LUTTRELL. There are 171 hospitals across the Continental United States, and so far, it has cost us $5 billion for four hospitals, five of which the one in Chicago, that is not stood up yet. Is that correct?

Dr. EVANS. That is correct, North Chicago.

Mr. LUTTRELL. $5 billion, and we have got another 166 to go. Give me a good round number on how much that is going to cost us.

Dr. EVANS. I do not have the——

Mr. LUTTRELL. Remember, I have to answer to my——

Dr. EVANS. I understand.

Mr. LUTTRELL [continuing]. my base back home. If I am going to tell them I have to spend a billion dollars on every single hospital.

Dr. EVANS. Yes. I think the first thing is to understand that of that $5 billion, much of—a good portion of that investment has also been made in the infrastructure improvements in many sites that we are preparing to go live, and we will not lose that investment.

Mr. LUTTRELL. Which we have absolutely failed on if we are in a hard reset. The young ladies at the end of the table just said that it is not working well enough for their employees to maneuver through it.

Dr. EVANS. Right, but these are infrastructure——

Mr. LUTTRELL. If we are in a hard reset, which in your statement, you said, we do not have a firm timeline for completion of this project. As a military man myself, I do appreciate if we are going to run an operation, the one thing that we do know is when it is going to happen. I find it challenging to understand how you are going to complete this journey that you are on without any given timeframe whatsoever, because next time you sit in front of us and ask for a couple of billion dollars, we are more apt to say no.

Dr. EVANS. Yes, so I think two things. We are making an investment. It is the investment in infrastructure is providing value now. That is improved Wi-Fi networks. The network upgrades that were necessary to support the system benefit the delivery of care with the current record, telehealth care, telehealth delivery at those sites.

One of the things we have promised is that as we come out of reset, we will do two things. We will publish a schedule and a lifecycle cost estimate. That is part of the analysis we are doing right now. We feel an urgency to get restarted. We do feel an urgency to get restarted. We can not restart until we see sufficient improvement at the live sites, until we have learned from——

Mr. LUTTRELL. Is it too deep of a hole for me to ask what that looks like to you?

Dr. EVANS. What improvement looks like?

Mr. LUTTRELL. Yes.

Dr. EVANS. Rock solid technical performance of the system. Improved user satisfaction as measured by the voices of our clinicians.

Mr. LUTTRELL. What does that number look like, Ms. Nelson? Is that a 95 percent? Is that 100 percent? I am curious how he is going to know how to activate, what number is going to come from the hospitals that you operate, any one of you, in order for our leadership to move forward.

Ms. NELSON-BROOKS. Specifically looking at user satisfaction?

Mr. LUTTRELL. Yes, ma'am, we can start with that.

Ms. NELSON-BROOKS. I would say that, you know, if we take into account the survey that we did in April, where 86 percent of our staff did not agree with deployment in——

Mr. LUTTRELL. Eighty-six percent did not?

Ms. NELSON-BROOKS. Eighty-six percent of staff did not agree with future deployment of the record in its current state. I would

say that at a minimum, we would have to get to more than 50 percent of our staff would recommend use of the system.

Mr. LUTTRELL. Seems like a pretty deep hole, Mr. Evans.

Dr. EVANS. That is why we are in a reset.

Mr. LUTTRELL. With no timeline.

Dr. EVANS. I would not say that we have no timeline. I think we have had, you know, in this program, and again, I am not——

Mr. LUTTRELL. I understand this is probably frustrating to you, but you got positioned——

Mr. EVANS. I——

Mr. LUTTRELL [continuing]. in this little spot, so I am going to have to hold you accountable because you are the boss.

Dr. EVANS. I understand. You know, it—when I transitioned to this program 6 months ago, it was very—as the leader, it was very clear to me that we had to take the time to get things right. It has been mentioned, you know, we took earlier in the program a strategic pause, and we spent a lot of time thinking about the strategy. One of the challenges there was we had—we put a hard stop on that. We said we are going to start deployment activity again, right, and so, we did not take the time that we needed to get it right.

Frankly, what I have heard from this committee and the Technology Modernization Subcommittee very consistently has been VA, take the time to get this right. Not VA, take the time to get this right and take your time. No. Feel an urgency to get it right. I feel an urgency because of the folks to my left and the frontline providers that they represent and the veterans that they serve. We feel that urgency, but we are taking the time.

We are very specifically saying there is not a hard end date to the reset because we need to get this right. I think we can not be in reset forever, right? This is an investment we are making. We are again measuring our improvement. We are going to be looking at how things are improving over the coming months. We are going to learn from a go-live at the North Chicago facility at the Lovell Federal Health Care Center in the spring of 2024. That will be the first level-one facility where we go live. We will benefit from partnership from the DoD in that.

Then as we move toward the, you know, early summer next year, I think we should be having some very significant discussions about restart. Now, restart does not mean a go-live right away. It means that we are starting to do the deployment preparations for other sites while continuing to improve. We are on a journey where we will need to be continuing to improve this record in perpetuity. No record is static.

Mr. LUTTRELL. Thank you.

Dr. EVANS. Thank you.

Mr. LUTTRELL. I yield back, sir.

The CHAIRMAN. Mr. Ciscomani, you are recognized.

Mr. CISCOMANI. Thank you, Mr. Chair. I would like to allow my colleague, Ms. McMorris-Rodgers, to go before me, sir, if that is okay?

The CHAIRMAN. That is perfect because she is the one that probably has been affected the most by this.

Mr. CISCOMANI. Absolutely, please.

The CHAIRMAN. Ms. McMorris-Rodgers, you are recognized.

Ms. MCMORRIS-RODGERS. Thank you. I thank the gentleman for yielding. Thank you, Mr. Chairman and ranking member, for bringing us all together here today, holding this hearing, and giving me an opportunity to address the committee.

The Oracle Cerner electronic health record system has been a complete failure. It has created more problems than it has solved. From the beginning, veterans in Eastern Washington have been sounding the alarm about the issues with the EHR. We have had prescription errors, dropped appointments, lost referrals, costly mistakes that have directly harmed nearly 150 veterans, 150 men and women who risked their lives for our country, harmed by the very agency who promised to care for them upon their return.

Irresponsible does not even begin to describe it. To make matters worse, this broken system has completely demoralized employees who were not adequately trained on the new system. Providers and support staff have struggled to overcome the software glitches and the constant outages.

They have been hung out to dry trying to help frustrated veterans navigate a system that they themselves are burdened by. For too many, it has become too much. The devastating amount of employees that are quitting because they are exhausted and just can not take it anymore. This is making bad staff shortages worse, creating longer wait times, and making it even more difficult for veterans to get the care that they need. This system has become such a problem that it is consuming the budgets of our local VA facilities, causing them to operate at a loss.

For months, we have heard rumors of reducing staff and services to make the numbers work, which is not the solution that should even be on the table. While Secretary McDonough committed to me that this will not happen, I need to reiterate that any cuts would be unacceptable. We have already invested billions of dollars into what was once a great idea that has unfortunately failed to achieve its sole purpose to improve healthcare for veterans in the United States.

We have given the VA and the Oracle Cerner every possible opportunity for improvement, but the problems with the system are endless. Veterans in Eastern Washington have had enough, and they are tired of being the guinea pigs in this failed experiment. They have pleaded for it to stop, but their concerns and mine have been dismissed at every turn. The VA's lack of transparency has led to a devastating breakdown in trust among veterans, and it must change.

We all agree that we have to get this right for our Nation's heroes. I believe it is time to pull the plug on this deeply broken system and let us go back to one that is going to work. Until then, I am committed to helping get this working as much as we can for our veterans who have no other choice. I wanted to ask just a couple of questions. Dr. Fischer and Dr. Arensman, I understand Mann-Grandstaff in Columbus are the only VA medical centers using the Oracle Cerner's oncology modular right now, and it has created serious problems. Can you explain some of the multi drug chemotherapy orders work and where the problem is, starting with you, Dr. Fischer?

Dr. FISCHER. Well, we have a very experienced medical oncologist in Spokane, and he is very reluctant to utilize multi-agent chemotherapy currently. He would like to test those power plans in production to make absolutely sure that there are no medication errors because they can be lethal with the use of these very, very significant medications.

Ms. MCMORRIS-RODGERS. Thank you.

Dr. FISCHER. Sure.

Dr. ARENSMAN. Thank you for that question. The power plans have been a significant challenge in Columbus as well. We have actually dedicated a half-time oncologist and a half-time pharmacist. They are full-time employees, but half of their time is spent essentially editing, correcting, and validating power plans.

The caveat that I mentioned with Ms. Mace's question earlier was actually standardization is wonderful and it is important, and I fully believe in it, but we do not want to standardize to the point where the only anti-nausea med on a power plan is one you do not have in stock in your city. We do not want to standardize to the point when there is supply chain shortages, we can not meet the care of the veteran because we do not have that particular bag of saline or the diluent that is necessary. That is why it takes a long time to try to get this right, and we want to make sure——

Ms. MCMORRIS-RODGERS. Thank you.

Dr. ARENSMAN [continuing]. we are doing that.

Ms. MCMORRIS-RODGERS. Thank you. Dr. Evans, I would like to ask how long you have known about the oncology prescription problem with the Cerner software and what you are doing about it.

Dr. EVANS. I visited the Columbus facility probably within 2 weeks of my starting in this position approximately 6 months ago, and this was a point of significance—We spent an entire hour on the oncology discussion.

We are spending a lot of time working on the Power Plans as has been mentioned and also essentially empowering us as an organization to edit our Power Plans and determine what those look like. That is part of this workforce development I was talking about earlier about bringing the expertise into VA so that we can configure the ordering and make sure we deliver that to Oracle to put into the system in a way that best meets the needs of veterans.

Ms. MCMORRIS-RODGERS. Thank you. This is just one example, but it underscores how grave the situation is. To all who work at the VA at the medical centers I represent in Spokane and Walla Walla, I just want to say thank you for trying to make the best of what has been an extremely difficult situation for our veterans. I yield back.

The CHAIRMAN. Mr. Ciscomani.

Mr. CISCOMANI. Thank you, Chairman Bost. Thank you to the witnesses for being here today for providing your testimonies as we conduct oversight over the effort to replace the VA's electronic health record.

Now, for years, Cerner has been working to develop this software for our veterans and the VA facilities, but this system has been plagued with issues. I think we have been discussing a lot of them here today. Issues with the electronic health record crashing and freezing and requiring excessive steps to complete routine functions

resulting in software not being user friendly, difficulty in veterans ordering prescription refills, and other problems that five VA medical facilities with the system are now facing.

Now, I represent Arizona's 6th congressional District, and veterans in my district go to the Tucson VA Medical Center, which luckily is not one of these five facilities mentioned. Mr. Evans, Dr. Evans, the VA gave the committee a timeline showing what steps you intend to take during the reset period that you have talked about to improve the Oracle Cerner electronic health record system. One of the steps is to, and I quote, "initiate team efforts at one of the five live sites to address and identify issues." In other words, put boots on the ground at one of the medical centers to figure out what they really need. Which facility has been picked for that and why? How is it going to represent the other four facilities?

Dr. EVANS. We hosted several weeks ago, a planning event in Kansas City to plan the work. The specifics on that is some of the configuration changes that we need to make do not require us to be onsite and sort of in the operations. We do not want to interfere with the delivery of patient care in fixing the EHR, but there are times where being onsite, observing exactly how the system is working is going to help us make the right decisions.

All five sites are involved with all of the discussion, and as I mentioned before, the national programs, since we need to not just configure the record for the benefit of——

Mr. CISCOMANI. I am sorry, I have limited time here. What you are saying is you have not picked one yet.

Dr. EVANS. We are going to work with all five sites.

Mr. CISCOMANI. You changed course?

Dr. EVANS. It is not just one.

Mr. CISCOMANI. The plan to pick one and tackle that, you know, after what you just mentioned, you decided to go after all five at the same time?

Dr. EVANS. We are going to go to where we need to go in order to fix the problem, yes.

Mr. CISCOMANI. Okay, so you changed plans and so you are not choosing one anymore on that. Then the question for, I guess, the center leaders here, you know, now that your facility is not going to be chosen individually, because that was going to be one of my questions, once that facility is chosen, what happens there? Since now the plan changed, apparently, and you are tackling where it needs it and quite frankly seems to be that all five it, the question is for all of you, when your facility is chosen, which has been declared now that everyone is chosen, how are you going to make sure that these needs are addressed? How do you go into there and actually look at the needs and then make sure that they are addressed? I do not have a lot of time, so I would appreciate a direct concise answer.

Mr. KELTER. I think there would be different capabilities that would be appropriate to test at each facility. Certain capabilities exist at different facilities that do not exist at all of them. That approach makes sense from that perspective.

Then how do we make sure they work? What can be tested without actually making the configuration changes may be limited. I

am not sure what can be done in a test environment versus in the production environment at this point.

Mr. CISCOMANI. Dr. Fischer.

Dr. FISCHER. Ask the end user. I have 1,400 experts that function every day to deliver healthcare or support healthcare. We will know we are making traction by simply asking the end user, is the product better? Do you like it? Is it helpful? These are simple assessments and we will need to do those type of surveys repeatedly.

Mr. CISCOMANI. Is that being done now?

Dr. FISCHER. It is, but it is——

Mr. CISCOMANI. Are you seeing results now?

Dr. FISCHER. Not yet. These type of surveys——

Mr. CISCOMANI. Something is not working here. We are missing something here. It is just, you know, that sounds to me, Dr. Evans, like a meeting to plan for the meeting that we are going to plan to do something. I am not understanding maybe this correctly. It just seems that we are not addressing the issue. You are not addressing the issue directly here. You have a plan that seemed like a plan that might work of choosing a facility, digging deep into that. Now you are going across all five. As we are going across here, whatever plans that are being shared with us here, they sound good, but they may not or may be working. We do not know that. The timeline here is what worries me. You are way behind.

Dr. EVANS. Yes, if I may. The timeline that we shared with the committee, we initially thought we would have our initial kick off meeting at one of the sites. We chose to have that in Kansas City so we did not disrupt operations. Then we have identified where do we need to go. You heard that two of our facilities have oncology services, two do not. Where we need to go to make changes if we need boots on the ground, will be determined on the impact on that site, whether they can host us and what services are delivered there. We are all in this together. We are building a single and we are improving a single electronic health record.

Mr. CISCOMANI. I have got more to say, but I am out of time. Thank you. I yield back.

The CHAIRMAN. Mr. Crane, you are recognized.

Mr. CRANE. Thank you, Mr. Chairman. Thank you all for coming today. I understand centralization and standardization of a system this large nationwide is a monumental task. I also understand the benefit this effort could create for staff and patients alike. However, it obviously sounds as if right now it has been an absolute failure.

I want to start with you, Doc, on the end. Knowing that you and the rest of Americans continue to pay for this debacle, Doc, what level of confidence do you have in partnerships, the current partnerships, and leadership engaged in this effort? I am really asking clearly about your level of confidence moving forward.

Dr. ARENSMAN. Thanks for the question. Obviously, it is a hugely challenging process and a daunting task. I think I have been very pleased to see Dr. Evans' leadership and understanding of the issues and commitment to stop and take the time we need to get this right and not push forward when things are not safe or when things could be improved.

Mr. CRANE. What is your level of confidence? That was a question I asked you.

Dr. ARENSMAN. In what? In an individual, in a process?

Mr. CRANE. Yes. In the partnerships that we have, the company that you are, the corporation company that you are working with, and in the leadership that you have.

Dr. ARENSMAN. I think I have a moderate level of confidence.

Mr. CRANE. Okay, moderate. Ms. Nelson-Brooks, what about you, ma'am?

Ms. NELSON-BROOKS. In terms of my level of confidence in or leadership's ability or their commitment to getting this right, I would say I have a high level of confidence. I believe that Dr. Evans, Dr. Elnahal, Secretary McDonough are committed to fixing the system as it exists currently. In terms of Cerner's ability to meet our needs, I would say my level of confidence is a lot lower. On a scale of one to 10, I would give it a five.

Mr. CRANE. Ms. Nelson-Brooks, do you think that we should scrap what we are doing and go back to the old system, based on what you are observing and the percentage of your staff that seems to be very disappointed with where things are?

Ms. NELSON-BROOKS. I agree that our staff are very disappointed with the way things have gone. I do not believe that we are at the point currently where we need to pull the plug entirely.

Mr. CRANE. What is the biggest effect that you have seen on patients with the rollout of this new system?

Ms. NELSON-BROOKS. The biggest effect for our facility has been our increase in wait times. Pre-Cerner, we were able to see new patients in for primary care appointments in less than 30 days. Currently, our new patient wait times in Eugene, one of our largest facilities, is approaching 80 days. For Roseburg, our other location, it is over 80 days. It is closer to 85 days for in person care. The caveat that I will mention there, however, is that if patients are willing and able to be seen by telehealth, we do have the ability to get them in within seven days.

Mr. CRANE. Doc Fischer, what is your level of confidence?

Dr. FISCHER. I would agree with Dr. Arensman. I would say it is moderate.

Mr. CRANE. Moderate. What would you like to see going forward, Doc?

Dr. FISCHER. Improvements in the functionality of the system, less degradations, more user satisfaction, things you would anticipate you would see with a successful electronic health record.

Mr. CRANE. Are you saying that most of your disappointment is in the partner that we have chosen here?

Dr. FISCHER. Hard for me to say, sir. I am not an expert in IT. All I know is that our employees are fatigued, tired, stressed. They feel like they are the individuals that stand between the health record and making our patients safe. They have been largely successful, but at a cost.

Mr. CRANE. Mr. Kelter, same question for you.

Mr. KELTER. I would say between the commitment of our leadership from the Secretary on down to the recently renegotiated contract and the fact that we have a 1-year contract options instead

of a 5-year contract option, and the current reset period, I think our chances are better now than they have been in the past.

Mr. CRANE. Doc Evans, did I hear you say you have been doing this role now for 6 months?

Dr. EVANS. That is correct.

Mr. CRANE. Are you ahead or behind of where you thought you would be coming into this at the 6-month mark?

Dr. EVANS. I would like to have been further. I do not think we are—you know, I think the changes have been slow and incremental. They need to accelerate. Anytime you are starting the reset and sort of retooling for moving forward, it is going to take a little time to get the engine running and to build the momentum that we need to build.

Am I proud of the organization for listening to this committee, for making the right decision on behalf of veterans and the staff that you know or you have heard are represented by the folks to my left? Absolutely. We made the right choice to reset. We still have a lot of work to do, and we are committed to doing it.

Mr. CRANE. Thank you, Mr. Chairman. I yield back my time.

The CHAIRMAN. Thank you. At this time, I would like to recognize Mrs. Cherfilus-McCormick for the closing remarks of the ranking member.

Ms. CHERFILUS-MCCORMICK. Thank you, Mr. Chairman. I thought we had a productive discussion today. Dr. Evans and his team have their work cut out for them. I look forward to working with you all to make sure that veterans and VA staff get the technology they need to support the world class care our veterans deserve. I would like to thank the chairman again for his and his staff's collaboration and effort on the House's version of the EHR reset.

It is even more evident to me now how necessary this legislation is. We need to put the VA on a course where they can be successful. Veterans and staff have endured enough. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you. I want to thank everybody for being here today. I want to thank the witnesses for joining us, especially the medical center directors who traveled here.

The VA EHR is a bipartisan mess, and it calls for bipartisan solutions. We can not stand by anymore and hope VA and Oracle-Cerner figure it out. That approach already produced two pauses and failed to solve the problem. We have to insist on results and accountability. I appreciate the Ranking Member Takano and Chairman Rosendale, and Ranking Member Cherfilus-McCormick for standing shoulder to shoulder with me to do that.

Now, I ask unanimous consent that all members shall have 5 legislative days in which to revise and extend their remarks and include any extraneous material. Hearing no objection, so ordered. This hearing is now adjourned.

[Whereupon, at 12:49 p.m., the committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF WITNESS

Prepared Statement of Neil Evans

Good morning, Chairman Bost, Ranking Member Takano and distinguished Members of the Committee. Thank you for the opportunity to testify today about VA's initiative to modernize its electronic health record (EHR) system. I am accompanied by Mr. Scott Kelter, Director, Jonathan M. Wainwright (Walla Walla, Washington) VA Medical Center, Robert Fischer, M.D. Director, Mann-Grandstaff (Spokane, Washington) VA Medical Center, Thandiwe Nelson-Brooks, Associate Director, Roseburg, Oregon VA Medical Center and Allison Arensman, M.D. Chief of Staff, Chalmers P. Wylie (Columbus, Ohio) VA Medical Center.

I want to begin by thanking Congress and this Committee for your continued support and your shared commitment to Veterans, and more specifically, for your support of VA's electronic health record modernization efforts. For VA, successful deployment of the Federal EHR system will facilitate seamless health care transitions for Service members and Veterans among Federal care settings. The Federal EHR will provide an accurate, lifetime health record for Veterans among partners using the Federal EHR. For the newest members of the military, this EHR will serve them from the day they begin their military service through the rest of their lives.

The suite of technologies that make up a modern EHR are part of a larger ecosystem of orchestrated technologies needed by VA to enhance the quality and safety of health care delivery; empower clinical teams with effective decision support; and advance Veteran engagement. In furtherance of these goals, the new Federal EHR system integrates with other health information technologies and will ultimately simplify the experience for Veterans and for VA staff; enhance standardization across the VA enterprise; and improve VA and Department of Defense's (DoD) interoperability with the rest of the U.S. health care system.

Moreover, the adoption of a product used by both VA and DoD will help to simplify health care delivery by providers in both Departments, benefiting patients who receive care in both systems or who are transitioning from DoD to VA for care. One of the program's other goals are to deliver and optimize unified, seamless, trusted information flow between VA, DoD, the U.S. Coast Guard (USCG) and community providers.

DoD has completed its deployment of the Federal EHR, which in DoD is known as Military Health System (MHS) GENESIS, at all its clinical sites in the continental United States, with the exception of the Captain James A. Lovell Federal Health Care Center (Lovell FHCC) in North Chicago, Illinois, a joint VA/DoD facility. DoD will complete its deployments outside of the continental United States this fall, and the final implementation at Lovell FHCC in Spring 2024. In addition to VA and DoD, the USCG and National Oceanic and Atmospheric Administration have also adopted the Federal EHR. Their deployments, while smaller than VA's and DoD's, are both complete.

In VA, the Federal EHR is currently in use at five VA medical centers (VAMC), 22 community-based outpatient clinics and 52 remote sites (such as VA call centers, consolidated patient accounting centers, clinical resource hubs and the like, which support the aforementioned medical centers and clinics). The five VAMCs where the Federal EHR is currently in use are the Mann-Grandstaff VAMC in Spokane, Washington; the Jonathan M. Wainwright Memorial VAMC in Walla Walla, Washington; the Roseburg VA Health Care System in Roseburg, Oregon; the VA Southern Oregon Healthcare System in White City, Oregon; and the VA Central Ohio Health Care System in Columbus, Ohio.

Since the initial go-live dates of the Federal EHR in VA, we have been listening to Veterans and clinicians, and it's clear that the system is not yet fully meeting their expectations. As part of an Electronic Health Record Modernization (EHRM) Program Reset (Reset) announced in April 2023, VA halted work on future deployments of the Federal EHR, with the exception of our planned deployment at Lovell FHCC, while the Department prioritizes improvements at the five sites that currently use the Federal EHR. The purpose of the Reset is to optimize the current

state of the Federal EHR; closely examine and address the issues that clinicians and other end users are experiencing; and position VA for future deployment success.

During this Reset, VA is fixing issues with the Federal EHR, redirecting resources from deployment activities to work on optimizing the Federal EHR at the sites where it is currently in use. Staff productivity levels, revenue cycle management, technical systems performance and other areas require dedicated attention and resolution before deployments resume at full pace.

VA has an obligation to Veterans and taxpayers to get this right. We understand the concerns of this Committee regarding the Federal EHR system and its impact on Veterans and VA staff who rely on it. We are committed to full transparency, and we appreciate your oversight. We look forward to further engagement with you and your staffs to ensure that this modernization effort, and related health information technology modernization efforts, are successful.

Program Reset

To successfully support the deployed sites and continue to position the new system to meet the pace and rigor of future deployments, VA has three primary goals for the Reset: address the concerns of the live sites and ensure the new system is working as promised; invest in the necessary enterprise work to ensure we are positioned for success when deployments resume; and prepare for the Lovell FHCC deployment in March 2024. During its first three-month increment of effort, which began June 1, 2023, VA is managing the Reset work through six workstreams. All six workstreams are focused on continuous value delivery; many of these workstream efforts will continue into the second increment of work, which begins this month. Several additional focus areas will likely also be added.

The current Reset focus areas/workstreams include the following: (a) an effort to more rapidly improve the Federal EHR baseline through configuration changes and optimization of the change process and user adoption support; (b) workforce development to increase VA's ability to independently manage the Federal EHR, initially focused on informatics staff both at the enterprise and field levels; (c) work to improve end user support with a focus on Help Desk functions and incident management; (d) a technical "Get Well" plan to improve system reliability and performance; (e) work to enhance transparent communications for all stakeholders in the project; and (f) preparation for the Lovell FHCC deployment. As mentioned, VA is prioritizing the work that can be achieved using its current resources; VA will likely be adding further workstreams in the second increment of effort beginning in September 2023. Examples include: (a) standardizing key clinical workflows; and (b) evaluating VA's deployment methodology and initiating planning for a deployment schedule for the remainder of the project.

As part of regular and ongoing operations, VA is implementing a range of enhancements and improvements to the Federal EHR system and associated processes in the areas of system stability and reliability, usability, training, change management and end-user engagement. Further, VA is continuing to refine functional and technical standards, defining success metrics regarding access to care, clinical operational efficiency, financial performance and more.

Readiness to Resume Deployments and Lovell FHCC

VA has decided that the Federal EHR will not go live at any new site until that site and the system are ready. We also remain firm in our resolve to continue deployments of a modern Federal EHR. We do not have a firm timeline for completion of this project. Rather, we are committed to getting this right for Veterans and VA clinicians alike and to taking the time necessary. VA will not schedule additional deployments of the Federal EHR until we are confident that it is highly functioning at current sites and is ready to deliver for Veterans and VA clinicians at future sites. That assessment will be based on measurable improvements in the clinician and Veteran experience; sustained high performance and high reliability of the system; improved productivity at the sites where the Federal EHR is in use; and more. When our goals have been met, and the Reset concludes, VA will release a new deployment schedule and resume deployment activities with greater confidence in the readiness of both the Federal EHR system and the VA health care system to successfully navigate the change.

The only exception regarding future deployment activities is the planned deployment at the Lovell FHCC in March 2024. Lovell FHCC is the only fully integrated, jointly run VA and DoD health care system and will be the final deployment of the Federal EHR at a DoD-affiliated site, thus ensuring that the Lovell FHCC is using the same EHR as all other continental United States DoD sites. The joint VA/DoD deployment will go ahead as planned to ensure that all patients who visit this facility are covered by one EHR system. Given the unique mission at Lovell FHCC and

singular focus on this joint medical center, this deployment will benefit from the added support VA will be able to provide during this Reset period and will also help inform decisions about restarting deployments at other VA facilities. Support efforts include resources across VA, DoD, the Federal Electronic Health Record Modernization (FEHRM) office, the Leidos Partnership for Defense Health and Cerner Government Services, Inc.

Contract Update

Since the announcement of the Reset, VA negotiated a new option period structure for its current EHR contract with Cerner, modifying from a single 5-year option period award to five 1-year option periods. This will allow regular re-evaluation of the program and contract performance each year, with the potential to re-open contract negotiations, if needed. New accountability metrics around system performance and user support were also added to the contract. In addition, after the first 1-year option period was exercised and in place, VA reviewed active contract actions and issued stop work orders to Cerner with respect to activities that were not slated to continue during the Reset period. These stop-work orders allow for a more coordinated focus on improving the Federal EHR system. Deployment efforts can be reinitiated when needed.

System Stability, Reliability and Usability

VA is working to resolve issues with the Federal EHR system's performance and usability. VA has significantly reduced unplanned outages through corrective actions taken within the Cerner data base configuration. Until an unplanned outage on April 17, 2023, it had been nearly nine months since the last complete outage. Performance degradations of the system have also decreased. Improving system reliability and availability remains a critical focus. Cerner is contractually obligated to meet 99.95 percent uptime commitment per measurement period (i.e., monthly) for the Federal EHR system, meaning that the system is functional and available for use. For the last seven months ending July 31, 2023, Cerner met that requirement for six months. Beginning September 1, 2023, Cerner will also be contractually obligated to achieve at least 95 percent system incident-free time, which is defined as the percentage of time the hosted environment was free of unplanned events impacting user functionality and/or system performance. Incident free time is trending upward since April 2023. Although not yet contractually obligated, Cerner exceeded incident-free time requirements in May, June and July 2023. Because issues with other systems that connect to the Federal EHR can impact the system, VA continues to work with its partners at DoD and the FEHRM to reduce downtime within the Federal EHR enclave and the systems connected to it.

VA has also completed several tasks to address usability issues identified by its health care providers who are currently using the system and continues to make further improvements. VA is standardizing activities across the VA health system to optimize business processes, reduce user adoption issues and improve training and testing.

Training, Change Management and End-User Engagement

Supporting VA's end users and helping them fully adopt the new EHR is a key to program success and integration of the Federal EHR into VA operations. VA continues active engagement with the sites that are using the Federal EHR. These sites have provided vital feedback on challenges with the Federal EHR and with training and adoption initiatives to date. As part of continued support at existing sites, VA has developed a training regimen to ensure new hires are properly trained, and existing users have opportunities to optimize their performance using the Federal EHR system. VA routinely communicates system changes, planned maintenance events and system upgrades to facility leadership, informatics leadership and end users. VA also communicates through a weekly User Impact Series, attended by over 200 super users; site and VA leaders; and subject matter experts. The lessons learned to date will enable VA to improve the level of support provided before, during and after future go-lives.

To ensure users have completed assigned systems training on the Federal EHR system, the Electronic Health Record Management Integration Office (EHRM-IO) has developed a robust data management system to extract and share data from VA's Talent Management System, showing training completions. EHRM-IO provides Power Business Intelligence (or BI) dashboards to help key stakeholders monitor day-to-day training of thousands of users across various sites and populations. In addition to the dashboards, EHRM-IO supports local facilities to ensure the sites complete training by delivering daily supplemental reports; monitoring open bridge

lines to facilitate real-time response to concerns; and deploying EHRM-IO staff on-site to support active training.

VA has also taken a number of steps to address training concerns. First, VA addressed user concerns with contracted trainers and the sandbox simulated training environment. Second, we established core competencies and optimized the involvement of super users, who are critical in providing specific, on-the-job guidance to our health care providers. Last, we made training more modular and based on specific system functionality. This allows us to further target training requirements to end users' specific system roles, aligning content with the work users perform and reducing the overall amount of training required for many users. Beyond these specific changes, we are doing a better job managing expectations around training, so that our staff understand it is only one part of the overarching adoption pathway for the new system.

To that end, in Fiscal Year (FY) 2023, EHRM-IO and VHA assigned training to National Councils and the Office of Health Informatics (OHI) to provide foundational knowledge of the system for users to perform their job duties and collaborated to define user readiness and adoption and improve end user engagement. EHRM-IO also converted 200-level curricula to computer-based trainings (CBT) to reduce scheduling complexity and increase flexibility of training and updated more than 200 training artifacts, while also piloting the transition of 400-level curricula to VA ownership. These activities demonstrate continued progress in the areas of change management and training and provide increased collaboration with VHA, in line with the 10 recommendations from the General Accountability Office's (GAO) March 2023 report.

Program Accountability and Governance

EHRM-IO, VHA and the Office of Information Technology are working in a collaborative fashion to address program accountability, integrated readiness criteria, enterprise standards, change management and training. VHA has already made internal changes to further drive accountability across the enterprise. Specifically, EHRM-IO and VHA are developing more robust system-lifecycle governance that clarifies the business need and/or issue; prioritizes solutions for development; secures customer agreement on user acceptance criteria; and ensures customer (e.g., clinicians, nursing staff, administrative staff) signoff on user acceptance criteria. VHA EHRM National Councils will represent the customer for this purpose. Additionally, VHA is planning to develop oversight programs for compliance with user acceptance and realization of business goals which will be reported to committees of the VHA Governing Board.

To further drive program accountability, VA appreciates the continued oversight of the VA Office of Inspector General (OIG) and GAO. As of August 2, 2023, 47 of 68 OIG recommendations are closed; 21 remain open. There are only two OIG recommendations that are older than 3 years; these and several others may be put on pause for the duration of the Reset. EHRM-IO continues to work closely with its partner offices to expeditiously adjudicate the outstanding recommendations. As of July 18, 2023, three of the five GAO recommendations have been sent to GAO for closure. The remaining two will remain open for program monitoring.

Budget Overview and Cost Estimate

In April 2023, VA reviewed impacted financial resources in the context of the Reset and determined that FY 2023 costs could be reduced by approximately $400 million. As a result, VA did not seek the 25 percent funding withhold (totaling $439,750,000) of the VA EHRM budget line for FY 2023. VA also proposed reducing the FY 2024 budget request by $529 million and the FY 2025 initial budget calculation by $481 million. VA requests FY 2023 funding that is unobligated as a result of the Reset remain available in FY 2024. EHRM-IO will continue to require FY 2024 funding to support Federal EHR operations, sustainment, infrastructure and integration, as well as continued improvements to the Federal EHR at current productionsites. FY 2024 funding will not support any new site deployments, but it may support current site reviews.

VA is committed to fiscal responsibility and transparency with this Committee as we implement an enterprise EHR system that meets the combined needs of the Veterans and the medical professionals serving them. VA continually drives toward meaningful standardization and prioritizes system changes that have the most beneficial enterprise impact (i.e., not customizing based on the needs of every site). This includes cost considerations, with the end goal of delivering a system that can support improved access, outcomes and experiences for Veterans through a single health record from entry into military service to VA care.

Federal EHR System Imperative

VA must continue to move forward with a modern, commercial EHR solution in close coordination with our Federal partners, including DoD and FEHRM. This new Federal EHR will allow VA to standardize workflows, training and systems across VA, to better coordinate with the DoD, other Federal partners and private sector health providers, and to spread innovation system-wide more quickly through new integrated health information technologies and capabilities.

Conclusion

Veterans remain the center of everything we do. They deserve high-quality health care that is safe, timely, Veteran-centric, equitable, evidence-based, and efficient. As improvements continue to be made through the duration of this Reset, VA will continually evaluate readiness of sites and the Federal EHR system to ensure success and patient safety. With the activities and improvements that are now underway, VA leaders are optimistic about the eventual success of the current Reset and subsequent full implementation of the Federal EHR throughout VA.

I again extend my gratitude to Congress for your commitment to serving Veterans with excellence. We look forward to responding to any questions that you may have.

STATEMENT FOR THE RECORD

Prepared Statement of Teresa Boyd

Good morning, Chairman Bost, Ranking Member Takano and distinguished Members of the Committee. I very much appreciate the opportunity to provide testimony in support of VA's journey to modernize its electronic health record (EHR). During the past 5 years, I have been involved in the EHR modernization from many vantage points – as former Assistant Deputy Under Secretary for Health for Clinical Operations (ADUSH/CO), and since Fall of 2020, as the Network Director for VISN 20 – a Network that encompasses most notably four (4) of the facilities that are now live with the new EHR system. Dr. Evans has introduced the three leaders that were able to travel to be here today. These leaders – Mr. Kelter, Ms. Nelson-Brooks, and Dr. Fischer – led their respective staff through the early days of training, excitement, and uncertainty as a new electronic heath record was deployed at their sites – one that was new to VA. Dr. Cellura, Medical Center Director, and former Chief of Staff at Southern Oregon Rehabilitation Center and Clinics was unable to join today, but my comments incorporate her input. It is not lost on anyone that healthcare delivery is complex, and the transition to any new system or tool or process brings with it, challenges. Over 4500 VISN 20 staff use the new EHR each day – whether at the local facility, the clinical resource hub, or the clinical contact center (call center). The facility leaders, including their respective leadership teams, continue to champion quality and timely healthcare delivery as they support their frontline staff through the sometimes frustrating, and seemingly never-ending, growing pains of the new EHR. The staff at the collective five (5) live sites are to be commended for not only their resiliency and perseverance but for their unmatched contribution to the important work of "getting it right" with regards to the new electronic health record.

VISN 20 EHRM Deployment Team has been an integral part of our day-to-day operations with regards to the activities involved with pre-deployment and now through sustainment and improvements. In addition to daily touchpoints with facilities, the team rapidly socializes any new or urgent issues so that all live sites are aware – including our VISN 10 counterparts – a model for a learning organization in action. This deployment team reinforces clear and transparent communication among all live sites as well as the conduit to national councils, program offices, VHA EHR leadership and EHRM IO.

I look forward to being a part of change that VISN 20 is leading. If the 4500 plus VISN 20 users were to speak, they would ask for improved education on proper workflows that would inspire confidence and no doubt increase positivity among the staff; increased bi-directional transparent communication regarding issues at hand (tickets); and streamlining of workflows to decrease the number of clicks. No doubt the dedicated staff from the field and VACO will formulate a successful way forward as we keep lessons learned front and center as we focus on our humble missions.

Chairman Bost, Ranking Member Takano and Member of the Committee, thank you for this opportunity and for your unwavering support of our nation's Veterans and those who have dedicated their life work to delivering on our promises.