Why VA's $16B (and counting) Electronic Health Record Modernization is doomed

In Part 2, Former Veterans Affairs Deputy CIO Ed Meagher offers specific recommendations for solving this conundrum.

Although there was no formal announcement of its intention to proceed with the deployment of the currently paused Cerner based Electronic Health Record Modernization (EHRM) program, the Department of Veterans Affairs recently awarded Cerner two task orders totaling $157 million to implement its system at VA facilities in Cleveland and Detroit and to assess future sites in the Midwest.

This decision to proceed is reckless and doomed to fail.

Beginning with the fact that the two most commonly expressed justifications for proceeding with this program — VistA needs to be replaced and that the Defense Department and VA can't share data — are both false.

VistA needs to be modernized, not replaced. VistA meets all of VA's current needs. It does need to be "replatformed" and key elements need to be modernized, but those efforts were underway, at several orders of magnitude lower cost and risk, when the Cerner system was imposed on the VA.

Compounding this is the fact that the decision to impose the DoD-based Cerner system on the VA as a replacement for the current VistA system clearly indicates a lack of understanding of the role that VistA actually plays in the business processes of all aspects of the VA. VistA represents 30-years-worth of knowledge, experience, data standardization, education, integration, reliability, research, institutional memory and best practices. Much of this will be lost or degraded under the Cerner system.

Currently, both VA and DoD clinicians can view health information in the other's system through the Joint Legacy (Longitudinal) Viewer (JLV) and most importantly the JLV is connected to no fewer than 400 health information exchanges (HIEs) nationally in the private sector.

The EHRM "requirement" was imposed on the VA in order to supplement the absurdly low funding of the original DoD Project Genesis contract.

This imposition, a $16 billion sole source, directed award, forms the basis for reason number one of why EHRM is doomed to failure. A long-standing reality in systems development is embodied in the truism, "What is imposed will be opposed." The VA will have no success forcing the hundreds of thousands of medical professionals to accept a system that makes them less productive, that does not improve their outcomes and turns them into insurance coding clerks. The Cerner-based system solves no VA-based problems and potentially causes several severe problems for veterans, VA clinicians and administrators.

No amount of good intentions, hard work, heroic management, relentless oversight or endless funding will be able to overcome the fatal flaws of this massive, misbegotten program.

Even more baffling is the risk tolerance that senior executives of both DoD and the VA have so far found acceptable. Given that both Genesis and EHRM, if fully implemented, will become the most mission critical

system for both the Military Health System (MHS) and the VA, it would be reasonable to assume that this system has been implemented elsewhere or at least tested in a simulation at the scale, scope and complexity that reflects the reality of the needs and requirements of the VA and MHS. However, despite the fact that both organizations have committed the future of these organizations, not to mention having obligated over $20 billion with no idea how much more will be required, to a system that was not designed for and has never operated at anywhere near the scale imagined for these two organizations.

I use the word "imagined" advisably because there is no known documentation of what that requirement will be, it can only be imagined. Compounding that is the fact that there is no documented capability for the currently architected, single instantiated, cloud-based, single database system that is imagined serving this unknown requirement.

Then, as if that wasn't enough risk to deal with, this imagined requirement will need to be supported by this imagined capability across what can only be described as an imagined infrastructure. Both organizations are in the midst of massive, long-term telecommunications and information security architecture, acquisition, testing and implementation upgrade programs. This risk tolerance forms the basis for reason number two as to why the EHRM is doomed to fail.

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As several long-term professional studies have shown, the failure rate for major IT programs, even well designed and well executed large IT programs, is upwards of 75%. These programs are neither well designed nor well executed. Both organizations are being asked to drastically change their business processes to meet the structured, insurance-based, commercial-off-the-shelf (COTS) processes baked into the Cerner product.

There are several other serious issues that exist with the current VA solution, any one of which pose the potential for failure. The clash of unresolved governance issues and joint management of a system in two organizations with different missions, approaches, priorities and cultures should give any experienced government executive grave concern about the viability of such a joint system. The lack of specificity for contract enforcement for key performance indicators, contract deliverables, schedules and ultimately successful contract delivery should be alarming.

The VA's decision to perform a strategic review was very encouraging but the report and subsequent Congressional hearings have been very disappointing. First, and perhaps foremost, there is no indication that any consideration was given to the legality, structure or even the need for the EHRM contract. There was no

indication that any consideration was given to whether or not this contract would produce a system that actually works. Several other underlying assumptions were not even identified much less addressed. Instead, a laundry list of high-level issues were identified, and high-level remedies recommended. At the heart of each of these remedies was the belief that better management, better oversight and just plain trying harder would ultimately succeed.

There are several other critical risk factors such as the fact that the VA has two other large scale, highly complex mission critical programs underway including a highly controversial and failing military logistics system and a revamping and modernization of the VA's financial management system that must be integrated with the already challenged EHRM. All these systems will place burdens on the other systems and challenge each other for talent, resources, funds and management attention.

The VA seems committed to "heroic management" as the fix for all problems. While a can-do attitude and total commitment are admirable qualities to be appreciated, they are no substitute for the ability to recognize a dead hand and the courage to fold it.

In Part 2 of this column, I will identify specific next steps to avoid this looming catastrophe. There are several concrete steps that are available to the VA to salvage some of the investments made under the current EHRM modernization program and to reestablish the VA's VistA Legacy system and the VA's leadership role in the future of U.S. healthcare.

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