

**DEPARTMENT OF THE AIR FORCE**  
**PRESENTATION TO THE COMMITTEE ON ARMED SERVICES**  
**SUBCOMMITTEE ON MILITARY PERSONNEL AND**  
**SUBCOMMITTEE ON TERRORISM, UNCONVENTIONAL THREATS**  
**AND CAPABILITIES**  
**UNITED STATES HOUSE OF REPRESENTATIVES**

**SUBJECT: Department of Defense Health Information Technology: AHLTA  
is “Intolerable”, Where Do We Go From Here?**

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**UNITED STATES HOUSE OF REPRESENTATIVES**

Chairwoman Davis, Vice Chairman McIntyre, Ranking Member Wilson, Ranking Member Miller and esteemed members of the Committee, it is my honor and privilege to be here today to talk with you about the Air Force Medical Service. In support of our Air Force priorities, the Air Force Medical Service (AFMS) is on the cutting edge of restorative and preventive care, protecting the health and well-being of our troops everywhere. No where is this more evident than in the field of information technology, an absolutely critical component of our mission success. I am honored to help lead our Air Force team of dedicated professionals in joint efforts with OSD Health Affairs, sister Services and the Department of Veterans Affairs (VA) to address the IT issues confronting us today.

I commend Dr. Casscells, our Assistant Secretary of Defense for Health Affairs, for recently seeking user feedback on AHLTA on the Military Health Service internet site. AHLTA users were asked to submit questions, comments or suggestions that would improve AHLTA, and there were more than 200 replies from the user community. The primary criticisms of AHLTA continue to be speed/performance, reliability, and difficult user interface with an emphasis on poor readability of notes. By contrast, there were multiple references to the VA's VistA electronic health record (EHR), pointing out some of the user-friendly attributes of this system.

Significantly, these issues resulted in low productivity and provider morale. Multiple medical specialty providers, including obstetrics, pediatrics, and ophthalmology, clearly articulated AHLTA did not address the requirements unique to their practice, as AHLTA was primarily designed for general (primary) care. The lack of capability to efficiently capture standard DoD forms, such as physical examinations and Service profiles also hampers daily operations. The current AHLTA version was scheduled for worldwide deployment by the end of

last year, but problems with the initial large scale rollout caused this date to slip. As a result, there have been no substantial functionality improvements in AHLTA in the last four years.

Deployment of EHR systems on DoD networks is complicated by non-standard architecture and changing business processes. DoD network security requirements compound the problem, creating slowdowns and impediments to the efficient operation of a modern EHR. DoD security policies are often implemented differently across Services. Application fixes and patches are required to reach each end-user workstation. Firewalls, routers, non-standard architecture, and security requirements all make software updates difficult to implement. Recent experience at Wright-Patterson Air Force Base rolling out the new AHLTA version highlighted the need for standardized network management and security practices conducive to workflow. The Air Force is making great strides in centralizing and automating network command and control to reduce human error. Stringent but necessary Line of the Air Force implementation of DoD network security requirements often lead to greater restrictions, such as the recent DoD ban on rewriteable media that hampers ability to transfer medical related data (medical photos, retinal images, etc.) from one location to another. Modern EHR systems must adapt to the ever changing security landscape as it adjusts to new and emerging threats.

The Air Force Medical Service has taken a multitude of steps to find viable solutions to these issues and improve speed and reliability. We are moving toward a thin client and application virtualization at a number of Air Force facilities to reduce the requirement for individual session Common Access Card (CAC) log-ins and provide remote access. This has benefitted us in many ways, to include easier log-in routines, faster application speed, increased stability of the application, and reduction in the time and effort of computer support staff in updating and patching AHLTA.

Remote access has improved provider satisfaction with the ability to access patient information from home while on call, or complete patient encounters after duty-hours. Wireless tablets are deployed for use at several sites with the additional speed benefits of a single log-in requirement at the beginning of each duty day along with the advantages of using a pen vs. keyboard to assist with data entry. We funded a comprehensive hardware refresh to ensure each workstation exceeds the baseline memory and processor speed requirements to run AHLTA efficiently. Speech recognition software has been used throughout Air Force clinics for nearly two years, helping providers document many sections of the medical note in a more efficient and timely manner. A recent update to this software has continued to improve speed and accuracy.

In addition to these improvements, we have developed and will deploy two synergistic programs in Air Force clinics: the Family Health Initiative (FHI) and Clinical Optimization for Military Provider AHLTA Satisfaction Strategy (COMPASS). FHI enhances our staffing plan with more support personnel to directly assist clinicians in patient care and improves patient scheduling and access. COMPASS takes full advantage of these enhancements. The COMPASS workflow uses team documentation, teaches simplified coding algorithms, and uses an advanced generation of alternate input method (AIM) forms to reduce time spent writing notes. It also improves note readability and standardizes documentation throughout the clinic. The end result is optimal use of all of the skills of clinicians and support staff while reducing the non-value added time of many clinic functions. Although the COMPASS workflow is still in the preliminary phase of rollout, the initial response of providers and support staff has been very positive.

Resuming worldwide deployment of the latest upgrade of AHLTA is a very high priority for us, as it has many of the provider-requested functional enhancements. This effort has resulted in continued improvement in stability and speed, permitting a limited but successful rollout and the planning of a new deployment schedule. Specialty services are included in this AHLTA upgrade. Obstetrics receives a summary module that gives a single screen comprehensive overview of the obstetric patient. Pediatricians can access a pediatric growth chart that automatically plots height, weight, and head circumference and allows printing. Ophthalmology has a drawing tool which permits a graphical depiction of eye findings. Many other enhancements in functionality have been addressed that will further reduce the time spent in documentation.

We looked closely at the VA's VistA EHR, which was developed to support their business practices. The Air Force and our sister Services continue to partner with the VA in our developmental efforts and lead the nation in sharing healthcare information. VistA, in its current form, is tailored for local or regional healthcare with a generally static population. By contrast, AHLTA was developed to support a global and transient population. We recognize the strengths of VistA and are diligently working toward adding those strengths into AHLTA. Furthermore, VA and MHS representatives, with AFMS participation, are collaborating in an architecture blueprint to bring seamless interoperability between our departments. The new proposed Integrated Regional Distribution Architecture is flexible, scalable, and will allow us to manage data networks much more efficiently to enhance healthcare delivery.

Balancing the non-medical network security requirements and certification process with the unique requirements and capabilities of medical applications and devices has been challenging. We work in collaboration with Air Force Communications to field and maintain

secure systems; however, the processes do not facilitate timely deployment of advanced medical systems. As AHLTA continues to expand in capability, the demand for bandwidth will increase as well, and it is imperative that future network planning take this into consideration.

In closing, Madam Chairwoman, I am intensely proud of the daily accomplishments of the men and women of the United States Air Force Medical Service. As we look ahead, I see a great future for the AFMS, built on a solid foundation of professionalism and strong partnerships. We thank you for your continued support and look forward to working together to improve health care for soldiers, sailors, airmen, marines, their families and all Americans.