GO-LIVE MARCH 2020: THE STATUS OF EHRM READINESS

HEARING

BEFORE THE

SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION

OF THE

COMMITTEE ON VETERANS' AFFAIRS

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C O N T E N T S

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

The subcommittee met, pursuant to notice, at 1:36 p.m., in room 210, House Visitors Center, Hon. Susie Lee [chairwoman of the subcommittee] presiding.

Present: Representatives Takano, Cunningham, Schrier, Kilmer, Larson, Banks, Watkins, Rodgers.

OPENING STATEMENT OF SUSIE LEE, CHAIRWOMAN

Ms. LEE. Good afternoon. This hearing will come to order. Before we begin, I would like to ask for unanimous consent for members of the Washington delegation to participate in today's hearings, should they be able to attend, and, without objection, so ordered.

Today, the subcommittee continues its oversight of the Department of Veterans Affairs implementation of the Electronic Health Record Modernization (EHRM) program. We have reached a critical juncture in the implementation. We are now a little more than 4 months from the plan go live in Spokane, Washington, on March 28th, 2020.

Over the last 18 months, many activities have occurred in support of this effort. I commend the VA and thank you for being here for your approaching this as much more than an IT upgrade. It is an opportunity to modernize the way the VA provides healthcare to veterans and has the potential to improve healthcare outcomes throughout our Nation.

However, many questions remain about VA's readiness to operate the Cerner Millennium system in a clinical environment. The outstanding punch list of configuration, interface development, testing, and training does not fully express just how complex and necessary each of those elements are. If any of those items are not completed in a timely manner, it will be very difficult for the VA to bring the system online in a manner that does not compromise patient care.

In just a couple weeks, the VA will need to pass through a major milestone, the first of two integrated validation events or dry runs. These events will essentially allow the VA to assess how the new system works and if the VA is ready to go live.

I know that Cerner has been engaged in testing individual modules, but we need the entire integrated system to be tested so that

it can be used for training. We cannot make the same mistake that the Department of Defense (DOD) did in its Initial Operational Capability (IOC) where it tested on a mock-up system.

As I have said since I became chair of the subcommittee, the most important thing is that the VA get this right, not that it hits an arbitrary deadline. I am concerned that the VA has not given itself enough time to fully test the system, nor have they allowed time for all users to adequately train on it.

I think the full complexity of this project became apparent when the VA decided to roll out capabilities in two different sets. While it certainly makes it more digestible to make two smaller bites, that does not alleviate the pressure of infrastructure, staffing, and community-access concerns at Mann-Grandstaff. Those issues need to be resolved or mitigated for a successful rollout to occur.

This subcommittee needs an honest assessment of where things stand with readiness at the individual facilities. There are also joint decisions and actions that the VA and DOD must make together, including data strategy and rules governing the connection to existing systems. I believe that if the VA and DOD had invested more fully into joint governance, these potential pitfalls could have been mitigated, yet here we are right now and must take the necessary steps to address these issues moving forward.

I am also concerned about the level of communication between the VA and our veterans. While having an integrated health record someday will improve veteran care, the process of implementing it will be far from painless for its users.

As I learned when I traveled to Madigan Army Medical Center earlier this year, there were a lot of patient-care pain points, including referral management, pharmacy access, and patient communication. I still have not seen enough information from VA to understand how these issues have been addressed for the VA go live.

Before us today we have accountable officials from each level of implementation. I am pleased to have the deputy secretary joining us today as the lead accountable official on this program. I especially want to hear your perspective on the State of readiness.

We also have officials representing the clinical operations of the VA, the program office, and most important, the facility leadership. I look to our facility leadership as the last bastion of patient care and safety.

Both, Dr. Fischer and Dr. Tadych have been observing the day-to-day process of EHRM implementation and I want to hear your perspectives on your facilities' preparations. I expect each official at the witness table to provide an honest assessment of where things stand and what more needs to be done.

While there are no certainties in any IT implementation, there should be no surprises, due to a lack of preparation. We will judge whether this program is ready to meet the needs of clinicians and veterans by what we hear today.

I thank all of you for being here and I look forward to your testimony. I would now like to recognize my colleague Ranking Member Banks for 5 minutes to deliver his opening remarks.

OPENING STATEMENT OF JIM BANKS, RANKING MEMBER

Mr. BANKS. Thank you, Madam Chair.

First, I want to thank our witnesses for joining us this afternoon. This is a large and distinguished panel. I especially want to thank Deputy Secretary Byrne and Directors Fischer and Tadych.

Dr. Fischer and Mr. Tadych, our goal is to make sure you have everything you need to be successful.

I am cautiously optimistic that a March 28, 2020, go live is still achievable in Spokane. That being said, a few weeks may make the difference between a relatively smooth go live and a rough go live. A rough go live is clearly not in anyone's interests.

The schedule is a tightly linked series of milestones from now until March. Configuration and design decisions were made to be made even after the end of the workshops. Dozens of more systems interfaces must be built and authorizes to connect to the network must be received from DOD. Each of the precursors must be completed in order to proceed with testing and training.

It is easy to imagine some of these targets may slip. If that happens, I urge VA and Cerner to take the time necessary to get it right, rather than adhering to a symbolic deadline. I understand VA's rationale for going live with an initial set of Cerner capabilities known as block one in Spokane. Somewhere has to go first and Spokane is first.

The need to navigate back and forth between Vista and Cerner will undoubtedly impact this user experience. That is why it is so important that the Spokane employees be able to train on the actual production system before go live, not merely a mock-up training system. If a few more weeks are needed to make the training more meaningful, I take the VA to take it.

Similarly, if an interface cannot be completed in time or DOD does not grant an authority to connect when needed, I hope VA will seriously consider taking additional time to complete the task, rather than allowing that particular Cerner module to fall out of block one and into block two.

There is no question that the Spokane Medical Center has a bumpier road ahead of it and by virtue of going first than the medical centers that will follow. That means Spokane needs resources. I have been hearing VHA leaders make significant commitments to provide Spokane with the resources and that is encouraging. Little time remains before March 2020 to translate these commitments into action.

I very much appreciate Dr. Lieberman joining us today and I hope to get some conclusive assurances as to when additional funding and personnel will be provided to mitigate the disruptions.

Finally, I would like to turn to the subject of the Federal EHR Modernization Office. It is clear to me that the firm's interim leaders, Dr. Evans and Ms. Jowers, are making a positive impact. Notwithstanding their tiny staff and shoestring budget, they have taken the initiative to unblock as many decisions as they can between VA and DOD.

However, after several letters, staff meetings, a hearing, and a roundtable discussion with leaders from both departments, I am still uncertain what the ultimate plan for the Federal Electronic Health Record Modernization (FEHRM) is, and the behind-the-

scenes maneuvering that I have observed in recent months over which department will control the office concerns me. After being assured since the summer that the signing of the firm's charter was close at hand, I was surprised to receive a letter last week informing me that its organizational structure will be finalized over the next 6 months and its processes will be forthcoming over the next year.

If that is the case, given where we are in the calendar, I think the size and scope of the FEHRM should be scaled according to what is achievable at this point. The original vision of a large, centralized program management office sitting on top of the existing VA and DOD Electronic Health Record (EHR) program offices and absorbing their joint functions no longer seems realistic. An empowered, small, agile firm seems to be more realistic.

Regardless of when the FEHRM takes shape and how big or small it may be, the one thing that has always been clear is its mission should be broadly focused on the exchange of health information for patient-centered care. It was a mistake to narrowly focus the Interagency Program Office's mission on EHRs and we would be foolish to repeat that mistake.

With that, Madam Chair, I yield back.

Ms. LEE. Thank you, Mr. Banks.

I would now like to introduce the witnesses we have before the subcommittee today. Mr. Jim Byrne, the deputy secretary of the Department of Veterans Affairs. With the deputy secretary is Dr. Steven Lieberman, acting principal deputy under secretary for health within the Veterans Health Administration; Mr. John Windom, executive director of the Office of Electronic Health Record Modernization (OEHRM); Dr. Laura Kroupa, chief medical office, OEHRM; and Mr. John Short, chief technology and integration officer for OEHRM; Dr. Robert Fischer, director of Mann-Grandstaff VA Medical Center; and Mr. Michael Tadych, director of Puget Sound's VA Medical Center.

We will now hear the prepared statements from our panel members. Your written statement in full will be included in the hearing record, without objection.

Secretary Byrne, you are now recognized for 5 minutes.

STATEMENT OF JAMES BYRNE

Mr. BYRNE. Madam Chair Lee, Ranking Member Banks, distinguished members of the subcommittee, good afternoon, and thank you for this opportunity to testify about VA's transformation of our electronic health record system, and thank you, also, for your unyielding support of veterans and their families.

It has now been about 18 months since VA awarded a contract to implement the same EHR solution being deployed by the Department of Defense. We awarded this contract because this solution keeps patient data in a single hosting site using a common system. It enables easier and more efficient sharing of health information between VA and DOD, creating seamless transitions and servicemembers become veterans. It improves delivery and coordination of care, scheduling of appointments, reimbursement to providers, and efficient healthcare research, and it provides clinicians with the data and tools to support timely, safe, quality care.

Our goal at VA is to improve veterans' lives. We can do that by delivering an EHR that is easier for veterans, VA clinicians, employees, and Community Care providers to understand and use. This is the right thing to do for veterans.

VA has accomplished several key milestones in support of our electronic health record modernization effort. First, we have awarded and are executing 20 task orders, leveraging the indefinite delivery, indefinite quantity contract structure, which assures firm, fixed pricing, as requirements are validated. This strategy affords us the flexibility to efficiently moderate work and deployment plans.

Second, we have continued to refine our organizational structure for success. In June 2018, we established our VA Office of Electronic Health Record Modernization, OEHRM, to ensure that we successfully prepare for and manage deployment of our new EHR solution.

John Windom leads OEHRM, reporting directly to me, while working closely with the Veterans Health Administration and our Office of Information Technology and ensuring coordination with the Department of Defense. That coordination with DOD is critical for transparency between departments, open decisionmaking, risk mitigation, and rapid implementation of recommended changes.

Our two departments have also instituted an interagency working group facilitated by the Federal Electronic Health Record Modernization Office, the FEHRM, to ensure we achieve interoperability objectives, address challenges, and reduce potential risks.

We are working with DOD to fully develop a firm joint governing strategy to further promote rapid and agile decisionmaking. We will jointly present our final plan to Congress, including our implementation, phase execution, and leadership plans.

Third, we are continuing to refine implementation planning and strategy to carry us through the decade that it will take to fully implement the new EHR solution and enable us to integrate new technical advances as they are made. Critical to this is working proactively with DOD and private sector experts to reduce potential risks by using lessons learned from DOD and others.

Madam Chair, in my travels to VA sites across the country, I have encountered a palpable sense of excitement about our electronic health record modernization, and as I have said before, I have had hospital directors, administrators, and clinicians ask me how their facility can be moved up on the schedule for fielding the EHR solution. Because they work closely with veterans and their families, they recognize the vast potential for improvements in timeliness, quality of care, reducing risk, treatment of chronic conditions, research, and in many other areas of care. They want it now because they know it will help veterans.

Fourth, we established 18 EHR councils to support the development of national standardized clinical and business workflows. These councils are primarily comprised of clinicians who provide care for our veterans and represent each of the functional areas of the EHR solution, including behavioral health, pharmacy, ambulatory, dentistry, and business operations. The council members supported the 8 national workshops we planned and executed to educate diverse clinical-end users and validate workflows to ensure our

EHR solution meets our needs. We will continue to seek information, advice, and recommendations from VA employees and clinicians who provide care to veterans every day.

Last, VA identified infrastructure challenges at our initial operating capability sites to require upgrades to support the optimal use of VA's new EHR solution and to date, VA improved system performance by increasing network bandwidth and upgrading aging infrastructure which has led to reduced log-in times at our IOC sites from over 30 minutes to 15 seconds.

In closing, thank you all once again for your support of veterans and VA and for helping us tremendously with generous and flexible funding for this important EHR solution. We recognize the imperative for transparent and careful use of those appropriated funds and we are all committed to strengthening the VA system in support of veterans, their families, caregivers, and survivors. Our new EHR will help us do just that and strengthen the ties that bind veterans to their VA.

Thank you, and we look forward to your questions.

[THE PREPARED STATEMENT OF JAMES BYRNE APPEARS IN THE APPENDIX]

Ms. LEE. I will now recognize Chairman Takano for 5 minutes.

Mr. TAKANO. Thank you, Chairwoman Lee, Ranking Member Banks. Thank you for letting me join you today. Unfortunately, I have another obligation so I cannot stay very long, but I am committed to the success of this project and I wanted to be here for as much time as I am able.

I was in a chairman's or chairperson's meeting this morning and I brought up the Tech Modernization Committee meeting and our chairwoman of appropriations leaned over and said, I want more details on this, because she remembers the previous times that the integration did not work. I want you to know that senior members of this Congress have burned in their memory, the failure of our previous attempts to integrate the records.

Mr. Deputy Secretary and all witnesses, thank you for joining us today and thank you for your commitment to this project and our veterans and I hope we are going to get it right. Our committee has been tracking the progress of VA's modernization efforts for almost 20 years. We are cautiously optimistic that VA is engineering the goal of a single health record for servicemembers and veterans with its implementation of the Cerner Millennium product.

I echo Chair Lee's concern that it is critically important that VA get this right. Budgets and timelines are important, but we cannot afford to get this wrong; our veterans expect and deserve better.

For Secretary Byrne, I want to ask you: How confident are you that Mann-Grandstaff is going to be ready to go live in March and that it will be a successful go live?

Mr. BYRNE. I am very confident, sir.

Mr. TAKANO. What makes you say that?

Mr. BYRNE. We have a governance construct that is in place that provides oversight and drills down into the various issues and challenges we have. We very much appreciate that this is a major, major undertaking for any agency or any healthcare system, but we have metrics that we are tracking very closely. We have go to green plans for those that are behind or not on track and at this

point, I have a tremendous amount of confidence in the team that we have assembled to do this.

The cooperation between Office of Information and Technology (OIT), Veterans Health Administration (VHA), and the OEHRM office is superb. What I can also share with you, too—it may have been by circumstance that I can explain if you would like—that we picked Veterans Integrated Services Network (VISN) 20 in Washington State and the facility in Spokane. I have had an opportunity to visit with the director, his leadership team, and many of the employees. If I had to pick a facility to launch it in, I would have picked that site.

Mr. TAKANO. All right. Thank you.

Dr. Fischer, Mann-Grandstaff in Spokane, when—this is about Mann-Grandstaff, the Spokane site—when the committee staff visited your facility this summer, they heard from your staff that there were grave concerns about staffing shortages in productivity loss during the go live process. Is there a plan to bring temporary staff onboard at Mann-Grandstaff or to use staff from other VA or DOD facilities to cover gaps?

Dr. FISCHER. Sir, we have a plan to augment our staffing by hiring permanent staff to the tune of 108 full-time equivalents. Many of these staff members are in high-turnover areas, so depending on the requirements at 6 months, 9 months, 12 months after go live, we would allow those positions to attrition over time.

We also are leveraging telehealth. We have a telehealth hub in Boise. We are bringing 30 traveling nurses to the campus. If asked, I would say I am optimistic, as well.

Mr. TAKANO. I am pleased to hear you have augmented your staff with permanent full-time equivalents and there must be, then, what exists is a plan anticipating this loss of productivity that would happen at a go live.

Would you share that plan with the committee.

Dr. FISCHER. Sure. The augmentation plan is under execution right now. I do not want to misdirect the committee. We have hired roughly 50 percent of that 108 Full Time Equivalency (FTE) augmentation and we continue to recruit right up through go live.

Mr. TAKANO. Not only do you have a plan, but you are executing the plan?

Dr. FISCHER. Yes, sir.

Mr. TAKANO. Just have us—if you could get us the plan——

Dr. FISCHER. Sure.

Mr. TAKANO.—and the sort of fuller, flushed-out plan that you have so the committee could review it.

Dr. FISCHER. Along with the VISN and Veterans Affairs Central Office (VACO) leadership, we started to model what we thought efficiency loss would be as we went live as the first pilot site for EHR modernization. We know in speaking with Fairchild leadership after I arrived, they had recently implemented the DOD solution, Cerner solution, and we felt that a 30 percent estimate for some periods of time seemed quite reasonable.

Based on that we went service by service and looked at what that would mean in terms of augmented staff to limit purchased care during that period of transformation.

Mr. TAKANO. My time is up. What I just want is your assurance you will get us the plan.

Dr. FISCHER. Oh, no problem. It has been written and established for many months.

Mr. TAKANO. That is what I am asking. Thank you, sir.

Dr. FISCHER. You are welcome, sir.

Mr. TAKANO. I yield.

Ms. LEE. Thank you, Mr. Chairman.

I now recognize Ranking Member Banks for 5 minutes for his questions.

Mr. BANKS. Thank you, Madam Chair.

Deputy Secretary Byrne, I believe you coined the term "purple people" or "purple person" earlier this year in testimony to another committee. I understand that a purple person is meant to mean someone who represents the priorities of DOD and VA equally and is an honest broker in inter-departmental debates.

Am I describing that correctly?

Mr. BYRNE. Yes, sir. It is modeled off of a concept of as, the joint chairman—the chairman of the joint chiefs of staff and DOD—exactly right—they may wear the uniform or be paid by a particular service, but they watch out for the broader interest of our Nation's military.

Mr. BANKS. Great. Do you believe that Dr. Evans, the interim director of the FEHRM is a purple person?

Mr. BYRNE. He is an incredible person and he was not necessarily selected for his purple characteristics, per se, nor was Ms. Joers, but they have proven to be an incredible team that, together, I think give the balance that we need for the decisions that need to be made during this interim period of time.

To answer your question, the focus was not on looking at them as a purple person. I would suggest it is possible that he has grown into that purple person as we look for a more permanent leadership going forward.

Mr. BANKS. They do not necessarily fit the description or the intent of what you meant by a purple person?

Mr. BYRNE. For the interim, that was not, from my perspective, was not one of the major, driving factors.

For the permanent position, that is a requirement; something we will demand from that. Yes, there was a look at both of those individuals who are now in the interim FEHRM to ensure that they were mature, professional, balanced; they could embrace making the decision for the best.

I guess I do not want to put too much of an emphasis that we hired them because they were purple; they very much come with stripes from their respective organizations. The big focus will be on the permanent positions. That is where the purple is a requirement.

Mr. BANKS. As I said in my opening remarks, I commend Dr. Evans and Ms. Joers for their initiative and I am interested in how the strategic vision for the FEHRM has changed over the course of this year.

Is the FEHRM now intended to be a decisionmaking authority, similar to how it functions now or a program management office in your best estimation?

Mr. BYRNE. The first: a decisionmaking body. We have a program management office that is in place led by John Windom, seated to my left.

Mr. BANKS. Good. Got it.

Secretary Byrne, in February and March of next year, the EHR program in the Spokane Medical Center is supposed to go through the final milestones in a go/no-go indicators to determine whether everything is in order for the March 28 go live.

What is your role and authority in making that decision?

Mr. BYRNE. You are talking about a delay or a stop production is what I presume you are asking?

Mr. BANKS. A go/no-go decision ongoing live.

Mr. BYRNE. I have the authority as the accountable official under the Appropriations Act of 2018, but a go or no-go decision would be made by the secretary with the recommendations coming from me and several people on this panel today.

Mr. BANKS. What would you say Dr. Evans' role in authority would be in making those decisions?

Mr. BYRNE. He does not have the authority to stop the trains, but he is in a position like a lot of people are, particularly those who are out in the field, particularly those who are seated to my right, that if there is a patient-safety issue, we expect and demand that they raise their hand and we address whether we need to have a delay or stop things in process.

Dr. Lieberman, I ask you this as Dr. Stone's representative. What is Dr. Stone's role in authority in making that decision?

Dr. LIEBERMAN. Dr. Stone is very involved with this process, all of our meetings; is just so involved, so invested in this. We all want to see this program succeed.

Certainly, we are supporting the field leadership, again, sitting to my right. We are looking for them to tell us whether they think that they have what they need to go live or not go live and we will certainly advocate for their recommendations.

Mr. BANKS. Dr. Fischer, what would you like to add about your role in making the go live decision?

Dr. FISCHER. Well, Dr. Stone and the Office of EHR Modernization have made it clear that I would have an opportunity to make a recommendation whether we were prepared or not.

I am an obstetrician by training. I know what it is to assess risks and to make difficult decisions and I am prepared to do so in this case.

Mr. BANKS. All right. My time is expired. I yield back.

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

Secretary Byrne, what has been—and this is more for the record—what has been your role in the preparations for go live?

Mr. BYRNE. I have been intimately involved in the governance construct that we have set up metrics, milestones, to move this initiative forward; mostly, at the strategic and operational level, but I have had some involvement at the tactical level, as well.

What I mean by that is we have, three times a week, we have a meeting of over 200 folks that have an equity in this matter to work through and wrestle on particular focused issues. I have also had the good fortune of visiting the Cerner facility where they have hosted workshops for workflows in Kansas City, at least twice. And

then as I mentioned earlier, I had the opportunity to visit both of the sites. I met the leadership team in Spokane and Seattle, the leaders, and many of the employees.

My job is an oversight role—give direction, be sure we are on the right track, support those leaders that are actually making decisions and making things happen—but I am the accountable official and I very much understand and appreciate that role.

Ms. LEE. Thank you. So, given that—your involvement, looking forward to March 2020, what do you envision as the process that you will undergo to finally sign off on go live?

Mr. BYRNE. So——

Ms. LEE. Let me follow up, and I just want to ask one more question: And what scenario would you not sign off?

Mr. BYRNE. The easy answer to that second question is if anything is going to impact a patient's safety, that is a no-go; that rules over everything.

We are going to stay on the current trajectory and path that we are on. We are on a go to green, go live for March 28th trajectory right now with the governance structures that I can burrow into as deep as you would like to discuss.

The answer to your question is, I want to keep it on the path and the trajectory that we are on right now.

Ms. LEE. OK. Earlier in response to Ranking Member Banks' questions, you said, well, you do not have the authority. I want to know, are you comfortable telling leadership that EHR deployment needs to be delayed?

Mr. BYRNE. Yes, that is correct, and maybe I should put some context on the authority. I have not had that specific discussion with the secretary about it because it has not ripened yet.

He may well say, you are the accountable official, you make the final call, but it will be one of the two of us to be making that final decision and we are both accountable for it, regardless of who makes it.

Ms. LEE. Great. Thank you.

Dr. Fischer, in the event that you believe things are not ready, do you have the authority or are you comfortable telling departmental leadership that EHR deployment needs to be delayed at Mann-Grandstaff?

Dr. FISCHER. Extremely comfortable.

Ms. LEE. Mr. Tadych, the same question: In the event that you believe things are not ready, do you have the authority and are comfortable telling leadership that EHR deployment needs to be delayed?

Mr. TADYCH. Yes, I am.

Ms. LEE. Dr. Lieberman, in the event that you believe things are not ready, do you have the authority and are comfortable telling leadership that the deployment needs to be delayed?

Dr. LIEBERMAN. Absolutely. We all work really well together and we are very transparent about this, and we make it clear that if anybody has a concern, we want to hear about it.

Ms. LEE. Dr. Windom, I am sure you are wondering what I am going to ask you: Do you have the authority and are you comfortable?

Mr. WINDOM. Well, I do appreciate you elevating me to doctor status, ma'am——

Ms. LEE. Oh, yes, sorry.

Mr. WINDOM.—but I am not a doctor.

Ma'am, I have had a number of chances to appear before you and the committee and this remains an end-user decision. This remains a clinical decision. This is about end-user adoption.

I am very comfortable with the teamwork here on the panel and back at VA is that it will not be a decision that is—surprises any of us because we are talking every day, and so we will understand how we migrated to the point and we would owe you that engagement and I know——

Ms. LEE. But are you comfortable calling for a delay, should you personally feel that?

Mr. WINDOM. I would be comfortable, but I would make sure that the delay—I am not a doctor. I have doctors around me who I would be counting on to advise me appropriately. I would be comfortable, but would be seeking their counsel.

Ms. LEE. Thank you. And Dr. Kroupa, same question: Do you feel you have the authority and are comfortable asking for a delay, should you believe that it is needed?

Dr. KROUPA. Absolutely.

Ms. LEE. Thank you. My time is now expired and I am going to recognize Mr. Watkins for 5 minutes for questions.

Mr. WATKINS. Thank you, Madam Chair. Thank you.

Mr. Windom and Dr. Lieberman, VHA staff has a significant amount of mandatory training, in addition to the Cerner training. That said, the Cerner training absolutely must happen, so what will you be doing to monitor and support VHA staff to make sure that they are participating and actually benefiting from the training?

Mr. LIEBERMAN. As you stated, the training is critical and no one can use the system until they complete the training and they will also have to complete an examination. That is just critical; nobody should be touching the new system without that kind of training.

We have planned—I have actually led the national effort to come up with how we can mitigate the known loss in productivity that will occur for months before going live, and so we are prepared to staff up in response to that, to make sure everybody has the time to go through the complete training.

Mr. WINDOM. Sir, we have got a change management team led by Dr. Jill Durant under the auspices of Dr. Kroupa's team. They have been putting many, many hours into developing a training portfolio in coordination with Cerner.

I can tell you, we had a chance to observe the DOD go live at Wave Travis from the headquarters. One of the major emphasis points was you have to have the training prior to accessing the system. We intend to follow suit. The efficiencies of their deployment reflect that that is the right way to do business.

Mr. WATKINS. Right. How heavily have you and the VHA leadership been involved in establishing the Cerner training domain and the training programs?

Mr. WINDOM. Sir, I am going to defer to Dr. Kroupa after this remark is that Dr. Kroupa leads—Dr. Kroupa is a Title 38 em-

ployee; she effectively works for Dr. Stone and Dr. Lieberman. The tie-in between her efforts and the council's, who are largely VHA employees, makes our integrated efforts just that more integrated.

If I could defer to Dr. Kroupa on maybe some details, I would appreciate it.

Dr. KROUPA. Certainly. The training program for our users has been designed by Cerner with our team intimately involved and for every role, they get a certain number of hours of training. You know, a registration clerk may get 8 hours of training. A specialized cardiac nurse may get 40 hours of training. We have gone through the math of assigning roles to all of the staff at Mann-Grandstaff and laying out how many hours of training they will need.

Then they, as Dr. Lieberman mentioned, they have to pass a competency test at the end of that training. If they do not pass, they get more training, they get more support, and more help until they are comfortable with the record.

Mr. WATKINS. Thank you. Now, I am have Kansas and Topeka, Leavenworth, and Kansas City are all in the later waves of the Cerner implementation, but we will be watching the Spokane go live closely for lessons learned.

How will you and your team be monitoring and responding to situations that arise during and after the March 2020 go live? That is for anybody—perhaps, Mr. Windom or Dr. Lieberman.

Mr. WINDOM. I come from 33 years in the Navy. This is probably the most dynamic environment I have ever been in. Medicine is constantly evolving.

I think the flexibility we have in our relationship with Cerner and that the contract affords us those lessons learned should always be brought forward and will always be brought forward to subsequent deployments. So, really, no matter where you are on the deployment cycle, you will benefit from the lessons learned of previous deployments, and not only the previous deployments, but our relationship with DOD and, oh, by the way, the innovation of not only VA, but the commercial environment.

We think we have got a multi-pronged approach, sir, that is going to support us making sure we deliver to VISN 15 what they will need in the best possible way at the best possible time.

Mr. WATKINS. Thank you. Dr. Lieberman, the same question, please: What role will you and the VHA leadership play in the monitoring and responding to issues during the Spokane go live?

Dr. LIEBERMAN. We have meetings with Spokane and Puget Sound three times a week—"we" being the larger we—for an hour, talking about what are the challenges that are being faced, what is it going to take to get us over the finish line. Those meetings will continue afterwards; they are very detailed and very helpful.

We will be studying lots of things after go live and these folks here will know how to approach us. If anything needs to be raised, we quickly will raise it up the ranks. We will be studying everything, including even how we mitigated the productivity, so we can learn for future deployments, did we do it right, should we modify it for the future.

Mr. WATKINS. Thank you. I yield.

Madam Chair, I yield. Thank you.

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

Ms. SCHRIER. Thank you all for coming. I am from Washington state—not from Spokane—but I am excited that this pilot is happening in our State and it sounds like you are putting a lot of effort into launching this. Frankly, if there was ever a group of people or veterans who needed a smooth launch and the best care in this transition, it is our veterans. We have about a half a million veterans in Washington State, about a tenth of them in my district.

Now, I am also a doctor, so I am probably the only person up here who is used Cerner and has been through some of these go lives and however smooth you want them to be, there is bumps in the road. I am thrilled to hear about superusers and to have Cerner staff onsite and even anticipating lower productivity, because that does happen.

I wanted to get a sense of how this will feel for the patient, for our veterans, and also for the doctors, like, how this really plays out in the exam room, and so, I as I was thinking through some of the issues that we have had, a veteran who has had a complicated operation, for example, has a very thick medical record and then comes to a VA for continuing care, the only thing I could parallel that to would be a baby with congenital heart disease who is at Children's Hospital—they have Cerner also—and that baby comes to me with a stack of medical records this thick. The way we had to do it was to literally—I would go through the record, pick out the most important pieces, we would scan them and then I would have this big, long record in Cerner.

How will clinic notes get transferred over? Will it just populate the Cerner notes field or will you have a big, long 100-page file to go through when the patient is in the office?

Mr. BYRNE. Can I answer your question, ma'am, from a strategic level and then, of course, pass it off to a real doctor—I am a doctor of jurisprudence; that does not account for much—you had asked the question about how this—would help with the veteran patient.

The hope is that they have no idea that this is going on at all, but we know—you know—that they are going to be getting much better care and treatment as we revolutionize the amount of information that the providers have when they are treating the patient. They will have that whole picture of this veteran and that is where the magic is. The veteran will maybe notice it because they are getting better care in the big picture, but my understanding is they are not going to notice—I hope they do not notice anything when they go in for their next treatment and care in April, May, and June.

Ms. SCHRIER. OK. I need a doctor to answer on this, because you know it is easier to click through note to note to note and see the title on it than it is to have a file of 100 pages that you have to scroll through.

Dr. FISCHER. Ms. Schrier, I would like to answer your question, and I will, but I am going to defer to Laura Kroupa, because she has that information, having been so active with our national councils.

Laura.

Dr. KROUPA. Yes. This is going to be different than many other transitions. We have spent time bringing over data, to a great extent, from our VistA legacy system. In addition, we already have the Joint Legacy Viewer (JLV), which is a viewer that we can read both, DOD and VA data, so that will be a tab within Cerner. You can just click on it and it will go right to that patient JLV to see old data.

We are also bringing over every record from every veteran from all time in VistA. It is already in the Kansas City data base and so over this next year, we will be able to have basically 20 clinical domains of data in the record in the longitudinal order. You know, I think our users are going to find that they have much more data than they have had before, better organized data, and there is not going to be a lot of time spent bringing—transcribing old data into the record.

Ms. SCHRIER. Will things like lab results come in, in table form so you can see old labs in the same table as new ones? The same thing with problem lists and medication lists?

You have thought everything through this. I am feeling very optimistic. I wanted to ask if you have a backup plan? Our backup plan was that to a year, at least, we had the paper record that also came into the room, so if we really needed it as a crutch, we would have it.

What is your backup plan if the electricity goes down—whatever the headache may be?

Dr. KROUPA. I can take that.

The Joint Legacy Viewer is a read-only, so that is going to be available. In addition, we also have a backup plan where we have viewers that back up the Cerner system, so that if something gets cut, we will be able to see it on those—so special computers will have a backup plan—a backup copy of the record.

Ms. SCHRIER. Well, thank you very much all for your service and your help and for taking care of our veterans, and I applaud you and wish you luck. Thank you.

Ms. LEE. Thank you. I now recognize Ms. McMorris Rodgers for 5 minutes.

Ms. RODGERS. I thank the chair and the ranking member for allowing me to participate in today's hearing. I also want to thank all the witnesses for being here, especially Dr. Fischer, who has been keeping me updated along the way and I appreciate the fact that you are on the front lines of this significant effort which is so important——

Dr. FISCHER. Thank you.

Ms. RODGERS.—to the veterans that I have the privilege of representing in Eastern Washington.

I represent more than 70,000 veterans. I am also proud to represent Fairchild Air Force Base, the Mann-Grandstaff Medical Center, as well as the Walla Walla Medical Centers. I recognize that we are on the forefront of this exciting, but also challenging endeavor. We have now over $16 billion in upgrades and investments in making this transition, and certainly this is an important piece of making sure that the VA is able to deliver efficient and effective care. My goal is to always see us rolling out the red carpet to our

veterans and the proper implementation of this electronic medical record will be really important.

I have a few questions that I just wanted to raise this morning to Dr. Lieberman, Dr. Fischer. I understand Dr. Stone has committed to "flood Mann-Grandstaff with resources to cushion the impact of the Cerner rollout." I was glad to hear that. Certainly, you know, we have had our challenges in staffing up through the years.

First, the medical center was exceeding its budget target by approximately 75 full-time equivalent and I do not know when that budget was involved, but I just wanted to ask where we are currently. Recognizing that we have had staffing difficulties through the years at Spokane, I think the worst thing would be for the VA to cut existing positions.

Can you assure me there will be no cuts to existing positions?

Dr. FISCHER. Good afternoon. I will tell you, without hesitation, that there are currently no constraints on hiring at Mann-Grandstaff to include maintenance of our baseline mission staffing and that augmentation that I spoke about earlier. We understand that as the first pilot site we have to get this right and we have to maintain patient safety. This would be the exact wrong time to constrain hiring in my opinion and I have had nothing but full support by VHA, OEHRM, and VA, in general.

Ms. RODGERS. Great. Can you just give me a breakdown right now of, in terms of position, permanent versus temporary staff, VA employees versus contractors?

Dr. FISCHER. I can give you some of that, and I am willing and certainly happy to provide that in writing. Right now we have roughly 1,235 full-time equivalents on our campus and our Community Based Outpatient Clinics (CBOCs). On our organizational chart we have somewhere around 1,400 positions.

We have been, over the last 5 years, experiencing significant growth and when you do that, your vacancy rate tends to fluctuate somewhat until you reach a steady State. We are anywhere between 87 and 91 percent staffed at any given time, based on where we are with growth.

Ms. RODGERS. Okay. Perhaps, you can get me that breakdown later.

Dr. FISCHER. Yes, ma'am.

Ms. RODGERS. Do you have any thoughts on how we can expedite the hiring process, recognizing that March 2020 is right around the corner for some of the 108 new employees?

Dr. FISCHER. Well, VA has consolidated human resources, and so we can leverage our VISN and other VISNs to help us with expedited recruitment, which they are in the process of doing.

Ms. RODGERS. Okay. I know there is been discussions about assigning up to 30 nurses from VA's Travel Nurse Corps and possibly—locum tenens physicians to Mann-Grandstaff on a temporary basis.

Can you give me a sense as to when that is going to happen and how many personnel will be assigned?

Dr. FISCHER. Well, the 30 traveling nurses are—we are planning to have them arrive roughly 3 months before go live. We are exhausting all opportunities to enhance our recruitment and our staff onboard. But as you know, some of these solutions are untested in

the face of EHR modernization and that is why we feel that permanent hires, as well as leveraging telehealth and some of these other somewhat untested expansion for clinical care, are important to exhaust all opportunities.

Ms. RODGERS. Okay. I know there is also been discussions about personnel from Seattle, potentially in VISN 21 and California or Nevada being temporarily housed at Spokane. Do you believe this is going to happen?

Dr. FISCHER. I am optimistic.

Ms. RODGERS. Do you know when?

Dr. FISCHER. I do not at this moment.

Ms. RODGERS. Okay. Well, thank you, and I appreciate all your hard work and commitments.

Dr. FISCHER. I very much appreciate your support, ma'am.

Ms. RODGERS. Thank you. I yield back.

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

Mr. CUNNINGHAM. Thank you. Thank you to each and every one of you all for not only showing up here today, but for all of the work that you all do to improve the delivery of care to our veterans who deserve the highest quality of care possible. I appreciate all of your efforts.

I have got the privilege of representing the low country in South Carolina, the first congressional district, which has the highest number of veterans of any district in the entire State and so it is incredibly important to me that the VA's health record modernization is well executed. To that end, I would like to turn to the leaders of the VA facilities, or I would like to refer to them as the tip of the spear of these modification efforts to locations across the country such as Ralph Johnson VA Hospital in Charleston can benefit from your example, specifically, on the subject of veterans outreach.

Dr. Fischer, can you let us know what your staff is doing to communicate with the veterans that receive care at Mann-Grandstaff about the go live?

Dr. FISCHER. Sure. Thank you for the opportunity.

I meet monthly with our veteran service organizations and they are rather robust in the State of Washington. They are deeply embedded among the veteran population. We have veteran town halls, at the CBOC locations, rural health clinics, as well as in Downtown Spokane.

I can tell you from my perception of the veteran perspective as I talk about Cerner Corporation and the complexity of modernization and typically their eyes tend to glaze over. A veteran only wants to know will he have access or will she have access to care. I believe that they assume that the documentation of that healthcare will exist and I do not know that they care whether it is through Computerized Patient Record System (CPRS) or through the Cerner product. We are outreaching frequently and I think as we get closer and have more granularity about what an appointment will look like at go live, we will absolutely share that information with our veterans.

We also have a bi-weekly newsletter that is widely distributed and often veterans access that newsletter. We have Facebook. We

have a button on our page for Cerner and electronic health record modernization. We are doing our best on outreach and as we learn more, we will share that with our veterans.

They do know—I have represented that there will likely be inefficiencies at the time of go live and that we rely on them to help us modernize the health record and modernize VA health care and they are generally very, very supportive in that regard.

Mr. CUNNINGHAM. Thank you for that.

Have you communicated that veterans should consider reordering medication before the go live?

Dr. FISCHER. We have not yet, because we are still waiting for the final look at what pharmacy renewals will actually look like at go live. There is still lots of work being done, and I would defer to Laura Kroupa if she has any more information related to the pharmacy piece.

Dr. KROUPA. There will be probably some changes in how they order their medicine just for a few months, and so we are planning on putting out some information through the pharmacy; also, we will probably send something out in their co-pay bills that will inform them about changes coming to both, billing and in-pharmacy. We are looking at a variety of different ways to get the word out.

Mr. CUNNINGHAM. Okay. Thank you for that.

Mr. Tadych, what has your staff done to communicate with the veterans that receive care at Seattle or American Lake?

Mr. TADYCH. Very similar to what Dr. Fischer mentioned. In addition, we have regular tele-town hall meetings that we reach out to a large number of meetings, typically, four to 500 veterans who participate are tele-town halls. The Cerner implementation is a point of discussion during those town halls, as well as involving our veteran family engagement or community-veteran-engagement board and our veteran family advisory council in the discussions.

Mr. CUNNINGHAM. Okay. I appreciate all of your efforts and I want to thank you again for everything you all do for our veterans and thank you again for appearing today to answer questions.

I yield back.

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

Mr. KILMER. Thank you, Madam Chair, and I would like to thank you and Chairman Takano for allowing me to sit in.

This is a big deal for the region I represent. Nine days ago we celebrated Veterans Day. I am honored to represent more military veterans than any Democrat in Congress. I think we are a much stronger region as a consequence of the men and women who serve and who choose to make my region their home. The work we do to make sure we have the backs of those who serve is the most important work we do and I want to thank each of you who are testifying today for your work in that regard.

Why am I here? Well, we saw when the DOD did the rollout of their electronic health record in my region, a bit of a bumpy rollout and I appreciate the work that the DOD has done since then, along with its industry partners to try to right those issues, to identify some lessons learned in hopes that the rollout elsewhere is more smooth.

I think we owe it to our vets to make sure that we do not have a repeat performance of what we saw within the DOD system. I do

not think there is any reason to repeat those mistakes and I guess that is what I wanted to hear more from you is what is the VA doing, specifically, to make sure it is ready for the rollout this spring and what lessons were learned from the DOD experience and how are they being applied within the VA?

In particular, I am hoping you can speak to how do we make sure that the DOD lessons learned are not repeated? I know I am conscious that it is a different contractor, and I want to make sure that even though it is a different contractor, we are still learning the lessons we learned from the last experiences.

Mr. BYRNE. I can tell you that we do have a very close relationship with DOD and we are incredibly conscious of those lessons learned. I think Mr. Windom might be able to be a little bit more specific on the history of that relationship and the lessons, in particular, that we have learned.

We did have the luxury of visiting Madigan 2 month or so ago and we now see where they are and they did share several of those lessons with us.

Mr. Windom.

Mr. WINDOM. Thank you, sir.

Sir, we appreciate your concern and we very much are in a similar posture. One thing I want to applaud DOD is being willing to share their lessons learned, their challenges, and I can tell you it just did not start with us incorporating those yesterday. We started incorporating those lessons learned before contract award.

Within the framework of the terms and conditions of our contract are things like help desk support. You may have seen some of the gaudy statistics regarding trouble tickets. We made sure we put in a robust help desk support mechanism because we want end-users' questions answered the first time the right way. That eliminates frustration.

I can tell you field participation, another major lessons learned, and I will let Dr. Kroupa—making sure the field understands what is coming, making sure they are well-trained, well-educated in what is to come so they are not—they do not reject what is about to transpire.

You have heard me emphasize time and time again, this is about end-user adoption, infrastructure readiness. A state-of-the-market, state-of-the-art electronic health record does not run better on an old infrastructure. Congress has been incredibly supportive, financially, in providing us the requisite sources of funding to upgrade our infrastructure well in advance of the deployment of EHR. You heard that in the deputy secretary's comments regarding log-in times. Just the upgrades of the infrastructure have improved log-in times thousands of percentage from minutes—30 to 40 minutes to 15 to 30 seconds.

There are a myriad of other areas. I want to give my compatriots here an opportunity, because from a clinical and then John Short, from a technical perspective, they really, I think, can give you the rest of the story.

Dr. Kroupa.

Dr. KROUPA. I think the main lesson we took from the DOD is that we made sure that we included frontline clinicians in the design and build of the record. We spent a lot of time with the clinical

councils, meeting on a recurring basis to make decisions. We included DOD on those councils so they could hear directly from their compatriots about how it worked in their system and could make decisions together. We also brought in industry, best-practice associates from other healthcare systems to help us make those decisions.

John.

Mr. SHORT. I will just add a couple of items. As an example, DOD, at first when they rolled out they did just-in-time infrastructure. Just-in-time infrastructure for most people's experience is just-in-delayed infrastructure, and so, they learned to go to 3 to 6 months ahead of schedule. We mirrored that, most of the infrastructure already in place for the go live sites. We are already working in wave one, wave two, and wave three sites already, putting that infrastructure in place. So many elements like that.

Another example was making sure we are going to go live over the weekend, to have the IT contracts in place where you can call those vendors in on the weekend to make sure that is available. So, that is another lesson learned. DOD is constantly providing those to us and we are using those.

Mr. KILMER. Thank you.

Thank you, Madam Chair.

Mr. WINDOM. Sir, may I add just one thing, because I think it is important. The Wave Travis deployment that DOD just executed—phenomenal.

So, the experiences at Fairchild, they have taken onboard their own lessons learned and they have been willing to continue to share those. We have watched them return to efficiency levels within 6 weeks that far exceeded expectations. I just wanted to make sure that was known, that they have not rested on their laurels either, and we continue to learn and share.

Mr. KILMER. Thank you.

Thank you, Madam Chair. I yield back.

Ms. LEE. Okay. I now recognize Mr. Larson for 5 minutes.

Mr. LARSON. Madam Chair, thanks for indulging us from Washington State and we are obviously very interested in this program and we appreciate you allowing us to ask questions and waiting for us to get from other markups. There is actually other things going on in the Hill today, so it is really great.

I am sorry that I am late and maybe—this question, but the rollout in Washington State and especially in Puget Sound has been delayed and with regards to that delay, is there anything that you need—I guess this is for Mr. Tadych—I cannot see that far without my glasses. I lost my glasses—oh, there you. How you doing? Sorry for being so informal today.

Is there anything else you need to ensure that the rollout happens on time or actually, now in the fall, as opposed to any delays?

Mr. TADYCH. We have had very good support throughout from both, OEHRM and VHA through this process. The discussions around the different capability blocks was a very collaborative approach and based on concerns we raised, the leadership at both, VHA and OEHRM, were willing to delay our implementation until those different blocks could be—different capabilities could be delivered to us.

Mr. LARSON. Are you anticipating learning anything in Spokane that you would pick up and put down in the fall?

Mr. TADYCH. Absolutely.

Mr. LARSON. Do you have an idea of what those are?

Mr. TADYCH. I am sure there will be many bumps in how they implement with primary care and other areas that will be very valuable to our implementation process.

Mr. LARSON. Thank you. How about in terms of the capabilities that you are rolling out in Spokane, any of those that you anticipate that are not in Puget Sound that you would pick up and put down in the Puget Sound?

Mr. TADYCH. I think with the capabilities, one of the lessons learned will probably be around some of the how patients flow, workflows that we need to address more than anything. Those capabilities should be well in place by the time that Puget Sound goes live.

We will also have to look at how the capability block two workflows work at that point as we get ready to go.

Mr. LARSON. I noted that Bellingham and we have a vet center are on the list at some point. Do you know what the timeline is for those?

Mr. TADYCH. I do not know about the vet center.

Mr. LARSON. Okay. Does anybody know about the vet centers? How are they?

Dr. KROUPA. The vet centers do not actually write into the electronic health record; they are records are separate. They will have the ability to see, but they are not going to be actually entering information into the electronic health record.

Mr. LARSON. Okay. All right.

Dr. KROUPA. Those are kept separate on purpose.

Mr. LARSON. What purpose is that?

Dr. KROUPA. So that veterans can go to the vet centers and have confidential information that is not revealed anywhere else.

Mr. LARSON. Then, finally—and, again, I apologize if this has been asked—but perhaps, for Mr. Windom, what efforts has the VA taken to familiarize, you know, older veterans with the changes with the new system?

Mr. WINDOM. Sir, I think that one thing we recognize is that communications to the veterans that will be called to use upon the system is imperative. One of the struggles with comms is not to get there too soon. So, we intend to really saturate the area, in a matter of a couple of months or 6 weeks out to make sure people are well-versed on what is about to occur.

Mr. Tadych and both, Dr. Fischer and Dr. Kroupa, have already commented on the fact that they are having town halls, they are meeting with the VSOs. I meet quarterly with the VSOs. I have already asked them to help me best understand how to engage the veterans.

We appeal to you. If you have ideas, we would love to sit down with you and listen to those, because I can assure you in no way, shape or form do we think we have cornered the market on how to communicate. We welcome your thoughts on enhancing our communication profile, and so we look forward to a following discussion on that. We look forward to continue to share our ideas.

Mr. LARSON. Yes. I just finished six more veterans town halls in my district and they all went very well, in part, because Mr. Tadych was there helping us out. One of the things that happens at these town halls is—case work; these are more policy-oriented and we talk about changes in the VA, and we end up getting sometimes surprised by those questions because maybe our offices have not been briefed or maybe we missed something.

I would just really encourage full outreach to congressional offices so we know who to send these folks to when we get the calls, as well as, so that we have some basic information on the implementation to help me out.

Thanks. I yield back.

Ms. LEE. Thank you. I now recognize Ranking Member Banks for 5 minutes.

Mr. BANKS. Thank you, Madam Chair.

Deputy Secretary Byrne, I have a series of questions about VA's My HealtheVet patient portal and the Cerner HealtheLife patient portal. Please feel free to direct any of these questions to members of your team if appropriate.

When Cerner goes live in Spokane, what health records will a veteran be able to access in the Cerner patient portal and what records will he or she need to use My HealtheVet to access?

Mr. BYRNE. Thank you for that question. I think Dr. Kroupa might be best to answer that.

Dr. KROUPA. Certainly. In Spokane at the go live, the veterans will be able to access through the Cerner portal, their Spokane records. If they want to look back at a previous secure message or something from another VA, they will access My HealtheVet.

Mr. BANKS. Okay. Doctor, which types of appointments will veterans be able to schedule using the Cerner portal and which appointments will they need to use the My HealtheVet to view or make?

Dr. KROUPA. I believe that they will be able to make appointments in Spokane in the Cerner portal, but I can take that for the record to be sure on that one.

Mr. BANKS. Fair enough.

Which patient portal and which other systems will veterans of Spokane need to use to schedule a Community Care appointment?

Dr. KROUPA. Well, I do not know that they currently use a portal to do all of their Community Care appointments now, so I will have to take that for the record unless, John, if you know?

Mr. BANKS. Okay. Mr. Short, you are making a lot of progress with VA.gov in expanding the online self-service tools for veterans. Has anyone figured out how to integrate all of that with the Cerner HealtheLife patient portal?

Mr. SHORT. Currently, sir, there is work being done on development to be able to allow them to use those tools. It is in the development phase right now. We will provide additional information for the record, if you would like.

Mr. BANKS. Okay. Secretary Byrne, OEHRM has the lead responsibility for the Cerner implementation, but it is by no means alone in this effort. How much funding has been transferred or allocated from the veterans electronic health record account to other VA offices to support the work?

Mr. BYRNE. I think Mr. Windom might have some specifics on that.

Mr. WINDOM. I will have to take that for the record, sir, for exact accounting, but what I will say is this, is that as we discussed in previous hearings, it made sense to leverage the contracting of vehicles that existed within OIT. We have allocated moneys to use their vehicles with strict accountability between the two organizations being maintained, but that made sense to get infrastructure off the ground sooner rather than later.

In addition, as we expressed at various hearings, we had a debt to VHA for allowing us to use their clinicians to support our requirements, development efforts, clinical workshops, efforts. We have, actually, written guidance in place to how we, if you will, reimburse VHA and other organizations for their efforts. We will gladly share that, sir.

Mr. BANKS. I appreciate Mr. Windom taking that back for the record and providing us with a complete list.

My next question is for Dr. Kroupa and Dr. Fischer. Please tell me about the training system, meaning the version of the Cerner EHR that will soon be available to Spokane personnel to train on. How similar is it to the Cerner EHR that will go live next year?

Dr. Kroupa.

Dr. KROUPA. The training environment is being imaged now. It is being based on the decisions that we made at the workshops, so it is going to be very—have a high level of fidelity to the production account and so, it should—it is a VA-specific build. It is not the Cerner major product or the DOD product. It is being imaged, based on our design decisions.

Mr. BANKS. Okay.

Mr. WINDOM. Yes, I would add, sir, that in advance of our build, what we did was set up what we call a "flight simulator," which is a training environment that incorporated the DOD build so that people could start getting oriented on the Cerner Millennium solution. We put that in place and have allowed clinicians access to that, if you will, as a preface to the training they will receive on their actual build.

Mr. BANKS. Okay. Thank you very much. I yield back.

Ms. LEE. Thank you. I now recognize myself.

As the subcommittee understands that patient information will be flagged as either VA or DOD, depending on where the treatment occurred and where the data originated, Mr. Short, is that a correct assessment?

Mr. SHORT. Yes, ma'am, that is correct.

Ms. LEE. A provider in either department can access a patient's full record and full medical history, regardless of whose flag is on the data, either through Millennium or use in the JLV; is that correct?

Mr. SHORT. For the purposes of patient care, yes, ma'am.

Ms. LEE. We have heard that a patient who has been treated at both, the VA and DOD would have to request their records separately from the two departments due to restrictions caused by data ownership policies; is that accurate?

Mr. SHORT. I believe that is accurate, ma'am. I will take the full question for the record to validate that for you.

Ms. LEE. This is concerning to me, because the goal of Congress in establishing the EHRM programs was to establish one single record that follows servicemembers as they enlist in the military, perform their service, transition, and then for the rest of their lives.

Secretary Byrnes, if a portion of the veteran's health record is held by DOD and another is held by VOA, is that truly a single, unified record?

Mr. BYRNE. As I understand it, it is all in an enclave right now. It was ingested from DOD and we have had some records that we have had ingested from the Department of Veterans Affairs.

For the ability of the record to go to a Department of Defense healthcare provider and then back into the enclave and then back into a VA facility for care and back in again, that is the interoperability component of the enclave that I understand we should have the capability of doing. Granted, that is challenging, that is a capability that I believe we intend to have if we do not have it already.

Now, Mr. Short is that——

Mr. SHORT. That is correct, sir.

Madam Lee, the question, I believe, was if a veteran asked for their entire record from the DOD to VA, could one part of the DOD or VA pull the whole record? We will have to take that one for the record.

Dr. KROUPA. Yes, there is a lot of law and regulation around what each agency can release, and so I think that is where there is been a lot of discussion about how to adjudicate that and who has providence over different parts of the record.

Ms. LEE. Yes, I mean, I just—you know, to me, if a patient needs to go to both, the VA and DOD, to get their complete record, we are not establishing—we are not meeting the goal of the system. It sounds like there are some——

Dr. KROUPA. I can tell you that we have had discussions with Dr. Evans about what might be some possible ways to try and improve that. Because, of course, those laws and regulations were never written at a time when we had the same instance of an electronic health record. We are going into a new era here.

Ms. LEE. Okay. To the extent that there needs to be a change in laws and regulations, obviously, we would like to understand exactly what needs to happen so we can be of assistance and expedite that.

Secretary Byrne, are there policies in place or in involvement regarding this joint ownership or is this something that we are at a standstill because of these laws and regs?

Mr. BYRNE. I would like to toss that to Mr. Windom, if I can, ma'am.

Mr. WINDOM. Madam Chair, this is at the forefront of data syndication discussions. I can tell you this consumes Dr. Neil Evans, who is the FEHRM chair. He is squarely leading this effort.

I want to make sure you walk away with the understanding that the patient still owns his data, the access to his or her data. The access to that data is still controlled by the patient. The roles of care are being worked out of who will have access and whether there is any legislation relief that we need.

We owe you a follow up discussion, but that is a follow up discussion that I would really want Dr. Neil Evans, with us in a support role, to come and brief you on, because I think he is squarely at the forefront of working with DOD.

Ms. LEE. Is Dr. Evans the person who is responsible to setting the policies and finalizing them? Who is responsible?

Mr. WINDOM. What I would offer, ma'am, in his role as the FEHRM lead, he is the responsible element that is brokering the relationship and the understanding between DOD and VA, such that we have a single conduit. I think VA and DOD are prepared to for his lead, but I do not want to speak for the Dep. Sec., but he has been empowered and he has been acting as the FEHRM director for months in advance of this point.

We are comfortable with the movement in this arena. I don't want to overspeak the situation. I think we owe you greater granularity on how we are going to get there, but we appreciate your offer of legislative support because no one contemplated this single enclave, this single hosting site and we may need your involvement in support of delivering.

Ms. LEE. Okay. As soon as those policies are ready, we would love to have a copy of them——

Mr. WINDOM. Yes, ma'am.

Ms. LEE.—or a further discussion on what needs to be done.

Mr. WINDOM. We understand. Thank you, ma'am.

Ms. LEE. Just—I am not going to recognize Ranking Member Banks for 5 minutes.

I am going to close out with one more question about staffing, Dr. Fischer. Did you have a hiring plan in place before Mann-Grandstaff was selected to go first?

Dr. FISCHER. Not for augmentation of staff, ma'am, no. That occurred approximately 1 month after the Cerner contract was signed.

Ms. LEE. Okay. And just a question: You have 108 FTEs that you are going to hire. Where are you on that?

Dr. FISCHER. We have hired over 40 of the 108 and there are several recruitments that are in various phases of having those folks on the campus and fully starting work.

Ms. LEE. When do you want to—like, what is the goal date to have these 108 in place? Is it January? Is it March? Is it December?

Dr. FISCHER. As soon as possible. We are aggressively pursuing those hires.

You know, this is kind of a living document. When we looked at the model and staffing requirements in June 2018, as time progresses and we learned more about the initial capability set and the other information, we have morphed some of those positions. It is a living document.

We just identified the last 20 and we are pursuing those recruitments. I do not think it is a static requirement and I do not think it should be, because we are all learning as time progresses.

Ms. LEE. Yes, I guess my question is, you have a March 28th rollout. You know that you need to provide training for all of the staffing. Are you planning on a month of training? Are you plan-

ning on 2 months? Like, obviously, you need to have the staff in place to train to implement the program.

Dr. FISCHER. Well, end-user training, in addition to a few hours of computer-based training, is 1 week in length. I think we will find time to get new employees trained up in Cerner before they start work.

Ms. LEE. How long did it take you to get those 40 of the 108 onboard from initiation to in your building?

Dr. FISCHER. Well, I think it depends—oh how long does it takes to recruit——

Ms. LEE. How long from when you decided you needed the people to—you advertised, you interviewed, till they are in your building? I am just sort of curious.

Are you on track to fill those 108?

Dr. FISCHER. Ma'am, I can give you an estimate. I would prefer to give you something that is more reliable. I do not perceive a significant delay between identification of a position and recruitment and presence oncampus, providing care and/or support, but it certainly depends on what I am hiring.

If you ask me how long it takes to hire an oncologist, it might take forever based on our market. If you ask me how long it takes to hire an administrative assistant, we can do that pretty quickly.

It is hard to come up with a generalized answer. But there are no significant obstacles that I am aware of when we have identified a recruitment action to getting someone onboard.

Ms. LEE. Okay. Thank you.

Well, thank you all for being here for providing this informative update and answering our questions. We look forward to continuing to have the conversation, particularly with respect to the data migration and data—I know it is not ownership—data stewardship areas, because, ultimately, again, this is all about having one seamless record for veterans from enlistment to active-duty to becoming—transition, and then for the rest of their lives.

If we are going to have this management issue back and forth, we are really not achieving the underlying goal of this whole project. I am wishing you all the best of luck and we will continue to work together and we look forward to hearing about your success, come March 28th. Thank you.

All members will have 5 legislative days to revise and extend their remarks and include extraneous material. This hearing is now adjourned.

[Whereupon, at 2:56 p.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF WITNESS

Prepared Statement of James Byrne

Madam Chair Lee, Ranking Member Banks, and distinguished Members of the Subcommittee. Thank you for the opportunity to testify today in support of the Department of Veterans Affairs (VA) initiative to modernize its electronic health record (EHR) through the acquisition and deployment of the Cerner Millennium (Cerner) EHR solution. I am accompanied today by Dr. Steve Lieberman, Acting Principal Deputy Undersecretary for Health, Veteran health Administration (VHA); Mr. John Windom, Executive Director, Office of Electronic Health Record Modernization (OEHRM); Dr. Laura Kroupa, Chief Medical, OEHRM; Mr. John Short, Chief Technology and Integration Officer; Mr. Michael Tadych, Director, Puget Sound Veteran Administration Medical Center (Seattle); and Dr. Robert Fischer, Director, Mann-Grandstaff Veteran Administration Medical Center (Spokane).

I want to begin by thanking Congress, and specifically this Subcommittee, for your continued support and shared commitment to the success of the Electronic Health Record Modernization (EHRM) program. Because of your unwavering support, VA is able to continue its mission of improving health care delivery to our Nation's Veterans and those who care for them while being a responsible steward of taxpayer dollars.

Background

On May 17, 2018, VA awarded an Indefinite Delivery/Indefinite Quantity (ID/IQ) EHR contract to Cerner. Given the complexity of this endeavor, VA awarded this ID/IQ to provide maximum flexibility and the necessary structure to control cost. Through this acquisition, VA will adopt the same EHR solution as the Department of Defense (DoD). The solution allows patient data to reside in a single hosting site, using a single common system and enables the sharing of health information; improves care delivery and coordination; and provides clinicians with data and tools support patient safety. VA believes that implementing this single EHR solution will allow for seamless care for our Nation's Servicemembers and Veterans. Since the last EHRM update on June 12, VA has accomplished several key milestones.

Task Orders

VA has cumulatively awarded 20 Task Orders (TO). VA leverages the ID/IQ contract structure awarding firm-fixed-price TOs as requirements are validated. This strategy affords VA the flexibility to moderate work and modify implementation and deployment plans efficiently. Since June 12, VA has awarded and begun execution on 12 new TOs to include:

- **TO 9 – Registry and Report Development for IOC:** development, testing, and execution in support of registries and reports required for EHRM IOC. More specifically, these tasks include project management, registry development, report development, training, and development of measures.
- **TO 10 – Additional Data Migration Development for IOC:** additional data migration development, testing, and execution in support of data migrations required for EHRM IOC. These tasks include project management and IOC site-specific data migration/ingestion development.
- **TO 11 – Cerner Standalone Scheduling Pilot Site Surveys:** conduct Cerner Scheduling Solution (CSS) site survey (SS) activities for the Chalmers P. Wylie Veterans Outpatient Clinic and the Ohio Veterans Affairs Medical Center and both sites' associated facilities. These deliverables include the Technical Kickoff, Pilot Plan Tailoring, Pilot Site Technical SS, Pilot Functional SS, and Milestone Decision Review.
- **TO 12 – Current State Review (CSR) Waves 1 – 3:** conduct technical and functional CSR activities for sites in Preliminary Waves 1 – 3. These activities

will include the Technical Kickoff, Wave Plan Tailoring, Wave Technical CSR, and Wave Functional CSR.

- **TO 13 – Cerner Scheduling Solution (CSS) Project Management, Planning, and Strategy:** provide project management and planning support services for the VA CSS solution. These services include CSS Project Management, CSS Enterprise Management Support, CSS Functional Management Support, and CSS Technical Management Support.
- **TO 14 – Revenue Cycle Workflow Strategy Support Services for IOC:** provide resources to support system and process design to accommodate the unique needs of the Veterans Benefits Administration, the Office of Community Care, the Consolidated Patient Account Centers, and the Veterans Health Administration.
- **TO 16 – EHRM Wave 1 Deployment:** conduct Wave 1 deployment activities for the following VISN 20 Sites and associated facilities: Jonathan M. Wainwright Memorial VA Medical Center (VAMC) and White City VAMC.
- **TO 17 – Data Syndication Development and Execution for IOC:** provide additional data syndication development, testing, execution, and sustainment required for EHRM IOC.
- **TO 18 – Revenue Cycle Development for IOC:** test and deploy additional revenue cycle functionality in support of VA revenue cycle requirements for IOC.
- **TO 19 – Encoder and Clinical Documentation Improvement (CDI) Services for IOC:** develop, test, and deploy encoding and CDI functionality in support of VA EHRM revenue cycle requirements for IOC.
- **TO 20 – Revenue Cycle Managed Services for IOC:** develop, test, and execute managed services in support of VA revenue cycle requirements for IOC.
- **TO 21 – EHRM Wave 2 Deployment:** conduct Wave 2 deployment activities for the following VISN 20 Sites and associated facilities: Portland VAMC, Vancouver VAMC, Roseburg VAMC.

Current State Review

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

VA reviewed final reports analyzing the CSR in October 2018 and discovered there are infrastructure readiness areas that require slightly more investment due to aging infrastructure and areas that will not require as much investment as initially predicted. To date, improved network and system performance by increasing network bandwidth and upgrading aging infrastructure resulting in reduced login times at IOC sites from 30–45 minutes to 15 seconds. VA conducted an analysis of industry and DoD/DHA health IT infrastructure to develop EHRM Requirements and Specifications which will optimize usage of the new EHR solution. As a result of these standards, enhancements were made to the local area network (LAN) and wide area network (WAN) at IOC sites, to minimize potential latency with data transfer from IOC sites to the Cerner Data Center. VA procured approximately 21,700 desktops and laptops of which over 50 percent are configured and in use by end users.

Organizational Structure and Strategic Alignment with DoD

On June 25, 2018, VA established OEHRM to ensure that we successfully prepare for, deploy, and maintain the new EHR solution and the health information technology (IT) tools dependent upon it. OEHRM reports directly to VA Deputy Secretary and works in close coordination with the Veterans Health Administration and Office of Information Technology.

To ensure appropriate VA and DoD coordination, we emphasize transparency within and across VA through integrated governance and open decisionmaking. The OEHRM governance structure has been established and is operational, consisting of technical and functional boards that will work to mitigate any potential risks to the EHRM program. The structure and process of the boards are designed to facilitate efficient and effective decisionmaking and the adjudication of risks to facilitate rapid implementation of recommended changes. As a result, since the June 12 hearing,

the two Departments have supported closure of 20 out of 27 critical VA/DoD joint decisions.

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

FEHRM

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

Implementation Planning and Strategy

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

VA's approach involves deploying the EHR solution at IOC sites to identify challenges and correct them. With this IOC site approach, VA will hone governance, identify efficient strategies, and reduce risk to the portfolio by solidifying workflows and detecting course correction opportunities prior to the deployment at additional sites. Specifically, At the IOC sites, VA will implement new workflows in discrete capability sets, also known as blocks. This phased implementation plan supports end-user adoption of new functionalities and interoperability between DoD and VA. As mentioned, VA and Cerner have conducted Current-State Reviews for VA's IOC sites. These site assessments included a current-State technical and clinical operations review and the validation of each facility's capabilities list. VA started the go-live clock for the IOC sites, as planned, on October 1, 2018.

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

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

During the multi-year transition effort, VA will continue to use Veterans Information System and Technology Architecture (VistA) and related clinical systems until all legacy VA EHR modules are replaced by the Cerner solution. For the purposes of ensuring uninterrupted health care delivery, existing systems will run concurrently with the deployment of Cerner's platform while we transition each facility. During the transition, VA will ensure a seamless transition of care. A continued investment in legacy VA EHR systems will ensure patient safety, security, and a working functional system for all VA health care professionals.

National Workshops

In September 2018, VA held its Model Validation Event, where VA's EHR Council met with Cerner to begin the national and local workflow development process for VA's new EHR solution. There was a series of working sessions designed to examine Cerner's commercial recommended workflows and evaluate the current workflows used at VAMCs. Because of Model Validation, VA planned eight national workshops to educate diverse clinical end-users and validate workflows to ensure VA's new EHR solution meets the Department's needs.

VA completed the eight national workshops that spanned nearly 1,500 sessions and over 50,000 cumulative work hours by over 1,000 frontline clinicians and end users from across the enterprise. VA was supported by DoD, who brought lessons learned and context to the DoD's EHR configuration, and by industry advisors who shared commercial best practices. Through these workshops consensus was reached on over 1,300 design decisions and over 850 workflows were standardized to best meet the needs of our Veterans. VA also held seven of eight local workshops to validate national design decisions and configure to meet local site requirements. This educated local sites in how their facilities would use the new EHR solution to deliver quality health care to their Veteran population.

Change Management and Workflow Councils

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

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

Further, in response to lessons learned from DoD and commercial EHR deployments, VA designed the VA Innovative Technology Advancement Lab (VITAL) to provide advanced, hands-on education for VA informatics and analytics leaders as a lesson learned from DoD. The VITAL program consists of four, three-day, in-person sessions and a capstone project. The capstone project allows for participants to solve real-world problems, so they gain confidence and competence to take full advantage of the advanced capability in the new EHR solution. These participants are an important component of the super user community as they can support their peers during training, Go-Live, and sustainment activities. Initially 76 trainees were divided across four cohorts to participate from across 40 point-of-care clinical and support functions from VISN 20 sites.

Centralized Scheduling Solution

VA accelerated the timeline to implement a resource-based scheduling solution across the enterprise in advance of the delivery of the full EHR solution. VA currently manages clinical scheduling using the Veterans Health Information Systems and Technology Architecture (VistA). According to a VA study VistA scheduling does not provide VA with the requisite functionality, usability, and overarching business benefits. Additionally, the outdated user interface and cumbersome manual processes create inefficiencies and prevent schedulers from viewing the medical provider's complete picture of available appointments.

As a result, in 2018, VA piloted the Medical Appointment Scheduling System (MASS), a commercial resource-based, scheduling solution in Columbus, Ohio, to replace the clinic-based VistA scheduling system. This pilot site demonstrated that a resource-based solution improved timely access for Veterans, increased provider productivity, and enhanced scheduling accuracy. Further, the resource-based solution:

- Increased visibility of available appointments,
- Allowed providers a comprehensive view of their entire day, and
- Enabled staff to efficiently manage resources needed for appointments.

Because a resource-based solution supports delivering better health care for Veterans, VA will implement the Centralized Scheduling Solution (CSS) to bring these benefits to all Veterans.

VA's EHR modernization contract contains the licenses to implement CSS across the enterprise to fulfill interoperability objectives. Like MASS, CSS is a resource-based scheduling solution and will be implemented in a number of VA facilities in advance of full EHR modernization capabilities. The Chalmers P. Wylie Ambulatory Care Center, in Columbus, Ohio, will serve as the pilot site for CSS, with Go-Live scheduled for April 2020. The Louis Stokes VA Medical Center in Cleveland, Ohio, will serve as the next and larger pilot site for CSS. VA will leverage the architecture and lessons learned from the MASS solution by collaborating with key stakeholders from the MASS implementation to ensure these lessons learned are incorporated in VA's new scheduling initiative.

VA established a dedicated pillar, or division, within OEHRM to provide oversight of CSS integration, deployment, and change management activities. Further, the pillar will collaborate with partners such as the Veterans Health Administration, Office of Information and Technology, and the Veterans Benefits Administration to successfully implement the CSS solution. Accelerating CSS implementation will enable VA to provide a resource-based scheduling solution across the enterprise sooner, and also replace VistA Scheduling Enhancements (VSE), which is the current temporary bridge for scheduling needs.

Funding

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

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

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

Conclusion

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