

TOPIC OUTLINE: CONTRACTING

Transform contracting services to create a more flexible and responsive approach [system?] to supporting business operations across VHA.

Background

Contracting described.

Contracting touches on most activities and processes across the enterprise. List some of these that are relevant to the Commission's work:

- Integrated local VA and non-VA provider networks
- IT systems development
- Facilities construction and leasing
- Support services contracts

Effective contracting is essential to a successful transformation. The future of the VA health care system depends on an effective and efficient contracting capability.

What is the essence of the problem that needs to be addressed?

Findings

Together, VA and VHA have 28 entities involved in aspects of contracting in some way. There are 4 contracting entities within VA – the Strategic Acquisition Center (SAC) and the Technology Acquisition Center (TAC) that sit within OAO, and the National Acquisition Center (NAC) and Denver Acquisition and Logistics Center (DALC) that sit within OAL. There are 24 contracting entities within VHA for the medical supply chain – 21 Network Contracting Offices (NCOs) that establish contracts for each VISN and three Service Area Organizations (SAOs) that establish contracts on behalf of multiple VISNs. The SAOs are geographically aligned to the western, central, and eastern regions of the country. (IA J- pg IX)

The assessment team's analysis showed that there are several areas of overlap between VA and VHA overall, between national and regional contracting organizations, and between the four VA-level contracting organizations, particularly the NAC and SAC. Senior leaders in VA's and VHA's supply chain organizations who were interviewed unanimously said that the current organizational structure is too complex and should be simplified. Several interviewees described tension between some of the groups involved in supply chain management. Others described a vacuum of ownership and accountability because of the organization's siloed and fragmented structure as well as lack of clarity on roles and responsibilities. (IA J- pg IX)

The performance of VA's contracting organization does not meet customers' expectations, so frontline staff have developed workarounds: Ninety one of 122 interviewees we spoke to regarding contracting for clinical supplies and medical devices, including contracting leadership, expressed concerns about the proliferation of VA contracting organizations or their ability to collectively meet performance needs of the organization. When the assessment team asked clinicians, logistics staff, and facility administrators to identify three areas they would most like to improve, speed and responsiveness of contracting was almost always one of their recommendations. (IA J- pg X)

As a result of the ongoing contracting challenges, frontline staff reported that they had developed two interrelated workarounds to avoid using contracting. First, they try to buy the majority of their clinical supplies and devices on VA-issued purchase cards because this gives them more autonomy to choose the products they want and to buy through their preferred channel (for example, directly from a manufacturer or through a local distributor). Second, they try to ensure that any orders placed (regardless of payment mechanism) are below the \$3,000 micro purchase threshold that would trigger involvement of contracting. **As a result, approximately 98 percent of VA's purchases of clinical supplies are made on purchase cards, which accounts for around 75 percent of VA's spend on that category (VA, FY2014a).** Ninety-seven percent of VA's clinical supplies and prosthetics purchase orders are below \$3,000, although this only accounts for 59 percent of the total spend for those categories (VA, FY2014a; VA, FY2014c). Data also confirmed that a disproportionately high number (two to three times the expected number) of purchase orders for clinical supplies are within \$500 of the micro-purchase threshold (\$2,500 to 3,000) (VA, FY2014a). (IA J- pg XI)

Use of purchase cards is encouraged in Federal Acquisition Regulations (FAR), partly because their use reduces the need for contracting to make multiple small-value awards. However, their use limits VA's ability to ensure compliance with government contracting regulations because purchase card holders are responsible for identifying appropriately priced goods and contracted vendors, and VA's current systems do not support these tasks with integrated catalogs and controls. **This likely leads to higher than necessary prices paid for goods.** (IA J- pg XI)

Purchase card purchasing processes are also inefficient when compared with modern alternatives, such as electronic order transmission and funds transfer. Purchase card holders are required to maintain appropriate documentation and to reconcile purchases. Electronic ordering and payment can automate reconciliations, reduce errors, and also enable automatic reordering based on utilization forecasting. (IA J- pg XI)

Our analysis confirmed issues with the responsiveness of contracting. For example, at one facility, if a request was submitted to contracting that was incomplete or inaccurate, it took on average 21-39 days from the date of initial submission to receive the first response from contracting requesting, for example, additional information or paperwork (VAMC site visit, 2015).

During site visit interviews we heard that **VA vendor contracting processes regarding ordering equipment valued at less than \$3,000**, for example, scalers for dentistry, can be confusing and lengthy, **leading to shortages in equipment and delays in clinic** as equipment is located. Delays in sterile processing was also indicated by providers as an issue pertaining to equipment availability. (IA G- pg 91)

VHA customer surveys show that communication from contracting is another area for improvement. **Of all the dimensions assessed in surveys of contracting users (included on all email communications by contracting), communication received from contracting officials scored lowest by customers** (3.3 average NCO score out of 5, ranging from 2.7 to 4.0 for overall communication effectiveness and 2.8 to 3.8 for status updates) (VHA, 2015a). Several interviewees recommended that VA provide more clarity on the status of a contracting request to help them plan and schedule care. (IA J- pg X)

Conversely, individuals in contracting believed that VAMC staff were responsible for some of the delays in the contracting process. **They reported that requests submitted to them from VAMCs were often incomplete or unclear and that facilities were poor at forecasting demand for items, leading to unpredictable peaks in demand for contracting services that exceeded their capacity.** PLO and facilities are seeking to address these challenges by placing Contract Liaisons in facilities to better support Contracting Officer Representatives throughout the process (VHA Assistant Deputy Under Secretary for Health Administrative Operations, 2014). (IA J- pg X)

In addition, contracting compliance analysis showed significant opportunity for improvement. Analysis of purchase order data showed that **38 percent of purchases were made on a government contract**, 27 percent were made at open market prices, and 34 percent did not have a source type specified (VA, FY2015). **Private sector organizations typically aim to buy 80-90 percent of their clinical supplies and medical devices on some type of negotiated contract** (High performing health system interviews, 2015). (IA J- pg XII)

Interviews and observations revealed that there are two primary reasons for VA's relatively high share of open market purchasing. First, in contrast to pharmaceutical purchasing, VA's supply purchasing systems are not integrated with contract or pricing catalogs. Therefore, the purchasing process relies on buyers (often clinical staff) to research whether an item is on contract and through which contract a purchase should be made. Because of that complexity, several buyers reported that they bypass this step and buy products through the channel that is most familiar and convenient, for example, by replicating previous orders to their usual supplier, despite changes that may have occurred (new contracts and pricing arrangements, for example). Second, VA has limited ability to monitor and drive compliance with the contract hierarchy because the required data is not captured electronically. In fact, over 60 percent of all clinical supply items do not have a contract number listed (VA, FY2014a). (IA J- pg XII)

There are pockets of good performance and innovation in VA that could be replicated across its supply chain: The Denver Acquisition and Logistics Center (DALC) is a bright spot within VA's supply chain organization in its acquisition and distribution of select devices such as hearing aids to Veterans. **It has developed an integrated operating model that brings together clinicians, contracting, finance, logistics, and program management.** That integrated team makes decisions around product and supplier selection based on a holistic view of what is best for Veterans and for VA. (IA J- pg XIII)

Additionally, contracting and other supporting entities should be accountable and equipped to support a fast-paced project environment and facilitate the needs of construction projects and leases. (IA K- pg VIII)

VA leasing contracts are typically favorable to VA, but are often not enforced. While VA does an excellent job negotiating tenant favorable terms while typically remaining within benchmark rental rates, these favorable terms are often not enforced. When VHA staff identify concerns about the quality of a facility, contracting staff may not enforce these terms with lessors, given skill and capacity constraints. (See Section 8.2.1.3) (IA K- pg 23)

Given the different reporting structures, there are different views in the organization on who is the overall project owner (for example, Project Manager, Senior Resident Engineer, Contracting Officer) and who is accountable in the different project phases (for example, Design, Construction, Activation). Based on CFM manuals, Project Managers are effectively responsible for overall project goals. However, they lack formal authority over the other key figures in project teams (for example, Resident Engineers and Contracting Officers) and according to interviews they do not feel empowered for fast and effective decision making. (IA K- pg 119)

There Are not Consistent Staffing Guidelines for Major Projects That Consider Size or Complexity of Projects. There is not a clear policy that sets project staffing guidelines for major projects. Currently, there is not visibility on how critical project factors such as volume or project technical complexity are factored in to design project teams.

It has also been shared during VA stakeholder and expert interviews that VA project staffing levels are significantly below other major agencies (such as USACE, NAVFAC), especially in the Resident Engineer and Contracting side. In some projects, the relationship of CFM staff to Contractor is above 1:10, and project managers could oversee portfolios of approximately \$1 billion. This situation limits the ability of CFM staff to address all issues identified in the field, thereby impacting project execution timelines. (IA K- pg 119)

The contracting organizations are overwhelmed and burdened by complex approvals and struggle to effectively manage construction and leasing contracts. Interactions between the contracting organizations and their customers (for example, VAMCs) are reported as ineffective by both parties, as also discussed in Assessment J. CFM contracting officers (COs) manage contracts for major construction and leases, while all other construction, leasing, and maintenance contracts are executed by VHA Network Contract Offices (NCOs) which are aligned with, but do not report to, VISNs. Both of these organizations face challenges including a heavy workload, a lack of training for the complexities of construction and leasing contracts, and lack of integrated involvement of the contractor and customer throughout the process. Some interviewees cited that COs cover double the contract volume as counterparts in the government, have not been effectively trained to cover the complexities of construction and leasing contracts, and due to the low approval authority given to most COs must pass leases through high levels of oversight which delay programs. (See Sections 5.2.2.4, 6.2.3.4, and 7.2.3.1) (IA K- pg 21)

Alabama VAMC: The local team created an online tracker system with electronic signatures to monitor different approvals and contributions to RFIs and contracting packages. The system allowed the organization to have visibility on bottlenecks and have performance dialogues on how to optimize response times and time to approvals. (IA K- pg 140)

VISN 4: This VISN takes a long term strategic approach to the implementation of its NRM program by using a rolling plan to strategically prioritize projects VISN-wide across fiscal years. With this system, the capital team can develop contracting packages in advance of the next fiscal year, using the historical funding levels as a predictor the volume of projects which will be funding in the coming fiscal year. This enables projects to be ready for award during the first quarter of the fiscal year, increasing the likelihood that projects will be completed as scheduled. As a result, VISN 4 is a leader in the amount of funds obligated for NRM projects, though it should be noted that this has not improved their construction execution timelines. (IA K- pg 140)

VA's fragmented inventory management systems and processes also create challenges. VA's current inventory management does not have a feedback loop that links inventory to product utilization, contracting, ordering, and vice versa. This prevents optimal utilization of the Medical/Surgical Prime Vendor (MSPV) program and missed opportunities to establish more effective volume-based national or regional contracts. It also leads to peaks and troughs in demand for contracting services, which can overwhelm contracting's capacity. (IA J- pg XIII)

Conclusions:

In contracting, compliance often trumps performance. Successful compliance does not always lead to successful outcomes.

VA/VHA lacks integrated support services teams comprised of multiple functions (IT, contracting, HR, etc.) focused on the same outcomes.

Its contracting processes are bureaucratic and slow, which can delay Veterans' access to care. Purchasing processes are cumbersome, which has driven VHA staff to workarounds and exacerbates the variation in prices VA pays for products. Utilization is difficult to measure or manage given lack of data, which likely leads to significant avoidable expense for the VA. (IA J- pg V)

Enabling Requirements:

- Transform and consolidate VA's entire medical supply chain organization Rationalize the organizational structure by consolidating entities into one integrated supply chain organization that manages all VA contracting and logistical management of clinical supplies and medical devices.

- Establish robust performance management of supply and device procurement that is focused on Veteran outcomes
- Develop deep category-level expertise within the organization

(IA J- pg XIV)

- Streamline, standardize, and integrate key supply chain management processes
Expedite product selection and standardization in key product categories
- Rationalize contracting requirements wherever possible and provide VAMC-level staff with access to contracting status
- Standardize and simplify purchasing processes by automating wherever possible, linking inventory management systems to ordering systems, and driving greater use of electronic order entry
- Systematically identify, collect data from, and propagate innovations across VA
- Transform the Contracting Organization to Align Contracting and Contract Modifications Approvals Processes to a Fast-Paced Environment (IA K- pg 128)

This would include:

Conduct an effort to map and streamline major processes and systems within the contracting organization (for example, approval processes for contract modifications, response for RFIs) to increase agility of the decision making process and alleviate current workload levels.

- **Consider increasing warrants on site for faster decision making:** Increase skill requirements and warrant levels for SREs. For example, other delivery organizations required all SREs to have Professional Engineering Licenses and level 2 contracting warrant to reduce workload for contracting officers.
- Adequately staff projects with contracting officers and support teams to ensure contract compliance and rapid response, including on-site teams for mega projects.

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Implementation

Legislative Changes

- The Legislative Changes subsections will be presented as bulleted lists. If there are no legislative changes needed, this section will include one bullet that state, “None required.”
- The lists will identify will any changes to the U.S. Code that must be made for the recommendation to be implemented.

VA Administrative Changes

- The VA Administrative Changes subsections will be presented as bulleted lists. If there are no VA Administrative changes needed, this section will include one bullet that state, “None required.”
- The lists will identify will any changes to VA Administrative required for the recommendation to be implemented.

Other Departments and Agencies

- The Other Department and Agency Administrative Changes subsections will be presented as bulleted lists. If there are no Administrative changes for other departments or agencies needed, this section will include one bullet that state, “None required.”
- The lists will identify will any changes to policy for other Departments or Agencies required for the recommendation to be implemented.