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VA-DOD SHARED MEDICAL RECORDS—20 YEARS AND WAITING

HEARING

BEFORE THE

SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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VA-DOD SHARED MEDICAL RECORDS—20 YEARS AND WAITING

WEDNESDAY, NOVEMBER 19, 2003

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC

The subcommittee met, pursuant to notice, at 10:30 a.m., in room 334, Cannon House Office Building, Hon. Steve Buyer (chairman of the subcommittee) presiding.

Present: Representatives Buyer, Bilirakis, Everett, Boozman, Evans, Filner, Hooley, and Udall.

OPENING STATEMENT OF CHAIRMAN BUYER

Mr. BUYER. Good morning. The Subcommittee on Oversight and Investigations on the Committee of Veterans' Affairs shall come to order.

This hearing is entitled, "The VA-DOD Shared Medical Records: 20 Years and Waiting." Since we currently have thousands of servicemembers who are transitioning from active duty to civilian, and who will need health care, and other veterans' benefits, this hearing cannot be more timely. I believe it is critical that VA and DOD share medical information to ensure the continuation of health care to returning soldiers, sailors, and marines, and airmen.

This is an essential component of the processing of VA claims for benefits to which the veteran may be entitled. It is very challenging for the VA to determine what is service-connected if the flow of information is not accessible and easily retrievable.

What we are left with are servicemembers with duplicate or incomplete medical records. Earlier this year, the President's Task Force to improve health care delivery for our nation's veterans issued its final report. The Task Force summarized its findings this way: The VA and DOD's responsibility for veterans' health begins as soon as an individual enters the Armed Forces. And please let me interject here that should be—that should also include pre-and post-deployment medical examinations.

The Task Force summary went on to say, collecting and capturing baseline medical information upon entry into the military and an interoperable, bidirectional, and standards-based electronic medical record is the first step in the process.

I intend to ask both the VA and DOD how these stated goals are being met, and what specific progress has been made in these three critical areas.

I understand that headway has finally been made on all of these issues regarding the setting of standards.

It is an established fact that technology exists today to accomplish the mission, and I will acknowledge that there have been—in fact, there has been movement in the last 14 months, perhaps even more so than the last 20 years.

However, the endgame is not yet in sight.

What we hope to learn today is what are the impressions of insurmountable obstacles that keep these two departments from accomplishing the goal that was first set back in 1982 by Public Law 97-174. The repeated question is always the same: Why is it taking so long, and when will VA-DOD have systems that can talk to each other?

Ever since the first Gulf War, I followed this issue with great interest because I believe it is our responsibility to ensure that we avoid the problems that the returning servicemembers face in the early 1990's, which made it very difficult for the VA to make determinations on the disability of claims.

Today, after some 20 years, and untold billions of dollars, we're going to hear how close that horizon is that will allow our men and women that have bravely served our country to have a seamless, electronic medical record that captures and documents all of the data on their deployment and other issues, such as nuclear, chemical, or biological exposures; medical care and conditions during the service to their country.

As I was reviewing all of the written testimony last night and this morning, I noted that DOD did not submit written testimony, and I find that unacceptable. And, in my first and only time as ever having been a Chairman, whether it was on the Armed Services Committee or on this Committee, have I ever confronted such a case.

General Farmer, I'm pleased that you're here today, but I am displeased that there is not written testimony, and I will 10 days to the Department of Defense to submit written testimony to back up the oral testimony for which you will give to the Committee.

And, General Farmer, if you disagree with that, we'll give you the opportunity when you testify to discuss that further.

At this point, I will yield to Ms. Hooley for any comments that she may have at this point.

OPENING STATEMENT OF HON. DARLENE HOOLEY

Ms. HOOLEY. Thank you, Mr. Chairman. Obviously, the concept of DOD-VA sharing is not a new idea, but it is an idea whose time has come. With servicemembers returning from missions abroad, and with the VA responsible in many circumstances for assuming some important aspects of veterans' health care, immediate transfer of personnel and medical data is more than just a convenience. It is a necessary to account for servicemembers in theatre, track their return, and assure that he appropriate care is tendered.

We do in each of our offices a lot of case work, and I cannot tell you how many members' veterans we work with who do not have their records. They don't know where they are. No one can find them. But to have, certainly have the ability to keep those records

electronically, and to transfer them is clearly important to every veteran.

Accumulating this information will also assist in tracking of emergent and long-term medical problems of returning veterans. This could be readily accomplished today electronically. It should be an important element of DOD-VA sharing. But its level of development is not always what this Committee had anticipated. The time for meaningful electronic DOD-VA sharing, the time has come.

Actually, it came in 1982, with Public Law 97-174, authorizing sharing activities between those two large agencies. So DOD-VA sharing is now of age. It turned 21. But this 21-year-old needs a lot of attention, and often more than a little encouragement. It cannot yet run nor even walk swiftly. At age 21, its performance is close to that in its developmental childhood, not yet possessing a two-way vocabulary that fully realizes electronic medical record transfer or the significant transfer of personnel data between two agencies that individually have far more robust data systems already in place in these areas.

As Subcommittee clinicians to the body of law wishing to determine why this 21-year-old is not performing, we must ascertain if it now has the ability to do what we ask of it regarding electronic medical record transfers and other IT sharing issues. If the problem is in the maturity of the design of the DOD-VA sharing concept, we must be patient and wait for it to mature and wait for performance.

But if we think the sharing concept is able to perform today, we must ask why it toddles behind the private sector in working out these basic sharing issues. If we determine that the ability to provide electronic medical records transfers and many other issues at the heart of the two-way data sharing between the agencies exist today, we must hold those agencies accountable for their non-performance. Lives are potentially at stake. And most certainly management efficiencies are on the line.

At previous hearings by this Subcommittee, we have taken testimony about what will happen regarding some program or agenda. We sometimes get a date or set a milestone, only to have agency priorities change and a sharing issue moved from the front of the parade of ideas to the back burner priority.

Twenty-one years of planning. Twenty-one years of promise. I ask what is the actual level of performance today regarding sharing of electronic medical and personnel data. The GAO statement offers us cause for hope, but the real performance questions must be answered by you and the stakeholders at field-level activities. It is their metrics that matter most.

In testimony during the May 17, 2000 hearing, both principals from DOD and VA, Ms. Gwen Brown and Dr. Garthwaite, testified regarding the Government computer-based patient project. The testimony was then in terms of what will happen and notes that the agencies had entered agreements to share.

The GAO tells us now that this precursor system to the current Federal Health Information Exchange is yielding one-way transfers of information today, and that's a good beginning. DOD-VA sharing was 18 years old at the time of that hearing.

A 1995 hearing on DOD/VA sharing included an agreement to develop joint and coordinated efforts with regard to developing telemedicine as a means to improve medicine and as a means to improve readiness and patient care and improve interoperability and interconnectivity between VA and DOD services.

This was a strong portend of electronic medical records transfers. DOD-VA sharing was about 13 years old.

In June of 1986 hearing, on implementation, Chairman Sonny Montgomery asked the DOD about its policy regarding the sharing of automatic data processing resources with VA. The DOD response to the number of working groups focused on sharing. A DOD-VA sharing was about three years old.

We still await the full two-way exchange of patient health information between the agencies in a meaningful and useful way to all field-level activities. We do note substantive recent progress toward this goal. We have asked for a single form, the form DD–214, to be electronically created, archived, and readily available to VA to facilitate a myriad of issues regarding VA benefits.

Is there technology to make the work available today? Is there anyone in this room who doubts that this is problematic today from a technical perspective. I think not.

Real progress will be indicated when appropriate people at VA are able to access this timely information electronically and nationwide.

Mr. Chairman, we have heard a litany of promises in the past on this and related sharing issues. Sometimes, there's progress. Sometimes, there's not.

The technology available to facilitate DOD-VA sharing regarding medical and personnel record transfers has improved dramatically since 1982, when it was just a vision.

The technology hurdles to achieve full two-way transfers are not difficult to overcome so long as the old cultural barriers to sharing between the agencies have been overcome.

If any remaining cultural barriers to this level of sharing are overcome, the problem related to technology will be minor.

I'm anxious to hear from our panel. Thank you.

Mr. BUYER. Thank you very much. On the outset, to set the tone for this hearing, it is not the intent of the Chair to be combative with any of the witnesses today. The ranking member in her testimony I think did a good job of setting the tone. President Bush, when he put together his Task Force to Improve Health Care Delivery for Our Nation's Veterans, one of the provisions, recommendation 3.1, VA and DOD should develop and deploy by Fiscal Year 2005, electronic medical records that are interoperable, bidirectional, and standards-based.

When the VA and DOD create separate systems, and we begin to mature them, and now we're trying to bring them together. We understand those key challenges, and this Committee will accept the oversight responsibility to make sure that the goals for which we are, I believe, in agreement and are congruent can be reached.

And that's the purpose of this hearing. And I want to find out where you are, and how are we going to get there. And the only time I think I'll ever raise my voice is if I ever sense excuses.

I now will recognize Ms. Linda Koontz, Director of the Information Management Issues, U.S. General Accounting Office, who will now be recognized. And, ma'am, would you please introduce who you have with you at the table.

STATEMENT OF LINDA D. KOONTZ, DIRECTOR, INFORMATION MANAGEMENT ISSUES, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY VALERIE MELVIN, ASSISTANT DIRECTOR

Ms. KOONTZ. Thank you. Mr. Chairman and members of the Subcommittee, thank you for inviting us to testify on actions of the Department of Veterans Affairs and the Department of Defense to achieve the ability to exchange patient health care data and create an electronic record for veterans and active duty personnel.

With me today is Valerie Melvin, Assistant Director, who is responsible for managing our work at VA and who will assist me in answering your questions.

VA and DOD, collectively, provided health care services to approximately 13 million veterans, military personnel, and dependents at a cost of about $47 billion in Fiscal Year 2002.

While in military status and later as veterans, many patients tend to be highly mobile, and, consequently their health records may be at multiple federal and non-federal medical facilities, both in and outside the United States. Further, with soldiers returning from various armed conflicts, having readily accessible data on active duty personnel and veterans is important to facilitate providing them with high-quality health care.

VA and DOD have been pursuing ways to share data in their health information systems and create electronic records since 1998, their actions following the President's call for the development of an interface to allow the two departments to share patient health information. Since undertaking this mission, however, the departments have faced considerable challenges, leading to repeated changes in the focus of their initiative and target dates for its accomplishment.

Our prior reports discussing the initiative noted disappointing progress, exacerbated in large part by inadequate accountability, poor oversight, and planning, which raised doubts about the departments' ability to achieve an electronic interface among their health care systems. When we last reported on the initiative in September 2002, DOD and VA had taken some actions aimed at strengthening their joint efforts. For example, they had clarified key roles and responsibilities for the initiative and begun executing near- and long-term strategies for achieving the electronic information exchange capability.

My statement today will discuss our observations regarding VA's and DOD's continued actions over the past year to further their implementation of the electronic information exchange, including an update on the status of and reported benefits of the near-term initiative, the Federal Health Information Exchange, and the departments' progress and challenges in achieving the longer term initiative, the HealthePeople (Federal).

The current one-way transfer of health information resulting from the departments' near-term solution represents a positive undertaking that has begun enabling information sharing between

DOD and VA. As part of the initiative, electronic health data from separated servicemembers contained in DOD's Composite Health Care System are being transmitted monthly to a repository, which VA clinicians access through the department's existing system. As a result, VA clinicians now have more readily accessible health data, such as laboratory, pharmacy, and radiology records, on almost 2 million patients and have noted the benefits of this current capability in improving health care delivery.

Realizing the departments' longer term strategy, HealthePeople (Federal) is farther out on the horizon, VA officials have stated that the departments are on schedule to provide limited capability for an electronic, two-way exchange of patient health information by the end of 2005. However, DOD and VA face significant challenges in implementing a full data exchange capability. Although a high-level strategy exists, the departments have not yet clearly articulated a common health information infrastructure and architecture to show how they intend to achieve the data exchange capability or what exactly they will be able to exchange by the end of 2005.

In addition, critical to achieving the two-way exchange will be completing the standardization of the clinical data that these departments plan to share. Without standardization, the task of sharing meaningful data is made more complex and may not prove successful.

Mr. Chairman, access to medical data that includes information on the entire lives of veterans and active duty personnel represents an enormous step toward enhanced and more efficient medical care. To their credit, VA and DOD have achieved short-term success by making DOD health care available to VA clinicians.

However, critical challenges must still be addressed to successfully implement the longer-term strategy. Unless these challenges are adequately resolved, the departments' goal of a virtual medical record based on a two-way exchange of data between VA and DOD may be at risk.

That concludes my statement. We would be happy to answer any questions that you might have.

[The prepared statement of Ms. Koontz appears on p. 45.]

Mr. BUYER. Excuse me, would you recognize who's sitting with you at the table, please?

Ms. KOONTZ. Pardon?

Mr. BUYER. Would you please recognize who's sitting with you at the table?

Ms. KOONTZ. Valerie Melvin, Assistant Director, GAO.

Mr. BUYER. Thank you, Valerie. To the Committee Clerks, prior to the introduction of our first witness or the first panel, I was remiss when I turned to the right. I did not see the ranking member of the Full Committee was here, who wished to give an opening statement. So, to make the public record clear, what I would prefer that you do is I'm going to recognize two members who would like to give an opening statement. They'll give their opening statement. Please insert that prior to the GAO's testimony when you develop the record. And then we'll seek regular order.

I now recognize Mr. Lane Evans for an opening statement.

OPENING STATEMENT OF HON. LANE EVANS

Mr. EVANS. Thank you, Mr. Chairman. I am pleased that you're holding this hearing. I was elected to Congress in the same year that this DOD/VA sharing was mandated by law. Over the years, the success of sharing has been a recurring theme on this Committee.

Whenever we research or view this issue in search of a cause for sharing problems, discussion often turns to organizational culture.

VA and DOD have always had opportunities to enhance effectiveness and services through sharing. Too often, they don't avail themselves of those opportunities, at least without a general nudge from somewhere.

Today's hearing involves the electronic medical records transfers. I'm pleased that progress has been made and that an information flow now exists from DOD to VA for some medical records.

Yet, timeliness, completeness, and bidirectional data flow limitations remain as problems.

It's not likely that these problems were caused by technological limitations. That they could not be solved, and could not be solved in a short order. It's just that some cultural barrier remains at the progress in this area. We need to explore this. I thank you, Mr. Chairman, for giving this time, and I yield back the balance of time to you.

Mr. BUYER. Thank you, Mr. Evans. Mr. Udall, you're now recognized for an opening statement.

Mr. UDALL. Thank you very much, Mr. Chairman. I don't have an opening statement. Pleasure to be here, and happy to go to the witnesses.

Mr. BUYER. Thank you. Ms. Koontz, in your testimony, you stated that our prior reports discussing the initiative noted disappointing progress, exasperated in large part inadequate accountability and poor planning and oversight, which raised doubts about the departments' ability to achieve an electronic interface among health information systems.

Give me your overall—I've read your report, but I just want to hear from your testimony orally, what's your report card on their overall efforts to these two departments?

Ms. KOONTZ. The near-term effort, the Federal Health Information Exchange, has clearly been a short-term success for both departments. And this occurred I think largely because both DOD and VA recognize the need for more accountability, better oversight, and better planning that they were able to execute this particular initiative, and by all reports this is working very well. VA clinicians are getting information that they never had before, and they find that the performance of the system is very quick. The data is accessible. It's what they need.

I think an assessment of the longer term effort remains more in question because we would like to see a more detailed plan, a more detailed architecture and infrastructure that would explain exactly how the interface is going to be accomplished.

Mr. BUYER. VA officials have stated that the departments are on schedule to provide a limited capability for an electronic two-way exchange of patient health information by the end of 2005. Do you

find their scheduled milestone realistic, and how did the VA, to you, define a limited capability?

Ms. KOONTZ. The 2005 date seems generally realistic. But you have to keep in mind that it is dependent on many, many variables, including both DOD's progress and VA's progress in developing their own systems. And when you look at what's going to be, it's not clear to us at this point exactly what capability is going to be provided at 2005. However, it will be limited by the fact that VA's data repository of health information won't be ready until 2006. It won't be completed until then. So in 2005, they're hoping that they would have enough capability to begin exchanging information. The capability at that time may also be limited by what extent standards are in place. As of right now, there is a laboratory results standard in place. But it's unclear that the standards that would, you know, facilitate the exchange of information, which ones of those will be ready by 2005.

Mr. BUYER. Would you please give your assessment on how much longer you believe it will take for the two departments to complete the standardization of clinical data?

Ms. KOONTZ. According to the schedule that is in the joint VA-DOD strategy, I think they anticipated having health data information standardized by the end of this year. That appears as though that's not going to happen.

I would say it's not completely unreasonable, though, that it's difficult for anybody to say when the standardization is going to be complete, because this is part of a larger government-wide effort to standardize health data. And usually the development of standards involves a long sort of consensus-based discussion, with lots of negotiations, and it's often very difficult to say when those discussions are going to be concluded.

Mr. BUYER. On page 5 of your testimony, your written testimony, you provided a timeline for completion of health vet initiatives. When you look at the timeline, VA will have an appointing schedule capability in 2012. Does DOD currently have one in place?

Ms. KOONTZ. What's the capability in place by 2012? Oh, the full capability—they don't have the full capability. Their target date is 2008.

Mr. BUYER. For DOD?

Ms. KOONTZ. For DOD. DOD is going to be done sooner than that.

Mr. BUYER. Why do you think it will take nine years for the VA to complete that initiative?

Ms. KOONTZ. I would agree that the timeline looks very long. But I have to say that without a more—we have not yet done the work that would look at the detail of that system's development——

Mr. BUYER. Okay.

Ms. KOONTZ. We've been concentrating on the interoperability issues. So, without having looked at that detail, I can't say if there's opportunities to speed that up or whether that's a reasonable time frame.

Mr. BUYER. All right. Maybe that's an answer that Dr. Murphy could give us.

Ms. KOONTZ. Mm hmm.

Mr. BUYER. Ms. Hooley, you're now recognized.

Ms. HOOLEY. Thank you, Mr. Chair. Ms. Koontz, you paint a promising picture in your testimony. The effective use of FHIE is already contributing to VA health care by providing ready access to DOD records. The Healthy People Program is a program designed to support two-way data exchange in a myriad of areas. What this system will eventually do does look impressive. The program includes a timeline, and I have two questions in regards to the timeline.

Ms. KOONTZ. Uh-huh.

Ms. HOOLEY. If you were to review past projections by DOD or VA in pursuing either department-wide or joint information technology based projects, have the estimates given for specific goals, have they usually been met? Are they too generous or too conservative in their estimates? That's the first question.

And two, what's the state of the technology to accomplish the Healthy People Program goals? Is there a comparable system anywhere in the private sector? And when was that technology available?

Ms. KOONTZ. As to the timelines, I think we have to admit that when you look at the, you know, the development of an interoperable health record over time that historically there has been problems with meeting timeframes. I mean there's been problems with DOD in terms of developing its own medical records system, CHCS II. I would say that the record in the past would probably make one question whether moving forward, whether they can meet these dates. I think this is largely dependent on the more specific planning that we're calling for, that I'm sure will be coming in the future. That was one of the issues that plagued the development of the prior system.

So, with proper planning, I think that they'll be able to give you a lot better idea of when these achievements are going to occur.

The second one on technology.

Ms. HOOLEY. Is there a comparable system in the private sector, and when was that technology available? I'm just trying to figure out is the technology there to do this, and it is available?

Ms. KOONTZ. We're not aware of any comparable situation in the private sector that we could point to in terms of a success on this. We're just not aware of anything.

Ms. HOOLEY. So the technology is not available?

Ms. KOONTZ. I'm just not aware of it. I don't know. And it is unclear to us at this point. Without the more detailed planning, it's unclear exactly how it is that they plan to accomplish this interface between these two systems. I'm just not aware of that.

Ms. HOOLEY. I have another question. This has been a very long planning process, and I know that there are a lot of things that take a long, you know, a long time to plan——

Ms. KOONTZ. Uh-huh.

Ms. HOOLEY. You're dealing with two huge agencies. You're dealing with technology. But my question is: is there something that we should have done or should be doing to have made this happen more quickly. I mean, it seems like the progress we've made have been some, but in 21 years, it's not what I would expect.

Ms. KOONTZ. Like so often with any kind of systems development project, it comes down to how the project is managed. From the be-

ginning, I think the problems that we identified were the lack of accountability. There was not adequate planning, and there was inadequate oversight by management. And those were the things that prevented them at least since 1998 from making this a reality at that point.

Ms. HOOLEY. Do you think those things are in place today?

Ms. KOONTZ. I think that VA and DOD have made great progress in all those areas.

Ms. HOOLEY. Do you think those are—do you think we have enough in place that we can move, actually make progress on this?

Ms. KOONTZ. I don't——

Ms. HOOLEY. I mean, this has a been long time in coming.

Ms. KOONTZ. I agree with you. I think the key thing that we saw that one would need in order to move forward was when you look at—let me back up. When you look at the DOD—the joint DOD-VA strategy for achieving interoperability between the two systems, the strategy is articulated at an extremely high level. It's very much at the level that we're going to build an interface between these two systems.

The thing that is needed next in order to move forward is a much more specific articulation of how that is going to be accomplished—what technology will be used. What hardware and software? Specifically what information—what data will be exchanged? What are the requirements of the interface? What security will be needed? These are all the kinds of things one needs to know in order to progress with a disciplined approach to developing interoperability.

Ms. HOOLEY. Do you think those have been articulated?

Ms. KOONTZ. No, they have not been articulated yet. No.

Ms. HOOLEY. Okay. All right. Thank you.

Mr. BUYER. Mr. Evans.

Mr. EVANS. Reflecting on my past experience from the House Armed Services Committee, the Composite Health Care System 1 that Ike Skelton, then Chairman of the Personnel Committee, put a lot of time and effort in. And then I ended up with CHCS II. And my question is: when I look at the billions of dollars that have put into the system, do you believe it's realistic that CHCS II is going to be online by 2005?

Ms. KOONTZ. CHCS II is not scheduled to be totally online by 2005. I understand that CHCS II release one, first release, is in limited deployment, and they recently got approval to go to full deployment. That deployment of the first release will occur, I understand in September 2005. There is a lot more work that needs to occur after that time.

Mr. BUYER. Am I correct in my assumption that the VA is dependent upon DOD getting this done?

Ms. KOONTZ. They are both dependent on each other getting their systems done——

Mr. BUYER. Right.

Ms. KOONTZ. Because in order to exchange data, each of them—now, DOD has already built a data repository; that is, the storage of their health care information. It's not fully populated yet, but they do have the repository. VA's repository won't be ready fully until 2006. It's essential that both of them have those—they have to have the repositories. They have to have them populated with

data, and they have to have the standards in order to exchange, and they have to have an interface that will allow that exchange. All those things need to happen, and they are dependent on each other to make this vision a reality.

Mr. BUYER. Give me your, please, your educated best guess on when do you think this can be achieved, realistically, between these two departments? I know you set out the timelines.

Ms. KOONTZ. Uh-huh.

Mr. BUYER. Give me your best guess based on where you are right now.

Ms. KOONTZ. We from GAO do not like to speculate, as you might imagine.

Mr. BUYER. That's why I said your educated best guess——

Ms. KOONTZ. And so——

Mr. BUYER. Personal opinion.

Ms. KOONTZ. My personal opinion is that it can be achieved. Will it be achieved on this time frame? I just don't know, and I would be hesitant to guess that.

Mr. BUYER. All right. Thank you very much for your testimony. The first panel is now excused.

Ms. KOONTZ. Thank you.

Mr. BUYER. Please extend my compliments to your staff for their good work.

The second panel will now come forward. We recognize Dr. Frances M. Murphy, Deputy Under Secretary for Health Policy Coordination, Department of Veterans Affairs. Also is Major General Kenneth L. Farmer, the Deputy Surgeon General of the U.S. Army, representing Dr. Winkenwerter. Also Ms. Jeanne Fites, Deputy Under Secretary of Defense for Program Integration; and Mr. James C. Reardon, Chief Information Officer for the Military Health System.

Dr. Murphy, Good morning.

STATEMENTS OF FRANCES M. MURPHY, M.D., MPH, DEPUTY UNDER SECRETARY FOR HEALTH POLICY COORDINATION, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY EDWARD F. MEAGHER, ACTING CHIEF INFORMATION OFFICER, DEPARTMENT OF VETERANS AFFAIRS; JEANNE B. FITES, DEPUTY UNDER SECRETARY OF DEFENSE (PROGRAM INTEGRATION), DEPARTMENT OF DEFENSE; JAMES C. REARDON, CHIEF INFORMATION OFFICER FOR MILITARY HEALTH SYSTEM, DEPARTMENT OF DEFENSE; AND MAJ. GEN. KENNETH L. FARMER, JR., DEPUTY SURGEON GENERAL, U.S. ARMY

STATEMENT OF FRANCES M. MURPHY

Dr. MURPHY. I am pleased to appear before the Subcommittee to discuss the progress being made by the Department of Defense and the Department of Veterans Affairs to share health information and to develop a veteran-centric, seamless electronic health record. I'm accompanied this morning by Mr. Ed Meagher, Deputy Assistant Secretary of VA's Office of Information and Technology. With your permission, I'd like to enter my entire testimony into the

record, but I will summarize briefly this morning, and then Mr. Meagher and I will be prepared to respond to your questions.

Mr. BUYER. Your written testimony shall be entered.

Dr. MURPHY. One of the most important lessons learned from the previous wars is the need for interagency collaboration on deployment health issues. VA needs information that may be relevant to recently deployed servicemembers' or veterans' immediate health care needs, to clinical and administrative data to establish combat theatre veterans' status, and to evaluate and meet long-term health care needs of America's veterans.

The "President's Task Force to Improve Health Care Delivery For Our Nation's Veterans," the PTF, focused upon the importance of providing for a seamless transition from military to veteran status, and included in that focus the coordination and sharing of electronic health information between VA and DOD. Furthermore, the record shows that in the past decade alone, almost a dozen expert panels have provided valuable advice on the content of the seamless, life-long record system for these purposes.

Through the VA-DOD Health Executive Council and the Joint Executive Council, VA is working with DOD in other venues to keep up the focus on this critical goal of information sharing. It's important to recognize the importance and significant first steps that have already been taken by VA and DOD in these areas. We have developed a joint business case for electronic health record exchange through the Federal Health Information Exchange, and have substantially implemented the records exchange.

As a result, VA clinical staff now have access to information that was collected in DOD's Composite Health Care System on veterans who have been discharged since that system was implemented in 1989.

Progress towards development of electronic medical records that are interoperable, bidirectional, and standards-based by the end of 2005 is also taking place. It's important to note that VA's health data repository is projected to be available in 2005, and that the Joint VA-DOD Interoperable Electronic Health Record Plan, which has also been known as Healthy People Federal, further commits the two departments to implementing compatible IT enterprise architectures and adopting common standards by 2005.

This will be a significant step towards reaching our goal of achieving a lifelong health record for veterans. That health record starts with the Recruit Assessment Program (RAP) and continues throughout the remainder of the life of the veteran.

Mr. Chairman, as discussed during the full Committee hearing on October 16, VA's Seamless Transition Task Force has led to development of a number of new initiatives to assure VA is providing world-class service to those returning from Operation Iraqi Freedom and also to the Afghanistan Enduring Freedom Veterans.

This task force continues to monitor services being provided to these veterans and to develop further system improvements to support attainment of these goals.

VA has successfully adapted many existing programs and created new programs, as necessary, that have improved outreach, improved clinical care through practice guidelines and educational ef-

forts, and improved VA's health care providers' access to medical records.

We're actively working with DOD to attain the maximum level of sharing of information on injured combat veterans and recently discharged veterans. My statement provides a report on our Joint Interoperable Health Records Plan, and the progress to date, as well as other efforts that are underway to expand VA and DOD information and information technology systems sharing.

This concludes my statement, and my colleagues and I will be happy to answer your questions.

[The prepared statement of Dr. Murphy appears on p. 60.]

Mr. BUYER. Thank you, Dr. Murphy. Major General Farmer, you're now recognized.

Ms. FITES. Let me start out. I'm Jeanne Fites, the Deputy Under Secretary for Program Integration——

Mr. BUYER. Is not General Farmer representing the Secretary of Health; are you not? You are. All right. You're recognized.

STATEMENT OF JEANNE FITES

Ms. FITES. I'm really pleased that we have the Under Secretary for Personnel and Readiness to appear before this Committee, Mr. Chairman and Members, to talk about the initiatives that we are trying to take to expedite the sharing of personnel and health information with the Veterans' Administration.

We have been working on this since the last Gulf War, and we are committed to making it work. What I would like to do is introduce my colleagues who have more of the substantive part of the statement, then I'll come back and answer the explicit questions I can answer for you.

I'd like to introduce Mr. Jim Reardon, who's the Chief Information Officer for the Military Health System, and Major General Kenneth Farmer, who's the Deputy Surgeon General of the U.S. Army.

Mr. BUYER. Are you testifying?

Ms. FITES. Yes, but since I'm testifying on the Defense Integrated Military Human Resources System Personnel Pay Questions, and the DD–214's, I thought that you wanted to hear first from them on the bigger systems.

[The prepared statement of Ms. Fites, with attachments, appears on p. 71.]

Mr. BUYER. All right. Go ahead.

STATEMENT OF JAMES C. REARDON

Mr. REARDON. Okay. Mr. Chairman, thank you very much. Distinguished members of the Committee, thank you very much for providing the opportunity to appear before you today. With your permission, I would like to submit my written testimony for the record and provide the Committee with a brief summary.

Mr. BUYER. No objections. Your statement shall be entered in the record.

Mr. REARDON. Thank you, Mr. Chairman. I want to assure you that our highest priority is to maintain the health of our military members with a continuum of medical care. This care begins with

entry into military service and ends with separation or retirement and transition to the VA health care system.

The ability to transfer electronic health information is a significant factor for improving the continuity of care for those who have so loyally served our country.

Over the past two years, the Department has made unprecedented strides toward a level of partnership, launching a new era of collaboration between DOD and VA. This partnership has fostered several initiatives between the departments.

There is still much to be done, but a number of these initiatives address clinical data interoperability that will benefit servicemembers as they transition to veteran status.

The Federal Health Information Exchange, which has been discussed earlier, supports the secure transfer of electronic health information from DOD to VA at the time a servicemember separates or retires from active duty.

To date, DOD has transmitted electronic medical information to the VA on more than 1.7 million retired or discharged servicemembers. This number continues to grow as health information on recently separated and retired servicemembers is packaged and electronically transmitted to the Veterans' Administration.

VA providers and benefits administrators within the VA nationwide are utilizing this information for the delivery of health care, as well as the adjudication of disability claims. The departments are working on interoperability between DOD's clinical data repository and the VA's health data repository. This initiative will provide a more robust capability and institute a two-way exchange of information responding to the needs of DOD and VA providers. It will also meet the recommendations of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans and address the interoperable electronic medical records objectives in the VA-DOD Joint Strategic Plan.

Indicative of the senior leadership's support for this initiative is that at that September 2002 DOD-VA Health Executive Committee Meeting, the Assistant Secretary of Defense for Health Affairs and the Veterans' Affairs Under Secretary for Health co-signed an executive decision memorandum defining the goals of the Joint DOD Electronic Health Records Plan. A DOD-VA team is now in place, led by senior clinical managers and information technologists from both departments, managing the plan's execution.

A prototype test supporting bidirectional exchange of pharmacy and drug allergy information will begin in 2004. One of the cornerstones of this initiative is DOD's clinical data repository, developed for the Composite Health Care System II, which is DOD's electronic health record.

CHCS II was created by providers for providers, allowing care givers at all military hospitals, clinics, and dental facilities worldwide, immediate, and secure access to beneficiary health records day or night.

DOD's clinical data repository is operational today, supporting more than 17,000 patient encounters per week. It is maintaining a master patient index of all DOD beneficiaries and the clinical data records of more than 400,000 individual patients are online at that repository.

Having successfully completed the limited production phase of this program, full fielding of CHCS II will begin in January. The initiatives highlighted today and in my written testimony directly support sharing of DOD-VA medical information and development of seamless interoperable medical records. Mr. Chairman and distinguished members of the Committee, the Department of Defense and the Department of Veterans Affairs have joined forces to improve the sharing of medical information in accordance with the Health Insurance Portability and Accountability Act of 1996 and the Privacy Act of 1994. Our efforts are focused on continually enhancing the continuity of health care to active servicemembers and our veterans.

Thank you for the opportunity to testify before your Committee today on this important issue, and I will be pleased to take your questions. Thank you, sir and madam.

[The prepared statement of Mr. Reardon appears on p. 88.]

Mr. BUYER. All right. Major General Farmer.

STATEMENT OF MAJ. GEN. KENNETH L. FARMER, JR.

General FARMER. Mr. Chairman and members of Committee, I'm Major General Ken Farmer, the Deputy Surgeon General of the Army, and I thank you for this opportunity to represent General Peak, our Surgeon General, and to appear before your Committee today and discuss our ongoing efforts to electronically share medical information with the Department of Veterans Affairs.

I will submit testimony for the record, Mr. Chairman, as you requested earlier this morning. And we'd like to provide this oral statement.

As you heard from Mr. Reardon, we are collectively involved in the development and implementation of multiple information management and information technology programs to improve our ability to electronically share patient information between the Department of Defense and the VA.

The implementation and next generation of the Composite Health Care Systems, CHCS II, across the military health care system represents the heart of our effort to create a seamless, longitudinal electronic medical record that captures patient care from the first medical visit at the medical entrance station to the last visit as a solider, including all care provided from fox hole to medical center.

The first step in this complex effort is the development of outpatient care functionality, found in CHCS II block one, which the senior military medical advisory committee recently approved for a 30-month accelerated fielding beginning in January of 2004. Using spiral development processes that are closely to evolving medical requirements, additional CHCS II functionality blocks are under development and testing and will collectively represent all patient care provided across the entire health care continuum.

The military health system patient care data will be deposited into the clinical data repository, and, because of joint DOD-VA effort, will be available for two-way interface with the VA health data repository in 2005, thus establishing the seamless electronic record envisioned by all.

I'd like to focus the remainder of my remarks on specific Army Medical Department initiatives to reengineer clinical and business practices that underpin the successful deployment of CHCS II and other electronic patient care systems.

I'll discuss also interim electronic solutions and the Army participation on DOD and VA joint demonstration projects.

Establishing close partnerships with the VA such that clinical and business requirements are understood represents an important first step. Over the past two years, the Army and VA have developed a process to provide a single separation physical examination at all but one Army medical treatment facility, and that one will come on line before the end of the year that meets both DOD and VA requirements, establishing the identification of requirements that can be developed into a data lexicon and mapped both DOD's clinical data repository and the VA's health data repository.

Force health protection and the associated pre- and post deployment health assessments represent another area of joint focus by DOD and VA. In September of 2002, the Army Medical Department launched an initiative to improve the process of pre- and post-deployment health assessments by automating the collection, distribution, and archiving of the data.

The goal is to streamline the data entry process, standardize the data fields, and eliminate the need for copying, mailing, and scanning paper forms. These paper forms, which included a four-page questionnaire filled out by the servicemember, was a labor-intensive manual process, leading to inevitable lost records, erroneous data entries, and delays in getting the data scanned into the Central Army Medical Surveillance Activity database.

An Internet version of automated pre- and post-deployment health assessment forms was activated in the Army's Medical Operations System website on April 1st of 2003. A hand-held computer version, with the automated forms, was successfully integrated into the system on the 23rd of July of 2003 and was sent for use by the Coalition Forces Land Component Commander in the Middle East and to the European Theater in August of 2003.

Over the past five months, about a fifth of the worldwide collections of the post-deployment surveys have been collected using these various electronic tools, and this percentage is increasing.

Recently, the Army used a hand-held device at Fort Lewis, Washington, to support the automated collection and archival of pre-deployment health assessments for 98 percent of the 4,400 troops deploying.

Today, military providers can access the completed electronic pre- and post-deployment forms at the Army's Medical Surveillance Activity Database through Tracker Online, which provides the encrypted HIPAA-compliant portal for accessing protected patient information, and efforts are underway to provide the same kind of access to VA providers.

We have a number of Army medical treatment facilities in which a VA clinic is embedded. At Tripler Army Medical Center, VA physicians have access to the CHCS host server. Pharmacy orders placed in CHCS, to be filled at a VA pharmacy, are sent electronically to the Veterans Health Information System and Technology Architecture, called VISTA, and the laboratory orders placed by VA

physicians in VISTA, to be completed at the Tripler Laboratory, are sent electronically to CHCS, and the results are sent back to VISTA so that they are visible in both systems.

DOD providers will soon have access to the VA computerized patient records system and VISTA through a web-interfaced Army Interim Patient Record System, the ICDB.

This effort provides practical experience in our effort to create the seamless transfer of electronic information. William Beaumont Army Medical Center in El Paso, Texas, is another Army location where the transfer of CHCS laboratory data to the VA VISTA host server occurs. In fact, William Beaumont, where CHCS II has already been fielded as one of two Army limited deployment sites, is also one of eight DOD medical demonstrations sites selected to participate in joint demonstrations with VA medical facilities, as mandated by the FY 2003 National Defense Authorization Act.

A second Army medical information system demo site is between Madigan Army Medical Center in Tacoma, Washington, and the Puget Sound VA Health Care System. And that demo site will provide read-only access to both the Army's Interim Health Forces Integrated Clinical Database and the VA's computerized patient record system and will provide visibility of clinical information at the point of care in either health care system.

The Army Medical Department is committed to improving the delivery of health care to all its military beneficiaries through the seamless exchange of electronic medical information with the VA. This effort requires not just the implementation of technical solutions, but also reengineering of clinical and business processes supported by these information management tools.

Collectively, the DOD initiatives described by Mr. Reardon and the examples of reengineering efforts underway in the Army Medical Department represent the critical steps to realizing the seamless electronic medical record that captures and shares patient care information, beginning with the first encounter at the entrance station through the provision of military care over the servicemember's career, followed by the care rendered in the VA facilities.

In closing, I would like to thank the Committee for your continued commitment and support to provide quality care for our soldiers and for our veterans, and I will be happy to take questions with the panel. Thank you.

[The prepared statement of General Farmer appears on p. 99.]

Mr. BUYER. I'd like to know how you are going to address HIPAA concerns as we move forward.

General FARMER. Mr. Chairman, I will respond, and my colleagues may have also some information on that. But, as you know, the HIPAA law does have a——

Mr. BUYER. This question, though, General Farmer, is not just to you. It's also to the VA, because this data and information is going to be going both directions, and the VA may end up with information for which DOD doesn't have and for whatever reason may be shipped back.

General FARMER. Yes, sir, the exemption in the law that allows us to pass information to the Veterans' Affairs for determination of benefits and for the provision of health care is an important vehicle

that allows us, at the point of separation or retirement, to pass that information to the VA.

Mr. BUYER. I just didn't know if you have to create a document with guidelines or that the law in and of itself is sufficient.

Dr. MURPHY. No, the HIPAA regulations themselves have a provision——

Mr. BUYER. Good.

Dr. MURPHY. That allows us already, with the existing HIPAA regulations, to pass this information back and forth. No special agreements or new provisions are necessary.

Mr. BUYER. Thank you. Dr. Murphy, with regard to these discussions about measurable milestone objectives, would you like to comment on them, please?

Dr. MURPHY. I would like to comment on that because, in fact, the VA Health Data Repository is expected to be ready by 2005, and the scheduling ready by 2006. As with any development process, depending on whether unrecognized difficulties are encountered along the way, the timeline might slip.

However, we do have a system of accountability that allows us to adjust and actually recover from those situations. In addition, we have instituted a better project planning process through the Department CIO that we believe will improve the performance in the future. And I'd like to ask Mr. Meagher to add anything that he'd like to about that process.

Mr. MEAGHER. Thank you. First of all, I have to decline the honorific. It's not doctor. It's mister. But we have, in fact, established a standardized program management system throughout the Department, and we have, in fact, submitted all our A-300s to OMB this year, with a certified level three program manager. And we are tracking these projects now by cost, performance across the Department on a real-time basis or actually it's now once a week, but it will soon be real-time.

Mr. BUYER. Dr. Murphy, is the VA, are they getting any of the DOD's pre- and post-deployment screening data in any format?

Dr. MURPHY. At this time, I'm not aware that we have access to the pre- and post-deployment screening; however, we are working on getting that capability in the very near future. The records are available in a database and can be transferred to VA as soon as DOD makes a policy decision to do so.

Mr. BUYER. Well, I think it's pretty exciting, General Farmer, that you went out, and you obtained this technology and did it paperless. It saves a lot of time. But somehow, it's got to get to where it needs to be.

General FARMER. Yes, Mr. Chairman, if I may. Right now, whether we do those surveys electronically or in paper, we are putting a copy of those surveys and reports into the paper record. So, one of the ways now, in the interim, that that information is available to the VA upon separation is that upon separation the appropriate medical or health record of the soldier is made available to the VA, and it will have that screening form in it.

Now, as I said, we are working toward being able to provide that electronically to them. That is a work in progress.

Mr. BUYER. Dr. Murphy, by 2005, are you going to be able to access DEERS in real-time?

Dr. MURPHY. I don't believe that we will be able to access DEERS. By 2005, we will have access to the available electronic medical records. However, we do have access to personnel information at this point, and I ask Ms. Fites to respond in more detail to the issue of DEERS.

Ms. FITES. We are working together with the VA to share the DEERS information base. We have not worked out how we're going to do it all the way. We do give them nightly feeds, the personnel parts of the information. But we are committed to working together to have it shared.

Mr. BUYER. So any rumors that we hear on the Hill that that initiative has been derailed or stopped is strictly a rumor?

Ms. FITES. As far as I know.

Mr. BUYER. Okay. I accept your testimony.

Dr. MURPHY. Mr. Chairman? Mr. Chairman?

Mr. BUYER. Yes.

Dr. MURPHY. Could I offer—part of the confusion may be that we expected to adopt DEERS as the VA enrollment system and therefore to be able to share the DOD information contained within DEERS. However, at this time there has been no decision made by VA to move forward with adoption of DEERS as our enrollment system. That may be where you're hearing rumors that we've taken a step back in the planning process, and we're back at stage one looking at the content and requirements in DEERS. And I'm sure Mr. Meagher would be happy to expand on that for you.

Mr. MEAGHER. Yes, sir, I think there's no question on our part that DEERS data is the most relevant data, and we currently are looking at standardizing that. Currently, we receive 31 data feeds from DEERS, and we give them 11. And I think one of the problems has been some inconsistency. So, we have not changed at all in our commitment to working with DOD and using the DEERS data. We've simply put a step in front that says we need to understand this data just a little bit better, and we need to understand our own requirement. It's a very short-term step, and I think it's the most prudent thing we can do. But it does not or should not reflect in any way a lack of commitment or a change in direction.

Ms. FITES. And the Department of Defense is committed to providing the data. It's a matter of we're working together to figure out——

Mr. BUYER. In real time?

Ms. FITES. The best way to do it. Yes.

Mr. BUYER. In real time.

Ms. FITES. Yes.

Mr. BUYER. Thank you. To my colleagues, we have the right people sitting at the table here, and I have no objections at all for taking up the five minute rule so you can develop your questions even further. I yield to Ms. Hooley.

Ms. HOOLEY. Thank you, Mr. Chair. First, I would like to acknowledge a group of students here from Washington, DC, participating in the Close Up Program, and welcome. This is a committee where we're talking about issues that are very current right now with the VA Veterans Affairs and DOD, Department of Defense, talking about how they share information for medical records, because they really are interwoven. And so we're asking questions

about whether they're doing this and how the process is working. Welcome. Dr. Murphy, you indicated in your testimony that VA needs certain information regarding servicemembers returning from overseas and locations like Iraq and Afghanistan. You note that they received an initial list of 17,000 veterans from DOD and that some had sought health care from VA. When did you receive that list—first list, and when was the next list due? And what information should be included in the member record? In your statement, you suggested a number of service indicators. Is the record complete and timely?

Dr. MURPHY. We're working closely with DOD to obtain a complete roster of individuals who have served in Operations Iraqi Freedom and Enduring Freedom. So far, we've received one list in the past couple of months of 17,000 individuals who have been discharged and served in that theater of operations.

We believe that a complete roster is necessary for us to understand the full impact on the health of veterans, and we're working closely to obtain that roster. So far, the information has been helpful to us in understanding which individuals have accessed the VA health care system and what kinds of complaints and diagnoses they have presented with.

A you know, the issue of creation of lifelong health records system for servicemembers and veterans has been explored very well over the past decade. A number of very distinguished groups and expert panels have given us advice on what kind of information is important to providing quality health care to veterans.

Those groups recommended that we need a complete roster of all deployed individuals for every combat theatre; that we have baseline information on recruits. In response, VA has asked for a complete roster card and we've worked together with DOD to pilot a recruit assessment program.

In addition, we do need outpatient and inpatient records. We need access to in-theatre medical records. We need the pre- and post-deployment health screens. We need obviously the personnel information and the DD–214 in order to be able to determine eligibility, and we need to be able to connect all of that with the veteran's health care record in the Department of Veterans Affairs. These are the *basic* components of a lifelong health record for veterans.

It would be nice to be able to have that all collected in a veteran-centric record rather than in disparate databases. However, that is a challenge for both Departments at this time. Furthermore, we need to create real-time interoperability of our record and IT systems in the future.

The challenges are even more difficult to solve as they relate to National Guard and Reservists, and in accessing records on active duty members who have been treated in TRICARE.

Ms. HOOLEY. I was going to ask you a question on Guards and Reservists. How do you get their records?

Dr. MURPHY. The paper medical records on Reservists are located at the individual local unit. We'll also be able to, through the Army Reserve, be able to get copies of their pre- and post-deployment screening as they are put into the electronic data system that the Army is providing.

Ms. HOOLEY. For the Reserves and National Guard, are those—is that information taken on some way to transfer that information other than on a piece of paper? Is that taken electronically, the information? Any one of you. Major Farmer.

General FARMER. Ma'am, are you talking about the pre- and post-deployment surveys, specifically?

Ms. HOOLEY. Right that the Guards will have to take.

General FARMER. My comments on the use of the electronic systems for capturing that apply to all components. As I said, we are using that for some of the collections. Most of the post-deployment surveys that are being done in the deployed theater of operations are now being done electronically, irregardless of whether they are active reserve or guard. And some of those being done here in the deployment and redeployment are being done electronically.

Ms. HOOLEY. Are all of those—is all of that information taken with hand-held devices—I mean where you can take the—where you can take all the information, and it's on a hand-held device?

General FARMER. Ma'am, as I mentioned, we have both a hand-held device, a portable hand-held device module, as well as an Internet web module, in order to do that. And so it depends on the setting. In the deployed theater of operations, for example, we're largely using the hand-held. For those that are being done in our treatment facilities, many of those are being done, for example, using the web module.

Ms. HOOLEY. Is there any reason that you can't get to the Veterans' Department, is there any reason that you can't get the list of all of the people that are currently serving overseas. I mean, you've got a list of 17,000. There's something like, I don't know, 200,000 troops. Is there any reason they can't get that list to them?

Ms. FITES. We're in the process of developing the list. We're not confident yet that what we have is accurate. So, we're working back and forth with the Veterans' Administration as we clean up the information.

Ms. HOOLEY. When do you think that will be accurate?

Ms. FITES. I'll have to provide that for the record. I'm not sure. (See p. 142.)

Ms. HOOLEY. Is there a technical reason why they're not accurate? I mean what's?

Ms. FITES. Yes. It's database information inaccuracies that we're cleaning up, and I just don't have the timelines for when that will be completed. But we are working on it. We know it's important.

Ms. HOOLEY. Okay. Thank you.

Dr. MURPHY. We have had good cooperation from the DMDC in working out the data issues. But, you know, so far we've not been able to get a completed roster.

Mr. BUYER. Mr. Evans?

Mr. EVANS. Thank you, Mr. Chairman. Mr. Reardon, in your statement you discuss HHS standards adopted in March 2003 for electronic health data transfer. Are these standards enmeshed with the private sector's standards, and are we leading the charge or retreating?

Mr. REARDON. Sir, excuse me. Thank you. These are the standards that are being developed through the HHS-led Consolidated Health Care Informatics Project. And it is primarily a Federal

membership on these standards. However, as the standards are being developed, they do ask for comment from the public and private sectors on those standards.

Once the standards are adopted, they are adopted for use in Federal systems as new systems are developed. And they're continuing, at this point, to develop more of those standards. They have somewhere around six to seven standards adopted now, and the objective I believe is approximately 15 standards. So there is input from the private sector, sir, but it is primarily a Federal group that is selecting those standards.

Mr. BUYER. Mr. Udall.

Mr. UDALL. Thank you, Mr. Chairman. From hearing you describe it, you talk about the seamless interoperable system, where individuals move from the military to the veterans system, and you're able to move these records back and forth. I mean, is that basically what we're talking about in this system that we're trying to develop?

Dr. MURPHY. That's basically it. We'd like to have completely interoperable records so that we can provide the highest quality health care and benefits to veterans. And in order to do that, we need a lifelong, seamless medical record. Not only a medical clinical care record, but a health record that connects a lot of other kinds of information that are important for us in analyzing the potential health impacts of service in the military. An example is environmental and occupational exposure information for military servicemembers interoperational.

I would say that VA and DOD are actually leading the interoperabling effort. If you look at what the capabilities are in the private sector for doing this, they're extremely limited. And they're really only a few sites in the country who would have any capability to be able to have an interoperable electronic health record. The national health infrastructure at this point is very limited, and I think that in the most positive context, it's actually important to recognize that if it wasn't for VA and DOD, we would not have, we would not likely have any ability at all to transfer electronic health records, because electronic health records in the private sector are not available.

Mr. UDALL. To what extent today do we have this seamless, interoperable system working for numbers of veterans, percentages, what you all have been working on this I guess about seven years; right? Or more?

Dr. MURPHY. In terms of percentage, you know, there are approximately 25 million living veterans in this country, and we've said that we have records on 1.7 million in the data repository at this point. It's a small portion of the veteran population, but an important first step. The effort will allow us to have access to the electronic health records that DOD has at this point. And by 2005, we will have the first interoperable records system available.

Mr. UDALL. Of the 1.7 million that we developed the system, are these recent veterans leaving the military and going into veterans health care, or are they—is it an older set?

Dr. MURPHY. As I understand it, it's all of the available records in CHCS first instituted since 1989. So all discharged individuals with an electronic record will be included in the records exchange.

Mr. UDALL. All discharged individuals with an electronic record since 1989? Okay. And what is the—has Congress or have you been given instructions to try to include all 25 million. I mean, are you attempting to get there. Is there some timetable for that?

Dr. MURPHY. It won't be possible to get electronic records on all 25 million veterans. Many of them served in the military prior to 1989, and would not have electronic records available. We'll still be relying on the St. Louis records center and their paper records for those who served prior to 1989.

Mr. UDALL. And you're in—you don't put those—there isn't going to be an attempt to put those in an electronic format?

Dr. MURPHY. At this point, we're working prospectively.

Mr. UDALL. Prospectively. So your intent is to include everybody in the future that comes out in this same situation.

Dr. MURPHY. That is correct.

Mr. UDALL. Not to necessarily go back? And to not go back, I mean, is that—you're nodding, but the record doesn't pick that up.

Mr. REARDON. Sir, starting at the time at which the Department of Defense started collecting the information electronically, which was, as Dr. Murphy said, in the late 1980s, we've gone in, and we've pulled out the information on all our separated and retired servicemembers since that point; and our intent is to continue to do that. As members separate or retire, we get a notification. We in the medical community, General Farmer and I, get a notification from the personnel community, and it says, Jim Reardon has separated. And that information comes to us. We go out, pull the information out of our electronic health records systems, package it, and send it to the VA. So it's very prospective in nature. And we're doing roughly 17,000 to 20,000 notifications every month on separations that we pull the information, and we provide it to the Veterans' Administration.

Mr. UDALL. And think you will be able to do all the future people, include them in this system?

Mr. REARDON. Yes, sir, we're doing that now, and we are actually, as we move forward, increasing the types of information. We started out with demographics and laboratory and pharmacy, and we're moving to consults and retail pharmacy. So the amount of information that we're providing is continuing to grow.

Mr. UDALL. And you're putting adequate, in the budget request, you're putting adequate resources in there in order to make sure you're able to carry this out?

Mr. REARDON. Yes, sir. We are. It's a funded program.

Mr. UDALL. Okay. Mr. Chairman, I noticed the light's red, but can I continue for a minute or two here?

Mr. BUYER. Yes. No objections.

Mr. UDALL. Just to—thank you. And I'd like the DOD and the VA to comment on this. When you have a database like this, laden with protected privacy-related information and it's shared among agencies, that information is only as secure as the weakest link among shared systems. Is this an issue for you? Is it perceived as an issue among DOD and VA?

Mr. REARDON. Information security is a significant issue and a significant point of focus for the Department of Defense and for the Veterans' Administration. The information, when it comes to us

and when we transmit the information, we're transmitting it in an encrypted fashion. So when we're moving the information out of our local records systems and packaging it up and sending it to the VA, it is encrypted. It's also secure in those facilities that the databases themselves reside on, in that they are either on military installations or in secure facilities in the Veterans' Administration—I think in Austin, Texas, right now. So information security is an issue that is higher on our radar screen.

Mr. UDALL. Yes. Okay.

Mr. MEAGHER. I'd just add that as the previous CIO has testified before this committee that security—IT security is the number one priority for information technology at the VA is to improve that security, and we take that very seriously.

Mr. UDALL. Okay. Thank you for that answer. Let me return just one more time to the seamless, interoperable system that you're trying to put in place. Many of the veterans in my state of New Mexico, a very rural state, more rural than others, and there's been a real attempt by the Veterans' Administration to reach out to veterans where they live and provide health care. And so we have the Veterans' Administration entering into contracts with community health care providers. And many of our veterans are getting their primary health care, obviously not specialty health care, but primary health care right in their communities where they live, rather than having to travel 200, 300, or 400 miles to a Veterans Hospital.

Is this system you're putting together a doctor in one of these community health care clinics would be able to access these kinds of records in order to give the veteran the very best medical care?

Dr. MURPHY. In our contracted community-based outpatient clinics, the providers often use the VA records system. For those who have a fee basis arrangement for care, an individual doctor with an individual veteran, we often have to rely on paper records. But we do have the ability to image those records and include them as a image file in their overall health record.

Mr. UDALL. But the system you're talking about could be very, very effective for veterans; couldn't it, to alert doctors of problems and things if they could get all this information at their fingertips through this electronic means. Is that correct?

Dr. MURPHY. Absolutely. And, as I said, we are providing access to the VA records system for our community-based outpatient clinics, where we have a contract with private providers to provide health care to a large number of veterans. And our vision is that hopefully the rest of the country in a short period of time will adopt electronic records.

And one of the reasons that the CHIE initiative, the data standards initiative, is so important for the Federal Government to lead is that only by having data standards in place will we get interoperable commercially developed records systems that will be able to communicate with the VA and the DOD records. Hopefully in the future we'll have a national health information infrastructure that we'll be able to share privacy—protected information much more broadly than just between the VA+DOD systems, but will include the private providers also.

Mr. UDALL. Great. Thank you very much. And, Mr. Chairman, thank you for allowing me to go on a little longer there.

Mr. BUYER. You're quite welcome. We'll have another round of questions. Dr. Murphy, you also state that the VA can now access DOD's—the Composite Health Care System for veteran information such as lab results, x ray reports, outpatient pharmacy prescription information, admission disposition transfer records, discharge summaries, and near future information will occur for allergies, consult reports, and summary outpatient appointments information.

You further state that the Veterans Benefit Administration used this information to "fulfill the evidentiary requirements for processing disability compensation claims, as well as determine the eligibility for other benefits." My question is what about the entrance and separation physicals? What about the inpatient hospitalizations? What about the pre- and post-deployment assessments? Aren't all of these pieces of information absolutely necessary to adjudicate a compensation and pension claim?

Dr. MURPHY. I'm going to ask Mr. Reardon to expand on my comments related to that question.

The information that's currently available is being taken out of CHCS1, which includes hospital discharge information. When we get to the fully interoperable health record exchange, it will involve information being exchanged between health data repositories in VA and DOD, including outpatient records that are now being piloted in CHCS II. You know, in order to be able to provide full access to a full record, we need to get to the fully interoperable health record exchange. And for the details of whether——

Mr. BUYER. But, Dr. Murphy, as of right now, you've got a great program with DOD and VA to make sure that that individual, upon discharge, has a physical. It's all about the baseline. When will that physical be included in the repository?

Dr. MURPHY. If it's being done at one of the places where we do a single discharge physical, that is already available in our records system in VA and DOD.

At the sites who are not participating in those programs and pilots, that is not yet available, to my knowledge. I'd ask Mr. Reardon to tell us exactly what's available in CHCS1, and what the timeline is for the remainder of those records being available.

Mr. BUYER. All right. Thank you, Dr. Murphy. Mr. Reardon.

Mr. REARDON. Sir, we're providing the VA discharge summaries, so there is some inpatient information-inpatient history, diagnosis, and procedures. In February, we will be beginning to provide more ambulatory data, which will be the appointments that a particular individual has had, what the appointment type was, the date that it was made. So that information will come across.

To the extent of getting to your question about the information on the physical, which occurs in a military hospital, and the information that is being entered into the CHCS system at that hospital, sir, then that information would be packaged up and come across in the area of the labs, the RADS, and the diagnostic codes that would come across. But I don't know to what degree the exit physical for our military members are being put into the CHCS system. Maybe General Farmer might be able to answer that.

General FARMER. I think Dr. Murphy said it correctly, sir, that in those sites where we have an agreement for a single separation physical that meets the requirements of DOD and the VA, whether it is done in one of our facilities or, in many cases, in one of their facilities, either way, that data is then populated into both systems; and so it is electronically available in both of our systems.

Mr. BUYER. I think I'm challenged. When you—and help with this scenario. There are no perfect analogies, but these are very real-life scenarios.

You have a soldier on the battlefield that is wounded or injured. He's seen at a combat support hospital. He's then medevac'd to Landstuhl. From Landstuhl, he comes to Walter Reed. After Walter Reed recovery, rehabilitation, perhaps it was time for his separation from the military. They're now being seen at a VA. That doctor at the VA, of whom receives the soldier, the veteran now, comes in and complaining about maybe it's his back, when, in fact, maybe the back now—he has muscular, because now he has to walk a little different. That doctor at the VA ought to be able to trace back and see the records from the combat support hospital to Landstuhl to Walter Reed. Would you concur, Dr. Murphy?

Dr. MURPHY. Yes, that would be the optimal situation.

Mr. BUYER. But today, Dr. Murphy, can that doctor at a VA access those records? How do they—there's no electronic medical record in order to do that; correct?

Dr. MURPHY. That is correct. At this point, we do not have real-time electronic interoperability in the two systems. However, the scenario you're talking about is exactly the one that we've tried to address with the seamless transition task force. And I have to compliment General Peak and the Army, because they have been exceedingly collaborative and great partners in this process.

We've set up a system so that we make sure that before someone is discharged from Walter Reed today, that they've been seen by a VA social worker, who has made a contact to the local hospital that the patient will be transferred to or nearest to his home. And those records can be provided, not necessarily always electronically at this point, but a coordinator at the local medical center is responsible for making contact with that individual and ensuring that there is a direct handoff between VA and DOD.

That was not present in the very recent past. And we had some very unfortunate occurrences of people who may not have had that seamless transition and didn't receive immediate access to the—either care at the VA medical center or have their records available.

For that particular instance, we believe we've put a system in place that, while not fool proof, does give us what we believe is the best handoff between VA and the Army at this point.

Mr. BUYER. So presently in this world, let's take the record lists—strike that. Digital—well, no. Radiology. Digital radiology. So the VA is doing it. DOD is doing it. But then the two can't even—you can't even talk to each other. So, for example, that VA doctor, of whom wants to access then the images that may have been taken at Landstuhl, they cannot—they've got two systems that are not interoperable; correct?

Dr. MURPHY. At this point, our imaging systems are not interoperable.

Mr. BUYER. That's crazy. I recall being at Tripler in Hawaii, and Tripler and the VA they have done an excellent job with their interoperability. And that was the first time that I had seen two fantastic systems—you can make a paper airplane and hit the VA from Tripler. But they can't talk to each other with regard to that digital record? Ouch. That really—that smarts.

Now, let me—help me so if I can understand where we're trying to go. And, Dr. Farmer, please jump in to correct me.

You envision what we are hope—where we're trying to go is our soldiers when they go on the battlefield will have a dog tag. And on that dog tag, we'll have their—medical information will be on the dog tag.

When they are injured, maybe the soldier is found on the battlefield and is unconscious, so there's a lot of things we don't know about them. They're taking to the combat support hospital. That information can be taken off the dog tag, put into the system, and they're going to know everything about their present health, whether they have allergies, whether they—their blood types. You name it. It will be on there. Now that we're in that digital world, things that occurred at the combat support hospital then can be linked through a satellite so when the patient arrives at a military medical treatment facility, the doctors of whom are waiting to receive that patient, they know in real-time what the situation is and are in contact with the patient in flight when they arrive and then as they transfer back to the states. And this is not occurring just with the Army. We want this to occur with the Air Force, with the Marine Corps, and Navy.

And then that life that is accompanied by a real-time medical record then finds its way to the VA. And, in the end, when we are treating this human being and are providing timely adjudication of claims, that all of this can be done quicker. Now is this where we're trying—this is where we're trying to move to? Dr. Murphy and General Farmer, isn't that where we're trying to move to?

Dr. MURPHY. I think you've presented a wonderful vision of where, (hopefully), the technology will take us in the future. VA+DOD need to be able to coordinate our activities so that an individual servicemember and veteran gets seamless care. And in order to get that seamless care, we need to have our digital information be interoperable.

General FARMER. Yes, sir, I think you have described a vision of that ideal future that we're trying to move toward. We have a number of pilots, of incremental initiatives toward that future. For example, the Striker Brigade that is just deploying now out of Fort Lewis, Washington, that I mentioned in my opening statement, 4,400 troops.

Not only did we mention that we did their pre-surveys electronically, but we also loaded onto an electronic information carrier with each of those troops a record from Madigan, from their local health clinic their medical information in an electronic information carrier that they will have with them. And we will do some incremental utilization and testing of that ability to access that and then transfer that from the theater during the deployment.

Secondly, in response to your question a moment ago, in Afghanistan today, we do have in our Army health facilities over there

CHCS1 capability, and so the labs and the x rays and pharmacy data, for example, that is given in our facilities over there will be in CHCS1; and, therefore, does become under the Federal Health Information Exchange part of that transfer of information that we were talking about earlier.

So I think that this is a work in progress, but we have a number of good steps to get us toward that future that you outlined.

Mr. BUYER. Well, I can't speak for my colleagues, but from the perspective of looking out for the taxpayer and giving oversight of where you're trying to go, I think it's a noble cause. And the purpose of this hearing is for us, we're challenged. I think our challenge is we look out there.

We deal with corporations and the private sector and companies and other countries, and we see things happening, but we don't understand why DOD and VA don't—can't talk to each other when it's—when we can talk with our own staff and our own states. And I know you have different procurement routes that you do, but what I do find unacceptable as we move into this world of being seamless is to have—gosh—state of the art systems that cannot talk. I just find that dumbfounding.

Let me ask this—let me ask this, and I'll yield to my colleagues. Mr. Reardon, earlier when the Secretary—Secretary Principi was going to take on these IT issues and removing the stove pipes within the VA, and the question that we asked of his IT czar was whether or not he was going to have the authority, the actual authority, to do his job. So I did take a look at your resume, as I do all witnesses, and I know that you have 28 years in the IT systems, but what I missed is I don't know how long you've worked in your present job or for the Government. Can you tell me that?

Mr. REARDON. Yes, sir. I've been in the present job for five years.

Mr. BUYER. For five years.

Mr. REARDON. Yes, sir.

Mr. BUYER. And you are working at OSD level?

Mr. REARDON. I work in the TRICARE management activities, sir. So it's one level below OSD. I'm not actually in the Office of the Secretary.

Mr. BUYER. Okay. So you are outside of the line on budget authorities. In other words, you got to turn to somebody to implement that which you want to do; right?

Mr. REARDON. That's correct, sir.

Mr. BUYER. So you don't have any control over the dollar?

Mr. REARDON. Well, sir, we do prepare a budget request and forward that up through health affair, the Office of the Assistant Secretary, Health Affairs, which forwards it as part of the Defense Health Program budget or program objective memorandum. So we would lay the programs on the table, sir. We would estimate the cost over a five——

Mr. BUYER. This is an issue I brought up earlier, and I need to address right now, because I know that different agencies, whether it's in Agriculture and in the Government agency, and the real question is should Congress accept this new world that we're in and give some real authority to an individual who is an MIS Director or the individual who's the Director of the Information Technology—if you have to turn to others, you're begging. And when we

find ourselves in a time of war, sometimes if you're not banging loud enough, you're not able to achieve particular timelines. I don't know if you have the specific authority to do the job for which you are asked to do.

Mr. REARDON. I believe I do, sir. I receive very strong support from the OSD staff. We have a Board of Directors that oversees what we do, and it's General Farmer and the other Deputy Surgeons, and also the Deputy Director of Medical Readiness on the Joint Staff, Major General Porr right now. They help us prepare what the requirements are. We package up our requirements and our funding requirements that go along with those, as many other components in the Defense Health Program do. And those are forwarded up for approval at the assistant secretary level, and other budgets come in through the services for the Defense Health Program.

Mr. BUYER. Right. I understand how to be a good listener, but here's evidence: evidence of that inability is you can't even give an electronic DD2-14 to the VA. If you can't even do a personnel action, what makes us satisfied that we can take on these bigger causes? That's what I'm really challenged. Those are very challenging—oh, my gosh, I'm about to yield, because I'm going to go nuts. Would you please——

Ms. FITES. That's a fair statement. We cannot give an electronic DD–214 to the VA, because we do not have electronic DD–214s.

Mr. BUYER. Why can't you make electronic——

Ms. FITES. The defense—we are going to. That is part of the Defense Integrated Human Resources System that we are building right now. It's integral to the system. It will be one-time data entry, all components, all services. It will eliminate all the errors that we have from multiple data entries everywhere. Right now, the DD–214 is paper. It's done in thousands of places around the world. It is not transmitted electronically. It does not have standard data elements that are the same. That is one thing we are trying to correct with the Defense Integrated Human Resources System.

Mr. BUYER. You know, Dr. Murphy, I sit here and look out, and I see you, and I think it's Ground Hog Day. You and I have been here at this Committee for 11 years, and I hear things like this—and, it is—it's the movie Ground Hog Day, because we've asked this—this particular question has even come up in the past. And that's the kind of answer we've even gotten. Let me just—let me yield. Ms. Hooley will be recognized.

Dr. MURPHY. If I could——

Ms. HOOLEY. Thank you, Mr. Chair. I haven't been here since Groundhog Day. I'll give her a chance to answer. I haven't been here over and over and over again, but let me give you just a couple of incidences and maybe they don't even apply here. But several years ago, and I served for six years on a major hospital board, a series of hospitals went to electronic records. It was difficult. I mean, it took time, but I was there from beginning to end. Nurses went in and hand-held devices when they went and visited the patient. Everything was done electronically.

So I think it can be done. And then when you look at a lot of other businesses who are compiling huge amounts of records for

millions of people and they deal with privacy and deal with a lot of other things in that process. I guess knowing that this is 21 years old, I'm frustrated by it just like everybody else is. And why it takes so long to happen. Why you only have 17,000 names on your record from the people that are currently have been deployed, when we're talking about 200,000, 300,000 people. You got 17,000? And that's due to data error.

It is just frustrating, and I have a hard time understanding why something like this, where two agencies who care very much about the same person haven't been able to make this move forward a little faster. I mean, and I would feel better if you said, well, the technology is not there. I think it is, but I would feel better about that. I mean, I just understand why this has taken so long, and I share our Chair's vision of what this should be.

Every single member in Congress also knows the frustration of veterans who can't get information—that it's not shared. I mean, here is a fabulous opportunity, and I guess I would just like your comment on why, from Dr. Fites or Dr. Murphy on why we only have 17,000, and then whatever else you were going to say to the Chair that I interrupted you on.

Ms. FITES. First, I'd like to say for the interim, until we have our new system, we have developed with the Veterans' Administration a Defense Personnel Records Image Retrieval System that gets not only the 214s, but other personnel records that the VA needs.

It's taking the paper records. It's making them electronic, and the VA is getting them in the average now of 60 days. And it's not overnight, which is what we want. But it is working very well, and 2,380 Veterans Benefit Administration users are submitting a thousand—1,500 requests a month against that system.

So, we're pleased we've been able to put in that interim, and that is helping.

Dr. MURPHY. And what I'd like to reiterate is that there has been progress made. The Federal Health Information Exchange is an important first step forward. Jeanne Fites and I have been working together since the early '90s. And I think that both of us have seen the changes in the exchange of information that have occurred over that decade.

We all recognize that we're nowhere near the optimal system or nowhere near meeting the vision that you've set out and the Chairman has set out. But I think we now have a roadmap towards the Joint Interoperable Electronic Health Record.

The technology is there to support that, and we have the planning process in place to get us there within the timelines that have been set out by VA and DOD. The leadership of both departments have set up a joint management structure through the Joint Executive Council and are closely tracking those items that have been agreed to within the Joint Strategic Plan.

So I think we can be hopeful that this time we will move through that list of items that have been identified as being important to be included in the lifelong health record that should be produced for veterans. And I hope that I don't come back here in the next decade saying we still haven't completed it, but in fact, say, in a very short period of time, in 2005, that we've been able to deliver on the promises we made today.

Mr. BUYER. Mr. Udall.

Mr. UDALL. Thank you, Mr. Chairman. The Indian Health Service, is it a part of this system? I mean, how does it interface with a soldier that moves through, that starts let's say before they enlist or are taken care of by the Indian Health Service and then goes through the system; discharged by the military and then comes back, and is near an Indian Health Service Hospital. Is the—are they included in the Federal Health Information Exchange. I mean, what is the——

Dr. MURPHY. At this point, the Federal Health Information Exchange is an initiative between VA and DOD. Part of my responsibilities as the Deputy Under Secretary for Health for Health Policy Coordination is to interface with HHS organizations, including the Indian Health Service. VA signed a memorandum of understanding with IHS in February of 2003, and, over the past year, have worked on several national initiatives to try to create the most accessible, highest quality health care for Native American veterans. Part of that now consists of a national initiative in health information technology. Our CIO's office in VHA has been working on a program to bring the VISTA-CPRS electronic health record system, in its current version, to the Indian Health Service.

That is a program that has been funded through the HHS budget this year and hopefully will move forward to full implementation in the future. So there is the opportunity if VA and IHS use identical health records systems and to include IHS in a Federal Health Information Exchange, or this real-time interoperable medical records system.

Mr. UDALL. Do they have the same system?

Dr. MURPHY. At this point, they have a system that they call RPMS, which is similar to our records system in VA but is about three versions older. IHS has recognized the need to upgrade it and include a more integrated package of IT services through their health records system and will adopt, hopefully in the future, the same system that VA is using.

Mr. UDALL. Thank you. Thank you, Mr. Chairman.

Mr. BUYER. That was a great question. I got an area I wanted to cover. Ms. Fites, your testimony indicates that it takes 60 days to get an image of the DD–214 to DPRIS, the Defense Personnel Records Image System; is that correct? Sixty days?

Ms. FITES. That's about the average.

Mr. BUYER. We don't know if any VA claims are delayed because of 60 days, do we, Dr. Murphy? It's kind of hard to tell, isn't it?

Dr. MURPHY. I don't know. We can certainly provide an answer for the record.

Mr. BUYER. That's all right. I'm just——

Dr. MURPHY. Most veterans know that they need to hand carry their paper, DD–214.

Mr. BUYER. You were an officer in the military, were you not?

Dr. MURPHY. Yes, sir.

Mr. BUYER. Ma'am, do you know the number of monthly requests the VA submits to DPRIS? And if you have it, can it be broken down by services? For the record?

Ms. FITES. Yes.

(See p. 137.)

Mr. BUYER. Do you know what the service turnaround times are for the VA when they make these requests to the personnel system?

Ms. FITES. No, I do not. But we can provide that——

Mr. BUYER. Can anybody help me out here?

Dr. MURPHY. We have somebody here from VBA. Yesterday, when I asked the same question, we were told that for individual records we sometimes get an immediate response. For batched records, the DD–214s are sent within 48 hours.

Mr. BUYER. Ma'am, can you answer this? What is your name?

Ms. ST. CLAIR. My name is Norma St. Clair. I work for Ms. Fites.

Mr. BUYER. Oh. Why don't you tell Ms. Fites, and Ms. Fites will testify.

Ms. FITES. Before the Defense Personnel Records Imaging System, it would take months to get the DD–214s to VA. Now, that it's in the system, it takes on the average to get it in the system the 60 days, but then it's either real-time or 48-hours in batch.

Mr. BUYER. Well, I'm going to stop beating you up on that. I guess where I'm left is, you know, Mr. Udall, my experience in dealing with DOD is that sometimes the only way you can get them to do things is you find out what their toys are, and you take them away. And it's called power on power.

I mean, it's really ridiculous, but it's something that—it happens sometimes. Maybe what we do, I'm just speaking out loud, what we ought to do is this Committee, coordinating with the Armed Services Committee, say, and we'll be prospective here, and we put a limiting amendment on an appropriations bill that says something to the effect that no monies shall be spent for future information technology systems, medical IT that is not interoperable between DOD, VA, or subsidiary health agencies. So we stop. We stop.

We actually stop the Army or the Navy or the Air Force buying medical IT systems that are not compatible or interoperable with the VA; and, at the same time, we tell the VA you can't go out there and buy this new flash bang item that somebody wants to sell you unless it can talk to DOD. You know, that's probably where I am, that we're going to have to actually do something like that.

Now, that will cause tremendous heartache. That, in fact, could cause tremendous problems, as you're trying to move toward "that vision." But that's about where I am. So, I'll give you an opportunity right now to tell me what your thoughts are if Congress were actually to do that in the Omnibus Bill that's going to happen here in two days. What do I do to you if we do that?

Ms. FITES. I think you hurt the people you very much want to help.

Mr. BUYER. Who, you?

Ms. FITES. No, you don't want to help me.

Mr. BUYER. That's right.

Ms. FITES. You want to help the servicemember and the veteran, and any delays in getting these programs more interoperable, and such language would cause delays, because the departments wouldn't know what to do.

Mr. BUYER. Wouldn't know what to do. Wouldn't the departments—let me turn to General Farmer.

General FARMER. Yes, sir, I believe that could hurt us very much and serve to undermine the vision that you have outlined. And let me tell you one of the ways is that in the Army, our medical information systems really have to do two things. We have to be interoperable with DOD, the Air Force and the Navy and ultimately the VA, but we also have to be interoperable with the rest of the Army on the battlefield in the many of the connections that we have—logistics and operations and other areas with the Army.

Many of those IM—IT systems that we put into Army medicine do not need to be both. So, we are running——

Mr. BUYER. So, General Farmer, if we give you a bridge, right? Because you've got a lot of systems out there, and we bridge it and say that no monies shall be spent after 2005. I'm just throwing something out here that I think it's a waste of money to allow the VA and DOD to continue to buy these medical technology systems, and you continue to purchase them through your own procurement routes knowing, knowing that while you're trying to move to seamless, you're buying systems that you know are not. So, General Farmer, help me out here? How do I—do I have to break—how do you break the culture. Generally, what we've found here on Capitol Hill is you break the culture through the dollar.

General FARMER. Sir, I believe that the leadership in the Department and in our service and our Army Medical Department is very dedicated to what you are after. The Health Executive Committee has been referenced a couple of times here this morning. It includes the Under Secretary of Health from the VA, Assistant Secretary of Defense for Health Affairs, and the Surgeons General, and our CIOs. And we are very dedicated toward getting to the future that you envision.

I would—I think we've talked about some of the future and some of the interim things that we're doing, demonstration projects and so forth, to get there. I would hope that we would not have barriers toward getting there, and I'm afraid that if you were to put into statute an absolute that precluded any systems that were not interoperable that it might backfire, sir.

Dr. MURPHY. From a VA standpoint, putting the restrictions on future IT purchases that you've proposed, I think would be counterproductive. We've come forward with a very good plan for creating interoperable records by 2005. There's already exchange of health records between VA and DOD. And I would ask that you monitor what we're doing.

I agree that putting an overall restriction on any IT spending could have a whole host of domino effects that could potentially affect the quality of health care for both active duty military members and for veterans. And I know that you don't want to do that, Mr. Chairman.

I think that there are other ways to accomplish what we *all* believe needs to be done. And we've committed today that we will complete the Joint Interoperable Electronic Health Record. And I can tell you that Dr. Roswell and Secretary Principi will keep the pressure on to keep this progress going. And there are other ways to encourage interdepartmental, inter-agency cooperation.

Mr. BUYER. Dr. Murphy, we do have the ability to be artful and clever on how to draft specific measures that are not harmful, yet

achieve what we desire. I'll tell you—here's where I think the Committee will be pretty upset—is we go out and we visit a facility next fall. And in that facility, we find out that the VA has just purchased a particular system, and I'll use the example of digital radiology, again, and it may be at a particular facility. Maybe it's Nellis. I don't know. Just pick one. And I see two brand new systems, just purchased, and they can't even talk to each other. I just want you to know—I just want to lay down the signal.

Mr. Udall, do you have anything on this panel? Last thing: I know you continue to meet. Will you bring up this discussion that we just had today? I want you to bring up the discussion because—well, have the discussion. And then I'll talk with you in the future. This panel is now excused. Thank you for your testimony today.

Sorry for taking so long. We now recognize Mr. Kem Clawson, Director of Advanced Solutions for EMC Corporation. You are now recognized. I thank you for your patience. Not that you haven't seen these types of things in the corporate world, but we are interested in your testimony. If you have a written statement, it will be submitted for the record. No objections, it shall be submitted, and your oral testimony, please proceed.

STATEMENT OF KEM CLAWSON, DIRECTOR OF ADVANCED TECHNOLOGY SOLUTIONS, EMC CORPORATION, McLEAN, VA

Mr. CLAWSON. Thank you, Chairman Buyer and distinguished members of the Oversight and Investigations Subcommittee. I am Kem Clawson, Director of Advanced Technology Solutions at EMC. It is an honor to be here today.

I welcome the opportunity to offer an industry perspective on the benefits and technological feasibility of developing a seamless, electronic record and sharing medical information between the DOD and the VA.

EMC has a deep understanding of the information storage and management challenges at the heart of health care today. Over 90 percent of the world's largest health care organizations depend upon EMC to store and manage their data.

Historically, the health care industry has been slow to adopt information technologies that provide dramatic increases in efficiency and reductions in cost. From our experience in the private sector, it requires active, forceful, senior executive direction from within an organization. Evidence of growing collaboration between the VA and DOD in the delivery of health care is a positive indicator that these agencies are firmly committed to overcoming institutional and cultural resistance to change often inherent in large organizations.

As the members of this Subcommittee know, the challenge of squeezing inefficiencies out of the health care system while improving the care that patients receive is considerable.

One obvious impediment is that our health care system remains a stubbornly paper-intensive and minimally automated environment. It has not fully embraced the productivity enhancing benefits of an electronic health care information capability.

The good news, Mr. Chairman, is that the impetus for change exists. It's a Patient Information Lifecycle Management Strategy. In simple terms, this refers to providing medical caregivers, regard-

less of time, distance, or geography, with an electronic patient record, a comprehensive unified digital record that encompasses a patient's medical information from birth to death. By pursuing this approach, DOD and VA can provide medical professionals with vital information that can be managed and shared. In other words, it can be seamless.

So how do we make progress today? Here are four steps in the right direction.

First, acknowledge a fundamental inconsistency of health care: it is one of the world's most information-intensive yet one of the world's least electronically-enabled industries.

Second, we must fully digitize and automate the collection, movement, and management of information throughout the health care environment. Electronic records can improve both our public and governmental health systems' ability to share medical information.

Third, take inspiration from medical organizations making the transition to electronic health records. In central Alabama, the name Baptist Health Montgomery is synonymous with high-quality health care. Baptist Health Montgomery has implemented an integrated health information system that ties together administrative, financial, imaging, and patient care applications.

From a business perspective, the system provides Baptist Health Montgomery with a business continuity capability that virtually eliminates downtime. It also enables clinicians and administrative personnel to better manage and share vital patient data for faster patient diagnosis; supports HIPAA requirements and state regulations more effectively; and facilitates a highly effective business decision making process.

Fourth, recognize that if we do not take full advantage of today's information technology, health care costs are going to continue to devour a larger and larger share of the annual budgets of both the DOD and VA. Moreover, critical patient information will remain fragmented, and, in many cases, unavailable when needed.

In closing, Mr. Chairman, please allow me to make one final observation. While the technology exists to establish a seamless medical record between the DOD and the VA, the complexity of these health care systems create enormous challenges. These challenges can be and will be overcome. Success, however, will not be achieved over night. Nor will it be attained without the continued and forceful involvement of each department's executive leadership, as well as Congress' commitment to provide each department with the resources it needs, in people and dollars, to execute on this vision. At the end of the day, even the world's best technology is only an enabler. What's needed is the determined resolve to build bridges between the DOD, VA, and Congress to get the job done. Thank you.

[The prepared statement of Mr. Clawson appears on p. 105.]

Mr. BUYER. Thank you very much. In terms of resources, metric is the word you've just used. Can you make a recommendation to the Committee regarding what metric should be used to determine the amount of money that we're to provide to the VA and DOD to make this initiative a reality?

Mr. CLAWSON. I'd be delighted, sir. Many projects are obviously underway. At this time, we don't have sufficient detail on those

projects to assess how far along they are. We believe that there are some metrics in the private sector that we could use as a benchmark——

Mr. BUYER. Okay.

Mr. CLAWSON. And what I'd like to suggest is that we get back to the Committee for the record with an answer in a very short time period as we look at some private sector benchmarks and compare it to knowledge we will hopefully be receiving from both departments.

Mr. BUYER. I think that would be extremely helpful to us. I appreciate——

Mr. CLAWSON. We'd be delighted.

Mr. BUYER. Your willingness to do so. There are instances where Congress, we've thrown a lot of money at these major IT systems, and, as you could tell from the last panel, that we're pretty challenged at the amount of money that we spend and continue to see cultures that they're moving incrementally together, but not at a speed at which we're satisfied. Well, actually this is—this question really shouldn't even go to you. I guess my mind is still back on the last panel. I apologize.

Mr. CLAWSON. That's quite all right, sir.

Mr. BUYER. Would you have a comment with regard to the timelines, since EMC—you do contracting, obviously with DOD, and do you have contracts with VA?

Mr. CLAWSON. Yes, sir.

Mr. BUYER. EMC. You do? Do you have the ability to comment on the reality of these timelines as they've been discussed in the last panel? Do you have the competency to testify to that?

Mr. CLAWSON. Mr. Chairman, we're not currently involved in any of the data sharing projects directly. We do have other contracts with both sides. On the surface, it sounds like a long time.

I think the March agreement to standardize on the emerging health standards is very positive. I'd like to see what the plans are in terms of execution against that agreement.

Standards are now considerably in place. We didn't have those five or ten years ago. There have been many enhancements to computer technology that have come out of the Internet world. We need to employ those.

There's an emerging standard, XML, which is extensible markup language. It's a way of facilitating data interchange between disparate systems. So, my answer is a bit long winded. I apologize. I think on the surface, it sounds like a conservative plan. We don't have the insight to what challenges may be coming upon them that we haven't seen.

Mr. BUYER. But let me use your term disparate systems. If we here in Congress permit these two agencies, of which we're trying to be more seamless, to continue to purchase disparate systems with varying capabilities, does that not then become an impediment to what we're trying to achieve?

Mr. CLAWSON. Mr. Chairman, it appears that way on the surface, certainly.

Certainly any enhancements that they're making should be made in view of data interchange compatibility being a requirement.

Mr. BUYER. All right. Mr. Udall?

Mr. UDALL. Thank you, Mr. Chairman. Mr. Clawson, on page 5 of our testimony you discuss HIPAA and how the new system supports privacy-related issues. As the size of the shared system gains access points, does it become more or less secure?

Mr. CLAWSON. Congressman, with best practices employed, current available technology does not increase the exposure. Electronic-based records, when we're employing our current best practices for security and privacy, are more secure and private than the paper-based records. The key imperative there is: are we employing current best practices? I believe that that technology is available. I believe the practice are established and proven; we just need to ensure that we're employing them.

Mr. UDALL. What are some of those best practices that would assure that privacy.

Mr. CLAWSON. I think there's several layers, and, please, I hope I'm not going to get too technical. I believe one is access control. It says we look at who has access to our networks. We have capability for authentication to ensure that only authorized people are accessing networks. We have technology to then control—so that gets them into the network to some servers. We then have capability to ensure that only the proper servers have access to the certain databases. So we can control internally.

Security experts tell me that the challenge of security is, in many cases, larger within an organization than from the outside. But we need to be sure to look at both sides of that. So, again, I believe network access control standards, and there's a wealth of technology there available; then at the server and data level, we have additional levels.

It reminds me of my home security. I have a door knob with a lock and a deadbolt. I want multiple layers there. And so I think that technology is well known and in existence and should be employed.

Mr. UDALL. Thank you. And thank you, Mr. Chairman.

Mr. BUYER. Based on experience in the private sector, can you tell us with regard to any risk or threat potential that there has been with regard to a digitized medical record that you should warn us about?

Mr. CLAWSON. Mr. Chairman, I'm not aware of any particular threat. Again, I think we need to employ all of our current best practices for security and HIPAA compliance. I think that body of knowledge is well known and documented. There are professionals with that expertise. We need to ensure that it's put to use.

Mr. BUYER. All right. So obviously the great fear is what happens—the computer goes down. You have a system outage. A system has been corrupted. Viruses. I mean, that's the reason I asked that particular question. So, yeah, we're moving to this digital world. It gives us benefits, but we also know that there are also some threats out there. That was the purpose of—I should have defined my question a little bit better, and now let me throw it back to you.

Mr. CLAWSON. Thank you, Mr. Chairman, for the clarification. You know, I pretty much live my life with my Palm Pilot. And I remember the first one I bought people said to me, oh, yeah, that's great. What happens when you lose it or it breaks? Aren't you

going to be in trouble? And, of course, the person that was asking me that had the proverbial little black book, with all their phone numbers and addresses, which had been lost before. And I said, well, you know, this is backed up. It's synchronized with my lap top, which is backed up to my file server, which is every other night backed up to magnetic tape and stored off site. So, I said, I feel like we have the capability, and we certainly espouse in those best practices of replicating key information such that it's done in a non-invasive fashion and multiple copies are available should one become lost or corrupted.

So to your point, there are best practices today that will ensure the ongoing availability of those accurate records.

Mr. BUYER. Well, with regard to the vision on where we're trying to take DOD and VA as a provider of storage, you guys got to be happy. Who else is out there in the industry with regard to storage? EMC and who else? I don't know who all's in the storage business.

Mr. CLAWSON. Mr. Chairman, all of the major computer server vendors also have storage. So, of course, IBM, Sun, Hewlett-Packard. Storage Technology is another firm, and then there are a number of smaller firms. But those——

Mr. BUYER. How many do government contracting?

Mr. CLAWSON. Pardon me?

Mr. BUYER. How many are in the business of government contracting with regard to server storage?

Mr. CLAWSON. I believe all of them are.

Mr. BUYER. And with regard to major systems?

Mr. CLAWSON. Mm hmm.

Mr. BUYER. Okay. The contracts that you have with DOD right now and VA, were those competitively bid or were they sole source contracts.

Mr. CLAWSON. I believe those were competitively bid, to the best of my knowledge.

Mr. BUYER. All right. Okay. Mr. Udall, do you have any follow-up? Mr. Clawson, I want to thank you for your patience, and I also want to thank you for the extra project that you're taking on for us with regard to the financial matrix. I think that will be helpful to us. And I appreciate you working with DOD and VA on these larger issues.

Dr. Murphy, I want to thank you for sticking around, and if I could see you immediately after the hearing, I would appreciate it.

This hearing is now concluded. Thank you very much.

[Whereupon, at 1:00 p.m., the subcommittee was adjourned.]

APPENDIX

The Honorable Steve Buyer
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
Hearing on VA-DOD Shared Medical Records –
20 Years and Waiting
November 19, 2003

Good morning. Today's hearing is entitled: VA-DOD Shared Medical Records – 20 Years and Waiting. Since we currently have thousands of service members who are transitioning from active duty to civilian and who will need health care and other veteran's benefits, this hearing cannot be more timely.

I believe it is critical that VA and DOD share medical information to ensure the continuation of health care to returning soldiers, sailors, and marines. This is an essential component in the processing of VA claims for benefits to which the veteran may be entitled.

It is very challenging for the VA to determine what is service-connected…if the flow of information is not accessible and easily retrievable. What we are left with are service members with duplicate or incomplete medical records. Earlier this year, the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans, issued its final report. The Task Force summarized its findings this way: VA and DOD responsibility for veterans' health begins as soon as an individual enters the Armed Forces. [Let me interject here, that should include pre-and post-deployment medical examinations.] The Task Force summary went on to say: Collecting and capturing baseline medical information upon entry into the military in an interoperable, bi-directional, and standards-based electronic medical record is the first step in the process. I intend to ask both the VA and DOD how these stated goals are being met and what specific progress has been made in these three critical areas. I understand that headway has finally been made after all these years regarding the setting of standards.

It is an established fact that the technology exists today to accomplish this mission. And, I will acknowledge that there has been more movement in the last 14 months than in the past 20 years. However, the end game is not yet in sight. What we hope to learn today is what are the impressions of insurmountable.obstacles that keep these two departments from accomplishing the goal that was first set back in1982 by Public Law 97-174. The repeated question is always the same, "Why is it taking so long and when will VA and DOD have systems that can talk to each other?"

Ever since the first Gulf War, I have followed this issue with great interest because I believe it is our responsibility to ensure that we avoid the problems that the returning service members faced in the early 1990's, which made it very difficult for the VA to make determinations on disability claims.

Today, after some 20 years and untold billions of dollars, we are going to hear how close that horizon is that will allow our men and women that have bravely served our country to have a seamless electronic medical record that captures and documents all of data on their deployment; nuclear, chemical, or biological exposures, medical care and conditions during their service to their country.

Opening Statement for Honorable Darlene Hooley, Ranking Democratic Member
Subcommittee on Oversight and Investigations
Hearing on DoD/VA Sharing, November 19, 2003

This concept of DoD/VA sharing is not a new idea, but it is a good idea whose time has come. With service members returning from missions abroad and with the VA responsible in many circumstances for assuming some important aspect of veterans' health care, immediate transfer of personnel and medical data is more than just a convenience. It is necessary to account for service members in theater, track their return, and assure that the appropriate care is tendered. Accumulating this information will also assist epidemiological tracking of emergent and long-term medical problems of returning veterans. This can be readily accomplished today, electronically. It should be an important element of DoD/VA sharing, but its level of development is not always what this committee has anticipated. The time for meaningful electronic DoD/VA sharing has come.

Actually, its time officially came in 1982 with Public Law 97-174 authorizing sharing activities between those two large agencies. So, DoD/VA sharing is now of age; it just turned 21 years old. But this 21-year-old needs much attention and often more than a little encouragement – it can not yet run nor even walk swiftly. At age 21 its performance is close to that in its developmental childhood -- not yet possessing a two-way vocabulary that fully realizes electronic medical records transfer or the significant transfer of personnel data between two agencies that individually have far more robust data systems already in place in these areas. As subcommittee clinicians to the body of law wishing to determine why this 21-year old is not performing, we must ascertain if it now has the ability to do what we ask of it regarding electronic medical records transfer and other IT sharing issues.

If the problem is in the maturity of the design of the DoD/VA sharing concept, we must be patient and wait for it to mature, to wait for performance.
If we think the sharing concept is ***able*** to perform today, we must ask why it toddles behind the private sector in working out these basic sharing issues. If we determine that the ability to provide electronic medical records transfer, and many other issues at the heart of two-way data sharing between the agencies exists today, we must hold those agencies accountable for their non-performance. Lives are potentially at stake and, most certainly, management efficiencies are on the line.

At previous hearings by this subcommittee, we have taken testimony about what will happen regarding some program or agenda. We sometimes get a date and set a milestone, only to have agency priorities change and a sharing issue move from the front of the parade of ideas to a back-burner-priority. Twenty-one years of planning; 21 years of promises – I ask, what is the actual level of performance today regarding sharing of electronic medical and personnel data? The GAO's statement offers us cause

for hope, but the real performance questions must be answered by the clinicians and stakeholders at field-level activities. It is their metrics that matter most.

In testimony during a May 17, 2000, hearing, both principals from DoD and VA [Ms. Gwen Brown and Dr. Garthwaithe, respectively] testified regarding the Government Computer-based Patient Project. The testimony was then in terms of what "will" happen and notes that the agencies have entered agreements to "share." The GAO tells us now that this precursor system to the current Federal Health Information Exchange is yielding one-way transfers of information today and that it is a good beginning. DoD/VA sharing was 18 years old at the time of that hearing.

The October 18, 1995, hearing on VA/DoD Sharing includes an agreement between DoD and VA to develop joint and coordinated efforts with regard to developing telemedicine as a means to improve medicine and as a means to improve readiness and patient care and improve interoperability and interconnectivity between VA and DoD services. This was a strong portend of electronic medical records transfer. DoD/VA sharing was about 13 years old.

Following the June 26, 1986, hearing on implementation of P.L. 97-174, Chairman Sonny Montgomery asked the DoD about its policy regarding the sharing of Automatic Data Processing resources with VA. The DoD response listed a number of working groups focused on sharing. DoD/VA sharing was about three years old.

We still await the full, two-way exchange of patient health information between the agencies in a way meaningful and useful to all field level activities. We do note substantive recent progress toward this goal.

We have asked for a single form, the form DD-214 to be electronically created, archived, and readily available to VA to facilitate a myriad of issues regarding VA benefits. Is the technology to make this work available today? Is there anyone in this room who doubts that this is problematic today from a technical perspective? I think not. Real progress will be indicated when appropriate people at VA are able to access this timely information, electronically, nationwide.

Mr. Chairman, we have heard a litany of promises in the past on this and related sharing issues. Sometimes there is progress, sometimes there is not. The technology available to facilitate DoD/VA sharing regarding medical and personnel records transfer has improved dramatically since 1982 when it was just an embryonic vision. The technological hurdles to achieve full, two-way transfer are not difficult to overcome so long as the old cultural barriers to sharing between the agencies have been overcome. If any remaining cultural barriers to this level of sharing are overcome, the problems related to the technology involved will be minor.

Opening Statement of Lane Evans

I was elected to Congress in the same year that DoD/VA sharing became law, 1982.

Over the years, the success of "sharing" has been a recurrent theme on this Committee.

Whenever we research or review this issue in search of a cause for sharing problems, the discussion often turns to organizational culture.

VA and DoD always have had opportunities to enhance efficiencies and services through sharing. Too often, they don't avail themselves of those opportunities, at least without a gentle nudge from somewhere.

Today's hearing involves electronic medical records transfer. I am pleased that progress has been made and that an information flow exists from DoD to VA for some medical records.

Yet, timeliness, completeness, and bi-directional data flow limitations remain as problems.

It is not likely that these problems are caused by technology limitations – that they could not be solved in short order. Does some cultural barrier remain that slows progress in this area?

Mr. Chairman, I yield back the balance of my time.

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 10:30 a.m. EST
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COMPUTER-BASED PATIENT RECORDS

Short-Term Progress Made, but Much Work Remains to Achieve a Two-Way Data Exchange Between VA and DOD Health Systems

Statement of Linda D. Koontz, Director
Information Management Issues

GAO-04-271T

November 19, 2003

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Highlights

Highlights of GAO-04-271T, a report to the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs

COMPUTER-BASED PATIENT RECORDS

Short-Term Progress Made, but Much Work Remains to Achieve A Two-Way Data Exchange Between VA and DOD Health Systems

Why GAO Did This Study

For the past 5 years, the Departments of Veterans Affairs and Defense have been working to exchange health care data and create electronic records for veterans and active duty personnel. Such exchange is seen as a means of reducing the billions of dollars that the departments spend annually on health care services and making such data more readily accessible to those treating our country's approximately 13 million veterans, military personnel, and dependents. This is especially critical when military personnel are engaged in conflicts all over the world, and their health records can reside at multiple locations.

GAO has reported on these efforts several times, most recently in September 2002. At the request of the Subcommittee, GAO is updating its observations on the departments' efforts, focusing on (1) the reported status of the ongoing, one-way exchange of data, the *Federal Health Information Exchange*, and (2) progress toward achieving the longer term two-way exchange under the *Health People (Federal)* initiative.

What GAO Found

Access to medical data that includes information on the entire lives of veterans and active duty military personnel represents an enormous step toward enhanced and more effective medical care. VA and DOD are pursuing this goal in two stages.

- ***Federal Health Information Exchange.*** This current, one-way transfer of health care data from DOD to VA is already allowing clinicians in VA medical centers to make faster, more informed decisions through ready access to information on almost 2 million patients, thereby improving their level of health care delivery. The program's fiscal year 2003 cost was just over $11 million.

- ***Health People (Federal).*** The realization of this longer term strategy to enable electronic, two-way information sharing is farther out on the horizon. The departments are proceeding with projects that are expected to result in a limited two-way exchange of health data by the end of 2005. However, VA and DOD face significant challenges in implementing a full data exchange capability. Although a high-level strategy exists, the departments have not yet clearly articulated a common health information infrastructure and architecture to show how they intend to achieve the data exchange capability or what they will be able to exchange by the end of 2005. In addition, critical to achieving the two-way exchange will be completing the standardization of the clinical data that these departments plan to share. Without standardization, the task of sharing meaningful data could be more complex and may not prove successful.

VA, DOD Systems to Support Two-Way Data Exchange Strategy

VA Initiatives	Projected Completion	DOD Initiatives
	2005	Graphical User Interface, General Dentistry
Health Data Repository, Billing Replacement	2006	Pharmacy, Laboratory, Radiology, Immunizations
Laboratory	2007	Inpatient and Scheduling
Pharmacy	2008	Additional Capabilities as Defined
Imaging	2011	
Appointment Scheduling Replacement	2012	

Source: VA and DOD.

www.gao.gov/cgi-bin/getrpt?GAO-04-271T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Linda D. Koontz at (202) 512-6240 or koontzl@gao.gov.

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting us to testify on actions of the Department of Veterans Affairs (VA) and the Department of Defense (DOD) to achieve the ability to exchange patient health care data and create an electronic record for veterans and active duty personnel. VA and DOD, collectively, provided health care services to approximately 13 million veterans, military personnel, and dependents at a cost of about $47 billion in fiscal year 2002. While in military status and later as veterans, many patients tend to be highly mobile and, consequently, their health records may be at multiple federal and nonfederal medical facilities, both in and outside of the United States. Thus, having readily accessible data on active duty personnel and veterans is important to facilitate providing quality health care to them.

VA and DOD have been pursuing ways to share data in their health information systems and create electronic records since 1998, their actions following the President's call for the development of an interface to allow the two departments to share patient health information.[1] Since undertaking this mission, however, the departments have faced considerable challenges, leading to repeated changes in the focus of their initiative and the target dates for its accomplishment. Our prior reports discussing the initiative[2] noted disappointing progress, exacerbated in large part by inadequate accountability and poor planning and oversight, which raised doubts about the departments' ability to achieve an electronic interface among their health information systems. When we last reported on the initiative in September 2002,[3] VA and DOD had taken some actions aimed at strengthening their joint efforts. For example, they had

[1]In 1996, the Presidential Advisory Committee on Gulf War Veterans' Illnesses reported on many deficiencies in VA's and DOD's data capabilities for handling service members' health information. In November 1997, the President called for the two agencies to start developing a "comprehensive, life-long medical record for each service member," and in 1998 issued a directive requiring VA and DOD to develop a "computer-based patient record system that will accurately and efficiently exchange information."

[2]U.S. General Accounting Office, *Computer-Based Patient Records: Better Planning and Oversight by VA, DOD, and IHS [Indian Health Service] Would Enhance Health Data Sharing,* GAO-01-459 (Washington, D.C.: Apr. 30, 2001); *VA Information Technology: Progress Made, but Continued Management Attention Is Key to Achieving Results,* GAO-02-369T (Washington, D.C.: Mar. 13, 2002); and *VA Information Technology: Management Making Important Progress in Addressing Key Challenges* GAO-02-1054T (Washington, D.C.: Sept. 26, 2002).

[3]GAO-02-1054T.

clarified key roles and responsibilities for the initiative and begun executing revised near- and long-term strategies for achieving the electronic information exchange capability.

My statement today will discuss our observations regarding VA's and DOD's continued actions over the past year to further their implementation of the electronic information exchange, including an update on (1) the status and reported benefits of the ongoing near-term initiative, the Federal Health Information Exchange (FHIE), and (2) the departments' progress and challenges in achieving the longer term, two-way exchange of data under the HealthePeople (Federal) initiative.

In conducting this work, we obtained and reviewed relevant documentation and interviewed key agency officials regarding VA's decisions and actions, in conjunction with DOD, to develop an electronic medical record for exchanging patient information. We analyzed the departments' plans and strategies for the HealthePeople (Federal) initiative and data on patient information that is currently being transmitted by DOD to VA. In addition, to observe data retrieval capabilities of the Federal Health Information Exchange, we conducted a site visit at the VA medical center in Washington, D.C. We performed our work in accordance with generally accepted government auditing standards, from March through November 2003.

Results in Brief

The current one-way transfer of health information resulting from the departments' near-term solution—the Federal Health Information Exchange—represents a positive undertaking that has begun enabling information sharing between DOD and VA. As part of the initiative, electronic health data from separated (retired or discharged) service members contained in DOD's Military Health System Composite Health Care System are being transmitted monthly to a VA FHIE repository,[4] which VA clinicians access through the department's current health system, the Veterans Health Information Systems and Technology Architecture. As a result, VA clinicians now have more readily accessible DOD health data, such as laboratory, pharmacy, and radiology records, on almost 2 million patients and have noted the benefits of this current capability in improving health care delivery. Further, although not

[4]A repository is an information system used to store and access data.

originally included in the FHIE plan, VA officials have stated that efforts are underway to provide access to outpatient and retail pharmacy data.

Realizing the departments' longer term strategy—HealthePeople (Federal)—is farther out on the horizon. VA officials have stated that the departments are on schedule to provide a limited capability for an electronic, two-way exchange of patient health information by the end of 2005. However, VA and DOD face significant challenges in implementing a full data exchange capability. Although a high-level strategy exists, the departments have not yet clearly articulated a common health information infrastructure and architecture to show how they intend to achieve the data exchange capability or what exactly they will be able to exchange by the end of 2005. In addition, critical to achieving the two-way exchange will be completing the standardization of the clinical data that these departments plan to share. Without standardization, the task of sharing meaningful data is made more complex, and may not prove successful. Until these essential issues are resolved, the departments cannot be assured that the HealthePeople (Federal) initiative will deliver expected benefits within established time frames.

Background

In 1998, VA and DOD, along with the Indian Health Service (IHS), began the Government Computer-Based Patient Record (GCPR) project—an initiative to share patient health care data. At that time, each agency collected and maintained patient health information in separate systems, and their health facilities could not electronically share patient health information across agency lines. GCPR was envisioned as an electronic interface that would allow physicians and other authorized users at VA, DOD, and IHS health facilities to access data from any of the other agencies' health facilities. The interface was expected to compile requested patient information in a "virtual" record that could be displayed on a user's computer screen.

In reporting on the initiative in April 2001,[5] we raised doubts about GCPR's ability to provide expected benefits. We noted that the project was experiencing schedule and cost overruns and was operating without clear goals, objectives, and consistent leadership. We recommended that the participating agencies (1) designate a lead entity with final decision-making authority and establish a clear line of authority for the GCPR

[5]GAO-01-459.

project, and (2) create comprehensive and coordinated plans that included an agreed-upon mission and clear goals, objectives, and performance measures, to ensure that the agencies could share comprehensive, meaningful, accurate, and secure patient health care data. VA, DOD, and IHS agreed with our findings and recommendations.

In March 2002, however, we again reported that the project was continuing to operate without clear lines of authority or a lead entity responsible for final decision-making.[6] Further, the project continued to move forward without comprehensive and coordinated plans, including an agreed-upon mission and clear goals, objectives, and performance measures. In addition, the participating agencies had announced a revised strategy that was considerably less encompassing than the project was originally intended to be. For example, rather than serve as an interface to allow data sharing across the three agencies' disparate systems, as originally envisioned, the revised strategy initially called only for a one-way transfer of data from DOD's current health care information system to a separate database that VA hospitals could access. In further reporting on this initiative in June 2002, we recommended that VA, DOD, and IHS revise the original goals and objectives of the project to align with their current strategy, commit the executive support necessary to adequately manage the project, and ensure that it followed sound project management principles.[7]

When we last testified on the initiative in September 2002,[8] VA had reported some progress toward achieving shared patient health care data and the two departments had formally revised both the name and the strategy for the initiative. Specifically, the two departments had renamed the project the Federal Health Information Exchange (FHIE) Program. In addition, consistent with our prior recommendation, they had finalized a memorandum of agreement designating VA as the lead entity in implementing FHIE.[9] With this agreement, FHIE became a joint effort

[6]GAO-02-369T.

[7]U.S. General Accounting Office, *Veterans Affairs: Sustained Management Attention Is Key to Achieving Information Technology Results*, GAO-02-703 (Washington, D.C.: June 12, 2002).

[8]GAO-02-1054T.

[9]IHS, which had been a part of the early efforts, was not included in FHIE, but was expected to assume a role in the longer term project—*Healthy People* (Federal).

between VA and DOD to achieve the exchange of health care information in two phases. The first phase, completed in mid-July 2002, enabled the one-way transfer of data from DOD's existing health care information system to a separate database that VA hospitals could access.

Further, the revised strategy envisioned VA and DOD pursuing a longer term, two-way exchange of clinical information. This initiative, known as HealthePeople (Federal), is premised upon the departments' development of a common health information infrastructure and architecture comprising standardized data, communications, security, and high-performance health information systems. The departments developed the strategy for achieving the two-way exchange in September 2002 and anticipated achieving a limited capability by the end of 2005.

VA and DOD Continue to Report Success in Implementing the Federal Health Information Exchange Near-Term Solution

Over the past year, VA and DOD have continued to realize success in the implementation and use of FHIE. In achieving the exchange of health care information, electronic data from separated (retired or discharged) service members contained in DOD's Military Health System Composite Health Care System (CHCS) are being transmitted monthly to a VA FHIE repository, which VA clinicians access through the Computerized Patient Record System (CPRS) in the Veterans Health Information Systems and Technology Architecture (VistA), VA's current health care system. This information exchange capability is currently available to all VA medical centers and has given VA clinicians the ability to access and display the data through CPRS remote data views[10] about 6 weeks after the service member's separation. VA and DOD reported spending about $11 million in fiscal year 2003 to cover completion and maintenance of FHIE.

According to program officials, FHIE is showing positive results by providing a wide range of health care information to enable clinicians to make faster and more informed decisions regarding the care of veterans. The officials stated that the repository presently contains data on almost 2 million patients. This includes clinical data on almost 1.8 million personnel who separated from the military between 1987 and June 2003. The data consist of over 23 million laboratory records, 24 million pharmacy records and over 4 million radiology records. A second phase of the FHIE initiative, completed in September 2003, added to the base of health

[10]CPRS remote data views is an application that allows authorized users to access patient health care data from any VA medical facility.

information available to VA clinicians by including discharge summaries;[11] allergy information; admissions, disposition, and transfer information; and consultation results. A clinician at VA's Washington, D.C., medical center noted that the information provided through FHIE has proved particularly valuable for treating emergency-room and first-time patients by providing ready access to information on patients' existing medical conditions and current drug prescriptions.

The program manager added that FHIE is allowing quick access to health information. It is currently capable of accommodating up to 800 queries per hour, with an average response rate of 4 seconds per query. For the month of September 2003, VA clinicians made over 1,900 authorized queries to the database. Further, as we observed during an FHIE demonstration at the medical center, the capability has resulted in an almost instantaneous display of DOD patient data in the same format as other data residing in CPRS, thus facilitating its use.

Although nearing completion, VA officials indicated, additional patient information from DOD will be added to the FHIE database. For example, they stated that efforts are currently under way to add, by the end of December, outpatient pharmacy data (such as mail order and retail pharmacy profiles) that are housed in DOD's Pharmacy Data Transaction Service, and by the end of February 2004, other outpatient records.

Actions Toward a Common Health Information Infrastructure Are Progressing, but Significant Challenges Remain

Beyond FHIE, VA and DOD are proceeding with a joint, long-term strategy involving the two-way exchange of clinical information. Under this strategy, VA and DOD plan to seek opportunities for sharing existing systems and technology and explore the convergence of VA and DOD health information applications consistent with mission requirements. According to the Veterans Health Administration's Acting Deputy Chief Information Officer (CIO) for Health, and the Military Health System's CIO, this joint VA/DOD initiative is expected to allow the secured sharing of health data required by their health care providers between systems that each is currently developing—DOD's Composite Health Care System II (CHCS II) and VA's HealtheVet VistA. Critical to achieving this capability is an interface to allow the exchange of patient health information between each system's data repository.

[11]Discharge summaries include inpatient histories, diagnoses, and procedures.

Under the HealthePeople (Federal) strategy, upon entering military service, a health record for the service member will be created and stored in DOD's CHCS II clinical data repository. The record will remain in the clinical data repository and be updated as the service member receives medical care. When the individual separates from active duty and, if eligible, seeks medical care at a VA facility, VA will then create a medical record for the individual, which will be stored in its health data repository. Upon viewing the medical record, the VA clinician would be alerted and provided access to clinical information on the individual also residing in DOD's repository. In the same manner, when a veteran seeks medical care at a military treatment facility, the attending DOD clinician would be alerted and provided access to the clinical information existing in VA's repository. According to VA and DOD, the planned approach would make virtual medical records displaying all available clinical information from the two repositories accessible to both departments' clinicians.

VA and DOD Are Making Progress, but Full Implementation of Joint Strategy Is Years Away

VA's and DOD's joint strategy for accomplishing the two-way exchange of health information, developed in September 2002, depends on successfully implementing and achieving an electronic interface between individual health information systems that each department is currently developing. These systems development efforts began as separate, department-specific initiatives in which VA aimed to enhance its existing health information system utilizing modern tools and languages, and DOD aimed to replace several of its health information systems to achieve cost efficiencies and a computer-based patient record. Work on modernizing VA's new system, HealtheVet (VistA), began in 2001, and development of DOD's new system, CHCS II, began in 1997.

Since establishing the strategy, VA and DOD have made some progress on systems development efforts that will support achieving health data exchange. Currently, VA and DOD are in different stages of completing their systems. As shown in table 1, VA began work on one of the key initiatives intended to support HealthePeople (Federal)—the health data repository—in June 2001; it is currently testing the design of this database. VA plans to complete the repository by July 2006; it projects completing all six initiatives comprising HealtheVet (VistA) over the next 9 years, with a final module on scheduling replacement expected in May 2012.

Table 1: HealtheVet (VistA) Initiatives

HealtheVet Initiative	Purpose	Initiative Start Date	Projected Completion Date
Health Data Repository (HDR)	Establish a repository of clinical information normally residing on one or more independent platforms	June 2001	2006
Billing Replacement	Obtain a modern, high- performance billing system that will support an increase in third- party payments	April 2002	2006
Laboratory	Clinically oriented system designed to provide data to health care personnel	February 2003	2007
Pharmacy	Facilitate improved VA pharmacy operations, customer service, and patient safety, concurrent with the pursuit of full reengineering of VA pharmacy applications	April 2002	2008
Imaging	Provide complete online data to healthcare providers, to increase clinician productivity, facilitate medical decision-making, and improve quality of care	October 2002	2011
Appointment Scheduling Replacement	Provide VistA users with a redesigned scheduling capability to better meet the needs of VHA facility staff and patients	May 2001	2012

Source: VA

As table 2 reflects, DOD is incrementally deploying CHCS II in five blocks, with each block providing additional capabilities to its system. The department is currently proceeding with limited deployment of its graphical user interface for clinical outpatient processes. In addition, DOD has completed its clinical data repository, and a department official stated that as each site implements CHCS II, data in CHCS will be converted to the new system. DOD expects to complete deployment of all of its major system capabilities by September 2008.

Table 2: CHCS II Deployment Information

Block Number	Major Capabilities	Status	Projected Completion Date
1 (release 1)	Adds a graphical user interface for clinical outpatient processes	Limited deployment underway	September 2005
2 (release 2)	Support for general dentistry	Deployment to Operation, Test & Evaluation sites during the 2nd Qtr of FY04	September 2005
3 (releases 3&4)	Provides pharmacy, laboratory, radiology, and immunizations capabilities	Plan under way to award a contract for Block 3 in 2nd Qtr FY 04 and begin requirements analysis by 4th Qtr FY04	September 2006
4 (releases 5&6)	Provides inpatient and scheduling capabilities	Begin requirements development and analysis in 2nd Qtr FY 04	September 2007
5 (release 7)	Additional Capabilities as Defined	Begin requirements development and analysis in early 1st Qtr FY05	September 2008

Source: DOD.

Although VA and DOD officials do not expect their departments' systems to be fully implemented until 2012 and 2008, respectively, they anticipate being able to exchange some degree of clinical information through an interface between DOD's clinical data repository and VA's planned health data repository by the end of calendar year 2005. VA officials explained that by that time, they expect to have developed the HealtheVet (VistA) health data repository to a point at which it will have limited data. However, the departments have not yet articulated exactly what data will be available.

Also critical, VA and DOD have begun adopting data standards. Data standardization is essential to allowing the exchange of health information from disparate systems and improving decision-making by providing health information when and where it is needed. In accordance with the Consolidated Health Informatics Initiative,[12] in March 2003, VA and DOD, along with the Department of Health and Human Services, announced the adoption of four standards to allow the transmission of messages and one standard that allows laboratory results to be presented uniformly in any system. In addition, VA officials stated that the departments have examined and concluded that their existing legislation and policies meet the intent of the Health Insurance Portability and Accountability Act.

VA and DOD Face Challenges in Moving Toward HealthePeople (Federal)

VA and DOD face key challenges to completing HealthePeople (Federal) that raise doubts as to when and to what extent a true virtual health record will be achieved. Although a high-level strategy exists, the HealthePeople (Federal) joint work group faces the challenge of clearly articulating a common health information infrastructure and architecture to show how they intend to achieve the data exchange capability, or just what they will be able to exchange by the end of 2005. Such an architecture is necessary for ensuring that the departments have defined a level of detail and specificity needed to build the data repository interface, including interface requirements and design specifications. For example, having detailed specifications would assist VA in making critical decisions such as the manner in which it will store its electronic data. According to VA officials, they have not yet determined whether one central or several regional data repositories would best facilitate access to the patient

[12]The Consolidated Health Informatics Initiative, created under the President's Management Agenda, identified a portfolio of 24 target areas for data and messaging standards that would enable all agencies in the federal health enterprise to more readily exchange clinical health information.

information and achieve the timely response rates required by clinicians at its medical facilities.

Another critical challenge to successfully implementing HealthePeople (Federal) will be completing the standardization of the data elements of each department's health records. While standards for laboratory results were adopted in 2003, VA and DOD face a significant undertaking to standardize the remaining health data. To lend perspective to the enormity of this task, according to the joint strategy that VA and DOD have developed, VA will have to migrate over 150 variations of clinical and demographic data to one standard, and DOD will have to migrate over 100 variations of clinical data to one standard. VA officials have indicated that as various HealtheVet (VistA) applications are developed, they plan to incorporate clinical data standards. Further, they and DOD officials maintain that their departments, along with the Department of Health and Human Services, are actively pursuing the development and adoption of such data standards. Nonetheless, they remain uncertain as to what degree of standardization (beyond the laboratory result standard that has been adopted) will be achieved by the 2005 milestone for implementing the two-way exchange of health information.

In summary, in pursuing an electronic exchange of patient health information, VA and DOD are taking a vital step toward facilitating services to our nation's active duty personnel and veterans. The ability to readily access medical records covering the lifecycle of service members and veterans would enhance the effectiveness of care to these individuals. In working toward this capability, VA and DOD have achieved a measure of success in sharing data, as evidenced by VA clinicians now having access to military health records for veterans through FHIE. However, a virtual medical record based on the two-way exchange of data between VA and DOD is far from being achieved. The departments face significant challenges in realizing this longer term strategy. Without having clearly articulated a common health information infrastructure and architecture, the departments lack the details and specificity essential to determining how they will achieve the data exchange capability.

Mr. Chairman, this concludes my statement. I would be pleased to respond to any questions that you or other members of the Subcommittee may have at this time.

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Statement of
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Department of Veterans Affairs
Before the
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U. S. House of Representatives

November 19, 2003

Mr. Chairman and Members of the Committee, I am pleased to appear before you today to give testimony regarding the progress being made by the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to share health information and to develop a veteran-centric, seamless electronic health record.

One of the most important lessons learned from the 1st Gulf War is the need for interagency collaboration on deployment health issues, and the need for health data regarding a service member's deployment, occupational exposures and health conditions that will allow VA to provide the best possible health care and benefits for veterans. VA applauds the efforts of DoD to prevent health problems among deployed troops. Furthermore DoD is providing cutting edge care in-theater for combat casualties. However, the wounds of war are not always obvious, and we appreciate today that military service may have enduring health consequences long after the actual war has ended.

Improved medical record keeping and data from environmental surveillance during deployments can be invaluable for addressing the short and long-term health care and benefits needs of America's veterans. In the short-term, VA needs information that may be relevant to recently deployed service members' or veterans' immediate health care needs, looking for any unusual health problems among newly separated veterans from a specific deployment, and to establish special health care eligibility for returning combat theatre veterans. In the long term, VA needs clinical and

administrative data to evaluate the long-term health of veterans from a specific deployment – to be able to answer key questions and concerns from veterans and their families about important matters like reproductive health issues or cancer rates among veterans in comparison with their non-deployed peers.

To this end, the "President's Taskforce to Improve Health Care Delivery For Our Nation's Veterans" (PTF) focused upon the importance of providing for a seamless transition from military to veteran status, including the coordination and sharing of electronic health information between VA and DoD. VA is working with DoD through the VA/DoD Health Executive Council and Joint Executive Council and in other venues to keep the focus upon this critical goal of information sharing.

Create a Seamless Transition

The President's Task Force recommended that the two departments use standardized electronic health-related information nationwide to help ensure a seamless transition from military to veteran status. As the Task Force has noted, information systems coordination is a critical link between the two Departments.

DoD and VA are moving forward jointly to improve the efficiency and accuracy of enrollment information through the creation of integration points that will permit VA to access the Defense Enrollment and Eligibility Reporting System (DEERS) in real time by the end of 2005, a key objective in the President's Management Agenda. The Veterans Health Administration (VHA) has identified a need for service indicators (such as contingency locations and dates of service, receipt of imminent danger and hazardous duty pay, etc) from DoD that will support VA's delivery of special health care benefits to Combat Veterans. As this information sharing becomes a reality, we expect that a service member's transition from active duty to veteran status will be simplified significantly while improving the process of accurately informing the veteran of all potential benefits for which s/he may be eligible.

Another key information technology initiative in the President's Management Agenda addresses the sharing of individual health care information between the two systems. We believe that VA and DoD are making progress towards deployment of electronic medical records that are interoperable, bi-directional, and standards-based by the end of 2005. Our Departments have formed a close collaborative partnership, to include the development of a joint business case for electronic health records, under the

Federal Health Information Exchange (FHIE) and HealthePeople (Federal) projects. In addition, we have signed formal Memoranda of Understanding on development of additional joint activities under both FHIE and HealthePeople (Federal).

As a result of the implementation of FHIE, VA clinical staff have access to information that was collected in DoD's Composite Health Care System (CHCS) on veterans who have been discharged since that system was implemented in 1989. Information available up to the time of their separation includes laboratory results, radiology reports, outpatient pharmacy prescription information, admission/disposition/transfer records, discharge summaries, and in the near future information on allergies, consult reports, and summary outpatient appointment information. The Veterans Benefit Administration (VBA) staff use this information to fulfill the evidentiary requirements for processing disability compensation claims as well as in determining eligibility for Vocational Rehabilitation and Employment benefits.

The joint VA/DoD Interoperable Electronic Health Record Plan (HealthePeople (Federal)) goes much further by committing our two Departments to implementing compatible IT enterprise architectures and adopting common standards, both of which serve as the essential technical foundation to achieve interoperable electronic health record systems. The end result will be interoperable electronic health record systems that will serve the needs of our nation's veterans and service members and that could potentially serve as a model for a national health information infrastructure.

Mr. Chairman, we testified before the subcommittee on July 9, 2003 and before the full committee on October 16, 2003 on current efforts to assure a seamless transition for veterans returning from Operations Iraqi Freedom and Enduring Freedom. I would first like to update the committee on the efforts of our Seamless Transition Taskforce and then discuss our plan and progress toward improving electronic transmission of health information.

Seamless Transition Taskforce

In August of this year, VA's Under Secretary for Benefits and the Under Secretary for Health charged a new VA Taskforce for the Seamless Transition of Returning Service Members to intensify and continue efforts to assure world class services are provided to our military and veterans. This taskforce focused initially on internal coordination, communication and staff training efforts to ensure that VA

approaches this mission in a comprehensive manner. Also, efforts are targeted on improving dialogue and collaboration with DoD at all levels between our two Departments, including the Military Services, Personnel and Readiness, Health Affairs, and Reserve Affairs. We have been working closely with DoD to enhance our ability to identify and serve all returning service members that sustained injuries or illnesses while serving our country.

Thanks to the leadership of Dr. David Chu and Dr. Bill Winkenwerder, I am pleased to report that DoD transferred to VHA a list of military personnel who recently served in theaters of combat in Afghanistan and Iraq and subsequently separated from active duty. Our records indicate that of the approximate 17,000 veterans on this initial list, as of September 30, 2003, about 2,000 (12%) had sought health care from VA for a wide variety of health problems. Of this group, most have been seen as outpatients. VA looks forward to timely updates of this list and to the sharing of a complete roster of deployed troops, as was provided after the Gulf war in 1991. With a complete roster, VA can ensure that combat veterans receive new health care benefits and that emerging health problems are rapidly identified. VA also looks forward to receiving DoD pre- and post-deployment screening data, which will assist VA in the clinical evaluation of returning war veterans.

To ensure that our commitment is understood and shared at every level of the Department of Veterans Affairs, the Seamless Transition Taskforce has developed training materials for staff including a script and video for front line staff to ensure that they can reliably identify veterans who have served in a theater of combat operations and take the steps necessary to ensure they receive appropriate care. A software package was recently released to identify these combat veterans and a video for staff training has been finalized and will be provided to every VHA and VBA field site.

As discussed during the October 16 full Committee hearing, we have taken a number of additional steps including assignment of points of contact at each facility; issuance of case management guidance; assignment of VA staff to Military Treatment Facilities to provide information and assistance concerning VA benefits and to arrange for transfer of patients to VA health care facilities; and expanded outreach efforts to assure a seamless transition. We are working to expand these efforts and have partnered with the Army Disabled Solder Liaison Team. An MOU is being worked on which will help to standardize information transfer processes to sustain our progress.

Mr. Chairman, we testified before the Oversight and Investigations Subcommittee in early July of this year on the long - term outreach strategies that VA is pursuing to assure the best possible care is provided to returning Iraqi Freedom and Afghanistan Enduring Freedom service members. Many of these efforts are coordinated with DoD under the umbrella of the Health Executive Council.

All health or exposure data that DoD collects during deployment will be useful to VA. Through the Deployment Health Work Group, we are actively engaged with DoD in obtaining as much deployment health and exposure information as is available. Members of the Work Group are also charged with reviewing eventual sharing of data on troop locations, deployment health risks, and pre- and post-deployment health screening. Further, we are actively working with DoD to develop separation physical examinations that thoroughly document a veteran's health status at the time of separation from military service and that also meet the requirements of the physical examination needed by VA in connection with a veteran's claim for compensation benefits. We are optimistic that as a result of the improved collaboration between VA and DoD in these programs, we will be better positioned to evaluate health problems among service members and veterans after they leave military service, to address short and long-term post-deployment health questions, and to document any changes in health status that may be relevant for determining disability.

VA understands that veterans and their families will have questions and concerns about any special health problems that may be associated with a particular deployment, including infectious diseases and other deployment hazards. To respond to those concerns, VHA has produced and widely distributed a brochure addressing the main health concerns for military service in Iraq today, and a similar brochure for veterans serving in Afghanistan. Recently VHA distributed another brochure on health care for women veterans returning from the Gulf region. These brochures answer health-related questions that veterans, their families, and health care providers may have about these hazardous military deployments. They also describe relevant medical care programs that VA has developed in anticipation of the health needs of veterans returning from combat and peacekeeping missions abroad. These are also widely distributed to military contacts, veterans service representatives and are on VA's website.

Other Long-Term Strategies

Since the 1991 Gulf War, VA has developed a broad array of programs and policies to assist veterans returning from combat missions abroad. These were discussed during the subcommittee's July 9, 2003 hearing and the full committee's October 16, 2003 hearings. Two initiatives are particularly important to assuring recognition of service related health problems:

- Implementation of a screening instrument in the form of a clinical reminder triggered by the veteran's separation date to assist our health care providers to properly identify and treat returning Iraqi Freedom and Afghanistan veterans that present for care in VA. This assessment tool will prompt the provider with specific data requirements to assure that veterans are screened for medical and psychological conditions that may be related to recent combat deployment. This clinical reminder is in final pilot testing at several VAMC's.
- VA has developed evidence based clinical approaches for treating veterans following hazardous deployments. These clinical practice guidelines (CPGs) give health care providers the needed structure, clinical tools, and educational resources that allow them to diagnose and manage patients with deployment-related health concerns. Two post-deployment CPGs have been developed in collaboration with DoD, a general purpose post-deployment CPG and a CPG for chronic fatigue and pain. These CPGs will substantially aid VA and DoD efforts to care for veterans with unexplained illnesses, which are found among veterans following all wars.
- VA and DoD will soon release a new CPG on the management of traumatic stress. This guideline pools DoD and VA expertise to help build a joint assessment and treatment infrastructure between the two systems in order to coordinate primary care and mental health care for the purpose of managing, and, if possible, preventing acute and chronic Post Traumatic Stress Disorder (PTSD).

The Electronic Health Record Systems Plan – HealthePeople (Federal)

Having documented many lessons from treating returning veterans after the 1991 Gulf War, VA implemented a number of initiatives to better support sharing medical information with DoD. In addition, it became quite evident that the Departments needed

a workable strategy whereby they could effectively transmit health information between Departments for the purpose of providing high-quality, effective, safe healthcare for beneficiaries of both Departments. Also, the electronic transfer of medical information will improve the quality of care to the over 700,000 individuals who receive care from both DoD and VA annually.

During this past year the Departments developed and received approval for a strategy to achieve interoperability of health information systems for the purpose of sharing health data. The plan documents the roadmap for VA and DoD to demonstrate interoperability in 2004 and to achieve initial interoperability between health information systems in DoD and VA by 2005. The plan provides for the exchange of health data by the Departments and development of a health information infrastructure and architecture supported by common data, communications, security and software standards and high performance health information systems.

The Joint Plan will support Health*e*People (Federal), a long-term strategy to achieve full interoperability among Federal health information systems starting with the ability to provide a two-way exchange of health related information between VA and DoD. Providers of care in both Departments will be able to access relevant medical information to aid them in patient care. Health*e*People (Federal) was initiated to:

- Improve sharing of information
- Adopt common standards for architecture, security, communications, data, technology, and software
- Seek joint procurements and/or building of applications where appropriate
- Seek opportunities for sharing existing systems and technology
- Explore convergence of VA and DoD health information technology applications where feasible and within mission requirements
- Develop interoperable health records and data repositories

The standards and processes developed in this VA – DoD initiative will be beneficial to the private sector effort to transmit medical information electronically. Full interoperability is dependent upon both Departments deploying their next-generation health information systems, the DoD Composite Healthcare System II (CHCS II) and the VA Health*e*Vet-VistA system.

Plan Initiatives

There are several major initiatives that form the Electronic Health Record Systems Plan – HealthePeople (Federal). The Departments are presently collaborating on the development of interoperable data repositories that will form the backbone for all sharing of electronic health information; joint or interoperable software applications; and the adoption and identification of common data, architecture, communications, security and software standards.

The backbone of the Electronic Health Records Plan is the co-development and acquisition of interoperable data repositories by the Departments. By linking the DoD Clinical Data Repository (CDR) to the VA Health Data Repository (HDR), the Departments will achieve full interoperability of health information between DoD's CHCS II and VA's HealtheVet-VistA. Using clinical decision support applications, providers of care in both Departments will be able to access and use the relevant health information to aid them in making medication decisions for their patients regardless of whether that information resides in VA's or DoD's information systems.

The Departments are on track to demonstrate bi-directional health information using interoperable data repositories beginning with pharmacy data this fiscal year. VA and DoD have formed an active working integrated product team to lead this effort and development efforts are underway to deploy a working prototype in a lab environment.

Collaborative Software Applications

Since June 2002, phase I of the Electronic Health Record Systems Plan, the Federal Health Information Exchange (FHIE) (Its predecessor was the government computer based patient record (GCPR)) has provided all medical centers the capability to access historical data on separated and retired military personnel from the DoD's Composite Health Care System (CHCS I). Current patient data that are being sent from DoD to VA via secure messaging include laboratory results, radiology reports, outpatient pharmacy information, patient demographics, admission discharge transfer (ADT) data, discharge summaries and allergies. This includes (a) providing such information at the time of the service member's separation from military service, and (b) gathering and transmitting, under a set schedule, the same protected electronic health information on previously separated veterans. The original requirements for FHIE were revised to make them HIPAA compliant. The current phase of FHIE work continues in

operational status and adds three more data categories as part of the enhancement work or planned product improvements. All of the initial requirements for FHIE have now been met through the implementation of Version 4 in September 2003. Additional capabilities have been added to the original project to transmit data from the DoD Pharmacy Data Transaction Service (PDTS) and the DoD Standard Ambulatory Data Record (SADR).

Beyond FHIE and as part of the joint plan, VA is working closely with DoD to jointly develop or acquire other software applications that will support the delivery of health care by enabling the sharing of health information. The Departments have made significant progress toward development of interoperable software applications to include credentialing, scheduling laboratory and electronic portal systems for beneficiaries. The Departments are presently enhancing the Laboratory Data Sharing and Interoperability software application to permit bi-directional support of lab requests and results between VA and DoD reference labs.

Additional VA Work on the Electronic Health Record

A significant, supportive component of our better serving veterans is VA's new web application, "My HealtheVet". My Health*e*Vet creates an Internet environment where veterans, family, and clinicians may come together to optimize veterans' health care. An early release of this application on Veterans Day 2003 provides powerful health education information and health self-assessment tools. In the future, veterans will be able to reorder medications, view appointments and review copies of their health records online. In addition, My Health*e*Vet will allow each Veteran to share important military service history that can be utilized for evaluating health and disability status with the veteran's permission. Nationwide implementation will occur through three phases, each with increasingly complex functionality and security. Project implementation is targeted for completion by October 2005. VA is closely working with DoD on its portal application, TRICARE Online. The Departments presently share the same health and wellness content and are exploring additional collaboration.

VA/DoD Medical Demonstration Sites

The FY 2003 Defense Authorization Act mandated eight medical sites for joint demonstrations between VA and DoD medical facilities. VA and DoD recently

announced the demonstration sites – three of which are pilot efforts to enhance medical information and information technology systems sharing between the two systems:

- Madigan Army Medical Center and Puget Sound VA Health Care System are to be part of the piloting for a joint VA/DoD Electronic Health Record Systems Interoperability Plan;
- El Paso VA Health Care System and William Beaumont Army Medical System will conduct a Laboratory Data Sharing Initiative (LDSI); and
- South Texas Veterans Health Care System and Wilford Hall Medical Center and Brooke Army Medical Center will develop and test a Laboratory Data Sharing Initiative (LDSI) and test an integrated credentialing system.

These demonstration projects will run through FY 2007.

Summary

A service member separating from military service and seeking health care through VA today will have the benefit of VA's more than decade-long experience with Gulf War health issues as well as the President's commitment to improving VA/DoD collaboration. VA has successfully adapted many existing programs, and created new programs as necessary, that have improved outreach, improved clinical care through practice guidelines and educational efforts, and improved VA health providers access to DoD medical records. VA is actively working with DoD to attain the maximum level of sharing of information on injured combat veterans and recently discharged veterans. As a first step in creating a lifelong electronic health record for veterans, VA and DoD have developed a plan to share available electronic medical records by FY 2005.

A key component of optimal health care and assistance will be the development with DoD of a veteran-centric, life-long health record. Because this record has to begin at the start of military service, VA has been actively engaged with DoD in the development of the Recruit Assessment Program (RAP), which will collect comprehensive health data from all service personnel at entry into the military. A life-long health record will then be updated with clinical and exposure data during military service, pre- and post-deployment health screening data, discharge health data, and then clinical data from health care within VA. This information will enable VA to provide the best health care possible for our Nation's veterans.

I note finally that the collection and sharing of medical information by and between the Departments of Veterans Affairs and Defense is subject to all privacy safeguards afforded by the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996.

This concludes my statement. My colleague and I will be happy to respond to any questions that you or other members of the Subcommittee might have.

Prepared Statement

of

Jeanne B. Fites

Deputy Under Secretary of Defense

(Program Integration)

Before the

House Veterans Affairs Committee

Subcommittee on Oversight and Investigations

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Biography

Office of the Under Secretary of Defense

Personnel and Readiness
Washington, D.C. 20301-4000

JEANNE B. FITES
Deputy Under Secretary of Defense
(Program Integration)

Mrs. Fites was appointed Deputy Assistant Secretary of Defense for Requirements and Resources on December 26, 1993 and Deputy Under Secretary of Defense for Requirements and Resources on July 7, 1994. (On January 10, 1997 the name was changed from Requirements and Resources to Program Integration.) Prior to that, she served as either Principal Director to or Acting Deputy Assistant Secretary of Defense (Requirements and Resources) since 1985. She is responsible for the research and analytic program for the Under Secretary of Defense (Personnel and Readiness), as well as his participation in the Program, Planning and Budgeting system and corporate information management activities. She is also responsible for presentation of the Defense Manpower Program to the Congress; determination of total force manpower requirements; and for providing Defense support to special events such as the Olympics and the Pan American Games.

From July 1978 to August 1985, as Director, Intergovernmental Affairs, Office of the Assistant Secretary of Defense (Manpower, Installations and Logistics), she managed the presentation of Defense manpower, logistics and military construction program before Congressional committees, the DoD program to avoid tuition charges to military dependents attending public school, support to other agencies in drug interdiction, customs inspection, youth employment. Managed Defense support to the 1980 Winter Olympics at Lake Placid, 1984 Summer Olympics in Los Angeles, and the U.K. sponsored Operation Raleigh.

She was a research psychologist for the Marine Corps, Navy and Air Force, specializing in performance of low aptitude military accessions, training technology and education programs (1966-1974). Member of OSD Central All Volunteer Force Task Force (1972). Assistant Director for Research, Defense Manpower Data Center (1974-1976). Director for Research, Office of the Assistant Secretary of Defense for Manpower and Reserve Affairs (1976-1977).

Mrs. Fites received a Master's Degree in Personnel and Industrial Psychology from George Washington University in 1969; a Baccalaureate in Psychology from Wake Forest University in 1966. She was awarded the Presidential Meritorious Executive Rank in 1982, 1991, and 2000, the Department of Defense Medal for Distinguished Civilian Service in 2001, and the Defense Meritorious Civilian Service Award in 1981, 1984, 1989, and 1997.

Mr. Chairman and members of the subcommittee, thank you for the opportunity to come before you today to brief you on our efforts on the expeditious transfer of military personnel information to the Department of Veterans Affairs. The Under Secretary (Personnel and Readiness) and the Department take very seriously our responsibility to our Service members to ensure that they have timely access to benefits they have earned through their service. The Defense Manpower Data Center (DMDC) and the Joint Requirements and Integration Office (JR&IO) in my office, as well as other offices throughout P&R, have worked closely with representatives from the Department of Veterans Affairs, the Department of Labor, and the National Archives and Records Administration over the years to improve our interfaces. Information sharing and interoperability are strategic objectives and we are committed to achieving effective interfaces to provide Service members and veterans their benefits and entitlements for so selflessly serving their country.

I understand that you have three basic concerns that I will address in this testimony: 1) Delays in the implementation of the Defense Integrated Military Human Resources System Personnel/Pay (DIMHRS (Pers/Pay)); 2) The lack of an electronic transfer of the DD Form 214 to Veterans Affairs upon separation; and 3) The need for better access to DD Form 214s for personnel who have already separated. I will address these three issues and answer any questions that you have.

DIMHRS (Pers/Pay) will be a totally integrated pay and personnel system supporting the operational requirements of all the DoD Components. The Department has fully funded DIMHRS through the Future Years Defense Program (FYDP). DIMHRS will resolve the inefficiencies and deficiencies of our legacy personnel and pay systems and it will be the vehicle through which we transform military personnel and pay management. DIMHRS is fully supported by all the Services and is based on full business process re-engineering. It is fully compliant with the Clinger Cohen Act, the Government Performance and Results Act and has received full certification from the Under Secretary of Defense (Comptroller) for compliance with the DoD Business Management Enterprise Architecture. The attached papers provide additional information on DIMHRS, including a description of roles and responsibilities for the program.

The DIMHRS Developer/Implementer contract was awarded to Northrop Grumman in September 2003. The system will be operational in the Army (all components) in late 2005 and fully operational in all Services in late 2007. The program was initiated in 1998 when it received Milestone 0 approval from the OSD Milestone Decision Authority. When the program was initiated, Congress directed that program management be located in New Orleans, with the Program Manager reporting to the Commander, Naval Reserve Force. Although the support for the program was appreciated, the Commander, Naval Reserve Force is not an acquisition authority in DoD, and some difficulties arose in completing the acquisition requirements for the program. Upon request from my office, and with permission from Congress, the Navy changed the acquisition reporting chain for DIMHRS to its present structure. The current program management team began work in August of 2001. Since that time, the program has gained significant support within the Department, from the Services and the OSD Milestone Decision Authority. The new program management team re-baselined the program, sought, and received, full funding with the support of P&R, and developed a new acquisition strategy. The new strategy, aimed at risk reduction, caused a slip in the contract award for the Developer/Implementer, but was successful in acquiring a highly skilled vendor who can now quickly proceed to development.

DIMHRS will electronically feed to the Department of Veterans Affairs (VA) the authenticated DD Form 214 data.

The DD Form 214 is the document used to satisfy the requirements of title 10 United States Code (USC), Section 1168. The DD Form 214 provides the Service member and the Service with a concise record of a Service member's periods of active service. It also acts as an official source of essential information that is needed to administer various laws pertinent to veterans that are administered by federal, state and local government agencies. Corrections to the DD Form 214 are accomplished on a DD Form 215. DD Form 214s are produced from hundreds of different separation sites all over the world. The information required on the DD Form 214 is not currently available in any automated system. The information that populates the form has to be pulled from the hard copy personnel records and manually entered into the DD Form 214. Although some sites may be able to produce the DD Form 214 using electronic form software, they do not retain an automated copy - - further, the data on the form is put in

manually, not automatically filled from a database since the Services legacy systems do not support this capability. The form must be printed out to be signed (authenticated) and there is currently no way to electronically store or maintain the authenticated data. Additionally, since the DD Form 214 contains personal information that is covered by the Privacy Act, access must be carefully controlled. Resolving these and other technical problems and creating a system to do this would take longer than it will take to implement DIMHRS and would not be as efficient.

DIMHRS will provide the electronic DD Form 214 for people who separate from the Service after it has been implemented. There will still be a need for historical access to personnel data (including DD Form 214s) for people who separated (or retired) before DIMHRS was implemented. To serve that need we have developed the Defense Personnel Records Image Retrieval System (DPRIS). DPRIS is a secure web-based image retrieval system for authorized access for Federal agencies that need information from Military Service official military personnel file (OMPF) repositories. It enables outside user agencies, such as the VA, to request and receive electronic images (directly from the Service imaging systems) of personnel documents necessary to adjudicate Service member and veteran claims for benefits and entitlements. DPRIS interfaces provide standard automated query support for authorized VA claims adjudicators and other authorized VA users. There are currently 2,380 authorized Veteran Benefit Administration (VBA) users that submit a monthly average of 1500 requests for information maintained in the Service optical personnel records.[1] To date DoD has provided almost 600,000 images to VA through DPRIS. One of the most requested documents is the imaged DD Form 214. There are about 3,000 military personnel document types, mapped to VA request codes that can be pulled via DPRIS. When the Air Force interface is complete there will be over 192 million images available via DPRIS, from over six million military personnel records maintained in the four official military personnel file systems.[2]

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[1] Department of the Navy Electronic Military Personnel Records Management System (EMPRS), the Department of the Army Personnel Electronic Records Management System (PERMS), and the U.S. Marine Corps Optical Digital Image Records Management System (ODIRMS), Air Force Records Management System (ARMS).

[2] Navy Electronic Military Personnel Records Management System: 80 million individual images (3 million OMPF records); Marine Corps Optical Digital Image Records Management System (ODI-RMS: 23 million individual images (500 thousand OMPF records);Army Personnel Electronic Records Management System: 48.4 Million individual Images (1.2 million OMPF Records); Air Force Records Management System (ARMS): 41 million individual images (1.5 million OMPF records).

DPRIS is an advanced technical demonstration and is currently operational in the Army, Navy, and Marine Corps. The interface with the Air Force is expected to be completed in late 2004. This interface between DPRIS and the VA Personnel Information Exchange System has been leveraged to support an additional interface with the Army Center for Unit Records Research, which will assist the VA in expeditiously obtaining information to make determinations on Agent Orange exposures and post traumatic stress disorder. Since all veterans were in the military, DoD's sharing of medical information is advantageous to the care provided by VA. I note that all personal and medical information in DIMHRS and DPRIS will continue to be administered and safeguarded in accordance with the Privacy Act of 1974, the Health Insurance Portability and Accountability Act, and the E-Government Act of 2002.

Since a document must be in a Service imaging system before it can be accessed through DPRIS, it does not solve the problem of immediate access for personnel as they separate. It takes an average of about 60 days for the DD Form 214 to be available through DPRIS after a Service member leaves the military. Once it is imaged, however, it can be retrieved in real-time or in batch with a 48-hour turn around. In order to achieve the appropriate security, however, VA had to build the appropriate firewalls and access lines. The VA interface development process was about six months and was completed in August 2002. DPRIS came on line with the VA on October 7, 2002.

I would like to reiterate our commitment to our Service men and women and this nations veterans. We are working very hard to provide them an integrated personnel and pay system that will support them through their entire military lifecycle and afterwards as veterans and retirees.

DIMHRS Overview

Once implemented, the Defense Integrated Military Human Resources System for Personnel and Pay (DIMHRS (Pers/Pay)) will provide an end-to-end, integrated military personnel and pay system for all military services including their active, reserve and National Guard components. As the cornerstone of military personnel transformation, DIMHRS (Pers/Pay) is the vehicle for fielding and resourcing a fully integrated human resources system, while concurrently supporting reengineered business processes, replacing failing systems, reducing data collection burdens, enhancing readiness, and connecting soldiers, sailors, airmen and Marines directly to their personnel and pay system.

Background

In late 1995, the Under Secretary of Defense (USD) for Personnel and Readiness (P&R), the USD Comptroller, and the Assistant Secretary of Defense Command, Control, Communications, and Intelligence asked the USD for Acquisition and Technology to convene a Defense Science Board Task Force on Military Personnel Information Management to advise the Secretary of Defense on the best strategy for supporting military personnel and pay functions. In a report published in August 1996, the Task Force concluded that the Department of Defense's (DoD) multiple service-unique military personnel and pay systems caused significant functional shortcomings (particularly in the joint arena) and excessive development and maintenance costs. Their central recommendation was that, "...the DoD should move to a single all-service and all-component, fully integrated personnel and pay system, with common core software...."

Roles and Responsibilities

The Joint Requirements and Integration Office (JR&IO), within the Office of the USD (P&R), is responsible for defining functional requirements for personnel and pay and provides those joint requirements to the DIMHRS Acquisition Executive, the Department of the Navy Program Executive Office for Information Technology (PEO-IT). To ensure DIMHRS (Pers/Pay) uses common processes and data to fulfill the needs of the DoD, JR&IO defines, documents, and maintains a single set of functional (program) requirements. JR&IO does this in a joint environment, staffed by members of all services and components, and the Defense Finance and Accounting Service (DFAS). PEO-IT is responsible for ensuring those requirements are implemented in accordance with federal acquisition regulations. Once PEO-IT identifies the appropriate acquisition method, implementation of the program is the responsibility of the Joint Program Management Office (JPMO).

Requirements

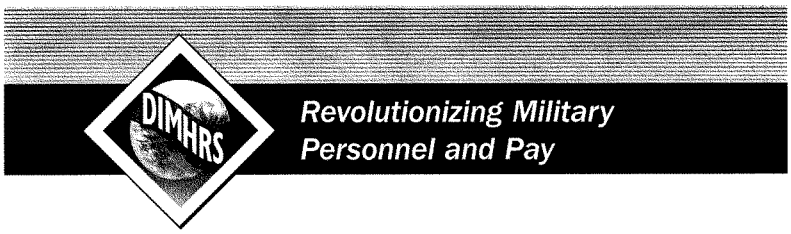
DIMHRS (Pers/Pay) will retain and maintain data in a single, comprehensive record of service that will be available to the service member. Appropriate data and information will also be available to the service personnel chiefs, combatant commanders, military personnel and pay professionals and authorized users in DoD and other federal agencies. DIMHRS (Pers/Pay) will also be consistent

with Office of Management and Budget (OMB) and Clinger-Cohen Act guidance, and is based on commercial-off-the-shelf (COTS) software.

DIMHRS (Pers/Pay) Implementation

JPMO will oversee the developer and implementer (D&I) through the key phases of the DIMHRS (Pers/Pay) lifecycle, to include: design and build, system development and demonstration, developmental test and evaluation, operational test and evaluation, fielding decision, deployment and training.

JPMO will work closely with the Joint Requirements and Integration Office, the services and Defense Finance and Accounting Service (DFAS) representatives regarding data and deployment information, as well as coordinate program operations, cost, business, integrated logistics support, system engineering, testing and training. The deployment schedule will be solidified when the D&I provides a post-contract implementation plan. Under the current roll out strategy, the Army is the first to implement DIMHRS (Pers/Pay) followed by the Navy, Marines and Air Force. Once fully implemented, DIMHRS (Pers/Pay) will provide a comprehensive, integrated military personnel and pay system to all services and their components within DoD.



1. DIMHRS (Pers/Pay) will integrate personnel and pay.

Integration of personnel and pay is considered a best practice in the private sector. For the military, it is more than a best practice—it is essential to the timely and accurate compensation of military personnel. The complexities of the relationship between military personnel and pay exceed by far the complexities of the relationship in the private sector due to frequency of changes in laws and regulations, mobility of military personnel, and the Department of Defense (DoD) compensation structure which is based on factors, such as marital status, housing status (e.g., base housing), duty status (e.g., Absent Without Leave (AWOL)), duty type (e.g., hazardous duty); reserve status; and prior service factors. Without full integration, DoD systems cannot stay synchronized.

2. DIMHRS (Pers/Pay) will enable full integration of human resource customer service for the service member and the DoD.

Separate customer service operations require military personnel and their family members to go to multiple locations, deal with multiple customer service personnel, and (if self service is available) sign on to separate web sites to conduct routine business. A single integrated system with a single integrated customer service location will provide better service for both self-service and human resource offices.

3. DIMHRS (Pers/Pay) will integrate active, reserve and National Guard personnel, pay and human resource processes.

Separate systems for active, reserve and National Guard personnel lead to inaccuracies in pay and entitlements. When reservists and Guardsmen are called to active duty, they often do not get proper credit for their service. This can have immediate effects (loss or delays in pay and current benefits (e.g., family health care) and long-term effects (incorrect accounting for retirement pay). Full integration of the systems will support full accountability of service and timeliness of pay and benefits. Separate treatment of active, reserve and National Guard personnel results in highly inefficient processes for transfers between components. When reserve personnel are called up to active duty and then returned to the reserves, the process mirrors the process of separation and enlistment rather than a simple assignment for duty in a different component. DIMHRS (Pers/Pay) enables the streamlining of inter-component and inter-service transfers.

4. DIMHRS (Pers/Pay) will provide a single, comprehensive record of service throughout a Service member's life.

Military personnel are followed from the moment they enter the service throughout their lives. Military personnel and their family members are entitled to service-related benefits even after separation or retirement. Fragments of documentation are often separately filed and sometimes not available to support claims filed by veterans and retirees. It can often take years to obtain valid documentation of service-related activities. A single, comprehensive record of service will ensure that all activities are documented and available and will ensure that military personnel have timely access to entitlements.

5. DIMHRS (Pers/Pay) will enable a cross-service support capability.

Combatant commanders are dependent on multiple personnel offices to provide service to military personnel under their command. With cross-service support, the number of personnel required to perform this support function could be reduced and day-to-day personnel support could be provided by a single personnel function. Today, when military personnel are assigned to units controlled by another service, day-to-day personnel support becomes very complex because services do not have access or authority to complete transactions in each other's systems.

6. DIMHRS (Pers/Pay) will enable a full self-service support capability.

A full spectrum of self-service support is a best practice in the private sector that is also applicable to the military. Service members must have access to make routine changes and updates (e.g., address changes) and to request (on-line) that specific information be reviewed for accuracy (e.g., date of promotion).

7. DIMHRS (Pers/Pay) will fully track personnel on temporary duty assignments and will also enable the full documentation of health and safety incidents in the permanent record.

Deployments are often treated as temporary duty assignments and as such are not tracked in personnel systems. This leads to both immediate and long-term problems. Immediate problems include a lack of full accountability of personnel, inefficiencies in the ability of combatant commanders to fully use personnel assets, delays in pay and benefits associated with the deployment, and the lack of effective management information on personnel deployed. Long-term problems include inability to identify populations who were exposed to specific hazards on specific dates, and potential impact on entitlements because of loss of documentation of specific events.

8. DIMHRS (Pers/Pay) will provide timely and accurate cross-service information on personnel, their qualifications, their success, and their retention.

Military personnel are not "hired" in the same sense of the word as employees in the private sector. In the private sector, applicants are usually being considered for a specific job—there is a many to one relationship between the applicants and the job. Military personnel are brought into the service in entry-level positions—most military personnel are accepted into the military based primarily on their future potential and they are trained and educated after entry. (There are some exceptions to this in the officer ranks, for instance in the medical professions.) In the military, candidates are evaluated based on criteria related to their potential—and an individual may be considered for many different types of jobs—there is a many to many relationship between applicants and jobs. This system enables the identification of the best fit for a high-potential candidate rather than the best candidate for a specific position. Increased analytical capabilities from DIMHRS (Pers/Pay) will help better estimate the needs of the objective force, specific qualifications that lead to success in the military, the potential retention of qualified personnel and better relationships between pay and scarce skill sets.

9. DIMHRS (Pers/Pay) will ensure accountability and care for family members.

Family members of service personnel very often have separate domiciles when personnel are on deployment, sea duty, or other unaccompanied assignments. Family members must be able to get health care and other benefits from wherever they are located. DIMHRS (Pers/Pay) will track family members in locations that are separate from their sponsors—whether it is a student at school, a child living with a relative in accordance with a family care plan, or a spouse and children who have moved closer to other family members during an operation. In some locations, other family members, and even family pets, are tracked as non-combatant civilians in case of the need for evacuation.

"DIMHRS (Personnel and Pay) is the vehicle through which the Department will transform military personnel and pay management. It will be the modern, responsive system that supports commanders, the Services, and Service members and their families in the 21st century."

—Paul Wolfowitz
Deputy Secretary of Defense
In a letter to Chairman House
Appropriations Committee
US House of Representatives
July 29, 2002

10. DIMHRS (Pers/Pay) will fully track all skill sets: those competencies required by the position and those held by the service member. Competencies will be matched between service members and potential positions and any discrepancies or additional training requirements will be identified prior to assignment.

Combatant commanders and other DoD managers very often require specific skill sets for mission-essential operations. Multiple personnel systems provide inconsistent data of variable accuracy across the services and the managers are dependent on the individual services to search multiple databases to identify qualified individuals. Knowledge of civilian-acquired skills (especially for reserve and National Guard personnel) is not readily available. DIMHRS (Pers/Pay) will enable managers to search the full range of personnel (active, reserve and National Guard) to identify personnel with specific skills (whether military or civilian acquired) and to quickly form task force rosters.

Accurate and timely pay and benefits for service members and their families—They deserve it!

Key Organizations and Agencies

Developing and implementing DIMHRS is more than the deployment of an information technology solution—it is revolutionary change in how the military services conduct their personnel and pay business. It is an immense project that requires the collaborative efforts of multiple agencies, offices and organizations. Integrating personnel and pay systems, reviewing and improving the processes that drive these systems, identifying requirements, and validating solutions are tasks that require a challenging level of collaboration and coordination within the services and across the Department of Defense (DoD). The organizations listed here have vital roles in meeting this unprecedented challenge to revolutionize DoD's pay and personnel operations.

Functional

- The **Under Secretary of Defense (Personnel and Readiness)**, Dr. David S.C. Chu (USD(P&R)), is the functional sponsor of the program and oversees all functional aspects of the program. The **Deputy Under Secretary of Defense (Program Integration)**, Ms. Jeanne Fites, DUSD (PI), is the delegated authority for all functional matters pertaining to the program.

- The **Director, Joint Requirements and Integration Office**, (JR&IO), OUSD(P&R), Ms. Norma J. St. Claire is the senior executive with responsibility for direct oversight of all functional aspects of the program. In conjunction with the services and the Defense Agencies, as well as other Federal Agencies, JR&IO defines and documents the requirements for DIMHRS (Pers/Pay). JR&IO supports the priorities of the USD(P&R), the services, and the military personnel and compensation communities. JR&IO is the single source for functional requirements.

Acquisition

- The **Office of the Assistant Secretary of Defense (Networks and Information Integration)**, OASD(NII) The Assistant Secretary of Defense (NII), Mr. John Stenbit is the principal staff assistant to the Secretary of Defense for the development, oversight and integration of DoD policies and programs relating to the strategy of information superiority for DoD. The ASD(NII) is the designated Milestone Decision Authority for DIMHRS (Pers/Pay) and as such is the arbiter of any acquisition issues and acquisition approval authority for the program.

- The **Assistant Secretary of the Navy (Research, Development and Acquisition)**, ASN(RD&A), Mr. John Young serves as the Navy Acquisition Executive for the Department of the Navy and represents the Department to the Under Secretary of Defense (Acquisition, Technology, and Logistics) on all matters relating to the acquisition and execution of DIMHRS (Pers/Pay). The ASN(RD&A) is responsible for establishing acquisition policies and procedures in accordance with DoD directives and guidelines.

- The **Program Executive Office for Information Technology**, (PEO-IT), Mr. Steven Ehrler is the senior executive with management oversight for the acquisition and accountability of DIMHRS (Pers/Pay) and for ensuring that the program is implemented within technical, cost and schedule parameters approved by the milestone decision authority.
- The **DIMHRS (Pers/Pay) Joint Program Management Office** (JPMO), Capt. Valerie Carpenter, USN, is the Joint Program Manager and is the single acquisition agent responsible and accountable for managing the DIMHRS (Pers/Pay) program and delivering the required capability to satisfy the functional responsibilities.
- The **Space and Naval Warfare Systems Command**, (SPAWAR), Rear Adm. Kenneth Slaght, USN, is the Head of Contracting Agency (HCA) with responsibility for providing contracting, legal and comptroller functions, pursuant to the Federal Acquisition Regulations, to support the acquisition and contract management of DIMHRS (Pers/Pay).

The services and the Defense Finance and Accounting Service (DFAS)

Office of the Secretary of Defense (OSD) representatives, the Joint Staff, the services and DFAS fully participate in every aspect of the DIMHRS (Pers/Pay) program by participating in the requirements definition process, identifying business process reengineering opportunities, providing support to technical and acquisition aspects of the program, and participating in issue identification and resolution.

The DIMHRS (Pers/Pay) Difference

For the War Fighter

To keep pace with the modern war fighter, military personnel systems must be transformed to be more streamlined, efficient and deliver on the personnel transformation goals to:

- Provide better service to military personnel and their families—timely and accurate record of service and delivery of compensation, benefits and entitlements;
- Ensure the most efficient use of human resources in the conduct of the military mission—including support to the war fighter;
- Ensure visibility and accountability of military personnel to authorized users;
- Provide timely and accurate human resources information to authorized users; and
- Enhance the ability to put the right person in the right place as quickly as possible (including acquisition and retention as well as assignment and deployment).

For the Human Resource Community and Service Member

The Defense Integrated Military Human Resources System Personnel and Pay (DIMHRS (Pers/Pay)) also enables the transformation of the Department of Defense (DoD) by dramatically changing how DoD manages military personnel and pay. The new system will facilitate organizational transformation through systems integration and human interaction and support the following key elements of military personnel transformation:

DIMHRS (Pers/Pay) will:

- Integrate personnel and pay;
- Enable full integration of human resource customer service for the service member and the DoD;
- Integrate active, reserve and National Guard personnel management and pay into one human resource process;
- Provide a single, comprehensive record of service throughout a service member's life;
- Enable cross-service support capability;
- Enable full self-service support capability;
- Track personnel on temporary duty assignments and document health and safety incidents in the permanent record;
- Ensure accountability and care for family members;
- Provide timely and accurate cross-service information on personnel qualifications and retention; and
- Track all skill sets and match service members with appropriate assignments.

DIMHRS (Pers/Pay) Fast Facts

The Defense Integrated Military Human Resources System (DIMHRS) for Personnel and Pay (Pers/Pay) will result in the largest, fully-integrated human resources information management system in the world. Using commercial off-the-shelf software, the program will deliver improved processes and delivery of timely and accurate pay and benefits to all service members and their families, anytime, anywhere.

- **Will be the largest commercial-off-the-shelf (COTS) human resources system in the world**
- Will support 3.1 million active, reserve and National Guard service members
- Will support full mobilization
- Will support 869 military personnel and pay locations worldwide
- Will accommodate 80,000 concurrent users
- **Will process $93 billion pay and allowances**
- **Will subsume approximately 80 legacy systems**

Frequently Asked Questions

1. What is DIMHRS (Pers/Pay)?

The Defense Integrated Military Human Resources System (DIMHRS) for Personnel and Pay (Pers/Pay) will be a fully-integrated, all-service, all-component, military personnel and pay system that will support military personnel throughout their careers and retirement—in peacetime and war. With DIMHRS (Pers/Pay), 3.1 million military service members will be able to access their personnel and pay records via the Internet, eliminating the need for multiple human resources databases and paper forms.

DIMHRS (Pers/Pay) will provide each service member with a single, comprehensive record-of-service that will be available to the service member, allowing individuals to update select personal information. The personnel records will be available to service personnel chiefs, combatant commanders, military personnel and pay managers and other authorized users throughout the Department of Defense (DoD) and other federal agencies. This web-based human resource tool will be open for business 24 hours daily.

2. Why is DIMHRS (Pers/Pay) needed?

DIMHRS (Pers/Pay) will solve the following problems:

- The Office of the Secretary of Defense, joint command managers and other users of military personnel information are hindered by the lack of standard data definitions and cannot make necessary comparisons across the services.
- Military reservists who are called up for duty are sometimes "lost" in the system; impacting their pay, credit for service and benefits.
- Combatant commanders do not have access to accurate or timely information on personnel needed to assess operational capabilities.

With DIMHRS (Pers/Pay), commanders of joint and multi-service units will have the ability to access personnel information for all members assigned to their units regardless of branch of service.

3. Why is the program designated DIMHRS (Pers/Pay)? Are there other DIMHRS programs?

DIMHRS (Pers/Pay) is the first of the DIMHRS enterprise systems. At this time, there are no other DIMHRS programs. In 1998, however, congressional language expanded the scope of the DIMHRS program to include future manpower and training components [1999 Defense Appropriation Act, Sect. 8147].

4. What is the goal of DIMHRS (Pers/Pay)?

When implemented, DIMHRS (Pers/Pay) will provide accurate and timely data on military personnel, standardized data for comparison across services and components, integrated personnel and pay

functions, track personnel in theater and record both pay and service credit for reservists. "Track personnel in theater" in this context means the ability to associate a service member with an organization at a given point in time.

5. What is DIMHRS (Pers/Pay) replacing?

DIMHRS (Pers/Pay) will subsume approximately 80 existing manpower, personnel and pay processing systems across the four services and the Defense Finance and Accounting Service (DFAS).

6. What is the value of DIMHRS (Pers/Pay) to each service?

By standardizing human resources information and processes across the services, personnel and pay information can be shared across components and throughout the DoD. DIMHRS (Pers/Pay) will also allow commanders and leaders to more easily identify and use their human resources, making competency skill matches more efficient for example.

DIMHRS (Pers/Pay) will provide the following:

- Integrated personnel and pay processes;
- Common database for all services and their reserve components;
- Common processes across all components and services;
- Assistance in streamlining processes;
- Reduced maintenance and support costs for human resources information technology systems; and
- Open architecture.

The implementation of a common DIMHRS (Pers/Pay) will provide the military services a fully-integrated military personnel and pay system that will be supported in a common operating environment, thereby reducing operation and maintenance costs.

7. When will DIMHRS (Pers/Pay) be implemented?

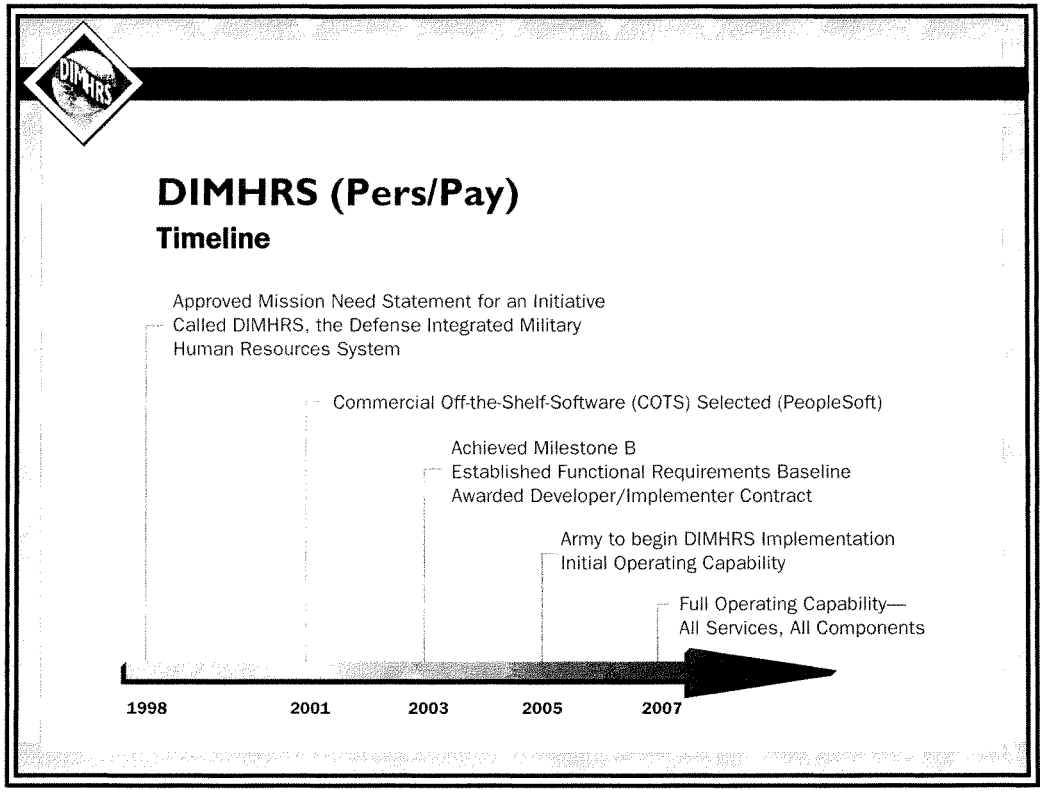
The Army is scheduled to be the first to receive DIMHRS (Pers/Pay) approximately two years following exercise of the contract option. The Navy, Marine Corps and Air Force will be rolled-out consecutively.

8. What is the relationship between DIMHRS (Pers/Pay) and PeopleSoft?

The Developer & Implementer (D&I) will use the PeopleSoft product as the basis for DIMHRS (Pers/Pay). The DoD is committed to using the product without modification except where necessary to meet mission essential requirements. The D&I will offer alternatives and recommendations for addressing functional "gaps" (requirements not supported by PeopleSoft).

9. Where can I find more information about DIMHRS (Pers/Pay) on the Internet?

To find out more about DIMHRS (Pers/Pay) on the Internet, go to https://www.mpm.osd.mil/ and http://www.peo-it.navy.mil. Look for http://www.dimhrs.mil after October 1, 2003.


DIMHRS (Pers/Pay)
Timeline
Approved Mission Need Statement for an Initiative Called DIMHRS, the Defense Integrated Military Human Resources System
Commercial Off-the-Shelf-Software (COTS) Selected (PeopleSoft)
Achieved Milestone B
Established Functional Requirements Baseline
Awarded Developer/Implementer Contract
Army to begin DIMHRS Implementation
Initial Operating Capability
Full Operating Capability—
All Services, All Components
1998
2001
2003
2005
2007

Prepared Statement

of

Mr. James C. Reardon

Military Health System, Chief Information Officer

on

The Progress Being Made by the Department of Defense and the Department of Veterans Affairs with the Sharing Of Medical Information and the Development of a Seamless Electronic Medical Record

Before the

Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U.S. House of Representatives
November 19, 2003

Not for Public Release until 10:30 am
on November 19, 2003

Introduction

Mr. Chairman and members of this distinguished committee, thank you for the opportunity to be here today to discuss the progress being made by the Department of Defense (DoD) and the Department of Veterans Affairs (VA) with the sharing of medical information and development of interoperable electronic medical records.

Today, we have more then 253 thousand service men and women deployed in support of our nation's defenses, including those in Afghanistan and Iraq. DoD is firmly committed to providing the best health care services for our operating forces. In the past year, more than 180 thousand men and women have left military service, and the vast majority are eligible for VA care. I want to assure you that as the Military Health System, Chief Information Officer, my highest priority is to maintain the health of our military members with a continuum of medical care protecting each service member from entrance into the military to separation from the military and the transition to the VA health care system. Over 700,000 individuals receive care from both DoD and VA annually, thus the ability to transfer electronic health information is a significant factor for improving the continuity of care for those who have served our country.

As you know, DoD and VA have joined forces to provide our nation's military and veterans with improved health care services. Over the past year, many initiatives between the two Departments have launched a new era of DoD/VA collaboration, with unprecedented strides toward a new federal partnership that promises to transcend business as usual, and is already seen as a model for inter-agency cooperation across the federal government.

We are pleased to report that we have approved a VA/DoD Joint Strategic Plan to guide our relationship over the coming years. We believe that this plan not only institutionalizes our current collaborative efforts but also identifies joint objectives, strategies, and best practices for future collaboration. Through our VA/DoD Joint Executive Council, we will ensure leadership oversight is given to all of these initiatives as we continue to develop our strategic partnership. The ability to transfer and share electronic health information is a major area of focus in this joint strategic plan. In fact, many of the recommendations of the President's Task Force to Improve Health Care Delivery For Our Nation's Veterans are reflected in the VA/DoD Joint Strategic Plan and also in the initiatives underway between the Departments.

Seamless Exchange of Electronic Health Care Data

There are a number of current initiatives addressing clinical data interoperability and data exchange that will benefit Service members as they transition to veteran status. The Federal Health Information Exchange (FHIE) supports the transfer of electronic health information from DoD to VA at the point of a Service member's separation. As an exemplary model of collaboration between DoD and VA, it markedly enhances the continuity of care to our nation's veterans. VA providers nation-wide, at over 200 VA medical facilities, have access to this data on Service members. This initiative leverages existing agency information systems to facilitate the electronic transfer of patient information from DoD to VA. To date, DoD has transmitted electronic medical information to the VA on more than 1.7 million retired or discharged Service members. This number is consistently growing as health information on recently separated and retired Service members is packaged and transferred to the VA.

The information currently available to VA providers includes demographic data, laboratory results, outpatient military treatment facility pharmacy data, radiology results, allergy information, discharge summaries, consult reports, and admission, discharge and transfer information. All information is sent using secure messaging to protect this information during the transfer process.

Future enhancements will include additional pharmacy information, and key elements of the standard ambulatory data record, such as the diagnosis codes, primary care manager, treatment provider, and other pertinent data. The FHIE initiative is planned and executed as required under the Health Insurance Portability and Accountability Act, the Privacy Act of 1974, and other privacy regulations that protect the sensitive health care information of our beneficiaries.

FHIE is also being used by authorized Veterans Benefits Administration personnel. The FHIE Compensation and Pension Record Interchange allows selected Veterans Benefits Administration personnel to access DoD clinical data resident in the FHIE repository in support of disability claims processing. This enables them to begin adjudication of disability claims.

Finally, in support of these efforts, DoD and VA have successfully conducted joint acquisitions, are sharing contract vehicles, coordinating FHIE funding, and have developed a process to efficiently apply funds to joint contracts. Our success in FHIE has been made possible by a strong spirit of teamwork and cooperation from our contractor team members such as Northrop-Grumman Information Technology and Science Applications International Corporation.

The Departments continue to build on the successful implementation of the Federal Health Information Exchange. To provide a more robust capability and institute a two-way exchange of information, the Departments are working on interoperability between DoD's Clinical Data Repository (CDR) and VA's Health Data Repository (HDR). This initiative, which will be functional in FY05, responds to the needs of DoD/VA providers and will meet the recommendation by the President's Task Force to Improve Health Care Delivery For Our Nation's Veterans and the VA/DoD Joint Strategic Plan objective for interoperable electronic medical records.

At the September 2002, DoD/VA Health Executive Council meeting, the Assistant Secretary of Defense (Health Affairs) and the Department of Veterans Affairs Under Secretary for Health signed an Executive Decision Memorandum defining the goals of the DoD/VA Electronic Health Records Interoperability Initiative. To manage the development of this important capability and ensure interoperability between the DoD CDR and the VA HDR, a DoD/VA working integrated product team was formed. It is led by senior health information technology managers from both Departments. The group is actively developing information exchange requirements, technical and data standards, and a technical architecture to support the exchange which includes appropriate security and data protection. The Departments are actively engaged in the design of a prototype

which will support the bi-directional exchange of health information beginning with pharmacy data, allergy information, patient identification, and demographic information. Testing in a laboratory environment is scheduled to begin in 2004. Work on subsequent data elements will continue in parallel so that development is ongoing in multiple areas at any given time. The standards and processes developed in this VA – DoD initiative will be beneficial to the private sector effort to transmit medical information electronically.

One of the cornerstones of this initiative is DoD's Clinical Data Repository (CDR) developed for the Composite Health Care System II (CHCS II), the military Electronic Health Record. DoD's CDR is operational, supporting 20 thousand patient visits per week, and contains enrollment eligibility records for all DoD beneficiaries and clinical data records for 447 thousand individual patients. CHCS II is an enterprise-wide medical and dental clinical information system that maintains and provides secure online access to comprehensive longitudinal health records. Worldwide deployment of CHCS II will begin in January 2004.

The DoD and VA have selected eight medical demonstration sites that will test the capabilities of the two departments to provide a seamless delivery of benefits and services to military members and veterans by sharing information and other efficiencies. Mandated by the FY03 National Defense Authorization Act, the

demonstrations will test three separate areas: budget and financial management; staffing and assignment; and medical information technology systems. These projects will operate through FY07.

Another significant DoD/VA medical information sharing initiative is Laboratory Data Sharing and Interoperability (LDSI). This initiative facilitates the electronic transfer/sharing of laboratory order entry and results reporting among DoD, VA, and commercial reference labs. Computerized order entry and results reporting support the delivery of higher quality patient care and patient safety by eliminating much of the manual entry that was the practice in the past. Following a successful pilot test in Hawaii, this initiative is being deployed to other DoD and selected joint venture sites during FY04.

Underpinning many of the initiatives that support sharing and interoperability is DoD/VA work in the area of health care standards. DoD and VA are actively engaged in the study and adoption of common information standards in the areas of technical, information, data, security, and communications standards. The Departments participate in multiple standards boards, and collaborate and share expertise.

In addition, DoD and VA continue to be leaders in the health care standards arena through their roles as lead partners in the Consolidated Health Informatics project, one of the 24 eGov initiatives in support of the President's Management Initiative, and participation in many of the nation's standards development organizations.

The goal of the Consolidated Health Informatics initiative is to establish federal health information interoperability standards as the basis for electronic health data transfer in federal health activities and projects throughout the federal government. The new standards will help improve the quality of care by ensuring federal entities use common standards that will make it easier to exchange needed information. In March 2003, the Department of Health and Human Services (HHS) announced the first set of standards to be adopted. They include standards in the areas of clinical laboratory results, health messaging, prescription drug codes, digital imaging, and connectivity of medical devices to computers. Work in many more areas, such as demographics, immunizations, and interventions/procedures is underway. The Departments also provided key support to HHS in the recent purchase of a U.S. wide license for the use of the Systematized Nomenclature of Medicine (SNOMED) clinical terminology.

The initiatives highlighted today directly support sharing of medical information and development of a seamless electronic medical record and are administered in

compliance with all applicable privacy safeguards. To ensure that these, and other DoD/VA initiatives, continue to progress, the VA/DoD Joint Executive Council receives quarterly updates. In addition, DoD and VA share information on a quarterly basis with the Office of Management and Budget on the status of DoD/VA Joint Electronic Health Care Records Plan.

Closing

Mr. Chairman, the Department of Defense and Department of Veterans Affairs have joined forces to improve the sharing of medical information and continue to make progress on development of interoperable electronic medical records. This past year has seen DoD and VA continuing to make solid progress in the secure sharing of medical information and the development of interoperable electronic medical records. Our shared commitment to strong DoD/VA collaboration and the bi-directional exchange of appropriate electronic health information will ensure significant progress is achieved in the future. This collaboration allows us to be in the forefront of inter-agency cooperation and health data exchange across the federal government.

The VA/DoD Joint Strategic Plan will serve to guide us in the future. In addition, through the VA/DoD Joint Executive Council, senior leadership will continue to provide the necessary oversight to all of these initiatives.

Thank you for the opportunity to testify before your Committee on this important issue.

UNCLASSIFIED RECORD VERSION

STATEMENT BY

MAJOR GENERAL KENNETH L. FARMER, JR.

DEPUTY SURGEON GENERAL

UNITED STATES ARMY

BEFORE THE

HOUSE VETERANS AFFAIRS COMMITTEE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

FIRST SESSION 108TH CONGRESS

ON ELECTRONIC MEDICAL RECORD

NOVEMBER 19, 2003

NOT FOR PUBLICATION
UNTIL RELEASED BY THE
HOUSE VETERANS AFFIARS COMMITTEE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

Mr. Chairman and Members of the Committee, I am Major General Kenneth Farmer, Deputy Surgeon General of the United States Army. I thank you for this opportunity to represent Lieutenant General James B. Peake, the Army Surgeon General, and to appear before your committee today to discuss our ongoing efforts to electronically share medical information with the Department of Veterans Affairs. I will submit testimony for the record as you requested earlier and would like to provide my oral statement.

As you heard from Mr. Reardon, we are collectively involved in the development and implementation of multiple information management and information technology programs to improve our ability to electronically share patient information between the Department of Defense and the VA. The implementation of the next generation of the Composite Health Care System, CHCS II, across the Military Healthcare System represents the heart of our effort to create a seamless longitudinal electronic medical record that captures patient care from the first medical visit at the Medical Entrance Processing station to the last visit as a soldier, including all care provided from foxhole to medical center.

The first step in this complex effort is the deployment of outpatient care functionality found in CHCS II Block 1, which the Senior Military Medical Advisory Committee recently approved for a thirty-month accelerated fielding beginning in January 2004. Using spiral development processes that are closely tied to evolving medical requirements, additional CHCS II functionality blocks are under development

and testing, and will collectively represent all patient care provided across the entire healthcare continuum. MHS patient care data will be deposited into the Clinical Data Repository and because of a joint DoD/VA effort will be available for a two-way interface with the VA Health Data Repository in FY 05, thus establishing the seamless electronic record envisioned by all.

I would like to focus my remarks on specific Army Medical Department initiatives to reengineer clinical and business practices that underpin the successful deployment of CHCS II and other electronic patient care systems. I will also discuss the deployment of interim electronic solutions and Army participation in DoD and VA joint demonstration projects.

Establishing close partnerships with the VA such that clinical and business requirements are understood represents an important first step. Over the past two years, the Army and VA have developed a process to provide a single separation physical examination at all but one Army Medical Treatment Facility that meets both DoD and VA requirements, establishing the identification of requirements that can be developed into a data lexicon and mapped to the DoD Clinical Data Repository and VA Health Data Repository.

Force health protection and the associated pre and post deployment health assessments represent another area of joint focus for DoD and the VA. In September 2002, the Army Medical Department launched an initiative to improve the process of pre- and post-deployment health assessments by automating the collection, distribution, and archiving of the data. The goal of this project was to: streamline the data entry process; standardize the data fields; and eliminate the need for copying, mailing, and scanning

paper forms. Initially the military used a paper process for filling out the forms, which included a four-page questionnaire filled out by the Service member. The paper-based process was a labor-intensive manual process, which led to lost records, erroneous data entry and delays in getting the data scanned into the central Army Medical Surveillance Activity database. An internet version of automated pre and post deployment health assessment forms was activated on the Army's Medical Operations Data System web site on 1 April 2003. A hand held computer version with the automated forms was successfully integrated into this system on 23 July 2003 and was sent for use by the Coalition Forces Land Component Command in the Middle East and to the European Theater in August 2003. Over the past five months about a fifth of the worldwide post deployment surveys have been collected using these various electronic tools and this percentage is increasing. Recently, the Army used the hand held device at Ft. Lewis, Washington to support the automated collection and archival of pre-deployment health assessments for 98% of the 4,400 deploying troops. Today, military providers can access the completed electronic pre and post deployment forms at Army Medical Surveillance Activity data base through Tricare-on-Line, which provides the encrypted HIPAA compliant portal for accessing protected patient information. Efforts are underway to provide the same kind of access to VA providers.

We have a number of Army Medical Treatment Facilities in which a VA clinic is imbedded. At Tripler Army Medical Center, VA physicians have access to the CHCS host server. Pharmacy orders placed in CHCS to be filled at a VA pharmacy are sent electronically to the Veterans Health Information System and Technology Architecture also called VistA. Laboratory orders placed by VA physicians in VistA to be completed

at the Tripler laboratory are sent electronically to CHCS and results are sent back to VistA providing result visibility in both systems. DoD providers will soon have access to the VA Computerized Patient Record System and VistA through a web interface to an Army interim patient record system, the Integrated Clinical Data Base (ICDB). This effort provides practical experience in our effort to create the seamless transfer of electronic information.

William Beaumont Army Medical Center is another Army location where the transfer of CHCS laboratory data to the VA VistA host server occurs. In fact, William Beaumont, where CHCS II has already been fielded as one of the two Army limited deployment sites, is one of the eight DoD medical demonstration sites selected to participate in joint demonstrations with VA medical facilities, as mandated by the FY 2003 National Defense Authorization Act.

A second Army medical information systems demonstration site is between Madigan Army Medical Center in Tacoma, Washington and the Puget Sound VA Health Care System. This demonstration project will provide read-only access to both the Army's interim HealtheForces Integrated Clinical Data Base and the VA's Computerized Patient Record System and will provide visibility of clinical information at the point of care in either health care system.

The Army Medical Department is committed to improving the delivery of healthcare to all of its military beneficiaries through the seamless exchange of electronic medical information with the VA. This effort requires not just the implementation of technical solutions but also necessitates the reengineering of clinical and business processes supported by these information management tools. Collectively the DoD

initiatives described by Mr. Reardon and the examples of reengineering efforts underway in the Army Medical Department represent the critical steps to realizing the seamless electronic medical record that captures and shares patient care information beginning with the first healthcare encounter at the entrance station through the provision of military care over the service members career, followed by the care rendered in VA facilities.

In closing, I would like to thank the Committee for your continued commitment and support to provide quality care for our Soldiers and for our Veterans. I am happy to answer any questions that you have at this time.

Statement of Kem Clawson
Director, Advanced Technology Solutions
EMC Corporation

House Committee on Veterans' Affairs
Subcommittee on Oversight & Investigations
U.S. House of Representatives
November 19, 2003

Chairman Buyer, Congresswoman Hooley, and distinguished members of the Oversight and Investigations Subcommittee, I am Kem Clawson, Director of Advanced Technology Solutions at EMC. It is an honor and pleasure to be here this morning.

EMC is the world leader in enterprise information storage systems, software, networks and services. Our company is focused exclusively on delivering solutions that enable organizations of all sizes to better and more cost-effectively manage, protect, share, and store information. Every dollar we invest, every engineer we employ, is focused on information storage. With revenues of over $5 billion in 2002, EMC has developed storage solutions for the majority of the world's largest banks, financial institutions, airlines, telecommunication companies, transportation companies, Internet Service Providers, educational institutions, and Federal government agencies.

I welcome the opportunity to offer an industry perspective on the benefits and technological feasibility of developing a seamless electronic record and sharing medical information between the Department of Defense (DoD) and the Department of Veterans Affairs (VA). EMC has a deep understanding of the information storage and management challenges at the heart of healthcare today; over 90 percent of the world's largest healthcare organizations depend upon EMC to store and manage their data. Major customers include the UCLA Medical Center, University of Chicago Hospitals, Johns Hopkins Medical Center, Memorial Sloan Kettering Cancer Center, and Harvard Medical School, among others.

The fact that the VA and DoD have established a joint executive committee to oversee this worthy initiative, and have identified specific goals and objectives for information sharing, is extremely positive. Because of the size and complexity of the DoD's and VA's healthcare

delivery systems, Congress should not underestimate the significant challenges facing these Departments in creating a seamless patient information exchange.

Historically, the healthcare industry has been slow to adopt information technologies that provide dramatic increases in efficiency and reductions in cost. However, the number of successful implementations of integrated healthcare information systems in single-site and regional hospital systems is growing daily. In most cases, the obstacles to achieving this end are just as great from an organizational standpoint as from a technological standpoint. Change is never easy. From our experience in the private sector, it requires active, forceful, senior-executive direction from within an organization. Evidence of growing collaboration between the VA and DOD in the delivery of healthcare is a positive indicator that these agencies are firmly committed to overcoming institutional and cultural resistance to change often inherent in large organizations. The executive leadership of each agency must maintain this focused and continuous commitment to succeed.

As the members of this Subcommittee know, the challenge of squeezing inefficiencies out of the healthcare system, while improving the care that patients receive is considerable. One obvious impediment is that our healthcare system remains a stubbornly paper-intensive and minimally automated environment. It has not fully embraced the productivity enhancing benefits of an electronic healthcare information capability. Walk into almost any doctor's office today and the first thing you'll see through the glass partition is a floor-to-ceiling file of patient records held inside bulging manila folders. Each day, doctors and their staffs spend time retrieving files, adding new records that often come in by FAX, moving them to exam rooms, and then refiling the record when the patient's visit is over. Rarely are these records complete because documents get misplaced and because important patient treatment history is often scattered across the offices of various specialists, hospitals, pharmacies, insurers, and patients' homes. The nation's nearly 20,000 group practices and clinics generate billions of pages of medical records each year. That equates to incredible inefficiencies and results in time wasted in shuttling documents back and forth.

When given a prescription, for example, we carry a small piece of paper with illegible script to the pharmacy. The pharmacist has trouble deciphering the handwriting and may misread the prescription. And without a call to the doctor's office, the pharmacy often has no way of knowing what, if any, drugs we're allergic to or whether a new drug will cause an adverse reaction with other medications that we may be taking. The Institute for Safe Medication Practices estimates that pharmacists make about 150 million phone calls back to physicians' offices each year just to clarify prescriptions.

If we're referred to a specialist, most of us are forced to carry our own medical files, assuming we've bothered to corral and retain all of this information, or rely on our memory, when recounting our history. If we find ourselves incapacitated in the emergency room and unable to recall our medical history, our diagnosis may be delayed and, in some cases, our treatment is compromised. An Institute of Medicine study conducted a few years ago found that between 44,000 and 98,000 Americans die in hospitals each year from preventable medical errors.

So, what would be *the ideal scenario* of patient information sharing? Consider, for instance, an American serviceman serving in Iraq who is wounded; transferred to a medical hospital in Germany; flown to Walter Reed Army Medical Hospital in Washington; and lastly, flown home to receive treatment at a local VA hospital. How is this soldier's medical information going to be shared between the medical professionals at these DoD and VA facilities in different locations and on separate continents? Currently, that soldier's medical information is contained in a mixture of paper and electronic formats. These records reside in separate information domains and do not adhere to a standard format. As a result, a comprehensive view of the soldier's entire medical record by an attending physician is not possible.

The good news, Mr. Chairman, is that the impetus for change exists—it is called the *"Patient Information Lifecycle Management Strategy."* In simple terms, this refers to providing medical caregivers—regardless of time, distance or geography—with an *"Electronic Patient Record"*—a comprehensive, unified, digital record that encompasses a patient's medical information from birth to death. By pursuing this approach, the Department of Defense and Department of

Veterans Affairs can provide medical professionals with vital information that can be managed and shared. In other words, it *can* be seamless.

So, how do we make progress today toward remedying the inefficiencies in the healthcare system and arriving at a future of providing the best possible care at the lowest cost? Here are four steps in the right direction:

First, acknowledge a fundamental inconsistency of healthcare: it is one of the world's most information-intensive yet one of the world's least electronically-enabled industries. Other information-dependent industries like financial services and retailing have experienced extraordinary productivity improvements by applying information technology to harness exploding accumulations of information. This technology provides direct online access to information and facilitates collaboration among individuals, groups, and entire organizations. By contrast, in healthcare, most patient records remain on paper. Even electronically enabled clinical and administrative systems remain stove-piped; information exchange is impeded or precluded without tying disparate applications and systems into one unified network.

Second, we must fully digitize and automate the collection, movement, and management of information throughout the healthcare environment. Doing so enables patient health information to be immediately accessible to authorized caregivers, thereby improving the likelihood that the most accurate diagnoses are made, the most appropriate procedures are performed, and that treatments are ultimately successful.

Digitization also amplifies a physician's diagnostic knowledge. When physicians are deciding what kind of diagnostic tests to order, instead of relying solely on their own clinical experience, they could draw on a rich database of hundreds or thousands of other physicians' experiences about which tests resulted in positive outcomes for patients with similar symptoms. The more often an *evidence-based* system is used, the larger its database grows, and the better it becomes at identifying the best tests up front. In Boston, as part of its effort to build a fully digital healthcare imaging environment, Brigham and Women's Hospital is piloting this very approach

to eliminate unnecessary imaging exams which are estimated to cost between $3 billion and $10 billion a year nationally.

Electronic records can improve both our public and governmental health systems' ability to share medical information. In the event of a terrorist act, a networked, online healthcare infrastructure can quickly arm state and Federal health officials with a comprehensive view of the number of available hospital beds, medical supplies, and personnel, as well as the urgent-care needs of ill or injured people.

Third, take inspiration from medical organizations making the transition to electronic health records. In central Alabama, the name Baptist Health Montgomery is synonymous with high-quality healthcare. The not-for-profit provider offers leading-edge health services and wellness programs from three core medical facilities and 11 additional locations including clinics, surgical centers, and administration. Baptist Health Montgomery has implemented an integrated Health Information System that ties together administrative, financial, imaging, and patient care applications.

From a business perspective, the new system provides Baptist Health Montgomery with a business continuity capability that ensures continuous access to information and virtually eliminates downtime. It also enables clinicians and administrative personnel to better manage and share vital patient data for faster patient diagnosis; supports Health Insurance Portability and Accountability Act (HIPPA) requirements and state regulations more effectively; and facilitates a highly effective business decision-making process. Similar implementations of multi-site integrated health information systems are ongoing at Yale/New Haven Health System, North Bronx Healthcare Network, Cornell/Columbia Presbyterian Medical Centers, Kindred Healthcare, Inc., and elsewhere.

In another example of pushing healthcare fully into the digital age, *"Connecting for Health,"* a collaboration of more than 100 public and private stakeholders from every part of the healthcare system convened by the Markle Foundation, has reached a consensus on adopting an initial set of data standards and communication protocols for the sharing of healthcare information. These

standards will serve as the foundation for building secure communications among healthcare organizations.

Fourth, recognize that if we do not take full advantage of today's information technology, healthcare costs are going to continue to devour a larger and larger share of the annual budgets for both the DoD and VA. Moreover, critical patient information will remain fragmented and, in many cases, unavailable when needed. Again, the goal is to create a unified healthcare network that ties together disparate, stove-piped medical systems. Information technology delivers dramatically higher levels of efficiency to health care and lowers overall health care costs. Embraced by the VA and DoD, a *Patient Information Management Lifecycle Strategy* will provide the best possible medical care to active and retired military personnel at the lowest total cost.

In closing, Mr. Chairman, please allow me to make one final observation. While the technology exists to establish a seamless medical record between the DoD and the VA, the complexity of these healthcare systems create enormous challenges. These challenges can be—and will be—overcome. Success, however, will not be achieved overnight. Nor will it be attained without the continued and forceful involvement of each Department's executive leadership, as well as Congress' commitment to provide each Department with the resources it needs—in people and dollars—to execute on this vision. At the end of the day, even the world's best technology is only an enabler. What's needed is a determined resolve to build bridges—between the DoD, VA, *and* Congress—to get the job done. The result of this shared commitment will be better healthcare for the men and women who serve our country, and greater efficiencies and cost-savings for the American taxpayer.

Thank you.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CHAIRMAN BUYER TO GENERAL ACCOUNTING OFFICE

December 15, 2003

The Honorable Steve Buyer
Chairman, Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

Subject: *Veterans Affairs: Response to Subcommittee Post-Hearing Question Concerning the Benefits of VA-DOD Shared Medical Records*

Dear Mr. Chairman:

This letter responds to your November 26, 2003, request that we answer a question relating to our testimony of November 19, 2003.[1] In that hearing, we discussed the ongoing efforts of the Departments of Veterans Affairs (VA) and Defense (DOD) to exchange health care data and create electronic records for veterans and active duty personnel. Your question, along with our response, follows:

> On page two of your testimony, you state that electronic health data from separated service members contained in DOD's Military Health System Composite Health Care System are being transmitted to a VA Federal Health Information Exchange repository. This exchange results in VA clinicians now having more readily accessible DOD health data, such as laboratory, pharmacy, and radiology records on almost 2 million patients, and have noted the benefits it provides in improving health care delivery. Please elaborate on what those benefits are.

Federal Health Information Exchange (FHIE) program officials and physicians cited various clinical and other benefits from using information provided via the FHIE data retrieval capability. In elaborating on the specific benefits, they reported the following:

- *Enhanced standardization and continuity of health care.* FHIE has enhanced the standardization of care by enabling VA physicians to review and apply approaches used by DOD physicians for diagnosing and treating particular illnesses or injuries. This capability has improved coordination by allowing the VA physicians to understand the outcomes of treatment provided by DOD physicians while the patients were on active duty, thus contributing to the continuity of health care, and improving the quality of care for each patient.

- *Improved clinician satisfaction.* The availability of electronic records has enabled physicians to spend less time searching for patient records and has provided them with more complete health information for diagnosing and treating patients' illnesses. Prior to FHIE, VA physicians had to rely on the veterans themselves to provide their military health records to the medical facility or request separated service members' paper records from VA's Medical Records Center or the National Personnel Records Center, both located in St. Louis, Missouri.[2] Using FHIE's data retrieval capability, however, physicians are able to retrieve veterans' medical information within approximately 4 seconds. Further, program officials stated, as a result of having the electronic medical

information, for some patients, fewer repeat tests are necessary, thus freeing health care resources for other medical needs.

Improved patient satisfaction. Veterans seeking medical care at VA facilities have greater confidence that their electronic medical information is secure and well preserved.[1] Unlike with paper files, which are subject to loss and destruction during transfer and storage, electronic medical information is available to the VA physicians when needed.

In addition, during a demonstration of FHIE's capabilities at VA's Washington, D.C., medical center, the Chief of Staff of the medical center noted that the availability of health care information on separated service members has proven particularly valuable for treating emergency room and first-time patients.

Sincerely yours,

Linda D. Koontz

Director, Information Management Issues

(310700)

CHAIRMAN BUYER TO DEPARTMENT OF VETERANS AFFAIRS

Questions for the Record
Honorable Steve Buyer, Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
November 19, 2003

Hearing on VA-DoD Shared Medical Records – 20 Years and Waiting

Question 1: In your testimony, you state that "VA is working with DoD through the VA/DoD Health Executive Council and the Joint Executive Council" or what is referred to as the JEC. The Subcommittee requested the minutes of all the JEC meetings to see exactly what progress, agreements, or some measurable milestone objectives were adopted or accomplished. I understand that there is a great reluctance to provide these meeting minutes. Actually, we have a copy of the agenda and discussion of one of these meetings. Please provide copies of minutes of these meetings as requested in our letter dated November 10, 2003.

Response: We appreciate your detailing the reasons for requesting the minutes - so that you may discern "what progress, agreements, or . . . measurable milestone objectives were adopted or accomplished" with regard to VA/DoD development and sharing of electronic records. The minutes themselves would provide only limited insights into these issues, and so we are instead providing in the attachments to these responses a comprehensive account in order to more fully satisfy your stated need. The first of these attachments is a narrative account; the second is a milestone chart.

Question 2: You stated that VA can now access DoD's CHCS system for veteran information such as lab results, x-ray reports, outpatient pharmacy prescription information, admission/disposition/transfer records, discharge summaries and in the near future information on allergies, consult reports, and summary outpatient information. You further stated the Veterans Benefits Administration use this information to fulfill the evidentiary requirements for processing disability compensation claims as well as determining eligibility for other benefits. What about the entrance and separation physical? What about inpatient hospitalization? What about the pre-and post-deployment assessments? Aren't all those pieces of information absolutely necessary to adjudicate a compensation and pension claim?

Is the VA getting any of DoD's pre- and post-deployment screening data from all services in any format?

Response: VHA and DoD are aware that VBA needs the entrance and separation physicals, inpatient hospital records, pre- and post- deployment assessments, etc., in order to adjudicate claims. Currently we are receiving these records in paper form either at the Benefit Delivery Discharge sites when

the service member separates or within a couple of weeks if a claim is filed after the veteran is separated and has returned home.

Before the war in Iraq, VA provided DoD with a concise list of questions that would provide health information that is useful to veterans' health care and could be used post-deployment to screen military personnel. VA subsequently received a copy of the final DoD post-deployment health assessment questionnaire prior to its implementation. As DoD indicated in their testimony, it is expected that a hard copy of the completed questionnaire will be placed in the veteran's military medical record, which is eventually sent to the Military Records Center in St. Louis.

Obtaining paper records from St. Louis can be a time-consuming process. Therefore, as DoD and VA continue to move forward with patient medical records that can be accessed electronically by both Departments instantly in FY 2005 we expect to improve our responsiveness to the veterans. Representatives of DoD's Deployment Health Support Directorate indicated that DoD is developing an automated system that will allow VA health care providers and benefits personnel to request and view an individual's pre- and post-deployment data in an electronic format.

Question 3: Is the VA receiving medical information from DoD on all separating service members?

Response: VA has been working with DoD to obtain a complete roster of recent combat veterans. To date, the Defense Manpower Data Center (DMDC) has created a preliminary file of the Operation Iraqi Freedom (OIF) participants using Active Duty and Reserve Pay files, and Combat Zone Tax Exclusion and Imminent Danger Pay data fields.

In September 2003, DoD provided VA with a list of 17,000 veterans of Operation Iraqi Freedom who had separated as of June 30, 2003. VA received a second list from DMDC in November 2003, and a third list in December. For this current list, veterans discharged from active duty included discharges through August 2003, and veterans discharged from Reserve and Guard included discharges through July 2003. VA merged the three lists to form a single list of discharged veterans who had participated in Operation Iraqi Freedom. VA has noted certain discrepancies in the data both within and between the two deployment lists. DMDC plans to address these data discrepancies in future roster preparations.

The combined file provides basic military and demographic data on 83,752 service members who served in Operation Iraqi Freedom since October 1, 2002, and have been separated from active military service, 24,094 active duty members (29%) and 59,658 Reserve or National Guard unit members (71%). The DoD file did not include actual date of separation for everyone but the last out–of-theater date was September 2003, for active duty personnel and August

2003, for members of the Reserve/National Guard.

The lists from DMDC also included veterans of Operation Enduring Freedom (OEF), many of whom had also served in OIF. There were 15,137 separated veterans who had served in OEF (12,731 of whom also served in OIF). Of these 15,137, 2,602 (17%) had been active duty personnel (1,027 in both operations), and 12,535 (83%) had been in the Reserves or National Guard (11,704 in both operations).

We have no specific knowledge at this time concerning other veterans who have separated from military service after these wartime deployments. However, DoD does provide VA on a regular basis with the name of each individual who separates and a copy of DD Form 214, which summarizes the individual's active duty.

Question 4: Does the VA receive information from DoD about who is getting medically boarded?

Response: At present, VA does not routinely receive in an organized manner a list of service members who enter the medical disability process. This is a prime goal of the Seamless Transition Task Force. We are aggressively working with the various branches of services to have them provide information on all service members who enter the disability process. This will allow for early outreach by VA and ensure a smooth transition from DoD to VA.

Question 5: The Presidential Task Force (PTF) recommended that VA and DoD develop an electronic medical record by FY 2005 that should be interoperable, bi-directional, and standards based. Please provide the Subcommittee with a list of the standards that have been established to date.

Response: VA and DoD have developed a joint strategy to ensure the development of an interoperable electronic health record by 2005. The approach is set forth in the Joint VA/DoD Electronic Health Records Plan – HealthePeople (Federal) strategy. This plan is dependent on VA's completion of its Health Data Respository and DoD's implementation of CHCS II This plan, approved by OMB in 2002, provides for the exchange of health data by the Departments and for the development of a health information infrastructure and architecture supported by common data, communications, security, and software standards and high-performance health information systems. Providers of care in both Departments will be able to access relevant medical information to aid them in patient care.

Interoperability is dependent, in part, upon the adoption of common standards. The Departments have begun to adopt standards in key clinical areas, and expect to adopt a comprehensive set of joint standards by 2005. Pursuant to the federal interagency Consolidated Health Informatics (CHI) effort, VA, DoD, and

HHS have identified 24 domain areas in which standards should be adopted. To date, standards have been adopted in the following 5 domain areas:

1. Laboratory Results Names [Logical Observation Identifier Names and Codes (LOINC)];
2. Messaging Standards For Scheduling, Medical Record/Image Management, Patient Administration, Observation Reporting, Financial and Patient Care [Health Level 7 (HL7) version 2.4, XML encoded];
3. Messaging Standards for Pharmacy Transactions for electronic retail pharmacy transactions [National Council on Prescription Drug Programs (NCPDP)];
    - NCPDP SCRIPT Standard is a HIPAA data transmission standard intended to facilitate the communication of prescription information between prescribers and pharmacists. It provides the functionality to digitize the requests and notifications associated with the prescription business lifecycle, including fill requests, status reports, and cancellations. This standard has been approved by the VA and DoD for electronic retail pharmacy transactions.
4. Digital Imaging Standards [Digital Imaging Communications In Medicine (DICOM)]; and
    - The DICOM standard is approved for VA and DoD in support retrieval of information from imaging devices/equipment to diagnostic and review workstations, and to short-term and long-term storage systems for VA and DoD internal use.
5. Standards for Connectivity of Medical Devices [Institute of Electrical and Electronics Engineers (IEEE) 1073].

The CHI Council has tentatively approved standards in an additional 6 domain areas and will soon recommend adoption of those standards listed below. The Veterans Health Administration has already approved these standards for adoption.

6. Medications [Federal Drug Terminologies];
7. Laboratory Interventions and Procedures [LOINC];
8. Demographics [HL7];
9. Immunizations [HL7];
10. Lab Content [Systematized Nomenclature of Medicine (SNOMED)]; and
11. Units [HL7].

VA and DoD have also successfully adopted the X12 transactions set standards as required by HIPAA regulations. Remaining milestones under the CHI effort relate to the other clinical areas targeted for standards review and/or adoption in phase I of the CHI initiative. These include:

1. Anatomy and physiology;
2. Diagnosis and problem lists;

3. Nursing;
4. Financial/payment;
5. Medical devices and supplies;
6. Interventions and procedures (non-laboratory);
7. History and physical;
8. Genes and proteins;
9. Disability;
10. Clinical encounters;
11. Text-based records;
12. Chemicals;
13. Population health; and
14. Multimedia,

In addition, VA and DoD are addressing data standardization issues through a health data standardization workgroup co-chaired by the two Departments. This workgroup is focused on achieving the degree of standardization necessary for two-way exchange of health data. In addition, the Departments have formed an active working integrated project team to achieve interoperability between the DoD Clinical Data Repository (CDR) and the VA Health Data Repository (HDR). This project, known as "CHDR", will demonstrate the bi-directional capability to exchange pharmacy and demographic data in a prototype in 2004, and will achieve interoperability by 2005.

Question 6: In its testimony, the Government (sic) Accounting Office stated that DoD, VA, and HHS adoption of one standard, the laboratory standard, is a long way from meeting the 2005 milestone for implementing the two-way exchange of health information. Please provide the Subcommittee with the remaining milestones for adoption of standards that need to be met by 2005.

Response: The departments have made significant progress in the adoption of standards to support interoperable health records, both in their work together and in their leadership roles with the Consolidated Health Informatics (CHI) initiative. CHI recommended the use of LOINC for laboratory test result names; this standard was adopted in 2003.

CHI subsequently considered LOINC as a candidate standard for the Laboratory Interventions and Procedures domain. In its final recommendation, the domain workgroup noted that LOINC had received a prior recommendation as the CHI standard for laboratory test result names, and recognized that LOINC is flexible enough to meet the needs of the Laboratory Test Order domain as well. The workgroup's recommendation was approved by the National Committee on Vital and Health Statistics (NCVHS) in October 2003; however, the adoption of standard has not yet been formally announced by HHS. No other domains currently identified by CHI are relevant to the exchange of lab information.

Currently, VA and DoD employ the HL7 messaging standard to support unilateral transmission of chemistry lab test orders and results (where DoD serves as the reference lab). The agencies are testing the bilateral, real-time exchange of lab data, allowing either agency to serve as reference lab for the other. This capability will enable both departments to optimize the use of lab resources and reduce costs. The system is expected to be ready for deployment in May 2004.

In addition to their collaboration on the laboratory standards outlined above, DoD and VA are working together and through CHI to address the standards needed to achieve the two-way exchange of health information between the VA-DoD Clinical Data Repository and the VA Health Data Repository in 2005. Through the effort known as "CHDR", the departments are evaluating standards necessary to achieving interoperability in 2005.

Question 7: The Departments should implement a mandatory single separation physical as a prerequisite of promptly completing the military separation process by 2005. How is this progressing?

Response: VA currently has 11 BDD sites at which a single separation physical is being conducted. Each of these sites has a Memorandum of Agreement (MOA) that defines the roles of VA and DoD in the examination process and specifies the necessary information that must be obtained from the examination. The Benefits Executive Council (BEC) is currently working on an MOA, based upon the 11 MOAs currently in existence that will be signed by VA and DoD and become the basis for a single separation physical across all branches of the military.

Question 8: Please explain why the DoD and VA are not instigating a single physical with our National Guard and Reserve soldiers being medically boarded at Ft. Stewart?

Response: Ft. Stewart is one of the BDD sites, referred to in the response to question 7, at which we conduct a single examination for active duty soldiers who file claims for VA benefits prior to separation from active duty. The MOA does not cover National Guard and Reserve soldiers. We are investigating the potential for expanding the MOA to Reserve/Guard members.

Question 9: The PTF recommends DoD and VA expand their collaboration in order to identify, collect, and maintain the specific data needed by both Departments to recognize, treat, and prevent illness and injury resulting from occupational exposures and hazards while serving Please provide the Subcommittee with a summary of the items on which DoD and VA have collaborated to date.

Response: All data that DoD collects on occupational and deployment health risks are of potential benefit to VA in the provision of health care and assistance

to veterans. Therefore, data sharing has been a principal focus of the Health Executive Council (HEC), which is co-chaired by VA's Under Secretary for Health and DoD's Assistant Secretary of Defense, Health Affairs and which has increasingly coordinated an array of diverse health matters between VA and DoD. The HEC has established a total of 11 Work Groups comprised of representatives from both VA and DoD to address specific issues of common interest to the VA and Military Health Care System.

For deployment health issues, VA and DoD jointly decided to move coordination of deployment health concerns into the HEC by creating a new Deployment Health Work Group, which assumed the responsibilities of the Military and Veterans Health Coordinating Board in order to ensure continued, high-level, inter-agency coordinating on critical deployment health issues. The new Deployment Health Work Group has representatives from VA, DoD, and HHS, and reports directly to the HEC.

For health data collaborations, the Deployment Health Work Group has been discussing VA's need for a complete roster of troops deployed to Southwest Asia. To date, DoD has given VA an initial list and one update of veterans who had been deployed to Iraq and Afghanistan and then subsequently separated from military service. These veterans include activated Guard and Reserve personnel, as well as active duty service members. Preliminary evaluation of health care provided by VA to troops who have been deployed to Iraq and Afghanistan indicate that troops who have separated from active duty are presenting with the wide range of both medical and psychological problems expected in young veteran populations. No particular health problem stands out in the initial analyses of VA health care data.

VA looks forward to further updates of these deployment lists and to the sharing of a complete roster of deployed troops, as was provided after the Gulf War in 1991. With a complete roster, VA can ensure that combat veterans receive new health care benefits and that emerging health problems are rapidly identified. VA also looks forward to receiving from DoD pre- and post-deployment screening data, and environmental exposure data and health care data collected during the period of deployment to Southwest Asia. This health and exposure information will aid VA in the recognition, treatment, and prevention of illness and injury from occupational exposure and hazards during military service.

In future meetings, the Deployment Health Work Group will address the recent PTF recommendation that VA and DoD collaborate to identify, collect, and maintain the specific data needed by both Departments to recognize, treat, and prevent illness and injury resulting from occupational exposures and hazards while serving. VA is committed to better addressing these issues in the future.

Attachment to Response to Question 1

STATUS OF THE
VA/DOD JOINT ELECTRONIC HEALTH RECORDS PLAN –
HEALTHePEOPLE (FEDERAL)
IN RESPONSE TO POST-HEARING QUESTION 1 (NOVEMBER 19, 2003)
FROM THE HOUSE VETERANS' AFFAIRS COMMITTEE

VA and DoD have developed a joint strategy to ensure the development of an interoperable electronic health record by 2005. The approach is set forth in the Joint VA/DoD Electronic Health Records Plan – HealthePeople (Federal) strategy. This plan, approved by OMB in 2002, provides for the exchange of health data by the Departments and for the development of a health information infrastructure and architecture supported by common data, communications, security, and software standards and high-performance health information systems. Providers of care in both Departments will be able to access relevant medical information to aid them in patient care. The implementation plan to attain full interoperability is contained in the VA/DoD Electronic Health Records Plan – HealthePeople (Federal). A copy of the implementation project plan is attached to this document.

The Departments continue work to fully update the plan for interoperability. Since the initial plan was provided to GAO in December, the Departments have actively worked to define requirements for the interoperable pharmacy prototype and to update the implementation strategy, including implementation of jointly adopted data standards to support interoperability. The Departments anticipate completing the updated strategy by the end of the 2nd Quarter, FY 2004. Upon completion, the updated strategy shall be forwarded to GAO and OMB.

- The Departments are on target to demonstrate interoperability of pharmacy and demographic data through a prototype in 2004. The Departments will achieve interoperability by 2005 through the adoption of common standards and convergence of software applications. To date, the Departments have adopted standards in 5 of the 24 clinical domain areas identified by the interagency Federal Consolidated Health Informatics (CHI) effort, with an additional 6 domain areas cleared for adoption. These 6 additional domains were recently adopted by the VA. Furthermore, the Departments are actively collaborating on multiple software applications for scheduling, credentialing, laboratory, and e-portal systems. Since June 2002, the Departments have successfully exchanged military health data on separated service members through the Federal Health Information Exchange (FHIE). FHIE (formerly known as the government computer based patient record (GCPR)) supports the transmission of laboratory, pharmacy, radiology, allergy, and consult data

from DoD to VA for viewing by clinicians in the VA Computerized Patient Record System. The Departments will deploy another enhancement to FHIE that will support the transmission of DoD Pharmacy Data Transaction Service (PDTS) and Standard Ambulatory Data Record (SADR) data in the 2nd Quarter of FY 04. FHIE is currently in use in all VA medical centers as well as supporting the examination of separating service members for disability benefits from the Veterans Benefits Administration.

The provision of full interoperability in VA and DoD hospitals is contingent upon full deployment of VA and DoD next-generation health information systems, HealtheVet-VistA and CHCS II and data repositories. Presently, VA is scheduled to deploy HealtheVet-VistA in 2005, the date of deployment for the Health Data Repository.

Attachment to Response to Question 1

KEY POINTS
CONCERNING JEC OVERSIGHT OF THE
VA/DOD JOINT ELECTRONIC HEALTH RECORDS PLAN –
HEALTHePEOPLE (FEDERAL)

BACKGROUND: The Joint Executive Council (JEC), co-chaired by the VA Deputy Secretary and DoD Under Secretary of Defense, Personnel and Readiness, has met on a quarterly basis since February 2002. The JEC provides oversight to two major bodies, the Health Executive Council (HEC), co-chaired by the VA Under Secretary for Health, and the Assistant Secretary of Defense, Health Affairs, and the Benefits Executive Council. The HEC, pursuant to guidance from the JEC, provides direct oversight and executive management of the VA/DoD Joint Electronic Health Records Plan – HealthePeople (Federal). Since its inception, the JEC has considered the following items related to the Plan:

- The Chief Information Officers for Veterans Health Administration (VHA) and for the Military Health System (co-chairs of the Information Management/Information Technology work group of the HEC) and the Senior Advisor to the VA Under Secretary for Health provided the JEC/HEC an update of the VA/DoD IM/IT initiatives. The following highlights items that have been reviewed by the JEC:
    - Process to monitor the recommendations of the Presidential Task Force to Improve the Health Care of our Nations' Veterans.
    - FHIE progress.
    - Development of the Electronic Health Records Plan.
    - Signed a Memorandum of Agreement and a High Level Planning Document designed to formalize progress on the FHIE.
    - Approved the Joint Electronic Health Records Plan– HealthePeople (Federal) that had been signed by the HEC Co-chairs.
    - Several other collaborative projects, including joint use of health information content by the e-Health portal projects and collaboration on the VA Consolidated Mail Order Pharmacy (CMOP) program. The JEC expressed support for DoD adoption of the CMOP program at select sites.
    - Considered the integration of VA and DoD's credentialing/privileging programs and the development of Federal standards for data and information through the OMB e-gov initiative led by HHS (now referred to as the Consolidated Health Informatics (CHI)).

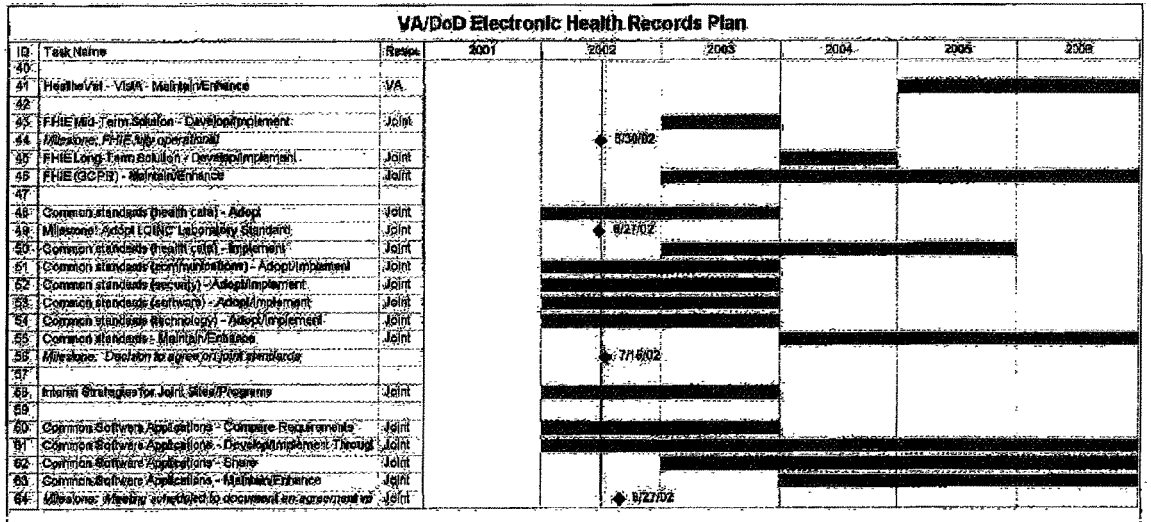
Attachment to Response to Question 1

- The JEC approved the strategy to achieve full interoperability through the development of interoperable data repositories for next-generation health information systems. Further, the JEC reviewed the Departments' collaboration on interoperable scheduling applications and noted the solid rationale for each Department's decision to build an in-house enhancement (VA) and to purchase a commercial off the shelf product (DoD). Both VA and DoD agreed there was substantial value derived from the collaborative efforts, and the Departments will deliver interoperable scheduling capabilities. The JEC approved the Departments' respective strategies to proceed with enhancing scheduling applications.

(NOTE: Attachment continues with milestone chart.)

VA/DoD Electronic Health Records Plan

ID	Task Name	Resp.
40		
41	HealthVet - VistA - Maintain/Enhance	VA
42		
43	FHIE Mid-Term Solution - Develop/Implement	Joint
44	*Milestone: FHIE fully operational*	
45	FHIE Long-Term Solution - Develop/Implement	Joint
46	FHIE (GCPII) - Maintain/Enhance	Joint
47		
48	Common standards (health care) - Adopt	Joint
49	Milestone: Adopt LOINC Laboratory Standard	Joint
50	Common standards (health care) - Implement	Joint
51	Common standards (communications) - Adopt/Implement	Joint
52	Common standards (security) - Adopt/Implement	Joint
53	Common standards (software) - Adopt/Implement	Joint
54	Common standards (technology) - Adopt/Implement	Joint
55	Common standards - Maintain/Enhance	Joint
56	*Milestone: Decision to agree on joint standards*	
57		
58	Interim Strategies for Joint Sites/Programs	Joint
59		
60	Common Software Applications - Compare Requirements	Joint
61	Common Software Applications - Develop/Implement Theory	Joint
62	Common Software Applications - Share	Joint
63	Common Software Applications - Maintain/Enhance	Joint
64	*Milestone: Meeting scheduled to document an agreement*	Joint



Project: VA_DoD Electronic Health Rec
Date: Mon 7/1/02

Task
Milestone
External Milestone
Deadline

CHAIRMAN BUYER TO DEPARTMENT OF DEFENSE

Hearing Date: November 19, 2003
Committee: House Veterans Affairs Committee
Member: Congressman Buyer
Witness: Ms. Jeanne Fites
Question # 1

Question: How many monthly requests does VA submit to the Defense Personnel Records Image Retrieval System (DPRIS)?

Answer: The table below reflects the distribution of monthly requests among the Army, Navy, and Marine Corps for the months of July, August, and September 2003. There were over 2,500 requests each to the Navy and the Army, and almost 900 to the Marine Corps during these three months.

Designated for:	Jul-03	Aug-03	Sep-03	Qtr 4 Totals
Navy	662	973	1,095	**2,730**
Army	635	940	996	**2,571**
Marine Corps	200	309	390	**899**
Monthly Totals	**1,497**	**2,222**	**2,481**	**6,200**

The table below reflects the quarterly requests by Service for all quarters of Fiscal Year 2003. As stated in our written testimony, the Air Force interface is anticipated to be complete by the end of 2004.

Designated for:	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Navy	1,641 51%	1,639 49%	1,917 49%	2,730 44%
Army	1,070 33%	1,252 37%	1,493 38%	2,571 41%
Marine Corps	515 16%	477 14%	515 13%	899 15%
Quarterly Totals	**3226**	**3368**	**3925**	**6200**

Hearing Date: November 19, 2003
Committee: House Veterans Affairs Committee
Member: Congressman Buyer
Witness: Ms. Jeanne Fites
Question # 2

Question: What are Services turn around times for VA information requests to DPRIS?

Answer: Currently VA requests to DPRIS are being answered in real-time since it is still an advanced technology demonstration and is only used by VA adjudicators that have access to the VA Personnel Information Exchange System (PIES). The key performance parameter for the system is to respond to VA requests within 48 hours.

Hearing Date: November 19, 2003
Committee: House Veterans Affairs Committee
Member: Congressman Buyer
Witness: Ms. Jeanne Fites
Question # 3

Question: How sufficient is the information? In other words, how often does VA request additional clarifying information?

Answer: Although follow ups have been going through DPRIS for some time, DPRIS just started to capture follow up messaging metrics last month. In November 2003 there were 2,241 VA requests to DPRIS and there were 175 follow up messages sent. This is 7.8% of the total messages sent for November.

Hearing Date: November 19, 2003
Committee: House Veterans Affairs Committee
Member: Congressman Buyer
Witness: Ms. Jeanne Fites
Question # 4

Question: Is there not a better way to get this information to the VA sooner?

Answer: For Service members who have been out of the Service for more than 60 days, DPRIS provides information immediately upon request. Service members receive copies of their DD-214 upon separation. VA could use the Service member's copy as an interim qualifier while they pursue authentication from DoD.

The Defense Integrated Military Human Resources System is being developed and engineered to provide authenticated electronic data to the VA.

Hearing Date: November 19, 2003
Committee: House Veterans Affairs Committee
Member: Congressman Buyer
Witness: Ms. Jeanne Fites
Question # 5

Question: Does not the agreement between DoD and VA for the transfer of (health treatment records) service medical records (SMR) require a 10 day timeline for receipt at VA?

Answer: The timeline stated in the agreement is for five days.

Hearing Date: November 19, 2003
Committee: House Veterans Affairs Committee
Member: Congressman Buyer
Witness: Ms. Jeanne Fites
Question # 6

Question: Does not the agreement also require a copy of Copy 3 of the DD214 to be included in the SMR?

Answer: The agreement does state that a copy of Copy 3 of the DD214 will be placed in the SMR.

Hearing Date: November 19, 2003
Committee: House Veterans Affairs Committee
Member: Congressman Buyer
Witness: Ms. Jeanne Fites
Question # 7

Question: Do you agree that the purpose for including a copy of copy 3 is to allow the DD-214 data to be inputted into VA's Beneficiary Index Locator Subsystem (BIRLS) for use in determining eligibility and entitlement? Are Services meeting the 10 day time line for receipt at VA?

Answer: Copy 3 of the DD-214 is sent to Austin Automation Center where it is used to input information into the Veterans Assistance Discharge System (VADS). The copy of Copy 3 goes to St. Louis. If there is not already an entry in the Beneficiary Index Locator Subsystem (BIRLS) from VADS, when the record is received at the Records Management Center (RMC), then the RMC uses the copy of Copy 3 to initiate a record in BIRLS. VA does not use either Copy 3 or the copy of Copy 3 as an authenticated DD-214. The VA Records Management Center reports that they are receiving most of the records within 10 to 30 days.

Hearing Date: November 19, 2003
Committee: House Veterans Affairs Committee
Member: Congressman Buyer
Witness: Ms. Jeanne Fites
Question # 8

Question: Are Services including a copy of copy 3 of the DD-214 with the SMR?

Answer: The VA Records Management Center reports that they are receiving health treatment records with a copy of Copy 3 of the DD-214.

Hearing Date: November 19, 2003
Committee: HVAC
Member: Congressman Buyer
Witness: Ms. Jeanne Fites
Question # 9

Question: The Presidential Task Force (PTF) recommended that VA and DoD develop an electronic medical record by Fiscal Year 2005 that should be interoperable, bi-directional, and standards based. Please provide the Subcommittee with a list of the standards that have been established to date.

Answer: DoD and VA continue to play key roles as lead partners in the Consolidated Health Informatics (CHI) project, one of the 24 eGov initiatives in support of the President's Management Initiative. CHI's goal is to establish federal health information interoperability standards as the basis for electronic health data transfer in all activities and projects among all agencies and departments. The new standards will help improve the quality of care by ensuring federal entities use common standards that will make it easier to exchange needed information.

Since its inception, CHI has identified a target portfolio of 24 clinical domains for standards adoption. Teams to research and review standards for all 24 domains are in place. These teams are in various stages of review and analysis. CHI has formally adopted four messaging and one vocabulary standard government-wide, plus the X12 messaging standard required by the Health Insurance Portability and Accountability Act. The standards adopted are:

- Logical Observation Identifier Names and Codes (LOINC) for laboratory result names
- Messaging Standards for Scheduling, Medical Record/Image Management, Patient Administration, Observation Reporting, Financial and Patient Care [Health Level 7 (HL7) version 2.4, XML encoded]
- Messaging Standards for Pharmacy Transactions, including retail pharmacy [National Council on Prescription Drug Programs (NCPDP)]
- Digital Imaging Communications in Medicine (DICOM) for digital mapping
- Standards for Connectivity of Medical Devises [Institute of Electrical and Electronics Engineers (IEEE) 1073]

Additional standards that will soon be presented to the CHI Council for adoption are the following:

- Medications [Federal Drug Terminologies]
- Laboratory Interventions and Procedures [LOINC]
- Demographics [HL7]
- Immunizations [HL7]
- Lab Content [Systemized Nomenclature of Medicine (SNOMED)
- Units [HL7]

In addition, the Departments also use X12 transaction set as required by the Health Insurance Portability and Accountability Act.

Hearing Date: November 19, 2003
Committee: HVAC
Member: Congressman Buyer
Witness: Ms. Jeanne Fites
Question # 10

Question: In its testimony, the Government Accounting Office stated that DoD, VA and HHS adoption of one standard, the laboratory standard, is a long way from meeting the 2005 milestone for implementing the two-way exchange on health information. Please provide the Subcommittee with the remaining milestones for adoption of standards that need to be met by 2005.

Answer: DoD and VA continue to play key roles as lead partners in the Consolidated Health Informatics (CHI) project, one of the 24 eGov initiatives in support of the President's Management Initiative. CHI's goal is to establish federal health information interoperability standards as the basis for electronic health data transfer in all activities and projects among all agencies and departments. The new standards will help improve the quality of care by ensuring federal entities use common standards that will make it easier to exchange needed information.

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- Messaging Standards for Pharmacy Transactions, including retail pharmacy [National Council on Prescription Drug Programs (NCPDP)]
- Digital Imaging Standards [Digital Imaging Communications In Medicine (DICOM)]
- Standards for Connectivity of Medical Devices [Institute of Electrical and Electronics Engineers (IEEE) 1073]

Additional standards that will soon be presented to the CHI Council for adoption are the following:

- Medications [Federal Drug Terminologies]
- Laboratory Interventions and Procedures [LOINC]
- Demographics [HL7]
- Immunizations [HL7]
- Lab Content [Systemized Nomenclature of Medicine (SNOMED)
- Units [HL7]

Thirteen additional teams are in various stages of review and analysis of other domains. Examples of items being examined are lab results contents, demographics, immunizations, and interventions/procedures.

Adopted standards will be used for new systems development and in the requirements for acquisition of commercial-off-the-shelf (COTS) software. Federal adoption of standards, and requiring their use in COTS acquisitions and software development efforts, should become a catalyst for their adoption in the private sector.

Hearing Date: November 19, 2003
Committee: HVAC
Member: Congressman Buyer
Witness: Ms. Jeanne Fites
Question # 11

Question: The Departments should implement a mandatory single separation physical as a prerequisite of promptly completing the military separation process by 2005. How is this progressing?

Answer: Currently more than 30 individual discharge sites and Veterans Benefits Administration (VBA) regional offices (RO) across the country have developed their own memorandums of understanding with military treatment facilities under which a single separation examination is provided to active duty Service members who intend to file a claim for VA disability compensation. Additionally, a work group is being assembled, composed of representatives from the VBA, Veterans Health Administration (VHA), Health Affairs and each of the three Services to monitor progress, identify and build upon successes, and avoid duplication of effort. The Departments have every intent of streamlining the process and meeting the 2005 milestone.

Hearing Date: November 19, 2003
Committee: HVAC
Member: Congressman Buyer
Witness: Ms. Jeanne Fites
Question # 12

Question: Please explain why the DoD and VA are not investigating a single physical with our National Guard and Reserve soldiers being medically boarded at Ft. Stewart?

Answer: The single physical exam serves the dual purpose of documenting that the Service member meets medical standards for retention and hence may separate from the Service for reasons other than medical disqualification, and also provides the information necessary upon which the VA can adjudicate a claim for disability, should one be filed. Military members who have been identified as apparently not meeting medical retention standards, however, must first be referred to the DoD Disability Evaluation System for a determination of fitness. A single separation physical is not applicable to such individuals. The National Guard and Reserve soldiers being medically evaluated at Ft. Stewart had already been flagged as apparently not meeting medical retention standards; hence a single exam is of no utility to them. The medical evaluations for which they are waiting are for the purpose of determining their medical care needs and overall fitness for duty, prior to action on a separation from active duty.

Hearing Date: November 19, 2003
Committee: HVAC
Member: Congressman Buyer
Witness: Ms. Jeanne Fites
Question # 13

Question: The PTF recommends DoD and VA expand their collaboration in order to identify, collect, and maintain the specific data needed by both departments to recognize, treat, and prevent illness and injury resulting from occupational exposures and hazards while serving. Please provide the Subcommittee with a summary of the items on which DoD and VA have collaborated to date.

Answer: There are many examples of DoD and VA coordinating and sharing information to attempt to evaluate or determine symptoms or illnesses in veterans that may be related to events or exposures during their service. The following list provides some specific instances.

Gulf War

The DoD developed a roster of individuals who deployed to the Gulf War and a roster of all others who were on active duty at the time but did not deploy. Those rosters have been used by DoD and VA to conduct multiple studies to compare the rates of illness, hospitalization, death, cancer, etc., and determine if there are indications of increased disease rates or unique diseases in Gulf War veterans.

The DoD and VA performed a combined analysis of the information collected during medical examinations done by DoD under the Comprehensive Clinical Evaluation Program and by the VA under the Persian Gulf Registry Program which evaluate Gulf War veterans and their families.

The DoD used data from ambient air monitoring and unit locations to develop a model of exposure to smoke from oil well fires in Kuwait that has been used by CDC and VA to evaluate respiratory symptoms/illnesses in Gulf War veterans.

The DoD used data from intelligence sources, open-air simulant testing and climate controlled evaporation testing to develop a model of chemical warfare agent (sarin and cylcosarin) exposure following US demolition of munitions at Khamisiyah, Iraq. DoD then amplified knowledge on unit location to develop a roster of possible individual exposures from the chemical warfare agent release. DoD has used these data and VA research to determine whether there were identifiable differences in health outcomes in those individuals identified as possibly exposed and those identified as not exposed.

The DoD developed rosters of individuals exposed to depleted uranium at Level I (in or on a vehicle hit with depleted uranium munitions) or Level II (duty required spending extensive time inside military vehicles damaged from depleted uranium munitions). The DoD notified these

individuals and VA has used these rosters to provide comprehensive medical evaluation and medical follow-up for those individuals who volunteered for this care.

The DoD developed a list of the agents/substances/medications that were recognized to be present or were used during the Gulf War. That list was provided to the VA and the VA has contracted with the National Academy of Science, Institute of Medicine to have expert, independent panels evaluate the literature to determine if there is any evidence for an association between these agents/substances/medications and any adverse health outcome.

The DoD developed a roster of individuals who applied pesticides during the Gulf War. This roster and details of pesticide exposures have been shared with the VA. The VA is conducting a neuropsychological follow-up study to determine if pesticides could be a factor in subsequent health outcomes.

Project 112/SHAD

The DoD has conducted an investigation of operational chemical and biological testing done from 1962 to 1973 to determine who was present during this testing; where and when the testing was done; what chemical or biological agents, simulants or tracers were used; and what decontamination agents were used. These data have been provided to the VA. The VA is notifying each individual and offering a complete medical evaluation. The VA has also contracted with the Medical Follow-up Agency of the Institute of Medicine to conduct a health survey of the veterans who participated in shipboard testing, with a comparison group of veterans of the era who were on ships that did not participate in the testing.

Prospective Study

The DoD and VA have collaborated on developing and initiating a 21-year prospective study of 140,000 military personnel to determine if there are relationships between health outcomes and their military service. An extensive health survey is used to establish each individual's baseline, and repeat surveys are done at three-year intervals. Extensive data on occupational and environmental exposures, worldwide locations, medical treatment or interventions and health concerns are recorded.

Sharing of Information and Data on In-garrison Occupational and Environmental Exposures

The primary information sharing occurs as a result of the occupational and environmental exposure data that is filed in individual Service members' medical records. This includes workplace exposure summaries and more specific surveillance data for those enrolled in mandated occupational health surveillance programs (e.g., radiation, noise, lead, and cadmium exposure). Note that some Services do better with the filing of occupational and environmental exposure summaries in medical records than others (the Air Force probably leads in this area).

Additional information is provided to the VA on a case-by-case basis when more information is required. In this case, the VA (or in some cases, DoD) generally goes directly to the installation

in question to obtain any additional clarifying data that the VA or the individual veteran may require.

Also, beginning in 2002, there has been close coordination and collaboration between the VA and the Air Force regarding the initiation of an epidemiological study examining the incidence of ALS at Kelley AFB. The Air Force approached the VA to help ensure that the Air Force study would build on the VA's experience in order to discern whether former workers at Kelly AFB may have been at a higher risk for ALS as a result of occupational or environmental exposures.

Hearing Date: November 19, 2003
Committee: House Veterans Affairs Committee
Member: Congressman Buyer
Witness: Mrs. Jeanne Fites
Question # 14

Question: VA acknowledges receipt of a list of approximately 17,000 veterans who served in theaters of combat in Afghanistan and Iraq and who subsequently separated from active duty. When asked about follow up lists and other useful data VA requires, you responded that there were errors with that data. Has DoD compiled a data list to follow the 17,000 veteran list noted above and did this list contain data errors preventing its transfer or acceptance by VA? Please explain in detail what these errors were. If a subsequent list contained errors, when will an accurate list containing all information requested by VA be available to VA? Does this indicate that DoD cannot account for all Service members in theater or when these members return? If the individuals can be accounted for, which data cannot be accessed to match with the individual returning Service members and why was this data not available?

Answer: There were no errors in any records sent to the VA. 17,000 records were sent in the agreed upon first submission of monthly data to the VA Epidemiological Service. These were personnel identified as in theater Persian Gulf and Afghanistan, both Reserve and Active Duty, from October 1, 2002, through June 2003 who later separated from the Defense Department. This was sent in September 2003. In October the DoD sent 61,000 records meeting the criteria of being in theater from October 1, 2002, through August 2003 and subsequently leaving DoD. The November submission should go out soon and will include October 1, 2002, through September 2003. Everything is correct. The DoD is sending data as it becomes available. We do realize that the Services and Components are somewhat late in responding perfectly to requirements for reporting, but the data sent to the VA is deemed accurate.

Hearing Date: November 19, 2003
Committee: House Veterans Affairs Committee
Member: Congressman Buyer
Witness: Ms. Jeanne Fites
Question # 15

Question: On page 4 of your testimony, you discuss a change in the acquisition reporting chain for DIMHRS and note that the "current program management team began work in August of 2001." Please provide a comparison of the timeline and milestones of DIMHRS prior to this management team change [circa late Calendar Year 2000 or early 2001], and the current DIMHRS timeline. Provide the milestone chart from each of the two management teams indicating the relative completion dates for critical DIMHRS milestones. Explain the impact of the change in management teams, if progress was impacted.

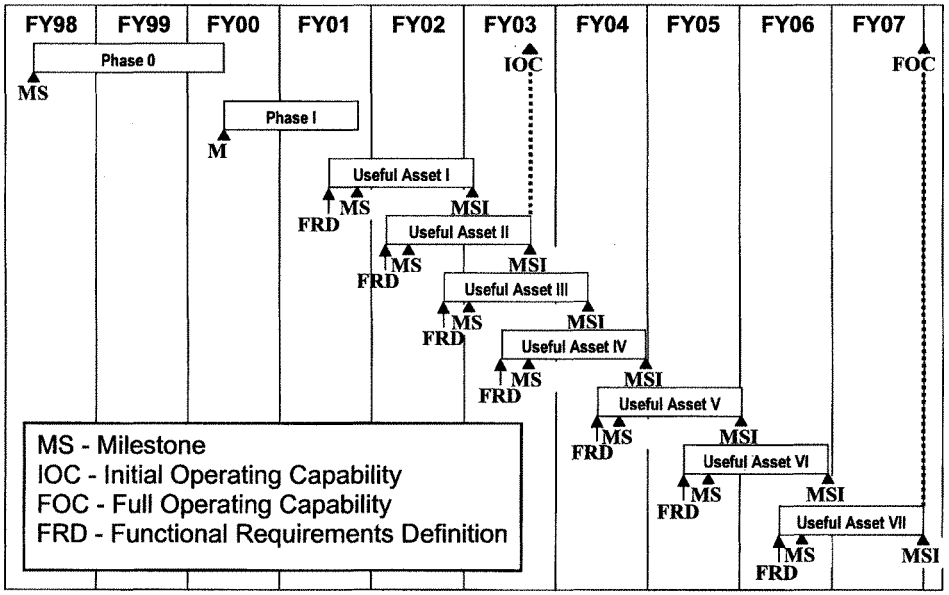
Answer: The Milestone-A (called Milestone 1 at the time) schedule is provided on page 1 of the enclosed charts. At that time, the seven useful assets were notional and had not been defined in terms of functionality. Initial operating capability was planned for 2003, but it was not a full operational capability in any Service. Final operating capability was planned for 2007.

The current program schedule is provided on pages 2 and 3 of the enclosed charts. The useful assets are fully defined. Initial operating capability is the full DIMHRS capability operational in the Army. Final operating capability is the full DIMHRS capability operating in all Services in late 2007. The schedule is generous in that it allows as much time for development of the capability after IOC as it does for IOC. In fact, very little additional development will be required after IOC. The main activity after IOC will be setting up the Service specific organizational structures and position competencies.

When the current Program Manager came in, she found that the program did not have a full work breakdown structure, it had no Acquisition Program Baseline, it was under-funded to provide the full capability, and the notional schedule did not track to capabilities that were deployable. In order to bring the program into compliance with DoD regulations, she had to completely restructure the program, develop a full baseline, and request additional funding to complete the development.

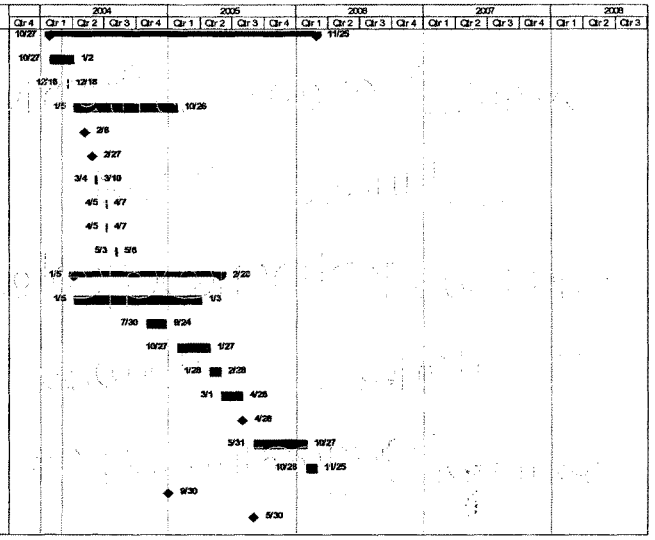
DIMHRS (Pers/Pay) Program Schedule

October 2000



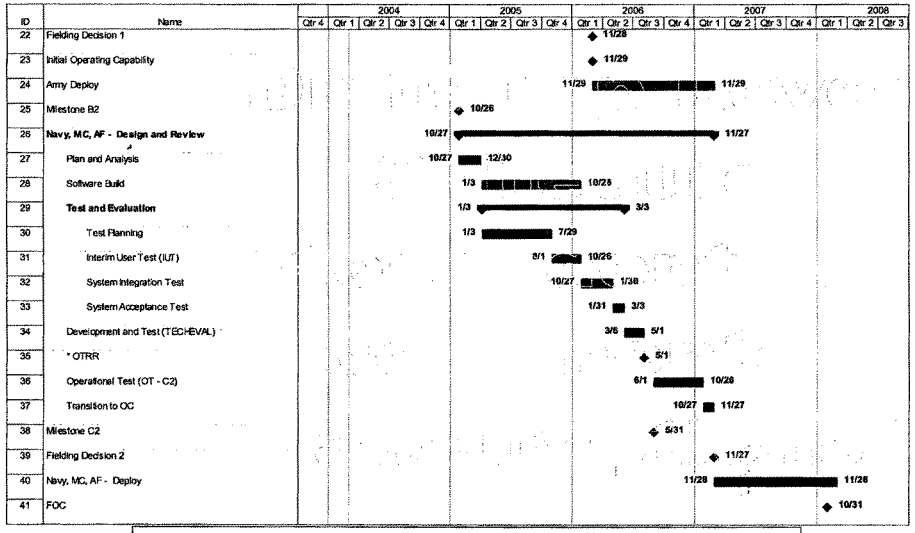
Draft Top Level Schedule as of 1 Dec 2003

ID	Name	Start	Finish
1	**Army Design and Review**	10/27	11/25
2	Plan and Analysis	10/27	1/2
3	Preliminary Design Review	12/18	12/18
4	Software Build	1/5	10/26
5	Integrated Baseline (IBR) Review	2/6	
6	Interim Progress Review (IPR)	2/27	
7	Critical Design Review - Build 1	3/4	3/10
8	Critical Design Review - Build 2	4/5	4/7
9	Critical Design Review - Build 3	4/5	4/7
10	Critical Design Review - Build 4	5/3	5/6
11	**Test and Evaluation**	1/5	2/20
12	Test Planning	1/5	1/3
13	Interim User Test (IUT)	7/30	9/24
14	System Integration Test	10/27	1/27
15	System Acceptance Test	1/28	2/28
16	Development and Test (TECHEVAL) (DT - B)	3/1	4/26
17	* OTRR	4/26	
18	Operational Test (OT - C1)	5/31	10/27
19	Transition to IOC	10/28	11/25
20	Exercise PeopleSoft Contract	9/30	
21	Milestone C1	5/30	



* OTRR: Contract modification may be required.

Draft Top Level Schedule as of 1 Dec 2003



* OTRR: Contract modification may be required.

8

Making the DIMHRS Pers Pay Difference

Hearing Date: November 19, 2003
Committee: House Veterans Affairs Committee
Member: Congressman Buyer
Witness: Ms. Jeanne Fites
Question # 16

Question: From a strategic perspective, how do you assure buy in from DoD in this sharing plan?

Answer: DoD and the VA have developed a joint strategic plan, and have established the Joint Executive Council chaired by the Under Secretary of Defense for Personnel and Readiness, and the Deputy Secretary of the VA. These principals personally chair the group, review strategic objectives, and collaborate on interagency initiatives. To further demonstrate the commitment to interagency collaboration and sharing they have established a Benefits Executive Council chaired by the Principal Deputy Under Secretary of Defense for Personnel and Readiness, and the Under Secretary of the VA for Benefits. They have also established a Health Executive Council that is chaired by the Assistant Secretary for Health Affairs and the Under Secretary of the VA for Medical Benefits. Both of these committees oversee the organizational staffing and operations that are implementing the strategic objectives and report directly to the principals chairing the Joint Executive Council. Services fully participate in working groups and Steering Committees that are directed by senior DoD managers from my office and other major directorates within Personnel and Readiness.

Hearing Date: November 19, 2003
Committee: HVAC
Member: Representative Buyer
Witness: Mr. Reardon
Question # 1

Question: I noted in your biography that you worked on the IT infrastructure that supports TRICARE. Was DoD able to assist all the Guard and Reservists family members with respect to their TRICARE benefits when their spouses were activated?

Answer: The Department of Defense has launched an extensive education and marketing effort targeted to inform beneficiaries, the Services, Lead Agent Offices, Managed Care Support Contractors, and the media about TRICARE benefits offered to Reserve Component Service members. Moreover, information is provided to beneficiaries during the pre-mobilization phase, during the mobilization itself, and upon demobilization. Also, in addition to current education and marketing efforts, the National Defense Authorization Act for Fiscal Year 2004 establishes TRICARE Beneficiary Counseling and Assistance Coordinators (BCAC) for Reserve Component Beneficiaries. These BCACs will be assigned to each TRICARE region, with at least one person serving full-time as a BCAC, solely to answer questions and assist Reserve Component members.

Hearing Date: November 19, 2003
Committee: HVAC
Member: Representative Buyer
Witness: Mr. Reardon
Question # 2

Question: In your opinion, why is it that the DD 214 form is not yet available in an electronic version?

Answer: The information on the DD Form 214 is taken from the hard copy or electronic personnel records and the information is manually entered onto the form. Services' current systems do not support an automatic populating capability. The form must be printed out to be signed (authenticated), and there is currently no way to electronically store or maintain the authenticated data. Additionally, since the DD Form 214 contains personal information that is covered by the Privacy Act, access must be carefully controlled. Resolving these and other technical problems and developing a system to do this would not be cost effective, especially in light of a new personnel and pay system which is to be fielded beginning in Fiscal Year 2005.

With this system, the Defense Integrated Military Human Resources System Personnel/Pay (DIMHRS (Pers/Pay)), the Department of Defense will have the capability to produce an electronic DD Form 214. DIMHRS (Pers/Pay) will be a totally integrated pay and personnel system supporting the operational requirements of all the DoD Components and will resolve the inefficiencies and deficiencies of our legacy personnel and pay systems. It will be the vehicle through which we transform military personnel and pay management.

Hearing Date: November 19, 2003
Committee: HVAC
Member: Representative Buyer
Witness: Mr. Reardon
Question # 3

Question: What would you identify as the three greatest obstacles in developing a seamless VA/DoD electronic medical record?

Answer: We do not foresee any obstacles that will impede our progress toward achieving seamless VA/DoD electronic medical records. Various DoD/VA joint working groups have been put in place to manage all the different key areas such as technical, functional, architecture, information management/standards, project management, imaging, and information assurance/privacy. Updates on their efforts are provided on a monthly basis to the VA/DoD Health Executive Council's Information Management/Information Technology Work Group. As challenges arise, they are addressed with mitigating plans.

Hearing Date: November 19, 2003
Committee: HVAC
Member: Representative Buyer
Witness: Mr. Reardon
Question # 4

Question: In your testimony you stated the Veterans Benefits Administration uses the Federal Health Information Exchange (FHIE) to process disability claims. Does FHIE capture the disabilities being claimed with VA by separating or retiring Service members?

Answer: No, the Title 38 disability claims process generally begins after a Service member's separation or retirement. The Federal Health Information Exchange (FHIE) provides DoD electronic health data for the period prior to a Service members' separation. However, FHIE may contain clinical results directly associated with a claim, such as laboratory results, radiology reports, consult reports, and other data elements. DoD data transferred through FHIE is available for use by authorized Veterans Benefits Administration personnel through the Compensation and Pension Record Interchange system.

Hearing Date: November 19, 2003
Committee: HVAC
Member: Representative Buyer
Witness: Mr. Reardon
Question # 5

Question: What data elements of FHIE are used by the Veterans Benefits Administration to support a veteran's disability claim? Are these data elements used in lieu of the exam results from the separation/retirement physical? Or, does FHIE include the results from the Service member's entrance and separation or retirement physical examinations? If not, when will these be included in FHIE?

Answer: Federal Health Information Exchange (FHIE) data elements currently available for Veterans Benefits Administrator's use are demographic data, laboratory results, outpatient military facility pharmacy data, radiology results, allergy information, discharge summaries, consult reports, and admission, discharge and transfer information. Data elements from the separation physical, such as laboratory results and radiology reports, are also included in the information that is sent through FHIE. For Fiscal Year 2004, planned product improvements for FHIE will add DoD outpatient mail order pharmacy and retail network pharmacy data and elements of the Standard Ambulatory Data record such as the ICD-9 diagnosis code, primary care manager, treatment provider, clinical service, and appointment date/time.

Hearing Date: November 19, 2003
Committee: HVAC
Member: Representative Buyer
Witness: Mr. Reardon
Question # 6

Question: Is FHIE consistent with the scope of VA's Benefit's Delivery at Discharge (BDD) process?

Answer: Benefit's Delivery at Discharge (BDD) enables VA representatives to process disability claims and to review proposed disability ratings with military personnel prior to their separation/retirement from active duty. Eleven major military facilities have a full-time BDD counselor. Since the BDD process is taking place before the Service members' separation, FHIE is not utilized in the process, rather VA providers nation-wide and Veterans Benefits Administration personnel have access to the FHIE data which are being utilized in the delivery of health care and adjudication of disability claims. The paper medical record is being utilized in this process. The Federal Health Information Exchange (FHIE) program supports the transfer of electronic health information from DoD to VA at the point of the Service member's separation.

Hearing Date: November 19, 2003
Committee: HVAC
Member: Representative Buyer
Witness: Mr. Reardon
Question # 7

Question: Is there an existing DoD/VA project team charged with developing the linkage among VA's BDD and DoD's FHIE and DIMHRS? If so, what is the timeline? If not, why not?

Answer: No, there is no project team charged with developing the linkage among VA's BDD and DoD's FHIE. Currently, the Federal Health Information Exchange (FHIE) program supports the transfer of electronic health information from DoD to VA at the point of the Service member's separation. Since the BDD process is taking place before the Service members' separation, FHIE is not utilized in the process. Appropriate VBA personnel are given access to view DoD clinical data in FHIE in support of disability claims processing for separated or retired Service members. To date, DoD has transmitted over 56 million messages to the FHIE data repository on 1.78 million unique retired or discharged Service members. This number is constantly growing as health information on recently separated and retired Service members is packaged and transferred to the VA. The information currently available to VA providers includes demographic data, laboratory results, outpatient military facility pharmacy data, radiology results, allergy information, discharge summaries, consult reports, and admission, discharge and transfer information. All information is sent using secure messaging to protect this information during the transfer process.

In regard to the DIMHRS interface with VA, under the direction of the Joint Executive Council, the Benefits Executive Council is developing interoperability plans for exchange of personnel information between the VA and DoD. The personnel information interface requirement between DIMHRS and the VA is fully documented (at the data element level) in the DIMHRS requirements that have now been provided to the DIMHRS developer. The technical solution for this interface will be determined by the DIMHRS developer in concert with the Joint Requirements and Integration Office and the VA systems staff. The interoperability plan is currently in draft at DoD and will be forwarded to VA by the end of the calendar year. In addition, the Deployment Health Working Group, under the guidance of the Health Executive Council, was briefed on December 8, 2003, on the interface between the Defense Personnel Records Image Retrieval System and the VA Personnel Information Exchange System to see if there are opportunities to extend this information exchange source to the Veterans Health Administration.

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December 5, 2003

The Honorable Steve Buyer
Chairman, Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
337A Cannon HOB
Washington, DC 20515

Chairman Buyer:

On behalf of EMC Corporation, I want to express my thanks for the opportunity to testify at the recent hearing entitled "Joint VA-DOD Medical Records - On the Horizon...Since 1982." I am responding for the record to a question you posed at the conclusion of my testimony. The question related to the metric that should be used to determine if the appropriate resources are being provided to the VA and DoD for this initiative. My response during the hearing was that while we don't have sufficient details on the VA and DoD data sharing initiative, there are some metrics in the private sector that we could use as a benchmark.

With regard to determining an appropriate metric, that would ideally involve a specific dollar amount and number of personnel appropriated to the initiative. Presently, I am unable to provide a specific response because it requires information we do not have regarding VA and DoD's historic activities and current projects relating to creating a seamless healthcare information exchange.

Alternatively, it is probably most helpful for EMC to address this question from the perspective of what we see in the commercial healthcare industry. There have been a number of studies on IT spending within the healthcare industry that provide valuable insight. This data can be used as a baseline to compare with VA and DoD Healthcare IT spending as a portion of overall medical care discretionary dollars.

As surveys of the leading industry analysts (Gartner Group, IDC, and Meta Group) indicate, IT spending within the healthcare industry ranges from 3.15% to 5.0% of total revenues. Overall IT spending is expected to *rise* as a percentage of revenue through 2006. By contrast, the financial services industry, another information intensive industry, is investing some 6.09% of revenues on Information Technology.

Subsequent to the hearing, we met with both the VA and DoD. They indicated that both Departments are spending 4-5% of discretionary funding on IT. This puts them in line with the industry averages. With regard to the focus of their spending, it appears that the

top priority for both DoD and VA are system upgrades for their respective healthcare applications—CHCSII and HealtheVet. When completed, they will serve as the foundation for bi-directional information sharing. Each department will maintain a centralized repository that can be used to share information with the other. This approach to sharing information relies on well-established technology using traditional, centralized database technology. Once deployed, this can be very effective as long as it is properly managed for continuous availability and meets access time requirements.

The question, however, is this: What is the proper level of effort (people and funding) that should be focused on the creation of a seamless electronic patient record? Kaiser Permanente, a large health maintenance organization that provides health care for 8.4 million members in 9 states and employs 12,000 physicians, recently announced a $1.8 billion IT investment. The goal is to adopt more comprehensive and portable Electronic Medical Records and a networked billing and scheduling system-wide in three years. With 2003 revenues estimated at $25 billion, a three-year investment of $1.8 billion (solely for modernization) equates to about 2.5 percent of total revenue.

Although Kaiser Permanente is only one example, it is meaningful because the size and scope of its operations are comparable to that of the VA and DoD. Additionally, it is noteworthy that Kaiser Permanente established a budget and committed a timeline for accomplishing this program.

In order for VA and DoD to be successful in achieving this goal, they must articulate a common health information infrastructure and architecture that provides the details and specificity essential to determining how they will accomplish the data exchange capability. Further, they must convert this goal to a defined project that has assigned management, personnel resources, funding, and date of completion. Finally, Congress and the Executive leadership of the Departments need to prioritize, fund, and track progress toward this goal in light of all the other competing objectives and priorities.

Thank you for the opportunity to provide this response.

Yours truly,

Kem Clawson

Kem Clawson
Director Advanced Technologies
EMC Corporation