

**SHARING OF ELECTRONIC MEDICAL RECORDS
BETWEEN THE U.S. DEPARTMENT OF DEFENSE AND
THE U.S. DEPARTMENT OF VETERANS AFFAIRS**

HEARING
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
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CONTENTS

May 8, 2007

	Page
Sharing of Electronic Medical Records Between the U.S. Department of Defense and the U.S. Department of Veterans Affairs	1
OPENING STATEMENTS	
Chairman Harry E. Mitchell	1
Prepared statement of Chairman Mitchell	34
Hon. Ginny Brown-Waite, Ranking Republican Member	2
Prepared statement of Congresswoman Brown-Waite	34
Hon. Timothy J. Walz	3
Hon. Ciro D. Rodriguez	4
Hon. Cliff Stearns, prepared statement of	35
WITNESSES	
U.S. Government Accountability Office, Valerie C. Melvin, Director, Human Capital and Management Information Systems Issues	4
Prepared statement of Ms. Melvin	36
U.S. Department of Veterans Affairs, Gerald M. Cross, M.D., FAAFP, Acting Principal Deputy Under Secretary for Health, Veterans Health Administration	15
Prepared statement of Dr. Cross	48
U.S. Department of Defense, Stephen L. Jones, DHA, Principal Deputy Assistant Secretary of Defense (Health Affairs)	17
Prepared statement of Dr. Jones	54

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TUESDAY, MAY 8, 2007

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

The Subcommittee met, pursuant to notice, at 10:03 a.m., in Room 334, Cannon House Office Building, Hon. Harry E. Mitchell [Chairman of the Subcommittee] presiding.

Present: Representatives Mitchell, Space, Walz, Rodriguez, Brown-Waite, Stearns, Bilbray.

OPENING STATEMENT OF CHAIRMAN MITCHELL

Mr. MITCHELL. Good morning and welcome to the Oversight and Investigations Subcommittee for the Committee on Veterans' Affairs. At this particular hearing we are dealing with sharing electronic medical records between the U.S. Department of Defense (DoD) and the U.S. Department of Veterans Affairs (VA). This meeting will come to order. And let me just give my opening statement and then I will ask Ms. Brown-Waite to give hers.

One of the concerns I have heard from veterans is how difficult the process can be in the transition from their active duty status to veteran status. One of the great difficulties they experience is having their full and complete medical records from the Department of Defense available to their VA doctors. This problem isn't new.

In 1998, President Clinton called on the VA and DoD to develop a "comprehensive, life-long medical record for each servicemember." That was nearly 10 years ago. But up to this point, progress has been painfully slow and increasingly expensive. That is why we are having this hearing today, so that this Subcommittee can continue its efforts to provide an oversight and do what we can do to speed up the process and make electronic medical records sharing a reality.

We all know that there are many benefits to this. First, we will be making sure that veterans receive better medical care by saving time and avoiding errors. And second, we will also lower costs so taxpayer dollars are more wisely spent. That is a worthy goal as well. I am glad to know that the VA and DoD are working on some

demonstration projects in this area and I am eager to get an update on it.

I want to take a moment to acknowledge the VA and DoD's progress in the long-term efforts to achieve a two-way electronic data exchange capability. They have implemented three or four earlier U.S. government Accountability Office (GAO) recommendations, including developing an architecture for the electronic interface between DoD clinical data repository and VA's health data repository, selecting a lead entity with final decisionmaking authority for the initiative and establishing a project management structure. That is a good start, but there is much more to do.

One of my greatest concerns is that the VA and DoD have not yet developed a clearly defined project management plan that provides a detailed description of the technical and managerial process necessary to satisfy project requirements as the GAO has repeatedly suggested in the past.

For example, all the way back to December 2004, the VA/DoD Joint Executive Council annual report found that the cost for government computer-based patient record Federal Health Information Exchange (FHIE) was approximately \$85 million through fiscal year 2003. But here we are 4 years later, the cost continuing to grow and the consequences for today are growing too. We want to know why this isn't getting done and how much longer our veterans have to wait. I believe they have already waited too long.

I look forward to today's testimony and before I recognize the Ranking Member for her remarks, I would like to swear in our witnesses. Would all the people who are presenting, all panelists please rise and be all sworn in at one time?

[All witnesses were sworn.]

[The prepared statement of Chairman Mitchell appears on p. 34.]

Mr. MITCHELL. Thank you. I will now recognize Ms. Brown-Waite for her opening remarks.

OPENING STATEMENT OF HON. GINNY BROWN-WAITE

Ms. BROWN-WAITE. Thank you, Mr. Chairman. This Committee has held at least 16 hearings since 2002 to try to push the sharing of critical medical information on patients being transferred between the Department of Defense and the Department of Veterans Affairs. The movement of this information is vital to the safety and well-being of our veterans and military active duty servicemembers as they transfer between the two agencies and become finally integrated back into civilian life.

Our staff and Members have visited many VA and DoD medical centers. Of particular interest are the four VA polytrauma units where servicemembers sustaining severely disabling injuries to include traumatic head, traumatic brain injury, rather, TBI, and spinal cord injuries are being cared for, while still in service as well as many after discharge in VA facilities.

We have frequently heard the concerns of VA doctors and medical personnel at these facilities that the information they are receiving isn't timely enough or missing critical data necessary to properly treat these severely injured and disabled servicemembers.

Throughout the past 20 years, the VA and DoD have spent billions of dollars working on independently stove-piped electronic

medical record systems that would provide better care to those serving on the frontline of our Nation's efforts to freedom. Yet to date, neither seems to work together in a coordinated effort of care.

On April 10th, 2007, an article appeared in the Washington Post which touted the VA's VistA System as a means to lower cost and provide better treatment to our Nation's veterans. Can the VistA System receive information from the Department of Defense?

We have also heard about the joint patient tracking system which permits the transmission of patient care notes from the battleground up the line to the patient's final destination, whether for continued care at a VA facility or to prepare for redeployment. However, in January, the Department of Defense temporarily cut off access of this critical data to the VA.

Today we have sitting before us both departments. It is my sincere hope that after two decades, that finally there is good news on the horizon and we will see a system that will permit the exchange of critical medical information that is interoperable, bidirectional and occurs in real time. The care for those who serve our country does not stop at the exit door of the Department of Defense, but continues through the doors of the VA. And the hand-off between the two medical systems should be seamless, not a fumble. Our Nation's heroes deserve no less.

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

[The prepared statement of Congresswoman Brown-Waite appears on p. 34.]

Mr. MITCHELL. Thank you. Mr. Walz.

OPENING STATEMENT OF HON. TIMOTHY J. WALZ

Mr. WALZ. Well, thank you, Mr. Chairman, and in the sake of time, I will make this brief and submit my written opening statement. But I wanted to thank the witnesses for coming today. I thank each and every one of you for being here. Our job up here and Congress' job is to provide oversight and we share in the teamwork between what you are trying to do and what we are trying to do, is to care for our veterans in the best possible way.

So I thank you for that ahead of time. But as it was stated, and I would associate my comments with the Ranking Member, of the time that it has taken and the cost, and yet, still not being at the point where we need to be. My concern from this comes from—I represent the district that is home to the Mayo Clinic—and I have had many, many conversations on this issue of medical records and have been given some great advice on this. And I want to hear today in what direction we are moving and what are the lessons learned with the private sector, because trust me on that, I know they are not infallible too. And one of the complaints I hear from the VA is sometimes it is more difficult to get records from the private sector than it is from DoD. So that is a fact too.

We are here today to try and solve this problem, to try and do whatever we can. As the Ranking Member said, we have been at this for nearly two decades and 16 hearings. At some point, the group that is in this room has to decide that maybe it is time to move forward and maybe we can get some things done. So I look forward to your testimony. I look forward to whatever we can do to help assist you to get that done. We are in this together. And

the bottom line is, if we get this done, we will get it done right, and all of our veterans benefit. And that is a positive.

I yield back, Mr. Chairman.

[No statement was submitted.]

Mr. MITCHELL. Thank you.

Mr. Bilbray.

Mr. Rodriguez.

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Let me just thank you, Mr. Chairman, for holding this hearing. And I also want to emphasize the importance of moving as quickly as we can and of doing a good job in the process. I know that technology exists out there that can actually check all those that are in the Department of Defense and follow up and anticipate what is going to be needed medically. We can be on top of it, especially for proposals in terms of what is needed, in terms of resources to be able to meet those gaps for those soldiers that will become veterans in the future.

So we are ready to work with you. I do feel that because I had spent 8 years on this Committee before. I was gone for 2 years. I am back and we are still not where we want to be. And so, I would hope that we would move as quickly as possible on some of the information.

I know that it also deals with the whole issue of the new technology that is out there that we can make it happen, which is the same area that we have had difficulty with the VA in terms of using some of that technology and not coming to grips with that in terms of those records of some of those soldiers. And so, somehow, we need to come to grips with that and also make sure that whatever information we do have, that it is available, but that it is also secure and hopefully strike that balance.

Thank you very much and I yield back the balance of my time.

Mr. MITCHELL. Thank you, Mr. Rodriguez.

We will now proceed to panel one. Ms. Valerie Melvin is the Director of Human Capital and Management Information Systems Issues for the U.S. government Accountability Office. She will be accompanied by her Assistant Director, Ms. Barbara Oliver. We look forward to hearing your unbiased view of this situation. Thank you.

STATEMENT OF VALERIE C. MELVIN, DIRECTOR, HUMAN CAPITAL AND MANAGEMENT INFORMATION SYSTEMS ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; ACCOMPANIED BY BARBARA OLIVER, ASSISTANT DIRECTOR, HUMAN CAPITAL AND MANAGEMENT INFORMATION SYSTEMS ISSUES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. MELVIN. Thank you. Mr. Chairman and Members of the Subcommittee, I am pleased to be here to discuss VA's and DoD's efforts to share electronic medical records. Sharing medical information can help ensure that active duty military personnel and veterans receive high quality healthcare and assistance with disability claims, goals that are more essential than ever in the face of current demands on our military.

For almost a decade, VA and DoD have been pursuing ways to share medical information. These includes efforts focused on the long-term vision a single, comprehensive, lifelong medical record for each servicemember to allow a seamless transition between the departments, and more near-term efforts to meet immediate needs to exchange health information. Since undertaking these efforts, however, the departments have faced considerable challenges leading to repeated changes in the focus of and target dates of their initiatives, and in our recommending greater project management and accountability.

Currently, each department is developing its own modern health information system to replace existing systems and they are now collaborating on the development of an interface to enable these systems to have interoperable electronic medical records. The modernized systems are based on using computable data; that is, data in a format that a computer application can act on, for example, to alert clinicians of a drug allergy or of significant changes in vital signs such as blood pressure.

The departments have made some progress toward their long-term objectives. They have begun implementing the first release of an interface between their modernized data repositories. Now at seven DoD sites, the interface allows the departments to exchange computable outpatient pharmacy and drug allergy data. Although the data being exchanged are limited, this interface is an important milestone. Nonetheless, the departments still need a project management plan that is sufficiently detailed to effectively guide this effort and ensure its full implementation as we have previously recommended and as you have noted here today.

In parallel with their long-term objective, VA and DoD are also pursuing short-term initiatives to share information in their existing health information systems. One of these, the laboratory data sharing interface project, has developed an application that allows the departments to share medical laboratory resources. This application is currently implemented at nine sites. The other, the bidirectional health information exchange, or BHIE, has developed an interface that provides a two-way, almost instantaneous view of selected categories of health data on shared patients from VA's existing systems, and from those DoD sites where the interface is implemented.

Current BHIE capabilities are available throughout VA and DoD plans to make these capabilities available throughout its department by next month. Further, responding to a demand for more access to health data, the departments have begun expanding BHIE's capabilities and implementation, in effect using the interface to connect not only VA and DoD, but also DoD's multiple legacy systems which were not previously linked. In this way, the departments plan to share more of their current information more quickly.

Beyond these two efforts, the departments have also established various ad hoc processes to provide data on severely wounded servicemembers to VA's polytrauma centers which specialize in treating such patients. These processes included manual work-around such as scanning paper records to transfer records to incompatible systems. While particularly significant to the treatment of servicemembers who sustain traumatic injuries, such laborious

processes are generally feasible only because the number of poly-trauma patients is small.

Mr. Chairman, although the departments are sharing some health information, including certain computable data, they still face considerable work and challenges to achieve this long-term goal. Their multiple initiatives and ad hoc processes, while significant, highlight the need for continued efforts to integrate information systems and automatic information exchange. However, it is not yet clear how all the initiatives that VA and DoD have undertaken are to be incorporated into an overall strategy focused on achieving the ultimate goal of a comprehensive, seamless exchange of health information.

This concludes my prepared statement. I would be happy to respond to any questions that you might have.

[The prepared statement of Ms. Melvin appears on p. 36.]

Mr. MITCHELL. Thank you very much. Do you have any idea, Ms. Melvin, why there has not been a clearly defined project management plan? What do they tell you?

Ms. MELVIN. Throughout our reviews over the years—and we have been reviewing this since approximately 2001 in detail—one of the concerns that we have noted, as you have said, is the project management plan and what we learned is that VA and DoD do, in fact, recognize the need for such project management. However, the actions relative to actually putting those plans in place and specifying in detail, the level of detail, what is necessary is where they tend to fall short.

We have seen efforts on their part to, in fact, indicate or develop project plans in some respects for some of the systems. However, as they move forward, we don't see the detail that would show how these plans would move beyond perhaps the immediate systems that they are looking at, or certainly to show how they would integrate future systems and how they would then manage and ensure the outcomes of those initiatives.

Mr. MITCHELL. Do they give you any reasons why they are not doing what they should be doing? Do they say they don't have money, they don't have staff? What are the reasons they give you for not moving ahead and doing this? You know, this is a long time coming.

Ms. MELVIN. Yes. It is a long time project. In our discussions with VA and DoD, there is continual recognition that there is a need to move forward on these systems. We have not gotten explanations from VA or DoD that suggest that they don't feel that they can move forward. However, what we do not see in the work that we have conducted has been the—I guess the overall recognition of the specific requirements that it would take to have the project planning in place for these systems.

Mr. MITCHELL. Do you think they are making any progress toward this? And if they are—I don't want to hold these hearings just to hear everybody talk and then we leave and nothing happens. Is there some type of a time line or something you might be able to suggest that we ought to have another hearing say, 6 months from now or a year from now, or whatever it may be, and ask what has happened? Do they not recognize the importance of what you are suggesting?

Ms. MELVIN. I believe they do recognize the importance. However, through the work that we have conducted over the years, one of the things that we found is that your continued oversight has been critical to making sure that both departments move forward on this effort. We don't see that the departments don't have a common understanding of the goal that they are trying to achieve. However, we do feel that they fall short relative to the particular actions that they take relative to planning for this initiative, the particular strategies that they identify.

One of the key things in the work that we have noted is that VA and DoD have—their systems development efforts toward the modernized systems that they are trying to put in place are initiatives that have always been on separate tracks. So it is very critical for those departments to be able to develop the type of collaboration, or have the type of collaboration that will be geared toward making sure that the strategy that is put in place identifies clearly and acknowledges the steps and the timeframes that are necessary to get them to a shared type of capability.

We have seen action on their part relative to the Clinical Data Repository/Health Data Repository (CHDR) interface that the departments are putting in place. However, as our work has shown, we do still feel that there is a need for a more defined time line or more specific risk management and certainly for more performance-based measures to guide their efforts.

Mr. MITCHELL. One last question on my part. As I noted in my statement, President Clinton called for VA and DoD to develop “a comprehensive lifelong medical record for each servicemember.” Do you think that these two branches, the DoD and VA, believe in this mission? Because I think that is what we are all here trying to do. A lifelong medical record for each servicemember that follows them through, that is what we are trying to accomplish.

Do you think that they view this as one of their goals, one of the things that they are trying to accomplish? And if so, why are they taking so long? In the meantime, there are many, many veterans and servicemembers who are falling through the cracks because of the lack of a lifelong medical record that follows each person.

Ms. MELVIN. Each of these organizations certainly have had its own objectives relative to creating its systems. We have not heard anything from VA or DoD to suggest that they don't believe in this mission. However, I think that there are organizational cultures that do have to be overcome on the part of VA and DoD relative to achieving the particular capability that they desire as far as a lifelong medical record.

VA certainly has developed a comprehensive record that includes inpatient and outpatient data. DoD's systems are set up much different in the way that they currently exist. There are a number of multiple systems that are not integrated in the same capacity. So for each of these agencies to move forward, there has to—first of all, the Department of Defense, for example, has to deal with its own internal issues of how it will manage and address the multiple systems that it has in place. And then beyond that, both of these departments must have a dedicated collaboration on how they will either develop one common record or at least have systems that are

interoperable and can exchange data in the way that would be needed to develop a seamless transition in the exchange of records.

Mr. MITCHELL. Thank you. It seems to me that they are really more concerned about defending their own system instead of the ultimate goal of taking care of these veterans.

Ms. MELVIN. Organizational culture of each department must be considered, yes.

Mr. MITCHELL. Thank you.

Ms. Brown-Waite.

Ms. BROWN-WAITE. I thank the Chairman.

And I thank the witnesses for being here. You know, I think this gives new meaning to Yogi Berra's "this is déjà vu all over again." There is a report that was dated the first year I came to Congress, and this is my fifth year here. And that report is dated November of 2003.

It was also from the Subcommittee on Oversight and the response from the DoD from your predecessor was that they were still working on it. Then there was an Executive Order, Executive Order 13410, which gave a deadline for implementation of a joint system of January 1, 2007. This tells me that not only are the agencies dragging their feet, they are ignoring Congress, they are ignoring the President. And in the meantime, people at the polytrauma unit down in Tampa and other polytrauma units, the spinal cord injury units, those injured warriors who are coming back are suffering.

The foot-dragging is inexcusable. It absolutely is. It is like—it is déjà vu all over again. Tell me why I shouldn't be cynical that you are just giving Congress lip service and ignoring an Executive Order.

Ms. MELVIN. Through the work that we have conducted, certainly one of the critical issues that we have emphasized has been the repeated change in strategy, the repeated change in milestones of the initials that VA and DoD have undertaken to get their systems in place. I think that over the years, because you do see the multiple changes, the multiple projects, first of all, that have come into play, as well as the strategies and the lack of clarity relative to how they plan to get to the end results of the record, does in fact raise skepticism in the minds of those who look at the actions being taken on these systems.

Ms. BROWN-WAITE. Ma'am, let me point out that the title of this is VA/DoD shared medical records, 20 years and waiting. This report was November of 2003.

Ms. MELVIN. Mm-hmm.

Ms. BROWN-WAITE. It was 20 years then. This is 2007. You missed the deadline. Could we have from you a precise date when these records are going to be easily transferable? Do you have a date in mind? Do you have a contract out there? Is there a system that is going to work? You know, this isn't rocket science. Help me out here.

Ms. MELVIN. I can't speak for DoD and VA. The work that GAO has done does support the concerns that you raise about the fact that these systems have been in play for a long time, that the agencies are, in fact, pursuing a strategy or a series of strategies

that have been changed along the way, and that the milestones accompanying those strategies have certainly changed also.

We have not gotten specific reasons from VA and DoD to suggest why, in fact, their strategies are different. We do know, however, that again, each of these departments is working on their separate systems and they are also working on multiple systems in the short-term to address these initiatives, or at least to address the immediate needs for data, which have to be weighed against the overall long-term objective of a comprehensive, lifelong medical record.

Ms. BROWN-WAITE. Is it your opinion that this will happen in the next three years, 5 years, 1 year? You know, you have looked at both systems, correct?

Ms. MELVIN. We have not looked at DoD's system in detail. We have only looked at DoD's system as it pertains to the interface with VA systems. The majority of the work that we have done has been for the Veterans' Affairs Committee examining the VA system so far.

What I can tell you, though, in response to the early part of your question about the timeframe, we don't feel positioned to give you a timeframe for when VA and DoD can have this in place. We have looked over the years at what they are doing to develop these systems and we have seen multiple changes. And I think by the very nature of the fact that we do not see an integrated strategy or a defined project plan for the systems at this point, we are not in a position to be able to say when they would have these systems developed.

Ms. BROWN-WAITE. Thank you. I will ask that question of others also in the future. Thank you.

Mr. MITCHELL. Thank you.

Mr. Walz.

Mr. WALZ. Well, thank you, Mr. Chairman.

And I too think that many of these questions will cut between the two panels. But I do want to make it clear that in my speaking with and having people come in and brief me, specifically from the Mayo Clinic, I understand this was a difficult prospect. I understand it is much more difficult than a common software issue, that there are many things that have to take place.

But I, too, share the concern of this Subcommittee that this is a long time coming, especially when we have focused and tried to put our emphasis on doing this. It is a very important project. It is important for our veterans. It is important for their care. But I think it is important also in that we can prove that this can work on a scale that is large enough to get the rest of the country moving in this direction.

But the one thing I want to make note of—and I am going to ask a couple of specific questions. I am much more concerned with quantifiable data, but I think this anecdotal evidence is pretty telling.

I had the opportunity, about a month ago, to meet with a high ranking General Officer in the Medical Corp of the Army and had mentioned that that week I had just sat down for a 2-hour briefing on electronic medical records. And this was again with the Mayo Clinic and their top experts on this. They are convinced that the

VA has this figured out in a very, very good way, and that it is very cost effective and it should be adapted, that that is the starting point on this.

Now, I don't know that to be a fact and I didn't have anything other than the two-hour briefing on this, but I started to mention this to this officer and was cut short and it became apparent that this person, without mentioning names and they may be up here soon enough, had totally disregarded anything that I had to share on that, that the official didn't want to hear about that. And that made me very, very concerned. And my civilian career before Congress was as a cultural studies teacher. So I appreciate, Ms. Melvin, your bringing up on cultural side of this, because this deeply concerns me.

A couple of questions for you. Obviously, we have to have ad hoc solutions, in the short-term for the polytrauma centers. Are those setting us back in the long-term goal of integration here, in your opinion?

Ms. MELVIN. The short-term initiatives are very critical to helping the immediate needs of the servicemembers who are severely wounded. So from the standpoint of setting us back, I can't really say. What I do say, however, is that it is important to examine what VA and DoD are doing relative to implementing the short-term initiatives and how—what bearing this does have on their plans and their strategies and approaches for leading to the longer term goals.

What I would be concerned about seeing is the long-term initiative of the comprehensive lifelong record being, for lack of a better word, short-changed at the expense of immediate needs. There is a need to balance on both of those areas. It is important to serve the critical needs of the returning soldiers now. At that same time, there needs to be continued effort, continued dialog and collaboration relative to making sure that they continue to move toward the longer term objective.

Mr. WALZ. The last question I would have. Our job is obviously oversight and guidance. We don't want to tell either one of these agencies specifically how to do things. But in your opinion, are we reaching a point on this where—I am quoting outside experts on this, people who have no financial gain in this, but have expertise, like the Mayo Clinic in this record. Are we at the point now, in your opinion, where DoD needs to start thinking about adapting the way the VA is doing this? And is that where we need to give the guidance to start moving in that direction? Would you be comfortable in saying that that looks like it has the strongest possibility to get this done?

Ms. MELVIN. Because of the nature of the work, I wouldn't say that it is definitely the way to go. But I would say, however, that it is certainly an option that should be considered by the agency as it proceeds with determining on how it is going to integrate its systems, achieve the modernized health system that it has been trying to develop, and work toward the longer term goal with VA.

Mr. WALZ. Thank you. I yield back.

Mr. MITCHELL. Thank you.

Mr. Bilbray.

Mr. BILBRAY. For the record, how long have we been working on this project?

Ms. MELVIN. How long have we been working on this project?

Mr. BILBRAY. How long have the DoD and Veterans been working at trying to have a consolidated record system?

Ms. MELVIN. The start date that we have been using in our work is 1998, and that was at the point in which the President called for the comprehensive record. However, there were efforts on the part of VA and DoD prior to that in the way of developing modernized systems.

Mr. BILBRAY. You know, my 18 years before coming to Congress I was in local government and watched this type of bureaucratic run around. Everybody wants to control their record system and wants it to be their little possession because it has traditionally been their possession. And to try to break down the barriers of bureaucracy set-up is a major challenge.

And, you know, when you are talking about—how long would you predict it is going to take now to finally get the system consolidated?

Ms. MELVIN. How long would I predict that it is—

Mr. BILBRAY. Yeah.

Ms. MELVIN [continuing]. Going to take? I really cannot—

Mr. BILBRAY. Working at the present pace.

Ms. MELVIN. VA and DoD have indicated that they would have their modernized health systems developed by, I believe, 2012 and 2011, respectively. However, in the work that we have done, we have seen delays in their efforts, at least in the efforts of VA—I am sorry, DoD to get its modernized system and all of its systems put together.

And also, VA and DoD, I believe, recently have indicated that they have now changed those milestones and don't have a specific date for when those systems would be completed. Lacking that and lacking more specifics relative to the strategy that they are actually taking, I am not sure that anyone could say at this point how long it is going to take them to get there. We certainly are not in a position to do so at GAO.

Mr. BILBRAY. Okay. Let me shift around now. Were you including—seeing what technology you are looking at, there is not that many Bilbrays running around America right now. But Mr. Rodriguez would agree that there is a whole lot of Rodriguezes and that right now working with just a number and a name, the potential that hospitals in the private sector run into of mixing names and numbers up and going to biometric confirmation. Are they including the concept of biometric confirmation in the recordkeeping capability?

Ms. MELVIN. We have not gotten any information on that concept in the work that we have done.

Mr. BILBRAY. Okay. And in the private sector more and more is really looking at this as not only being a recordkeeping, but an absolute lifesaver in a critical time to be able to identify somebody when they are unconscious and to make sure that you are not triaging the wrong person for a procedure. And what I am worried about is we will get all the way down this line and then all of the sudden someone says oops, we didn't consider the cutting edge.

You know, Mr. Chairman, I really would suggest that we take a look at the fact that if we continue to go the way we are going, we are all going to be retired and gone by the time somebody goes the promise. I am not one for commissions. But I would strongly believe that we are probably looking at needing direct oversight, a taskmaster here. And if I would—let me just say flat out.

I would say that a five-member commission not made up of veterans, but made up of three members of high tech information specialists, one member from military hospital capabilities and another member from a civilian hospital capability so we can sort of intermix. But not being the focus of just complaining about the system, but bringing people in with the expertise to drive the system toward cutting edge approaches to recordkeeping rather than always the defensive.

And I just think what we are looking at is, we need a taskmaster that we can empower with the ability to hang over them and say we want to see this report in six months. We want to have another report and we want to see this product ready to go in 2 years and somebody hounding over them to where they have one and one purpose only, and that is to make sure the bureaucracy works.

I only throw this out with no research on it, but I just think that when I am told that a responsibility that has been dragged on this long does not have a foreseeable sunset, it tells me that we need to modify our approach to it and be a little more hands-on to it and I just think it is something that we may want to discuss as a Subcommittee and talk to the Ranking Member and the Chairman about getting somebody to look over the shoulder of these guys every week to finally get them moving in the right direction.

And with that good information and that cheery news, I will yield back to my Chair.

Mr. MITCHELL. Thank you. You know, it is one thing to be concerned about a bureaucracy and the cost. But what we are really dealing with here are people's lives and bureaucracies can go on and on and waste lots of money. The very fact that we have got people's lives involved here I think is very important.

Mr. BILBRAY. Mr. Chairman, would you yield just on that point?

Mr. MITCHELL. Yes.

Mr. BILBRAY. I think too often the cost is an issue because it costs money to do things and if you waste money, that is money you can't use for other work. But you have got the private sector, you got local governments that are looking at the same crisis. They all—this happens in government and business all over America. And I assure you that there is a privacy issue here, but that applies in private and public sector. This challenge is not unique and we ought to be looking around at all the things that are being done by everyone else and finding ways to get over the barriers of privacy, funding and other related—and getting the job done. And right now, we just don't see that happening and I yield back. Thank you.

Mr. MITCHELL. Thank you.

Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you very much for the testimony. And I had indicated to you that I had been 8 years on this Committee before and then gone for two years and then came back and we are

still talking about the same thing. And I remember getting up here in 1997 and we were talking about this.

Would it help—and I am just throwing this out—if we did a pilot program and included just the Marines or maybe just the Air Force where we got someone to basically get that data and transfer it over after they become veterans? Would it help in any way that maybe—or an external group did that, because you seem not to indicate that they still need a lot of communicating among themselves because I know that technology is there.

I have seen the technology there that can even get different languages to be able to put it together and come up with one system. And I have seen where you can get a soldier, and even with a thousand soldiers, and know exactly what you are going to be needing in terms of the access to the healthcare that is there.

And so can you provide me feedback on that, please?

Ms. MELVIN. I think that VA and DoD have a lot of initiatives underway and they have already accomplished a lot relative to the actions that they have taken. VA has an integrated system which I believe there are a lot of lessons that can be learned from relative to how to put together a comprehensive medical record.

These agencies have also engaged in a previous effort to—that has resulted in the one-way transfer of data from DoD's computerized system into VA's to give VA the capability to see critical data elements related to patients. So I would hesitate to say that a pilot project necessarily would be the answer, but I would say that I believe it is very important that these two departments borrow on the experiences that they have already undertaken.

They have a—DoD in particular is engaged in a number of short-term initiatives to provide critical health information on servicemembers at this time. And I think coupled with what VA has already accomplished in its way, there should be room for very serious and very productive dialog on how to take the lessons learned from what they have already accomplished and what they have learned about their needs and capabilities and to allow that to move them forward in deciding what strategy—

Mr. RODRIGUEZ. But apparently the will has not been there. So do you have any suggestions? There were suggestions that maybe we have an external group come in and force them to do that. Do you have any other recommendations?

Ms. MELVIN. I think there is certainly room for continued oversight and for holding VA and DoD accountable for making, for coming to a point where they have a definite strategy on this. I believe that there is certainly room for continued oversight. Perhaps there is room for lessons learned from other bodies, private entities that have been involved in looking at the development of electronic medical records. But again, I would stress that these agencies have a wealth of information, or should have a wealth of information.

I believe, though, that they have to held accountable for—

Mr. RODRIGUEZ. But you don't—

Ms. MELVIN [continuing]. Deciding how to move forward—

Mr. RODRIGUEZ. Yes, because it is extremely costly for them to—when the Department of Defense has done some work already with the soldiers and you have all these documents that are already on the soldiers, a packet, and then you have to start from scratch in

the VA to redo some of the stuff because of the fact that they don't communicate and they don't pass that information on.

It not only hurts the soldier in terms of the access to quality care, but it also costs the taxpayer money in terms of having to redo a lot of the stuff that maybe has already been done. From your perspective, what can you do or what kind of direction can we give you that would help in this process to force them to communicate and force them to come up with an approach?

Ms. MELVIN. What we have seen in the past is where we have been asked to conduct continued oversight and comprehensive oversight relative to the actions that VA and DoD have taken. We have seen some progress relative to their identifying the lead entities for their efforts and trying to clarify strategies. At least on some of the prior initiatives that have been undertaken from our role as an oversight body, I would suggest that continued oversight on our part—

Mr. RODRIGUEZ. Let me ask you, if it is okay with the Chairman, to submit to the Chairman those guidelines that would allow you that opportunity to have that oversight that would force them to move quicker in coming together to make this happen, because then maybe they might have it by 2011, 2012 when they started and, you know—but they started before 1998. You started to look at it in 1998—

Ms. MELVIN. That is correct.

Mr. RODRIGUEZ [continuing]. But they started before then. So it is going to be, what, 14, 15 years, and maybe we might have something by 2011, 2012. That is not satisfactory. It has been 15 years or more, and I would ask that you submit some specific recommendations to the Chairman and we will see if we can help in this process, to expedite that, and see what other things we can come up with in addition to the possibility of a Committee that can do the oversight and ask them to come up with additional recommendations.

Ms. MELVIN. We would be happy to respond to any requests that you have for additional work on our part to support you in that effort.

Mr. RODRIGUEZ. Thank you very much.

Mr. MITCHELL. Thank you. Thank you.

Mr. SPACE, would you like to—

Mr. SPACE. I don't have any—

Mr. MITCHELL. Okay. Thank you.

Thank you very much. We appreciate your testimony and hopefully you do keep on this and help us out.

Ms. MELVIN. We look forward to working with you.

Mr. MITCHELL. Thank you.

At this time we will have the second panel. And I want to welcome the second panel to the witness table. Dr. Gerald Cross is here to represent the viewpoints of the VA. Dr. Stephen Jones is here on behalf of the Department of Defense. And I welcome the opportunity to hear both sides of this issue in this setting.

Dr. Cross and Dr. Jones are accompanied by key IT and transition officers from their central offices, as well as Dr. Gordon Starkebaum and Dr. Glenn Zwinger from the Seattle VA Medical Center and Puget Sound VA Health Care System, and Lieutenant

Colonel Keith Salzman from the Madigan Army Medical Center in Seattle, Washington.

There is an interesting electronic sharing process taking place in Seattle and I am eager to learn more about this program.

I would also like to welcome Lieutenant Colonel Michael Fravell. He is not representing either the views of the VA or the Department of Defense, but is here at the request of the Subcommittee to answer questions about the Joint Patient Tracking Application (JPTA). I welcome his views on this issue.

Dr. Cross, if you would. You are recognized for 5 minutes.

STATEMENTS OF GERALD M. CROSS, M.D., FAAFP, ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY CHARLES CAMPBELL, ASSISTANT CHIEF OFFICER FOR HEALTH INFORMATION, VETERANS HEALTH ADMINISTRATION; CLIFF FREEMAN, DIRECTOR, VA/DOD HEALTH INFORMATION TECHNOLOGY SHARING, OFFICE OF INFORMATION TECHNOLOGY; GORDON STARKEBAUM, CHIEF OF STAFF, PUGET SOUND VETERANS AFFAIRS HEALTHCARE SYSTEM, SEATTLE, WA, VETERANS HEALTH ADMINISTRATION; GLENN ZWINGER, CHIEF INFORMATION OFFICER, PUGET SOUND VETERANS AFFAIRS HEALTHCARE SYSTEM, SEATTLE, WA, VETERANS HEALTH ADMINISTRATION; AND STEPHEN L. JONES, DHA, PRINCIPAL DEPUTY ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS), U.S. DEPARTMENT OF DEFENSE; ACCOMPANIED BY CHARLES HUME, DEPUTY CHIEF INFORMATION OFFICER, MILITARY HEALTH SERVICE, U.S. DEPARTMENT OF DEFENSE; LOIS KELLETT, DIRECTOR OF INTERAGENCY AND COMMUNICATIONS FOR THE TRICARE MANAGEMENT ACTIVITY (TMA), U.S. DEPARTMENT OF DEFENSE; LIEUTENANT COLONEL KEITH SALZMAN, CHIEF OF THE WESTERN REGIONAL COMMAND INFORMATICS, MADIGAN ARMY MEDICAL CENTER, SEATTLE, WA, U.S. DEPARTMENT OF DEFENSE; LIEUTENANT COLONEL MICHAEL FRAVELL, JOINT PATIENT TRACKING APPLICATION SPECIALIST, U.S. DEPARTMENT OF DEFENSE

STATEMENT OF GERALD M. CROSS, M.D., FAAFP

Dr. CROSS. Well, good morning, Mr. Chairman and Members of the Subcommittee. Accompanying me are Charles Campbell, VHA's Assistant Chief Officer for Health Information, Cliff Freeman, VHA's Director of VA/DoD Health Information Technology Sharing, and behind me I have Gordon Starkebaum, Chief of Staff at the VA Puget Sound and Glenn Zwinger, Chief Officer of Information at the Puget Sound VA Medical Center.

The VA is fully committed to ongoing collaboration with DoD in the development of interoperable electronic health records. Until that is achieved, we are using technology and processes to exchange information. We, VA and DoD, share patients and we must effectively share the clinical information necessary for their care.

Now, relevant to injured servicemembers, the starting point for the electronic transfer of clinical information from DoD to VA is in Iraq and Afghanistan. Information from that point on is entered in

the Joint Patient Tracking Application, JPTA. When the patient is ready to be transferred to a VA medical center, VA staff working at the military hospital copy the record and fax it to the VA facility which prepares to receive the patient.

VA now has a version of JPTA called Veterans Tracking Application. This contains all of the information in JPTA except that information deemed sensitive to military activities. Also, DoD has begun to transform other key portions of their medical records into electronic documents that are accessible to us in our program called VistA. This reduces the number of documents that must be copied and faxed back and forth.

The patient may ultimately be cared for at several VA military facilities. The VA is increasingly using VTA, Veterans Tracking Application, to track patients through each of these steps. Let me emphasize that we do not exclusively rely on any electronic system to ensure the transfer of information. We have VA staff at military facilities working with their DoD counterparts to assist the patient and family during the transfer and to ensure the information we need is sent.

The development of information exchange systems like JPTA and VTA for tracking, the Federal Health Information Exchange, called FHIE, which is for separating servicemembers, and the Bidirectional Health Information Exchange, BHIE, for two-way exchange of information represents significant milestones VA and DoD have accomplished together. However, none of these systems by themselves are sufficient. Neither JPTA, nor FHIE, nor BHIE contain the complete set of clinical information. Work is continuing to expand the reach of these systems.

An example of this cooperation is the work done at VA's Puget Sound Regional Center and the Madigan Army Medical Center. Once the veteran is enrolled in the VA healthcare system, all clinical information related to VA care is available at every VA medical facility. Using a secure virtual private network called VPN and a web browser, our doctors can assess a patient's record on the Internet from anywhere. VA, through its affiliation with 107 medical schools, has already trained many of the Nation's doctors and other providers on VA's electronic health record system.

In addition to the electronic pathways I discussed, we are taking additional steps, including stationing VA staff at the military hospitals to ensure we have redundant capabilities. And we are adding 100 transition patient advocates and placing them across the country at VA medical centers. When seriously injured servicemembers arrive at military hospitals, the advocate closest to the patient's home will fly to the military hospital to meet the patient and the patient's family. The advocate will stay in contact with the patient as he or she seeks additional care and the advocate will enter information about the care received into VTA. Ultimately, the advocate will greet the patient upon arrival at their hometown VA medical center.

VA and DoD are collaborating at the highest levels to determine that progress is made toward our ultimate goal, fully interoperable electronic health records. Together, VA and DoD can lead the way toward the adoption of electronic health records throughout the Nation's healthcare system. Indeed, VA's VistA System was awarded

the Innovations in American government Award in July 2006 by Harvard University.

I would like to submit my written statement for the record. My colleagues and I look forward to your questions. And, sir, we have given you two documents in addition for each of the members. One is a list of acronyms. I note we use a lot of acronyms and I apologize for that. But there are lots of acronyms. And then a simple diagram that shows how information is exchanged. And it also has some dates and numbers on there.

[The prepared statement of Dr. Cross, along with the attachments, appears on p. 48.]

Mr. MITCHELL. Thank you.

Dr. Jones.

STATEMENT OF STEPHEN L. JONES, DHA

Dr. JONES. Mr. Chairman, thank you very much. Members of the distinguished Subcommittee, I appreciate your inviting us here today to discuss the sharing of electronic health records between the Department of Defense and the Veterans Administration.

DoD and VA currently share a significant amount of health information data. I know you are frustrated and we are frustrated also. But we are making progress. And I guess you have heard that before, but I think in this case it is correct.

I am aware, however, of your concerns regarding the time it has taken to establish this level of sharing and recognize there is room for continued improvement. By 2008, DoD and VA will achieve all of our current health information exchange goals.

Mr. MITCHELL. Excuse me, Dr. Jones. Could you move the microphone closer—is it on? Do you see a green light there?

Dr. JONES. Yeah, I am sorry.

Mr. MITCHELL. Okay. Thank you.

Dr. JONES. No one recognizes the need for information sharing more than DoD and VA. Our ability to share information affects the quality of healthcare delivery and sometimes determines the benefits earned by veterans and servicemembers. We have to get it right. DoD and VA have the ability to enhance clinical processes and workflow through technology, and to collaborate on better processes for our deserving beneficiaries.

But digitization and automation are only the first part of the solution. DoD and VA are also prepared to collaborate on a new level for our shared patients, to create a better paradigm for care. No single organization has all the answers to these technological challenges and at DoD we are melding our expertise with the VA and other experts, both in the private and public sector.

This collaboration will continue to ensure that our systems and our partner's systems support the continuum of care and stay ahead of the technological curve.

Dr. Chu, our Under Secretary for Personnel and Readiness and Mr. Mansfield with the VA have two top priorities; first addressing the continuity of care for returning wounded warriors, and second, modernizing our inpatient systems together through a joint acquisition development effort over the next several years.

As one who has spent many months traveling and visiting VA and DoD medical centers, including the VA's polytrauma center, I

know from personal experience that our wounded warriors are best served by our specialized care. As you know, our shared patients sometimes begin treatment at a DoD facility and transferred to a VA polytrauma center and sometimes returned to a DoD facility for necessary medical procedures. Recently, to better support the transition of care, we began sending radiology images and scanned medical records to the four VA polytrauma centers.

Today, DoD and VA providers are able to view data from each of those departments for their shared patients. The health data elements we currently share include outpatient pharmacy data, inpatient and outpatient laboratory and radiological results, allergy data, pre and post-deployment health assessments and post-deployment health reassessment.

If you have ever spent time in a hospital, you know how important a discharge summary is to your personal physician. Today, five DoD sites share electronic discharge summaries with VA and we will soon expand this capability to 13 of our largest DoD inpatient facilities.

As I said earlier, collaboration is the right thing to do and it is the only way that organizations can ensure that they take advantage of the expertise necessary to be leaders. In this spirit, we recently announced that DoD and VA will modernize our inpatient systems together through a joint acquisition development effort over the next several years.

Both departments believe the timing is right for this initiative. VA is planning to modernize the inpatient portion of its electronic health record and DoD is poised to incorporate documentation of inpatient care into a fully deployed Armed Forces Health Longitudinal Technology Application (AHLTA) electronic health record. Over the next year, DoD and VA will analyze the requirements of this convergence. Our goal is to concurrently support the needs of the clinicians of both departments and enhance continuity of care for our patients.

In addition, DoD and VA are driving forces in the national level activities to support the President's Executive Order to require Federal agencies to use recognized health exchange standards to promote the direct exchange of health information between agencies with non-Federal entities.

Before I close, I will mention that the certification commission for healthcare information technology recently awarded premarket conditional certification of a version of AHLTA that will be released this fall. This certification of quality and safety is a giant step and shows that our electronic health records meet expected industry standards.

Thank you for the opportunity to appear before you today and we look forward to your questions, Mr. Chairman.

[The prepared statement of Dr. Jones appears on p. 54.]

Mr. MITCHELL. Thank you. I would like to ask my first question to both Dr. Cross and Dr. Jones. Are you aware of any negative impacts that have occurred to veterans and/or servicemembers because of the lack of compatibility of those two systems, the record-keeping systems?

Dr. CROSS. What we have done—yes, I know of one case that—
Mr. MITCHELL. Just one?

Dr. CROSS. I know of one case that has caused me concern as being an issue in this. And that is why as a result we have put in this redundant capability with our people on site to make sure that we have every aspect of every piece of information that we need.

Mr. MITCHELL. But if you are just aware of one—what about you Dr. Jones? If there have been no negative impact, then maybe there is no need to share this information. But I get the feeling, and I think everybody up here does too, that there has been a number of negative impacts on veterans and servicemembers because of a lack of shared information.

Dr. JONES. Mr. Chairman, I am not aware, but—as you know our America's healthcare recordkeeping has been based on a paper record and our providers tend to communicate to ensure when a hand-off occurs that, you know, the appropriate information is shared. Electronic data when it works, of course, enhances that communication. So while I am not aware of any specifics, I mean I think electronic data will help provide better quality care.

Mr. MITCHELL. Do you think it is a waste of time to go through all of this then? If there has really been only one case between the two of you, a negative case, because of a lack of compatibility of records, maybe we are wasting our time and money on bringing all these records together.

Dr. CROSS. No, sir. That is not how I see it. I don't think that is how Dr. Jones sees it either. We are moving on a pathway toward interoperability. And quite frankly, it has been an incremental path. But a great deal of progress has been made. We talk about an end point. I don't really see an end point as being what we are aiming for. There is going to be a progressive interoperability over a period of time, step-wise making more and more progress. The systems are going to change. They are going to modernize throughout that period of time and we will have to adjust.

But I think if you look at what we have achieved so far, we are getting more and more data electronically and exchanging it back and forth. If you look at the diagram, you will see what those pathways are. This isn't the end point though. We are not there yet. We have to keep working on this and there is much more to be done. As you will see some of the dates on here, we have some goals coming up very shortly.

Mr. MITCHELL. I understand and I understand about the IT and interoperability and so on, but you are talking about people's lives. That is what this is all about. And I think that you are going to say well, we are going to meet these goals because we have got to do this because there is new technology and electronic medical records are important and so on. But in the meantime, there are people's lives who are being affected by this, very real lives.

I just find it—you know, when I heard from Ms. Melvin and she talked about your plan is to have everything working right by the year 2012 and it started in 1983. That is what, 29 years. I think a person can retire after 20 years in the military. There are people who will go through this whole system with an inadequate medical record transfer.

I see some people out here in uniform. I would think they would feel—and one of these days you are going to be out of uniform and

you are going to be a veteran and you are going to go into the veterans' program. I would think that these people would feel that they would like the very best records kept. They would like to be—have the very best care.

I just don't understand how this thing can drag on and drag on. And as Ms. Melvin said, it seems like the only way this is going to get anywhere is continual oversight and accountability. Otherwise, you know, nothing seems to be happening. Thirty years to finally get to what you want. In the meantime, the electronic and the IT information, or the processes are all going to change.

Are you satisfied, either one of you, with the way this is going?

Dr. CROSS. Sir, we can't wait until 2012. We are—

Mr. MITCHELL. That is what Ms. Melvin said is going to happen the way you are headed.

Dr. CROSS. We are providing medical care today. I am a family physician. I understand this. We have to have certain pieces of information. That is why—because we can't wait and because we are providing that care today, we have our people on the ground at—working with our DoD colleagues at the military treatment facilities, ten of them, to make sure that whatever information we need as that patient transfers, they are there on the spot in person to make sure that gets to us. Whether it is electronic or other means, I have got to have the information and they are doing it.

Mr. MITCHELL. If the panel will indulge me a second. One of the things that Ms. Melvin also said is there is a culture you have to go through. And it seems to me, from what I have heard, that the DoD has about three or four systems they are using. Each branch has their own. DoD is trying to create one that will talk with the VA.

All these—I know it is important for the culture. But, you know, we are talking about, again, individuals, where it doesn't matter what uniform you are in. You are a veteran. You have served your country. And these people ought to be not concerned about the culture. And I get the impression—and I know neither one of you are going to point the finger at each other—that the real problem here is in the DoD because they have got so many different systems that they are trying to coordinate with that doesn't coordinate with the VA.

I would hope that, as the rest of the questions are answered here and we investigate this, that there—I mean you take into the fact you are dealing with human beings, not figures and not a system. And I think that is vital.

I will yield to Ms. Brown-Waite.

Ms. BROWN-WAITE. I thank the gentleman and I thank the panel for being here.

You know, what we are really talking about here is continuity of care. And certainly, both Dr. Cross and Dr. Jones realize how important that is.

Dr. Cross, I believe you were previously with DoD; is that correct?

Dr. CROSS. Twenty-five years.

Ms. BROWN-WAITE. Twenty-five years, a little less time than what Congress has been promised that there would be some interoperability here.

While the statement was made—and I apologize. I was writing. I don't know which one made it—that there was only one medical problem. I think what the term should have been was maybe one death. I am sure there have been other medical problems because of lack of information being transferred. Do you have a handle on what kind of medical problems, perhaps the loss of a limb, a diagnosis that went unknown? Could you supply the Committee with this information?

Dr. CROSS. The kind of problem that we face every day is quite frankly the labor intensity that it requires to assemble the information that we have to transfer on each patient, that we have our staff in those facilities putting that together every day doing this, to make sure that that happens. I think that is really the challenge.

The one case I referred to, I am not sure if any of the information issue or electronic issue played a definitive role in that or not. But it did cause me some concern. I will ask Dr. Jones.

Dr. JONES. Of course, as you know, DoD and VA monitors quality and outcome very carefully. You know, we believe that electronic health records will expedite communications, encourage communications and the lack of miscommunications, allergy information, pharmacy potential misuse. I mean there is a number of studies, long-term studies that show that safety is assisted by having adequate information and electronic health records help with this.

Ms. BROWN-WAITE. Sir, the VA is the receiving entity of the veterans that need this information. For years we have known that VA systems have been excellent, indeed far superior to those in the private sector. The private sector is finally catching up.

I think our real problem here is with the foot dragging at DoD. And, you know, long before I got here—as I look around this panel, except maybe for Mr. Stearns and staff who have been here, this is an ongoing situation.

Dr. CROSS. Well—

Ms. BROWN-WAITE. 2012 is when DoD thinks that it will be up and operating. Have you asked for any outside help or is this just the people in DoD who are wed to their system that aren't willing to accept change? Because having been involved in the installation of a major new IT system at a government agency, I know we ended up having to fire some people who would not adjust to the new system that was there. They continued using a dual system.

Why in God's name has it taken so long? And I would say that would be Dr. Cross. And I am not picking on you. I know simultaneously DoD is running a war.

Dr. CROSS. I want to say that in working with my DoD colleagues, I think we have the closest working relationship that I have ever heard of in the history of the two organizations in terms of the interactions that we have, the frequency and the structure with which we do that. And I think we are both committed to the same goal.

I would like to ask a couple of my colleagues now—as I said, I am a family physician. I am the receiver of the information. I have two IT experts that I think might want to provide just a bit more information for you, ma'am.

Ms. BROWN-WAITE. I would like to hear from Dr. Jones because I believe the foot dragging is actually taking place at DoD. And is there some reason why Executive Order 13410 calling for this to be developed by January of this year has not been met? And did you notify the President it wasn't going to be met?

Dr. JONES. Let me comment on the culture and the foot dragging. I would just like to echo Dr. Cross' comments. I have only been with DoD two and a half years, but I mean we work closely with VA. I know the IT people work closely. We have a joint strategic plan. Of course, IT is a part, an integral part of that strategic plan. We are building trust among our representatives and VA representatives are trying to work as one system when it comes to health information IT.

So while I can understand you may—and it may appear that there is a foot dragging, I can assure you from our part, from our leadership in working with Dr. Cross and his colleagues, that is not the case. I mean we would like to see this process move forward just as rapidly as you would—

Ms. BROWN-WAITE. I appreciate your building trust, sir. I would like to see you build a system that is interoperable. I am glad that you are building trust. That makes me feel very good. However, I don't think that the families of the veterans feel very good that there isn't a system there of record transfer the way that it should be.

Dr. JONES. Well, if you look at, as you said—I mean as I have assessed the situation now, we have built a foundation. I say we. DoD has built a foundation which we now can exploit and start those timbers coming up and if you will look at the charts and even, I think, look at the GAO report that was in the press today, you will see that we are making more progress, you know, each year more rapidly than we were the year before. So—

Ms. BROWN-WAITE. Sir, I will summarize this. This Dubuy has built huge cities in the amount of time that DoD cannot build an operable system to help our military. That, sir, is just unacceptable.

With that, I yield back the balance of my time.

Mr. MITCHELL. Thank you.

Mr. Walz.

Mr. WALZ. Well, thank you both for your testimony. And one thing I would say—and this is an area that I am trying my best to get more expertise in. I would agree, it is an incredibly complex undertaking. It absolutely is. But I would also associate with the Ranking Member. It can be done. There are challenges here. There are barriers. And we do need to figure out a way. And my goal is to try and see what we can do to get you there.

So I just had a couple of questions. How close are we on standardizing the categories of information that should be shared? Is that part of what we are working on? Is that part of what the delay is, or is that part figured out?

Mr. FREEMAN. One of the harder pieces to the work that we are doing together is the standard—

Mr. WALZ. Yes.

Mr. FREEMAN. As the Members know, there is a national effort under the umbrella of Health and Human Services. Both the VA and DoD play very active leadership roles in that effort.

Without the standardization at the national level, one of the risks we take is to go ahead and standardize something and then the national agenda go in a different direction.

So—and I guess, if I could, I will give you a couple of examples. There is a standard for moving the data between the two. However, within a standard, you also have to implement it in a uniform way. And so that is another complicating factor. It is not just standardizing the data, but it is also agreeing to how you are going to implement it.

Some standards that don't exist, for instance, with the CHDR project, the computable data that we move bidirectionally. There were no national standards for allergy. And so VA and DoD had to develop those ourselves in order to move that data and it was very time consuming to do that work.

Mr. WALZ. Do we have the ability to interject in that from a national standards perspective, the private sector or Health and Human Services? Can they help you with that?

Mr. FREEMAN. I believe that the private sector is a key player in this effort also.

Mr. WALZ. Okay. Very good.

Dr. Jones, I had a question on this as we are developing these programs. The AHLTA, why that over JPTA? When we looked at some of the research in my office, we saw that they were very, very similar. But the one we have chosen to implement is much more expensive. Can you tell me what we are getting for our money, or if that is true, what we are looking at?

Mr. HUME. Sir, JPTA was designed to support the tracking of patients as they are evacuated through the echelons of care. It was intended to provide a snapshot of the healthcare information relative to that transfer, both back to the referring facility and to the facility the patient is being referred to. It doesn't contain the workflow, the physician workflow, the orders management, the longitudinal care capabilities that AHLTA does. AHLTA is deployed across our fixed facilities and then a version of AHLTA is also deployed in theater to support the care delivered in theater.

Mr. WALZ. All right. Very good. Now, I am asking you to be somewhat subjective here on this one, but we brought you here to get your opinions on this. My experts at the Mayo Clinic have come to the assessment that DoD simply needs to adopt the way the VA is doing it. It is the most effective. It is the best for care and it is the most efficient in terms of use of resources. How would you respond to that, when they tell me that?

Mr. HUME. Sir, I think VistA is designed to meet the needs of VA very well and it does meet those needs. DoD has some unique requirements that drove us in a different direction. I would say the principal difference is the mobility of our patient population. The typical DoD patient over a career in the military will have records from ten or more facilities. DoD's requirement was to have a single central data repository which all of the DoD facilities would feed the records to.

The other area where we differ somewhat is the requirement, particularly in theater, to have a note, have a clinical encounter note that contains structured data elements so that we can use that clinical data record for disease surveillance, biomedical, bio and chemical disease surveillance both in theater and frankly, back here in the United States also. Those are some of the principal drivers for why DoD and VA chose separate paths.

Mr. WALZ. So you would say that Mayo's assessment of this is wrong even though they tell me they think they share the same issues you have because they receive patients from 176 foreign countries and try and integrate this together. So you are telling me they don't have a handle on exactly what you need in the environment that you work in?

Mr. HUME. Sir, I would have to see what the Mayo Clinic said specifically to be able to respond.

Mr. WALZ. Okay. I yield back.

Mr. MITCHELL. Thank you.

Mr. Bilbray.

Mr. BILBRAY. I have no—

Mr. MITCHELL. Mr. Space?

Mr. SPACE. Thank you, Mr. Chairman.

And while I share my colleague's concern over the duration and time lapse in the development of a more seamless transition of data, I do have some questions about a more human component, specifically, your reference to the advocates, the transition patient advocates. I find that idea somewhat intriguing. But I do have some questions.

The first question I have is, what steps, if any, have been taken to ensure that these advocates are advocating on behalf of the patient as opposed to a seemingly unending bureaucratic process? In other words, I have concerns about maintaining no conflict of interests are being paid presumably by the VA. So I would be interested in your thoughts on ensuring that they are, in fact, advocating for the patient. And second, whether there are plans to extend the number of advocates beyond the current number of one hundred. Thank you.

Dr. CROSS. Thank you so much for that. The patient advocates are going to be—we have already hired a bunch of them, of the hundred. They are going to be paid for—paid salary by the VA, of course. But they are going to have a case mix of, I think, about 25 per. They are going to have human to human contact with these compelling patients and their families. And if nothing else works in that regard, that kind of contact carries the imperative that they must be advocates for that patient. And I think that is what they will do.

As far as expanding them, if they exceed that case mix that we have assigned for them, that caseload, we would have to add on more individuals. One more thing. The type of people that we are selecting for these jobs, to the degree possible within, you know, within the hiring regulations, we are looking for people who had the experience of the people they are going to be working with. We are looking for people that are coming back from Iraq and Afghanistan, quite frankly.

Mr. SPACE. I yield back.

Mr. MITCHELL. Thank you.

Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman. I ask unanimous consent my opening statement be part of the record.

Mr. MITCHELL. So moved.

[The statement of Congressman Stearns appears on p. 35.]

Mr. STEARNS. Dr. Jones, I guess a question—my first question would be for you, I understand the DoD has seven separate electronic health records system; is that true?

Mr. HUME. Sir, I am not familiar with the precise number—the precise records that you are referring to. AHLTA is the enterprise outpatient electronic record deployed across DoD facilities. There are some legacy operations that that has replaced and—

Mr. STEARNS. Well, I mean—

Mr. HUME [continuing]. Are in the process of replacing.

Mr. STEARNS. Well, isn't there seven legacy applications? Just yes or no.

Mr. HUME. I don't know, sir.

Mr. STEARNS. Okay. Well, we understand that—and my question was going to be that I understand that the VA has three separate electronic health record system; is that true? Anybody know? Mr. Freeman?

Mr. FREEMAN. I believe that VistA is our primary electronic—

Mr. STEARNS. So you don't think—

Mr. FREEMAN [continuing]. Health record.

Mr. STEARNS. There is not three sets. I guess the question I have is within the VA or DoD, is there communication between all of your electronic systems? And I guess that is for you, Dr. Jones. You know, if we can't get communication between the VA and DoD, can we get communication within the DoD? Is there assurance here that you are getting communications within your electronic systems within DoD?

Mr. HUME. The outpatient electronic medical record is AHLTA and it is a single system deployed across all of DoD.

Mr. STEARNS. Okay. Well, I have in front of me selected DoD medical information systems. There is a Composite Healthcare System, the CIS, the Clinical Information System, the ICDB, the Integrated Clinical Database, the Theater Medical Data Store, the Joint Patient Tracking Systems. There is two more. So you have got one, two, three, four, five, six, seven. That is what I am talking about. Is there communication between these seven systems so that one system can talk to another? Is there interoperability is what I am asking.

Mr. HUME. Between—

Mr. STEARNS. Just yes or no.

Mr. HUME. Between most of those, yes.

Mr. STEARNS. There is interoperability?

Mr. HUME. Yes, sir.

Mr. STEARNS. Okay. Within DoD?

Mr. HUME. Yes, sir.

Mr. STEARNS. Okay. And it is true in the VA that you have I think three systems I could point out to you. Again, we have interoperability between the three systems in the VA? You can assure me that you have the Veterans Health Information System and

Technology Architecture, the HealthVet VistA program and you have the Health Data Repository (HDR). So those three systems, is there interoperability between those three?

Mr. FREEMAN. Yes, sir.

Mr. STEARNS. Okay. I think the concern that a lot of us have is traumatic brain injury (TBI) that is so prevalent for veterans coming back. Secretary Nicholson issued a report April this year in which he talked about that all incoming veterans returning from the Global War on Terror seen in the VA healthcare facilities will be screened, from mild to moderate traumatic brain injury. But the problem is that all this information is in the DoD when they come out of—when they are in the service.

So wouldn't you think all that information should be available? I mean how effective is the Secretary's plan here to actually screen veterans for mild to moderate traumatic brain injury if there is no records being transferred from the Department of Defense to the veterans so they can do this?

Dr. CROSS. Sir, we are—the VA is actually the ones who are screening all the Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) for TBI.

Mr. STEARNS. Yeah, but doesn't the DoD have all this information when they come into Walter Reed? I mean don't they do the same thing? And doesn't the active military do the same thing? And shouldn't they take all their records and transfer them to you so that the veterans have this before you start the screening?

Mr. HUME. Sir, in the case of the polytrauma patients, we are scanning that entire inpatient and—any paper and electronic record we are consolidating along with the digital imagery and sending that—

Mr. STEARNS. So the Department of Defense is making that available information to the veterans on traumatic brain injury?

Mr. HUME. If they are going to a polytrauma center, yes.

Mr. STEARNS. Well, could you take—that is only 300 patients I am told. Now, coming back from the military it is much more than 300 patients. I think the problem I have here is that you folks are sort of not too transparent. I mean here we have the Secretary of Veterans Affairs saying we are going to screen all these people and yet the DoD is not even providing the information.

Let me ask you something. Could somebody in the VA just walk over to the DoD or fly or go by train? Would the DoD allow physicians to go over to the Department of Defense and look at, let's say, a Cliff Stearns who came back from Iraq and he had brain injury, traumatic brain injury? Would the DoD allow a doctor to go over there? Yes, Dr. Cross?

Dr. CROSS. Sir, let me give you a bit more detail, if you don't mind.

Mr. STEARNS. Okay. Don't make it too complicated. Just keep it very simple for us.

Dr. CROSS. The answer is we are getting the information from the PDHRA. Now, I had to use so many acronyms, so I am going to apologize. As to post-deployment health reassessment—

Mr. STEARNS. So if I came back from Iraq and I was in Walter Reed and then they made me—and then I became a veteran, all

the information on my traumatic brain injury is available and DoD sends it to Veterans Affairs? Just yes or no.

Dr. CROSS. Electronically, some of it, yes.

Mr. STEARNS. Why not all of it?

Mr. HUME. Sir, it doesn't exist in electronic form across all of the—

Mr. STEARNS. No, but we have a got a Xerox machine. You make copies of this and you can just make copies and give it to me when I left and I could take it with me to Veterans Affairs.

Mr. HUME. We are currently doing that for the polytrauma patients. That was a new initiative and we are certainly—

Mr. STEARNS. When did you start with that?

Mr. HUME. March, sir.

Mr. STEARNS. This long. We have been at this war now almost four and a half years and the people have been coming back steadily and you just started in—

Mr. HUME. Prior to that, sir, the data was being moved with the patient on a compact disc. The VA facilities asked if they could get it transferred to them electronically and we worked together a system to do that.

Mr. STEARNS. Well, Mr. Chairman, my time has expired. But we can see right now the crucial problem with traumatic brain injury. There is no interoperability between DoD and VA and this is life-saving information for the veterans and yet the Secretary of the Veterans Affairs, Mr. Nicholson, thinks they are going to start this screening process. It seems to me they should have all the information from DoD first before they even start the screening, Mr. Chairman.

So with that, I yield back.

Ms. BROWN-WAITE. Mr. Chairman?

Mr. MITCHELL. Yes. Ms. Brown-Waite.

Ms. BROWN-WAITE. Colonel Fravell of the U.S. Army who is a medical service corp officer is in the audience and I don't know if he was sworn in or not, but I think that we may want to ask him about the Joint Patient Tracking Application system.

Mr. MITCHELL. Very good.

Ms. BROWN-WAITE. If we could perhaps call him up?

Mr. MITCHELL. Colonel? I think—did you stand, I think, when you—

Colonel FRAVELL. I did not, sir.

Mr. MITCHELL. Would you raise your hand?

[Lieutenant Colonel Michael Fravell was sworn.]

Mr. MITCHELL. Thank you.

Ms. BROWN-WAITE. Do you want to—

Mr. MITCHELL. Excuse me. No, go ahead, Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you.

I understand that you are responsible for the Joint Patient Tracking Application system. Could you tell me where it is and the Xeroxing of records and giving them to a patient I don't think is exactly what Congress had in mind. So could you tell me what we can do to make the Joint Patient Tracking Application system work so that it truly is a patient tracking for both of the agencies?

Colonel FRAVELL. I think we are currently on the right track, ma'am, for sharing the Joint Patient Tracking Application and es-

essentially its sister application, the veterans tracking application, to the VA. We have great cooperation between DoD and the VA for sharing all of the JPTA records. I think there is a lot of potential to expand JPTA's use within the DoD, specifically as an interim solution to gather additional information from some of the seven disparate systems that were mentioned by your colleague.

That information could be pushed into JPTA quite easily and then as a result, shared quite easily, essentially overnight, with the VA through the connection it has to the veterans tracking application.

Ms. BROWN-WAITE. Is there resistance? Is there organization resistance to doing that? Because as Mr. Stearns said, we have a list of seven separate systems here. If six of them could be combined into JPTA, it seems to me as if that would be the answer here instead of reinventing the wheel. Am I missing something?

Colonel FRAVELL. I think that we do want to strive toward the health data repository and clinical data repository interoperability in sharing computable data. JPTA could be viewed, along with VTA, as an interim solution to bring the other systems together. At the present time, six of the seven systems, with the exception of Clinical Information System (CIS), the inpatient system used in many State-side DoD facilities, that data is already residing in large part within JPTA. And as a result of the sharing initiatives in cooperation between the DoD and the VA, that data is available to the VA.

So, for example, a severely injured servicemember—and by and large, every severely injured servicemember has been registered in the JPTA and data along the way from each of the facilities that have treated the servicemembers and veterans is now available to them in VTA on the VA side.

Ms. BROWN-WAITE. Are you still working on this system and is there reluctance on DoD's part to have it in one system that is supposed to be interoperable?

Colonel FRAVELL. I have been working on the veterans tracking application. Control of the Joint Patient Tracking Application is under the Office of Force Health Protection. And I don't have purview over that system since developing it in Landstuhl and moving into Force Health Protection in 2005. However, this year, as a war college fellow at the VA, I have presided over the project to build the veterans tracking application.

On the DoD side I think things are sometimes very territorial and there are a lot of initiatives for developing other systems. JPTA has been latched onto by many providers and providers have been able to provide a great deal of input in terms of building the system and seeing very quick and immediate results, resulting in a great deal of user buy-in and increasing the accuracy and use of the JPTA in the theater hospitals. It is a great tool for what it is now as an interim solution.

Ms. BROWN-WAITE. Could you give me an idea of the cost of developing JPTA?

Colonel FRAVELL. Over the course of JPTA's initial development that started in September of 2003, with fielding and production at Landstuhl Regional Medical Center on 1 January 2004 to the present, I think—and I don't have, again, over side of the current

contract mechanism and I have not since 2005. I think the costs have been about \$1.8 million total. And I would estimate that an annual operating cost of probably about \$400,000 to \$500,000, to continue maintenance.

If the application was expanded, you would look at some additional costs to increase the hardware capacity, storage capacity and things like that, but nothing too significant.

Ms. BROWN-WAITE. Perhaps that is part of the problem. It is not expensive enough. Is it feasible that this one system, that JPTA could be used and could be used effectively for interoperability?

Colonel FRAVELL. I think it could easily be used effectively for interoperability as it is now by serving as essentially a window into the other existing systems. And while development would likely need to occur on a parallel track for the clinical data repository and health data repositories, JPTA or an application like JPTA could very easily and quickly provide a bridge between the two organizations, sharing data essentially in both directions.

Ms. BROWN-WAITE. I thank you for your response and I yield back the balance of my time.

Mr. MITCHELL. Thank you.

Yes. Mr. Stearns.

Mr. STEARNS. Mr. Chairman, my colleague from Florida just asked Colonel Fravell questions.

Dr. Cross, I got more out of what the Colonel indicated, substance stuff, than I got from you or Dr. Jones. It seems like he is trying to solve the problem where the rest of you are sort of feathering the answers and looking around. And just in all honesty, I mean you are both M.D.'s. I would think you would want to solve this problem, particularly dealing with traumatic brain injury for these young men that are coming back from the Global War on Terror and all their information can't even be transferred from the Department of Defense to the Veterans Affairs, and yet the Veterans Affairs is willing to screen it.

I just think you would have to take a little advice from Colonel Fravell that he is trying to solve the problem. I don't hear that from your folks. And this thing goes on and on and on. I think it is—frankly, it is a scandal that this information is not being transferred 3 years ago. But the fact is, one of your aides, Mr. Hume, mentioned that just March we started this information.

So I think for the benefit of our young men and women that are coming back, you have got to somehow set up a demonstration project or something in place so that all this information is transferred over to Veterans Affairs so when they do their screening, they start with the record from DoD. Does that make sense?

Dr. Cross.

Dr. CROSS. The information that you asked about was electronic. We are getting other information on paper. And let me say something about TBI. We are leading the way on this. We have trained 61,000 of our clinicians in our TBI supplemental education program. We have done the screening questions and are screening every OIF and OEF veteran coming through our system. We have trained our staff and put them in place, our polytrauma system of care, our level one, our level two, to get these folks the care—

Mr. STEARNS. But you are talking from the Veterans Affairs standpoint. You are not talking from the DoD. I am talking—Dr. Jones, I mean this information should at the very least be transferred completely over to Veterans Affairs from the Department of—DoD and it is not being done.

Dr. JONES. Mr. Congressman, we don't disagree with you at all.

Mr. STEARNS. So you are in total agreement that this information should be transferred—

Dr. JONES. Yes. I mean—

Mr. STEARNS [continuing]. Electronically and whatever means possible. So why can't we just put a pilot program in and start doing it immediately?

Dr. JONES. Well, I mean our vision, as you say, is to be able to have an interoperable—and be able to transfer all the information. And of course, that is what we have been doing. I mean we have developed a number of demonstration projects and enterprise initiatives and that has allowed us to move forward the way we have. In FHIE, you know, we are transferring 3.8 million unique patients' information right today.

Mr. STEARNS. When would you say it would be totally complete, the transfer interoperability between DoD and Veterans Affairs on traumatic brain injury? When could I actually put this date in concrete and say it will be accomplished?

Dr. JONES. I would have to get back with you on that, sir.

Mr. STEARNS. Well, just give me an approximate date. Mr. Hume, I mean are you talking about—

Mr. HUME. For the primary driver for the comprehensive solution is the—where once we have the joint—

Mr. STEARNS. You are talking about 2012?

Mr. HUME [continuing]. DoD/VA—well, we have to—the plan is to build a joint DoD/VA inpatient application, the same application used by both organizations. Until that time, DoD won't have a comprehensive inpatient solution across all of DoD.

Mr. STEARNS. So the transfer of traumatic brain injury will not be accomplished—this interoperability will not be accomplished in the next five years?

Mr. HUME. We will work on interim solutions.

Mr. STEARNS. But you are not willing to give a date this morning about a date when it will be accomplished?

Mr. HUME. I can't give a date when the comprehensive solution will be accomplished.

Mr. STEARNS. Will it be more than 5 years or less than 5 years?

Mr. HUME. Right now there is—we have contracted out for an independent study of the two departments' requirements for an inpatient application and for that organization to come back with a way forward on that development. Until we have that way forward, I can't forecast a date.

Mr. STEARNS. Well, that is 2008, staff said. So you are projecting this at least another year?

Mr. HUME. And in the interim we will have to come up with interim solutions and I think that Colonel Fravell suggested one of the interim solutions we are considering.

Mr. STEARNS. Okay. Mr. Chairman, I will just conclude by saying that Mr. Hume or Dr. Jones or Dr. Cross, if you had a son or

daughter that was fighting Global War on Terrorism and they came back with traumatic brain injury, I think you would want that son or daughter to have all that information that DoD has immediately transferred to Veterans Affairs when they became a veteran. And I am sure in your heart of hearts, you would like this done as soon as possible. Thank you.

Mr. MITCHELL. I would just like to close with a few comments. First of all, things that happen with the VA and the negative impact on the VA may not be your fault. Now, it may be because you don't have—you mentioned you only knew of one case that there might be any negative impact for lack of records. But I think there is a lot more anecdotal evidence about that.

And in order for—because as soon as anyone is hurt badly enough or is sick, they will be transferred out of the DoD and it will become your problem. So you are going to get them very quickly, those who have lost limbs, those who have suffered traumatic brain injury, whatever it may be. They become your problem and the DoD gets rid of them. So it is really in your best interest to push for every bit of information you can get.

And with the Department of Defense, I think if we don't take care of the people who serve in uniform and give them what they expect, we are going to find it much more difficult to recruit when all of the sudden they find that they are not getting the kind of service they need after they leave your purview and become part of the VA. They can say, you know, no one is really looking out for our interest.

I will feel embarrassed as will every Member of this Committee, if we find another booklet like this one that says "Shared Medical Records, 20 Years and Waiting." And 20 years from now and my name is on here and they are still having the same hearing. Is there anything that you can give us, any timeframe that you say well—I don't know what your next steps are, either one of you, on this recordkeeping.

But whatever they are, when do you expect the next leap to be made? Because I would like to have another hearing. I want to know when that should be. Are we going to not have anything happen for the next—for this term of Congress, the 110th Congress, or is there something else planned between now and the end of this Congress? Do you have any idea, either one of you? What are the next steps? I would hate to have another hearing and have you say exactly the same thing again. I would like to see some progress.

Ms. BROWN-WAITE. Mr. Chairman, while they are preparing, I would just ask for unanimous consent to request that GAO continue to follow up on this with the Department of Veterans Affairs and the Department of Defense. And I would also perhaps suggest that if either department wrote to the President as to why the Executive Order dates were not met, that the Committee also get a copy of that "please excuse me for my tardiness" letter.

Mr. MITCHELL. So ordered.

Ms. BROWN-WAITE. I think it probably would be—

Mr. MITCHELL. Absolutely.

Ms. BROWN-WAITE [continuing]. Appreciated by all of the Committee Members. Thank you.

[The following was subsequently received from the U.S. Department of Veterans Affairs regarding Executive Order 13410.]

Question 1: Did VA notify the White House it would be unable to comply with the requirements of Executive Order 13410, "Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs?"

Response: (19) Executive Order 13410, "Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs," included a deadline of January 1, 2007; however, the deadline did not require implementation of a single system. Instead, January 1, 2007, was selected to mark the beginning of executive branch commitment to the goals of the EO. The Office of Management and Budget (OMB) is responsible for tracking executive branch progress in implementing the initiative.

The Department of Veterans Affairs (VA) has moved forward on many initiatives essential to the EO objectives, and VA has set the benchmark in the area of electronic medical records with its award-winning and internationally recognized VistA/CPRS medical record system. VA is working with OMB, other Federal agencies, the private sector, and internally to achieve the President's vision of Promoting Quality and Efficient Health Care in the Federal Government.

VA jointly collaborates with public/private organizations including academia, professional organizations, and other state and government agencies. VA is also coordinating and leading several organizations committed to developing clear standards for health information and interoperability. Working through this many bodies requires compromise and consensus, which sometimes take longer than expected, thus influencing the Department's timeline for project completion. Were VA to proceed without consulting other healthcare providers, either public or private, VA would risk delaying national interoperability.

Executive Order 13410 addresses four main components, including clear systemic interoperability standards, performance measurement, transparent pricing, and high quality, efficient healthcare.

Health Information Technology—Interoperability Standards

VA works closely with the Secretary of Health and Human Services (HHS) to support infrastructure and activities essential to developing interoperable standards for new or renovated Federal systems. These standards will be used for exchanges of health information.

Transparency of Quality Measurement—Performance Measurement

The Veterans Health Administration's Chief Quality Officer is leading a partnership with public/private entities in developing standards for the measurement and collection of quality measures. A Steering Committee, including VA, the Department of Defense (DoD), and Indian Health Services (IHS), was formed in October 2006 to begin developing quality measures at both the facility and (where appropriate) the provider level.

The Steering Committee created two subgroups. The first was charged with identifying three to five measures proving 100% electronic abstraction for facilities and providers. An example of electronic abstraction for this purpose is "pulling" a lab value for every member of a specific patient category (such as diabetes). The second subgroup was directed to develop a plan for communicating the quality of care VA provides, based on objective quality measures, to providers and users.

In the future, VA will work with other agencies to modify the current quality reporting initiatives.

Transparent Pricing Information

VA Health Service users do not pay market price for services.

Promoting High Quality and Efficient Care

The Department of Health and Human Services is leading the effort to meet this EO goal.

Dr. JONES. Mr. Chairman, we do have a milestone chart here that goes through 2008 which we will provide the Subcommittee

and we will also address the question for the record, if you don't mind, about after that what does the prognosis look like with—

Mr. MITCHELL. Well, you can only expect to come back again with some other answers, and not the same answers we have heard today.

Dr. JONES. Yes, sir.

Mr. MITCHELL. And I would also like the information that Ms. Brown-Waite has asked for as well.

Dr. JONES. Yes, sir.

Mr. MITCHELL. Thank you.

With no further comments, the meeting is adjourned.

[Whereupon, at 11:42 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Opening Statement of the Honorable Harry E. Mitchell, Chairman, Subcommittee on Oversight and Investigations, and a Representative in Congress from the State of Arizona

This hearing will come to order.

One of the concerns I have heard from veterans is how difficult the process can be as they transition from their active duty status to veteran. And one of the great difficulties they experience is having their full and complete medical records from the Department of Defense available to their VA doctors.

This problem isn't new.

In 1998, President Clinton called on the VA and D-O-D to develop a—quote—“comprehensive, lifelong medical record for each servicemember.” That was nearly 10 years ago. But up to this point, progress has been painfully slow and increasingly expensive.

That's why we're having this hearing today . . . so this Subcommittee can continue its efforts to provide oversight, and do what *we* can to speed up the progress and make electronic medical records sharing a reality.

We all know that there are many benefits to this. First, we will be making sure that veterans receive better medical care by saving time, and avoiding errors. Second, we will also lower costs so taxpayer dollars are more wisely spent. That's a worthy goal as well.

I'm glad to know that the VA and D-O-D are working on some demonstration projects in this area, and I'm eager to get an update on it.

I want to take a moment to acknowledge the VA and D-O-D's progress in their long term efforts to achieve a two-way electronic data exchange capability. They have implemented 3 of 4 earlier GAO recommendations, including

- Developing an architecture for the electronic interface between D-O-D Clinical Data Repository and VA's Health Data Repository
- Selecting a lead entity with final decisionmaking authority for the initiative, and
- Establishing a project management structure.

That's a good start, but there's much more to do.

One of my greatest concerns is that the VA and D-O-D have not yet developed a clearly defined project management plan that provides a detailed description of the technical and managerial process necessary to satisfy project requirements as the GAO has repeatedly suggested in the past.

For example, all the way back in December 2004, the VA/D-O-D Executive Council Annual Report found that the cost for the Government Computer Based Patient Record/Federal Health Information Exchange was approximately \$85 million through FY 2003.

But here we are, 4 years later . . . the costs continue to grow . . . and the consequences for delay are growing too.

We want to know why this isn't getting done, and how much longer our veterans have to wait. I believe they've already waited long enough.

I look forward to today's testimony.

Opening Statement of the Honorable Ginny Brown-Waite, Ranking Republican Member, Subcommittee on Oversight and Investigations, and a Representative in Congress from the State of Florida

Thank you, Mr. Chairman.

This Committee has held at least 16 hearings since 2000, to try and push the sharing of critical medical information on patients being seen or transferred to VA between the Department of Defense and the Department of Veterans Affairs. The movement of this information between the two departments is vital to the safety and well-being of our veterans and military active duty servicemembers as they transfer between the two agencies and become finally integrated back to civilian life.

Our staff and members have visited many VA and DoD Medical Centers. Of particular interest are the four VA poly trauma centers where servicemembers sustaining severely disabling injuries to include traumatic brain injuries (TBI) and spinal cord injuries are being cared for while still in service, as well as after discharge. We have frequently heard the concerns of VA doctors and medical personnel at these facilities that the information they are receiving isn't timely enough, or missing critical information needed to properly treat these severely injured and disabled servicemembers.

Throughout the past 20 years, the VA and DoD have spent billions working on independently stove-piped electronic medical records systems that would provide better care to those serving on the frontline of our Nation's efforts for freedom. Yet, neither to date seem to work together in a coordinated effort of care. On April 10, 2007, an article appeared in the Washington Post, which touted the VA's VISTA system as a means to lower costs and provide better treatment to our Nation's veterans. Can the VISTA system receive information from the Department of Defense? We have also heard about the Joint Patient Tracking Application (JPTA), which permits the transmission of patient care notes from the battleground up the line to the patient's final destination, whether for continued care at a VA facility or to prepare for redeployment. However, in January, the Department of Defense temporarily cut off access to the VA to this critical data.

Today, we have sitting before us both departments. It is my hope that after two decades, all these attempted starts that finally there is good news on the horizon, and we will finally see a system that will permit the exchange of critical medical information that is interoperable, bi-directional, and occurs in real-time. The care for those who serve our country does not stop at the exit door of the Department of Defense, but continues through the doors of the VA, and the hand off between the two medical systems should be seamless, not a fumble. Our Nation's heroes deserve no less.

Opening Statement of the Honorable Cliff Stearns, a Representative in Congress from the State of Florida

Over and over again, for several years now, we have held hearings, heard testimony, and listened to a number of recommendations to make the transition of active duty servicemembers to the Veterans' Administration as smooth as possible. And here we are again today, with many of the same issues outstanding, and numerous recommendations left undone!

Last year's GAO report quoted VA officials as saying that the transfer of servicemembers to their system from the DOD would be more efficient if the Polytrauma Rehabilitation Center's (PRC) medical personnel had real time access to the servicemembers' complete DOD electronic medical records. As Yogi Berra said, this is déjà vu all over again! These are the same opinions we have heard from all medical personnel in the VA system for years, and yet little has been accomplished to provide access to patient's comprehensive medical files.

Allow me a brief moment to recap the history of this issue. Back in 1982, Congress identified the sharing of medical records as a critical need, and passed the 'Veterans Administration and the Department of Defense Health Resources Sharing and Emergency Operations Act' that created the first interagency Committee to supervise those opportunities to exchange information between the two departments. 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 servicemembers' health information. In November 1997, the President called for the two agencies to start developing a "comprehensive, lifelong medical record for each servicemember," 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." In 2003, President Bush established the Task Force to Improve Health Care Delivery for Our Nation's Veterans. The first recommendation of this task force 4 years ago was that the VA and DOD should "develop and deploy by fiscal year 2005" electronic medical records that are interoperable for both systems and standards based. We are 2 years beyond that deadline and not much closer to its completion.

GAO has previously commented on the departments' initial project, and described the results as "disappointing progress, exacerbated by inadequate accountability and poor planning and oversight." The VA has 3 separate electronic health records systems that it uses, and has spent \$76 million on this interoperability project since its inception. The DOD has 7 separate electronic health records systems, and also has spent \$76 million for its portion of the interoperability project since its inception. So we are left with \$152 million in expenditures for 10 different systems, and none of them can effectively share information as we have been requesting for over

a decade! I understand that the departments are now considering further compromise by trying to provide 'read-only' access to VA centers instead of requiring full interoperability because the process has become so complicated. This is simply unacceptable. DOD and VA must come up with a plan, with clear assignments, timelines and responsibilities to implement information sharing between the departments. Our veterans' medical treatments are being delayed, our patience is wearing thin, and we will not spend another decade in fruitless hearings. Our veterans deserve better.

Thank you Mr. Chairman.

**Statement of Valerie C. Melvin, Director,
Human Capital and Management Information Systems Issues,
U.S. Government Accountability Office**

INFORMATION TECHNOLOGY—VA and DOD Are Making Progress In Sharing Medical Information, But are Far From Comprehensive Electronic Medical Records

Mr. Chairman and Members of the Subcommittee:

I am pleased to participate in today's hearing on sharing electronic medical records between the Department of Defense (DOD) and the Department of Veterans Affairs (VA). For almost 10 years, the departments have been engaged in multiple efforts to share electronic medical information, which is important in helping to ensure that active-duty military personnel and veterans receive high-quality healthcare. These include efforts focused on the long-term vision of a single "comprehensive, lifelong medical record for each servicemember"¹ that would allow a seamless transition between the two departments, as well as more near-term efforts to meet immediate needs to exchange health information, including responding to current military crises.

Each department is developing its own modern health information system to replace its existing ("legacy") systems, and they are collaborating on a program to develop an interface to enable these modernized systems to share data and ultimately to have interoperable² electronic medical records. Unlike the legacy systems, the modernized systems are to be based on computable data: that is, the data are to be in a format that a computer application can act on, for example, to provide alerts to clinicians (of such things as drug allergies) or to plot graphs of changes in vital signs such as blood pressure. According to the departments, such computable data contribute significantly to patient safety and the usefulness of electronic medical records.

While working on this long-term effort, the two departments have also been pursuing various near-term initiatives to exchange electronic medical information in their existing systems. These include a completed effort to allow the one-way transfer of health information from DOD to VA when servicemembers leave the military, ongoing demonstration projects to exchange particular types of data at selected sites, and efforts to meet the immediate needs of facilities treating veterans and servicemembers with multiple injuries.

As you requested, my testimony will summarize the history of the two departments' efforts to develop the capability to share health information, and provide an overview of the current status of the long- and near-term efforts that the departments are making to share health information.

The information in my testimony is based largely on our previous work in this area. To describe the current status of VA and DOD efforts to exchange patient health information, we reviewed our previous work, analyzed documents on various health initiatives, and interviewed VA and DOD officials about current status and future plans. The costs that have been incurred for the various projects were provided by cognizant VA and DOD officials. We did not audit the reported costs and thus cannot attest to their accuracy or completeness. All work on which this testimony is based was conducted in accordance with generally accepted government auditing standards.

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 servicemembers' health information. In November 1997, the President called for the two agencies to start developing a "comprehensive, lifelong medical record for each servicemember," 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 Interoperability is the ability of two or more systems or components to exchange information and to use the information that has been exchanged.

Results in Brief

VA and DOD have been pursuing ways to share data in their health information systems and create comprehensive electronic medical records since 1998, following the call for the development of a comprehensive integrated system to allow the two departments to share patient health information. However, the departments have faced considerable challenges, leading to repeated changes in the focus of their initiatives and target dates. In reviewing the departments' initial project, we noted disappointing progress, exacerbated by inadequate accountability and poor planning and oversight, which raised doubts about the departments' ability to achieve a comprehensive electronic medical record. We made recommendations aimed at enhancing management and accountability by, among other things, the creation of comprehensive and coordinated plans that included an agreed-upon mission and clear goals, objectives, and performance measures. In response, the departments refocused the project and divided it into long- and short-term initiatives. The long-term initiative, still ongoing, is to develop a common health information architecture that would allow the two-way exchange of health information through the development of modern health information systems. The short-term initiative (the Federal Health Information Exchange) was to enable DOD to electronically transfer to VA health information on servicemembers when they leave the military; this initiative was completed in 2004. Other short-term initiatives were subsequently established that were similarly focused on sharing information in existing systems, an important requirement until the departments' modern health information systems are completed. In particular, two demonstration projects were established in 2004 in response to congressional mandate, one of which led the two departments to develop an interim strategy to connect existing systems and allow information sharing among them. Finally, the two departments announced in January 2007 a further new strategy: their intention to jointly develop a new inpatient medical record system. The departments have indicated that by adopting a joint solution, they could realize significant cost savings and make inpatient healthcare data immediately accessible to both departments.

VA and DOD have made progress in both their long-term and short-term initiatives to share health information, but much work remains to achieve the goal of a shared electronic medical record and seamless transition between the two departments. In the long-term project to develop modernized health information systems, the departments have begun to implement the first release of the interface between their modernized data repositories, and computable outpatient pharmacy and drug allergy data are being exchanged at seven VA and DOD sites. Although the data being exchanged are limited, implementing this interface is a milestone toward the long-term goal of modernized systems with interoperable electronic medical records. In the meantime, the two departments have also made progress in their short-term projects to share information in existing systems. Besides completing the Federal Health Information Exchange, the departments have made progress on two demonstration projects:

- The Laboratory Data Sharing Interface, which allows DOD and VA facilities serving the same geographic area to share laboratory resources, is deployed at 9 localities to communicate orders for lab test and their results electronically and can be deployed at others if the need is demonstrated.
- The Bidirectional Health Information Exchange, which allows a real-time, two-way view of health data from existing systems,³ provides this capability (for outpatient data) to all VA sites and 25 DOD sites and (for certain inpatient discharge summary data)⁴ to all VA sites and 5 DOD sites. Expanding this interface is the foundation of the departments' interim strategy to share information among their existing systems.

In addition to their technology efforts, the two departments have undertaken ad hoc activities to accelerate the transmission of health information on severely wounded patients from DOD to VA's four polytrauma centers, which care for veterans and servicemembers with disabling injuries to more than one physical region or organ system. These ad hoc processes include manual workarounds such as scanning paper records and individually transmitting radiological images. Such processes are generally feasible only because the number of polytrauma patients is small (about 350 in all to date).

Through all these efforts, VA and DOD are achieving exchanges of health information. However, these exchanges are as yet limited, and it is not clear how they

³DOD's Composite Health Care System (CHCS) and VA's VistA (Veterans Health Information Systems and Technology Architecture).

⁴Specifically, inpatient discharge summary data stored in VA's VistA and DOD's Clinical Information System (CIS), a commercial health information system customized for DOD.

are to be integrated into an overall strategy toward achieving the departments' long-term goal of comprehensive, seamless exchange of health information. To achieve this goal, significant work remains to be done, including agreeing to standards for the remaining categories of medical information, populating the data repositories with all this information, completing the development of their modernized systems, and transitioning from the legacy systems. Consequently, it is essential for the departments to develop a comprehensive project plan to guide this effort to completion, in line with our earlier recommendations.

Background

In their efforts to modernize their health information systems and share medical information, VA and DOD begin from different positions. As shown in table 1, VA has one integrated medical information system, VistA (Veterans Health Information Systems and Technology Architecture), which uses all electronic records. All 128 VA medical sites thus have access to all VistA information.⁵ (Table 1 also shows, for completeness, VA's planned modernized system and its associated data repository.)

Table 1. VA Medical Information Systems

System name		Description
Legacy systems		
VistA	Veterans Health Information Systems and Technology Architecture	Existing integrated health information system.
Modernized system and repository		
HealtheVet VistA		Modernized health information system based on computable data.
HDR	Health Data Repository	Data repository associated with modernized system.

Source: GAO analysis of VA data.

In contrast, DOD has multiple medical information systems (see table 2). DOD's various systems are not integrated, and its 138 sites do not necessarily communicate with each other. In addition, not all of DOD's medical information is electronic: some records are paper-based.

Table 2. Selected DOD Medical Information Systems

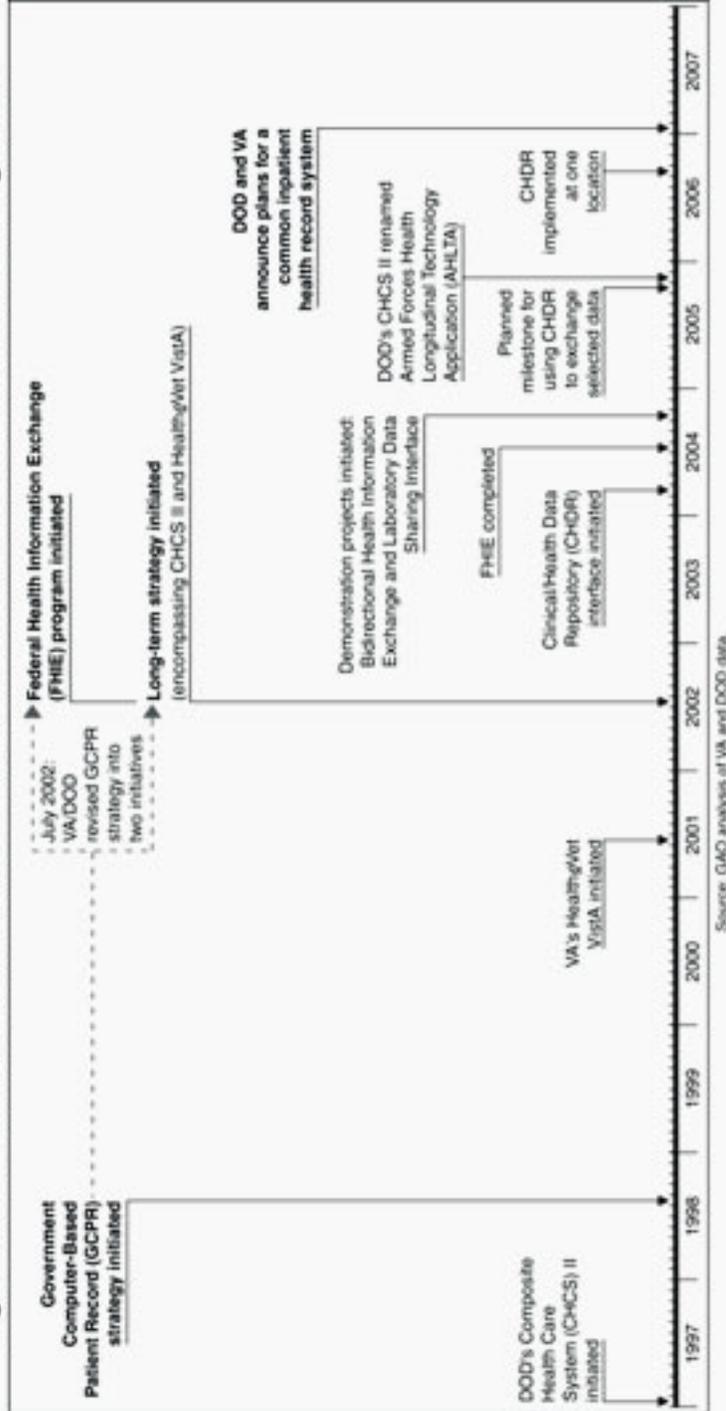
System name		Description
Legacy systems		
CHCS	Composite Health Care System	Primary existing DOD health information system.
CIS	Clinical Information System	Commercial health information system customized for DOD; used by some DOD facilities for inpatients.
ICDB	Integrated Clinical Database	Health information system used by many Air Force facilities.
TMDS	Theater Medical Data Store	Database to collect electronic medical information in combat theater for both outpatient care and serious injuries.
JPTA	Joint Patient Tracking Application	Web-based application primarily used to track the movement of patients as they are transferred from location to location, but may include text-based medical information.
Modernized system and repository		
AHLTA	Armed Forces Health Longitudinal Technology Application ^a	Modernized health information system, integrated and based on computable data.
CDR	Clinical Data Repository	Data repository associated with modernized system.

Source: GAO analysis of DOD data.

^aFormerly CHCS II.

⁵A site represents one or more facilities—medical centers, hospitals, or outpatient clinics—that store their electronic health data in a single database.

Figure 1: Timeline of Selected VA/DoD Electronic Medical Records and Data Sharing Efforts



VA and DOD Have Been Working to Exchange Health Information Since 1998

For almost a decade, VA and DOD have been pursuing ways to share data in their health information systems and create comprehensive electronic records.⁶ However, the departments have faced considerable challenges, leading to repeated changes in the focus of their initiatives and target dates for accomplishment.

As shown in figure 1, the departments' efforts have involved a number of distinct initiatives, both long-term initiatives to develop future modernized solutions, and short-term initiatives to respond to more immediate needs to share information in existing systems. As the figure shows, these initiatives often proceeded in parallel.

The departments' first initiative, known as the Government Computer-Based Patient Record (GCPR) project, aimed to develop an electronic interface that would let physicians and other authorized users at VA and DOD health facilities access data from each other's health information systems. The interface was expected to compile requested patient information in a virtual record (that is, electronic as opposed to paper) that could be displayed on a user's computer screen.

In 2001 and 2002, we reviewed the GCPR project and noted disappointing progress, exacerbated in large part by inadequate accountability and poor planning and oversight, which raised doubts about the departments' ability to achieve a virtual medical record. We determined that the lack of a lead entity, clear mission, and detailed planning to achieve that mission made it difficult to monitor progress, identify project risks, and develop appropriate contingency plans.⁷ We made recommendations in both years that the departments enhance the project's overall management and accountability. In particular, we recommended that the departments designate a lead entity and a clear line of authority for the project; create comprehensive and coordinated plans that include an agreed-upon mission and clear goals, objectives, and performance measures; revise the project's original goals and objectives to align with the current strategy; commit the executive support necessary to adequately manage the project; and ensure that it followed sound project management principles.

In response, the two departments revised their strategy in July 2002, refocusing the project and dividing it into two initiatives. A short-term initiative (the Federal Health Information Exchange or FHIE) was to enable DOD, when servicemembers left the military, to electronically transfer their health information to VA. VA was designated as the lead entity for implementing FHIE, which was successfully completed in 2004. A longer term initiative was to develop a common health information architecture that would allow the two-way exchange of health information. The common architecture is to include standardized, computable data, communications, security, and high-performance health information systems (these systems, DOD's CHCS II and VA's HealtheVet VistA, were already in development, as shown in the figure).⁸ The departments' modernized systems are to store information (in standardized, computable form) in separate data repositories: DOD's Clinical Data Repository (CDR) and VA's Health Data Repository (HDR). The two repositories are to exchange information through an interface named CHDR.⁹

In March 2004, the departments began to develop the CHDR interface, and they planned to begin implementation by October 2005.¹⁰ However, implementation of the first release of the interface (at one site) occurred in September 2006, almost a year later. In a review in June 2004, we identified a number of management weaknesses that could have contributed to this delay¹¹ and made a number of recommendations, including creation of a comprehensive and coordinated project man-

⁶Initially, the Indian Health Service (IHS) was also a party to this effort, having been included because of its population-based research expertise and its longstanding relationship with VA. However, IHS was not included in a later revised strategy for electronically sharing patient health information.

⁷GAO, *Veterans Affairs: Sustained Management Attention Is Key to Achieving Information Technology Results*, GAO-02-703 (Washington, D.C.: June 12, 2002) and *Computer-Based Patient Records: Better Planning and Oversight by VA, DOD, and IHS Would Enhance Health Data Sharing*, GAO-01-459 (Washington, D.C.: Apr. 30, 2001).

⁸DOD's existing Composite Health Care System (CHCS) was being modernized as CHCS II, now renamed AHLTA (Armed Forces Health Longitudinal Technology Application). VA's existing VistA system was being modernized as HealtheVet VistA.

⁹The name CHDR, pronounced "cheddar," combines the names of the two repositories.

¹⁰December 2004 VA and DOD Joint Strategic Plan.

¹¹GAO, *Computer-Based Patient Records: VA and DOD Efforts to Exchange Health Data Could Benefit from Improved Planning and Project Management*, GAO-04-687 (Washington, D.C.: June 7, 2004).

agement plan. In response, the departments agreed to our recommendations and improved the management of the CHDR program by designating a lead entity with final decisionmaking authority and establishing a project management structure. As we noted in later testimony, however, the program did not develop a project management plan that would give a detailed description of the technical and managerial processes necessary to satisfy project requirements (including a work breakdown structure and schedule for all development, testing, and implementation tasks), as we had recommended.¹²

In October 2004, the two departments established two more short-term initiatives in response to a congressional mandate.¹³ These were two demonstration projects: the Laboratory Data Sharing Interface, aimed at allowing VA and DOD facilities to share laboratory resources, and the Bidirectional Health Information Exchange (BHIE), aimed at allowing both departments' clinicians access to records on shared patients (that is, those who receive care from both departments).¹⁴ As demonstration projects, both initiatives were limited in scope, with the intention of providing interim solutions to the departments' need for more immediate health information sharing. However, because BHIE provided access to up-to-date information, the departments' clinicians expressed strong interest in increasing its use. As a result, the departments began planning to broaden BHIE's capabilities and expand its implementation considerably. Until the departments' modernized systems are fully developed and implemented, extending BHIE connectivity could provide each department with access to most data in the other's legacy systems. According to a VA/DOD annual report¹⁵ and program officials, the departments now consider BHIE an interim step in their overall strategy to create a two-way exchange of electronic medical records.

Most recently, the departments have announced a further change to their information-sharing strategy. In January 2007, they announced their intention to jointly develop a new inpatient medical record system. According to the departments, adopting this joint solution will facilitate the seamless transition of active-duty servicemembers to veteran status, as well as making inpatient healthcare data on shared patients immediately accessible to both DOD and VA. In addition, the departments consider that a joint development effort could allow them to realize significant cost savings. We have not evaluated the departments' plans or strategy in this area.

Others Have Recommended Strengthening the Management and Planning of the Departments' Health Information Initiatives

Throughout the history of these initiatives, evaluations beyond ours have also found deficiencies in the departments' efforts, especially with regard to the need for comprehensive planning. For example, in fiscal year 2006, the Congress did not provide all the funding requested for HealthVet Vista because it did not consider that the funding had been adequately justified. In addition, a recent Presidential task force identified the need for VA and DOD to improve their long-term planning.¹⁶ This task force, reporting on gaps in services provided to returning veterans, noted problems with regard to sharing information on wounded servicemembers, including the inability of VA providers to access paper DOD inpatient health records. According to the report, although significant progress has been made on sharing electronic information, more needs to be done. The task force recommended that VA and DOD continue to identify long-term initiatives and define scope and elements of a joint inpatient electronic health record.

¹²GAO, *Computer-Based Patient Records: VA and DOD Made Progress, but Much Work Remains to Fully Share Medical Information*, GAO-05-1051T (Washington, D.C.: Sept. 28, 2005) and *Information Technology: VA and DOD Face Challenges in Completing Key Efforts*, GAO-06-905T (Washington, D.C.: June 22, 2006).

¹³The Bob Stump National Defense Authorization Act for Fiscal Year 2003 (Pub. L. 107-314, 2002) mandated that the departments conduct demonstration projects to test the feasibility, advantages, and disadvantages of measures and programs designed to improve the sharing and coordination of healthcare and healthcare resources between the departments.

¹⁴To create BHIE, the departments drew on the architecture and framework of the information transfer system established by the FHIE project. Unlike FHIE, which provides a one-way transfer of information to VA when a servicemember separates from the military, the two-way system allows clinicians in both departments to view, in real time, limited health data (in text form) from the departments' current health information systems.

¹⁵December 2004 VA and DOD Joint Strategic Plan.

¹⁶Task Force on Returning Global War on Terror Heroes, *Report to the President* (Apr. 19, 2007).

VA and DOD Are Exchanging Limited Medical Information, but Much Work Remains to Achieve Seamless Sharing

VA and DOD have made progress in both their long-term and short-term initiatives to share health information. In the long-term project to develop modernized health information systems, the departments have begun to implement the first release of the interface between their modernized data repositories, among other things. The two departments have also made progress in their short-term projects to share information in existing systems, having completed two initiatives and making important progress on another. In addition, the two departments have undertaken ad hoc activities to accelerate the transmission of health information on severely wounded patients from DOD to VA's four polytrauma centers. However, despite the progress made and the sharing achieved, the tasks remaining to achieve the goal of a shared electronic medical record remain substantial.

VA and DOD Have Begun Deployment of a Modernized Data Interface

In their long-term effort to share health information, VA and DOD have completed the development of their modernized data repositories, agreed on standards for various types of data, and begun to populate the repositories with these data.¹⁷ In addition, they have now implemented the first release of the CHDR interface, which links the two departments' repositories, at seven sites. The first release has enabled the seven sites to share limited medical information: specifically, computable outpatient pharmacy and drug allergy information for shared patients.

According to DOD officials, in the third quarter of 2007 the department will send out instructions to its remaining sites so that they can all begin using CHDR. According to VA officials, the interface will be available across the department when necessary software updates are released, which is expected this July.¹⁸

Besides being a milestone in the development of the departments' modernized systems, the interface implementation provides benefits to the departments' current systems. Data transmitted by CHDR are permanently stored in the modernized data repositories, CDR and HDR. Once in the repositories, these computable data can be used by DOD and VA at all sites through their existing systems. CHDR also provides terminology mediation (translation of one agency's terminology into the other's). VA and DOD plans call for developing the capability to exchange computable laboratory results data through CHDR during fiscal year 2008.

Although implementing this interface is an important accomplishment, the departments are still a long way from completion of the modernized health information systems and comprehensive longitudinal health records. While DOD and VA had originally projected completion dates for their modernized systems of 2011 and 2012, respectively, department officials told us that there is currently no scheduled completion date for either system. Further, both departments have still to identify the next types of data to be stored in the repositories. The two departments will then have to populate the repositories with the standardized data, which involves different tasks for each department. Specifically, although VA's medical records are already electronic, it still has to convert these into the interoperable format appropriate for its repository. DOD, in addition to converting current records from its multiple systems, must also address medical records that are not automated. As pointed out by a recent Army Inspector General's report, some DOD facilities are having problems with hard-copy records.¹⁹ In the same report, inaccurate and incomplete health data were identified as a problem to be addressed. Before the departments can achieve the long-term goal of seamless sharing of medical information, all these tasks and challenges will have to be addressed. Consequently, it is essential for the departments to develop a comprehensive project plan to guide these efforts to completion, as we have previously recommended.

VA and DOD Are Exchanging Limited Health Information through Short-Term Projects

In addition to the long-term effort described above, the two departments have made some progress in meeting immediate needs to share information in their respective legacy systems by setting up short-term projects, as mentioned earlier, which are in various stages of completion. In addition, the departments have set up

¹⁷DOD has populated CDR with information for outpatient encounters, drug allergies, and order entries and results for outpatient pharmacy/lab orders. VA has populated HDR with patient demographics, vital signs records, allergy data, and outpatient pharmacy data; this summer, the department plans to include chemistry and hematology laboratory data.

¹⁸The Remote Data Interoperability software upgrade provides the capability for the automated checks and alerts allowed by computable data.

¹⁹Inspector General, Army, *Army Physical Disability Evaluation System Inspection* (March 2007).

special processes to transfer data from DOD facilities to VA's polytrauma centers, which treat traumatic brain injuries and other especially severe injuries.

One-Way Transfer Capability Is Operational

DOD has been using FHIE to transfer information to VA since 2002. According to department officials, over 184 million clinical messages on more than 3.8 million veterans have been transferred to the FHIE data repository as of March 2007. Data elements transferred are laboratory results, radiology results, outpatient pharmacy data, allergy information, consultation reports, elements of the standard ambulatory data record, and demographic data. Further, since July 2005, FHIE has been used to transfer pre- and post-deployment health assessment and reassessment data; as of March 2007, VA has access to data for more than 681,000 separated servicemembers and demobilized Reserve and National Guard members who had been deployed. Transfers are done in batches once a month, or weekly for veterans who have been referred to VA treatment facilities.

According to a joint DOD/VA report,²⁰ FHIE has made a significant contribution to the delivery and continuity of care of separated servicemembers as they transition to veteran status, as well as to the adjudication of disability claims.

Laboratory Interface Initiative Allows VA and DOD to Share Lab Resources

One of the departments' demonstration projects, the Laboratory Data Sharing Interface (LDSI), is now fully operational and is deployed when local agencies have a business case for its use and sign an agreement. It requires customization for each locality and is currently deployed at nine locations. LDSI currently supports a variety of chemistry and hematology tests, and work is under way to include microbiology and anatomic pathology.

Once LDSI is implemented at a facility, the only nonautomated action needed for a laboratory test is transporting the specimens. If a test is not performed at a VA or DOD doctor's home facility, the doctor can order the test, the order is transmitted electronically to the appropriate lab (the other department's facility or in some cases a local commercial lab), and the results are returned electronically.

Among the benefits of LDSI, according to VA and DOD, are increased speed in receiving laboratory results and decreased errors from manual entry of orders. The LDSI project manager in San Antonio stated that another benefit of the project is the time saved by eliminating the need to rekey orders at processing labs to input the information into the laboratories' systems. Additionally, the San Antonio VA facility no longer has to contract out some of its laboratory work to private companies, but instead uses the DOD laboratory.

Two-Way Interface Allows Real-Time Viewing of Text Information

Developed under a second demonstration project, the BHIE interface is now available throughout VA and partially deployed at DOD. It is currently deployed at 25 DOD sites, providing access to 15 medical centers, 18 hospitals, and over 190 outpatient clinics associated with these sites. DOD plans to make current BHIE capabilities available departmentwide by June 2007.

The interface permits a medical care provider to query patient data from all VA sites and any DOD site where it is installed and to view that data onscreen almost immediately. It not only allows DOD and VA to view each other's information, it also allows DOD sites to see previously inaccessible data at other DOD sites.

As initially developed, the BHIE interface provides access to information in VA's VistA and DOD's CHCS, but it is currently being expanded to query data in other DOD databases (in addition to CHCS). In particular, DOD has developed an interface to the Clinical Information System (CIS), an inpatient system used by many DOD facilities, which will provide bidirectional views of discharge summaries. The BHIE-CIS interface is currently deployed at five DOD sites and planned for eight others. Further, interfaces to two additional systems are planned for June and July 2007: An interface to DOD's modernized data repository, CDR, will give access to outpatient data from combat theaters. An interface to another DOD database, the Theater Medical Data Store, will give access to inpatient information from combat theaters.

The departments also plan to make more data elements available. Currently, BHIE enables text-only viewing of patient identification, outpatient pharmacy, microbiology, cytology, radiology, laboratory orders, and allergy data from its interface with DOD's CHCS. Where it interfaces with CIS, it also allows viewing of discharge summaries from VA and the five DOD sites. DOD staff told us that in early fiscal year 2008, they plan to add provider notes, procedures, and problem lists.

²⁰December 2004 VA and DOD Joint Strategic Plan.

Later in fiscal year 2008, they plan to add vital signs, scanned images and documents, family history, social history, and other history questionnaires. In addition, at the VA/DOD site in El Paso, a trial is under way of a process for exchanging radiological images using the BHIE/FHIE infrastructure.²¹ Some images have successfully been exchanged.

Through their efforts on these long- and near-term initiatives, VA and DOD are achieving exchanges of various types of health information (see attachment 1 for a summary of all the types of data currently being shared and those planned for the future, as well as cost data on the initiatives). However, these exchanges are as yet limited, and significant work remains to be done to expand the data shared and integrate the various initiatives.

Special Procedures Provide Information to VA Polytrauma Centers

In addition to the information technology initiatives described, DOD and VA have set up special activities to transfer medical information to VA's four polytrauma centers, which are treating active-duty servicemembers severely wounded in combat.²² Polytrauma centers care for veterans and returning servicemembers with injuries to more than one physical region or organ system, one of which may be life threatening, and which results in physical, cognitive, psychological, or psychosocial impairments and functional disability. Some examples of polytrauma include traumatic brain injury (TBI), amputations, and loss of hearing or vision.

When servicemembers are seriously injured in a combat theater overseas, they are first treated locally. They are then generally evacuated to Landstuhl Medical Center in Germany, after which they are transferred to a military treatment facility in the United States, usually Walter Reed Army Medical Center in Washington, D.C.; the National Naval Medical Center in Bethesda, Maryland; or Brooke Army Medical Center, at Fort Sam Houston, Texas. From these facilities, servicemembers suffering from polytrauma may be transferred to one of VA's four polytrauma centers for treatment.²³

At each of these locations, the injured servicemembers will accumulate medical records, in addition to medical records already in existence before they were injured. However, the DOD medical information is currently collected in many different systems and is not easily accessible to VA polytrauma centers. Specifically:

1. In the combat theater, electronic medical information may be collected for a variety of reasons, including routine outpatient care, as well as serious injuries. These data are stored in the Theater Medical Data Store, which can be accessed by unit commanders and others. (As mentioned earlier, the departments have plans to develop a BHIE interface to this system by July 2007. Until then, VA cannot access these data.) In addition, both inpatient and outpatient medical data for patients who are evacuated are entered into the Joint Patient Tracking Application. (A few VA polytrauma center staff have been given access to this application.)
2. At Landstuhl, inpatient medical records are paper-based (except for discharge summaries). The paper records are sent with a patient as the individual is transferred for treatment in the United States. At the DOD treatment facility (Walter Reed, Bethesda, or Brooke), additional information will be recorded in CIS and CHCS/CDR.²⁴

When servicemembers are transferred to a VA polytrauma center, VA and DOD have several ad hoc processes in place to electronically transfer the patients' medical information:

- DOD has set up secure links to enable a limited number of clinicians at the polytrauma centers to log directly into CIS at Walter Reed and Bethesda Naval Hospital to access patient data.
- Staff at Walter Reed collect paper records, print records from CIS, scan all these, and transmit the scanned data to three of the four polytrauma centers. DOD staff said that they are working on establishing this capability at the

²¹To create BHIE, the departments drew on the architecture and framework of the information transfer system established by the FHIE project.

²²In particular, clinicians required access to discharge notices, which describe the treatment given at previous medical facilities and the status of patients when they left those facilities.

²³The four Polytrauma Rehabilitation Centers are in Richmond, Tampa, Minneapolis, and Palo Alto.

²⁴Pharmacy and drug information would be stored in CDR; other health information continues to be stored in local CHCS databases.

Brooke and Bethesda medical centers, as well as the fourth VA polytrauma center. According to VA staff, although the initiative began several months ago, it has only recently begun running smoothly as the contractor became more skilled at assembling the records. DOD staff also pointed out that this laborious process is feasible only because the number of polytrauma patients is small (about 350 in all to date); it would not be practical on a large scale.

- Staff at Walter Reed and Bethesda are transmitting radiology images electronically to three polytrauma centers. (A fourth has this capability, but at this time no radiology images have been transferred there.) Access to radiology images is a high priority for polytrauma center doctors, but like scanning paper records, transmitting these images requires manual intervention: when each image is received at VA, it must be individually uploaded to VistA's imagery viewing capability. This process would not be practical for large volumes of images.
- VA has access to outpatient data (via BHIE) from 25 military hospitals, including Landstuhl.

Although these various efforts to transfer medical information on seriously wounded patients are working, and the departments are to be commended on their efforts, the multiple processes and laborious manual tasks illustrate the effects of the lack of integrated health information systems and the difficulties of exchanging information in their absence.

In conclusion, through the long- and short-term initiatives described, as well as efforts such as those at the polytrauma centers, VA and DOD are achieving exchanges of health information. However, these exchanges are as yet limited, and significant work remains to be done to fully achieve the goal of exchanging interoperable, computable data, including agreeing to standards for the remaining categories of medical information, populating the data repositories with all this information, completing the development of HealthVet VistA and AHLTA, and transitioning from the legacy systems. To complete these tasks, a detailed project management plan continue to be of vital importance to the ultimate success of the effort to develop a lifelong virtual medical record. We have previously recommended that the departments develop a clearly defined project management plan that describes the technical and managerial processes necessary to satisfy project requirements, including a work breakdown structure and schedule for all development, testing, and implementation tasks. Without a plan of sufficient detail, VA and DOD increase the risk that the long-time project will not deliver the planned capabilities in the time and at the cost expected. Further, it is not clear how all the initiatives we have described today are to be incorporated into an overall strategy toward achieving the departments' goal of comprehensive, seamless exchange of health information.

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

Contacts and Acknowledgments

If you have any questions concerning this testimony, please contact Valerie C. Melvin, Director, Human Capital and Management Information Systems Issues, at (202) 512-6304 or melvinv@gao.gov. Other individuals who made key contributions to this testimony include Barbara Oliver, Assistant Director; Barbara Collier; and Glenn Spiegel.

Attachment 1: Supplementary Tables

Types of Data Shared by DOD and VA Are Growing but Remain Limited

Table 3 summarizes the types of health data currently shared through the long- and near-term initiatives we have described, as well as types of data that are currently planned for addition. While this gives some indication of the scale of the tasks involved in sharing medical information, it does not depict the full extent of information that is currently being captured in health information systems and that remains to be addressed.

Table 3. Data Elements Made Available and Planned by DOD-VA Initiatives

Initiative	Data Elements		Comments
	Available	Planned	
CHDR	Outpatient pharmacy Drug allergy	Laboratory data	Computable data are exchanged between one department's data repository and the other's.
FHIE	Patient demographics Laboratory results Radiology reports Outpatient pharmacy information Admission discharge transfer data Discharge summaries Consult reports Allergies Data from the DOD Standard Ambulatory Data Record Pre- and post-deployment assessments	None	One-way batch transfer of text data from DOD to VA occurs weekly if discharged patient has been referred to VA for treatment; otherwise monthly.
LDSI	Laboratory orders Laboratory results (chemistry and hematology only)	Microbiology Anatomic pathology	Noncomputable text data are transferred.
BHIE	Outpatient pharmacy data Drug & food allergy information Surgical pathology reports Microbiology results Cytology reports Chemistry & hematology reports Laboratory orders Radiology text reports Inpatient discharge summaries and/or emergency room notes from CIS at five DOD and all VA sites	Provider notes Procedures Problem lists Vital signs Scanned images and documents Family history Social history Other history questionnaires Radiology images	Data are not transferred but can be viewed.

Source: GAO analysis of VA and DOD data.

Reported Costs

Table 4 shows costs expended on these information sharing initiatives since their inception.

Table 4. Costs of DOD and VA Initiatives Since Inception

Project	VA Expenditure	DOD Expenditure
HealtheVet VistA	\$514 million through FY 2005	—
AHLTA	—	\$755 million through FY 2006 (estimated)
Joint initiatives:		
CHDR	5.3 million	DOD does not account for these projects separately.
FHIE	62.4 million	
LDSI	1.5 million	
BHIE	7.0 million	
Total	\$76.2 million	\$72.6 million through FY 2006

Source: GAO analysis of DOD and VA data.

Related GAO Products

Computer-Based Patient Records: Better Planning and Oversight by VA, DOD, and IHS Would Enhance Health Data Sharing. GAO-01-459. Washington, D.C.: April 30, 2001.

Veterans Affairs: Sustained Management Attention Is Key to Achieving Information Technology Results. GAO-02-703. Washington, D.C.: June 12, 2002.

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. GAO-04-271T. Washington, D.C.: November 19, 2003.

Computer-Based Patient Records: Sound Planning and Project Management Are Needed to Achieve a Two-Way Exchange of VA and DOD Health Data. GAO-04-402T. Washington, D.C.: March 17, 2004.

Computer-Based Patient Records: VA and DOD Efforts to Exchange Health Data Could Benefit from Improved Planning and Project Management. GAO-04-687. Washington, D.C.: June 7, 2004.

Computer-Based Patient Records: VA and DOD Made Progress, but Much Work Remains to Fully Share Medical Information. GAO-05-1051T. Washington, D.C.: September 28, 2005.

Information Technology: VA and DOD Face Challenges in Completing Key Efforts. GAO-06-905T. Washington, D.C.: June 22, 2006.

DOD and VA Exchange of Computable Pharmacy Data. GAO-07-554R. Washington, D.C.: April 30, 2007.

GAO HIGHLIGHTS

INFORMATION TECHNOLOGY—VA and DOD Are Making Progress In Sharing Medical Information, But are Far From Comprehensive Electronic Medical Records

Why GAO Did This Study

The Department of Veterans Affairs (VA) and the Department of Defense (DOD) are engaged in ongoing efforts to share medical information, which is important in helping to ensure high-quality healthcare for active-duty military personnel and veterans. These efforts include a long-term program to develop modernized health information systems based on computable data: that is, data in a format that a computer application can act on—for example, to provide alerts to clinicians of drug allergies. In addition, the departments are engaged in near-term initiatives involving existing systems.

GAO was asked to testify on the history and current status of these long- and near-term efforts to share health information.

To develop this testimony, GAO reviewed its previous work, analyzed documents, and interviewed VA and DOD officials about current status and future plans.

What GAO Recommends

GAO has previously made several recommendations on these topics, including that VA and DOD develop a detailed project management plan to guide their efforts to share patient health data. The departments agreed with these recommendations.

What GAO Found

For almost a decade, VA and DOD have been pursuing ways to share health information and create comprehensive electronic medical records. However, they have faced considerable challenges in these efforts, leading to repeated changes in the focus of their initiatives and target dates. Currently, the two departments are pursuing both long- and short-term initiatives to share health information. Under their long-term initiative, the modern health information systems being developed by each department are to share standardized computable data through an interface between data repositories associated with each system. The repositories have now been developed, and the departments have begun to populate them with limited types of health information. In addition, the interface between the repositories has been implemented at seven VA and DOD sites, allowing computable outpatient pharmacy and drug allergy data to be exchanged. Implementing this interface is a milestone toward the departments' long-term goal, but more remains to be done. Besides extending the current capability throughout VA and DOD, the departments must still agree to standards for the remaining categories of medical information, populate the data repositories with this information, complete the development of the two modernized health information systems, and transition from their existing systems. While pursuing their long-term effort to develop modernized systems, the

two departments have also been working to share information in their existing systems. Among various near-term initiatives are a completed effort to allow the one-way transfer of health information from DOD to VA when servicemembers leave the military, as well as ongoing demonstration projects to exchange limited data at selected sites. One of these projects, building on the one-way transfer capability, developed an interface between certain existing systems that allows a two-way view of current data on patients receiving care from both departments. VA and DOD are now working to link other systems via this interface and extend its capabilities. The departments have also established ad hoc processes to meet the immediate need to provide data on severely wounded servicemembers to VA's polytrauma centers, which specialize in treating such patients. These processes include manual workarounds (such as scanning paper records) that are generally feasible only because the number of polytrauma patients is small. These multiple initiatives and ad hoc processes highlight the need for continued efforts to integrate information systems and automate information exchange. In addition, it is not clear how all the initiatives are to be incorporated into an overall strategy focused on achieving the departments' goal of comprehensive, seamless exchange of health information.

**Statement of Gerald M. Cross, M.D., FAAFP,
Acting Principal Deputy Under Secretary for Health,
Veterans Health Administration, U.S. Department of Veterans Affairs**

Good morning, Mr. Chairman and Members of the Subcommittee. I am pleased to discuss sharing electronic medical records between the Department of Defense (DoD) and the Department of Veterans Affairs (VA) and the significant progress VA has made toward the development of a secure, interoperable and bidirectional electronic health data sharing with DoD.

Overview

This progress includes the development of one way and bidirectional data exchanges to support servicemembers who are separated and retired from active duty service. In addition, the data exchanges support active duty servicemembers and veterans who receive care from both VA and DoD healthcare facilities. VA's achievements in the area of electronic health data sharing with DoD directly support the efforts to seamlessly transition our service men and women as they move from DoD facilities to VA facilities and Centers of Excellence to continue their care and rehabilitation. Striving to provide world class healthcare to the wounded warriors returning from Iraq and Afghanistan remains one of VA's top priorities.

In March 2007, VA added a personal touch to seamless transition by creating 100 new Transition Patient Advocates (TPA). They are dedicated to assisting our most severely injured veterans and their families. The TPA's job is to ensure a smooth transition to VA healthcare facilities throughout the nation and cut through red tape for other VA benefits. Recruitment to fill the TPA positions began in March, and to date VA medical centers have hired 46 TPAs. Interviews are being conducted to fill the remaining 54 positions. Until these positions are filled, each medical center with a vacant TPA position has detailed an employee to perform that function. We believe these new patient advocates will help VA assure that no severely injured Iraq or Afghanistan veteran falls through the cracks. VA will continue to adapt its healthcare system to meet the unique medical issues facing our newest generation of combat veterans while locating services closer to their homes. DoD and VA sharing electronic medical records facilitate this process.

It should be noted that sharing electronic medical records between DoD and VA is a longstanding issue, which has been the subject of several GAO reviews. Developing an electronic interface to exchange computable data between disparate systems is a highly complex undertaking. Let me assure the Committee that VA is fully committed to ongoing collaboration with DoD and the development of interoperable electronic health records. While significant and demonstrable progress has been made in our pilots with DoD, work remains to bring this commitment to systemwide fruition. VA is always mindful of the debt our Nation owes to its veterans, and our healthcare system is designed to fulfill that debt. To that end VA is committed to seeing through the successful development of interoperable electronic health records.

As part of our commitment to being veteran centric, we recently deployed the Veterans Tracking Application (VTA). It brings data from three sources, DoD, the Veterans Health Administration (VHA) and the Veterans Benefits Administration (VBA) together for display on one platform creating the beginning of a truly veteran-centric patient tracking record.

Active Joint Governance

VA and DoD maintain an active joint governance structure at the highest levels of each department. This joint governance ensures ongoing collaboration and commitment to advance the further development of interoperable electronic health records. The records will be bidirectional, seamless, and available to support the care of our beneficiaries wherever and whenever treatment is sought.

The DoD/VA Joint Executive Council (JEC), co-chaired by the VA Deputy Secretary and the DoD Under Secretary of Defense for Personnel and Readiness, continues its ongoing active executive oversight of collaborative activities, including health data sharing initiatives. VA and DoD have documented a Joint Strategic Plan (JSP) that is maintained by the JEC. The JSP contains the strategic goals, objectives and milestones for VA/DoD collaboration, including VA and DoD health data sharing activities. Under the leadership of the JEC, VA and DoD realized significant success in meeting JSP health data sharing milestones.

VA and DoD also chartered the DoD/VA Health Executive Council (HEC), co-chaired by VA's Under Secretary for Health and the DoD Assistant Secretary of Defense for Health Affairs. The HEC serves to ensure full cooperation and coordination for optimal health delivery to our veterans and military beneficiaries. Through the HEC Information Management and Information Technology Work Group, co-chaired by the VHA Chief Officer, Health Information Technology Systems and the MHS Chief Information Officer HEC maintain management responsibility for the implementation of electronic health data sharing activities. These data sharing activities are largely governed by the DoD/VA Joint Electronic Health Records Interoperability (JEHRI) Plan, approved in 2002, which serves as the overarching strategy around which these data sharing activities are managed.

Supporting Separated Servicemembers and Shared Patients

VA and DoD began JEHRI implementation by developing the capability to support the one-way and bidirectional transmission of all clinically pertinent electronic health data between DoD's system, the Composite Health Information System (CHCS) and VA's medical record, VistA Computerized Patient Record System. These initial data exchanges permitted VA clinicians and claims staff to access data on separated and retired servicemembers coming to VA for medical care and disability benefits. This exchange allows VA and DoD clinicians to share data on patients who receive care from both systems. These initial data exchange initiatives remain an integral component of the ongoing partnership with DoD to share health data.

To date, DoD transferred electronic health data on almost 3.8 million unique separated servicemembers to VA. Of these individuals, VA provided care or benefits to more than 2.2 million veterans. On separated servicemembers, DoD is providing VA with outpatient pharmacy data, allergy information, laboratory results, consults, admission, disposition and transfer information, medical diagnostic coding data, and military pre- and post-deployment health assessment and reassessment data. Since mid 2006, when DoD first began transferring pre- and post-deployment health assessment and post deployment health reassessment data to VA, DoD made approximately 1.6 million of these forms available for viewing by VHA clinicians and VBA staff.

VA and DoD are bidirectionally exchanging electronic medical data that are viewable and computable on shared patients. In 2004, VA achieved the ability to match patient identities for active DoD military servicemembers and their dependents with their electronic medical records at VA facilities, and deliver care to these patients whether they present for care at VA or DoD facilities. Currently, VA and DoD are bidirectionally sharing viewable outpatient pharmacy data, anatomic pathology/surgical reports, cytology results, microbiology results, chemistry and hematology laboratory results, laboratory order information, radiology text reports and food and drug allergy information.

There are a number of ongoing pilot programs that have developed into operational capabilities to share increased amounts and types of viewable data being exchanged between VA and DoD. After a successful pilot in El Paso, Texas, VA and DoD are now sharing digital images at this location. The same is true in the Puget Sound area, Hawaii and San Antonio, Texas where VA and DoD can now share narrative text documents, such as inpatient discharge summaries. VA successfully implemented bidirectional capability at every VA medical facility. Bidirectional Health Information Exchange data is now available to DoD from all of these facilities. DoD implemented the capability at 25 DoD host locations. This means VA is receiving these data from 15 DoD medical centers, 18 DoD hospitals and over 190 DoD outpatient clinics. These sites include the Walter Reed Army Medical Center and the Bethesda National Naval Medical Center, the Landstuhl Regional Medical Center in Germany and the Naval Medical Center, San Diego. VA is working closely with

DoD to increase the scope of data available between DoD and VA and to ensure the data are available from all DoD medical facilities. By June 2007, VA and DoD will be sharing data bidirectionally between all facilities. Throughout the remainder of the year and into 2008, the types of data shared bidirectionally will increase by adding domains such as progress notes and problem lists.

In 2006, VA and DoD began sharing bidirectional computable data on our active dual consumers of both healthcare systems. This capability is now deployed to seven locations where patients receive care from both VA and DoD facilities and allows the sharing of computable pharmacy and allergy data. As a result of this capability, VA providers benefit by having DoD prescription and allergy data instantly available to check for medication interactions or medication allergies on patients who are active dual consumers of both healthcare systems. VA is also working with DoD to share standardized computable laboratory data.

In addition to the one way and bidirectional exchange of electronic medical information, VA and DoD successfully developed a number of other applications that support information sharing and improve the way both Departments care for beneficiaries. For example, one of the joint software initiatives permits VA and DoD to serve as reference laboratories for one another at locations where VA and DoD use each other's facilities to order and conduct chemistry laboratory tests and results reporting. The software is operational at nine locations where VA and DoD provide laboratory support to one another.

Sharing Inpatient Data and Support for the Seriously Wounded

VA and DoD's earliest efforts focused on the sharing of outpatient data in support of transitioning servicemembers and shared beneficiaries receiving care from both systems. VA and DoD are now making significant progress toward the sharing of inpatient data and data from the theater of operations to support the wounded warriors coming to us for care. As is commonly understood, much of the DoD inpatient data exists on paper and is not available electronically. To ensure VA is fully supporting the most seriously ill and wounded servicemembers transferred to VA polytrauma facilities, VA social workers are embedded in designated military treatment facilities to ensure all pertinent inpatient records are copied and transferred with the patient.

In addition to ensuring the manual transfer of these inpatient and paper-based records, we are now able to support the automatic electronic transfer of inpatient data to VA clinicians who will treat these patients upon their arrival at VA facilities. VA successfully achieved the capability to electronically transfer DoD medical digital images and electronically scanned inpatient health records to the VA. This effort has been successfully piloted, between the Walter Reed Army Medical Center and three of the four Level 1 VA Polytrauma Centers located in Tampa, Richmond, and Palo Alto, California. We are working now to add the polytrauma center at Minneapolis to this pilot project, and anticipate this will be accomplished soon. VA is also working to add this capability from Bethesda national Naval Medical Center and Brooke Army Medical Center to the four VA polytrauma centers. The pilot project currently provides VA clinicians, who receive these combat veterans, with immediate access to critical components of their inpatient care at DoD military treatment facilities. In the future, VA hopes to add the capability to provide this data bidirectionally to support any patients returning to DoD for further care. VA and DoD also established direct connectivity between the inpatient electronic data systems at Walter Reed Army Medical Center and Bethesda national Naval Medical Center and clinicians at the four Level 1 VA Polytrauma Centers. These direct connections are secure and closely audited to ensure only authorized personnel at the VA facilities access the electronic military data on the Operation Enduring Freedom and Operation Iraqi Freedom servicemembers who are coming to or have transferred to the VA Polytrauma centers. VA and DoD are finalizing a long term strategy that will facilitate the expansion of this work across the enterprise in both departments.

Finally, VA and DoD have undertaken a groundbreaking challenge to collaborate on a common inpatient electronic health record. On January 24, 2007, the Secretaries of VA and DoD agreed to study the feasibility of a common inpatient electronic health record system. The initial phase of this work is expected to last between 6 and 12 months. VA and DoD are working to identify the requirements that will define the common VA/DoD inpatient electronic health record. The Departments are working closely to conduct the joint study and report findings. The analysis is currently scheduled to be completed in mid FY 2008. At the conclusion of the study, work to develop the common solution will immediately begin. A common inpatient electronic health record will support the transfer of our most seriously injured pa-

tients between DoD facilities and VA facilities as well as broad enterprise-level data sharing between VA and DoD clinicians for all shared patients.

Veterans Tracking Application

VA also recently deployed a new application with the ability to track servicemembers from the battlefield through Landstuhl, Germany, to Military Treatment Facilities (MTFs) in the states, and on to VA medical facilities. The new application, known as the Veterans Tracking Application (VTA), is a modified version of DoD's Joint Patient Tracking Application (JPTA)—a web-based patient tracking and management tool that collects, manages, and reports on patients arriving at MTFs from forward-deployed locations. VTA is completely compatible with JPTA allowing the electronic transfer of DoD tracking and medical data in JPTA on medically evacuated patients to VA on a daily basis.

The VTA, also a web-based system, allows approved VA users access to this near real-time case management information about servicemembers and the ability to track injured active duty servicemembers as they move through the medical evacuation and care system and transition to veteran status. This additional information directly from the battlefield assists VA in coordinating the transition of healthcare to VA facilities and in providing high quality healthcare in those VA facilities after the transfer has been completed. The application is also designed to track the benefit claims process and greatly enhances our benefits counselors' ability to assist the servicemember or veteran with his or her benefit claims. VHA implemented the new system on April 23, 2007 and deployment across VBA is underway. Our VA Liaisons stationed at ten MTFs now use this new tracking system to communicate transfers of care to the OEF and OIF points of contact and case managers at each VA Medical Center. In addition the system provides electronic access to clinical information from the point of injury in the combat theater assisting VA medical providers in providing ongoing healthcare services. VTA brings data from three sources, DoD, VHA and VBA together for display on one platform creating the beginning of a truly veteran centric record.

Collaboration on Standards

VA and DoD's work to develop interoperable data exchanges are closely aligned and dependent upon parallel developments in health data standards. These efforts are led by the Department of Health and Human Services (HHS) Office of the National Coordinator for Health Information Technology (ONC) through which VA and DoD are closely partnered. As standards and technologies mature, interoperability will increase. Efforts to ensure the seamless exchange of data between departments and eventually as part of a national infrastructure, is dependent upon the adoption and implementation of health data and communication standards.

VA and DoD played a significant leadership role in the work done pursuant to the Consolidated Health Informatics (CHI) initiative, one of the 24 e-gov initiatives that were previously identified on the President's Management Agenda. Our successful efforts on CHI, under the guidance of HHS, facilitated the informed and collaborative federal identification and adoption of health information standards across the government. Some of these CHI standards have since been incorporated into our data exchanges. These standards adoption activities, including CHI, have since been referred to the Health Information Technology Standards Panel for inclusion in the standards harmonization process, an activity informed by ONC and the American Health Information Community (AHIC). VA is an active AHIC participant and will continue to play a leading role in the national-level discussions on health data standards adoption and implementation.

VA previously gave Congressional testimony about our close collaboration with DoD and other partners on the Federal Health Architecture initiative, known as "FHA." FHA provides VA with a framework in which we can operate to support the President's goal to promote interoperable health technology to improve access to information and efficiency of care across settings. VA remains actively engaged in FHA activities and appreciates the opportunity to rally around a unified strategy that ultimately will support provision of care for all of our veterans, regardless of the private or public setting. VA strongly believes every veteran's health information should be available in a secure manner, with the veteran's permission, wherever that information is needed to provide seamless high quality healthcare to that veteran.

Conclusion

VA is fully committed to ongoing collaboration with DoD and the development of bidirectional interoperable electronic health records. VA also will continue to promote world-class health technologies to improve healthcare for veterans. As an example, VistA, the VA's electronic health record was awarded the Harvard University

Innovations in American Government Award in July 2006. VistA was the only electronic health record to receive this award and was singled out for its innovation and contribution to provision of high quality care. The President is monitoring our progress in this area. The Task Force on Returning Global War on Terror Heroes has made specific recommendations to the President that DoD and VA continue to improve and ensure timely electronic access by VA to DoD paper and electronic health records for servicemembers treated in VA facilities. The President has accepted these recommendations and directed Secretary Nicholson to report back to him on how these measures are being implemented. My colleagues and I are happy to answer any questions you or other Members of the Subcommittee might have.

VA/DoD Interoperability Acronyms

Healthcare Delivery Systems

AHLTA—Armed Forces Health Longitudinal Technology Application—DoD Next generation Electronic Record System—formerly CHCS II
CHCS—Composite Health Care System (DoD legacy system housing order entry/labs/radiology/allergy/meds, largely used for ambulatory care)
CIS—Clinical Information System (new name is Essentris Clinicomp—DoD's stand-alone inpatient system installed in most major military treatment facilities)
CPRS—Computerized Patient Record System
HealtheVet—Next generation of VistA based on computable data
JPTA—DoD's Joint Patient Tracking Application
VistA—Veterans Health Information Systems and Technology Architecture
VistA Web—The VistA web-based application for viewing remote data (VA and DoD)
VTA—Veterans Tracking Application

Other

TPA—Transition Patient Advocates

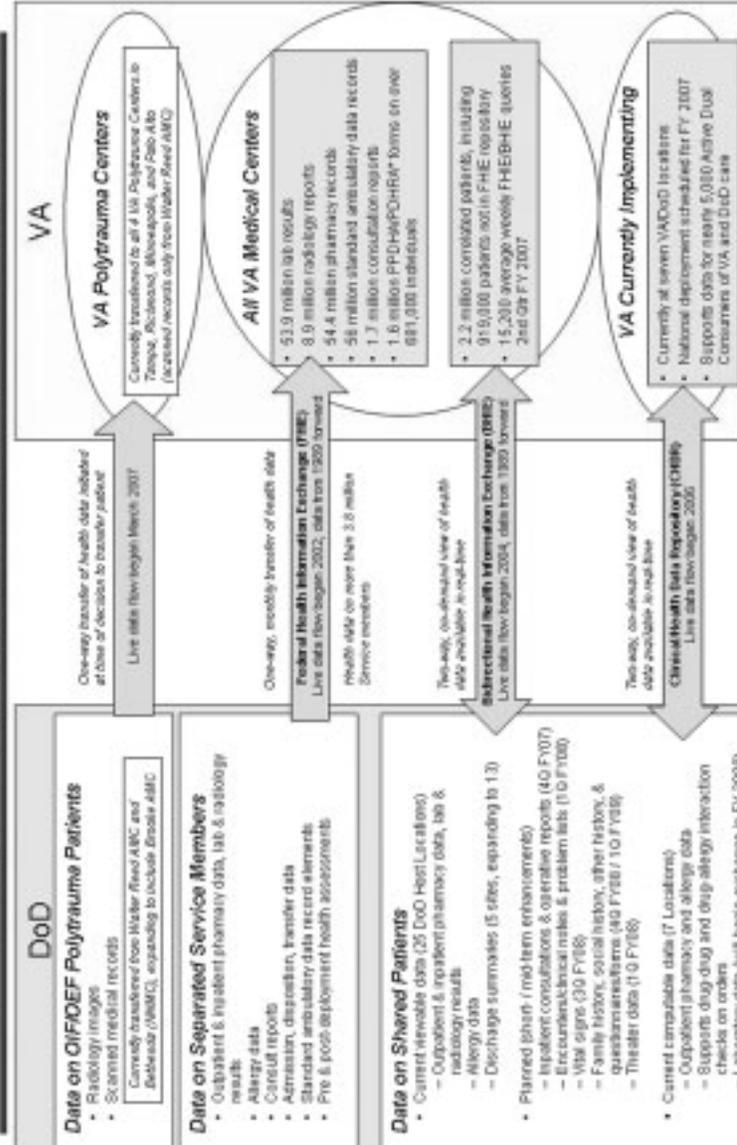
Healthcare Exchange Systems

BHIE—Bidirectional Health Information Exchange
CHDR—Clinical Data Repository/Health Data Repository (Interoperability Project)
FHIE—Federal Health Information Exchange (formerly GCPR)
LDSI—Laboratory Data Sharing & Interoperability
VPN—Virtual Private Network

Groups/Organizations/Plans

AHIC—American Health Information Community
CHI—Consolidated Health Informatics
HEC—DoD/VA Health Executive Council
JEC—DoD/VA Joint Executive Council
JEHRI—DoD/VA Joint Electronic Health Records Interoperability
JSP—Joint Strategic Plan
MTF—Military Treatment Facilities
ONCHIT—Office of the National Coordinator for Health Information Technology

DoDVA Health Information Sharing



**Prepared Statement of Stephen L. Jones, DHA,
Principal Deputy Assistant Secretary of Defense (Health Affairs),
U.S. Department of Defense**

INTRODUCTION

Mr. Chairman and Members of this distinguished Subcommittee, thank you for inviting me to be here today to discuss the sharing of electronic medical records between the Department of Defense (DoD) and Department of Veterans Affairs (VA).

DoD recognizes that the programs and benefits earned by veterans and service-members could not be delivered without the cooperation between DoD and the VA in the area of information sharing. While we are aware of the concerns regarding the time it has taken to establish the desired level of interoperability, I am pleased to tell you today of the many positive achievements we have made in sharing a significant amount of electronic health information between DoD and VA. I am also pleased to discuss with you the efforts we are taking to share more data.

TOP DoD AND VA PRIORITIES

Dr. Chu, Undersecretary of Defense for Personnel and Readiness, and Dr. Mansfield, Deputy Secretary for Veterans Affairs, recently identified the continuity of care for returning wounded warriors and the inpatient electronic health record project as two of their top priorities for DoD and VA sharing.

HISTORICAL OVERVIEW

DoD and VA have been sharing electronic health information since 2001 and we continue to enhance and expand our efforts. We recognize room for improvement remains. Nonetheless, we are leading the nation in health information technology, implementation of interoperability standards, and electronic health information sharing. By working together at the top levels of each Department, we have established effective policies for sharing. Under our joint governance process and VA/DoD Joint Strategic Plan (JSP) goals (which I will discuss later in my statement), we are collaborating in ways that enable each Department to address unique requirements as well as common requirements.

CURRENT ACTIVITIES

Continuity of Care for Shared Patients. Today for our shared patients, those treated at both VA and DoD facilities, VA and DoD providers are able to view data from the other Department. By the end of 2007, DoD and VA will share electronically many health record data elements identified in our VA/DoD Joint Strategic Plan for health information transfer. This means we will have largely established VA and DoD health record interoperability as agreed to in the JSP by the Departments' leadership. Specifically, at our fixed facilities we now share electronic health data elements for outpatient pharmacy data, laboratory and radiology results, allergy data, Pre- and Post-Deployment Health Assessments and Post-Deployment Health Reassessments for individuals referred to VA for care or evaluation. We also share electronically discharge summaries at 5 sites currently, but will expand to 13 DoD facilities with the greatest inpatient volume. Additionally, we have planned near-term enhancements to add encounters/clinical notes and problem lists, inpatient consultations and operative reports. In June, all DoD medical facilities will share electronic health information on shared patients with all VA facilities. In 2008, we will be sharing the remaining health record data elements identified in the VA/DoD Joint Strategic Plan including family history, social history, other history, and questionnaires/forms. At this point we will have achieved our current health information interoperability goals as defined in our JSP.

Continuity of Care for Shared Patients: Drug-drug and drug-allergy interaction checking

For our shared patients we also make outpatient pharmacy and drug allergy data available in real-time to allow drug-drug and drug-allergy interaction checking using data from both departments. This capability is operational in seven locations:

- William Beaumont Army Medical Center/El Paso VA Health Care System
- Eisenhower Army Medical Center/Augusta VA Medical Center
- Naval Hospital Pensacola/VA Gulf Coast Health Care System
- Madigan Army Medical Center/VA Puget Sound Health Care System
- Naval Health Clinic Great Lakes/North Chicago VA Medical Center
- Naval Hospital San Diego/VA San Diego Health Care System

- Mike O'Callaghan Federal Hospital and VA Southern Nevada Health Care System

All 65 DoD hospitals and 412 DoD medical clinics and all VA sites have access to this data for patients presenting to them for care. This capability will be deployed DoD-wide this fiscal year.

Continuity of Care for Polytrauma Patients (Wounded Warriors). For severely wounded or injured patients transferred to VA polytrauma centers, we begin sending information upon the decision to transfer a patient to the VA. We already transmit digital radiology images and scanned medical records between Walter Reed Army Medical Center and each of the four VA Polytrauma Centers, and have partially implemented this solution for the National Naval Medical Center, Brooke Army Medical Center and the four VA Polytrauma Centers. All three of our DoD major trauma centers and the VA Polytrauma Centers will have this capability to transfer images and scanned medical records this year.

Separated Servicemembers (Potential VA Patients). For more than 3.8 million former servicemembers eligible for care from VA, we have made electronic health information available to VA. In 2001, we began sharing historical information dating from as early as 1989. Monthly transfers of electronic health information from DoD to VA began in 2002. The data elements transferred include:

- Outpatient pharmacy data, laboratory and radiology results
- Inpatient laboratory and radiology results
- Allergy data
- Consult reports
- Admission, disposition, transfer data
- Standard ambulatory data record elements (including diagnosis and treating physician)
- Pre- and post-deployment health assessments
- Post-deployment health reassessments

Business Practice Coordination. Where it makes sense or will enhance quality of care, DoD and VA have collaborated on additional sharing initiatives. For example, the Laboratory Data Sharing Initiative established the bidirectional electronic exchange of laboratory chemistry orders and results when one Department's lab acts as a reference lab for the other. This means expedited lab testing and results that enhance the quality of care for our patients. We are exploring other opportunities such as charge master billing, eHealth portals, and expanded image sharing, to expand our business practice coordination.

A Health Information System Tailored to Meet the Needs of the Warfighter and Military Families (Outpatient Medical Record System). The question often asked is why do DoD and VA have separate electronic health record systems. Simply put, DoD and VA have different requirements.

The Readiness Requirement. DoD must track care in theater using information systems that operate on desktop computers at a fixed hospital, laptops at a deployed Combat Support Hospital in Theater, or handheld devices on the battlefield. In addition, we must have an electronic health record system that supports continuity of care through availability in no- and low-communications environments. Importantly, our medical systems must operate on the command and control information technology infrastructure. Our requirement is to use a single system at both fixed facilities and our deployed units so our servicemembers will not have to learn a new system when they deploy. Our guiding principle is that we "train as we fight." In addition, DoD requires highly structured medical data, enabling us to conduct medical surveillance to identify potential natural disease outbreaks and/or biological attacks in theater.

Our Beneficiary Population. Finally, the high mobility of both our patient and provider populations led us to establish a centralized clinical data repository.

JOINT INPATIENT ELECTRONIC HEALTH RECORD

Recently, we announced that DoD and VA will modernize our inpatient systems together through a joint acquisition/development effort over the next several years. Because we have similar inpatient requirements there is a unique opportunity to explore a coordinated approach with seamless transition built in. Both Departments believe the timing is right for this initiative. VA is planning to modernize the inpatient portion of its electronic medical record, and with the full deployment of DoD's electronic health record—AHLTA—across the Military Health System, DoD is

poised to incorporate documentation of inpatient care into AHLTA. Done right, this will support the needs of both Departments and help ensure the continuity of care, better meet requirements for joint facilities, and leverage economies of scale in terms of development and/or integration costs, license fees, and hardware purchases. To get it right, our approach is to document and assess DoD and VA inpatient clinical processes, workflows, and requirements; identify and analyze alternatives for acquisition or development approaches; and determine benefits and impacts on each Department's timelines and costs for deploying a common inpatient electronic health record solution. I also would like to point out that the solution is not yet defined, and that we should expect one system, not necessarily one database. Regardless of the solution, we will implement in a way to ensure data interoperability is built in. Once the requirements analysis is completed in 2008, we will establish the acquisition/development timeline based on our assessment of the alternatives.

JOINT GOVERNANCE

Our DoD/VA electronic health information collaboration efforts I've described are a major component of the VA/DoD Joint Strategic Plan. The goals of the DoD/VA Joint Executive Council (JEC) are described in the VA/DoD Joint Strategic Plan for Fiscal Years 2007 through 2009 and cover a full spectrum of DoD/VA health related sharing. The JEC was established in January 2002 and cochaired by Under Secretary of Defense for Personnel and Readiness and the VA Deputy Secretary. It includes senior DoD and VA health managers involved in sharing initiatives and meets quarterly. The JEC provides leadership oversight of interdepartmental cooperation at all levels and to oversee the efforts of the Health Executive Council and Benefits Executive Council. The Health Executive Council (HEC) is cochaired by the Assistant Secretary of Defense (Health Affairs) and VA Under Secretary for Health. It was formed to establish a high-level program of DoD/VA cooperation and coordination in a joint effort to reduce costs and improve healthcare for VA and DoD beneficiaries. The HEC Information Management/Information Technology (IM/IT) workgroup is co-chaired by Health Chief Information Officers (CIOs) of the MHS and Veterans Health Administration. The HEC IM/IT workgroup ensures that appropriate beneficiary and medical data is visible, accessible and understandable through secure and interoperable information management systems.

NATIONAL STANDARDS ADOPTION AND IMPLEMENTATION

As I mentioned earlier, we believe we are leading the nation in health information technology, implementation of interoperability standards, and electronic health information sharing. As an example of our efforts to conform to national standards, the Certification Commission for Healthcare Information Technology (CCHIT) announced on April 30th that they awarded pre-market, conditional certification of AHLTA version 3.3 (DoD's electronic health record system). CCHIT is an independent, non-profit organization that sets the benchmark for electronic health record systems. AHLTA 3.3 passed a rigorous inspection process and met 100% of their criteria and we are very proud of this accomplishment. DoD and VA have been and will continue to be driving forces supporting the American Health Information Community (AHIC), the Health IT Policy Council (HITPC), and the Health IT Standards Panel (HITSP). Our efforts participating in these national level activities support Executive Order 13410, issued August 2006, which requires Federal agencies to use recognized health interoperability standards to promote the direct exchange of health information between agencies and with non-federal entities. We know that together the Medicare beneficiaries, DoD beneficiaries, VA beneficiaries, and Federal employees represents a significant percentage of insured Americans. This means our efforts can have a potentially dramatic effect on the private sector adoption of health IT and will ultimately impact our ability to exchange electronic health information with private sector providers.

CONCLUSION

I would like to reiterate that the continuity of care for returning wounded warriors and the inpatient electronic health record project are our top priorities for DoD and VA electronic health information sharing. In the last several years, DoD and VA have made significant progress and are leading the nation in many ways in the sharing of electronic health information, but there is room for improvement. We are accelerating our efforts to achieve a greater degree of health information sharing to support our top priorities. The President is monitoring our progress in this area. The Task Force on Returning Global War on Terror Heroes has made specific recommendations to the President that DoD and VA continue to improve and ensure

timely electronic access by VA to DoD paper and electronic health records for servicemembers treated in VA facilities. The President has accepted these recommendations and directed Secretary Nicholson to report back to him on how these measures are being implemented. DoD and VA are already working together to accomplish the recommendations made in the area of electronic health information sharing. In addition, we have jointly briefed the President's Commission on Care for America's Returning Wounded Warriors on the current status of DoD/VA electronic health information sharing and future plans. We look forward to receiving their recommendations as well. With your support, we will continue building on our achievements in sharing electronic health information in support of the men and women who serve and have served this country.

