Statement of
The Honorable James P. Gfrerer
Before the House Veterans Affairs Committee
Subcommittee on Technology Modernization
March 7, 2023

Chairman Rosendale, Ranking Member Cherfilus-McCormick, thank you for the opportunity today to appear before the Technology Modernization Subcommittee with my fellow former VA Technology Panelists to address the VA's current Electronic Health Record.

As a Veteran, I am a patient in the VA health system, and a beneficiary in the VA benefits system, and now pre-registered for VA burial benefits. And as a more-than 28-year career Marine Infantry Officer with 4 combat deployments, I fully empathize with all our Veteran men and women who endure both the visible and invisible wounds of military service.

There is much misunderstanding around VA health care in general. VA Health care is unlike commercial systems. VA is funded by government appropriation versus commercial health systems who operate on a business revenue model. In commercial health care, each patient is eligible for all services, where in VA eligibility is based-on complex service-connected conditions. VA health care is more specialized and expansive than commercial systems comprising unique clinical services such as prosthetics, long term care, and dental among others. These are substantial differences, even as compared to Department of Defense Health care, and are the first set of challenges for any commercial EHR to be successfully implemented in the Veterans Health Administration (VHA).

The bottom line is that Federal law, regulation, and policy have created this unique health system – and the Veteran Health Information and Technology System Architecture (VistA) Electronic Health Record is representative of those complex and unique business rules. So it may come as no surprise that when a commercial EHR programmed for different financial frameworks, with significantly different eligibility rules, and not addressing unique VA clinical services, that there are problems – and problems that can't be overcome by "change management." Without substantial customization, no commercial EHR could address the business rules that law, regulation, and policy mandate for Veteran Health care. So, if you didn't have a business system configured like VistA, you'd have to create or heavily-customize a system to perform just like it.

In the remainder of this Hearing, we will get into greater detail about VistA, its modernization efforts, and some additional facts and misconceptions, but allow me to offer some highlights as a capstone to the larger conversation:

- First, VistA is more than an EHR. It is what professionals term an Enterprise Resource Planning or "ERP" system, which has grown over the years to encompass

many administrative, financial, and other modules. A number of these will live-on, past any end of service date for VistA.

- Second, it is not – I repeat – not an "IT system" but rather a BUSINESS/MISSION system. Why does this matter? First, because the "Business" – in this case, VHA – must take prime ownership, to include the lifecycle management, capital investment, and change management, with OIT playing a continue supporting and technical role.

- Third, some would have you believe that VistA has not been modernized, but that assertion is predicated on the fallacy that modernization can only occur by replacement. Tech modernization as defined by Gartner, Forrester, and others, can be achieved in a myriad of other ways from rehosting (e.g., moving to the Cloud), refactoring (optimizing the existing code), and encapsulating (exposing to APIs) – all of which were done to VistA during my VA tenure.

Also, let me offer that in many respects Veteran Health Care business and technology discussions remain mired in 2017. It was in this time frame that the pursuit of a fully longitudinal health record was revalidated with the assumption that it must be on the same platform in order for this to be achieved. In 2023, with the maturity and adoption of Health Information Exchanges and Heath data standards such as HL7 and FHIR, that is no longer the case, which raises another topline business issue. Which is the greater challenge for VA presently – is it DoD/VA interoperability – or is it VA/Community Care interoperability?

In an era of increasing technical debt and mounting technology modernization cost, the Congress must determine where the greatest need is for precious technology budget. Presently there are roughly 300,000 active-duty members annually who matriculate from DoD to VA. Last year on the Community Care side, VA saw 6 ***million*** referrals out of network for 36 ***million*** episodes of care. To recap – a one-time transfer of 300K servicemember records as compared to 6 million referrals with 36 million appointments – there is no doubt that the latter is the substantially larger problem, across ***thousands*** of Community Care providers, who are on every available EHR, not one single EHR on which DoD and/or VA are operating. Community Care is only anticipated to grow larger every year, so VA must address it soon.

Finally, in an era where technology plays and increasingly mainstream and critical role in healthcare delivery, VA must begin to operate more efficiently and effectively, as do its Commercial and Non-Profit Health System counterparts, who are well on their way in this regard. These systems understand that technology and information technology is the success path, and reciprocally, Health Systems can't hire there way out of the problem, much as VHA attempts to do every year.

Mr. Chairman, thank you and the Subcommittee for your interest in this vital topic, and I look forward to our discussion.