

**VA LOGISTICS MODERNIZATION: EXAMINING THE
RTLS AND CATAMARAN PROJECTS**

HEARING

BEFORE THE

**SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS**

OF THE

**COMMITTEE ON VETERANS' AFFAIRS
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VA LOGISTICS MODERNIZATION: EXAMINING THE RTLS AND CATAMARAN PROJECTS

Tuesday, May 8, 2018

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON DISABILITY ASSISTANCE
AND MEMORIAL AFFAIRS,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 2:08 p.m., in Room 334, Cannon House Office Building, Hon. Jack Bergman [Chairman of the Subcommittee] presiding.

Present: Representatives Bergman, Poliquin, Dunn, Arrington, Rice, Peters, and LAMB.

OPENING STATEMENT OF JACK BERGMAN, CHAIRMAN

Mr. BERGMAN. Good afternoon. This hearing will come to order. Please have a seat.

I want to welcome everyone to today's hearing on VA's efforts to modernize its medical supply chain.

Ordering, stocking, and locating medical equipment and supplies are fundamental to VA's mission of providing medical care to our veterans. Unfortunately, these logistics functions seem to have degenerated in recent years. We read about them in the press on a regular basis.

The Real-Time Location System, or RTLS, and Catamaran point-of-use projects were conceived as technological leaps forward, enabling VA medical centers to manage logistics more efficiently. Catamaran was intended to replace the 25-year-old Generic Inventory Package, or GIP, VA's primary inventory system. Catamaran included modern point-of-use capabilities and analytics tools. And a \$55 million contract was awarded in September 2013, with a potential value of \$275 million.

Expectations were high, and VA began pilot implementations in 22 facilities, including Pittsburgh and Washington, D.C. Unfortunately, early results were overwhelmingly negative. In Pittsburgh, users reported the software was plagued by login failures, slow loading times, malfunctions, and problems integrating with VistA. Catamaran was generally cumbersome and inefficient, not any better than the existing inventory system.

In 2015, the Pittsburgh medical center decided to revert to GIP. That eventually happened, after the VA central office originally ordered Catamaran to remain in place but eventually relented.

Meanwhile, in Washington, D.C., Catamaran was similarly unsuccessful. The Office of Inspector General has demonstrated that,

unlike in Pittsburgh, the D.C. medical center's logistics operation was already in disarray before Catamaran came along. The staff had largely abandoned GIP and fallen into a pattern of tracking inventory manually, in a disconnected fashion, in various areas of the hospital.

It remains a matter of debate to what extent Catamaran was ever used in D.C. up until VA halted the project and terminated the contract in August of 2016. What is clear is Catamaran was a harmful distraction. OIG has reported that logistics at the D.C. medical center got worse due to a variety of factors in 2015 and 2016 during the Catamaran implementation that occurred.

The Subcommittee has determined that logistics operations are actually in worse shape today than they were before Catamaran began. I hope to determine the reasons for this today.

I will now turn to the Real-Time Location System, which is still ongoing.

The RTLS project entails attaching radiofrequency identification tags to a range of medical equipment, some supplies, and surgical instruments in the catheterization lab and the sterile processing department. With RTLS, VA aims to count and track the physical locations of these assets in real-time on one computer screen.

VA awarded the RTLS contract, which originally had a potential value of \$543 million, in June of 2012. After a series of modifications, the contract is scheduled to end next month.

An initial pilot in VISN 23, in the Northern Great Plains, very quickly became an implementation throughout nearly the whole country, before test results had ever come back from VISN 23. The test results in March 2015 were troubling. There were over 200 defects, and the RTLS could only track equipment accurately 40 percent of the time.

This led to conflict between VA and the contractor. Specifically, VA threatened to terminate the contract if a satisfactory corrective action plan was not produced. Over a year later, in June 2016, there were still almost 50 defects. The contractor blamed VA's inadequate WiFi, and VISN 23 withdrew from the project.

According to the OIG, there were also cybersecurity deficiencies. The contractor connected RTLS to VA's network before receiving authority to operate.

In September 2016, VA and the contractor signed a global settlement agreement that remains sealed. I requested a copy on April 12, and VA has so far declined to provide it. But what we do know is that the contract was extended through June 2018, its requirements were significantly reduced, and the contractor was released from any liability for its performance up to that point.

The facilities slated to receive the RTLS asset tracking capability, its main component, were cut from 92 to 47. The facilities scheduled to receive RTLS in the catheterization labs and sterile processing departments were also pared down. The temperature monitoring component of RTLS was almost completely eliminated. Today, VA still has a significant amount of work to do to meet even these reduced goals.

The question before us today is: What should be done with the RTLS program, how much has been spent, and what has the VA gotten for the money? The goalposts have been lowered, but can

they be met? And how much additional investment will that require? The contract's expiration is only weeks away.

I now yield to Miss Rice, who has graciously agreed to fill in for Ranking Member Kuster, for any opening statement or remarks she may have.

OPENING STATEMENT OF KATHLEEN RICE, ACTING RANKING MEMBER

Miss RICE. Thank you, Mr. Chairman.

Good afternoon. And I want to thank the Chairman for holding this important hearing. I also want to thank all of our witnesses for coming here today.

I continue to be alarmed at the number of mismanaged and failed information technology programs at VA. Attempts to modernize VA's IT infrastructure always seem to hit implementation roadblocks, cost overruns, and result in products that are unusable for the frontline employees entrusted with delivering health care and benefits to our veterans. It is not surprising that IT is one of the five areas of concern GAO identified when it decided to place the Veterans Health Administration on its high-risk list.

In its testimony today, the Office of Inspector General yet again finds that VA faces significant challenges in managing its IT development projects. Whether it is VA's inability to manage its medical supply inventory at the Washington, D.C., VA Medical Center, too many false starts on an interoperable electronic health record with DoD and now the delayed signing of the contract with Cerner, or even delayed deployment of the caregiver IT system, it seems VA witnesses frequently shift the blame on the Office of Information and Technology during oversight hearings when things go wrong.

As late as March of this year, the D.C. VAMC was still delaying treatment for veterans due to medical supply shortages. It has been over a year since Congresswoman Kuster led Committee Members on an oversight visit to the D.C. VAMC after the OIG reported that patients were being put at risk due to care delays. This site visit revealed that supplies were not being tracked by any inventory management system or any automated system to process sterile supplies, not the GIP system, nor the RTLS, the Real-Time Location Service, nor Catamaran system. Due to failed management of RTLS and Catamaran, the medical center did not know when it was running low on some supplies and, in other cases, was ordering too many supplies that remained unused.

It took extra dedication and commitment from clinical staff to ensure no patients were harmed. However, veterans sometimes had procedures delayed or canceled. This significantly increased patients' risk of harm, in part due to a failed IT project that made it difficult for the medical center to manage its medical supply chain and ensure sterile equipment was processed and available to providers when they needed it to treat patients.

OIG found in its review of the RTLS project that, due to inadequate project management, VA did not have assurance that it received an effective return on the \$451 million it invested in RTLS or that Hewlett-Packard met the contract requirements because the contract was mismanaged. This mismanagement caused delays

in veterans' care and wasted taxpayer dollars. It is beyond unacceptable.

We are holding the hearing today to get the necessary facts so we can be sure that VA is properly managing its medical supply chain. We cannot have what happened at the D.C. VAMC take place in other VA hospitals and clinics around the country.

According to the OIG, VA needs enhanced discipline, oversight, and resource management to support successful IT development. I look forward to hearing from VA about how the agency plans to enforce discipline, resource management, and ensure proper oversight so we can get this project back on track and prevent any future risk of harm for our veterans.

Thank you, Mr. Chairman. I yield back.

Mr. BERGMAN. Thank you, Miss Rice.

I now welcome the members of our first and only panel, who are seated at the witness table.

With us today from VA, we have Ms. Tammy Czarnecki, the Assistant Deputy Under Secretary for Health for Administrative Operations in the Veterans Health Administration. She is accompanied by Mr. Alan Constantian, the Deputy Chief Information Officer and the Account Manager for Health in the Office of Information and Technology.

Also on the panel we have Mr. Nicholas Dahl, Deputy Assistant Inspector General for Audits and Evaluations, representing the VA Office of Inspector General. He is accompanied by Mr. Michael Bowman, the Director for the Information Technology and Security Audits Division in the Office of Inspector General.

I ask that the witnesses please stand and raise your right hand.

Mr. BERGMAN. Let the record reflect that all witnesses have answered in the affirmative.

Ms. Czarnecki, you are now recognized for 5 minutes.

STATEMENT OF TAMMY CZARNECKI

Ms. CZARNECKI. Good afternoon, Chairman Bergman, Acting Ranking Member Rice, and Members of the Subcommittee. I appreciate the opportunity to discuss the Department of Veterans Affairs' Real-Time Location System project and the point-of-use program.

I am accompanied today by Dr. Alan Constantian, Deputy Chief Information Officer, Office of Information and Technology.

In 2011, VA chartered several major transformation initiatives. Two of these initiatives included the RTLS project and the point-of-use program.

The RTLS project was chartered to automate processes and improve health care services that VA provides to veterans. In June of 2012, VA awarded a contract to Hewlett-Packard Enterprise Systems. The contract's scope encompassed design, installation, testing, and maintenance of RTLS. Task orders were to be issued against the contract, which had a ceiling of \$543 million.

The RTLS project is jointly managed by OI&T and VHA per a memorandum of understanding signed in 2011 by the Under Secretary for Health and the Chief Information Officer. The RTLS solution utilizes COTS technology and software to directly support patient care delivery and outcomes.

RTLS requires extensive infrastructure to be installed throughout the hospital, with design and installation generally taking 1 to 2 years. Fargo VAMC was the first site to complete installation and test the system in March of 2015. VA identified several issues, and the contractor was charged to correct them.

In September of 2016, VA made a program decision to realign the RTLS program and entered into negotiations, with the shared goal to expedite the implementation of RTLS. To capture the agreements made during these negotiations, VA modified the existing RTLS contract and executed a global settlement agreement, resulting in an implementation strategy to decouple the applications, allowing each application to be tested and deployed on their own schedule. Additionally, it was agreed that the vendor would install additional technology to improve the accuracy, and a new deployment schedule was issued through 2018.

The deployment of RTLS was accelerated, with many positive outcomes, continuing through present. The sterile processing solution has been successfully implemented at 60 facilities. With over 1.4 million surgical and dental instruments being tracked, VA can be assured instruments have been through the required steps of the sterilization process and the right instruments are being delivered to the right operating room for the right procedure. Also, the cath lab solution has been deployed at 28 facilities and is generating notable supply savings.

VHA and OI&T have continued to align and improve project management processes following the conclusion and the publication of the OIG report. The RTLS deployment efforts have been managed utilizing sound project management principles. VA will perform continual risk assessments to assure that risks associated with deploying RTLS on the VA network are minimized.

Moving to the point-of-use program, a point-of-use system provides asset visibility down to the point at which the asset is used. VA defines our point of use as our medical supply rooms located throughout the medical center.

The point-of-use program was envisioned and intended to provide an integrated supply chain solution capable of providing consolidated data. The consolidated data would be used to effectively manage consumable medical supply inventories throughout the hospital.

Shipcom Wireless was awarded the point-of-use contract on September 23rd of 2013. While the first and second options of the contract were exercised, contract requirements were not being met. The contract was not meeting operational or contractual deliverables, and, after further review and based on a new return-on-investment analysis, it was determined that the point-of-use program would not see a break-even in the investment for over a decade. These figures were deemed unsustainable, and the decision was made not to exercise future option periods of the contract.

A plan has been derived to transition the 22 sites that had converted to Shipcom's Catamaran system, including the D.C. VA, back to the VA's Generic Inventory Package. In January and February of 2017, the point-of-use program team traveled to the sites to educate the staff on a tour to transition the data.

RTLS has made significant improvements in the efficiency and safety of health care for our veterans. It's critical that we continue to move forward with the gains that we have made thus far. Your continued support is essential to providing care for veterans and families.

Mr. Chairman, this concludes my testimony. My colleagues and I are prepared to answer any questions.

[THE PREPARED STATEMENT OF TAMMY CZARNECKI APPEARS IN THE APPENDIX]

Mr. BERGMAN. Thank you, Ms. Czarnecki.

Mr. Dahl, you are recognized for 5 minutes.

STATEMENT OF NICHOLAS DAHL

Mr. DAHL. Mr. Chairman, Congresswoman Rice, and Members of the Subcommittee, thank you for the opportunity to appear today.

The focus of my comments are the OIG's review of whether VA effectively managed the RTLS project to meet cost and schedule targets and performance and security needs.

OIG audits in recent years establish that IT systems development at VA is a longstanding high-risk challenge, with projects susceptible to cost overruns, schedule slippages, and performance problems.

In June 2012, VA awarded a contract with a \$543 million ceiling to Hewlett-Packard Enterprise Services to deploy RTLS nationwide over the course of 5 years. The RTLS procurement and implementation process was a cooperative effort between VHA, the Office of Acquisitions and Logistics, and the Office of Information and Technology.

VA was required by policy to manage the RTLS project under VA's Project Management Accountability System, which was a project management system intended to establish a discipline to ensure that an IT project's customer, project team, vendors, and stakeholders would focus on a single compelling mission—that is, achieving on-time project delivery. PMAS used incremental product build techniques, with delivery of new functionality tested and accepted by the customer in cycles of 6 months or less.

We received a complaint alleging VA management failed to comply with VA policy and guidance when it deployed RTLS assets without appropriate project oversight and that RTLS assets were deployed without meeting VA information security requirements.

We reported management failed to comply with VA policy and guidance when it deployed RTLS assets without appropriate project oversight. Specifically, the RTLS Project Management Office, or PMO, did not follow guidance from the Technical Acquisition Center to use an incremental project management approach during the acquisition and deployment of RTLS assets to compensate for known project management risks. Also, the RTLS PMO did not comply with VA policy requiring the use of PMAS for all acquisitions and delivery of RTLS assets.

Despite the guidance from the Technical Acquisition Center and VA policy, the RTLS PMO did not ensure the vendor could meet contracted functionality requirements, such as accurate asset tracking, on the initial \$7.5 million task order before ultimately

committing a total of \$431 million to the same vendor for further RTLS deployments.

VHA had awarded the initial task order to deploy RTLS in VISN 23 with an expected delivery date in December of 2013. However, initial operational testing in March 2015 identified 245 functionality defects that resulted in the issuance of a contract cure notice to the vendor.

In June 2016, the cure notice was still unresolved, as significant defects, including the inability of RTLS to meet contract requirements for asset tracking, remained outstanding.

In September 2016, VHA renegotiated the RTLS contract due to the vendor's inability to implement a functional RTLS solution. The renegotiation was intended to expedite the implementation of RTLS in each VISN. VA executed a global settlement agreement that resulted in extensive changes to the vendor's contract requirements, to include expiration of task orders, reduction in the scope of RTLS applications deployed, extension of the contract period of performance, and commitment of \$431 million to the vendor as of December 2016. According to the agreement, VA also released the contractor from any liability claims related to prior performance on the contract.

We also substantiated the allegation that VA deployed RTLS assets without meeting VA's information security requirements. We reported inadequate oversight of RTLS risk management activities left VA mission-critical systems and data susceptible to unauthorized access, loss, or disclosure. Consequently, VA's internal network faced unnecessary risks resulting from untested RTLS system security controls.

We reported VA must exercise cost control, sound financial stewardship, and discipline in RTLS development. As a result of inadequate project management, VA lacked assurance of an effective return on the \$431 million invested in RTLS. We provided recommendations for improving controls over the VA's oversight of system development projects, and VHA and OI&T concurred with our recommendations.

Our review of the RTLS project demonstrates VA continues to face challenges in managing its IT development projects. VA has taken some actions to address issues we identified in our RTLS report and in other recent reports. However, it remains to be seen whether the actions will effectively improve VA's ability to meet cost, schedule, performance, and security goals when managing mission-critical system initiatives.

Mr. Chairman, this concludes my statement. We would be happy to answer any questions you or other Members of the Subcommittee may have.

[THE PREPARED STATEMENT OF NICHOLAS DAHL APPEARS IN THE APPENDIX]

Mr. BERGMAN. Thank you, Mr. Dahl.

The written statements of those who have just provided oral testimony will be entered into the hearing record.

We will now proceed to questioning. We'll begin—Miss Rice, you're recognized for 5 minutes.

Miss RICE. Thank you, Mr. Chairman.

So who—I'm just trying—I can't read any names. Mr. Dahl, so this is what I want to ask you about. The contract cure notice the VA had issued to Hewlett-Packard in 2015 was still unsolved by June of 2016, including RTLS's inability to meet fundamental contract requirements for asset tracking and software functionality.

Instead of terminating the contract, it was renegotiated. HP's responsibilities were reduced by nearly 50 percent, and the vendor was released from any liability claims related to prior performance of the contract.

Can you explain why the VA decided to renegotiate the contract with HP?

Mr. DAHL. Well, I think VA may be better suited to answer that question.

Miss RICE. The VA? Oh, yeah, you're the—all right. I'm sorry. Yeah.

Mr. DAHL. I would speculate the VA management was concerned that the contractor was behind schedule and there were concerns as to whether they would be able to deliver this system on time and within costs.

Miss RICE. Ms. Czarnecki, maybe you could—

Ms. CZARNECKI. Yes. So there was a number of items that were—remember, the RTLS was new in the medical space at that time. So there were a number of items that were in the contract that there were differences of opinion between the contractor and VHA—for example, location accuracy.

As Mr. Dahl stated, initially there was only a 40-percent location accuracy. So in the contract we had placed that we needed to have location accuracy for asset tracking. Their definition of location accuracy and our definition was different. We needed clinical accuracy. We needed to know that piece of equipment was in that particular room so that we could go to that room, get that piece of equipment, and move it.

So there were a number of clarifications. So the contractor wasn't necessarily wrong; there were definition differences between the contractor and VHA in a number of the areas. And so those needed to be clarified, and that was part of the change.

The second piece of it is, initially, VHA went into the contract saying that if you were getting asset tracking, cath lab, and SPS, you had to have all of those installed and tested at the same time. Part of the settlement agreement is that we decoupled those so that each one of those applications were independent and could be tested and deployed.

Miss RICE. So can you pinpoint how this mismanagement occurred and how the VA is going to ensure that this doesn't happen again?

What I fail to see in all of these hearings that we have is any level of accountability. I mean, you're talking about a half a billion dollars being spent on a system that was totally mismanaged. It doesn't seem like there was a proper protocol for how it was going to be implemented.

I just don't understand—the process, maybe, is what I don't understand. Do you learn from these instances of mismanagement, and who is accountable?

Ms. CZARNECKI. So, in this case, it takes 1 to 2 years to deploy the infrastructure. And, as I stated, in this particular case, they were getting two applications, both asset tracking as well as sterile processing. And so, when it went into testing, that was when we identified errors—not errors, but deficiencies, things that were not working the way we anticipated that they would work.

And so, yes, we have learned from those. We issued a cure notice. We didn't do any further deployments until after the global settlement agreement. We continued the infrastructure work, but we didn't test or deploy anything further until we were sure that the contractor was able to meet the deliverables.

Miss RICE. So the accountability?

Ms. CZARNECKI. I believe that there is accountability throughout the entire process. There was a senior-level project manager, both from IT as well as VHA, that worked with the contracting—or with the vendor. And I believe we held the vendor accountable as well as our own staff.

Miss RICE. How did you hold the staff accountable?

Ms. CZARNECKI. With the staff being held accountable, the staff were required to work through the process with the vendor. There was a list of items that needed to be negotiated, definitions to be clarified, and so I believe that we worked through those issues.

I don't believe that there was any intention not to have a working, functional RTLS system, but this was new in the medical space at that time. It was the largest deployment of a real-time tracking system in health care. It was a definition problem. And we have run into this before, where clinical people do not necessarily speak the same language as the business community. And those ended up not being performance issues but, rather, clarification of requirements.

There needed to be very clear definitions of what each and every requirement was. And I think that we have learned that, as well, going forward, as we talk about what does, and I'll use, "accuracy" mean. There is a very big difference between what I think clinical accuracy is as a nurse and what the vendor thought accuracy was. The accuracy for them was "it's in the director's suite." The accuracy for me, "it's in the director's suite, it's in the director's office"—

Mr. BERGMAN. We have to move on. The gentlelady's time has expired.

Miss RICE. Thank you, Mr. Chairman.

Mr. BERGMAN. Okay.

Dr. Dunn, you are recognized for 5 minutes.

Mr. DUNN. Thank you very much, Mr. Chairman.

And welcome, to the panel. I'm going to ask everybody to try to keep their answers concise, because, as you can see, we're on the clock. So let me start with Ms. Czarnecki.

In your testimony, you described site assessments that were conducted to determine where to implement or where to pilot Cata-maran. How were those sites chosen? And, in retrospect, were the chosen sites good choices?

Ms. CZARNECKI. I don't know how the sites were selected.

Mr. DUNN. Okay. So, in retrospect, would you say that we made good choices in site selection?

Ms. CZARNECKI. I do believe we made good choices in site selections. We chose a mix of both small and large facilities.

Mr. DUNN. Okay.

So, now we know that the D.C. medical center actually had a lot of problems ahead of time. Logistically, they were struggling. Did the people managing these choices know that the D.C. medical center had trouble with logistics?

Ms. CZARNECKI. I do believe they knew that there were trouble with logistics. They thought the Catamaran system would actually help that.

Mr. DUNN. So they thought that was the solution. All right.

So let's turn to the RTLS. Again, Ms. Czarnecki, you represent health, and, Mr. Constantian, you represent IT, I believe, right? All right. So this is a question for both of you. Who should have been in charge of the RTLS implementation from each of your organizations, and who actually was in charge?

Ms. CZARNECKI. I'll start with that one.

This was a—RTLS is like a medical device, like an anesthesia monitor—

Mr. DUNN. I know what it is.

Ms. CZARNECKI [continued].—or a medical screen in a colonoscopy suite. So it was a mix of VHA and OI&T. So there were components—there were 22 task orders—

Mr. DUNN. The question was who was supposed to be in charge, not what is RTLS.

Ms. CZARNECKI. It's comanaged.

Mr. DUNN. So it's at, what, 50/50? Is there—did you have the right people from your department, Mr. Constantian, in charge, and did you, Ms. Czarnecki?

Ms. CZARNECKI. Yes. I had a senior-level project manager who was certified in project management principles.

Mr. DUNN. And the same guy actually did it? So it wasn't one person said—okay.

And the same for you?

Mr. CONSTANTIAN. Sir, we had a senior lead for this implementation. There was a departure. We filled the position later. There was a gap, but now we have a senior lead again in OI&T.

Mr. DUNN. Mr. Dahl, what would a well-run project look like in the VA or in the civilian world with this kind of implementation?

Mr. DAHL. I would say as we've learned, that this was new in the medical space, the RTLS, I think that following an incremental approach from the start may have been more prudent, in that they probably should have made sure that the things that needed to be functional were functional before deploying elsewhere.

Mr. DUNN. We've heard testimony that this is some novel technology in the health care space. I'm a physician. I've worked in a lot of hospitals, in and out of the military. This is not that novel. I mean, we track millions of pieces of equipment through multiple hospital systems. Some of them are State, some of them are—many of them are private, you know, HCA-type hospitals.

This is not rocket science, and it's not something that hasn't been done. It is mature technology that's used throughout the business world. Walmart does it, Target does it, PetSmart does it. Why can't the VA do it?

Maybe that's a question for Mr. Dahl. You're the one who inspects people, or—go ahead.

Mr. BOWMAN. I do think VA has the capability of managing these kind of projects. They just chose a big-bang approach as opposed to an agile, incremental approach. If you break the project up in smaller pieces and get the end-user involved early on, you discover early on whether or not your contract requirements are being met.

Mr. DUNN. We've actually had this problem with the EMR, as well, right? I mean, this is the same sort of failure to implement?

Mr. BOWMAN. This is a theme that has showed up in various IT development projects over the years.

Mr. DUNN. It has. And, obviously, it's a disappointment to see that we can throw away so many billions of dollars and actually tread water, not making any headway on that.

My time is about to expire, so I will yield. But let the record reflect that it is disappointing that we can't implement mature technology in an agency that is so very well-resourced.

Mr. Chairman, I yield back.

Mr. BERGMAN. Thank you.

And, Mr. Lamb, you're recognized for 5 minutes.

Mr. LAMB. Thank you, Mr. Chairman.

Ms. Czarnecki, I have a question about the policies in place, if any, to identify potential conflicts of interest.

In Pittsburgh, there was a former VA regional director who was identified by our local paper as having an advising role to Shipcom, which was one of the contractors that the VA hired to do the tracking in the Catamaran system.

Can you tell me about any policies that would have caught that on the front end or that prevented it? Or if they don't exist, is that ever discussed?

Ms. CZARNECKI. I'll need to take that one for the record. I'm not sure. I'm not sure if general counsel reviewed that or not.

Mr. LAMB. Okay. Are you aware of the incident that I'm talking about, where the former regional director was—

Ms. CZARNECKI. Yes, I am.

Mr. LAMB. Okay.

Now, I think in the gentleman's previous question we were just starting to get into the issue of coordination and project implementation between the VHA headquarters and regional VA systems. So I'm not sure which of the witnesses is best to answer this, but could somebody talk about, going forward, what's the best way to allow the regional VA systems to have input into a policy or system change like this from the beginning so that they can actually implement it more successfully than was done here?

Ms. CZARNECKI. So the regions are called our VISNs. And our medical centers did, in fact, have input into the RTLS project as well as Catamaran. They're involved from a project management standpoint, a contracting officer representative is part. And then the staff do get to give us feedback and input. It's just like trialing any other product, where you would have your staff providing ongoing feedback.

Mr. LAMB. Well, Mr. Bowman, from what you were saying, this wasn't done in an incremental manner. Is that right?

Mr. BOWMAN. That's correct.

Mr. LAMB. Would you say that there is an opportunity to do that differently in the future by trying this maybe in one region and not others or trying—I mean, can you kind of address that issue?

Mr. BOWMAN. So we recently received a corrective action plan in response to our report from VHA and OI&T. And they laid out a case where they're using incremental methodologies to change the way they're deploying RTLS, which is breaking up the application into discrete functionality. That way, they're not having to have so many interdependencies that they have to resolve.

So that would be a case where they're changing their approach. And so far, from what I hear, they're achieving success doing it that way.

Mr. LAMB. Okay. Thank you.

Mr. Chairman, I yield the remainder of my time.

Mr. BERGMAN. Thank you.

Mr. Arrington, you're recognized for 5 minutes.

Mr. ARRINGTON. Thank you, Mr. Chairman.

I want to first of all congratulate my colleague Mr. Lamb on his election victory, and I look forward to getting to know you better. And we're glad you're on our Committee, and honored to serve with you. So congratulations to you and your family.

There is not a more perennial issue of disappointment to me in the lack of management of the big beast, bureaucratic beast of the VA than IT systems. I mean, I have heard this is the—I don't know how many stanzas of the same song, but it's getting really old.

So I'm going to ask the same questions I ask at, it seems like, every one of these meetings where we can't get IT systems right. But let's start by just answering this in a very simple way, in a very quick way.

Ms. Czarnecki, what are we trying to achieve with RTLS? What happens to our customer if RTLS or these logistics management systems aren't in place? If they're not in place or they're not working, what happens to our customer, the veteran?

Ms. CZARNECKI. For RTLS—and I'll use sterile processing as the example. Every single instrument is tracked to make sure that it is reprocessed appropriately. The trays are built, delivered to the right operating room for the right patient.

Mr. ARRINGTON. So, potentially, if we don't get this right, they're not getting the right device or therapy to the right patient? It's that serious? I mean, that sounds like life or death. That's a public safety issue. Am I overstating it?

Ms. CZARNECKI. Potentially, we couldn't miss a step in the reprocessing of sterilization—

Mr. ARRINGTON. So, I mean, we could have unsterilized equipment? I mean, this is serious.

And we have—our veteran patients who are coming in, where do they go if they feel like this thing is just all jacked up and you just can't get it right, they don't have any confidence you can get it right? Where do they go? Where can they go so they can have peace of mind that a health care provider is actually going to take care of them and manage all these things so they get the right therapy, the right device, it's sterile, and it's well-suited to put them on the path of healing? Where do they go if you guys can't get it right?

Ms. CZARNECKI. I hate to say this, but it could happen in any health care—

Mr. ARRINGTON. I know it could happen anywhere, but where would they go if they couldn't get it at the VHA? Can they access other hospitals? I mean, who's competing for their business?

Here's my point: Too many veterans are trapped in this system, and it's failing them.

Who has been fired on account of losing hundreds of millions of dollars? Because that's what I'm hearing. We've lost hundreds of millions of dollars. Now I'm going to talk about the shareholder. We're fiduciaries for the taxpayers. Who has been fired on account of hundreds of millions of dollars? Because I can tell you, outside of the fantasy world of the VA, people would lose their jobs over that.

How many people have been fired in the mismanagement of the Catamaran and the RTLs?

Ms. CZARNECKI. I really don't have that information.

Mr. ARRINGTON. I can tell you. Nobody has been fired.

But I'll ask Mr. Dahl. Maybe he knows.

How many people were fired over this?

Mr. DAHL. I'm not aware of anyone.

Mr. ARRINGTON. Nobody gets fired. I've asked that question, colleagues have asked that question almost at every hearing, and they don't know. And then I ask them to submit it for the record. I've never received anything, so I assume that you never submitted it.

There is no accountability. So this is—I almost feel like I'm wasting my time at these hearings.

You say that these are jointly managed between the OI&T and the VHA. So, you know, the old saying, if multiple people are accountable, nobody is accountable.

Who is ultimately accountable for information technology systems, the enterprise architecture? Who's ultimately responsible at the VA for all of this?

Mr. CONSTANTIAN. Sir, enterprise architecture is the responsibility of the Office of Information and Technology.

Mr. ARRINGTON. And who is the head of that office?

Mr. CONSTANTIAN. The Chief Information Officer.

Mr. ARRINGTON. And where is he or she?

Mr. CONSTANTIAN. At the VA central office.

Mr. ARRINGTON. How long have they been in that office?

Mr. CONSTANTIAN. Mr. Sandoval was appointed Acting in that role 2, maybe 3 weeks ago.

Mr. ARRINGTON. Two or 3 weeks ago. I think there is a really issue with continuity over there, but there's certainly an issue of accountability.

I know I've gone over my time. I'm not even close to finishing, so I hope we get more opportunities. I yield back, Mr. Chairman.

Mr. BERGMAN. Thank you.

Mr. Peters, you're recognized for 5 minutes.

Mr. PETERS. Thank you, Mr. Chairman.

I mean, I share Mr. Arrington's frustration. I will say that we voted for the Accountability Act here in order to give more flexibility for hiring and firing. And I did that in good faith. And what I saw was that the people who have been fired are cooks and gar-

deners. And those people didn't cost anything close to millions of dollars. And I think that I feel a little bit taken advantage of, because that was not the intent of the vote that I took. The intent was to get to things like this.

And I will just say, too, you know, when you were testifying about the mismatch between what doctors say and what IT people say, that's not the first time we've heard this. And I was trying to remember what it was. It was the Medical/Surgical Prime Vendor Program too.

And I would maybe direct this to Mr. Dahl. What is the appropriate response for the Department to take, so that when we do these—these are novel contracts, but, you know, you can lose \$5 million before you lose \$500 million. What should they be doing up front to make sure that these people are speaking the same language and, if they're not, that we catch it early and we don't spend so much money, waste so much money down the line that we're having a hearing like this?

Mr. DAHL. In this case, the approach was they awarded that initial task order where they were going to deploy this in a VISN. It was a \$7.5 million task order. So, in theory—

Mr. PETERS. Right.

Mr. DAHL [continued].—that would seem like a reasonable approach.

But that was due—they awarded that task order in 2012. It was due to be completed in late 2013. They didn't get to operational testing on that until March of 2015, so they had already slipped about 15 months. That's when they identified some deficiencies. But, in the meantime, they had been awarding additional task orders before they knew that it was functional in that VISN.

I assume that there was a desire to get this RTLS up and running across the enterprise, but, with this unproven technology, we really believe that they should've been taking a more incremental approach.

Mr. PETERS. This is gasoline on the fire. I mean, we would all be upset if they lost \$7.5 million, right? But before figuring out whether this would work, before figuring out whether the doctors and the IT people were speaking the same language, we went and deployed the same thing over and over again, even though it was behind schedule. That's what happened, right?

So, you know, I'm at a little bit of a loss, what to do now. I mean, we're going to be under the gun on the budgets. Now the Congress is talking about spending a trillion dollars a year in deficits in good times. And we can't have this kind of money wasted. We got nothing for this.

And I know we're still paying for this, right? Is that right, Mr. Dahl?

Mr. DAHL. Yes.

As Mr. Bowman noted, we did recently get an action plan from VHA and OI&T in response to our recommendations. They're portraying to us that they have gone to a more incremental approach and they are making progress. Of course, we haven't done any follow-up on that yet to validate or verify that.

Mr. PETERS. We also—we probably can't blackball this contractor either, I don't suppose, can we, because of the process concerns about that, right?

Mr. DAHL. I would have to defer to probably the Office of Acquisition and Logistics on that, whether there's grounds for that.

Mr. PETERS. Well, \$500 million, \$420 million, whatever it is, I guess—I don't—I think we're being taken advantage of. I think taxpayers are being taken advantage of. I'm a big fan of the VA. I would not describe VA as a failure. I think it gets overstated sometimes. But this is really outrageous.

And I just think the fact that I've heard this same song about the doctors not being able to speak the same language as the IT people—one, I have heard of that in other contexts. That's a management issue. That's a cultural issue that you've recognized you've got to get a hold of; you can't do this again.

And the fact that we spent \$7 million to figure out if it worked, and no one could wait to figure out if it was working? You know, it's just shameful to spend that kind of money, especially when we all know it's novel. So please don't come back to me again with this kind of stuff.

And as to the Accountability Act, I would say, you know, this is exactly what this is meant for, not for cooks and gardeners. It's outrageous that my vote was taken advantage of in that way, because it's the middle management that's the problem in the VA, to the extent there's a problem in the VA, and it's not being dealt with.

I yield back.

Mr. BERGMAN. Thank you.

Mr. Poliquin, you're recognized for 5 minutes.

Mr. POLIQUIN. Thank you.

This nice staffer right in front of me, could you get back a little bit so I can make sure I can see everybody at the table? Thank you very much.

Mr. Dahl, make sure I get this straight. Make sure I understand this. You're in the IG's office, right?

Mr. DAHL. Yes, sir.

Mr. POLIQUIN. Okay. So you've got the VA that's trying to figure out how to control and keep track of their inventory, right?

Okay. So, roughly around 2012, they implement or they started to implement a Catamaran system, right? It's one of these systems. Right? And then within a year they implement a second system called RTLS. Is that correct, roughly?

Mr. DAHL. I think it's the other way around.

Mr. POLIQUIN. Okay. Okay. But you see my point? Okay.

And, first of all, Ms. Czarnecki, why would you implement two programs or two systems, start them at effectively the same time? Why? Tell me.

Ms. CZARNECKI. This was during a time where we were trying to transform, and we had what we called T21 initiatives. And these were two different initiatives. One was for the supply chain. The other was sterile processing, cath lab, asset tracking—

Mr. POLIQUIN. Could you have combined them together? In hindsight, could you have done that?

Ms. CZARNECKI. I'm not sure the technology would've been able to combine those.

Mr. POLIQUIN. Who made that decision to have two programs going forward?

Ms. CZARNECKI. I believe that was made at a leadership level.

Mr. POLIQUIN. Okay.

Ms. CZARNECKI. These were all projects that were—

Mr. POLIQUIN. You've got to make sure that we get this from your office, who that person was. I want to know if that person is still at the VA, and, if so, I want to speak to that person.

Okay. Let's go down the path here a little bit more. This has been discussed a moment ago. I think, Mr. Dahl, you've mentioned it. I think Mr. Peters did too.

To start this thing off, you spent about \$7.5 million of taxpayer money to see if this thing would work. And then, within a short period of time, you found out it wouldn't. But then you expanded it anyway to 19 different sites, right? You spent about 430 million bucks to do that, and the thing was a complete failure, right?

Okay. Who made that decision?

Ms. CZARNECKI. I believe that the Deputy Under Secretary for Health made the decision to go ahead.

Mr. POLIQUIN. Okay. Who's that person?

Ms. CZARNECKI. That person would have been Bill Schoenhard.

Mr. POLIQUIN. Okay.

Dennis, I want to make sure that we know this fellow, and I want to get him on the phone if he's still at the VA. Okay?

Is that person still at the VA?

Ms. CZARNECKI. No, sir.

Mr. POLIQUIN. Okay. Where is that person?

Ms. CZARNECKI. That person's retired.

Mr. POLIQUIN. Okay. How about the other person I mentioned? Is that person at the VA? The first person we mentioned, was that person at the VA?

Ms. CZARNECKI. No, that person is not at the VA.

Mr. POLIQUIN. Retired also?

Ms. CZARNECKI. I believe deceased.

Mr. POLIQUIN. Okay.

All right. Let me ask you this: When this mess that has happened over the past 5 or 10 years, which has cost about, I think Mr. Peters said, about 400 million bucks, roughly—okay? There is a settlement agreement with the RTLS contractor, correct? Who negotiated that settlement agreement?

Ms. CZARNECKI. That was negotiated between Dr. Stone and Hewlett-Packard and—

Mr. POLIQUIN. Who is Dr. Stone?

Ms. CZARNECKI. Dr. Stone, at that time, was the Principal Deputy Under Secretary.

Mr. POLIQUIN. Okay. Is he still with the VA?

Ms. CZARNECKI. No, he's not.

Mr. POLIQUIN. Where is he?

Ms. CZARNECKI. He left the VA about a year and a half ago.

Mr. POLIQUIN. Where is he now?

Ms. CZARNECKI. I don't know.

Mr. POLIQUIN. Okay. You're going to find out. Dennis will find out. Okay.

Mr. DAHL, have you taken a look at this agreement with the contractor?

Mr. DAHL. No, I don't believe—like the Chairman said, I don't believe that we've seen the entire agreement. I think we may have seen pieces of it, but VA has not shared that agreement.

Mr. POLIQUIN. Why not?

Okay. Jack, we have subpoena power here, don't we, Mr. Chairman?

Do you need help getting that contract settlement agreement? Do you have subpoena power?

Mr. DAHL. We have subpoena power.

Mr. POLIQUIN. So what's the problem?

Mr. DAHL. We reported on the result of that global settlement agreement, how it led to decrease in the scope of the project, and that was what we reported.

Mr. POLIQUIN. Okay. So let me get this straight. So the vendor who screwed this whole thing up and the folks within the VA that allowed this to happen, hired the vendor in the beginning, now you're going through a settlement agreement after we've lost 400 million bucks, and you can't get the complete terms of the settlement agreement. Is that right? So we don't know if the folks that screwed this up have been given more time and less liability, correct?

Mr. DAHL. Our understanding is they have been relieved of liability for any issues that happened before the settlement.

Mr. POLIQUIN. Okay. So let me get this straight. So they've lost \$400 million of taxpayer money, which has put some of our veterans at risk from a health standpoint, and we've relieved them of liability going forward, or liability that they could've incurred going backwards?

Mr. DAHL. It may not be an accurate statement to say—

Mr. POLIQUIN. But we don't know, because we don't have the contract settlement agreement, right?

Mr. DAHL. No. What I'm saying is I'm not sure it's an accurate statement to say that we lost the entire \$430 million. I think VA has gained some value from this system. It's just hard for us to assess—

Mr. POLIQUIN. How much? How much?

Mr. DAHL. I couldn't answer that question.

Mr. POLIQUIN. Okay. But we need that settlement agreement, don't we?

Mr. DAHL. You may find it interesting.

Mr. POLIQUIN. Good. Who do we get it from?

Mr. DAHL. Acquisition and Logistics.

Mr. POLIQUIN. Ms. Czarnecki, do you have that contract settlement agreement?

Ms. CZARNECKI. We'll get you a copy.

Mr. POLIQUIN. Do you have the contract settlement agreement?

Ms. CZARNECKI. Do I have the contract?

Mr. POLIQUIN. Who signed the contract settlement agreement? Did you sign the contract?

Ms. CZARNECKI. No, I did not.

Mr. POLIQUIN. Who signed the contract?

Ms. CZARNECKI. Dr. Stone.

Mr. POLIQUIN. Who's no longer with the VA. Okay. But we have a copy of the contract somewhere? You've got it somewhere?

Ms. CZARNECKI. Yes. Somewhere we have a copy of the contract.

Mr. POLIQUIN. Okay. Good. We're going to make sure Dennis gets the contract, and we're going to make sure Mr. Dahl gets the contract.

Is there any reason why we can't get that contract, Mr. Dahl?

Mr. DAHL. I missed that, sir.

Mr. POLIQUIN. Any reason why we can't ask for it? Am I not supposed to ask for the contract and settlement agreement?

Mr. DAHL. No. I would think it would be well within your rights to ask for it.

Mr. POLIQUIN. Okay. Have you asked for the contract?

Mr. DAHL. Did we ask for it?

Mr. POLIQUIN. Did you ask for it?

Mr. BOWMAN. Yes, we did.

Mr. POLIQUIN. And who said no?

Mr. BOWMAN.—we did ask to—

Mr. POLIQUIN. And who said no?

Mr. BOWMAN [continued].—go over the settlement agreement—

Mr. POLIQUIN. And who said no?

Mr. BOWMAN. I believe that we got a majority of it. Not sure if we got the complete settlement agreement.

Mr. POLIQUIN. Who said no? Who decided to withhold how much of that contract settlement agreement? Who was it?

Mr. BOWMAN. Could we take that for the record, please? And we can give you a more accurate response.

Mr. POLIQUIN. This is unbelievable. I'm not even sure I want to yield back my time; I'm having fun doing this. What a mess.

Anybody embarrassed here?

We've got 7 million veterans we're trying to take care of. We've got a budget that's gone up from, I don't know, from \$90 billion to \$187 billion over 8 years. We can't keep track of stethoscopes and tongue depressors?

We're losing our pants on deals, and after the deal, after we find out we've lost it all, we relieve them of responsibility. This is unbelievable.

I yield back my time, but before I do, I want to make it short and clear: We want that contract settlement agreement.

Thank you.

Mr. BERGMAN. Thank you.

In case you haven't figured out—have any of you testified in the last 18 months before this panel before?

Ms. CZARNECKI. No, sir.

Mr. CONSTANTIAN. Yes, sir, I have.

Mr. BERGMAN. You know probably what I'm about to say, because you've heard it before, the lack of a sense of urgency in all accounts. And the point is we are living one more example here, that the need for the sense of urgency on the part of everyone within the VA, because when the men and women who serve our country in uniform—they have a sense of urgency in what they do, and shame on anyone, especially in the VA or on this Committee, who

doesn't have that same sense of urgency when it comes to meeting those veterans' needs and getting it done right.

I'll claim my time here for my 5 minutes.

Ms. CZARNECKI. I'd like to start with the money question. How much was spent on the Catamaran point-of-use project up until its termination? And how much has been spent on RTLS to date? What is the total?

Ms. CZARNECKI. So Catamaran is still going through an equitable adjustment, but so far, \$117 million. And for RTLS, we have obligated \$360 million.

Mr. BERGMAN. Okay. So you said \$117 million or \$171 million?

Ms. CZARNECKI. I believe we have so far paid out \$117 million.

Mr. BERGMAN. Okay. Now, we know how much we've paid out. How much additional funding is going to be necessary to finish RTLS?

Ms. CZARNECKI. My understanding is that we are ending this contract, so it will be roughly around \$360 million.

Mr. BERGMAN. So another \$360 million?

Ms. CZARNECKI. No, no, total. We've already obligated the \$360 million. We are finishing the work on this contract.

Mr. BERGMAN. So no more money. We're just terminating, finishing the contract?

Ms. CZARNECKI. Right. That's my understanding.

Mr. BERGMAN. Okay. So no more funds expended.

Ms. CZARNECKI. No more funds expended. We will be looking at our return on investment in the business cases of the equipment that has been deployed, the applications that have been deployed, to determine if we want to further expand.

Mr. BERGMAN. Okay. So you're just terminating the contract when it expires, not renewing it?

Ms. CZARNECKI. Right. Not renewing.

Mr. BERGMAN. Okay.

And, again, Ms. Czarnecki, I understand that the chief logistics officers in the VISNs inspect the medical center logistics departments annually. Is that correct?

Ms. CZARNECKI. Yes, they do.

Mr. BERGMAN. Okay. So it's also my understanding that VISN 5 did not conduct any logistics inspections of the D.C. facility, in 2016 or 2017. That was during the OIG's investigation when the supply issue was under intense scrutiny.

How do you explain the fact, when there's a lot of bad things going on that you can see, why weren't there inspections?

Ms. CZARNECKI. There was actually an inspection done in 2017 by the program office. We actually had people from the program office who staffed the D.C. medical center through November of 2017. Their staffing was down to 40 percent of what they should have had.

Mr. BERGMAN. Okay. Well, I'll tell you what. What was the result of the inspection?

Ms. CZARNECKI. They were not, in fact, using the Catamaran system. They did not have an inventory management system. They were not using GIP. They were using paper systems.

Mr. BERGMAN. So, basically, they weren't complying with any of the directives. That was determined during an inspection. Were the

people in charge on a daily basis monitoring the fact that they weren't doing what they were supposed to be doing with RTLS or Catamaran or whatever else?

Ms. CZARNECKI. The Chief Logistics Officer at the medical center would've been ultimately responsible. The medical center director was aware of the issues as well. Both of them have since been removed from their positions.

Mr. BERGMAN. "Removed" as in still employed by the VA, or removed and terminated?

Ms. CZARNECKI. The medical center director was terminated. I believe the Chief of Logistics was also terminated, but I'm not positive if he voluntarily left or if he was terminated.

Mr. BERGMAN. Okay.

Mr. Dahl, your colleagues in the Office of Inspector General conducted the investigation at the Washington, D.C., medical center's logistics and supply practices. As I mentioned in my opening remarks, there seem to be varying accounts as to the extent Catamaran was ever used there at all. What did your office observe?

Mr. DAHL. The team that was there determined that Catamaran was never fully used at the D.C. medical center and that, prior to the Catamaran, they weren't using the GIP fully before the transition to Catamaran as well.

Mr. BERGMAN. So they were a little bit behind the power curve, as we might say in flying, already. Why would we even consider choosing them if they're already struggling to do their day-to-day operations? Why would we choose them as a pilot site or a test site if they don't have their act together on the front end?

Ms. CZARNECKI. We thought that installing the Catamaran system would actually assist them. The Shipcom organization came in and built the inventory system for them, so they did utilize it for a very short period of time. But it's something that you need to maintain, and as soon as folks were not paying as much attention, they quit maintaining the system and went back to their paper system.

Mr. BERGMAN. Okay.

I see my time has expired here. I'm going to ask my colleagues, would anyone like a second round of questions?

You're good? Okay.

I'm going to ask one final one here as I go into the closing remarks.

I heard you mention that, in trying the Catamaran system or RTLS, there was nothing like this that existed in the health care system, in hospitals around the country, outside of federally run.

So why would VA try to eat this elephant, if you will, in one bite without having any reference point to start from, as far as success or failures, in—whether it be Humana, pick your hospital chain that is run around the country. Why would VA gamble the valuable, limited taxpayers' dollars focused on the veterans? Why would they gamble on being a lab for this? What was the risk management involved with that?

Ms. CZARNECKI. So Catamaran is an integrator of software. Automated supply chain systems do exist and have existed in private sector. Perhaps this wasn't the best choice for us. We had made an incorrect assumption that, with a COTS product, it was off-the-

shelf and that we would be able to implement it fairly easily. That did not happen.

RTLS was kind of new for the health care space back in 2010. It's being used widely now to manage sterile processing, cath labs, track patients, track providers, frankly, so I know where a doctor is, whether he's in the OR, or whether he's in clinic. So I think that VA wanted to be on the cutting edge and make sure that our veterans had the latest technology.

We have received benefit from the RTLS system. We are seeing cost savings every day in our cardiac cath labs. Our sterile processing—

Mr. BERGMAN. But is the VA, given the fact of maybe its decentralized nature of some of the operations and the fact that I think we've seen before that some of the VISNs don't necessarily coordinate and talk with one another—and when you put test sites together or pilot programs together, unless you focus the group and hold the people accountable for that mission of “here is what we're trying to accomplish, here are our timelines, here are the metrics that we are trying to achieve,” it would seem to me that the VA is not the place capable of doing as complex a technology project as objects this. And, therefore, because it's not the right place, the veterans' care potentially suffers much more than it should.

So, I guess it concerns me that we are trying to do too much, when we may not have the expertise and the tight coordination to actually assess the results of what it is we're trying to achieve.

So I would ask that you would submit for the record any and all disciplinary action taken as a result of poor performance relating to the Catamaran and RTLS projects so that we know who in fact was held accountable for those failures.

With that, I'd like to thank the witnesses for your testimony. The panel is now excused.

The failure of the Catamaran point-of-use system and the rocky experience with the RTLS to-date should serve as cautionary tales. What the two efforts have in common, beyond both being logistics technology projects, is that they are complex collaborations between the Veterans Health Administration and the Office of Information and Technology. Nearly everything VA does in the medical arena relies on software, and most of the Department's software impacts that medical care.

In RTLS specifically, many of the problems encountered were not just the result of the two organizations struggling to cooperate; they were the result of VHA deliberately avoiding OI&T and its processes. Although the events in question took place several years ago, this sort of friction, the natural friction between bureaucracies, between VHA and OI&T, has been an issue since OI&T was first established in 2006.

We have to get it right, because the stakes are dramatically increasing. The Electronic Health Record Modernization Program, which we have been awaiting since last year, is perhaps the largest medical information technology collaboration in the history of the Federal Government. Its scope and its scale are challenging enough, and the VA cannot afford this sort of organizational infighting.

The Committee is committed to exercising vigorous oversight of the Cerner implementation. We are united on this issue. This is bipartisan.

This morning, we approved H.R. 4245 in markup, the EHRM Oversight Act. I am proud to cosponsor the legislation with Ranking Member Walz, Chairman Roe, and Ranking Member Kuster.

I believe that the many lessons learned through the RTLS project are directly applicable to the Electronic Health Record Modernization. RTLS, without a doubt, produced some tangible benefits despite its setbacks. And, by all means, it is preferable to learn these lessons in a half-billion-dollar project—that’s “half-billion” with a “B”—before taking on the \$16 billion project. But VA cannot—I repeat, cannot—repeat the same mistakes again. That will be totally unacceptable.

We will continue to monitor the RTLS as it enters what I hope are its final months, not years.

I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous material.

Without objection, so ordered.

I would once again like to thank my colleagues and all our witnesses and the audience members for joining us here this afternoon.

With that, the hearing is now adjourned.

[Whereupon, at 3:16 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Tammy Czarnecki, MSOL, MSN, RN

Good afternoon Chairman Bergman, Ranking Member Kuster, and Members of the Subcommittee. I appreciate the opportunity to discuss the Department of Veterans Affairs (VA) Real-Time Location System (RTLS) project and VHA's Point-of-Use (POU) program. I am accompanied today by Dr. Alan Constantian, Deputy Chief Information Officer, Office of Information and Technology (OIT).

Introduction

In 2011, VA chartered several major transformation initiatives, including two to improve Health Care Efficiency, the RTLS project and the POU program. RTLS project was chartered to automate processes and improve health care services that VA provides to Veterans. The primary objectives of RTLS are tracking medical and surgical instruments through sterile processing, automating inventory management of specialized medical supplies in Cardiology, extending utilization and safety of medical equipment by knowing its location in real time, and monitoring temperature of medication storage areas. In addition to improving operational efficiency, these RTLS applications create a safer system of care for Veterans. VA planned to deploy RTLS in several phases within the Veterans Integrated Service Networks (VISN) and Consolidated Mail Outpatient Pharmacies, with the goal of deploying RTLS to all VA medical facilities.

The VHA POU program was chartered to acquire and install a Commercial-Off-The-Shelf (COTS) supply chain management system to effectively manage the consumable medical supply inventories throughout the medical center. An effective supply chain management system would allow visibility of stock levels of consumable supplies by employing different technologies to provide data to minimize stock outs, decrease process inefficiencies, and create cost savings by reducing excessive supply inventories.

The RTLS and POU programs had separate and distinct functions relating to health care operations and the VHA supply chain. RTLS centered on medical equipment and instrument tracking and specialized medical supplies specifically in the Cardiac Catheterization (Cath) Lab, while POU focused on all consumable supplies used in patient care.

Deployment of RTLS

While basic RTLS technology (otherwise known as Radio Frequency Identification) is commonplace in several industries, it is relatively new to health care. VA conducted market research through site visits, industry days, and limited scope demonstrations. We defined requirements and determined an acquisition strategy. In June 2012, VA awarded a firm-fixed-price, indefinite delivery, indefinite-quantity contract to Hewlett Packard Enterprise Services (HPES). The contract scope encompassed design, installation, testing, and maintenance of RTLS. Task orders were to be issued against the contract, which had a \$543 million ceiling. The two initial task orders issued were for deployment of RTLS in VISN 23 and for system design standards and interface development. Sixteen task orders were subsequently issued. As of April 2018, the total awarded value was \$345 million against the contract.

The RTLS project is jointly managed by VHA and OIT, per a Memorandum of Understanding signed in 2011 by the Under Secretary for Health and the VA Chief Information Officer. The RTLS solution utilizes COTS technologies and software to directly support patient care delivery and outcomes. VHA established a Project Management Office to assist VHA facilities with the procurement and deployment of RTLS and to coordinate project execution with OIT. Contracting Officer Representatives (COR) were assigned to manage each task order, typically a VISN-level biomedical engineer for VISN task orders, or an information technology (IT) project manager for IT task orders.

RTLS requires extensive infrastructure to be installed throughout entire hospital buildings, with design and installation generally taking 1–2 years. Consistent with objectives of the major transformation initiative, installation progressed simultaneously at facilities to achieve transformational benefits across VA. The Fargo VA Medical Center (VAMC) in VISN 23 was the first site to complete installation and test the system in March 2015. VA identified several defects, and the contractor was formally charged to correct them. The progress on deployment in other facilities was delayed or halted while Fargo VAMC discrepancies were investigated. During that time, VISN 23 and VISN 8 task orders expired.

With technology projects of the scope and complexity of RTLS, it is common to periodically reassess the program and adjust the approach to achieve the best outcome and minimize programmatic and cost risks. In September 2016, VA made a program decision to realign the RTLS program and entered into negotiations with HPES with a shared goal to expedite the implementation of the RTLS solution. Specifically, to capture the agreements made during these negotiations, VA modified the existing RTLS contract and executed a Global Settlement Agreement that resulted in a realigned implementation strategy, agreement on system requirements, improved clarity of location accuracy objectives, and a new deployment schedule through 2018. Changing the implementation strategy to deploy applications independently and in phases has led to positive deployment progress.

Positive Outlook

The deployment of RTLS accelerated following the contract renegotiation, with many positive outcomes continuing through the present. VHA is realizing benefits from all RTLS applications. The Sterile Processing solution has been successfully implemented at 60 facilities. With 1,000,000 surgical and dental instruments being tracked, the right instruments are being delivered to the right Operating Room for the right surgical procedure. The Cath Lab solution has been deployed at 28 facilities and is generating notable supply cost savings. In fiscal year (FY) 2017, one VAMC reduced Cath Lab supply costs by \$700,000 due to more efficient management. Many VISNs, including VISNs 8 and 23, are utilizing the Sterile Processing and Cath Lab solutions.

Asset Tracking deployment, the most infrastructure-intensive RTLS application, has also progressed. Asset Tracking has enhanced the safety, utilization, and maintenance of medical equipment. For example, one hospital remediated a safety issue with 300 infusion pumps within 2 weeks because all infusion pumps were quickly located. Without RTLS, it would have taken 2 months and significantly more labor hours to complete the safety remediation. Infusion pumps administer medication intravenously and equipment errors may lead to patient harm. VA intends to use RTLS to track location of its entire fleet of 35,000 infusion pumps, which will have immense positive impact on patient safety. An additional example of the efficacy of RTLS is that it allows hospital staff to proactively retrieve equipment for cleaning after patient use, thus maximizing availability of equipment for patient care. Asset Tracking installation is substantially complete at 32 sites, with system testing in progress. 105,000 equipment assets are tagged for real time location awareness.

VHA is gathering benefits data and will assess the return on investment over the next year. The early measures of success in both Cath Lab and Sterile Processing is positive and has led to increased interest from other VHA facilities to implement the solutions.

VHA and OIT Response to OIG Report Findings

In September 2015, the VA Office of the Inspector General (OIG) received an allegation claiming VA management failed to comply with VA policy and guidance when it deployed RTLS without appropriate project oversight. OIG conducted an official review, spanning the time period during and after completion of the Global Settlement Agreement. The review resulted in three findings that VA contested, but agreed to implement to further strengthen the program.

OIG recommended that VA apply additional resources and implement improved integrated project management controls for the remainder of the project. VHA and OIT have continued to align and improve project management processes following the conclusion of the contract renegotiation and publication of the OIG report. More than 100 gate reviews have occurred since October 2017 at various steps in the deployment and testing process.

The OIG finding that VA did not follow an incremental project management approach was based on an interpretation of VA policy regarding management of IT projects. The September 29, 2017, OIG Report, "Review of Alleged Use of Wrong VA Funds to Purchase Information Technology Equipment," concluded that the use of medical funds for RTLS was appropriate. The RTLS deployment efforts have been

managed utilizing sound project management practices. For example, gate reviews are conducted for various milestones, and deployment work in several VISNs was paused following unsuccessful testing at the Fargo facility. Additionally, planned investments were suspended pending successful deployment of RTLS at lead facilities.

OIG identified the need for VA to implement improved risk assessment oversight to identify potential vulnerabilities that may adversely affect other VA systems. VA conducted risk assessments prior to previous RTLS deployments and an Authority to Operate was in place for all systems that were deployed to the network. VA will perform continual risk assessments to assure that the risks associated with deploying additional RTLS systems on the VA network are minimized.

The VHA POU Program

A POU system provides asset visibility to the asset's POU. VA defines our POU as the medical supply rooms scattered in the wards and other clinical care facilities located throughout VAMCs. POU systems rely on enabling processes and technologies to include automated storage units, bar coding, and Kanban. The premise behind Kanban involves using a highly visual cue, such as an empty bin, to signal the need for replenishment. The VA system would utilize an integrating software system to bring these capabilities together to improve asset management efficiency. POU system software provides a fully integrated and intuitive platform through which an organization can analyze, monitor, and conduct the majority of data-driven tasks. There is an opportunity to collect, store, and administer data analysis through a single convenient portal, ensuring seamless communication within an organization. Integration would also allow for optimal tracking, collection, and analysis of data on all tasks, records, information, and activities performed within a system. This would increase efficiency on a large scale, ensuring smoother operations and improved productivity.

On April 11, 2013, the Executive Decision Memorandum creating the VHA POU program was funded with \$58 million of FY 2013 expiring funds. The POU program was envisioned and intended to provide an integrated supply chain management system capable of providing consolidated data to facilitate supply chain management. The consolidated data would be used to effectively manage consumable medical supply inventories throughout the VAMC, including the secondary (patient care area) inventory level, decreasing excessive stock levels, decreasing process inefficiencies and providing costs savings opportunities, and providing for expanded use of medical and surgical vendor contracts.

In June 2013, an acquisition package was assembled and provided to the contracting office, Program Contracting Office - East. VA solicited a full and open competition request for proposals, ultimately netting three proposals. The competitive range reduced the number of offerors for consideration to two. Both offers were evaluated in accordance with the source selection plan and based upon their technical proposal. Shipcom Wireless, Inc., a small disadvantaged business, was awarded the contract on September 23, 2013.

The contract required 20–35 assessments and implementations in each contract period. Assessments were to document current state of technology, inventory management processes and procedures, and stock levels in each facility. After an assessment was completed, the Contractor was to propose a POU solution, including automation, storage equipment, and processes, designed to create efficiencies and provide data to manage inventory stock levels. During the base period of the contract 27 site assessments were completed, but due to contractor and government delays, only 8 of the 27 sites were implemented with the Contractor's solution (Catamaran). The first option period was exercised in September 2014 and while no new assessments were completed, 14 more sites were implemented. The contractor was significantly behind schedule, and because there were other implementation delays, it became apparent that they would not be able to complete the required number of facilities within the contractually specified time period. Thus, modifications to the contract were executed. The second option period was exercised in September 2015, but due to schedule delays, assessments for this period did not begin until December 2015. VHA leadership was committed to the continuation of the program, and the Contractor was required to submit a corrective action plan, outlining a schedule catch up. No assessments or implementations were completed in the second option period as the Contractor proposed significant changes to the contract pricing to complete the work.

In April 2016, a new Contracting Officer and COR were assigned to the project who in turn reiterated to the contractor that the contract was firm-fixed-price and clearly restated the contract requirements and deliverables. The Program Office worked with the vendor to identify specific shortcomings in the required site assess-

ment reports, such as lack of site implementation plans, billing and invoicing deficiencies, and insufficient site documentation and equipment inventory records.

On June 3, 2016, a corrective action plan was submitted by the vendor requesting another time extension for an additional \$59.9 million to complete the contract requirements. This corrective action plan did not provide corrective actions based on governmental concerns, rather it proposed additional work and additional costs to the performance work statement already part of the contract. The contractor was unable to complete site assessment reports in accordance with the contract requirements despite numerous attempts to review report deficiencies and to provide guidance to correct said deficiencies. The Program Office also began investigating the recurring costs of future software licenses and maintenance. Research showed that these costs would be an estimated \$54 million per year, even with a proposed decrease in license fees. This figure was deemed unsustainable based on the following: a new Return on Investment analysis was performed by the Veterans Engineering Resource Center, utilizing the vendor's new implementation costs and extension request. The result of this analysis indicated that the POU program would not see a "break even" on the investment of \$275 million for over a decade.

In addition to escalating costs proposed by the vendor, the Shipcom POU solution, including its supporting Catamaran software, was not meeting contractual requirements, nor was it meeting the intended operational needs of the program to "establish an integrated supply chain system that was capable of providing consolidated data to facilitate supply chain management." The decision was made to stop further assessments and implementations and not exercise future option periods of the contract.

Upon decision to discontinue the contract effort, a plan was derived to transition the 22 sites that had converted to the Catamaran system, including the DC VAMC, back to VA's Generic Inventory Package (GIP). The POU program team pulled the consumable supply inventory data from the Catamaran system and uploaded that into GIP using the Excel tool. Over the course of seven weeks in January and February 2016, the POU program team traveled to the sites to educate the facility staff on use of the tool and to transition the data.

Conclusion

RTLS has significantly improved the efficiency and safety of health care of our Veterans. Patient safety and infection control are improved because surgical instruments are being tracked through sterile processing. Utilization, safety, and maintenance of medical equipment are improved. Cost savings are being realized in Cath Labs. In order to sustain these efforts, we ask Congress for continued support of VA modernization by investing attention and financial resources into this process automation system that is crucial in keeping our Veterans safe. It is critical that we continue to move forward with the current momentum and preserve the gains made thus far. Your continued support is essential to providing care for Veterans and their families. Mr. Chairman, this concludes my testimony. My colleague and I are prepared to answer any questions.

Prepared Statement of Nicholas Dahl

Mr. Chairman, Congresswoman Kuster, and Members of the Subcommittee, thank you for the opportunity to discuss the Office of Inspector General's (OIG) report, Review of Alleged Real Time Location System Project Mismanagement.¹ Our statement today focuses on our review of whether VA effectively managed the Real Time Location System (RTLS) project to meet cost and schedule targets, and performance and security needs. I am accompanied by Mr. Michael Bowman, Director, OIG's Information Technology and Security Audits Division.

BACKGROUND

Since 2000, the VA OIG has identified Information Technology (IT) Management as a major management challenge because VA has a history of not properly planning and managing its critical IT investments. OIG audits in recent years established that IT systems development at VA is a long standing high-risk challenge, susceptible to cost overruns, schedule slippages, performance problems, and in some cases, complete project failures. VA continues to face challenges in developing the IT systems it needs to support VA's mission goals.

¹ Published on December 19, 2017.

In 2011, the Veterans Health Administration (VHA) selected RTLS as the technology to provide tools to assist in the automation and improvement of operations and health care services that VHA provides to its veterans. RTLS was created to support VA's Health Care Efficiency major transformation initiative and to enable VHA to achieve clinical objectives, administrative process efficiency, and total asset visibility. In particular, RTLS uses multiple technologies for locating and tracking medical equipment. VHA intended to deploy it at all medical facilities nationwide.

In June 2012, VHA awarded a firm-fixed-price, indefinite-delivery, indefinite quantity negotiated contract with a \$543 million ceiling to Hewlett Packard Enterprise Services to deploy a nationally integrated RTLS solution over the course of five years. This solution was to include commercial off-the-shelf technologies and software applications. The RTLS procurement and implementation process was a cooperative effort between VHA, the Office of Acquisitions and Logistics, and the Office of Information and Technology (OIT).

VA policy required that the RTLS project be managed under VA's Project Management Accountability System (PMAS). PMAS was a project management system intended to establish a discipline to ensure that an IT project's customer, project team, vendors, and all stakeholders would focus on a single compelling mission—achieving on-time project delivery. PMAS used incremental product build techniques for IT projects with delivery of new functionality, tested and accepted by the customer, in cycles of six months or less.

REAL TIME LOCATION SYSTEM PROJECT

We received a complaint alleging VA management failed to comply with VA policy and guidance when it deployed RTLS assets without appropriate project oversight. The complainant also stated that VA deployed RTLS assets without meeting VA information security requirements. Consequently, we focused our review on whether VA effectively managed the RTLS project to meet cost and schedule targets, and performance and security needs.

In December 2017, we reported that management failed to comply with VA policy and guidance when it deployed RTLS assets without appropriate project oversight. Specifically, we concluded the RTLS Project Management Office (PMO) did not follow guidance from VA's Technology Acquisition Center (TAC) to use an incremental project management approach during the acquisition and deployment of RTLS assets to compensate for numerous known project management risks. We also reported that the RTLS PMO did not comply with VA policy requiring the use of the PMAS incremental oversight processes for all acquisitions and delivery of RTLS assets. Despite TAC guidance and VA policy, the RTLS PMO did not ensure the vendor could meet contracted functionality requirements on the initial \$7.5 million task order, such as accurate asset tracking, before ultimately committing a total of \$431 million to the same vendor for further RTLS deployments.

VHA had awarded an initial \$7.5 million task order to deploy RTLS to one of its Veterans Integrated Service Networks (VISN) with an expected delivery date in December 2013.² However, during initial VISN operational testing in March 2015, VHA identified 245 functionality defects that resulted in the issuance of a contract cure notice³ to the vendor. By June 2016, the cure notice was still unresolved, as 46 significant defects were still outstanding including RTLS' inability to meet contract requirements for asset tracking and software functionality. Overall, the VISN task order included more than 20 contract modifications that resulted in changes to the project's scope and schedule, and significantly increased the final task order costs. The VISN allowed this task order to expire on the contract end date in July 2016 and ended its participation with the RTLS project.

In September 2016, VA renegotiated the RTLS contract due to the vendor's inability to implement a functional RTLS solution. The renegotiation was intended to realign RTLS and expedite the implementation of the RTLS solution in each VISN. Specifically, VHA executed a Global Settlement Agreement that resulted in extensive changes to the vendor's contract requirements, to include expiration of task orders for two VISNs, reduction in the scope of RTLS applications deployed, extension of the contract period of performance through June 2018, and commitment of \$431 million in total costs to the vendor as of December 2016. According to the agreement, VA also released the contractor from any liability claims related to prior performance on the contract.

We also found that VA deployed RTLS assets without appropriate project oversight because management failed to provide effective oversight of the RTLS project

² VISN 23 - VA Midwest Health Care Network (Eagan, Minnesota and Lincoln, Nebraska)

³ Per FAR 49.607, a cure notice informs the contractor of a specific failure and gives them an opportunity to cure the defect within 10 days.

from acquisition through development and implementation. Specifically, VA's Office of Planning and Policy's Enterprise Program Management Office provided minimal oversight of RTLS project management activities. Further, the RTLS PMO did not follow project implementation policy, including adherence to VA's PMAS process and lacked the oversight authority to ensure success of an enterprise level deployment involving information technology.

We also substantiated the allegation that VA deployed RTLS assets without meeting VA's information security requirements. VA's fundamental mission of providing benefits and services to veterans is dependent on the Department deploying secure IT systems and networks. VA's information security program and its practices are designed to protect the confidentiality, integrity, and availability of VA systems and data. Specifically, we reported the RTLS PMO and OIT personnel deployed RTLS assets without the appropriate system authorizations needed to connect such devices to VA's network. This inadequate oversight of RTLS risk management activities left VA mission critical systems and data susceptible to unauthorized access, loss, or disclosure. Consequently, VA's internal network faced unnecessary risks resulting from untested RTLS system security controls.

Given the uncertainty of the project, future RTLS cost estimates are unknown. Further, we reported, that VA must exercise cost control, sound financial stewardship, and discipline in RTLS development. VA also must demonstrate that RTLS is a worthwhile investment, providing taxpayers with a good return on investment. Consequently, we stated that it is imperative that VA use incremental and validation-based project oversight processes to ensure that VA does not incur additional project costs without achieving RTLS required functionality. VA's failure to deliver a successful RTLS solution will prevent the Department from achieving its Health Care Efficiency goals of facility automation, administrative process efficiency, and total asset visibility. As a result of inadequate project management, VA lacked assurance of an effective return on the \$431 million invested in RTLS and that deployed assets were operating in accordance with contract requirements.

We provided several value added recommendations for improving controls over VA's oversight of system development projects. This included recommendations addressing the need for VA to apply additional resources and implement improved integrated project management controls for the remainder of the project to restrict further RTLS cost increases and the need to enforce the use of incremental project management and validation controls on all remaining RTLS task orders to ensure such efforts will provide an adequate return on investment.

The Executive in Charge, Office of the Under Secretary for Health and OIT's Acting Assistant Secretary concurred with our recommendations. The Executive in Charge reported VHA and OIT are addressing program resourcing and project management controls and will implement improved controls. Management also stated that OIT committed a senior project manager resource and VHA will pursue approval of increased staffing. Additionally, an RTLS Governance Council, which will have responsibility for defining cost, scope, and schedule performance metrics, is in development. Furthermore, the Executive in Charge reported the RTLS Governance Council will assure implementation of project management oversight that includes organizational risk management for technology deployment. Regarding the information security finding, the Acting Assistant Secretary reported that OIT will conduct risk assessments prior to future deployments to minimize risks associated with the deployments. The OIG will monitor implementation of planned corrective actions to ensure that our recommendations are addressed.

CONCLUSION

Our recent work demonstrated that VA continues to face challenges in managing its IT development projects. Our review of RTLS indicated VA needs enhanced discipline, oversight, and resource management to support successful IT development. VA has taken some actions to address issues we identified in our RTLS report and in other recent reports; however, it remains to be seen whether the actions will effectively improve VA's ability to meet cost, schedule, performance, and security goals when managing mission-critical system initiatives.

Mr. Chairman, this concludes my statement. We would be happy to answer any questions you or Members of the Subcommittee may have.

