

**Written Statement of  
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Before the House Veterans Affairs Committee  
March 7, 2023**

Thank you for the privilege of testifying before you today regarding the Electronic Health Record Modernization effort at the Department of Veterans Affairs.

I am deeply grateful to Chairman Rosendale, Ranking Member Cherfilus-McCormick, and members of this subcommittee for the opportunity to share with you my perspective on one of the largest civilian information technology projects in history.

Our commitment to our nation's veterans transcends party lines and political ideology. In an era of especially deep ideological divide and social tension, I applaud your leadership, Mr. Chairman, in soliciting the best ideas and constructive, fact-based perspectives from across the spectrum.

During my time in public service, and under the leadership of Assistant Secretary Baker with whom I am delighted to appear this afternoon, I had the honor of working on several medical information technology systems that are still in use today. Especially relevant to this testimony are the Joint Longitudinal Viewer (JLV) (originally known as "Janus") and the Blue Button personal health record. Launched during a Democratic administration, Blue button was warmly embraced by the most recent Republican one, too, "as a fundamental component of any effort to empower patients in their healthcare decisions." And JLV enables hundreds-of-thousands of clinicians to see records across platforms every day.

It is in that context – access to and interoperability of clinical data – that I respectfully offer my observations.

In my opinion, there are three issues before the government regarding VistA at Veterans Affairs:

- 1) That the billions of dollars already spent on the Cerner implementation will not scale to enterprise-wide clinical care services on the current path, budget, or timeline

- 2) That VA can-and-should sustain the data interfaces and connection frameworks already built to send and receive data from MHS GENESIS
- 3) And, most important of all, that VA consolidate its current instances of VistA onto a VA-centered clinical workflow, and augment the VistA model to receive data from third-party providers

Our ability to deploy VHA's nearly 1,300 facilities is hopelessly challenged by the incompatibility of those with each other. Leadership – then and now – presumed that VistA instances are fundamentally congruent, from clinical workflow as well as data interoperability perspectives. This is incorrect. VistA instances do not inter-operate, and the agency was unsuccessful in catalyzing alignment around a single clinical process and record, the sine qua non of a commercial deployment.

Thoughtful members of our community will sensibly ask how it was possible to install Cerner at the Military Health Service was ostensibly successful, while the VA's has been a failure. There are three reasons. First, DoD had already made the transition to a centrally administered system, as opposed to VA's decentralized approach that perpetuates workflow (and data model) autonomy across 130 hosts. Second, the DoD's "command and control" structure not only enforced protocol alignment, every deployment was preceded by careful preparation, training, and integration. Third, their system was in substantially worse condition than ours, and Cerner is perceived as an improvement over AHLTA, although according to KLAS this is not a widely held perception, even at MHS.

Although VA is one the nation's largest integrated delivery platforms, there are several others in the private sector – including, for example, HCA (186 hospitals), Ascension (150 hospitals), and Kaiser Permanente (39 hospitals) – each with similarly sized patient populations. Before VA embarked on a multi-billion dollar health record modernization, we should have been clear on the price-and-performance benchmarks from near peer enterprises. We should well understand the capabilities they prioritize in their information systems *before* we try to install one ourselves. As you'll hear from other witnesses, the differences in VA healthcare between cities is simply not that large. It is not tens-of-billions-of-dollars large.

The inescapable solution to the real-world challenges of first-class healthcare services at VA is an institutional commitment to rebalance the "have it our way"

approach. VA must truly, sincerely, authentically, put the Veteran first, and streamline its own processes before it attempts to automate them. As straightforward as this sounds to anyone who works for (or is a customer of) a manufacturer, a school, a hospital, a store, a publisher, or a transportation, energy, or services company, it is exactly not what happens at VA. Veterans receive terrific healthcare, but their care is delivered with different processes depending on which hospital or clinic they go to.

There is surprisingly little in the operational literature about how to drape an enterprise management framework over complex clinical environments, never mind one as large and diverse as VA's.

From a data perspective, this has profound implications. When we try to connect applications-to-pipelines-to-governance, the transactional perspective and the analytical one are, literally, geometrically orthogonal to each other. Transactions are row based (every new interaction, like delivering a vaccine, or serving a meal, requires a new entry) and analytics are column based (so as to avoid the need to ingest *every* attribute of *every* transaction for *every* report, like how many injections were made, and how many meals were served).

In practical terms, while VistA communicates between members of the care team one patient at a time, all of its data is exported to a separate system to measure outcomes and improve service. The current effort to replace both components of that at once is difficult to do. We're trying to fit round transactional pegs into square analytical holes. We should stop doing that.

In my opinion, the department should not announce its intention to change the contract unless and until it has a backup plan in place. That plan cannot be "revert back to VistA" in its current form, or anything that concedes to VA's continued digital isolation and process insularity. Yes, Cerner has performance deficits in response time, uptime, and data syndication latency; these will only get worse as more hospitals are brought online.

The problems are compounded, however, by VA's inability to prepare for Cerner's deployment. VA in general relies too much on industry to "tell it what it needs," never mind what it could have. Unless and until the institution is committed to aligning its internal processes, no amount of technology will automate its operations, and no amount of money will solve its policy problems.

The trade-space is simple: VA must go on the record and publicly-state their commitment to a single enterprise -workflow and -data model. Congress could develop objective and quantitative measures to validate compliance, with real consequences for noncooperation or nonparticipation.

If we change the agreement with the commercial vendor, VA must also prepare itself for an onslaught of criticism because of previous attempts that also failed, including HealthVet, iEHR, and Vista Evolution. Switching back to VistA and walking away does not fix the root problems. How do we address the issue?

First and foremost, cloud technologies are now stable and mature enough to enable consolidation onto an authentically single platform. Additionally, there have been substantial improvements to the codebase that are now available to VA from the commercial sector. I believe that the Open Source Electronic Health Record Alliance was the right idea, but it was poorly implemented because of VA's (and DoD's) lack of sustained commitment and the peculiarity of a "single customer" market. Nonetheless, it would be straightforward to re-instantiate OSEHRA with a powerful charter and legislative mandate. It would certainly be objectively better, and cheaper, than what we have now.

Moreover, commercially available data management infrastructure has made substantial progress in the last five years. The VA has been dreadfully slow to adopt these standards and tools, including FHIR and bi-directional Blue Button, because of VistA's inability to ingest third-party clinical data into the enterprise model. There are no technology impediments here; this is simply a matter of political will, imaginative leadership, and execution accountability.

Indeed, both these policy changes – consolidation onto an enterprise clinical workflow, and adoption of proven platform and data management services – would accelerate health record modernization at a fraction of the costs now earmarked for EHRM. They can be systematically procured, thoroughly tested, and methodically deployed during this Congress and sustainably thereafter.

Software is designed to help automate repetitive tasks that we do every day. If what clinicians do every day is different at every hospital, and we allowed those points of care to grow their own for decades, it is no surprise that all the software is going to be different. How we got here is no mystery.

If VA shared best practices between hospitals, identified optimal workflows, disseminated them to their network, and updated the software unto a unified platform, then clinicians throughout the enterprise would provide care in a similar (and probably better) way. This would not only improve safety and outcomes, it would be more amenable to a wholesale replacement.

The transcendent goal is continuously better healthcare for Veterans. Until VA resolves its internal tension around a consolidated workflow and comprehensive data management, no new or renovated electronic record will be successful.