READY, SET, GO-LIVE: ASSESSING VA'S EHR MODERNIZATION DEPLOYMENT READINESS

HEARING

BEFORE THE

SUBCOMMITTEE ON TECHNOLOGY MODERNIZATION

OF THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

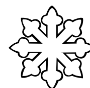
ONE HUNDRED NINETEENTH CONGRESS

FIRST SESSION

MONDAY, DECEMBER 15, 2025

Serial No. 119–40

Printed for the use of the Committee on Veterans' Affairs



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62–607 WASHINGTON : 2026

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READY, SET, GO-LIVE: ASSESSING VA'S EHR MODERNIZATION DEPLOYMENT READINESS

MONDAY, DECEMBER 15, 2025

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

The subcommittee met, pursuant to notice, at 3:01 p.m., in room 360, Cannon House Office Building, Hon. Tom Barrett (chairman of the subcommittee) presiding.

Present: Representatives Barrett, Luttrell, and Budzinski.

OPENING STATEMENT OF TOM BARRETT, CHAIRMAN

Mr. BARRETT. All right. Good afternoon. The Subcommittee on Technology Modernization will now come to order. I want to thank our witnesses for joining us.

We continue our oversight of the U.S. Department of Veterans Affairs (VA) Electronic Health Record Modernization (EHRM) Program. I was actually joking with some friends back home recently. They were asking me what it is like my first year in Congress, and I was telling them a little bit about the work we are doing on this subcommittee. I said, before I came here, I did not even—I could not have even told you what health record system the VA had and now I spend far too much of my waking hours thinking about it. But appreciate the work that we have done on this committee and for the witnesses that are here today.

Right now, of course, we are at a pivotal moment. I think we are down to 117 days until the new system will be launched at 4 of the medical facilities in my home State that serve the veterans, of course, from my district, but across Michigan and parts of other states as well. This timeline is locked in and the countdown is on. The question remains, when the switch is flipped in April, will the system deliver and will it do what we need it to do? Are we going to run into snags like we have in the past?

For millions of veterans relying on VA hospitals and staff supporting them, this is not something that is theoretical. It is real, it is happening, and we have to do it right. As I said before, the veterans that we serve and that the Department is going to serve have the right to be a little bit unaware of the nuance of which health record system the VA is using. They want it to work right, be able to schedule their appointments, go see their specialists, and move on with their day in a timely way.

Veterans expect more than just promises. They expect safe and timely care. We all expect systems that support our doctors, not

work against them. Technology should be a tool that opens doors, not a barrier that adds more steps, more clicks, and more frustration. We heard about some of that earlier in this committee term when we saw that providers were getting frustrated with some of the interfacing with the system they have.

When we first met on this topic in February, VA was just emerging from a very long pause. While progress has been made since then, we know that significant work remains before we go live. VA has standardized over 1,000 workflows into a national baseline, with Michigan being the first to use it. VA has tightened their timeline, and for the first time since the pause, we saw large system updates roll out this August without disrupting care. These are meaningful, good signs, but we cannot ignore other red flags that are warnings.

Behind the scenes, many tools slated for Michigan have never been tested on a large scale. Thirty-four new complex clinical workflows will debut there for the first time. VA plans to test across four sites simultaneously, a strategy that leaves really no margin for error and something that I have concerns about the risk associated with that.

We need assurance that this plan is feasible in the real world, not just on paper or in a computer laboratory. We need to know that the lessons of the past have been learned and not just observed and acknowledged. The user experience also remains a concern. While satisfaction is slightly up, more attention is needed.

The committee has heard from physicians that the critical function system remains unstable. We hear from VA pharmacists, I know that is a very unique role that the VA has, that tools for monitoring drug interactions are still a major pain point. VA staff are now burdened with more manual processes to ensure patient safety with drug interactions. We need to know where these issues stand today so Michigan clinicians and veterans are not left holding the bag on day one.

Finally, we must address the sheer scale of the cost. This program began in 2018 with a $10 billion price tag. It quickly ballooned far beyond its original expectations, and the latest estimate stands at $37 billion. We cannot keep writing blank checks that risk taxpayer money and slows down or, worse, endangers delivery of veteran care.

I am encouraged by the momentum we have seen. I am encouraged by the commitment of my friend Secretary Collins and the Trump administration team, but encouragement only goes so far as reality sets in. We need proof and we need transparency. The clock is ticking down for Michigan for this to go live and the time for promises is over. The only acceptable result is a flawless Go-Live because our veterans cannot accept failure.

Thank you, again, for being here today. I do want to say it is never my intention to take gratuitous shots at anybody appearing before this committee, but we do have a role to play in oversight of what is taking place, and we intend to vigorously and robustly carry that forward.

With that, I will yield to Ranking Member Budzinski for her opening statement.

OPENING STATEMENT OF NIKKI BUDZINSKI, RANKING MEMBER

Ms. BUDZINSKI. Thank you, Mr. Chairman, and I agree with you. Thank you to our witnesses for being here today. It seems we are bookending this year with EHRM hearings, and I look forward to hearing how the program has improved and how the Department has prepared to resume Go-Live activities.

To start, I do want to address an article that I read over the weekend about Secretary Collins' plans to eliminate 35,000 positions from the Veterans Health Administration (VHA). I am disappointed that we had to learn about this through the media and not from the Secretary himself. Something this significant, I believe, warrants proactive communication with Members of Congress.

The Department is quick to say that most of these positions are vacant, but the word is "most" and they do not use "all." The VA workforce is already stretched too thin. Eliminating positions does nothing to help veterans who in many places, like my district, are waiting months for appointments. In fact, these actions threaten to undermine VA's ability to deliver timely care.

Only at the VA can veterans expect to receive care from providers who have a deep understanding of their unique experiences. That is irreplaceable. If Secretary Collins is serious about keeping veterans at the center of everything, VA healthcare must continue to lead the way. VA must be fully staffed and resourced. The continued efforts of this administration to bleed VA dry will make it harder for us to honor the service of our Nation's veterans.

Their efforts to outsource veterans' care will also have dire impacts on the success of the EHRM program. Today we are 117 days from VA's EHRM Go-Live at 4 VA medical centers in Michigan. After the program was reset for 3 years, the Department made the decision not only to restart, but to accelerate the Go-Lives in an effort to finish almost on schedule. I am sure the chairman is anxious about this. I know I am. There are VA facilities around my district that are scheduled to go live right after the Michigan sites.

The veterans of Michigan's 7th District and Illinois' 13th District are next to be impacted by EHRM. We need assurances that Oracle and VA have fixed the issues that are still plaguing the first six sites.

At the time of our last hearing on EHRM in February, the Department had dozens of outstanding recommendations from VA's Office of the Inspector General and the U.S. Government Accountability Office (GAO). According to GAO's testimony, it has not changed. Our goal is to ensure that we are setting VA up for success. However, what I have heard in the past year has not convinced me that VA is ready for launch at 13 facilities in 2026. I have raised many questions with VA and Oracle, but the answers do not give me confidence. In fact, I worry that we are spending billions of dollars while simultaneously setting this program, particularly the six sites that are already live, up for failure.

I need both VA and Oracle to tell me what they have done to address concerns raised by VA employees and veterans at the first six sites, such as prescription errors and incorrect alerts. For veteran patients, the consequences of these errors range from discomfort to

death. We must know the catastrophic errors in the system are not putting veterans' lives at risk.

I also want to hear what state the system is going to be in when EHRM goes live at the next four sites. Earlier this year, we learned that VA was looking for an EHRM systems integrator. I was hopeful that this might be a positive change in the program rollout. There are a lot of questions about this contract, which was awarded to Accenture in November, and how it is going to work. In fact, Ranking Members Takano and Blumenthal sent a letter to Secretary Collins shortly after the award was announced and have yet to receive a response.

What will Accenture actually do to make EHRM more successful? Is it a true systems integrator or is it a continuation of the role currently held by Booz Allen Hamilton? How will Accenture be effective given its lack of authority over the Oracle Prime contract?

Unfortunately, the more I hear about this contract, the more it seems to be a replacement for VA's program management contract, not an actual systems integrator. In September, Deputy Secretary Lawrence informed me that VA estimates the life cycle cost of this program to be $37.2 billion, but it seems like this estimate has changed quite a few times. VA originally told Congress, as Chairman Barrett mentioned, they needed $10 billion for the entire program.

Shortly after that, they came back and asked for an additional $6 billion for VA's program costs. In 2022, VA contracted with the Institute for Defense Analysis to conduct a true life-cycle cost estimate, which shifted the estimate for the project to almost $50 billion. Now the Deputy Secretary is backtracking and saying that it is only going to cost $37.2 billion.

I am concerned that nobody actually knows what the bottom-line cost is. I need to hear today that VA has a grasp on this. The American taxpayers and veterans deserve transparency.

Finally, I want to address a recent article in the Washington Post about VA's EHRM program. I believe this article highlighted real concerns from Department employees about the system, concerns expressed from a place of worry for patient safety and provider burnout. I wish the Department would take these concerns seriously and use that feedback in their change management efforts.

I find it very troubling that the Department instead seems to be minimizing the concerns raised. Their framing of the story takes their usual tack: blame everything on the previous administration. I will be honest, I think there is plenty of blame to go around. Of course, it was the first Trump administration that rushed VA into a sole-source contract with Cerner before either was ready.

Ultimately, we should not be pointing fingers. We need to have the difficult conversations to make sure that both Oracle and VA are accountable to Congress, to VA employees, and, most importantly, to veterans. We need to ensure that this new EHR supports VA's provision of world-class healthcare.

Thank you, Mr. Chairman, and I yield back.

Mr. BARRETT. Thank you, Ranking Member Budzinski.

I will now introduce our witnesses. From the Department of Veteran Affairs, we have Dr. Neil Evans, acting program executive di-

rector of the Electronic Health Record Modernization Integration Office. Did I say that correctly, Doctor? All right, very good. From Oracle, we have Hon. Seema Verma, executive vice president and general manager of Oracle Health and Life Sciences. From the GAO, we have Ms. Carol Harris, a familiar face to this committee, the director of Information Technology (IT) and cybersecurity at GAO.

I will ask the witnesses to please stand and raise your right hands. Well, your right hand.

[Witnesses sworn.]

Mr. BARRETT. Thank you. Let the record reflect that all witnesses have answered in the affirmative.

Dr. Evans, you are now recognized for 5 minutes to deliver your opening statement on behalf of VA.

STATEMENT OF NEIL EVANS

Dr. EVANS. Thank you. Good afternoon, Chairman Barrett, Ranking Member Budzinski, and distinguished members of the subcommittee, including Mr. Luttrell. I want to begin by thanking Congress and this committee for the opportunity to testify today and for your continued support of VA's electronic health record modernization efforts. VA remains committed to successfully implementing a modern interoperable Electronic Health Record (EHR) system , which we refer to as the Federal EHR, and we intend to implement that across the entire VA enterprise.

As was mentioned, since our last hearing in February, VA has made significant progress toward meeting that goal. In March, VA announced its plans to deploy the Federal EHR to nine additional VA medical centers and associated clinics in Ohio, Indiana, Kentucky, and Alaska by the end of calendar year 2026. Those were in addition to the four previously announced medical centers in Michigan slated for deployment, bringing the total number of planned deployment sites in 2026 to 13. That encompasses more than 100 physical locations, when clinics are considered in addition to the medical centers, and will involve transitioning more than 27,000 VA employees from Veterans Health Information Systems and Technology Architecture (VistA) to the Federal EHR in this coming year.

In addition, we have begun deployment work at 7 additional facilities, with 19 more on the way, all with planned Go-Lives in 2027. Furthermore, as evidence of our commitment to full implementation of the system across the VA enterprise, we recently shared a schedule with this committee outlining our plans to complete deployments of the Federal EHR at all VA medical facilities as early as 2031.

Based on lessons learned, VA will now be using a market-based approach for deployments, with multiple medical centers working together and going live simultaneously in each deployment wave. This approach allows us to scale up the number of deployments, enhance efficiencies, and improve the sharing of best practices within and between markets.

Now, I would like to bring our focus back to the near term. As was mentioned, we are only 117 days, less than 4 months, away from our planned Go-Lives in Michigan, and less than a year away

from the remainder of our deployments across all of Veterans Integrated Service Network (VISN) 10 and Alaska. The title that you chose for this hearing is apt: "Ready, Set, Go-Live." Teams at all the 2026 sites have been preparing diligently for upwards of a year. The gun has already gone off, Go-Live dates are imminent, and we are on track for successful deployments.

Contributing significantly to VA's current momentum has been leadership ownership of this project at all levels of our organization, starting at the very top. Since assuming their roles, Secretary Collins and Deputy Secretary Lawrence have prioritized attention to this critical project and have taken significant steps to ensure that all stakeholders are aligned. Dr. Lawrence has been talking to site and VISN leaders weekly and has made multiple visits to sites scheduled for Go-Live in 2026, where he has made it a priority to listen to fellow veterans and VA staff talk about their experiences and expectations, and to respond quickly when adjustments are needed. Just as important, leadership and staff at both the individual sites and the VISN level are encouraged by the program's direction and newfound momentum and are perhaps the most important drivers behind our current progress.

As for the system itself, VA and Oracle Health have made significant strides in assuring the Federal EHR is performing reliably and meeting our expectations. As an example, as of November 19th, Oracle Health Systems within the Federal EHR maintained an incident-free time of 95.93 percent, exceeding our agreement of greater than 95 percent for 21 consecutive months. We are also delivering system enhancements, new features and system changes that are responsive to the feedback we are hearing from VA staff and are driving improved standardization across the enterprise.

For example, I know we have often spoken about the system's pharmacy capabilities in this committee and we will be delivering seven further pharmacy improvements before our Go-Lives in Michigan in April. As another example, we just released new system functionality called "Seamless Exchange" in September, reducing by more than 95 percent the volume of external data requiring manual review and reconciliation by VA clinicians.

We are seeing evidence of the results of the change we have made. We continue to administer the Federal EHR User Experience Survey twice yearly and I am pleased that we have seen consistent improvement survey over survey. Ultimately, our goal is to deliver an EHR system that earns the trust of veterans, clinicians, and staff. That means a system that works efficiently, enhances care coordination, reduces administrative burden, and improves health outcomes for veterans.

With the partnership of this Subcommittee, we look forward to continued and accelerated progress over the remainder of the 119th Congress and beyond.

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

Mr. BARRETT. Thank you, Dr. Evans. The written statement of Dr. Evans will be entered into the hearing record.

Ms. Verma, you are now recognized for 5 minutes to deliver your opening statement on behalf of Oracle.

STATEMENT OF SEEMA VERMA

Ms. VERMA. Thank you. Chairman Barrett, Ranking Member——

Mr. BARRETT. Can you please use your——

Ms. VERMA. Oh, I am sorry.

Mr. BARRETT. Yes.

Ms. VERMA. Let us try again.

Mr. BARRETT. Thank you.

Ms. VERMA. Good afternoon, Chairman Barrett, Ranking Member Budzinski, and members of the subcommittee. Thank you for the opportunity to speak with you today about Oracle's work with the VA's EHR Modernization Program.

Since the last hearing, VA announced an accelerated deployment schedule that will complete the full implementation for all sites by 2031. Next year, the Federal EHR will go live at 13 sites and we are preparing to launch at 26 facilities in 2027. I am pleased to report significant progress on the accelerated deployment plan and that Oracle is confident that we are prepared and fully aligned with the VA to meet this goal.

Most importantly, leadership engagement and ownership for the EHR implementation has never been stronger. There is clear direction from the highest levels and a deep sense of accountability across all partners.

We also want to recognize and commend VA leadership for their clear commitment to standardization across the enterprise. Their decisive leadership has strengthened the program and demonstrated a shared determination to deliver a unified, high-performing EHR for veterans.

Overall system performance is strong, the system is stable and there is notable decrease in interruptions to end users. We have met or exceeded the 95 percent incident-free time requirement for 21 consecutive months and we have been free of any systemwide outages for 8 consecutive months. These improvements are a direct result of the coordinated effort between Oracle and VA. Together we have formalized our incident review process and implemented proactive monitoring and targeted upgrades.

We have optimized the EHR to improve veteran health outcomes, enhance provider productivity, and strengthened financial performance results. With these optimizations, productivity has increased at all facilities and cash collections exceeded Fiscal Year 2025 goals, achieving 180 percent of target.

Last, as Dr. Evans referenced, we have expanded Seamless Exchange to all Federal EHR facilities. Seamless Exchange compiles and deduplicates patient data from multiple sources. This reduces the volume of external data that requires manual review and enables improved medical charting and decision-making efficiency.

Finally, we have strengthened every part of our deployment methodology with a focus on improving staff readiness. This includes enhanced training and change management, both virtual and in-person, that allows end users to not just learn about changes, but to actually try the system out in advance of Go-Lives.

We are modernizing the underlying infrastructure through the migration of the Federal EHR to Oracle's cloud. This move will not only provide better system performance and security, but will also allow VA to adopt modern tools, including our clinical Artificial In-

telligence (AI) agent. The clinical AI agent reduces clinical burden and supports safer, more efficient care, all while ensuring the provider remains at the center of decision-making.

Our work does not end here. With VA's commitment to a commercial solution, they will continue to benefit from Oracle's ongoing innovation, including our new Voice-First Ambulatory EHR, recently certified by U.S. Department of Health and Human Services (HHS). With this certification, ambulatory clinics across the United States, including the VA, can begin planning for the adoption of our transformative EHR. Unlike other EHRs, Oracle's was built from the ground up on a secure, modern cloud. This allows for streamlined clinical workflows and automation of manual tasks so providers can spend more time with patients.

Oracle continues to lead on data interoperability. We have taken the White House Interoperability Pledge and have recently been designated as a Qualified Health Information Network, or QHIN, by HHS. This achievement will enable broader and more secure exchange of patient data records across disparate systems as veterans receive care from multiple sites and multiple providers. Our QHIN will streamline connectivity, enhance data accessibility, and help ensure that every care provider has timely, comprehensive information to support better outcomes for veterans everywhere.

In closing, as we move into 2026, we are confident and prepared to deploy the Federal EHR under the accelerated deployment schedule. This will bring a unified health record to veterans, which we can all agree brings incredible opportunity to improve their experience with the VA and the health of our veterans.

Thank you and I look forward to answering your questions.

[THE PREPARED STATEMENT OF SEEMA VERMA APPEARS IN THE APPENDIX]

Mr. BARRETT. Thank you, Ms. Verma. The written statement of Ms. Verma will be entered into the hearing record.

Ms. Harris, you are now recognized for 5 minutes to deliver your opening statement on behalf of the GAO.

STATEMENT OF CAROL HARRIS

Ms. HARRIS. Thank you, Chairman Barrett, Ranking Member Budzinski, Congressman Luttrell. Thank you for inviting us to discuss the readiness of VA's EHRM program.

In June 2017, the Department initiated this program to replace the legacy VistA system and has since deployed the new EHR to six of its medical centers at a cost of about $12.7 billion. The rollout of the system has been met with poor user satisfaction, change management issues, and slow resolution of trouble tickets, among other things. Given the magnitude of user concerns, VA paused deployments in April 2023 to improve the system and address those concerns.

On December 2024, VA announced it would resume deployment, starting with four Michigan sites in April. By the end of 2026, VA plans to complete another nine sites under an accelerated deployment schedule and roughly 170 more throughout the Nation by 2031.

Over the past 5 years, we have issued five reports on VA's efforts to deploy its new EHR system. These reports describe actions

taken by the Department and identify challenges with key planning tools critical for program oversight. We also reported on challenges experienced with the initial deployments, such as the ones I just noted.

To address these challenges, we made 18 recommendations, 12 of which we have marked as priority because of the critical impact they have on strengthening successful future deployments. While VA has taken action to address our recommendations, it has not fully implemented 16 of them. I will highlight the 12 priority recommendations here.

The first two are that VA needs to produce an updated cost estimate and schedule. The latest independent cost estimate of roughly $50 billion does not reflect the many changes and delays to the program. I know you have said that they have provided you with an updated estimate of 37 billion. We have not received that estimate, and so I would ask the Department to provide that to us so we can review it. The updated estimate is imperative to understanding the full magnitude of VA's investment.

We have also yet to see an updated integrated master schedule. Consequently, as the Department increases its momentum to complete 170 total site deployments by 2031, more information critical to controlling risks and informing congressional oversight is needed. Additionally, more work is needed to demonstrate results of VA's actions to address user concerns and system issues.

In May 2023, we reported on gaps in VA's organizational change management activities for EHRM. We also reported that users expressed great dissatisfaction with the new system and that VA did not adequately identify and address those issues. We made 10 priority recommendations to address change management, user satisfaction, system trouble tickets, and independent operational assessment deficiencies. VA concurred with those recommendations, and, as of December 2025, VA has partially implemented 1 of the 10 priority recommendations and continues to work toward implementing the remaining 9.

For example, VA partially implemented the recommendation to address users' barriers to change. To do so, VA developed plans to address user concerns about the new system identified in a strategic review of the program. However, VA has not yet adequately demonstrated that corresponding improvement projects have fully addressed underlying barriers.

VA has also not yet approved and implemented a VA-specific change management strategy to formalize how it will improve the readiness of end users to adapt to working in the new EHR system. Further, VA has no plans to conduct an independent operational assessment or an Independent Verification and Validation (IV&V) test to determine whether the system is operationally suitable. Without an IV&V, the Department increases the risk of deploying the system prematurely, thereby posing unnecessary risks to patient health and safety.

Moving forward, it will be critical for VA to address the 12 priority recommendations along with the other 4 open ones as soon as possible. Until these are fully implemented, future deployments are at risk of prolonging challenges like those experienced in the initial

deployments. Doing so will position VA to more effectively deliver a modern health record system our veterans deserve.

That concludes my statement. I look forward to addressing your questions.

[THE PREPARED STATEMENT OF CAROL HARRIS APPEARS IN THE APPENDIX]

Mr. BARRETT. Thank you, Ms. Harris. The written statement of Ms. Harris will also be entered into the hearing record.

We will now proceed to questioning. I will recognize myself for 5 minutes.

Ms. Harris, thank you. You mentioned some of the cost-associated considerations and concerns that are out there, what the true price tag of this is going to be. Dr. Evans, is this something that you can furnish through the Department over to the GAO for them to review that life cycle cost analysis?

Dr. EVANS. Yes, we provided that to this committee on September 30th and we certainly can provide it to the GAO.

Mr. BARRETT. Okay, appreciate that. Then, anecdotally, so I go to predominantly the Battle Creek VA Hospital near my district for most of my care, occasionally go to the Lansing Outpatient Clinic there. I will usually ask the folks that I interact with kind of their thoughts on this coming up. They are all well familiar with it. I mean, there are posters up, you cannot pull into the driveway of the hospital without seeing this announcement of the, you know, unrolling of a new electronic health record management system. I do not advertise to them the, you know, role that I have on this committee of oversight of this process. I will just kind of get their opinion as to how it is going.

I would say it is not great. There is a bit of a mixed opinion. Some of them feel like they are not fully ready for the new system at this point. Dr. Evans, can you walk me through? I mean, I understand we are not going to train people on this prematurely, but do you have confidence, does the Department have confidence that the end user, the people that are actually interfacing with this program, are going to be well equipped to deal with it at the time that we go live?

Dr. EVANS. In short, yes, but let me give you some——

Mr. BARRETT. Yes.

Dr. EVANS [continuing]. comfort behind that answer. For the four sites in Michigan, we just completed last month super user training. Super users are folks who are in every department of the medical centers in Michigan, who will be the kind of experts in the Federal EHR for their peers. I think there was over 400 folks who went through super user training. I do not have the exact number here, but it is a sizable number. The super users are going to basically help the end users when they start their training. For the average user, so that is somebody who has not been selected as a super user, they start their training February 1st, so the beginning of February.

With super user training, we have introduced a lot of changes to how we do training and how we support adoption for the Michigan Go-Lives. We had 96 percent of those we expected to complete super user training completed super user training. On average, they rated the classes four out of five. We had a lot of direct feed-

back that this was significantly better than the first time. For those who had gone through this before, before we paused at the Michigan sites, they said, yes, this has been much better.

In addition for the super users we have added, and for all end users, something called learning labs. This was a success at Captain James A. Lovell Federal Health Care Center (FHCC). Learning labs are when we finish classroom training or what is—well, it is delivered virtually, virtual instructor-led training. After that we do a learning lab which is where users can come together and practice using the system in the sandbox together with their colleagues and see exactly how it works.

We had 13 scenarios at FHCC in North Chicago when we went live there, got a lot of great feedback about that. We have now built 98 scenarios and went through those learning labs with the super user, got a lot of great feedback about it. I would say that the end users should expect their confidence to start to grow as they get into training in February and learning labs in March.

Mr. BARRETT. Okay. Thank you.

Then the Ms. Harris, the IV&V test that you pointed out, is that the one I think you had mentioned to me separately, that the kind of four parallel testing going on instead of sequential testing, is that part of the IV&V or is that a separate test that would be required?

Ms. HARRIS. Well, given the change in the strategy for testing with this market-based approach where they are going to be basically simultaneously testing at four sites, it will make it more difficult to do an IV&V, which is that end-to-end test.

Mr. BARRETT. That is a separate then——

Ms. HARRIS. Yes.

Mr. BARRETT. Okay.

Ms. HARRIS. Yes.

Mr. BARRETT. Both are, in your opinion, complicating—could lead to significant risk?

Ms. HARRIS. I do believe so. I think that the simultaneous testing at the four sites, it will take a tremendous amount of resources. To deal with the issues that come up inevitably with a Go-Live, to be able to handle it at all four sites simultaneously could be, you know, significantly risky for the Department.

Mr. BARRETT. Ms. Verma, when I get back to my next order of questions, I will have a question for you about that. Beforehand, I want to yield to Ranking Member Budzinski for 5 minutes for her questions.

Ms. BUDZINSKI. Thank you, Mr. Chairman.

Dr. Evans, VA's plan to accelerate EHRM deployments will rely on sufficient—on having sufficient manpower. In the history of this program, the Program Office has never really been fully staffed. I have a couple quick questions. How many open positions do you currently have in the Program Office?

Dr. EVANS. Just over 100. That is also because we just had a new signed org chart which increased the number of positions that we are authorized to hire. We are now actively hiring to fill the additional positions that we have added to the Program Office docket.

Ms. BUDZINSKI. Your plan is to fill all of those positions then?

Dr. EVANS. Absolutely.

Ms. BUDZINSKI. Okay. How will your current staff levels be able to not only resume Go-Lives, but support for the four Go-Lives at one time—but support up to four Go-Lives at one time? I guess that would be taking into account the hundred that you would be adding.

Dr. EVANS. Yes, we will be—we are—so we are actively hiring. In addition, at the sites that are going live, there is active hiring going on. There are 510 positions in recruitment. Actually, I think 163 of those folks are already on board at the sites that are going live to support operations locally. Plus, we are hiring in the Program Office. Then, of course, we have a significant amount of help from our contract partners, Oracle, Booz Allen, and Accenture Federal Services, as you just heard.

Ms. BUDZINSKI. Okay. You have significant hiring that needs to happen, though there are a lot of vacancies in the Program Office.

Dr. EVANS. There are vacancies in the Program Office in part because we are expanding the size of the Program Office. From the perspective of our ability to execute to the Go-Lives in April in Michigan, we are confident that our current staffing is sufficient to get us there.

Ms. BUDZINSKI. Okay. Ms. Verma, the scope of what Oracle and VA are planning to do is almost unprecedented. The number of simultaneous Go-Lives and the time between the waves will require a massive pool of contractors to support all of these facilities, as Dr. Evans has mentioned. How is Oracle going to ensure that these people understand the system and the VA well enough to be helpful?

Ms. VERMA. Sure. First, I would say that Oracle does implementations all over the world for systems. You know, this amount and the number of sites is not unusual for Oracle as a worldwide company in terms of the deployments. That being said, we also continue to add more staff to our teams to make sure that we can scale with the deployments as well. I think this is not an unusual thing for our company. We feel very well prepared to deal with the expansions and the challenges of something of this scale.

Ms. BUDZINSKI. Can I just—drilling down just a little bit more beyond just having the bodies, the VA itself is unique in its mission and culture. When someone were to hit the ground, what is Oracle doing to make sure that that additional capacity understands the uniqueness of the VA and its challenges?

Ms. VERMA. Sure. Well, there are requirements around training, and then there are also some Federal certifications that are required as well. It is not like we interview somebody and put them on the ground. There is some training that happens internally, and then there are, also, like I said, the Federal certifications and some required training that the Federal Government requires as well around security as well as the specific needs around the VA.

Ms. BUDZINSKI. Okay. Dr. Evans, as I mentioned in my opening, I have serious concerns about the Secretary's plan to eliminate 35,000 positions at VHA. In a Department that has been chronically understaffed, where veterans sometimes wait months for appointments, how can these cuts—how will these cuts impact your program?

Dr. EVANS. They will not. As I just mentioned, we are hiring additional staff at the sites where we are going live with the Federal EHR over the course of calendar year 2026, 510 additional staff. Currently, recruitment is ongoing. I do not anticipate any issues.

Ms. BUDZINSKI. Okay. Then just to go to the life cycle cost estimate questions, does the VA have a definition for life cycle cost estimate, Dr. Evans?

Dr. EVANS. What we provided to the committee was what we call a program cost estimate. It is the estimated cost for us to complete deployment of the Federal EHR across the enterprise by 2031 and to operate that Federal EHR. That is, to support, or what some might call sustainment, to support that EHR at the existing sites that have gone live. That cost estimate, that program cost estimate includes all money spent in the EHR appropriation to date and our estimate of what it will take to get to the finish line of finalizing deployment. Again, not just finalizing deployment, but finalizing deployment and supporting the operations across this timeline.

Ms. BUDZINSKI. Can I just interrupt? Does that break down then program versus contract expenditures, like the details, or is it just a top line number?

Dr. EVANS. It does. It does break down. We broke it down into four categories. One is implementation costs, so you can think of that as the cost to actually deploy the system. The second category being site and system operations. That in many ways is the cost of running the system, the hosting of the system, help desk support, the operational support. The third being infrastructure. I think we have talked about this in this committee before, that a significant part of the spend here has been an uplift of the IT infrastructure to support the new modernized EHR. That has sort of had to occur in parallel with the EHR rollout. Then the fourth we call office operations, but it is really the staff, both government staff and contract staff, necessary to deploy the EHR.

Ms. BUDZINSKI. Okay, thanks.

Mr. BARRETT. All right. Thank you.

Mr. Luttrell, recognized for 5 minutes.

Mr. LUTTRELL. Thank you, Mr. Chairman.

Dr. Evans, what is the dollar sign on sustainment for this software once EHR is implemented in all 170 sites and running?

Dr. EVANS. I do not have a number for you that is specific to sustainment, but what I can tell you is that our estimate in the final year when it comes to system operations, which I mentioned——

Mr. LUTTRELL. After 2031, moving forward, what are we going to have to pay for this?

Dr. EVANS. Yes, I would estimate it is—our, again, our estimate for the operations in the final year that we estimated was 2.1 billion.

Mr. LUTTRELL. Annually?

Dr. EVANS. Correct.

Mr. LUTTRELL. Ms. Verma, if we have four sites that are going to go live in April, I am sure Oracle's hovering over the top of those four sites. If those four sites going off of what Ms. Harris laid out for us, if those four sites fail, are other sites, will we continue to

move forward and fire up those other sites? Or is it an all-stop evolution?

Ms. VERMA. I cannot speak exactly, you know——

Mr. LUTTRELL. Oracle is not doing contingency planning on if these sites fail——

Ms. VERMA. First——

Mr. LUTTRELL [continuing]. in 117 days?

Ms. VERMA. Yes. First off, I would say that we are focused on a successful deployment. We are doing——

Mr. LUTTRELL. Are not we all?

Ms. VERMA [continuing]. everything we can to make sure that that happens: training and support, testing of the system, making sure that the teams are adequately supported. You heard about super users——

Mr. LUTTRELL. Yes, ma'am. I got you. I am just worst-case scenario, that is the kind of guy I am, worst-case scenario, these four sites do not go like they should. What is the contingency plan that day?

Ms. VERMA. Well, you know, when something goes live and there is a deployment, there are teams in place, there is elbow-to-elbow support. We have war rooms. If there is an issue that is going on, we are rapidly able to assess what the problem is and fix it.

The other thing that over the last few years we have been doing a number of optimization projects. Right? You heard about our capability block updates?

Mr. LUTTRELL. No, I got it. Yes, ma'am. If those four sites fail, is Oracle going to continue to move on the other sites that need to be activated or is it——

Ms. VERMA. Yes, that is a decision I think that we would discuss with the VA and figure out the appropriate course. Like I said——

Mr. LUTTRELL. We have not had that discussion yet?

Ms. VERMA. We have not had that discussion. Our discussions are focused on successful implementations. Because of the previous experiences, right, we have gone through a number of deployments, there has been a lot of lessons learned. If we look at the past deployment that we had at Chicago, again, that went very well and we continue to learn, we continue to do upgrades. In these last few upgrades as well as in Chicago, those have gone successfully well. We have no reason to believe that there would be a total failure of the system because we have not seen that in our—you know, the last few projects. Whether it is our optimization projects or the Go-Live at Chicago.

Mr. LUTTRELL. Well, I hope, you know, I hope that does not happen. We have been waiting 10 years for this thing to work correctly. Just from my experiences in the past, if you are not contingency planning on the worst-case scenario when it shows up, we are in a lot of trouble. Fair enough?

How are the sites chosen? We have these four in Michigan that are being activated. We had Chicago earlier. We have six sites online, if I am reading this correctly. How are the specific sites? Is there connectivity currently between sites that we are going live on so it is an easier lift? Then the sites that are kind of expanded out in like where I live, they are going to be the last ones to get a shot at it? Mr. Evans?

Dr. EVANS. Yes, I can answer that. Let me just—I will answer that question about how the sites are selected. I want to quickly correct the record on your sustainment cost question. I do not have a definitive estimate for the cost. What I was giving you there was the potential cost of operations. We do not have the sort of nailed down number for what it is going to cost yearly.

Mr. LUTTRELL. Well, I appreciate you saying that because eventually the Secretary is going to have to come back to the committee and ask for a substantial amount of money to sustain the EHR.

Dr. EVANS. Correct.

Mr. LUTTRELL. I mean, we are almost 50 billion into it and it is not even working.

Dr. EVANS. Right.

Mr. LUTTRELL. That is going to be a very interesting conversation.

Dr. EVANS. Right. There will be—and part of that conversation is also what money comes off the books as we do not have to sustain, you know, legacy technology that we will be able to shut down at that point in time.

Coming back to how sites were selected, we started, we spent a lot of time looking together to say what sites have the highest level of readiness to move forward? Part of that was based on where we had already made investments. The sites that are the earliest sites in our schedule that we provided to you through 2031 were the sites where oftentimes we had started deployment activities and we had already made an investment and we could save resources essentially by getting restarted there earlier. We had already done the infrastructure upgrades at those sites. We were ready to roll.

We chose to move forward, as I mentioned, with a market-based approach. One of the things that we have learned, lessons learned, is that it is better for sites in a region to all be using the same electronic health record. That is, if you take a look in Michigan, there are a lot of interdependencies between the VAs there. You look at Ann Arbor as an example. I think it is more than 20 percent of the patients they see in Ann Arbor have a primary care provider elsewhere in Michigan, for example, in Battle Creek or Saginaw, and come there for specialty care. Having those sites on the same——

Mr. LUTTRELL. Mr. Chairman, can he keep going? Is it Okay?

Mr. BARRETT. Yes, I will allow you to finish the question.

Mr. LUTTRELL. Thank you.

Dr. EVANS. Same electronic health record allows us to have some efficiencies. We were looking by market, going one VISN at a time. We are going to complete by the end of 2026, VISN 10 and then we will go to VISN 12 and 23 and beyond from that based on the schedule.

Mr. BARRETT. All right, thank you. I am going to recognize myself for 5 minutes for another round of questioning.

Ms. Harris, I started to ask you about the kind of simultaneous testing that is going on, that is, you know, the GAO has raised as a concern. Ms. Verma, what do you feel is a counterpoint to that? What can you do to convince me and the GAO that doing this in a simultaneous fashion is the appropriate way to do it without just hitting a deadline for a date, without thinking through the risks associated with it?

Ms. VERMA. Sure. Well, first of all, we strongly support, you know, robust testing. That is an important part of an implementation. When you do testing, that is when you may see things that you did not anticipate. Agreed that it is a very important part of an overall deployment.

I think it is important to recognize in this situation is that the system is live in six sites today. Since we have implemented in those six sites, we have also done a number of optimization projects. In—when we do those optimization projects, we go through a big process of testing the system. We do that with the VA. Then what we have also more recently implemented is that instead of waiting till the end to do testing, we kind of do it on an ongoing basis. We show them the optimization work. I think we have had very strong robust testing. We feel confident that the system that we have in place around testing is working. There have been improvements.

I think an IV&V vendor at this point would just add to costs and not necessarily add anything new. We have had now successful implementations through our optimization work that shows that the testing is working. There are times when we have done testing, we have picked up things, we have delayed in some cases when we realized we needed——

Mr. BARRETT. Right.

Ms. VERMA [continuing]. to spend more time on it. I think at this point, the IV&V vendor is——

Mr. BARRETT. Laying aside the IV&V, just doing all four sites simultaneously instead of one after another does increase the risk if something is discovered that needs action. Correct? Increases the risk of potential problems, would it not?

Ms. VERMA. Right. This is more of a scale issue. When we know we have four sites, we make sure that there are adequate teams on the ground to do elbow testing. We also have a war room so that our teams are actively monitoring what is going on on the ground.

Mr. BARRETT. Right. That is when it goes live, correct, not——

Ms. VERMA. Not even before that. Even before that. Right? That is when Dr. Evans and I spoke about hiring enough staff to make sure that we can scale so that we are testing, we are supporting those sites as that is going on. It is just a matter of scale. The process is the same around testing, around training, around supporting. It is just a matter of having enough staff to do it. This is a——

Mr. BARRETT. Each of these are very unique in their application. Each of these VA hospitals, they are not——

Ms. VERMA. Correct.

Mr. BARRETT [continuing]. you know, cookie-cutter stamped out. These are very, very customized to their unique situation. Doing them all four together, to me, elevates the risk that there is going to be problems that arise or issues that are overlooked, or we are batching these all together and then we are going to have them all go live nearly simultaneously without a lot of, you know, without a lot of consideration for what happens if, as Mr. Luttrell pointed out. I think those are the things that we have to bear in mind.

You know, not to discredit what you are saying, but it feels like a lot of that is, you know, we have these things and, you know, we

are a big company and we can do that. I do not think that Oracle has had a project like the one that the VA is undertaking right now. Would you agree with that?

Ms. VERMA. I think we feel very confident that we can do this and we can do it at more than one site at a time.

Mr. BARRETT. I would expect and hope that you would be confident in it, for sure, but.

Ms. VERMA. We are very confident. We feel very confident in doing that. I agree with you that every VA is different, which is why we have had teams on the ground. It is not like we are turning on the system quickly. We have been in these sites, we have been doing assessments of the site so we can understand what they have on the ground, what are the differences between each site. We have a plan for each site, and we have adequate staff and support for each of those sites.

Mr. BARRETT. Ms. Harris, do you feel like these commitments by Oracle are satisfactory to the overall concerns that the GAO raise?

Ms. HARRIS. I mean, in taking a look at the previous history of the initial six sites, particularly in the five, I mean, when they went live, Oracle Cerner did have a difficult time in addressing those ticket—resolving those tickets in a timely manner. I know that they did a lot of streamlining in that process so that they would be able to meet their contractual marks for completing or resolving those tickets, you know, against their contractual obligations.

I think, again, when you are doing it for simultaneous ones, I mean, there is a tremendous amount of resources that are going to go toward ensuring, for example, that ticket resolution is done, you know, under the contractual obligation. That alone, I think, is very risky. It is going to take a tremendous amount of resources that I am not quite sure is sustainable for multiple sites at once.

Mr. BARRETT. Okay. Last question. Is that something that was at the request of the VA or Oracle to do these four simultaneously?

Dr. EVANS. If I may.

Mr. BARRETT. Either one of you. Go ahead, Doctor.

Dr. EVANS. Yes. It was VA. VA asked to do this. I would say I would like to kind of take us back a step. One of the parts that we have talked about in this committee that is super important for us to succeed is to standardize our workflows. One of the things we have done over the last year is establish very clearly what the Federal EHR baseline is.

As a reminder, this system is one instance, one system to support all of these medical centers. Part of being—locking down a baseline will actually streamline our ability to do testing because some of that variation that you are mentioning from one site to the next becomes less and testing becomes much easier at scale when you are testing against a standardized set of workflows and a standard baseline.

The other—the second thing is that we are—you know, as our——

Mr. BARRETT. Sorry, I got to yield to the ranking member. We will come back for more questions, time permitting.

Ranking Member Budzinski is recognized for 5 minutes.

Ms. BUDZINSKI. Thank you. I actually just want to pick up on some of your questions about readiness. I was curious, Dr. Evans, because I think you and Ms. Verma have talked a lot, pointed to North Chicago as the example of how—of readiness. I am curious of how well the readiness is going there and the development since its Go-Live. That is a unique case, as we know, though, because that was with U.S. Department of Defense (DOD). Can you speak, though, to the other sites that have already gone live as well and just, you know, what is happening at those sites as it relates to readiness?

Dr. EVANS. Sure. At the sites other than FHCC, which are in Spokane, Walla Walla, Roseburg, White City, and then also Columbus, Ohio, I would say overall we have—we are tracking numerous metrics at those sites. You heard Ms. Verma mention about the revenue capture. We are doing very well with regard to appropriate revenue capture. Productivity at all sites at Roseburg has returned to greater than the 2019 pre-pandemic baseline productivity.

We continue to hold a problem management forum with live site representatives every single day, every single workday where issues are surfaced, we address those. We have done a lot of work to work down the ticketing backlog for significant change requests, reduced that by well over 40 percent, and are being quite responsive to the sites with their needs. Frankly, they can escalate anything any day at our 10 a.m. meeting.

We are seeing definite improved operations with the EHR at those original five sites. At FHCC, likewise, it is pretty similar performance.

Ms. BUDZINSKI. Can I just ask, on those sites, how are you measuring then productivity and how it has changed at those sites?

Dr. EVANS. For the productivity at those sites we are looking at something called Relative Value Units (RVU), which is a mechanism, it is an industry standard for measuring productivity. It is captured through billing encounters or encounters that sort of capture the documentation or the work that was done at the time of visit. We look at RVUs per provider.

Ms. BUDZINSKI. Okay. I would like to shift to Ms. Harris. We talked about the testing. I also just wanted to circle back to your testimony about the GAO recommendations more broadly that are still open. What do you think are some of the most concerning of those that are still open today?

Ms. HARRIS. I think one of the most concerning ones is change management. VA still has yet to have an approved informal policy in place there. As part of change management, there is training as well. When you take a look at the first five sites as well as FHCC, those are vendor-led trainings. At all of those sites they have—the feedback has been that those vendor-led trainings had failed to prepare them for their specific roles and workflows. I think it is important for VA to take a more leader—to take the leadership role in that training. Again, we have those open recommendations there. That is vitally important.

Ms. BUDZINSKI. Okay. Dr. Evans, in addition to those recommendations that Ms. Harris identified, I think there are 28 open from VA's inspector general as well. What is the plan and timeline to close them?

Dr. EVANS. With regard to the GAO recommendations, we take, of course, all of the GAO recommendations seriously. Of the 17 open GAO recommendations, I do want to highlight that for 8 of those, nearly half of those, VA has made very significant progress. GAO has asked to keep those recommendations open until after we get past some of these initial Go-Lives in Michigan specifically.

For example, there is an open recommendation about making sure that our contractor staff and the VA is using the right terminology. This was a recommendation from 2020. We fully implemented that recommendation. GAO asked us to wait to see how things go in Michigan to close that recommendation.

Ms. BUDZINSKI. Can I just interrupt? I am running out of time. Ms. Harris, would you agree with that? I did note that some of the recommendations do say partial, but many of them just still say open. Is there more to the story from what Dr. Evans is saying?

Ms. HARRIS. There has been action taken on many of the recommendations, for sure. The one that Dr. Evans noted is not one that we do consider to be priority. It is important, of course, but certainly all 12 of our priority recommendations, those are still—the majority of them is not in the situation that he had mentioned. However, I will say they have done work, but we do need to hold some of those open to ensure that the actions that they have taken are effective, because we will see those results at Michigan.

Ms. BUDZINSKI. Okay. I yield back.

Mr. BARRETT. Thank you.

Mr. Luttrell, for 5 minutes, sir.

Mr. LUTTRELL. Thank you, Mr. Chairman.

The six active systems say that the system itself has proven difficult to use and is not well-suited for VA workforce—workflow, excuse me. Staff have reported slow performance, excessive clicks, data loss, and a cumbersome documentation process. All six facilities that implemented the new system have faced increased workloads due to workaround processes, burnout, staffing shortages. The report goes on about talking—speaking on because of the weight of the implementation of this, morale is down.

There have been system updates. There has been a standardization and readiness improvements, and the user experience apparently went from 7 percent in 1922 to 33 percent in 1925. These are the six sites that are currently working under the system, Oracle system, and you are about to add four more.

Mr. Evans, you said in your previous statement that all the—you are doing Michigan because Michigan is the same. We are going to do Washington because Washington is the same. You come down to Texas, Texas is Texas. Now, if you have these particular sites that are having these issues, you are going to add these other sites on board that are different, and then you are going to try to complete the entire system. That is an extremely heavy weight.

I am curious, Ms. Verma or Dr. Evans, what does that even look like? If the current system does not work effectively at 33 percent and we are about to add 4 next year or 4 in April, and then what is the number in 2027, please?

Dr. EVANS. Twenty-six sites.

Mr. LUTTRELL. Twenty-six in 2027. You see where I am going with this? Walk me through it.

Dr. EVANS. I do. First of all, I think we have—just to give you a sense for the change, over the course of the reset we were introducing—we introduced over 1,500 functional changes, that is changes responsive to end users, where end users said, hey, the system needs to work better in the following way.

Mr. LUTTRELL. Just on these six sites, the active sites.

Dr. EVANS. At the six sites, 1,500 changes over the course of the reset. That was more than 50 changes on average a week that we were introducing responsive to their feedback. That is not—beyond that, thousands of other changes that were introduced as part of block upgrades, which are platform upgrades, where Oracle's improvements to their base platform are being introduced to the VA, there has been a significant amount of improvements to the user experience.

I think the data that you were quoting, the 33 percent, is from our end user experience survey. You know, I believe that we are seeing direct line improvement. That is as we pay attention to end users, as we address the change requests in a standardized way at the national level that is responsive to our clinical communities, and as we deliver those in a way that, as Ms. Harris mentioned, is rolled out in a way where users feel supported, where they get adequate communication, where they get training to the changes, we are seeing confidence improve. Now, it is not where I want it to be, but we are seeing confidence improve at the six live sites.

Mr. LUTTRELL. Are the four active sites in Michigan, this implementation, has this been handed off to them, so you will not be surprised when something like this populates after they go active 117 days? They are not going to say, hopefully not, I should not—I am not going to call it a mistake, but they are not going to have the same issues that the current sites are having because everything that we have learned off the current six sites has been pushed over to the four sites are going to go active in April?

Dr. EVANS. That is correct. All of the improvements that the six sites—that we have learned from the six sites and, frankly, from our lessons learned working with the DOD and working with Oracle and commercial customers about what best practices are, all of that value will be delivered to Michigan.

Mr. LUTTRELL. Hopefully.

Dr. EVANS. Yes, it will.

Mr. LUTTRELL. I yield, sir.

Mr. BARRETT. Thank you, Mr. Luttrell. I will recognize myself for another 5 minutes.

I know this issue of change management and everything is difficult. Dr. Evans, I think I shared with you that I think as a classification, physicians tend to be a little bit stubborn. I think you agreed with me. Then I think physicians within the VA might be a particularly stubborn bunch. With that being the case and laying that aside, who is ultimately responsible for that change management? Is it Oracle, is it VA, or is it Accenture? Like, who is responsible for that part of this?

Dr. EVANS. I mean, at the end of the day, VA is responsible. This is our healthcare system. This is the VA healthcare system. This is our project to implement a new electronic health record.

One of the things that we—as we during—you know, as we sort of sat before we started to accelerate deployments, we said we need a new change management strategy. We worked that out. One of the big pieces of that is that it is VA leaders standing in front of their peers that kick off this process. We introduced a new event. It is the Change Leadership Team, Executive Leadership Team onboarding event. We do it in every market. It is led by VA leaders who are speaking as peers to their staff to say, this is what the change will feel like. This is what it is going to be.

I can own a little bit of stubbornness as a primary care provider in VA, as you pointed out, but I will say this, my experience is that VA clinicians, they circle around the veteran. If you are delivering a better experience to the veteran, that is a worthwhile change to adopt. Part of this is building a real sense of the why. Why is there value in us coming together around a single electronic health record that supports veterans wherever they are, where the care surrounds the veterans, regardless of what physical geographical location they walk into in a VA? I am not seeing objections from our clinical staff or our administrative staff when they understand that why and when they are adequately supported.

We own it, VA owns it. I am very grateful as well for the contractors who are supporting us in executing that change management tasking.

Mr. BARRETT. Okay. Then the surveys that you are undertaking, you know, Mr. Luttrell pointed out you guys went from 7 percent to 33 percent. Congratulations, you are more popular than Congress finally. With that being the case, do you feel the survey methodology is accurate or is it one of those things that tends to attract more negative response bias?

Dr. EVANS. Yes, it is a good question. We get about 20 percent participation in the surveys on average when we send them out twice a year. That is actually a good response rate for a survey with when we are asking busy folks in the medical centers to take their time out to do the survey.

Point number two, the survey methodology, the survey questions that we use are a standardized set of questions used by many healthcare systems, both in the private sector as well as in the Federal Government and are comparable with the DOD. Those questions, I do believe that they are robust questions that we can learn from and from which we can look at other health systems that have engaged in a similar transition and track our progress accordingly.

Mr. BARRETT. Okay. Do you feel that VA end users, as they are being trained on this, have adequate, you know, authority to raise their concerns without feeling like they are being—you know, that there is going to be not punishment, but just, you know——

Dr. EVANS. Absolutely. I mean, it is an anonymous survey. We expect——

Mr. BARRETT. Yes.

Dr. EVANS [continuing]. complete honesty on the survey.

Mr. BARRETT. Okay. Switching briefly, because I have only got about 1 minute left. I know we talked, Ms. Verma, a little bit about some of the pharmacy-related implementation and things like that being a unique role that the VA has and some of the drug inter-

action pieces. I guess, where do you see Oracle integrating into this to make sure that we can resolve that going forward for the understandably unique way that the VA does the pharmacy role?

Ms. VERMA. Sure, and you are absolutely right. Right? We are taking an off-the-shelf solution and bringing it to the VA, and the VA has some very specific and unique needs. I think that there has been some points that we have implemented or some projects that we have implemented that have really upscaled the level of safety, things like opioid prescribing. We have also improved communication between pharmacies and the providers if a drug's not available, to have that conversation so that they make sure that what is being prescribed is available. We are seeing some definite improvements. We are seeing some providers out there that have a level of productivity to pre-deployment.

That being said, I think we would recognize that we—that this is an area of continued focus where we want to make sure that we have adequate training. We also sent—you know, our Chief Executive Officer (CEO) went to go visit one of the centers and specifically looked at pharmacy because we do know that this is going to be something that we are going to continue to improve.

I think we have made progress. I would also acknowledge that this is an area that we continue to focus on at the highest levels of Oracle and we continue to make improvements and we have conversations about this on an ongoing basis.

One of the things that I really appreciate the leadership doing——

Mr. BARRETT. I am going to have to cut you off in just a second. I apologize.

Ranking Member Budzinski for 5 minutes.

Ms. BUDZINSKI. Thank you. Ms. Verma, Oracle has been touting its effort to build a new EHR. I think you have gone as far as to say that Cerner's EHR is equivalent to crumbling infrastructure. Is this crumbling infrastructure the product that is being deployed at VA?

Ms. VERMA. We are making improvements to the Cerner system that is being implemented in the VA. We took the Cerner system. You have heard about all the different optimization projects that we are doing. We are also introducing a lot of AI agents that will sit on top of the Cerner system to help it, you know, to help it provide, you know, the best experience for providers on the front lines.

Ms. BUDZINSKI. How much of this is informed by lessons learned at the VA?

Ms. VERMA. I think a lot of it is informed by lessons learned. One of the things that we appreciate is that the leadership today is very active in terms of visiting the sites, seeking input from providers and understanding what are the pain points, and then communicating it to us. We meet very frequently with the VA, almost every 2 weeks, there are weekly meetings with the Secretary. In those meetings we are identifying where are there opportunities for optimization?

We have executed on a lot of these projects. You have heard of the capability block updates that we have been doing. Those represent the optimization projects and I think that is why we are starting to see better results in terms of the experience of pro-

viders. I think the sentiment overall is increasing as well in terms of the positivity.

Ms. BUDZINSKI. We have spent a lot of time today talking about cost, and I am just curious how you would respond, you know, hearing this, is this going to all lead us down the path of additional cost from Oracle's perspective?

Ms. VERMA. Yes, so I have not reviewed any of the new estimates that have come out, but I think that is something that we are very cognizant of with—of cost. I think that some of the more recent changes that we have made, the first one I would say is the standardization. You know, having a system where you had six different sites requesting different types of changes, those kinds of things contribute to increased cost. We are very excited about the changes that we have heard about in terms of moving to standardization. That is going to make the cost more predictable and more sustainable.

That being said, it is always, you know, foremost on our minds. This is why Oracle agreed to move the Federal system to our cloud to make sure that we had, you know, greater security and performance. We are doing that at our cost as well. We advise the VA. One of the things that we really advocated for was the standardization because we also knew that not being standard would contribute to increased costs.

I think the pause in and of itself has not helped in terms of cost because you are maintaining two systems. Moving forward I think will also help make sure that we are using taxpayer dollars appropriately and efficiently.

Ms. BUDZINSKI. You have talked a little bit about in your testimony, obviously, AI. Is AI capability included in VA's contract with Oracle and is there additional cost to that?

Ms. VERMA. It depends on which AI agent. There is not a one size fits all approach. We are bringing the brand new EHR to the VA. We are not charging for that, you know, new ambulatory system, but there are—there will be some AI agents that are included inside the EHR and there are some that are additional, and the VA will have to assess those and decide which ones that they want to use.

Ms. BUDZINSKI. Okay. Ms. Harris, can I just ask you, in your testimony, you had flagged, we were talking about the overall cost in the beginning of this hearing, and I did not—I wanted to get to you, but could you—I think you had flagged some concerns around that number, the 37 billion. Could you speak to that?

Ms. HARRIS. Yes. Well, we have not seen the 37 billion number. As soon as our office receives that, we will, you know, certainly do a deep scrub of that and then get back to you on that. I will say the independent cost estimate that is out there is—the total life cycle cost is roughly $49.8 billion, so roughly $50 billion. You know, we are going to have to go through the differences.

That number also is outdated because it does not reflect the changes in the delays, including the pause. That is also something that we will have to take a look at, but we will certainly do a comparison there of that.

Ms. BUDZINSKI. Okay. Thank you, when you get that.

Ms. Verma, if I could just ask again, going back to Oracle Health Software and specifically the veterans' data, is it being used to train the AI that Oracle will use for its commercial clients?

Ms. VERMA. Absolutely not. We do not have any data rights, so we do not use that data to train our models. No.

Ms. BUDZINSKI. Okay. Will VA receive credits of some sort for the benefit Oracle has derived from the information?

Ms. VERMA. We do not use their information for any of our training for AI models.

Ms. BUDZINSKI. Okay. Okay. Ms. Harris, your testimony indicated the VA has not instituted plans to conduct an independent operations assessment to evaluate the suitability and effectiveness of Oracle's EHR. We have been contemplating the need for such an evaluation. What do you think this should entail and what do you think should—who should conduct it?

Ms. HARRIS. Yes. I think that given this approach to go live at four sites at Michigan, once that takes place, I think that there should be an IV&V after that looking at all four sites to do that systematic cataloging of those defects, and it should be an independent third party that goes in and does that review.

Again, I cannot stress enough the reason why Military Health System (MHS) GENESIS was so successful in their deployments, you know, we have spent a lot of time with them. A large part of that was because of the IV&V test that they performed.

Mr. BARRETT. Sorry. Thank you very much.

Mr. Luttrell, for 5 minutes. Then we will do closing.

Mr. LUTTRELL. Thank you, Mr. Chairman.

The VA did not—Dr. Evans, I do not know how long you have been in the VA, but I was curious, we did not negotiate into our contract with Oracle any kind of AI footprint? What I heard her say is we are just going to get to the baseline. This is like when my 8-year-old comes up and wants to buy a video game. Hey, we can get the baseline model. Then when you are inside, you got to buy everything else to get it where it needs to be. It kind of sounds like where we are at. You do not have to answer that question. I just wanted to say that out loud.

We have six sites that are currently on Oracle. Right, Ms. Verma? The rest, 160-plus, are still on, what, VistA, Dr. Evans? We have spent roughly about a billion dollars on software across the board. Correct? Some of the VA facilities use software that other VA facilities do not use. Some have the highest level of software advancements inside their facilities and some do not. We have to pay for it all, whether or not we even use it or not. Like my little facility in Conroe, Texas, still uses some software that helps VistA, but DeBakey does not, but we still have to fund the whole thing and it is almost a billion dollars if I am correct. I may be off on that, but I think it is almost a billion dollars.

Ms. Verma, when Oracle activates on every single site, do we have the ability to tell everybody else, hey, we do not need you anymore? I think your button is off.

Ms. VERMA. Yes, Okay. I think it is going to depend on every site. My——

Mr. LUTTRELL. No, it cannot depend on every site——

Ms. VERMA. Well——

Mr. LUTTRELL [continuing]. because the whole purpose of us doing this with you guys is that every site is the same.

Ms. VERMA. Yes. My——

Mr. LUTTRELL. It says that multiple times.

Ms. VERMA. Yes. My expectation would be that with a new Oracle EHR that they should be able to use our system and that should address the needs that they have. I do not know whether—you know, every single site and what they have, but I would anticipate that this EHR with the standardization that we are bringing, that it should be able to meet the needs of any hospital or clinic across the country.

Mr. LUTTRELL. I hope so for $50 billion. We are going to have to have a conversation with everybody saying, hey, look, we implemented this at $50 billion, plus the dollar sign, Dr. Evans, of what sustainment looks like. Then, hopefully, at the end of the day, we do not have to say we have to continue to pay for everything that is in VistA because we already have it in the system and then we are going to pay for Oracle on top of it. Are we going to have to have that conversation?

Ms. Harris, what do you think about that? Does that sound reasonable? This is kind of the math problem I am drawing out in my head, but it is where we are. The slide deck that they brought to my office 1 day, it shows every single software that we pay for. We have one software program that only one VA uses and we still pay for it because they have to have it for some reason.

What do you think about that, Dr. Evans?

Dr. EVANS. I think that you are—this is a very important point. As we move forward, the Federal EHR, think of that as the operating system for the hospital, will be the same at all hospitals. Not all hospitals offer the same clinical services. For example, we are going live in Michigan. For the first time we will be implementing Radiation Oncology. There is some unique software that is necessary to support a radiation oncology clinic and operation that will not be needed at every site.

One of the real advantages, one of the reasons why, when you hear me and us and VA talk about what we call the Federal EHR baseline, we think that is so important, is because we are going—we are publishing, it is published right now on our website, these are the software systems that we will support and can support connected to the Federal EHR. By definition, it also means there are those that we will not support.

Mr. LUTTRELL. Every system that we have in place currently, once Oracle activates in all sites, they are going to come running to you guys and say, you have to use this?

Dr. EVANS. Well, again——

Mr. LUTTRELL. We are already here.

Dr. EVANS. No, no, we are making the decisions now as we go from site to site around what the standard is going to be.

Mr. LUTTRELL. I am sorry, I am still under the impression that every site is going to be the same.

Dr. EVANS. Not every site has the same clinical services.

Mr. LUTTRELL. I understand that.

Dr. EVANS. When we go to a site——

Mr. LUTTRELL. Every site can have what Oracle is populating and the 6 sites that have are active and 4 sites are coming up and the 27 next year will be the exact same. Correct? I have that in my little satellite campus in Conroe.

Dr. EVANS. I will give you an example. Bedside monitors, when you walk into an intensive care unit, the thing that is hanging up above the bed with the Electrocardiogram (EKG) on it.

Mr. LUTTRELL. Yes, sir.

Dr. EVANS. That is not a core part of the electronic health record. That is a biomedical device. It has software that runs it that we will need to plug into the electronic health record. One of the ways we will be able to manage cost is by standardizing which of those devices we can support. It should be a limited number in order to be able to manage the EHR in a more cost effective way across the enterprise.

Mr. BARRETT. Thank you. I apologize, we are up against a bit of a hard stop for the committee. We are going to move on to closing statements.

Okay. I will go to Ranking Member Budzinski for her closing statement first.

Ms. BUDZINSKI. Thank you, Mr. Chair. Thank you.

I agree that we need to give veterans and VA employees the modern tools that the new EHR can offer. Those tools have to work for the VA, and I just do not believe that we are there yet. I do not want to be a pessimist, but I do not feel like I am leaving this hearing having my mind changed on this point.

Dr. Evans and Ms. Verma are quick to point out that the new administration is driving increased momentum and leadership involvement in the project. I am concerned that the administration's involvement is only moving the program forward faster, not better. There are so many recommendations from the GAO and the Inspector General, as well as Congress, that will continue to sit unheeded. I have no confidence that the next round of Go-Lives is going to be any better than the last.

I would implore Secretary Collins and the Trump administration to pay attention to their own words and put the veterans at the center of everything. Anything else puts the health and safety of our veterans at risk.

Thank you and I yield back.

Mr. BARRETT. Thank you, Ranking Member Budzinski.

I was actually voted most optimistic of my high school graduating class. Mostly because I thought it was the Lions' year every year. Again, we find ourselves on the edge of not even making the playoffs perhaps.

In my old age, I have moved from an optimist to more of a realist. I think the issue before our committee is what is the real assessment of where we are at and what we need to do to prepare going forward. I think a healthy amount of question, concern, and even a little bit of skepticism is appropriate for our committee to feel given the past performance of how this has gone and what we need to be prepared for.

I can tell you with candor what I will not accept if we fast-forward the tape 117 days from today is if things do not go well and do not go as necessary to protect the health and benefit and wel-

fare of the veterans that we serve, is finger-pointing and blame between, you know, various different vendors, the Department, and who had what, and musical chairs as to where things land.

This committee, our work here is not going to tolerate that. If there are differences between opinions as to what needs to take place, I encourage you to resolve those. If you need help from this committee to do that, I am very willing to be the person to step into that role and, with the ranking member, to assist in doing that. We need to absolutely make sure that we have a no-fail mindset going into this Go-Live 117 days from today.

When I was at my last appointment in Battle Creek for a physical, they sent a follow up that was a few months into the future, and it happened to land on the week that this Go-Live is. You know, I am comparing my session calendar with when I can be back home. I am like, well, I am available on this date. They are like, oh, no, we are getting a new electronic health record system. We hare not scheduling appointments on that day.

I know that they are taking it seriously. I just want to make sure that the tools are going to be there for the end user, the practitioners, the doctors, the medical assistants, the nurses, and all the other various people involved in this from front to back are going to be ready for this as it comes up. I am hopeful and encouraged that you pointed out the super users have begun getting their training now, but then the more, you know, rudimentary kind of day-to-day users are going to be getting that and at a point that is appropriate for them.

I have concerns about the, you know, simultaneous testing going on, as we pointed out in the questioning, and I want to make sure that that is done appropriately. I think there are questions that the committee has that are still unresolved and a few more that Mr. Luttrell raised as well.

We want to be partners in this, not antagonists. We do not want to slow you down. We do want to maintain the appropriate level of accountability to make sure that this goes as well as we need it to.

With that, I think I have some disclaimers I got to say here at the end. I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include extraneous material. Without objection, so ordered.

With that, this hearing is adjourned.

[Whereupon, at 4:26 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Neil Evans

Good afternoon, Chairman Barrett, Ranking Member Budzinski, and distinguished Members of the Subcommittee. Thank you for the opportunity to testify today about the initiative of the Department of Veterans Affairs (VA) to modernize its electronic health record (EHR) system.

I want to begin by thanking Congress and this Committee for your shared commitment to Veterans and for your continued support of the VA Electronic Health Record Modernization (EHRM) efforts. VA is committed to successfully implementing a modernized, interoperable Federal EHR system across its enterprise. Implementation of the Federal EHR system will facilitate unprecedented ease of transition from Department of War (DoW) to VA and quality of care coordination between the agencies. VA's focus is keeping Veterans at the center of everything we do. Veterans deserve high-quality health care, which means health care that is timely, safe, Veteran-centric, evidence-based, and efficient. The EHR is, and will remain, a key enabler of VA's ability to deliver the comprehensive health care Veterans deserve.

The Federal EHR will provide a framework for improved enterprise standardization of evidence-based health care delivery, positively impacting patient care quality and safety. The Federal EHR will support simpler integration of other modern health information technologies and infrastructure to provide a more coordinated experience for VA staff and clinicians as they care for Veterans. The modernized EHR will also support improved interoperability with the rest of the American health care system. In addition, the adoption of a single system used by VA and DoW will help simplify health care delivery for providers in both Departments, benefiting patients who receive care in both systems or who are transitioning from DoW to VA for care.

Since our last hearing in February 2025, VA has continued to build on previous milestones to achieve the mission objectives set for the EHRM program. In March, VA announced its intention to deploy the Federal EHR to nine sites in Ohio, Indiana, Kentucky, and Alaska by the end of calendar year 2026, in addition to four previously announced sites in Michigan. This brings the total sites to go live in calendar year 2026 to 13, with all sites in Veterans Integrated Service Network (VISN) 10 going live by the end of calendar year 2026, supporting better coordinated care across the entire regional network. VA aims to complete deployment of the Federal EHR to all VA medical facilities as early as 2031.

VA closed out Fiscal Year (FY) 2025 on target in meeting deployment activity milestones to ensure timely go-lives in 2026. Based on the lessons learned from our prior VISNs 20, 10, and 12 deployments, VA is using a market-based approach for future deployments to scale up the number of concurrent deployments, enable staff to work more efficiently, and increase the sharing of best practices by frontline staff and the Federal EHR community. Training schedules and course loads were adjusted to better support end-users and patient scheduling. VA also provided Congress with an updated long-term cost estimate for the EHRM program, along with a timeline for deployments through 2031. To demonstrate VA's commitment to successfully meeting that timeline within the expected cost, we have augmented our team by contracting a systems integrator to help coordinate deployment activities. We have always relied on the expertise of our government contractors. We need their functional and technical expertise and resources, working together with the government, to execute our programmatic goals and deliver on VA's promise to our Veterans.

VA has made significant strides in stabilizing its systems, with improved performance metrics demonstrating system reliability. As of November 19, 2025, Oracle Health-owned systems maintained an incident-free time (IFT) of 95.93 percent, exceeding the Service Level Agreement (SLA) requirement of 95 percent consistently for 21 consecutive months. Ten of the 12 months in Fiscal Year 2025 were free of

any system-wide outages. At the conclusion of Fiscal Year 2025, the system had experienced more than 200 consecutive days without any outages.

The momentum demonstrated this year can be attributed to increased VA leadership involvement under this new Administration. Since assuming their roles, Secretary Collins and Deputy Secretary Lawrence have prioritized attention to this critical project and have taken significant steps to assure alignment across all stakeholders in support of the accelerated implementation of the system in support of Veterans. Dr. Lawrence has been talking to site and VISN leaders weekly and making multiple visits per month to sites set to go live with the system in 2026, making it a priority to listen to fellow Veterans talk about their experiences and expectations. During visits across Michigan, Ohio, and Indiana, he has met with executive leadership teams, change leadership teams, super users, and frontline clinicians to discuss preparations for the 2026 deployments and to review how recent improvements have helped frontline staff. While these visits are ongoing and will continue, the feedback has been positive. Leadership and staff at both the individual sites and the VISN level are encouraged by the program's direction and newfound momentum and are confident in this administration's path forward.

VA has continued to listen to and engage with Veterans and clinicians about their experience with the Federal EHR, and is seeing meaningful success with deployments, according to results of the most recent Federal EHR User Experience survey completed in Spring 2025. For the first time since the survey's inception, at least half of survey respondents felt positive about some aspects of the Federal EHR system. On November 21, 2025, we completed our Fall 2025 survey and look forward to sharing those results when they are available.

VA is continuing to move forward with a modern, commercial EHR solution in close coordination with our Federal partners, including DoW and the Federal Electronic Health Record Modernization office. This new Federal EHR system will empower Veterans to receive care that is more seamlessly coordinated across the enterprise. It will help providers more holistically understand injuries or illnesses that Veterans suffered years ago, so that they can provide those Veterans with the best possible care today. It has the potential to further streamline VA operations and most importantly, it will improve the Veteran experience.

Ultimately, our goal is to deliver an EHR system that earns the trust of Veterans, clinicians, and staff. This means a system that works efficiently, enhances care coordination, reduces administrative burden, and will improve health outcomes for Veterans. We are not simply continuing business as usual; we are committed to getting this right. The responsibility we carry is immense, and we will not rest until this system delivers what our Veterans and providers truly need. With the activities and improvements that are now underway, VA leaders are optimistic about the success of our Federal EHR system optimization efforts and the eventual full implementation of the system throughout VA.

With the partnership of this Subcommittee, we look forward to continued and accelerated progress implementing the Federal EHR across VA over the remainder of the 119th Congress and beyond. We are only 117 days away from our planned go-lives in Ann Arbor, Battle Creek, Detroit, and Saginaw, Michigan, with many more sites following quickly thereafter.

This concludes our testimony. We look forward to responding to any questions that you may have.

Prepared Statement of Seema Verma

Statement of the Honorable Seema Verma, Executive Vice President and General Manager, Oracle Health and Life Sciences, Oracle Corporation

Before the

U.S. House of Representatives
Committee on Veterans' Affairs
Subcommittee on Technology Modernization

Hearing on:
"READY, SET, GO-LIVE: ASSESSING VA'S EHR MODERNIZATION DEPLOYMENT READINESS"

December 15, 2025

Introduction

Chairman Barrett, Ranking Member Budzinski, and members of the Subcommittee, thank you for the opportunity to speak with you today about Oracle's work with the Department of Veterans Affairs' (VA) Electronic Health Record Modernization (EHRM) program.

Since the last hearing, VA announced an accelerated deployment schedule that will complete the full deployment by 2031. In 2026, the Federal EHR will go-live at 13 sites in Michigan, Ohio, Alaska, and Indiana, and will go-live at 26 facilities in Minnesota, Wisconsin, Oregon, Washington, Missouri, Idaho, Nebraska, South Dakota, North Dakota, Illinois, Iowa, and Kansas to go-live in 2027. I am pleased to be able to report significant and successful progress on the accelerated deployment plan for EHRM, and to express that Oracle is confident, prepared, and fully aligned with VA to meet this goal.

First, and most importantly, leadership engagement and ownership for the EHR implementation across VA has never been stronger. There is clear direction from the highest levels and a deep sense of accountability across all partners. This alignment is driving faster decisions, tighter coordination, and an overall program posture focused squarely on deployment readiness and sustained success.

Second, overall system performance is strong. We are seeing stable uptime and a decrease in interruptions to end users. These improvements are the result of coordinated efforts between Oracle and VA to identify issues and implement consistent end-user monitoring across all deployed sites.

Third, we have implemented targeted EHR optimizations, projects designed to address VA's unique needs in the areas most critical for a successful expansion. Many of these enhancements were delivered as part of the Capability Block (CB) 13 upgrade in August, which introduced a set of focused improvements in care coordination, revenue cycle, and staff efficiency. For example, the new Bed Capacity Management and Command Center tools now give staff real-time visibility into bed availability and patient flow, replacing manual spreadsheets and reducing delays in care. The

Interfacility Consults (IFC) interface improves care coordination between facilities by reducing clicks, eliminating manual steps, thereby improving access to timely care. Additionally, the bi-directional copay synchronization optimization established between the Federal EHR and VistA reduces errors and protects Veterans from incorrect billing.

Finally, we have strengthened every part of our deployment methodology, with a deliberate focus on improving staff readiness. This includes clearer and more proactive communications, more rigorous workflow and content validation, enhanced training and change-management programs, expanded testing protocols, and a more structured post–go-live support model. Together, these improvements ensure that clinicians are better prepared, workflows are better aligned, and facilities enter go-live with greater confidence and fewer disruptions. At the same time, we are modernizing the underlying infrastructure through the migration of the Federal enclave to Oracle Cloud Infrastructure (OCI) and the introduction of new AI-assisted capabilities, including our Clinical AI Agent (CAA), to reduce clinician burden, improve documentation accuracy, and support safer, more efficient care. -For these reasons, Oracle is fully prepared for the accelerated deployment schedule.

Strong Partnership with VA Leadership

Oracle and VA are working more closely together than ever before, and we are united in our commitment to efficiently and successfully deploy the EHRM program. This collaborative effort reflects Oracle's dedication to harnessing advanced technology in partnership with VA's unwavering focus on service, ensuring veterans benefit from modern, integrated healthcare solutions sooner than ever before.

We greatly value the leadership of this administration, and we are particularly appreciative of Secretary Collins' and Deputy Secretary Lawrence's steadfast commitment to advancing this transformative initiative. The OH team meets weekly with the Deputy Secretary, acting Deputy Under Secretary for Health, EHRM IO Program Executive Director, and other key VA leaders to conduct detailed progress reviews, focusing on key areas such as deployment progress, EHR optimizations, operational performance, and the resolution of open actions and decisions. In addition, Deputy Secretary Lawrence and I, along with Oracle's CEO, meet twice each month in person to ensure everyone is on track for our full court press to complete

deployment. Our frequent meetings are a testament to our shared dedication to driving meaningful progress and achieving successful deployment on schedule.

We also want to recognize and commend VA leadership for their clear commitment to standardization and accountability across the enterprise. Their willingness to be out front, consistently visiting VA Medical Centers, engaging directly with frontline staff, and making themselves available for real-time issue escalation, has created a level of partnership that is both rare and invaluable. This hands-on decisive leadership has strengthened the program, reinforced trust across the field, enhanced facility enthusiasm, and demonstrated a shared determination to deliver a unified, high-performing EHR system for veterans.

***System Performance* is Strong**

From July 2023 through November 2025, a 29-month period, Oracle met or exceeded the Outage Free Time (OFT) requirement in 25 of 29 months, with only four isolated exceptions: March 2024, April 2024, January 2025, and March 2025.

Equally important, system performance has shown a clear, sustained upward trajectory. Oracle has achieved seven consecutive months of OFT compliance, meeting or surpassing the 99.95 percent threshold every month since April 2025.

This level of reliability is especially important as VA prepares for the rollout schedule in 2026. The consistency demonstrated throughout 2025 provides a strong foundation and builds the confidence necessary to support 13 planned calendar year 2026 deployments and beyond. The system's recent performance shows that it is stable and fully capable of supporting deployments at scale while maintaining the reliability veterans and clinicians expect.

Federal EHR Optimizations are Delivering Results

VA and Oracle have worked together to deliver a broad set of targeted improvements across workflows most essential to safe, efficient, and coordinated care. These enhancements, spanning critical areas such as pharmacy, referral management and care coordination, research, revenue cycle, clinical documentation and order management have directly strengthened patient safety, provider productivity, and interoperability across the live sites.

- **Pharmacy**: The transition to the Federal EHR and the Medication Manager Retail (MMR) application for outpatient pharmacy, has introduced standardized workflows and new patient safety features across VA facilities. Pharmacists now work within a unified, queue-driven system that supports more consistent processes and improves coordination with the Consolidated Mail Outpatient Pharmacy (CMOP) and community care providers. Clinical information, such as lab values and community prescriptions, is now integrated into pharmacy workflows, helping to reduce the risk of dosing errors and support timely prescription processing. Oracle and VA have collaborated on multiple targeted system optimizations, including features that help pharmacists quickly find the right version of a medication that can be filled; improved visibility into prescription expiration dates; and, mobile inventory scanning, which have helped improve efficiency and safety. While adoption and operational improvements are ongoing, early evidence indicates that some pharmacists across the six live sites are achieving productivity levels comparable to the average performance under the legacy system, and prescription fulfillment rates at live sites are aligning with legacy benchmarks.

- **Referral Management and Care Coordination**: VA and Oracle have fully expanded Seamless Exchange to all six Federal EHR sites as of September 2025, marking a significant advancement in patient care, interoperability, and provider satisfaction. Seamless Exchange integrates directly into clinical workflows, automatically syncing and reconciling patient data from internal systems like VistA and external Health Information Exchange (HIE) networks. By eliminating redundant data across all encounters, Seamless Exchange reduces the volume of external data that requires review, improving both medical charting efficiency and decision-making accuracy.

  In its first month after expansion, Seamless Exchange processed over 412 million records, removing 99.3% of duplicate data and significantly reducing administrative work for clinicians. Providers now have access to a comprehensive view of veteran health information in a single system—minimizing time spent switching between systems, avoiding unnecessary services or tests, and closing information gaps for safer, more effective care. Key data, such as allergies, immunizations, and procedures, are automatically

written into patient records, supporting best practices and improving provider satisfaction with fewer clicks and better visibility.

In addition to Seamless Exchange, VA and Oracle have implemented six other major enhancements aimed at simplifying and automating referral and transfer processes. Improvements to the HealthShare Referral Manager (HSRM) interface reduce duplicate documents and streamline workflows, while updates such as auto-text for referral comments cut down on manual copy-and-paste tasks and lower the risk of transcription errors. Together, these changes save care teams time, reduce manual work, and strengthen care coordination for veterans.

- **Revenue Cycle**: VA and Oracle have strengthened revenue cycle operations by improving cash collections, notably exceeding FY25 goals following the Change Healthcare cyberattack, achieving 180% of VHA's target, with standout performance at sites such as Columbus (217%) and Spokane (216%). The teams have put in place clear rules, policies, and national workflows to make processes consistent across facilities. More than 30 projects have been completed to make daily work easier, including improving billing statements, providing better end-of-month reports, and simplifying worklists so staff spend less time on tasks that don't generate revenue. Automatic processing of coding data now removes duplicate work and saves time, and a long-term project is underway to better track clinician work and forecast funding for each facility.

- **Clinical Documentation, Decision Support, and Patient Safety**: To further enhance clinical efficiency, VA and Oracle have implemented standardized quick-orders within the Federal EHR. This customizable page organizes frequently used orders by specialty and functionality across VA facilities, improving the accuracy and consistency of order placement, simplifying the ordering process, and supporting appropriate charge capture. The teams also enhanced the EHR message-center experience by establishing consistent practices for the creation and maintenance of messaging pools to reduce variability and support clearer communication.

  Additionally, VA and Oracle collaborated to reduce unnecessary drug–drug interaction alerts that were overwhelming providers and contributing to alert

fatigue. By reviewing contraindications and refining alert logic, the system now surfaces fewer low-value alerts, including a 75% decrease in duplicate antidepressant drug notifications, thereby improving workflow efficiency and reducing clinician burden while maintaining patient safety.

Oracle has also achieved significant advancements in patient safety and clinical decision support. Configurable alerts at the point of care enhance clinicians' ability to make safer, evidence-based decisions regarding medications, treatments, and testing. Comprehensive medication management solutions now support seamless transitions of care through features such as Medication Reconciliation and Barcode Administration, while new safety tools for medication ordering and dispensing streamline workflows and reduce the risk of error. Implementation of opioid risk management tools has provided an additional safeguard: since 2021, over 5,000 opioid prescriptions have been modified by VA providers in response to these alerts, reducing patient risk and earning a Federal Innovation Award.

As a result of all these improvements, workflows are more standardized, frontline tools are more effective, and users are experiencing clear, measurable gains in efficiency and safety. We continue to observe meaningful, quantifiable gains in provider-level productivity across the enterprise. As of September 2025, all facilities, except for Roseburg, are performing above baseline productivity levels, according to the EHRM Focus dashboard. Although productivity experienced a temporary dip during the transition period, consistent with typical EHR modernization initiatives, it has since rebounded and, in many locations, now exceeds baseline benchmarks. For example, provider time spent in the EHR has decreased due to system updates implemented by both Oracle and VA: Primary Care Providers in Columbus reduced their average time in the EHR from 66.2 minutes per patient during the initial go-live month to approximately 29.2 minutes per patient by November 2025.

Taken together, these gains demonstrate that we are now operating from a significantly stronger foundation than at any previous deployment. This strengthened foundation gives us greater confidence as we prepare for the deployments and ensures that Veterans and clinicians alike will continue to benefit from a modern, integrated, and reliable Federal EHR.

Improving Staff Readiness Through New Strategies
Effective training, robust support, and high adoption rates are critical to the success of any EHR implementation, it's not just about the technology, but ensuring that users know how to use it efficiently and confidently. Since Oracle acquired Cerner and the ownership of the VA EHRM contract in 2022, change management strategies have evolved significantly, placing stronger emphasis on alignment between Change Management (CM), Training, and Communications. Leveraging lessons learned from earlier deployments, Oracle and VA now provide end users with more robust support both before Deployment Kick Off and after go-live.

A super user is a federal EHR expert who reinforces the knowledge and skills of all staff. The role has been strategically expanded with dedicated onboarding workshops, earlier training opportunities, and increased responsibilities such as proctoring hands-on learning labs. These labs, which offer approximately 100 real-world sandbox scenarios, enable interdisciplinary care teams to practice VA-approved workflows and gain practical experience with integrations between roles. Learning labs were first piloted at FHCC and based on their success we have expanded them. The number of scenarios increased nearly fivefold, and the number of sessions grew fourfold, allowing more users to gain confidence and competence with the system. We have begun hosting learning labs for super users in the Michigan market, four months before deployment. In the first two weeks alone, we held more than 350 sessions with over 1,300 super users participating. Of those participants, 59% said that they felt moderately or greatly more able to lead their staff/peers through the EHRM transformation due to attendance at the learning labs. If you include feeling "slightly more ready," the percentage jumps to 91%. Additionally, 63% said that they felt moderately or greatly more capable of using the Federal EHR after the learning lab. If you include "slightly more capable" the percentage jumps to 95%. We expect these scores to continue to increase the closer we get to go-live.

Further improvements include the addition of a virtual and market-based approach to instructor-led training, providing sites greater scheduling flexibility. Training schedules are now delivered 90 days in advance of sessions and revised super user pre-requisite computer-based training programs required to gain access to the Sandbox have reduced the training burden by 87%. Clearer messaging and targeted invitations have improved engagement and helped users better understand the purpose of each activity. Additionally, workflow readiness activities and market-based sessions are now

prioritized, while the shift from track-based to role-based programs requires every critical role – including providers – to have an assigned, trained super user. Together, these enhancements in change management have helped accelerate deployment, increase user preparedness, reduce support tickets, and drive successful adoption of the Federal EHR at VA sites.

Transition to the Cloud

In my testimony in February, I reflected on the widespread recognition of the need to move the Federal EHR to the cloud. I explained the benefits of Oracle Cloud Infrastructure (OCI), including enhanced security, scalability and performance, improved reliability and resilience, in addition to allowing VA to adopt innovative modern technology.

The Federal EHR migration to OCI will be completed in phases, which will move groups of solutions and services from the on-premises data center to OCI. Since the Federal EHR is shared, the migration will be a coordinated effort between Federal EHR partners, including DoD, VA, and the Federal Electronic Health Record Modernization (FEHRM) office. The goal of this migration is to enhance the performance, security, scalability, stability, and innovation of the federal government's health care solutions, thereby better serving the nation's Service members, Veterans, and other beneficiaries.

I'm pleased to share that we successfully completed the migration of the first phase to the cloud on time earlier this month. This first phase was a foundational milestone for the OCI migration program. Completing it meant we established the core technical and security underpinnings that every subsequent phase will depend on. It delivered the required cyber authorizations, created connectivity between OCI and the Kansas City data center to enable new, cloud-based and AI-enabled technologies that do not have to be adjacent to the EHR, and, critically, set the repeatable pattern for migrating all remaining services and applications. In simple terms, this first phase "built the house" and the remaining tranches are about "moving the furniture" and configuring it for clinicians and veterans. We look forward to completing the full migration of all remaining tranches and as a reminder, Oracle has committed to making this move at our expense.

Future Opportunities

Interoperability

Oracle Health Information Network's (OHIN) recent official designation as a TEFCA Qualified Health Information Network (QHIN) within the Trusted Exchange Framework and Common Agreement (TEFCA) will empower even broader and more secure exchange of patient health records across disparate health systems. As a designated QHIN, OHIN will streamline connectivity, enhance data accessibility, and help ensure that every care provider has timely, comprehensive information to support better outcomes for veterans everywhere. As pledged participants of the Center for Medicare and Medicaid Services (CMS) Aligned Network at the Department of Health and Human Services, we are exploring ways to leverage the network to create further data exchange solutions to serve veterans wherever they are receiving care. Oracle will invite all providers in America to connect directly with us to allow for real-time data exchange on behalf of Veterans

AI

I am optimistic about introducing our Clinical AI Agent software to the Federal EHR. CAA enables providers to spend less time in the EHR and more time engaging with their patients, and user feedback has been overwhelmingly positive. The agents we have implemented do not replace the provider, and humans are always in the loop and the decision maker. Rather, they empower and allow providers to concentrate on patient care instead of a computer screen. Providers retain full authority over all clinical decisions. By automating routine documentation and administrative tasks within the EHR, AI helps doctors reduce burden reclaim valuable time, increase their productivity, and devote more energy to meaningful face-to-face engagement with their patients – ultimately allowing them to focus on what brought them into medicine in the first place.

One of our commercial customers shared that their facility's providers were using CAA less than 30 minutes from its installation, without training, and found it improved treatment and outcomes, had intuitive user interface, shaved minutes off their visits, and resulted in no calls to the helpline for support. We are hoping to deliver the same positive experience with CAA at VA.

New EHR

I'm excited to announce that Oracle's next-generation ambulatory EHR has received Health IT certification from the Department of Health and Human Services (HHS)

Office of the National Coordinator (ONC). This marks a significant milestone for Oracle and the broader healthcare industry.

With this certification, ambulatory clinics across the U.S.—including VA—can begin planning for the adoption of our transformative, AI-powered EHR. Unlike other EHRs, Oracle's solution was built from the ground up with AI embedded in every layer and workflow, on a secure, modern cloud architecture. This allows for streamlined clinical workflows, automation of manual tasks, and enhanced patient care, supporting clinicians with actionable, explainable insights at the point of care.

In addition to ONC certification, the EHR has met DEA Electronic Prescriptions for Controlled Substances (EPCS) compliance requirements, enabling secure e-prescribing and helping reduce administrative burdens and the risk of prescription fraud. Looking ahead, we anticipate our acute care EHR will follow soon with its own certification, paving the way for VA and other health organizations to plan for a comprehensive migration to Oracle's new platform. We're committed to helping VA harness the full potential of agentic AI to improve outcomes, operational performance, and the patient and clinician experience.

Closing

Chairman Barrett, Ranking Member Budzinski, and members of the Subcommittee, thank you once again for the opportunity to appear before you today and for your continued oversight of the VA's EHR modernization program. Oracle is proud to be a partner in this vital mission to improve the health care our nations Veterans deserve. We are working alongside VA leadership and frontline staff to deliver the modern, reliable, and interoperable health record system America's veterans need. The progress we have made together has been substantial, and we stand fully committed to building on this foundation—supporting the accelerated deployment schedule and ensuring every VA facility has the tools, training, and technologies needed to deliver safe, efficient, and high-quality care. As we move into 2026, we are confident and prepared to deploy the Federal EHR in partnership with the VA.

As we move forward, we will remain vigilant about system performance, relentlessly focused on staff readiness, and unwavering in our commitment to patient safety. By harnessing innovation—whether through cloud migration, artificial intelligence, or next-generation EHR platforms—we are enabling VA clinicians to spend more time

with patients and less time on administrative tasks, ultimately fulfilling the promise of modern healthcare for our nation's veterans.

Thank you for your leadership and partnership in this endeavor. I look forward to answering your questions.

Prepared Statement of Carol Harris

United States Government Accountability Office

Testimony

Before the Subcommittee on Technology Modernization, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 3:00 p.m. ET
Monday, December 15, 2025

VA ELECTRONIC HEALTH RECORD MODERNIZATION

Critical Actions Needed to Support Accelerated System Deployments

Statement of Carol C. Harris, Director, Information Technology and Cybersecurity

GAO-26-108812

Highlights

VA ELECTRONIC HEALTH RECORD MODERNIZATION

Critical Actions Needed to Support Accelerated System Deployments

GAO-26-108812 December 2025

A testimony before the Subcommittee on Technology Modernization, Committee on Veterans' Affairs, House of Representatives

For more information, contact: Carol Harris at HarrisCC@gao.gov

What GAO Found

After three unsuccessful attempts over two decades, the Department of Veterans Affairs (VA) undertook a fourth effort in 2017—the Electronic Health Record Modernization (EHRM) program—to modernize its legacy health information system. GAO has previously reported on the challenges VA has experienced with this effort. In these reports, GAO made 18 recommendations to improve cost estimating, schedule, program management, user adoption and satisfaction, and operational testing. GAO deemed 12 of these as priority recommendations because of their criticality to successful future deployments. VA has not yet fully implemented 16 of the 18 recommendations.

Implementation Status of GAO Electronic Health Record System-Related Recommendations to the Department of Veterans Affairs as of December 2025

Report	Total number of recommendations	Number of priority recommendations	Implementation status of recommendations
GAO-25-106874 (March 2025)	3	2	2 priority open (not implemented) 1 closed (implemented)
GAO-23-106731 (May 2023)	10	10	9 priority open (not implemented) 1 priority open (partially implemented)
GAO-22-103718 (February 2022)	2	0	1 open (not implemented) 1 closed (implemented)
GAO-21-224 (February 2021)	2	0	2 open (not implemented)
GAO-20-473 (June 2020)	1	0	1 open (not implemented)

Source: GAO reports. I GAO-26-108812

In March 2025, GAO reported that VA had made improvements at five initial sites but noted that the department's actions to address challenges had impacted the program's total cost estimate and schedule. Accordingly, GAO made two priority recommendations to update the cost estimate and schedule. Senate and House Authorizing and Appropriations Committees subsequently sent a letter to VA requesting a detailed cost estimate and schedule before September 30, 2025. While VA has delivered a notional schedule to congressional committees, it has not provided a cost estimate or detailed documentation of its schedule necessary to determine the extent to which it is consistent with leading practices.

In May 2023, GAO reported that users expressed dissatisfaction with the new system and VA did not adequately identify and address system issues. GAO made 10 priority recommendations to address change management, user satisfaction, system trouble ticket, and independent operational assessment deficiencies. VA has not yet fully implemented the 10 recommendations.

Until VA fully implements the priority recommendations, future deployments risk prolonging management challenges like those experienced in the initial deployments and users will likely not be positioned to achieve optimal usage of the new electronic health record (EHR) system.

Why GAO Did This Study

VA depends on its EHR system to manage health care for its patients. Since 2017, the department's EHRM program has undertaken efforts to replace its legacy EHR system with a modernized, commercial system.

VA first deployed its new EHR system in October 2020 and followed up with further deployments to four additional sites in 2022. However, in 2023, it halted future system deployments due to feedback from veterans and clinicians that the new system was not meeting expectations. In December 2024, VA announced plans to restart deployments beginning with four facilities in Michigan. The department plans for nine additional site deployments in 2026. VA plans to accelerate deployments to complete approximately 170 sites by 2031.

GAO has previously designated VA health care as a high-risk area for the federal government, in part due to its challenges implementing EHRM initiatives.

GAO was asked to testify on its key prior reports and related recommendations to improve VA's EHRM program. GAO summarized the results of five prior reports and followed up with VA on actions to implement recommendations.

What GAO Recommends

GAO has made a total of 18 recommendations in prior reports to VA to improve its EHRM efforts, 12 of which GAO has deemed priority recommendations. The department has fully implemented two of the 18 recommendations and partially implemented one priority recommendation, but has not fully addressed 15, including the remaining priority recommendations.

Chairman Barrett, Ranking Member Budzinski, and Members of the Subcommittee:

Thank you for the opportunity to discuss the readiness of the Department of Veterans Affairs' (VA) Electronic Health Record Modernization (EHRM) program. As you know, VA operates one of the largest health care systems in the nation. It provides services to more than 9 million veterans who generally have greater health care needs than the broader population. To support this mission, VA depends on its electronic health record (EHR) system to manage health care for its patients.[1] Since 2017, the department's EHRM program has undertaken an effort to replace its legacy EHR system with a modernized, commercial system.

VA first deployed the new EHR system in October 2020 and followed up with further deployments to four additional sites in 2022. In April 2023, VA paused deployments to additional sites due to feedback from veterans and clinicians that the new system was not meeting expectations. An exception to this pause was the Captain James A. Lovell Federal Health Care Center in North Chicago, which was deployed in March 2024.[2] In December 2024, VA announced that it was resuming planning for future deployments starting with four facilities in Michigan. After the Michigan deployments, the department plans to deploy the new EHR to nine additional sites in 2026.

We have previously designated VA health care as a high-risk area for the federal government, in part due to its challenges with IT and

[1]An EHR is a collection of information about the health of an individual or the care provided, such as patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports.

[2]The Captain James A. Lovell Federal Health Care Center in North Chicago is the only fully integrated health care system operated by both VA and the Department of Defense (DOD).

implementation of EHRM initiatives.[3] In our 2025 high-risk update, we noted that VA had halted the EHR system deployment and focused on making improvements at the five initial sites using the system. However, efforts to deploy the new EHR system remained in the early stages and VA had not refined its corrective action plan to provide a clearer roadmap for addressing root causes of IT concerns related to deploying the new system.

In this statement, I will summarize the results of our key prior reports that describe the challenges in VA's implementation of the new EHR system—including the status of actions taken by the department to implement recommendations—that could impact future planned deployments of the system.

In developing this testimony, we summarized challenges identified in five of our prior reports on VA's efforts to implement its EHRM. Specifically, we included results from our prior reports and incorporated information on the department's actions taken in response to key recommendations made in our prior work. The reports cited throughout this statement include detailed information on their scope and methodologies.[4]

The work on which this statement is based was conducted in accordance with generally accepted government auditing standards. Those standards

[3]VA's IT issues were highlighted in our 2015 high-risk report and subsequent high-risk reports. See GAO, *High-Risk Series: An Update*, GAO-15-290 (Washington, D.C.: Feb. 11, 2015); *High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others*, GAO-17-317 (Washington, D.C.: Feb. 15, 2017); *High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas*, GAO-19-157SP (Washington, D.C.: Mar. 6, 2019); *High-Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas*, GAO-21-119SP (Washington, D.C.: Mar. 2, 2021); *High-Risk Series: Efforts Made to Achieve Progress Need to Be Maintained and Expanded to Fully Address All Areas*, GAO-23-106203 (Washington, D.C.: Apr. 20, 2023); and *High-Risk Series: Heightened Attention Could Save Billions More and Improve Government Efficiency and Effectiveness*, GAO-25-107743 (Washington, D.C.: Feb. 25, 2025).

[4]GAO, *Electronic Health Records: VA Making Incremental Improvements in New System but Needs Updated Cost Estimate and Schedule*, GAO-25-106874 (Washington, D.C.: Mar. 12, 2025); *Electronic Health Records: VA Needs to Address Management Challenges with New System*, GAO-23-106731 (Washington, D.C.: May 18, 2023); *Electronic Health Records: VA Needs to Address Data Management Challenges for New System*, GAO-22-103718 (Washington, D.C.: Feb. 1, 2022); *Electronic Health Records: VA Has Made Progress in Preparing for New System, but Subsequent Test Findings Will Need to Be Addressed*, GAO-21-224 (Washington, D.C.: Feb. 11, 2021); and *Electronic Health Records: Ongoing Stakeholder Involvement Needed in the Department of Veterans Affairs' Modernization Effort*, GAO-20-473 (Washington, D.C.: June 5, 2020).

require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Within VA, the Veterans Health Administration (VHA) operates one of the nation's largest health care systems. The administration relies on its legacy health information system—the Veterans Health Information Systems and Technology Architecture (VistA)—to deliver health care to veterans and to document this care. This technically complex system has been in operation for more than 30 years, is costly to maintain, and does not optimally support VA's need to electronically exchange health records with other organizations, such as the Department of Defense (DOD) and community providers (who are non-VA providers that provide care to veterans and are reimbursed by VA).

The department has undertaken, and we have reported on, a number of initiatives to modernize and improve interoperability (i.e., the ability to exchange and use electronic health information) across the department.[5] These initiatives have included four efforts over two decades to modernize VistA. The first three efforts—HealtheVet, the integrated Electronic Health Record (iEHR), and VistA Evolution—reflect varying approaches that the department had taken since 2001 to achieve a modernized electronic health record system. However, these approaches were abandoned due to concerns about project planning, high costs, and undelivered capabilities.

VA's current approach, its EHRM program, began in June 2017. At that time, the former VA Secretary announced that the department planned to acquire the Oracle Health EHR system—the same commercial system that DOD was implementing across the military health system—and

[5]See, for example, GAO-25-106874, GAO-23-106731; GAO-22-103718; GAO-21-224; GAO-20-473; GAO, *Electronic Health Records: VA Needs to Identify and Report System Costs*, GAO-19-125 (Washington, D.C.: July 25, 2019); *VA Health IT Modernization: Historical Perspective on Prior Contracts and Update on Plans for New Initiative*, GAO-18-208 (Washington, D.C.: Jan. 18, 2018); and *Electronic Health Records: Outcome-Oriented Metrics and Goals Needed to Gauge DOD's and VA's Progress in Achieving Interoperability*, GAO-15-530 (Washington, D.C.: Aug. 13, 2015).

configure it for VA.[6] Further, the department decided to acquire the same system as DOD because it would allow all of VA's and DOD's patient data to reside in one system. A single system is intended to enable seamless care between VA and DOD without the manual and electronic exchange and reconciliation of data between two separate systems.[7]

VA's EHRM Integration Office manages the EHRM program and coordinates with stakeholders (e.g., VHA subject matter experts and site-specific staff) at the facility, regional, and national levels on the transition to a new EHR system. According to the department, EHRM is designed to improve veterans' experiences by establishing a modernized, seamless, and secure EHR for VA. This modernization approach is also intended to improve VA health care providers' ability to deliver care by standardizing clinical practice workflows, enabling interoperability between VA and DOD, and increasing interoperability with community care partners.

The EHRM program originally planned to implement the new EHR system across VA's medical facilities in phases over the span of a decade. VA deployed the new EHR system at its first location, the Mann-Grandstaff VA Medical Center in Spokane, Washington, in October 2020. In 2021, VA performed a strategic review of the program and decided to pause new deployments and focus on fixing initial deployment issues.

In fiscal year 2022, VA moved forward with implementation of the new system at four additional locations:[8]

[6]VA and DOD use the same Oracle Health Millennium system with agency-specific configuration differences. VA refers to its EHR system as the Federal EHR, while DOD refers to its system as Military Health System (MHS) GENESIS. VA contracted with Cerner Government Services, Inc. for the department's new EHR system in May 2018. Subsequently, in June 2022, Cerner was acquired by Oracle Health Government Services, Inc. We use Oracle Health throughout this statement.

[7]DOD's initial implementation of MHS GENESIS began in 2017 at four military treatment facilities in the state of Washington. The department completed the last of its deployments of the EHR system in March 2024.

[8]VHA is divided into regions called Veterans Integrated Services Networks (VISN). There are currently 18 VISNs throughout VHA based on geographical location. VISNs provide oversight and guidance to the VA Medical Centers and VA Health Care Systems within their areas and are sometimes called a "network." The five initial sites are within VHA's VISN 20 and VISN 10. VISN 20 includes medical centers and community-based outpatient clinics in the states of Alaska, Washington, Oregon, most of Idaho, and one county each in Montana and California. VISN 10 serves veterans in Ohio, Indiana, and Michigan.

- Jonathan M. Wainwright Memorial VA Medical Center in Walla Walla, Washington, in March 2022.
- VA Central Ohio Health Care System in Columbus, Ohio, in April 2022.
- Roseburg VA Health Care System in Roseburg, Oregon, in June 2022.
- VA Southern Oregon Rehabilitation Center and Clinics in White City, Oregon, in June 2022.

Following the Roseburg and White City deployments, VA decided to delay upcoming deployments to address feedback from users at the initial sites who identified patient safety and system reliability issues. In addition, the department performed an assessment to diagnose and address problems with program governance and associated processes. In April 2023, VA announced that feedback from veterans and clinicians continued to indicate that the new system was not meeting expectations at the five deployed sites. Consequently, the department halted future deployments, with the exception of the Captain James A. Lovell Federal Health Care Center in North Chicago, to focus on making improvements at the five initial sites.[9] VA referred to these improvement efforts as a program “reset”.

While the reset efforts continued, VA deployed the new EHR system at the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois, in March 2024. On December 20, 2024, VA announced that it was beginning early-stage planning for restarting deployments to four sites in Michigan in mid-2026.[10] In March 2025, VA announced nine additional medical facilities at which it planned to deploy the new EHR

[9]The Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois, integrates services previously provided by the former North Chicago VA Medical Center and its community-based outpatient clinics and the Naval Health Clinic Great Lakes and its associated clinics. The Federal Health Care Center provides health care to service members, veterans and other beneficiaries throughout northern Illinois and southeastern Wisconsin. Additionally, the Federal Health Care Center ensures that Navy recruits who pass through Naval Station Great Lakes each year are medically ready. The Federal Health Care Center is part of VISN 12, the VA Great Lakes Health Care System, which serves veterans who reside in Illinois, the Upper Peninsula of Michigan, Wisconsin, and northwestern Indiana.

[10]The four Michigan facilities are: (1) John D. Dingell VA Medical Center in Detroit, Michigan; (2) Battle Creek VA Medical Center in Battle Creek, Michigan; (3) Lieutenant Colonel Charles S. Kettles VA Medical Center in Ann Arbor, Michigan; and (4) the Aleda E. Lutz VA Medical Center in Saginaw, Michigan.

system in 2026 under an accelerated deployment schedule.[11] VA plans to accelerate deployments to complete approximately 170 sites throughout the nation by 2031.

For the period of fiscal year 2018 through the second quarter of fiscal year 2025, VA reported that it obligated a total of about $13.84 billion on the EHRM program. This total is comprised of the following elements:

- EHR contract ($5.85 billion)
- IT infrastructure ($3.35 billion)
- Program management ($1.48 billion)
- VHA ($2.85 billion)
- Office of Information and Technology (OIT) ($324 million).

VA Faced Challenges with EHR System Deployments and Has Not Addressed Key GAO Recommendations

From June 2020 to March 2025, we issued five reports on VA's efforts to deploy its new EHR system.[12] The reports described actions taken by the department and identified challenges with key planning tools critical for program oversight. We also reported on challenges experienced with the initial deployments, including user dissatisfaction with the new system.

To address these challenges, we made 18 recommendations—12 of which we deemed priority recommendations because of the critical impact they would have on strengthening successful future deployments. While VA has taken actions to address our recommendations, the department has not fully implemented 16 of these recommendations. Table 1 shows the implementation status of the recommendations. See appendix I for a detailed list of recommendations on the VA EHRM program.

[11]Additional planned deployment sites for 2026 are: (5) the Cincinnati VA Medical Center in Cincinnati, Ohio; (6) Cincinnati VA Medical Center at Fort Thomas in Fort Thomas, Kentucky; (7) Chillicothe VA Medical Center in Chillicothe, Ohio; (8) Dayton VA Medical Center in Dayton, Ohio; (9) Fort Wayne VA Medical Center in Fort Wayne, Indiana; (10) Marion VA Medical Center in Marion, Indiana; (11) Richard L. Roudebush VA Medical Center in Indianapolis, Indiana; (12) Alaska VA Healthcare System in Anchorage, Alaska; and (13) Louis Stokes Cleveland VA Medical Center in Cleveland, Ohio.

[12]GAO-25-106874, GAO-23-106731; GAO-22-103718; GAO-21-224; GAO-20-473.

Table 1: Implementation Status of GAO Electronic Health Record System-Related Recommendations to the Department of Veterans Affairs (VA) as of December 2025

GAO report	Total number of recommendations	Number of priority recommendations	Implementation status of recommendations
GAO-25-106874 Electronic Health Records: VA Making Incremental Improvements in New System but Needs Updated Cost Estimate and Schedule (March 2025)	3	2	2 priority open (not implemented) 1 closed (implemented)
GAO-23-106731 Electronic Health Records: VA Needs to Address Management Challenges with New System (May 2023)	10	10	9 priority open (not implemented) 1 priority open (partially implemented)
GAO-22-103718 Electronic Health Records: VA Needs to Address Data Management Challenges for New System (February 2022)	2	0	1 open (not implemented) 1 closed (implemented)
GAO-21-224 Electronic Health Records: VA Has Made Progress in Preparing for New System, but Subsequent Test Findings Will Need to Be Addressed (February 2021)	2	0	2 open (not implemented)
GAO-20-473 Electronic Health Records: Ongoing Stakeholder Involvement Needed in the Department of Veterans Affairs' Modernization Effort (June 2020)	1	0	1 open (not implemented)

Source: GAO reports. | GAO-26-108812

VA Needs to Produce Updated Cost Estimate and Schedule

In March 2025, we reported that the many changes undertaken by VA to pause deployments and make improvements impacted the program's total life cycle cost estimate and integrated master schedule.[13] Regarding costs, in 2022 the Institute for Defense Analyses estimated that EHR

[13]GAO-25-106874.

modernization life cycle costs would total $49.8 billion—$32.7 billion for 13 years of implementation and $17.1 billion for 15 years of sustainment.

Updating that estimate to reflect events over the last 2 years, such as the pause, is imperative to understanding the full magnitude of VA's investment. Similarly, it is critically important that VA update its schedule to inform decision-making. Accordingly, we made two priority recommendations to the Secretary of VA: (1) obtain an updated and independent total life cycle cost estimate using best practices described in GAO's Cost Estimating and Assessment Guide, and (2) expeditiously and reliably update its integrated master schedule using best practices described in GAO's Schedule Assessment Guide.[14] VA concurred and planned to update the cost and schedule.

Senate and House Authorizing and Appropriations Committees subsequently sent a letter to VA requesting that it provide a detailed cost estimate and schedule before September 30, 2025. As of December 2025, the department has not provided an updated cost estimate. In addition, while the department has delivered a notional schedule to congressional committees, the EHRM program has not yet provided the detailed documents needed to determine the extent to which the schedule is consistent with leading practices. Consequently, as the department increases its momentum to complete 170 total site deployments by 2031, more information critical to controlling risks and informing congressional oversight is needed.

In our March 2025 report, we also determined that VA had identified performance measures for the new EHR reset and identified baselines and targets for eight of nine metrics to measure the impact of the new system at the live sites. However, VA had not established baselines and targets for one metric: the time to user-acknowledged ticket resolution for change requests. We recommended that VA identify baselines and performance targets for all nine identified metrics intended to measure program and system performance and VA concurred with the recommendation. Subsequently, in September 2025, VA provided evidence that it had established baselines and targets for all nine

[14]GAO, *Cost Estimating and Assessment Guide: Best Practices for Developing and Managing Program Costs*, GAO-20-195G (Washington, D.C.: Mar. 12, 2020) and *Schedule Assessment Guide: Best Practices for Project Schedules*, GAO-16-89G (Washington, D.C.: Dec. 22, 2015).

identified metrics, and we closed the recommendation as implemented.[15] By identifying baselines and performance targets for its identified metrics, VA has improved its ability to measure and communicate the performance expected to be achieved by the program in current and future deployments.

More Work Needed to Demonstrate Results of VA's Actions to Address User Concerns and System Issues

In May 2023, we reported that the organizational change management activities for the EHRM program were partially consistent with seven leading practices and not consistent with one leading practice.[16] We also reported that users expressed dissatisfaction with the new system and that VA did not adequately identify and address system issues. We made 10 priority recommendations to address change management, user satisfaction, system trouble ticket, and independent operational assessment deficiencies. VA concurred with the recommendations.

As of December 2025, VA has partially implemented one of 10 priority recommendations and continues to work toward implementing the remaining nine. For example, VA partially implemented one recommendation to address users' barriers to change. Specifically, VA had developed plans to address user concerns about the new EHR system identified in a strategic review of the program. However, the department has not yet adequately demonstrated that corresponding improvement projects have fully addressed underlying barriers.

In addition, VA had not approved and implemented a VA-specific change management strategy to formalize how it will improve the readiness of end users to adapt to working in the new EHR system. Further, VA had not instituted plans to conduct an independent operational assessment to evaluate the suitability and effectiveness of the new EHR system for users in the operational environment. An operational assessment, particularly if it were conducted by an independent entity, would help VA catalog findings with greater rigor, transparency, and accountability. In addition, without having conducted an independent operational assessment, VA had not validated that the system satisfies user needs in an operational environment. This elevates the risk of deploying the system prematurely, thereby posing unnecessary risks to patient health and safety.

[15] VA determined that resolving change request tickets in 80 days or less was a stable baseline measure and its target was established to maintain that level of performance.

[16] GAO-23-106731.

We will continue to monitor the 10 priority recommendations made to VA. Until these recommendations are fully implemented, future deployments are at risk of prolonging challenges like those experienced in the initial deployments. This in turn could hinder users' ability to interact with the system and impede their knowledge of new workflows.

Continued Focus on Efforts Related to Data Quality, Stakeholder Input, and Resolution of Test Findings Needed

GAO issued three additional reports on EHRM in 2020, 2021, and 2022. Our February 2022 report on VA's data management plans discussed migrating data to the new EHR system and supporting the continuity of reporting.[17] We noted that VA had made progress towards implementing planned data management activities, but clinicians faced challenges with the quality of migrated data. In addition, VA had not established performance measures and goals for data quality and had not used a stakeholder register to identify and engage all stakeholders. Accordingly, we made two recommendations to VA to (1) establish performance measures and (2) use a stakeholder register to meet reporting needs. VA concurred and took action to fully implement the second recommendation. However, because the program had paused system deployments and lacked a path to migrating data at the next sites, we do not yet have sufficient evidence to demonstrate that the first recommendation has been implemented.

In February 2021, we reported that VA had made progress toward implementing its new system but needed to postpone further deployment until it had addressed all critical and high severity test findings.[18] We made two recommendations that it do so, and VA concurred. In March 2025, we reported that the department had made progress toward implementing the recommendations as it had no critical or high-severity test findings at subsequent locations.[19] To gauge the extent to which VA has fully implemented our two recommendations, we plan to observe the sustained resolution of significant test findings in the upcoming 2026 deployments.

Our June 2020 report found that VA's decision-making procedures for configuring the EHR system were generally effective but did not always ensure key stakeholder involvement.[20] We recommended that the

[17] GAO-22-103718.

[18] GAO-21-224.

[19] GAO-25-106874.

[20] GAO-20-473.

department ensure the involvement of all relevant medical facility stakeholders in the EHR system configuration decision process. VA concurred with our recommendation and stated that it intended to refine local workshop agendas and descriptions to facilitate subject matter expert identification and participation. However, VA has not yet provided sufficient support that the recommendation has been implemented.

In summary, we will continue to assess the extent that VA has implemented our recommendations, with particular attention to the 12 priority ones. Full implementation of our recommendations will help ensure the department's actions are sustained and that the program is well positioned to support its accelerated deployments and optimal use of the new system.

Chairman Barrett, Ranking Member Budzinski, and Members of the Subcommittee, this concludes my prepared statement. I would be happy to answer any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Carol C. Harris at harriscc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement.

GAO staff who made key contributions to this testimony include Jennifer Stavros-Turner (Assistant Director), Merry Woo (Analyst-in-Charge), Christy Tyson Brown, Chris Businsky, Jess Lionne, Anh-Thi Le, Jacqueline Mai, and Norma-Jean Simon.

Appendix I: Summary of GAO's Recommendations on VA's Electronic Health Record Modernization

Table 2: GAO Recommendations to VA on Electronic Health Record Modernization

Report	Recommendation	Priority recommendation?	Status
GAO-25-106874 Electronic Health Records: VA Making Incremental Improvements in New System but Needs Updated Cost Estimate and Schedule	The Secretary of VA should direct the EHRM Integration Office to obtain an updated and independent total life cycle cost estimate using best practices described in GAO's Cost Estimating and Assessment Guide. (Recommendation 1)	Yes	Open - Not Implemented
GAO-25-106874 Electronic Health Records: VA Making Incremental Improvements in New System but Needs Updated Cost Estimate and Schedule	The Secretary of VA should direct the EHRM Integration Office to expeditiously and reliably update its integrated master schedule using best practices described in GAO's Schedule Assessment Guide. (Recommendation 2)	Yes	Open - Not implemented
GAO-25-106874 Electronic Health Records: VA Making Incremental Improvements in New System but Needs Updated Cost Estimate and Schedule	The Secretary of VA should direct the EHRM Integration Office and the VHA to identify baselines and performance targets for all nine identified metrics intended to measure program and system performance. (Recommendation 3)		Closed - Implemented
GAO-23-106731 Electronic Health Records: VA Needs to Address Management Challenges with New System	The Secretary of VA should ensure that VA documents a VA-specific change management strategy to formalize its approach to drive user adoption. (Recommendation 1)	Yes	Open - Not Implemented
GAO-23-106731 Electronic Health Records: VA Needs to Address Management Challenges with New System	The Secretary of VA should ensure that the department's planned improvements to communication of system changes meet users' needs for the frequency of the updates provided. (Recommendation 2)	Yes	Open - Not Implemented
GAO-23-106731 Electronic Health Records: VA Needs to Address Management Challenges with New System	The Secretary of VA should take steps to improve change readiness scores prior to future system deployments. (Recommendation 3)	Yes	Open - Not Implemented
GAO-23-106731 Electronic Health Records: VA Needs to Address Management Challenges with New System	The Secretary of VA should ensure steps taken by the EHRM program and Oracle Cerner to increase workforce skills and competencies through improved training and related change management activities have been effective. (Recommendation 4)	Yes	Open – Not Implemented
GAO-23-106731 Electronic Health Records: VA Needs to Address Management Challenges with New System	The Secretary of VA should address users' barriers to change, by ensuring planned completion of all actions identified in the Secretary's Strategic Review. (Recommendation 5)	Yes	Open – Partially Implemented
GAO-23-106731 Electronic Health Records: VA Needs to Address Management Challenges with New System	The Secretary of VA should develop a plan, including a timeline, for establishing (1) targets for measuring the adoption of changes and (2) metrics and targets to measure the resulting outcomes of the change. (Recommendation 6)	Yes	Open – Not Implemented

Report	Recommendation	Priority recommendation?	Status
GAO-23-106731 Electronic Health Records: VA Needs to Address Management Challenges with New System	The Secretary of VA should measure and report on outcomes of the change and take actions to support users' ability to use the system to reinforce and sustain the change. (Recommendation 7)	Yes	Open – Not Implemented
GAO-23-106731 Electronic Health Records: VA Needs to Address Management Challenges with New System	The Secretary of VA should establish user satisfaction targets (i.e., goals) and ensure that the program demonstrates improvement toward meeting those targets prior to future system deployments. (Recommendation 8)	Yes	Open – Not Implemented
GAO-23-106731 Electronic Health Records: VA Needs to Address Management Challenges with New System	The Secretary of VA should make certain that future system trouble tickets are resolved within established timeliness goals. (Recommendation 9)	Yes	Open – Not Implemented
GAO-23-106731 Electronic Health Records: VA Needs to Address Management Challenges with New System	The Secretary of VA should reinstitute plans to conduct an independent operational assessment to evaluate the suitability and effectiveness of the new EHR system for users in the operational environment. (Recommendation 10)	Yes	Open – Not Implemented
GAO-22-103718 Electronic Health Records: VA Needs to Address Data Management Challenges for New System	The Secretary of VA should direct the Deputy Secretary to establish and use performance measures and goals to ensure that the quality of migrated data meets stakeholder needs for accessibility, accuracy, and appropriateness prior to future system deployments. (Recommendation 1)		Open – Not Implemented
GAO-22-103718 Electronic Health Records: VA Needs to Address Data Management Challenges for New System	The Secretary of VA should direct the Deputy Secretary to use a stakeholder register to improve the identification and engagement of all relevant EHRM stakeholders to address their reporting needs. (Recommendation 2)		Closed - Implemented
GAO-21-224 Electronic Health Records: VA Has Made Progress in Preparing for New System, but Subsequent Test Findings Will Need to Be Addressed	The Secretary of VA should direct the Executive Director of the Office of Electronic Health Record Modernization to postpone deployment of the new EHR in new locations until all existing open critical severity test findings are resolved and closed, and until any additional critical severity findings identified before planned deployment are closed. (Recommendation 1)		Open – Not Implemented
GAO-21-224 Electronic Health Records: VA Has Made Progress in Preparing for New System, but Subsequent Test Findings Will Need to Be Addressed	The Secretary of VA should direct the Executive Director of the Office of Electronic Health Record Modernization to postpone deployment of the new EHR in new locations until all existing open high severity test findings are either resolved and closed or deferred, and until any additional high severity test findings identified before planned deployment are either closed or deferred. (Recommendation 2)		Open – Not Implemented

Report	Recommendation	Priority recommendation?	Status
GAO-20-473 Electronic Health Records: Ongoing Stakeholder Involvement Needed in the Department of Veterans Affairs' Modernization Effort	For implementation of the EHR system at future VA medical facilities, we recommend that the Secretary of VA direct the EHRM Executive Director to clarify terminology and include adequate detail in descriptions of local workshop sessions to facilitate the participation of all relevant stakeholders including medical facility clinicians and staff. (Recommendation 1)		Open – Not Implemented

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STATEMENTS FOR THE RECORD

Prepared Statement of The American Legion

Chairman Barrett, Ranking Member Budzinski, and distinguished members of the subcommittee, on behalf of National Commander Dan K. Wiley and more than 1.5 million dues-paying members of The American Legion, we thank you for the opportunity to offer our statement for the record on the Department of Veterans' Affairs' modernization efforts.

The American Legion is guided by active Legionnaires who dedicate their time and resources to serve veterans, service members, their families, and caregivers. As a resolution-based organization, our positions are directed by over 106 years of advocacy and resolutions that originate at the grassroots level of our organization. Every time The American Legion testifies, we offer a direct voice from the veteran community to Congress.

As the United States Department of Veterans Affairs (VA) resumes rollout of the Electronic Health Record Modernization (EHRM) program it is important to note that the VA began the EHRM program to make critically needed updates to the VA's software systems. VA's current electronic health record (EHR), the Veterans Health Information Systems and Technology Architecture (VistA), is *extremely* outdated and simply cannot serve current or future veteran needs.

Though the name VistA was adopted by VA in 1994, the system itself can date its origins back to 1977.[1] While it was a triumph of its age, this decades-old system lacks many modern features available to civilian hospitals. The VA's new EHRM, Oracle Cerner Millennium, is intended to bring new, modern capabilities to the VA such as more accurate and faster tracking and identifying of potential health risks, scheduling features that would improve on wait times, and a seamless experience across different hospitals and departments.[2] The EHRM program, as intended, will provide veterans with an easily updated health record that follows a veteran for life, from the time of their service in the Department of War (DOW) through their time in VA healthcare. The American Legion strongly supports these goals.[3]

However, the rollout has not gone as intended. The deployment of this new system began in 2020 at Mann-Grandstaff VA Medical Center in Spokane, WA, and was almost immediately inundated with issues.[4] Several of these issues were severe, such as veteran data being migrated to the new system with outdated prescriptions and emergency contact information, or dropping prescriptions altogether. Problems with further rollout sites led to the program being put on pause in April 2023, with one exception allowing for a rollout to the Captain James A. Lovell Federal Health Care Center (FHCC) in Chicago, Illinois.

The American Legion visited the Lovell FHCC in August 2025 to review how the facility has adopted and implemented the new electronic health record system. The results we saw reflected a marked improvement from prior rollout experiences at other locations. Facility staff reported zero instances of critical harm, and no veterans' health seriously affected due to problems resulting from the rollout. Staff further reported that VA had provided ample staff to assist with the rollout, complemented by Oracle employees who spent significant time at the facility assisting with the process. All the departments with which we spoke to reported being gen-

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

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

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

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

erally pleased with the new software, and the facility has since been able to return to near-normal staffing levels. TAL is hopeful that Lovell FHCC's successes can be duplicated in future rollouts.

Staff at the Lovell FHCC reported that the software itself has significantly improved operations at the facility. Medication ordering systems are tied together so, for example, once a pharmacist scans out a medicine, the logistics team is immediately informed so that they can order more. Tasks take fewer clicks than with the previous system, reducing the amount of time to perform routine functions. Total patient records from every medical center department are immediately available at a single click. These and many more updates to the system help Lovell FHCC provide the world-class, modern healthcare that veterans have earned.

For these successes to be duplicated, it is critical that facilities with upcoming rollouts are provided with the same level of support, training, and oversight. Specifically, VA and Oracle must commit increased facility staffing during rollouts similar to the levels provided to Lovell FHCC during the transition. Software changes led to planned and unforeseen complications, and the increased staffing helped ensure that veteran health and safety was not lost in the change-management process. A lack of adequate vendor support from Oracle would undermine the VA staff's ability to properly do their jobs, potentially risk lives, and any system downtimes could force staff to rely on time-consuming paper records, slowing processes to a crawl and impacting health and safety. When this happened during previous rollouts veterans were directly harmed, including six veteran deaths in Spokane, WA.[5] Lovell FHCC's successful roll-out shows that adequate staffing and preparation by the vendor and by VA are necessary and will lead to success. The American Legion National Staff routinely attends briefings from Oracle to track progress, and we have been assured the Millennium EHR deployment at new sites will not face the same difficulties and setbacks as at the first six sites. Oracle has committed to the necessary investments needed to ensure the deployment of the EHR at new sites will be more stable. Also, the system has extensive updates, enhancements, and simplifications to improve usability. Oracle report targeted EHR optimizations, designed to address VA's unique needs in the areas most critical for a successful expansion. TAL urges Congress, VA, and Oracle to ensure adequate staffing augmentation and robust technical support for all future deployments in order to duplicate the successes seen at Lovell FHCC.

The American Legion's position and outlook on the upcoming EHRM rollouts remains positive. The rollout at Lovell FHCC was an overall success, but VA and Oracle must heed the important lessons learned there and put them to future use. Absent the same level of preparation given to Lovell FHCC, future EHR rollouts should not be expected to achieve comparable results. Oracle must strengthen all aspects of their deployment methodology, with a deliberate emphasis on improving staff readiness. Significant improvements must be made in testing and aligning Change Management (CM) through increased training and communications.

Similarly, VAMC leadership must take ownership of the EHR deployment at their sites, while continued oversight from Congress and stakeholders remains essential, particularly as EHRM rollouts accelerate. TAL urges Congress to conduct regular oversight hearings with Oracle and VA stakeholders to ensure transparent, ongoing updates throughout the deployment process.

Chairman Barrett, Ranking Member Budzinski, and distinguished members of the subcommittee, The American Legion thanks you for your leadership on this matter and for allowing us the opportunity to explain the position of our more than 1.5 million members. The American Legion stands ready to work with the subcommittee on changes as they develop, and we look forward to sharing the feedback we receive from our membership. For 106 years, The American Legion has never shied away from the responsibility of being a voice for veterans, and we will not start now. For additional information regarding this testimony, please contact Ms. Bailey Bishop at The American Legion's Legislative Division at b.bishop@legion.org.

[5] Donovan Smith and Desmond Butler, Orion. "VA Staff Flag Dangerous Errors Ahead of New Health Records Expansion." Spokesman.com, December 3, 2025. https://www.spokesman.com/stories/2025/dec/03/va-staff-flag-dangerous-errors-ahead-of-new-health/.