U.S. House of Representatives
COMMITTEE ON VETERANS' AFFAIRS
ONE HUNDRED FIFTEENTH CONGRESS
335 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
http://veterans.house.gov

July 26, 2018

The Honorable Jefferson Sessions
Attorney General
950 Pennsylvania Avenue, N.W.
Washington, D.C. 20530

Dear Attorney General Sessions,

We refer Mr. Peter O'Rourke, Acting Secretary, Department of Veterans Affairs (VA), for investigation of alleged perjury, misleading or withholding information from Congress, or making otherwise unlawful statements in testimony and communications before the Committee on Veterans' Affairs on June 26, 2018 and July 17, 2018. The alleged statements were made during two oversight hearings in response to questions regarding the withholding of access to information and a database from the VA Office of the Inspector General (VA OIG), and the status and disposition of a VA whistleblower complaint.

Notably, in every invitation to testify at Committee oversight hearings, all witnesses, including those representing VA, are reminded that the testimony they will provide will be subject to sections 1001, 1505, and 1621 of Title 18 of the U.S. Code. Relevant excerpts of Mr. O'Rourke's testimony are attached to this letter.

On June 26, 2018 and July 17, 2018, when questioned about whether VA had restricted access to its Office of Accountability and Whistleblower Protection (OAWP) documents and database, Mr. O'Rourke stated, "…[W]e provided documents all through this period of time. So it is not like they have been refused things. We provide disclosures to them on a daily basis as soon as they come in."[1] He also testified, "…[W]e have provided them disclosures consistently."[2]

According to VA OIG, OAWP was not in daily contact, and VA OIG received less than 20 referrals from OAWP in approximately 8 months. Additionally, Mr. O'Rourke's statements on June 26 were contradicted by two letters VA OIG sent to VA Office of General Counsel (OGC) on June 28, 2018 and July 10, 2018 requesting access to the OAWP information and its

[1] 06/26/18 Tr. 77. Citations to the transcript of the June 26, 2018 and July 17, 2018 hearings are to "06/26/18 Tr. and "07/17/18 Tr." followed by the relevant page number.
[2] 06/26/18 Tr. 104- 107.

database that would not have been necessary if OAWP had not withheld information from VA OIG.

When questioned again about access to the OAWP database and information in a hearing on July 17, 2018, Mr. O'Rourke testified, "[IG's] access to OAWP has been unfettered since day one."[3] Letters exchanged between VA OIG and Mr. O'Rourke, letters from VA OIG to OGC, and notifications from VA OIG to Congress—including notification that it had been granted OAWP database access the morning of the July 17 hearing after 8 months of VA stonewalling—contradict this statement and provide evidence that Mr. O'Rourke's statement that VA OIG had "unfettered access since day one" is false.

On July 17, 2018, when questioned about the status of a whistleblower complaint made by Dr. Dale Klein, a VA employee, Mr. O'Rourke was dismissive of Dr. Klein's case, stating:

> "His case, in particular, has been reviewed by OSC…[W]e didn't have the chance to investigate it because it wasn't even in our hands. But I believe that case resolved with him being removed and the Office of Special Counsel supporting that decision."[4]

Emails provided to the Committee from Dr. Klein to Mr. O'Rourke demonstrate OAWP had received Dr. Klein's complaint. VA had been involved in Dr. Klein's case as it has yet to be resolved. Furthermore, the Office of Special Counsel has not made any findings or recommendations regarding Dr. Klein's case, nor would it have the authority to support a decision that must ultimately be made by the VA Secretary. This inaccurate and misleading statement is another example in which Mr. O'Rourke has been less than forthcoming with Congress.

As such, we request that you open an investigation to determine whether Mr. O'Rourke made unlawful statements (perjury or otherwise) in providing false testimony in the two subject hearings. If you determine that Mr. O'Rourke did in fact make an unlawful statement, or that others conspired with, instructed, or encouraged him to do the same, we request that you pursue immediate prosecution.

If you have any questions, please contact Ms. Grace Rodden, Minority Staff Director, Subcommittee on Oversight and Investigations, at (202) 225-9756 or at grace.rodden@mail.house.gov.

Sincerely,

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[3] 07/17/18 Tr. 23
[4] 07/17/18 Tr. 63

TIM WALZ
Ranking Member

Enclosures:

1. Excerpts June 26, 2018 and July 17, 2018 hearing transcripts
2. Transcript: June 26, 2018, *VA Electronic Health Record Modernization: The Beginning of the Beginning*
3. Transcript: July 17, 2018, *The VA Accountability and Whistleblower Protection Act: One Year Later*
4. Letter from Hon. Michael Missal, Inspector General, Department of Veterans Affairs, to Peter O'Rourke, Acting Secretary, Department of Veterans Affairs, (June 5, 2018).
5. Letter from Peter O'Rourke, Acting Secretary, Department of Veterans Affairs, to Hon. Michael Missal, Inspector General, Department of Veterans Affairs (June 11, 2018).
6. Letter from Hon. Michael Missal, Inspector General, Department of Veterans Affairs, to Peter O'Rourke, Acting Secretary, Department of Veterans Affairs, (June 18, 2018).
7. Letter from Hon. Michael Missal, Inspector General, Department of Veterans Affairs, to James Byrne, General Counsel, Department of Veterans Affairs, (June 28, 2018).
8. Letter from Hon. Michael Missal, Inspector General, Department of Veterans Affairs, to James Byrne, General Counsel, Department of Veterans Affairs, (July 10, 2018).

June 26, 2018 | VA Electronic Health Record Modernization: The Beginning of the Beginning

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Secretary *O'Rourke.* And we provided documents all through this period of time. So it is not like they have been refused things. We provide disclosures to them on a

daily basis as soon as they come in.

- pp. 104- 105

  Mr. *Walz.* Just some yes or no, Mr. O'Rourke. Isn't it true the OIG has not received any information to date from the OAWP?

  Secretary *O'Rourke.* No, that is not correct.

  Mr. *Walz.* That is not true?

  Secretary *O'Rourke.* They have provided--we have provided them disclosures consistently.

July 17, 2018 | The VA Accountability and Whistleblower Protection Act: One Year Later

- p. 23

  Secretary *O'Rourke.* Your request as made has been complied with even before this morning's recent access to a SharePoint site.

  Secretary *O'Rourke.* It is unfortunate that that has been such a public about one issue, because this has been--his access to OAWP has been unfettered since day one.

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  Ms. *Rice.* The first was from a physician by the name of Dale Klein (phonetic) who stated that it was difficult to

get the opportunity to talk to his OAWP case manager and that the case manager had not even planned to interview him in reviewing his case. He said his case manager was not even aware of an OIG finding on his whistleblower case and that ultimately OAWP did nothing to protect him from being fired. So that is number one.

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Secretary *O'Rourke.* We will address Dr. Klein first. That case predated the establishment of OAWP and his case was much down the road before any of us got involved in that. So his identity, of his own accord, was already proliferated everywhere. His case, in particular, has been reviewed by OSC. We didn't even--we didn't have the chance to investigate it because it wasn't even in our hands. But I believe that case resolved with him being removed and the Office of Special Counsel supporting that decision.

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VA ELECTRONIC HEALTH RECORD MODERNIZATION:
THE BEGINNING OF THE BEGINNING
Tuesday, June 26, 2018
House of Representatives
Committee on Veterans' Affairs
Washington, D.C.

The committees met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. David R. Roe presiding.

Present: Representatives Roe, Bilirakis, Coffman, Bost, Poliquin, Dunn, Arrington, Higgins, Bergman, Banks, Walz, Takano, Brownley, Kuster, O'Rourke, Rice, Correa, Lamb, Esty, and Peters.

The *Chairman.* The committee will come to order. And before we get started today, I want to thank the committee members for all the hard work they did on the Blue Water Navy. This has been a passion of this committee and mine and Mr. Walz for literally the whole time I have been in the Congress. And this committee delivered, by voice vote and then yesterday, I think we can say we made our case for a 382-to-zero, finally this wrong is being righted. And I want to personally thank every member of this committee for the work you did, the dedication on both sides of the aisle.

So, from me to you, thank you.

[Applause.]

The *Chairman.* Thank you all for being here today to discuss VA's Electronic Health Record Modernization Program.

Much has been said and written about the program since June 1st of last year when former Secretary Shulkin announced his decision to commence negotiations with Cerner; opinions have been formed and conclusions have been drawn. The reality is, even with the contract awarded and work underway, we are at the beginning of the beginning. We all know the broad strokes that led to the EHR modernization. The VA IT

budget is consumed by operations and maintenance costs. VA's Health Information System, VistA, is functional, but increasingly complicated, while the EHR industry continues to evolve. Also, it is well past time for VA and DOD to achieve seamless interoperability, because servicemembers and veterans deserve a lifetime medical record. I have heard Mr. Walz say that for 10 years.

VA leaders were guarded in how much they would discuss during the negotiations. To some extent, that is understandable, but it is time to delve into the details. Fifteen point eight billion dollars over 10 years, including $10 billion to Cerner, is a staggering number for an enormous government agency. That is $15,800 million when you put it in terms like that. I don't know about where you are from, but where I am from, that is a lot of money. However, EHR software is only a relatively small part of the overall price tag. What exactly does all that money buy?

Everyone here today knows the adage: if you have seen one VA hospital, you have seen one VA hospital. Part of the reason for that is for 35 years VHA has had a culture of creating software to fit any process and a technology

platform, VistA, that facilitated it. There is much to be said for local authority in health care, I agree with that, but it seems to have gotten out of control and made the IT landscape ungovernable.

EHR modernization is not just a technology project, it will have a major impact on the way VHA operates, that means clinical and administrative workflows. It also reshapes the culture, as VistA has. However, if imposed on clinicians from the top down, the culture will reject it and no amount of technological savvy will be able to save it.

If we were creating a Veterans Health Care System from scratch, implementing an EHR would be relatively easy, but that is not the reality. Transitioning away from VistA is the most difficult aspect of the EHR modernization. VHA and VistA have built up around each other for decades. Amazingly, even after all these years, the Department does not seem to have a complete technical understanding of where VistA begins and ends. It is not an oversimplification to say the EHR modernization team may still be figuring out what VistA is up and when until the day they turn it off, if ever.

The scale is daunting and the ambition is impressive,

that is evident. I am interested in the benefit at the end of the 10 years to a veteran and to the clinician. The lifetime health record has to be worth the potential disruption. The ease of use, the new analytics in the EHR have to be worth the learning curve. Those things are difficult to quantify, but if the equation does not balance it will be abundantly clear as soon as the system is turned on in the first medical center.

I believe VA has been realistic about the level of resources needed to manage the EHR modernization and by every indication the EHRM Program Executive Office is building a good structure to do that, but they will need a great deal of help. The program cannot be seen as just the responsibility of an office in Washington. VA senior leaders, VHAs throughout the country and Office of Information and Technology, and every other corner of the Department must be invested in its success.

I especially appreciate all our witnesses agreeing to testify today. It is a large and impressive group on two panels, including some new faces for the committee. You have all demonstrated an interest in the EHR Modernization

success.

My colleagues on the committee and I are committed to doing our part, that is why Ranking Member Walz and I have decided to create a new Subcommittee on Technology Modernization, to focus on oversight of the EHR Modernization Program, as well as VA's other enterprise modernization projects and programs. The subcommittee will allow a small group, three to five people, of committee members to focus intensively on these issues and strengthen the work the staff has already been doing. The EHR Modernization is a big bet on the future of VA and we simply must make sure it succeeds. More details will be available as we constitute the subcommittee in the coming weeks.

I have been through this process from paper to electronic, it is not easy; going from electronic to electronic I feel is going to be even harder. I think the technology is going to be difficult and we have to be patient, and we certainly have to start at the supply person who is working in the ER supplying things, from the nurses who are spending way too much time looking at a computer screen and not at patients, and to doctors who are doing

exactly the same thing. If it doesn't free up our clinicians and our supply people and our other people for more time with our patients, then we have failed.

So, with that, I yield to Ranking Member Walz for his statement.

[The statement of David P. Roe appears on p.]

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Mr. *Walz.* Well, thank you, Chairman. And again, I want to thank each and every one of you and your leadership on Blue Water Navy. You set out to do and, as everything you have done, you accomplished it, and I am grateful for that and so are many of our warriors.

The chairman is right, 12 years ago in the first committee here I remember saying that I hope I would be here long enough to see the implementation and a movement towards electronic health record, a joint electronic health record with DOD. And having an understanding that that is far more than a database, that is a diagnostic tool and everything else that goes with it. No one knows better than the chairman on the complexities of this.

To get this done right is going to take transparency and oversight; the creation of this subcommittee is a great first step. If I have learned nothing in those 12 years of being here that especially when it comes to everything but the VA in particular, and whether it is Denver, Phoenix, or projects that have worked wonderfully in moving forward like Omaha, leadership will make or break this project. So will the oversight, which is why I enthusiastically support the

creation of this new subcommittee overseeing a $16 billion, decades-long process.

There are going to need to be eyes on this all the way and every one of us up here, we own this now, we own this. We can complain about Denver, we can try and get fixes, we get to start fresh. And I would own that and I said I think we should take the responsibility that everything that goes wrong with this now or goes right should be the responsibility of this committee to take a look at it and that is what the chairman is putting in place. But to do that, we need to have the capacity, and that means the GAO and the IG must be given the access they need to independently oversee progress on implementation.

GAO should be in attendance at every single governing board meeting; GAO must have direct and frequent access to VA, Cerner, and program management support contractors. I want the GAO to review quarterly progress reports. IG must have access to these documents and information it needs to regularly monitor implementation and be ready to follow up, audit, and investigate when significant issues arise.

We are going to have to partner in this. So today at

9:01, I received the documentation that talks about the establishment of the Office of Electronic Health Records Modernization. No communication with us before this, nothing there. You sent this to us electronically and on the second page, Mr. O'Rourke, it has your signature with attachment, no attachment was there. It is Electronic Health Records Management, you can't make this stuff up. We get an improper electronic transfer of information setting up the office. This is why there needs to be oversight.

And I am going to have questions as we go through. Where is Mr. Sandoval today? Where is the Chief Information Officer? Where is the person that is going to ultimately or should be ultimately responsible for this?

It is important our watchdogs are empowered to effectively hold VA accountable to veterans and taxpayers. This committee has done that. We have held people accountable, we have protected whistleblowers, and we have uncovered abuses that hurt veterans. That only happened because the IG and the GAO were there.

It is not up to the VA Secretary or Acting Secretary to decide when an IG investigation occurs. You do know, Mr.

O'Rourke, you have no authority to remove an IG, none; statute does, you do not have that authority. When something occurs, IG needs to access documents and records. It is not up to you to determine GAO's level of access. I raise this issue because VA OIG has yet to be granted access to the Office of Whistleblower Accountability and Protection database. Mr. O'Rourke said that organization is accountable to him and loosely tethered to him, that is not the case. They are true through your budget, but not for the authority.

What is true is, you are not loosely tethered to this committee, you are constitutionally tied to this committee and the oversight that will be provided from this committee. I don't want to hear reports a year from now, IG are being denied access to documents relating to electronic health record modernization. VA stonewalling must not be tolerated, it cannot be tolerated by any administration. It happened where we had it last time and we needed to subpoena documents to get that from the administration to find out what was happening in Phoenix. Now we have the IG clearly asking for these things and being denied those things.

So today I am going to want assurances that the IG will

be granted access to the Whistleblower Protection Program, the IG and the GAO will be granted ready access to oversee electronic health record modernization. Capable and good leaders welcome transparency and independent oversight, capable and good leaders do not threaten the independence of the IG. Capable and good leaders welcome GAO's involvement in every aspect of this project because the outcome is a product that delivers and improves care for our veterans, that is what all of us want. We cannot have a bureaucracy clogging that up, we cannot have a bureaucracy that will not let independent eyes see that, we cannot let a bureaucracy not be accountable to the elected officials that sit here who are responsible for those veterans.

So I find it deeply concerning Executive in Charge of the Office of Information Technology Mr. Sandoval is not testifying today, since the Office of Information Technology is responsible for EHR's successful implementation. We are kicking off a glorious day, we are at the beginning of the beginning, and the person responsible is not here, the first transmission we get is incomplete, the ability to get documentation with the IG who is going to have to be there

every step of the way is asking us to step in and get them information that is not being willingly given to them. That is not an auspicious start.

Governance and leadership, including active engagement of senior officials with stakeholders and supportive senior department executives are critical. We don't have leaders in place to participate in the project's government or set the strategy for this project. Who is meeting with the stakeholders? Where is the support from senior executive departments? We don't have governance because critical leadership positions are unfilled.

I have seen too many VA projects fail because of lack of leadership. Every one of you Members of Congress own this now. If they don't do this, it is on each of us.

Last month, media outlets reported Cerner failed to effectively implement their EHR at multiple DOD facilities, citing a botched rollout that put patients' lives at risk and lacked operational effectiveness. I find the details of these reports disturbing and unacceptable. The root cause must be identified and remedied. VA cannot fail veterans again. VA and the White House must act now to remedy the

deficiencies so that we have qualified leaders in place before the project implementation begins this fall. There is too much at stake, veterans have been waiting too long for this seamless coordinated care between DOD, VA, and private providers.

I want to thank the chairman. He understands this, that is what this subcommittee is going to do, and you can rest assured they will carry out their responsibility.

I yield back.

[The statement of Timothy Walz appears on p.]

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The *Chairman.* I thank the gentleman for yielding. And just for the record, we did not invite the Chief Information Officer, Mr. Sandoval, and VA did not offer him to be here. And I would like to associate with your remarks, I agree with that.

On the panel we have Acting Secretary of Veterans Affairs, Mr. Peter O'Rourke. He is accompanied by leaders of the EHRM Program Executive Office: Mr. John Windom, welcome, the Program Executive Officer; Mr. John Short, the Chief Technology Officer; Dr. Ash Zenooz, the Chief Medical Officer.

On the panel we also welcome Vice Admiral Bono, the Director of the Defense Health Agency. Welcome, Admiral.

I ask the witnesses from both panels we hear from today to please stand and raise your right hand.

[Witnesses Sworn.]

The *Chairman.* Thank you, and you may be seated.

Let the record reflect that all the witnesses have answered in the affirmative.

Acting Secretary O'Rourke, you are now recognized for 5 minutes.

STATEMENTS OF PETER O'ROURKE, ACTING SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY JOHN WINDOM, PROGRAM EXECUTIVE OFFICER, ELECTRONIC HEALTH RECORD MODERNIZATION PROGRAM, U.S. DEPARTMENT OF VETERANS AFFAIRS; JOHN SHORT, CHIEF TECHNOLOGY OFFICER, ELECTRONIC HEALTH RECORD MODERNIZATION PROGRAM, U.S. DEPARTMENT OF VETERANS AFFAIRS; ASHWINI ZENOOZ, M.D., CHIEF MEDICAL OFFICER, ELECTRONIC HEALTH RECORD MODERNIZATION PROGRAM, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND, VICE ADMIRAL RAQUEL BONO, DIRECTOR, DEFENSE HEALTH AGENCY, U.S. DEPARTMENT OF DEFENSE

STATEMENT OF PETER O'ROURKE

Secretary *O'Rourke.* Thank you, Chairman.

Good morning, Chairman Roe, Ranking Member Walz, and members of the committee. With me from VA are Mr. John Windom, Dr. Ashwini Zenooz, and Mr. John Short, respectively the Program Executive Officer, Chief Medical Officer, and Chief Technology Officer for VA's Electronic Health Record Modernization. Thank you for inviting us to testify.

Let me acknowledge as well Vice Admiral Raquel Bono, Director of the Defense Health Agency, with us this morning.

In just the past 18 months, five major Acts of Congress have benefitted veterans and VA: The Veterans Accountability and Whistleblower Protection Act, the Veterans Choice and Quality Employment Act, the Forever GI Bill, the VA Appeals Improvement and Modernization Act, and, most recently, the VA MISSION Act. To find another period of such significant change, we would have to go back to Omar Bradley's days.

Yet another significant step forward is Electronic Health Record Modernization. For transitioning servicemembers and veterans, it will improve care coordination and delivery. It will provide clinicians the data and tools they need to support patient safety, and veteran data will reside in a single hosting site, using a common system that enables health information sharing. So we deeply appreciate your leadership and bipartisan support.

Achieving full operating capability across VA with the new EHR is a sizable task; it will take several years to complete. And we recognize and fully appreciate the challenges the Defense Department has faced in its own EHR

implementation experience, so we have designed a proactive and preemptive contract management strategy. We are working closely with DOD, we are listening to advice from respected leaders in health care, and we are fully engaged with the Cerner Corporation regarding all critical activities: establishing governance boards, conducting current state reviews, and optimizing the deployment strategy. We intend to anticipate challenges and take full advantage of lessons learned to mitigate risk in VA's implementation, and our strategy will adapt as we learn and technology evolves.

VA's EHR modernization will be a flexible, incremental process, welcoming course corrections as we progress. Effective program management and oversight will be critical, critical to cost adherence, to time lines, to performance quality objectives, and to effectively implement risk-mitigation strategies. So we are committed to a PMO properly staffed with exactly the right functional, technical, and advisory subject matter expertise.

To facilitate decision making and risk adjudication, we have designed an interim governance structure of five functional, technical, and programmatic teams. They are the

EHR Steering Committee, the EHR Governance Integration Board, the Functional Governance Board, the Technical Governance Board, and the Legacy EHRM Pivot Work Group.

We will continue to refine this structure and our processes over the next few months to further enhance performance and outcomes. In July, August, and September, VA will assess, validate initial operating capabilities in Medical Centers in Spokane, Seattle, and American Lake, Washington, as previously negotiated. In October, we will begin EHR deployment to these three sites with a full capability goal of March of 2020.

VistA and related clinical systems will continue serving veterans until the EHR is fully capable.

EHR modernization is a deep change; it is a technical and a cultural challenge, and the human component is central success. So we will fully engage end users early to train facilities staff and promote successful adoption. Clinical councils of doctors, nurses, and other front-line users will support workflow configuration, and they will help identify staff concerns and propose responsive solutions. VISNs will have the opportunity to configure workflows without

customization based on their unique circumstances. And we will continue to work with our DOD counterparts to help navigate joint costs, schedules, performance, and interoperability objectives. It is a user-centric approach to a veteran-centric change.

VA's Electronic Health Record Modernization represents a monumental improvement for veterans, possible only with the strong support of the President, this committee, and the Congress, Veterans Service Organizations, and other stakeholders. Thank you for honoring our Nation's commitment to veterans and I look forward to your questions.

[The statement of Peter O'Rourke appears on p.]

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The *Chairman.* Thank you, Mr. Secretary.

Admiral Bono, you are recognized.

STATEMENT OF VICE ADMIRAL RAQUEL BONO

Admiral *Bono.* Thank you, sir.

Chairman Roe, Ranking Member Walz, and distinguished members of the committee, thank you for the opportunity to testify before you today. I am honored to represent the Department of Defense and discuss the Department's experience in implementing a modernized electronic health record, EHR, and I am excited about the tremendous opportunity we have to advance interoperability with the VA and private sector providers as a result of the VA's recent decision to acquire the same commercial EHR that the DOD is now deploying.

The decision by DOD to acquire a commercial EHR was informed by numerous advantages: introducing a proven product that can be used globally in deployed environments, as well as in military hospitals and clinics in the United States; leveraging ongoing commercial innovation throughout the EHR life cycle; improving interoperability with private sector providers; and offering an opportunity to transform the delivery of health care for servicemembers, veterans, and their families.

In 2017, the Department deployed MHS GENESIS to all four initial operational capability, IOC, sites in the Pacific Northwest, culminating with deployment to Madigan Army Medical Center, MAMC, the largest of the IOC sites in Tacoma, Washington. The other sites include the 92nd Medical Group at Fairchild Air Force Base, Naval Health Clinic Oak Harbor, and Naval Hospital Bremerton, all in Washington State.

Over the next 4 years, MHS GENESIS will replace DOD Legacy Health Care Systems and will support the availability of electronic health records for more than 9.4 million DOD beneficiaries and approximately 205,000 MHS personnel globally.

By deploying to four hospitals and clinics that span a cross-section of size and complexity of MTFs, we have been able to perform operational testing activities to ensure MHS GENESIS meets all requirements for effectiveness, suitability, and data interoperability.

Right now we are in the midst of making important improvements to software, training, and workflows, addressing the lessons we learned in the initial deployment as we prepare to continue our deployments into 2019.

End user feedback to our changes have been relatively positive. Our success is dependent on strong clinical leadership, both here and our headquarters, and by clinical champions at the point of care. The Department is focused on maintaining this clinical leadership as we move to the next deployment wave.

To best support MHS GENESIS, the Defense Health Agency is also fielding a cost-effective communications infrastructure and network throughout the military health system.

When completed, DOD medical providers, whether they are affiliated with the Army, Navy, or Air Force, will be able to use their Common Access Card, CAC, into any computer on the DOD Health Care Network and access their identical desktop as they travel from one location to another, inside or outside the continental United States.

We have also optimized our network to help ensure continuity of care for our beneficiaries. Over the past 5 years, DOD steadily increased its data-sharing partnerships with private sector health care organizations. Today, DOD has nearly 50 health information exchange partners in the

private sector.

Since award of the VA contract, leaders of both departments have been meeting to more formally integrate our management and oversight activities. We are sharing all of our lessons and future plan deployments with our colleagues at the VA, and plan to synchronize deployments where possible. The VA and DOD understand that the mutual success of this venture is dependent on our continued close coordination and communication.

Thank you again for the opportunity to come here today and share the progress we have made to transform the delivery of health care, as well as discuss the opportunity to strengthen the DOD/VA partnerships as we move forward together with a common EHR that will benefit millions of servicemembers and veterans. As a partner in our progress, we appreciate Congress' interest in this effort and ask for your continued support to help us deliver on our promise to provide world-class care and services to those who faithfully serve our Nation.

Thank you for this opportunity and I look forward to your questions.

[The statement of Raquel Bono appears on p.]

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The *Chairman.* Thank you, Admiral, and thank all of you all for being here.

And this is--first of all, I want to thank the Members for being here--this is not the kind of a hearing that you are going to go home to the Kiwanis Club and say I am going to talk about the electronic health record. People are going to start looking at their watch and heading to the doors. But it is--I know this personally--it is incredibly important that we get this right.

And I have only made one visit to begin to see the rollout, but I intend to make others as quickly as I can. And one of the things that first to make this all work, we have spent a year and a half doing the VA MISSION Act where people that can't access care timely or whatever the reason is, maybe live in a rural area, that they access care outside the VA, it is incredibly important that these health information exchanges work, that we can share information. It is a problem in the private sector, trust me. I mean, you can't go to your hospital and get the information, you can't get a lab test.

One of the things that bothered me when I was out at

Fairchild was on MHS GENESIS, when you came in, what was entered into the EHR was basically allergies, medications, procedures, immunizations. I can get that in one minute of asking somebody. Other data, which included what I really want to see, are your lab results, X-ray reports, notes from previous visits, discharge summaries, you have to use the Joint Legacy Viewer to look back. And my question is, our providers--that slows you down.

I have told people all along, if you are in a busy practice like I was and saw 25 people a day, you took 2 minutes is all, it added 2 minutes to each patient, I am an hour late at the end of the day. And you have frustrated people, the doctors and nurses are staying after hours to fill in the reports.

So are we going to be--Mr. O'Rourke, you can answer it, any of your team can or, Admiral Bono, you can--are we going to be able to put all this information where the practitioner, the nurse, and the other providers are able to access it without using two systems? And if we do, what is the point of using Cerner if we have keep two systems live?

You have then got the cost of the old system, which I

think is about a billion dollars a year, and then what would be the cost of the new system, Cerner, to maintain it? If we have just added cost and haven't added value, we haven't added much.

So I will start with Admiral Bono.

Admiral *Bono.* Yes, sir, thank you very much. And you are exactly right, you have described that perfectly.

And so one of the things that we did is we embedded the Joint Legacy Viewer within our MHS GENESIS, so that it is just within the people in the past that had to log out, log in, contributing to the time, now it is a click within the MHS program. Because having access to that information that we put in the Joint Legacy Viewer, that is not only a part of the care that people may have received in VA hospitals, but also in the private sector, is incredibly important to the continuity of their care. So what we did is we have embedded it into MHS GENESIS.

The *Chairman.* Well, especially for you all at DOD where 60 percent of people--

Admiral *Bono.* Yes, sir.

The *Chairman.* --get their care outside the Department

of Defense, if that information doesn't flow--

Admiral *Bono.* Yes, sir.

The *Chairman.* --bad results happen.

Will the VA be able to do that, Mr. O'Rourke, be able to put--because basically the people I saw at Fairchild are healthy airmen, I mean, they are young, healthy people for the most part; if not, they are not in the military. So will the VA be able to take these very complicated medical records, which have--I mean, many patients are ill and older.

Secretary *O'Rourke.* Absolutely. Our goal is to make sure that we have seamless data transfer in all those different aspects.

I am going to let Dr. Ashwini address that specifically.

Dr. *Zenooz.* Congressman, we understand at the VA, as well as the DOD, that a complete longitudinal record is the ultimate goal. And as part of the lessons learned from not only the DOD implementation, but our use in the VA with JLV and external implementations, when we go live at our Cerner sites, Cerner implementation sites, we will have a single system that ingests all of the records not only from DOD, anything that is coming in, but also from our community

providers into the appropriate place for a long record. That is above and beyond the PAMPI data that you just noted. That will include notes, clinic notes, laboratory exams, radiology exams, and much more.

The *Chairman.* Well, that is a robust--because we are talking about March of 2020, and hopefully most of these Members will still be sitting here in 2020, if they desire, but that is not that long. If you are starting in October, we are at that point almost in 2019, so you are a looking at an 18-month rollout in the Northwest. Would it make sense to roll out a Great Lakes, which is where you have a combined VA/DOD facility, are you going to roll that out simultaneously?

And I know, Admiral Bono, that may not be in the works, but it seems like that would sense.

Admiral *Bono.* Yes, sir. I think that by working with the VA we have identified areas where we do have some synergies that we want to capitalize on. We certainly looked at the Great Lakes area. I know that there are some infrastructure things that we have to address there, but I think that would be an opportunity we definitely want to

explore.

The *Chairman.* the other thing I would like to ask, are you all working together, sharing this information, so we don't recreate the wheel? And what I am asking about that is, I think when I read in DOD the people on the ground, the people that are every day I have got to click this thing on and try to make it work, they didn't really know who--when they had a work order or something, they needed an answer to a question, they couldn't get the answer to that question. It was basically there was like me calling a prescription to one of these large drugstore chains, 1-800-HOLD.

So basically that is what was happening, it looks to me like they couldn't get an answer, so they had to do a work-around. Have we learned things from that, so that the people actually implementing this thing that, you know, their stomach is hurting, they are taking another Zantac because of it, do they have a way to get an answer quickly without going through back to D.C. and through this big hoop?

Admiral *Bono.* Yes, sir. As a matter of fact, based on the feedback that we were getting from the end users, as well as the report and observations that your group was able

to share with us, we have put in place a more streamlined process to be able to address these. And we have stood up an Office of Chief Health Information and what that does is allow us to make some decisions closer to the actual site.

The *Chairman.* Yeah, that would be the trouble-ticket resolution.

Admiral *Bono.* Yes, sir.

The *Chairman.* And you said DOD is making adjustments to software, training, and workflows; what adjustments have you made?

Admiral *Bono.* Yes, sir. So some of the training is extremely important and we realize that, and that is one of the lessons that we have shared with the VA. Training has a large part to do with the changed management and, as I think you mentioned, it needs to be something that the providers can easily adapt to. And I think that is one of the pieces that we have learned is that the providers need to be very much a part of that training and that changed management.

And so the workflows that we have introduced have to reflect what best supports the clinical practice.

The *Chairman.* Okay. My time has expired.

Mr. Walz?

Mr. *Walz.* Thank you, Chairman Roe.

I want to get us all on the same sheet to start with, so Mr. O'Rourke, let's clear this thing up from the beginning. I want you to guarantee me the IG will immediately have access to that Office of Accountability Whistleblower Protection database and any other information it needs to audit that program today. Can you give me that assurance they can have all the data they ask for?

Secretary *O'Rourke.* Absolutely, sir. The IG has had access to any information of the Office of Accountability that he would request--

Mr. *Walz.* That is incorrect.

Secretary *O'Rourke.* --appropriately.

Mr. *Walz.* That is not the understanding of the IG.

Secretary *O'Rourke.* So there is just one thing to clear up. The information that we protect in the Office of Accountability is privacy information and, just like this committee, what the accountability law prescribed was the privacy of whistleblowers, which is sacred to us in the office. The privacy of whistleblower identities is

specifically called out in the accountability law that it cannot be shared with anybody, including the Secretary. I can't even see at this point in my current role unless given written authorization by the whistleblower.

Now, that is a Privacy Act now record that applies in Title 5, which only requires that the IG request--he doesn't have to provide a reason, he just has to say I would like this information, and he will be provided that. That is all we have asked for.

In fact, we took the extra step, one of the things that I tried to do as the Executive Director, which was to have a liaison from the IG in the Office of Accountability to review these records as we received disclosures. It wasn't something they were interested at the time, that's fine, it is up to their discretion, but that request only needs to be made so we can both Title 5 and the accountability law be covered, and he can have any information that he would like.

Mr. *Walz.* We will get back with the IG today--

Secretary *O'Rourke.* Absolutely.

Mr. *Walz.* --and make sure that they are satisfied, and we get in and we get that done. That's great. And I

understand why Chairman Roe said Mr. Sandoval was not invited here. The thing I would mention to you, though, is at the heart of the single biggest electronic project maybe we have ever done in government, we haven't received one phone call, one text, or one interaction at all with Mr. Sandoval at the people who are involved in this.

Secretary *O'Rourke.* Sure.

Mr. *Walz.* So my team, so we need to know who to contact. And, again, we have a new office set up, the only contact was you. Do you want the staff to go directly through you or is there someone over there manning that? Is there someone we can contact to talk to about the issues?

Secretary *O'Rourke.* Absolutely. This team that is with me here today is leading up the core part of that new office. As we stated and as we talked about in the opening statement, we are continuously improving both the structures and the approaches, that is how we are going to approach this entire project. We are going to share that with you as many times as we have the opportunity and we are highly--we are excited, frankly, with the special oversight committee.

Mr. *Walz.* Can they send us the attachment?

Secretary *O'Rourke.* Absolutely.

Mr. *Walz.* Okay. I want an assurance too that the GAO will have access to the officials and the contractors involved in the project. Can you assure me that GAO will sit in on those governance meetings and be allowed to review the quarterly reports--

Secretary *O'Rourke.* Absolutely.

Mr. *Walz.* --at will? All right.

Secretary *O'Rourke.* Absolutely.

Mr. *Walz.* So setting up that governance board, now that the contract is out there, I am assuming that it is in place, who will be part of the five project governance boards and how often do they meet? We are just unsure of how that is going to function and what is there, who is on it, how it has been done. How far, in your assessment, on that process are you?

Secretary *O'Rourke.* Well, I think it is helpful for you to see how the leadership is looking at this. We know and we agree with both you and the chairman that leadership has to be involved in this, although this can't turn into some top-down implementation. So I know for me personally, I

will be involved. We have set up not only the governance boards, we have set up overall management boards where we are looking at all of our priorities, this being one very specific. And so we are bringing the entire VA senior leadership team to view these projects.

Now, specifically for the governance boards, John, do you want to give him some more specifics?

Mr. *Windom.* Yes, sir. As we assessed potential governance actions, it was important to have a cross-functional team composing these governance boards. So you will see representation from the field, probably most importantly, but also from headquarters, from OINT, from VHA, from other representatives. And it is often an issue-dependent makeup of the board, so we will ad hoc members of the board based on an issue in particular that may be at hand.

Those boards are set to meet--again, I need to emphasize that governance has to take place at the lowest level. We can't escalate things continually to the Secretary's office; otherwise, we are failing. And so we don't intend to fail, so we will be managing these governance evolutions at the

lowest level.

To my left, Dr. Ashwini Zenooz, she leads the Chief Medical Board, and to my right, John Short leads the Technology Board.

So, again, cross-functional membership, timely resolution will be imperative for our boards to be successful.

Mr. *Walz.* Well, I am hopeful. I know no one intends to fail, but I have seen it. We are going to have to find out what your full-time needs are and who has been staffed into that.

The thing I will say and it is probably not for this group, this is a higher level, but we still don't have a confirmed Secretary, Deputy Secretary, Under Secretary for Health, or Chief Information Officer. It is pretty important that those positions be filled with some stability. I pass that on for anybody who is listening, or if you have got a direct line to the person who can nominate and get those done, that would be great.

Secretary *O'Rourke.* Yes, sir.

Mr. *Walz.* So I yield back.

The *Chairman.* I thank the gentleman for yielding.

Chairman Bost, you are recognized for 5 minutes.

Mr. *Bost.* Thank you, Mr. Chairman.

First off, let me tell you that I agree with the chairman on how important this is. One of the biggest shocks that I had whenever coming and becoming a Member of Congress was working to try to get the medical records simply transferred from DOD into Veterans Affairs, which is just amazing to me in a nation of this size and that it has taken us this morning. Of course, you have got to remember, I came from a time when I left the Marine Corps, my medical records were on microfiche. So now we need to step forward.

But, Mr. O'Rourke, I need to find out, you know, the Commission on Care report issued June 30th, 2016, recommended that the VHA produce and implement a comprehensive commercial, off-the-shelf information technology solution to include clinical, operational, and financial systems that can support the transformation of VHA. And I believe this is a good thing and that the VA has finally listened to the recommendations after a few years, but it does not seem as though the VA has already--or it does seem as though the VA

is already experiencing some delays during the contracting phase with Cerner.

How does the VA plan to work with Cerner and DOD to ensure that the implementation time line is met?

Secretary *O'Rourke.* Sir, that request to us to transform VHA was one of the things that has driven us to look at every aspect of our health care delivery system. So I can assure you that we are taking that charge very seriously.

When it comes to working with DOD, I think we have talked this morning and I think by having the Admiral here this morning with us shows that we are hand-in-hand with DOD to make sure that veterans are served from the time that they sign up on active duty to the time that they come to the Veterans Administration for service. We are not going to run away from that challenge. We see that it is one of the more important things that we have to face today.

So I can assure you our full leadership team is involved in making sure that we address those issues.

Mr. *Bost.* Okay. I think that is what is vitally important to this committee, because many of us see as you

move forward, when we hear reports and the questions that are out there, the big fear we have is those dates are not going to be met and we want to make sure--we want to make sure it is done right, but we also want to make sure that it is done in a way where the American citizens and our veterans can actually see it come to pass in a quick and efficient manner.

Kind of on that is the second part of my question. According to an article on Military.com, it appears some of the hospitals implementing MHS GENESIS have been experiencing delays, especially at the pharmacies. Has the VA discussed with the DOD ways to avoid these increased delays due to the EHR and its systems?

Secretary *O'Rourke.* So we have been reviewing those reports and actually the documents that we share together with the DOD continuously since we have started this process. So we are aware of what the issues are there and we have worked together to provide our input on those solutions, but also taking what the DOD has done to solve those issues as well and integrated those into our plan.

Mr. *Bost.* Just for me knowing, how many staff do you have working on this at this time, and is it a large group or

is it pretty much turned over to Cerner?

Secretary *O'Rourke.* We are not going to turn everything over to Cerner. We will have our internal team built, as you know, we are continuously developing that org structure and what is going to be the best to not only make sure that we have top-level oversight from a management standpoint, but also have the right governance and the right decision-making being happened at the deployment sites, and then also in a Program Executive Office.

Mr. *Bost.* Thank you.

Mr. Chairman, I yield back.

The *Chairman.* I thank the gentleman for yielding.

Mr. Takano, you are recognized.

Mr. *Takano.* Mr. O'Rourke, I first want to echo the concerns raised by Ranking Member Walz. While serving on this committee, I quickly learned the important role the IG plays in helping Congress to provide proper oversight of the VA and ensure that veterans are getting timely access to the benefits and care they deserve. The independence, the independence of the IG is absolutely crucial and proper oversight will be extremely important in the years to come as

VA undertakes the massive endeavor of updating its EHR system, and I believe the Senate expressed itself unanimously in a funding bill on this issue.

But to the matter at hand. The GAO identifies involvement of senior agency officials as a fundamental practice necessary to the successful acquisition and implementation of the EHR. We also heard at the hearing last week on staffing, that having strong leadership in place is crucial for the success of a new initiative.

Mr. O'Rourke, where is the VA in the process of identifying a qualified Deputy Secretary, Under Secretary of Health, and a Chief Information Officer?

Secretary *O'Rourke.* I completely agree with you that the top--that senior leadership involvement in these is absolutely critical for success. Take a look at any implementation with a leadership is not there--

Mr. *Takano.* I get that. My time is short, but just tell me where you are. Where are you in the process? Have you been interviewing people? When can we expect these positions to be filled?

Secretary *O'Rourke.* For the Deputy Secretary, that is

something I will have to defer to the White House, that is a decision that they make on who they are going to pick for those senior leadership positions.

Mr. *Takano.* Okay. And what about the Under Secretary of Health and the Chief Information Officer?

Secretary *O'Rourke.* So for the Under Secretary for Health, there is a process for that with the Commission. So we will be conducting a Commission here very shortly--

Mr. *Takano.* I remind you, we are undertaking a 10 to $15 billion initiative and we don't have these critical positions filled.

Secretary *O'Rourke.* I agree.

Mr. *Takano.* How many FTE are needed to fully staff the Project Management Office and how many positions remain unfilled?

Secretary *O'Rourke.* I can assure you that we are going to have the appropriate amount of FTE. For that specific question, I will turn it to John.

Mr. *Windom.* I will touch on that, sir. We have 260 identified as our organizational requirements at this phase. We expect that to grow as we obviously implement to more

sites. Right now we have the requisite technical expertise on staff or access to that. Field support is imperative in this effort, and so being able to reach out to the field component, and so I would defer any additional comments to the Chief Medical Officer.

Mr. *Takano.* Okay. No one has given me a number. How many FTE are really needed here?

Mr. *Windom.* Two hundred and sixty for the next phase, sir.

Mr. *Takano.* Okay. And how many positions remain unfilled of that 260?

Mr. *Windom.* At this point right now, sir, the staffing is over the period of time. We have 135 clinicians that we need in-house to conduct the workload--

Mr. *Takano.* It is a simple answer--

Mr. *Windom.* --all but thirty five--

Mr. *Takano.* --you gave me a direct answer of 260, how many of the 260 remain unfilled?

Mr. *Windom.* Thirty five, sir.

Mr. *Takano.* So you have filled 260 minus 35? I can't do the math in my head.

Mr. *Windom.* Sir, the fill rate is--again, accessibility is important, it is imperative that we don't disrupt the care being delivered to our veterans today, so we are accessing field support from their respective activities. So, again, the important thing is that we have access to the requisite knowledge, whether it be clinical or technical, and we have that at this stage.

Mr. *Takano.* All right. So you said all but 35 have been filled?

Mr. *Windom.* Thirty five, sir. And those are likely permanent hires, full-time hires that the hiring process is presently being--

Mr. *Takano.* So, just to be clear, 35 positions remain to be filled, is that what you are saying?

Mr. *Windom.* Yes, sir.

Mr. *Takano.* Okay. All right. Well, that is better than I thought. All right. Has the VA/DOD interagency working group met?

Mr. *Windom.* Has the D--sir, the interagency working group has met to solidify its governance processes. So that is an ongoing process. We meet formally monthly, we meet

routinely every Friday, and we meet--

Mr. *Takano.* So you have met. Who attends these meetings, who attends the meetings?

Mr. *Windom.* Sir, I lead the effort for the VA side and Stacy Cummings, who is the PEO for the DHMS effort or the MHS GENESIS effort leads on the DOD side.

Mr. *Takano.* And you did give me an idea of how often it meets. It meets how often?

Mr. *Windom.* It meets monthly formally, all-day session monthly, it meets every Friday for approximately 45 minutes, and it is continuously amongst the field experts and the clinicians and the technicians that are working specific issues.

Mr. *Takano.* I will just conclude my time by just saying that I don't see how this is going to end well unless we get the top leadership positions in place and that these folks that fill, especially the Chief Information Officer as a highly qualified individual to oversee this project. And it is not on you, it is on the White House for leaving these positions unfilled, especially when we have this massive, massive contract that we have got to oversee.

Mr. *Windom.* Yes, sir.

Mr. *Takano.* Thank you.

The *Chairman.* I thank the gentleman for yielding.

Dr. Dunn, you are recognized for 5 minutes.

Mr. *Dunn.* Thank you very much, Mr. Chairman, and I thank the panel for coming today. I know it is--I can imagine how much fun it is to be here.

So I want to say at the outset, I am a physician, my career spans the period of time that began with handwritten notes and faxes, a new invention back then. So now we are in fifth generation EHRs. I have lived through EHR purgatory on multiple occasions and spent a great deal of my own office's money on EHRs. So I am certainly sympathetic and I understand the size of the project that we are taking on.

I want everybody here to remember that fundamentally, most importantly, what we are doing is not building an EHR, we are taking care of our patients, the veterans. That our goal was quality, timely care for veterans, it is not to have, you know, the best EHR that has ever been invented.

So with that in mind, let me start, if I may, Mr. Secretary, I know you have a deep experience at the VA and in

other organizations and in health, can you address what you think are some of the barriers to and challenges to implementing this new EHR?

Secretary *O'Rourke.* Thank you. What we face, as you said, is a historic opportunity. I think everybody at this table is committed to the outcomes for veterans that we all desire, which is a great health care delivery system, benefits delivery system. We see this opportunity as the next step in that journey of being able to provide veterans exactly what they deserve. We all come to this with somewhat of excitement in a sense of being able to be on the front end of history, of what we see as an opportunity that doesn't come along once or twice in a generation. So we are looking forward to that.

From anything that is standing in our way, I really don't see that. I think we have gotten the support from the Congress that we absolutely need, that will come in the form of an oversight, working with us, taking on anything that we see as a problem for us. But, you know, when it comes to just communication between us and you all amongst ourselves with DOD, those are really going to be what we face.

Mr. *Dunn.* So we have a historic opportunity to succeed or fail, and certainly I want you and your team to keep us informed about what we can do to push the needle towards success. How are we explaining this to the average, all your clinicians? You have got a lot of doctors and nurses, how are you explaining to them the benefits of this change?

Secretary *O'Rourke.* We understand this was going to be a deep cultural change, but luckily I have a Chief Medical Officer here that can provide some more detail.

Mr. *Dunn.* Dr. Zenooz, go ahead.

Dr. *Zenooz.* Thank you, sir. We understand that this requires a cultural change and that this is first and foremost a business transformation more than just an IT project. So with that in mind, changed management is number one on our list. We have a robust change-management plan that not only involves training, elbow-to-elbow, virtual sessions, et cetera, but we also involve the field at the very beginning of the process here.

Mr. *Dunn.* That's good. I was going to ask you about that. So your doctors, your nurses, your clinical

specialists, they are actually involved in helping design the interface, and also what you need to have in the way of information coming out of that?

Dr. *Zenooz.* Correct. They will be involved not only in designing, but will also lead the way as we go forward.

Mr. *Dunn.* So and to Admiral Bono, we say this is interoperable between DOD and the VHA, will it really be? I mean, I am a doctor in the DOD, I am doing a medical record, I walk over to the VA, would I be able to recognize and operate the system over there?

Admiral *Bono.* Yes, sir. I think that is one of the benefits that we have got here is it is a single instance of the EHR record, so it is the same product.

Mr. *Dunn.* Same interface?

Admiral *Bono.* Yes, sir. And that is why we are very invested in their success, because it will mean our success as well.

Mr. *Dunn.* So this really would be a first time. I have worked in I don't know how many hospitals, how many clinics, and every single one of them has a different interface and it is maddening, I can tell you. It is a

reason to actually constrict where you work.

I have this for Secretary O'Rourke. The VHA clinicians, are they actually already being prepared for this standardization? Maybe that should be to you, Dr. Zenooz.

Secretary *O'Rourke.* I know that we are making it a regular component of leadership communications with the field. I know every visit that I take to a Medical Center director we are making this a topic of discussion, preparing our clinicians, our leadership at the local levels for what is coming, and providing them a positive outlook. It is going to be hard enough, as Dr. Ashwini had mentioned, as with the cultural change. So we are working very hard with what we can do at our level to make that--

Mr. *Dunn.* Well, my time is about to expire, but I do want to encourage you to work with the clinicians very, very proactively. You mentioned a cultural change, it is a huge change for them, and they are focused on their patients and they think that, you know, sometimes we irritate them with the EHR changes.

I yield back, Mr. Chairman. Thank you.

The *Chairman.* I thank the gentleman for yielding.

Ms. Brownley, you are recognized for 5 minutes.

Ms. *Brownley.* Thank you, Mr. Chairman.

So where does the buck stop on this implementation plan?

Secretary *O'Rourke.* With me.

Ms. *Brownley.* And when a new Secretary is appointed there will be a transference of information to the new Secretary?

Secretary *O'Rourke.* It is a very good thing to point out, because I think it goes back to an earlier question. Without a Deputy Secretary, and it is very clear right now that the Deputy has a pivotal and a critical role in this, right now without one that role is up to the Secretary. It will stay with me until we have a new nominee confirmed, and then it will be with him until we have a Deputy Secretary in place.

Ms. *Brownley.* Thank you. So I have been on this committee for five and a half years and one thing that I can say based on historical experiences is that lack of leadership or turnover in leadership has caused delays in almost, you know, any endeavor that has been undertaken. And so I think I share the concerns of many on the committee

that, you know, at the outset we are worried about various deadlines and meeting the interim goals as we move forward on this.

The early time line the chairman mentioned, the preliminary plans to include an 8-year deployment schedule beginning with the initial implementation sites within 18 months of October 1, I am concerned about that. Also, I understand that there is an ongoing development that the VA is working on on life-cycle costs, on data migration, a change-management plan, and an integrated master schedule to establish key milestones over the life of the project.

So I think the GAO reported that the Department intends to complete the development of its initial plans for the program within 30 to 90 days of awarding the contract between--and that is between mid-June, mid-August of 2018. Are you still on schedule to meet these deadlines?

Secretary *O'Rourke.* As we discussed earlier, it is our work and the planning and development of those milestones over the next July through September of this year.

Ms. *Brownley.* So do you know now when the first sort of key milestone will be?

Secretary *O'Rourke.* Having our IOC plan to start on October 1st.

Ms. *Brownley.* Then the second milestone?

Secretary *O'Rourke.* The second milestone will be getting to an initial operating capability at those initial sites.

Ms. *Brownley.* Okay. Well, so I just--you know, I am not sure what the driving question is here to get some assurances, but certainly meeting those first couple of milestones I think is going to be very important in terms of reassuring this committee that we are indeed on track with this implementation. And has been already stated, this is obviously an extremely, extremely important endeavor that we have invested a tremendous amount of tax dollars into and our desire to be successful.

And I will just reaffirm what others have already said, is that the lack of leadership or the turnover in leadership right now is a major concern.

The last question that I just wanted to ask you, Secretary O'Rourke, is that I know earlier this year there were some reports that the signing the Cerner contract was

delayed based on sort of outside, non-governmental individuals were attempting to influence perhaps the use of commercial off-the-shelf electronic health records rather than proceeding with this Cerner agreement. Can you just assure the committee and assure me that you feel that your work is really free from any undue outside political influence?

Secretary *O'Rourke.* Absolutely. As you all know, I became the Chief of Staff in an interesting time and one of the key tasks I had at that time was to bring some sense of order to the Department in a time when we were struggling in some ways. One of the key things that I focused on very quickly was the EHRM process, I guess if you can call it at the time, and seeing where it was and how do we get it finished, because I knew from this committee's perspective that they wanted to see a result. So I became very involved in making sure that we were pushing toward the right result.

So I would not characterize this as anything other than providing the best product for veterans which we knew was going to be, like we talked about, a historic opportunity, we weren't about to let that be changed in any

way and demystify that.

Ms. *Brownley.* Thank you.

My time is up, I yield back.

The *Chairman.* Thank you for yielding back.

Mr. Higgins, you are recognized for 5 minutes.

Mr. *Higgins.* Thank you, Mr. Chairman.

Secretary O'Rourke, thank you for your service to your country, sir. I would like to dive deeper into what the ranking member asked you about regarding GAO and IG records requests.

We are all pretty much universally concerned about transparency in government and there is no more opaque alphabet branch of our government than the VA, historically. So we have a greater responsibility to be more transparent, more reflective of the will of we the people in service to the veterans that we are dedicated to, my brother and sister veterans. It is more crucial that we are completely transparent regarding our reactions to whistleblowers and requests thereof.

My understanding is there is a proposed rule in the VA to amend the Department of Veterans Affairs regulations

governing the submission and processing of requests for information under the Freedom of Information Act and the Privacy Act in order to reorganize, streamline, and clarify existing regulations; is that true?

Secretary *O'Rourke.* I would have to take that back for the record, I am not personally aware of that.

Mr. *Higgins.* Okay. Specifically regarding the confidentiality of whistleblowers' data, it seems to me that if the IG or the GAO has requested data and that would include some whistleblower information, it seems to me that could be redacted, but that there can be no guarantee of confidentiality for whistleblowers.

Certainly none of us in America, certainly not on this committee, we don't want the VA investigating itself. We don't want the DOD investigating itself, we don't want the FBI investigating itself, and we don't want the VA investigating itself. The GAO and IG and the committees like this are bound by oath to perform those tasks.

And from the U.S. Director of National Security government website, in a question-and-answer segment regarding the question how realistic is it that I will

maintain my confidentiality, it says on our website, "At some point in an inquiry, it may be necessary to reveal your identity to further the whistle-blowing process or as otherwise required by law. Additionally, dependent upon the nature of the inquiry, the information disclosed may make your identity obvious despite all precautions taken to maintain your confidentiality."

So please explain to us and I ask you this respectfully, sir--I understand you have a job to do, I was a police officer for 14 years, I understand internal investigations, but this is the VA, man, we have major problems here that it is our responsibility to fix and our investigative services for government branches that respond to whistleblower data, if they request that data, they need to get it. So please explain to us what you had stated regarding whistleblowers having to get permission for their data to be revealed.

Secretary *O'Rourke.* I will do it very concisely. It is very clear what the accountability law states about the identity of whistleblowers and what that--who and how that information is revealed or shared. Privacy law, since we keep that information in the system of records, Privacy Act

law covers that information. For all of those entities that need that information, it is a simple written request. They don't have to provide a reason. They don't have to provide an excuse. They just say we want this data provided and it is provided, without redaction. The only redaction we--

Mr. *Higgins.* Does the answer to the--in the question and answer section on the U.S. Directive National Security Government website, does that reflect the reality that you are explaining today regarding government employees questioning their confidentiality if they bring whistleblower data to a supervisor?

Secretary *O'Rourke.* When they bring it to their supervisor, there is a less of a hold on their privacy because they are bringing up a--the disclosure that is maybe process base or things like that, retaliation, things of those nature when they are disclosing those have to have their names attached to them, otherwise you can't prove the retaliation.

Mr. *Higgins.* Doctor, you had something to add? You motioned--did you raise your hand, Madam?

Secretary *O'Rourke.* They are both from the H.R.

program, I am the guy that gets to answer the questions about accountability.

Mr. *Higgins.* All right, Mr. Chairman, my time is expired, but I will have a written question to submit to the panel if that is within the parameters of our authority, sir.

The *Chairman.* It is.

Mr. *Higgins.* Thank you.

The *Chairman.* Ms. Kuster, you are recognized.

Ms. *Custer.* Thank you very much, Mr. Chairman. I noticed at the outset that our Chair was quite clear that he had not included Acting Chief Information Officer Camilo Sandoval in the invitation to be here today, but I just want to note for the record that it does trouble me. I--this is not the subject of this hearing, but I can't pass it up to say that the merit system's protection board study has found the Veterans Administration as being the highest incidents of sexual harassment across all federal agencies.

I won't get into the details of Mr. Sandoval's situation but do you have confidence that Mr. Sandoval can accomplish his mission, which is so crucial to our veterans all across this country? Many of us joined this committee five and a

half years ago. Our very first hearing was about the fact that we could not communicate between the Department of Defense and the VA, we are spending millions--hundreds of millions of dollars, and yet the very person that is supposedly in charge is not able to focus on his duties because of allegations during the campaign about sexual harassment.

Secretary *O'Rourke.* I can't address what is in, I guess, in a lawsuit, but I can tell you we are setting--

Ms. *Kuster.* Well, can he get the job done? Should he be replaced and is he being replaced? How are we going to get the job done?

Secretary *O'Rourke.* I have a lot of confidence in Camilo Sandoval and what he has been able to do as the executive in charge.

Ms. *Kuster.* Is he on the job to get the job done?

Secretary *O'Rourke.* Absolutely. He has been finding--working with us to find, and restructure, the Office of Information Technology because of some of the poor leadership that it has had in the past.

Ms. *Kuster.* But if he loses his job because of these

allegations, do you have another plan?

Secretary *O'Rourke.* If the President decides to remove a political appointee, then we will have somebody else step into that role, just like he stepped into that role when the previous executive in charge left.

Ms. *Kuster.* It just seems that with an acting secretary waiting for confirmation with a number of these offices that we have all discussed today, including the Chief Information Officer, I just have to note for the record we are not putting our best foot forward on this project and it is a disappointment.

Admiral Bono and Mr. O'Rourke, can you please describe how you hope to use the Cerner EHR to improve the management of pain and opioid prescriptions with our nation's service members and veterans?

Secretary *O'Rourke.* I know that there is some unique features within the Cerner product that help us provide that kind of oversight.

Ms. *Kuster.* Is there anyone on the panel that could describe those features?

Secretary *O'Rourke.* And I am going to pass that off

to my Chief Medical Officer.

Ms. *Kuster.* Thank you very much.

Dr. *Zenooz.* Thank you. One of the main components of the Cerner plan for opioid risk is a risk stratification tool. It not only brings in all of the information from the various PDMS's, the prescription drug monitoring programs across all of the different states that participate in it, it brings it to a single place so that our providers have it at their fingertips. But it also gives them a scoring for the patient's risk for opioid abuse.

So it takes it not only from the community provider's VA prescriptions but also any input that we get from the military of history of opioid prescriptions for the patient. So I think it is very effective.

Ms. *Kuster.* Good. I would like to be kept apprised of the progress of that and any results, or data, or findings if there is research on how that has been effective.

Dr. *Zenooz.* Absolutely.

Ms. *Kuster.* You mentioned community care and another concern that I have, one of the largest concerns with interoperability is with the VA's community providers. What

are Cerner's current plans to facilitate interoperable functionality with community care providers?

Dr. *Zenooz.* Absolutely. We recognize that more than 30 percent of the care in the VA is delivered in the community and that we need to have our providers across the care continuum to have access to all of the data. Our goal is not only to have data that is available to them through current practices, but to build on it. Whether it is our 168 HIE's that we are currently using, that we participate in, direct messaging, provider portals that we provide to the community. But also have the ability for the providers, inside and outside of the VA that participate in the care to have the analytics tools and the registries available to them so that they can participate and improve the outcomes of the patient.

Ms. *Kuster.* That is another piece that we would like continual monitoring on.

Dr. *Zenooz.* Absolutely.

Ms. *Kuster.* My time is short but just briefly, if the community provider does not use Cerner, can you have an interoperable function?

Dr. *Zenooz.* Yes, absolutely. We have health information exchanges that we participate in. We have a network of 168 that we partner with currently. So it doesn't have to be Cerner. It could be any of the other EHR systems and record sharing systems that they use. If the community providers--

Ms. *Kuster.* My time is up. I apologize. I truly don't like being rude, but I know I need to yield back. Thank you, Mr. Chairman.

The *Chairman.* Thank you for yielding. Mr. Banks, you are recognized for five minutes.

Mr. *Banks.* Mr. Windom, I was much confused a moment ago as you were answering Mr. Takano's questions about the inter-agency working group. Have you met more than once just to discuss governance, as you put it?

Mr. *Windom.* Yes, sir. We have been meeting for the past year. As we negotiated the Cerner agreement, we knew governance would be imperative. So we have been working with the DOD--

Mr. *Banks.* How many times have you met? How many times have you met?

Mr. *Windom.* I would estimate somewhere around six or seven.

Mr. *Banks.* On a monthly basis?

Mr. *Windom.* Correct.

Mr. *Banks.* Do you speak with your colleague more than once a month or do you only speak with your colleague during the inter-agency meeting?

Mr. *Windom.* No. We have a Friday call, standing Friday call at 11:00 a.m. and we also have continuous interactions at the technical and the clinical levels. That is where the hard work is really being done.

Mr. *Banks.* Okay. Thank you. Mr. O'Rourke, an article was published at the very start of this hearing, just a little bit ago, stating that Genevieve Morris, who is seated right behind you, will be leading the GENISIS office. If that is true, when was that decision made and why isn't she testifying today?

Secretary *O'Rourke.* It is premature reporting. We were going through the process of actually setting up the industry standard structure for these kind of implementations, which uses more often than a chief

information officer, a chief medical information officer.

Ms. Morris has been instrumental with helping us through really the past few months. She has been loaned to us from HHS and has been critical to this team and has helped us with some broader perspectives of the industry and successful ways of implementing this project.

Mr. *Banks.* So she won't be leading this officer?

Secretary *O'Rourke.* We are evaluating that chief medical--

Mr. *Banks.* Premature, perhaps inaccurate reporting?

Secretary *O'Rourke.* The accuracy of it is--definitely she is a candidate for that job. She would be perfectly qualified for that.

Mr. *Banks.* So to be determined.

Secretary *O'Rourke.* To be determined.

Mr. *Banks.* Okay. Mr. O'Rourke, in your testimony, you state the VA structure, the IDIQ contract to, "Provide maximum flexibility." Can you explain what that means and what freedom of flexibility the VA has?

Secretary *O'Rourke.* Early on, we were very concerned about being tied to a specific set of boundaries when it came

to these kind of implementations. So we were very intent in the negotiations that John led to make sure that the VA has the primacy in making decisions on where we go with this and not be stuck with the contractor driving us to decisions we may or may not want to make. So we were intent on making sure that flexibility was there.

Mr. *Banks.* So how can you use that contract flexibility to respond to hurdles during the implementation? For instance, if the planning takes longer than expected or the implementation in the initial sites don't go as smoothly as expected.

Secretary *O'Rourke.* I would like to have John Windom specifically talk through that.

Mr. *Windom.* Yes, sir. IDIQ stands for indefinite delivery indefinite quantity. The way that works is task orders are issues in support of the foundational contract such that you can issue task orders to increase timelines, increase scope, increase the waived appointments, or you can restrict task orders to more control in support of cost schedule and performance objectives, and obviously the management of risk.

We never want to bite off more than we can chew. We understand the importance of our veterans and the care we deliver. And therefore, we want to make sure we optimize the use of that IDIQ vehicle in delivering those support services that we anticipate being able to deliver.

Mr. *Banks.* Okay. Thank you. Mr. O'Rourke, can you assure me that the EHR modernization will result in one and only one EHR system?

Secretary *O'Rourke.* That is definitely our intent.

Mr. *Banks.* That would include for interoperability purposes and to access the Legacy data. And can you confirm to me that once the Cerner Millennium EHR is implemented, the VA will completely stop using VistA and the Joint Legacy Viewer?

Secretary *O'Rourke.* It is our intent to not use Visa. The Joint Legacy Viewer, I think, may need some life cycle, but we are still in that planning part.

Mr. *Banks.* But that is your intent?

Secretary *O'Rourke.* Yes.

Mr. *Banks.* Okay. Admiral, how is this dynamic working in MHS GENISIS, will Cerner completely replace CHCS

and Ulta?

Admiral *Bono.* Yes, sir. That--we are going to transfer all of our functions onto the new electronic health record, MHS GENISIS and sunset the Legacy lens. We will still maintain some connection to our Legacy databases, but in terms of the Legacy applications and programs that are associated with Ulta and CHCS, those will be sunset.

Mr. *Banks.* So that is a definite, that is not just your intent, that is definite?

Admiral *Bono.* Yes, sir.

Mr. *Banks.* Okay. Thank you very much. I yield back.

The *Chairman.* I thank the gentleman for yielding. Ms. Rice, you are recognized for five minutes.

Ms. *Rice.* Thank you, Mr. Chairman. I would like to direct my questions to you, Mr. O'Rourke. So before you were in the position that you presently hold, you were actually the first executive director for the VA's Office of Accountability and whistleblower protection, right?

Secretary *O'Rourke.* Yes.

Ms. *Rice.* And you did that for approximately how long?

Secretary *O'Rourke.* From when we stood up the office in May through the time I became Chief of Staff.

Ms. *Rice.* So that was what kind of time period?

Secretary *O'Rourke.* Through I believe February of this year.

Ms. *Rice.* And I--you would agree that in that position, which I believe is the first of its kind in any governmental agency, a large part of your duty there was to ensure a level of accountability?

Secretary *O'Rourke.* Yes, it was. It was to implement the new accountability and whistleblower protection law and to set up the new office.

Ms. *Rice.* So can you just go back again in your thought process in terms of not wanting to respond to the OIG's request for that information?

Secretary *O'Rourke.* I think the broader story should be told on that. From day one, we realized that the relationships between the Office of Special Counsel, the Office of Investigative General, and others, frankly, this committee, were not good. There was previous offices with MVA that had this responsibility to investigate senior

leaders. It did not have a great track record.

It was my intent early on to break through those barriers between those very important entities that all had their statute driven mandates to make sure that we were all working together to protect whistleblowers first and to make sure that we were investigating misconduct and holding people accountable.

With the IG, that took the form of trying to find some creative and new ways to work together. There is some hard walls you can't cross with the IG, especially when it comes to criminal activity, those kind of things. Those are not investigative responsibilities of our office that we were starting up. That is where we would partner with the IG. But as you can appreciate, a lot of things that happen in the VA cross different boundaries. And holding a senior leader accountable is sometimes a complex situation.

So we wanted to work closer with the IG, especially when it came to disclosures because part of the accountability law actually puts the weight on the Office of Accountability to review IG received whistleblower disclosures.

Ms. *Rice.* Right. But the problem is in the past, and

we have heard this time and time again--

Secretary *O'Rourke.* Yes.

Ms. *Rice.* --here on this committee is that the VA is incapable of holding anyone accountable in their ranks. And so it is essential that you have a body like an OIG to be able to look into allegations, whatever they may be, and be able to do that in an independent way. Do you--you made, to me, what I thought were disturbing statements about how the OIG actually works for you and you are the supervisor of the OIG.

Secretary *O'Rourke.* The IG is attached to the department.

Ms. *Rice.* But they are independent.

Secretary *O'Rourke.* In their investigative capability and their freedom to look anything in the department, absolutely.

Ms. *Rice.* So then how can you deny them--giving them what they request?

Secretary *O'Rourke.* The statute is very clear on protecting the identity of whistleblowers. The IG had

requested--

Ms. *Rice.* But don't you think that there is a way that you can do that and also respond to the request of an OIG, which has a very important function, one that the VA has not been able to do on their own?

Secretary *O'Rourke.* Again, the IG requested unfettered access to a system that had Privacy Act information. If they want those documents, those records, they can be provided those. They just have to provide a written request. No reason for the request, which was part of the rub here. All they need to say is we request these things. That provides coverage for that--for this office, for the records that they hold to provide them.

That is all they have to provide.

Ms. *Rice.* So it was a technical objection that you were making to what they did?

Secretary *O'Rourke.* Well, it came--borne more out of we wanted to cooperate with the IG and provide them access to this directly, working with us, but not unfettered access to where they just come in and out of that system for non-investigatory reasons. So we were trying to work on a way to

do that. That Is not something that worked out initially, so now we are just back to what the statute says is just provide the request and the documents are provided.

Ms. *Rice.* So much of--

Secretary *O'Rourke.* And we provided documents all through this period of time. So it is not like they have been refused things. We provide disclosures to them on a daily basis as soon as they come in.

Ms. *Rice.* So much of how much faith the public has in their governmental institutions is the level of transparency and very often the facts don't carry the day, it is the perception of whether there is real transparency, real accountability. So when you act in the way that you do, I am sure, coming from where you did from the accountability and the whistle blowing, you have to be aware that visual, that perception is not a good one. And it actually seems to kind of track a disturbing trend in this administration in different agencies and positions as well that they are the king and they control everything, and all of these agencies just are meant to serve the President.

That is not the way the government works. So when you

take a position like you do, that is the perception that you leave. And I would hope that someone with your level of experience would understand that and try not to make that mistake again.

I think my time is up. Thank you. Thank you, Mr. Chairman. I yield back.

The *Chairman.* I thank you, gentle lady, for yielding.

Ms. *Radewagen.* Hello for Chairman Roe and Ranking Member Walz. Thank you for holding this important hearing today. I also want to welcome the panel. Thank you so much for your service to our nation.

Following up on a colleague's earlier question, Admiral Bono, as VA's EHR modernization program staffs up, do you believe it would be useful to have staff from it working on MHS GENISIS?

Admiral *Bono.* Yes, ma'am. I think that is one of the reasons why we have continued--why we started to do our collaboration very early on as the VA was even in the early stages of getting the Cerner product. I very much want to be able to leverage off of any lessons learned that the VA has, as well as be able to share what we are learning on the DOD

side with the VA.

Ms. *Radewagen.* Can you elaborate on how this cross-pollination can be helpful?

Admiral *Bono.* Yes, ma'am. So a really good example is in the change management and the involvement of the clinicians. We have a fair amount of experience now with the change management and the workflow adoption and that is something that we want to be able to make sure and share with the VA.

Because this is a signal instance of a medical record, that is it is the same medical record, we recognize that being able to assist in the adoption of work flows that are common across DOD and VA will enable a faster deployment for us both.

Ms. *Radewagen.* Thank you, Mr. Chairman. I yield back.

The *Chairman.* I thank you gentle lady for yielding. Mr. O'Rourke, you are recognized for five minutes.

Mr. *O'Rourke of Texas.* Thank you, Mr. Chairman. And I want to begin by thanking you and the ranking member for taking this committee's oversight and accountability

responsibilities seriously. I am glad that you are standing up a new subcommittee to track this contract, which I think all cost in may total $16 billion that we know of now. And I am just grateful on behalf of our constituents, the veterans in El Paso, in making sure that we see this through and that there is the oversight and accountability necessary that has been missing in the past.

I wanted to ask the Acting Secretary, what paused the April 30th DOD report from the Director of Operational Test and Evaluation gave you in moving forward with Cerner? One of the bottom lines in that report was a recommendation to freeze EHR rollout indefinitely. There are 156 reports of critical deficiencies. There was the suggestion that this Cerner platform may not be scalable. As they added new medical centers onto the system, those that had already been added slowed down significantly. It took pharmacists two to three times as long to fill a prescription as it would have had they not been using the Cerner system.

There were reports that clinicians literally quit because they were terrified that they might hurt or even kill one of their patients. The user score out of a possible 100

was 37. And there is--there are open questions about the accuracy of the information that is exchanged there. So what did that do to your, and the VA's, decision on adopting Cerner as a platform going forward?

Secretary *O'Rourke.* I think as we discussed earlier, we have been working hand in hand with DOD and knew of some of the implementation issues that were described in the report and how they had been resolved. We have integrated everything that we have learned from them into our--both our negotiating strategy and into product and then into our deployment strategy.

Mr. *O'Rourke of Texas.* Yes, so what pause did that give you? When you saw this did you say, "Holy smokes. There are some significant problems here. We are going to put all of our eggs in this one basket: every DOD, every VA health record, every active duty service member, every veteran, every military retiree." Did it give you any pause or did you say, "Hey, it looks like they have corrected all of these problems. And even though that report was a little more than two months ago, everything is fine."

Secretary *O'Rourke.* We have never approached this

project as just some sort of rose colored glasses. We know this is going to be an extreme challenge for the VA and DOD, especially on the collaboration.

Mr. *O'Rourke of Texas.* Let me ask it this way. What existing concerns do you have? So you saw the report. You believed that DOD/Cerner are addressing the issues. Do you have any outstanding concerns, anything that gives you pause, keeps you up at night?

Secretary *O'Rourke.* So I am going to turn it to John, but it is cost, schedule, and performance but --

Mr. *O'Rourke of Texas.* How about you just because you said the buck stops with you, so I would love to hear what you--

Secretary *O'Rourke.* Absolutely. It is cost, schedule, and performance. It is our ability to track to the milestones that we have developed.

Mr. *O'Rourke of Texas.* Anything in that report that you do not think has been addressed or resolved?

Secretary *O'Rourke.* There are items in that report we will resolve and continue to work on throughout the lifetime of this program.

Mr. *O'Rourke of Texas.* Any fundamental issue like the scalability of it, like the accuracy of information, like the fact that clinicians have quit out of fear that their patients lives may be endangered? Any of that unresolved to your satisfaction at this point?

Secretary *O'Rourke.* We continue to work with DOD to watch how they are resolving their--the things that have come up in that report and making sure that we learn those lessons.

Mr. *O'Rourke of Texas.* The question that the Chairman asked about how information would be accessed going forward once this is fully online, and the response about the Joint Legacy Viewer being embedded and the ability to see information through that, what--when this, if this is ever fully working, for service members who are going to be transitioning out over the next 10 years, there will be no Legacy Viewer for their information. It will seamlessly transfer from DOD to VA to third party provider. Is that correct?

Secretary *O'Rourke.* That is the intent of the program.

Mr. *O'Rourke of Texas.* For all three?

Secretary *O'Rourke.* Absolutely.

Mr. *O'Rourke of Texas.* Including the third party provider. Whose information will still be in the--be viewed in the Legacy Viewer 10 years from now once this is fully implemented according to the proposed schedule and budget in here?

Secretary *O'Rourke.* Our intent is that everyone departing DOD, coming to VA, has a seamless transition and then they are able to use all of the VA capability that we have.

Mr. *O'Rourke of Texas.* Those veterans whose records appear in the Joint Legacy Viewer today, will they be in the Joint Legacy Viewer going forward, or will there be some fix to that?

Secretary *O'Rourke.* That is the intent.

Mr. *O'Rourke of Texas.* Okay. To still be in the Joint Legacy Viewer?

Secretary *O'Rourke.* No, to be in our system--

Mr. *O'Rourke of Texas.* To be fully dumped and--

Secretary *O'Rourke.* --fully integrated.

Mr. *O'Rourke of Texas.* -- the data fully integrated.

Secretary *O'Rourke.* Yes.

Mr. *O'Rourke of Texas.* Okay. Mr. Chairman, I yield back.

The *Chairman.* Thank you, Mr. O'Rourke. Mr. Bilirakis, you are recognized for five minutes.

Mr. *Bilirakis.* Thank you, Mr. Chairman. Secretary O'Rourke, it seems to me that electronic health record modernization is as much a process restructuring and standardization program as it is an IT program. Would you agree with that?

Secretary *O'Rourke.* Yes.

Mr. *Bilirakis.* Okay. Admiral Bono, same question.

Admiral *Bono.* Yes, sir. I fully agree with that.

Mr. *Bilirakis.* Okay. How much of MHS GENISIS has so far been in process redesigning exercise as opposed to an IT exercise, meaning writing code and installing hardware?

Secretary *O'Rourke.* We are fully aware of the depth of change this is going to bring to our healthcare delivery system and we are on the front end of working on restructuring those work flows and looking at what we have to

change across our system.

Mr. *Bilirakis.* Thank you. Admiral Bono, which aspects has--what has been the most challenging part of it?

Admiral *Bono.* Yes, sir. I think that the two most challenging parts, and I am gratified to see that the VA is working on this up-front, is governance and change management. Certainly, the ability to make the decisions that are needed at the enterprise level to maintain that interoperability and the connection with the DOD effort is extremely important.

And I think that what the VA is doing to help make sure that governance structure and framework is in place is extremely important.

The second piece that is extremely important is the change management. And as members and others here at the table has already identified, being able to involve the clinician right from the start is a very important part of that change management effort. And again, I see that what we have learned in our own efforts of deployment and the VA's initial steps to address that are very much in keeping with what we have learned.

Mr. *Bilirakis.* Thank you. Secretary O'Rourke, how much of the process redesign is Cerner involved in and how much is purely VA responsibility?

Secretary *O'Rourke.* When it comes to this project, Cerner will be working with us directly to make sure that the process as we redesign it will work in their platform.

Mr. *Bilirakis.* Very good. Admiral Bono, the MHS GENISIS contract was awarded in 2015 and your testimony indicates its implementation will finish in four more years. That is a total of eight years, VA's schedule is ten years. Are you confident you will be able to finish on schedule? I know that is so important. If you are confident in that, how is the military health system, which spans the whole country, as well as overseas bases, able to do this relatively more quickly than the VA?

Admiral *Bono.* Yes, sir. So we will be doing--I feel very confident that we will be able to stay within our timeline that we have projected. Part of our deployment schedule provides that we will be able to do many of this in parallel as we have been able to apply some of our lessons learned. So there is a lot of synchronization and

amplification that we will be able to do as we have put in place not only the lessons learned from our own personal experience, but also from the lessons learned that we are getting from those that are reviewing our progress.

Mr. *Bilirakis.* Okay, final question for Admiral Bono. You have already bought your version of the Cerner EHR and implemented it in your first sites. How did you decide to select some Cerner software packages and no others?

Admiral *Bono.* Yes, sir. That was part of our requirements process in which we put together those functions and capabilities that we felt that we most needed to be able to replace our Legacy systems.

Mr. *Bilirakis.* Very good. I yield back, Mr. Chairman. I appreciate it.

The *Chairman.* I thank the gentleman for yielding. Mr. Lamb, you are recognized for five minutes.

Mr. *Lamb.* Thank you, Mr. Chairman. I want to follow up first on a question by my colleague, Mr. O'Rourke, about integrating what you learned from the DOD failures into the rollout of the new system. And whoever is best to answer this, please answer it, but some of the specific problems

that they saw in the DOD rollout were, for example, prescription requests coming out wrong and referrals not going through to specialists.

So just take those two specific issues, if you can tell us what you learned from the DOD rollout and how this program is being changed to prevent something simple like that from happening.

Secretary *O'Rourke.* Absolutely. Let me let Dr. Ashwini answer that.

Dr. *Zenooz.* Yes, absolutely. So one of the big lessons learned that we had was that, again, front live providers have to be involved not only in designing the process but also in the testing process. I cannot emphasize that enough for myself everyday, as well as the people that are involved on the team. Our users will be an integral component of the user testing process to ensure that all of this works before we go live, that patient safety is accounted for, that we check off all of the boxes to ensure safety is maintained and the process works if not as well as but better than the way it works today.

Mr. *Lamb.* Okay. So how will you ensure that a

prescription is always going to come out correctly? Do you do like a drill or a rehearsal or something with fake patients, basically, and your users on the other end to make sure that it works or--explain to me how that is going to happen.

Dr. *Zenooz.* Absolutely. So the process is testing is where this happens. We not only test the technology to ensure that all of the technology behind the scenes works so that the prescriptions are going where it needs to go, but also that the correct prescriptions for the right patients are going to the right place at the right time.

So that not only involves the technical component, but also the users, like I said, on the front end to ensure that all of those boxes are checked. Only when you have all of those things checked off that says the process is working appropriately and that patient safety is maintained, can you go live in that process. And we have that accounted for in our testing process.

Mr. *Lamb.* Okay. Is that a different testing process than what the DOD used before they rolled this out the first time?

Dr. *Zenooz.* I am going to defer to--

Admiral *Bono.* We tested it through many instances of the different MTF's that we had in the Pacific Northwest. What we actually found, though, was one of the challenges for us is that we had different staffing models up there and we had not accounted for that in the program. We have since addressed that.

Mr. *Lamb.* Okay. So it will be a different testing and rehearsal process this time than last time is my question.

Admiral *Bono.* Yes. We have incorporated that.

Mr. *Lamb.* Now, Mr. O'Rourke, question for you about the VA budget. We just passed, and the President signed into law, the VA Mission Act which basically changes the funding for the Veterans Choice Program from mandatory to discretionary funding and creates an issue next year for the budget cap on the overall VA budget because there--this new funding that has now become discretionary and will count against the VA budget. Are you aware of the issues that could create for your overall budget?

Secretary *O'Rourke.* We are aware.

Mr. *Lamb.* Okay. Are you concerned about the VA's ability to implement this project with the electronic health records given the constraints that are now going to be on your budget?

Secretary *O'Rourke.* I believe the Congress has made it very clear on their intent on this project. So we have less concern about the execution side.

Mr. *Lamb.* Okay. Do you agree that although the contract is for $10 billion, there could be an additional $5 or $6 billion needed for infrastructure and project management?

Secretary *O'Rourke.* We are aware of that.

Mr. *Lamb.* Okay. Do you agree that is not really accounted for in the current budget planning, especially with this new money from VA Choice going into discretionary funding?

Secretary *O'Rourke.* I believe they have been very transparent with the requirements of this contract, both from the contract execution side--

Mr. *Lamb.* And I am not saying--I am not asking about the transparency. All I am asking about is do you believe

that the money that you need, the additional $5 or $6 billion is threatened by this change in overall funding that is going to put a--

Secretary *O'Rourke.* No.

Mr. *Lamb.* --push you up against the budget cap?

Secretary *O'Rourke.* No, I don't.

Mr. *Lamb.* So you feel fully confident that despite that change in the Mission Act that you will have the money you need to implement this project?

Secretary *O'Rourke.* Yes.

Mr. *Lamb.* Okay. Mr. Chairman, I yield back. Thank you.

The *Chairman.* Thank you, Mr. Lamb. Mr. Poliquin, you are recognized.

Mr. *Poliquin.* Thank you, Mr. Chairman, very much. Mr. O'Rourke, thank you very much for being here and all of you for being here. I understand you are a graduate from the University of Tennessee. Our great Chairman also represents a terrific part of the State of Tennessee. I am assuming that neither one of you have been colluded about anything and you will be treated as directly as everybody else is on this

committee.

Going forward, let us take a look at this, Mr. O'Rourke, if you don't mind, since you are now the fellow sitting in the head seat over here. The reason why we are here today is because over a very long period of time, we have had over 100 different medical facilities that the VA is involved with, or owns, or runs, or whatever you want to call it. And they have, over time, created their own Legacy systems, their own IT systems.

Now, I am a very direct person and we love our veterans in the State of Maine that I represent. We have the first VA facility in the country, Togus, up in Augusta. However, I have never seen a part of our federal government, to be very honest with you, Mr. O'Rourke, who is--tries to be less accountable than the VA. 385,000 employees. You get folks that--not you folks, of course, but folks that come before us and no one wants to take account.

You look at the Denver medical facility that is a billion dollars over budget and no one takes responsibility for it. So I have it up to here when it comes to a lot of these issues. So you look like a reasonable fellow, I just

want to make sure that I am understanding that what we have had in the past when it comes to folks at the VA developing their own IT systems, to build their own bureaucracies to protect their jobs is not going to be a problem going forward. Give me confidence.

Secretary *O'Rourke.* Sir, that is one of the most straightforward concerns that I have had when I looked at our IT office. In fact, that is the thrust of the work that we are doing right now since the previous executive in charge left was to go in and look and find where all of those instances are, remove the waste of our spending, and find each and every opportunity we have to reinvest--

Mr. *Poliquin.* Let's stop right there, Mr. O'Rourke, if you don't mind. My colleague, Mr. Lamb, mentioned just a moment ago that it is a $10 billion contract. My understanding, it is a $15 billion contract over five years. What is it?

Secretary *O'Rourke.* It is a $10 billion contract to Cerner Corporation.

Mr. *Poliquin.* Okay.

Secretary *O'Rourke.* The mention--what Congressman

Lamb was referring to is other infrastructure and personnel cost outside of what we will pay--

Mr. *Poliquin.* Okay. Thank you for clarifying that. Thank you, Mr. Lamb. I want to make sure I am looking at the right person so when you come before us in the future, if it is you, sir, you are the person responsible for getting this done, is that correct?

Secretary *O'Rourke.* Absolutely.

Mr. *Poliquin.* Okay, good. There was another--I think it was Dr. Bono--Vice Admiral Bono, excuse me, a moment ago explaining that there needs to be deep cultural changes. What the heck does that mean to you because you are the head guy? What does that mean?

Secretary *O'Rourke.* It means exactly what you described. When we have different hospitals creating different instances of IT systems, different groups that feel that they are not accountable to each other, to their veterans, to their leadership. Something that we addressed early on with the Office of Accountability and Whistleblower Protection of finding misconduct.

Sir, I can just tell you that the process under work

right now in VA is to become more accountable to you. We have done unprecedented ways of becoming more transparent, providing data, whether it is online or--

Mr. *Poliquin.* And you know, Mr. O'Rourke, you have the ability to terminate people who are ill-performing, correct, or under performing?

Secretary *O'Rourke.* I have exercised that authority.

Mr. *Poliquin.* We have--yes, okay, good. We have given you that authority. The President signed that. You can do that. Okay, good.

I am guessing that somewhere in your office, you have a whiteboard or you keep it on an IT system or a computer or some darn thing where you have a timeline, what you are going to get done, what the deliverables are, and how to measure that performance. Do you have that?

Secretary *O'Rourke.* I have a 10 by 8 whiteboard in my previous office. They wouldn't let me bring that into the Secretary's office, but I frequently go back there to sketch out those timelines.

Mr. *Poliquin.* Great. Wonderful. And are--is your vender, Cerner, is that entity paid up-front to deliver

product or does the deliverable have to occur and you sign off on it before they are compensated?

Secretary *O'Rourke.* With a firm, fix price IDIQ contract, we have that flexibility. That is what we discussed earlier to make sure we can hold the contractor accountable. And if they aren't then we can counsel task orders or delay other task orders if we were looking at a performance issue.

Mr. *Poliquin.* Okay. And that is a fixed-base contract over 10 years. You know, it is hard to project as a business owner anything two years out, but ten years out is a long period of time. What confidence level do you have you won't be coming before us asking for more money?

Secretary *O'Rourke.* Our intent is to execute within the cost and schedule that we have today. To do that, we are making sure that our leadership is engaged personally, I am engaged. We have our senior leadership team meeting monthly and we have weekly updates to me on this project specifically.

Mr. *Poliquin.* Good luck to you, Mr. O'Rourke, and everybody, we are all behind you. But we are going to hold

your feet to the fire.

Secretary *O'Rourke.* Thank you.

Mr. *Poliquin.* Thank you, Mr. Chairman.

The *Chairman.* Thank you, Mr. Poliquin, for finishing four seconds early. That is a first. I would not recognize General Bergman for five minutes.

Mr. *Bergman.* Thank you, Mr. Chairman. And you know, I feel listening here for the last hour or so, I feel compelled to say and I know you--we are all on the same sheet of music here but why we are here. We are here to provide quality results for our veterans over the long-term. It is no more complicated than that, but we can make life complicated if we allow the way we do things to get in the way.

We talk seamless, but historically bureaucracies walk a rice bowl silo mentality of self-preservation. We know that. Only through proactive leadership that establishes a culture of civil collaboration across all boundaries will we even begin to have a chance of success in the change management that you talk about.

People throughout VA, at all levels, must feel empowered

to be part of solutions focused on results for veterans. I mean that is pure and simple. It is as quickly and short as a Marine can state it.

So having said that, Mr. O'Rourke, the Appropriations Act stipulates that the EHR modernization program be controlled and administered by the Office of the Deputy Secretary. We have talked about the steering committee, we have talked about the governance, we have talked about the meetings. We also know that position is vacant right now.

So what is the plan here for the interim vacancy? Who has got the dot?

Secretary *O'Rourke.* I do. And that will stay with the Secretary until we have a Deputy Secretary appointed.

Mr. *Bergman.* Okay. So you have the dot. How much of your daily time is it going to take to do this because we can only be in one place at one time as an individual?

Secretary *O'Rourke.* Weekly briefings to me from this team on the status, the milestones, progress, cost, schedule. Every visit that we make to facilities, whether it is a communications mission, if it is somebody that is not actively involved in the implementation at this point. And

then with those places that are actively involved, taking an on the ground look and being able to come back and have a perspective.

Mr. *Bergman.* Okay. Thank you. Admiral, you have a great deal of experience with operational and clinical standardization. The defense health agency was created in part to unify military treatment facilities in the military departments. Please walk me through standardization--

Admiral *Bono.* Yes, sir.

Mr. *Bergman.* --in the military health system.

Admiral *Bono.* Yes, sir. So we have taken an approach with standardization that first encompasses some of our back office functions. That is those functions that are common to all hospitals across Army, Air Force, and Navy. Those would be things like logistics, facilities, education and training, and in this case health information technology.

So being able to deploy the MHS GENISIS has been a significant enabler for us to obtain standardization. And what that does then in standardization, if I could just use health information technology as an example, is using MHS GENISIS, the Cerner product as an enabler to help us drive

towards more efficient work flows that put the patient right in the center and are responsive to their needs versus systems that have been responsive to the provider's needs.

Mr. *Bergman.* Okay. So what you learned--from what you have learned so far, can you compare and contract basically the military health system and the VA system? Are there specific crossover points or in other cases specific divides that there is no crossover?

Admiral *Bono.* Yes, sir. I believe that there are going to be some significant crossovers. And that is some of the things that we have already identified in many of our conversations, as well as in some of our earlier collaboratives.

Mr. *Bergman.* Thank you. And in an effort to beat Representative Poliquin, I yield back 50 seconds.

The *Chairman.* I thank the gentleman for yielding. And I want to thank the panel. I am going to a lightning round. And Mr. Lamb, one of the things that you brought up with the pharmacy. These clinicians are going to want to make a medical visit, which is what VHA is all about, as seamless and as good as they can. They want to make it

quality. They want to make it a pleasant experience. People are intimidated when they come in and can be until they get familiar with the system.

So that would be our objective. And Dr. Bono knows this as an Admiral in the Navy, we in the military, and there are five of us all who are sitting up here, we will salute, and say yes, ma'am, and make it work, no matter how awful it is. And you are going to want to make that.

So when your wife goes in to get a prescription, all she may know is hey, it took me five minutes. I walked up and got it. There are a lot of people behind the curtain to make that happen. And what we don't want this system to do is make that harder for the people to do it. It will frustrate them and they will leave, I am telling you.

I say this as a joke, but in much way it is not, an electronic health record made we a Congressman. So people will search out something that is easier. So we have to make this as user friendly. And I know Cerner is here and will be on the next panel. My one question and one minute, I am going to yield everybody a minute if they want it, and I didn't get it answered. Maybe Cerner will do this, but--and

Mr. O'Rourke, you may be able to answer this also.

We are spending a billion dollars a year to maintain the current Legacy system. When that handoff occurs, will there be any savings or will that system still cost a billion plus to maintain the Cerner system each year?

Secretary *O'Rourke.* Theoretically, that would be the cost savings once we have a fully implemented Cerner solution. That is what we have to work towards. That has to be our intent.

The *Chairman.* Is it -- does it look like that can happen? I mean, where it--in other words, we replace a piece of technology, is it going to cost us just as much as what we had to maintain it? It is new. I mean, is there a contract afterwards? I know there are--you are going to have to maintain this system.

Secretary *O'Rourke.* I am sure we would have to maintain that system. Whether it will cost the same as what we have today, I would suspect not.

The *Chairman.* Because the $10 billion and the extra $5, almost $6 billion is for the rollout, but after 10 years or whenever this thing is fully operational, you are going to

have to pay--there is going to have to be a management contract after that, I am sure. And my question is how much is that money--how much money is that going to be?

Secretary *O'Rourke.* We will have to take that question back, sir, and come back to you, but we will keep that in mind.

The *Chairman.* I yield to Mr. Walz, one minute.

Mr. *Walz.* Just some yes or no, Mr. O'Rourke. Isn't it true the OIG has not received any information to date from the OAWP?

Secretary *O'Rourke.* No, that is not correct.

Mr. *Walz.* That is not true?

Secretary *O'Rourke.* They have provided--we have provided them disclosures consistently.

Mr. *Walz.* True, OIG has agreed to--by sending two staff members on May 2nd to review referrals but were denied access due to lack of reciprocity?

Secretary *O'Rourke.* They were requested by us for--to have a meeting to collaborate with and then they requested that, unbeknownst to us.

Mr. *Walz.* True that you conditioned access to the

OAWP files contingent on OIG providing their files?

Secretary *O'Rourke.* That is not exactly true.

Mr. *Walz.* Right.

Secretary *O'Rourke.* That was whistleblower disclosures to be shared under the statute.

Mr. *Walz.* And I will state for the record that confidentiality was never raised by the IG to this office of talking to us until this testimony today, which I remind everyone was under oath. With that, I yield back.

The *Chairman.* I thank the gentleman for yielding. Dr. Dunn?

Mr. *Dunn.* Thank you, Mr. Chairman. I want to get a level of comfort. This is probably Dr. Zenooz. I was reading through the memos and the briefs there and I was seeing standardized work flow, and to me that meant standardizing the way the clinicians are using EHR, the way we enter and retrieve information. But as I kept reading on, it sort of morphed into a best practices thing.

And I want to be reassured that what we are not talking about, this is not code for clinical medical practice guidelines, treatment guidelines. Tell me it is not code for

that.

Dr. *Zenooz.* So work flows are the way we do business. And our goal is to involve our frontline clinicians to ensure that the way we want to do business--

Mr. *Dunn.* Treatment guidelines, you know what I mean.

Dr. *Zenooz.* Yes.

Mr. *Dunn.* Diagnosis related treatment guidelines.

Dr. *Zenooz.* So the EHR system does allow for collaborating with DOD to input clinical practice guidelines and have that be part of the clinical decision support.

Mr. *Dunn.* So that would be suggestions like the NCI guidelines, things like that.

Dr. *Zenooz.* That is correct.

Mr. *Dunn.* And this is not like this is the way you will practice medicine.

Dr. *Zenooz.* That is correct.

Mr. *Dunn.* You understand as a physician, I am sure--

Dr. *Zenooz.* That is correct.

Mr. *Dunn.* --my concern here.

Dr. *Zenooz.* Absolutely. So our goal is if a clinician is ordering something, for example, and has the

option to have decision support available--

Mr. *Dunn.* So my time has expired, but I do want to make sure that you understand that when we start doing top down treatment guidelines, you will treat this diagnosis this way, we always, always get it wrong. Reliably get it wrong. The government has proven that repeatedly.

Dr. *Zenooz.* Absolutely.

Mr. *Dunn.* I yield back, Mr. Chairman.

The *Chairman.* We always get it wrong. Correct. Mr. Takano, you are recognized.

Mr. *Takano.* Mr. O'Rourke, I want to follow up on my earlier questions. I understand that the Deputy Under Secretary role and the Deputy Chief Information Officer are the province of the VA, not the White House. It has come to my attention that prior to Dr. Shulkin leaving, that a committee--an internal committee of VA, was--has reviewed potential Under Secretary names and has already met three times and passed the name along.

Can you comment on that?

Secretary *O'Rourke.* It--for the Under Secretary for Health?

Mr. *Takano.* Yes.

Secretary *O'Rourke.* Actually, we have had three commissions over the past year to evaluate names for that position.

Mr. *Takano.* And that they have passed a name along, is that correct?

Secretary *O'Rourke.* They did pass candidates along to the White House and I believe they weren't selected.

Mr. *Takano.* Mr. Secretary, I am just really concerned that there seems to be no urgency to fill these positions that are critical to oversee a $15 billion project.

Secretary *O'Rourke.* I can tell you that we are starting a new commission--

Mr. *Takano.* And this is on you, not the White House.

Secretary *O'Rourke.* Okay.

Mr. *Takano.* Thank you.

The *Chairman.* Ms. Brownley, you are recognized for one minute.

Ms. *Brownley.* Thank you. I just wanted to get a clarification. I wanted to follow up on Congressman O'Rourke's question about the Legacy data being built in

seamlessly to the Cerner. And Mr. O'Rourke, you said that was the goal, that is the intention to do it. Then I heard from the Admiral that you--within the DOD system that you have a portal, if you will, for the Legacy data, which sounds to me like you push that button and you get the Legacy data and it is not necessarily integrated into the system.

So is that true, Admiral, in terms of what the DOD is doing? So you have a different objective than the VA?

Admiral *Bono.* Thank you, ma'am, for letting me clarify. No, this is--we have the same objective, it is just that we are in transition. And while we are in transition, until we get onto the single instance of the electronic health record, we have to use some kin of bridging product that allows us to maintain visibility of it. So that is the Joint Legacy Viewer.

In DOD we are also using that because in some instances for our patients and our MTFs, not all of us have been deployed to MHS GENISIS yet, so that is an interim support.

Ms. *Brownley.* Thank you. I yield back.

The *Chairman.* Thank you. Mr. Poliquin, you are recognized for one minute.

Mr. *Poliquin.* Thank you, Mr. Chairman, very much. Mr. O'Rourke, are we on schedule and on budget with this contract?

Secretary *O'Rourke.* Today, yes.

Mr. *Poliquin.* Okay. And when did you start the contract? When did you start the project?

Secretary *O'Rourke.* We started negotiating the contract May 17th of 2017.

Mr. *Poliquin.* Okay.

Secretary *O'Rourke.* We signed it last month.

Mr. *Poliquin.* Okay, but you have started. You are not waiting. There is no reason to wait. You are moving forward.

Secretary *O'Rourke.* We are moving forward today as you can see. We are putting together organization plans and milestones as we speak.

Mr. *Poliquin.* What keeps you awake at night that can cause this thing to derail and you have to come back to us and say it has been a failure or you need more money. We don't want that, either one of those to happen. So what could cause that to happen?

Secretary *O'Rourke.* A lack of focus on cost, schedule, and performance. Any time you let your eye get off that ball, you are going to run into problems.

Mr. *Poliquin.* And you are not going to let that happen?

Secretary *O'Rourke.* No.

Mr. *Poliquin.* Thank you, sir. I yield back my time. Ten seconds, Mr. Chairman.

The *Chairman.* I thank the gentleman for yielding. Mr. Lamb, you are recognized for one minute.

Mr. *Lamb.* Question about the risk score when it comes to opioid abuse risk. I think that was you, Doctor, that talked about that. Can you just tell me who created that score and a little bit more about the criteria, as much as you can in this short time frame?

Dr. *Zenooz.* Sure. I cannot remember the name of the company that Cerner uses, so I will have to take that for the record. VA internally has its own risk scoring system. We will be evaluating to see what efficiencies we can take out of that system and incorporate it into the Cerner system.

But what we have seen so far is that all of the PDMPs

that participate--all of the states that participate in the PDMPs are available to the system to aggregate and create the risk score. And the military health system, if they participate, or if they share data with--when they share data with the VA, will be aggregated and incorporated into that scoring system.

Mr. *Lamb.* Got it. If you wouldn't mind just following up and letting me know who it was that created that, I would appreciate it.

Dr. *Zenooz.* Absolutely.

Mr. *Lamb.* Thank you, Mr. Chairman. I yield back.

The *Chairman.* I thank the gentleman for yielding and there are no further questions. So Mr. Secretary and Dr. Bono, you--thank you for being here. It has been very helpful and very information and you are now excused. Thank you.

The *Chairman.* On the second panel, we have again Mr. John Windom and Mr. John Short and Dr. Zenooz, representing the VA. They are accompanied by Mr. Zane Burke, president of Cerner Corporation. And on the panel, we also have Dr. David Powner, director of IT Management Issues for the Government Accountability Office.

For those of you all who have not been sworn in, would you please rise and raise your right hand?

[Witnesses sworn.]

The *Chairman.* Let the record reflect that the witnesses have answered in the affirmative. Mr. Powner, you are recognized for five minutes.

TESTIMONY OF DAVID POWNER, DIRECTOR OF IT MANAGEMENT ISSUES U.S. GOVERNMENT ACCOUNTABILITY OFFICE.

Mr. *Powner.* Chairman Roe, Ranking Member Walz, and members of the committee, thank you for inviting GAO to testify on VA's EHR modernization and our ongoing work for this committee looking at VistA.

Our review is looking at both the cost to operate and maintain VistA and exactly what VistA is. Understanding the costs are important since VistA will be around until EHRM solution is fully employed. Knowing the full scope is important to inform the planning of the EHR modernization.

This morning I will cover the cost of VistA, what VistA is, and provide suggestions as the VA proceeds forward with the EHR modernization.

The VA currently spends about a billion dollars a year to operate, maintain, and enhance VistA. Major components of these costs include interoperability efforts, electronic health records, and infrastructure costs for hosting and storage. Tallying these costs is not an easy exercise since it entails contracts, internal labor, major programs, and

components funded by both VHA and OINT. These detailed costs over the past three fiscal years are provided in my written statement.

Now turning to what VistA is. Understanding the full scope of VistA is essential to effectively planning for the new system. There is no single source that fully defines the scope of VistA. However, VA has undertaken several analysis to better understand it. One that I would like to highlight is their application view of their health IT environment.

There are over 330 applications that support health care delivery at a VA medical center. About 128 of these are identified as VistA applications and 119 have similar functionality to the Cerner solution. The bottom line here is that it is important to know how much of VistA the Cerner solution will replace. Some analysis say around 90 percent. The application view suggests a much lower percentage.

Mr. Chairman, we want to avoid a situation down the road where there are surprises as to exactly what the Cerner solution is replacing. This understanding of VistA is further complicated by unknowns caused by individual facility customization that has occurred over the years.

Now turning to the 10 year, $10 billion Cerner contract that was awarded last month. It is important to note, as mentioned prior, that the EHR program is expected to cost about $16 billion because VA estimates about $5.8 billion for project management support and infrastructure over the 10 years. Not included in the $16 billion are all internal government employee costs. So the 10 year price tag is even higher.

I want to be clear here that going with DOD Solution is the right move, but given the complexity and cost, and the fact that both VA healthcare and IT acquisitions and operations are both on GAO's high risk list, this acquisition needs to be effectively managed.

My written statement highlights several detailed practices that we have seen applied to successful IT acquisitions that are important to the EHR program going forward. But there are some big ticket items that are critical to pulling this off. These are number one congressional oversight. We commend this committee for proactively establishing the technology modernization subcommittee. Continuous oversight of the EHR program will

make a different in ensuring that it is executing according to plans and budgets.

Number two, executive office of the President involvement. The White House involvement can elevate the importance in accountability here. The current administration has several EOP offices who involvement can help. We also think that the federal CIO's involvement is important.

Number three, governance in building a robust program office. Both interagency governance with DOD, as planned, as is the governance process that reports the VA's deputy secretary. It is important that this governance structure has a strong CIO role and that it ensure better collaboration between VHA and the CIO shop than has historically occurred.

Also, we have seen governance structures embed the contractor to create better transparency and teamwork. In addition, if a governing structure is robust and open to risk. We have also seen congressional and GAO staff welcome to attend these meetings. We believe this is a best practice and frankly save agencies time in responding to oversight questions.

Number four, business change management. A major issue with federal agencies is adopting commercial products and their unwillingness to change their business processes. For the EHR initiative, this entails clinical work flows. This is definitely a high risk area for VA.

And finally number five, building an appropriate cybersecurity measures and optimizing infrastructure. VA has cyber challenges that are important to this new EHR acquisition, including controls associated with network security and controls for monitoring systems hosted by contractors. Regarding infrastructure, these costs appear exceptionally high with the VistA program and VA needs to consider a more comprehensive data center optimization strategy that coincides with their new EHRM approach.

Mr. Chairman, this concludes my statement. I look forward to your questions.

[The testimony of David Powner, appears on p.]

**********INSERT**********

The *Chairman.* Thank you very much for your testimony. Mr. Burke, you are recognized for five minutes. We will go to questions Bill tells me. So I will go to questions.

First of all, I would like to start and I appreciate you all being here. And Mr. Burke, help me with some back of the envelope math here. The EHR modernization is going to cost almost $16 billion over 10 years, $1.58 billion per year. According to the GAO, the cost to run VistA is about $1 billion a year.

And again I asked this a minute and the Secretary couldn't tell us. What does the cost to run the Cerner EHR look like after the 10 year implementation? And does the total cost of Cerner drop below the billion a year, is that just going to be the cost to keeping this up and running? Or does anybody know that answer yet?

Mr. *Burke.* Mr. Chairman, thank you for conducting this hearing and our participation in it. As it relates to that question, we do believe that the costs will be less than the ongoing costs of the current VistA system. Several of those items that reflect some savings will be around the fact that today the VistA instances--over a hundred different

instances. You have a number of different training. The people, the upgrades, the updates, those kinds of things are significantly more expensive in those models. So we do anticipate taxpayer savings over time.

The *Chairman.* Well, 10 years is a long time. I was at Oak Ridge national labs a couple of weeks ago. They spent $200 million on a supercomputer in 1996. They told me that now your iPhone has as much computing power as that 200. So in 10 years, who knows how much the technology is going to--it is going to change dramatically. I can tell you from the rollout that DOD is doing right now in the northwest and what VA is starting in October is going to look totally different in 2028.

So I think there will be added cost and they--I don't see how it couldn't be more cost. Dr. Zenooz, one of the things that--and again, Dr. Dunn and I will continue to go back to this, is how important it is to make an EA--I hear this all the time, to make the clinicians job easier and more efficient instead of just--just punching boxes and entering data.

You know, that is what we feel like we are now. And I

understand that in some respects and VistA, believe it or not, people kind of liked that system. They are used to it. So we are asking the clinicians and people, 380,000 people to make a gigantic change in the way they do their business right now.

And is it designed around how people want to do things, not necessarily the most efficient way. And you have to configure the EHR from the ground up, not the top down. Dr. Dunn just mentioned that. And that starts by collecting input from really thousands of people who you--nurses, and doctors, and supply technicians, and all that, scheduling people. All of those have ideas and many of them good ideas. Are we doing that or are we just turning that into a check the box and we are going to go on and do exactly what Cerner has already laid out.

Which is it doing to be?

Dr. *Zenooz.* Thank you so much. As the -- in my role as the functional champion, change management obviously is the number one priority for me. And I recognize as a clinician that burnout because of checking boxes, as you say, is a key reason why people get frustrated with this process.

So we have ensured from the very beginning that we have front line folks involved in this process, in the requirements process. So not just the doctors, and the nurses, and the dentists, but also the medical support assistants, the schedulers, etcetera, supply chain folks sitting at the table with us to put in the requirements for this process.

They will be integral in designing the work flows to ensure that it is both efficient and meets their needs. I mean, we have to look forward to make sure that we are no just doing things current state, because we understand in VA that there are efficiencies to be gained. But at the same time, we will make sure that we take in best practices and work with our front line folks to design the system that works for VA.

The *Chairman.* What we are doing is we are making data entry people out of our clinicians. And we have--we are doing, I think, a pilot program now on scribes just to help let the doctors and nurses be doctors and nurses. And then a few years--several years ago when my wife was critically ill in the hospital and I got to sit there and watch a system,

not as a physician going around making rounds, but as a patient, I saw the clinicians and the nurses spend more time entering data than actually at the bedside.

That is not good. That is where technology has not helped us. It has not made quality better. It has not done any of that. So I would strongly encourage you to make sure that you include al of these people that are going to be using it.

And then the other thing, I think, was said by the Admiral Bono was that you have to train people on what you are going to use. I don't think DOD actually did that to start with. And you have to have them well trained because it is going to be a very anxiety-producing incident when we roll this out. The next 18 months, if I am at--if I am in the northeast, if I am in Washington State and I am at a VA, I might want to transfer to Mountain Home.

So I now yield to Mr. Walz.

Mr. *Walz.* And thank you all for being here. Mr. Powner, you talk about the governance board. It sounds like you are pretty confidant they are standing that up and you are--my request was is that you be involved as you say you

are and that you be involved in those quarterly progress reports. Do you feel at this point in time that is one track and you feel comfortable being part of that team?

Mr. *Powner.* Yes, we feel that is important. We have experience doing this with other modernization efforts too, when you look at some of the things that have gone on like at IRS and other agencies. We have been embedded in some of those governance processes. And, again, if you are confident in your governance process and I have talked to Mr. Windom about this, he is confident, and I think he welcomes us there. I think it -- it saves time for everyone.

Mr. *Walz.* This is really encouraging and I think that is where you saw the line of questioning. There is always another partner at the desk with us on this because oftentimes you ask us to implement the IG findings, the IG that does that. It is obvious that the IG is not a welcome partner at this point in time. There is open hostility. It is no secret to anyone here. And that is the point we are trying to get you.

In your experience, how important is it from those IGIs in these types of projects and implementation?

Mr. *Powner.* Well, I think both GAO and IGs need to have access to the right information and timely. I will say from GAO's perspective, we get access. Historically, it has been slow. Okay? We get data but it is slow. But I will say Mr. Short and Mr. Windom, they have been more responsive than others in the past, but we--in needs to be timely. We don't have time to be slow here.

And the bottom line is you got it or not, don't create it.

Mr. *Walz.* This is a--

Mr. *Powner.* If you are creating it, you are not managing it.

Mr. *Walz.* Yes, this is a new dynamic, though. It is not just a slowness or whatever. There is a reinterpretation of what we have to do and what we don't have to do. There is a whole new dynamic at play here with the secretary basically saying I am in charge with you and I will tell you when you investigate. That is what is different here.

And at the start of a project like this, I cannot stress enough that I think that is your fatal flaw if this is not fixed, addressed, and cleared up immediately because so many

things have come out of that IG. So I appreciate you being there.

Mr. Burke, congratulations. You got a $10 billion contract and now you have got a whole bunch of partners. So we are here to ask how you interface on this. How do you see the role of this new subcommittee that is set up with the responsibility to the veteran and the taxpayer, and you as a private entity that is providing a contract and a service to improve veterans' healthcare, to do is what is needed for our warriors, but rightfully so, you have a financial stake, as you should, to make this work? How do you view what we are setting up here and how that interaction would work and how you would view our request for information in the appropriate way to find out where we are at.

Mr. *Burke.* We view it as part of an appropriate governance model. So we are very excited actually about this subcommittee and think that it is a great approach. Our obligation is to serve the veterans at the end of the day. And we want to bring seamless care, help the clinicians who serve those veterans, and have them have the most effective means possible to do that. And so we view that very

positively.

Mr. *Walz.* I really appreciate that. And I know your team. This was months ago, way before this was going when I wanted to come up to speed on different systems and you set really good people out who sat down with a layman to look at how this would work with myself. Dr. Roe knows a lot more about this and understands this. I represent the area of Southern Minnesota where the Mayo Clinic is. So I am familiar with their electronic record, their switch to Epic, and looking at all of that.

So I said from the very beginning, though, I really want to make note that your team was very open, they were there. They were talking about things that worked and didn't work. They were projecting ahead of potential problems that may arise. And I think that openness, the transparency, that seeing us as partners in different eyes on this to the same goal is really healthy. So I am grateful for that and I yield back.

The *Chairman.* I thank the gentleman for yielding. Dr. Dunn, you are recognized.

Mr. *Dunn.* Thank you, Mr. Chairman. Mr. Burke,

welcome to our panel. I look forward to working with you. I am the Chairman of VA Health subcommittee, so I think we will be seeing a lot of each other over the next few years.

What--I want to address a question of work flow counsels right now that are doing the mapping and the work flow standardization. What is Cerner's interaction with them at this point?

Mr. *Burke.* We are just beginning that process. So the teams are coming together. The plan is basically we will work with the VA. And we will also bring other third party industry partners that are industry experts in that space and the VA will supply the leading folks on their side to be part of those counsels as we move forward.

Mr. *Dunn.* Okay. So you have an immense amount of experience with EHR's. I do too. I am one of your clients. I want to know how you are making--to Dr. Roe's point, how are we going to make this a not frustrating--a productive interface for the--for all of the clinicians: doctors, nurses, everybody. How do you do that? Because I can tell you, there is a lot of frustration.

Just as a point, last--two weeks ago there was an

article that came out and said that the average physician in America spends 53 hours a year just logging onto his EHR, 53 hours a year longing on. Help--make me feel better.

Mr. *Burke.* Well, first off here, and it is an appropriate question to ask is the process by which we will go forward and come up with best practice. We will bring the best practice. The buy in from the clinicians is incredibly important. We will do--together, we are doing current state analysis. So what do the clinicians have today and then do a crosswalk, what will it look like in the future.

So the set of expectations, we understand if they already have certain capabilities. Will they get enhanced capabilities. Are there elements where we will be challenged? We try to understand those kind of things up-front so that we can do that work, along with those best practice elements.

The other side that I would look at is as a company, our number one priority is the clinician experience. And unfortunately, EHRs have become really box ticking exercises for the clinicians. And it is the little--it has reduced the time with the patients overall. And our obligation as an

industry is to come forward with other technologies, which make it where people--where the clinicians can actually spend more time with the patients. It can be much more natural in the work flow and those kind of things.

And over time, what the VA has done has really contracted for those upgrades to be part of the solution set. So as you think about the go forward spaces, absolutely the EHR of today will be different--the EHR in the future, the VA is contracted for those upgrades. That is part of the process--

Mr. *Dunn.* Do you currently have biometric log ons?

Mr. *Burke.* That is part of the capabilities.

Mr. *Dunn.* So that can if it works, you can make that a lot faster?

Mr. *Burke.* Correct.

Mr. *Dunn.* Of the $10 billion contract, how much is hardware and how much is software?

Mr. *Burke.* I am sorry, sir. I would have to get back to you on exactly--that is--

Mr. *Dunn.* Does it include hardware?

Mr. *Windom.* Sir, we have acquired software and

related services from Cerner Corporation. Things like maintenance, software updates, installation--

Mr. *Dunn.* I am asking, you know, do the laptops and things, are they included in that?

Mr. *Windom.* That is part of our infrastructure buy. Cerner is not buying those.

Mr. *Dunn.* So outside of the $10 billion, there is a whole lot of computers to be bought?

Mr. *Windom.* That is why the $16 billion number, $10 billion is allocated to Cerner--

Mr. *Dunn.* Okay, so it is in the other $5.8 billion.

Mr. *Windom.* --for the Cerner contract. $4.59 billion for infrastructure upgrades that would include that type of hardware and then 1.2 billion for program management oversight.

Mr. *Dunn.* I was just trying to get a sense of where that was located. That is very good. So I am getting short on time, but I do want to leave--Mr. Burke, we are happy to work with your people. We are going to be working with them. We want to work with them up-front. We want to make sure that you have got a system that is palatable to the people

who are actually using it.

And I know you know in your business that is really not a very common thing. We all have a love/hate relationship with REHRs. I have spent literally millions of dollars on EHRs. And I was kind of hoping I wouldn't have to do that when I got to Congress, but now I went from millions to billions.

Mr. Chairman, I yield back.

The *Chairman.* I was going to say you are spending billions now, not millions. Mr. Takano, you are recognized for five minutes.

Mr. *Takano.* Thank you, Mr. Chairman. Mr. Powner, you in the opening testimony said something about the percentage of VistA that needed to be replaced or addressed varied, can you expound on that a little more because I want to understand what you are saying?

Mr. *Powner.* Yes. So there is a couple different views when you look at what VistA is. And you can define it in what is called modules. And the module view says that the Cerner Solution will replace about 90 percent of what VistA is. But if you take an application view, it is much less.

So that is why it is a little confusing. I don't have an exact number for you and I do think the VA has attempted to look at this.

But again, I think what is very clear here is similar to how Mr. Windom just answered this question. What is in the Cerner contract and what isn't? And then what is in the $5.8 billion? You don't want surprises that you have got $10 billion here and $5.8 billion here to cover infrastructure and program management and you find out there is another $2 billion outside of that to implement the solution.

That is still a little fuzzy in our mind. We have a report that we are currently working on for this committee that we will be hoping to provide some more clarity on that.

Mr. *Takano.* Do you believe you--within GAO have the requisite expertise, the numbers of experts to be able to perform this analysis?

Mr. *Powner.* That analysis, no. We are not performing--well, we are relying on VA's analysis on the specific applications and modules. But I have got experts that could say whether that analysis that VA is conducting is appropriate or not, yes.

Mr. *Takano.* And do we--do they believe that VA has the resources, the personnel?

Mr. *Powner.* Yes, they have got the resources and the personnel. The problem is the--they have got a lot of unknowns because of the customization. I mean, I think it is very unclear. The best way to characterize it, there are all of these unknowns and how much of those--you don't know what you don't know. And when these specific site reviews that are currently ongoing are going to shed a lot more light on that.

Mr. *Takano.* So there is kind of a scan of all of the different sites and what individual customizations occur in those sites and--

Mr. *Powner.* Yes, exactly.

Mr. *Takano.* You said it could be up to 90 percent, what is the other view? How much--

Mr. *Powner.* Well, the other view is like in the 50 percent range. But again, we think that application view and tells a little more than VistA, so it is hard to compare the two. But I will get back to this question about long-term post 10 years about the O&M cost. I sure hope that it is a

hell of a lot less than the $1 billion that we currently spend.

We have got standardization, we won't have an old language. And we can save a lot of money in the hosting arena. I can tell you the data center optimization initiative that the federal government undertook, VA is one of the worst agencies on consolidating and optimizing their data centers. This is an opportunity to do that right with the Cerner implementation.

Mr. *Takano.* And so on balance, you believe--you stand by the decision to go with the, as you said, DOD's solution, right? I mean, there were people who were advocating--

Mr. *Powner.* No, we advocate go with a common solution and go with a commercial product. We have advocated that all along because you have got to get there eventually or you are--VistA, it is just long-term it is going to be more and more to maintain.

Mr. *Takano.* Mr. Burke, I know that the emphasis, and my colleagues were all excited about the potential of integrating to interoperable degree these systems--the VA system with the DOD system. I am also concerned about the

interoperability with the non-VA providers because that is a significant part of what we do.

And I am concerned about the idea of portability of data, patient data. And I think viably that data belongs to the patient. But I don't believe that is how even the private sector operates, that we have proprietary behavior among the other EHRs out there. Is this an opportunity for the VA to be a leader in this case? And I will just stop and let you comment on what I have raised here.

Mr. *Burke.* I appreciate the question. It is absolutely a space where the VA can be a--is--we believe will lead the country on this side and both the DOD will help in that perspective.

I have a personal belief that is the same as your, is that the personal health record ought to be mine, ought to be yours. As part of that, we will actually be offering personal health record for free to the--in terms of any one of our clients in that space. And we announced that probably nine months ago, in that realm. We participate in all of the HIEs and all the connections. We also believe that other technologies will be written, that will need to go on top of

our platform. And so making our platform more open in that perspective is also important.

So interoperability/openness is part of the foundational elements of the contract and really what we anticipate doing both with the DOD and the VA.

Mr. *Takano.* Mr. Chairman, I look forward to this new subcommittee you are setting forward because I think we can help the American people understand what is at stake here in terms of the potential--greater portability and the VA's ability to leverage its position with regard to the other EHR systems that are out there. I yield back.

The *Chairman.* Thank you for yielding. Mr. Powner, I hope you are right, but my experience in the private world was that I always spent more and more on technology, not less.

Mr. Banks, you are recognized.

Mr. *Banks.* Thank you, Mr. Chairman. Mr. Windom, how did you select the Spokane, Seattle, and American Lakes as your initial implementation sites? And was this because the defense health agency had already selected nearby sites or did VA reach this conclusion independently?

Mr. *Windom.* We had an ongoing negotiation with Cerner Corporation as part of our contract award actions that took place this past May. And so as we sit down and we negotiate parameters that are going to be cost drivers and variables within the framework of that negotiation, the economies of scale associated with labor were one. DOD was in that region.

Negotiating on behalf of the taxpayers and our veterans, I am always conscious of what we are going to pay, especially and still with an eye on not compromising the care of--to our veterans. So economies of scales of labor were introduced by Cerner Corporation and going to the Pacific Northwest.

In addition, that foundational issue of interoperability. If we were in the region with DOD, that is a quick way to test whether our interoperability strategies work. And so being in that same region, to me, demonstrated one of the major premises of the D&F, the determination and findings, that were at the forefront of our efforts, which was interoperability.

So we look forward to demonstrating that in the Pacific Northwest once we deploy there. But that is part of the

terms and conditions that we agreed to and with a focus on economies of scale with labor and also interoperability objectives, sir.

Mr. *Banks.* Have you been to each of the initial implementation sites?

Mr. *Windom.* Sir, I had the fortunate opportunity to lead the DOD effort. I was the program manager overseeing that while I was still on active duty in the Navy, so I am now on the VA side. So the answer to your question is I have been to those sites, I have--

Mr. *Banks.* But not since they were selected as the initial implementation sites?

Mr. *Windom.* Not since they have been selected, not since I have been working with the VA, I have not been to those sites.

Mr. *Banks.* What about our other VA guests, have you been to all three?

Mr. *Windom.* Mr. Short has been there.

Mr. *Banks.* Mr. Short?

Mr. *Short.* I was at the Fairchild go-live when--

Mr. *Banks.* And Doctor?

Dr. *Zenooz.* I have been to other sites in that area, but the particular site. I have worked in several VAs--

Mr. *Banks.* So you have not been to the initial implementation sites?

Dr. *Zenooz.* Not to the initial sites. I have visited Seattle, the city, the Seattle VAMC, but not in this capacity.

Mr. *Banks.* Okay. So, I just want to clarify, Mr. Short, you have been to the initial implementation sites since they have been the initial implementation sites?

Mr. *Short.* The DOD sites when they went live.

Mr. *Banks.* The DOD sites.

Mr. *Short.* We went through them as they brought in new patients and processed them, and we went through their training facilities, their war room, went through all that.

Mr. *Banks.* Okay.

Mr. *Windom.* Sir, I just want to make sure I am clear. We just characterized our initial visits to the DOD sites.

Mr. *Banks.* I understand.

Mr. *Windom.* Our initial operating capability sites we have visited as part of our pre-screening efforts associated

with establishing them as the sites to be deployed to.

Mr. *Banks.* I apologize. I am easily confused, I suppose. So do you believe that the IT and clinical departments at these Medical Centers are sufficiently strong, or will the VA be making additional investments in them to prepare the implementation?

Mr. *Windom.* Sir, they deliver high-quality care today. I can't emphasize the change-management strategy that we are about to subject them to and how difficult that is, so I am going to defer to the clinician, because she has got the pulse of the people on the ground and she can give you more of a characterization.

Mr. *Banks.* Doctor?

Dr. *Zenooz.* Thank you. So we have been working with the VISN director in that area since the sites were selected and we have been working with them to ensure that they will have the staff that is required. We have identified change-management leaders on the ground, executives as well as informaticists that will be participating in this project. Several of the folks are involved on my team directly and have received the appropriate change-management training.

If we go to the--not if, when we go to the site review and identify any gaps, we intend to address that immediately, so that by the time of go-live, which is 18 months from October 1, they will be ready for what is coming.

Mr. *Banks.* Doctor, are there any discussions at all occurring about changing the implementation sites, to your knowledge?

Dr. *Zenooz.* I think we are always evaluating what is best. We have had several discussions to see if we should be looking at other sites, but we have always been talking about it from day one to ensure that we are going to the right place. As we evaluate leadership, informatics leadership, IT leadership, executive leadership--

Mr. *Banks.* So, yes or no, are there conversations about changing the implementation sites?

Dr. *Zenooz.* We have had these conversations since day one. So, yes, we are continually evaluating, absolutely.

Mr. *Banks.* Okay, my time has expired.

The *Chairman.* Thank you.

Ms. Brownley, you are recognized.

Ms. *Brownley.* Thank you, Mr. Chairman.

Mr. Burke, I wanted to ask you, this might be an elementary question, but it relates to the interoperability issue and the concern about being compatible in the community. It seems to me that Cerner, Epic, nobody has been able to achieve interoperability so far. So it seems to me that--I get that we will be able to communicate with DOD, being the same system, but to be able to go out and communicate with the other systems out in the universe, it seems to me like we are going to have to create new software, a new system that has not been identified yet to be able to do that, so we are going to have to invent somehow to make that possible.

Mr. *Burke.* It is a great question. Historically speaking, there were a lack of standards as it related to data flowing between systems, and so there were some technical elements between different systems. And there is, interestingly, almost 200 different EHRs out there between the ambulatory side and the acute side. And beyond just the ambulatory and acute, there is the full continuum of care that ultimately we need to connect.

There has been quite an evolution of those standards,

which has been very helpful, and part of that has been part of our conversations as we paused in the contracting process was to go through that evolution and codify that in the contract to say what is possible today and then what is the art of the future tomorrow. And so there are parts of those elements which are let's go implement the things that we can go do today and then there are other elements in there that we are contractually obligated on a go-forward basis for enhanced interoperability as we move forward.

So I would look at it and say that technically speaking there isn't as big a challenge on interoperability today as there once was from a technical perspective. There are still business processes within the communities that create a different experience on the availability of that information, one of those is who actually does own the personal health record itself. And so that is one of the reasons why we are offering a personal health record for free for any of our clients, anybody that wants to do that, because we think that is ultimately one of the ways we move past some of those business model challenges in that space.

So it is a very complex arena. I can assure you that we

have spent a significant amount of time on that. We are committed to this process and we actually do think it is an opportunity for the VA and the DOD to lead in the space, and I am convinced that we have the capabilities to go forward and do that. And VA also has the funding mechanisms by which to really enhance the community to want to participate in the process as well.

Ms. *Brownley.* So to sort of break those barriers, if you will, is it going to require the cooperation of the other electronic health records out there to be able to get to the ultimate, as you said, the art of the future? Is it going to--is that the requirement or is it, you know, some really IT person back in a room creating a system that is going to, you know, encompass all these other systems out there to make it compatible?

Mr. *Burke.* Today there is an organization called CommonWell, which is a not-for-profit interoperability group that actually is committed to standards, which is it has over 50-plus different members from the EHR community that have agreed to code their solutions to a certain spec. And so that has been an industry-led element, we were one of the

founding members of that organization.

In addition to that, that group, CommonWell, is what is called a Care Quality Implementer. So it is a second group that really has a set of standards which connects my major competitor and as they are not part of the CommonWell standard, but they are Care Quality standard.

So CommonWell will do the implementation, so it should connect all those pieces there. It will--

Ms. *Brownley.* But if they don't succeed, we don't succeed?

Mr. *Burke.* That is part of the dynamic of the interoperability side. The pressure side coming from the providers and their clients will be quite significant in that--and I am in a spot where I think I should defer to Ash and let her communicate as some of the sticks that the VA has for compelling some of that in the community care.

The *Chairman.* Just to--

Ms. *Brownley.* My time is up.

The *Chairman.* --let you know, one of the big mistakes we made in electronic health record was that we didn't make them where there is the same platform look. Everybody,

whether it is Cerner or Epic or Allscripts or whomever, they all silo their information, because information is money. And I do understand--

Ms. *Brownley.* They have to know how we are actually going to do this--

The *Chairman.* Yeah, and it is incredibly important to be able to share this data. And I agree with you all, the person's health record is whomever the person's health record is. It is yours, Mark, or mine or whomever's record, I totally agree that is who owns it.

Mr. Poliquin, you are recognized.

Mr. *Poliquin.* Thank you, Mr. Chairman.

Doctor, use some of my time right now to go ahead and answer your question or answer the question that Mr. Burke threw over to you.

Dr. *Zenooz.* Absolutely. Interoperability is not an end state, it requires constant care and maintenance, and it is not just you get to a certain data element or you share something and it is done. Users are going to continually ask for more and more things to be shared for the providers to provide adequate care and patients are going to want that

data available to them.

For that to be possible, I think there are a couple of different elements that you need to address, one is the technology. As technology advances, we need to ensure that VA keeps up, and it is our intent and part of our contract to keep up with that through innovation, through adoption, et cetera. Number two is policy and legislation, which is very important. I know that Congress had pushed forward on information blocking to ensure that that ends, that we share more information across the system, but obviously that can be expanded, as you have said. And, number three, I think the VA will participate and engage directly with the Office of Community Care and the Community Care networks that we contract with to ensure that we get as much information as possible. And not just limited to certain data elements, whether it is allergies or medications, et cetera, that we get as much information as we can and need to provide the adequate care that is necessary.

So I think it is a three-pronged approach.

Mr. *Poliquin.* Thank you, Doctor, very much.

Mr. Burke, congratulations for your company winning a

$10 billion contract over a 10-year period of time. Your job, and you know this better than I do, is to deliver a project that works, on budget and early, and I am going to be one of the people on the committee that is going to hold you accountable and everybody else that is involved.

That being said, I would love to have you comment on this, sir, if you don't mind. I think you have two problems, one of which is convincing people that it is better for them to use this instead of a flip phone, that is one. That is the technology piece that I am sure you folks can get to.

And the second one is one I think is more significant and I would love to hear your comment on this, is how do you convince the people at one of the--arguably the largest bureaucracy in the world, or one of them, to do something differently that might, at least they might have the perception it is going to threaten their job. Because they have built these Legacy systems throughout our country that are incredibly expensive, they don't talk to each other, so our veterans are being hurt, but now you are asking them to do something entirely different, not only using different technology as time goes on and maybe now, but also

threatening the bureaucracies they have built up in the protection of their jobs. How do you tackle that problem?

Mr. *Burke.* Well, as you described, the technology works, it is just really these projects are very complex and this will be a significant undertaking, and all of these kinds of projects have some what I call white-knuckle moments in them and I would anticipate that this will have a handful of those.

What I do feel good about is that we have a governance model to address those and one of the key, you know, reasons for success or failure.

Mr. *Poliquin.* Give us an example.

Mr. *Burke.* Of when they work well?

Mr. *Poliquin.* Give us an example of how you are going to be asking one of the 385,000 employees at the VA to do something different that they will embrace, even though they might perceive that it threatens their job?

Mr. *Burke.* Right. It is a continual sales process, as I describe it, which is we legitimately go out and meet with those individual groups and you are actually continuing to sell them, here are the advantages. It is why it is

really critical we do this cross-walk properly.

We did have an opportunity as part of this contracting process to do something different than there was in the DOD process, because the DOD process was a response to a request. In this case, this was a direct to contract. It allowed us to work together for the past year to really learn and understand what each one of the--what really are the hot buttons here--

Mr. *Poliquin.* Now, the DOD is ahead of the VA in this whole scheme and how are they doing?

Mr. *Burke.* I believe that they are doing well. Like all complex projects--

Mr. *Poliquin.* Are they on time and on budget?

Mr. *Burke.* To date, they were on that side. We think we will be able to stay on time and on budget--

Mr. *Poliquin.* Good.

Mr. *Burke.* --as it relates to that and in that perspective. But I do feel like that the teams that we have put together and how we will go about the sales process and the collaboration will be effective here. It is critical we get the right people to the table. When these projects do

well, you have the key clinicians that people look to; when they don't do well, it is done by a committee, that it is not part of those that are seen as maybe the informal versus the formal leaders.

Mr. *Poliquin.* We wish you tremendous success, Mr. Burke, and everybody else involved. Thank you.

I yield back my one second of time.

The *Chairman.* I thank the gentleman for yielding back.

And just to show you how rapidly technology is changing, the new, the fastest new super-computer in the world at ORNL that calculates 200,000 trillion calculations per second, that is 10 to the 18th power. So that is how fast this technology is changing.

General Bergman, you are recognized.

Mr. *Bergman.* Well, given that bit of data, Mr. Chairman, I am going to reflect to you a bit of change that occurred about, oh, 18 to 20 years ago when we were designing the Joint Strike Fighter. And I had a chance to sit in a meeting where one of the initial design criteria was to design an entirely new aircraft around a 2,000-pound bomb.

Think about how backwards that was. Someone very wise at the meeting said, how about changing the bomb? We are designing an airplane here, not a bomb carrier.

And that is exactly what we are doing here in different ways. We are designing a system of systems that is going to be flexible enough to take advantage of changing technology. We have used the word change management here several times. Well, part of the change management is to manage the changes in technology so you stay ahead of the power curve as best you can.

And as it relates to my district, one of the serious considerations we have in technology is rural broadband. Okay? We think about this system that we are going to design has to work for all of our veterans and all of our providers in those remote areas that as we transition the entire country to rural broadband, we have to realize that we don't want to leave anyone or any area behind.

Now, Mr. Powner, how do you assess VA's readiness to standardize their clinical and administrative workflow, how ready are they to do that?

Mr. *Powner.* I think it is in its early stages right

now and I do think that is something that this tech subcommittee, I know it is a tech subcommittee, but it is almost like the technology, it probably isn't as hard as the standardizing the clinical workflows, and I think that tech subcommittee needs to have a hand-in-hand focus on that. Right now, it is in the early stages.

Mr. *Bergman.* So compare that to the task of mapping VistA?

Mr. *Powner.* I think mapping VistA is further on down the pike. Again, that is close to being finished with the work that we looked up on mapping VistA.

Mr. *Bergman.* Okay. Well, your written testimony mentions VA's present efforts to standardize VistA. Medical Centers have to request approval to alter their version of VistA and apparently there have been roughly 10,000 of these waiver requests in recent years. What can you tell me about these requests? What does a typical request entail?

Mr. *Powner.* So we don't have specific details on those requests, Congressman, but I will tell you this: there are thousands of those requests and that is too many when you start looking at the customization that needs to occur. And

that is the whole reason why we are going the route that we are going here--

Mr. *Bergman.* So would you consider--

Mr. *Powner.* --we need to control that. If there is any customization, it needs to be a waiver, and you really need to control it or deny it.

Mr. *Bergman.* So in some ways is this an attempt for the tail to wag the dog, we would like to do it our way here locally and we want to get a waiver because we don't like change?

Mr. *Powner.* Absolutely.

Mr. *Bergman.* Okay. So we need to, again, going back to build that culture that embraces the change necessary.

Doctor, VA's testimony states that its planning will be in full swing over the next 3 months, implementation begins October the 1st and is scheduled to finish in Spokane in March of 2020. Do you believe that is enough time to conduct those thorough site assessments, finish VistA mapping and map all the workflows, have we got enough time to do that?

Dr. *Zenooz.* Based on our discussions with several industry experts and bringing in those experts who in these

conversations we feel that that is adequate time for our workflow decisions and site reviews. We also have a partner that has done this at least 15,000 times. So, you know, I am hoping that Cerner, with all of their experience and expertise that they bring to the table, can add to this.

I think what really helps here is that we are not trying to customize things and we are trying to adopt--or we are adopting industry best practices and we are adopting what Cerner has already built in to ensure that it fits our model.

So I think there is adequate time for us, but of course, you know, we will be working with the committee very closely and keeping you appraised of our progress. If we feel that we need adequate time to evaluate or work on something or delay the process, I think that is absolutely okay on my end from a clinical perspective and I will be the first to speak up.

Mr. *Bergman.* Okay.

Dr. *Zenooz.* On the VistA mapping, I would defer to Mr. Short.

Mr. *Bergman.* Okay. In 17 seconds or less.

Mr. *Short.* On the VistA mapping, we have done a

couple different things. Right now we have identified all the functional clinical modules we are confident that Cerner will replace. The non-clinical modules that do other functionality, we have five of them left, we are still analyzing them.

Mr. *Bergman.* Okay, thank you.

Mr. Chairman, I yield back.

The *Chairman.* I thank the gentleman for yielding.

Mr. Short, I was about to--you were about to remind me of what one of my good friends who was the mayor of the county I lived in, retired now, George Jane said--he said, son, when you go to Congress, remember, you can't vote silence. I was about to ask you if you wanted to speak after almost 3 hours at this hearing.

Mr. *Short.* Thank you, sir.

The *Chairman.* So one question that--and we will just do a 2-minute lightning round here--that came up with the DOD application--and I know, Mr. Windom, you know the answer to this, but became so enamored with the security, as obviously we can, obviously cyber security we are very concerned with about protecting patients, it slowed the process down so much

that it became almost too cumbersome to use. I think that has been worked out and I think that is one of the scalable things that VA can learn from what DOD did, and I am glad you are where you are to sort of pass that information along. Am I correct or not?

Mr. *Windom.* Sir, I am going to defer one more time to the Chief Technology Officer, because he is my expert that we pay in that arena. And I think I have the answer, but I will let him give you the answer, if you don't mind, sir.

Mr. *Short.* DOD has been very successful in getting the latency--along with Cerner, getting the latency out of the system. VA is going to be incorporating the same security model the DOD put together that has a higher security posture than we normally have historically in VA to make sure everything is encrypted, secure perimeter-wise, and have been following that same model.

The *Chairman.* And, as I understand, that was one of the things that slowed the DOD implementation down initially. That should not slow VA down?

Mr. *Short.* That is correct. From the lessons learned, we are taking the best of that. I am in talks with

the DOD on security every week.

The *Chairman.* Thank you.

I yield now to Mr. Takano.

Mr. *Takano.* Mr. Burke, does the contract you have with VA also include responsibility for the Community Care interoperability?

Mr. *Burke.* It does, there are the standards for that Community Care interoperability, yes, sir.

Mr. *Takano.* And do you know on the DOD side whether the Cerner contract with DOD, it covers the internal medical operations, as well as TRICARE and that sort of thing? Because TRICARE is going to, you know--

Mr. *Windom.* Sir, we can take that for the record. We don't really want to speak on behalf of DOD, if we--

Mr. *Takano.* Okay, fine. Mr. Burke, we started to get into a conversation with Ms. Brownley about the sticks that the VA might have in order to compel the other EHRs out there to kind of meet VA standards, and you were about to defer to the Doctor to talk about that. Could you comment on the possible sticks?

Mr. *Burke.* Are--Doctor--

Mr. *Takano.* Either you or the Doctor.

Dr. *Zenooz.* I will just to make a comment quickly that, you know, I think the big thing on our end is user adoption, it is measuring to ensure that our users are actually using it and embracing the new technology to improve their work. And we have several ways to monitor that through things that we are purchasing in Cerner, several tools and dashboards. And we will continue to do that if we feel that it is inadequate training or we need better training--

Mr. *Takano.* What I am getting at is that the Community Care providers, that obviously we have provider agreements that we have with them and that we could through those provider agreements leverage the interoperability and the standards that they must adopt in order to meet VA's. I don't think it is fair we compare VA care to Community Care without comparing apples to apples and having equivalent transparency, is what I am getting at.

Dr. Burke, do you want to--or Mr. Burke?

Mr. *Burke.* The reimbursement piece from the VA and the Community Care is the important, what I refer to as stick. It is basically the VA can compel those organizations

to at least meet some of the data standards and the transaction elements, and that is what we are looking for on some of the business side from a provider perspective.

So, technically speaking, I feel confident that actually the industry is moving towards the right pieces around interoperability. It will be about how we get the rest of the ecosystem of health care to participate. And so what I am referring to specifically is some of the reimbursement elements of the VA as they engage with those Community Care providers.

Mr. *Takano.* Well, thank you.

I yield back, Mr. Chairman. Sorry for going over.

The *Chairman.* Okay, I appreciate the gentleman for yielding. And I will now yield to you if you have any closing comments.

Mr. *Takano.* Mr. Chairman, let me just say that I agree with you, I feel a sense of trepidation about the amount of money that we are about to expend on this project. I also certainly hope, along with the GAO, that the ongoing costs after full implementation is going to be far less than the billion dollars we are spending to maintain VistA. And

there are plenty of people out there watching from the IT world who regularly see the Government being hoodwinked by--well, people seeking an advantage, taking advantage of the Government's lesser ability to kind of judge these systems. This is one of the reasons why I have asked the Congress to actually re-fund, to fund again the Office of Technology Assessment, so that we are in a better position to be able to interact with technology issues.

But I also see with the VA being the largest health care provider in the country and our potential ability to interact with many, many private sector entities in health care, that we have a real chance to push issues like who owns medical data and to truly put that data in a portable position for the patient, and to really shine a light on the proprietary practices of health care systems.

The VA is publicly owned and is therefore in many ways far more publicly accountable, and I think we have an opportunity to extend that accountability into the private sector. And, you know, that is my hope in this opportunity and that is why I want to make sure we get this right, because we have not only the ability to affect the health

care of veterans, but potentially all Americans through what we are trying to do here.

So I yield back.

The *Chairman.* I thank the gentleman for yielding.

Sorry, General Bergman, I missed you over there. You are recognized.

Mr. *Bergman.* Well, as a Marine, I spent a lot of time camouflage, so there is nothing wrong with that, nothing wrong with that.

Doctor, I would like to just follow up with you just one more time to dig a little deeper into the planning activities and the implementation. Do you have any triggers in place that is going to give you a sensing if the schedules are all of a sudden not matching or things are out of whack?

Mr. *Windom.* Sir, within the next 60 days from Cerner we have a multitude of deliverables, including an integrated master scheduling, an implementation plan, a change-management plan. We are reviewing those documents in earnest, so we are going to make sure we apply the appropriate rigor.

Mr. *Bergman.* Let me ask you the question--

Mr. *Windom.* Yes, sir.

Mr. *Bergman.* --a different way. You have got all the documents, you have got everything, is there anything in place to--when a red--call it a dashboard, all of a sudden it goes from green to red--

Mr. *Windom.* Yes, sir.

Mr. *Bergman.* --you know, is there anything in place, that is all your documents, the interplay between all the things you are doing--

Mr. *Windom.* Yes, sir.

Mr. *Bergman.* --to all of a sudden raise a flag?

Mr. *Windom.* Yes, sir. The risk management plan that we manage captures a multitude of risks that we think exist throughout the program. Red flags, yellow flags, green flags are all being monitored to assess whether we have a problem. We want to be preemptive and proactive. We have got a team of experts, both technical and clinical, to support that. And so we will be ready to respond, sir.

Our success revolves around program management oversight and picking the right partner; we think we have both and so we are ready to execute.

Mr. *Bergman.* In terms of--I have got 23 seconds--in terms of an airline flight from takeoff to cruise to touchdown, where are you?

Mr. *Windom.* I would say on the runway, sir.

Mr. *Bergman.* Okay.

Mr. *Windom.* On the runway, yes, sir.

Mr. *Bergman.* Very good. I yield back.

The *Chairman.* That is a very good question.

You know, at the end of the day, I am going to simplify this. This is obviously a highly technical thing we are doing. At the end of the day, all the patient wants to know is why did I come in and how am I doing. I mean, that is really why you came--any of us that go to the doctor, that is what you want to know, am I all right, did you find out what I need to know. And does this new tool we have allow us providers to easily access that information, give that simple answer to the question to you. That is a simplified why somebody goes to the doctor, why are you here today. At the end of the day, can we figure out what is wrong with you in simple terms, tell you what is wrong and how we are going to help you fix that.

And we are going to continue. As I was sitting down thinking about how enormous this project was, I know the little rollout we did in our practice was not the easiest thing we ever did, and this is an enormous rollout and it is going to take a team effort from everybody. And we are on the team with you. We are not here to fuss at you, we are here to try to make you successful, because ultimately it is about the quality of care we provide our veterans and our patients, and that is what it is all about.

And so we are going to have many of these and I thought standing up a separate, very small committee, probably we will have five members on that committee, that is all, and that is their only focus is to keep an eye on this and keep us on track, and find out where we get off track and how we can get back on.

I am going to head back out to the Northwest at some time in the fairly near future and get a look and see how it is looking, so that I can be up to speed in October when VA kicks this off.

I really appreciate all of you being here today. I know you saw how many of our committee members engaged in this

long hearing.

If there are no further questions, I ask unanimous consent that all members have 5 legislative days in which to revise and extend their remarks, and include extraneous material.

Without objection, so ordered.

The hearing is adjourned.

[Whereupon, at 12:49 p.m., the committee was adjourned.]