LEGISLATIVE HEARING ON H.R. 592; H.R. 608; H.R. 1658; H.R. 1659; AND H.R. 2499

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS

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C O N T E N T S

WEDNESDAY, APRIL 19, 2023

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WEDNESDAY, APRIL 19, 2023

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

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 390, Cannon House Office Building, Hon. Jen Kiggans [chairwoman of the subcommittee] presiding.

Present: Representatives Kiggans, Rosendale, Mrvan, Pappas, and Cherfilus-McCormick.

Also present: Representative Takano.

OPENING STATEMENT OF JENNIFER A. KIGGANS, CHAIRWOMAN

Ms. KIGGANS. Good morning. Thank you to our witnesses for being here today. In today's hearing, we will examine legislative options to check the struggling Electronic Health Record (EHR) modernization effort to address VA management concerns, and to authorize VA's newest effort to modernize its supply chain. I will begin with my bill, which is H.R. 2499, the Supply Chain Management System Authorization Act.

Though I have been in Congress a short time, I have learned that the VA's major modern modernization efforts over the past decade have been plagued by some challenges. Government Accountability Office's (GAO's) written testimony highlights one of the roots of this problem, and to quote them, "the VA often puts actions ahead of planning."

This reality at the Department is precisely why Congress must be involved in VA's major programs and why I believe we need to specifically authorize VA's supply chain effort.

My bill would give Congress the ability to have more control over the scope, planning, and spending of this major project by authorizing the VA to purchase and implement a system for Veterans Health Administration (VHA) focused specifically on inventory management, requiring the system to be implemented in 3 years, and directing VA to begin with a pilot of the system at one location to make sure it really works for the VA before implementing it across the country.

I appreciate that the Department still has some concerns with the bill but considering the VA's struggle with a number of major

projects like the EHR Modernization Program, which is the subject of the next two bills, I am convinced that H.R. 2499 is vitally important.

Now, I will turn to H.R. 592, the Department of Veteran Affairs Electronic Health Record Modernization Improvement Act introduced by Chairman Bost. Congress never authorized the EHR Modernization Program, and it has struggled from the very beginning. The program is live at only five medical centers after 5 years, and over $5 billion have been spent. It has faced issue after issue, and providers and veterans at these five sites are not getting the support and care they need. That is why H.R. 592 would require medical center and Veterans Integrated Services Network (VISN) leadership to certify the EHRs ready for their hospital before it can be installed. It would also require the Secretary to certify the EHRs running without issue 99.9 percent of the time, which is a requirement in the contract before the EHR can be installed anywhere else. VA must take these steps to make sure it does not repeat mistakes made at the first five sites. I look forward to hearing from our witnesses about this bill.

Also on the agenda today is H.R. 608, to terminate the Electronic Health Record Modernization Program of the Department of Veteran Affairs. This bill was introduced by Mr. Rosendale, the Chairman of the Subcommittee on Technology Modernization. I will let him speak to the details of this bill.

Another bill on today's agenda that would impact the EHR Modernization Program is H.R. 1659, the Department of Veteran Affairs IT Modernization Improvement Act. This bill was introduced by Ranking Member Takano and would require VA to contract for an independent verification and validation assessment of five major IT modernization efforts to include the EHR Modernization Program and the Supply Chain Program.

Last, we have H.R. 1658, the Manage VA Act. Also introduced by Ranking Member Takano, this bill would create an undersecretary for management. The position would be responsible for VA's budget, accounting, procurement, human resources, information technology, and other VA central office functions. I will recognize Ranking Member Takano in a few minutes to speak to his bills.

Again, thank you all for being here today and I look forward to our discussion. I now recognize Ranking Member Mrvan for his opening remarks.

OPENING STATEMENT OF FRANK J. MRVAN, RANKING MEMBER

Mr. MRVAN. Thank you, Chair Kiggans. I am looking forward to discussing two bills that I have co-sponsored with Ranking Member Takano at our hearing today. As the Chair of Technology Modernization Subcommittee last Congress, I have seen firsthand the impacts of failures to improve VA's large IT systems. The Department of Veterans Affairs IT Modernization Improvement Act is a strong first step to introducing a higher level of support and accountability for the VA and for Congress.

Independent verification and validation is not a new concept and has been successfully utilized at the Department of Defense to ensure that the Department and the taxpayers get what they pay for.

I am very pleased to see that VA supports this effort and I look forward to hearing their testimony on this bill today.

A second broader and more aspirational bill we will discuss today is the Manage VA Act, which would create an undersecretary of management at the VA and consolidate acquisition and business functions at the Department. Creating one management position is not going to fix every issue that VA has had with managing acquisitions, budget, and IT across the Department, but it is a start. I feel it is time to provide a position that has the authority and weight to ensure that we do not keep making the same mistakes over and over and over again.

We found out last Congress that it took a decision from the Secretary to end the failed supply chain modernization attempt with Defense Medical Logistics Standard Support (DMLSS). As we move toward yet another attempt at modernizing supply chain management, I want to ensure we are providing VA with every resource possible to get a successful program at this time.

I would also like to acknowledge my colleagues' bills concerning the Electronic Health Record Modernization (EHRM) program. I was happy to lead the EHRM Transparency law with Chairman Bost and Ranking Member Takano on a bipartisan basis last Congress. I look forward to continuing to work on a bipartisan basis on this program and get a system and result that will benefit veterans and employees.

I am happy to say that we will be introducing and I will cosponsor the EHRM Reset Act introduced by Senator Tester. This bill is an ideal platform for negotiating a long-term bipartisan fix to the program. This bill will address a number of issues, including in Chairman Bost's legislation today. I look forward to collaborating across the aisle, as we successfully accomplished last Congress. I look forward to hearing from our witnesses today, and I yield back my time.

Ms. KIGGANS. Thank you, Ranking Member Mrvan. I now recognize the ranking member for the full committee, Mr. Takano, to speak on his bills H.R. 1658 and H.R. 1659.

STATEMENT OF MARK TAKANO, RANKING MEMBER, FULL COMMITTEE

Mr. TAKANO. Well, thank you, Chair Kiggans. I am happy to discuss two bills today that I have introduced in this Congress. I am also happy to say that Chairman Bost and I will be working together on a bipartisan basis on a long-term solution to the EHRM program with our planned introduction of Senator Tester's EHRM Reset Act this week. We have had a lot of success working together on a bipartisan basis, and I look forward to continuing to work across the aisle to fix this problem.

The Department of Veterans Affairs IT Modernization Improvement Act will require VA to contract for independent verification and validation of the EHRM, Financial Management Business Transformation (FMBT), supply chain, and Veterans Benefits Management System (VBMS) modernization programs. The key word there being independent. For too long, Congress has not had the visibility into these large IT modernization programs that we need to provide necessary oversight. This will also be an invaluable tool

for VA to ensure that the government, veterans, and taxpayers are getting what they pay for. This is a long-standing best practice of Department of Defense (DoD). Given the ever-increasing size of the VA, the time is now to create this capacity.

My second bill, the Manage VA Act, will create an undersecretary for management at the VA and consolidate acquisition and business functions at the Department. With the continued appearances of acquisition management and management IT acquisitions and operations on the GAO high risk list, it is past time that we designated an undersecretary whose expertise will be the business of government.

The failures to modernize VA's financial systems, supply chain management, health records, et cetera, has had a direct impact on the care and benefits we provide to veterans. VA has not been provided with the management and acquisition resources commensurate with their responsibilities. Leadership is needed on these business functions so that our VA employees can do what they do best, which is provide exceptional care and benefits to our veterans.

I hope both bills can get bipartisan support. It is in everyone's best interest to ensure that we are managing the business of VA wisely. I encourage all my colleagues to support these bills and I yield back.

Ms. KIGGANS. Thank you, Ranking Member Takano. We will now turn to witness testimony. Testifying before us today we have Mr. Phillip Christy, who is the Deputy Executive Director for the Office of Acquisition, Logistics, and Construction at the Department of Veteran Affairs. He is accompanied by Ms. Catherine Cravens, who is the Chief of Staff for the Office of Information Technology at the Department of Veteran Affairs. We have Dr. Leslie Sofocleous, who is Executive Director of the Program Management Office for the Electronic Health Record Modernization Integration Office at the Department of Veteran Affairs. We have Ms. Shannon Love-Holmon, who is Acting Assistant Secretary for the Office of Enterprise Integration at the Department of Veteran Affairs. Last but not least, we have Ms. Shelby Oakley, who is Director for Contracting and National Security Acquisition at the Government Accountability Office. Ms. Oakley, you appear outnumbered by Veteran Affairs members, but I trust you are not outgunned.

Now I would like to swear in our witnesses. I will ask all witnesses to please stand and raise your right hand.

[Witnesses sworn]

Ms. KIGGANS. Thank you so much. Let the record reflect that all witnesses answered in the affirmative. Mr. Christy, we will start with you. You are recognized for 5 minutes to provide your testimony.

STATEMENT OF PHILLIP CHRISTY

Mr. CHRISTY. Good morning, Chairman Kiggans, Ranking Member Mrvan, and other members of the subcommittee. Thank you for the opportunity to appear before you to discuss the pending legislation that would affect VA programs and services. Today, I am blessed and flanked by some incredible talent. Joining me are Dr. Leslie Sofocleous, Executive Director of Electronic Health Record and Modernization and Program Management Office, Ms. Shana

Love-Holmon, the Acting Assistant Secretary, Office of Enterprise Integration, and Catherine Cravens, the Chief of Staff for the Office of Information and Technology.

Madam Chairwoman, in my oral testimony, I will highlight the Department's views concerning the five bills on the agenda. Regarding the five bills we are here to discuss, the VA supports certain provisions of the proposed bills and would like to highlight areas of concern and certain provisions we oppose. VA appreciates the intent behind the bills and looks forward to discussing the opportunities to continue to improve program management, accountability, and jointness within the Department. The rationale for our VA's position is outlined in our written statement.

First, the VA Electronic Health Record Modernization Improvement Act, H.R. 592, which VA supports, in part. VA supports the bill's requirement that VA continue to partner with the Department of Defense and the Federal Electronic Health Record Modernization Office to improve overall performance within the EHR and the systems connected to it. However, VA does not fully support some of the specific prohibitions and certification requirements. As currently written, the proposed limitations would pause program activities and cause significant cost impacts. We suggest modifications to the bill text to ameliorate these concerns, and we believe the modifications would work toward facilitating the intent of the bill.

The second bill focused on EHR, H.R. 608, would require the Secretary to terminate the program, abolish the EHR Integration Office, and revert facilities where the new EHR is deployed back to Veterans Health Information Systems and Technology Architecture (VistA). VA opposes this bill, as it would frustrate VA's ability to have an interoperable and longitudinal record with the Department of Defense. Modernizing VA's EHR is critical for providing the best care for our veterans and facilitates advancements in the delivery of that care. We believe terminating the program would work against those goals.

As for H.R. 1659, the IT Modernization Improvement Act, the VA supports the bill if amended and with appropriations. This bill would direct VA to contract for independent verification and validation of certain modernization efforts of the Department. Ideally, VA would have in-house team with the expertise to conduct Independent Verification and Validation (IV&V) of its major modernization efforts. Contracting IV&V support while VA builds internal capacity, makes practical sense, and will help expedite the resulting delivery of benefits and services to veterans, their caregivers and family members. VA anticipates an IV&V contract of this size would be extremely expensive. Appropriate and timely funding of this bill is critical.

Regarding H.R. 1658, the Manage VA Act, the VA does not support. This bill would create a new undersecretary for management as the chief management officer of the Department. Integrating the Department's efforts in creating operational jointness in our support of veterans, their families, caregivers, and survivors is essential to veterans choosing VA for care, benefits, and services. VA has implemented robust governance to drive jointness and integration in support of the Secretary and the Deputy Secretary who serves

as VA's Chief Operating Officer. This framework enables evidence-based risk informed decisionmaking that advances the mission of the VA.

Currently, the Assistant Secretary for Enterprise Integration serves as the VA accountable executive for enterprise management and governance in support of the Office of the Secretary. In addition, VA has one of the most outstanding customer experience offices in the Federal Government, which serves as a key partner within our enterprise governance framework to ensure we continue to put veterans first in all of our decisions and all of our program execution. The VA already has in place many of the functions this bill prescribes.

Finally, VA cites concerns with a draft bill that would authorize the Secretary to carry out an IT system and prioritize certain requirements to manage supply chains for medical facilities. As written, the bill may impede ongoing efforts toward an enterprise supply chain solution. We are concerned about the timeline for implementation does not accurately reflect the complexities involved in successful procurement and execution. VA welcomes the opportunity to continue working with the committee to provide additional technical assistance that will create the flexibility and the scope and timing needed to ensure the success of the supply chain mission.

Madam Chairwoman, before I close, I wanted to share our deepest appreciation to the committee and all of the staff that have worked with us regarding these bills. This concludes my statement, and we would be happy to answer any questions you or other members of the subcommittee may have.

[THE PREPARED STATEMENT OF PHILLIP CHRISTY APPEARS IN THE APPENDIX]

Ms. KIGGANS. Thank you so much, Mr. Christy. Ms. Oakley, you are now recognized for 5 minutes to provide your testimony.

STATEMENT OF SHELBY OAKLEY

Ms. OAKLEY. Chairwoman Kiggans, Ranking Member Mrvan, and members of the subcommittee, I am pleased to be here today to assist you with your consideration of the legislative proposals to improve VA management and key modernization programs. While Congress provides VA with hundreds of billions of dollars each year, we are all aware of the opportunities VA has wasted because it has not followed disciplined management approaches when planning and executing its programs. EHRM is just one example, but a critical one.

We added VA acquisition, management, and healthcare to our high-risk list because VA lacks a disciplined management approach, among other challenges. Our updated assessment of these high-risk areas will be issued tomorrow.

The five bills the committee is considering reflect the underlying theme that change is needed. As I laid out in my written statement, we have issued an expansive body of work on effective management practices and made prior recommendations in line with aspects of the proposed legislation. Today, I will discuss ways in which this work could help Congress and VA as you seek lasting and transformative change.

For example, we identified key strategies for implementing chief management officer positions, like the proposed VA undersecretary for management. These include ensuring that the Chief Marketing Officer (CMO) responsibilities are clearly defined and documented, and that the CMO have a high and sustained level of authority. We have also recommended CMO positions be established by other departments, such as DoD and Department of Homeland Security (DHS). Each department followed or identified key strategies to different degrees, and, as a result, have experienced varied success in integrating this position.

Leadership is essential, but so is good information for decision-making. We have long recognized independent verification and validation as a best practice. When agencies are developing or acquiring a system IV&V can help reduce risk by having a knowledgeable independent party determine that the system meets users' needs and fulfills its intended purpose.

We have identified key elements of effective IV&V plans that may be helpful to Congress as it considers this proposed legislation. These include risk-based criteria for determining which programs or aspects of programs require IV&V and establishing standards for independence. We recently recommended that VA reinstitute plans to conduct an EHRM independent operational assessment, which could be an element of an overall IV&V review. IV&V is a specific solution to one of the challenges the EHRM program faces.

As the draft legislation indicates, the subcommittee is greatly concerned with broader program challenges. Our reported findings and those of the Inspector General (IG) over many years validate your concerns. For instance, we recently reported to Congress that the overwhelming majority of users are not satisfied with the system. Whichever approach Congress chooses for this program, heeding the numerous GAO and IG recommendations and lessons learned from the current effort could help ensure that VA uses a more disciplined management approach in pursuit of programmatic success.

Finally, as VA pursues a new supply chain management system, our recommendations and our leading practices for effective pilot programs could come in handy. For instance, 2 years ago, we recommended that VA develop a comprehensive supply chain management strategy to guide its multiple interrelated efforts. This strategy should drive the development of whatever system VA requires, not vice versa. VA is moving forward with its system acquisition despite still developing this strategy.

Additionally, our prior work, consistent with the draft legislation, indicates that effective pilots can inform and facilitate program and policy decisions, especially for significant modernization programs. These practices for pilot programs call for having clear, well-defined, appropriate, and measurable objectives, among other things.

In conclusion, the challenges these bills are trying to fix are complex, and there are really no easy solutions. However, consistently applying leading practices and strategies summarized in my testimony will better position VA to fulfill its mission in the years ahead. Your continued oversight will be essential to holding VA accountable for delivering what it has promised to our veterans.

Thank you again for having me here this morning. This concludes my statement, and I look forward to any questions you have.

[THE PREPARED STATEMENT OF SHELBY OAKLEY APPEARS IN THE APPENDIX]

Ms. KIGGANS. Thank you so much, Ms. Oakley. Now I would like to recognize Mr. Rosendale to speak on his bill H.R. 608.

STATEMENT OF MATTHEW M. ROSENDALE

Mr. ROSENDALE. Thank you, Chairwoman Kiggans, for holding this hearing and to Chairman Bost for making oversight of electronic health record modernization project a major priority for this committee. We owe it to our Nation's veterans to have a safe, fully functioning electronic records system. Quite frankly, I feel sorry for the witnesses that are here trying to defend a demonstrably failed system.

The Oracle Cerner electronic health record system operates at five of the 171 VA medical centers. The VA acknowledges the system has created unacceptable levels of productivity losses, patient safety risks, and stay at burnout at these five small to medium-sized facilities. Veterans at these five facility centers have complained about lost medication in the mail, receiving other veterans' medication, delayed specialist appointments and diagnostic tests, confusion with the patient portal, and generally increased wait times, widespread errors in their personal information.

We are also seeing experienced employees at these five medical centers leaving their jobs because of frustrations with the system. In a survey, 60 percent of the staff at one of the centers said the system has made them question whether to continue working there. I was pleased with Secretary McDonough's recent decision to continue the pause on implementing the disastrous system at other VA sites. While Secretary McDonough deserves credit for this decision, I think it is unwise to delay the inevitable. This system and this project have simply not worked out and are bleeding critical resources from the VA at astronomical rates, and there is no reason to believe that that is going to change.

It is not just bad execution. It is flawed concept. The VA is not ready to accomplish a massive EHR replacement. The VA's cost estimate was initially $16.1 billion over 10 years. Now, the Institute for Defense Analysis is estimating up to $38.9 billion for implementation over 13 years. Our Nation is over $31 trillion in debt, yet we are throwing billions of dollars at a failed EHR system that is compromising veterans' safety. This is unacceptable.

I introduced the EHR Termination Act to put a stop to this madness before the VA spends billions of dollars more of taxpayers' money. My legislation would abolish the Electronic Health Record Modernization Integration Office and transfer any functions to the Veterans Health Administration or the Office of Information and Technology at the VA. It would also revert all five medical centers using the Oracle Cerner EHR system back to VistA and Computerized Patient Record System (CPRS). Moreover, it would prevent the VA from exercising any options on Oracle Cerner's contract, causing it to expire within 1 year.

The Congressional Budget Office estimated my legislation would reduce discretionary costs by about $8 billion over 5 years. The tax-

payer has already shelled out over $5 billion for this project, and the only thing we have to show for it is worse care for our veterans. Money that the taxpayer expended should be returned because of this poor performance. The job of the VA should be providing veterans the world class benefits and services that they have earned, not doling out billions of dollars to Silicon Valley companies. It is time to put our Nation's veterans first by terminating the Oracle Cerner electronic health record system. Thank you, Madam Chair, and I yield back.

Ms. KIGGANS. Thank you, Mr. Rosendale. Now we will turn to questions, and I would like to yield myself 5 minutes. Starting with Mr. Christy, H.R. 2499 would authorize a VA supply chain management system. I know the VA is pursuing a massive enterprise-wide VA supply chain management system under its own authority, but what is the VA's independent lifecycle cost estimate for that effort?

Mr. CHRISTY. Ma'am, as we are working through the concepts of the supply chain and the overarching strategy, we still do not have a finalized cost estimate for what that will be in its total. It is something that is under development. Understand that when that number is arrived at that we could share it with you and the committee.

Ms. KIGGANS. Do you think you could get it to us by the end of the week? Could you commit to that or?

Mr. CHRISTY. I cannot commit to the end of the week that we will have that number. It is still under development.

Ms. KIGGANS. Do you know approximately how long it will take?

Mr. CHRISTY. Two components here. There is the internal estimate that the program office will be working up. As part of the acquisition strategy, we are using a statement of objectives for the actual procurement. What that means is we are going to lay out the objectives and industry will come back to us with their solutions and their cost to deliver on those solutions. Depending who wins through that procurement competition, that would be the cost of the procurement itself.

Now, obviously, a program is just more than the contract with all the ancillary and overhead costs with that. That will be a key component into what is the cost of this program. Yes, the program is taking its stab at what will this cost through a lifecycle. A big, really important step to this, though, is what will be the procurement cost? That is where a lot of the money will go, frankly. Until we have those numbers, we are not able to provide that to you. We still do not have the procurement out on the street, right? That is still under development along with the strategy.

Ms. KIGGANS. Are we talking weeks or months or is this going to take another year? I am just wondering what the timeline looks like for that cost estimate.

Mr. CHRISTY. Just for as a working concept, I would say about 6 months before we could have that number ratcheted down.

Ms. KIGGANS. Okay. We would like that number as soon as you have that available, please.

Mr. CHRISTY. We will try to.

Ms. KIGGANS. We just need that before going forward, I will say that. Ms. Oakley, you testified that just to quote your statement,

"a recurring theme from our findings has been that the VA often puts action ahead of planning." Would you please explain why this finding is so important when we are talking about starting major projects like the supply chain management system?

Ms. OAKLEY. Absolutely. Thank you for your question. Yes, it has been a recurring theme that we have seen, especially with regard to the supply chain management approaches that VA has attempted over the years in terms of putting action ahead of strategy. I think, you know, a perfect example of this is the fact that 2 years ago we made a recommendation about instituting or developing a comprehensive supply chain management strategy that would guide acquisition of the individual technical solutions that VA is seeking for the system itself. Unfortunately, that strategy is not finished, but the acquisition is proceeding.

To comment on the lifecycle cost estimate issue, having a lifecycle cost estimate before committing to a program is super important. Our work in other agencies has validated having that as a key piece of the business case information for committing to a program is essential to understanding if you are going to get what you are saying for the cost and within the timeframes that you are anticipating.

Ms. KIGGANS. I agree, and it is hard to do much without having that before we can go forward. Mr. Christy, do you agree with the GAO's testimony that the VA has often or has in the past acted before it is sufficiently planned?

Mr. CHRISTY. Yes, I do concur with that. There are numerous GAO findings and IG findings. This is what we are trying to correct through the——

Ms. KIGGANS. Yes.

Mr. CHRISTY [continuing]. supply chain and I know it is probably frustrating to say, hey, when are you going to give me the number? It is——

Ms. KIGGANS. Yes.

Mr. CHRISTY [continuing]. wanting to make sure that we do not repeat the sins that GAO, and IG, and others have identified. We want to get this right and not go out the door and repeat the same things that we have been doing for years.

Ms. KIGGANS. Agree very much. Ms. Oakley, my bill would esquire the VA to pilot the new supply chain platforms function prior to wider deployment. Can you explain why it is important to pilot a program like this before rolling it out VA-wide?

Ms. OAKLEY. Absolutely. Piloting a program can provide you with valuable information on whether it is going to meet its intended purpose and whether it is even scalable across the enterprise. When you consider an organization like VA as big and complex with medical centers with different needs and different, you know, configurations and whatnot, a pilot would allow you to understand those pain points, get feedback from users, people who are actually going to be implementing the system, and incorporate that feedback to make changes to the program, to be able to then scale it and distribute it across the organization.

You know, it is not, you know, as my testimony stated, and as my written testimony stated, it is not just as simple as putting in place a pilot. It has to be structured effectively such that you can

collect data from that pilot to be able to use going forward. Our leading practices would indicate ways in which that can happen for VA.

Ms. KIGGANS. Out of curiosity, did we pilot the EHR program then as well before moving forward?

Ms. OAKLEY. I am not certain of that answer. Maybe VA can answer that question. I am not sure I have been around long enough to know that.

Ms. KIGGANS. Mr. Christy, do you know?

Mr. CHRISTY. I am going to pass to Dr. Leslie Sofocleous.

Ms. SOFOCLEOUS. Ma'am, I would say based off of the conversation here, it is probably not the same type of pilot. We were in Integrated Operations Center (IOC), and we had some initial sites, but I can say that, you know, there was an ability for us to probably have some lessons learned from the approach that was just referenced.

Ms. KIGGANS. Yes, I would agree with that. Just and agreeing with the value of piloting a program, I think going forward, and hindsight is always 2020, and lessons learned, but that probably would have been a great idea.

Ms. Oakley, the VA's healthcare and acquisition management are on GAO's high-risk list. Could a supply chain management system focused on the VHA and with clear metrics help fix the VA's healthcare and acquisition management issues?

Ms. OAKLEY. I think it would go a long way. It is certainly a driver of many of the challenges that we have identified in that area for VA over the years. I think one thing that you mentioned that is important to note is, you know, our work for product development, system development would indicate that kind of taking an incremental approach to developing a system as critical as the supply chain management system would give VA an opportunity to release initial capabilities, understand how those are working, and then continue to build on those capabilities going forward. I think your bill advocates for limiting the scope of the effort, at least initially, to then be able to understand how it could be expanded to VA's enterprise-wide supply chain. We think that that is a good, measured approach.

Ms. KIGGANS. Thank you. Thank you, and I concur. I look forward to seeing bill to fruition. Next, I will turn to Ranking Member Mrvan for his questions.

Mr. MRVAN. Thank you, Chairwoman. Ms. Oakley, my first question for you is regarding H.R. 1659, Ranking Member Takano's IT Modernization Improvement Act. Specifically, from your experience with independent verification and validation, is there any major IT program that VA that you think would not benefit from the IV&V?

Ms. OAKLEY. I definitely do not think I can think of any program that would be considered under this bill that could not benefit from additional quality information to support decisionmaking. In fact, one of the criteria that we have, one of our best practices for IV&V would focus on risk-based criteria for determining which programs are suitable for IV&V, or which aspects of programs are suitable for IV&V. That would be things like the maturity of the technology, the criticality of the system to the mission, things like that, that would drive the decisions. I think the programs that you mentioned

are all pretty critical to VA. I can not think of one that would not benefit.

Mr. MRVAN. Specifically for a program like EHRM, do you feel like the program is too far along for the IV&V to be a benefit going forward?

Ms. OAKLEY. I do not think it is ever too late to do the right thing. You know, the program is in the pretty early stages with only five sites rolled out. There is a lot more work that needs to be done from a development perspective. I think it is also important to note that each location has different needs, and so there might be different requirements for each location. Having a concerted IV&V effort for a program like EHRM as it continues to roll out, I think is critically important to provide that really good quality information to make those go-no-go decisions, and the certifications that are outlined in the bill.

Mr. MRVAN. Mr. Christy, from your testimony, I see that you have some good constructive technical amendments to the bill, which we will definitely consider. From your perspective overall, I would really like to hear your opinion of this bill and the IV&V overall as it relates to these large IT modernization programs at VA.

Mr. CHRISTY. Yes, I think through the identification of what we talked about earlier with many GAO reports, an IV&V support of those modernization efforts or any large programs is extremely helpful to the VA. Fully support this.

Back to the comments by Ms. Oakley. You know, I think the key thing there is I wanted to kind of lock in, is that we believe in all the best practices that were put out into those different reports, you know, the criteria when you are using the independents, the upfront rules, making sure what we are paying for, and that there is oversight of itself of the IV&V program. From an acquisition and a VA perspective, this is a good thing for the VA and veterans. We are going to start getting help with making sure the money that is spent we are getting the buck—getting the money that we are—getting the value from the money we are spending on veterans. Again, fully support this.

Mr. MRVAN. I appreciate those comments and appreciate your attention to helping to increase accountability and results from these programs. I want to give you the opportunity as well right now to offer any thoughts you may have on the support outside of IV&V that you need in the Office of Acquisitions, Logistics and Construction (OALC). I realize that Congress has put an enormous burden on your office in executing these large acquisitions, and I want to give you the opportunity to let us know what else you need from us to help increase effective acquisitions at VA.

Mr. CHRISTY. Yes, I am going to pull a line from GAO's testimony. If you saw in there, there was 147 percent increase in procurement in the last 10 years. That is just the procurement piece, not the program management. I am using that to kind of highlight how much work has come to the VA, how much responsibility that is laid on acquisition officials. Both contracting folks but also program folks.

I will share with you the steady State of how many acquisition folks we have at the VA has not grown with that 147 percent spike

in 10 years. You got a huge workload on the acquisition workforce here. We would welcome opportunities to discuss how can we approach that, streamline, you know, procurements, program oversight, et cetera. As the IV&V, now, that is another great example of help the VA needs to improve acquisition and program management accountability and jointness.

Some of this gets down to resources that I think, you know, maybe an offline TA or discussion would be really helpful to that conversation. Generally speaking, the acquisition workforce has a huge workload on it and the requirements are growing without corresponding growth of the workforce.

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

Ms. KIGGANS. Thank you very much, Mr. Mrvan. Now, the chair would like to recognize Mr. Rosendale for 5 minutes.

Mr. ROSENDALE. Thank you, Madam Chair. I appreciate it. While it was not designated as such, unfortunately, the Oracle Cerner EHR system has been a multibillion-dollar pilot project that has not even vaguely worked out and stands to consume billions of valuable resources in the future with no foreseeable improvement if not stopped.

Ms. Sofocleous, 2 weeks ago, the VA announced through an email from the Director of VISN 10 that implementation of the Oracle Cerner EHR will be postponed in Saginaw, Michigan. That announcement left a lot of things unsaid. I will not allow you to set the record straight today. Are there other upcoming sites also postponed, including Battle Creek, Detroit, Chillicothe, Dayton, and elsewhere in Michigan, Ohio, Indiana, and Wisconsin?

Ms. SOFOCLEOUS. Sir, thank you for the question. We have said that we would evaluate the sites as we move forward to ensure that we do not have any of the additional patient safety issues we have talked about. We make the improvements in terms of system uptime and performance and then we also address some of the change management and adoption issues. We will continue to do that and make informed decisions moving forward on those additional sites. We can see that veterans and the clinicians need to have a system that works for them and we will continue to do that as we move forward, sir.

Mr. ROSENDALE. Will you be setting another go-live date for any of these sites?

Ms. SOFOCLEOUS. Sir——

Mr. ROSENDALE. How much lead time will you be giving this committee in advance of going live in those additional sites?

Ms. SOFOCLEOUS. Sir, we will inform this committee of any decisions we will make and we will assure that there is informed time so that there are questions and that the sites are aware of our plans moving forward. Obviously, we want to make sure that we have all stakeholder involvement in any decisions we make moving forward.

Mr. ROSENDALE. Before we are announcing, I am trying to narrow down some timeframes so I know what I am going to be dealing with, okay? Are we looking at 30 days' notice, 60 days' notice, 180 days' notice? What kind of notice do you commit to this committee giving us before we go live on any additional sites?

Ms. SOFOCLEOUS. Sir, I will take that of record to come back with a timeframe on that.

Mr. ROSENDALE. Thank you very much.

Ms. SOFOCLEOUS. You are welcome, sir.

Mr. ROSENDALE. Appreciate it. Thank you. Ms. Sofocleous, tell me about the decision not to proceed with implementing the Oracle Cerner system in Ann Arbor, Saginaw, and elsewhere. Who made the decisions, how were they made, and what was the role of the medical center directors from each of these VISNs?

Ms. SOFOCLEOUS. Yes, sir. In other sites, we have—I think we have briefed before previously, we have the site readiness, which we use in our previous sites, you know, albeit we have had some issues after our previous deployments that look at key categories in terms of, you know, training, adoption, whether or not we have technology in place, interfaces in place. Those are all decisions that we use to evaluate. We have, based off of the Sprint Report and assess and address, come up with additional operational metrics that we want to incorporate. As we use that, we will use that to inform decisions, in terms of joint decisions, I might say in terms of whether or not we want to proceed with any deployments at the site. That framework was used for Ann Arbor and Saginaw. Ann Arbor, we did reference that that had pharmacy tied to it—sorry, research tied to it. We wanted to make sure that we had that effectively addressed. Then for Saginaw, we still had additional work that had to be performed in terms of the site readiness.

Those decisions are collaborative decision. They are not made in a vacuum. We do involve the VISN and site leadership. VHA is involved and Office Of Information and Technology (OIT), and then obviously, the Deputy Secretary is informed and provides the final viewpoint and a vote on us to proceed. It is a collaborative process under governance.

Mr. ROSENDALE. This local decisionmaking process sounds like a lot like H.R. 592, the EHR Improvement Act, would require. Would you agree with that?

Ms. SOFOCLEOUS. Yes, sir, it does, in a sense. Yes, sir.

Mr. ROSENDALE. Okay. When you go through this analysis and this collaboration, are you deferring to the directors of those facilities to give them any type of veto power whatsoever?

Ms. SOFOCLEOUS. I think we allow them——

Mr. ROSENDALE. I mean, if they identify deficiencies, they identify areas that they just are not ready, are we going to defer to the people on the ground?

Ms. SOFOCLEOUS. We make informed decisions. I think the key part here is mitigations that we have in place, and that is a conversation that we would have. Like, hypothetically, we would have to talk about whether or not the mitigations are in place, the mitigations are effective, and also whether or not they are going to impact operations at the ground to make that decision. I think that is the approach we would take and what we have made previously in terms of whether or not the mitigations are the effective mitigations to allow the sites to continue to perform effectively.

Mr. ROSENDALE. Okay. Not to put words in your mouth, but it still sounds to me like what we have is a discussion, a collaboration. At the end of the day, the heavy hand of the Veterans Admin-

istration is going to make the decision about whether something is going to be implemented or not.

Ms. SOFOCLEOUS. Sir——

Mr. ROSENDALE. Thank you, I yield back, Madam Chair.

Ms. KIGGANS. Thank you, Mr. Rosendale. The chair now recognizes Ms. McCormick for 5 minutes.

Ms. CHERFILUS-MCCORMICK. Thank you. Ms. Love-Holmon, I realize that the VA feels that they do not need an undersecretary for management and that the Deputy Secretary has had this authority previously. Unfortunately, I think that we all know that proficiency in the business of government is not a prerequisite for the Deputy Secretary. I know that in your current position, you are performing some of the governance that we are looking for. I would like to hear from you the opportunity to answer these questions. The current governance structure for the management of the VA, what is your view on it? Two, what improvements would you recommend?

Ms. LOVE-HOLMON. Thank you very much for the opportunity to speak. I would first like to start off by just saying this is an organization that I am very proud to work for VA, and we have an amazing mission. Specifically with regard to the current structure, I have had the pleasure of being there from the ground up in creating the enterprise governance framework that we have now. We have the VA Operations Board that is chaired by the Deputy Secretary, who serves as our chief operating Officer. We have the VA Executive Board that is chaired by the Secretary of Veterans Affairs.

As we have put these two boards together, we were very thoughtful about who needs to participate in these boards. There is a mix of participants from the political staff, the career staff, participants from VA Central Office, as well as field leadership to ensure that we have representation from across the organization. Also, the chief executive officers participate as well, the chief acquisition officer, information officer, et cetera, to ensure that everyone has a seat at the table.

There are really three parts to these boards that I am very proud of, and we really did look also at the GAO report and try to understand the intent there and those comments and the criteria for what it looks like to create a good Chief Operating Officer (COO). The governance framework is around transparency, making sure that all folks that are going to be impacted by a decision are brought to the table. Going back to a previous comment, that means that if there is something that is happening about you, we are bringing you there to the table to have an opportunity to talk about it.

Also, about accountability in terms of making sure that we have accountable officials for the various projects or programs that are there at the table, but there is also accountability across the table, meaning even if you are not the chief for a particular program, what is my responsibility as the Acting Assistant Secretary in supporting this initiative? What is the Chief Information Officer's (CIO's) responsibility in supporting it, in supporting the various initiatives?

Last, we have also tried to be grounded in evidence-based and principle-based decisionmaking in terms of as decisions are coming

through governance, really understanding what is the data telling us about the decisions and the recommendations that are coming. Also, from a principles-based perspective, ensuring that we are really looking at is this the best decision for veterans and our employees as we are moving forward.

In terms of opportunities for improvement, I think I would agree with my colleagues and the comments that have been made with regard to our opportunity to put in more disciplined management framework, particularly around some of our program management. We have already begun that for several of our strategic initiatives, many of which are being discussed here today. We have bringing those projects through the governance framework where we are asking those hard questions. Sometimes the hard question is what is the problem we are trying to solve and making sure that everyone at the table understands what the problem is, understands what the plan is to move forward so that we are moving forward and creating strategy into action. Again, I think that is my response.

Ms. CHERFILUS-MCCORMICK. Thank you. My next question is for Ms. Christy—Mr. Christy. I know in your position you are under tremendous pressure to execute a giant acquisition program. I know you have had issues with resources. Would it be beneficial to have an advocate in upper management for the VA to champion your needs?

Mr. CHRISTY. We will always welcome advocates, no matter where we are and what we are doing. I think to have somebody above the chief acquisition officer, so at the VA, that is the political appointed person for the acquisition. If it is even higher than that, obviously that helps with, you know, being at the table and communicating those risks and where we can get help within acquisition programs. Absolutely would welcome that.

Now, back to the point of what Ms. Love-Holmon said, we do have governance, right? There are those avenues when there are concerns to bring those up. Those go to both the Deputy Secretary, and depending on what the issue is, it could go up to the executive board, which is chaired by the Secretary himself. I think we have those advocates through our governance process but would always welcome more voices at the table in support of acquisition.

Ms. CHERFILUS-MCCORMICK. Thank you so much. I just want to emphasize that as the Ranking Member of Technology and Modernization Subcommittee, I am interested in finding ways I can support the VA to modernize its IT program. I think Ranking Member Takano's bills are a great start to get us back on track in delivering better healthcare benefits to our veterans and supporting the VA. Madam Chair, I yield back.

Ms. KIGGANS. Thank you very much for your comments. Just to wrap up and close, I just had a couple of extra questions for really just for personal knowledge. Mr. Christy and maybe Dr. Sofocleous, when looking at how we are assessing our electronic charting implementation in the five facilities that have begun that process, specifically, we have an outside group, this IV&V, coming in to do some just overarching critique, I guess, of how that is going. How long do we expect that this IV&V to be in place for?

Ms. SOFOCLEOUS. You are talking about the new IV&V. I guess the new IV&V, based off of what was proposed, I would think we would want to have that in for long term for the program in order to be able to help assist with some of the program management and technical pieces of it. There are multiple components of that. I think, you know, Mr. Christy said we are already open into. It is probably not a one or done. I think we would be open to that.

Ms. KIGGANS. It is a long-term commitment?

Mr. CHRISTY. Yes, absolutely. I am sorry if I might have misunderstood. I was not sure, because there are some current IV&V efforts that are going on in the EHR program today. It is not as formalized as the bill talks about. If the question is geared toward the bill, yes. You will see in there, we are talking over the period of this and to follow the GAO recommendations, right? Risk-based, so there might be parts up front really heavy into many topics and areas. As you get to the back part of the acquisition of it, you might taper down on the risk of that. I would see IV&V going through the total lifecycle of an acquisition.

Ms. KIGGANS. I know it is a huge expense.

Mr. CHRISTY. Yes.

Ms. KIGGANS. I am wondering what other resources are out there for us to maybe do the same job. Does, for example, does Cerner Oracle now do they play any role in this transition process? Just as a nurse practitioner thinking through when we have gone to electronic charting systems, transition to that on a much smaller scale than what the VA is trying to do, we had the team come in from, you know, the company who owned the program. They sat there in a trailer next to the facility and they made sure every patient was, their records got transferred, that their current notes were getting transferred, that all the test results, and whatnot were getting transferred. What role is Cerner Oracle playing in this whole process?

Mr. CHRISTY. Yes, so, I think Dr. Sofocleous will answer this in a second, but I just want to quickly add, you know, we are in current negotiations with the Oracle Cerner team. A lot of these new standards are being negotiated. In a public hearing, we can not disclose them. I think we can get you that information.

It is to the point you are asking it is like, hey, what is their involvement, and what are the standards, and how is that being wrapped back into the program office? You just do not get us to do all the work. You own the contract, deliver the results——

Ms. KIGGANS. Right.

Mr. CHRISTY [continuing]. that are expected of you——

Ms. KIGGANS. Right.

Mr. CHRISTY [continuing]. in that contract. Those things are ongoing, but I am going to have Les pile on to what I am saying here.

Ms. SOFOCLEOUS. Ma'am, I think, you know, we have talked about like change management, some of the areas you were talking about change management, training, adoption issues, and we are talking about from the technical standpoint, which we do have IV&V already for testing. Obviously, Oracle Cerner is involved in that. I think if we are talking about independent, then obviously we want to take their input and then have a separate validation to ensure what they are providing is a service that we are paying

for, it is effective, and it is of use to the sites and to VA. There are two components of that, I would say.

Ms. KIGGANS. I do not want too many cooks in the kitchen, you know. Sometimes we get so convoluted, like how many people and the most important people we need to be talking to are the providers, right? The people that are the end users of this program. Those are the people who have the responsibility to make sure that continuity of care piece and patient safety, all of those really big issues are the ones that we hear about in our offices, we want to make sure that end product is accomplished. Making sure the providers, the healthcare provider, the physicians, the nurses, those guys who are already busy and already hard to get in a room, and to say, we are going to have an hour meeting about how you feel about this electronic charting. Those should be the loudest voices at that table. I do not want all of us to get not only does it cost a lot of money to have all these outside groups looking at that, but just, you know, tightening that up and making sure we can make the best product possible for the end user, I think, is where I would like to see just to pass my priority along.

Thank you. I know it is a work in progress and I am finished with my questioning. Ranking member Mrvan, do you have one?

Mr. MRVAN. Just 5 minutes, yes.

Ms. KIGGANS. Yes, go ahead.

Mr. MRVAN. For Mr. Christy, I am going to follow on that. What is the timeline do you believe for the negotiations to be complete and what are the outcomes that you are looking for from those negotiations?

Mr. CHRISTY. Right, and I will ask Les to assist me again. There is an option period that comes to May 16 that we have to get past those negotiations so we can move forward to the next options. For the initial, it was a 5-year period. We are coming up on that 5-year period, May 16, and we are negotiating the next 5 years currently. I will turn it over to Les a little bit more about the details of the outcomes of that.

Ms. SOFOCLEOUS. Yes, sir. We are in negotiations. As Mr. Christy said, May 16 is the period. I think we had some productive negotiation conversations. Obviously, we are focusing on some of the areas we have talked about. Obviously, system performance is one of the big issues. Our ability to hold Oracle Center accountable, which we tend to continue to enforce in our negotiations. We do have backup strategies in place and we will be more than happy to provide updates as we move forward with the negotiations.

Mr. MRVAN. Okay. I guess why I bring that up is because the disconnect between the pharmacy and the different type of results that we were talking about in past meetings, just making sure that those errors are being fixed. You are to kind of focus on what the chairwoman was saying, making sure that the providers are included and have a seat at the table is so vitally important. That is why I followed up with that question and just wanted to make sure I understand you do not want to negotiate here at the table, and so, your answer. The outcomes, making sure that the providers have a seat at the table seem to be one of the priorities through the past meetings, along with accountability. I thank you very much.

Ms. KIGGANS. Thank you, ranking member. Thank you to all of our witnesses for being here today. 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 objections, so ordered. This hearing is now adjourned. Thank you.

[Whereupon, at 10:28 a.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF WITNESSES

Prepared Statement of Phillip Christy

Chairwoman Kiggans, Ranking Member Mrvan and other Members of the Subcommittee: thank you for inviting us here today to present our views on several bills that would affect VA programs and services. Joining me today is Dr. Leslie Sofocleous, Executive Director, Electronic Health Record Modernization (EHRM) Integration Office's (IO) Program Management Office (PMO), Ms. Shana Love-Holmon, Acting Assistant Secretary, Office of Enterprise Integration (OEI), and Catherine Cravens, Chief of Staff, Office of Information and Technology.

H.R. 592 – Electronic Health Record Modernization Improvement Act

Section 2(a) of the bill would prohibit the Secretary of Veterans Affairs from commencing a program activity at a Veterans Health Administration (VHA) facility where such activity is not being carried out as of the date of enactment until the Secretary of VA submits to the House and Senate Committees on Veterans' Affairs written certification that the electronic health record (EHR) system has met each of the following improvement objectives prior to implementation: (A) a monthly uptime for the electronic health record system of 99.9 percent for 4 sequential months, and (B) the completion of all improvements or modifications of the EHR system required to be completed pursuant to a contract, task order, modification or other similar instrument, entered into before the date of the enactment of this Act.

VA does not fully support section 2(a) of this bill. Specifically, VA does not support the prohibition of commencing program activities until the completion of section 2(a), which would pause program activities and cause significant cost impacts. However, adjustment to the "program activities" definitions outlined in section 2(c) would address this issue by allowing certain activities that support early pre-deployment to start, while limiting the commencement of full deployment.

VA suggests the following:

- Modification: Update section 2(a)(1) to read: "(1) Prohibition.—The Secretary of Veterans Affairs may not **deploy the electronic health record system** at a facility of the Veterans Health Administration until the date on which the Secretary of Veterans Affairs..."

VA supports section 2(a)(2)(A) of this bill, in part. Improving system reliability and availability remains a VA focus. Corrective actions within the Cerner data base configuration have resulted in more than 6 months of system uptime above 99.9 percent without a complete outage. As written in section 2(a)(2)(A), if the 99.9 percent metric dropped the month prior to deployment then VA would not have the 4 sequential months prior to deployment.

VA suggests the following:

- Modification: Update section 2(a)(2)(A) to read: "(A) monthly uptime for the electronic health record system of 99.9 percent for four sequential months **or documented risk mitigation and certification for deployment under 99.9 percent**.

VA does not support section 2(a)(2)(B) of this bill. The Electronic Health Record Modernization Integration Office (EHRM-IO), VHA and Office of Information Technology have worked collaboratively to assess and remediate a subset of identified system challenges and continue work to expediently resolve all identified and validated issues.

There are many improvements and proposed modifications that are already on task orders. These are all in flight, with varying dates of completion – some of which extend beyond 2023. Many of these improvements are important, but not essential, for a future go-live. To require all system modifications to be completed in their entirety before allowing resumption of any program activities would introduce significant delay. Additionally, given the complexity of heath care and potential policy

changes it is anticipated that ongoing additional changes will be required. While all system modifications may not be completed prior to deployment, mitigations should be in place.

VA suggests the following:

- Modification: Update section 2(a)(2)(B) to read: "The completion of improvements or modifications of the electronic health record system **as agreed upon by the VA Deputy Secretary, VA Under Secretary for Health, EHRM-IO and VISN leadership**."

Section 2(b) would require the VHA facility director, the facility chief of staff, and the director of the VISN in which such facility is located to each submit written certification that: (1) the build and configuration of the EHR system, as proposed to be carried out at such facility, are accurate and complete; (2) the staff and infrastructure of such facility are adequately prepared to receive such system; and (3) the implementation of such system will not have significant, sustained adverse effects on patient safety, patient wait-times for medical care, or health care quality at such facility.

VA supports section 2(b) of this bill, with amendments. VA uses a consistent process for each deployment of the EHR system to approve the decision to go-live. Infrastructure readiness is assessed through the current State review (CSR) process and addressed before deployment operations begin. Deployment kickoff starts 13 months prior to go-live, and there are weekly working deployment meetings with the facility, Change Leadership Team and change sponsor to walk through outstanding issues. Approximately 4–8 weeks before go-live, VHA, EHRM-IO, Veterans Integrated Service Network (VISN) and site leadership begin to meet weekly to review the readiness checklist and areas of concern. Last, a go/no-go decision meeting with VHA, EHRM-IO, the VISN and the facility is held no later than the week before go-live based on the elements of the readiness checklist, along with the people, process and technology elements of readiness for personnel at the site. The written certification outlined by the bill would support the existing concurrence process.

VA suggests the following:

- Modification: Update section 2(b)(1) to read: "(1) the build and configuration of the EHR system, as proposed to be carried out at such facility, are accurate and complete **based on the approved enterprise standard**."
- Modification: Update section 2(b)(3) to read: "(3) the implementation of such system will not have known significant, sustained adverse effects on patient safety, patient wait-times for medical care, or health care quality at such facility."

Section 2(c) includes definitions for EHR and program activity. VA supports this section with amendments.

- Modification: Update section 2(c)(2) to read: "(2) The term "program activity" means any local or national workshop and/or training activities under the Electronic Health Record Modernization Program before the certification of the electronic health record system."

H.R. 608 – Terminate VA's EHRM Program

Section 1(a) of the bill would require the Secretary of Veterans Affairs to terminate the Electronic Health Record Modernization (EHRM) program. VA opposes section 1(a) of this bill. Without a modern EHRM program, VA would not have an interoperable, longitudinal record with the Department of Defense and community care partners; therefore, VA could not provide the Veterans with an electronic health record (EHR) that tracks the first day of service delivery with DoD to through the transition to VA, thereby limiting care and services to the Veteran.

Modernizing the electronic health record (EHR) system is critical to providing the best care for Veterans and facilitates advancements in delivery of care in the following ways:

1. Increased access to new technologies both now and in the future.

2. Standardized workflows and systems across VA and to automate and integrate manual processes, resulting in efficiencies and better service and care to Veterans.

3. Standardized EHR system reducing training and delivers a more integrated and skilled workforce.

4. Facilities use of telehealth services to share clinical expertise across VA's expansive health care delivery network.

5. Improved scheduling and smarter clinical decision support, driven by a comprehensive view of a Veteran's medical history and service record.

6. Reduced sustainment costs of an enterprise EHR system.

If enacted, section 1(a) would have additional costs. VA may need to initiate "stop work" and/or termination activities depending on timing of enactment Claims resulting from government stop work and/or termination activities could vary by a wide range, are contract dependent, and would need to be evaluated on a case-by-case basis to determine the costs to the government.

Section 1(b) would require the Secretary to carry out the following activities within 180 days of enactment: (1) Abolish the Electronic Health Record Modernization Integration Office (EHRM-IO); (2) Transfer any activities or functions carried out under such office that are not terminated pursuant to this section to the Veterans Health Administration or the Office of Information and Technology of the Department of Veterans Affairs; (3) With respect to each facility of the Veterans Health Administration that uses the EHR system implemented pursuant to the EHRM Program, revert the facility to instead use the Veterans Health Information Systems and Technology Architecture (VistA) and the Computerized Patient Record System (CPRS) of the Department.

VA opposes section 1(b) of this bill. VA's existing EHR system, VistA, is almost 40 years old. In its current State, however, VistA is comprised of 130 distinct instances and cannot deliver the benefits of a modern, enterprise system or provide a seamless health record system from military service to Veteran status. Previous attempts to upgrade VistA have been unsuccessful; there is potential risk in repeated efforts.

Integration with DoD would not be as strong on separate platforms and there would be decreased access to innovations being driven by a commercial provider. Moreover, critical solutions that have been deployed to enhance interoperability between VA and DoD, such as the Joint Health Information Exchange (JHIE), are reliant on the joint platform and do not have a replacement. Previous solutions that enabled interoperability have been sunsetted. Significant resources and funding would be required to develop a replacement platform that could effectively and efficiently handle the clinical data exchange volumes and adheres to current and upcoming regulatory requirements. Connections with national health care organizations that enable health information exchange with community providers would also have to be reestablished.

Lastly, section 1(b) would have significant personnel impacts across the enterprise. EHRM-IO alone has approximately 300 Federal staff, in addition to contractors, nonpermanent staff and staff hired to VHA, OIT and EHRM in support of the EHRM program. The timeframe for this change in personnel is extremely narrow and will not afford VA the time needed to ensure personnel are appropriately relocated to positions elsewhere within the Department and would result in significant loss in institutional knowledge and subject matter expertise.

Given the breadth and complexity of the impacts of EHRM termination, VA does not have an estimate for section 1(b) of this bill. However, VA anticipates cost considerations to include (1) resources required to sustain the existing EHR solution at deployed sites; (2) additional costs for VA to execute a plan to revert back to VistA, which would not be feasible within the specified 180-day timeframe; and (3) significant additional costs and resourcing required to modernize VistA. Appropriations language would also need to be updated, since the EHRM program is funded as a separate appropriation.

H.R. 1659 – VA IT Modernization Improvement Act of 2023

This bill would direct the VA Chief Acquisition Officer (CAO) to contract for the independent verification and validation (IV&V) of certain modernization efforts of the Department within 90 days of enactment. It prescribes the characteristics and experience (linked to the Department of Defense Acquisition Program) required of entities eligible to compete and details the oversight functions to be accomplished under the IV&V contract.

The bill defines "covered programs" to include ongoing VA modernization efforts, e.g., EHRM, Supply Chain Modernization, Financial Management Business Transformation (FMBT), Human Resources (HR) Systems and Veterans Benefits Management Systems (VBMS) and excludes any entity currently performing or having performed on a contract for VA within the 5 years preceding issuance of the solicitation, including contracts or subcontract related to a covered program. The bill also institutes a new annual reporting requirement and directs the CFO to work with heads of department offices to ensure the amount of the IV&V contract awarded is paid proportionately from respective appropriations.

VA supports this bill if amended, and subject to the availability of appropriations. Section 2(a) of the bill directs VA's CAO not later than 90 days after the date of the enactment of this Act to enter into a contract with an eligible entity under subsection (b) to carry out the oversight functions described in subsection (c). VA strongly supports the importance of and need for IV&V for VA modernization programs. Although VA does not object to the direction given to the CAO, it may be more appropriate "*to direct the Secretary of Veterans Affairs*" given that "covered programs" defined in the bill, e.g., EHRM, FMBT, SC Modernization and H.R. Systems, have major IT components and impact across the enterprise.

The requirement in section 2(a) to, "enter into a contract within 90 days," is not sufficient time to conduct market research, identify qualified entities and award a contract. VA proposes the following for section 2(a): "*conduct market research to identify one or more eligible entities as described in subsection (b)*." Initiation of market research within 90 days is feasible; awarding a large and comprehensive IV&V contract or contracts within a 90-day timeframe is not realistic.

Alternatively, VA suggest the language and format of Public Law 114–286, The Faster Care for Veterans Act of 2016. Specifically,

2(a) CONTRACTS–

(1) AUTHORITY. –Not later than 120 days after the date of enactment of this Act, the Secretary of Veterans Affairs shall enter into a contract with an eligible entity under subsection (b) to carry out the oversight functions described in subsection (c).

(2) NOTICE OF COMPETITION.—Not later than 60 days after the date of the enactment of this Act, the Secretary shall issue a request for proposals for the contract described in paragraph (1). Such request shall be full and open to any eligible entity as described in subsection (b) and has the capacity detailed in subsection (c).

(3) SELECTION.—Not later than 120 days after the date of the enactment of the Act, the Secretary shall award a contract to one or more contractors pursuant to the request for proposals under paragraph (2).

Section 2(b) ELIGIBILITY. – describes the characteristics of an eligible entity.

VA supports section 2(b) of this bill, with amendments. VA notes the criteria in paragraph (1) coupled with the exclusion in paragraph (2) may severely limit the pool of eligible entities and potentially frustrate VA's ability to award a contract. Paragraph (2) as written, will likely exclude many vendors and could result in legal challenges. VA suggests replacing the proposed text with the following:

"(2) performed the work at a satisfactory or better level as indicated by the past performance information in the Contractor Performance Assessment Reporting System for any contract used to demonstrate eligibility under subsection (b)(1)."

Section 2(c) FUNCTIONS. – describes the oversight functions to be carried out by the contract awardee. Paragraph (3) of subsection 2(c) currently reads – (3) Conducting continuous oversight of the activities carried out under, and the system associated with each covered program, including oversight of the status, compliance, performance, and implementation of recommendations...

VA supports section 2(c) of this bill, with amendments. VA recommends revising paragraph (3) of subsection 2(c) to acknowledges the need for a VA adjudication process regarding the IV&V findings and recommendations. VA recommends revision as follows:

"Conducting periodic oversight of the activities carried out under, and the system associated with each covered program, including oversight of the status, compliance, performance, 'and adjudication' and implementation of recommendations..."

VA recommends amending subsection 2(c) (3) subparagraph (A) to read:

"(A) Program management, including *but not limited to*, management of the governance of the program...A comprehensive IV&V assessment would incorporate a broader range of assessment areas than stated in the proposed text.

Subparagraph (F) of subsection 2(c) (3) lists several items with respect to associated systems for evaluation. However, validation of the measurable benefit of the system (i.e., business impact, outcomes, value, return on investment...) is not listed. These measures of benefit would be a subset of the overall set of measures of effectiveness for the program.

VA recommends adding "vi" validation of measurable benefit of the system at the end of subparagraph (F) and following that a subparagraph (G) Change management approach. Change management and realization of program value must be tightly connected, i.e., the connection to the proposed value/impact/business-functional outcomes of the program. The revised paragraph (3) would appear as follows:

"(3) Conducting continuous oversight of the activities carried out under, and the systems associated with, each covered program, including oversight of the status, compliance, performance, and implementation of recommendations with respect to, for each covered program, the following:

(A) Management, including governance, costs, and implementation milestones and timelines.

(B) Contracts for implementation, including financial metrics and performance benchmarks for contractors.

(C) Effect on the functions, business operations, or clinical organizational structure of the health care system of the Department of Veterans Affairs.

(D) Supply chain risk management, controls, and compliance.

(E) Data management.

(F) With respect to such systems, the following:

(i) Technical architectural design, development, and stability of the systems.

(ii) System interoperability and integration with related information technology systems.

(iii) System testing.

(iv) Functional system training pro-vided to users.

(v) System adoption and use.

(vi) Measurable benefit of the system as measured by the program's approved base line Objective Key Results (OKR) and Key Performance Indicators (KPI), (i.e., business impact, outcomes, value, ROI"

(G) Change Management approach effectiveness"

VA believes these amendments, if adopted, would strengthen the bill consistent with congressional intent.

Subsection 2(e) AWARDED AMOUNTS.—Not later than 90 days after the date on which the Chief Acquisition Officer of the Department enters into the contract under subsection (a), the Chief Financial Officer of the Department, in coordination with the heads of such office of the Department responsible for the management of a covered program, shall ensure that amounts awarded to an eligible entity under such contract are derived, in proportionate amounts, from amounts otherwise authorized to be appropriated for each such office of the Department, respectively. VA supports subsection 2 (2e) of this bill and has no objection to this provision.

Subsection 2(f) DEFINITIONS – list key terms and authorities that are referenced throughout the bill, e.g., "covered program." The bill identifies the Electronic Health Record Modernization Program (EHRM), the Financial Management and Business Transformation Program (FBMT), the Veterans Benefits Management system (VBMS), any program related to supply chain modernization, and any program related to the modernization of information technology systems associated with human resources as the "covered programs".

VA offers for consideration that the scope of this undertaking is likely going to create Organizational Conflicts of Interest (OCI) at a level which will dissuade many vendors. VA currently has IV&V contracts in place for EHRM and FMBT. It is unclear how enactment of this law would affect existing contracts. Ideally, VA would have an in-house team with the expertise to conduct IV&V of its major modernization efforts.

Contracting for those services as VA builds internal capacity makes practical sense and will help to expedite the resulting delivery of benefits and services to Veterans, their caregivers and family members. VA does not have cost estimates for this bill but anticipates an IV&V contract of this size would be extremely expensive. Appropriate and timely funding of this bill is critical.

H.R. 1658 Manage VA Act

H.R. 1658 would add 38 U.S.C. § 307A which would establish in the Department of Veterans Affairs (VA) an Under Secretary for Management (USM). The new subsection would establish a new USM to serve as the Chief Management Officer of the Department, reporting directly to the Deputy Secretary and as a principal advisor to the Secretary on matters related to the management of the Department, in-

cluding management integration and transformation in support of Veterans operations and programs. The USM responsibilities would include budget and finance, procurement, human resources, information technology, management integration and transformation, development of transition and succession plans, certain GAO reporting, management of the Office of Enterprise Integration, and the supervision of the Director of Construction and Facilities.

VA does not support this bill. Integrating the Department's efforts and creating operational jointness in our support for Veterans, their families, caregivers and survivors is essential to Veterans choosing VA for care, benefits and services. VA appreciates that this bill generally seeks to address management, integration, and transformation issues within the Department, however, VA already has established and continues to mature its joint oversight and decisionmaking roles and processes, focused on the integrated customer journey it needs to work toward these outcomes. Together these are successfully driving the integration envisioned by this legislation without the need for a new position such as an Undersecretary for Management.

Oversight and Accountability. The VA Deputy Secretary serves as the Department's Chief Operating Officer, supported by a robust governance structure that ensures the Chief Executive Officer (CXO) roles (i.e., Chief Acquisition Officer, Chief Information Officer, Chief Financial Officer, Chief Human Capital Officer, and Chief Experience Officer) are brought together regularly for joint decisionmaking. The Deputy Secretary chairs the VA Operations Board, which serves as the most senior operations implementation management body for the Department providing oversight of the implementation and execution of the Secretary's strategic direction. Its purpose is to enable the Deputy Secretary to critically evaluate evidence-based, risk-informed recommendations about the operational implementation and execution of the Department's Strategic Plan and provide Department-level oversight and operational direction of key enterprise programs (e.g., Electronic Health Record Modernization (EHRM), Financial Management Business Transformation (FBMT), Supply Chain transformation), to support well integrated operational plans and impactful outcomes. Department of Veterans Affairs Operations Board (VAOB) membership includes all the CXO roles as well as the Administrations and other key VA leaders.

Robust Governance with Integrated Customer Focus. VA already has implemented robust governance to drive jointness and integration, as outlined in VA Notice 22–15 (September 15, 2022). The purpose of the VA Governance is to enable evidence-based, risk-informed decisionmaking that advances the mission of VA and enables VA to meet its promise to provide timely access to world-class health care and earned benefits and services to all Veterans.

Departmental governance includes the VA Executive Board chaired by the Secretary and the VA Operations Board chaired by the Deputy Secretary that ensure critical risks and opportunities are discussed by all leaders from across VA and result in well-integrated decisions that matter to Veterans. These two boards are supported by the Evidence Based Policy Council, which ensures policy options are developed jointly and founded on rigorous evidence, and the Investment Review Council, which ensures investment decisions reflect an enterprise-wide view of what will make the biggest impact for Veterans.

Likewise, VA has one of the most outstanding customer experience offices in the Federal Government, the Veterans Experience Office (VEO). Our Chief Experience Officer is a key partner within our enterprise governance framework, facilitating human centered design efforts that ensure the Veteran's journey through VA is seamless and that each policy and operational decision impacting one of VA's components naturally contributes to a well-integrated customer experience. The Assistant Secretary for Enterprise Integration serves as the VA accountable executive for enterprise management and governance in support of the Office of the Secretary. Serving as the Governance Executive Secretariat for these four principal Department-level Governance bodies.

VA does not have a cost estimate for this bill.

H.R. XXX – VA Supply Chain Management System Authorization Act

This bill would authorize the Secretary of Veterans Affairs to carry out an information technology (IT) system and prioritize certain requirements to manage supply chains for medical facilities of the Department of Veterans Affairs. Specifically, it would give VA discretion to procure an IT System to manage the supply chains for the Veterans Health Administration (VHA). It details the desirable functions and capabilities of such a system and lists specific items to be included or excluded. It requires the prioritization of inventory management capability and specifies, that should the Secretary choose to carry out such a system, it must first be piloted at

a VHA facility, and that full implementation be completed within three (3) years of enactment of this Act. The bill also provides for the system to apply across the enterprise, e.g., to the Veterans Benefits Administration (VBA) and the National Cemetery Administration (NCA) to the extent items VBA and NCA procure can be accommodated by VHA processes.

VA cites concerns with this bill. The reason for VA's concern is twofold. First, as written, the bill may impede ongoing efforts toward an enterprise supply chain solution. Second, the timeline does not accurately reflect the complexities involved in successful procurement and execution. As such, VA welcomes the opportunity to continue working with the Committee to provide additional technical assistance that will create the flexibility and scope of timing needed to ensure success of the mission.

VA began an enterprise-wide supply chain assessment in October 2021. Leveraging previous internal and external investigations, assessments and reports, VA mapped and validated all current supply chain processes including, facilities, High Tech medical equipment, IT, medical supplies, the National Cemetery Administration, pharmaceuticals, prosthetics, and the Veterans Benefits Administration. VA also completed a detailed gap analysis comparing the "as-is" State with the desired objective of an Easy to Use, Integrated and Intelligent Supply Chain system.

VA is far along in the process that will culminate in the identification and eventual selection of an IT system or systems that will provide a modernized enterprise-wide solution for the supply chain and logistics management. VA has engaged with industry on multiple occasions for feedback and to gain a better perspective on what best practices can be leveraged in our efforts to modernize. We recognize that the most critical aspect of this endeavor is to ensure the continued and consistent delivery of high-quality health care products and services for our providers, Veterans, Caregivers, and their families. VA is committed to an approach focused on lessons learned, end-user input and phased implementation.

Although VA expected to solicit proposals and complete evaluations in January 2023, that timeline has shifted to the right as we learn more from internal and industry feedback. VA continues to socialize the anticipated organizational and staff changes needed to properly execute the mission. This methodical approach enables VA to better understand the issues to be solved, effect change management, and refine and revise our requirements before determining which potential technical solutions will be needed.

VA is nearing completion of the acquisition strategy for the enterprise supply chain modernization effort which will enable VA to develop an Independent Lifecycle Cost Estimate for the overall enterprise supply chain modernization effort. Currently, VA is preparing to issue a Request for Proposals and expects to issue the solicitation by late April or early May. VA does not currently have a cost estimate for this bill.

Conclusion

This concludes my statement. We would be happy to answer any questions you or other members of the Subcommittee may have.

Prepared Statement of Shelby Oakley

United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, House of Representatives

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VETERANS AFFAIRS

Observations for Proposed Legislation

Statement of Shelby S. Oakley, Director,
Contracting and National Security Acquisitions

GAO-23-106765

GAO Highlights

Highlights of GAO-23-106765, a testimony before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives.

Why GAO Did This Study

The House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations is considering five bills related to improving VA management and key modernization programs, such as the EHRM program. GAO's High-Risk List includes (1) managing risks and improving VA health care—added in 2015, and (2) VA acquisition management—added in 2019. Among other reasons, GAO added these areas to the list due to information technology, policy, and leadership challenges.

Since GAO added these issues to the list, VA has made important progress in addressing them such as by developing corrective action plans to document its approach and implementing GAO recommendations. However, VA continues to face numerous challenges that show that there is much work that remains ahead to drive significant transformation within the department.

This statement highlights findings from prior GAO work that the Subcommittee may find useful as it considers potential legislation. To do this work, GAO reviewed five pieces of proposed legislation that the Subcommittee is considering. GAO identified relevant prior work on current or recent VA modernization efforts, as well as on leading practices and strategies related to relevant topics. Prior GAO reports include GAO-08-34, GAO-11-581, and GAO-16-438. Detailed information on the objectives, scope, and methodology for that work can be found in the issued reports.

View GAO-23-106765. For more information, contact Shelby S. Oakley at (202) 512-4841 or oakleys@gao.gov.

April 19, 2023

VETERANS AFFAIRS

Observations for Proposed Legislation

What GAO Found

The Department of Veterans Affairs (VA) provides health care and benefits to about 9.2 million veterans through a number of major programs. Over the last 10 years, VA contract obligations climbed 147 percent, to more than $56 billion in fiscal year 2022—second only to the Department of Defense. This increase in VA contract obligations has been driven in part by programs directly connected to serving veterans, such as those related to community care, electronic health records, and medical supply chain.

Department of Veterans Affairs Medical Center, Washington, D.C.

Source: GAO photo. | GAO-23-106765

GAO's prior work could inform Congress as it seeks to help VA address management challenges and improve key modernization efforts. For example:

Leadership and management. One proposed bill would establish a VA Under Secretary of Management position—who would also serve as the Chief Management Officer—to oversee VA's management integration and transformation efforts. GAO-08-34 identified key strategies for implementing these positions in federal agencies.

Contracting to inform program oversight. Another bill would direct VA to enter into a contract for independent verification and validation (IV&V) of certain modernization efforts. IV&V can reduce risk by having a knowledgeable, independent party determine that a system meets users' needs and fulfills its intended purpose. GAO-11-581 includes key elements for effective IV&V plans.

Electronic health record modernization (EHRM). Two bills present different options for the future of EHRM—VA's effort to replace its aging electronic health records system. GAO and VA's Office of the Inspector General have made numerous recommendations to improve EHRM over the years. GAO testified in March 2023 that its rollout at VA medical centers continues to be challenging.

VA supply chain. Another bill would direct VA to acquire a supply chain management system within 3 years, and require the system to be piloted prior to VA-wide use. GAO-16-438 found that a well-developed pilot program can help ensure agencies make informed decisions.

Chairwoman Kiggans, Ranking Member Mrvan, and Members of the Subcommittee:

I am pleased to be here today to assist the Subcommittee in its consideration of legislative proposals to improve Department of Veterans Affairs' (VA) management and key modernization programs.

VA's acquisition function is large, and essential to its mission. VA is not typically the first agency that comes to mind when considering major acquisitions, but VA's contract obligations for goods and services have increased significantly. Over the last 10 years, VA contract obligations climbed 147 percent to more than $56 billion in fiscal year 2022—the second-largest in the federal government, second only to the Department of Defense. The recent increase in VA contract obligations has been driven in part by programs that are directly connected to serving veterans, such as community care, electronic health records, and medical supply chain.

As obligations have grown in the last decade, we have added VA health care and acquisition management to GAO's High-Risk List, alongside VA's disability compensation program, which has been on the High-Risk List since 2003.[1] We, along with VA's Inspector General, continue to identify significant deficiencies in VA's leadership oversight and operations—all of which can affect health care and benefit programs for the nation's veterans.[2] We added VA health care to the list in 2015 due to challenges we documented over time related to VA's management and oversight of its health care system, which serves about 9.2 million veterans as of 2022. We identified five specific areas of concern related to VA health care, including inadequate oversight and accountability, ambiguous policies and inconsistent processes, as well as information technology challenges.

Similarly, we added VA acquisition management to our High-Risk List in 2019 due to numerous issues we identified in our body of work since 2015, including a lack of reliable data, challenges managing its acquisition workforce, leadership instability, and inadequate strategies and policies. Since that time, VA has developed a corrective action plan

[1]GAO, *High-Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas*, GAO-21-119SP (Washington, D.C.: Mar. 2, 2021).

[2]GAO, *Veterans Affairs: Addressing Longstanding Management Challenges Requires Sustained Leadership*, GAO-23-106636 (Washington, D.C.: Feb. 28, 2023).

to address these issues, and has implemented 38 of the 60 recommendations we have made in this area. These steps represent important progress, but the challenges VA continues to face in a number of its key acquisition programs show that there is much work to do to address the agency's fundamental acquisition management challenges. It is clear from the several pieces of proposed legislation on the agenda at today's hearing that there is concern that change is needed to put VA on the right track for transformation. As our High-Risk designations for VA indicate, we agree.

In this statement, I will highlight findings from prior GAO work that the Subcommittee may find useful as it considers potential legislation related to (1) VA leadership and management, (2) contracting to inform program oversight, (3) the Electronic Health Record Modernization (EHRM) program, and (4) VA supply chain efforts.

To do this work, we reviewed the five pieces of proposed legislation that the Subcommittee provided to us, including H.R. 1658, Manage VA Act; H.R. 1659, *Department of Veterans Affairs IT Modernization Improvement Act*; H.R. 592, *Department of Veterans Affairs Electronic Health Record Modernization Improvement Act*; H.R. 608, *To terminate the Electronic Health Record Modernization Program of the Department of Veterans Affairs*; and a draft bill, *VA Supply Chain Management System Authorization Act*. We then identified relevant work that we published on current or recent VA modernization efforts, leading practices related to independent verification and validation (IV&V)[3], establishing Chief Management Officer (CMO) positions, designing effective pilot programs, and other related topics. Prior GAO work used to develop this statement is noted throughout the text. Detailed information on our objectives, scope, and methodology for that work can be found in the issued reports.

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

[3]IV&V is a process whereby organizations can reduce the risks inherent in system development and acquisition efforts by having a knowledgeable party who is independent of the developer determine that the system or product meets the users' needs and fulfills its intended purpose. IV&V involves proactively determining early in a program's life cycle what its risks are likely to be and then identifying those that could be mitigated or lessened by performing additional reviews and quality assessments.

provides a reasonable basis for our findings and conclusions based on our audit objectives.

Leadership and Management

H.R. 1658, *Manage VA Act*, would establish a VA Under Secretary of Management position—who would also serve as the CMO. The Act also identifies the position's responsibilities, which would include serving as the principal advisor to the Secretary of Veterans Affairs on matters related to management integration and transformation. GAO has recommended this type of position in other agencies to provide sustained focus on transformation efforts.

In related work, we identified six key strategies for agencies that can be useful when implementing CMO or Chief Operating Officer (COO) positions in federal agencies:[4]

1. Define the specific roles and responsibilities of the CMO/COO position.
2. Ensure that the CMO/COO has a high level of authority and clearly delineated reporting relationships.
3. Foster good executive-level working relationships for maximum effectiveness.
4. Establish integration and transformation structures and processes in addition to the CMO/COO position.
5. Promote individual accountability and performance through specific job qualifications and effective performance management.
6. Provide for continuity of leadership in the CMO/COO position.

These would be key factors for Congress and VA to consider in any effort to implement a CMO position through legislation and agency policy. The proposed legislation includes elements of some of these key strategies, including defining the role of the CMO position, establishing high-level authority, and providing a mechanism for continuity of leadership. Additional consideration—in legislation or as part of VA's implementation of a CMO position—would be necessary to fully satisfy these key strategies. For example, VA would need to clearly identify how the CMO would exercise its authorities and delineate its responsibilities as they

[4]GAO, *Organizational Transformation: Implementing Chief Operating Officer/Chief Management Officer Positions in Federal Agencies*, GAO-08-34 (Washington, D.C.: Nov. 1, 2007).

relate to those of other senior officials who currently oversee department information technology, acquisitions, and finances.

Other prior GAO reporting on similar senior management positions at other federal agencies could also be instructive to this Subcommittee and VA as the proposal in H.R. 1658 is considered. For example, the Department of Homeland Security's (DHS) Under Secretary for Management is the acquisition decision authority for the department's largest acquisition programs and has, over the years, established policies, roles, and responsibilities for decision makers in the acquisition management, resource allocation, and requirements processes.[5] The Under Secretary has also established cross-functional teams to support those decision makers. Specifically, to fulfill the role of acquisition decision authority, the Under Secretary of Management is supported by the Acquisition Review Board, which consists of key DHS senior leaders responsible for managing the department's finances, contracts, and testing, among other things.

Establishing a CMO position is not a solution on its own—it must be accompanied by other supporting organizational changes. Efforts to establish a CMO at the Department of Defense (DOD) provide a cautionary example. In 2005, we identified the need for a CMO position with significant authority and experience to provide focused and sustained leadership over efforts to improve DOD's business operations.[6] Congress and DOD took steps in successive years to establish this position with responsibilities that included managing DOD's enterprise business operations and shared services, as well as business systems or management that are overseen by the DOD Chief Information Officer.[7] In 2019, we found that, while DOD tried to establish and then restructure the

[5]GAO, *Homeland Security Acquisitions: Leveraging Programs' Results Could Further DHS's Progress to Improve Portfolio Management*, GAO-18-339SP (Washington, D.C.: May 17, 2018); *Homeland Security Acquisitions: Joint Requirements Council's Initial Approach Is Generally Sound and It Is Developing a Process to Inform Investment Priorities*, GAO-17-171 (Washington, D.C.: Oct. 24, 2016).

[6]GAO, *Defense Business Transformation: Achieving Success Requires a Chief Management Officer to Provide Focus and Sustained Leadership*, GAO-07-1072 (Washington, D.C.: Sept. 5, 2007); *High-Risk Series: An Update*, GAO-05-207 (Washington, D.C.: Jan. 1, 2005).

[7]The Department of Defense, Deputy Chief Management Officer, was established in 10 U.S.C. § 132a, but was subsequently disestablished when the section was repealed by the *William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021*, Pub. L. No. 116-283, § 901(b) (2021).

Office of the CMO, it had yet to fully address issues, such as how the CMO would exercise authorities and responsibilities over the military departments and determine which responsibilities, if any, would transfer from the Chief Information Officer to the CMO.[8] We also reported that DOD did not commit funding to many of the cross-functional teams that were charged with leading reform initiatives, hindering their ability to achieve their goals and support the CMO's efforts.[9] In 2021, DOD disestablished the CMO position after Congress repealed the underlying statutory requirement.[10]

Our work has shown that leadership challenges, including instability in key positions and a lack of accountability for decisions and oversight, are at the root of why VA is on GAO's High-Risk List. For example, leadership instability was one of the factors that led us to add VA acquisition management to our High-Risk List in 2019. Since then, VA has taken important steps to address this issue.[11] In particular, the Secretary of Veterans Affairs appointed a permanent Chief Acquisition Officer in August 2018, as we had recommended in November 2017. Likewise, the current Senior Procurement Executive—the Chief Acquisition Officer's top deputy—has been in that role since 2018. Despite filling these positions, we found in 2022 that almost none of VA's most costly and mission-critical acquisition programs followed a VA policy guiding major acquisitions.[12] VA itself identified a lack of accountability for key decision makers, including authorities and other senior officials as a cause of this lack of policy compliance. In one example, the Chief Acquisition Officer—serving as the program decision authority for a supply chain modernization program—did not ensure the program complied with major acquisition policy.

The proposed CMO position would be responsible for aspects of VA human capital, information technology, and financial management—in

[8]GAO, *Defense Business Operations: DOD Should Take Steps to Fully Institutionalize the Chief Management Officer Position*, GAO-19-199 (Washington, D.C.: Mar. 14, 2019).

[9]GAO, *Defense Management: DOD Needs to Implement Statutory Requirements and Identify Resources for Its Cross-Functional Reform Teams*, GAO-19-165 (Washington, D.C.: Jan. 17, 2019).

[10]Pub. L. No. 116-283, §901(b) (2021).

[11]GAO-21-119SP.

[12]GAO-22-105195.

addition to acquisition management. However, these examples from our prior work illustrate potential challenges that efforts to establish a VA CMO may face and that Congress should consider as a part of any legislative direction to VA.

Contracting to Inform Program Oversight

H.R. 1659, *Department of Veterans Affairs IT Modernization Improvement Act*, directs VA's Chief Acquisition Officer to enter into a contract for IV&V for certain modernization efforts.[13] IV&V can help organizations reduce the risks inherent in system development and acquisition efforts by having a knowledgeable party, who is independent of the developer determine that the system or product meets the users' needs and fulfills its intended purpose. We have previously identified IV&V as a leading practice for large and complex system development and acquisition programs. Our work has shown that IV&V can provide agencies with information to better manage their IT investments.[14]

We have previously assessed how VA has used IV&V to provide additional information to department leaders about the readiness of key technology systems, including VA's Patient Self-Scheduling System.[15] IV&V includes attributes that are comparable to the independent operational assessment that we recently recommended for the EHRM program.[16] In March 2023, we recommended that the Secretary of Veterans Affairs reinstitute plans to conduct an independent operational assessment to evaluate the suitability and effectiveness of the new electronic health record system for users in the operational

[13]The bill would require the following current or future VA efforts to use IV&V: (1) EHRM or any successor program, (2) Financial Management Business Transformation or any successor program, (3) any supply chain modernization program, (4) any human resources IT modernization program, and (5) any Veterans Benefits Management System program.

[14]GAO, *Information Technology: Actions Needed to Fully Establish Program Management Capability for VA's Financial and Logistics Initiative*, GAO-10-40 (Washington, D.C.: Oct. 26, 2009).

[15]GAO, *VA Health Care: Independent Verification and Validation of Patient Self-Scheduling Systems Was Consistent with the Faster Care for Veterans Act of 2016*, GAO-18-442R (Washington, D.C.: June 13, 2018).

[16]GAO, *Electronic Health Record Modernization: VA Needs to Address Change Management Challenges, User Satisfaction, and System Issues*, GAO-23-106685 (Washington, D.C.: Mar. 15, 2023).

environment.[17] We found that VA's EHRM program will be limited in its ability to validate that the system is operationally suitable and effective, and to identify, track, and resolve key operational issues until an independent operational assessment of the new information system is conducted. An operational assessment, particularly if conducted by an independent entity, would enable the department to systematically catalog, report, and track resolution of assessment findings with greater rigor, transparency, and accountability.

Effective IV&V plans should reflect the five key elements that we previously identified based on leading practices across industry and the federal government:[18]

1. **Decision criteria.** Risk-based criteria should be used to determine which programs or aspects of programs should be subject to review. The determination to conduct IV&V and its extent should be made on the basis of the relative mission criticality of the program and its components, as well as on the potential impacts of to the program from undetected system errors, immaturity of the technology to be used, and unreliability of program schedule and cost estimates, among other program risks.
2. **Standards for independence.** Organizations should also include standards that describe the degree of technical, managerial, and financial independence for those performing IV&V.
3. **Defined scope of the effort.** The effort should document which program development or acquisition activities will be subject to IV&V as well as establish compliance criteria to assess each activity.
4. **Required program resources.** Plans should identify the required personnel, funding, facilities, tools, and methods that will be required to perform the activities necessary for the defined scope of the IV&V.
5. **Management and oversight.** Organizations should conduct proper management and oversight of their IV&V efforts and provide the means for senior management to obtain timely information regarding the progress of their IV&V investments in terms of cost, capability, timeliness, and quality.

[17]These recommendations were conveyed in a March 10, 2023 GAO briefing to Congressional committees and members and will be published in a forthcoming report.

[18]GAO, *Information Technology: DHS Needs to Improve Its Independent Acquisition Reviews*, GAO-11-581 (Washington, D.C.: July 28, 2011).

The proposed legislation contains elements that generally align with these key elements. For instance, the bill identifies programs subject to IV&V and a mechanism to fund this work. Congress may want to consider whether to include all of these elements in its legislation, including identifying additional VA programs that might benefit from IV&V and allowing for VA to tailor the scope of such activities using risk-based criteria.

Conducting IV&V alone does not produce better program outcomes. However, federal decision-makers can bolster their ability to make more informed programmatic decisions at critical junctures by developing and executing IV&V plans that reflect these key elements.

EHRM Program

H.R. 592, *Department of Veterans Affairs Electronic Health Record Modernization Improvement* Act, and H.R. 608, *To terminate the Electronic Health Record Modernization Program of the Department of Veterans Affairs*, present different options for the future of the EHRM program. The former directs VA to pause the expansion of the effort to additional VA facilities until it meets certain performance and preparation milestones, while the latter terminates the program. Both pieces of legislation reflect concern with VA's management of the program and the performance of the system to date.

In 2017, VA started the EHRM program—its fourth attempt in 20 years to replace its aging health information system. VA's current 30-year old system is technically complex, costly to maintain, and does not fully support the need to exchange health data with other organizations, such as DOD. VA has reported obligating more than $9.4 billion for the EHRM program from fiscal year 2018 through the first quarter of fiscal year 2023. It expects to make significant continued investments for system implementation and sustainment. According to a 2022 life-cycle cost estimate, the program will cost about $49.8 billion over a projected 28-year period.

The rollout of the EHRM system has faced challenges, and users are dissatisfied. VA planned to deploy the new electronic health record system nationwide in phases over a 10 year span, concluding in 2028. However, following the deployment of EHRM at the initial operating site in October 2020, VA identified issues during the first 6 months of use, leading to a strategic review of the program. This review identified eight challenge areas for the program, as well as plans and progress toward

addressing those challenges.[19] GAO and VA's Office of Inspector General have continued to report on the EHRM program's challenges, including those related to migrating data, addressing user requests for assistance, and care coordination.[20] We testified in March 2023 that some of the challenges facing the EHRM program remain acute.[21] For instance, most EHRM users VA surveyed in 2021 and 2022 expressed dissatisfaction with the new system. About 6 percent of the electronic health record system users who responded to a VA survey agreed that the system enabled quality care, and about 4 percent of survey respondents agreed that the system made them as efficient as possible.

Additional steps are needed to ensure that VA avoids previous challenges during future EHRM site deployments, such as by ensuring the system is reliable, staff and infrastructure are prepared, and that the system aids—and does not hinder—VA's provision of care and service to veterans. Overall, successful implementation of the EHRM system across VA will require a level of program management, adaptability to change, and sustained system performance that the department and its contractor have yet to demonstrate. Whether Congress chooses to allow VA to continue with the current program or requires it to move in a different direction, VA should take steps to build upon past investments and lessons learned from the current effort. Applying a more disciplined management approach that takes into account recommendations GAO and the Inspector General have made to the program over the years can help VA meet its goals for this program.

[19]VA summarized the results of its strategic review in *the Electronic Health Record Comprehensive Lessons Learned* report. Department of Veterans Affairs, *Electronic Health Record Comprehensive Lessons Learned* (Washington, D.C.: July 2021). The eight challenge areas described in the report are improving the veteran experience, ensuring patient safety, providing extended training to the frontline employees, building confidence at VA sites, implementing organizational and program improvements, making governance effective, improving operational efficiencies, and centralizing data management for workers and veterans.

[20]GAO-23-106685; GAO, *Electronic Health Records: VA Needs to Address Data Management Challenges for New System*, GAO-22-103718 (Washington, D.C.: Feb. 1, 2022); Department of Veterans Affairs, Office of the Inspector General, *Care Coordination Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane* (Washington, D.C.: Mar. 17, 2022); and *Ticket Process Concerns and Underlying Factors Contributing to Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane,* (Washington, D.C.: Mar. 17, 2022).

[21] GAO-23-106685.

VA Supply Chain

The draft bill, VA Supply Chain Management System Authorization Act, would authorize the Secretary of Veterans Affairs to implement an information technology system to manage supply chains for VA medical facilities within 3 years. It would also require VA to pilot the system at one location prior to full deployment. This system would include functions such as management of inventory, receipt of items, storage, distribution, tracking, and capital assets, among others. In June 2022, VA released a pre-solicitation notice for a new enterprise supply chain modernization software platform intended to meet many of these same needs.

VA struggled during its most recent effort to update its antiquated supply chain management systems, recently abandoning the new platform it had been working to implement, Defense Medical Logistics Standard Support (DMLSS). DMLSS was to fully or partially replace many of VHA's supply chain management systems across VA medical centers by 2027, at an estimated cost of $2.2 billion. VA delayed its initial rollout of the DMLSS system from October 2019 to August 2020 due to challenges integrating it with VA's legacy financial system and other factors. The VA's Office of the Inspector General reported in November 2021 that DMLSS did not meet nearly half of all high-priority needs at the initial deployment site, among other deficiencies.[22]

A recurring theme from our findings has been that VA often puts action ahead of planning.[23] This draft bill would require VA to pilot this new supply chain platform's functions prior to wider deployment, which could help identify problems while they can still be fixed. Our prior work has shown that a well-developed and documented pilot program can help ensure that agency assessments produce information needed to make effective program and policy decisions.[24] To achieve an effective supply chain system pilot program, Congress may wish to consider taking steps

[22]Department of Veterans Affairs, Office of Inspector General, *DMLSS Supply Chain Management System Deployed with Operational Gaps That Risk National Delays*, (Washington, D.C.: Nov. 10, 2021).

[23]GAO, *VA Acquisition Management: Actions Needed to Improve Program Oversight and Acquisition Outcomes*, GAO-22-106220 (Washington, D.C.: Sept. 20, 2022); GAO-22-105195; *VA Acquisition Management: Comprehensive Supply Chain Management Strategy Key to Address Existing Challenges*, GAO-21-445T (Washington, D.C.: Mar. 24, 2021); *VA Acquisition Management: Actions Needed to Improve Management of Medical-Surgical Prime Vendor Program and Inform Future Decisions*, GAO-20-487 *(Washington, D.C.: Sept. 30, 2020).*

[24]GAO, *Data Act: Section 5 Pilot Design Issues Need to Be Addressed to Meet Goal of Reducing Recipient Reporting Burden*, GAO-16-438 (Washington, D.C.: Apr. 19, 2016).

to ensure VA's approach reflects our five leading practices for effective pilot design:

1. Establish well-defined, appropriate, clear, and measurable objectives.
2. Clearly articulate assessment methodology and data gathering strategy that addresses all components of the pilot program and includes key features of a sound plan.
3. Identify criteria or standards for identifying lessons about the pilot to inform decisions about scalability and whether, how, and when to integrate pilot activities into overall efforts.
4. Develop a detailed data-analysis plan to track the pilot program's implementation and performance and evaluate the final results of the project and draw conclusions on whether, how, and when to integrate pilot activities into overall efforts.
5. Ensure appropriate two-way stakeholder communication and input at all stages of the pilot project, including design, implementation, data gathering, and assessment.

In addition to an effective pilot, to ensure success, the decision making process leading up to the choice of a system must be sound. In March 2021, we reported that VA was pursuing several major supply chain initiatives that were highly interrelated and had overlapping timelines—potentially leading to cascading effects in the event of changes to initiatives or delays.[25] We recommended that VA develop a comprehensive supply chain strategy to address this complexity and create an implementation plan with key milestones. VA concurred with the recommendation and continues work to develop this strategy. This planned comprehensive supply chain management strategy should drive its acquisition of a new supply chain IT platform—not vice versa.

In conclusion, VA's current major acquisition efforts deserve sustained attention from senior VA officials and this Subcommittee, as they are essential to meeting VA's mission of serving veterans. Congress has provided significant resources to VA to execute the department-wide efforts, and in many cases, the capabilities that VA has expected—and needs—to deliver have been delayed or remain elusive. Your continued oversight will be essential to holding VA accountable and ensuring that it can deliver what it has promised our veterans. These are complex programs and there are no easy fixes. However, consistently applying the

[25] GAO-21-445T.

leading practices and strategies summarized here—developed across our long-standing body of work, and applicable to similar management challenges across the federal government—can help achieve better results for the department and for veterans.

Chairwoman Kiggans, Ranking Member Mrvan, and Members of the Subcommittee, this concludes my prepared statement. I would be happy to answer any questions that you may have.

GAO Contact and Staff Acknowledgements

If you or your staff have any questions about this testimony, please contact Shelby S. Oakley at (202) 512-4841 or OakleyS@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals making key contributions to this testimony include Teague Lyons (Assistant Director), Zachary Sivo (Analyst in Charge), Mark Bird, Laura Greifner, Tonya Humiston and Christine Pecora.

Related GAO Products

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STATEMENTS FOR THE RECORD

Prepared Statement of The American Legion

Chairwoman Kiggans, Ranking Member Mrvan, and distinguished members of the subcommittee, on behalf of National Commander Vincent J. "Jim" Troiola and more than 1.6 million dues-paying members of The American Legion, we thank you for the opportunity to comment on H.R. 592 – Department of Veterans Affairs Electronic Health Record Modernization Improvement Act.

The American Legion is directed by active Legionnaires who dedicate their time and resources to serve veterans and their families. As a resolution-based organization, our positions are guided by more than 104 years of advocacy and resolutions that originate at the grassroots level of our organization. Every time The American Legion testifies, we offer a direct voice from the veteran community to Congress.

H.R. 592 – Department of Veterans Affairs Electronic Health Record Modernization Improvement Act

To prohibit the Secretary of Veterans Affairs from carrying out certain activities under the Electronic Health Record Modernization Program until certification of system improvements and facility readiness.

In 2018, the Department of Veterans Affairs (VA) began its Electronic Health Record Modernization (EHRM) program to replace its current operating system, Veterans Health Information Systems and Technology Architecture (VistA), which originally dates to 1977.[1] The VA's new EHR system, Oracle Cerner Millennium, is intended to bring new capabilities to VA, such as a more efficient process for identifying potential health risks, scheduling features that would improve wait times, and a seamless experience across VA, Department of Defense (DOD), and civilian healthcare facilities and their departments.[2] The EHRM program aims to provide veterans with an easily updated health record that follows a veteran for life, from when the service member joins the military to their time in VA healthcare. The American Legion strongly supports these goals.[3]

The first deployment of Oracle Cerner Millennium began in 2020 at Mann-Grandstaff VA Medical Center in Spokane, Washington. It immediately faced problems with transferring medical records to the new system.[4] For example, it imported outdated emergency contact information and eliminated essential prescription histories. As detailed in two VA Office of Inspector General (OIG) reports, the rollout also had training and reporting issues, and caused multiple incidents where veterans were harmed.[5] On one occasion, the Oracle Cerner Millennium system shut

[1] Allen, Arthur. n.d. "A 40-Year 'Conspiracy' at the VA." The Agenda. Politico.com. https://www.politico.com/agenda/story/2017/03/vista-computer-history-va-conspiracy–000367/.Unless otherwise noted, all cited hyperlinks accessed March 28, 2023.

[2] Communication, IT Strategic. 2022. "What Veterans Need to Know about How VA's Health Record System Is Changing—VA EHR Modernization." Digital.va.gov. July 21, 2022. https://digital.va.gov/ehr-modernization/resources/fact-sheets/what-veterans-need-to-know-about-how-vas-health-record-system-is-changing/.

[3] "Resolution No. 83: Virtual Lifetime Electronic Record." 2016. https://archive.legion.org/node/329.; "Resolution No. 12: Implementation of the MISSION Act." 2022. https://archive.legion.org/node/14050.

[4] VA OIG Details Continued Deficiencies with VA's EHRM." n.d. www.meritalk.com. https://www.meritalk.com/articles/va-oig-details-continued-deficiencies-with-vas-ehrm/.

[5] Department of Veterans Affairs Office of Inspector General. "The New Electronic Health Record's Unknown Queue Caused Multiple Events of Patient Harm." 2022. va.gov https://www.va.gov/oig/pubs/VAOIG–22–01137–204.pdf.

down for over 4 hours at Mann-Grandstaff, causing medical center staff to rely on outdated paper records and leaving veterans at risk of medical error.[6]

After several more deployments, the system continued to experience installment and operational issues, eventually leading to VA's decision to put the rollout on hold. The most recent pause started in October 2022 and was indefinitely extended in April 2023. During this time, VA established an EHRM Sprint Project Team to identify the solutions necessary to move forward. [7] After reviewing more than 450 issues, the Sprint Project Team released a report focusing on 30 current critical issue areas in the EHRM implementation.

The critical issues identified include diagnostic echocardiogram orders being entered incorrectly, problems with home oxygen requisition, lost prosthetic orders, medication lists disappearing, and prescription delays and omissions. In these areas of care, patient safety must remain a top priority – where one mistake can kill or severely harm a veteran and their quality of life. In its current State, the Oracle Cerner Millennium system makes these levels of care vulnerable and potentially harm veterans in the future. Last month, on March 21, 2023, VA informed the Senate Veterans Affairs Committee that EHRM issues were linked to at least four veteran deaths and two additional instances of critical harm to veterans.[8]

It is important to note that the report is not intended to fix issues with the EHRM program but rather to identify and recommend solutions, leaving VA and Oracle Cerner to further develop and implement them. The American Legion recognizes this is a complex, time-consuming process, and fixes will take time and effort.

H.R. 592 would address some of the major problems facing the EHRM program rollout. The act implements reasonable recommendations and requires two main certifications from current facilities using the Oracle Cerner Millennium system before it is deployed to further facilities.[9]

The first such requirement is a monthly average uptime of 99.9 percent for facilities currently using the Oracle Cerner Millennium system, which is key for any system, especially one meant to care for veterans. The American Legion believes an average monthly uptime of 99.9 percent would allow the maximum ability for VA to deliver world-class care to our veterans.

The second requirement is that any new EHR system will not launch in a new facility unless the facility's director, chief of staff, and Veterans Integrated Services Network (VISN) director certify that the facility and its staff are prepared for system deployment and use. VISN and facility leadership are the most qualified to assess a facility's readiness. Furthermore, if leadership and staff are properly prepared and ready to receive the new system, the willingness to learn and operate the system will likely assist in a successful implementation. Together, these requirements are sensible safeguards moving forward to ensure the success of the EHRM program.

Through Resolution No. 83: *Virtual Lifetime Electronic Record*, The American Legion supports the implementation of an electronic health record and wants the EHRM program to succeed and serve veterans safely.[10] The VA and veteran service organizations, like The American Legion, work tirelessly to improve the lives of our Nation's veterans. H.R. 592 and the Oracle Cerner Millennium system will provide the capabilities to ensure that American veterans receive the world-class care they deserve.

The American Legion supports H.R. 592 as currently written.

Conclusion

Chairwoman Kiggans, Ranking Member Mrvan, and distinguished members of the subcommittee, The American Legion thanks you for your leadership on this matter and for allowing us the opportunity to share the position of our more than 1.6 million members. For additional information or questions regarding this testimony,

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[6] Krishan, Nihal. "VA Cerner Ehr System Goes down for over 4 Hours Due to Patient Data base Corruption Issue ." FedScoop, August 5, 2022. https://fedscoop.com/va-cerner-ehr-system-goes-down-for–3-hours-due-to-patient-data base-corruption-issue/.

[7] Department of Veterans Affairs Veterans Health Administration. "EHRM Sprint Report." 2023. veterans.senate.gov. https://www.veterans.senate.gov/services/files/5B5776E7–8765–4303–9B93-D2BCBF8D5A33.

[8] Rodriguez, Sarai. (2023, March 21). "VA Admits Oracle Cerner EHRM Issues Contributed to 4 Veteran Deaths." ehrintelligence.com. VA Admits Oracle Cerner EHRM Issues Contributed to 4 Veteran Deaths (ehrintelligence.com).

[9] Congress.gov. "Text—H.R. 592—118th Congress (2023–2024): Department of Veterans Affairs Electronic Health Record Modernization Improvement Act." February 16, 2023. https://www.Congress.gov/bill/118th-congress/house-bill/592/text's=1&r=28.

[10] The American Legion Resolution No. 83 (2016): Resolution No. 83: Virtual Lifetime Electronic Record : Digital Archive (legion.org).

please contact Legislative Associate, John Kamin, at The American Legion's Legislative Division at (202) 861–2700 or jkamin@legion.org.

Prepared Statement of Fleet Reserve Association

The FRA

"Heading to 1OO Years"

The Fleet Reserve Association (FRA) is the oldest and largest organization serving enlisted men and women in the active, reserve, and retired communities plus veterans of the Navy, Marine Corps, and Coast Guard. The Association is congressionally Chartered, recognized by the Department of Veterans Affairs (VA), and entrusted to serve all veterans who seek its help.

FRA started in 1924 and its name is derived from the Navy's program for personnel transferring to the Fleet Reserve after 20 or more years of active duty, but less than 30 years for retirement purposes. During the required period of service in the Fleet Reserve, assigned personnel earn retainer pay and are subject to recall by the Secretary of the Navy.

The Association testifies regularly before the House and Senate Veterans' Affairs Committees, and it is actively involved in the Veterans Affairs Voluntary Services (VAVS) program. A member of the National Headquarters' staff serves as FRA's National Veterans Service Officer (NVSO) and as a representative on the VAVS National Advisory Committee (NAC). FRA's VSOs oversee the Association's Veterans Service Officer program and represent veterans throughout the claims process and before the Board of Veteran's Appeals.

In 2016, FRA membership overwhelmingly approved the establishment of the Fleet Reserve Association Veterans Service Foundation (VSF). The main strategy for the VSF is to improve and grow the FRA Veterans Service Officers (VSO) program. The newly formed foundation has a 501(c) 3 tax exempt status and nearly 800 accredited service officers with FRA.

FRA became a member of the Veterans Day National Committee in 2007,joining 24 other nationally recognized VSOs on this important committee that coordinates National Veterans' Day ceremonies at Arlington National Cemetery. FRA will host the ceremony in their centennial year, 2024. The Association is a leading organization in The Military Coalition (TMC), a group of 35 nationally recognized military and veteran groups jointly representing the concerns of over five million members.

The Association's motto is "Loyalty, Protection, and Service."

Introduction

The FRA welcomes this and other numerous oversight hearings because the Association believes congressional oversight of the VA technology program is vital to ensuring improvements to the system. The VA healthcare structure is a hybrid system consisting of inpatient and outpatient care, telehealth, and community care. Ensuring that the VA is equipped to meet the unique needs of veterans requires the VA to fully leverage all components of the VA healthcare system and create a seamless and paperless transition from active-duty service to veterans status. The Electronic Health Record Modernization (EHRM) is an essential element in modernization of the VA healthcare system.

EHRM

"The VA uses the Veterans Health Information Systems and Technology Architecture (VistA), which includes the VA's Electronic Health Record (EHR) system to provide healthcare to patients. In June 2017 the agency initiated the EHRM program to replace VistA because it is technically complex, costly to maintain, and does not fully support the need to exchange health data with other organizations." [1] The VA has spent more than $9.42 billion on the EHRM program.

FRA appreciates the House Veterans Affairs Committee oversight hearings on the Electronic Health Record Modernization at the VA. The plan has been plagued with ongoing problems dating back to its initial launch at the VA Medical Center in Spokane, Washington. Serious issues related to patient safety, training, employee morale, and several other deployment problems still exist, though some progress has been made. Office of Inspector General (OIG) report revealing serious issues with

[1] GAO report –23–106685, March 15, 2023

the deployment of VA's new Electronic Health Record Modernization (EHRM) program.

The VA first launched its new electronic health record (EHR) system more than 25 months ago. The program was scheduled in July 2022 to expand to include the VA Medical Center in Boise, Idaho. The expansion was delayed from October 2022 until June 2023 when VA wanted to expand the software to new VA medical centers.

Oversight committees were told that the VA is using this pause to make system enhancements and to perform tests to ensure the system is stable, resilient, and provides the capability VA employees and veterans need to improve access and quality of care. Department of Veterans (VA) Secretary McDonough has extended the pause for implementing the Electronic Health Record Modernization (EHRM) program. There is growing concern on Capitol Hill about the long-term cost, safety, and reliability of the program. This new delay did not specify when implementation would resume. When the program started it was estimated that the cost would be $16 billion over 10 years. However, a more recent independent estimate predicts $33–36 billion over 13 years.

Nevertheless, progress has occurred since the VA joined with the DoD in a joint contract to modernize its EHR system in 2017. The huge $16 billion project raised lots of concerns with lawmakers after decades of attempts by both departments to develop a joint interoperable health record that never materialized.

The House and Senate passed the "Electronic Health Record Transparency Act" (H.R. 4591) to require the VA to submit to Congress quarterly reports that evaluate the performance of the EHR, and it was signed into law in June 2022. The FRA wants to ensure adequate funding for DoD and the VA health care resources delivering seamless, cost-effective, quality services to personnel wounded in combat and other veterans and their families. Some Members of Congress have expressed concern about the cost and length of time to fully implement this program. The cost and the long time for implementation notwithstanding, the FRA believes there is a tremendous opportunity with the two departments using the same Electronic Health Records.

Implementation Problems

The recent acquisition of the Cerner system by Oracle has come with a wide variety of challenges. The VA staff has experienced difficulties adjusting to the new system. The VA claims this is due to a lack of proper training. The new system created an "unknown queue," a problematic feature that has caused referral orders to effectively go missing at the VA. Additionally, an audit by the Office of Inspector General (OIG) claims that the VA lacked a reliable integrated master schedule consistent with scheduling standards, which increases the risk of missing milestones and delaying the delivery of a system to provide timely, quality care to veterans. Schedule delays that extend the program are also likely to result in about $1.95 billion in annual cost overruns and may determine the VA's other modernization efforts on supply chain and financial management system. The report claims that Cerner failed to deliver more than 11,000 orders for specialty care, lab work and other services—without alerting health care providers the orders had been lost. Those lost orders, resulted in delayed care and what a VA patient safety team classified as dozens of cases of "moderate harm" and one case of "major harm." It should be noted that the Department of Defense (DoD) waited for roughly 2 years after implementing the EHR at its first four sites, and the glitches DoD was focused on fixing (primarily with its networks) were smaller than what VA is trying to fix. As VA leadership has confirmed, they will not deploy the new EHR system at any facility until they are certain it is ready to deliver for veterans and VA providers. Based on recent assessments, the VA has determined that the new EHR is not yet ready for further deployment at this time.

Legislative Action

There have been two legislative proposals introduced in the House that pertain to the VA's EHRM program. FRA believes congressional oversight of VA technology is vital to ensuring improvements in the system. Legislation introduced in the House the "EHRM Improvement Act" (H.R. 592) to block further implementations of the system until the medical centers determine they are well– equipped to receive and use it, without hindering the delivery of care to veterans and hurting productivity. The HVAC Chairman and sponsor of the bill, Rep. Mike Bost (IL) believes that the Oracle Cerner system should not be implemented at any more VA sites until the VA Medical Centers leadership certifies that the medical center is ready.

Other legislation introduced "the EHRM Termination Act" (H.R. 608) which would end the project altogether if VA and Oracle Cerner are unable to make significant improvements. FRA supports H.R. 592 and has not taken a position on H.R. 608.

Conclusion

In closing, FRA wants to express its sincere appreciation for the opportunity to present its views on the EHRM program to this distinguished Subcommittee. The FRA believes there is a tremendous opportunity with the two departments using the same Electronic Health Records.