Written Testimony for the Record

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Chairman Takano, Ranking Member Bost, and members of the committee, thank you for the opportunity to discuss the lessons we learned as we led the Veterans Health Administration (VHA) through the initial eighteen months of the COVID-19 pandemic. We welcome the opportunity to support the ongoing bipartisan work of this committee as it considers how best to prepare for the next public health challenge that may place veterans and other Americans at risk. The opinions we express are our own and do not necessarily reflect the positions of our current or former employers. We are here as private citizens and former senior government leaders who care deeply about our nation and its ability to handle crises.

Let me begin by recognizing the extraordinary heroism of our nation's frontline healthcare workers, and specifically the 363,000 employees of the VHA. Since the beginning of the pandemic, these outstanding men and women have been at the bedside of millions of veterans and have consistently volunteered to serve non-veterans severely infected with the COVID-19 virus. Their contributions individually and collectively have saved lives and demonstrated the remarkable skills VHA employees possess in the care of critically ill patients. Each one is a hero in their commitment to care for America's veterans and citizens in need. Sadly, more than 250 VHA employees have lost their lives to COVID-19, and many more lost family members. I appreciate you joining me in honoring them and continuing the hard work we have ahead of us.

I want to draw attention to three areas that we as leaders of America's largest health care system faced in the pandemic, broadly defined as interagency coordination, supply chain risks, and the management of State Veterans Homes. We recommend that this committee and other government leaders consider changes in these areas as America prepares for future public health challenges.

First, the National Security Act of 1947 established the current security structure that responds to national defense threats. It was not until 2012 that the Biodefense Act ordered both the creation of a national biodefense plan and also ordered the establishment of a position on the National Security Council for biodefense expertise. Unfortunately, this change did not mandate the unified governance that is needed to facilitate an agile federal response to public health threats. This lack of unified governance, with clear lines of authority resulted in substantial delays in the delivery of much-needed federal health support to overwhelmed private sector health systems. The current approval process is not responsive or agile and should be restructured.

We strongly recommend that interagency governance of health emergencies be reexamined to ensure there is a rapid, unified, and transparent federal health care response to the provision of much needed support to communities. We recommend that Congress consider that the recently expanded authorities of the renamed Administration for Strategic Preparedness and Response at HHS (the former ASPR) be the coordinating administration with appropriate authorities to create the tools to not only vet requests for health care support, but also to ensure all accepted support missions are accomplished successfully.

Second, profound risk occurred within America's medical supply chain during the pandemic. This happened due to the significant amount of

non-US manufactured consumable and pharmaceutical products necessary to deliver health care support during this emergency. In our opinion, although the causes of this situation are complex, the lack of a healthy domestic manufacturing base for these products and many essential pharmaceutical agents constitutes a fundamental national security risk and should be addressed with urgency. The general acceptance of overseas pharmaceutical manufacturing for essential medications to manage chronic and acute disease fails to recognize that even America's closest allies will provide limited-availability medications and materials to their own citizens before meeting any contractual demands to provide them to Americans. There are over 100 high use pharmaceutical products that are simply not produced domestically but are essential to the care of common diseases such as diabetes. These drugs are therefore vulnerable to global supply change disruptions.

There is a model for mitigation of this risk. The DOD war reserve management, or "War stopper" program, mandated the formation of a program to create a domestic industrial base for essential materials used primarily in war time. Congress created this program after recognizing the war reserve material shortages during the 1991 Gulf War in which America and its allies found themselves unable to obtain essential items.

These "War stopper" items, such as nerve agent antidotes, are now closely managed and domestic-based manufacturing and storage is assured. Similar models of manufacturing and materiel stockage are possible for both Personal Protective Equipment (PPE) and pharmaceuticals. We cannot overemphasize the importance of guaranteeing the safety and protection of Americans, particularly healthcare workers, during future disease occurrences or pandemic responses.

Finally, we strongly recommend that this committee re-examine the authorities that VA possesses to correct operational and safety deficiencies in state-run veteran nursing facilities. As you are aware, more than 8,000 of America's veterans reside in VHA-run extended care facilities, but more than 25,000 veterans reside in state government-operated nursing facilities, and VHA funds substantial reimbursement for the construction and operation of these facilities. VHA also inspects these facilities and, during the pandemic, these unfortunately became our most vulnerable populations. It is a matter of public record that there was inadequate staffing, infection control protocols that were not followed, and a shortage of consumable supplies. The high death rate in these facilities should generate significant reexamination of the relationship of these facilities to VHA. The VHA found itself supporting many state-owned and operated facilities, as well as commercial nursing homes, across the nation, because of our experience in both eldercare and infection control. Unfortunately, VHA does not possess the authority to make operational changes to state veteran homes or to mandate those standards to help ensure Veteran safety. We therefore recommend that the committee examine the authorities VA possesses to help correct deficiencies at state-run veteran homes, particularly when these facilities fail the regular inspections by VHA. These authorities should also consider whether the VHA could assume temporary management of those facilities where deficiencies place veteran lives at risk.

In closing, I want to reemphasize the commitment of the VHA team to this response. More than 6,000 of VHA's employees have volunteered for missions to support commercial, state owned and operated, and tribal health systems, who were short on essential staff and professional expertise. Many others volunteered to travel to other VHA facilities across the nation to support Veterans as surging cases of

COVID-19 occurred. These were not just doctors and nurses; they were engineers, maintenance and food service workers, law enforcement professionals, and more. We must not forget the human toll that fighting and defeating this deadly disease took on our people, their families, and communities.

I will end with a note of thanks and a recognition of the bipartisan work of this committee and its staff that was so essential to our success during the pandemic. The significant funding of our emergency response, contained in the CARES Act at the beginning of 2020, the early provision of those funds, and the vision of the bipartisan leaders and committee members, are a testament to good governance. Thank you for being the partner that we needed to save every life we could.

That concludes our statement. We welcome your questions and look forward to working with you over the months and years ahead.