MODERNIZING HEALTH RECORDS FOR SERVICEMEMBERS AND VETERANS: THE CONTRACTOR PERSPECTIVE

HEARING

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C O N T E N T S

Tuesday, June 4, 2019

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COMMITTEE ON VETERANS' AFFAIRS,
U. S. HOUSE OF REPRESENTATIVES,
Washington, D.C.

The Subcommittees met, pursuant to notice, at 2:40 p.m., in Room 210, House Visitors Center, Hon. Susie Lee presiding.

Present: Representatives Lee, Brownley, Lamb, Cunningham, Banks, Watkins, and Roy.

OPENING STATEMENT OF SUSIE LEE, CHAIRWOMAN

Ms. LEE. Okay. Good afternoon, everyone. This hearing will now come to order. I would like to welcome you all here, welcome Ranking Member Banks.

And I wanted to start first with an opening statement. Today, the Subcommittee on Technology Modernization will hold the first in a series of hearings on the implementation of the electronic health records at the Department of Veterans Affairs. This effort, known as EHRM, is projected to take at least 10 years and cost $16 billion. To say it is a major undertaking is an understatement.

It has the potential to transform health care for our veterans and to finally realize the goal of having one seamless lifetime health record for our servicemembers as they transition from the military to veteran status; however, this effort also has the potential to fail. VA, unfortunately, does not have a great track record when it comes to implementing information technology. Decades of oversight by the Government Accountability Office and the Inspector General have documented a troubled history of failed IT projects, including several failed attempts at a modernized electronic health record.

At the Subcommittee's hearing on April, I asked the IG and GAO what it would take for the VA to be successful and it really comes down to two things: management and leadership. VA's inability to manage IT programs and have accountable leadership has plagued many of its recent IT efforts and it threatens EHRM. The lack of an accountable joint governance structure between the VA and DoD also threatens the success of this project.

After months of requesting information, we have yet to receive anything of substance about a proposal to address the non-functioning interagency program office. What we have heard is not promising. It sounds like it is the status quo with a new name.

Congress first mandated an interoperable health record in 2008 and it is beyond time for the Department of Defense and the VA to have a fully functioning health record systems that can talk to one another and support seamless health care. Seamless health care is what this effort really is about, and it is more than any one system, contractor, or agency. It is not about the technology, but about the human interaction with the technology.

The system we are spending at least $21 billion on at both the departments is merely a tool that will allow clinicians and others to provide the best possible health care experience to those that served our country. We owe them nothing less.

Because this mission is so important and because taxpayers have made and will make a significant investment in it, this Subcommittee owes it to veterans we serve to ask difficult questions and demand full answers at every step of this project. We need leadership to be transparent about the challenges and accountable for their decisions.

Additionally, we are aware that there is some rhetoric out there about speeding up the EHRM implementation, but I want to be very clear that I do not share the opinion that we should move faster for the sake of moving faster. We should, instead, spend the time getting it right at the initial sites in the Pacific Northwest before we move on to other implementation stages.

This spring I spent some time at the Madigan Army Medical Center and heard from frontline staff about the problems that were experienced when things like testing and training were rushed. Further, I visited the Seattle VA and saw the very serious infrastructure issues there that threaten or delay or to derail the implementation.

There are many lessons to be learned from the DoD rollout of MHS Genesis, including obvious pitfalls that need to be avoided by the VA. This Subcommittee will be conducting oversight of all of these things.

For the first time, and thank you very much, we have the major contractors involved in both, the VA and DoD efforts before us. I am pleased that we can make this happen, because I believe it is a real opportunity to examine these programs from every perspective and ensure their successful implementation.

Cerner, Leidos, and Booz Allen Hamilton are part of the day-to-day efforts of the EHRM at the DoD and VA and they know, intimately, the lessons learned, and they are helping prepare for the potential problems ahead. I know we all want the MHS Genesis and the EHRM to succeed for our servicemembers, veterans, their families, and taxpayers, and I hope we use this opportunity to figure out how we get these IT projects right.

I thank all of the witnesses for being here and I look forward to their testimony. I would now like to recognize my colleague, Ranking Member Banks for 5 minutes to deliver any opening remarks that he may have.

OPENING STATEMENT OF JIM BANKS, RANKING MEMBER

Mr. BANKS. Thank you, Madam Chair.

I am pleased to be back here with you to discuss VA's Electronic Health Record Modernization, EHRM program. It has been just

over 1 year since VA awarded its primary EHRM contract to Cerner. I continue to believe this program is so large and important, not just for our veterans, but also for American health care. The status report should happen in public. My goal today is to make sure that one is provided.

We are still in the middle of the beginning, but vague conceptual notions are becoming pressing questions and decisions with real impacts on people's lives. VA's first site, the Mann-Grandstaff Medical Center in Spokane is scheduled to go live with the Cerner EHR less than 1 year from now. There is an even earlier deadline right around the corner.

The councils of employees who are test-driving the Cerner her and designing the new workflows are scheduled to finish their meetings in September. These 18 councils are each at very different points in their respective processes. Some are still near the beginning, while others are ahead of expectations. September through March 2020 will be an intensely active period while milestone after milestone must be completed in quick succession. The risk of delay is very real.

Some of my colleagues who do not sit on this Committee have expressed frustration with the length of the site-by-site implementation. No delay is ever welcome, but taking a few extra months to get its right is imminently preferable and responsible, compared to cutting corners or rushing a half-baked system into use in order to avoid criticism. The reality is the performance of this Cerner EHR and VA's initial operating capability sites will determine the course of the rest of the program, including in all likelihood, whether it continues at all.

Much has changed since our last EHRM hearing. VA and Cerner have agreed to an ambitious data-migration plan that hinges on repurposing Cerner's HealtheIntent population health software. I have some questions about how this will actually work.

VA has demonstrated some impressive use cases in connecting to external apps through the API gateway. The most high-profile success is enabling veterans to access their records through Apple Health. This sort of capability would have cost the Department hundreds of millions of dollars to develop in the past, but the partnership was accomplished in about a year for a tiny fraction of that. I suspect that there may be some more big app partnerships in the near future.

On the other hand, some things haven't really changed at all. Interoperability with the community providers is still the elephant in the room. Cerner has some strong interoperability offerings inside and outside of the EHR, but millions of veterans already get care in the community and no matter how long or short the site-by-site implementation may be, they rightfully expect their records to follow them.

The MISSION Act, which is only 2 days away will streamline community care administratively. We need a comparable solution to deploy the interoperability technology in months, not years, and nationwide, not place by place. We can do better than repackaged email or fax.

Relatedly, beyond some platitudes, no innovation strategy has been articulated. The Cerner contract contains an innovation line

item, but it is the smallest line item in the contract, and it has not yet been touched. Cerner has a multi-hundred-million-dollar research and development budget and VA will make up about a quarter of the company's revenue in a few years. The Government negotiated extraordinary data rights in this contract, but I am still eager to hear how all of this investment is supposed to translate into some specific advancement to solve VA's specific problems.

I understand the desire to get the basic EHR in place before turning to innovation. That reflects caution and modesty, which are both admirable. But it is very important to me, and I hope to the rest of this Committee, that innovation does not get neglected.

Finally, in addition to an extraordinarily number of decisions to be made, there are bound to be many unforeseen issues that will arise that will test the management structures that VA, DoD, and these companies have in place. I wish I could say I have more confidence in those management structures.

VA and DoD opted for a single, common system, but after 9 months of haggling and jockeying for power, a suitable, single, common-management structure has still not yet emerged. Frustratingly, the Departments have refused to share virtually any information with Congress.

In the absence of a comprehensive solution, the technical personnel at EHRM and MHS Genesis have put together some effective coordination mechanisms; however, that is unlikely to be sufficient to address clinical questions or resolve programmatic disputes.

I appreciate our witnesses from Cerner, Leidos, and Booz Allen Hamilton, being here to speak to us directly about these issues. Next week, we will hear from the VA and DoD witnesses about your work, as I am sure we will do many more times, but this is your opportunity here to give us your perspectives and I appreciate that very much.

With that, Madam Chair, I yield back.

Ms. LEE. Thank you, Mr. Banks.

I would now like to introduce the witnesses we have before the Subcommittee today. Travis Dalton is the President of Cerner Government Services, which is leading the health record modernization effort at the VA and is a subcontractor on the DoD effort. Mr. Dalton is accompanied by David Waltman, Vice President for Strategy And Technology, and Julie Stoner, Director and Client Accountable Executive.

Jon Scholl is the President of Leidos Health Group, which is the lead integrator for the DoD implementation of MHS Genesis. Leidos also has a role in the VA effort as a subcontractor.

And, finally, Mr. Richard Crowe is an Executive Vice President at Booz Allen Hamilton, which has a contract to support the EHRM program office.

We will now hear the prepared statements from our panel Members. Your written statements, in full, will be included in the hearing record.

Without objection, Mr. Dalton, you are recognized for 5 minutes.

STATEMENT OF TRAVIS DALTON

Mr. DALTON. Thank you, Chairwoman Lee, Ranking Member Banks, and distinguishing Members of the Committee.

My name is Travis Dalton. I am the president of Cerner Government Services. Appearing with me are David Waltman and Julie Stoner from Cerner. We thank you for the opportunity to be here today and for your continued support of the Department of Veterans Affairs' Electronic Health Record Modernization program.

Just over a year ago, VA partnered with Cerner to proactively transform care for veterans and help them lead longer and healthier lives and we remain honored and humbled to be a part of this mission and we have assembled a world-class partnership to deliver it. EHRM is not just about technology; it is about transformation at scale. We realize the size and complexity of the VA. This won't be easy, but it is achievable, and we are making progress.

This program will ensure a lifetime of seamless care for veterans and servicemembers across the Department of Defense, VA, and community providers. VA has a long history of innovation and excellent care for all of those who have served us. We are building on that foundation together.

This project will give providers the right tools and data at the right time to make the right decision. With EHRM, servicemembers and veterans will no longer have to carry stacks of paper. Providers will have access to the veteran's record wherever they deliver care.

Using advanced analytics and decision support, we will be able to identify, diagnose, and manage chronic conditions, combat suicide, opioid, and substance abuse through interoperability and workflow tools, operationally move from 130 disparate systems to one open, modern integrated system that is easier and more efficient to update and maintain. It won't happen overnight, but we can and will achieve these goals together.

This undertaking is immense. It carries a risk and we don't take the challenges lightly. We must deploy at over 1,700 sites, train over 300,000 VA employees, collaborate with DoD, interoperate with the community, aggregate decades of clinical data, and update technology. The only way to get there is for us to work together: VA, DoD, all of you, our partners here today, VSOs, and other stakeholders.

We are on the right track. We have confidence in Mr. John Windom in his leadership of this effort at the VA. That has been imperative to our progress. Some examples of that progress include, we have established 18 councils made up of VA care providers, nationwide center experts, industry leaders, and DoD. The councils have completed 5 of 8 national workshops. They are making decisions, setting standards, and bringing best practices to the table.

We created an advanced learning academy. Along with Booz Allen, we have a robust team in the Pacific Northwest. We have completed 18 of 19 road shows to engage providers and we have migrated 23 million veterans' health records into the Cerner data center. VA and the DoD health data are in the same system.

We are impressed with the dedication, spirit, and passion of the providers we work with inside VA and DoD. We are humbled by the opportunity to be in VA medical centers and to interact with providers and veterans receiving care.

This is personal for many of you. I know it is for me. We can do this, but it will take all of us working closely together. On behalf of Cerner, we are honored to be a part of it.

Thank you, and I look forward to the discussion today.

[THE PREPARED STATEMENT OF TRAVIS DALTON APPEARS IN THE APPENDIX]

Ms. LEE. Thank you, Mr. Dalton.

Mr. Scholl, you are now recognized for 5 minutes.

STATEMENT OF JON SCHOLL

Mr. SCHOLL. Thank you, Chairwoman Lee, Ranking Member Banks, and Members of the Subcommittee. Thank you for the opportunity to provide a contractor's perspective on modernizing the health records at the Department of Defense.

My name is Jon Scholl. I am the president of the Leidos Health Group. We are the prime contractor for the DoD Health Management System Modernization, also known as DHMSM.

On a personal note, I graduated from the Naval Academy. I am a former submarine officer who deployed to the Western Pacific. I have children and a spouse who have been treated in the military health system. I have a son who served in the 82nd Airborne in Afghanistan and depends on VA services for service-related injuries. So, this mission of health records and interoperable solutions is very personal for me, as it is for many others on my team who have served or have family members that served.

With me today is my senior team associated with this work. Debbie Opiekun is the senior vice president for Federal health; Doug Barton is the chief technology officer for the health group and chief engineer of the DHMSM program; Dennis Nihiser is a senior program manager for DHMSM; and Rob Thomas, the acting deputy president for the health group.

To best encourage teaming and sharing lessons within and across the DHMSM team, we created the Leidos Partnership for Defense Health, which consists of four core partners: Leidos, Cerner Corporation, Accenture, and Henry Schein One, as well as many other supporting businesses. Together, we are developing an integrated, modern, and secure health information system that includes an electronic health record system, a dental system, identity management capability, cybersecurity, and other supporting components. This integrated system is calls MHS Genesis and it will provide a solution for managing the health and readiness for the DoD, ultimately, the VA, and the U.S. Coast Guard.

Although information sharing is possible today between the DoD and VA, it is limited by the fact that these organizations have operated systems that are mostly independent from one another, largely requiring view only, and some patients still carry paper medical records as they move between organizations. We know this is a significant frustration to many and, appropriately, Congress has directed the agencies to fix this longstanding problem. MHS Genesis

is ultimately incorporating VA-essential requirements is the solution.

I can assure you that from initial contract award until now, we have learned a lot and we will continue to learn. I am pleased to be with you today to share some of the insights we have gained.

We work extremely closely with our DoD customer and the partnership is committed to executing three equally important objectives: one, deploying MHS Genesis on time and on schedule; two, continually improving the implementation of MHS Genesis based on lessons that we have learned; and, three, successfully modernizing the delivery of health care in the military health system.

MHS Genesis is well underway to transforming how health care is delivered to nearly 10 million servicemembers and their families. The solution consists of integrated commercial products designed to help efficiently manage the health of our servicemembers, veterans, retirees, and their families. MHS Genesis allows clinicians and patients to access needed health records and, importantly, ensures our servicemembers receive the same standard of care no matter where they are in the world.

The Leidos Partnership for Defense Health went live at the initial operating capability sites in 2017. This included four military treatment facilities and more than 20 ancillary clinics. It allowed the team to pilot MHS Genesis to learn and to incorporate feedback into future implementations. This learning loop will continue as more facilities go live.

We are counting on the process of implementing and learning in order to accelerate and provide the best solution possible in the best possible ways. These initial sites continue to use MHS Genesis today to safely deliver care to patients, completing more than 100,000 patient encounters every month. In our opinion, the intended purpose of the go-live at the initial sites was achieved, which was to provide an outstanding health information system and to identify areas of improvement and set the course for corrections, prior to broader deployment.

Here's a quick overview of 3 things that we—insights that we gain from implementation. One, we refined our approach to training. The curriculum is now better aligned to clinical processes, also called workflows, and we are using improved team-based, roll-based, and just-in-time-based training methods. Two, the underlying IT backbone, the networks, the computers, the printers, the medical devices, must be mapped and tested to support the new system. The implementation at our initial pilot sites identified the critical importance of validating and revalidating that the necessary infrastructure is, in fact, ready. And, three, implementing complex systems is fundamentally a people business. Changing clinical processes is hard.

The commercial technologies that comprise the MHS Genesis system are operational in health facilities around the world. The most challenging work ahead is not only the engineering, to ensure that the underlying components continue to work in a secure environment, but also work closely with the dedicated and amazing medical staff to best placement the MHS Genesis solution.

In closing, Leidos and its partners are confident in our ability to placement the integrated tell me if I'm wrong health record system,

MHS Genesis, across the defense health community by the end of 2023. Our team is honored and committed to fulfilling this noble mission.

Thank you, and I look forward to your questions.

[THE PREPARED STATEMENT OF JOHN SCHOLL APPEARS IN THE AP-PENDIX]

Ms. LEE. Thank you, Mr. Scholl.

Mr. Crowe, you are now recognized for 5 minutes.

STATEMENT OF RICHARD CROWE

Mr. CROWE. Good afternoon, Madam Chair Lee, Ranking Member Banks, and other Members of the Subcommittee. My name is Richard Crowe. I am an executive vice president at Booz Allen Hamilton and client service officer for Booz Allen's health account.

In that role, I lead a diverse portfolio of health service contracts, including IT and health care operations contracts. That portfolio includes our electronics health record modernization program management office support contract at the Department of Veterans Affairs.

Booz Allen has a strong demonstrated commitment to serving our Nation's veteran population. Booz Allen was founded by a veteran, and the company has continuously supported the Department of Veterans Affairs since 1952. Booz Allen takes great pride in our sixty-five year history of supporting veterans, which we do in multiple ways.

Approximately 30 percent of our over 25,000 employees are military-connected, meaning they are veterans in the National Guard or military spouses. And Booz Allen invests in helping our military-connected employees thrive through career-building, best-in-class benefits, formal programs for military-spouse support, and support to the military and veteran communities through innovative and impactful, nonprofit partnerships. We are committed to the Department of Veterans Affairs' mission to serve our Nation's veterans.

I am pleased to be here with you today to discuss Booz Allen's support in the role of the VA's Electronic Health Record Modernization program. I would like to begin today by discussing an overview of the role of the PMO support contract in our work, who we support, and how we interact, contractually, with the other witnesses here today.

The role of the PMO contract support: As the VA's PMO contractor, our role is to help position the VA for success in three main areas. First, we provide search staffing, resources, and tools, as well as management, engineering, government expertise, to augment the VA program office's own capabilities.

Second, we help the Government obtain specific skills and talent relevant to the EHR implementation for the necessary duration at the relevant stage of the implementation process in time-bound manner.

Third, assist the implementing organizations by helping the respective workstream leaders break enormous projects into discrete, actionable, trackable, and measurable tasks.

The VA's use of a PMO support contract is consistent with other commercial and governmental EHR implementations.

Who we support: Our role as the PMO contract support, Booz Allen works at the direction and supervision of the OEHRM PMO under a time-and-materials contract? Our job is to respond to a range of VA taskings required for successful EHRM implementation. We play a supporting role to the PMO and do not have our own independent development scope, nor responsibility over specific EHRM development, deployment, and implementation tasks.

Structurally, our team mirrors the VA PMO, in that we are organized into workstream pillars which we support at the direction of the VA lead. The primary workstream's focus on assisting the chief medical officer, Technology Integration Office, and program control.

How we interact with other contractors: We do not have independent scope or responsibility for the EHRM implementation, nor do we direct Cerner. Our interaction with Cerner is at the direction and in support of VA.

Thank you for the opportunity to testify before the Subcommittee today. Booz Allen is proud of the support we are providing the VA and we have great confidence in the VA's leadership of the EHRM PMO.

I look forward to your questions.

[THE PREPARED STATEMENT OF RICHARD CROWE APPEARS IN THE APPENDIX]

Ms. LEE. Thank you. I will now recognize myself for 5 minutes of questioning.

This is for both Mr. Dalton and Mr. Scholl: From a joint-governance perspective, how are Leidos and Cerner working together to ensure that seamless care and interoperability are at the forefront of both of your respective implementations?

Mr. DALTON. Thanks for the question. I will apologize for my voice. My team is happy I can't talk, but it is not very helpful in this environment.

You know, I think the important thing around decision-making is that we are really working on focusing on decision-making at the lowest levels. We work closely together, obviously. We are on their team and they are on our team. We have a great working relationship. We know each other. We know our skill sets well.

We have joint working sessions where we work closely together. Leidos is closely involved in the workshop process with us and the VA. We also have an environment-management operating group that consists of VA, DoD, Cerner, and Leidos, which is working closely together on a regular basis.

We have great relationships at the corporate and other levels. I think we work closely together in that capacity on the solution and we continue to do so.

I don't know if Mr. Scholl, if you have anything to add to that?

Mr. SCHOLL. Not much incremental, other than to emphasize that we are in operating rhythms, where we are in meetings together, we review findings together, we work closely together from the lowest levels of our team to the highest levels of our organization, including recurring meetings at the most senior levels, myself and even our CEOs.

Ms. LEE. Mr. Dalton, Cerner's monthly project reports list delays in decision-making, summarizing carrying over from month-to-

month. How much of that is a product of a lack of effective governance structure on behalf of the VA and DoD?

Mr. DALTON. I think, look, I mean, it is hard. Clinical decisionmaking is not easy. We have 18 councils. We are running a process. We are getting into—I mentioned transformation at scale. It is a big project. There is much to do. We are getting into difficult decisions around referral management, processes, workflow. I think all of those elements play into kind of where we are at on status.

We are also making sure that we are getting national representation and local representation as part of this process and tuning that into decision-making is not always an easy thing to do, but I think all of that has led into kind of where we are at today.

We are behind in a few areas. We know what those areas are. We have eyes on the target. We have the ability and the reporting to know where they are. We are having daily meetings, daily cadence. We are meeting with the DoD and VA. We have escalation paths to resolve those.

Ms. LEE. All right. Thank you.

This is for Mr. Scholl and Mr. Dalton. For some decisions, such as which access card would be used, the resolutions seem to take quite a long time to get to. Cerner developed a working group in an attempt to provide the DoD and VA with some viable options.

Is that working group something that should exist as part of the joint governance structure or was it a workaround due to the lack of an effective governance structure?

Mr. SCHOLL. I think we had, from inception, always intended to have working groups at the Cerner-Leidos level, so I wouldn't characterize it as a workaround to anything that DoD and VA, you know, are striving for; rather, we view it as our mutual responsibility to bring solutions to our respective customers.

Travis?

Mr. DALTON. Yeah, I am going to let Mr. Waltman comment on that.

Ms. LEE. Okay.

Mr. WALTMAN. Yes, ma'am, thank you.

I agree, I don't think that it represents a lack of or that progress was impeded, specifically, by a lack of joint governance. This was a very complex decision and a process that required a lot of input from within VA, with various departments within VA, and stakeholders, especially given the complexities of VA's contemplating moving to the U.S. access card from General Services Administration. So, there were a lot inside-VA decisions that needed to be worked through and I think that happened relatively effectively.

Between the two Departments, there are also decisions that need to be made, such as enumerating users of the system with an EDIPI, which is the common identifier for the system, and the Departments are still working through those. I think there are certainly opportunities for a potential joint entity to help facilitate some of that decision-making. The EDIPI is a good example. Other memoranda of understanding and agreements between the Departments for how these systems will operate, particularly including privileges and things like that for access to the record would be facilitated by joint decision-making.

Ms. LEE. All right. Thank you very much. I yield the remainder of my time.

And now, I would like to recognize Mr. Watkins for 5 minutes.

Mr. WATKINS. Thank you, Madam Chair.

Mr. Dalton, we hear the term "interoperability" a lot in these discussions about electronic medical health records. It is more than just sharing data between multiple systems.

Can you expand on the concept what it means for EHRM and how it impacts the care of our veterans?

Mr. DALTON. I am happy to. Thank you for the question.

Interoperability to us is more than just—to the community; it is many things, as you mentioned. So, our goal and our focus is the right data at the right time and the right place so that the provider can make a truly informed and best decision. There are a number of things that go into that.

So, we are bringing VA and DoD into a single instance in the domain. We have VistA history that is coming into the environment. We have got device integration, real time. We have reference lab and state PDMP data for opioid-risk scoring. And we have also got open-standards-based APIs. All of that is interoperability in our mind and allows the provider to have a true view of the longitudinal record and make an informed decision.

Mr. WATKINS. You mentioned opioid addiction. It and suicide are a problem among veterans. Not a day goes by when I don't think of a veteran, I served with who committed suicide and so, it is a personal issue.

How can the VA and DoD, creating a single record based off of a Cerner platform, support us combatting those efforts?

Mr. DALTON. With opioid, we have the opportunity to integrate into the state prescription drug monitoring programs, so we can actually pull that data and have a risk score. So, it allows us early identification and allows us to proactively look at those issues, inside of the workflow. That is very different than a reactive situation or at guessing. So, that is one area.

I think we also have the opportunity to innovate with the VA, as it relates to data analytics, predictive modeling, early intervention related to suicide and PTSD. That is an area we want to focus on with them going forward.

Mr. WATKINS. Thank you, Mr. Dalton.

Madam Chair, I yield my time.

Ms. LEE. Thank you. I now recognize Mr. Lamb for 5 minutes.

Mr. LAMB. Thank you, Madam Chair.

I want to thank all of you for being with us here today. I know it is not easy to come all this way, and I also know we may or may not get a chance to be in front of you again for a while, just the way this process works out.

So, for the 3 Cerner witnesses in particular, I would just like to ask now, you know, it is June of 2019. We are all expecting a go-live, I think it is October 2020, but at some point, in 2020 you will be really ramping around next year around this time. Is there anything that you don't have from the government-VA side or you fear you aren't going to have between now and then that could impact the planned launch, anything at all?

Mr. DALTON. I think the primary element we talked about earlier is around making quick decisions, so we need to continue to focus in that area. You know, it is hard. It is complex. I appreciate the commentary around getting it right. We also want to get it right, but I think, just, we do need that joint decision-making authority. We are operating effectively—I believe that—and we are getting things done, but there comes a point where you have to have that joint capability.

We have a few examples. I am happy to let the team describe what those, sir, if you would like?

Mr. LAMB. Please. Yeah, please go ahead.

Mr. WALTMAN. Yes, thank you. I appreciate the question.

I agree with Mr. Dalton in that there are a number of things that if we can ensure that they are facilitated between now and that time, will make things much more effective and much more likely to be the success that we all expect them to be for veterans and servicemembers. So, for example, there are realities of working in a joint environment with the Department of Defense that we have to have a common cyber posture between the two environments, and there are decisions that the Department of Defense needs to make in authorizing, for example, assessment strategies for some of the technology, for example, container technology, or other decisions regarding connections between aspects of the system from VA to DoD.

And although some of those decisions have been in process, we have not seen, between the Departments, all of those at the speed that we would like to be able to ensure we maintain the expected schedule. So, certainly, joint decision especially in that cyber area is one area that I think is very important to us.

Mr. LAMB. Thank you. And just to be clear, have you made clear to the decision-makers, the impact that that could have on your schedule and the ability to launch this on time next year?

Mr. WALTMAN. Yes, sir. We absolutely have done that, and we continually monitor the status of these decisions and decision requests and brief their status and request facilitation and updates.

Mr. LAMB. Okay. Go ahead, Ms. Stoner.

Ms. STONER. Yes, thank you for the question.

We have had a number of items, things that require either joint or VA decisions. We have been working closely with the VA between workshops, in addition to the surging during the workshops to close out those decisions, and while we acknowledge that both Departments have different missions, there are a number of things that have to be decided on jointly; for example, what do particular results appear to the clinician for.

And so, there have been a number of items that we are tracking to close out, bringing the two groups together. And as Mr. Dalton said, we are seeing progress there, but it is how fast and how scalable is that process and how consistent is it to be able to do on a regular basis.

Mr. LAMB. Okay. So, one example was, basically, data and cybersecurity and assessment of the technology that is being used. Were there any other concrete examples that you can give us today? Because if we are going to have the DoD and VA decision-

makers in front of us regularly, it would be helpful to ask about these things.

Ms. STONER. So, I think the biggest thing that we are looking for is a process by which we always make those decisions.

Mr. LAMB. Okay.

Ms. STONER. So, things like results-viewing; that has to be consistent across the agencies. How the Department of Defense takes on new capabilities that become available because the VA has provided them, and as well, how do we continue to push both agencies to move on a commercial baseline, take advantage of those investments.

Mr. LAMB. Okay. Thank you.

Madam Chair, I yield back.

Ms. LEE. Thank you. I now recognize Ranking Member Banks for 5 minutes.

Mr. BANKS. Thank you, Madam Chair.

A few months ago, Kaiser Health News and Fortune published a truly sobering piece of investigative reporting on the EHR industry. Any case anyone missed it, I ask unanimous consent to enter the article "Death by a Thousand Clicks" into the record.

Ms. LEE. Without objection.

Mr. BANKS. What I find most alarming is the issue of gag clauses, which are terms that some EHR companies put in their contracts threatening buyers with litigation if they speak publicly about the problems with the systems.

Mr. Dalton, has Cerner ever imposed a gag clause, meaning any term or condition in any software-license agreement or other contract that discourages any user from speaking publicly about any subject?

Mr. DALTON. No, not that I am aware of.

Mr. BANKS. The negotiations between DoD and VA over leadership of the Joint Program Management Office, the firm, are probably one of the worst-kept secrets in Washington. This has been going on since last fall, and the goalpost seems to have been lowered to putting interim leadership in place and standing up the office in phases through March 2020.

This question is for everyone who wishes to answer. The two Departments that have some technical integration in place, but what is going to happen to—hold on—the two Departments have some technical integration in place, but what is going to happen to the EHRM and MHS Genesis if they don't integrate the other aspects? What is the impact on you, the contractors, trying to implement these projects?

And we can start on our right.

Mr. CROWE. Well, I think we support the PMO on the VA side, and so, in that, we support the VA. Specific to your question, obviously, strong governance across both of these programs for common decisions is going to be critical. I think when you look at the proposed firm, this is a ten-year—as you said earlier, sir, it is the beginning—it is the middle innings of the beginning, and this is a 10-year process. So, it is not necessarily inappropriate to take some time and pause to think how you want to have this structure come together from a governance standpoint.

So, I know the agencies are talking, and I am not really in a position to comment on how they are going to ultimately come together.

Mr. BANKS. Mr. Scholl?

Mr. SCHOLL. Yeah, thank you.

If I could play the question back to you and make sure that I am answering precisely, Ranking Member Banks, what I thought you asked is: How much do we move beyond the pure technical integrations into other issues and how important is that to us as the contractors?

Mr. BANKS. Yes.

Mr. SCHOLL. Much has been said of decision-making and I think as the DoD and VA get together and solve the decision-making processes to increase speed and efficacy, I think those are things that would be required. But we, from the DHMSM rollout, feel confident where we are in the decision-making inside the DoD program and look forward to working with Cerner and the Departments, as they implement new processes and procedures to make better decisions.

Mr. BANKS. Mr. Dalton?

Mr. DALTON. We aren't directly involved in the conversation with the firm. We provided some data points and some inputs and some thought, and so I just can't comment on specifically where the agencies are at in relation to that.

But it goes without saying when you are in a single instance, a single environment, there comes a point in time if you can't agree and you can't make some decisions, it is hard to proceed forward. They need to maintain standards. There needs to be clinical decision-making. There needs to be timing. There needs to be joint milestone management. Upgrades will be done at the same time.

So, not only is it difficult to proceed, but you miss out on a great opportunity to actually work together and get the efficiencies and synergies that the two agencies could get with one another by doing so.

Mr. BANKS. So, to Leidos and Booz Allen, how can you implement Cerner as a single common instance if they don't have some sort of unified management structure, in your opinion?

Mr. SCHOLL. Well, you know, the contracts were sequenced in time. So, the DHMSM contract started before even the award of the Cerner contract. So, I think there is going to be a process of the implementation of MHS Genesis and, you know, as the VA requirements emerge, then we need to have this joint decision-making and process to resolve any conflicts, so we end up with a single instance and a single system.

Ms. LEE. Thank you. I now recognize Ms. Brownley for 5 minutes.

Ms. BROWNLEY. Thank you, Madam Chair.

So, I wanted to go back and follow up on Mr. Lamb's questioning. If I understood you correctly, that you said that one of the issues in terms of meeting timelines and completion dates is, in essence, creating a system of joint decision-making. And my understanding of joint decision-making is DoD and the VA and all of you, right?

So, let's just say, hypothetically, that that system isn't created. I mean, do you have a timeline to get that? Does the VA understand the urgency?

And, you know, if that isn't established, then it sounds to me like you are going to continue to fall behind schedule due dates—correct me if I'm wrong. Am I wrong? Yes? No?

Mr. DALTON. Yeah, I think, as I had commented earlier, we are making some decisions and we are proceeding forward, but, yeah—

Ms. BROWNLEY. No, I understand that. But what I don't understand is that there are some key decisions that, you know, have to be made before you can make another big significant step in the process.

Mr. DALTON. Yes, there are. Correct. Yes, ma'am.

Ms. BROWNLEY. So, if nothing is done, then sort of some key, essential decisions aren't going to be made.

Mr. DALTON. That is correct.

Ms. BROWNLEY. Hopefully that won't be the case, but if it is the case, is there a place in this process where we, as Congress, would understand that those decisions aren't being made and that we should anticipate further delays or is that simply something that you will make the VA aware of that we are not going meet these deadlines because X, Y, and Z, and that is as far as the information flow goes?

Mr. DALTON. We have a process for risk management, obviously, that we work with both, Booz Allen Hamilton and the VA. We are constantly evaluating risks. We are constantly evaluating our integrated master schedule and timeline. I believe we provide reporting on a regular basis to Congress, and, otherwise, related to that.

Our goal is for that to be readily transparent to all involved so that there is clear decision-making, clear understanding, and that we are able to proceed forward.

Ms. BROWNLEY. Thank you. And for Cerner, too, you indicated that, you know, there are a few things that are behind schedule, and I think one of those is that you had indicated that Cerner is saying that they are going to test every function throughout the build phase of the EHR and, actually, the VA is holding its last workshop or workflows are being developed and fine-tuned, and that is in September/October of 2019.

So, that leaves the VA and Cerner less than 6 months to complete the design and development, perform these tests on the completed system, correct any issues, and then design and deliver training to the end-user. So, this time frame, to, seems ambitious, at best, and little room for error.

Mr. DALTON. I think one major advantage that we have is that we are largely using some of the work that we have built together off of the DoD. So, much of the workflow and the system will be the same, and so, we are able to re-leverage some of the work that we have done collectively together on behalf of the VA.

It is consistent with our commercial timelines. We are testing in training, and so we feel confident, but we are able to leverage that baseline.

Ms. BROWNLEY. And, you know, there are rumors that the VA is looking for another contractor to perform the testing. Do you know about that at all?

Mr. DALTON. I do not know about that.

Ms. BROWNLEY. Okay. The last thing I wanted to ask is around data ownership. And the VA and the DoD's data have or will be moved into the Cerner's data center in Kansas City. What impact will the data being in a commercial data warehouse, have on portability, access, and privacy, and then who ultimately owns the data once it is moved to the Cerner's data center?

Mr. DALTON. I am going to pass that to Mr. Waltman.

Mr. WALTMAN. Yes, ma'am, thank you.

So, I think the answers to your questions are VA and veterans and the people whose data it is always own the data. The data is not owned by Cerner.

And in terms of access and privacy, first of all, from a privacy standpoint, this is probably the most secure health-information environment in the world at this point with the requirements that have been needed to be met for DoD, and I think I am out of time.

Ms. LEE. You can have a few more seconds.

Mr. WALTMAN. Okay. Great.

And in terms of access, I think that the access for folks to use that data, veterans themselves, servicemembers themselves, and other companies what are interested in providing capabilities to help them will be greatly increased. We have APIs that provide access to that information, as appropriately managed through our code, program, and so forth, and there will be a tremendous ability for vendors and people interested in helping veterans to provide capabilities that leverage that data being in one place.

Ms. BROWNLEY. Thank you.

Thank you, Madam Chair. I yield back.

Ms. LEE. Thank you. I will now recognize myself for 5 minutes for questions.

And I would like to focus a little bit on the different contractor responsibilities, and I will start with Mr. Crowe. In your testimony, you note that Booz Allen's role is to support the program office of EHRM. The executive director for EHRM has stated something to the effect that when you think that EHRM, think Cerner and Booz Allen.

How is Booz Allen augmenting the staffing in the EHRM office?

Mr. CROWE. Thank you for the question. That is a good question.

We provide, as I testified, surge support, a variety of management, technical, engineering, clinical support. We bring folks with significant background in EHR implementation, a lot of experience in the Federal space and significant experience in supporting the VA directly.

Tests that are typical for a PMO contractor: We typically aggregate data, collect data, support field trips, support a variety of engineering reports, studies. We pool this together and we present documentations and maintain documents and artifacts for the PMO that enable the Government to make decisions and move forward in their role as the oversight and program management of the effort.

Ms. LEE. Thank you. The VA stressed the importance of these Command Action Teams in the implementation. What is the role of the CAT and when will they come into play?

Mr. CROWE. So, currently, Booz Allen has 30 people, approximately 30 people—a bit over—in the Pacific Northwest. And the Command Action Team, simply put, is an extension of the PMO. They make the PMO extensible to the local PAC Northwest facilities helping provide connectivity directly back to facilitate, you know, visits out there, information collection, deployment, and as we move forward into IOC, they will be enabling the IOC.

Ms. LEE. Okay. Thank you.

Mr. Dalton, as the prime contractor, Cerner is responsible for overseeing I think at least 24 subcontractors. So, I would like to just get a basic understanding of which vendor or vendors are responsible for certain aspects of the implementation. So, specifically, who has the ultimate responsibility for training?

Mr. DALTON. Thank you. I guess I would start by saying, I think we are ultimately responsible for everything that happens. You know, we purpose built the team based on experience with the VA, gaps or needs. It is an ongoing process, and so I think we will continue to evaluate. You may be aware of it, last week we held an industry day with over 400 companies in attendance. So, we will continue to evaluate the best capabilities.

As it relates to training, Cerner is going to be doing the vast majority of the training for the VA.

Ms. LEE. Okay. What about testing?

Mr. DALTON. Again, it is a joint team. It is our team and then we have a small business contractor that we are working closely with.

Ms. LEE. Who is that?

Mr. DALTON. MicroHealth.

Ms. LEE. And then what about hardware deployment and configuration?

Mr. DALTON. The majority of that, if not most of it, will be done by Cerner, but we work closely with Leidos in technical areas. Accenture is also on the team, helping us with technology and interfaces, as well.

Ms. LEE. So, you say it is pretty much a 30–30 jointly responsible for Cerner?

Mr. DALTON. In general, I would say we have the majority of the responsibility right now.

Ms. LEE. Okay. At the elbow, support during go-live?

Mr. DALTON. It will be a combination of Cerner and a number of other small business partners, most likely.

Ms. LEE. Can we get the names of who those are?

Mr. DALTON. Yeah. And can I provide them post? I don't have them.

Ms. LEE. All right. Thanks. I understand.

And, then, finally, help desk support?

Mr. DALTON. That would be done by Cerner Corporation. We will, also, again, work closely with our partners from Leidos on help desk and sustainment.

Ms. LEE. Great. Finally, just, you know, Leidos, you were the main contractor for DoD, now you are a subcontractor. I am trying to get an essence for how the relationships work.

And so, given these different contractual relationships that exist between each of you as the prime vendor and the constraints that

those different relationships impose, how are you communicating with each other and really identifying lessons learned from the challenges? How does the day-to-day communication work?

Mr. SCHOLL. Yeah, thank you. Well, first of all, I would lead by saying that in many ways, we have a boundary list conversation that goes on. So, in a day-to-day interaction, we are not actually reflecting on our respective work shares in a contract or things that, you know, that are written down on paper, but, rather, we are mission-oriented and trying to solve problems. So, that would be just the ethos of team.

Secondly, we are in operating rhythms, daily, weekly, monthly operating rhythms where we are sitting next to one another with very defined lessons learned and action plans going forward, and that is a team effort. And not only us, but also with our customer, the DoD, in the DHMSM program, and I would assume, also, Travis does the same thing with the VA, and then we are in joint DoD and VA meetings, occasionally, as well.

So, you know, to summarize that, operating rhythms are strong and vibrant, and the ethos of the team is very mission-oriented.

Ms. LEE. Great. Thank you. I am now finished with my questioning.

I would now like to recognize Ranking Member Banks for 5 minutes.

Mr. BANKS. Thank you, Madam Chair.

Look, this is a huge investment. A lot of money is getting invested in this contract. And while there is a lot of confusing terminology that gets thrown around in hearings like this, I always think it is important to that we get to the bottom line. What are our veterans going to get out of this at the end of the day?

So, my first question is for you, Mr. Dalton. Can you guarantee me that if completed, EHRM and MHS Genesis will produce a single, longitudinal medical record?

Mr. DALTON. I don't like to make many guarantees in life, but that is ultimately, certainly our goal, sir, yes.

Mr. BANKS. Okay. Mr. Dalton, does that mean that each person, as he or she moves from enlistment to active-duty to reserve to veteran status, will exist in the system as a single record and that will be the same record for both, the DoD and VA?

Mr. DALTON. Yes. Longitudinally, yes.

Mr. BANKS. Okay. Mr. Waltman, I want to throw this over to you. A true single health record means the patient has a single patient locator number in the system. Is each person going to have a single patient locator record number in DoD and VA?

Mr. WALTMAN. Yes, sir, they will.

Mr. BANKS. Okay. Mr. Waltman, after some debate last year, VA and DoD decided to pursue a single common system, a single common Cerner instance. The overwhelming majority opinion was that that was the right thing to do.

So, I have a couple more questions to you. First, this has been characterized as interoperability, but isn't it more appropriate to describe what VA and DoD are doing as pursuing or making interoperability unnecessary, in terms of assessing each other's records?

Mr. WALTMAN. Thank you for that question. So, I think there is multiple parts to that. So, having a single record shared between

two departments will certainly facilitate certain aspects of operations between them and for veterans; however, there are many, many other sites of care where both, servicemembers and veterans, will receive care and all that must be integrated into becoming part of the veteran or servicemember's health record. So, interoperability between the departments and between the departments and other entities of care remains critical.

Mr. BANKS. So, stick with that for a moment. What is the practical difference between interoperability and the single common instance?

Mr. WALTMAN. So, I think the practical differences arise in how the information is integrated to become meaningful to whoever is looking at it at the point of care. The information between the DoD and the VA will be simpler to integrate because it will be starting from the same basis and the same framework. It will be in the same database in many instances.

However, for legacy information, information outside of those two systems of care, that has to also be commonly integrated and that is part of interoperability.

Mr. BANKS. Okay. Mr. Waltman, another question: No one has fully explained what would happen if the Departments decided to go the other route, to each install the Cerner EHR, but to do so separately. What would have been lost under that scenario and does it indicate some limitations of Cerner's ability to interoperate with itself if the EHRs are not identical?

Mr. WALTMAN. So, the evolution of the EHR, in general, is such that all EHRs have some differences and instantiations or deployments of EHRs, even the same her have some differences. By implementing both departments in the same common system, we eliminate the risk of many, many, many baseline decisions being different.

As Mr. Dalton indicated, we have the DoD system to work from as the baseline, and so that creates instant commonality between the departments that far exceeds what would be done if all of the decisioning were made independently and separately for two different instances of the system.

Mr. BANKS. So, if VA and DoD had separate Cerner instances, how would that differ from what exists now with the joint legacy viewer?

Mr. WALTMAN. That would be different in that the joint legacy viewer is, of course, read-only, and each Department can see the records of their Department and the—Department and community providers in a read-only context. Two implementations of Cerner would be actually somewhat similar to that, in which providers in each Department would be able to see into or see information from the other systems, but not be able to interact and write with it.

In this case, both Departments will have providers who are able to interact and write to and read from the same record. So, that is a big difference between how it would be with two instances.

Mr. BANKS. Thank you. My time is expired.

Ms. LEE. Thank you. I now recognize Ms. Brownley for 5 minutes.

Ms. BROWNLEY. Thank you, Madam Chair.

So, just to follow up on interoperability or maybe not interoperability, but what does it really mean with the Community Care providers, not just between VA and DoD, but Community Care providers?

Mr. WALTMAN. Yes, ma'am. Thank you.

So, the interoperability between Community Care providers and either Department will be provided via networks of health information exchange. So, of course, once we have implemented our health information exchange, the Cerner health information exchange for both Departments, which is underway, as we speak, then the Departments will have access to literally hundreds and hundreds of care provider organizations, as well tens of thousands—10,000, at least—providers of care. And that will be through the set of networks and health information exchanges which Common Well provides access to, care quality from The Sequoia Project provides access to, and the eHealth Exchange, which VA is already a member of, and has access to many care providers.

So, the network will greatly expand and the ability to exchange that information effectively, at scale, will be provided by our health information exchange.

Ms. BROWNLEY. So, that capability, then, is already in the marketplace; is that what you are saying, in terms of different systems talking to each other?

Mr. WALTMAN. Absolutely. It has just not been implemented in the integrated extent that we will be able to have the leverage to do from VA and DoD.

Ms. BROWNLEY. Uh-huh. One of the other issues that was raised in terms of timeline and meeting timelines is that the VA doesn't have the right equipment, doesn't have the right computers, in some cases, the Wi-Fi network, the band is not large enough to handle the data, and this is at large quantities at large scale. Is that something that VA is committed to getting done and if they don't, does that slow things down?

Mr. WALTMAN. Well, we certainly have the understanding that VA is entirely committed to doing what is necessary in those terms. We have not seen all of the specific plans in that regard.

I know that, for example, in our site assessments, we have provided recommendations for what they should have and what would be necessary to operate the system, including the provider equipment, including forward-deployed hardware that we would need to provide, as well as bandwidth and circuits. And our belief and understanding is that they are diligently working on all of those things.

Ms. BROWNLEY. So, you have made it clear to the VA what you need in order to, you know, proceed on this. And I understand that you are having constant communication with them, but they haven't given you an affirmative that they are, you know, in procurement, they are in the process of receiving this equipment and it will be in place by X period of time?

Mr. WALTMAN. There are certainly things that we are aware of them doing. For example, I know that they have been working on circuits for system bandwidth and things like that, and I know that they are working on, you know, other aspects of the infrastructure required, but the details of that, we would have to defer to VA.

Ms. BROWNLEY. Do you think the VA, at this particular point in time, has the correct amount of staff focused on this to be able to complete their tasks?

Mr. DALTON. I think, obviously, as resource-intensive, I think they are working closely with Booz Allen in search of support and otherwise. We haven't—I haven't seen an instance where their lack of staff has hindered our progress at this time.

Ms. BROWNLEY. Thank you. I yield back, Madam Chair.

Ms. LEE. Thank you. I now recognize Mr. Roy for 5 minutes.

Mr. ROY. I thank the chair and the Ranking Member. I thank y'all's indulgence. I have a competing hearing which I am the Ranking Member, so I had to sprint from Rayburn to here. So, I apologize for missing your opening statements. I would have liked to have heard those, and I hope nothing I am going to ask is going to be duplicative.

You know, I was kind of gearing up for the hearing and looking at what y'all were going to be talking about. I have just a few questions, and I will start with you, Mr. Dalton, if you don't mind. You know, obviously, the MISSION Act allows the VA to disclose veterans' medical records to their Community Care providers unless the veterans opt-out, right? I think I understand that correctly. And this replaces the previous law that required the veteran to opt-in because anything could be shared, because Community Care was not designated as a bona fide reason to be sharing records.

How is Cerner planning for this new authority to be used in the EHR?

Mr. DALTON. I think from our perspective, our goal is to open and interoperable at all times. One of the reasons to do this is the modern capability and technology, data liquidity, the ability to flow data in and out. Regardless of where anyone is seen, our goal would be that the data is all available in the right location for the provider to make the right decision. You know, that has been our goal since the beginning and that is how I would expect us to interact in that capacity.

Mr. ROY. And I can certainly say from the conversations—and I represent Texas 21, which has a significantly veteran population, you know, outside of San Antonio—and this would be maybe, I think, the issue that I hear most about when I am hearing and listening to veterans about what is impacting them and their ability to actually use Choice/MISSION, being able to get out and this is a significant barrier to that.

And I guess you guys are doing the market assessments and so forth, you know, what do you see that you might need to change or adjust in this framework?

Mr. DALTON. It would be important that the community providers are participating in this effort. Our belief is that this will actually derive interoperability across the country. That those in the community will want to make sure that they are interoperating through the—with the VA. So, we believe that this could be a significant driver for interoperability.

Mr. ROY. Get yourself some water.

Mr. DALTON. Tough day.

Mr. ROY. Another request is a little more technical in nature, and this is back to you, Mr. Dalton, but a quick question about the

software costs. The most recent report VA has provided us indicates a total of $494 and a half million has been obligated on Cerner's contracts. How much of that represents software licenses and how much of that represents work or other work beyond the licenses, do you know?

Mr. DALTON. I am going to have to provide that post for the record.

Mr. ROY. That is fine.

Mr. DALTON. I apologize.

Mr. ROY. Has VA purchased and paid for all of the Cerner software that will be used in this project?

Mr. DALTON. No, they haven't. They are paying as they go.

Mr. ROY. Okay.

Mr. DALTON. So, as it is being put into use, it is being paid for.

Mr. ROY. Okay. And what software has VA not yet purchased or paid for, do you know?

Mr. DALTON. They pay for it by a facility, which is by solution.

Mr. ROY. Okay. And how much has the VA obligated and paid out for software so far, do you know, or is that another you will get back to me on?

Mr. DALTON. No, I will have to get back to you, sir, with the numbers.

Mr. ROY. Okay. Here's a question, and if I may, a question for Leidos, broadly. You spoke about achieving health outcomes to enable military readiness, which is very important, obviously, to protecting our country. How can that focus on military readiness transfer to the VA? What is the DoD doing right that the VA can learn from?

Mr. SCHOLL. Well, I think there are many things being done right. You know, the ultimate objective of the system is to move the medical records to a modern, commercial off-the-shelf, continually upgraded system. And I think when we do that, we achieve outcomes like you are starting to see in the Pacific Northwest as it relates to a number of clinical appointments, the increase in, you know, detecting, you know, prescription errors or other safety events, as well as prescription fill rates, things like that. And those will translate into improved health and prove readiness and lessons learned for the VA.

Mr. ROY. Okay. So, one last question—my time is winding up—this will be for you, Mr. Crowe. Some questions about the role that y'all are playing. First, can you elaborate on what you believe the value add is for having a program management office? Can you just walk through that and I will leave it at that?

Mr. CROWE. Sure. Thank you.

First of all, it is a best practice in commercial and government on any kind of major rollout of any—particularly in electronic health record. So, it is consistent with best practices.

What we have been providing for the VA is surge support in a variety of different areas, ranging from electronic health record, technical engineering, but it is pretty evenly spread across the three pillars that we support, from program control, chief medical officer, as well as the technical integration office, and it is a range of functions from analysis, data collection, aggregation, preparing

and maintaining artifacts, and supporting the VA in their role of oversight.

Mr. ROY. Thank you.

Ms. LEE. Thank you. I now have a few questions about expectations.

So many times when the VA is implemented changes to its information technology and different changes, I feel like a lot of the potential failure is because of unrealistic expectations about what will happen when these changes are made. And I want to just set some clarity around the expectations of what the Cerner Millennium will achieve.

There is been talks about veterans having to lug around 30 years' worth of paper records and that will no longer be the case when the Cerner product is implemented. Isn't it true that some records, however, will not be migrated or not be available in Millennium?

Mr. DALTON. I am going to pass that to Ms. Stoner.

Ms. STONER. Thank you, ma'am.

There will be some records, particularly on the DoD side, just due to a different data-migration strategy, that will not be moved over to Cerner Millennium thanks to the acquisition approach from the DoD and, therefore, the DNF allowed us to take a different data-migration strategy with the VA because of our HealtheIntent platform was part of the plan from the beginning.

So, all VA records will be within the Cerner Millennium. As DoD rolls out, all of those will also fall in line. Within Cerner Millennium, within the physician's workflow, there is the ability to access the joint legacy viewer and that will remain there forever. Part of that, as part of our training in change-management activities, is to make sure that clinicians understand where they can see all of that information, whether it is from legacy systems, a different location that has not yet transitioned over to Cerner Millennium or from the community providers.

Ms. LEE. So, let me clarify. The VA has selected 30 data domains and the DoD has chosen 5; is that correct? So, there is like 25 data domains that are different—are not—that you are just going to be able to view in the legacy viewer?

Ms. STONER. Correct, on the DoD side. So, problems, allergies, medications, procedure history, and immunization history will be available for all patients that have been seen—

Ms. LEE. And then what is the length of time represented in that?

Ms. STONER. On the DoD side, it is all information, because an allergy is an allergy forever, similar with your immunization history and things like that.

On the VA side, it would encompass that 30 years of history, as we complete that data migration.

Ms. LEE. Okay. How does this compare with best practices in the commercial sector?

Ms. STONER. So, the DoD was similar to what we do commercially. I think this represents some of the innovation that we are able to do with the VA, kind of exploring this new data-migration strategy that would allow for more robust data from the beginning. I think it is an opportunity that as we prove that out and integrate

all of that information over, it may change the way we go commercially.

Ms. LEE. Let me see. Explain how this difference will affect the interoperability eventually.

Ms. STONER. So, in terms of interoperability between the Departments, all of that information will be available to all users within the system. So, if a DoD patient has been active-duty, changes to veteran status, is now being seen within the VA, all of their active-duty information, with the exception of some sensitive data, things like that, all of that information will be able to be seen by future providers, because it will all be inherent in the system.

Obviously, as time goes, historical data becomes less and less relevant in the clinical record, so all of that information from day forward will be data in the record.

Ms. LEE. Okay. Thank you.

Finally, one question I have about infrastructure. And sort of at what point we know that there are incredible infrastructure needs that the VA decision-making structure around infrastructure makes it, I am just going to say, difficult for Cerner to basically proceed. And there is certainly kinks in the system in terms of when this infrastructure will be purchased, when it will be implemented, even to the extent of planning on what exactly is needed.

At what point do we get alerted that the rollout of infrastructure on behalf of the VA is going to affect your rollout date? Like, at what point, what is the time lapse that you come to us and say, Hey, this is a problem. We are not going to make our deadline.

Mr. WALTMAN. Yes, ma'am. So, I think that the critical aspect there is that at the time that we have to have capability ready to be tested in the environments and to ensure that those capabilities are ready to meet the training requirements and so forth to go-live at the sites, that is the drop-dead date for the capability to be there. I think that we would have a pretty good idea of whether that looks realistic or not, you know, several months before that. So, I think that that time frame is not too far from now.

Ms. LEE. Okay. So, we will know in a couple of months if we are ready for you to or if the VA is ready for implementation?

Mr. WALTMAN. Or on track.

Ms. LEE. On track, okay. I am sorry, I am beyond my time, and I will recognize Ranking Member Banks for 5 minutes.

Mr. BANKS. Thank you, Madam Chair. You get to have all the time that you want.

Mr. Waltman let's pick up where we left off a moment ago. Congress gave the Departments an interoperability mandated in 2014. They certified that they met it in 2016 based on the joint legacy viewer. I believe that you still worked for VA at that time.

Either JLV achieve interoperability and solve the problem and the Cerner implementation is unnecessary or JLV did not really solve the problem. Both things can't be true. Which one is it?

Mr. WALTMAN. I think that, sir, as we have talked about, there is a continuous evolution of capability in health information technology. At the time that the requirements were given to the Departments for what needed to happen in regard to interoperability, the expectation was to be able to see the entire record from each

Department in one place. That capability was provided in JLV, as I and Chris Miller, testified at that time.

Since then, the Departments have decided, and it has been required that they have a system in which they can provide care together in the same system. That is beyond the capabilities of JLV. So, for the requirements that existed at the time, I think that has evolved and the expectations and desires for how to provide seamless care, which is the requirement now, requires a health record system that both Departments can use together and write into and operate from the same system.

Mr. BANKS. All right. So, this will be my last question on the single versus separate instances debate, and this question is for Cerner, as well. You have established that the single instance is going to be more effective in the long run and I believe you, but what is downside? Why was there such a heated, months-long discussion last year when Genevieve Morris was running EHRM, about what VA was giving up in the single instance?

Mr. WALTMAN. I think, sir, that is a great question. And there were lots of important discussions that had to take place for both Departments to understand what the extent of configurability would be to meet their differing needs to an extent. Not every process or every workflow is identical between the Departments; however, I think what folks realized is that much of the differences between the Departments are external, even to the EHR.

And so, in terms of both Departments understanding that we are starting with a commercial baseline and there is a configuration band, as Mr. Windom likes to refer to it, in which the system can support variability between workflows and requirements of the Departments and do so successfully in one system. That took a while for people to explore and understand.

Mr. BANKS. All right. Well, I find it hard to believe that VA isn't losing any autonomy in the single common system; in other words, that VA can have their cake and eat it, too.

What do you say to that?

Mr. WALTMAN. I think that autonomy and operation capability, I think I would describe it as this. There are certain decisions that were made in the DoD baseline. From the last workshop, for example, I was in a meeting where they were discussing what went into a drop-down for selections in prosthetics workflow. There were already decisions made there, and the discussion was around, do those words work for VA, as well? Those are kinds of things where VA would have just decided what they needed, otherwise; however, what they are—so, they may be giving up having to adapt to a few of those kinds of decisions or figure out how to integrate and work with it, but the benefits far outweigh the challenges in doing that, I think, in our view, given that the seamless care providers will be able to provide for veterans and servicemembers on both sides, far exceeds the limitations imposed by some of those word choices and other things in the system.

Mr. BANKS. All right. Mr. Dalton, Cerner's HealtheIntent software is a popular health system. Can you explain how HealtheIntent is different from the core EHR Millennium?

Mr. DALTON. HealtheIntent is a product we use to aggregate data from multiple data sources and Millennium is the core EHR. So,

HealtheIntent is a platform that coexists with Millennium and we use it to ingest, integrate, normalize, and data into the MR.

Mr. BANKS. Okay. That is all I have got. Thank you very much. I yield back.

Ms. LEE. Thank you. I now recognize Ms. Brownley for—you are done. Okay.

I just have a couple more questions I wanted to ask. The VA has said some functionalities are not available in Cerner's commercial modules, including nutrition, long-term care, base of cardiology, and prosthetics. For each of those modules, what is Cerner's approach to assessing how it can improve or acquire those functionalities to meet VA's needs?

Mr. DALTON. Working closely with the agency, obviously. They have unique needs, based on their patient population. I am going to kick it over to Julie to go a little further.

Ms. STONER. So, a lot of this process gets identified during what we call our current state assessments or current state reviews, where we have teams on-site and can understand some of the niche workflows, things that are different than what we see commercially. For example, the nutrition care or example that you provided, that was identified pretty early on and then we have been working with the agency to determine what is the best path forward; whether it is integrating with a new solution that we work with, if it is integrating with something that they use at one of their existing facilities, so we can still provide that service to them, just in this case, through integration, rather than native to the EHR.

Ms. LEE. How are you using this workshop process to balance like what VA's expectations are versus potentially a push to meet what is available in the commercial market?

Ms. STONER. So, thorough our iterative approach, we have had the 8 national—well, we will have 8 national workshops, as well as the local workshops. A large part of those workshops is change management and training of, what is the capability, how does that work into their workflow.

One of the biggest things in this space is standardizing an organization that has been independent for so long with the 130 different instances of VistA. Each area has been allowed to do things a little bit differently. So, I would say the biggest challenge has been what does standard in the VA look like and how can we integrate that into the EHR.

And then through the iterative process, we are allowed to make a decision. We can configure it, and then in the next workshop, provide that back to them to review and react to. Sometimes that may mean we have to reverse the previous decision, because it sounded like a good idea, but now they have seen it in reality, that doesn't quite jibe with what we want to do. And that is why we have so many workshops, is to allow that ready feedback so that we don't get to the end and go live and find out that it doesn't really—

Ms. LEE. Didn't work. Okay. Thank you.

Well, I think this is the end of the questioning, and I would like to thank all of you for this very helpful discussion. We all look forward, when we have our next hearing on EHRM on June 12th, and I would like to thank all of you for your attendance and hope we

can work together, and, obviously, have the transparency and the notification that is needed to make sure that we remain on track and, obviously, produce a successful product that delivers health care to our veterans and our servicemembers in a seamless manner. So, thank you very much.

All Members will have 5 legislative days to revise and extend their remarks and include extraneous materials, and the hearing is now adjourned. Thank you.

[Whereupon, at 4:00 p.m., the Subcommittees were adjourned.]

A P P E N D I X

Prepared Statement of Travis Dalton

Thank you, Chairwoman Lee, Ranking Member Banks and distinguished members of the Committee. My name is Travis Dalton, President of Cerner Government Services. Appearing with me are David Waltman and Julie Stoner from Cerner.

We thank you for the opportunity to appear before you today, and for your continued engagement and support of the Department of Veterans Affairs' (VA) Electronic Health Record Modernization (EHRM) program.

Just over a year ago, VA partnered with Cerner to proactively transform care for Veterans to help them lead longer and healthier lives. We remain honored and humbled to be part of this mission, and we have assembled a world-class partnership to deliver it.

Electronic Health Record Modernization is not just about technology, but transformation at scale. We realize the size and complexity of VA. This won't be easy, but it is achievable and we are making progress.

This program will ensure a lifetime of seamless care for Veterans and Service members across the Department of Defense (DoD), VA, and community providers.

The Department of Veterans Affairs has a long history of innovation and excellent care for those who have served all of us. We are building on that foundation and moving forward together.

This project will give providers the right tools and data at the right time to make the right decisions. With EHRM, Service members and Veterans will no longer have to carry stacks of paper records. Providers will have access to the Veteran's record wherever they deliver care.

Using advanced analytics and decision support we will be able to: better identify, diagnose, treat and manage chronic conditions; combat suicide, and opioid and substance abuse through interoperability and workflow tools that support clinicians; operationally move from 130 disparate systems to one open, modern, integrated system that's easier and more efficient to update and maintain.

It won't happen overnight, but we can and will achieve these goals.

This undertaking is immense. It carries risks and we don't take the challenges lightly. We must deploy to over 1,700 sites, train over 300,000 VA employees, collaborate with DoD to make decisions, interoperate with the community, aggregate decades worth of clinical data, and update technology.

The only way to get there is for all of us to work together: VA, DoD, all of you, our partners here today, VSO's and other stakeholders.

We are on the right track. We have confidence in Mr. John Windom and his leadership of this effort at VA. That has been imperative to our progress. Examples of that progress include:

We have established 18 councils made up of VA care providers nationwide, Cerner experts, partners, industry leaders, and DoD.

The councils have completed 5 of 8 National Workshops in Kansas City. They are making decisions, setting standards, and bringing best practices and lessons learned to implement one health record system across all VA.

We created an advanced learning academy to ensure early training of super users and advocates for the program.

Along with Booz Allen, we have a robust team in the Pacific Northwest hosting local workshops and implementing our change management plan.

We have completed 18 of 19 roadshows to engage clinicians at each VISN.

We migrated 23.5M Veterans health records consisting of 70 billion data records into the Cerner data center. This is the first time that VA data is in the same system as DoD health data.

We are impressed with the dedication, spirit and passion of the providers we work with inside VA and DoD. We are humbled by the opportunity to be in VA Medical Centers and to interact with clinicians and Veterans receiving care. It reminds all of us every day why we work so hard on this program.

This is personal for many of you who have served and so many of us who have a history of service in our families. I know it is for me. I think about my grandfather and the issues he suffered from upon return, and how health record modernization would have helped him.

We can do this, but it will take all of us working together. On behalf of Cerner we are honored to be part of it.

Thank you and I look forward to our discussion today.

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Prepared Statement of Jon Scholl

Chairwoman Lee, Ranking Member Banks, and distinguished members of the Subcommittee, thank you for the opportunity to provide a contractor perspective on modernizing health records at the Departments of Defense (DoD) and Veteran's Affairs. It is my privilege to represent Leidos - the prime contractor for the Department of Defense on the Defense Healthcare Management System Modernization (DHMSM) contract. The Leidos Partnership for Defense Health consists of four core partners. They are Leidos, which is the prime integrator and developer of the project, along with Cerner Corporation, Accenture, and Henry Schein One. The Leidos Partnership for Defense Health (LPDH) is complemented by 30 businesses with expertise in commercial hospitals and the Military Health System.

Together the Leidos Partnership for Defense Health is developing a modern, secure, connected Electronic Health Record (EHR) - called MHS GENESIS - that will provide a state-of-the-market, commercial-off-the-shelf solution consisting of Cerner Millennium, an industry leading medical EHR, and Henry Schein One's Dentrix Enterprise, a best-of-breed dental record system, as well as several other commercial software packages that make the system work together. This team is responsible for helping the DoD achieve its mission of standardized care for Military members, higher states of readiness for our armed forces, and to make possible essential data and record interoperability across the DoD, the Department of Veterans Affairs (VA), US Coast Guard, and private sector providers.

Implementing this program is complex and benefits from the holistic partnership and collective capabilities brought to bear by the Leidos Partnership for Defense Health. I am pleased to share that implementation is on track and on budget, and is projected to document health across the Military Health System (MHS) by the end of 2023.

The Mission of Leidos is "to make the world safer, healthier, and more efficient through information technology, engineering, and science." Implementing MHS GENESIS embodies that mission. For fifty years, Leidos has proudly served the interests of our country and embraced the mission of our customers. We recognize that our responsibilities to the DoD are great because they directly impact the health and well-being of our fighting forces and their families. Some of us who have served and raised families in the Military recognize the need to now replace the current system that has served us for so long. We are proud to be a part of this and we are committed to success.

Objective of Our Work

Working closely with our DoD customer, the Leidos Partnership is committed to executing three equally important objectives: deploying the single, integrated inpatient and outpatient EHR; incorporating continuous improvement to the implementation of MHS GENESIS through lessons learned; and successfully transforming the delivery of healthcare in the Military Health System (MHS) to ensure our Service members receive the same standard of care no matter where they are in the world.

What is MHS GENESIS?

MHS GENESIS is a healthcare transformation system designed to standardize the delivery of healthcare for nearly 10 million Service members and their families. MHS GENESIS is a collection and integration of products that will help the DoD and VA efficiently manage the health of our Service members, retirees, Veterans, and their families.

The Defense Healthcare Management System Modernization (DHMSM) contract was awarded to Leidos in 2015. At present, the program is on schedule to be fully deployed in 2023. While there are many partners involved with the DHMSM program and MHS GENESIS system, the program's contractor team is led by Leidos. The Leidos Partnership is a team of proven innovators who have consistently delivered large, complex solutions for the DoD and VA on time and within budget for decades. We specialize in delivering patient and clinician-centric tools, training, and

organizational change management support to offer high-quality health care technology. As one of the most experienced IT integrators in the federal space, Leidos was chosen as the prime integrator for the DHMSM program, and is responsible for the its day-to-day management and overall success.

Once implemented, MHS GENESIS will seamlessly integrate patient records so providers spend less time managing records - and more time with patients. At completion, the program will have modernized the military's healthcare system and enabled patients and clinicians to capture and share health data that improves continuity and quality of care for all active military, their families, and their beneficiaries.

MHS GENESIS is currently operating the Pacific Northwest at our Initial Operational Capability (IOC) sites. We are proud to report that MHS GENESIS is successfully managing more than 100,000 encounters per month at military treatment facilities. Children recently born at the OB GYN clinic at the Naval Clinic Oak Harbor in Washington State, for example, have an MHS GENESIS health record, and should those children join the military and eventually become beneficiaries of the Veterans Benefits Administration, they will carry the same single health record with them throughout their lives. If they choose to go with private health care, they will have an MHS GENESIS record that can be integrated into a commercial system at any hospital or clinic. This is an important differentiator from past efforts by the DoD and the VA.

Timeline

The DoD was an early pioneer in the development of a centralized, global electronic medical record when it introduced the Armed Forces Health Longitudinal Application - or AHLTA - in 2004. At the time, the private sector viewed the DoD's in-house EHR solution, like the VA's similar system, as advancing the state of healthcare documentation. However, by today's standards, DoD's health information technology (IT) systems are dated and need replacing. As well, because DoD and VA installations evolved independently, the EHR systems are not designed to interoperate, and this must be solved. We know this is a significant frustration to our veterans, to the agencies, and to Congress.

In 2013, then Secretary of Defense Chuck Hagel directed DoD to seek a commercial off-the-shelf software solution that would better integrate military health care records with the VA. This was the first step toward creating the single-instance program that DoD and VA are now working toward. This is important to highlight - a single-instance program is not the same as "interoperable", it is much better, as I will discuss a bit later.

In November 2017, the Leidos Partnership for Defense Health initiated "live" operations of MHS GENESIS in Washington State at our initial operational capability sites, which included four military treatment facilities and more than 20 ancillary clinics. These IOC sites initiated a period of use expressly intended to operate and collect "lessons-learned" and refine implementation practices that can be applied to future sites. The results are impressive: in 2018, our pilot sites experienced a 32 percent increase in outpatient appointments, a 63 percent increase in new prescriptions and refills, and more than 4,500 duplicate lab orders were avoided - improvements all achieved while maintaining stable staffing levels at each military treatment facility.

After gathering feedback at these sites intended to enhance the system for future deployment, DoD approved its deployment to the first wave of military hospitals and clinics, which includes Travis AFB, Naval Health Clinic Lemoore, Presidio of Monterey, Mountain Home AFB, and surrounding clinics.

MHS GENESIS will go live at these locations in September 2019.

We cannot over emphasize how important DoD's intentional and methodical approach to implementing, learning and improving is to successfully rolling out MHS GENESIS. Implementing a new platform of this scale and complexity requires a process with reasonable steps and multiple feedback loops.

What We Have Learned

The IOC sites, which ranged in size and complexity, allowed for feedback to be gathered and incorporated into the refined MHS GENESIS deployment strategy. As of today, those four pilot sites continue to use MHS GENESIS to safely deliver, manage, and document healthcare - documenting more than 100,000 patient encounters each month.

DoD plans to deploy MHS GENESIS by geographic region-three in the continental U.S. and two overseas-in a total of 23 waves. Each wave includes an average of three hospitals and 15 physical locations, and lasts approximately one year. Waves will run concurrently. This wave-based approach allows the DoD and LPDH to take

full advantage of lessons and experience gained from prior waves to maximize performance in subsequent waves. Full operational capability, to include medical and dental facilities worldwide, is scheduled to be completed by the end of 2023.

We acknowledge that the IOC go-live effort was not flawless - but its intended purpose was achieved - and that was to identify areas for improvement and set course corrections to address issues prior to full deployment. This may be the most important lesson of the pilot, which is that learning is constant and incorporating those lessons as the system is developed will make the implementation of MHS GENESIS that much more of a success. And I would again emphasize that the initial pilot sites are successfully using the system and improving healthcare outcomes though its use.

I'd like to provide you with a quick overview of some of the insight we gained from the IOC implementation. They include: improved training, necessary infrastructure investments, and change management across military treatment facilities.

Training

Our partnership has refined its training approach through three fundamental changes to the overall strategy. First, workflow adoption in key areas is being trained in advance of MHS GENESIS deployment and being led by the functional community. Second, training is being tailored to focus on role-based workflows that teach the user how to perform key tasks using MHS GENESIS. Third, the health system utilizes proven commercial best practices that deliver team-based training and just-in-time training during and after the system goes live.

Our pilot deployments provided critical insight on the importance of defining user roles and assigning targeted curriculum using a scenario and workflow-based approach, thus ensuring the training technical environment is in sync with the production environment.

Infrastructure

Highly-reliable hosting services are fundamental to enabling the delivery of MHS GENESIS. The Leidos Partnership has worked closely with DoD technical and cyber threat management leadership to build, deliver, and protect hosting services capable of storing personal health information and enabling the delivery of effective care.

Hosting services must be connected to each military treatment facility with high-speed/highly-reliable and secure Network Services. The DoD's Medical Community of Interest, or MED–COI, is a virtual, private network that DoD is investing in to ensure each Wave delivers sound connectivity to patient care locations.

Patient care workflows and services that take place within each treatment facility are enabled/supported with a variety of medical devices, lab instruments, patient monitors, imaging tools, and end-point Electronic Medical/Dental Record access devices. Our Wave deployment plan includes a rigorous assessment of existing military treatment facilities' equipment against MHS GENESIS requirements, followed by "refreshment as needed," which enables clinical staff to operate at peak efficiency and effectiveness.

Change Management

Implementing systems is a people business and change is hard. Fundamentally, the technologies that this system are commercially available and in production in hundreds of commercial locations. Technically, this system, while complex, is absolutely feasible. The most essential challenge is a people-challenge. A program of this size and complexity fundamentally changes the way people perform their jobs. Thus, we have worked side-by-side with clinicians to better understand their workflows in order to design a system that makes the delivery of healthcare more efficient and produces better clinical outcomes.

We have refined our deployment approach to ensure that change management begins on day one. Our team works with the staff at each military treatment facility to ensure they understand not only how things are changing, but also why, enabling greater ownership and engagement throughout the implementation process. We have developed enhanced materials and resources to address any gaps in order to ensure a smoother transition for future Waves. We will continue to refine and improve our process with continued feedback from each Wave deployment. The Leidos Partnership is fully committed to making this transition as seamless as possible for the Military Health community.

Joint Governance

The FY2008 National Defense Authorization Act (NDAA) directed the creation of an interagency program office for the DoD and VA. The DoD/VA Interagency Program Office (IPO) was established to lead EHR efforts between the DoD and VA

to improve the quality of healthcare, improve clinical and patient experiences, and increase interoperability among the Departments and the private sector.

Ultimately, it was the lack of standardization between the Departments' policies that inhibited the ability of the DoD and VA to implement the technologies available at the time and define long-term success. Joint leadership and consensus is fundamental to the ability to deliver a single, seamlessly integrated electronic health record.

Earlier I mentioned the importance of having a single-instance for health records keeping. Rather than having two separate systems, as DoD and VA have historically had, and have them "interoperable" in that they can read one another's data, MHS GENESIS is intended to be one instance, or one record used across both agencies. I used the example of a baby being born at Oak Harbor earlier - that is single instance. That child will have one record throughout their life, so long as they are in the defense health or VA systems. So in order for this to succeed, both programs must be near identical to allow for seamless transition of information and data.

To that end, on September 28, 2018, the Secretaries of Defense and Veterans Affairs signed a Joint Commitment Statement pledging to align VA and DoD strategies to do just that - to implement the same MHS GENESIS system. In response to this commitment, the DoD and VA evaluated program dependencies such as infrastructure, incorporation of clinical and business processes, and other requirements from the functional, technical, and programmatic communities. The DoD and VA leadership determined that the optimal and lowest risk alternative was to re-charter the DoD/VA IPO into the Federal Electronic Health Record Modernization (FEHRM) Program Office.

The FEHRM, which is intended to incorporate key members of the IPO, as well as DoD and VA program office staff, will provide a more comprehensive, agile, and coordinated management authority to execute requirements necessary for a single, seamless integrated EHR. Leadership commitment and alignment is critical to drive change. This is especially true when deploying a single, integrated inpatient and outpatient EHR, while standardizing enterprise-wide workflows across more than 400 military treatment facilities. While the scope of our mission remains unchanged, the scale will continue to grow and we are prepared to deliver.

We believe the key to success is to empower the FERHM to make decisions that ensure the joint requirements are in place for both the DoD and the VA.

We believe this program office should be small, nimble, and they should be an arbiter of key decisions, not an overseer of each program. In other words, the FERHM should not be tasked with delivering a product, but rather driving requirements that are universal across DoD and VA.

Commitment to Protecting Patient Data

An essential priority is keeping patients safe and protecting their personal data. This principle guides the implementation of MHS GENESIS. We work closely with the MHS community to continuously refine and enhance the system to meet the needs of the military health community based on ongoing, real-time feedback from the testing sites (Fairchild Air Force Base, Naval Health Clinic Oak Harbor, Madigan Army Medical Center, and Naval Hospital Bremerton).

Closing

The Leidos Partnership for Defense Health team collectively brings decades of experience implementing healthcare IT solutions in the federal space. Together, we have the experience and know-how to deliver a project of this magnitude through to completion.

In closing, I would like to share a quote from Vice Admiral Raquel Bono who said, "We have the potential to create the very best healthcare system ever, not just for the military, but for the United States, our Nation, and across the world." Leidos and its partners are confident in our ability to make that vision a reality, by implementing the integrated electronic health record system - MHS GENESIS - across the military health community by the end of 2023. On behalf of the Leidos Partnership for Defense Health, I promise we are committed to honoring this noble mission. Thank you and I look forward to your questions.

Prepared Statement of Richard Crowe

Good afternoon, Chairman Lee, Ranking Member Banks, and other Members of the Subcommittee. I am Richard Crowe, an Executive Vice President at Booz Allen Hamilton and the Client Service Officer for Booz Allen's Health Account. In that

role, I lead a diverse portfolio of health services matters, including IT and healthcare operations service contracts, to include our EHRM Electronic Health Records Modernization (ERHM) program management support contract at the Department of Veterans' Affairs. I am pleased to be here with you today in my capacity as the head of Booz Allen's Health Account to discuss Booz Allen's role as an EHRM program management support contractor.

Booz Allen has a strong, demonstrated commitment to serving our nation's veteran population. Booz Allen was founded by a veteran, and the company has continuously supported the Department of Veterans affairs since 1952. Booz Allen takes great pride in our 65-year history of supporting veterans, which we do in multiple ways. Approximately 30 percent of our over 25,000 employees are military-connected - meaning they are veterans, in the National Guard, or military spouses - and Booz Allen invests in helping our military connected employees thrive through career building, best in class benefits, formal programs for military spouse support, and support to the military and veteran communities through innovative and impactful nonprofit partnerships. We are committed to the Department of Veterans Affairs' mission to serve our Nation's veterans.

The VA contract that brings me before the Committee today is Booz Allen's contract to provide Program Management Office (PMO) support for the VA's planning for and implementation of the overall EHRM solution. This testimony summarizes what we do under that contract, who we do it for, and what our role is relative to the other contractors supporting EHRM implementation.

What we do. As the Committee is aware, the VA Office of Electronic Health Record Modernization (OEHRM) is overseeing the implementation of a new electronic health record (EHR) system to be used across the VA healthcare enterprise. It is common for large EHR implementation contracts to have a significant PMO, because preparing to go live with a new electronic health record system is a complex undertaking. Ensuring the continuity and safety of health care delivery is a main VA priority and, as the PMO support contractor, we support the VA's efforts to better serve and honor the men and women who are America's veterans.

Speaking generally, a PMO support contractor provides the surge staffing, resources, and tools, as well as management, engineering and governance expertise, to provide additional resources to a government program office to augment the government's own capabilities at the government's direction. EHRM PMO support contractors allow the government to obtain specific skills relevant to the EHR implementation at the relevant stage of the implementation process and in a time-bound manner. For example, we have engaged a number of individuals with Cerner technical expertise (i.e., experience implementing the Cerner product as implementation consultants or users of prior EHR implementations), as well as clinicians to support the VA in its review and execution of key implementation tasks in preparation for initial operating capability (IOC). By engaging such individuals on a temporary basis during implementation, we provide the specific personnel when the VA directs, and the VA is able to reduce its overall long-term spend. We also equip the VA with key resources and tools for identifying, tracking, and managing risks identified across each of the main PMO workstreams. PMO contractors provide key assistance to implementing organizations as those organizations work to convert enormous projects into discrete, actionable, trackable, and measurable tasks. The VA's use of such a PMO support contract is consistent with other commercial and governmental EHR implementations, to include the DoD's EHR implementation.

Who we do it for. Booz Allen is working at the direction and supervision of the VA under a time and materials contract. In that role, our job is to respond to a range of VA taskings required for successful ERHM implementation. We do not have our own independent development scope nor responsibility over deployment and implementation tasks. The actual development and integration are being undertaken by Cerner.

Substantively, the VA determines the support it needs from Booz Allen and closely directs our efforts. Those efforts include providing program management, administrative, functional, technical, and logistical support to the EHRM Program Office as required under our contract's Performance Work Statement.

Structurally, our team mirrors the VA PMO team in that we are organized into workstream pillars. For each of those functional areas, the government workstream lead is paired with a Booz Allen workstream lead who assists their government counterpart. Booz Allen works at the direction of the government workstream lead with the approval of the Executive Director for VA Electronic Health Records Modernization and our Contracting Officer's Representatives (COR). The primary workstreams focus on assisting the Chief Medical officer, the Technology Integration Office, and Program Control. Additionally, we have staff located near the IOC sites

as part of the Command Action Team (CAT) as a local extension of the broader PMO support.

Our role relative to Cerner. Booz Allen's work is distinct from Cerner's. Cerner is the principal contractor and is the technical. While we have some interaction with Cerner in our PMO support role, we do not direct Cerner. We support the VA's oversight role. There is no contractual relationship between Booz Allen and Cerner, and we do not have any technical or implementation responsibility over Cerner's scope of work.

Thank you for the opportunity to testify before the Subcommittee today. I look forward to your questions.

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