Regional Tri-Service Medical Logistics Support Program

Implementation Guidance

(Version 3.0C-1)

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Executive Summary

This is an update to version 3.0C (10 July 2000), which was a complete rewrite of versions 1.98 and 2.0 of the *Implementation Guidance for Tri-Service Medical Logistics Support Programs*. It combined all versions into a single document, incorporates Service comments to date, and consolidated policy and guidance into a single chapter. Additional chapters provided details on background, rationale, and procedures. Version 3.0C also built on the progress that was made in establishing regional business offices and the partnerships that developed between the DoD healthcare regions ("TRICARE regions") and the Defense Supply Center, Philadelphia (DSCP). Version 3.0C of the *Implementation Guidance* is still a dynamic document, as the program is still evolving. The Update Number 1 contains some editing changes and incorporates Appendix F, Associated Policies. Future updates will continue to be released to this document, rather than as separate volumes.

This *Implementation Guidance* provides the framework for implementation of DoD Health Affairs Policy 98-013, 23 January 1998, which directs the establishment of regional tri-service medical logistics support programs. It also enables DoD to pursue its targeted savings goals for regional purchasing and maintenance in support of Defense health program operations.

The regional medical logistics support program is the first major revision of the peacetime healthcare logistics system in almost a decade. It has the potential to reduce costs, improve responsiveness, strengthen collaboration with suppliers, and enhance readiness.

Chapter 1. Introduction

A. BACKGROUND

In late 1997, a study commissioned jointly by the Acting Assistant Secretary of Defense (Health Affairs) (ASD[HA]) and the Assistant Secretary of Defense (Comptroller) issued eight broad recommendations aimed at improving the effectiveness and efficiency of tri-service managed healthcare operations within the Military Healthcare System (MHS). Two of the eight recommendations affected the medical logistics functional area by directing the establishment of regional, tri-service medical materials management and biomedical maintenance programs in each DoD healthcare region. The recommendations form the basis for the ASD(HA)-led Medical Consolidation Initiative. The Army was designated as the Executive Agent for the regional programs, and the Army's Deputy Surgeon General was named as the principal official. Viewed together, the materiel and maintenance functional areas form a powerful nucleus for creating regional programs for the entire spectrum of logistics support functions. This study subsequently was given further impetus by the Acting ASD(HA), who signed HA Policy 98-013 in January 1998 to direct implementation of the regional concept. A Draft Concept of Operations (ConOps) was distributed in February 1998, which served as the starting point for this implementation guidance. The regional operations will be designed to capture cost savings and efficiencies resulting from regional actions. They will target the optimal use of available commercial support. The Medical Logistics Proponent Subcommittee (MLPS) will provide logistics program development and review, guidance for regional structures and operations, and general logistics advice to the Executive Agent. Medical logistics policy development will rest with the services' medical logistics chiefs or consultants, who will coordinate their work jointly through the forum of the MLPS.

Regional medical logistics programs have been initiated in several DoD healthcare regions. Early results indicate without exception that there is significant potential for program growth and resultant cost savings. This *Implementation Guidance* provides a framework for the systematic application of regional business practices throughout the MHS.

B. CURRENT OPERATIONS

Medical logistics in the MHS is big business. The MHS is a $15 billion-per-year entity. As a rule, private sector consulting firms estimate that 40 percent of a healthcare system's costs are logistical.[1] Of that, roughly half involves nurses, technicians, and other clinicians. The remaining half can be traced directly to the materials management, biomedical maintenance, and facilities management

[1] Source: Thomas Hughes, Concepts in Healthcare, Inc., Waltham, MA: 1997.

processes commonly found in the logistics operations of DoD's MHS. This means that medical logistics accounts for approximately $3 billion of the $15 billion spent on Defense healthcare.

The single largest element of these logistics operations is the medical materials acquisition and management function. Medical materials cost DoD approximately $2 billion annually.[2] Programs such as Prime Vendor have been successful because they drive inventory out of DoD's warehouses, reduce logistics cycle times dramatically, and permit pricing analysis and improved item selection at the facility level. These gains have been largely local, and current medical materials management activity is structured and operated around the concept of activity- or installation-level stock record accounts. Beyond the level of individual medical treatment facilities, there is little to no ability to analyze buying patterns, pricing levels, distribution trends, or perform other acquisition analysis functions. Moreover, the significant benefits of Prime Vendor were achieved through changes that were largely supplier-focused, rather than internally focused on DoD's healthcare and medical logistics activities. Finally, use of accepted commercial practices, such as standardization, consolidation of buying power through aggregated consumption tracking, and committed volume purchasing is limited. Systemic tools such as standard electronic commerce transactions and universal product identification numbers are being implemented, but on a limited, incremental basis.

Another major component of DoD's logistics operations is the biomedical maintenance. As with materials management, biomedical maintenance activities are almost exclusively a hospital-level function. Virtually all military medical treatment facilities (MTFs) have in-house maintenance experts, with extensive augmentation by contractors. Most such contractors operate under contracts developed locally, although the military does award some national contracts for widely used equipment items. Stockage of repair parts is more decentralized and less systematized than the medical materials described above. It is difficult to estimate the investment they represent. Each facility operates its own repair shop, with extensive (and expensive) test, measurement, and diagnostic equipment (TMDE), repair parts stockpiles, and repair equipment. Most significant is the decentralized negotiation, awarding, and administration of service contracts. While this ensures responsiveness to local needs, it also adds to local contracting and administrative workload, Regionalization may represent an area for additional savings. Some regionalization of maintenance activities already has occurred, particularly for complex medical devices which require repair expertise. These activities probably can be expanded significantly.

C. FUTURE VISION

Medical logistics leaders have moved away from an MTF-centered view of logistics and materials management, in which purchasing, management, warehousing, distribution, and maintenance of medical supplies and equipment is conducted independently within each hospital. The new view involves a regional logistics management operation with "hub-and-spoke" flow of information, materials, and services between military medical facilities using state-of-the-art information

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[2] Functional Economic Analysis for Defense Medical Logistics Standard Support, Office of the Assistant Secretary of Defense (Health Affairs), 1996.

systems and their commercial suppliers, who operate lean, just-in-time distribution and maintenance systems. Following is a vision statement for this new, regional tri-service operation:

> Clinical and logistical leaders in the MHS will operate an integrated, tri-service medical logistics system, organized on a regional basis within DoD healthcare regions, to provide quality materials and services at the lowest delivered costs, and to increase the efficiency and effectiveness of clinical outcomes.

Regional medical logistics management activities will operate according to four performance imperatives:

1. Clinically driven standardization programs will reduce the number of different products within specific product lines to allow for volume discounts and more efficient distribution.

2. Purchasing methods and processes will be geared toward best-value purchasing to obtain the lowest delivered costs for supplies and services.

3. Information about contracts, equipment status, product purchasing, pricing, distribution, consumption, and other acquisition activities will be available across and between DoD healthcare regions.

4. Information flows based on electronic commerce (EC) functionality will provide feedback to enable monitoring of local and regional buying patterns and to improve compliance with standardized product formularies or portfolios.

The future vision will occur in four phases over 3 to 5 years. The existing logistics management system, which has focused on hospital-level inventory and maintenance management systems, will be converted gradually to regional coordinated business units. Hospital-based logistics staffs will continue to provide intra-hospital materials distribution, emergency support, and other strictly local functions. Many logistics management functions can be coordinated regionally for better inter-organizational collaboration, reduced overhead, and improved local support. Substantial benefits are available through pooled purchasing, regional standardization, and integration with regional suppliers. These benefits will be captured in the first two phases of regional implementation, shown in Figure 1. The first phases also will establish the procedural and organizational framework for true regional operations. These first phases will include the fielding of new information systems by the Defense Medical Logistics Standard Support (DMLSS) program office that will permit interorganizational, real-time analysis of purchasing patterns. The next two phases will provide the opportunity to reengineer existing hospital-centered logistics operations into regional multi-facility support organizations. The final goal of regional reorganization is a series of fully mature, regional operations at each DoD healthcare region, with the likely emergence of an overarching integration or coordination function at the DoD or joint services level.

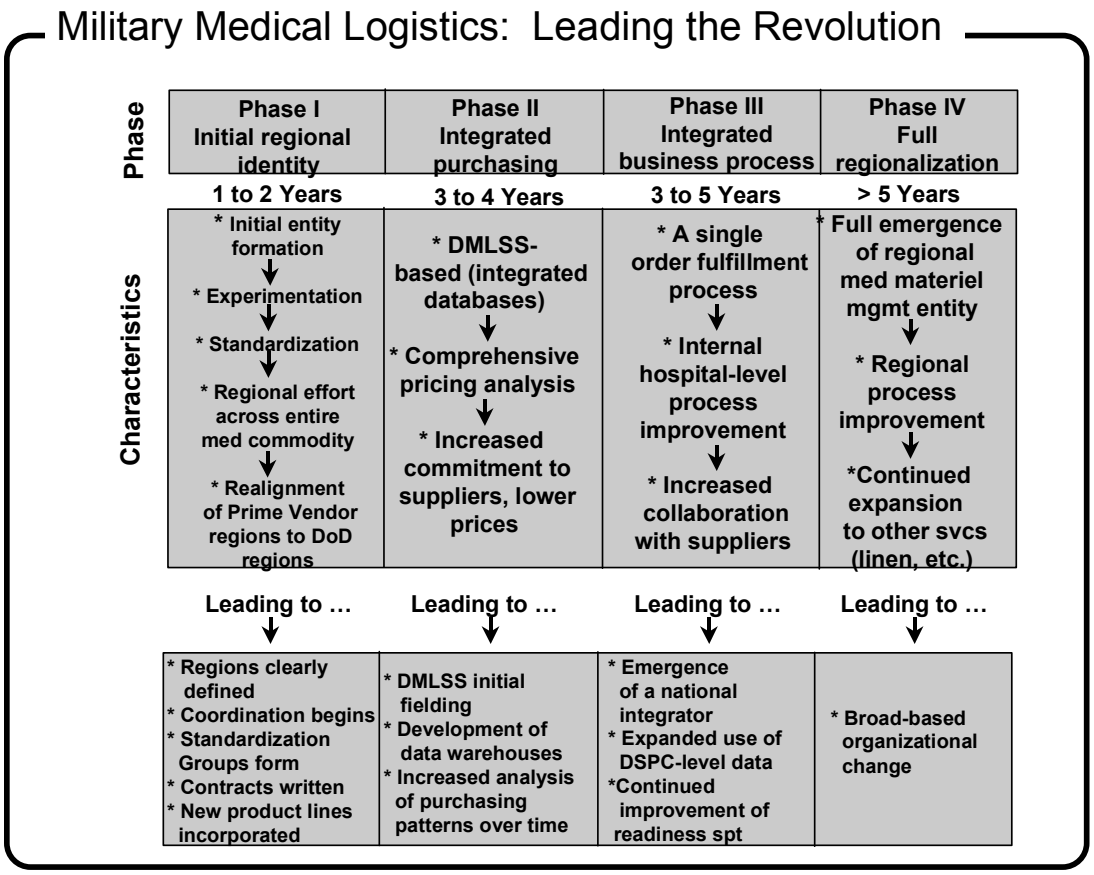


Figure 1. *Implementation of Regional Logistics Operations*

DoD also is working to develop its standardization concepts through the use of Internet information clearinghouses, sites that can collect and relay the valuable lessons learned, procedural tips, and organizational hints to support standardization activities. The Army Medical Department (AMEDD) has developed an Internet site, the AMEDD Knowledge Management Network (KMN), which allows users to read current information, post their own information, or submit comments, questions, and observations for response by others. DoD regions should examine the KMN to see if its tools fit their needs.

By using our combined purchasing volume and standardization potential, all DoD healthcare regions can leverage centralized, aggressively negotiated, tiered-pricing contracts. DoD or the Department of Veterans Affairs (DVA) will negotiate these contracts through the DSCP Prime Vendor vehicle. The contracts should be studied to determine the most favorable *regional* use of *national* contracts. DSCP is introducing a suite of new acquisition strategies, including the Electronic Catalog (ECAT) acquisition tools, regionally targeted Distribution and Pricing Agreements (DAPAs), and access to DVA price schedules. All of these tools are targeted at reducing the use of inefficient local buying methods, such as local purchase, credit cards, and Blanket Purchase Agreements (BPAs). This will be accomplished by substituting more efficient contracts negotiated from a leveraged position of volume and strength. Regional integration with DSCP programs is crucial.

DoD's position is that committed volume purchasing through standard contracts is necessary and desirable. Regionalization, standardization, and consolidation of supply procurements offer great potential for improving DoD's logistics and clinical care. Because of this potential, DoD remains committed to the use of Prime Vendors as the preferred source for its supplies, and will measure purchasing ratios for its regions (see "Measuring Success" in the following section). These purchasing ratios will be used to monitor the proportional distribution of purchase volume among various sources of supply, including Prime Vendors, credit cards, local purchase, and BPAs and Decentralized Blanket Purchase Agreements (DBPAs).

Chapter 2. Policy and Guidance

A. GENERAL

The DoD policy for regional logistics is contained in HA Policy 98-013, January 1998. It prescribes the establishment of regional medical logistics programs organized under the leadership of DoD healthcare region ("TRICARE region") Lead Agents. All DoD Military Healthcare System (MHS) activities will participate in regional tri-service medical logistics programs according to the policies and procedures outlined in this *Implementation Guidance* and directives from their respective Services. To the extent possible, regional logistics programs will seek economies through partnership with activities of the DVA and other federal agencies within each region. Regional programs will be established for each of the medical logistics business areas:

- Materials standardization and purchasing
- Clinical engineering/biomedical equipment maintenance
- Logistics services (housekeeping, linen, and laundry services).

B. GOAL AND OBJECTIVES

The goal of tri-service regional logistics is to *support the MHS with logistics processes that will provide the most appropriate products and services at the lowest delivered cost*. Key objectives for achieving this goal are to create regional programs that will

- establish regional standardization of materials,
- establish regional or national committed volume-purchasing strategies,
- promote the development of best clinical practices,
- increase the use of DoD Prime Vendors and other electronic commerce,
- establish regional standardization of biomedical equipment,
- improve the regional coordination of biomedical maintenance services,
- develop an information architecture to support regional business processes,
- promote knowledge sharing among DoD TRICARE regions,
- establish regional tri-service business support offices, and

- promote centralized contracting for logistics services.

C. REGIONAL BUSINESS ORGANIZATION

Medical Logistics Regional Business Units. Regional logistics support programs generally will be focused on DoD healthcare regions; however, where appropriate to achieve economy and reduce redundancy within the MHS, these regions will be organized into alliances called Medical Logistics Regional Business Units. Where Medical Logistics Regional Business Units are established, one Service will be responsible for coordinating efforts among the Lead Agents that comprise the alliance. Chapter 3, "*Organizational Framework*," provides the current configuration of Medical Logistics Regional Business Units and designates Service responsibility for leadership.

Tri-Service Regional Business Offices. Tri-Service Regional Business Offices will be established and aligned with Medical Logistics Regional Business Units to support regional logistics initiatives, particularly efforts for regional standardization and committed volume purchasing. These support offices provide a focal point for coordination among regional customers, supporting acquisition agencies, and private-sector vendors. Normally they will fall under the direction of the senior logistician of the lead Service for the Tri-Service Medical Logistics Regional Business Unit. Specific responsibilities are described in Appendix D**. Army Regional Medical Commands vs. Medical Logistics Medical Logistics Medical Logistics Regional Business Units.** The Army is unique among the Services. It has a formal medical command and control structure in the form of Regional Medical Commands (RMCs). In general, the Army RMC structures parallel the designated Medical Logistics Regional Business Units described in this *Implementation Guidance* and will support its tri-service logistics initiatives. When an Army activity is located outside of the TRICARE region or Medical Logistics Regional Business Unit that constitutes most of its RMC, it will be aligned with the TRICARE region or Medical Logistics Medical Logistics Regional Business Unit where it resides. During the implementation phase of this program, this may require these activities to transition from one regional program (RMC) to another (TRICARE).

Defense Supply Center, Philadelphia. DSCP is the principal source of acquisition support for regional materials purchasing programs. DSCP will establish a forward presence in the Tri-Service Regional Business Offices, and support the establishment of regional pricing agreements and contracts. DSCP also will be the primary focal point for national cooperative agreements for supply and equipment acquisition with the DVA.

D. PROGRAM OVERSIGHT

The success of regional logistics initiatives depends on the exercise of *authority* and the achievement of *consensus* among the stakeholders to achieve program goals and objectives. Stakeholders exist at the MHS, regional, and local levels.

Authority for overall program implementation and execution is derived from two sources:

- ASD(HA) establishes the responsibilities of the Lead Agents for DoD healthcare regions and delegates Executive Agency for development of program implementation guidance, and

- Deputy Surgeon Generals of the Military Services provide direction to the MHS commanders of their respective Services; authority for logistics initiatives within each DoD healthcare region resides with those commanders.

Consensus for decision-making at the MHS and regional levels will be achieved through the following program framework:

Executive Agency. Office of the Army Surgeon General is the Executive Agency for development of this program guidance. Executive Agency provides program leadership, facilitation, and integration of MHS program issues and policies. The Army Deputy Surgeon General (DSG), staff principal for this Executive Agency, establishes responsibilities for implementation of the program through this *Implementation Guidance* to the regional Lead Agents. The Healthcare Logistics Directorate (DASG-LOZ) of the Army Surgeon General's Office and the office of the Assistant Chief of Staff for Logistics (ACSLOG) will provide staff support to the Executive Agency. The Army DSG will report program status to ASD(HA) as required.

Medical Logistics Proponent Subcommittee (MLPS). The MLPS will provide logistics policy oversight and serve as the forum achieving MHS-level consensus and approval for this *Implementation Guidance*. The MLPS is chartered to manage MHS logistics business process reengineering, implementation of best practices, and development of standard, tri-service medical logistics information systems. The MLPS will identify, validate, and prioritize system requirements for DMLSS that emerge from this initiative. The Services' MLPS members will report to their respective Deputy Surgeons General, establishing a link between logistics policy contained in the *Implementation Guidance* and the Services' direction to their respective MHS commanders.

Lead Agent. The Lead Agent for each TRICARE region is responsible for the operational execution of tri-service regional logistics initiatives in accordance with this *Implementation Guidance* and as directed by ASD(HA). Lead Agent responsibilities include the implicit requirement to establish a regional framework to manage logistics support initiatives, achieve regional consensus for decision-making, and provide clinical direction and accountability to regional logistics processes. These efforts will be coordinated with supporting agencies, which may, in select instances, assist with staffing, providing resources, and providing functional guidance for regional logistics policies, procedures, and practices. The senior logistician reporting to each Lead Agent will provide leadership for coordinating regional logistics activities to support this program. The Lead Agent will report program status to the Executive Agency, as required.

E. LEAD AGENT RESPONSIBILITIES

All TRICARE region Lead Agents will establish regional medical logistics support programs to achieve the goals and objectives outlined in this *Implementation Guidance*. Although specific processes and procedures need to be tailored to the organization, requirements, and opportunities particular to each region, each Lead Agent will take the following actions:

- **Establish Framework for MHS Commanders' Support.** Each Lead Agent must establish a regional process to achieve consensus and authority for logistics initiatives among MHS commanders in the region, particularly with respect to regional standardization and purchasing.

Generally, this is accomplished through the regional executive or governing committee that most TRICARE regions establish to manage TRICARE implementation within the regions. The framework for specific programs may be accomplished by developing regional policies that are ratified by the MTF commanders. Appendix G contains a sample policy for a regional standardization and purchasing program.

- **Designate a Clinical Leader.** Each Lead Agent will designate a clinician to provide direction, oversight, and support for product standardization and utilization, quality assurance, and other clinical aspects of regional initiatives.

- **Establish or Support a Tri-Service Product Review Board.** Each TRICARE region or Regional Logistics Business Unit will establish a standing committee with tri-service representation to provide coordination and oversight of the regional standardization processes. Each Tri-Service Product Review Board (TPRB) will have clinical and logistics representation from each Service to provide an appropriate balance of interests. The chairperson of the TPRB usually will be the senior logistician or clinical leader for the region or business unit.

- **Develop a Regional Medical Logistics Business Plan.** Each Lead Agent must establish, implement, and monitor the progress of initiatives to meet the goals and objectives of this program. Lead Agents will be responsible for reporting regional program status to the Executive Agency, as required.

- **Establish Lead Agent Procedures for Documenting Program Costs and Savings.** Each Lead Agent must establish procedures to identify and document resource costs and savings attributable to this program.

F. COMMANDERS

Regional logistics initiatives are intended to help commanders maximize the use of their resources; however, the success of this program depends on the discipline and support they devote to the program. In the military culture, only commanders can direct the efforts necessary to accomplish clinically led product evaluations, make or authorize binding decisions on behalf of the facility, and impose the discipline necessary to achieve compliance. Command authority rests within Service channels; however, it is the expectation of the Deputy Surgeons General of each Service that their commanders will support regional logistics programs.

G. CLINICAL LEADERSHIP

Clinical leadership is essential in the selection of materials and services that can provide the best value for achieving desired clinical outcomes. It is also crucial to obtain clinical consensus and compliance for product standardization decisions. Regional logistics, in particular regional product standardization, must be a clinically led enterprise, with logisticians in a supporting role. Clinical leadership must be demonstrated through the active and visible support of medical activity commanders and department chiefs, as well as clinician participation in regional Tri-Service Product Review Boards and Clinical Product Teams. It also must be demonstrated through the leadership and involvement of Lead Agents and their staff.

H. ACQUISITION STRATEGIES

Regional initiatives for purchasing materials and services will be accomplished in partnership with supporting government contracting activities in accordance with Federal Acquisition Regulations (FAR). Standardization decisions and committed volume purchase agreements may follow a range of strategies, discussed in Chapter 4. The Tri-Service Regional Business Offices established in each TRICARE region or business unit will ensure that these decisions and agreements are documented properly.

Prime Vendor. The primary acquisition method for regional materials purchasing programs will be the DSCP Prime Vendor program. A major program objective is to increase the use of DSCP Prime Vendors for medical surgical supplies (pharmaceuticals already are nearly exclusively obtained through the Prime Vendor program). The use of the DSCP Prime Vendor program is mandatory for the acquisition of products that are available through it.

Electronic Catalog. The DCSP ECAT program provides Web-based ordering capability for products not normally provided by Prime Vendors. Examples include laboratory, optical, and dental products. Planned additions to ECAT are medical specialty items such as cardiac catheterization and surgical implants. A major program objective is to increase the availability of non-Prime Vendor products into ECAT, and to expand its use by DoD customers. The use of ECAT is mandatory for the acquisition of products that are available through it. If the ECAT price for a class of products is significantly higher than the total delivered price through local purchase (including cost factors for manual ordering, receiving, and bill-paying), DSCP will coordinate to determine the reasons for the cost differences. Efforts will be made to obtain lower costs through ECAT. Service representatives will call to the attention of the MLPS any differences that cannot be reconciled. Similar to Prime Vendor, ECAT represents a means of electronic order entry and bill payment. It also provides visibility of materials purchases throughout MHS that will facilitate future standardization and volume purchasing negotiations. These advantages offset marginal price differences that may appear to favor local purchase.

Contracts. As regional purchasing programs and ECAT mature, opportunities will exist to enter into formal committed-volume contracts with vendors at the national and regional levels. Current regional contracts are being awarded for core formulary laboratory items for TRICARE Region 6, with the provision that other regions may be added. DSCP has awarded several national pharmaceutical contracts, some in partnership with the DVA, for specific classes of drugs. Formal contracts are binding, and their use is mandatory for all facilities that are party to such agreements.

I. COMPLIANCE

Achieving compliance with regional standardization decisions and purchasing agreements is a command responsibility. The participation and leadership of clinicians in decision-making processes should ensure that product and service selections contribute to clinical outcomes and represent the best value to the government. Compliance with corporate purchasing agreements is the expected norm in the private sector. After decisions and commitments are made, vendors will have a reasonable expectation that the activities will comply with agreements made on their behalf.

Non-compliance may result in the government being held in breach of its agreements, the loss of anticipated savings and outcomes, and erosion of industry confidence that regions can negotiate in good faith. This will compromise the government's negotiating position in achieving future best-value agreements. Regional standardization and purchasing programs will include specific processes for implementing and monitoring compliance with regional product decisions.

J. REPORTING

The Deputy Surgeon General of the Army, as staff principal for the Executive Agency for Regional Logistics Programs, will report program progress to ASD(HA) as required. The Office of the Army Surgeon General will establish reporting requirements for Lead Agents and Medical Logistics Regional Business Units. Lead Agents and Medical Logistics Regional Business Units will provide information copies for the Service Logistics Chiefs, monitor the progress of regional logistics business initiatives and report periodic program status as required by the Executive Agency.

K. READINESS

Regional logistics programs focus primarily on peacetime business processes and not directly on readiness issues. As effective regional logistics programs are established, there is significant potential for both indirect and direct contributions to the logistics readiness of the MHS. Possible contributions include the following:

- Cooperation and coordination of logistics activities among the Services to support mobilization and deployment
- Cross-training of supply and maintenance personnel to support Service-unique requirements
- Use of regional standardization programs to select materials for deployable medical sets, kits, and outfits (SKO)
- Selection of materials and equipment that have been adopted for readiness use for regional standardization.

The development of regional logistics programs at the MHS level will include participation of readiness stakeholders such as the Joint Readiness Clinical Advisory Board (JRCAB) and the Services' medical logistics agencies. Where possible within the primary goal and objectives of these programs, readiness issues will be identified and opportunities to improve readiness will be exploited.

Chapter 3. Organizational Framework

A. ORGANIZING FOR REGIONAL SUPPORT

DoD Healthcare Regions. DoD healthcare regions will be the lowest common denominator for regional standardization and services; that is, the lowest level for regional product standardization agreements and central contracting initiatives will be the TRICARE region. During the formative stages of regional logistics programs, each TRICARE region will establish its own TPRB.

Medical Logistics Regional Business Units. Where it is appropriate to achieve economy and reduce redundancy, TRICARE regions will be organized into alliances called Medical Logistics Regional Business Units. Where Medical Logistics Regional Business Units are established, one Service will be responsible for coordinating efforts among the Lead Agents that constitute the alliance. Medical Logistics Regional Business Units will be established as follows:

Regional Business Unit	Member Regions	Business Unit Leader
Northeast	DoD Regions 1, 2	Army
Southeast	DoD Regions 3, 4	Army
Heartland	DoD Region 5	Air Force
Central	DoD Regions 6, 7, 8	Air Force
Southwest	DoD Regions 9, 10	Navy
Northwest	DoD Region 11	Army
Pacific	DoD Pacific Region	Army
Europe	DoD European Region	Army

Medical Logistics Regional Business Units will be the focus for end-state regional logistics programs, and Lead Agents are encouraged to support the strengthening of these regional alliances, which means close coordination among regional logistics and clinical leaders and TPRBs. As an objective, it means coordinating and developing regional programs and agreements that apply to the entire Medical Logistics Regional Business Unit and consolidation of effort at a single TPRB.

Prime Vendor Regions. The DSCP Prime Vendor program is the primary acquisition source for pharmaceutical and medical surgical supplies. Currently, each Prime Vendor region covers a limited geographic area. Future Prime Vendor contracts will align Prime Vendor regions to match TRICARE regions to provide significant advantages in the regional standardization of product numbers, collection of demand and compliance data, and standardization of inventories within distribution areas. As planned, the next generation of medical and surgical Prime Vendor contracts will be multiple-award contracts, providing a selection of service levels for each Prime Vendor region. Where this option is available, the regional logistics leader for that TRICARE region or regional business unit, will act with the input of MTFs and the approval of the Lead Agent, to make the Prime Vendor selection.

B. TRI-SERVICE REGIONAL BUSINESS OFFICES

Purpose. Tri-Service Regional Business Offices will be established and aligned with Medical Logistics Regional Business Units to support regional logistics initiatives, particularly efforts for regional standardization and committed-volume purchasing. These support offices provide a focal point for coordination among regional customers, supporting acquisition agencies, and private-sector vendors. They usually will fall under the direction of the senior logistician of the lead Service for the Medical Logistics Regional Business Unit. Regional business offices also will be the primary focal point for establishing contract support to regional logistics support programs. Where possible and appropriate, Regional business office contract support will be extended from the Medical Logistics Regional Business Unit to member TRICARE regions.

Objectives. The objectives of the Tri-Service Regional Business Offices are to obtain and document cost savings by

- achieving high levels of regional standardization among medical and surgical products and developing a common regional medical and surgical product formulary for MTF stock rooms;
- creating regional committed volume purchase agreements, providing analytical and organizational support to clinical product teams and the regional Tri-Service Product Review Board;
- reducing the number of line items (SKUs) purchased within product lines through better utilization management and support for outcome-based clinical pathways;
- identifying and substituting lower cost products, using product and price comparison (PPC), the Universal Data Repository (UDR), and other government and commercial product identification tools;
- increasing the use of the DSCP Prime Vendor program for medical and surgical purchases, and reducing credit card and local purchases; and
- monitoring and reporting program progress, to include analysis and documentation of program savings.

Organization. Local needs, resources, and market opportunities will determine the structure of each regional business office. Many of the functions may be performed through contracting, shared staffing, or other creative alternatives to the traditional staffing for regional initiatives. Lead Agents will need dedicated personnel to perform overall coordination and facilitation. Personnel in each business unit should be designated to perform the following functions:

- The senior logistician of the lead Service will provide overall direction of the Medical Logistics Regional Business Unit, to include coordination and integration among the member DoD healthcare regions.
- The clinical leader designated by the Lead Agent will serve as the key interface between clinical and logistical communities, and provide clinical oversight to the regional business office and the TPRB. The clinical leader also will provide coordination among clinical counterparts of the member DoD healthcare regions.

- A support team consisting of logistics, nursing, and data management specialists will support materials standardization, product review, clinical trials, technology assessment, data analysis, and program documentation. Contracts established through partnership between the region and DSCP will provide this support team.
- Qualified contracting personnel designated by the DSCP will oversee negotiations with vendors and establish regional purchasing agreements. In some regions, contracting personnel from other contracting agencies may provide on-site support through agreements with DSCP.
- A clinical engineer or health services maintenance technician should support regional medical equipment management, including development of regional maintenance strategies and contracts, equipment technology assessment, and equipment standardization.

Other key functions of the regional business office include management analysis, including managed care and business case analysis; development of logistics acquisition strategies; and information management, including database development, data mining, and other data management tasks. This function also will include integration of MTF-level data with regional data, linkage of logistics and clinical data, and other advanced data services.

Of particular importance is the development and tracking of baseline and performance metrics that can document the savings and other benefits achieved by the program.

C. KNOWLEDGE SHARING

Critical to achieving regional objectives is the ability to share information among activities in each region, as well as among regional logistics leaders and MHS logistics leadership.

Knowledge Management Network. A key enabler for establishing regional logistics programs is the use of the World Wide Web to promote sharing and collection of information. The Web-based Knowledge Management Network (KMN), a product of the U.S. Army Medical Department Center and School (AMEDDC&S), includes a logistics community interested in regional standardization. The KMN provides a repository of detailed information on products that have been standardized or are under consideration for regional standardization. It also provides a Web-based capability for Clinical Product Team (CPT) members to conduct private discussions among themselves regarding product evaluations, clinical trial results, and the like. The strength of this capability will be to enable CPT members from facilities throughout a region to participate in CPTs without needing to travel or rely on video or telephone conferences.

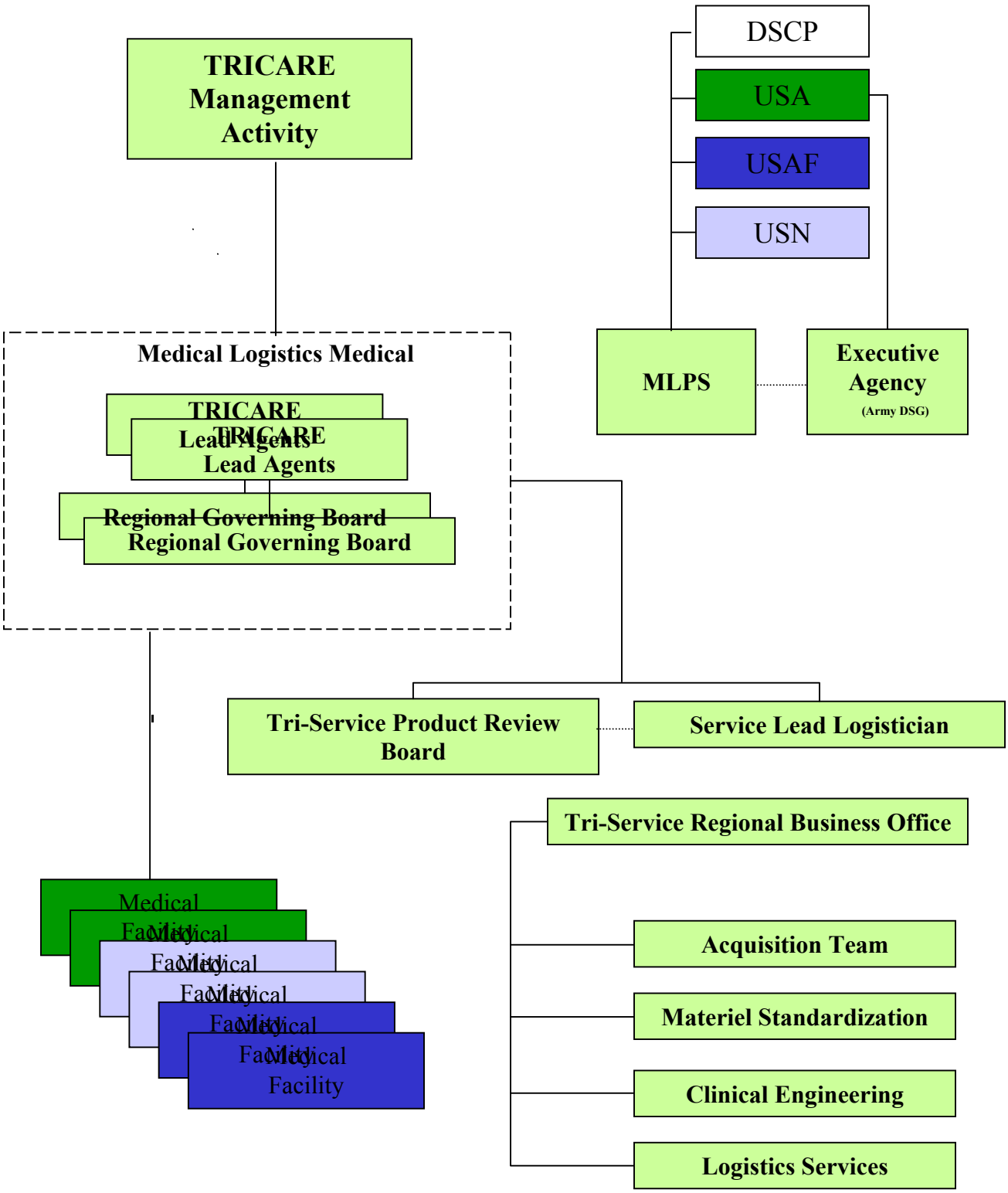
The KMN is accessible by Web browser at:

http://kmn.army.mil

Home Page. Another Web tool under development is a series of home pages for each Medical Logistics Regional Business Unit. These pages will provide common information on regional programs for logisticians, clinicians, CPT members, and vendors. These home pages will also include secure areas containing regional price-book information on existing regional agreements, and links to the logistics business area of the KMN.

Regional Logistics Teleconferences. The Assistant Chief of Staff for Logistics (ACSLOG), U.S. Army Medical Command, will host periodic teleconferences to review program status and provide a forum to compare experiences and ideas and to develop future strategies. The principal participants will be the regional logistics leaders and members of the regional business offices. The point of contact is the Chief, Business Operations Division, (210) 221-8527, DSN 471.

Organization for Regional Logistics



Chapter 4. Materiel Standardization and Regional Purchasing

A. MATERIEL STANDARDIZATION

Materiel standardization is the cornerstone initiative of regional logistics programs, and presents significant opportunities for direct and indirect financial savings. Materiel standardization also can support clinical efforts for utilization management and development of outcome-based pathways and protocols.

Within the context of this *Implementation Guidance*, materiel standardization is a clinically led process to select and procure the most appropriate products, based on cost and clinical acceptance, for use throughout a TRICARE region or Medical Logistics Regional Business Unit. Standardization ranges from the selection of individual items to broad product groups; it must be supported by purchasing methods appropriate to the cost and complexity of the standardization decision. Expected outcomes and benefits of regional standardization include

- availability and use of most appropriate products;
- lowering of supply chain costs through reduction in the purchase price of supplies;
- reduction in the amount of waste and excess;
- reduction in the variety and number of lines of materiel purchased;
- improved supply responsiveness;
- development of usage data for utilization management and outcome analysis;
- reduced consumption through improved utilization management; and
- intangible benefits through the synergy of regional logistics and clinical collaboration.

B. STANDARDIZATION PROCESS

Regional standardization must have certain enablers to succeed. Some do not yet exist, and regional business processes for materiel standardization use work-arounds. As regional logistics processes mature, information systems and acquisition strategies also should mature to support clinically led regional standardization as the norm for DoD.

Key Enabler	Current Method	Target Method

Key Enabler	Current Method	Target Method
❑ Information on product and product line usage	❑ Prime Vendor data ❑ Legacy materiel management systems	❑ DMLSS ❑ PVBMA ❑ PV Data
❑ Decision-making process that - is clinically led - has authority to make decisions - can mandate compliance	❑ TRICARE Regional Product Review Boards ❑ Clinical Product Teams ❑ Lead Agent and Command Leadership	❑ Medical Logistics Medical Logistics Regional Business Unit Product Review Boards ❑ Clinical Product Teams ❑ Lead Agent and Command Leadership
❑ Acquisition process that - is timely - responds to clinical requirements	❑ Regional Purchasing Agreements/DAPAs	❑ Regional purchasing agreements/DAPAs ❑ Regional contracts
❑ Means to communicate regional standardization decisions	❑ Knowledge Management Network ❑ Regional price books	❑ Knowledge Management Network ❑ UDR ❑ National agreements
❑ Information on product and product line compliance	❑ Prime Vendor data ❑ Legacy materiel management systems	❑ DMLSS ❑ PVBMA ❑ Prime Vendor Data

DMLSS Defense Medical Logistics Standard Support
DAPA Distribution and Pricing Agreement
PVBMA Prime Vendor Business Management Application
UDR Universal Data Repository

The following steps describe the standardization process that has emerged through efforts in TRICARE regions.

Define Target Products and Product Groups. This step defines where to start. It begins with an analysis of where regional supply dollars are being spent (i.e., determining which products and product groups are being purchased, what their costs are in dollars, and the effort required to manage them). This step identifies the primary users of each major product group (these are the users who should be represented in Clinical Product Teams and clinical trials). It assesses the degree of individual clinician preference for each product and group. (Items associated with a high degree of individual preference, such as suture, require more effort to obtain consensus before considering change, whereas other, low-threat, items may be standardized on cost alone.

Determining where supply dollars are being spent is a particular challenge to the MHS because there is no single usage database. Also, the lack of common product numbers makes it difficult to collect and consolidate demand data across multiple activities and sources of supply. Sources of information that may identify purchase data include the following:

- Individual activity Materiel Management Systems (MMS)
- DSCP Prime Vendor Business Management Application (PVBMA)
- Credit card records
- Prime Vendor sales records (most Prime Vendors can provide details of sales data and sort the data by product group, using commercial product codes such as HPIC or Owens Healthcare)
- Local purchase vendor records
- DMLSS 2.0
- Financial records (e.g., dCAS)

Select and Prioritize Products for Standardization. There are two broad strategies for selecting items for standardization: by individual line item and by product group. In both, the selection of items or groups selected for standardization is based on the anticipated benefit that can be achieved in return for the effort.

The standardization of broad product groups targets products that account for high-dollar expenditures. It allows the standardization of many lines of materiel with a single effort. It also provides the opportunity to leverage the purchasing power of an entire DoD region or business unit to obtain competitive pricing.

The EA, in coordination with the Military Logistics Proponency Subcommittee (MLPS) has designated several product groups that each TRICARE region or Medical Logistics Regional Business Unit initially should undertake for standardization in the region. These product groups are listed in Appendix C. They were selected because they generally account for either significant amounts of supply dollars or numerous line items, and are commonly targeted by private-sector hospitals and hospital networks.

Individual line-item standardization applied, in the past, to low-threat items that did not fall inside broad product groups and thus helped reduce the number of items stocked. Items can be selected for lowest cost and clinical acceptance. The standardization of items among several military medical facilities supported by a common Prime Vendor distribution center also can result in better supply performance.

Develop and Select Acquisition Strategy. Specific acquisition strategies vary by product groups. High-demand items (typically provided by Prime Vendors) that do not fall into major product groups can be standardized using tools such as PPC to find the lowest-cost item that meets clinical acceptance. Another approach is to use the activities' MMS to identify items stocked in supply accounts with a local purchase or credit card source of supply, then attempt to bring those items into the Prime Vendor program.

High-demand items that fall into major product groups are candidates for negotiated committed-volume Regional Purchasing Agreements (RPAs). The evaluation strategy depends on the complexity of the selection criteria and the extent of hands-on assessment needed to evaluate the products. It can range from a simple review of written vendor business proposals to product demonstrations or full clinical trials.

Prime Vendors usually do not provide low-demand items, items with high unit cost, and items with highly specialized clinical applications. Those items typically are obtained through local purchase. A major goal of regional logistics programs is to pull these items into an acquisition method that supports electronic ordering and bill payment, such as the Internet-based DSCP ECAT. While pricing may be established initially through vendor catalog pricing, ultimately regional or national contracts should reduce costs through competition.

EXAMPLES OF ACQUISITION STRATEGIES

Type of Product Group	Target Source	Target Acquisition Method
High-demand/low-cost items	Prime Vendor	National DAPA/PPC
High-demand/low-cost product groups	Prime Vendor	Regional DAPA/RPA
Low-demand/high-cost (specialty items)	ECAT	Regional contract
Laboratory supplies	ECAT	Regional contract
X-ray film	ECAT	Regional DAPA/RPA
Dental supplies	ECAT	Regional DAPA/RPA
Surgical Procedure Packs	Prime Vendor	RPA

Conduct Evaluation. Whereas materiel managers (with clinical validation) usually evaluate individual, low-threat items, CPTs chartered by the TPRB evaluate product groups. A CPT is composed of clinicians from appropriate specialties, and typically includes representation from each Service. The purpose of a CPT is to conduct an impartial, clinical evaluation of proposed products from the user's perspective. CPT members usually are nursing personnel who coordinate with a designated physician from the appropriate clinical department of their facilities.

One of the first tasks of a CPT is to establish the selection criteria and evaluation strategy for the product or product group under consideration. Cost is always a factor. Other factors may include specific attributes that contribute to desired outcome, ease of use, product support or other specific customer services, or other qualitative aspects that contribute to clinical acceptance.

Evaluation criteria are not limited to product attributes. Vendors often are willing to offer various services in their business proposal that can influence a best-value decision. Examples of such value-added services include vendor commitments to exchange or give credit for existing products, favorable (sometimes free) provision of equipment in return for use of consumables, staff in-service or patient education, or assistance with utilization management.

It is important that the evaluation criteria are identified, agreed to, and documented before vendors are asked to submit proposals for evaluation. Although the conduct of a CPT is not a formal contracting procedure, the criteria and the process must be documented to the extent that it can be shown to have been a fair and impartial evaluation.

When the evaluation is part of an effort to obtain an RPA that is based on committed volume, the request for vendor price or business proposals usually is separate from the CPT. Typically, this is

done by the Tri-Service Regional Business Office and under the review or supervision of a contracting specialist designated by DSCP. DSCP has developed a letter to DAPA holders to inform them of a pending initiative to standardize a product group. These letters are discussed in Appendix I.

In evaluating price proposals for broad product lines, it is imperative that the analysis is conducted at the line item level (i.e., each proposed line item price should be weighted with its expected demand). A manufacturer may state an aggregate discount in return for a purchase commitment, yet apply different discounts to each item within the product line. If high-demand items receive only a nominal discount while lower-demand items carry a higher rate, the total benefit may be less than expected and less than competing proposals. This analysis is labor intensive, and a reason that Tri-Service Regional Business Offices must have dedicated personnel to support these efforts.

Conclude and Implement Standardization Decision. Each region must establish the approval authority for standardization decisions. Typically, CPTs report findings to the regional TPRB with a recommendation for selection.

After the TPRB accepts the recommendation, it is referred to the regional commanders for final decision. In TRICARE Region 1, an executive committee of the TRICARE Regional Governing Board, consisting of the Medical Center and hospital commanders from each Service, makes decisions on behalf of the region. In other regions, the full Regional Executive Committee, consisting of all medical facility commanders in the region, approves standardization decisions. In either case, *the final standardization decisions must have the authority of commanders*.

Product decision implementation has two stages or processes. First is execution of the purchase agreement and regional Distribution and Pricing Agreement (DAPA) with the vendor, if applicable. (RPAs and DAPAs are described in the section on "Regional Purchasing Agreements.") This does not apply for simple standardization of low-threat items based on cost. The standardized product is phased in, usually in coordination with the Prime Vendor.

The second stage involves the implementation and introduction of the standardized product. For the materiel manager, this involves the phase-in of inventory in coordination with the Prime Vendor or other supplier, to include the execution of any product trade-in, credit, or equipment exchange called for in the agreement. For the new vendor and the CPT, it may involve marketing and education to promote use of the new product with the clinical staff. Clinicians often resist standardization decisions on principle. *The keys to effective implementation are staff assurance that clinicians are involved in the selection process; that outcome-based, best-value criteria were used in the decision; and that there is visible support by clinical leadership and commanders*.

Monitor Compliance. There are two aspects to compliance monitoring. The first is to ensure that the products are introduced and used as agreed with the selected vendor. The second is to ensure that expected benefits from the agreement are realized. This includes checking to ensure that discounted pricing and other incentives (such as equipment or value-added services) are provided. The Tri-Service Regional Business Office normally does this. Also, part of compliance monitoring is gathering of feedback from clinical users on the performance or acceptability of the standardized products. This reinforces clinical support for future standardization.

Compliance with purchase agreements usually is not 100 percent because specific clinical needs or stock outages may require use of a product from a competing manufacturer. Threshold compliance usually is set at 80 to 90 percent, and is specifically stated in the purchase agreement; nevertheless, Government compliance with agreed-to commitments is essential. Failure to comply likely will result in termination of the agreement by the vendor and a loss of credibility that will make future agreements more difficult.

No automated means of measuring compliance with product decisions currently exists. Prime Vendors usually can provide data on sales by product category and vendor. Other sources are reviews of stockage and usage data from Services' legacy MMS, feedback from clinicians through facility standardization committees or Clinical Services, and physical spot checks in stock rooms, wards, and clinics. Other important sources of compliance information are the vendors themselves, who usually are quick to point out if their products are not being used in the anticipated quantity.

DoD facilities should resist the attempt by unsuccessful vendors to undercut purchase agreements. Sometimes, these competitors will amend their offer on some or all products after the final decision has been made. Often, they market these prices directly to the user at the medical facility level. This is an overt attempt to undermine standardization decisions in order to retain sales or market share. This situation must not be allowed to occur. Another challenge is customers' desire to "cherry-pick" products from within product-line agreements. Sometimes it is possible to find lower-cost alternatives to individual items within a product line; however, purchase agreements are made on a total product line. If the proposal was properly evaluated, the aggregate savings from the total agreement will more than compensate for line-item differences.

C. REGIONAL PURCHASING STRATEGIES

A major objective of regional logistics programs is standardization to lower supply costs. Selecting the lowest-priced product that meets clinical acceptance can reduce supply costs, and this should be done for low-threat items that fall outside major product groups. Savings beyond that require some type of bilateral agreement between the region and vendor.

Generally, vendor reductions in product pricing are achieved in return for some guarantee of increased sales volume or market share. Such guarantees usually are made through contracts, a process that can be lengthy and taxing on clinicians' time, particularly in support of formal Source Selection Boards. Of equal concern is the risk that a contract may not meet clinicians' acceptance because of inadequacies or oversights in the selection criteria. An alternative acquisition strategy needs to provide a more responsive, flexible way to make regional agreements, without compromising legal requirements for fair, open competition among vendors. The result should be a range of acquisition strategies that can be matched to each standardization and purchasing initiative.

National DAPA. DAPAs establish product pricing nationally. They are a major component of the DSCP Prime Vendor program. DAPAs set a ceiling price, and vendors are allowed to reduce prices locally based on volume or market conditions. Some vendors have long provided the largest DoD facilities with lower prices than the national DAPA. A disadvantage of this practice is that the more favorable prices do not appear in the UDR or DAPA management system. Materiel managers must determine manually if they were charged the applicable price for their activity. Also, smaller DoD activities, which are often less flexible in operating budgets, have been unable to leverage their volume for more favorable prices.

National DAPAs will continue to be the basis of Prime Vendor pricing for products that are not covered by committed volume purchase agreements or contracts. Future partnership initiatives with the DVA may augment national DAPAs with Federal Supply Schedules (FSS) and regional blanket purchasing agreements where those agreements provide more favorable pricing. The DSCP DAPA will incorporate all such prices into the DSCP Management System (DMS), which will be the official repository of pricing information for the Prime Vendor program.

Regional Purchasing Agreements. Regional DAPAs help TRICARE regions and Medical Logistics Regional Business Units obtain more favorable pricing in return for a purchase commitment. Regional DAPAs apply to all medical facilities in the region and are recorded in the DAPA Management System and the UDR. RPAs convey the terms and conditions for regional DAPAs. RPAs reflect the intent and commitment of both parties but are not legally binding and may be terminated unilaterally by either party, usually with an agreed-upon termination notice. The chairperson of the regional TPRB or the senior lead logistician of the TRICARE region or business unit normally signs on behalf of the region.

Although RPAs are not formal contracts, they are entered into only by following the systematic, objective, and documented process described in the "Conduct Evaluation" section to determine which product or product group provides the best value to the government.

Regional Contracts. Regional contracts provide formal, legally binding agreements between vendors and the government. Regional contracts have not been used in medical-surgical standardization efforts; however, as the program matures, it may be appropriate to use formal contracts for some product groups. Because contracts are legally binding for specific periods, they may help achieve greater price concessions from vendors. Formal contracts require the most time and effort to put in place, and they may limit the government's ability to respond quickly to market changes in price, technology, or clinical practices.

Regional contracts also may be appropriate for biomedical equipment maintenance support and for other regionally obtained logistics services.

National Contracts. Although national contracts have achieved significant savings for pharmaceutical products, they have been viewed unfavorably as purchase instruments for MHS medical-surgical supplies primarily because of the difficulty in achieving national clinical consensus on products. Efforts have focused on involving clinicians regionally for product selection that to determine best value.

Future acquisition strategies may aim at national, multiple-award contracts that allow regional implementation. Such contracts would provide a portfolio of two to three manufacturers for a major product line, much like multiple-source contracts used by group purchasing organizations (GPOs). Each region could select the manufacturer with products, prices, and services offering the best value for that region. Portfolio prices would be tiered, based on aggregate dollar value or market share for each vendor in the portfolio. Regional selections still would be made through clinically led decision making and would be binding on all activities in the region. Such contracts may also facilitate participation by Veterans' Integrated Service Networks (VISN) of the DVA.

Chapter 5. Clinical Engineering and Biomedical Maintenance

The biomedical maintenance business area presents significant opportunities to reduce costs through regional cooperation and exploration of alternative maintenance management strategies. Maintenance activities present a substantial cost center for most medical facilities directly through labor and maintenance contract costs and indirectly through equipment acquisition and life-cycle management. Maintenance operations are predominantly facility oriented, with regional or area maintenance activities limited to within Service lines. Maintenance services that exceed in-house capabilities routinely are outsourced through local contracting.

A regional approach to biomedical maintenance services is consistent with other significant changes in this business area. Old-line maintenance functions are being broadened and deepened into the discipline of *clinical engineering*. The field of technology assessment and management is being formalized and integrated as a core competency of clinical engineering. Clinical engineering and medical equipment management functions, systems, and processes are assuming renewed significance in the overall management of healthcare operations as the entire medical logistics field becomes more synergistic and complementary.

A. Opportunities for Regional Partnerships.

Regional opportunities for clinical engineering and biomedical equipment management include

- shared services and expertise;
- a unified approach to technology assessment and equipment life-cycle management;
- a unified approach to levels of service;
- shared training;
- regional contracting for maintenance services;
- equipment standardization; and
- a unified approach to alternative maintenance strategies, such as risk-based maintenance, and “Prime Maintainer” contracts.

These opportunities come with notable challenges. Previous efforts to standardize equipment at the MHS level have not been successful in achieving clinical acceptance. Centralized contracting for maintenance services have had uneven success in reducing costs. Differences in Service culture and

business processes, as well as concerns over the effect of change on jobs and independence present further challenges that need to be addressed.

Each TRICARE region or regional business office should establish a subcommittee or process action team of clinical engineering leaders to develop cooperation and business process improvements. Results of these team efforts should be tied directly to capital equipment acquisition, developed and implemented by the command and local regional contracting. One approach is for teams to collect data on maintenance cost centers, identify high cost activities, and develop management strategies to achieve the goals of the program. Typical high-cost centers include the following areas:

▪ X-ray systems	▪ Anesthesia equipment
▪ Laboratory equipment	▪ Patient monitoring systems
▪ DINPACS or MDIS	▪ Fiber optic scopes
▪ Training	▪ Area maintenance support
▪ Annual maintenance contracts	▪ Repair parts

B. REGIONAL MANAGEMENT STRATEGIES

Regional clinical engineering offers various improvements over the current model of facility-centered maintenance operations. National trends indicate that savings are likely in three areas:

- Consolidation of maintenance services into hub-and-spoke service relationships
- Regional consolidation of contract maintenance services
- Alternative approaches to traditional maintenance strategies.

Some categories of regional opportunities are emerging as DoD further refines its logistics support capabilities. For example, Army, Navy, and Air Force activities across the MHS are beginning to share responsibilities for training and developing a tri-service cadre of biomedical equipment technicians. In some cases, Army and Navy activities are using Air Force assessment standards. This cross-pollination is strongly encouraged—it will build a stronger clinical engineering community and enhance the contributions of that community to the MHS at large.

Regional/National Contracts. Contractor services are an essential adjunct to DoD's in-house maintenance capabilities. Contractors provide more specialized maintenance capability than DoD can affordably train and retain. Contractors allow DoD to acquire and support a broader range of equipment types than otherwise would be possible. Contractors permit increased flexibility in the types and frequencies of maintenance services. Not all contracted services are efficient, however. When separate maintenance contracts are negotiated and administered locally for each DoD treatment facility, service prices may be higher, contractor responsiveness may be reduced, and

internal overhead to award-and-administer contracts is much greater. Individual facilities do not always have the expertise to develop, award, and administer the sophisticated contracts needed to obtain today's high-tech biomedical engineering services, but within most DoD TRICARE regions, the expertise does exist.

Maintenance service contracts are developed through statistical averages and expected mean time between service activities for particular equipment types. Regional contracts allow vendors to spread risks across a larger equipment pool and result in more cost-effectiveness than local contracts. Proven cost savings can range from 10 percent to 30 percent, according to prototype programs underway in DoD. Regional maintenance contracts also may allow consolidation of exchange items to provide "float" while services are performed and permit the consolidation of contractor-owned repair parts and TMDE regionally.

Managing Levels of Service. Service response standards can be a significant contributor to maintenance contract costs. The cost of 4-hour service response 24 hours a day, 7 days a week will be significantly more expensive than more liberal standards. A regionally coordinated approach to service levels may reduce costs by providing a more sophisticated approach to the development of Statements of Work and applying a more analytical risk-benefit assessment for equipment to be covered. In other cases, additional risk may be tolerable in an area if equivalent services or equipment are available in the region. Opportunities may exist for shared or back-up support for first response, allowing contract service response requirements to be reduced.

Prime Maintainer Contract. Some service organizations are broadening their offerings to provide "Prime Maintainer" services in which they provide maintenance services that otherwise would be outsourced to multiple equipment maintainers. Under the Prime Maintainer concept, a single service organization provides turnkey support, usually under a negotiated fee schedule, prospective warranty program, or on a capitated basis. Prime Maintainer programs usually allow the in-house clinical engineering organization to enhance its own technical expertise by giving them "first look" rights to service equipment or even an opportunity to be reimbursed by the Prime Maintainer for services provided in-house.

For remote sites with low equipment density or with little or no maintenance staff, credit cards rather than in-house or annual contract support may be a cost-effective solution. Credit card use must have well-defined controls, including maximum allowable ceilings, prohibitions on certain equipment items, and assurances that they will not be used when other services are available.

The most effective maintenance operation combines the benefits of regional consolidation with the flexibility and responsiveness available through other means. It is important to find the right balance among the various options on the maintenance continuum.

Time and Material versus Annual Contracts. As a variation of the "Prime Maintainer" concept, the in-house management of preventive maintenance and repair services on a time and materials basis (rather than an annual service contract) may provide cost savings. This approach may be advantageous particularly when there is potential for in-house maintenance support from elsewhere in the region, or the equipment or service is available.

Risk-Based Preventive Maintenance. Significant savings can be achieved by accepting fewer preventive maintenance or calibration services than are traditionally used. This approach is

supported by guidance that indicates healthcare systems may reduce preventive services by evaluating each generic type of equipment, performing a risk analysis, and matching an appropriate maintenance response. Risk analysis is ongoing and involves continuing adjustment of maintenance frequency, based on gradually accumulating maintenance experience, changing maintenance practices, and technology insertions and improvements. Much of today's equipment is highly reliable and engineered for increased time between preventive services and inspections. In addition, self-diagnostic or remotely diagnosable equipment permits diagnostics or repairs to equipment components without on-site service.

Preventive maintenance services risk adjustment requires more detailed analysis than simple scheduled services. Preventive maintenance is enhanced when equipment density is sufficiently high to spread risk across a larger number of equipment items.

DVA Repair Services (Scopes). Some DoD facilities (Walter Reed AMC [WRAMC] in particular) have realized significant savings by using the DVA repair facility in Chicago to repair fiber-optic scopes. These devices traditionally have been sent to their original equipment manufacturers (OEMs) for repair to ensure quality. Clinicians at WRAMC have been unable to discern a difference between repairs performed by the DVA and the OEM. The DVA cost has been 30 percent less, with excellent service turnaround times.

Regional economics may provide even more advantage for such services. In this example, fiber-optic scopes account for a large amount of costs. A regional evaluation of alternative sources, or a regional approach to contracting for such services, can bring these costs down.

Another factor that affects costs for scope repair is the cyclic arrival of new medical students or residents in larger facilities. Experience has shown that specific training targeted to these individuals can significantly reduce damage to these instruments, thereby reducing repair costs.

> Walter Reed completed a pilot program to evaluate the DVA Durable-Repair Program, using the DVA repair facility in Chicago for the repair of fiber-optic scopes. During FY99, documented savings were $124,000, with the average individual repair cost reduced by 35 percent. Using the DVA improved average turnaround time by 44 percent.

Equipment Standardization. The standardization of medical equipment may provide significant cost savings throughout the equipment life cycle. A regional approach to equipment acquisition may provide more favorable terms and prices—and also reduce costs for training and maintenance. A prerequisite for effective equipment standardization is a thorough, broadly accepted equipment requirements determination process, such as the technology assessment and requirements analysis (TARA) process used to develop Army requirements for radiology and laboratory equipment. Regions are encouraged to review the current TARA process and to find ways to use or adapt their equipment standardization.

Certain equipment categories lend themselves especially well to standardization because of their high cost, high density, relative criticality, and performance according to pre-existing commercial medical standards or degree of integration. These categories will provide the primary standardization targets for DoD healthcare regions during the next round of regional operations. Candidates for standardization include

- equipment approved for use on Air Force medical evacuation aircraft (patient movement items [PMI]);
- imaging equipment, including digital imaging, ultrasound, and other diagnostic imaging product lines;
- endoscopy equipment and other minimally invasive surgical or diagnostic items;
- physiological monitoring systems, especially integrated patient monitoring systems; and
- laboratory and diagnostic equipment, especially HL7-compliant computer integrated systems.

Hub-and-Spoke Services. By forming regional clinical engineering activities, logistics leaders can create hub-and-spoke maintenance organizations that pool technical expertise, TMDE equipment, repair parts inventories, and other assets that otherwise may be distributed unevenly among a region's facilities. The regional, tiered approach to clinical engineering concentrates highly technical and increasingly scarce clinical engineering staffs at the regional level. It permits implementation of the most effective training, cross-utilization, and professional development patterns within and between regions. It will permit the substitution of in-house, hub-owned clinical engineering staffs instead of expensive, seldom-used services contracts at spoke locations. Finally, it provides the most effective regional visibility of equipment density, utilization, repair record, and modernization needs, all of which are consistent with the shift to technology assessment roles for DoD's emerging clinical engineering organizations.

More collaboration is possible when DVA facilities are included in regional hub-and-spoke or other collaborative arrangements. DoD's facilities have a much different geographic distribution, with a tendency toward southern states and a concentration of larger medical centers in or near urban centers. DVA facilities, on the other hand, tend to be concentrated in the northeastern United States, and most are not located in urban centers, which suggests opportunities for mutual benefit to DVA and DoD. Each organization potentially can provide maintenance coverage for the other in areas where assets are spread thinly.

Technology Assessment and Requirements Analysis. In an environment of constrained resources, it is imperative to apply sound commercial business practices to capital investment equipment programs (procurement dollars, equipment costing greater than $100,000). The decision makers at the Lead Agent and MTF level must have viable means of acquiring the management information to effectively balance dwindling resources against clinical requirements. The ultimate goal of the TARA program is to establish a standardized methodology for assessing, planning, and pursuing the acquisition of technology within Health Affairs.

The TARA mission is to provide decision makers with the management information needed to make informed decisions on the technology resources required to accomplish business plan missions and optimize clinical outcomes. This is accomplished through an unbiased assessment of radiology and laboratory functional departmental operations.

A TARA consists of an assessment of requirements, current equipment, and operations as they relate to the equipment and clinical operations. Clinical issues are reviewed by the Service clinical

consultant/advisor or representative, and equipment issues are assessed by clinical engineers, medical physicists, and maintenance officers. The results of this assessment are provided only to the requesting facility and their respective Lead Agent. Trends and command-wide management issues discovered during these assessments will be presented to Health Affairs to assist in policy development and strategic planning. No specific reference will be made to issues at individual facilities except under extenuating circumstances, such as serious safety or risk management issues, or with the permission of the facility.

With Lead Agent visibility by tri-service regions, the return on investment is expected to be substantial. Such a program will assist in standardizing Health Affairs equipment and sustainment regionally, allow for seamless integration of technology, augment the tri-service equipment budget for high-dollar items (i.e., saving money with multi-system buys), and attempt to increase clinical availability and costs.

The Army has identified a cost avoidance of approximately $70 million over the life of the program and expects that this figure will at a minimum double by conducting TARAs on a tri-service regional basis. This cost avoidance is recognized by confining high-dollar equipment purchases to equipment that is needed and technologically relevant in military hospitals and clinics.

In addition, by conducting TARAs regionally, other costly issues such as clinical resource sharing can be resolved. For example, Army hospital A and Air Force hospital AF are within 45 miles of one another. Based on a TARA assessment, Hospital A has three radiologists with a workload for only 2.2, and Hospital AF has two radiologists with a workload for 2.5. Hospital AF sends remaining exams to a civilian group at a cost. The TARA would recommend that one of the Army radiologists share time with the Air Force facility, in return for support in other areas, thus decreasing costs and overhead for both facilities.

The Army's TARA team is working with the DVA and plans to incorporate it into regional issues where relevant and cost-effective.

C. THE TRANSITION FROM MEDICAL MAINTENANCE TO CLINICAL ENGINEERING

The MHS has been in the lead on medical maintenance issues for decades, and continues to set the standard as the profession is transformed from a *maintenance* orientation to a *clinical engineering* orientation. As defined by the American College of Clinical Engineers, a clinical engineer is

a professional who supports and advances patient care by applying engineering and management skills to healthcare technology. Clinical engineers manage personnel, finances, instrumentation, and projects to promote the safe and cost-effective application of technology.

Clinical engineering is a necessity for the complex, regionally based healthcare systems of the future. The growing complexity of medical technology means sophisticated equipment, software, and telecommunications systems must be integrated and interoperable. Clinical engineers will participate in the assessment and management of all healthcare technology throughout its acquisition life cycle. TARA of equipment utilization and needs will ensure deliberate management

of clinical technologies and match technology capabilities with healthcare needs. Clinical engineering operations will be tightly linked with capital and expense equipment acquisition, facility design and management, and maintenance.

As with other logistics disciplines, the emergence of clinical engineering heralds an important change for biomedical equipment maintenance and its place in the MHS. Increasingly, equipment maintenance is an integral part of a regional, tri-service, managed-care strategy to obtain the maximum possible yield from all of a healthcare system's assets. Clinical engineering is one of many new tools available to logisticians as they seek to define and enhance their role in the MHS and the TRICARE system. The many new directions available for clinical engineers fit seamlessly with the other management tools now being used to transform military healthcare.

Chapter 6. Regionalization of Logistics Services

Product standardization is only the beginning of the benefits available through regional coordination of logistics support. Better service at a better price probably is available in many logistics support areas. Across the MHS, regions are beginning to experiment with better regional support services to streamline and improve efforts that, until recently, were planned, conducted, and paid for locally. Some of the support functions being surveyed include

- linen management,
- laundry services,
- housekeeping services,
- energy management,
- contracting for clinical or clinical support services, and
- vehicle fleet management.

Further Information To Be Published As Developed

Chapter 7. Pharmacy Programs

TO BE PUBLISHED

Chapter 8. Performance Measurement

Measurement of program performance is essential for several reasons. It is necessary to determine if the savings achieved are worth the time and effort invested and to provide feedback helpful to redirect efforts and improve performance. It is needed to demonstrate to commanders and clinicians that regional programs such as standardization do save money and improve supply reliability to gain their support and compliance. It is needed to demonstrate to industry the value of the MHS as a partner for regional or national agreements.

Measuring the performance of regional logistics programs presents several challenges because current automated systems and business processes do not easily provide the data necessary for analysis. Most product numbers are non-standard, and the MHS legacy logistics systems do not have the ability to stratify items by product groups. It is not possible to collect data from individual activities to compare purchases regionally without much manual filtering and manipulation. In some services, a significant amount of purchasing is done outside of the Medical Supply Account using local contracting or credit cards.

The key objectives of regional logistics programs are to capture the data necessary to manage and measure program performance and to move purchasing activities into those practices that have proven to reduce overall supply chain costs. The emphasis on Prime Vendor and ECAT as a source for non-Prime Vendor materiel supports this objective. The fielding of the DMLSS system release 2.0 will provide far more robust capabilities to capture recurring purchases that use numerous acquisition processes, such as local purchase, ECAT, and credit card transactions. A pending change to DMLSS also should provide the ability to relate and sort items by product category. Future development of DMLSS at both the retail and wholesale (DSCP) levels should enable regional managers to monitor compliance with purchase agreements and contracts.

One of the Lead Agent responsibilities contained in current policy guidance is to collect data and measure performance as reported to the U.S. Army Medical Command (acting in support of the Executive Agency) to the TRICARE Management Activity (TMA). These metrics fall into two categories: *process metrics* and *outcome metrics*. Examples of these metrics are presented below. The Executive Agency, in coordination with the MLPS, will establish and adjust specific reporting requirements based on the metrics. Reporting will be through the TRICARE regions and business units and reflect tri-service progress.

A. Process Metrics

Process metrics reflect actions taken by activities and regions to establish regional logistics programs and the processes necessary to achieve program objectives. Examples of actions for which process metrics apply include the following:

- Established regional business office

  - Yes/No (Green/Red) by DoD TRICARE region

- Established regional policy for materiel standardization

  - Yes/No (Green/Red) by DoD TRICARE region

- Established baseline costs for product groups

  - Yes/No (Green/Red) by DoD TRICARE region and product group

- Standardization status for product groups

  - Not Started/In Progress/Completed (White/Yellow/Green) by product group for each DoD TRICARE region

- Compliance with mandatory purchasing methods

  - Prime Vendor

    Prime Vendor purchase data/overall purchase data for each DoD TRICARE region

  - ECAT

    ECAT purchase data/overall purchase data for each DoD TRICARE region

  - Regional or national contracts

    Contract purchase data/all purchase data for the product or its generic equivalent

B. OUTCOME METRICS

Outcome metrics track the results of actions to evaluate performance, analyze benefits, and contribute to program adjustments. Examples of outcome-based metrics include the following:

- Projected savings by product group

  - Sales history of past products within product group: sales projection of standardized product (e.g., hospital plastics: $6.2 million in FY99 [historic sales data] minus $4.82 million in FY00 (historic demand rate times standardized or new prices) equals money saved

- Actual savings by product group

  - Sales history of past products within product group minus sales data of standardized product (e.g., hospital plastics:, $1.2 million in Q1, FY99, minus $0.82 million in Q1, FY00, equals $200,000 saved)

- Number of lines (Stock Keeping Units, or "SKUs") stocked or managed on a Just-In-Time (JIT) basis.
  - SKUs and JIT line items of standardized product group compared to SKUs and JIT line items of past products within product group
- Purchase card activity: IMPAC credit card purchases by DoD TRICARE region (should show decreasing sales over time because standardized products will require other procurement methods such as Prime Vendor, ECAT, etc.)
- Decentralized BPA activity
  - DBPA purchases by DoD TRICARE region (should show decreasing sales over time as standardized products will require other procurement methods such as Prime Vendor, ECAT, etc.)
- Supply costs per enrollee
  - number of enrollees/total obligated medical supply expenditures
  - number of enrollees/total obligated pharmaceutical expenditures
  - number of enrollees/total obligated non-pharmaceutical medical supply expenditures

Appendix A. Text of HA Policy 98-013

23 Jan 1998

Memorandum for Surgeon General of the Army
Surgeon General of the Navy
Surgeon General of the Air Force

SUBJECT: Policy for Regional Tri-service Medical Logistics Support Programs

This memorandum requires the establishment of tri-service medical logistics support programs in each DoD healthcare region. These programs will be designed to capture cost savings and efficiencies as a result of regional actions.

The best logistics business practices of the most successful government and commercial organizations increasingly include regionalization, standardization, consolidation of requirements, coordinated planning and cooperative action. Together these practices have proven to result in significant cost savings and efficiencies.

In order to capture similar cost savings and efficiencies for the MHS, regional medical logistics support programs will be initiated within each DoD healthcare region. The Medical Logistics Proponent Subcommittee will provide overall program oversight and coordination. Program efforts will be targeted on the acquisition of medical materiel and the provision of other logistics support services.

My point of contact for this policy is Col. George D. Magee who can be reached at (703) 575-9771.

Edward D. Martin, M.D.
Acting Assistant Secretary of Defense

HA Policy 98-013

Appendix B. Guidance Memorandum from Services' Deputy Surgeons

[TEXT MISSING]

The following three pages make up Appendix B.

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, DC 20301-1200

23 Jan 98

MEMORANDUM FOR SURGEON GENERAL OF THE ARMY
SURGEON GENERAL OF THE NAVY
SURGEON GENERAL OF THE AIR FORCE

SUBJECT: Policy for Regional Triservice Medical Logistics Support Programs

This memorandum requires the establishment of triservice medical logistics support programs in each DoD healthcare region. These programs will be designed to capture cost savings and efficiencies as a result of regional actions.

The best logistics business practices of the most successful government and commercial organizations increasingly include regionalization, standardization, consolidation of requirements, coordinated planning and cooperative action. Together these practices have proven to result in significant cost savings and efficiencies.

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Edward D. Martin

Edward D. Martin, M.D.
Acting Assistant Secretary of Defense

HA Policy 98-013

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS
SKYLINE FIVE, SUITE 810, 5111 LEESBURG PIKE
FALLS CHURCH, VIRGINIA 22041-3206

TRICARE
MANAGEMENT
ACTIVITY

AUG 4 2000

MEMORANDUM FOR TRICARE LEAD AGENT DIRECTORS

SUBJECT: Implementation Guidance for Regional Tri-Service Medical Logistics Support Program

The promotion of regional logistics business practices among the Services is emerging as a major opportunity for the Military Health System (MHS) to achieve significant savings and optimization of services. Product and practice standardization, led by clinical interests and supported by organizational leadership, is the norm in the most successful private sector healthcare organizations. Regional logistics programs created within the framework of Military Health Service Regions have clearly demonstrated that such coordinated and cooperative efforts are the right and responsible approach to our business.

The enclosed Implementation Guidance is a complete rewrite of similar guidance issued nearly two years ago. It is the product of intense collaboration of logistics and clinical professionals among the Services, and reflects the tremendous progress that has been made in creating the foundation for integrated, regional medical logistics support. It also reflects the critical partnerships that have emerged within the DoD and other federal agencies to promote regional logistics initiatives, and the major acquisition strategies that are being developed to exploit those opportunities.

It is imperative our Lead Agents assert strong leadership in building regional logistics programs, and fostering the expectation that all MHS activities will participate fully in these efforts. This leadership is essential to obtain competitive advantage in the market for products and services, and to achieve the efficiencies, cost savings and effectiveness necessary to sustain military healthcare operations.

The Office of the Army Surgeon General is the Executive Agent for this program. The primary point of contact is COL Jonathan M. Kissane, Director of Logistics, (703) 681-8058 (DSN 761) [jonathan.kissane@amedd.army.mil].

H. James T. Sears, M.D.
Executive Director

Enclosure:
As stated

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
FALLS CHURCH, VA 22041-3258

REPLY TO
ATTENTION OF

DASG-LOG (700)

05 JUL 2000

MEMORANDUM FOR COMMANDERS, MILITARY HEALTHCARE SYSTEM

SUBJECT: Implementation Guidance for Regional Tri-Service Medical Logistics Support Program

1. The promotion of regional logistics business practices among the Services is emerging as a major opportunity for the Military Health Care System (MHS) to achieve significant savings and optimization of services. Product and practice standardization, led by clinical interests and supported by organizational leadership, is the norm in the most successful private sector healthcare organizations. Newly formed regional logistics programs created within the framework of Military TRICARE Regions clearly demonstrate the right approach to our business.

2. Available at address http://www.armymedicine.army.mil/medcom/dcslog/ is the newly updated implementation guidance. This new guidance represents intense collaboration between logistics and clinical professionals across the Services and documents the tremendous progress made in creating integrated regional medical logistics support operations.

3. It is imperative that all healthcare activities within the MHS support regional logistics efforts. Your support must include aggressive efforts to standardize and mandate compliance with regional price agreements. Clinical consensus and committed volume agreements will produce significant savings, and support the sustainment of military healthcare operations.

4. The Office of the Army Surgeon General is the Executive Agent for this program. The primary point of contact is Colonel Jonathan M. Kissane, Director of Logistics, (703)681-8058 (DSN 761) or Email [jonathan.kissane@amedd.army.mil].

PATRICK D. SCULLEY
Major General, DC, USA
Deputy Surgeon General

DONALD C. ARTHUR
Rear Admiral, MC, USN
Deputy Surgeon General

LEONARD M. RANDOLPH, JR
Major General, USAF, MC
Deputy Surgeon General

H. JAMES T. SEARS, MD
Executive Director
TRICARE Management Activity

Printed on Recycled Paper

Appendix C. Product Groups for Regional Standardization

The Executive Agency, in coordination with the MLPS, has designated several product groups that should be standardized within each TRICARE region or Medical Logistics Regional Business Unit. These product groups are listed below. They were selected because they generally account for significant amounts of supply dollars or a large number of line items and are commonly targeted by private-sector hospitals and hospital networks. Earlier versions of the *Implementation Guidance* called for each region to have these product groups standardized during FY99.

FY99 Target Product Groups

1. Drapes & Gowns
2. Needles and Syringes
3. Blood Collection Tubes
4. Pneumatic Compression Systems/Sleeves
5. T.E.D. Stockings
6. Endoscopy Supplies
7. Surgical tapes
8. Hospital Plastics
9. Masks
10. Sharps Containers
11. Surgical Sponges
12. Advanced Wound Care Products
13. Oxygen Regulators
14. Ostomy Supplies
15. Basic Urological Supplies
16. Examination Gloves

Appendix D. Business Unit Management Practices

Objective: *To discuss regional, Tri-service medical logistics business practices for obtaining best-value logistics support.*

One of the main reasons for the regional medical logistics support program is the opportunity to uniformly implement modern business practices across the MHS. Those business practices are based on adapting the best government and commercial practices to the unique needs of the MHS. For the regional medical logistics business units, those business practices will focus on four major functions:

- Clinical standardization of product lines
- Best-value acquisition practices
- Regional maintenance strategies
- Regional business case planning and analysis.

Each of these four functions will include the use of information systems to implement the policies adopted by Medical Logistics Regional Business Units. Decision support, acquisition analysis, and other information systems are a key element in the adoption of new business practices. Each of these four functions will be supported by measurable performance goals. Uniform measurement of performance and information reporting is key to achieving the truly global efficiencies envisioned in this guidance. The medical logistics structure defined here will manifest a true synergy between local and regional innovation, regional optimization, and global standards for information systems, performance measurement, and management. This synergy will optimize readiness support, obtain true systemic efficiencies where possible, and permit the level of strategic collaboration between suppliers and users needed to insure long-term viability of the military healthcare system.

A. Performance Imperatives

The vision outlined above will also support the development of distribution-oriented performance metrics for all DoD activities. Metrics now in use were developed for earlier logistics practices, which were focused on the management of relatively static inventories and local maintenance. Since the emergence of just-in-time logistics practices, that focus has shifted to managing the distribution of very volatile and rapidly changing supply channels. New metrics will permit even better, and more uniform, management of those practices. The new regionally organized logistics activities will operate according to seven performance imperatives:

- Information about purchasing, pricing, distribution, consumption, maintenance and other acquisition activities will be available across and between DoD healthcare regions. It will be possible to aggregate or de-aggregate that information to obtain “views” at the ward, department, hospital, regional, or national level.

- Purchasing methods and processes will be geared toward best-value contracting to obtain the lowest delivered costs for supplies and services. "Lowest delivered costs" will include costs generated internally in an MTF as a component of logistics, nursing, and other overhead cost factors, as well as the more traditional product pricing factors.

- Clinically driven standardization programs will reduce the number of different products and equipment items within specific product lines to allow for economies of scale, more efficient distribution, and simpler maintenance requirements. (See "Standardization Activities.")

- Regional logistics management activities will implement standardized, regionally structured order fulfillment cycles for materials and services based on electronic commerce (EC) models and processes. EC processes will also include electronic product cataloging tools, ordering mechanisms, and reporting tools, and may also use point-of-use or point-of-sale systems to further control the product distribution pipeline. (See "Information Systems.")

- Information flows will provide a feedback loop to enable monitoring of local and regional buying patterns and maintenance actions and to improve compliance with standardized product formularies or portfolios.

- Throughout the implementation phases described in this plan, logisticians and other leaders will deliberately bring about a transformation of existing work forces through retraining, reassignment, and career development efforts. This is needed because the work being done by logistics staffs has changed fundamentally. What used to be largely manual inventory management and storage work is now mostly automated distribution management work.

B. FOUR MAJOR BUSINESS PRACTICES

Standardization. To fully achieve the benefits of regional materials management, clinically driven standardization programs will need to reduce the numbers of different medical products and equipment items procured by the MHS. Standardization seeks to improve system performance and reduce costs by driving out unnecessary variance from standard purchasing practices. Inputs to a materials standardization process include clinical pathways, a process of standardizing clinical practice, and economic analysis. Analysis in the Army's Southeast Region has shown significant variation in the prices paid by individual activities for identical items, even using Prime Vendor procurement methods. For example, a pint of common rubbing alcohol costs between $.42 and $.94, depending on which manufacturer is providing it. Other examples from the capital equipment domain are abundant. The military's TARA process has shown wide variations in the utilization and maintenance of capital equipment among MTFs.

Regionally based standardization would provide consolidated, region-wide data about pricing and consumption, with which clinicians could select their preferred product based on quality, price, and usage patters. Regionally based standardization provides the appropriate compromise between national standardization efforts, which have been largely unsuccessful over the past 40 years, and the inefficient, costly practice of unconstrained local procurement. Finally, if conducted properly, regional standardization could serve as a data source for national standardization and procurement efforts. Some products or product types, such as drapes and gowns for surgical use, may lend

themselves well to national standardization and acquisition. Others, such as custom procedure packs, may be better suited to the development of regional standardization and acquisition methods.

Best-Value Acquisition. Standardization will ensure that the military is buying the right products. Improving acquisition strategies will ensure that the military gets the right price. To get the right price, buyers and managers at all levels will employ new tactics based on an understanding of the whole logistics system. "Committed volume" purchasing means that the military will negotiate tiered pricing schedules based on increasing levels of compliance with standardized product "menus." As vendors receive guarantees of increased volume (usually expressed not in absolute dollar terms but in terms of overall buying patterns), they are able to offer improved pricing. Usually, failure to meet a commitment target results in some form of penalty, generally in the form of a surcharge or fee, and better-than-expected compliance results in a reward.

Closely related to the committed volume concept is the concept of market share. Vendors will give favorable pricing to gain market share at the expense of their competitors. Standardization or product review committees should understand the implications of a shift in buying practices. Moreover, vendors should be directly queried during a product review period about the possible price differentials associated with shifting market share from one to another.

Group purchasing initiatives are now being studied by the MHS. It is expected that there will be at least a pilot test of this concept, in which military hospitals buy pre-negotiated contracts directly from a civilian group purchasing organization. Broader implementation of this program is also possible. Wholesale organizations in the government may focus in the future on designing and operating a global distribution system, leaving price negotiation, contracting, and compliance monitoring to trading partners from the group purchasing industry.

Ultimately, the MHS should be able to use the full measure of its global buying power to reduce prices. In an ideal system, all government purchasing may be pooled -- a feature that would provide the greatest possible volume discounts. This will only happen to the extent that the MHS operates and behaves as a system. This fact increases the pressure on regional organizations to improve their compliance with national standards and to expand their cooperation with other regions.

Regional Maintenance Strategies. Regional operation appears to offer substantial benefit for maintenance functions. By operating through regional mechanisms, economies of scale, concentration of expertise, and enhanced network support should all be possible. Several strategies appear promising. The first is the development of blanket contracts on a regional basis. The MHS has great experience with blanket contracts at the facility level but has only begun to expand those to regional contracts.

Another promising avenue is third-party asset management. Several national firms and a host of regional firms exist for such management services. Using them, the MHS could transfer responsibility for much or all of its medical equipment to a vendor, thereby concentrating maintenance expertise at the wholesale levels and reducing the logistics footprint at the facility level. The expanded use of credit cards to handle most small repair or maintenance needs is another area with promise. Using credit cards to handle these needs could potentially eliminate many traditional service contracts.

Regional Business Case Analysis. With good logistics practices, the MHS can achieve savings without impacting patient care and improve the support provided to clinical units. The primary mission of tomorrow's logisticians must be to provide leadership to the MHS's cost reduction efforts. Most opportunities to reduce expenses result from lower acquisition cost, reduced consumption, increased inventory turnover, lower inventory value, and a streamlined supply chain. However, these opportunities will not be intuitively obvious. Instead, they will require careful analysis and activity-based cost studies to pinpoint them.

Logisticians, as a key member of a clinically led, multi-functional team, will lead the way in expense reduction, and they will do so through the use of analysis methods that depict the actual cost of performing a function and the measurable benefit of changing, reengineering, or even eliminating functions. However, changing functions often involves some investment: additional staff for a reengineering project, contractor support for some analysis functions, or even acquisition of new information systems to support better decisions. Getting the money to make those investments will require the development of a business case—a means of showing those benefits in clear, objective, quantified ways.

Each regional medical logistics business unit will develop its own business case to highlight the benefits and specify the investment requirements needed to implement change in its region. The Executive Agency and the MLPS will need to weigh the relative merits of different investment requirements and establish funding priorities for various business units that will use the business cases.

C. PERFORMANCE METRICS

Standard, widely understood and widely used performance reporting is key to the success of the regional medical logistics program. This implementation document provides only notional ideas about the types of information needed. Further development of these ideas will be pursued as the initiative nears implementation. Performance reporting will be done at periodic intervals to Lead Agents and the MLPS. Performance reporting will include information about the following:

- *Macro Performance Indicators*. Macro-level indicators, such as supply costs per enrolled beneficiary, supply costs by MTF and medical specialty, and others, will be used to track logistics performance in a managed care environment. As DoD increasingly seeks to bring its procedure and utilization costs into line with capitated budget targets, it will be necessary to capture and compare costs by individual physician, by service or specialty, and by facilities or regions.

- *"Market Basket" product costs*. The DMLSS Program Office has developed a representative sampling of pharmaceutical and medical-surgical products. Logistics Business Units will be responsible for collecting pricing and consumption data about this "market basket" and reporting it upward to insure that regions are obtaining the best possible pricing for the products they are using. The market basket will be maintained by the DMLSS Program Office to ensure that it reflects current buying patters. Eventually, the market basket will be expanded to include dental, laboratory, and radiology products.

- *Delivered costs*. Logistics Business Units will be responsible for maintaining, updating, and reporting the activity-based costing data developed in their Business Plans to insure that total delivered costs for logistics products and services are used to manage Business Unit implementation.

- *Distribution Velocity Indicators*. Data about the operation of the healthcare supply chain will be collected to determine relative efficiency, permit business adjustments, and target areas of potential improvement. Desirable information about velocity includes inventory turn over data, delivery times, and error and return rates.

- *Staff savings and realignment*. One of the key imperatives in this Implementation Plan is the transformation of logistics work forces to provide more responsive, more customer-focused, and more knowledge-based logistics service. Data collected in this category could include indices of materials management or maintenance staff levels divided by actual workload, or maintenance costs as a proportion of on-hand equipment value. By creating regionally focused Logistics Business Units, substantial staff savings and realignment should be possible.

Performance metrics to assess the flexibility and responsiveness of the Business Units themselves will also be needed. In other words, it won't be sufficient to measure only those costs and improvements that lie outside the Business Unit -- the Business Units themselves will need "scorecards" that measure the quality of support they are providing to the MTFs in their regions.

D. INFORMATION SYSTEMS

Tri-service regional medical logistics activities will be supported by a suite of information systems based around legacy systems and, as they become available, DMLSS products developed for DoD medical activities. A migration from legacy systems to the DMLSS architecture and application products will insure smooth implementation of regional activities. In fact, DMLSS products are essential to successful implementation beyond Phase I of this program (i.e., to achieve the benefits of integrated purchasing, supplier collaboration, and reengineered business processes). Use of standard electronic commerce models and information systems will aid in the full integration of MHS activities with commercial vendors supporting them. To enable the consolidation and aggregated analysis of data at the regional level, ordering sites at the local level may need to use wide-area networks (WANs) or value-added networks (VANs) at the regional or national level to route supply and service transactions. The functions of the regional information system are as follows::

- Remove the burden of procurement analysis activities at the local level.

- Provide buffers for items, services, or product lines not available from Prime Vendors or maintenance contractors.

- Develop requirements for contracts for additional families or groups of products and services not already covered. (For example, laboratory supplies, a product category now being reviewed by DoD's Region 6 for standardization and Prime Vendor-type outsourcing.)

- Integrate emerging Internet-based procurement tools and methods into DMLSS retail or regional information systems.

The emerging DMLSS WAN for which infrastructure is now being fielded will permit the development and use of large, integrated databases of procurement, product, and distribution information across regional Logistics Business Units. These integrated databases will greatly aid the regional standardization and acquisition analysis goals outlined earlier and will be key information tools used regionally.

E. CONCLUSION

Implementation of regional logistics management activities according to this guidance will provide significant savings over the current decentralized processes. These savings will occur in five areas:

- **Supply Costs.** Through regional standardization, committed-volume purchasing, reductions in the number of different distribution channels, and improved contract compliance, the purchase price of supplies bought by DoD's hospitals can be reduced below current levels.

- **Overhead Costs.** The current process of fully staffed, stand-alone logistics operations—including contracting, stock record accounting, inventory management systems, and warehousing facilities—at each MTF involves considerable overhead: A significant portion of DoD's $2 billion annual medical logistics costs are actually internal overhead needed to operate hospital-level inventory management functions. Opportunities to reduce these costs deserve further study. .

- **Contract Services Costs.** Regional maintenance and other services contracts have the potential to reduce DoD's costs by standardizing the range of services procured and leveraging volume.

- **Electronic Commerce.** Cutting-edge commercial organizations are implementing electronic commerce systems based on enterprise-wide information systems, collaborative partnerships with suppliers, and vastly streamlined order fulfillment cycles. Similar systems offer DoD the potential for a more efficient and responsive medical logistics system built around regional, tri-service management processes.

- **Other Logistics Functions.** This ConOps applies to medical maintenance and medical materials management processes, but similarly decentralized operations are used to manage housekeeping, facilities management, real property maintenance, hospital linen, non-medical supplies, and nutrition services. All of these functions may offer potential for regional restructuring.

These savings are expected to lead to systemic savings of at least $20 million to $50 million annually, but the effort will require an offsetting investment. Based on preliminary estimates, Lead Agents can expect a return on investment of at least 10:1. That is, every dollar invested at the Lead Agent or Medical Logistics Business Unit level will return at least 10 dollars in savings.

The development of regional databases, electronic commerce systems, and information systems to manage distribution, maintenance, invoicing, and payment at the regional level will all be necessary.[3] This effort must be centered in the continuing development and fielding of the DMLSS systems and business processes. Staffing of regional offices (with government or contractor staff) may be achieved through redeployment of other existing resources.

Each regional Lead Agent, as defined earlier in the "Future Vision" section of this plan, will be responsible for developing and implementing a business plan. The business plan will define the regional savings potential for his or her region, along with the investment requirements needed to achieve those savings. The methodology for the business plan will use activity-based costing methods to determine actual costs and potential savings for implementing regional support in the region being studied.

The primary risk associated with this concept is the danger of lost opportunity. Experience in military and civilian healthcare systems has shown almost unequivocally that regional coordination of procurement, maintenance, and other support services offers benefit. Failure to implement regional entities and processes would result in an erosion of DoD's ability to deliver the most effective, cost-efficient care.

[3] Based on earlier work done in the Army's Southeast Regional Medical Command, which has been exploring regional operations for the past 2 years, the effort will require an investment in hardware, software, telecommunications, personnel, and office space, although marginal costs will decline as the number of sites increases.

Appendix E. Sample Instructions for Clinical Product Teams

CLINICAL PRODUCT TEAM GUIDANCE

1. PURPOSE. The purpose of this document is to provide background information and guidance to Clinical Product Teams (CPT) participants on the process for seeking regional standardization of Medical-Surgical (MedSurg) supplies.

2. DISCUSSION.

a. The Army, Navy & Air Force have been working together in the National Capital Area (NCA) and TRICARE Region 1 to standardize the MedSurg products that are in common use. We are doing that in order to save money through committed volume purchase agreements, as well as to improve supply effectiveness. To date, we have standardized approximately 12 product groups with potential regional savings of over $500K annually.

b. The process is guided by a Tri-Service committee called the Tri-Service Product Review Board (TPRB), but the real work is done by CPTs that are formed, as needed, to evaluate specific product groups from the user's perspective. Each CPT has at least one representative from each Service, one of who serves as the "lead" Service (Army, Navy, Air Force). In this case, "lead" does not infer authority for decision making; rather, it designates who is responsible for organizing meetings, and keeping the members informed, etc. Usually, CPT participants are nursing personnel who coordinate with a designated physician from the appropriate clinical department of their facilities. While direct physician involvement in a CPT is always welcome, we try to minimize the amount of time that is demanded from them.

c. The CPT meets as frequently as necessary to review a product line, collect vendor data, develop clinical critique, evaluate products (clinically), analyze usage and price, and select the best product. The Standardization Business Office (SBO) (consisting of a nurse, a logistician, and a data analyst) eases clinical representatives from this administrative workload by contacting vendors, facilitating CPT meetings, conducting data analysis, and other administrative and support functions necessary to sustain this program. Each CPT attends the monthly TPRB meeting (usually the 3rd Thursday of every month) to report on their progress and to present recommendations to board members.

d. The full approval process for the regional standardization of a product line includes a discussion by the full TPRB of the clinical factors evaluated by the CPT and an evaluation of vendor pricing & service proposals. A recommendation is made by the TPRB to the Federal Health Council, which is a committee formed by the Commanders of the three Medical Centers in the NCA and which makes the final decision on all standardization actions. Each TPRB recommendation is also coordinated with the NCA "Council of Deputies", which is committee of the Medical Directors of each NCA MEDCEN.

3. CONCLUSION. The process described above has been very successful in achieving consensus across Medical Treatment Facility and Service lines. In nearly every case, the recommendations made to the MEDCEN commanders have been unanimous, and as a result, the decisions have met overwhelming acceptance among using clinicians throughout the NCA and TRICARE region. And, we have achieved significant savings in the process.

4. POINTS OF CONTACT.

- The SBO can be reached at (202) 782-4020 or by using the following email addresses:

  Allan_Arnette@wramc1-amedd.army.mil

APPENDIX F: Associated Policies

REPROCESSING AND REUSE OF SINGLE USE DEVICES

TRI-SERVICE REGIONAL MEDICAL LOGISTICS SUPPORT PROGRAM
IMPLEMENTATION GUIDANCE
REPROCESSING AND REUSE OF SINGLE-USE DEVICES

1. The Food and Drug Administration (FDA) and other Federal agencies have disclosed that a number of health care institutions have engaged in the practice of reusing single-use sterile disposable medical devices. Since then, the FDA proposed guidance documents, "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals" and "Final Guidance for Reprocessing and Reuse of Single-Use Devices". These documents can be located at http://www.fda.gov/bbs/topics/ANSWERS/ANS01027.html.

A listing of other available documents for the reuse of single-use devices (SUD) can be located at http://www.fda.gov/cdrh/reuse/reuse-documents.shtml.

2. The FDA has issued final guidance on the practice of reusing medical devices intended to be used only once. The FDA will regulate third party reprocessors and hospitals that engage in reprocessing of single-use devices the same way the agency now regulates original equipment manufacturers. This includes: pre-market notification and approval requirements, registration and listing of firms, submission of adverse event reports, manufacturing requirements, labeling requirements, medical device tracking and correcting or removing from the market unsafe medical devices. The guidance, "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals," is available on FDA's web site at www.fda.gov/cdrh/reuse/042301 reuse.pdf.

3. The broad guidance is that reuse of single-use devices is an alternative that should be considered in regional standardization initiatives, but that it must be within FDA guidelines. Prior to soliciting information from a reprocessing third party vendor, review the FDA guidelines and understand what FDA requires when single-use devices are reprocessed for reuse. As military Medical Treatment Facilities (MTF) evaluate this option, through the Regional Standardization Team, it is imperative that the full scope of the issue be addressed by a multidisciplinary group made up of a physician, Infection Control Officer, Central Sterile Supply personnel, the Risk Manager, supply personnel, contracting, and other appropriate members. It is important to consider the effect reprocessing will have on the annual volume for any supplies where the price of the item from the original manufacturer is being driven by volume.

4. The general guidance to military medical facilities (hospitals and clinics) is:

a. Military medical activities should use third-party reprocessors to perform reprocessing procedures of SUDs. The SUD categories normally processed by the third-party reprocessors are:

(1). Devices opened-but-unused: A SUD whose sterility has been breached or whose sterile package was opened, but the device was not used on a patient. *These items must be repackaged and resterilized.*

(2). Devices used on a patient that fall within the third party reprocessors acceptance guidelines.

(3). Devices unopened but have expired based on the manufacturer's label.

b. If a Tri-Service region or any of its activities are interested in a reprocessing contract, they may join Indefinite Delivery Indefinite Quantity contracts already established or develop a regional contract initiative for their region.

c. The reprocessing contractor must:

(1). Comply with FDA guidelines.

(2). Be a member of Association of Medical Device Reprocessors (AMDR).

5. The Veterans Affairs Special Services (VASS) Division Contracting Office that is co-located with the Air Force Medical Logistics Office, offers a services contract for "Reprocessing of Single Use Medical Devices." The Air Force Medical Logistics homepage web site is: https://afml.ft-detrick.af.mil/AFMLO/va/cust.htm.

6. The definitions listed below are working definitions from the Food and Drug Administration:

a. Single-use device: A single-use device is intended to be used on one patient during a single procedure. It is not intended to be reprocessed (cleaned and disinfected/sterilized) and used on another patient. Opened but unused single-use device is a disposable single-use device whose sterility has been breached or whose sterile package was opened, but the device has not been used on a patient.

b. Reuse: The repeated use or multiple uses of any medical device, including reusable and single-use medical devices, on the same patient or on different patients, with applicable reprocessing (cleaning, and disinfection/sterilization) between uses.

c. Reprocessing: Includes all operations performed to render a contaminated reusable or single-use device patient-ready or to allow an unused product that has been opened to be make patient-ready. The steps may include cleaning and disinfecting/sterilization. The manufacturer of reusable devices and single-use devices that are marketed as non-sterile should provide validated reprocessing instructions in the labeling.

d. Resterilization: The repeated application of a terminal process designed to remove or destroy all viable forms of microbial life, including bacterial spores, to an acceptable sterility assurance level.

NEEDLESTICK SAFETY FOR HEALTH CARE WORKERS

ASSISTANT SECRETARY OF DEFENSE

WASHINGTON D.C. 20301-1200

HEALTH AFFAIRS

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (SAF/Ml)

SUBJECT: Policy Letter on Needlestick Safety for Health Care Workers

Needlesticks and other percutaneous injuries resulting in exposure to blood or other potentially infectious materials are a serious concern for health care workers. Newer, safer medical devices can reduce the risk of needlesticks and the chance of contracting deadly bloodborne diseases including human immunodeficiency virus (HIV), hepatitis B virus, hepatitis C virus and others. The Needlestick Safety and Prevention Act, Public Law 106-430, signed November 6, 2000, mandated specific revisions of the Occupational Safety and Health Administration Bloodborne Pathogens standard (29 CFR 1910.1030) with an effective date of April 18, 2001. This revision was intended to ensure widespread use of safer medical devices to prevent dangerous needlesticks.

Effective immediately, it is Department of Defense policy that Medical and Dental Treatment Facilities will comply with newly revised OSHA 29 CFR Part 1910 and all applicable state regulations with respect to needlestick safety. All decisions concerning safety devices will be coordinated with the Regional Tri-Service Product Standardization Boards. The Clinical Product Teams for needlestick safety devices should include employees representing the range of exposure situations encountered in the workplace. The Services will include information on any cost increases associated with this policy in their quarterly product standardization report to the TRICARE Management Activity.

I am confident that adherence to this guidance will afford our healthcare providers greater protection against deadly and debilitating bloodborne diseases. I request you direct immediate implementation within your Service and provide a copy of your implementation instructions to my office.

My point of contact is Gail Sanftleben, Deputy Director for Medical Logistics, at (703) 681-0039, and email, Gail.Sanftleben@tma.osd.mil.

Original Signed
J. Jarrett Clinton, MD, MPH
Acting Assistant Secretary

cc:
Surgeon General of the Army
Surgeon General of the Navy
Surgeon General of the Air Force

HA POLICY: 00013

Open to view original and related documents

HA Needlestick.pdf

Appendix G. Sample Regional Policy for Standardization and Committed-Volume Purchasing

TRICARE Region _____
REGIONAL MATERIALS STANDARDIZATION and PURCHASING AGREEMENT

1. **Purpose**: To establish a Regional Standardization and Purchasing Program for Medical-Surgical (MedSurg) products within TRICARE Region _____ .

2. **General**: The military medical facilities in TRICARE Region _____ will act as an integrated purchasing alliance for the acquisition of MedSurg products. To the extent possible, the region will standardize the use of MedSurg products, and wherever possible will take advantage of committed volume purchase agreements in order to obtain price reductions and overall supply chain savings. To achieve this:

   a. A Tri-service Product Review Board (TPRB) will be established to identify and pursue opportunities for standardization and volume purchasing within the region. The TPRB will act under the joint direction of the commanders of _____, _____, and _____ Medical Centers, which will provide the approval authority for regional standardization recommendations [NOTE: Will vary among regions. Intent is to provide senior command oversight from each Military Service within the region]

   b. Standardization recommendations of the TPRB that are approved by the MEDCEN commanders will be reported to the Regional Governing Board (RGB), and will be honored by all TRICARE Region ___ activities. In cases where local circumstances lead a local commander to non-concur with a TPRB decision, that issue may be brought to the TRICARE Executive Board for resolution. [NOTE: Will vary among regions. Intent is to provide senior command oversight from each Military Service within the region]

   c. The Chairman of the TPRB will be authorized to represent the region for the purpose of signing purchase agreements that have been approved by the FHC.

   d. Purchase agreements will be executed through the Defense Supply Center, Philadelphia (DSCP) Prime Vendor Program, which will be used as the primary source of MedSurg materials within the region.

   e. Pricing obtained through volume purchasing agreements must be available to all military facilities in the Region.

3. This initiative is consistent with ASD(HA) Policy 98-013, which requires the establishment of *Regional Tri-service Medical Logistics Support Programs* in each DoD Healthcare Region, and with the implementation guidance for this policy currently being drafted by the Services' Deputy Surgeons General. Regional standardization efforts cannot succeed without strong command emphasis and clinical support.

Approved _____

Appendix H. Request for Regional Incentive Agreement Quotation (RFRIAQ)

The Defense Supply Center, Philadelphia has developed a format for letters to be sent to DAPA holders in order to inform them of the pending initiative to standardize a product group.

Letter 1: To be sent to all DAPA holders who offer the specific product group being standardized:

- A statement that the request is pursuant to the DAPA clause by which DAPA holders agreed to the standardization process.
- The date and time by which responses (e.g. product literature, samples) are due, and where and how to send the responses.
- A description of the decision process, including the evaluation criteria and the selection method.
- The estimated requirements.
- The term of the resulting agreement (e.g., one year with extensions/options).
- If the agreement may become multi-regional and/or national, a statement explaining this to the vendors.

Letter 2: To be sent only to those DAPA holders whose product groups meet minimum needs:

- Contain a request for committed-volume pricing and any details on how that pricing is to be structured
- Introduction, incorporating DAPA terms and conditions
- Description of the supplies and the prices covered by the agreement.
- Estimated requirements.
- Terms of the agreement.
- Termination provision.
- Commitment statement. The agreement should make clear exactly what the MTFs are agreeing to do.