TESTIMONY

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BEFORE THE

HOUSE APPROPRIATIONS COMMITTEE

UNITED STATES HOUSE OF REPRESENTATIVES

MARCH 25, 2009

MEETING THE HEALTH CARE TRANSITION NEEDS OF SERVICE MEMBERS

NOT FOR PUBLICATION UNTIL RELEASED BY THE COMMITTEE ON APPROPRIATIONS

Thank you, Mr. Chairman, for the opportunity to speak to you today on the healthcare needs of service members as they transition to veteran status. The Department of Defense (DoD) is committed to protecting the health of our Service members, providing world-class healthcare to more than 9 million beneficiaries, and seamlessly coordinating the transition of Service members' medical care to the Department of Veterans Affairs (VA) to support continuity of care.

While the two Departments have been working together in earnest for more than two decades, over the past few years, we have taken truly great strides in coordinating and developing common health care and support services along the entire continuum of care. Both agencies have been making concerted efforts to work closely to maintain and foster a more effective, aligned federal healthcare partnership. We have jointly confronted the clinical and technical challenges of dealing with severe and complex war-related wounds, both physical and psychological, and with managing the increased demands on our systems for long term rehabilitative care for our wounded, ill, and injured combat veterans. We owe all of our service members and veterans so much for their past and present sacrifices to our nation, and we are committed to working together to ensure that they get the very best that our health systems can offer, and to keeping their associated bureaucratic burdens to a minimum.

Joint Executive Council

Established by the National Defense Authorization Act of Fiscal Year (FY) 2003, the VA/DoD Joint Executive Council (JEC) oversees and guides the joint health and benefits activities of the Departments. Under the JEC, dozens of highly dedicated professionals from both Departments have been working closely with one another across departmental lines in about 20 working groups to improve access, quality and efficiency in such areas as Information Management, Information Technology (IT), Mental Health, Clinical Practice, Deployment Health and Benefits Delivery at Discharge (BDD). These elements are the keys to maintaining and improving upon the firm foundation already in place for delivery of seamless, coordinated health care services and benefits. Indeed, the Joint Strategic Plan (JSP), which is our joint road map, contains seamless transition as one of its major goals. The JEC continues to push the Departments hard in the direction of increasing the numbers of service members in all Military Departments to enroll in VA health care programs and to file for VA benefits prior to separation from active duty status.

Senior Oversight Committee

In May 2007, a Wounded, Ill and Injured (WII) Senior Oversight Committee (SOC) was created by the two Departments, co-chaired by their Deputy Secretaries, and included the most senior staff of the Departments. The WII SOC was established to ensure senior level line and civilian oversight and interagency coordination of the various commissions and review groups looking at wounded warrior issues. In the past year, both

the WII SOC and the JEC have provided oversight and guidance to more than 500 new initiatives to improve inter-Departmental cooperation and reduce bureaucratic barriers impeding a seamless transition. The WII SOC efforts have focused on ensuring a smooth transition for severely injured service members returning from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF).

VA/DoD Disability Evaluation System

In order to update and simplify the disability determination and compensation system, VA and DoD initiated a Disability Evaluation System (DES) Pilot program in late 2007 for disability cases originating at the three major military treatment facilities (MTFs) in the National Capitol Region. The Pilot tests a new VA and DoD disability system designed around the service member to eliminate the duplicative, time-consuming, and often confusing elements of the two current disability processes of the Departments. Specifically, the Pilot features one medical examination and a single-sourced disability rating with the goal of reducing by half the time it currently takes to transition a service member to veteran status and provide them with their VA benefits and compensation. Between November 26, 2007 and the end of FY 2008, 723 service members participated in the Pilot. Of those, 119 completed the process in an average of 203 days – a 62 percent reduction in the amount of time previously required to complete the current DES and VA claim process. The Pilot was originally scheduled to run for one year; however, at the conclusion of FY 2008, senior leadership decided to expand the

Pilot to 17 additional sites. The expansion allows the Departments to test the viability of a new process under a broader number of local conditions.

Continuity of Health Care and Benefits

To provide comprehensive assistance to recovering service members and their families throughout recovery, rehabilitation, and reintegration, the WII SOC established the Federal Recovery Coordination Program (FRCP). The FRCP is operated as a joint VA/DoD program with VA serving as administrative home. VA also provides staffing for program personnel. The Executive Director of the program reports to the Secretary of VA and the WII SOC.

The FRCP is designed to assist recovering service members, veterans, and their families in accessing care, services, and benefits provided by the various programs in VA and DoD, other Federal agencies, states, and the private sector. Satisfaction surveys were also developed. Ten FRCs have been placed at MTFs where most newly evacuated wounded, ill or injured service members are taken. The program also placed FRCs at selected VA facilities to assist with assessing and enrolling those wounded, ill or injured veterans who passed through the system prior to the program's implementation.

A comprehensive, web-based National Resource Directory was jointly developed by DoD, VA and the Department of Labor to provide recovering service members, veterans, families, care coordinators, care providers and care partners with a single online reference for the full array of programs and benefits available. The directory was activated in November 2008 and contains checklists for common processes and a section

for frequently asked questions. It also provides information on services and catalogues resources available through national, state and local governmental agencies, veterans' benefit/service/advocacy organizations, professional provider associations, community/faith-based/non-profit organizations, academic institutions, employers, and business and industry's philanthropic activities. It provides information designed to help meet the medical or non-medical needs and personal goals of recovering service members and veterans regardless of location. Users are able to search for information by user type, geographic location, military affiliation, and specific service or resource.

The Polytrauma Liaison Officer/Noncommissioned Officer Program

In addition to the FRCP, the Departments have instituted the Polytrauma Liaison Officer/Noncommissioned Officer Program. This program was originally established in March 2005 as the Army Liaison/VA Polytrauma Rehabilitation Center Collaboration, a "boots on the ground" program specifically focused on providing non-clinical transition assistance for the most severely injured and ill service members being transferred directly from a MTF to one of the four VA Polytrauma Rehabilitation Centers (PRCs) in Richmond, VA; Minneapolis, MN; Tampa, FL; and Palo Alto, CA. However, in FY 2008, the program was expanded and now includes an Army and Marine Corps liaison at each PRC and a Navy liaison at the Palo Alto and Tampa locations. Each of the Military Departments has a formal chain-of-command in place to provide guidance and resolve issues for the program. The Army program operates under the auspices of the Army Office of the Surgeon General through the Regional Medical Commands down to the

Warrior Transition Units. The Navy and Marine Corps programs are overseen by the personnel community; the Navy Safe Harbor Command and the Wounded Warrior Regiment, respectively. Each Military Department has a dedicated program manager to oversee the liaison program and interface with the Veterans Health Administration (VHA) program manager to address issues related to the program.

DoD conducted a recent assessment of the program in accordance with Section 1665 of the NDAA for FY 2008. The Department reported that the primary objective of this program is to provide a uniformed advocate to support and assist injured service members and their families, particularly with resolving non-clinical, military related issues. Using this objective as a benchmark for effectiveness, it is the nearly unanimous consensus of everyone interviewed that the military liaisons provide great value to the comfort of the service members and their families. In executing their duties, the military liaisons unanimously cited that they do "whatever it takes." It is also widely noted that their advocacy in solving problems, providing a uniformed presence and perpetuation of military culture while being cared for in an unfamiliar VA environment, enables these service members to focus completely on recovery and rehabilitation.

High Quality Health Care

Over the past year, the Health Executive Council (HEC), under the JEC, has focused on joint efforts to improve access, quality, and effectiveness of health care for beneficiaries by fostering a greater understanding of issues directly related to forward

deployment as it relates to decreasing injury and illness, improving patient safety in both health care systems, and instituting evidenced-based clinical practice guidelines.

Over the past year, hundreds of mandates and recommendations to improve the psychological health of service members and veterans, as well as substantive Congressional funding to assure adequate numbers and training of mental health providers, have resulted in newly established structures to meet current wartime challenges. The Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury was stood up in November 2007 to help meet these challenges, and includes an embedded VA mental health leader.

Deployment Health

The VA/DoD Deployment Health Work Group (DHWG) was established to ensure coordination between the two Departments in order to effectively maintain, protect, and preserve the health of Armed Forces personnel, veterans, and their families during and after combat operations and other deployments. In FY 2008, the focus was predominantly on service members returning from OEF and OIF, while still continuing to coordinate initiatives related to veterans of all eras, going back to the 1940s. Through the Work Group, VA and DoD share information and resources in the areas of deployment health surveillance, assessment, follow-up medical care, health risk communication, and research.

This past year, the DHWG worked on two medical surveillance initiatives; one on a new National Veterans' Registry, and the other on exposure to depleted uranium (DU).

VA and DoD are working to develop a national listing of all living veterans, which will be called the VA National Veterans' Registry. Staff from several VA and DoD offices have started planning the registry. Veterans will not need to be enrolled in VA health care to be included in the registry. This database will be useful for policy development and planning, as well as for outreach and research.

In the early 1990s, we began joint medical surveillance for Depleted Uranium (DU) in the most highly exposed group of veterans of the 1991 Gulf War, which has since expanded to include all Gulf War and OIF veterans. More than 2,500 OIF veterans have now participated in the program. VA and DoD recently developed programs to respond to new requirements related to heavy metals. In December 2007, DoD implemented a policy for collection and chemical analysis of all metal fragments that are surgically removed from injured service members. DoD is establishing the DoD Embedded Metal Fragment Registry in order to identify and track service members who have retained fragments, the total number of which is unknown. Potential cases will be identified using two DoD databases, the Theater Medical Data Store and the Joint Theater Trauma Registry. Once DoD identifies cases, their names will be shared with VA.

VA and DoD jointly funded an Institute of Medicine (IOM) study of potential long-term health effects of DU, which resulted in the publication of two reports in July 2008. IOM concluded there was "inadequate/ insufficient evidence to determine whether an association exists between exposure to uranium and all the health outcomes examined." Regarding these 20 health outcomes, IOM also stated, "Exposure to uranium is not associated with a large or frequent effect. The committee's evaluation of the

literature supports the conclusion that a large or frequent effect is unlikely, but it is not possible to state conclusively that a particular health outcome can not occur." VA scientists will evaluate this report and make a recommendation to the Secretary of VA regarding whether there are diseases which are related to DU exposure, for which a presumption of Service connection is warranted.

DoD requested an IOM study to assist in responding to Section 716 of the NDAA for FY 2007, which required DoD to conduct a comprehensive study of the health of soldiers with potential exposure to DU, in consultation with VA and the Department of Health and Human Services. In evaluating the feasibility and validity of the type of study mandated in Section 716, IOM concluded, "it would be difficult to design a study to assess health outcomes of DU exposure in military and veteran populations comprehensively. Detecting a small increased risk for a given health outcome of DU exposure in military and veteran populations is not feasible in an epidemiological study." DoD will send a report to Congress that summarizes the IOM report, and describes DoD's plan to continue the biomonitoring program for service members in OIF and to coordinate the appropriate long-term care with VA.

Post-Deployment Medical Care.

The HEC, through the DHWG, is monitoring VA and DoD initiatives on the assessment, diagnosis, and treatment of TBI on an ongoing basis, in response to the recognition of TBI as an emerging problem in OEF/OIF. In October 2007, DoD directed the three Military Departments to identify, document, and report TBI cases into a central

database, established by the Defense and Veterans Brain Injury Center (DVBIC), on an ongoing basis. In the past, only TBI patients diagnosed at DVBIC-designated MTFs could be counted consistently. The new system requires reporting from all DoD medical centers nationwide. In May 2008, DoD mandated a program to collect baseline neurocognitive data on all service members before they deploy. The testing takes 15-20 minutes to complete, and includes domains sensitive to the effects of mild TBI. The Army started testing in August 2007; by January 2008, more than 48,000 soldiers had been tested.

VA and DoD began collaborating with the Centers for Disease Control and Prevention (CDC) to "conduct a longitudinal study on the effects of TBI incurred by members of the Armed Forces serving in OIF or OEF and their families" in accordance with Section 721 of the NDAA for FY 2007. DoD will evaluate the long-term physical and mental health effects of TBI and related health care needs over a 15 year period via annual telephone interviews. A total of 1,200 service members diagnosed with TBI will be recruited into the study starting in 2009.

Deployment Health Risk Communication

The DHWG continued its efforts to improve coordination of risk communication and outreach to service members, veterans, and health care providers for deployment related exposures and substantial emerging health concerns. A subcommittee to the work group was established to develop, coordinate, and disseminate risk communication products. In 2008, the subcommittee developed two pocket cards for both VA and DoD

clinicians; one on malaria and one on mefloquine, a drug used to prevent malaria infection. Additionally, the DHWG was instrumental in two communication efforts related to the notification of veterans who were involved in chemical and biological testing programs and related to potential environmental exposures in OIF.

The DHWG provides ongoing coordination of notification efforts on chemical and biological agent testing programs that took place from 1942 to 1975. DoD has compiled three databases: mustard/lewisite, Project Shipboard Hazard and Defense (SHAD), and Chemical/Biological Follow-on Database. The mustard/lewisite database includes a list of service members involved in testing of mustard agent and lewisite, another blister agent, from 1943-1946. VA used the findings of a 1993 IOM report to develop a list of medical conditions for which there is a presumption of Service connection for veterans who had fullbody exposure to these agents. The Project SHAD database includes a list of participants involved in testing U.S. warship vulnerability to biological warfare (BW) and chemical warfare (CW) agents during 1962-1973. VBA identified current addresses for 4,438 of these veterans, and sent them notification letters about their participation in Project SHAD and the availability of VA medical care and benefits. The Chemical/Biological Follow-on Database includes names of approximately 10,000 veterans involved in several tests of CW and BW agents from 1942-1975 in Edgewood, MD; Fort Detrick, MD Dugway Proving Grounds; and several other locations, which included more than 400 chemicals. Of the 6,700 participants identified by DoD in Edgewood, MD, the largest of the cohorts, VBA identified 2,987 current addresses for

these veterans and sent them notification letters. DoD is investigating other possible test locations, and continues to update the database and forward names of veterans to VA.

The DHWG recently facilitated VA and DoD outreach efforts related to two potential exposure incidents that occurred in Al Tuwaitha and Qarmat Ali, Iraq. In 2003, there was concern about potential radiation exposure at a damaged nuclear research center in Al Tuwaitha. An Army health physics team has since estimated soldier doses to be less than the safety standards set by the U.S. Nuclear Regulatory Commission. However, the news media raised concerns in November 2007 about service members who visited Al Tuwaitha. In response, an Army health physicist held three town hall meetings at Fort Campbell, Kentucky to hear first-hand from the soldiers and allay their concerns. In 2008, VA sent an announcement to VA health care providers on potential exposures to service members at Al Tuwaitha.

In 2003, military personnel, mostly from the Indiana National Guard, and contractors were potentially exposed to soil contaminated with sodium dichromate while conducting repair work at a water treatment plant in Qarmat Ali, Iraq. The Army performed environmental and medical surveys resulting in a fact sheet that was updated in 2008 to state that it is "unlikely that any current symptoms or health problems could be related to this past exposure or that future problems from this exposure are expected." The Army National Guard held multiple town hall meetings in Indiana in 2008 and sent letters to Guard members to notify them of the potential exposures at Qarmat Ali. VA participated in the DoD town hall meetings to assist in enrolling veterans in VA health

care. VAMCs in Indiana have offered to provide medical evaluations to concerned veterans.

Deployment Health Related Research

During the past year, the DHWG developed its annual research inventory, reviewed the progress of the Millennium Cohort Study (MCS), and participated in planning a research conference on the treatment of Post Traumatic Stress Disorder (PTSD). The DHWG has developed an inventory of more than 600 VA and DoD research projects related to the health of deployed service members and veterans. Collaborative efforts between the centralized research office in VA and many DoD research offices resulted in the institutionalization of a reporting system and a process to collect, organize, and archive data on relevant projects on an annual basis. The majority of the projects focus on injuries and mental health. Other research areas include infectious diseases, environmental and occupational exposures, vision and hearing, and pain management. The results of this collaborative effort have been published in a user-friendly format on a DoD research web site, DeployMed ResearchLINK, which also includes a continually updated bibliography of all 2002-2008 medical articles related to the health of service members returning from OEF/OIF. Publication of the projects and articles on this web site provides global access to current information on deployment health research to health care providers, researchers, service members, veterans, their families, Congress, and the general public.

The DHWG monitors the progress of the MCS on an ongoing basis. In February 2008, the DHWG invited the MCS Project Director to provide a detailed update. The Project Director reviewed the objectives of the MCS, which are "to evaluate chronic diagnosed health problems, including hypertension, diabetes, and heart disease, among military members, in relation to exposures of military concerns; and to evaluate long-term subjective health, including chronic multi-symptoms illnesses, among military members, especially in relation to exposures of military concern." The MCS Project Director also reported that several postdeployment health outcomes are being evaluated in the MCS, including PTSD, depression, alcohol abuse, TBI, smoking, and respiratory health. Approximately 150,000 personnel will be enrolled and followed until 2022, with a health evaluation conducted every three years to determine the course of diseases over time. Several articles related to the MCS were published in 2008, including papers that focused on PTSD and alcohol-related problems before and after combat deployments, as well as several papers on adverse events related to the anthrax and smallpox vaccines.

In January 2008, VA invited scientists from DoD and the National Institutes of Health (NIH) to participate in a two day research symposium on PTSD treatment. DHWG members participated in the planning and follow-up of this symposium, the goal of which was to identify state-of-the-art approaches for PTSD research. The meeting addressed an IOM report that was published in October 2007, entitled, *Treatment of Posttraumatic Stress Disorder: An Assessment of the Evidence*. The IOM concluded that the "evidence was sufficient to conclude the efficacy of exposure therapies in the treatment of PTSD." IOM also concluded the evidence was "inadequate to determine the

efficacy" of several other types of psychotherapy and several types of drug therapy. VA published a report on the symposium on the VA Office of Research and Development web site. The report provides guidelines to improve future PTSD research, which will be useful to researchers and VA, DoD, and NIH research administrators.

Patient Safety

In FY 2008, VA and DoD continued to collaborate on improving patient safety practices. Both Departments have nationally recognized patient safety programs and aggressively worked with other Federal agencies such as the Agency for Healthcare Research and Quality (AHRQ), the Food and Drug Administration (FDA), the CDC and the Institute for Healthcare Improvement to prevent harm to patients as they receive health care. Examples of VA and DoD coordinated efforts to improve patient safety include: VA and DoD sharing of relevant patient safety alerts and advisories as part of its routine operations, and VA and DoD development of plans for sharing protected patient safety data to be used following the establishment of a formal VA/DoD data sharing agreement. VA and DoD completed the Usability Testing white paper which was subsequently accepted by the JEC. Both systems are independently exploring usability testing while continuing to share lessons learned. VA and DoD have continued their joint work with AHRQ on the Patient Safety Work Group to develop common clinical definitions and reporting formats (Common Formats) for use by patient safety organizations (PSOs) in support of the Patient Safety Act of 2005. In this effort, for example, DoD worked collaboratively with VA and other health agencies in developing

Commons Formats for pressure ulcers, modeled on the on the pressure ulcer data collection tool developed by the DoD Patient Safety Center. AHRQ released the Common Formats for public review and use by PSOs and health care providers in August 2008.

Evidence-Based Clinical Practice Guidelines

In FY 2008, VA and DoD made significant progress in the development, updating, and adoption of Evidence-Based Clinical Practice Guidelines (CPGs). A collaborative work group under the auspices of the HEC continued its focus on identifying areas where the Departments could reduce variation in care, optimize patient outcomes, and improve the overall health of our populations. During FY 2008, the work group completed the Uncomplicated Pregnancy CPG, and nearly completed the CPG for Mild TBI (mTBI) in a record nine months. At the close of FY 2008, the work group was fast-tracking mTBI CPG for public review and comment and final edits. The work group also continued its work on the CPGs for Substance Abuse, Stroke Rehabilitation, Major Depressive Disorder, Bipolar Disorder and Asthma. Toolkits to support evidence-based culture and practice completed during FY 2008 were Cardiovascular Disease and Obesity materials. Work continues on the Amputation and Low Back Pain toolkits.

The work group aggressively pursued new opportunities to expand the use of jointly developed CPGs. During this timeframe, lines of communication were initiated to collaborate with other organizations in CPG development. Current Evidence-Based CPGs were promoted through educational material exhibits at 12 national and local

conferences for both military and civilian audiences. Evidence-Based Practice staff served as guest speakers at six national conferences. Conference topics included the advance of Evidence-Based delivery of health care as well as the utilization of CPGs to promote population health and disease management. Marketing efforts culminated in a 67 percent increase in CPG web views on the Quality Management Office web site from last year. Also noted was a 38 percent increase in the number of toolkit items shipped to DoD sites in support of CPG implementation and utilization from FY 2007.

IM/IT- Care for Separated Service members

For separated Service members, since 2001, DoD has supported the monthly transfer of electronic health information from DoD to a jointly developed data repository known as the Federal Health Information Exchange (FHIE). VA providers and benefits specialists access this data daily for use in the delivery of healthcare and resolution of claims. The transferred data includes: inpatient and outpatient laboratory results and radiology reports; outpatient pharmacy data from MTFs, retail network pharmacies, and DoD mail-order pharmacy; allergy information; discharge summaries; admission, disposition, and transfer information; consultation reports; standard ambulatory data record information such as diagnostic codes, primary care physician, treating physician; patient demographic information; Pre- and Post-Deployment Health Assessment (PPDHA) and Post-Deployment Health Reassessment (PDHRA) forms.

As of January 2009, DoD had transferred health information for over 4.7 million patients to the FHIE data repository. Of these 4.7 million patients, approximately 3.2

million patients have presented to VA for care, treatment, or claim determination. The amount of data available to VA continues to grow as health information on recently separated Service members is extracted and transferred to VA. Transfer of data to VA is executed in a manner that is compliant with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. DoD is also transferring data for VA patients being treated in DoD facilities under local sharing agreements. As of January 2009, over 3.6 million cumulative patient messages such as laboratory, radiology, pharmacy, and consults have been transmitted on VA patients treated in DoD facilities.

IM/IT - Care for Shared Patients

For shared patients being treated by both DoD and VA, the Departments continue to use the Bidirectional Health Information Exchange (BHIE) which enables real-time bidirectional sharing of allergy information; outpatient pharmacy data; demographic data; inpatient and outpatient laboratory results and radiology reports; ambulatory encounters/clinical notes; procedures; problem lists; vital sign data; patient histories; questionnaires, and Theater clinical data including inpatient notes, outpatient encounters, and ancillary clinical data, such as pharmacy data, allergies, laboratory results, and radiology reports. Access to BHIE data is available through AHLTA, DoD's EHR, and through VistA, VA's EHR, for patients treated by both Departments. As of January 2009, there were over 4.7 million correlated patients, including over 117,980 Theater patients, available through BHIE.

To increase the availability of clinical information on a shared patient population, VA and DoD leveraged the BHIE functionality to allow bidirectional access to inpatient documentation from DoD's inpatient documentation system. This capability is now operational at some of DoD's largest MTFs, accounting for approximately 51 percent of DoD total inpatient beds.

In addition to sharing viewable text data, VA and DoD are leveraging the BHIE infrastructure to support the exchange of digital radiology images to support continuity of care. The Departments will continue to monitor and evaluate this capability as a component to a broader image sharing capability.

For our most seriously wounded, ill, and injured Service members transferring to VA PRCs for care, the Departments continued to send radiology images and scanned medical records electronically from three major DoD trauma centers at Walter Reed AMC, Brooke AMC, and Bethesda National Naval Medical Center, VA PRCs located in Tampa, Richmond, Minneapolis, and Palo Alto. As of January 2009, scanned medical records for over 215 patients and digital images for over 155 patients have been sent.

Computable Data for Shared Patients

In September 2006, the Departments established interoperability between AHLTA's Clinical Data Repository (CDR) and VA's Health Data Repository (HDR). The DoD/VA Clinical Data Repository/Health Data Repository (CHDR) interface enables the first exchange of interoperable and computable outpatient pharmacy and medication allergy data between the Departments in a live patient care environment on

patients who receive care from both healthcare systems. The exchange of computable outpatient pharmacy and medication allergy data enables drug-drug interaction checking and drug allergy checking using data from both departments. This enhances patient safety and quality of care. DoD's outpatient pharmacy data exchange includes information from MTF pharmacies, retail pharmacies, and mail order pharmacies. Clinicians at several sites are actively using CHDR and continue to exchange outpatient pharmacy and medication allergy data on more than 27,150 patients who receive healthcare from both DoD and VA (active dual consumers). As of January 2009, over 3.9 million cumulative medications and over 119,950 cumulative drug allergies have been exchanged. This functionality is available to all DoD facilities. In September 2008, DoD implemented a process to automatically identify patients being treated in both Departments and began setting the active dual consumer "flag" on approximately 50 patients per day. This capability is being implemented in a phased approach to enable the Departments to monitor the impact on system performance and perform capacity planning.

Joint Inpatient Feasibility Study

The DoD/VA Joint Inpatient Electronic Health Record (EHR) Study was a multi-phased project, funded by the Joint Incentive Fund. The first phase, completed in January 2008, documented and assessed DoD and VA inpatient clinical processes, workflows, and requirements; identified areas of commonality and the areas of

uniqueness between the Departments; and determined the benefits and the impacts on each Department's timelines and costs for deploying a common inpatient EHR solution.

The second phase, completed in August 2008, provided a set of prioritized recommendations (options) for potential technical solutions. The analysis was accomplished through collaborative efforts between DoD and VA clinicians, technologists, and resource managers. The *DoD/VA Joint Inpatient EHR Study Analysis of Technical Solutions Final Report* was delivered to the Government in July 2008. The report described four alternative inpatient EHR data sharing strategies and the findings and conclusions of the study team. The option recommended in the report is for the Departments to jointly pursue the use of a common services strategy to support DoD/VA inpatient EHR data interoperability. Going forward, the DoD/VA Interagency Clinical Informatics Board will be engaged to review and prioritize common services for clinical care.

Medical Records Work Group

As DoD has been rolling out its EHR, AHLTA, and while utilization continues to increase within the Military Health System (MHS), the Departments' reliance on paper records to capture and document treatment will also continue. This finding and several other significant findings were reported in early 2007 by a specially chartered Interagency Task Force on Medical Records. The Task Force also found that a common term and standard definition were essential to decreasing if not eliminating the confusion that existed at the time with regard to what constitutes the medical record used by the

VBA to make benefits determinations. As a result, the Medical Records Work Group (MRWG) was chartered in FY 2008 for the purpose of addressing emerging issues associated with the hybrid records system currently in place during this period of evolution toward a fully electronic and interoperable record. During FY 2008, the MRWG presented for approval an Executive Decision Memorandum (EDM), which was signed by the VA Under Secretary for Benefits and the Principal Deputy Under Secretary of Defense for Personnel and Readiness. This joint decision memorandum clearly defined the Service Treatment Record (STR) as the "chronological documentation of medical and dental care received by a military member during the course of his/her military service." The MRWG also drafted a DoD Directive that was in coordination at the close of FY 2008. With expansions of the DES Pilot program and VA's BDD and Quick Start programs, as well as the issues regarding the Guard and Reservists, the MRWG's strategic goal was refocused this year to emphasize the simultaneous need for information contained in the STR by numerous offices within the Departments. The Departments collaborated in a Lean Six Sigma exercise whose overarching objective is to develop a media-neutral, 21st century solution for managing the STR life cycle. This solution will serve as a bridge between maintaining and transferring a completely paper based record and managing the record in its current hybrid state containing both paper based and electronic information until the Departments implement a complete EHR.

Conclusion

In summary, there are extraordinary joint efforts underway focusing on an efficient, seamless transition of personnel between the Departments.

I am proud of the hard work and dedication to duty that the professionals within both departments continue to display daily as we go forward together to improve the transition process. I am also certain that we will continue to build on what we have learned as we move forward. We recognize that the world of health IT and electronic health records is on the brink of great change. We will continue to contribute and be involved in the continuing development of standards. The existence of a DoD/VA JSP ensures that the leadership and members of the JEC, subordinate councils, committees, and workgroups will remain committed to improving the efficient and effective utilization of VA and DoD resources, including information data exchanges, and maintaining world-class health care and benefits delivery systems.

Mr. Chairman, this concludes my statement. I thank you and the members of this committee for your outstanding and continuing support of these heroes – our Nation's servicemen and women, veterans and their families.