

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

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

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

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

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

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

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**Question # 2**

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

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

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**Question # 3**

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

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

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**Question # 4**

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

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

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

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**Question # 5**

**Question: Does not the agreement between DoD and VA for the transfer of (health treatment records) service medical records (SMR) require a 10 day timeline for receipt at VA?**

**Answer: The timeline stated in the agreement is for five days.**

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**Question # 6**

**Question:** Does not the agreement also require a copy of Copy 3 of the DD214 to be included in the SMR?

**Answer:** The agreement does state that a copy of Copy 3 of the DD214 will be placed in the SMR.

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**Question # 7**

**Question: Do you agree that the purpose for including a copy of copy 3 is to allow the DD-214 data to be inputted into VA's Beneficiary Index Locator Subsystem (BIRLS) for use in determining eligibility and entitlement? Are Services meeting the 10 day time line for receipt at VA?**

**Answer:** Copy 3 of the DD-214 is sent to Austin Automation Center where it is used to input information into the Veterans Assistance Discharge System (VADS). The copy of Copy 3 goes to St. Louis. If there is not already an entry in the Beneficiary Index Locator Subsystem (BIRLS) from VADS, when the record is received at the Records Management Center (RMC), then the RMC uses the copy of Copy 3 to initiate a record in BIRLS. VA does not use either Copy 3 or the copy of Copy 3 as an authenticated DD-214. The VA Records Management Center reports that they are receiving most of the records within 10 to 30 days.

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**Question # 8**

**Question: Are Services including a copy of copy 3 of the DD-214 with the SMR?**

**Answer:** The VA Records Management Center reports that they are receiving health treatment records with a copy of Copy 3 of the DD-214.

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**Question # 9**

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

**Answer:** DoD and VA continue to play key roles as lead partners in the Consolidated Health Informatics (CHI) project, one of the 24 eGov initiatives in support of the President's Management Initiative. CHI's goal is to establish federal health information interoperability standards as the basis for electronic health data transfer in all activities and projects among all agencies and departments. The new standards will help improve the quality of care by ensuring federal entities use common standards that will make it easier to exchange needed information.

Since its inception, CHI has identified a target portfolio of 24 clinical domains for standards adoption. Teams to research and review standards for all 24 domains are in place. These teams are in various stages of review and analysis. CHI has formally adopted four messaging and one vocabulary standard government-wide, plus the X12 messaging standard required by the Health Insurance Portability and Accountability Act. The standards adopted are:

- ◆ Logical Observation Identifier Names and Codes (LOINC) for laboratory result names
- ◆ Messaging Standards for Scheduling, Medical Record/Image Management, Patient Administration, Observation Reporting, Financial and Patient Care [Health Level 7 (HL7) version 2.4, XML encoded]
- ◆ Messaging Standards for Pharmacy Transactions, including retail pharmacy [National Council on Prescription Drug Programs (NCPDP)]
- ◆ Digital Imaging Communications in Medicine (DICOM) for digital mapping
- ◆ Standards for Connectivity of Medical Devices [Institute of Electrical and Electronics Engineers (IEEE) 1073]

Additional standards that will soon be presented to the CHI Council for adoption are the following:

- ◆ Medications [Federal Drug Terminologies]
- ◆ Laboratory Interventions and Procedures [LOINC]
- ◆ Demographics [HL7]
- ◆ Immunizations [HL7]
- ◆ Lab Content [Systemized Nomenclature of Medicine (SNOMED)]
- ◆ Units [HL7]

In addition, the Departments also use X12 transaction set as required by the Health Insurance Portability and Accountability Act.

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Question # 10

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

**Answer:** DoD and VA continue to play key roles as lead partners in the Consolidated Health Informatics (CHI) project, one of the 24 eGov initiatives in support of the President's Management Initiative. CHI's goal is to establish federal health information interoperability standards as the basis for electronic health data transfer in all activities and projects among all agencies and departments. The new standards will help improve the quality of care by ensuring federal entities use common standards that will make it easier to exchange needed information.

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- ◆ Units [HL7]

Thirteen additional teams are in various stages of review and analysis of other domains. Examples of items being examined are lab results contents, demographics, immunizations, and interventions/procedures.

Adopted standards will be used for new systems development and in the requirements for acquisition of commercial-off-the-shelf (COTS) software. Federal adoption of standards, and requiring their use in COTS acquisitions and software development efforts, should become a catalyst for their adoption in the private sector.

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**Question # 11**

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

**Answer:** Currently more than 30 individual discharge sites and Veterans Benefits Administration (VBA) regional offices (RO) across the country have developed their own memorandums of understanding with military treatment facilities under which a single separation examination is provided to active duty Service members who intend to file a claim for VA disability compensation. Additionally, a work group is being assembled, composed of representatives from the VBA, Veterans Health Administration (VHA), Health Affairs and each of the three Services to monitor progress, identify and build upon successes, and avoid duplication of effort. The Departments have every intent of streamlining the process and meeting the 2005 milestone.

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**Question # 12**

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

**Answer:** The single physical exam serves the dual purpose of documenting that the Service member meets medical standards for retention and hence may separate from the Service for reasons other than medical disqualification, and also provides the information necessary upon which the VA can adjudicate a claim for disability, should one be filed. Military members who have been identified as apparently not meeting medical retention standards, however, must first be referred to the DoD Disability Evaluation System for a determination of fitness. A single separation physical is not applicable to such individuals. The National Guard and Reserve soldiers being medically evaluated at Ft. Stewart had already been flagged as apparently not meeting medical retention standards; hence a single exam is of no utility to them. The medical evaluations for which they are waiting are for the purpose of determining their medical care needs and overall fitness for duty, prior to action on a separation from active duty.

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**Question # 13**

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

**Answer:** There are many examples of DoD and VA coordinating and sharing information to attempt to evaluate or determine symptoms or illnesses in veterans that may be related to events or exposures during their service. The following list provides some specific instances.

### **Gulf War**

The DoD developed a roster of individuals who deployed to the Gulf War and a roster of all others who were on active duty at the time but did not deploy. Those rosters have been used by DoD and VA to conduct multiple studies to compare the rates of illness, hospitalization, death, cancer, etc., and determine if there are indications of increased disease rates or unique diseases in Gulf War veterans.

The DoD and VA performed a combined analysis of the information collected during medical examinations done by DoD under the Comprehensive Clinical Evaluation Program and by the VA under the Persian Gulf Registry Program which evaluate Gulf War veterans and their families.

The DoD used data from ambient air monitoring and unit locations to develop a model of exposure to smoke from oil well fires in Kuwait that has been used by CDC and VA to evaluate respiratory symptoms/illnesses in Gulf War veterans.

The DoD used data from intelligence sources, open-air simulant testing and climate controlled evaporation testing to develop a model of chemical warfare agent (sarin and cylcosarin) exposure following US demolition of munitions at Khamisiyah, Iraq. DoD then amplified knowledge on unit location to develop a roster of possible individual exposures from the chemical warfare agent release. DoD has used these data and VA research to determine whether there were identifiable differences in health outcomes in those individuals identified as possibly exposed and those identified as not exposed.

The DoD developed rosters of individuals exposed to depleted uranium at Level I (in or on a vehicle hit with depleted uranium munitions) or Level II (duty required spending extensive time inside military vehicles damaged from depleted uranium munitions). The DoD notified these

individuals and VA has used these rosters to provide comprehensive medical evaluation and medical follow-up for those individuals who volunteered for this care.

The DoD developed a list of the agents/substances/medications that were recognized to be present or were used during the Gulf War. That list was provided to the VA and the VA has contracted with the National Academy of Science, Institute of Medicine to have expert, independent panels evaluate the literature to determine if there is any evidence for an association between these agents/substances/medications and any adverse health outcome.

The DoD developed a roster of individuals who applied pesticides during the Gulf War. This roster and details of pesticide exposures have been shared with the VA. The VA is conducting a neuropsychological follow-up study to determine if pesticides could be a factor in subsequent health outcomes.

### **Project 112/SHAD**

The DoD has conducted an investigation of operational chemical and biological testing done from 1962 to 1973 to determine who was present during this testing; where and when the testing was done; what chemical or biological agents, simulants or tracers were used; and what decontamination agents were used. These data have been provided to the VA. The VA is notifying each individual and offering a complete medical evaluation. The VA has also contracted with the Medical Follow-up Agency of the Institute of Medicine to conduct a health survey of the veterans who participated in shipboard testing, with a comparison group of veterans of the era who were on ships that did not participate in the testing.

### **Prospective Study**

The DoD and VA have collaborated on developing and initiating a 21-year prospective study of 140,000 military personnel to determine if there are relationships between health outcomes and their military service. An extensive health survey is used to establish each individual's baseline, and repeat surveys are done at three-year intervals. Extensive data on occupational and environmental exposures, worldwide locations, medical treatment or interventions and health concerns are recorded.

### **Sharing of Information and Data on In-garrison Occupational and Environmental Exposures**

The primary information sharing occurs as a result of the occupational and environmental exposure data that is filed in individual Service members' medical records. This includes workplace exposure summaries and more specific surveillance data for those enrolled in mandated occupational health surveillance programs (e.g., radiation, noise, lead, and cadmium exposure). Note that some Services do better with the filing of occupational and environmental exposure summaries in medical records than others (the Air Force probably leads in this area).

Additional information is provided to the VA on a case-by-case basis when more information is required. In this case, the VA (or in some cases, DoD) generally goes directly to the installation

in question to obtain any additional clarifying data that the VA or the individual veteran may require.

Also, beginning in 2002, there has been close coordination and collaboration between the VA and the Air Force regarding the initiation of an epidemiological study examining the incidence of ALS at Kelley AFB. The Air Force approached the VA to help ensure that the Air Force study would build on the VA's experience in order to discern whether former workers at Kelly AFB may have been at a higher risk for ALS as a result of occupational or environmental exposures.

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**Question # 14**

**Question: VA acknowledges receipt of a list of approximately 17,000 veterans who served in theaters of combat in Afghanistan and Iraq and who subsequently separated from active duty. When asked about follow up lists and other useful data VA requires, you responded that there were errors with that data. Has DoD compiled a data list to follow the 17,000 veteran list noted above and did this list contain data errors preventing its transfer or acceptance by VA? Please explain in detail what these errors were. If a subsequent list contained errors, when will an accurate list containing all information requested by VA be available to VA? Does this indicate that DoD cannot account for all Service members in theater or when these members return? If the individuals can be accounted for, which data cannot be accessed to match with the individual returning Service members and why was this data not available?**

**Answer:** There were no errors in any records sent to the VA. 17,000 records were sent in the agreed upon first submission of monthly data to the VA Epidemiological Service. These were personnel identified as in theater Persian Gulf and Afghanistan, both Reserve and Active Duty, from October 1, 2002, through June 2003 who later separated from the Defense Department. This was sent in September 2003. In October the DoD sent 61,000 records meeting the criteria of being in theater from October 1, 2002, through August 2003 and subsequently leaving DoD. The November submission should go out soon and will include October 1, 2002, through September 2003. Everything is correct. The DoD is sending data as it becomes available. We do realize that the Services and Components are somewhat late in responding perfectly to requirements for reporting, but the data sent to the VA is deemed accurate.

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**Question # 15**

**Question:** On page 4 of your testimony, you discuss a change in the acquisition reporting chain for DIMHRS and note that the “current program management team began work in August of 2001.” Please provide a comparison of the timeline and milestones of DIMHRS prior to this management team change [circa late Calendar Year 2000 or early 2001], and the current DIMHRS timeline. Provide the milestone chart from each of the two management teams indicating the relative completion dates for critical DIMHRS milestones. Explain the impact of the change in management teams, if progress was impacted.

**Answer:** The Milestone-A (called Milestone 1 at the time) schedule is provided on page 1 of the enclosed charts. At that time, the seven useful assets were notional and had not been defined in terms of functionality. Initial operating capability was planned for 2003, but it was not a full operational capability in any Service. Final operating capability was planned for 2007.

The current program schedule is provided on pages 2 and 3 of the enclosed charts. The useful assets are fully defined. Initial operating capability is the full DIMHRS capability operational in the Army. Final operating capability is the full DIMHRS capability operating in all Services in late 2007. The schedule is generous in that it allows as much time for development of the capability after IOC as it does for IOC. In fact, very little additional development will be required after IOC. The main activity after IOC will be setting up the Service specific organizational structures and position competencies.

When the current Program Manager came in, she found that the program did not have a full work breakdown structure, it had no Acquisition Program Baseline, it was under-funded to provide the full capability, and the notional schedule did not track to capabilities that were deployable. In order to bring the program into compliance with DoD regulations, she had to completely restructure the program, develop a full baseline, and request additional funding to complete the development.



# Draft Top Level Schedule as of 1 Dec 2003

ID	Name	2004				2005				2006				2007				2008				
		Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	
1	Army Design and Review	10/27	10/27																			
2	Plan and Analysis			1/2																		
3	Preliminary Design Review		4/2/16	12/18																		
4	Software Build		1/5			10/26																
5	Integrated Baseline (IBR) Review		2/6																			
6	Interim Progress Review (IPR)		2/27																			
7	Critical Design Review - Build 1		3/4	3/10																		
8	Critical Design Review - Build 2		4/5	4/7																		
9	Critical Design Review - Build 3		4/5	4/7																		
10	Critical Design Review - Build 4		5/3	5/6																		
11	Test and Evaluation		1/5			2/23																
12	Test Planning		1/5			1/3																
13	Interim User Test (IUT)		7/30	9/24																		
14	System Integration Test		10/27	9/24		1/27																
15	System Acceptance Test		1/28	2/28																		
16	Development and Test (TEC-EVAL) (DT - B)		3/1	4/23																		
17	* OTRR			4/23																		
18	Operational Test (OT - C1)		5/31																			
19	Transition to IOC		10/23	11/25																		
20	Exercise PeopleSoft Contract																					
21	Milestone C1			9/30		5/30																

\* OTRR: Contract modification may be required.

Making the DIMHRS (Pers/Pay) Difference

# Draft Top Level Schedule as of 1 Dec 2003

ID	Name	2004				2005				2006				2007				2008			
		Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 1	Qtr 2	Qtr 3	
22	Fielding Decision 1																				
23	Initial Operating Capability																				
24	Amy Deploy																				
25	Milestone B2																				
26	Navy, MC, AF - Design and Review																				
27	Plan and Analysis																				
28	Software Build																				
29	Test and Evaluation																				
30	Test Planning																				
31	Interim User Test (IUT)																				
32	System Integration Test																				
33	System Acceptance Test																				
34	Development and Test (TECHVAL)																				
35	* OTRR																				
36	Operational Test (OT - C2)																				
37	Transition to OC																				
38	Milestone C2																				
39	Fielding Decision 2																				
40	Navy, MC, AF - Deploy																				
41	FOC																				

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Making the DIMHRS (Pers/Pay) Difference

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**Question # 16**

**Question: From a strategic perspective, how do you assure buy in from DoD in this sharing plan?**

**Answer:** DoD and the VA have developed a joint strategic plan, and have established the Joint Executive Council chaired by the Under Secretary of Defense for Personnel and Readiness, and the Deputy Secretary of the VA. These principals personally chair the group, review strategic objectives, and collaborate on interagency initiatives. To further demonstrate the commitment to interagency collaboration and sharing they have established a Benefits Executive Council chaired by the Principal Deputy Under Secretary of Defense for Personnel and Readiness, and the Under Secretary of the VA for Benefits. They have also established a Health Executive Council that is chaired by the Assistant Secretary for Health Affairs and the Under Secretary of the VA for Medical Benefits. Both of these committees oversee the organizational staffing and operations that are implementing the strategic objectives and report directly to the principals chairing the Joint Executive Council. Services fully participate in working groups and Steering Committees that are directed by senior DoD managers from my office and other major directorates within Personnel and Readiness.