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BUILDING A MORE RESILIENT VA SUPPLY CHAIN

HEARING

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COMMITTEE ON VETERANS' AFFAIRS
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BUILDING A MORE RESILIENT VA SUPPLY CHAIN

TUESDAY, JUNE 9, 2020

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 3:02 p.m., in room SD–430, Dirksen Senate Office Building, Hon. Jerry Moran, Chairman of the Committee, presiding.

Present: Senators Moran, Boozman, Cassidy, Rounds, Tillis, Blackburn, Tester, Brown, Blumenthal, Hirono, Manchin, and Sinema.

OPENING STATEMENT OF CHAIRMAN MORAN

Chairman MORAN. Good afternoon, everyone. The Committee will come to order.

Today's hearing is on building a more resilient VA supply chain with a focus on what we have learned from COVID–19's pandemic. A bipartisan enduring priority of this Committee is to ensure that the VA is equipped to fulfill its core mission to deliver timely, high-quality health care to the veterans it was created to serve.

Last August, as the VA entered into partnership with the Defense Logistics Agency to speed acquisition for materiel support, Secretary Wilkie stated, "In the 21st century, an ad hoc supply chain is not sufficient" and "It does not do justice to those we are sworn to serve."

The VA recognizes the need to build a more resilient supply chain. The question is always "How?" COVID–19 pandemic has put massive stress on the supply chain and created unprecedented global demand for personal protective equipment and other medical supplies.

Inherent fragilities in the just-in-time inventory model have been severely strained in recent months. This confluence of factors has highlighted the need and necessity to reform the VA's procurement organization and process.

The challenge VA confronts is how to strengthen the supply chain in real time, while also making it more resilient and operationally effective in the long term.

I am encouraged to see VA is moving quickly, but there is also a need to be certain that we are strategic in our decisionmaking.

I understand the need to have more inventory on hand, and reestablishing some form of supply depot may be part of that effort, but we also must take care not to establish parallel and competing supply chains.

Logistics is also fundamental to this equation. Inventory that is unable to move is no use to anyone.

The Veterans Health Administration is saddled with an aging, disparate inventory management system and a medical supply chain that was conceived over 30 years ago. Repeated reform attempts have too often misfired or added complexity, resulting in time-consuming and error-prone inventory counts.

Transferring supplies between the VA facilities in a different Veteran Integrated Service Networks is also unnecessarily burdensome and difficult. It is a testament to the dedication of VA's clinicians and administrators and staff that they make the system work despite the difficulties.

The Medical Surgical Prime Vendor contracts were once the backbone of this supply chain, but this program has been chaotic since it was relaunched in 2016. And I believe the strategy needs to be reevaluated.

These supply chain issues are not intractable, but they will require sustained attention to develop a modern inventory management system across the enterprise.

This administration has used the Defense Production Act to provide loan guarantees and cost-matching grants to help domestic manufacturers expand their production capacity in response to COVID–19. Many companies have added shifts and reconfigured equipment to boost output. For example, Spirit Aerosystems in Wichita, Kansas, is using the speed of their aircraft manufacturing line to build respirators.

The DPA also allows the Federal Government to allocate materiel and subcontracts on a manufacturer's behalf, and I commend the administration for doing so when asked.

Under the DPA, Federal agencies can prioritize the delivery of their contracts, but this results in an inherent tradeoff. I would like to understand how the coordination among VA, FEMA, and HHS may be affecting the VA supply chain.

Coordination is key in challenging circumstances, and I believe the VA Secretary should be added to the Defense Production Act Committee to efficiently facilitate veteran care and leverage VA resources.

Senator Tester and I expressed this desire in a letter to President Trump, and it is my understanding the VA concurs. There are substantive suggestions on how to strengthen the VA's medical supply chain, including recommendations from the Commission on Care, the VA's Office of Inspector General, and the Government Accountability Office. Each has called for a more unified supply chain from the VA's Central Office to the medical centers, supported by modern, integrated IT systems.

I am eager to hear the perspective of our witnesses on the second panel as to how the A can rise to this challenge.

The COVID–19 crisis has compounded persistent VA supply chain problems, and there is no better time than the present to address them. It would be a mistake to consider this pandemic transitory and let our guard down.

I look forward to hearing the testimony of our witnesses and working on solutions that can build a more resilient VA supply chain that meets the needs of our Nation's veterans.

I look forward particularly to hearing from Dr. Stone and his colleagues in this first panel, and, Dr. Stone, I take this opportunity to thank you for once again being before our Committee. It has become commonplace, and I appreciate your availability as well as that of your colleagues.

Let me now turn to the Senator from Montana, Senator Tester, the Ranking Member, for his opening Statement.

Jon?

OPENING STATEMENT OF SENATOR TESTER

Senator TESTER. Thank you. Thank you, Chairman Moran. I appreciate your remarks. I think you are spot on in a number of areas. I am going to touch on just a few of them, and before I start, I want to also welcome Dr. Stone and his leadership team to this hearing.

Look, we have been through some hard times with COVID–19. It showed where our weaknesses were in our supplies, and quite frankly, it has put a staff of frontline employees that have done an incredible job out there serving not only our veterans, but also nonveterans during this pandemic in a difficult situation.

We had austerity measures that were taken in April, and quite frankly, even now, Dr. Stone—and I brought this up in a previous hearing—we are hearing of shortages. We are hearing folks that are asked to reuse their mask, and even in the best of times—even in the worst of times, that is not something we should be doing.

So the bottom line is this hearing's title is "Building a Resilient VA Supply Chain." The Chairman mentioned in his opening remarks—I do not think we want to have VA setting up a whole bunch of PPE, along with HHS doing their own thing, with Commerce doing their own thing, and FEMA doing their own thing, and DoD doing their own thing. Hopefully, everybody is going to be working together, and that is why, by the way, the Chairman and I sent off that letter to the President saying—the VA needs to be part of the Defense Production Act Committee, because this needs to be a whole-of-government approach.

Now, make no mistake about it. If VA's staff needs to have personal protective equipment, VA needs to make sure it's available. And if the VA cannot depend upon FEMA or HHS to make sure that personal protective equipment is there or any other equipment as far as that goes, then I get it. You guys have to take care of your own staff because our veterans are too important for us to fail.

But the bottom line is that a government that works for the people works together, and that is why I think the Chairman and I feel so strongly about you guys being part of the Defense Production Act Committee. As I said earlier, you have the biggest integrated health care system in this Nation, and if you are not part of the equation, then I do not know who should be a part of that equation. You absolutely should be a part of it.

To add complexity to this whole situation, the VA is putting in three—and maybe more, but three new computer programs to do their outdated IT, one in electronic health records, one with the financial system program, one with DMLSS which is a DoD acquisition program that will, as I understand it, be replaced not long after you start it. All that has impacts on the supply chain, and

how the VA is going to deal with that, it is going to be interesting to hear in this hearing, because we spent a fair amount of money over two different administrations on EHR. That is for sure, and making sure that EHR works not only for electronic medical records, but also for making sure that we have the resilient supply chain that we need is critically important.

So I am not going to take up a lot more time. I would just say that I look forward to this hearing. I think it should be a good one. I look forward to figuring out how different agencies could work together to meet the needs. I look forward to hearing from the second panel, how much of things like masks and shields and gowns, regardless if you are a company that is domiciled here, how much of that is made in China.

Quite frankly, we heard stories of China saying, "You know what? This is a pandemic. This stuff is being made here. We are going to take care of ourselves first." I do not deny them that ability, but it shows that we have an inequity in our system. And I believe that much of that personal protective equipment, masks, shields, gowns, those sort of things, need to be built right here in America so that when we need them, we got them, and we can ramp it up. I will be pushing that moving forward, and hopefully, the folks from 3M and others would agree with that. But we will find that out during the second panel.

With that, Mr. Chairman, I am going to turn it back to you. I look forward to hearing from Dr. Stone and his leadership group, and we will have some good questions for him when he gets done with his presentation.

Thank you.

Chairman MORAN. Senator Tester, thank you.

I share your views in regard to the supply chain in China, and I look forward to working with you and our colleagues to accomplish a different circumstance in the near future.

Let me introduce our first panel from the Department of Veterans Affairs. Dr. Richard Stone is the executive in charge of the Veterans Health Administration. He is accompanied by Ms. Karen Brazell, principal executive director, Office of Acquisition, Logistics, and Construction, and Chief Acquisition Officer and Acting Assistant Secretary for Enterprise Integration—how do you have time to be with us today?—and Ms. Deborah Kramer, Acting Assistant Under Secretary of health and Support Services—just because your title is shorter, I could say the same ting to you, Deborah—and Mr. Andrew Centineo, executive director of the VHA Office of Procurement and Logistics.

I will reserve introductions of our second witness panel representing the Government Accountability Office and industry perspectives and now recognize our lead witness, Dr. Stone, for his opening remarks.

Dr. Stone, as I said earlier, thank you very much for your presence.

PANEL I

STATEMENT OF RICHARD A. STONE: ACCOMPANIED BY KAREN BRAZELL; DEBORAH KRAMER; AND ANDREW CENTINEO

Dr. STONE. Chairman Moran, Ranking Member Tester, and distinguished members of this Committee, thank you for the invitation to testify today about VHA's response to COVID–19 and our efforts to build a more resilient supply chain.

You have already introduced my fellow members here. We are all veterans. Andrew has joined us virtually. Andrew has been assigned to FEMA since the beginning of this pandemic as our lead logistician to represent VHA's interest.

Let me say that both Deborah and Andrew have deployed and been recognized for their work in combat, and I appreciate between the three of them, 60 years of supply chain experience to accompany me here today.

Chairman MORAN. Dr. Stone, let me express the Committee's gratitude for yours and their service and particularly their expertise on this topic, but mostly thank you for your service in caring for our Nation.

Dr. STONE. Thank you, sir.

COVID–19 has forever changed the world's approach to medical supply. For decades, the long-acclaimed just-in-time supply system kept shelves stocked because there was always another delivery of materiel on the way, usually from a prime vendor or a manufacturer who acted as an intermediary. The prime vendor is acting as an intermediary between manufacturers and the end user.

This system has not delivered the responsiveness necessary to support the worldwide demand of health providers on medical supplies during this pandemic.

More importantly, the pandemic forced us to recognize that we cannot depend on the global supply chain to equip VA just in time in a future disaster. VA is able to cross-level supplies, equipment, and personnel across our integrated system. No facility at VA ever ran out of protective equipment, and we are taking steps to ensure that we never risk exhaustion of our supplies in future disasters.

We are working diligently to not only prepare for a potential second wave of COVID–19 but also for any other disaster the Nation might face.

As the Secretary told this Committee last week, COVID–19 has shown the Nation what VA is truly capable of. In executing our fourth mission, VA has demonstrated extraordinary flexibility and responsiveness as we continue to delivery an integrated response to a first-in-a-hundred-year public health event, thus, allowing us to provide health care support to 46 States, Territories, and Tribal regions.

One of the good news stories to come out of this pandemic will be the positioning of the VA firmly at the center of the Nation's response to future public health disasters.

I could not be more proud of the fact that VA employees at every level have served with extraordinary heroism. VA professionals have responded day and night, week after week to save lives and make a difference in this pandemic, including hundreds who have volunteered to travel to the cities most impacted by this disease.

Never in our history has VA's fourth mission to backstop the American health care system been so expansive, and we continue to rally to this cause.

We cannot do our duty to America's veterans without an effective, responsive, and resilient supply chain. As the Nation's largest integrated health system, our demand for a complex combination of expendables, durables, equipment, and computers is unique in American medicine because of our sheer size.

I want to directly address the negative perception of our relationship with FEMA caused by a published article. At no time did FEMA "take" our supplied. There was a short period of time immediately after the activation of the Defense Production Act that every vendor and supplier in this Nation paused delivery of some materiel to await further guidance. As a result, there was a single week where we simply were not receiving supply orders; therefore, we employed measures to ensure our employees had the PPE needed to be safe. We followed CDC guidance for conservation and prioritization of equipment, and there was never a point that a VA health care worker was put in danger treating COVID–19 patients without the materiel they needed.

Our relationship to FEMA has always been and remains today strong, collegial, and productive across all levels. The safety of the heroic VA personnel serving our Nation's veterans remains my No. 1 priority.

As I close, I want to thank the Committee for the productive dialog and strong relationship between our Department and all members of your Committee in response to this pandemic. VA is better positioned today to provide health care services to veterans and support our Nation because of what we have learned in our response to COVID–19.

My colleagues and I look forward to answering your questions, sir.

Chairman MORAN. Dr. Stone, again, thank you.

Let me begin a round of questions. Let me first start with building on the current system. Obviously, the VA needs to deal in an all-encompassing, holistic approach to manage its system to make improvements. My question is if you set up supply depots with the existing inventory management system, GIP, I worry that you are building on something that in and of itself is not a very solid foundation.

But my understanding is to implement the new system, the Defense Medical Logistics Standard Support, is expected to take 7 to 8 years.

So how do those two things, the timing of replacing the existing system and the creation of the supply depots, how do they fit together?

Dr. STONE. Sir, we have the prototype sites in Chicago and the Pacific Northwest that we will exercise during this Fiscal Year for the DMLSS modernization.

You mentioned in your opening statement that the EHRM is the centerpiece of our modernization, but that must be supported by a modernized IT system for logistics and supply as well as a financial modernization system.

I will defer to Deb Kramer and Andrew Centineo for their comments on how we will proceed with this.

We do have funding this year that we are spending on the DMLSS modernization. We also have requested funds in the 2021 year and the 2022 year to do this, but the original plan was to go out 7 years in this modernization. This pandemic has revealed that that is too long a timeframe for us to execute that.

I will refer to Ms. Kramer.

Ms. KRAMER. Good afternoon, sir.

Chairman MORAN. Yes, ma'am.

Ms. KRAMER. Yes, sir. We were going to be looking for commercial and potentially Federal partners for the regional readiness centers. The most likely outcome is probably a combined, potentially, DoD commercial sector.

Those organizations already have IT systems. They already use electronic data interchange, or EDI, and through that, we can communicate with the existing VA systems.

You are absolutely right. CHIP is archaic. It is an inventory management system and not a supply chain management system. So we need to get DMLSS out there as well, but we can do the regional readiness centers using our partners' IT system.

Chairman MORAN. Ms. Kramer, my impression—you can correct me if I am wrong, but the Department of Veterans Affairs has had significant challenges with IT systems in the past and the present. What assurance should I have that this one is going to be what is needed to solve the problem and we are going to be able to accomplish the IT system that will go with the changes that you are proposing?

Ms. KRAMER. Yes, sir. The fact that we are using DMLSS, which is already in the field in DoD, a proven medical supply chain system, one that I used while I was on active duty, that is what we are doing. We are not doing a one-off. We are not developing our own system. We are going with a proven system, and we are working with DoD to do that implementation.

We are also not doing it ourselves. This is a full partnership with the Department of Defense.

Dr. STONE. Sir, Andrew may have some additional comments.

Chairman MORAN. Oh, yes.

Mr. CENTINEO. Yes, Dr. Stone. Yes, Senator Moran.

In addition to that, you mentioned how can we look at getting supportive energy behind this. The Department of Defense, both the Defense Health Agency, which is the element that supports the IT enabler DMLSS, and the Defense Logistics Agency, which is tied to the supply chain, are both going to be critical for the success moving forward.

You mentioned in the opening remarks a whole-of-government approach. Leveraging this application is certainly a whole-of-government approach, and it will take us well beyond just the supply element. It will also tie into the equipment. It will tie into the facilities.

Key to this PPE response was obviously our consumables, but we also had an equipment requirement. That certainly would be able to be facilitated through the DMLSS application, being able to see

the equipment that we needed, versus having to go through a manual process.

But, certainly, this is not VA alone. This certainly is going to require the partnership through our statute, 8111, to partner with other whole-of-government agencies.

Chairman MORAN. Thank you very much.

Maybe this was answered, but, Dr. Stone, you indicated there were two depots planned or in the works, and you mentioned Chicago and the Northwest. Is that the plan?

Dr. STONE. No. Those are the two prototype sites——

Chairman MORAN. Prototype sites.

Dr. STONE [continuing]. for DMLSS and to expand that relationship with the Defense Logistics Agency as a vendor for us.

Chairman MORAN. You absolutely did say that, but I had in my mind the question I had intended to ask you. How many supply depots do you intend to have, and what do you expect their locations to be?

Dr. STONE. So we see four readiness centers, which will not only house equipment for us but also house excess medical equipment that needs biomeds in order to sustain them, like the ventilators you talked about in your opening statement, as well as to house the four Battelle systems that we have attained from HHS and from FEMA that can sterilize reusable equipment. And we are in the process now of sterilizing masks for future waves.

Chairman MORAN. I will take from my vocabulary "depots" and replace it with "readiness centers," which is a much more appealing concept.

Dr. STONE. I think both you and Ranking Member Tester have brought up the point that this should not be independent.

We are a behemoth of health care system. At the height of this pandemic, we were consuming a quarter of a million N95 masks a day. That, when you begin to discuss with any supply chain system, is a daunting amount, and we do believe that our relationship to DoD, which is active—I meet with the DLA director on a monthly basis, also with their acquisition lead every 2 weeks. I also meet with Admiral Polowczyk, the admiral from the FEMA lead who has done the supply chain, on a weekly basis. We are unified in our approach to this but recognize that a future pandemic wave may test all of us in our preparation.

Chairman MORAN. Senator Tester?

Senator TESTER. Thank you, Mr. Chairman.

So I kind of want to followup a little bit with you, Dr. Stone, and whoever you want to refer to on DMLSS. DMLSS is not fully implemented currently. Is it implemented at all?

Ms. KRAMER. Sir, we are in the process of implementing it at the Federal Health Care Center, James A. Lovell Federal Health Care Center. That will go live in August of this year. So that will be our first site and followed this fall by two sites in the Northwest.

Senator TESTER. Okay. So you talk about how critical this was as it applied to the supply chain. I am not putting words in your mouth now, right? That is what you said, right?

Ms. KRAMER. That is correct, sir.

Senator TESTER. So when do you anticipate DMLSS will be fully implemented?

Ms. KRAMER. Sir, the current schedule calls for a 7-year fielding that would complete the——

Senator TESTER. Okay. That is the 7 years that Dr. Stone talked about, because that was my next question. It is too long. Boy, is it ever too long. I mean, we are not talking DHRM. We are not talking the financial system program. We are talking DMLSS, and both of those others impact our supply chain too, correct?

Ms. KRAMER. Yes, sir.

Dr. STONE. Yes, sir. That is correct.

Senator TESTER. So how do you shorten this up? What kind of timeframe are you looking at? If it is not 7 years, is it 5 years? I assuming working with the private sector is one way to shorten it up, but is there any other way you could shorten it up to get it done quicker? Because, gosh, within the next 7 yeas, we will probably have another pandemic. There is a possibility for a second wave. There is all sorts of bad crap that can happen.

Ms. KRAMER. Yes, sir. I think 5 years is perhaps possible, but we have got to talk to our Department of Defense colleagues. They are on the critical path to getting this system fielded. We cannot do it without their support, and we need to understand what their constraints are before we can actually tell you what a realistic schedule would be.

Senator TESTER. And it is my understanding the DMLSS is fully operational within DoD, correct?

Ms. KRAMER. That is correct.

Dr. STONE. It is the supply chain system, sir, that we use in deployment. All of us are familiar with DMLSS, and it has supported us throughout the years of the war.

Senator TESTER. I got it.

But it is also an old system, right, Dr. Stone? I mean, it is also a system that is pretty short term. No? I see someone shaking his head no.

Dr. STONE. Yes. It is being replaced. Actually, the next generation of DMLSS——

Senator TESTER. Okay.

Dr. STONE [continuing]. is going to be called LogiCole, and LogiCole is DMLSS On a cloud-based system——

Senator TESTER. I got it. Okay.

Dr. STONE [continuing]. which is scheduled to come out in 2022.

Senator TESTER. I have go to tell you, there are some things about virtual hearings that I really like. It is when I say something that nobody agrees with and I see two people shaking their head no before you even spoke, Dr. Stone, so that is good. That is good.

Say, tell me where we are at right now, Dr. Stone. What is the current State of the VA's PPE and medical supply chain and reserves? You talked about a second wave. If a second wave happened in 2 weeks, are you set up to take care of it and protect our frontline employees?

Dr. STONE. The answer is yes. Ms. Kramer and her team have developed a manual system that every day is updated from every single medical center in the Nation, and so we are at approximately 30 days on all PPE.

And I will defer to Ms. Kramer and Andrew for——

Senator TESTER. Dr. Stone, what does that mean? What does that mean, 30 days? Does that mean you have got a 30-day supply?

Dr. STONE. Yes.

Senator TESTER. And you believe that to be adequate?

Dr. STONE. No. I believe that we need to move to a 60-day supply. I believe that for a full second wave, we will need an additional 6 months of supply, and either that can be supplied by the vendors——

Senator TESTER. So we are——

Dr. STONE [continuing]. a manufacturing system, or must be in our readiness centers.

Senator TESTER. So, Dr. Stone, we are not where we need to be?

Dr. STONE. That is correct.

Senator TESTER. Okay. So the question is, When are we going to be where we need to be, and what is the issue? It sounds like—and I cannot say this because our cases in Montana are actually going up recently, but it sounds like we are kind of in a dip in this whole COVID–19 thing.

We have seen the cases—I mean, I heard the other day there were no deaths from it in New York City, for example. That is a very good thing.

But the question is, Are we taking advantage of this lag, or are we even seeing all that? You guys are not as busy as you were 2 months ago, are you?

Dr. STONE. So we have seen a reduction in the amount of hospitalization, and therefore, we have seen a reduction in our ICU demand. But what we have not seen is a reduction in materials that are necessary for us to even reopen our ambulatory services. Every single ambulatory services now needs masks, now needs PPE, needs cleaning materials, the sort of things that you have seated around this room on your desks. We are not——

Senator TESTER. So it sounds to me like, Dr. Stone, if we have a second wave, we are going to be back in the same boat we were in April.

Dr. STONE. Well, sir, my job on behalf of the Secretary is to make sure that we do not, and therefore, let me defer to Andrew and Deb to give you some comments on what we are doing to bring us to a readiness for wave two.

Ms. KRAMER. Thank you, sir.

We are working with our partners at DoD, FEMA, and Health and Human Services and our commercial partners to get the materiel to buildup and to sustain the operations that we currently have today.

But what I need to share with you is that supply chain system is still broken. There is still a tremendous demand on all of PPE, not just in the United States, but worldwide. And the manufacturing capacity has not caught up to the requirement. We are working hard every day to pull materiel in and to sustain operations, and we cannot let down.

And we are going to need your help in helping bring things onshore in terms of manufacturing. We need more 3M production. We need more production from every N95 mask producer. We need a U.S.-based gown manufacturing capacity here that can support readiness, but the current supply chain is still struggling to sup-

port not just our needs but the needs of every health care system and hospital in the country.

Senator TESTER. I am going to give this up right now, but as the Chairman already pointed out, I think you have got bipartisan support to give you whatever help you need to make sure that this manufacturing occurs.

I yield, Mr. Chairman. Thank you.

Chairman MORAN. You have nothing to yield.

Senator Boozman?

SENATOR JOHN BOOZMAN

Senator BOOZMAN. Thank you, Mr. Chairman, and thank you all for being here. We really do appreciate you, Dr. Stone, and your team and really all of those throughout the system that are working. They work so very hard, anyway.

In the midst of a pandemic, you mentioned that you truly have a huge system, an unimaginably large health care system. We appreciate all that you have done.

Also, being forward thinking and dealing with the problems of the telehealth, the tele-mental health, all of that has been a great success. Again, that is the ability of your team to really adapt and ramp up. So we appreciate that.

I agree with Senator Tester about the concerns of PPE, but the problem is that as we reopen—I am talking the daycares. They are being required to have all of this stuff, all of our businesses. As we reopen, we are still required—people are getting out more, so they are wearing the stuff more rather than sitting in their homes. So it is just a huge problem with the demand versus what even as we have ramped up, and it does tend to, in my mind, think of the importance of perhaps doing the stockpile that you suggested that we used to do.

Do you need any additional authority to do that?

Dr. STONE. Karen?

Ms. BRAZELL. Thank you, Senator.

At the time, what I would offer is that at least we have some—the authorities we have in place today will provide what we need, but we do need to make sure that VA is at the table anytime there are discussions with relationship to health care support across the Nation. That is one thing this pandemic has provided, but the authorities we have today will meet our needs.

Dr. STONE. Let me just add, sir, one thing, and that is following Desert Storm, DoD was given a authority called "Warstopper." War stopper allowed them to pre-commit inventory from a manufacturer.

When you heard about DoD committing 10 million masks to FEMA, that came from Warstopper, and what it does is it allows DoD to pre-commit that inventory. It is kept in a warehouse, but the manufacturer actually rotates it and keeps it fresh. So that if it begins to go toward expiration, it is a guarantee at a fraction of the cost to keep that fresh.

We believe having that type of authority would be very beneficial to VA also or to allow us to partner with DoD to actually execute that.

Senator BOOZMAN. That was really going to be my next question. Can you assure us that that would not be the case? Because, sadly, we have had some instances of that during this crisis that we found that the stuff was pretty old and maybe not where we would like for it to be. So that is good to know.

Tell me about the IG report regarding delivery orders and things. There is some concern there. I think they found that a percentage, a significant percentage perhaps, were getting the wrong stuff. I think there was an IG report in December, is that correct, the Medical/Surgical Prime Vendor program?

Dr. STONE. Andrew, do you have that one?

Mr. CENTINEO. Senator Boozman, I am not quite sure I understood the question. That there was a shortage or an inability to get materiel?

Senator BOOZMAN. They reviewed delivery orders and estimated that the medical centers received incorrect orders about 60 percent of the time, so a significant number.

Dr. STONE. Sir, I am going to have to take that one for the record.

Senator BOOZMAN. Okay.

Dr. STONE. I am not familiar with that report.

Senator BOOZMAN. Very good.

Are you adopting the Department of Defense Medical Logistics Standard Support system? Does that ring true? Are we upgrading that?

Ms. KRAMER. Well, we are going to adopt DMLSS. DoD is in the process of doing a tech refresh. That tech refresh is called "LogiCole." So we would begin fielding DMLSS, and then we would switch from DMLSS to LogiCole.

Senator BOOZMAN. So would that help with that kind of a problem?

Ms. KRAMER. It would help with that kind of a problem because we have much better ability to track everything that we are doing inside DMLSS. GIP does not give us that opportunity. In fact, our supply techs need to swivel between systems. They have to work in multiple systems at one time for a single order to make things work. In DMLSS, it will all be done in one box.

Senator BOOZMAN. Right.

Ms. KRAMER. Much simpler.

Dr. STONE. So, as the Secretary has discussed this extensively in previous testimony, because of this fractured system, a large percentage of our purchases are done locally at medical centers using government purchase cards with literally billions of dollars traversing those government purchase cards. So it is very difficult for us to track those as well as to track the contracts that are being used and to assure the validity and the transparency of the system that you expect.

Senator BOOZMAN. Okay. Thank you, guys. We do appreciate you very much.

Chairman MORAN. Senator Boozman, thank you.

Senator Manchin?

SENATOR JOE MANCHIN

Senator MANCHIN. Thank you all very much. Let me turn on my mic.

Like many of us, I am worried about the surge of cases in the fall and the winter and did not know what you all had planned to do to make sure that every frontline VA employee has the protections.

We have had some complaints, as you know, and you and I have talked about it before, Dr. Stone. It concerns in our VA hospitals that they did not have the proper protection and were not getting as much as they needed and were concerned about their own welfare.

So the gowns and the new masks that they are needing, I am sure you guys have been working on that, and I am hoping that you are able to fulfill that. But do you think the surge would be a strain on basically the supply chain that you have now?

Dr. STONE. Yes. I think the surge is a complete unknown. All we have to go by is what happened in the fall of 1918 with the influenza pandemic where the second wave had a dramatically greater mortality than the first wave.

Senator MANCHIN. Correct.

Dr. STONE. Certainly, a second wave is not an absolute. Dr. Fauci has said that in his testimony as well as his public Statements. It depends on the activity of the American people, and it depends on the virus and——

Senator MANCHIN. Let me ask this question. Are we moving in an area to be prepared in case it does happen? Do you think that we are as a country? Do you think we are as the Veterans Administration?

Dr. STONE. I think that we are moving in the correct direction in order to develop the resilience that will allow us to meet a second wave. It is why we have now hired over 18,800 employees and continue to hire to prepare for the second wave.

But prior to this, we purchased $10 million a month worth of PPE as the VA. We are now purchasing $100 million of PPE a month.

Now, certainly, costs have gone up dramatically as part of this, but that does reflect a massive consumption of PPE in which the industrial base of this Nation must be developed in order to develop that.

Ms. Kramer has been——

Senator MANCHIN. We have been begging the President to do the Defense Production Act on PPEs. We think, first of all, it would hold the price down. Next of all, it would increase the amount of supply all over our country, cannot figure out why we have not moved in that direction.

Dr. STONE. Sir, from our standpoint, every day Andrew and Deb's teams are in discussions with domestic vendors who are making investments in order to move us forward with a domestic supply chain.

The difficulty they have—and you may hear that in your second panel—is when all of this is over, how do they maintain that investment?

I think this is one of the things I would ask you to consider in the Warstopper program that has allowed DoD to do exactly that since Desert Storm for these type of materials.

Senator MANCHIN. But the Federal Government has a responsibility to make sure that we do have necessary equipment.

Dr. STONE. Yes, sir.

Senator MANCHIN. Ms. Kramer, would you want to respond to that?

Ms. KRAMER. Yes, sir.

I am actually a member of the committee that is working on the next-generation SNS with DoD, with Health and Human Services, with FEMA, and with a number of executive branch partners. And they are working very hard on working to set up that industrial base capability that we need.

Senator MANCHIN. Have you been on that for a while——

Ms. KRAMER. I have been on that for about 4 weeks, sir. It is just getting started and——

Senator MANCHIN. Have you all evaluated how we got behind the curve and got caught so flat-footed?

Ms. KRAMER. Well, sir, I think that no one ever—well, I had a chance to speak to a former Chairman of the Joint Chiefs this spring who had called the lead for PPE because he cares about veterans, and he shared that in his war-gaming experience, DoD never played out the biodefense events the whole way to the end, because it was just too hard to do. And what we are going to need to do now, sir, is play it out to the end to see how it really works.

It was a tough problem; it is a tough problem now. And we have a long way to go to bring us back to where we need to be.

Senator MANCHIN. Are you all looking at basically a deposit, if you will, a depot that we will have for national defense, have the PPEs that we need so we do not have to reply on other nations, other countries?

Ms. KRAMER. The Strategic National Stockpile is going to reestablish so that they can meet the second wave and then continue their readiness mission. We would like to work with DoD and our commercial sector partners to do things like the Warstopper program, Vendor-Managed Inventory, smart things that allow us to buildup what we need.

But just in time for PPE is not the way to go, because a just-in-time supply chain cannot support a tremendous surge.

Senator MANCHIN. We know that, yes.

Ms. KRAMER. Yes, sir.

Senator MANCHIN. We know we have been caught behind, but the bottom line is bring manufacturing back. And unless we are going to have a stockpile, then you are right, Dr. Stone, they are not going to invest in that because they are going to say, "What happens when it goes away?" Well, it is never going to go away. We are going to have to continue to be prepared, and we have not been.

Thank you.

Chairman MORAN. Thank you, Senator Manchin.

Senator Rounds?

SENATOR MIKE ROUNDS

Senator ROUNDS. Thank you, Mr. Chairman.

First, to the entire panel, thank you for your service to our veterans and to our country. Thanks for being here to talk today about one of the VA Secretary's top priorities.

I want to ask you about the VA's ongoing issues with its latest prime vendor program model, Next Gen 2.0.

Right now, the tiered acquisition rules give special considerations to certain small businesses. I recognize that that is important, but we also want to be sure that when it comes to large-scale critical missions like the VA supply chain that we are contracting with suppliers who have the experience and capability to deliver, even when times get tough.

But right now, as I understand it, it is up to the individual contracting officer who is reviewing the 2.0 supply contract bids to determine what fair and reasonable pricing is per the Kingdomware Decision that they are—that they are under right now.

This is one of the most important criteria involved in the contract award process. So my question is, What is the VA doing to set up standard criteria for defining fair and reasonable so that when they talk about pricing, we can be sure that these contracts are going to folks who have the supply and the distribution capability to succeed?

Ms. BRAZELL. Thank you, Senator.

Fair and reasonable pricing is driven—what we would do is we would look at the market. So a market research is going to drive the prices and who can provide that, being a supplier or a distributor.

I do want to point out, though, that the MSPV 2.0 contract is an active solicitation. So there is not a lot we can go into, other than the fact that we took the lessons learned from the previous MSPV Next Generation and GAO's recommendation as well as Congress, and we brought our clinicians in.

So this time around, it is clinically driven sourcing, and it is going to be competitive. We are going to have tier reviews. So our service-disabled veteran-owned community is your tier one. Your tier two is your veteran-owned small businesses. Then your tier three would be the larger businesses.

Those will all be vetted. They are going to be competitive, and again, the market research is going to drive what would be the fair and reasonable pricing.

Senator ROUNDS. Let me just kind of followup a little bit on some examples, perhaps. Let us take PPEs as an example. Let us take the gowns.

Right now, how many different providers, how many different markets are there for the gowns that you would need?

Ms. KRAMER. There are a number, and most of them are located overseas. There is very little cloth textile manufacturing in the United States, and we want to get to more reusables because that reduces the demand on the supply chain.

Senator ROUNDS. During this pandemic, have you had the opportunity to actually look at or negotiate with any manufacturers or suppliers that would do that within the United States?

Ms. KRAMER. Actually, that is something that the SNS Next Generation Committee is doing. So through DoD, they are actually having those discussions right now.

Senator ROUNDS. Were they successful during this pandemic in making any of that happen within the United States?

Ms. KRAMER. I think, sir, that that is a question that is probably addressed to DoD and FEMA.

Senator ROUNDS. So the VA probably would not be the lead agency in working through any of those? You would be tagging on with what others were doing?

Ms. KRAMER. Sir, we would be providing our requirements so that industry would understand what the government requires.

Senator ROUNDS. Would the same thing be true with regard to other necessary items within the realm of the PPEs——

Ms. KRAMER. Yes, sir.

Senator ROUNDS [continuing]. masks, face guards, and so forth?

Ms. KRAMER. Yes, sir.

Senator ROUNDS. Are there any examples where we have actually had progress made after this pandemic or during this pandemic where we started bringing any of those back into the United States?

Ms. KRAMER. Again, sir, I am not intimately involved with what DLA is doing with that effort between them. FEMA and they can provide the best answer to that question. It is also under solicitation, so there are some concerns about discussing it in an open forum, sir.

Senator ROUNDS. Would it be fair to say that making a transition from existing providers to new providers under emergency circumstances leave something to be desired right now?

Ms. KRAMER. Well, sir, what we would like to do is the current providers—we would like them to bring things back onshore, do it here.

Senator ROUNDS. But in order to do that, do not they have to be assured that you would continue to use their resources, even after this pandemic is over? I mean, they cannot just simply go out and put in whole new lines without having some assurance that you would participate with them for an extended period of time; is that fair?

Dr. STONE. Sir, you are exactly correct in that, and therefore, it has been very slow progress in this during the pandemic to move.

Every bit of domestic manufacturer has been completely overwhelmed by the demand. So if we are up 800, 900, 1,000 percent, so is every other health care system in America.

Let me give you one area of hope, and that is not clearly about PPE. As you know, there has been a worldwide shortage of swabs to do the testing on for COVID. We have been a leader in 3D manufacturing. We have been manufacturing a few thousand swabs a month—I am sorry—a week. We now have a plan in place to expand our swab manufacturing using advanced 3D manufacturing printers to the tune of about 100,000 a week by this fall.

So I think there is hope, but every small manufacturer we deal with in the United States is questioning a capital investment and whether that will be enduring.

Senator ROUNDS. Mr. Chairman, the only thing I would say—thank you. My time has expired, but I think we really have to talk about during an emergency situation when we run out of supplies. How do we cut through the bureaucracy to actually be able to award contracts on an emergency basis to individual entities who might very well be perfectly capable of providing, whether it be masks or other gowns and so forth, if allowed to do so in a timely fashion and with the appropriate assurances that it will not be a one-time shot that basically breaks them up in business?

I think we have got—as you say, I think we have got a long way to go, and perhaps the VA could be a part of helping to solve that problem.

Thank you, Mr. Chairman.

Chairman MORAN. Thank you, Senator Rounds.

Senator Blumenthal?

SENATOR RICHARD BLUMENTHAL

Senator BLUMENTHAL. Thank you, Mr. Chairman.

Thank you all for being here.

Dr. Stone, a GAO report last year on VA's Office of Health Equity—I am sure you are familiar with it—made two recommendations. One was to ensure that the VA was collecting reliable racial and ethnic data on veteran patients, and the other was to ensure that any Health Equity action plan included measurable criteria and clear lines of responsibility to specific offices within the VA.

These steps are really important—again, I do not need to tell you why—because racial and ethnic minority veterans currently make up about 22 percent of the total veteran population, and they are projected to make up 40—or almost 40 percent of the total veteran population by 2040.

The VA has identified worse health care outcome for some diseases among minority veterans at VA facilities with recent data showing that COVID–19 is affecting African Americans at a higher rate than any other racial or ethnic population.

I find it unacceptable that the VA has not implemented any meaningful reforms to address racial disparities within the VA system. You have established the Office of Health Equity to identify and address health care outcome disparities and to develop an action plan, but the GAO report published last year found that there are no clear lines of accountability or measurable data.

So my question is whether you are committed to act on these recommendations, when you will do so, and what immediate steps you can take to change the fact that black Americans are treated differently than others and what we can do in Congress to support you.

Dr. STONE. Senator, when I came back to the VA in 2018, it was about the time that this report was circulating. We established the Office of Health Equity under my principal deputy, Dr. Lieberman.

Right at the beginning of this pandemic, we began sending to the field, information on data on the relative risk of the black male population and the fact that they were testing positive at a higher rate than other ethnic groups.

What we have not seen is an enhanced death rate, unlike other health care systems, or the broader American population.

This is similar to what we have seen in prostate cancer, in black males enrolled in the VA health care system, where black males in the American public actually die at a higher rate from prostate cancer than do Caucasians or other ethnic groups.

That disparity is erased in the VA. We believe that that is erased in the VA because of our care of the comorbidities that exist with prostate cancer. We do not think that the disease is fundamentally different in black males versus Caucasian males or American Indian males, but we have been able to erase that disparity.

This is an absolute priority for us and reflects the respect that we hold for all veterans and our responsibility to deliver the utmost value in this integrated health care system.

Senator BLUMENTHAL. Do you attribute the absence of different death rates from COVID–19—if I understood you correctly, the death rates are the same for African American veterans as they are for Caucasians? Is that due also to your addressing the comorbidity factors? You just talked about prostate cancer, but is that the same?

Dr. STONE. For COVID, we believe the same thing, but it is too early to absolutely tell.

Since the beginning, our research team has been working this, and it is just too early to get the data out and to really discuss it, but it is an absolute priority. And they are meeting weekly and briefing me biweekly on the results of this.

Steve Lieberman, my deputy, is taking this on a weekly basis and working our way through.

But I think the question that you ask is really about the value of a fully integrated health care system in erasing access to health care problems that exist across American society, and that is the beauty of this system and why all of us choose to work within it.

Senator BLUMENTHAL. I agree totally that the thrust of the question is to address health care inequities, disparities in access to health care generally, which is, in my view, the reason why there are different death rates among black and brown Americans as opposed to others resulting from COVID–19. It is those comorbidity factors, whether it is respiratory problems or diabetes or—you can identify them better than I.

But if the VA is addressing those factors and diminishing disparities, I think that will be important to know.

Dr. STONE. So, with your forbearance, sir, we just took a look at a gene present in prostate cancer that allows the metastasis of prostate cancer and compared that to a gene that is present that opens lung cells to the penetration of COVID. It is that type of research and effort that you allow to go on by funding us in the manner you do that I think carries great hope and shows why all of this interrelates.

Senator BLUMENTHAL. I think that is very important.

One last question, and I am pretty much over time, but since the Chairman is not giving me a negative sign, I am going to go ahead quickly and ask it.

Active COVID–19 cases are on the rise in several States: North Carolina, Arkansas, Alaska, Texas. And my understanding is also on the rise in some VA facilities. Is it on the rise in those States

or in other States? Is there an overlap in the incidence of that trend?

Dr. STONE. Sir, as we discussed earlier with your colleague, our number of cases in both our med-surg units and our ICU continues to go down. I had predicted that we would stay at a 500–600 occupancy for COVID. We are down at 345 this morning, and so it continues to go down.

However, you have listed a number of very troublesome States. I would add to that Arizona, which in major areas are seeing an increase in cases. We have not seen that increase in cases correlate well to the veteran population; therefore, we remain with substantial capacity in those areas that we think the commercial health care systems may call upon us to execute our fourth mission if this wave continues in those multiple States.

Senator BLUMENTHAL. And you may have asked this already, in which case you can just say, "I have answered it." You do not have to be polite. Have you identified the reason for that non-correlation?

Dr. STONE. No, no. But I think it is part of the research that we have to go through.

We have questioned—70 percent of America's veterans have deployed. So they have been exposed to multiple immunizations. We have wondered is there something different about the American veteran that is allowing us to do very well in this.

With that being said, I think it is too early for me to really extrapolate that, and the researchers will be working on this for a fair length of time.

Senator BLUMENTHAL. Thank you. Thanks very much.

Chairman MORAN. Senator Blumenthal, I always look at the clock, and it is an inverse to the respect that one shows the Chairman once it goes beyond 5 minutes.

I recognize now Senator Tillis.

SENATOR THOM TILLIS

Senator TILLIS. Thank you, Chairman Moran. I am sorry you are not going to be able to see my face. I am having a problem with the camera, but I hope my audio feed is going Okay.

Chairman MORAN. We hear you well.

Senator TILLIS. I have got a real quick question. One question, I know that the DMLSS system of the VA medical center is not going to be implemented, I believe, until 2027, and the DLA is—I guess the VA is going to need to pay the DLA to support the DMLSS system.

The question I had is—we are going to be in a situation. I think there is also a relationship between the EHRM implementation and DMLSS, that they kind of roll out alongside one another. So I am just trying to get my head around some of the sequencing in some of the decisions that you all thought about.

The two questions that I have on the rollout really is, No. 1, have you all assessed the feasibility of speeding up the DMLSS implementation or the rollout of it? And I know that a part of that depends on the delay that we have seen with the EHRM system, but have you looked at how you sequence those and potentially speed up the rollout? That is one question.

The other question is, Have you all assessed the cost versus benefits to just transitioning all the VMACs to—is it LogiCole?

Dr. STONE. Yes, sir. It is LogiCole.

I am going to defer to Andrew Centineo to give the most depth to this, but our plan has been to field the DMLSS solution no less than 60 days prior to go live of EHRM, so that we would get out of their way.

One of the beauties of doing EHRM is we are upgrading all of our closets, all of our communication closets to accommodate these systems.

There has already been a more rapid effort to improve the closets in EHRM, which would allow DMLSS to go faster. I would not characterize the cost to do that at this point. I think we can work our way through that.

We have money in the 2021 and 2022 budget, but if we wanted to accelerate it, which we think is appropriate, that would cost additional dollars.

So let me defer to Andrew for additional details.

I want to make sure, because I made some comments before you go, Andrew. LogiCole is not a new software system. It is simply moving DMLSS to a cloud-based system, and so, Andrew, do you want to go ahead?

Mr. CENTINEO. Yes, Dr. Stone, I will. Thank you so much, and thank you, Senator Tillis, for the question.

So one of the key elements, as has been discussed here, has been documented in GAO reports, is to be able to have systemic business processes. So DMLSS needs to be the application. It has been decided to be the application to provide holistic enterprise logistics support.

I will just quickly touch on a few of the items because I do not want to lose sight of the fact that it will give us supply capability. It will give us enterprise equipment, ordering, receiving, accountability, maintenance. It will provide us facility management to include space or space file. So if we took, for example, today's environment for PPE, the need to expand our negative pressure rooms for patients, having that information resident in DMLSS could have an enterprise pull and an enterprise view for Dr. Stone to look at all of his facilities to say where do I have negative pressure rooms or where do I have capacity.

This enterprise application is fully integrated, unlike the current applications that we have today, AEMS/MERS, GIP, and Maximo, three islands, three completely separate instances across 170 facilities customized at every one of those locations.

So if we just look at the rudimentary business processes, DMLSS will give us the structural foundation to do that.

The question has been raised before. Senator Tillis, a great question. LogiCole is the future advancement. It will give us enhanced enterprise capabilities, but what we need to do is start with the technology that gives us the business processes and migrating it to that next level, which was already programmed within DoD. It will be nothing more than having it go from a Microsoft Office Version 1.0 to 2.0 with mild enhancements that then the end user will have to get prepared with.

I mentioned it early, and I would like to reiterate the point that this is not a journey for the VA alone. The way it thrusts to enable ourselves to do this is the partnership with the Defense Logistics Agency, which is the supply chain side of the house, and the Defense Health Agency, which is the IT enabler, to bring the capability to our organization.

Dr. Stone talked about funding. Funding is a component of it, but the capability and capacity for DoD to be lock step with us is absolutely something that we will need support with to make sure that we have a fundamental whole-of-government approach that positions VA, DoD, and other partners in the environment of the supply chain specifically for DMLSS for DoD and the VA.

I would personally ask for consideration from the Committee to look at how we can position ourselves with language to be able to get ourselves in that direction.

Senator TILLIS. Well, I would be happy to speak with you about that.

I have got limited time. I can barely see the clock, but one thing I just wanted to bring to your attention more than anything, we just got a recent announcement from HHS BARDA at Corning, got a $204 million contract to expand production lines for glass vials and preparation in anticipation of the vaccine.

So one of the questions I just had for VA, I would not expect you to answer it here, but just think about it. If you are taking a look at the promising reports that we are getting on the development of a vaccine and a large population and a fair number are in the at-risk category within the VA system, what are you all doing right now thinking through—let us say the clock ticks. We get into September-October. We could potentially have a vaccine that has already got the manufacturing capability to be manufactured at scale. What would you all need to think about now to make sure that you could take full advantage of that?

And then another question around syringes, other vials, other challenges. Are you thinking through the supply chain challenges for the vaccine response to COVID–19?

Ms. KRAMER. Yes, sir.

We are working with FEMA and Health and Human Services on this. That is a whole-of-government approach. They are producing it for the Nation, and we will be part of the group that is supported with that.

And we are evaluating our requirements for syringes and needles to be able to administer those, the vaccine, but we need to understand a little bit more about what FEMA and SNS are doing so we do not duplicate what they are also doing. They are planning on acquiring quite a few syringes and needles.

Dr. STONE. And our medical research team is participating with the development of the vaccine.

Chairman MORAN. Senator Tillis, that is an excellent question, and I look forward to hearing more about the plans for utilization of vaccines as they become available. And it is worthy of our Committee spending some time on.

I now recognize Senator Hirono.

SENATOR MAZIE HIRONO

Senator HIRONO. Thank you, Mr. Chairman.

Tragically, 33 VA employees have died due to COVID–19. Dr. Stone, does the VA have any data or accounting of how many of those employees were working in a facility that had implemented austerity measures with regard to the use of PPEs, and are you concerned that lack of proper PPEs led to employee deaths?

Dr. STONE. Senator, my No. 1 responsibility is the safety of veterans and safety of the employees that have pledged their work lives to the VA.

It is impossible for any of us to understand how these employees got this disease, and we can go through privately the events regarding a number of these.

We had an early death that occurred in someone who was moonlighting in another facility and carried it back to a number of coworkers in an area that really was in no-patient contact.

So to suggest——

Senator HIRONO. The record——

Dr. STONE. To suggest—please give me a minute here. To suggest that somehow we have endangered our personnel is just not borne out by the facts. We will be happy to go through and look at every single one. We are doing that at this time, and OSHA is involved in every one of our deaths, and so I appreciate it.

So let me say one other thing. In Italy and in Spain, 10 to 15 percent of health care workers actually caught COVID–19. In Detroit, which is one of the few health care systems that has actually talked about their infection rates, their rate of infection is between 2.5 and 4 percent. We are at 0.8 percent on our personnel who have become infected. That to me reflects the fact that we have done a good job of working to protect our workers.

Thank you.

Senator HIRONO. On the other hand, Dr. Stone, at our last hearing, VA acknowledged that it is not there yet with COVID–19 testing for employees, and VA specifically cited a lack of cartridges and swabs.

So you know that there is a very low rate of hospitals testing positive, but then we are told that you are not there yet with regard to adequacy of your testing program.

What is VA doing to procure enough testing supplies for robust testing of VA employees, and when do you expect to have sufficient supplies?

Dr. STONE. So——

Senator HIRONO. And once you have enough supplies, will there be restrictions on which VA employees can receive tests?

Dr. STONE. So what we would like to get to and I think what our employees deserve is on-demand testing. We, as of today, are just under 50,000 of our employees have been tested, which is about 17 percent of our work force. That is dramatically higher than the American population.

We have tested all of our work force in certain high-risk areas, including our CLCs as well as our spinal cord treatment areas.

We have the capacity at this time to test about 60,000 tests a week. We are running between 600 and 700 employees a day through that testing, and we hope to get there soon. But it is not

the equipment that we need. It is really the cartridges and the swabs that we must get to in order to get to the amount of testing that I think both you and I would agree would be the right amount of testing that any employees could feel safe going home at night, that they are safe for their family.

Senator HIRONO. So there is acknowledgement that you do not have enough cartridges and swabs. So are you getting them?

I realize that 50,000, that only represents 17,000 of your work force, but many of your work force work directly with patients who are, therefore, in a risk category. So I think it is more important that the people who are working directly with patients in the VA system get tested. So where are you procuring the cartridges and swabs that you need to perform adequate testing?

Dr. STONE. So these are coming from multiple manufacturers based on the multiple different types of machines that we have.

Ms. Kramer or Andrew, do you have——

Ms. KRAMER. Yes, sir.

And they come from a variety of places. Some of these are actually centrally controlled by Health and Human Services and are actually sent out on allocation. Again, these are products where there are shortages nationally. Swabs and these cartridges are not a challenge just for VHA. They are a challenge for many health care systems. So we get that allocation.

As they are able to—the manufacturers are able to speed up production and as we develop, there is only two—three swab manufacturers that I am aware of in the world: one in Italy, one here in the United States, one in China. We are hoping more people get into that market and begin producing more swabs that would actually relieve some of the shortages that we are experiencing today.

Senator HIRONO. Well, this is one of the reasons that so many of us have advocated that the President fully utilize the Defense Production Act because it is just unacceptable—that is kind of a nice way of putting it—that a system as large as the VA does not have an adequate amount of these kinds of materials, and yet you have to compete with other systems. Every State is competing for these materials.

I mean, I do not necessarily want to put you on the spot, Dr. Stone, but it would make a lot of sense if the Defense Production Act had been fully mobilized to produce all of these necessary testing supplies. I do not know if you care to answer. Would you care to answer?

Chairman MORAN. Senator Hirono, let me see if Dr. Stone wants to say something. If not, we will move on to Senator Cassidy.

Dr. STONE. I think that when you are dealing with a once-in-a-hundred-year pandemic, there are lots of lessons learned. One of them is how we use domestic manufacturing.

Chairman MORAN. Senator Cassidy?

SENATOR BILL CASSIDY

Senator CASSIDY. Thank you all. Again, Dr. Stone, thank you for the assistance the VA gave to the people in New Orleans, and you all stepped up. When I hear that your infection rate is 0.8 percent, as a physician, that is incredibly impressive, and so let me just say that as well.

Let me get to my question. Here is something. Let me just ask you. The VA clearly has enormous buying power. You can get the lowest price, if you wish, of all products.

Now, I hear from doctors, and they are telling me that they were not necessarily consulted in the decisions made as to what products to purchase.

It comes to mind that when I was practicing medicine, I worked in a State-run hospital, and you know those little packets of K-Y jelly that we use for endoscopy. We put it on the end, and we pass it. Somebody went out and bought a substitute for the normal vendor, and it turns out they only gave three-quarters of the amount per packet. So we ended up using more packets than we would have, even though they got a better price on the packets.

If they had asked a clinician who actually used it, we would have known.

So I am hearing from some of my folks within the VA that these standardization decisions are made as regards to purchasing, but the clinician himself or herself is not consulted in that decision-making process.

One more thing I will say, I think this is called the Next Generation Medical-Surgical Prime Vendor contracts, and as subsequent, it has not been embraced by the clinicians.

I will also say I had a bill pass in 2018, the VA Medical-Surgical Purchasing Stabilization Act, which was to ensure clinician input on formulary decisions, but again, I am hearing that that has not been implemented as per the purpose of the law.

So, Dr. Stone, what comments do you have on that? How involved are the clinicians in driving the contracting strategy?

Dr. STONE. Senator Cassidy, thank you.

You are talking about clinically driven sourcing, and I think that Andrew Centineo can talk a bit about that, as can Karen.

So, Andrew, do you want to take this?

Mr. CENTINEO. Yes, Dr. Stone, I will.

Thank you, Senator Cassidy, for the question.

Unequivocally, clinically driven strategic sourcing is at the center of where we are.

True, in our old-generation med-surge prime vendor contracts, that was lacking or perhaps not there.

I would offer that last year, we actually assembled over 150 clinicians as part of the clinically driven strategic sourcing initiative. That does have clinicians across the entire VA in areas of specialty that are required to be able to help us source our material as we are doing our MSPV 2.0 solicitations. It is with clinical technical review teams before those products are put into the sourcing selection.

We unequivocally have brought in leaders, to include Dr. Paul Varosy, who is one of the premier cardiologists. He is in there leading it from his vantage point, and he is working with the chief medical officers across all of our VISNs to be able to have their input providing clinically driven sourcing.

I would offer you have to have a background in supply and logistics to look at the factors that go in there. We also have to bring in there, how do we bring our buying power.

Although the VA is large, only if we are brought together in a larger entity, if we look at a whole-of-government approach, do we really start to see market share.

If we were to partner with DoD, we would probably get to the 4 to 5 percent market share. That is where we are. Although we have 170 medical facilities, we do not really dominate that much of a market, but we certainly can get buying power by collaborating more closely, but we——

Senator CASSIDY. Well, let me ask that because I am almost out of time. Thank you for that answer, and that is reassuring.

One of the problems we have right now, at least in pharmaceuticals, is that there can be a price driven so low with the sole-source provider that you end up with only one provider of a generic drug.

And I see you nodding your head. This is something we all recognize.

DoD will actually pay a little bit more to make sure that they have at least two providers of a certain widget, if you will, whatever they need to make things happen.

So has there been any consideration for VA to perhaps invest in—as some other big systems are—invest in making sure that we have more than one provider of key elements of that which we need?

And, Karen, you seem teed up to address it.

Ms. BRAZELL. Yes, Senator Cassidy. Thank you.

I just want to make clear that the current MSPV 2.0 contract is under active solicitation, but I can tell you what they did for MSPV Next Generation.

First and foremost, it was not competitively bid. What they did is took 400,000 items, and we were directed by GAO and, of course, Congress to bring in the clinicians for it to be clinically driven sourcing. So we are down to 22 categories, that each of those categories had a physician as part of that team in the development process.

Competition is what is going to drive the price, and so this contract is going to be competitively bid. And we are going to have it tier-reviewed. So there will be three different levels of tier review, starting first with our service-disabled, veteran-owned community.

Senator CASSIDY. That addressed my first but not my second, but I am out of time. So I will yield back. Thank you.

Chairman MORAN. Thank you, Dr. Cassidy.

Now Senator Sinema.

SENATOR KYRSTEN SINEMA

Senator SINEMA. Thank you, Mr. Chairman, and thanks to our Ranking Member for holding this hearing.

Thank you to all of our witnesses for being with us today.

This topic is extremely important to ensure VA can protect its staff and the veterans it serves as they continue to treat veterans during the coronavirus pandemic and prepare for future health emergencies that might occur.

My first question is for Dr. Stone. The VA has multiple avenues for procuring medical and surgical equipment and supplies, including government procurement cards for ad hoc purchases.

Given the short supply and high demand for personal protective equipment and other supplies during the pandemic, facilities have been making purchases in some cases from unknown or new vendors. Some of these purchases resulted in the VA facilities receiving expired or otherwise compromised supplies.

Does the VA Central Office have a way to identify and track these purchases to ensure that the VA does not spend taxpayer dollars on fraudulent sales?

Dr. STONE. Not as effectively as we should.

Ms. Kramer has been working this.

Ms. KRAMER. Yes. And I just actually would like to go back to Senator Cassidy's question to also mention that Warstopper is another way that we can make sure that we can maintain more than one manufacturer out there, but we do not have that authority. And we would need that authority to be able to support two manufacturers, especially if one is offering a significantly lower price.

We have a very difficult time, given the systems that we have at VA, on being able to see the government purchase card orders in real time. We are catching these typically later and typically after someone has reported a problem. That is one of the other big reasons that we need the Defense Medical Logistics Standard Support System because the government purchase cards are put into that system, and it can only be used through that system. And the system will actually stop you from making a purchase where there is a better source.

We are putting guidance out to support the facilities in terms of how to identify counterfeit products so they do not acquire those, and it sounds like I need to put a little more training out in the field in terms of how to identify manufacturers who can deliver FDA-cleared products.

Senator SINEMA. So a followup question to that, then. As the VA is moving forward with a plan to modernize the procurement systems, have you considered creating systems that have the capability to prevent flagged vendors from conducting business with the VA while also allowing the incorporation of vetted local suppliers that can provide local VISNs with more flexibility and shorten the supply chain, basically doing two things at once, stopping the guys who are fraudulent so no one else makes that same mistake and then also incentivizing using local folks who are trusted and proven?

Ms. BRAZELL. Senator, this is Karen Brazell.

Yes. We do have methods. When we have what we call a "bad actor," we flag those. So that message is promulgated throughout the VA, and that messages are sent out from our senior procurement executive.

And then we also flag it in our contract management systems. When we do have those bad actors, we make sure that we communicate to the entire acquisition community at the VA, what to look for and how to address fraud, waste, and abuse.

Senator SINEMA. Thank you.

My office has heard concerns from some VA health care personnel that as PPE shortages increased, they were given less PPE, and they did not understand why one person would receive a surgical mask while someone else would get an N95 respirator.

There were also strong concerns that we heard in our office that new CDC guidelines related to reusing and conserving certain types of PPE put the health of personnel and veterans at risk.

So, Dr. Stone, as part of evaluating the proper use of PPE during this pandemic, can the VA and other Federal agencies work with the CDC to reevaluate their guidelines? And can the VA and other Federal agencies track and evaluate the impact of changing PPE guidelines in the years to come?

Dr. STONE. I think we can, and I think we should. I think that one of the frustrations in a health care system not under stress is that you can throw a lot of things away that have usable life.

I think we saw that with the N95 masks. If I go into a surgery that I need a surgical N95 and that surgery takes 6 hours, I wear that mask for 6 hours, but yet on a floor when we are out in a medsurg floor, in an ICU, we might throw that mask away in 5 minutes, even if it has not been soiled or contaminated in some manner.

So when we said to employees that you can use a mask for your shift, whether that be 8 or 12 hours, it was done with CDC guidance and only after the CDC guidance, and it was reflecting the fact that studies have shown that those masks will work for that 8 to 12 hours.

So there was a lot of discomfort in that on the floors, and it has been an education for all of us who for my nearly 40 years of being a physician have just simply thrown those things away when I walked out of a room.

This was different but also reflected the experience that we have around the world as well as the research that has been done demonstrating those material safety.

Senator SINEMA. Thank you.

My time has expired. Mr. Chairman, thank you.

Chairman MORAN. Senator Sinema, thank you very much.

Now Senator Blackburn.

SENATOR MARSHA BLACKBURN

Senator BLACKBURN. Thank you, Mr. Chairman, and thank you to each of you for being there.

As we talk about having this inventory system, having the purchasing system, let me ask something I have not heard you mention in this hearing. How many purchasing agents does the VA employ, and where are those agents located?

Ms. BRAZELL. Thank you, Senator.

Specifically, I can address at least your contracting officers because purchasing agents may be like GPC cardholders vice a contracting officer.

So within the VA, we have at least 3,300 contracting officers geographically dispersed. The proponent of them reside in VHA. So about 2,200 of those contracting officers reside in VHA to make those decisions and award contracts.

Senator BLACKBURN. And how many hospitals are in the VA system?

Dr. STONE. 175.

Senator BLACKBURN. Say that again

Dr. STONE. 175.

Senator BLACKBURN. Okay. For 175 hospitals, you have 3,300 purchasing agents, and in addition to that, you have individuals that hold the GPD cards. Am I correct about that?

Dr. STONE. Yes. I think there are 17,000 GPC cards that are in the field.

Senator BLACKBURN. Let me ask you this. First of all, let me say your 7-to–8-year implementation plan is just way too long. That means the job is never going to get done, but let me ask those of you on the panel. Have any of you looked at any of the hospital chains, the hospital management companies like HCA or Community Health or LifePoint Health, and looked at their purchasing departments and the number of people that are there and how they make their purchasing decisions? Have you done a deep dive on this?

Dr. STONE. So I have, and I will defer to everybody else to answer also.

So we took this concept of moving to a more centralized and a more accountable system, and we took a look at Ascension Health, which is about the same size as us and has gone through multiple procurements of other hospitals. We presented this concept to our special medical advisory group, which has a number of health care leaders, including leaders from HCA.

We have dramatically more purchasers of materiel than any of the other commercial health care systems which is——

Senator BLACKBURN. Probably several hundred-fold.

Dr. STONE. Yes, ma'am.

Senator BLACKBURN. If most of those have purchasing departments, that would be about 25 people. Am I correct on that?

Dr. STONE. I am not sure it would be that austere.

Senator BLACKBURN. I think I am correct on that. Yes.

Dr. STONE. But you are correct that we are severalfold greater, and hence, we have a system that does not deliver the transparency or the level of accountability that either you or I would expect.

Senator BLACKBURN. So looking at that answer—and I know it is difficult to do this by video. So looking at that answer, then before we get going down into replacing any kind of system, we need to look at your structure and find a way for you to, first of all, take you—you would be better served to have 130 people as opposed to 3,300 people. You would be better served not to have 17,000 additional that can go make purchases, but looking at a different way to approach this and doing it more like a hospital system.

Ascension is a good one because they deal with pharmaceuticals. They deal with the hospitals. They deal with clinics. They deal with a variety of facilities within that framework. So you need a structural overhaul before you can even address your problem.

Mr. Chairman, I would recommend that we go back to the drawing board on this and that we work with the VA in a way to get their structural system in order first and then give them a timeline that is going to be more realistic. Seven or 8 months, they ought to be able to do this as opposed to 7 or 8 years.

I yield back.

Chairman MORAN. Senator Blackburn, thank you very much.

I would ask our witnesses, Dr. Stone, do you or any of your colleagues want to add anything to what has been said previously, any opportunity to correct to add or modify any of your testimony?

Dr. STONE. The only addition I would make, sir, is to reemphasize what I said at the opening.

The collegial relationship we have with your Committee and each of the principals is a dynamic and excellent discussion that helps us through all of these issues.

When the Secretary and I came to the VA, we recognized there were three major systems that must be fixed: our information system for collecting clinical records, the EHR; the supply chain; as well as financial modernization.

We have hit today on the second pillar, but in this pandemic, it is that pillar that has really created most risk for us.

We appreciate the manner of the questions and how you have conducted this and look forward to our next discussion.

Chairman MORAN. Dr. Stone, thank you to you and your colleagues, and we will now call the second panel for their testimony.

We have with us today: Ms. Shelby Oakley, the Government Accountability Office's director for Contracting and National Security Acquisitions; Mr. Roger Waldron, president of the Coalition for Government Procurement; Mr. Michael McDonald, director of Government Operations at 3M Health Care; and finally, Mr. Kurt Heyssel, a principal with Sightline Performance Advisors and the former Chief Supply Chain Officer at the Veterans Health Administration.

I am not sure who all are appearing in person and who are appearing by technology.

Thank you very much for joining us today and for providing your testimony and the conversation that I know we will have, and we will begin by recognizing Ms. Oakley.

PANEL II

STATEMENT OF SHELBY OAKLEY

Ms. OAKLEY. Thank you.

Mr. Chairman, Ranking Member Tester, and members of the Committee, thank you for having me here today to discuss our observations on VA's medical supply chain and its response to the COVID–19 pandemic.

Like most medical institutions nationwide, VA has faced difficulties obtaining personal protective equipment for its work force in recent months. VA's existing mechanisms for obtaining medical supplies, such as its Medical-Surgical Prime Vendor program and other national contracts, were not able to meet the demands for PPE at its 170 medical centers.

Global shortages of supplies led VA officials to use whatever means available to obtain supplies, including existing and new contracts and other means such as government purchase cards.

VA mobilized its work force, and it was—and still is—an all-hands-on-deck effort to respond. I commend VA's contracting and logistics work forces for their tireless efforts.

While some of the challenges VA experienced during the height of the pandemic were a result of an unprepared global supply

chain, some were due to longstanding problems with VA's acquisition management function that we have reported on in our work and that led us to elevate VA's acquisition management to our high-risk list in 2019, problems such as an ineffective program for purchasing medical supplies and old and unreliable systems.

VA has taken steps to address some of its acquisition management challenges, but our ongoing work indicates that some will not go far enough, and others are years away. For example, preliminary observations from our ongoing work show that VA has made improvements to the Medical-Surgical Prime Vendor program that have mitigated a few of the shortcomings we identified in prior work.

These shortcomings, including a limited catalog of supplies, led to low usage of the program by medical centers.

Despite making some improvements, medical center officials report continued challenges, even under normal circumstances, with receiving timely supplies. VA's planned improvements to the program will not likely address these challenges or others.

VA has a just-in-time inventory supply model, a practice employed by many hospital networks. As you can imagine, a strategy premised on historical demand signals, small stocks, and daily deliveries, if disrupted, could quickly lead to a situation where a medical center is lacking necessary supplies.

VA's current inventory management system does not provide decisionmakers with real-time information to monitor and assess supply levels and support critical decisions about where gaps, needs, or surpluses are located.

As early as February, the Nation faced unprecedented supply chain paralysis, bringing VA's lack of visibility into its agencywide inventory of PPE front and center. In March, VA officials implemented a patchwork approach to obtaining information that relies on daily manual reporting from its 170 medical centers on their provisions of PPE for COVID response.

VA has evolved this system over the past few months, for example, by putting in place a dashboard for decisionmakers and by issuing guidance to assure more consistent data, but the bottom line remains. Our Nation's largest integrated health care system relies on an antiquated inventory management system that even in the best of circumstances is inefficient.

While VA has improvements planned as part of its supply chain modernization efforts, a recent status update indicates that they are at critical risk of not meeting modernization milestones, even before COVID. For example, VA plans to roll out a Defense Logistics Agency system which provides more real-time inventory management. Technology integration issues, however, have delayed near-term implementation, and complete implementation throughout the VA hospital enterprise is not planned for at least 7 years.

In conclusion, VA experienced many of the same challenges obtaining PPE as private-sector hospitals and other entities in responding to this devastating pandemic; however, VA was particularly ill-positioned to respond efficiently, given its existing acquisition management and supply chain challenges, despite the valiant efforts of its work force.

Chairman Moran, Ranking Member Tester, and members of the Committee, this concludes my oral Statement. I would be happy to answer any questions that you have.

Chairman MORAN. Thank you very much. Mr. Waldron?

STATEMENT OF ROGER WALDRON

Mr. WALDRON. Chairman Moran, Ranking Member Tester, and members of the Committee. Thank you for the opportunity to appear before you today to address the challenges facing the Department of Veterans Affairs as it builds a resilient supply chain supporting the health care of our Nation's veterans.

I am Roger Waldron, president of the Coalition for Government Procurement, and our association is pleased that the Committee is focusing on the VA's supply chain and its role in delivering best value health care to veterans.

By way of background, the Coalition is a nonprofit association of small, medium, and large businesses collectively representing more than $145 billion in annual purchases through government contracts for commercial products and services.

Coalition members provide more than $12 billion in medical-surgical products and pharmaceuticals to support health care needs of our Nation's veterans and warfighters.

Today my remarks summarize my written testimony, which has been submitted to the Committee and which I ask to be included in the record.

Chairman MORAN. Without objection.

Mr. WALDRON. Coalition members strongly support the VA's efforts to implement a clinically led program office to develop sound requirements. These requirements will define the scope of the VA's formulary and the commercial and medical-surgical products available through the MSPV program, national contracts, and the Federal Supply Schedules.

A clinically led program office serves as a bridge between program entities generating requirements and VA procurement professionals and contractors by identifying, collecting, analyzing, and communicating formulary requirements across the Department and to industry.

Given this central role in the VA logistics supply chain, it is vital that the program office be managed and led by clinicians. This management includes the naming of a medical supply chain leader responsible for formulary management and engagement with industry along with the investment of resources to implement a robust clinically led program office for medical requirements development.

Further, this office should serve as the lead point of contact for industry about new products and innovations. This role would provide industry with a clear, direct channel through which it can engage with the Department and should have the latest developments in the rapidly evolving field of medical and surgical technologies.

Engagement with industry, however, is just one factor in developing a robust formulary. Input from health care providers and treatment facilities across the VA along with the availability and analysis of transactional data are critical to developing an efficient,

effective formulary. The lack of meaningful, accurate purchase data undermines the development of a comprehensive, holistic formulary. In this regard, the current significant reliance on government purchase cards undermines the VA's formulary because it fails to provide such data.

The condition is circular. Treatment centers use the purchase card because items are not on the formulary, and as a result of that use, the VA lacks the data necessary to improve the formulary.

The VA should enhance and expand the formulary to reflect clinical needs. This effort would provide the VA with a sound spend data, and that combined with clinical input can be used to improve the formulary incrementally, standardizing product categories, where appropriate, while providing clinical flexibility and choice in other product categories.

A first step in expanding the formulary would be to allow firms to offer their full product lines rather than picking and choosing subsets of products, lines, or individual products.

Coalition members support the VA's efforts to modernize its financial and logistics systems. These systems are critical, indeed foundational, to creating, managing, and collecting data to support clinically led sourcing.

With regard to DMLSS, transparency regarding implementation schedule, milestones, and operations will assist all stakeholders in responding to changes in the Federal health care market. The VA's industry partners need to understand the implications for their business of a transition to this new logistics channel.

Correspondingly, all stakeholders will need to understand how the DLA contracts will evolve over time with the expanded scope and increased usage by the VA.

Finally, regarding acquisition generally, streamlining processes and streamlining regulations would help the VA meet its needs. Efficiencies could also be obtained by centralizing procurement operations. This coordinated management would allow the Department to focus on all aspects of the supply chain, including small businesses.

Chairman Moran and Ranking Member Tester, the job is complicated, but the suggestions made here could help the VA improve the supply chain programs that serve our Nation's veterans.

Thank you again for the opportunity to address the Committee. I look forward to answering questions.

Chairman MORAN. Thank you for addressing the Committee. Now Mr. McDonald.

STATEMENT OF MICHAEL McDONALD

Mr. MCDONALD. Chairman Moran, Ranking Member Tester, and distinguished members of the Committee, thank you for the opportunity to appear before you today.

Mr. WALDRON. I think you have to press that button.

Mr. MCDONALD. Good afternoon, Chairman Moran, Ranking Member Tester, and distinguished members of the Committee. Thank you for the opportunity to appear before you today . My name is Michael McDonald. "Mac," they call me. I am the director of Government Operations for 3M's Health Care Business Group.

Prior to joining 3M in 2013, I served in the United States Army for 30 years. I retired at the rank of colonel. My area of medical specialty was as a medical logistician in the Medical Service Corps.

Arriving here, given my experience, I hope that my testimony today will provide helpful to your Committee and reviews possible steps and strengthens and improves the supply and delivery of medical materiel throughout Veterans Health Administration.

3M is a leading provider of personal protective equipment and medical solutions worldwide for medical professionals, workers, and the public. Besides disposable N95 respirators, we are also a leading manufacturer and supplier of reusable respirators.

In addition, 3M provides other critical solutions in support of a pandemic response, including hand antiseptics, industrial cleaning, and any microbial testing and monitoring.

3M is playing a unique role in the fight against COVID–19, and it is a responsibility we take seriously. Beginning in January, 3M began increasing its production of N95s and other respirators, doubling its global output. In the United States alone, we activated our surge capacity and made an additional investment, increasing our N95 rate from 22 million per month pre-pandemic to 35 million per month today.

By the end of this month, we will be producing at a rate of 50 million per month, and by the end of October, we will be producing 95 million a month. Total for the annual year projection, we will be producing 1.1 billion N95 respirators. That is four times pre-pandemic production rates.

In addition, 3M has launched a global effort to combat fraud and price gouging and help protect the public against those who seek to exploit the demand of critical 3M products during a pandemic. Most important, 3M has not and will not increase the prices for N95s and other respirators as a result of the pandemic. We have also created and made available a number of resources to help purchasers of respirators and the public to avoid price gouging and other unlawful activities.

3M and the VA have partnered together for well over 25 years, with 3M providing solutions through multiple contract vehicles and responding to the COVID–19 crisis. The VA has contracted with 3M and additionally has received 1.8 million respirators to date and have contracted for over 25,000 powered air purifiers and 25,000 elastomeric, which are the reusable respirators.

While working with the VA to deliver critical medical supplies during the ongoing COVID–19 pandemic, we observed that there would be value in implementing a clinically integrated supply chain system to ensure systemwide visibility and requirements-driven solutions. Going forward, the concept of a sale to centralize and coordinate acquisition and logistical efforts should be considered as a best practice.

Furthermore, VA should be considered a stockpile program, much like DoD. 3M currently works with the Department of Defense incorporating contingency matters that allows them to work rotatable sticks.

While significant reforms have been adopted to modernize the VA, Medical Surgical Prime Vendor program still remains a work in progress.

Health care supply chain transformation starts with the patient, clinical provider, and reform should aim to address those topics directly, a clinically driven, integrated, and clinical adopted solution where clinicians are involved in the decisionmaking. Automating systems and the process is just one component of that. Standardizing and simplifying processes will, indeed, increase efficiencies throughout the Department of Veterans Affairs. Besides these and other reforms that are delineated in my written testimony, one key concept in this development of this process is a process map, not 7 years, because this actually began in 2012 when they did a proof of concept with DMLSS at the level facility. So that process map will prove to be very effective.

3M is a proud leader and supplier of personal protective equipment and other health care-related solutions to assist not only with the COVID–19 pandemic but also enabling the VA to achieve its main goal and function, to serve our Nation's veterans.

We are committed to continuing to work with and to be a strong partner with the VA as they move forward in their efforts and modernization, their current procurement processes. We are dedicated in serving as a resource in both agency and the Committee during this ongoing process.

I would like to thank you again for this opportunity to appear before you today and happy to answer any of your questions.

Chairman MORAN. I thank you, Mr. McDonald, for appearing before our Committee. Mr. Kurt Heyssel is recognized.

STATEMENT OF KURT HEYSSEL

Mr. HEYSSEL. Thank you, Chairman Moran, Ranking Member Tester, and honored Senators. It is an honor for me to be here today as much as it was when I was originally asked to serve our veterans over 2 years ago. I believe there is no higher mission for this Nation than to ensure the care and well-being of those who have served to protect all that we know and love.

A lot has been said today regarding various issues facing the VA, and they are all pressing issues. However, I believe a fair amount of what ails the VA supply chain is due to an organizational structure that has evolved over time. The current structure lends itself not to a unity of mission, vision, or a shared sense of purpose, but to operational and functional independence. This creates a bias for action to do what is thought best locally, without thinking of the larger organization and oftentimes without all or much of the information. As a result, any nationwide standards of performance or best practices or efforts to develop systems of management are hard to implement and monitor, which leads to the greatly varying results across the system we see today.

It leads to an expenditure of effort and resources to create transparency and to understand the big picture facing VHA supply chain. Oftentimes, the left hand does not know what the right hand is doing.

VA corporate is not in control as it must be to achieve supply chain success. Many large private-sector health systems when faced with this same issue implemented a shared service organization. I believe this is the answer for the VA.

Again, this is not the fault of any one person or group of persons. It took years to become this way, and this situation is, in my opinion, the single largest reason the VHA runs a high risk of failure and often does fail whenever a large systemwide effort is undertaken, and the result is a failure to serve our veterans.

VHA supply chain can and should be much more effective than it is, and the very good news is that this is a fixable condition.

I am anxious to get the conversation started. Thank you so much for your time.

Chairman MORAN. Thank you for your time.

Let me begin with questions, and then I will turn it to Senator Tester.

I assume that you listened to the testimony in the previous panel, Dr. Stone and his colleagues. Let me just ask you. If you were in my place or our place, what did you hear that I should be asking questions about? What did you hear in regard to their plans that raises the significant concerns, any significant concerns? Help me know what it is that we should be observing and pursuing as we continue to look at this issue of procurement.

I ask that of any and all of you.

Mr. HEYSSEL. Mr. Chairman, if I might?

Chairman MORAN. Please.

Mr. HEYSSEL. This is Kurt Heyssel.

A good bit of time is spent talking about the contracting process and how there are so many contracting officers employed by the VA versus what the private sector has. While the difference is almost staggering, I think what does need to be recognized is I think the VAAR or FAR needs to recognize what a source is. A source for anything, be it an N95 respirator or a scalpel or a clip applier is not whoever can sell it to you. The source is the manufacturer. This is at the heart of the contracting issues the VA and perhaps the rest of the Federal Government's procurement and contracting offices have.

I think the VA, VHA—and even VHA, all the Federal agencies involved in health care need and should contract directly with the manufacturer and then hold separate contracts with the people or companies they are choosing to buy from. That is what happens in the private sector. I would have 1,600 contracts with 1,600 different manufacturers, and then I had a contract with my distributor and perhaps a contract with other independent distributors. We pay a guaranteed price for the suture, and then we pay a guaranteed markup to our distributor, oftentimes anywhere from 1.75 percent to 3 percent.

Then in order for the distributor to stay in business, because the distributor needs to make at least 8.5 percent to keep their doors open, they had a relationship with the manufacturer, and they would pick up back-end money or a rebate from the manufacturer, which was essentially the manufacturer's recognition of the important role the distributor plays. The distributor creates elasticity in the supply chain. The distributor helps the manufacturer by making sure the manufacturer is not managing 5-or 6,000 ship-to's, and the distributor is helping its customer by making sure the health system is not managing 5-or 6,000 purchase-from sites.

So this is something that really would help the VHA incredibly. It would shorten the time needed to make a procurement. It would actually shorten some time needed to make a decision as to what they are going to buy and from who.

Chairman MORAN. Thank you very much.

Others?

Ms. OAKLEY. This is Shelby.

First off, I would say that, unfortunately, I think the situation that Mr. Heyssel is describing is only going to get worse under the 2.0 contracts, but that gets a little technical. So I am not going to get into that. I can share it with your staff.

But one of the things that I would be asking questions about of VA is, What are their supply chain goals? It seems like, since we have been reviewing their medical supply program over the past several years, that it is a flavor-of-the-week kind of thing where it is one goal 1 day, one goal the next day, "Oh, wait. We are going to go look at DoD's MSPV program. Maybe that is our panacea," and I think that it has led to a kind of lack of focus on what the actual goals are of the medical supply program within the VA. So I would really be pressing them on all of their different approaches that they are taking to obtain medical supplies and all their pilots that they are going to be holding with regard to DLA's MSPV program and find out what, in fact, is their goal that they are trying to achieve through all of these efforts, because it is taking a lot of time and resources to continue to move forward with MSPV 2.0 and do all these other things on the side as well.

Chairman MORAN. Thank you.

Mr. WALDRON. Senator, I would just pick up on what Shelby said in talking about goals. I think how you set goals is you have the leadership to focus on a clinically led program office for the Prime Vendor program in particular and establishing the formulary.

The discussion in the last panel was about there were clinicians participating in, quote, the evaluation of offers or looking at products in different categories, but we are thinking about a comprehensive, strategic, overall approach led by a clinician and developing a formulary, which ultimately the goal is to serve our veterans.

So I would focus on that because, at the end of the day, I have worked in procurement for the government for over 20 years. I worked in the private sector. It is foundational, and the key that I always found, regardless of the industry or the sector, it is requirements development is the key to success, successful contract performance on behalf of whatever mission you are performing. And that is what the formulary is about. That is what a clinically led program office is about, overarching approach—and I think it dovetails with what Kurt said as well, an overarching approach to how you serve the veterans across 175 different hospitals and other treatment centers across the board.

Chairman MORAN. Thank you.

Mr. McDonald?

Mr. MCDONALD. Chairman Moran, the aspect that I bring to the table is I actually was part of the DMLSS development process, and prior to that, I worked with the Army's TMIS development system. I have seen what takes change, the necessary elements for

change to occur, and you have to have, as we all said, clear goals. But you have to have a milestone and objectives that you want to bring your partners together.

So we had three different stovepipes: Army, Air Force, Navy, et cetera. And how do we get them operating on an integrated, combined, clinically driven system? This is not a short panacea or a quick fix.

To do that implementation at the largest health care system in the United States, 13th largest in the world, it will be a yeoman's challenge to get done, phased in and implemented correctly, but when they are giving you a timeline could it be done faster or can it be done quickly, do you want it right, or will we be back here 5 to 7 years looking for another solution?

So taking a path and commitment and allowing them to establish clear process maps, so regardless who is in this room here today, you hold their feet to the fire for the execution of implementing and integrate clinically accepted supply chain system, and that will improve the VA's Veterans Health Administration moving forward.

Chairman MORAN. Well, thank you all. I may come back to request additional conversation about those topics, but let me now turn to the Ranking Member, Senator Tester.

Senator TESTER. Yes. Thank you, Mr. Chairman.

Look, we will get back to the IT systems here in a second. I have said this before in this Committee and other committees that it seems like every time we deal with IT systems, it ends up costing a lot of money. We end up with a bag of cow manure in the end. I mean, we have been dealing with electronic health records for a long time now, $7 billion right now. We have got nothing to show for it, at least not from my perspective. Let us put it that way.

I am not a techie. So I do not get all this stuff. I do not understand how you cannot take a system that DoD is using and roll it into your agency. I know it is a big agency. It is the second biggest in the government, but I just do not get why it takes 7 years to do that.

So I want to set up timelines, and I want to set up benchmarks, but to be honest with you, I do not want to set up ones that are unreasonable. But I do want to hold these birds accountable, and they know that, by the way. They are watching, and they know this is part of the deal. Moran is the same way I am. We want to make sure we are getting the biggest bang for the buck, and we want to make sure the doggone thing works for the veterans.

So we may have to have this conversation further because it is unfortunate that we are at the end of the day with you guys.

Mr. McDonald—or, Mac, I want to ask you something. You talked about 95 million masks a month that 3M is putting out. Look, I think 3M is a great company. I am not being critical of 3M at all. You guys run an incredible business. When you talk about 95 million masks being built a month now, that is impressive. The question I have is, Are any of those built in the United States?

Mr. MCDONALD. Senator Tester, in my previous capacity as a director of logistics at DLA and when this similar, not to this extent, but when we were hit with the avian pandemic flu, we were in the process of acquisitioning for the Department of Defense. As the director, I was saying there was only one company that actually

made the mask that we needed, and it was 3M. So I learned in 2005, and hence, here I am in 2020 with that company that never left the United States.

They do have and support regionally accordingly by ensuring that we work with sources locally to ensure that our manufacturing capability can surge much like we did from 22 million, now at 35 million. By the end of this month with the help of the DFAS through the utilization of Title VII and Title III authorities, accelerating production capability—and we never left. We always maintained manufacturing capability here in the United States, and with the help of the Department of Defense and the Federal Government, we will continue to have those lines now and in the distant future to move forward to support the U.S. as required.

Senator TESTER. So when you are talking about 95 million masks being built a month, you are talking about 95 million masks being built in the United States of America a month?

Mr. MCDONALD. Yes, sir, I am. We currently have——

Senator TESTER. That is good. Sorry for cutting you off, but the reason I ask that is because there were—and I believe it was a 3M manufacturing plant in China, and I could be wrong on this. You correct me if I am. That it was basically nationalized by the Chinese government when they needed masks, and they said, "No. We are keeping them here because they are for our people. They are built here. We are keeping them here. You are not shipping them anywhere else in the world, the United States or anywhere else, because we need them."

But what you are saying is you can build domestically, 3M can, 1.1 billion masks a year now?

Mr. MCDONALD. With the additional manufacturers that have come online with 3M under the Title III authorities, by the end of November, we will be producing roughly 95 million masks a month, and yes, we——

Senator TESTER. And then those are all domestic? Those are all domestic manufacturers? There are not a bunch of folks from Indonesia or China or Brazil or wherever?

Mr. MCDONALD. No.

Senator TESTER. They are all here?

Mr. MCDONALD. Yes, sir. Those are all domestic manufacturing plants. We have one, a new one coming online in Aberdeen, and the other one, I believe, is also in South Dakota.

Senator TESTER. Look, Montana is a much better place to do business than South Dakota. Rounds is sitting over there.

[Laughter.]

Senator TESTER. Well, that is good news. That is really good news.

I mean, that is just one component. I mean, we have also got shields and gowns and all that, but I can take that up via emails with you guys, if you want.

I just have a question, and any of you can answer it. Mac, you have done enough talking. So any of the others who have not talked yet can answer this. What kind of benchmark should we be setting up for the DMLSS fully integrated into the VA? How long should that take? What is a reasonable timeline?

I am hearing a lot of silence.

Mr. HEYSSEL. I will take a stab at it. To make a comparison, it took me 6 months to simply upgrade one academic medical center, a couple jumps forward in our Materials Management Information System. It is a complex process to upgrade a new system, much less implement one.

That being said, I think 7 years is a long time. I think we could find ways to compress that to 4, maybe 5, but recognizing that the more we compress the implementation timeline, the larger we expand the chances of something going wrong. So we have to find a way to mitigate all those risks.

It can be done any number of ways. I have always been more of a big-bang person than an evolution person, but I think 5 years is probably a doable timeframe. There is a lot of training that needs to happen. We have to make sure every facility has the right PCs. Even at this point, when I left as chief supply chain officer, there were facilities in the VA that had not upgraded their PCs to anything that is close to capable of running something as sophisticated as DMLSS. So all of that needs to be taken into consideration.

Senator TESTER. Anybody else want to answer that?

Mr. WALDRON. Yes, Senator Tester.

I was just going to mention the challenges the government faces in a lot of places—and I think VA is no different—are legacy systems, systems that have been around for 20, 30 years, and trying to modernize or move away from those systems creates huge challenges.

I think your question fundamentally should go directly to the VA. One of the things that our members are very interested in is transparency from the VA with regard to the rollout of DMLSS. What are the steps necessary? What are the expectations? What does the training look like for the hospitals that are going to be utilizing the new system?

Companies need to understand that timeline, just like Congress does, because companies want to be able to serve the VA and be able to react and respond.

So I think it would be great to have the VA lay out their implementation plan so we all could take a look.

Senator TESTER. I am way, way, way over time, but thank you, Mr. Chairman. I want to thank all of you.

Mr. Chairman, I just might add this is really a good panel, and we did not get them—at least I did not get the challenges as far as the questions. I hope they will accept some written questions in the free time that I have got to be able to answer those.

Chairman MORAN. Senator Tester, you are over time, but you are welcome to remain over time if you would like to ask another question.

Senator TESTER. Well, I mean, I appreciate that. I think most of it has to do with—Mac answered my question on the masks being built here.

I would ask that same question for shields. I would ask the same question for gowns. I would ask that same question for test kits. I would ask the same question for media that revolves around that. But I do not know that 3M does all those things.

Chairman MORAN. I do not know whether that was rhetorical or not, Mr. MacDonald.

Mr. MCDONALD. Sir, we do not do gowns at this time.

Senator TESTER. Right. And it is the same thing on all of them. I think the masks are good news. Those N95 respirators are good news that we have got them built here. We need to do the same thing with those gowns.

Somebody mentioned—I believe it was on this panel—that said we need to—no. I think it was actually on the previous one. We need to work with gowns that are washable and can be reused because that helps with the supply chain. I agree with that, but the truth is we have got to get them built first.

Anyway, thank you, Mr. Chairman.

Chairman MORAN. Thank you, Senator Tester.

Let me followup with a few more things. Mr. Waldron, let me start with you. At least there are reports of bidding between various Federal and private entities, Federal, State, and local businesses for the same equipment, and tell me whether that is true.

One of the primary purposes of FEMA task force and the Defense Production Act was to prevent bidding wars. Has it worked? Do you want to shift to Mr. McDonald?

Mr. WALDRON. What I have heard from members is around the issue of communication on the Federal level because our members focus primarily on the Federal level, and just, I guess, two things. One, understanding where the requirements are coming from and who is coordinating them, and I think the government over time has done a better and better job of that, the initial—just like this has not happened for 100 years, right? So we are all reacting, adjusting, and changing direction, and just the focus on a national strategy across a government versus local entities, you know, going out to buy because they are a local facility, needs the product immediately, and how you find that right balance. And I think that is kind of where the communication between the government and the producers of product could be a bit more focused. But that is just sort of a general reaction.

I think overall, the performances have improved over time in terms of that communication.

Chairman MORAN. Are there circumstances in which an entity has a contract, in your case, a Federal entity or, in other cases, a private company has a contract to be supplied, but the market forces change, the circumstances change, and you can make more money selling to someone else that you have not previously contracted for? You do not have more to sell. You just have a better buyer, a buyer that is willing to pay a higher price than what you previously contracted for.

Mr. WALDRON. Sure.

Chairman MORAN. Is that a problem? Is that real or just kind of talk?

Mr. WALDRON. I have not—our members have not reported that they have had that kind of issue.

My reaction to that is it goes to the idea, if you have a government contract and the government orders from you, there are consequences for not fulfilling that order at the price that has been negotiated in the contract.

Companies sign up to that. They have their obligations under the contract. Orders are placed. They have to fulfill those orders. Oth-

erwise, bad things happen to them in terms of their contract performance and that sort of thing. That is part of the remedy, and other things that would be in this context would be the Defense Production Act and utilization of that. That creates priorities.

I think one of the things that I have heard is it is very effective and it works when the government sits down with a major supplier and works through those supply issues and figures out how to proceed forward, not necessarily a meeting immediately going to issuing a rated order under the Defense Production Act. That way, the company understands the expectations, understands how to react quicker. You have worked together initially before you have actually placed the order and move forward from that perspective.

Chairman MORAN. Let me see if I can paraphrase what you are saying because this has become—I do not know whether it is a political conversation, but it has become a topic of conversation among colleagues.

You are saying that while the Defense Production Act can get a company's attention, rather than its full implementation or its full force and effect, that conversations, discussions, you can reach a better result?

Mr. WALDRON. The Defense Production Act will get the full attention of a company. Let me assure you of that. That is not what I was trying to say.

What I was trying to say is that there are multiple ways to go about attacking the supply issue. You can issue rated orders and more forward immediately. The company has to react to that. There are other people's orders who would go to the back of the line because of the rated order. Having conversations and that communication between government and industry in partnership to address that planning goes a long way to ensuring you will meet the Federal Government's requirements and at the same time be able to adjust and meet those order orders as well.

So I am promoting the idea of communication between government and industry, especially in our current context.

Chairman MORAN. I was trying to give you the opportunity to do that, but I must have inartfully asked my question. I was not suggesting that you did not believe the Defense Production Act was sufficient to get somebody's attention.

Mr. WALDRON. yes.

Chairman MORAN. But its full authorities forcing somebody to do something may not be the best way to get the result that you are looking for and also may be damaging to others who are trying to acquire, in this case, personal protection equipment for their own and very valid uses. Is that a better summary?

Mr. WALDRON. That is a fair way to look at it. One size does not fit all in the supply chain, and there is going to be different companies and different situations as well. And there are going to be different obligations between the government and the producer as well. So, yes, that is a fair, a good characterization of it.

Chairman MORAN. Ms. Oakley, I cannot tell if your hand is up, but I guess your finger is on the button.

Ms. OAKLEY. Yes. I just wanted to comment on how it worked with the Medical-Surgical Prime Vendor program contracts, and I think that while Mr. Waldron is correct, you are signed up to a

government contract, you have to fulfill those needs. But those supply contracts are based upon demand signals. So your historical demand signals are what drives what those prime vendors have in stock for you.

So what you saw at the beginning of the pandemic was this surging increase in demand from the VA contracts, from the VA medical centers, that was not supported by those prime vendor contracts because they did not have that demand signal in the past.

So then what ended up happening was that VA ended up getting its allocation of its percentage of business that they were typically for whatever supplier through that prime vendor. So that is where you saw some of the challenges with meeting those surge-in-demand needs from VA. So that is just kind of how it worked, at least initially, under the prime vendor contracts.

Chairman MORAN. Thank you for that.

Mr. HEYSSEL. Mr. Chairman?

Chairman MORAN. Yes.

Mr. HEYSSEL. This is Kurt Heyssel.

Chairman MORAN. Yes, sir.

Mr. HEYSSEL. If I might give one brief Statement. What happened with the health care supply chain since December-January was a test I have never seen before. Everybody from the manufacturer through the distributor to the health care provider was caught flat-footed. I am not sure there is anything that could have been done to avoid what we went through.

We all said after the end of the avian flu, "Oh, we will never be caught flat-footed again," and slowly but surely, as organizations do, we tend to forget.

But even if we had stayed prepared at the level we were for the avian flu, it would not have even touched the need created over the last 5, 6 months.

Chairman MORAN. Thank you.

There sometimes are the answers that nothing is going to work perfectly in the circumstances that we are in, and we are all looking for ways to make certain that everything works just as we wish it would.

I think maybe this is my concluding question. I will ask this of Mr. Heyssel. It seems to me that the VA is attempting to blend a just-in-time inventory system with a depot system. If we look back at the VA supply chain compared to other large health organizations, what are the strategic factors that need to be considered here?

Mr. HEYSSEL. The first I had really heard of the depot system was today, and if I heard it correctly, they are talking about four strategically located centers around the Nation to hold emergency stockpiles, which is something that I believe other private health care systems may be doing to be sure they have at least a month's worth of supply on hand to handle something like this.

The just-in-time approach has been working for years in the private sector. The just-in-time approach, I believe, is the least costly of all the methods of acquiring what is needed to adequately care for our patients, care for the veteran, care for any patient.

The notion that the VA should—I do not know if anybody is discussing it, but just in case they are, the notion that the VA should

move back to what was the old system in 1992 of the VA doing its own acquisition and distribution is probably a sizable mistake.

Certainly, you cannot do it without a system with at least the sophistication of DMLSS, but it is redundant. It actually adds a lawyer of cost for the supplies to the VA.

If you recall, I said the average distributor needs to make about an 8.5 percent margin to keep the doors open. So that can be applied to the costs of running those depots and the self-distribution around the Nation to feed the VA its products, and then you have the heightened risk of unused inventory spoiling, unused capital investment in that inventory—in other word waste. I just do not think that is the way it should be.

The distributors today are incredibly sophisticated. Cardinal, Owens & Minor, Concordance, Medline, you name them, they have the information systems set up. They have the logistics set up to do an amazing amount of work on behalf of the VA.

There is one distributor out there who can handle pretty much all of the health system's orthopedic implant needs and ships sterile containers of implants to the hospital according to the surgical schedule. That sort of partnership between distributor and health care provider and manufacturer is really what is needed rather than taking a step back into the 1990's and having distribution centers pretty much around the United States.

Chairman MORAN. Let me ask you about another partnership. It seems a natural fit—but I want you to tell me whether it is or is not—that we model ourselves or partner with the Department of Defense at the VA, and we see that in a number of circumstances and certainly trying to get an integrated health care system that takes care of a veteran from service to post—I should not say it that way—to being a veteran as compared to being a member of the active military. Is that a model that we should at least initially assume is a pretty good idea when it comes to the VA?

Mr. HEYSSEL. I do believe it should be investigated. I think it should be investigated in depth.

If you were to bring the VA and the Department of Defense together in such a manner, using the same information system, DMLSS, you then have the power to aggregate the purchasing volume across both networks of care, and the supply cost should drop. That would be a very good thing, but it would also require that clinicians from both organizations be heavily involved in the choice of products being selected and purchased.

You want to offer alternatives, but you do not want the Wild West, and you do not want the VHA using 15 different things and Department of Defense using 15 different things in the OR, if all of them do the same thing. When that occurs, you lose your leverage with the manufacturers.

But I think it is a model that must be investigated. VHA, DLA have already proven that they are pretty good at what they do. When I was with Owens & Minor, I worked very closely with Langley Air Force Base and Portsmouth Naval Medical Center. As a representative, I got to know their processes very well, and they were on top of the game.

So I think it should be investigated closely.

Chairman MORAN. Ms. Oakley—Senator Tester, I am going to conclude, but, Ms. Oakley, in your reviews and observations, I guess I will not ask you to—I do not know that it is a fair question to ask you to compare how DoD operates as compared to the Department of Veterans Affairs, and they are both large organizations, huge organizations. Is there ever a sense that the Department of Veterans Affairs is so large that we cannot get the services, the efficiency—we cannot get the VA to operate the way that we want it, just because of the size, or is size always to our advantage?

Ms. OAKLEY. I do not think that that should be the excuse for the VA not to be able to operate efficiently and effectively.

I think it really harkens back to part of what Mr. Heyssel was saying. Structurally, they have a lot of challenges with regard to executing and efficient procurement function within the organization, and part of that is driven by the fact that VHA drives so much of the procurement dollars within the Department of Veterans Affairs.

So I think from my perspective, it is less about how large VA is, and it is more about how leadership plans and implements large-scale change and transformation within the organization, and how even in the short time that I have been doing this work over the past 5 years, I have seen a number of different things come and go. So I think there is something to be said for laying out that plan for transformation and putting milestones associated with it and being held accountable to making those changes.

There is nothing wrong with modeling themselves after DoD or leveraging what they can from DoD, but there is stuff to be learned.

In fact, in our ongoing work on the MSPV program, we are taking a look at VA's pilot program where they are going to be using DLA's MSPV program. It is a very limited pilot at this point, but one of our preliminary findings is showing they do not even have a plan in place for assessing the outcomes of the pilot, to know is this something that we should do, is this something that we can scale within the Department of Veterans Affairs and apply to all of VA.

And I think just—I have to mention it because I am from the Contracting and National Security Acquisitions Team. VA does also have very specific procurement requirements that it has to abide by in the Kingdomware requirements, and that makes that kind of collaboration a little bit more challenging than DoD collaborating with any other organization.

Chairman MORAN. I make it a practice of asking any witnesses before our Committee if they have something they would like to augment what they said, correct what they said, add to what they said, anything that you would like to make clear for us or improve what you thought you said, which is always a chance I wish I had. Are we good?

[No response.]

Chairman MORAN. Senator Tester?

[No response.]

Chairman MORAN. All right. We will conclude this hearing, then. I thank you for joining us. Thank you for the opportunity to learn from you.

The hearing record will remain open for 5 legislative days, should any member wish to add a written Statement or submit a question for the record.

With that, this hearing is now adjourned. Thank you.

[Whereupon, at 5:29 p.m., the Committee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

Senate Veterans' Affairs Committee Hearing
Building a More Resilient VA Supply Chain

Opening Statement of Chairman Jerry Moran
Tuesday, June 09, 2020

"Good afternoon, everyone. The Committee will come to order. Today's hearing is on "Building a More Resilient VA Supply Chain," with a focus on what we have learned from this COVID-19 pandemic.

"A bipartisan, enduring priority of this Committee is to ensure that the VA is equipped to fulfill its core mission to deliver timely, high-quality health care to the veterans it was created to serve.

"Last August, as the VA entered into a partnership with the Defense Logistics Agency to speed acquisition for material support, Secretary Wilkie stated, "In the 21st century, an ad hoc supply chain is not sufficient," and, "It does not do justice to those we are sworn to serve."

"The VA recognizes the need to build a more resilient supply chain, the question now becomes "how."

"The COVID-19 pandemic has put massive stress on the supply chain and created unprecedented global demand for personal protective equipment – PPE – and other medical supplies. Inherent fragilities in the just-in-time inventory model have been severely strained in recent months. This confluence of factors has highlighted the need – the necessity – to reform the VA's procurement organization and processes.

"The challenge VA confronts is how to strengthen the supply chain in real-time, while also making it more resilient and operationally effective in the long-term.

"I am encouraged to see VA moving quickly, but there is also a need to be strategic in this decision-making.

"I understand the need to have more inventory on-hand and reestablishing some form of supply depots may be part of that effort. But we must take care not to establish parallel, competing supply chains.

"Logistics is also fundamental to this equation. Inventory that is unable to move is no use to anyone.

"The Veterans Health Administration is saddled with an aging, disparate inventory management system and a medical supply chain that was conceived over 30 years ago.

"Repeated reform attempts have too often misfired or added complexity, resulting in time-consuming and error-prone inventory counts. Transferring supplies between VA facilities in different Veteran Integrated Service Networks – or VISNs – is also unnecessarily burdensome and difficult.

"It is a testament to the dedication of VA's clinicians and administrators that they make the system work despite the difficulties.

"The Medical Surgical Prime Vendor contracts were once the backbone of this supply chain. But this program has been chaotic since it was relaunched in 2016, and I believe the strategy needs to be reevaluated.

"These supply chain issues are not intractable, but they will require sustained attention to develop a modern inventory management system across the enterprise.

"This administration has used the Defense Production Act to provide loan guarantees and cost-matching grants to help domestic manufacturers expand their production capacity in response to COVID-19.

"Many companies have added shifts and reconfigured equipment to boost output. For example, Spirit Aerosystems in Wichita, Kansas, is using the speed of their aircraft manufacturing line to build respirators.

"The DPA also allows the federal government to allocate materials and subcontracts on a manufacturer's behalf, and I commend the administration for doing so when asked.

"Under the DPA, federal agencies can prioritize the delivery of their contracts, but this results in an inherent tradeoff. I would like to understand how the coordination among VA, FEMA and HHS may be affecting the VA supply chain.

"Coordination is key in challenging circumstances, and I believe the VA Secretary should be added to the Defense Production Act Committee to efficiently facilitate veteran care and leverage VA resources. Senator Tester and I expressed this desire in a letter to President Trump and it is my understanding the VA concurs.

"There are substantive suggestions on how to strengthen the VA's medical supply chain, including recommendations from the Commission on Care, the VA's Office of Inspector General and the Government Accountability Office.

"Each have called for a more unified supply chain—from the VA's central office to the medical centers —supported by modern, integrated IT systems. I am eager to hear the perspective of our witnesses on the second panel as to how VA can rise to this challenge.

"The COVID-19 crisis has compounded persistent VA supply chain problems, and there is no better time than the present to be addressing them. It would be a mistake to consider this pandemic transitory and let our guard down.

"I look forward to hearing the testimony of our witnesses and working on solutions to build a more resilient VA supply chain that meets the needs of our nation's veterans."

STATEMENT OF
RICHARD A. STONE, M.D., EXECUTIVE IN CHARGE
VETERANS HEALTH ADMINISTRATION (VHA)

Good morning, Chairman Moran, Ranking Member Tester, and distinguished Members of the Committee. Thank you for the opportunity to testify today about the resiliency of the Department's supply chain. I am accompanied today by Ms. Karen Brazell, Principal Executive Director, Office of Acquisition, Logistics and Construction (OALC) and Chief Acquisition Officer, and Acting Assistant Secretary for Enterprise Integration, Ms. Deborah Kramer, Acting Assistant Deputy Under Secretary for Health for Support Services, Veterans Health Administration (VHA), and Mr. Andrew Centineo, Executive Director, Procurement and Logistics Office, VHA.

Introduction

VA's response to Coronavirus Disease 2019 (COVID-19) demonstrated the strength and agility of an integrated healthcare system geographically distributed across the United States and operating as a single enterprise. As COVID-19 incidence varied by jurisdiction, and despite global shortages of Personal Protective Equipment (PPE), critical equipment and consumable items, VHA was able to sustain operations in locations experiencing high demand (e.g., New York City, New Orleans) by cross-leveling staff, PPE and ventilators from areas with lower levels of disease.

Supply Chain challenges are not unique to VA. Due to the COVID-19 pandemic, we are experiencing the same challenges as every other hospital and hospital system in the country and the world. However, the advantage of being the largest integrated health care system in the country with 170 hospitals is our ability to share our supply and personnel resources between sites based on immediate healthcare needs. To be clear, we prepare year-round for all contingencies, to include infectious diseases and all other catastrophic events. However, the magnitude of this global pandemic has provided the opportunity for some improvements. Prior to this pandemic, VA embarked on a supply chain transformation program designed to build an efficient and effective medical supply chain to maximize value to clinical customers and deliver real-time analytics capability to support fast and accurate enterprise decision making. Now, more than ever, this work is essential, and building resiliency in VA's supply chain will ensure we stay prepared to meet our mission.

Supply Chain Modernization and Defense Medical Logistics Standard Support (DMLSS)

VA's effort will address people, training, processes, data, and automated systems. To achieve greater efficiency, VA will strengthen its long-standing relationships with Department of Defense (DoD) by leveraging expertise to modernize

VA's supply chain operations, while allowing VA to remain fully committed to providing quality health care. Through this collaboration with DoD, VA will transition to the DMLSS on an enterprise-wide basis to replace VA's existing inventory system. VA is currently operating with a legacy system designed and deployed in the 1970's, faces numerous challenges, and is not equipped to address the complexity of decision-making and integration required across functions, such as acquisition, medical supplies and equipment, medical maintenance, property accountability, facility maintenance and construction. VA's implementation of DMLSS will ensure enterprise visibility and decision-support tool capabilities that integrate with DoD prime vendor capability to deliver the right products to the right places at the right time, to ensure world-class Veteran healthcare while providing the best value to the government and taxpayers.

VA is piloting DMLSS at the James A. Lovell Federal Health Care Center and VA's initial Electronic Health Record (EHR) sites in Spokane and Seattle to analyze VA enterprise-wide application. In DMLSS, VA is leveraging a proven system that DoD has developed, tested, and implemented, and interfaced with DoD's EHR, the same Cerner platform being deployed across the Veterans Health Administration.

Medical Surgical Prime Vendor 2.0

The Medical Surgical Prime Vendor (MSPV) program is designed to help drive the Secretary's strategic vision and priority of modernizing the VA health care supply chain with a specific focus on improving business and operational processes, systems, and procurement capabilities. To accomplish this, we are aggressively preparing to deploy and stand-up MSPV 2.0 to replace MSPV-Next Generation, in order to ensure clinicians and other patient-centered teams have the right supplies in the right place, at the right time, and for the right price.

In support of MSPV 2.0 and VHA's strategic supply chain initiative, our team is focused on several key areas: modernizing enterprise systems and processes, simplifying operations, identifying efficiencies and digital solutions, using data to gain insights and support decision-making, and reducing operating expenses and costs. We continue to identify and pursue opportunities to transform and improve the way we do business by focusing on our Veterans, supporting supply chain programs, and our ability to effectively equip our clinicians and facility support staff.

MSPV 2.0 will enable expansion and enhancement of future MSPV supply availability and product list offerings and will incorporate a broader array of supplies and equipment, based on clinically unique requirements and health care operational needs. We continue to expand supply availability by working in tandem with established Clinical Integrated Product Teams, who work to ensure that safe, high-quality products are included in the current Formulary and future MSPV Product List.

We continue to simplify operations, gain efficiencies, and advance VHA's modernization strategic objectives by transforming our supply chain eco-system into a modern, lean, and integrated full-service health care supply chain. Additionally, we have

made significant progress toward improving our Prime Vendor accountability methods in order to maintain contractual obligations and achieve desired performance metrics. We aim to exceed commercial industry analytic solutions and business processes to promote informed and rapid decision-making through the automation of previously manual, labor intensive tasks. This will enable us under MSPV 2.0 to realize significant time savings and cost avoidance, as well as prioritize high value contracting activities. These data-driven advancements position the MSPV program to improve catalog maintenance and visibility into enterprise-level spend and usage data, which promotes efficiency, accountability, and transparency of VHA processes.

Capability Gap

VA intends to establish Regional Readiness Centers, geographically distributed to support the four Veterans Integrated Service Network (VISN) Consortiums. A VISN Consortium is a partnership between multiple VISNs located in the same region of the country. VISNs formed consortiums to foster collaboration among medical centers and to enhance operations and the delivery of health care to Veterans. To accomplish these goals, the consortiums use regional contracts, sharing FTEs and materiel, and joint networks for referring patients and conducting telehealth. VA's intent in establishing the Regional Readiness Center capability is to build resiliency into the supply chain to enable VHA to sustain continuous services to Veterans and the resumption of normal pre-COVID-19 operations. They will also support VHA readiness for local, regional and national COVID-19 outbreaks by minimizing medical supply chain disruptions due to increased global demand for PPE as well as other critical items (e.g., ventilators and ventilator consumables; dialysis machines and dialysis consumables; laboratory equipment, test kits and swabs) under high demand. In the long term, the Regional Readiness Centers will support VHA preparedness for regional and national public health emergencies, including those secondary to national disasters (e.g., hurricanes or floods).

The provision of medical products to hospitals, clinicians and patients depends upon a globally integrated supply chain designed to provide Just-in-Time (JIT) delivery. JIT, and the lean manufacturing practices it relies upon, cuts cost by reducing the amount of stock held at every link in the supply chain from raw material providers to the patient's bedside. In the JIT and lean models, the objectives are to reduce waste, increase efficiency, and cut cost throughout the supply chain. JIT and lean work well when the demand for end products is known and predictable, as is typically the case. And, in the past, when an event such as a natural disaster (e.g., hurricane) disrupted some segment of the global integrated supply chain, there was enough remaining supply chain capacity to limit disruptions to care.

While preparedness was always a consideration in commercial and federal healthcare contingency planning, that planning relied upon an intact and responsive global medical supply chain. COVID-19 shattered the global PPE and critical item medical supply chain. What began as a disruption in foreign manufacturing of PPE was quickly exacerbated by increased worldwide market demand and supply challenges driven by COVID-19 becoming a global pandemic.

As VHA confronted the same PPE and critical item shortages as other hospital systems, VHA began executing its “Fourth Mission” as a component of the Nation’s preparedness for national emergencies, including pandemic response. That mission rapidly expanded from accepting non-Veteran patients to help decompress overwhelmed public and private hospitals, to accepting what was, prior to COVID-19, a combined State and Federal Emergency Management Administration (FEMA) mission (e.g., support of State Veteran Homes).

The declaration of a nationwide emergency in March 2020 authorized the US Department of Health and Human Services (HHS) as the lead federal agency for ongoing COVID-19 pandemic response. Although FEMA now leads the coordination of Federal operations on behalf of the White House Coronavirus Task Force, HHS continues to provide subject matter expertise as the Nation's pre-eminent public health responder.

FEMA, acting in support of HHS, established a COVID-19 Supply Chain Task Force to stabilize the US medical supply chain. With FEMA's efforts to source PPE and other critical items came the need for VHA to provide its demand signal to FEMA.

VHA’s Healthcare Operations Center

The establishment and maturation of the VHA Healthcare Operations Center as the fusion center for collecting, analyzing, planning and disseminating data and information to all stakeholders created a key enabler to a VISN’s ability to cross-level staff and materiel between VAMCs and VISN to VISN. A further maturation of the enterprise approach to management of COVID-19 response effort, despite the fragmentation of the global PPE supply chain, was the work conducted by the VISN Consortiums. VISN Consortium partnerships fostered collaboration and enhanced operations and delivery of health care to Veterans. To accomplish these goals, the consortiums use regional contracts, share Full-Time Equivalent staff and materiel, and joint networks for referring patients and conducting telehealth. While VHA’s ability to sustain medical operations by cross-leveling assets is a testament to the strength of VHA leadership at every level of the organization, it is also an indictment of a globally distributed JIT PPE medical supply chain’s inability to support national readiness under pandemic conditions.

Evolving Approach

While the JIT model works for most medical materiel, the global demand for PPE created by COVID-19 proved JIT no longer works for PPE, ventilators and ventilator consumables; dialysis and dialysis consumables; and laboratory equipment, test kits and swabs. VHA must establish an enterprise wide capacity to store, maintain, manufacture, manage and distribute PPE, critical medical materiel and PPE preservation technology (e.g., PPE decontamination systems) if it is to sustain its traditional mission and “Fourth Mission” through the COVID-19 pandemic and any future regional and national emergencies.

VHA's COVID-19 response proved the VISN Consortium model is an effective component to VHA readiness. It also revealed that VHA must increase operational stock levels available to its medical facilities and establish its own capability to support the four VISN Consortiums. In order to minimize supply chain disruptions and shortages during COVID-19 demand surges, and support VHA's "Moving Forward Plan," VHA must source, deliver, and operate as an enterprise to effectively manage its supply chain, for PPE and other critical items.

Transitioning from our current state to sustainable and flexible supply chain operations requires building resiliency into our supply chain. VHA can advance its state of readiness by implementing a combination of immediate, short, mid and long-term actions. Effective and efficient contingency planning and execution will include partnering with other government Departments (e.g., DoD, HHS, the U.S. Food and Drug Administration (FDA), and the Indian Health Service) in addition to working with industry to refine models to optimize readiness and offset costs of potency and dated items.

In the immediate future, VA will establish a storage and distribution partnership with HHS. Through the establishment of an Interagency Agreement with HHS, VHA will ensure it has enough storage and distribution capacity for the critical supplies it is acquiring to enable VHA to sustain services to Veterans and the resumption of normal pre-COVID-19 operations. This capacity will also support VHA readiness for local, regional and national COVID-19 outbreaks. In the near-term, VA will increase the amount of critical medical materiel each VAMC maintains. Each VAMC must maintain 60 days of critical materiel (e.g., PPE, ventilators / ventilator consumables, and dialysis / dialysis consumables). For VAMCs a day of supply is equivalent to the typical pre-COVID-19 demand signal plus the materiel required to sustain the COVID-19 response as determined by the VAMCs proportional share of a COVID-19 demand benchmark (e.g., demand at the Southeast Louisiana Veterans Health Care System).

In the short-term, VA will establish a Regional Readiness Center for each of the four VISN Consortiums. The Regional Readiness Centers will act as a central source for management and resupply for the VISN Consortiums' VAMCs PPE and critical item needs. They may also support Fourth Mission customers as required and resourced (e.g., State Veterans Homes). Each Regional Readiness Center coupled with VHA medical facilities must be capable of maintaining a combined supply depth of 180 days of supply.

Additionally, each Regional Readiness Center must be capable of storing, maintaining and distributing critical equipment items that are immediately available should VAMCs / VISNs require additional equipment to support a disease outbreak. Regional Readiness Centers will each operate a Battelle Critical Care Decontamination System (CCDS) for decontamination of the VISN Consortium's N95 respirators, and as required by a FEMA Mission Assignment, to support local community hospitals.

Finally, in the mid-to-long-term, VA will determine and implement the appropriate blend of readiness capabilities. To ensure VHA can sustain its critical medical materiel needs for up to six months before it must seek support from HHS or FEMA, VHA must identify the proper mix of organic, federal and commercial capabilities required. It is anticipated this will include Regional Readiness Centers, Vendor Management of VHA owned inventory, 3D printing and agile manufacturing; VHA and/or VA-DoD manufacturing, and partnering and inclusion in DoD programs directly aligned to 38 U.S.C. 8111 - Sharing of VA and DoD health care resources such as participation in the FDA Shelf Life Extension Program. As a key component of VHA's all-hazard support plan, VHA will assess, in consultation with Clinical Services; Patient Services; Operations; and Discovery, Education and Affiliate Networks; other materiel VHA requires to support its contingency needs.

Conclusion

Veterans' care is our mission. We are committed to providing high-quality health care to all our Veterans even during these unprecedented times. Your continued support is essential to providing this care for Veterans and their families. This concludes my testimony. My colleagues and I are prepared to answer any questions you may have.

United States Government Accountability Office

Testimony
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VA ACQUISITION MANAGEMENT

Supply Chain Management and COVID-19 Response

Statement of Shelby S. Oakley, Director
Contracting and National Security Acquisitions

GAO Highlights

Highlights of GAO-20-638T, a testimony before the Committee on Veterans' Affairs, U.S. Senate

Why GAO Did This Study

VA spends hundreds of millions of dollars annually to meet the health care needs of about 9 million veterans. In March 2019, GAO added VA Acquisition Management to its High Risk list due to longstanding problems such as ineffective purchasing of medical supplies and lack of reliable data systems.

This statement summarizes findings from GAO's 2017 MSPV-NG report and 2019 High Risk report and preliminary observations from two ongoing GAO performance audits to discuss VA's progress in building a more resilient supply chain. For the ongoing work, GAO reviewed VA documentation and interviewed VA officials, and VA medical center staff. Finally, GAO met with senior VA officials on June 5, 2020, to obtain agency views on the new observations GAO discusses in this statement.

What GAO Recommends

GAO has made 40 recommendations since 2015 to improve acquisition management at the VA. VA agreed with those recommendations and has implemented 22 of them. Further actions are needed to implement the remaining recommendations, such as GAO's recommendation that VA implement an overarching MSPV strategy, and demonstrate progress toward removing this area from GAO's High-Risk list.

View GAO-20-638T. For more information, contact Shelby S. Oakley at (202) 512-4841 or oakleys@gao.gov

June 9, 2020

VA ACQUISITION MANAGEMENT

Supply Chain Management and COVID-19 Response

What GAO Found

The Department of Veterans Affairs (VA) has taken some steps in recent years to modernize its processes to acquire hundreds of millions of dollars-worth of medical supplies annually. However, implementation delays for key initiatives, including a new, enterprise-wide inventory management system, limit VA's ability to have an agile, responsive supply chain. Prior to the Coronavirus Disease 2019 (COVID-19) pandemic, in November 2017 and in GAO's High-Risk report in March 2019, GAO reported on weaknesses in VA's acquisition management. For example, GAO reported that VA's implementation of its Medical-Surgical Prime Vendor-Next Generation (MSPV-NG) program—VA's primary means for purchasing medical supplies—lacked an effective medical supply procurement strategy, clinician involvement, and reliable data systems. GAO also found that several of VA's medical supply management practices were not in line with those employed by private sector leading hospital networks.

VA is developing another iteration of its MSPV program, called MSPV 2.0, which GAO's preliminary observations show is intended to address some of the shortfalls GAO has identified in its past and ongoing program reviews. In November 2017, GAO recommended that VA develop, document and communicate an overarching MSPV-NG strategy—to include how the program office will prioritize categories of supplies and increase clinician involvement in this process. Preliminary observations from GAO's ongoing work indicate that VA has taken some steps, as it implements MSPV 2.0, to address this priority recommendation. However, GAO's preliminary observations also indicate that the MSPV 2.0 program implementation is delayed and some of these existing program challenges may not be remedied.

Based on preliminary observations from GAO's ongoing work, VA's implementation of a new supply and inventory management system is delayed. As a result, VA had to rely on an antiquated inventory management system, and initial, manual spreadsheets to oversee the stock of critical medical supplies at its medical centers. This limited the ability of VA management to have real-time information on its pandemic response supplies, ranging from N95 face masks to isolation gowns, to make key decisions. As of April 2020, VA has an automated tool to manage its reporting process, but the information must be gathered and manually reported by each of VA's 170 medical centers on a daily basis.

GAO's preliminary observations also show that in response to COVID-19, VA is using various contracting organizations and mechanisms to meet its critical medical supply needs. These include using national and regional contracting offices to obtain supplies from existing contract vehicles, new contracts and agreements, and the Federal Emergency Management Administration's Strategic National Stockpile to respond to the pandemic.

Chairman Moran, Ranking Member Tester, and Members of the Committee:

Thank you for having me here today to discuss our past work and observations on the Department of Veterans Affairs (VA) medical supply chain. VA spends hundreds of millions of dollars annually on medical supplies to meet the health care needs of about 9 million veterans and has one of the most significant acquisition management functions in the federal government.

Since 2015, we have issued five reports on VA's acquisition management challenges, with 40 recommendations, and we elevated this issue to GAO's High-Risk List in 2019, due to longstanding problems such as ineffective purchasing of medical supplies and lack of reliable data systems.[1] VA has addressed 22 of our prior recommendations. For example, in November 2017, GAO recommended that VA develop, document, and communicate an overarching Medical-Surgical Prime Vendor-Next Generation (MSPV-NG) strategy—to include how the program office will prioritize categories of supplies and increase clinician involvement in this effort. Our preliminary observations from our ongoing work indicate that although VA has taken some steps to address this priority recommendation, it has yet to fully implement it. Further, VA has also begun efforts to modernize its supply chain, but our ongoing work indicates that several key initiatives are delayed, further limiting VA's ability to have an agile, responsive acquisition management system.

Like most medical institutions nationwide, VA has faced difficulties obtaining personal protective equipment (PPE) for its medical workforce during the Coronavirus Disease 2019 (COVID-19) pandemic, and VA's antiquated inventory management system hampered its ability to identify the extent to which each of its 170 medical centers faced these shortages. VA officials reported that they had difficulty obtaining sufficient supplies from their existing supply chain and associated contracting vehicles; thus, VA used new contracts and agreements to fill some of this void.

[1] GAO, *High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High-Risk Areas,* GAO-19-157SP (Washington, D.C.: Mar. 6, 2019).

My remarks today are based on two issued reports—our 2019 High Risk report segment on VA Acquisition Management and our 2017 report on VA's MSPV-NG program—as well as our ongoing audits of VA's COVID-19-related medical expenditures and VA's MSPV program.[2] Today, I will summarize a few key findings from these reports and some of our initial observations from this ongoing work related to VA's progress toward building a more resilient supply chain.

As part of our work for our November 2017 and March 2019 reports and our ongoing MSPV 2.0 work, we reviewed VA policies, communications, briefings, prior GAO reports on best practices for organizational transformation, relevant legislation, and other documents.[3] We conducted interviews with VA officials responsible for Veterans Health Administration (VHA) and VA-wide procurement and logistics, program office managers, and supply chain managers, among other VA officials. We also conducted site visits to 12 medical centers, selected based on highest total spending on medical and surgical supplies, among other things. As part of our work on VA's response to the COVID-19 medical procurements, we reviewed VA memoranda, briefings, Federal Procurement Data System-Next Generation (FPDS-NG) procurement data, and we met with key VA personnel responsible for the agency's response to COVID-19. Finally, we met with senior VA officials on June 5, 2020, to obtain agency views on the new observations we discuss in this statement.

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[2] GAO, *Veterans Affairs Contracting: Improvements in Buying Medical and Surgical Supplies Could Yield Cost Savings and Efficiency*, GAO-18-34 (Washington, D.C.: Nov. 9, 2017).

[3] See GAO-18-34 and GAO-19-157SP; more detailed information on the scope and methodology is contained within these reports.

Longstanding Problems in VA Acquisition Management and Medical Supply Management Posed Additional Challenges in VA's COVID-19 Response

The issues VA experienced during the height of the COVID-19 pandemic were a result of global supply chain challenges, but longstanding problems that our work has previously identified posed additional challenges to VA's response.

In November 2017, we reported weaknesses in VA's implementation of its MSPV-NG program—VA's primary means for purchasing medical supplies. These included the lack of an effective medical supply procurement strategy, clinician involvement, and reliable data systems. We also found that several of VA's medical supply management practices were not in line with those employed by private sector leading hospital networks. We recommended, among other things, that VA develop, document, and communicate to stakeholders an overarching strategy for the program.[4] This strategy, originally planned for completion by December 2017, was delayed to March 2019, and then further delayed due to VA's implementation of its new MSPV 2.0 program, which is also delayed. We also found that VA's initial formulary consisted of around 6,000 items at launch, and, according to senior VA contracting officials, many items on the formulary were not those needed by medical centers. These factors resulted in an initial formulary that did not meet the needs of VA's medical centers (VAMC).

The MSPV-NG program office subsequently took steps to expand the formulary, growing it to over 22,000 items, and is developing the next iteration of the program, called MSPV 2.0. MSPV 2.0 is intended to address some of the shortfalls we previously identified in MSPV-NG, including more than doubling the number of items on the formulary, to a planned 49,000. VA's MSPV 2.0 prime vendor procurement has been subject to multiple bid protests. After three protests challenged the terms of the solicitation, VA responded by voluntarily taking corrective action and revising the solicitation. The terms of the revised solicitation were challenged in a subsequent protest that was sustained, resulting in VA further revising the solicitation to address the matter. Because of these events, agency officials told us that VA has altered its MSPV 2.0 procurement plans several times and there has been significant delay in program implementation from the originally planned March 2020 date to as late as February 2021.

Based on preliminary observations of our ongoing work, some of the current MSPV-NG challenges persist and may not be remedied by MSPV

[4] See GAO-18-34.

2.0. Specifically, medical center staff we interviewed from May 2019 through October 2019 cited continued problems with consistently receiving the supplies they order through MSPV-NG, such as backorders on frequently ordered items. For example, preceding the COVID-19 pandemic, supply chain problems with one of VA's prime vendors created supply shortages for infection control gowns, and staff at one VAMC we visited in June 2019 had to obtain gowns from its emergency cache as a temporary measure. Further, VA's plans for MSPV 2.0 give no indication that they will update their practice of manually maintaining the formulary using spreadsheets, which, based on our discussions with several VAMC logistics officers, can lead to errors such as inadvertent omission of items from the formulary. We plan to issue a report on our review of the MSPV 2.0 program in fall 2020.

VA's Antiquated Inventory Management System Limited VA Management's Ability to Oversee Real-Time Supply Data at Its 170 Medical Centers

According to senior VA procurement and logistics officials interviewed during our ongoing review of VA's COVID-19 procurement for critical medical supplies, VA experienced difficulty obtaining several types of supplies needed to protect its front-line workforce during the COVID-19 response, ranging from N95 masks to isolation gowns. According to senior VA acquisition and logistics officials, beginning in late February to early March 2020, VA requested that medical centers provide daily updates via spreadsheets to try to obtain the most real time information possible on the levels of PPE on hand, usage, and gaps. These spreadsheets, which were reported manually on a daily basis from each of the VAMCs, were the primary means by which Veterans Health Administration (VHA) leadership obtained detailed information on the stock of critical supplies at its VAMCs in real-time. The insight provided by these spreadsheets was not something that VHA leadership had in any type of ongoing or systematic way, prior to the COVID-19 pandemic. In April 2020, VA developed an automated tool to manage this reporting process, but, according to officials, the information must still be gathered and manually reported by each of the 170 VAMCs on a daily basis.[5]

In May 2019, the VA Inspector General found that proper inventory monitoring and management was lacking at many VAMCs, noting that

[5] VHA issued an April 17, 2020 memorandum to VAMCs "to reduce the variation in methods used to report and calculate PPE levels on hand within the VHA." According to VA's Acting Assistant Under Secretary for Health for Support Services, VA developed a Power Business Intelligence Tool in April 2020, in response to the pandemic, which allows VA senior procurement, health, and logistics officials to view PPE supply status at a national and VAMC level.

inventory management practices ranged from inaccurate to nonexistent.[6] In 2013, we also reported on weaknesses in VA's inventory management systems and made recommendations to VA to evaluate its efforts to improve in this area.[7]

However, our preliminary observations from our ongoing review of VA's MSPV program indicate that VA will likely rely on its antiquated system for the foreseeable future. Specifically, VA plans to transition to the Defense Logistics Agency's (DLA) inventory management system, called Defense Medical Logistics Standard Support (DMLSS). DMLSS serves as DLA's primary MSPV ordering system and supports DLA's inventory management, among other things. According to DLA officials, DMLSS produces data that VAMCs could use to analyze their order history and find recommendations for future purchases. VA's implementation schedule shows that it will take seven years to roll out DMLSS and its successor at all VAMCs. In the near-term, VA had planned to implement DMLSS at three medical centers in mid-to-late 2019. However, due to technology integration issues between VA's financial system and the DMLSS system, implementation at these three VAMCs is delayed. According to the Chief Supply Chain Officer at one of these VAMCs, the original DMLSS implementation date has changed several times from an initial start date of August 2019, which may be delayed to at least October 2020.

VA uses a "just in time" inventory supply model—a practice employed by many hospital networks where only limited stock is maintained on-site. However, for this model to succeed, VA needs both visibility into current stock and consistent deliveries from the MSPV-NG program. Based on our preliminary observations, VA faces challenges with both visibility and delivery. VA acquisition leadership has recognized the shortcomings in its medical supply chain management, and has identified supply chain modernization as a priority. As part of our ongoing review of VA's MSPV program, we reviewed VHA's Modernization Campaign Plan, dated March 2019, and VHA's Modernization Plan briefing slides, dated February 2020, which describe several modernization initiatives including MSPV

[6] Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration: Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package* (May 1, 2019).

[7] GAO, *Veterans Health Care: VHA Has Taken Steps to Address Deficiencies in Its Logistics Program, but Significant Concerns Remain*, GAO-13-336 (Washington, D.C: Apr. 17, 2013).

2.0 and DMLSS.[8] VHA's February 2020 update on its modernization effort identified both its DMLSS deployment and MSPV 2.0 program at critical risk of not meeting system modernization milestones.

VA's COVID-19 Emergency Procurement Included Various VA Contracting Organizations and Mechanisms

Based on our preliminary observations from our ongoing review of VA's procurement of critical medical supplies, in response to COVID-19, VA is using various existing and new contracting organizations and mechanisms to try to meet its PPE needs. These include using national and regional contracting offices to procure supplies and services, and using existing contract vehicles and new sources. In response to the pandemic, VA's Office of Acquisition and Logistics also issued a memorandum on March 15, 2020, to implement emergency flexibilities available under the Federal Acquisition Regulation, such as increasing the micro-purchase threshold to $20,000.[9]

Our analysis of contracting activity in the Federal Procurement Data System-Next Generation (FPDS-NG) indicates that VHA's Network Contracting Offices—which support the various regions of VA's hospital network—increased their supply purchases, mostly by entering into new contracts.[10] Department-wide contracting organizations that would normally not make individual supply purchases—such as VHA's Program Contracting Activity Central and VA's Strategic Acquisition Center—also played a substantial role.[11] In addition, logistics staff at VAMCs continued to use the MSPV-NG program to order supplies. VA had existing clauses in MSPV-NG contracts that established terms for the suppliers to maintain

[8]VHA Modernization Campaign Plan, dated March 2019, and VHA Plan for Modernization, Monthly Co-Leads Meeting (Feb. 28, 2020).

[9] A micro-purchase is an acquisition of supplies or services using simplified acquisition procedures, the aggregate amount of which does not exceed the micro-purchase threshold. VA's March 15 memorandum delegated authority to specified VA contracting officials to invoke emergency acquisition flexibilities available under Federal Acquisition Regulation part 18. See VA Executive Director, Office of Acquisition and Logistics and Senior Procurement Executive mem. re: Emergency Acquisition Flexibilities—Emergency Assistance Activities in Support of Global Pandemic for Coronavirus Disease 2019 (COVID-19) (Mar. 15, 2020).

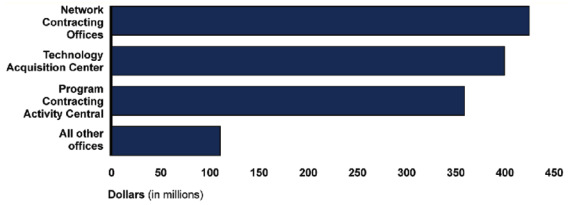
[10] FPDS-NG is the central repository for U.S. government procurement data. For contract actions over the micro-purchase threshold, agencies must submit detailed contract information to FPDS-NG. The database includes the product or service, agency and vendor information, contract start and estimated completion dates, and location of performance, among other elements.

[11] We have previously found FPDS-NG data sufficiently reliable for summarizing total obligations. FPDS-NG has added a new COVID-19 2020 value for the National Interest Action data element to track the relief contracts.

support to VA in the event of a catastrophe. But, according to senior VA acquisition officials, because those suppliers faced the same shortages in the broader market, they were not able to provide enough supplies to meet VA's surging demand.

Figure 1 shows the COVID-19-related contract obligations, from March 13, 2020 through June 3, 2020, made by the various VA contracting offices. These obligations include both supplies, such as PPE, and services, such as information technology systems to support telemedicine.

Figure 1: Total COVID-19-Related Obligations for Selected Department of Veterans Affairs Contracting Offices from March 13, 2020 through June 3, 2020



Source: GAO analysis of Federal Procurement Data System-Next Generation data. | GAO-20-638T

Our analysis of preliminary data on orders placed directly by VAMC staff for COVID-19-related items found that, in April 2020, the value of VA's reported COVID-19-related purchases through the MSPV-NG program began to decrease relative to the values reported in prior months.

According to senior VA acquisition and logistics officials, in part, because MSPV-NG and other existing VA supply contracts and agreements did not meet VA's needs, its acquisition workforce had to make purchases through other contracting mechanisms, such as micro-purchases using government purchase cards, to fill the gap. Between March 13, 2020 and June 3, 2020 VA obligated more than 51 percent ($687 million) of the $1.3 billion it spent on products and services for the COVID-19 response through purchases made outside the MSPV-NG program and other established VA contracting mechanisms. About 27 percent of this $1.3

billion ($364 million) was for veteran-owned small business set-aside purchases, under VA's Veterans First program.[12]

VA Collaborated with the Federal Emergency Management Agency (FEMA) in Response to COVID-19

On April 17, 2020, VA placed its first supply requests through the Federal Emergency Management Administration's (FEMA) Strategic National Stockpile program, according to VA senior acquisition and logistics officials.[13] As of June 5, 2020, according to information provided by the VA, it had received shipments of several different types of supplies through FEMA from these requests, as shown in Table 1.

Table 1: COVID-19-Related Items Requested by the Department of Veterans Affairs and Received from the Federal Emergency Management Administration, as of June 5, 2020

Item	Total Requested	Received as of June 5, 2020
N95 Masks	5,000,000	7,042,320
Eye Protection (Face Shield or Goggles/Glasses)	660,000	427,000
Generic Masks	7,500,000	0
Gloves (in pairs)	7,200,000	4,992,000
Gowns (Isolation gowns – Level 2)	3,400,000	0
Powered Air Purifying Respirator	11,500	3,258

Source: Department of Veterans Affairs.| GAO-20-638T

According to VA senior procurement and logistics officials, VA's Emergency Management Center has an existing relationship with FEMA. However, these senior procurement and logistics officials noted that VA support services officials—who had primary responsibility for requesting

[12] In 2006, in order to increase opportunities for veterans to do business with VA, Congress directed the department to apply a preference for contracting with Veteran-Owned Small Businesses (VOSB) and Service-Disabled Veteran-Owned Small Businesses (SDVOSB). VA created what it calls its Veterans First Contracting Program to implement the statute. The Veterans Benefits, Health Care, and Information Technology Act of 2006, Pub. L. No. 109-461, § 502(a), 120 Stat. 3403, 3431 (2016) (codified as amended at 38 U.S.C. § 8127).

[13] The Strategic National Stockpile's role is to supplement state and local supplies during public health emergencies. The supplies, medicines, and devices for life-saving care contained in the stockpile can be used as a short-term stopgap buffer when the immediate supply of adequate amounts of these materials may not be immediately available.

medical items through FEMA—did not have an existing relationship with FEMA or a process in place prior to the COVID-19 pandemic for placing medical supply requests through FEMA. Officials said that this led to a brief, initial delay in processing VA's first request.

In summary, VA experienced many of the same challenges obtaining medical supplies as most private sector hospitals and other entities in responding to this devastating pandemic. This situation put stress on an already overburdened acquisition and logistics workforce—resulting in staff initially scrambling to address supply chain shortfalls while simultaneously working with VA's antiquated inventory system, through manual, daily reports on PPE levels to VA leadership. While VA has made progress in addressing some of the issues that have led us to identify VA acquisition management as high risk, it will take many years for VA to put in place a modern supply chain management system that would position it to provide the most efficient and effective service to our nations veterans.

Chairman Moran, Ranking Member Tester, and Members of the Committee, this concludes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contacts and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Shelby S. Oakley at 202-512-4841 or OakleyS@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Lisa Gardner, Assistant Director; Teague Lyons, Assistant Director; Daniel Singleton, Analyst-in-Charge; Jeff Hartnett, Nicolaus Heun, Kelsey M. Carpenter, Sara Younes, Matthew T. Crosby; Suellen Foth, Lorraine Ettaro, Rose Brister, Susan Ditto, Roxanna Sun, Carrie Rogers, and Helena Johnson.

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STATEMENT OF

ROGER D. WALDRON

PRESIDENT OF THE COALITON FOR GOVERNMENT PROCUREMENT

Good afternoon Chairman Moran, Ranking Member Tester, and Members of the Senate Committee on Veterans' Affairs. Thank you for the opportunity to appear before you to the address the procurement challenges the Department of Veterans Affairs (VA) faces as it builds a resilient supply chain to support the healthcare of our nation's veterans.

The Coalition for Government Procurement (Coalition) is a non-profit association of firms selling commercial services and products to the Federal Government. Our members collectively account for more than $145 billion dollars of the sales generated annually through government contracts including the GSA Multiple Award Schedules (MAS) program, VA Federal Supply Schedule (FSS), the Government- wide Acquisition Contracts (GWACs), and agency-specific multiple award contracts (MACs). Coalition members include small, medium, and large business concerns. Coalition Healthcare members annually supply the Government with more than $12 billion in medical/surgical products and pharmaceuticals to support the healthcare needs of veterans and active duty service members. The Coalition is proud to have worked with the VA, the Department of Defense (DoD), and other Government officials for more than 40 years towards the mutual goals of common-sense acquisition and best value healthcare for our veterans.

The VA uses several contracting methods to meet its needs for medical/surgical equipment and supplies. These methods include the Medical/Surgical Prime Vendor (MSPV) Program, national contracts, the Federal Supply Schedules (FSS), open market purchases, the Government Purchase Card (GPC), and programs managed by DoD, such as DLA's Medical Surgical Prime Vendor program, which is priced using Distribution and Pricing Agreements (DAPAs), and the Electronic Catalog (ECAT). In March 2019, the Government Accountability Office (GAO) added VA procurement operations to its High-Risk List. GAO indicated that the VA's programs remain fragmented, utilize outdated systems, and rely on emergency acquisitions to purchase common goods and services. A clear indication of the challenges facing the VA is the current high level of Government Purchase Card (GPC) use. The VA uses GPCs to make almost $4.8 billion of *ad hoc* purchases without using an established contracting program. For comparison, DoD, which has more than three times the budget of the VA, makes $4.7 billion of *ad hoc* GPC purchases.[1]

To ensure best value healthcare for veterans, the VA's acquisition policies, programs, and systems need to be modernized to effectively support veterans' healthcare. To this end, the VA has begun addressing its supply chain management programs and e-systems to support its healthcare infrastructure, and, ultimately, the delivery of care to veterans. These management efforts include addressing clinical program leadership for the MSPV, launching the MSPV 2.0 program, engaging with

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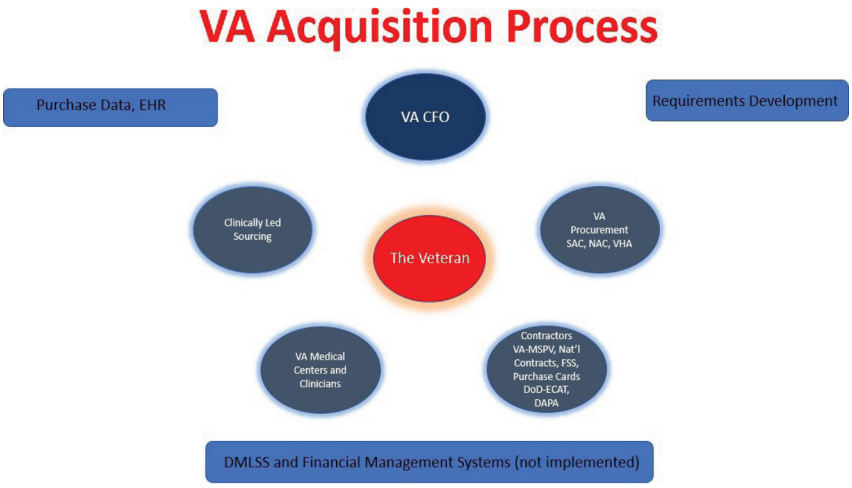
[1] See GSA Smart Pay Purchase Card Statistics Report for FPDS 2018, available at https://smartpay.gsa.gov/content/gsa-smartpay-purchase-card-statistics-reports-fpds

DoD to share resources, such as the Defense Medical Logics Standard Support (DMLSS) system, and modernizing its financial systems and the Electronic Health Record system.

Set forth below is a conceptual representation of the VA's acquisition process and supply chain infrastructure. The diagram shows the inter-relationship and co-dependency of each part of the chain in delivering medical/surgical products, devices, and technologies to support the VA's mission.



Conceptually, **Clinically-Led Sourcing** is executed by a clinically led and managed program office. Such an office is governed by healthcare professionals with both clinical and medical supply chain expertise, and it is responsible for establishing purchase requirements, including the organization, management, and maintenance of the MSPV formulary. Ideally, MSPV formulary decision-making is based on clinical input made through a transparent process with input from industry and other data from across the VA, including purchase data reported from healthcare treatment centers and the Prime Vendors.

The **VA Procurement** function is responsible for awarding contracts across the VA. With regard to the MSPV program, the VA's Strategic Acquisition Center (SAC) conducts the procurement for the MSPV 2.0 Prime Vendor contracts. At the same time, the Veterans Health Administration (VHA) conducts the open market Blanket Purchase Agreement (BPA) procurements for the products to be distributed by the MSPV 2.0 Prime Vendors. Both the SAC's Prime Vendor procurements and the VHA's supplier BPAs procurements are ongoing, with no awards made to date. The VA's National Acquisition Center (NAC) manages various national contracts and the Federal Supply Schedules.

The **Contractors** support the **VA Medical Centers and Clinicians** delivering medical/surgical products based on clinical needs/requirements. The acquisition of medical/surgical products is accomplished through a myriad of contracts, including the MSPV-NG, national contracts, the Federal Supply Schedules and ECAT. In all of this effort, the **VA CFO** accounts for and allocates funding for operations and payments to contractors.

These links in the acquisition process/supply chain are connected by procurement, logistics, and financial systems. The data regarding purchases, usage, outcomes, and clinical assessment of products travels across the VA's systems. Indeed, the systems themselves generate the data used in developing requirements, managing inventory, issuing delivery orders, and executing contracts. The VA's ongoing implementation of the Financial Management Business Transformation (FMBT) and the Defense MedicalLogistics Standard Support (DMLSS) systems is recognition of the vital importance that data plays in delivering best value healthcare for veterans. It often is said that you cannot manage what you cannot measure. Data allows the VA to measure and thus offers a tool to help improve management and process efficiency.

Coalition members very much have appreciated the VA's engagement with industry around these efforts, and we look forward to continuing to work together to deliver best value healthcare for our veterans. Our members recognize the significant complexities in the VA supply chain that I have outlined here, and they appreciate the work of the department as it undertakes the effort to address the enormous challenges of modernizing its systems. To assist this effort, the Coalition offers the following observations.

Clinically-Led Sourcing

Sound requirements development is foundational to efficient, effective procurements that deliver best value healthcare to veterans. A robust, empowered, clinically led program office supporting the VA's requirements development via a comprehensive formulary is vital to the success of the MSPV program in the support of veterans' healthcare. Coalition members strongly support the VA's efforts to implement/effectuate a clinically-led sourcing program that is executed by healthcare professionals with both clinical and medical supply chain expertise. It is fundamental,however, that the formulary reflect clinical needs, not contracting needs. In the interests of transparency, and to promote engagement with the VA's industry partners, the VA should provide an update on its efforts to stand up a clinically-led program office.

In addition, the Coalition recommends the creation of a new leadership role, the Medical Supply Chain Leader, responsible for formulary management and engagement with industry. Engagement with industry at a strategic level is vital to ensuring access to information regarding new healthcare technologies in the commercial market, technologies that can be brought to bear in treating our veterans. A single point of contact where industry can engage and share the latest development of capabilities is critical to ensuring the information exchange necessary for VA to take advantage of leading healthcare technologies. Medical/surgical technologies develop rapidly, and thus, the VA needs an open, nimble channel for research and engagement with industry on the latest developments and a transparent process by which the VA engages with industry on its product reviews and decision-making. Such an approach that maximizes access to the latest healthcare technologies available in the commercial market is a win-win-win for veterans, the VA, and the VA's industry partners.

Enhance and Expand the MSPV Formulary

The MSPV formulary should reflect clinical needs. As currently structured, the MSPV program does not include the depth and breadth of products necessary to meet operational needs. Thebillions of dollars annually spent on medical/surgical devices and products procured through the GPC reflect a program that is out of balance. The following timeline highlights the current state of the MSPV program and the evolving state of the MSPV formulary.

- April 2015 Initial Bridge Contracts for Legacy MSPV with hundreds of thousands of items available via the legacy contracts
- February 2016 VA awards MSPV-NG contracts
- April 2016 Second Bridge Contract for Legacy MSPV
- October-December 2016 MSPV-NG launched with 1600 items
- April 2017 Legacy bridge contracts expire
- April 2018 VA expands formulary to ***7800 items*** under MSPV-NG and continues working to expand it
- June 2020 currently ***21,000 items*** on the formulary

Currently, the VA is in the midst of the MSPV 2.0 procurement, with the SAC conducting the procurement of the Prime Vendor (distribution) contracts and the VHA seeking to establish open market BPAs with suppliers. The purpose of the BPAs is to compete and award specific products and product categories at fair and reasonable prices. Here again, however, the approach under MSPV 2.0 will establish only a limited formulary.

The current MSPV 2.0 formulary approach relies on limited and incomplete data because it does not capture the GPC purchases and other sources. The VA should develop a strategy to expand the formulary to allow industry partners to provide full portfolios of products. Expansion of the formulary will increase usage and provide the VHA with more holistic data upon which to make clinically-led sourcing decisions around standardization and product mix. An expanded formulary would allow for an incremental approach based on spend data and clinical needs in managing the appropriate product mix on the formulary. The data input, along with clinical input, should provide opportunities to standardize appropriate product categories while maintaining greater flexibility and choice in other product categories based on clinical needs. Further, an expanded formulary will enhance ongoing market competition across suppliers.

In addition, the VA should look to enhance and enable VA use of DoD's Electronic Catalog (ECAT) for purchases below micro-purchase ($10,000) involving products that are typically sold direct in the commercial market and not through a prime vendor. The current ECAT system provides access to products via contracts negotiated by the Defense Logistics Agency (DLA). The VA, through its ongoing collaboration with DoD, has access to ECAT as a source of supply. ECAT orders are made through a VA contracting activity in Cleveland. According to feedback from our members, there is a concern that current paperwork processing requirements limit VA Medical Center (VAMC) use below the micro- purchase threshold, as compared to the GPC. Streamlining the order requirements for purchases below the micro-purchase threshold will promote use of ECAT for products not on the formulary. The additional benefit from this action will be the availability of ECAT purchase data to the VA, as compared tothe lack of data under GPC purchasing.

Implementation of DMLSS

Coalition members are supportive of efforts to improve logistics systems across the VA and are interested in hearing more about the VA's progress to date regarding DMLSS. Under this effort, the VA should continue to build on its engagement with its industry partners and provide additional detail regarding the DMLSS timeline and implications for VHA operations. Transparency and engagement with industry ensure that the VA's industry partners can prepare for, and respond to, changes in the VA operations and the federal healthcare market, at large. For example, VA industry partners are interested in gaining a clear picture of how the DMLSS implementation impacts ongoing management of current MSPV program. DMLSS implementation and rollout will overlap with the current MSPV program, as such, providing key information regarding the timelines and impacts will ensure the VA's industry partners are better positioned to respond to the VA's needs. Further, as the DMLSS system utilizes the DLA Prime Vendor Program, it is important to understand how VA utilization of the DLA contracts will impact contractors across the federal healthcare market.

Finally, none of us should lose sight of the important role that small businesses play here. Pandemic or not, the Veterans First program and small businesses make up a major part of the vital economic engine that serves our nation and our veteran's healthcare system. They are a prime source of market innovation, and thus, they should not be overlooked as VA seeks to innovate its purchasing systems.

In closing, Mr. Chairman and Members of the committee, again, please accept my appreciation and the appreciation of Coalition members for the opportunity to appear before you today. I hope you found this testimony useful, and I would be happy to address any questions you might have.

STATEMENT OF

MICHAEL S. MCDONALD
DIRECTOR OF GOVERNMENT OPERATIONS, HEALTH CARE BUSINESS GROUP, 3M

Chairman Moran, Ranking Member Tester, and distinguished members of the Committee, thank you for the opportunity to appear before you today. My name is Michael "Mac" McDonald, and I am the Director of Government Operations for 3M's Health Care Business Group ("HCBG"). In this role, my areas of responsibility include leading and directing HCBG'sbusiness-related activities with government and creating solutions for our federal government customers,
including the VA.

Prior to joining 3M in 2013, I served in the United States Army for 30 years, retiring at the rank of Colonel, Medical Service Corps, area specialty, Medical Logistics Officer. Iserved in
numerous command and staff positions within the Department of Defense, culminating as the Director for Medical Logistics within the Office of the Assistant Secretary of Defense for Health Affairs.

By virtue of both my previous service in the military and my current position at 3M, I have had the unique opportunity to sit on both sides of the desk during a public health emergency–and have learned a great deal as a result.

Specifically, in 2005 during the H5N1 avian flu pandemic, while serving as the Director of the DLA Medical Material Division, I learned several important lessons, including how to refine procurement processes and how to improve surge capacity in response to a pandemic. At that time, 3M was one of the only companies that provided respirators that met the medical requirements to respond to the avian flu outbreak.

Today, amid the COVID-19 pandemic, I am now working *for* 3M and have also learned a great deal, including how a manufacturer responds to a surge event and the impact of a pandemic on a supply chain. And consistent with 2005, 3M remains at the forefront of providing respirators that help to protect both health care workers and first responders.

Given these experiences and perspectives, it is my hope that my testimony today will prove helpful as your Committee reviews possible steps to strengthen and improve the supply and delivery of medical material via the VA.

BACKGROUND

3M is a leading provider of personal protective equipment and medical solutions worldwide for medical professionals, workers and the public. Besides the disposable N95 respirators that are 3M's most widely known personal protective equipment product, we are also a leading manufacturer and supplier of reusable respirators, including Powered-Air Purifying Respirators (PAPRs), elastomeric reusable respirators, and Self-Contained Breathing Apparatuses (SCBAs). In addition, 3M provides other critical products in support of a pandemic response, including hand antiseptic, single patient use

stethoscopes and disinfectants, as well as oxygenator membranes, disinfecting wipes, and COVID-specific health data coding systems.

3M's Response to COVID

3M is playing a unique and critical role in the fight against COVID-19 and it is a responsibility we take seriously. During this global crisis, the safety of our employees andthe public, including healthcare workers and frontline workers responding to COVID-19, has been, and continues to be, paramount. We are grateful for the work our people are doing to support the public health response and are taking actions to help protect their well-being, including remote work when possible and robust safety protocols in our facilities.

Beginning in January, 3M began increasing its production of N95 and other respirators, doubling its global output. In the United States alone, we activated our surge capacity and made additional investments, increasing our N95 production rate from 22 million permonth pre-pandemic to 35 million per month today. By later this month, we will be producing at a rate of 50 million per month–and in October, we will be producing at a rate of 95 million per month. As a result, our annual United States production level will ultimately be 1.1 billion per year, which is more than *four times* our pre-pandemic production level. 3M is also increasing our supply of reusable respirators and powered air-purifying respirators (PAPRs) which are often suitable alternatives to disposable N95or similar respirators.

We recognize that the high demand for 3M N95 respirators and similar products continues to outpace the accelerated rate of production from our company and other respirator manufacturers. Accordingly, we will continue to prioritize critical healthcare needs, including respirators for front-line healthcare workers, first-responders, and other critical infrastructure users. As the country returns to work, our products will play an important role in helping to protect health care workers facing new risks as they provide services in health care settings such as non-emergency surgeries, dentistry, and orthodontics.

In addition, 3M has launched a global effort to combat fraud and price gouging and help protect the public against those who seek to exploit the demand for critical 3M products during a pandemic. Most important, 3M has not and will not increase its prices for N95 and other respirators as a result of the pandemic. We have created and made available a number of resources to help purchasers of respirators and the public avoid price gouging and other unlawful activities. For example, to help buyers identify and avoid inflated prices, we have taken the important step of publishing our list prices for N95 respirators. We have created a public hotline to help callers identify authentic 3M products and ensure products are from 3M authorized distributors, and on our website the public can report cases of suspected fraud. Also, we have established points of contact for federal and state procurement officials to validate third-party offers and quotes. We have worked with state and local government and federal agencies, including the VA, to help determine the validity of orders and proposals.

In the fight against fraud, we are working with federal and state law enforcement, technology companies, and online resellers to help prevent fraud before it starts andstop it where it is occurring. We have also filed multiple lawsuits to help protect the

activities, and we will donate any monetary damages recovered from these lawsuits to COVID-19 related nonprofit organizations.

3M's Partnership with the Department of Veterans Affairs and COVID Response Lessons

3M and the VA have partnered for more than 25 years, with 3M providing solutions through multiple contract vehicles, including Federal Supply Schedules, the GSA Schedule, Blanket Purchase Agreements, Direct Orders, and the Medical/Surgical Prime Vendor-Next Generation Bridge Program. In responding to the COVID-19 crisis, 3M has served as a critical supplier to the VA. Over the past five months, 3M has supplied the VA with 1.8 million N95 disposable respirators. There are existing contracts in place to provide continued support to the VA. The VA has projected a requirement of 60 million disposable respirators for the next 24 months. In addition, the VA has contracted with 3M for 25,000 PAPRs and approximately 25,000 elastomeric respirators.

While working with the VA to deliver critical medical supplies during the ongoing COVID-19 pandemic, we observed that there would be value in implementing a clinically integrated supply chain system to ensure system-wide visibility and requirements-driven solutions. A centralized system is critical to triaging needed supplies during a period of supply-demand imbalance. In February 2020, we met with VHA to discuss enhanced coordination with vendor partners to ensure logistical and acquisition efficiency for our veterans. As the COVID-19 Emergency intensified in March 2020, VHA facilitated coordination among all suppliers by developing a "Response Cell" charged with acquiring, prioritizing, and delivering PPE supplied by manufacturers. The VHA's Emergency Management Coordination Cell ("EMCC") centralized VHA acquisition programs to promote efficiency. For example, all Veterans Integrated Service Networks were directed to the EMCC's bulk supplies. The EMCC also took steps to reduce duplicated orders and ensured limited material was directed to points of need. 3M worked closely with EMCC program managers to track and manage weekly contract fulfillment ensuring that shipments were accurately delivered. The EMCC demonstrates that a centralized system of procurement and distribution works during a national emergency.

Going forward, the concept of a "cell" to centralize and coordinate acquisition and logistical efforts should be considered as a best practice. A centralized "cell" would give the VA enhanced control of its the supply chain and would help ensure that the right materials are at the right place at the right time. The VA could also standardize a centralized acquisition authority ahead of a COVID-19 second wave or a future emergency event.

The VHA should also consider a stockpile program like the U.S. Department of Defense stockpile program. Stockpiles provide an initial store of supplies that an EMCC can draw from while vendors ramp up.

Additional Proposed Reforms to the VA System

Due to our strong relationship with the VA, we are familiar with its planning and procurement processes and we stand ready to assist with its broader modernization efforts through programs like the Coalition for Government Procurement industry advisory program. Similarly, we are very encouraged by Secretary Wilkie's prioritization of business systems transformation because this effort will include the VHA's supply chain program.

While significant reforms have been adopted to modernize the VA, the Medical Surgical Prime Vendor Program remains a work in progress because of the limited capabilities that program has in the following areas: integrated inventory managementsystem, procurement processes, and system-wide visibility.

Health Care Supply Chain Transformation starts with the patient/clinical provider and reform should aim to address the following topics:

- Clinically driven and integrated and clinically accepted solutions where the clinicians are involved in decision making
- Automating systems and process integration (DMLSS/LOGICOLE)
- Standardizing and simplifying processes, leverage buying authority (MSPV 2.0)
- Clinical Process Review Committees / Value Analysis Teams
- Value based evaluations
- Adaptive scalable approaches to responses
- Critical Infrastructure Protection Manufactures

Finally, one of the key steps needed to drive change is the development of a process map to help direct and improve change management over time. This process requirestime, a phased approach, and strategic communications.

Conclusion

3M is proud to be a leading supplier of personal protective equipment and other healthcare related products to assist not only with the current COVID-19 pandemic, but also to continue to enable the VA to better serve our nation's veterans.

We are committed to continuing to work with –and be a strong partner to– the VA as it moves forward in its efforts to modernize its current procurement process. We are eager to serve as a resource to both the agency and this Committee during this ongoing process.

Thank you again for this opportunity to appear before you. I am pleased now to answer any questions you might have.

STATEMENT OF
KURT F. HEYSSEL, ASSOCIATE, PATHSTONE PARTNERS, LLC, PRINCIPAL, SIGHTLINE PERFORMANCE ADVISORS, LLC

Thank you for this opportunity to continue to serve our nation and our nation's Veterans. I hope my contribution today adds value to the discussion(s) regarding the Veterans' Health Administration and its supply chain. It was an honor to be allowed to serve several years ago and remains an honor to serve today.

In the private sector, the purpose of the healthcare supply chain is often thought of as a means of saving money. It is also thought of, by many in the private sector, as a means of generating revenue, either through the formation of a GPO or selling the health system's services (procurement, contracting, logistics or value analysis) to another system. In truth, it is neither. The one true mission of the healthcare supply chain is to deliver the right item or service, at the right time, to the right place, at the right cost, with the fewest handoffs possible. It really is that simple. Exceptionally hard to do, but that simple. And this is the most amazing thing about this simple mission: when all four goals are met, quality is built in, and no patient will want for the best care because the clinicians will always have what they need to heal the injured and sick. When all four goals are met, the supply chain is optimized and there will be little excess cost to find and "save."

The Veterans Health Administration (VHA), and its parent agency, The Department of Veterans' Affairs(VA), will most likely never be able to achieve this most favored state of the healthcare supply chain, given the current organizational structure. This is not the fault of either the department or of any one person or group of persons within the organization. I am aware of the recent changes in leadership within the VHA Supply Chain and know current leadership understands the challenges of managing a healthcare supply chain. Throughout the VHA, there are thousands of fine, dedicated people of all persuasions who live to serve our Veterans. And they do so well.

The current situation is a result of years of fixes and legislation and "work arounds". Over time, these actions have added layer upon layer of complexity, and, ultimately, uncertainty as to who owns the supply chain, how should it be managed, and what the mission and vision of the supply chain is. Today there are facility leaders, VISN leaders, VHA leaders, and VACO leadership with multiple offices, SAC, TAC, and NAC, all of which have to synchronize their efforts across hundreds of initiatives daily. Each actor has relative independence, and some have far more than others (e.g. SAC, TAC, NAC). To achieve what is described in the prior paragraph, the supply chain organization, including Contracting offices, must be of one mind, with one mission and vision, under leadership provided by one office. That is NOTto say that it must be a robotic organization, walking lock step with its leader, but ultimately, there needs to be one leader who has the responsibility to set the agenda, set forth the VA approved strategy and allow his or her designates to see it through to completion. As illustrated in the report I generated

for the Executive Suite, the Department of Veterans' Affairs and its child, the Veterans Health Administration, face significant challenges in this regard.

In large health systems, shared services are the key to maintaining higher quality outcomes at lower cost. Shared service structures allow for singular mission and vision, eliminate redundant functions, compress the time needed for decision-making and focus the service on its customer, the clinician. The supply chain is the perfect candidate for a shared service approach; It lends itself to centralized management and guidance with local execution in all things; contracting, procurement, logistics and product selection.

Supply chain management at each facility, while local, reports directly to the next level in the supply chain hierarchy and maintains a dotted-line (matrix) relationship to a clinical and administrative counterpart. This matrix relationship continues throughout the organization, from single facility through the VISN to VACO. The relationship is governed by a mutually agreed to service level agreement between supply chain and its customers, clearly spelling out the key performance metrics, the targets to be reached, and issues and problems will be dealt with. Thistype of shared service relationship is designed to create clear accountability and clear expectations at all levels of the organization. It is designed to enforce standards of performance effectively and create dependability and predictability.
Without this shared service structure, the history of the VHA shows that any large, system-wide supply chain project or initiative becomes bogged down and carries with it a high risk offailure. Maximo is a fine example, as are Catamaran, and MSPV.

Most importantly, the shared service organization will eliminate the "opt in or out" atmosphere that permeates the department. If each facility is essentially independent in their supply chain operations and decisions, then each facility will continue to do what it thinks best, what it wants or what is easiest, instead of taking action in an agreed manner. This is not best for the VA andis not best for the veterans the VA serves. Ultimately, it is the Veteran who pays the price. In my opinion, a Supply Chain shared service organization is what the department needs if it is tobe successful for any major undertaking, as well as for daily management of the supply chain.

Included in this shared service organization is management of the MMIS. The department has selected DMLSS as the replacement to GIP. This is a good and logical choice, as:

1. the cost of the project should be far lower than commercial, off the shelf, software
2. DMLSS was designed for use in a government procurement environment
3. at last look, DMLSS provides all that the department needs and any commercial product will deliver
4. many of those in the department are already familiar with DMLSS
5. DMLSS can be implemented, in my opinion, faster than most any other software

It could be said that had the shared service structure been in place when the subject of DMLSS v. Commercial first came up (several years prior to my service with the VHA), the decision would have been made and DMLSS would already be in place.

Just as all facilities need the same MMIS, all facilities also need to share the same point-of-use inventory management system. Currently, there are several systems in use across the VHA, if one is used at all.
And they are different, with different programming, different hardware and software requirements, and differing amounts of resources required to maintain them. None of them reduce the total amount of resources needed, either in worked hours or supplies purchased on any given day. None of them provide predictive analytics as to what the correct amount of inventory should be tomorrow (or next month) or live, visual and easy to recognize feedback regarding current inventory levels for any SKU. And, for various reasons, each system requires manual checking of the bins and/or updating of the counts for each bin, even though the system is supposed to maintain that count. The question is: Why do so many different systems exist in a single health system? The answer is: Because there is no centralized management of the supply chain. A shared service approach prevents such occurrences.

The establishment of a shared service approach to supply chain provides the department with the ability to standardize all it does. From key metrics to operations to customer service standards, each facility's supply chain, including contracting and procurement, must necessarily be operated in the same manner, with the same policies and procedures. While standard policies and procedures may be in place currently, there is no way to enforce them in real time, and without much hassle and generating exceptional amounts of additional work for all concerned. How does the Chief of P&LO on Vermont Avenue know that facility is always dangerously short in inventory? This would require the Logistics Chief at that facility to declare that his operation is consistently outside the norm of what is expected.
Human behavior tells us that is not going to happen very often. One of the main reasons this issue exists is the fact that the Facility Logistics Chief does not report to VACO in a manner that would enableVACO to act quickly and appropriately. In fact, VACO, in most cases, must wait for the issue to be written about by a whistleblower or a public watchdog, or the local newspaper. By then, the damage isdone.

Finally, if there is one other factor that impacts the effectiveness of the supply chain within VHA, it is theonerous contracting processes that must be adhered to. In my prior experience, I have had six contracting resources at one hospital, 28 contracting resources at another and finally 36 contracting resources at a third. Respectively, each of those contracting offices managed $2 Billion, $6 billion and
$9 billion in contracted and non-contracted spend. This begs the question: why does the VHA have over*2,500* contracting resources for *$30 billion* of spend (estimated) and far more than that for the entire VA? I do not claim to have an answer for this but feel this must be addressed. One option would be to allow the VHA to use a Group Purchasing Organization and to consider those contracts available to the VHA as duly competed. The VHA would then know that each facility, if it so chooses, has access to the same products and prices as every other facility in the system. The Commonwealth of Virginia allowed UVa Health to do this, bypassing most of its acquisition laws. It made the UVa Supply Chain far more responsive to the needs of the clinicians and other customers. It also reduced contracting time significantly, saving time and financial resources. I believe the VHA should be allowed to pursue this approach and determine if it is a viable one.

While most, if not all of what is in the attached report is included here, I have done my best to condense the message and provide examples.

CONGRESSIONAL TESTIMONY

STATEMENT FOR THE RECORD

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

Chairman Moran, Ranking Member Tester, and Members of the Committee, the American Federation of Government Employees, AFL-CIO (AFGE) and its National Veterans Affairs Council (NVAC) appreciate the opportunity to submit a statement for the record on today's hearing titled "Building A More Resilient VA Supply Chain." AFGE represents more than 700,000 federal and District of Columbia government employees, 260,000 of whom are proud, dedicated Department of Veterans Affairs (VA) employees. In our comments on needed improvements to the VA supply chain, we discuss how VA policies and practices have impacted the health and safety of the frontline workers who provide health care and other critical services to our nation's veterans. We hope that you find our recommendations reasonable, and we stand ready to work with the members of the Committee to make necessary and constructive changes.

Since the start of the COVID-19 pandemic, AFGE has received a tremendous number of urgent reports from panicked frontline health care workers facing unprecedented risks to themselves and their families while trying to care for veterans. Contrary to the public assurances made by the Secretary of Veterans Affairs, Robert Wilkie, VA medical facilities still do not have adequate masks, respirators, gowns, hand sanitizers, testing, and other medical treatment essential for the safe treatment of patients and necessary to control the spread of this deadly virus. Based on reports from our members, we are also doubtful about the Secretary's assurances that testing is widely available. We are quite troubled by the Secretary's admission to the House Appropriations Military Construction, Veterans Affairs and Related Agencies Subcommittee on May 28th that each VA facility only has a two-week stockpile of PPE.

Amidst the widespread chaos at almost every VA medical center, the only consistency appears to be inconsistency. The VA's medical equipment supply chain has been severely weakened by the absence of coordination, transparency, national guidance, and consultation with front line workers and their labor representatives. Personal Protective Equipment (PPE) acquisitions and distribution have been left largely to each medical center, without sufficient regard to guidance from the VA Central Office (VACO), recommendations from the Centers for Disease Control (CDC), or the extensive expertise and experience of VA contract officers and the front line employees who experience firsthand the risks of working during this pandemic without adequate protection.

As a result, local procurement offices are forced to compete for known PPE supplies instead of working together. At the same time, the VA's outdated inventory system does not allow for the accurate tracking of PPE inventory levels. There is no system in place for facilities to exchange information about best practices and good and bad suppliers, or to ensure reasonable pricing. Medical centers waste time, money and storage on purchases that cannot be used because of poor quality and improper decisions that cause unavoidable delays in the receipt of lifesaving PPE and other essential medical equipment.

At the VA specifically, every VA employee who works at a medical facility needs adequate PPE; not just those who work in COVID units and "hot zones." Every

employee can on short notice find himself or herself in a high risk situation even if his or her official duties are not within a “hot zone” because of a reassignment to a short staffed area, or an unexpected medical emergency involving a COVID-positive patient. Entrance screeners, housekeepers cleaning COVID units, maintenance workers disposing of trash, food service and canteen workers interacting all day long with large numbers of employees and veterans are denied adequate PPE at many facilities or provided none.

While poor management decisions are a primary cause of dangerous PPE practices, the chronic shortages resulting from supply chain problems have also contributed a great deal. We question why many medical facilities continue to ration PPE despite increased inventory and we are deeply troubled by reports that some managers hoard PPE or save PPE for colleagues who are not at risk, while forcing front line employees to go without or plead for more protective PPE and replacements of worn out PPE.

PPE purchasing and distribution decisions at VA medical facilities are too often arbitrary. The shortages and uncertainty about future inventory resulting from supply chain weaknesses exacerbate the problem. The need for a well-functioning supply chain will become even greater as the technology for testing, vaccines, and pharmaceutical treatments for the virus advances.

For these reasons, AFGE supports legislation that will increase the supply and proper distribution of PPE and other medical equipment through fuller utilization of the Defense Production Act (DPA), combined with vastly increased oversight and transparency of DPA activities. The country urgently needs a comprehensive strategy for ensuring

adequate production and distribution of PPE and other medical equipment necessary to fight COVID-19 for all workers who need them.

AFGE strongly urges lawmakers to enact the PPE provisions in H.R. 6800, the "HEROES Act" that enhance DPA authority, require the President to work with a team of federal agencies to carry out DPA activities, require extensive Congressional oversight through regular executive branch reports to Congress, and ensure transparency through public reporting requirements.

AFGE also strongly supports "HEROES Act" provisions that require the President and coordinating agencies to engage stakeholders, including labor unions representing health care workers and public sector employees, in medical equipment needs assessments. Stakeholder engagement will also be enhanced by provisions in the bill that establish a stronger oversight role for the Comptroller General. Every day, VA frontline employees and the veterans they serve feel the harsh effects of the Secretary's insistence of silencing the voices of the VA workforce and their labor representatives. From the outset of this pandemic, AFGE and other unions representing VA front line workers have been shut out of the agency's response teams at both the national and local level. All our requests to help the VA effectively respond to COVID-19 have been rejected, despite direct pleas to the Secretary and the much-appreciated requests to the Secretary by Members of Congress. The Secretary's unwillingness to listen to the front line employees who deliver the care, and their representatives, is a stark departure from the labor-management partnerships that allowed the VA to fulfill all its missions during hurricanes, epidemics, and other past national crises. Sadly, rather than take the

simple, cost saving and productive step of increasing dialogue, the Secretary continues to wage a war on our collective bargaining agreement by trying to force a new contract on AFGE's VA Council that eliminates longstanding contract provisions that enhance workplace safety, staffing levels and recruitment and retention of scarce medical professionals. For these reasons, stakeholder engagement in DPA activities including PPE needs assessment is even more critical.

More broadly, a strong federal supply chain is essential to ensuring that every federal and private sector worker who needs PPE and other medical equipment and services receives what he or she needs to perform their duties safely. The "HEROES Act" provisions strengthening the DPA will also enable our nation to achieve universal testing for COVID-19 that will finally allow us to fully assess the risk of transmission by knowing the extent of infection, and then take action to isolate those who have been in contact with infected individuals. Universal testing will help ensure the health and safety of VA employees and veterans as federal worksites reopen. Additionally, AFGE is pleased that provisions in S. 3627, the "Medical Supply Transparency and Delivery Act" that similarly increase the effectiveness, accountability, and transparency of the DPA, were included in the "HEROES Act."

We stand ready to work with the Committee on all the steps needed to protect veterans and the VA workforce as the nation continues to cope with COVID-19 and proceed to new stages of reopening. Thank you.

Questions for the Record
Responses by: Department of Veterans Affairs (VA)

Ranking Member Tester

Question 1. Please provide the strategic plan for VA's medical supply program as led by the Veterans Affairs Logistic Redesign (VALOR) Program Management Office. This should include, but not be limited to its vision and mission statement, detailed goals and objectives, current staff and staffing plan and organizational chart, budget, and scorecards or other methods being used to track progress. Please include three-month goals that the VALOR office is using for the next 12-month period to include planned activities related to the DMLSS/LogiCole deployment and integration.

VA Response:

VALOR Vision: VHA business and support functions – modernized, aligned, integrated and optimized.

VALOR Mission: Support the transformation of VHA supply chain and support services by fielding the Defense Medical Logistics Support System (DMLSS) and its technical refresh system, LogiCole.

VALOR Goals and Objectives:

VALOR Goals and Objectives .pdf

VALOR Organization Chart with Existing Staff and Staffing Plan:

VA VALOR Org Chart and Staffing Plan.pdf

VALOR Scorecard/Method to Track Progress: Progress is tracked via a dashboard that documents completed and in progress milestones, as well as planned milestones for each site.

VALOR Scorecard
and Method to Track

DMLSS Fielding Schedule (Current and Draft Accelerated)

DMLSS Fielding
Schedule Current an

Question 2. Please provide the current status of COVID-19 testing supplies, such as swabs, available for VA's workforce, as of June 2020.

VA Response: As of June 9, 2020, the VA has the requisite capacity to perform approximately 60,000 tests per week in aggregate. Employee testing accounts for 650 (mean value) tests daily. Despite global demand, manufacturing capacity, and total market supply availability of clinically approved swabs, VA has been able to procure adequate quantities of swabs to maintain consistent testing levels—but is limited in the ability to increase stock levels in excess of 30 days of on hand supply based on capacity to perform approximately 60,000 test per week.

Question 3. The VA Office of Inspector General (OIG) previously reported on VHA's increasing usage of Government Purchase Card (GPC) to purchase medical supplies. What enterprise metrics does VHA have in place today to reduce GPC usage?

VA Response: VHA's GPC metric is the ratio of GPC expenditures to direct Prime Vendor purchases, expressed as a percentage.

Question 4. Has VHA studied the impact of using GPC and strategic sourcing contract vehicles to purchase medical supplies? If so, please describe the results of this study.

VA Response: VHA has not conducted a study of the impact of using GPC and strategic sourcing contract vehicles.

Question 5. Do you view VA's adoption of the DoD DMLSS ordering system as a pathway to help VHA reduce its GPC usage? Further, could VAMC's migrate to MSPV and ECAT programs before DMLSS is fully implemented? If so, when would that happen?

VA Response: Yes, DMLSS will serve as a pathway to reduce VHA GPC usage by allowing VHA to implement electronic controls on the use of GPCs for the purchase of medical materiel. The DoD Electronic Catalog (ECAT) program is available to all VA Medical Centers (VAMCs) as a second eCommerce option for non-MSPV purchases to

further help reduce GPC usage. VHA can only access the DoD Prime Vendor programs via DMLSS; it cannot do so with its existing legacy systems.

Question 6. Please provide VA's plans to expand the MSPV formulary to reduce GPC usage. In addition, what efforts are in place for VA to use DoD's ECAT program instead of GPC for non-MSPV purchases?

VA Response: The MSPV-Next Generation Bridge contract enables VHA to reduce GPC usage by expanding the formulary of medical, surgical, dental, lab, and environmental medical supplies. Once awarded, VHA expects to see a long-term reduction of GPC usage across the enterprise due to the expanded MSPV formulary. All VAMCs can now use the Department of Defense Electronic Catalog (ECAT) program as a second eCommerce option for non-MSPV purchases, which will further help reduce GPC usage.

Question 7. Is there a process for inspections in VA hospitals and VISNs for supplies and stock levels? If so, who conducts them and how are the right stock levels of supply determined and then reported to whom?

VA Response: VA hospitals have a robust program of inspection. Veteran Integrated Service Networks (VISN) staff conduct Quality Control Reviews of their respective VA hospitals. The Veterans Administration central office manages the Facility Logistics Inspection Program and inspects VA hospitals. VISN and VA report inspection results to the VHA Procurement and Logistics Office.
VA defines its stock levels in policy (directive). For VA's COVID-19 response, and due to the instability of the global Personal Protective Equipment (PPE) supply chain, VA set stock levels for PPE at 60 days of supply at every VAMC.

Question 8. To what extent did VA utilize its Emergency Cache program during COVID-19? Were Emergency Cache use decisions made at the local, regional, or national level? Does the Department have any plans to reform or alter the Cache program?

VA Response: Seven VA medical facilities activated their All-Hazards Emergency Caches to remove swabs for use in COVID-19 testing. One facility activated the cache to remove hand sanitizer. No other Caches were activated for COVID-19 response. Decisions regarding use of the Cache were made at the national level. VHA published an updated version of the All-Hazards Emergency Cache Directive on April 22, 2020. This update establishes the VHA Office of Population Health as the response program office for the cache program, requires an annual cache exercise that includes physical movement of the cache and implements changes in the annual cache inspection process. No other changes are currently being considered for the cache program.

Question 9. How does VA reimburse FEMA for supplies it receives from the Strategic National Stockpile?

VA Response: VA reimburses FEMA through Inter-Agency Agreement funds transactions.

Question 10. What is the name of the system/IT tool/database VA deployed during COVID-19 to improve the manual reporting of PPE and other supply levels? VA previously reported to the Committee that this reporting change occurred toward the end of April 2020.

VA Response: VAMCs use the *VHA COVID-19 Response Field Validation Tool* to capture their daily (Monday to Friday) inventory levels for Personal Protective Equipment (PPE). The *COVID-19e Power BI Dashboard* displays the inventory data and usage rates ("burn rates") from the *VHA COVID-19 Response Field Validation Tool*. Yes, the tool and the dashboard went live on April 20, 2020, to correct the lack of enterprise visibility of VHA's PPE.

Question 11. Please provide a detailed accounting of VA's spend plan for VALOR and DMLSS/LogiCole efforts for FY 2020 and what spending has occurred for what purpose as of June 2020.

VA Response:

	FY20 VALOR PMO / DMLSS					
	Medical Appropriation				Total	Spend as of June 2020
Requirements	Services	Admin	Facilities	CC		
Salary		5,620,068			5,620,068	
Contracts	27,904,850				27,904,850	19,610,137
Start-Up Costs					-	
Leases					-	
Lease Build Out					-	
Contracts					-	
Non-IT Equipment					-	
Travel		500,000			500,000	
Total Request	**27,904,850**	**6,120,068**	-	-	**34,024,918**	**19,610,137**
FTEE		33			33	31

	FY20 VALOR PMO / DMLSS					
	IT Appropriation				Total	Spend as of June 2020
Requirements	Services	Admin	Facilities	CC		
Salary					-	
Contracts	22,220,539				22,220,539	15,529,503
Start-Up Costs						
Leases						
Lease Build Out						
Contracts						
Non-IT Equipment						
Travel						
Total Request	**22,220,539**	-	-	-	**22,220,539**	**15,529,503**
FTEE		0			0	0

Attached spreadsheet shows details of OIT spend plan.

DMLSS OIT FY2020
Spend as of June 20

*Question 11a***.** Please also provide a detailed accounting for the $308 million for supply chain modernization ($196 million from the VHA budget and $112 million from the Office of Information Technology budget) VA has requested in the FY 2021 budget.

VA Response:

The approved DMLSS VA FY21 budget is $196M, not $308M:

VHA appropriation $84.3M

OI&T appropriation $111.5M

Total FY21 appropriations.....$196M

	FY21 VALOR PMO / DMLSS				
	Medical Appropriation				Total
Requirements	Services	Admin	Facilities	CC	
Salary (VA Hires)		$5,766,190			$5,766,190
Contracts	$76,795,476				$76,795,476
Start-Up Costs					
Leases					
Lease Build Out					
Contracts					
Non-IT Equipment					
Travel		$1,750,000			$1,750,000
Total Request	$76,795,476	$7,516,190			$84,311,666
FTEE		33.0			33*

* 31 of 33 VALOR positions approved - (2) GS-15 positions still under review

	FY21 VALOR PMO / DMLSS				
	IT Appropriation				Total
Requirements	Services	Admin	Facilities	CC	
Salary (VA Hires)					
Contracts	$111,520,000				$111,520,000
Start-Up Costs					
Leases					
Lease Build Out					
Contracts					
Non-IT Equipment					
Travel					$0
Total Request	$111,520,000				$111,520,000
FTEE					0.0

Question 12. VA had previously set goals for calendar year 2019 for DMLSS/LogiCole pilots, including piloting the effort at three VAMCs. The timeline VA had set was not met. Please describe the goals you had set, what was achieved or not achieved, and why not. Please identify why integration or other IT issues that may have prevented achievement of timelines were not identified in advance of the pilot. Please describe the revised timeline for 2020 and 2021 calendar years.

VA Response:

The primary 2019 goals were to:

- Deploy DMLSS at the Captain James A. Lovell Federal Health Care Center (FHCC), satisfying the National Defense Authorization Act requirement.
  - Technical go-live: July 2019
  - Functional go-live: October 2019

- Establish initial operating capability within VISN 20:
  - Spokane VA Medical Center: November 2019
  - VA Puget Sound Health Care System: December 2019

Reason for not meeting the 2019 implementation milestones:

- DMLSS Go-Live at FHCC:

  The age and lack of formal documentation for the VA legacy systems was a known risk for implementation. As was the lack of personnel with direct first-hand knowledge of the development of the legacy systems (i.e., those with first-hand knowledge are long retired). The DMLSS program realized this risk during the go-live implementation at FHCC in October 2019. Technical difficulties emerged, identifying previously unknown integration requirements for supplementary financial interfaces within Health Connect to other VA legacy systems.

  Resolution of the new interfaces required the modification of DMLSS, and VA interface testing could not occur until the DOD completed the DMLSS modifications, resulting in additional delay. These issues are resolved.

  - VA initiated incremental cut-over from the legacy systems to DMLSS at FHCC on August 4, 2020.
  - VA is on schedule to complete cut-over by September 30, 2020.

- VISN 20:

  VA did meet the requirement to provide DMLSS Capability Set 1 at Spokane in December 2019 per the requirement but did not achieve cut-over, as the schedule required.

Reasons for the delay:

- Changes to the Electronic Health Record Modernization (EHRM) schedule were the primary drivers behind delaying DMLSS implementation in VISN 20, as the two systems have infrastructure dependencies.
- COVID-19 delayed all on-site efforts from April to July 2020, as VHA responded to COVID and curtailed non-essential visits to all medical facilities.
- Work is ramping up to achieve go-live for
  - Puget Sound: November 2020
  - Spokane: January 2021.

VA and DOD are reviewing lessons learned from the 2020 FHCC go-live and assessing the changes for all aspects of the deployment (e.g., technical, training, data migration, human factors related to business process changes and acceptance) for application to all future deployments.

At the request of the SVAC, VA is assessing accelerating DMLSS deployment to shorten the existing seven-year deployment schedule. The original seven-year and draft five-year schedule below.

DMLSS Fielding Schedule Current an

Questions for the Record
Responses by: Department of Veterans Affairs (VA)

Senator Blumenthal

Question 1. How is VA currently tracking PPE numbers in each facility and VISN?

VA Response: VA Medical Centers use the *VHA COVID-19 Response Field Validation Tool* to capture their daily (Monday to Friday) inventory levels for Personal Protective Equipment (PPE). The *COVID-19e Power BI Dashboard* displays the inventory data and usage rates ("burn rates") from the *VHA COVID-19 Response Field Validation Tool*.

Question 1a. When was this tracking system implemented?

VA Response: The tool and the dashboard went live on April 20, 2020.

Question 2. What is VA's plan for tracking PPE numbers in the future?

VA Response: VA will continue to track PPE as described above for the foreseeable future. VA will replace the manual data feeds with automated feeds following the implementation of the Defense Medical Logistics Standard Support (DMLSS) system at each VA Medical Center. As full implementation of DMLSS is a multi-year effort, VA will not be able to fully automate PPE tracking until the DMLSS fielding effort is complete.

Question 2a. When is this system planned to be implemented?

VA Response: The existing DMLSS fielding schedule for enterprise deployment begins in first quarter Fiscal Year (FY) 2021, with the last planned fielding occurring in FY 2027, a total of seven years. VA is exploring options to accelerate the fielding schedule to complete deployment in five years, ending in FY 2025.

Question 3. Are there any current shortages of PPE or testing supplies?

VA Response: VHA will return to the CDC Conventional Capacity Strategy when U.S. PPE shortages are resolved nationally. VHA has adequate supplies of the swabs used to collect samples for COVID-19 testing. Shortages in the manufacturing of cartridges, reagents and supplies to run COVID-19 tests themselves continue to be a nationwide challenge which also impacts VHA. VA plans to increase 3D manufacturing of swabs to roughly 100,000 in 2020 and continues to obtain testing kit supplies from multiple vendors and receive allocations from Federal Emergency Management Agency (FEMA). As of July 17, VA has tested more than 400,000 Veterans and employees.

Question 4. How is VA planning to address future shortages of PPE or testing supplies?

VA Response: VA has, and continues, to work with our government and private sector partners to secure what the VA needs to support its core Veteran healthcare mission and our 4th mission. These measures include:

- Increasing the days of supply on hand at each VAMC to 60 days of

supply.

- Establishing four Regional Readiness Centers (RRC), one for each of the four Veteran Integrated System Network (VISN) Consortiums to act as a central source for management and resupply for the VAMCPPE andcritical item needs. The RRCs will carry up to 120 days of supply.
- Obtaining four Battelle Critical Care Decontamination Systems, one for each of the Regional Readiness Centers, to decontaminate N95 respirators. VHA will hold the decontaminated respirators in reserve to provide capacity in a crisis.
- Determining and implementing the appropriate blend of readiness capabilities:
    - Negotiating higher allocation levels with prime vendors and manufacturers,
    - 3-D printing / agile manufacturing,
    - VA and/or VA/Department of Defense (DoD) manufacturing and/or public private partnerships,
    - Partnerships with DoD, Health and Human Services and the Federal Emergency Management Agency to better incentivize domestic manufacturing of PPE through the Strategic National Stockpile Next Generation program; and
    - New contracts and requests for proposals.

VA requires the help of Congress to participate in the DoD Warstopper Program, which offers:

- Vendor managed inventory (i.e., when items can't be kept fresh with VA demand, the vendor uses commercial demand to keep it fresh);
- Bumping up vendor inventory / paying fees to guarantee quantity and timeliness when needed;
- Staging long lead time materials and components / paying fees to guarantee quantity and timeliness when needed;
- Obtaining raw material buffers to put strategic raw materials in place downstream that facilitate surging of end items.

Question 5. What is VA's current guidance on which veterans and employees may be tested for COVID-19?

VA Response: VA's current guidance for COVID-19 testing is attached.

COVID Testing in VHA_1.0 .pdf

Question 6. Which COVID-19 tests are currently being used?

VA Response: COVID-19 Diagnostic Tests currently being used are (Assay and platform):

Assay	Platform
Abbott RealTime SARS-CoV-2 assay	Abbott m2000
Alinity m SARS-CoV-2 assay	Abbott Alinity M (machines being installed)
Aries SARS-CoV-2 Assay	Luminex Aries
BD SARS-CoV-2 Reagents for BD MAX system	Becton Dickinson BD Max
BioFire Respiratory Panel 2.1 (RP.2.1)	BioFire
CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel (CDC)	CDC
Influenza SARS-CoV-2 (Flu SC2) Multiplex assay	CDC
cobas SARS-CoV-2	Roche cobas 6800
ID NOW COVID-19	Abbott ID NOW
Panther Fusion SARS-CoV-2 assay	Hologic panther
Sofia SARS Antigen FIA	Quidel Sophia
TaqPath COVID-19 Combo Kit	Thermo Fischer
Xpert Xpress SARS-CoV-2 test	Cepheid

Question 7. What is VA's guidance on when austerity measures will be taken with regards to distribution of PPE to VA employees?

VA Response: VA adopts CDC guidance in determining when these measures are needed; capacity determination relies on knowledge of local PPE inventory, supply chain, and utilization.

The following guidance is taken from CDC:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html

Surge capacity can be considered in 3 general strata, which can help guide PPE conservation:

- **Conventional capacity**: measures consisting of engineering, administrative, and PPE controls that should already be implemented in general infection prevention and control plans in healthcare settings.
- **Contingency capacity:** measures that may be used temporarily during periods of anticipated PPE shortages. Contingency capacity strategies should only be implemented after considering and implementing conventional capacity strategies. While current supply may meet the facility's current or anticipated utilization rate, there may be uncertainty if future supply will be adequate and therefore, contingency capacity strategies may be needed.
- **Crisis capacity:** strategies that are not commensurate with U.S. standards of care but may need to be considered during periods of known PPE shortages. Crisis capacity strategies should only be implemented after considering and implementing conventional and contingency capacity strategies. Facilities can consider crisis capacity strategies when the supply is not able to meet the facility's current or anticipated utilization rate.

CDC has guidance on what measures might be implemented at each stratum: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/strategies-optimize-ppe-shortages.html

Decisions to implement contingency and crisis strategies are based on these assumptions:

1. Facilities understand their current PPE inventory and supply chain
2. Facilities understand their PPE utilization rate
3. Facilities are in communication with local healthcare coalitions and federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) to identify additional supplies
4. Facilities have already implemented conventional capacity measures
5. Facilities have provided HCP with required education and training, including having them demonstrate competency with donning and doffing, with any PPE ensemble that is used to perform job responsibilities, such as provision of patient care

CDC also has helpful guidance including a flow diagram for determining whether contingency or crisis capacity strategy is needed, specific to FFRs (filtering facepiece respirators, such as N95s): https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html

Question 8. What is VA's guidance on when and how often PPE should be reused?

VA Response: VA adopts CDC guidance on extended use and re-use of PPE. CDC has guidance for each type of PPE and what options to consider under different constraints.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/strategies-optimize-ppe-shortages.html

The first step is to determine what capacity the facility is operating under (conventional, contingency, crisis).

- This is outlined in the response to Question 7, above
- Note that this may be different for different types of PPE
    - For example, gloves may be in adequate supply when there are severe constraints on FFRs at the same site
    - So a single facility may be operating based on crisis capacity for one type of PPE, and conventional capacity for others.

The next step is to explore strategies specific to that capacity and determine what is best based on local needs and supply.
https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/strategies-optimize-ppe-shortages.html

Question 9. What is VA's guidance on when VA's would close facilities in the event of a future spike in COVID-19 cases?

VA Response: As a high reliability organization, VA prioritizes Veteran and staff safety. VISNs and facilities monitor local COVID-19 case growth daily. Sites offering or resuming face-to-face care have met the White House Gating Criteria and they will progressively expand services while prioritizing the safety of Veterans and staff.

Whether expanding, temporarily holding at the current expansion level, or temporarily reducing select services, all VA medical facilities continue to offer virtual care and Community Care options, as they have since before the pandemic. VA is committed to providing safe care to our Veterans while ensuring we have the capacity and equipment to care for our most critical patients. As it has throughout the COVID-19 response, VA will continue to provide essential services to Veterans, their families, and beneficiaries who rely heavily on VA for those services

Question 9a. Would this decision be made by VISNs or VA Central Office?

VA Response: Those sites anticipating or experiencing increases in COVID-19 cases that adversely impact their ability to meet the Gating Criteria may temporarily pause or reduce face-to-face services to ensure the safety of Veterans and staff. These decisions are made by facility clinical and administrative leadership in consultation with

VISN leadership. Additionally, these decisions are supported by daily communication between VISN leadership and VA Central Office to review the latest data on COVID-19 case growth and discuss barriers or concerns.

Question 9b. What is VA Central Office's role in determining when the number of COVID-19 cases, positive test rates, ICU or other bed capacity, or other standards that must be met for reopening or closing VA facilities?

VA Response: VA Central Office continuously monitors and shares local COVID-19 data with VISN and facility leadership to support informed, consistent local decisions to expand or pause services. This data includes, but is not limitedto, COVID-19 case growth, test rates and availability, bed capacity, personal protective equipment (PPE) and supply inventory, community care consults, ventilator utilization, COVID-positive employee and Veteran rates.

Question 10. What VA office/department is responsible for negotiating with HHS and/or FEMA to get supplies?

VA Response: The VHA Emergency Management Coordination Center (EMCC) is responsible for placing orders with HHS and FEMA for supplies.

Question 11. What is the process by which VA requests supplies from HHS or FEMA?

VA Response: The VHA EMCC submits a request for supplies via the FEMA Web Emergency Operations Center (WebEOC), a Crisis Information Management System (CIMS).

Question 12. Why is VA a secondary priority after public hospitals for getting supplies from HHS or FEMA?

VA Response: VA is no longer a secondary priority after public hospitals. The FEMA Resource Prioritization Bulletins #1 (4/3/20 – 4/7/20), #2 (4/8/20 – 4/12/20), #3 (4/12/20 – 4/15/20), #4 (4/16/20 to 4/19/20) and #5 (4/20/2–4/23/20), identified VA Hospitals as priority 2, after public hospitals, which were priority 1. With the publication of FEMA Resource Prioritization Bulletin #6 (4/24/20-4/27/20) VA hospitals were ranked as priority 1, along with public, private and long-term acute care hospitals.

Question 12a. What is the process for VA to get equal priority with public hospitals?

VA Response: VA Hospitals have equal priority with public hospitals.

Question 13. Is VA altering its national prime vendor program and moving away from the "just-in-time" supply chain?

VA Response: While the just-in-time model works for most medical materiel, the global demand for PPE created by COVID-19 proved just-in-time no longer works for PPE and other select readiness items (e.g., ventilators and ventilator consumables; dialysis and dialysis consumables; and laboratory equipment, test kits and swabs). While VHA will continue to use the just-in-time supply chain (e.g., Prime Vendors), VHA must also establish an enterprise wide capacity to store, maintain, manufacture, manage and distribute PPE and critical medical materiel if it is to sustain its traditional mission and "Fourth Mission" through the COVID-19 pandemic and future regional and national emergencies. The ways in which VHA will do this are in Question 4, above.

Question 13a. If so, what changes to the prime vendor program will be occurring?

VA Response: This analysis is still underway.

Questions for the Record
Responses by: Department of Veterans Affairs (VA)

Senator Sinema

Question 1. In the GAO report that added VA Acquisition Management to GAO's high-risk list, it identified outdated acquisition regulations as a major problem. The report says that VA has been working to do a comprehensive update to its regulations since 2011. What is the delay in completing this much needed revision?

VA Response: After an assessment by the VA Senior Procurement Executive there are several observations that contributed to delays related to updating the VA Acquisition Regulation (VAAR) such as planning efforts needed improvement, lack of dedicated leads for VAAR and VA Acquisition Manual (VAAM) projects, other areas considered priorities took focus away from regulation updates, etc. These issues have been addressed, there are dedicated leads, all of the efforts required to assure repeatable, sustainable processes for continuous timely updates have been identified, implementation of dedicated leads along with roles and responsibilities is being finalized. VA has a $27B acquisition mission which requires standardization, timely updates and intentional content management both of which are critical success factors necessary to drive change and to improve VA Acquisition Management along with planning for future removal from the GAO High Risk List. The current status of the VAAR updates is below, while a lot of work has been completed there is still more work required to assure sustained improvements in the future:

41 (Total Parts)
26 (Published in the eCFR)
4 (OMB - Final Rulemaking Process
1 (Federal Register - Public Comment)
10 (Internal to VA)

Question 2. The VA has several systems for procurement and several entities within its

organizational structure overseeing these procurement processes. As you look to modernize VA's procurement processes, how is VA assessing its organizational structure to streamline the process and what needed reforms are you identifying?

VA Response: There are several on-going efforts designed to improve, modernize, streamline, and transform Acquisition Management at the VA. For example:

1. The needed reforms include an intentional end-to-end lifecycle focus along with collaboration across the VA enterprise – Transform organizational structure (focus on people, processes and resources), VA business systems, apply proven best business practices, and continuous collaboration with OMB, other federal agencies, and industry.

2. Streamlining Methods and Current Initiatives:

   A. Implemented the Acquisition Knowledge Portal – One stop for all acquisition activities (federal/VA acquisition regulations, internal VA guidance/processes, access to webinars/training, collaboration rooms/dedicated café' specific to roles and responsibilities of the acquisition workforce, etc.)

   B. New Organizational Structure to dedicate leads for VAAR and VAAM

      - VAAR which is public facing and supplements the Federal Acquisition Regulation (Structured process collaboration with federal government and industry)
      - VAAM which is internal and will contain VA standardized internal procedures, guidance, and instructions (PGI) which will provide updates addressing acquisition business systems; organizational systems and structures required to streamline processes, implement emerging technology, and standardized VA internal PGI leading to modernization and transformation.

   C. Establishing an office led by a Senior Executive to lead the Office of Acquisition, Logistics and Construction (OALC) efforts required to assure the VA Strategic Objectives related to overarching Acquisition Management including an end-to-end acquisition lifecycle focus. This office will reside in the Office of Acquisition and Logistics (OAL), the proposed office name "Strategic Acquisition Management Initiatives (SAMI)." The Associate Executive, for SAMI will be responsible for assuring collaborating with the Administrations and VA Central Offices

socializing and implementing the VA Acquisition Lifecycle Framework (ALF) providing support and services throughout the various phases of the acquisition lifecycle and assuring best practices are applied from an end-to-end lifecycle perspective partnering with Office of Management, Office of Information Technology, and Office of Human Resource and Analysis.

D. Established an OAL Project Management Office managing the VA planning effort to deploy to modernize the VA contracting writing systems. This project led by the Executive Director, OAL support the VA Financial Management Business Transformation (FMBT) Program Office to assure all of the federal and VA acquisition business systems are considered and aligned to support VA Strategic Objectives and improve VA Acquisition Management. Improving access to the latest technological functionality and capability is available for use by the VA Acquisition Workforce. Continuously reviewing current state to harness emerging technology, reduce manual processes related to various acquisition activities and improve access to quality data required to support management decisions.

Question 3. During the COVID response, PPE has been in short supply and high demand. News outlets reported facilities were finding expired or deteriorated emergency stockpiles of PPE at VA and across Federal Agencies. How did this happen? Does VA have a streamlined mechanism to track stockpiles and ensure they are being used and replaced before they deteriorate?

VA Response: As a result of the robust and stringent inspection program the contents of the 143 VA All Hazards Emergency Caches (AHECs) across the VHA enterprise did not and does not have expired PPE and/or pharmaceuticals. VHA senior leadership early in the COVID response would not permit access and/or utilization of the PPE contents of the AHEC due to these limited supplies. The PPE contents of the AHEC would only be used in the event of an absolute worst-case scenario and at the time VHA was cross leveling PPE and receiving support from the SNS.

Locally, some VAMCs have created PPE and supply caches and the control over the contents, inventory and stock rotation is the responsibility of the local VAMC.

The Department of Veterans Affairs Emergency Preparedness Act of 2002 (Public Law 107-287) served as a catalyst for VA to develop resilient capabilities that would support continuous delivery of services to Veterans in an All-Hazards environment. The law established the requirement for emergency preparedness and readiness for VA medical facilities, the tracking of pharmaceutical and medical supplies, participation in the National Disaster Medical System (NDMS), and it amended the authority to furnish health care during major disasters and medical emergencies. The law references

preparedness for Chemical, Biological, Radiological, Nuclear, and Explosive weapons (CBRNE), and other public health emergencies including pandemic events.

The VA All Hazards Emergency Cache (AHEC) has been designed to complement the Strategic National Stockpile (SNS) and local pharmacy formulary and stock levels to ensure short-term preservation of the VA health care infrastructure until other resources can be made available in the immediate area. VISNs and VA medical facilities may find themselves receiving casualties from a CBRNE emergency or natural disaster that overwhelms local inventory of medications and supplies and replacement stock from prime vendors or the VHA Consolidated Mail Outpatient Pharmacy (CMOP). As part of a VA medical facility's emergency operations plan, VA medical facilities must prepare to provide care on a humanitarian basis for these victims and provide necessary support and protection to Veterans and VA staff. The AHEC does not provide all emergency supplies that may be required for a local disaster such as a flood, earthquake, hurricane, or fire. The AHEC may be used in response to an epidemic that arises from a local disaster.

On an annual basis, the cache is physically inspected, and all emergency operations policies are reviewed for inclusion of cache related activities. The inspection is initiated by the National Population Health program through the Performance Improvement Management System (PIMS). The National Population Health office maintains records and results of inspections. Inspections are coordinated with medical facility leadership to ensure all areas of the inspection are completed, entered in PIMS, and communicated to the facility. There are three areas of focus for this inspection:

a. **Physical Security.** VA Police will inspect the cache storage facilities for compliance with current policy for the storage of pharmacy drugs and AHEC specific security requirements.

b. **Pharmaceutical Inventory.** Pharmacy Service will inspect the contents of the cache for expiration dates, adherence to Shelf Life Extension Program (SLEP) requirements, and adherence to other VHA pharmacy policy.

c. **Emergency Plan Audit.** The VHA Office of Emergency Management (OEM) will perform an audit of all local documents covering emergency operations including the all-hazards cache. The audit will include but not limited to documentation and after-action reports on all cache activation exercises and Emergency Management Committee meeting minutes.

An annual exercise of cache activation and deployment will be included in at least one facility-wide emergency operations training exercise. This exercise must include physical movement of cache contents and deployment of the POD team. An inventory of the items opened in the exercise will be conducted by appropriate staff following the exercise. Emergency Pharmacy Service (EPS) will be notified of any replacement stock needed post exercise and all items will be replaced.

The PPE contained in the AHEC is extremely limited and the limited quantities are designed to provide critical staff protection for a very finite period of time. Depending on the size of the cache the quantities of PPE would only allow for an immediate response and would not be able to sustain any response.

Question 3a. If no, how will this be corrected with LogiCole?

VA Response: VA intends to use the Department of Defense (DoD) Defense Medical Logistics Standard Support (DMLSS) system to manage the emergency caches. LogiCole is the technical refresh for DMLSS and VA will implement LogiCole when DoD completes development and testing of the system. Implementation of DMLSS will reduce the amount of loss to expiration in facility caches. DMLSS capability includes an "assemblage management" module specifically designed to manage contingency stocks, including materiel with expiration dates. Management within DMLSS will provide the facility, Emergency Management Coordination Cell and VHA with visibility of the materiel in each cache. This will facilitate cache quality assurance, including rotation of short shelf-life materiel into operational stocks and replacement with materiel with longer shelf life.

Question 4. What has VA learned about improvements needed to cross agency communication and coordination, particularly for PPE and other medical supplies, as a result of the COVID pandemic response and how are these lessons being integrated into VA's procurement modernization plan?

VA Response: VHA's response to COVID-19 demonstrated the strength and agility of an integrated healthcare system geographically distributed across the United States and operating as a single enterprise. As COVID-19 incidence varied by jurisdiction, and despite global shortages of PPE, critical equipment and consumable items, VHA was able to sustain operations in locations experiencing high demand due to COVID-19 (e.g., New York City, New Orleans) by cross-leveling staff, PPE and ventilators from areas with low levels of disease.

The establishment and maturation of the VHA Healthcare Operations Center (HOC) as the fusion center for collecting, analyzing, planning and disseminating data and information to all stakeholders created a key enabler to a VISN's ability to cross-level staff and materiel between VAMC and for VISN to VISN cross-leveling. A further maturation of the enterprise approach to management of COVID-19 response effort, considering the fragmentation of the global PPE supply chain, was the work conducted by the four VISN Consortiums. A VISN Consortium is a partnership between multiple VISNs located in the same region of the country. VISNs formed consortiums to foster collaboration among medical centers and to enhance operations and the delivery of health care to Veterans. To accomplish these goals, the consortiums use regional contracts, sharing staff and materiel, and joint networks for referring patients and conducting telehealth.

Question 5. In Arizona and across the country, the pandemic has highlighted the need for VA to be more engaged with partner organizations serving the same veteran community the VA is serving. We've seen this particularly with the state Veterans homes and organizations supporting and housing homeless Veterans. These organizations have had several challenges supporting its community, including access to enough PPE to keep staff safe. In moments of emergency or disaster, is VA considering how it can expand its practices to ensure it can support these partners as they need and how could these modernization efforts help?

VA Response: Responding to disasters and emergencies requires the cooperation of a variety of organizations; the larger or more complex the incident, the greater the number and variety of organizations that must respond. The National Response Framework is built on scalable, flexible, and adaptable concepts identified in the National Incident Management System (NIMS) to align key roles and responsibilities across the Nation, including that of VA. The structures, roles, and responsibilities described in the Framework can be partially or fully implemented in the context of a threat or hazard, in anticipation of a significant event, or in response to an incident. VA will continue to work within this framework, along with the Department of Health and Human Services and the Federal Emergency Management Agency, to support the Nation and its Veterans.

Questions for the Record

Responses by: Ms. Shelby Oakley, Director of Contracting and National Security Acquisitions, GAO

Ranking Member Tester

Question 1. In March 2019, GAO added "VA Acquisition Management" as a new high-risk area in light of numerous contracting challenges and given the significant investment in resources to fulfill its critical mission of serving veterans. What progress does GAO want to see from VA in order for this area to be removed from the High-Risk list?

Response: Yes, our work thus far has identified a number of key acquisition management challenges ranging from the lack of an effective medical supplies procurement strategy to unreliable data systems. As the Comptroller General stated in May 2019 when he testified on VA's efforts to address longstanding management challenges—"VA is in need of transformation." GAO does not take the high risk designation lightly, and VA is taking steps, but transformation needs to occur at many levels within the VA enterprise and leadership to affect change, including greater stability in key acquisition positions, improvements in individual programs, and successful implementation of new financial and supply chain management systems. We will be issuing our next High Risk list update in early 2021, which will include a detailed evaluation of VA's progress against our High Risk list criteria.

Question 2. In GAO's experience, is it common to have a bifurcated management of procurement as exists in VA with some duties falling to OALC and others to VHA? Does this division and duplication of effort create challenges?

Response: We have not completed the engagement work to answer this question explicitly. However, we have observed that some VA contracting organizations report to the Veterans Health Administration (VHA) and other organizations report to the Office Acquisition, Logistics, and Construction (OALC). For example, Network Contracting Offices, Regional Procurement Offices, and Program Contracting Activity Central ultimately report to VHA while offices such as the National Acquisition Center, Technology Acquisition Center, and Strategic Acquisition Center report to OALC. This structure could make it challenging to make VA-wide strategic acquisition decisions.

Question 3. What are the key considerations Congress should ask VA before moving forward with expenditure of hundreds of millions of dollars on the DMLSS/LogiCole transition?

Response: Congress might consider focusing on the following areas with respect to VA's planned transition to DMLSS/LogiCole:

1. Whether VA staff are receiving the necessary DMLSS/LogiCole training.
2. if DOD and VA have demonstrated that their respective data systems can successfully pass information back and forth, including between VA's financial system and DMLSS.
3. Whether the VA has developed a realistic schedule for implementing DMLSS/LogiCole across the VA and demonstrated a successful track record of meeting schedule milestones.

Questions for the Record
Responses by: Ms. Shelby Oakley, Director of Contracting and National Security Acquisitions GAO

Senator Kyrsten Sinema

Question 1. In the GAO report that added VA Acquisition Management to GAO's high risk list, it identified outdated acquisition regulations as a major problem. The report says that VA has been working to do a comprehensive update to its regulations since 2011. Do you have any indications about why this is taking so long?

Response: As we reported in September 2016, a senior VA acquisition official cited that several reasons contributed to the delay, including that the revision of VA's acquisition regulations had not previously been a high priority. We also reported that VA planned to finalize the update to its regulations by December 2018. While VA missed this timeframe, it has made progress in this area. For example, in June 2020, VA reported that 30 of the 41 parts in its new acquisition regulations had been issued as draft or final rules and that the remainder are at an earlier stage of the rulemaking process. In our 2019 High Risk report, VA indicated that it did not expect the final version of its acquisition regulations to be completed until April 2021, but that date, however, has since slipped until September 2021.

Question 2. The VA has several systems for procurement and several entities within its organizational structure overseeing these procurement processes. As VA continues modernizing VA's procurement processes, what reforms need to be made to the organizational structure to better streamline acquisition processes? Do you have any concern that the addition of the VA Regional Resource Centers will add to, rather than detract from the confusion?

Response: We have not completed the audit work to determine whether VA's efforts to streamline its logistics operations through Regional Readiness Centers will be an effective strategy nor whether VA's organizational structure presents challenges with respect to modernizing VA's procurement processes. We have not completed the engagement work to answer this question explicitly. However, we have observed that some VA contracting organizations report to the Veterans Health Administration (VHA) and other organizations report to the Office Acquisition, Logistics, and Construction (OALC). For example, Network Contracting Offices, Regional Procurement Offices, and Program Contracting Activity Central ultimately report to VHA while offices such as the National Acquisition Center, Technology Acquisition Center, and Strategic Acquisition Center report to OALC. This structure could make it challenging to make VA-wide strategic acquisition decisions.

Question 3. What lessons have been learned about improvements needed to cross agency communication and coordination regarding procurement, particularly for PPE and other medical supplies as a result of the COVID pandemic response and how do you anticipate these lessons will be addressed as VA modernizes its procurement processes?

Response: It will take the VA many years to put in place a modern supply chain management system that would position it to provide the most efficient and effective service to our nation's veterans. The pandemic reinforced the importance of having complete, real-time visibility of supply inventories across all 170 medical centers. According to senior VA acquisition and logistics officials, beginning in late February to early March 2020, VA requested that medical centers provide daily updates via spreadsheets to try to obtain the most real-time information possible on the levels of PPE on hand, usage, and gaps. The insight provided by these spreadsheets was not something that VHA leadership had in any type of ongoing or systematic way, prior to the COVID-19 pandemic. As of April 2020, VA has an automated tool to manage its reporting process, but the information must be gathered and manually reported by each of VA's 170 medical centers on a daily basis. During the hearing, VA officials expressed a willingness to explore expediting the implementation of DMLSS/LogiCole, which should allow for improved visibility of supply inventories.

Questions for the Record
Responses by: Michael McDonald, Government Operations Director, BusinessGroup, 3M Health Care

Ranking Member Tester

Question 1. 3M is a leading provider of personal protective equipment (PPE) and other medical supplies. In response to COVID-19, 3M is producing N95 masks both in the U.S. and overseas. Please provide a breakdown of the number of N95 masks produced in the U.S. and overseas. In addition, please provide a similar breakdown of other COVID-19 related PPE supplies, or other medical supplies provided to the VA, produced by 3M in the U.S. and overseas. Please provide both categories of the above information in pre-COVID-19 and during COVID-19 timeframes so that the Committee can see the changes to your operations both in volume and geographic location of production.

Response: Thank you for your question, Senator Tester.

3M is proud to be a leading supplier of personal protective equipment and other healthcare related products to assist not only with the current COVID-19 pandemic, but also to continue to enable the VA to better serve our nation's veterans.

3M has thrived as an American manufacturing company for 118 years and remains committed to the U.S. manufacturing industry and the communities in which we operate. 3M has nearly 20,000 manufacturing jobs in the U.S.— about half of our global manufacturing capacity resides in the U.S. and more than half our capital investment.

3M immediately responded to the pandemic in late January to maximize production at all our factories in the U.S. and around the world. 3M always has worked in partnership with the U.S. government, supporting the public health and government response to the pandemic.
3M is unique in that we have continued to expand our production of N95 respirators in the U.S. even as we opened other respirator manufacturing plants in other regions of the world to supply those regions.

3M is a supplier of several types of PPE and medical supplies to the VA, including disposable, reusable, and powered air-purifying respirators, hand antiseptic, and single patient use stethoscopes. Of these products, respirators – and N95s, in particular – are our most significant product category by volume. Specifically, over the past five months, 3M has supplied the VA with 1.8 million N95 disposable respirators. In addition, the VA has contracted with 3M for 25,000 powered air-purifying respirators (PAPRs) and approximately 25,000 elastomeric respirators.

In terms of production, since January, 3M has doubled its global output of N95s and other respirators to a rate of more than 1 billion per year at our global manufacturing facilities, including locations in the U.S., Asia, and Europe. In the United States alone, we have increased our N95 production rate from 22 million per month pre-pandemic to approximately 50 million today – and in October, we will be producing at a rate of 95 million per month. As a result, our annual United States production capability will ultimately be 1.1 billion per year, which is more than four times our pre-pandemic production level.

Since the pandemic began, 3M has delivered nearly 100 million N95 respirators to hospitals in the U.S. In addition, 3M has delivered more than 100 million respirators to FEMA and the U.S. Strategic National Stockpile.

3M is also increasing our supply of reusable respirators and powered air-purifying respirators (PAPRs) which are often suitable alternatives to disposable N95 or similar respirators, with substantial increases in the U.S. production of these products. Overall, by the end of 2020, we will have taken additional measures to double our N95 and other respirator capacity to 2 billion globally.

Question 2: Does 3M have a strategy for its production of PPE and other medical supplies, such as N95 masks, in the U.S. and overseas? If so, please provide it. Further, in light of COVID-19, is there a plan to change the balance of how much is produced in the U.S. and overseas?

Response: Thank you for your question, Senator.

As previously outlined, increasing our capacity in the U.S. is the most significant portion of this expansion, with our monthly production of N95s increasing from approximately 22 million per month (or an annualized rate of 264 million) pre-pandemic to 95 million per month (or an annualized rate of 1.1 billion) by the end of the year.

But as discussed during the hearing, U.S. and global demand for PPE continues to far exceed supply for the entire industry. 3M is working with governments, health agencies, distributors and others to prioritize supplies to the most critical customers and public health needs. These organizations take chain of custody of products from 3M manufacturing facilities and distribute the products according to need and demand they see from their customers.

As a global company, 3M has manufacturing operations to serve local and regional markets (e.g. "region-for-region"). As a result, 3M has global capacity to manufacture respirators and many other products around the world including in the U.S., Europe and Asia

In regard to our production strategy and plan, 3M has already doubled its global output of N95 and other respirators to a rate of more than 1 billion per year at its global manufacturing facilities, including in the U.S., Asia and Europe. Furthermore, by the end of 2020, we will have taken additional measures to again double our N95 and other respirator capacity to 2 billion globally, including 1.1 billion per year in the U.S.

Question 3. What policy changes would 3M like to see from Congress, the Administration, or other stakeholder that would encourage production of PPE and other medical supplies here in the US and support your ability to surge production in the US?

Response: Thank you for your question, Senator Tester.

Congress has been actively engaged in discussions regarding how best to encourage domestic production of PPE and other medical supplies, and 3M is strongly supportive of such efforts.

Proposals that have been discussed include:

- The ongoing use of DPA Title III funding to provide for domestic capacity expansion.
- The development of a new program, similar to Title III, to ensure continued federal support for domestic capacity expansion ever after a public health emergency has abated.
- Funding for advanced manufacturing technologies.
- Fully funding and reforming the Strategic National Stockpile (SNS) to ensure increased supplies of PPE and more predictable, ongoing demand for domestic production.
- Simplifying and expanding the R&D tax credit.
- Modernizing and simplifying the permitting process.
- Providing funding for job training and advanced manufacturing skills development.

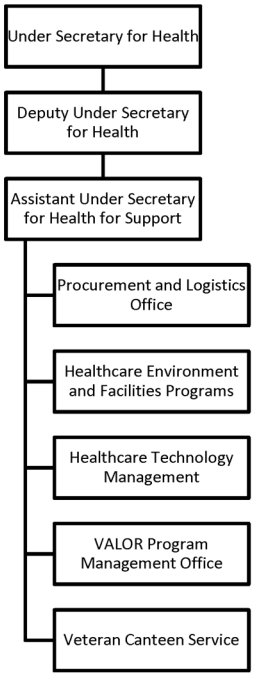
As a company that has maintained a strong manufacturing presence in the U.S. for more than a century, we are pleased to see so many proposals being actively espoused and considered.

Ultimately, a combination of policies that ensures the up-front costs associated with expanding production in the U.S. are globally competitive – and also ensures a robust market and demand for these products are maintained once the capacity has been expanded – will be critical to encouraging greater domestic production.

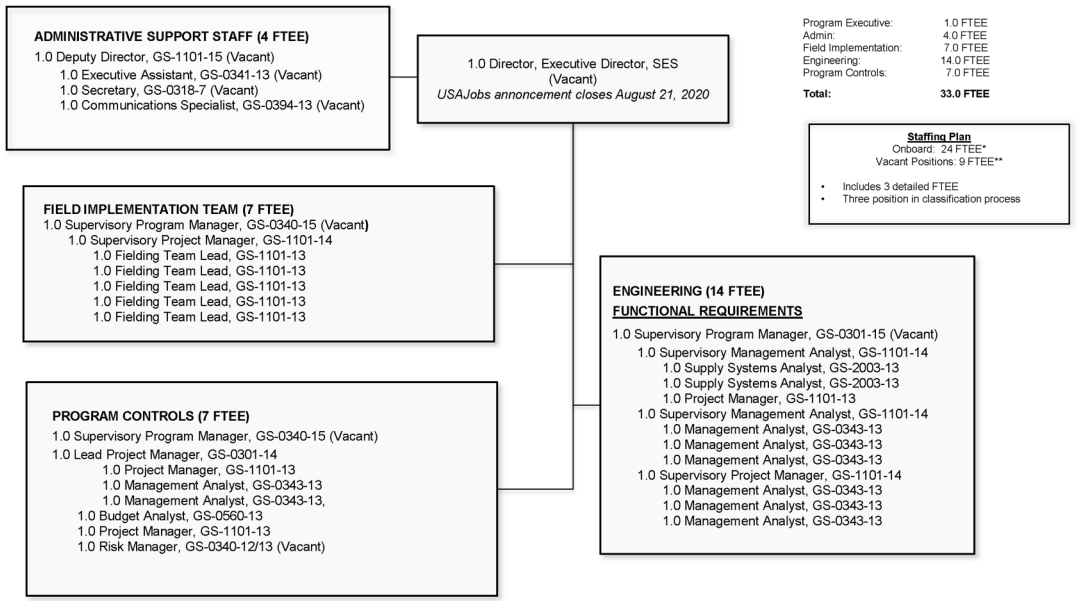
Of note, while many such proposals would be helpful in this regard, the DPA Title III program has demonstrated its effectiveness at rapidly expanding domestic manufacturing capacity. Accordingly, both support for an ongoing, robust Title III program – and the development of a similar competitive grant program post-COVID – could prove beneficial for encouraging and expanding domestic manufacturing capacity.

VA Logistics Redesign Goal and Objective Alignment	VA VALOR Goals			
	Modernize VHA healthcare logistics and support function IT capabilities in order to provide VHA staff with improved user experience and enterprise-wide standardized processes.	Modernize VHA healthcare logistics and support function IT capabilities in order to provide timely integrated internal customer support and optimize collaborative, high-performing and integrated delivery networks.	Modernize VHA healthcare logistics and support function IT to ensure accountability and transparency and deliver value to the Administration, Department, Veterans and Citizens.	Modernize VHA healthcare Logistics and support function IT to improve efficiency, management, oversight, governance.
VA PRIORITIES				
Customer Service	●	●	●	●
MISSION Act				
Business Transformation	●	●	●	●
Electronic Health Record Modernization		●	●	●
VHA PRIORITIES				
Restore Trust		●	●	●
Modernize Systems	●	●	●	●
Create a Learning Organization		●	●	●
VHA LONG RANGE GOALS AND OBJECTIVES				
GOAL 1: Make VHA the provider & care coordinator of choice for Veterans.		●	●	
1.1: Increase national recognition of VHA as a provider of high-quality health care services.		●	●	
1.4: Increase access to, and use of, a broad spectrum of services that support and encourage lifelong health and wellness.		●	●	
1.4.1: Increase customer satisfaction and experience by providing high-quality care and coordination.	●	●	●	●
GOAL 2: Deliver Comprehensive & integrated whole health care.		●		
2.2: Improve coordination, communication, and transparency across VHA Clinical Service Lines and Program Offices.		●	●	
2.2.1: Ensure am efficient governance structure and cooperative work across VISNs and Program Offices.				●
2.3: Enhancing continuity of care by strengthening and building relationships with internal and external partners.		●		
2.3.1: Foster information exchange and organizational alignment with DoD, Military and Veteran Service Organizations, academic affiliates, and other partners to play key roles in Veterans' health care delivery.		●	●	
GOAL 3: Innovate as a learning & teaching organization.	●	●	●	●
3.1: Transform VHA into a High Reliability Organization, building a culture of shared ownership. Accountability and collaboration.	●	●	●	●
3.1.1: Implement and embrace Just Culture principles and enable robust process improvement at all VHA facilities to achieve near-zero levels of harm.			●	●
GOAL 4: Increase the efficient & effective use of resources across the enterprise.	●	●	●	●
4.1: Modernize and enhance business and health information systems.	●	●	●	●
4.1.2: Transform supply chain.	●	●	●	●
FEDERAL HEALTH IT STRATEGIC PLAN GOALS AND OBJECTIVES				
2. Transform Health Care Delivery and Community Health	●	●	●	●
2B. Support the delivery of high-value health care		●	●	●
4. Enhance Nation's Health IT Infrastructure	●	●	●	●
4A. Implement the Nationwide Interoperability Roadmap		●		
4B. Protect the privacy and security of health and sensitive information.		●	●	
4C. Identify, prioritize, and advance technical standards to support secure and interoperable health information.	●	●		●
4D. Increase user and market confidence in the safety and use of health IT products, systems, and services			●	●
4E. Advance a national communications infrastructure that supports health, safety and care delivery		●	●	

VALOR Program Management Office is a Component of the Office of the Assistant Under Secretary for Health for Support



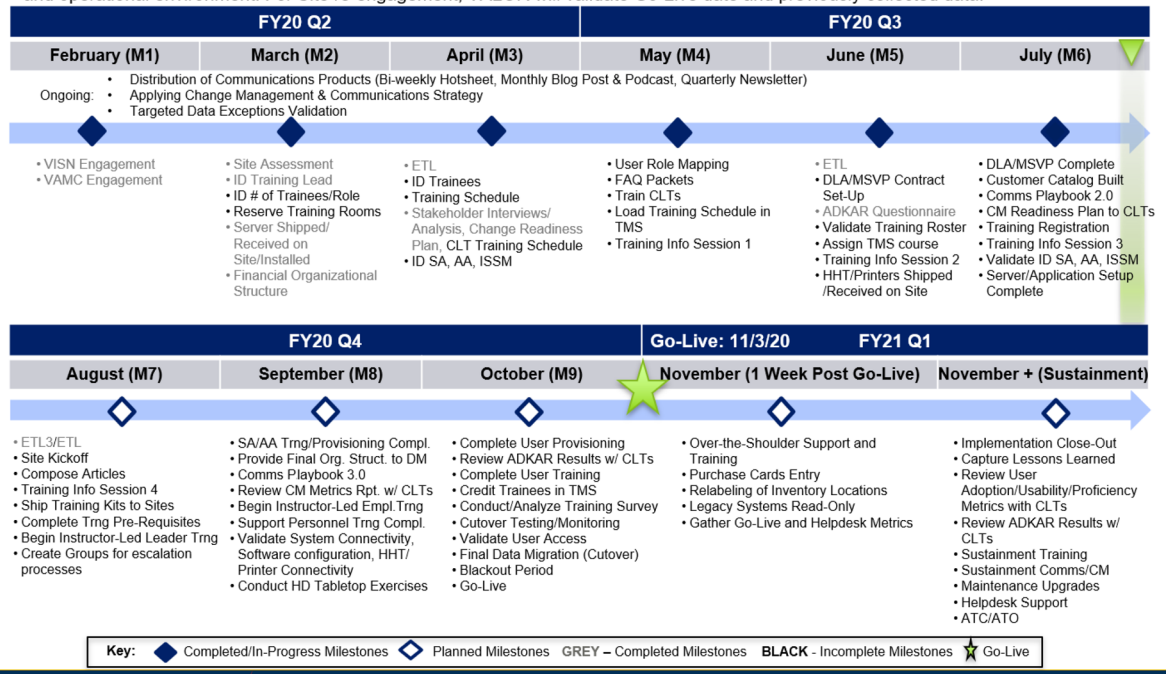
VALOR Program Management Office
Organization Chart with Existing Staff and Staffing Plan



This is the organization designed to support a 7-year fielding schedule.
VA is evaluating changes to organization and staffing required to support an accelerated fielding schedule.

Puget Sound Implementation

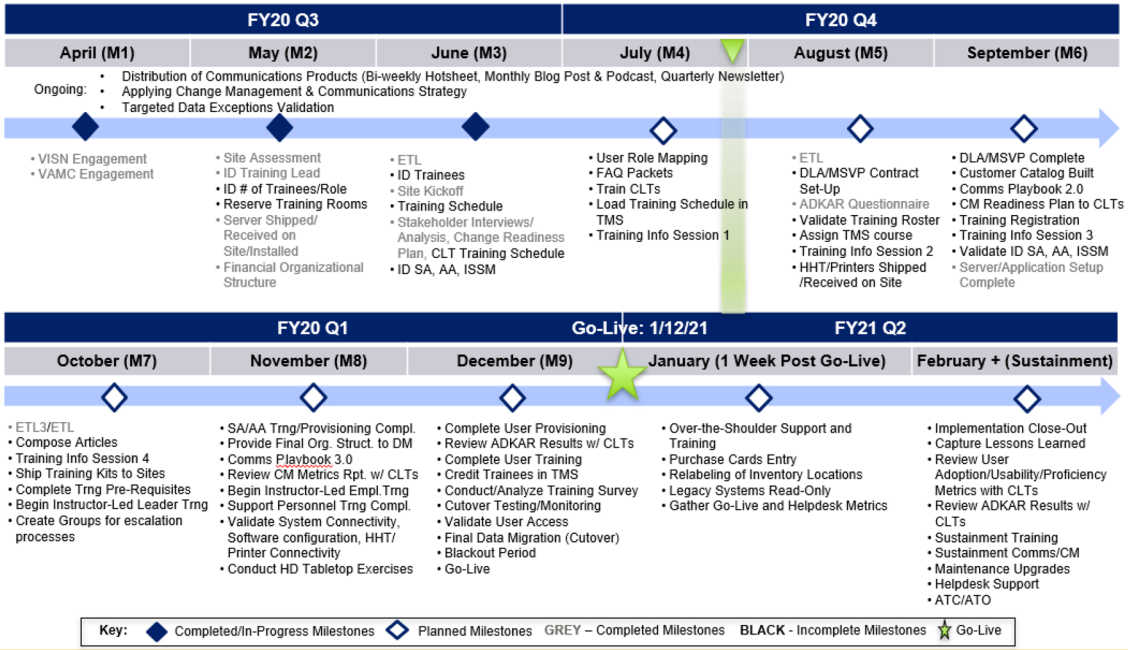
Prepare Functional Communities, Data and Technology to deploy Defense Medical Logistics Standard Support (DMLSS) within Puget Sound and operational environment. For Site re-engagement, VALOR will validate Go-Live date and previously collected data.



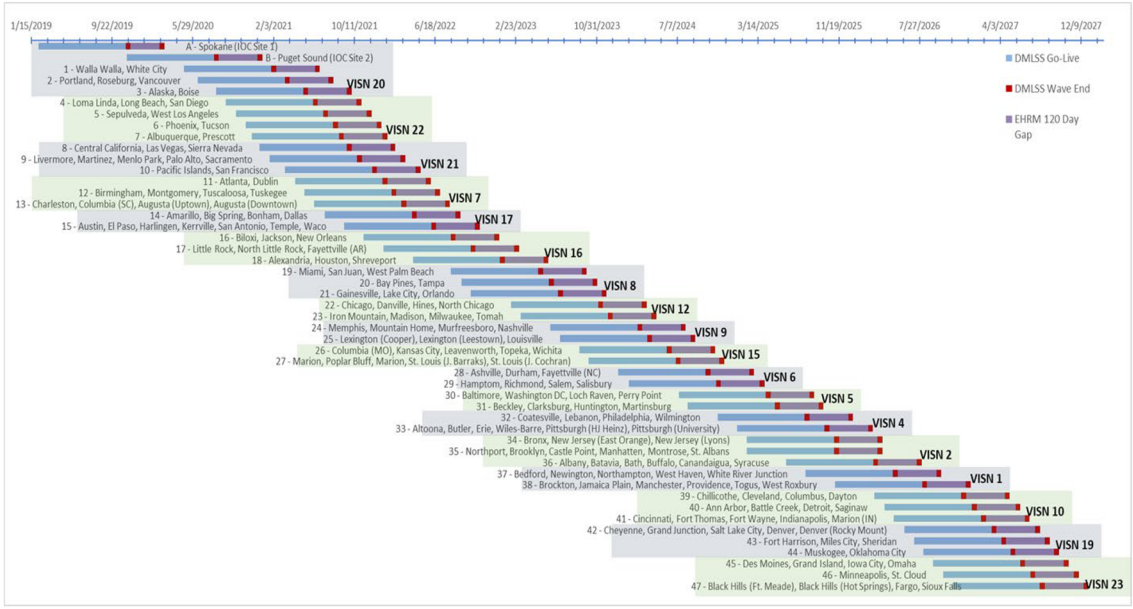
Key: Completed/In-Progress Milestones | Planned Milestones | GREY – Completed Milestones | **BLACK** - Incomplete Milestones | Go-Live

Spokane Implementation

Prepare Functional Communities, Data and Technology to deploy Defense Medical Logistics Standard Support (DMLSS) within the Spokane and operational environment. For Site re-engagement, VALOR will validate Go-Live date and previously collected data.

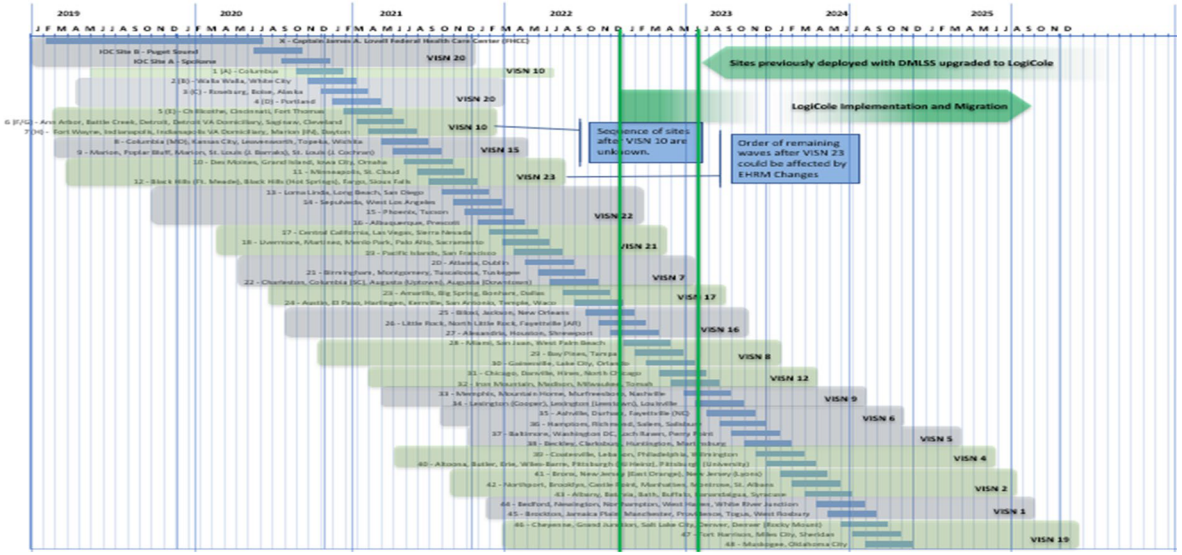


Defense Medical Logistics Standard Support (DMLSS)
Current 7 Year Deployment Schedule



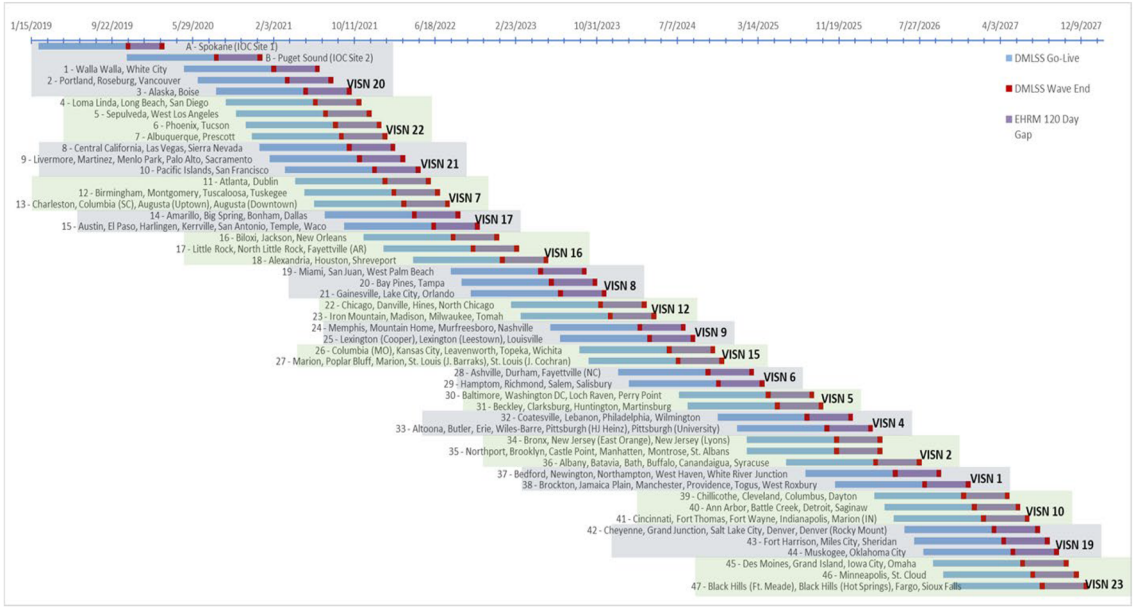
DRAFT DMLSS Accelerated Schedule

Schedule below assumes full funding, including transfer of COVID-19 funds and no delays due to COVID-19 disease surges.



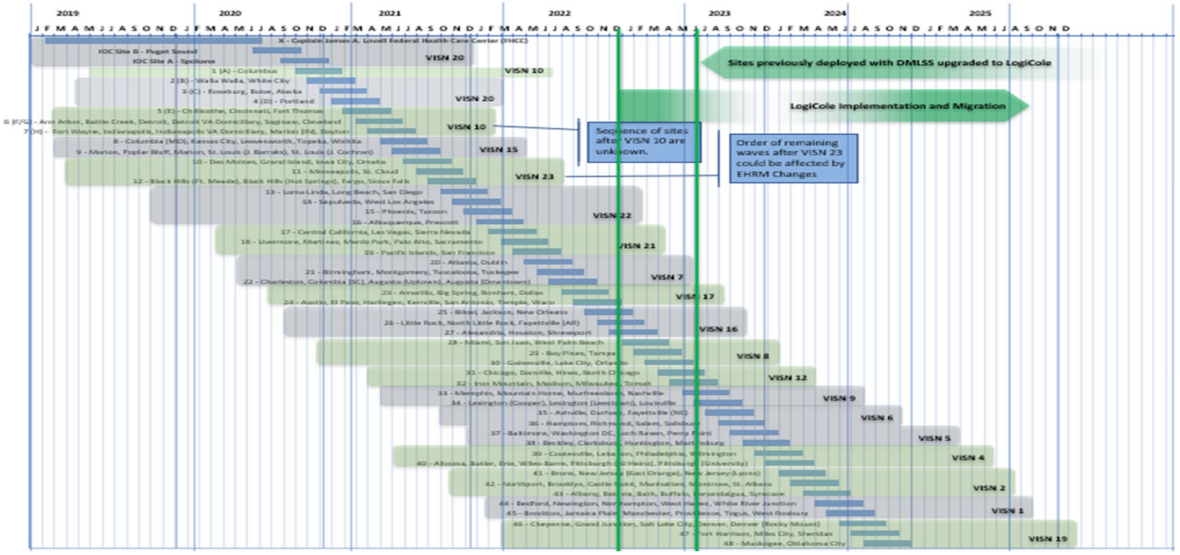
	PLANNED EFFORT	DEVELOPMENT	Period Of Performance	Spend through June 2020					
H-72-1	Balance Line								
H-72-2	Cloud N/A					In June Scope	Outside of June scope	Total	
H-72-3	Health Portfolio PMO and Technical Support- FFP (5%)	$ 1,839,250.00	8/23/2020 - 8/22/2021	n		15,529,503.25	6,691,035.50	22,220,538.75	
H-72-4	Health Portfolio PMO and Technical Support- T&M OP2	$ 741,844.55	8/23/2020 - 8/22/2021	n					
H-72-5	Health Portfolio PMO and Technical Support- T&M OP1	$ 1,300,000.00	01/30/2020 - 8/22/2021	y					
H-72-6	Technkal Support TISTA	$ 1,553,523.62	06/15/2020- 06/14/2021	y					
H-72-7	Technical Support OP2 OIT	$ 1,906,783.00	10/25/19- 09/27/2020	y					
H-72-8	Technical Support (BAH) OP 3 (12 Months)	$ 1,340,081.23	09/28/2020 -09/27/2021	n					
H-72-9	SLA Financial Service Center (FSC) Data Migration/ Cleansing	$ 930,000.00	12/01/2019- 09/30/2020	y					
H-72-11	IAT FMBT Part B (12 Months)	$ 3,628,647.48	06/01/2020 -05/31/2021	y					
H-72-15	Capital Region Readiness Center (CRRC) Standards and COTS Integration Platform (SCIP) Support	$ 455,000.00	09/30/2020- 09/29/2021	n					
H-72-16	JIRA SME Support	$ 107,159.00	04/21/2020 - 09/23/2020	y					
H-72-17	SLA Financial Service Center (FSC) Data Migration/Cleansing (12 Months PoP)	$ 3,000,000.00	01/01/2020- 12/31/2021	y					
H-72-18	Health Integration and Modernization Contract	$ 838,751.20	11/15/2020- 05/14/2020	n					
H-72-19	Health Integration and Modernization Contract	$ 1,861,638.40	04/25/2020 - 01/20/21	y					
H-72-20	VAEC Cloud AWS Four Point Technology	$ 92,102.55	01/15/2020 - 01/14/2021	y					
H-72-21	COMMs Contract Cognosante	$ 306,000.00	01/15/2020 - 01/14/2021	y					
H-72-22	OMNICELL Contract	$ 38,191.00	06/01/2020- 04/30/2021	y					
H-72-23	PAR-EXCELLANCE Contract	$ 50,000.00	06/01/2020- 04/30/2021	y					
H-72-25	JIRA SME Support OP1	$ 158,554.00	09/24/2020- 09/23/2021	n					
H-72-26	HTTs Procurement	$ 570,565.52	TBD requested for C/O	n					
H-72-27	EV SSL Certificates	$2,975.00	05/27/2020- 05/26/2021	y					
H-72- 28	Health Integration and Modernization Contract	$ 752,483.20	06/05/2020 - 01/04/2021	y					
H-72- 29	ZebraBar Code Scanners	$ 17,275.00	08/15/2020 - 10/31/2021	n					
H-72-30	Bar Code Printers	$ 4,085.00	08/15/2020 - 10/31/2021	n					
H-72-N	Proof of Concept for Virtualization SLAM DBP Platform	$ 30,000.00	09/15/2020 - 12/14/2021	n					
H-72-N	H&M Liberty Suppot	$ 695,629.00	09/06/2020 - 01/05/2021	n					
	Total								
	Amount:	**$ 22,220,538.75**							
	Obligated	**$ 19,584,263.00**							
	Committed	**$ 1,340,081.23**							

Defense Medical Logistics Standard Support (DMLSS)
Current 7 Year Deployment Schedule



DRAFT DMLSS Accelerated Schedule

Schedule below assumes full funding, including transfer of COVID-19 funds and no delays due to COVID-19 disease surges.



Veterans Health Administration
Moving Forward Together
Safe Care is Our Mission

COVID-19 TESTING IN VHA, v1.0

Contents

Document History Log

COVID-19 Screening and Testing is a living document that will be updated to reflect new guidance and resources. Below is the Document History Log of changes.

Document Type	Revision Date	Description
Baseline Release (1)	August 10, 2020	First version release

1. Summary

1.1. **Purpose**

1.1.1. This document provides a summary overview and update on VA's current guidance on testing across the healthcare system, for patients and staff, as well as additional considerations for local implementation.

1.1.2. The following VA guidance is now included in this document and will be updated as needed:

1.1.2.1. May 14, 2020 AUSHO: Guidance on Testing for Veterans and Employees

1.2. **Definitions**

1.2.1. The term "testing" refers to laboratory testing to determine the presence of the SARS-CoV-2 virus. Currently, most testing for active, or current, SARS-CoV-2 infection, is done with a viral test, such as polymerase chain reaction (PCR).

1.3. **How to Use**

1.3.1. The VA's *Moving Forward Together Plan* provides high level guidance on providing care during the COVID-19 pandemic

1.3.2. Guidance documents, including this one, provide more detailed information about how to implement *Moving Forward*

1.3.3. VA is currently in Contingency Status for PPE: DUSHOM Memo: *Update: Coronavirus (COVID-19) Return to a Contingency Strategy for Facemask and N95 Respirator Use*, published on April 16, 2020.

1.3.4. The VA's Moving Forward: *Prioritization for Consultations Procedures and Appointments, v3.0*, provides guidance on prioritizing patient procedures and appointments for many specialty areas in VA

1.3.5. Operational standards of care during a pandemic:

1.3.5.1. The Joint Commission defines conventional care as everyday healthcare services.

1.3.5.2. The Joint Commission considers a health care organization in contingency care status when demand for medical staff, equipment, or pharmaceuticals begins to exceed supply. Contingency care seeks functionally equivalent care, recognizing that some adjustments to usual care are necessary.

1.3.5.3. VA defines a crisis standard of care, as defined by the National Institutes of Health (NIH), as "a substantial change in usual healthcare operations and level of care it is possible to deliver, which is made necessary by a pervasive (e.g. pandemic influenza) or catastrophic (e.g. earthquake, hurricane) disaster. Additionally, the VA notes that civil rights protections remain in effect during emergencies, disasters, and pandemics. https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf

1.3.6. VISN and Facility Leadership should balance these, and other *Moving Forward* guidance, with local risk assessment, resource supplies, and local prevalence of disease.

2. Testing

2.1. **VA Testing Capacity**

2.1.1. Some VA facilities are in contingency status with testing supplies (see 1.3.5).

2.1.2. Diagnostic viral (molecular) testing (i.e., nucleic acid or antigen tests for SARS-CoV-2)

2.1.2.1. Generally available nationwide, although logistics including testing supplies and turnaround time may differ.

2.1.3. Antibody Testing (serology)

2.1.3.1. Interpretation and recommended frequency of serology testing is still being evaluated

2.1.3.2. VHA is evaluating COVID-19 antibody testing (also known as serology) to assess if an individual has been previously infected with SARS-CoV-2. It will take several weeks to validate and ramp up serology testing to levels that may serve large numbers of Veterans and employees. Facility participation with national validation efforts is encouraged.

2.2. **Testing Symptomatic Patients and Employees**

2.2.1. Symptomatic patients

2.2.1.1. The Centers for Disease Control and Prevention (CDC) recommends viral testing of individuals with signs or symptoms consistent with COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html

2.2.1.2. Rapid or in-house testing methodologies for symptomatic admitted patients, potential exposure situations, symptomatic employees who present with symptoms (particularly while in-house during their tours of duty) should be prioritized.

2.2.1.3. Consider testing for other viral infections (e.g., influenza, RSV, others), depending upon access to these modalities and what might be circulating in the community or the time of year.

2.2.1.4. For non-admitted symptomatic patients

2.2.1.4.1. Patients should be referred for second level triage per local process for determination of testing.

2.2.2. Symptomatic employees

2.2.2.1. Health care facilities should have a low threshold for evaluating symptoms and testing symptomatic employees after exposure to a suspected or confirmed COVID-19 patient. Symptomatic employees can request COVID-19 testing through Occupational Health (OH) or the OH designee at the VAMC facility, local health departments, or community resources.

2.2.2.2. **Testing of health care providers (HCP) with signs or symptoms consistent with COVID-19 should be prioritized for testing.**

2.2.2.3. Employees should not report in person to OH when ill. Instead, symptoms and history can be triaged over the phone with recommendations rendered for monitoring, testing, and work restrictions as applicable.

2.2.2.3.1. If an employee is found to have suspected or confirmed COVID-19, VHA and CDC criteria for exclusion and return to work recommendations, return to work practices, and work restriction recommendations can be found in the May 20, 2020 AUSHO Memo COVID-19: Updated Guidance for Return-to-Work Recommendations for Healthcare Personnel after

Exposure to Infection or with Confirmed or Suspected Infection from Novel Coronavirus 2019 (COVID-19)

2.3. **Testing of Asymptomatic Patients and Employees**

2.3.1. VHA can provide viral testing to Veterans and employees who are asymptomatic and request testing.

2.3.1.1. Availability may vary by facility or VISN based on its status with respect to testing supplies and/or PPE necessary to conduct testing.

2.3.1.2. Under this scenario do not use the rapid test method: reserve those supplies for Veterans and staff who have symptoms of COVID-19 (screen positive), Veterans admitted to the hospital and/or Veterans who are scheduled for surgery or certain high-risk procedures. Veterans and staff should be informed that test results may take several days.

2.3.1.3. Asymptomatic employees can request COVID-19 testing through OH, the OH designee, or through their VHA or private primary care provider.

2.3.1.3.1. Frequency of allowed testing should be determined locally based on volume of requests and test availability, and triage based on symptoms and/or exposure should be established.

2.3.1.3.2. If an employee is found to have suspected or confirmed COVID-19, VHA and CDC criteria for exclusion and return to work recommendations, return to work practices, and work restriction recommendations can be found in the May 20, 2020 AUSHO Memo COVID-19: Updated Guidance for Return-to-Work Recommendations for Healthcare Personnel after Exposure to Infection or with Confirmed or Suspected Infection from Novel Coronavirus 2019 (COVID-19)

2.3.1.3.3. HCP undergoing testing should receive clear information about:

2.3.1.3.3.1. the purpose of the test

2.3.1.3.3.2. the reliability of the test and any limitations associated with the test

2.3.1.3.3.3. who will pay for the test and how the test will be performed

2.3.1.3.3.4. how to interpret results and any next steps related to the results

2.3.1.3.3.5. who will receive the results

2.3.1.3.3.6. how the results may be used

2.3.2. As testing and PPE supplies allow, CDC currently states targeted SARS-CoV-2 testing of patients without signs or symptoms of COVID-19. These results might be used to identify those with asymptomatic or pre-symptomatic SARS-CoV-2 infection and further reduce risk for exposures in some healthcare settings. Depending on guidance from local and state health departments, testing availability, and how rapidly results are available, facilities can consider implementing pre-admission or pre-procedure diagnostic testing with authorized nucleic acid assays for SARS-CoV-2. Antigen testing is not currently recommended for this purpose. More information is available here:

https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html

2.4. **Pre- procedure Testing for SARS-CoV-2**
  2.4.1. VA's *Moving Forward Together: Guidance for Resumption of Elective Procedures, v2.0*, provides additional details on pre-procedure testing.

2.5. **Testing in Community Living Centers and Spinal Cord Injury and Disorder Units**
  2.5.1. Testing for Veterans and Staff in CLCs and SCID can be found on VHA HCI Preparedness Program SharePoint, and the June 11, 2020 DUSHOM: COVID-19: Guidance on COVID-19 testing for Community Living Centers and Spinal Cord Injury and Disorder Units

2.6. **Testing for patients with a tracheostomy or a laryngectomy**
  2.6.1. VHA's National Audiology & Speech Pathology Services recommends:
    2.6.1.1. For patients with a tracheostomy, testing should be done from both the stoma/trach via suction and nares by nasopharyngeal swab
    2.6.1.2. For patients with a laryngectomy, testing should be done from the stoma via suction and nares by nasopharyngeal swab
  2.6.2. Many VA labs may not be able to process a test for SARS-CoV-2 that is taken from a stoma/trach, or specimens collected by suction. If collected, those results may need to be sent out to an external lab that has the appropriate quality controls for processing these specimens.
  2.6.3. CDC currently recommends an upper respiratory tract specimen, such as nasopharyngeal (NP) or oropharyngeal (OP) specimen rather than a lower respiratory tract specimen

2.7. **Additional Considerations for Patient Testing**
  2.7.1. Test turn-around time; If the patient is tested at the time of the procedure, consider if the result will be back prior to the procedure
  2.7.2. The false-negative rate of testing, and if a negative test in a patient with suspected COVID-19 would change PPE or procedure considerations
  2.7.3. If the patient is recommended to self-quarantine between negative testing and procedure date to limit risk of interval exposure, is it possible for the patient to not encounter an exposure in that timeframe
  2.7.4. If the patient lives a distance from the VAMC or must take public transportation to get to the VAMC, consider if pre-procedure/appointment testing will be realistic/worth the risk
  2.7.5. If the patient is tested due to being considered high risk (predominantly symptom-based) and is positive, consider if the procedure or appointment would be postponed.
  2.7.6. Diagnostic, such as molecular or Antigen, testing is ordered based on clinical indication. Testing in most cases will refer to viral, or PCR, testing. Antibody testing may also be available. Generally, there is still limited data available on how to interpret antibody test results and how they should be used in patient management.

3. References

3.1. The following VA and CDC guidance is referenced in this document and is posted here:
  3.1.1. Moving Forward Together Screening Guidance

3.1.2. Moving Forward Together: *Guidance for Resumption of Procedures with Non-Urgent and Elective Indications*
3.1.3. Moving Forward Together: *PPE in Ambulatory Care Settings*
3.1.4. May 1 AUSHO Memo: Update: Coronavirus (COVID-19). Mask Use in Veterans Health Administration (VHA) Facilities
3.1.5. May 20, 2020 AUSHO Memo: COVID-19: Updated Guidance for Return-to-Work Recommendations for Healthcare Personnel after Exposure to Infection or with Confirmed or Suspected Infection from Novel Coronavirus 2019 (COVID-19)
3.1.6. June 11, 2020 AUSHO Memo: COVID-19: Guidance on COVID-19 testing for Community Living Centers and Spinal Cord Injury and Disorder Units
3.1.7. CDC Guidance: Interim Infection Prevention and Control Recommendations
3.1.8. https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-us-settings/hcf-visitors.html

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