Written Statement of:

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Presented to:

The Honorable Jerry Moran
Chairman, Senate Veterans' Affairs Committee

The Honorable Jon Tester
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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 NOT to 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. This type 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 of failure. 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 and is 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 to be 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 enable VACO 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 is done.

Finally, if there is one other factor that impacts the effectiveness of the supply chain within VHA, it is the onerous 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.

Honorable members of the Senate Veterans' Affairs Committee, thank you for your time.