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Affairs, House of Representatives

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VA REAL PROPERTY

Planning and Communication Improvements Could Help Better Align Facilities with Veterans' Needs

Statement of Debra A. Draper, Director, Health Care

GAO Highlights

Highlights of [GAO-17-745T](#), a testimony before the Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

VA operates one of the largest health care systems in the United States, providing care to more than 8.9 million veterans each year and as of September 2014, utilizing more than 6,000 federally-owned and 1,500 leased buildings.

This statement is based on GAO's April 2017 report (GAO-17-349) and discusses (1) the factors that affect VA facility alignment, (2) the extent to which VA's capital-planning process facilitates the alignment of facilities with the veteran population, and (3) the challenges VA faces in its alignment activities.

For the April 2017 report, GAO reviewed VA's facility-planning documents and data and interviewed VA officials in headquarters and at seven medical facilities selected for their geographic location, veteran population, and past alignment efforts.

What GAO Recommends

In the April 2017 report, GAO made four recommendations to VA to: (1) improve SCIP's scoring and approval process and address other limitations; (2) improve the utility of the VAIP facility master plans; (3) improve guidance to effectively communicate facility alignment decisions with stakeholders; and (4) evaluate these efforts. VA partially concurred with the first recommendation and fully concurred with the other recommendations.

View [GAO-17-745T](#). For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov

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Planning and Communication Improvements Could Help Better Align Facilities with Veterans' Needs

What GAO Found

Geographic shifts in the veteran population, changes in health care delivery, and an aging infrastructure affect the Department of Veterans Affairs' (VA) efforts to align its services and real property portfolio to meet the needs of veterans. For example, a shift over time from inpatient to outpatient care will likely result in underutilized space once used for inpatient care. Moreover, the historic status of some VA facilities adds to the complexity of converting or disposing of them. In such instances, it is often difficult and costly for VA to modernize, renovate, and retrofit these older facilities.

GAO found that two of the planning processes VA uses to align its facilities—VA's Strategic Capital Investment Planning (SCIP) and the VA Integrated Planning (VAIP)—have limitations that undermine VA's efforts to achieve its goals. Specifically,

- VA relies on the SCIP process to plan and prioritize capital projects, but VA routinely asks its facility planners to submit their next year's planned project narratives before knowing if their previous submissions have been funded. The overlapping budget cycle, which is outside of VA's control, combined with other SCIP limitations—including subjective narratives, long time frames, and restricted access to information—make it difficult for VA to rely on SCIP to accurately identify the capital necessary to address its service and infrastructure gaps. VA concurred that it needs to address SCIP limitations that are within its control, as GAO recommended.
- VA also relies on a second planning process, the VAIP process, that is intended to identify the best distribution of health care services for veterans and where the services should be located or adapted based on the veterans' locations and referral patterns. However, GAO found that the facility master plans prepared under the VAIP process assume that all future growth in services will be provided directly through VA facilities without considering alternatives, such as purchasing care from the community. In response to GAO's recommendation to address limitations with the VAIP process, VA noted that all future VAIP facility master plans will embrace all recent and evolving guidance, especially regarding care in the community opportunities.

Additionally, GAO's April 2017 report found that VA faced challenges when not fully engaging with stakeholders in its facility alignment decisions and actions that affect them. GAO has previously identified best practices for stakeholder involvement in facility consolidation actions, such as in utilizing two-way communication early in the process and using data to demonstrate the rationale for facility alignment decisions. GAO found that when VA engaged in two-way communication with stakeholders it resulted in more productive relationships and effective alignment efforts, than in those cases where it did not. This inconsistency could partly be caused by the lack of guidance for incorporating best practices into stakeholder communication and a mechanism for evaluating these efforts. In response to GAO's recommendations to develop guidance and implement an evaluation mechanism, VA outlined a plan to take these steps.

Chairman Roe, Ranking Member Walz, and Members of the Committee:

I am pleased to be here today to discuss our April 2017 report on the Department of Veterans Affairs' (VA) efforts to align its medical facilities and services.¹ As you know, VA operates one of the largest health care systems in the United States, providing care to more than 8.9 million veterans each year. VA is also one of the largest federal property-holding agencies. In September 2014, VA's reported inventory included 6,091 federally-owned and 1,586 leased buildings. However, in recent decades, the veteran population and preferences have shifted. VA has recognized this and the need to modernize its aging infrastructure and align its real property assets to provide accessible, high-quality and cost-effective services to veterans.

Aligning VA facilities to improve veteran access to services integrates two of GAO's high risk areas: veterans' health care and federal real property. In 2015, GAO placed veterans' health care on its High Risk List due to persistent weaknesses and systemic problems with timeliness, cost-effectiveness, quality, and safety of the care provided to veterans.² In 2003, GAO placed federal real property management—including management of VA real property—on its High Risk List due to long-standing challenges including effectively disposing of excess and underutilized federal property.³

¹GAO, *VA Real Property: VA Should Improve Its Efforts to Align Facilities with Veterans' Needs*, [GAO-17-349](#) (Washington, D.C.: Apr. 5, 2017).

²GAO, *High-Risk Series: An Update*, [GAO-15-290](#) (Washington, D.C.: February 2015). GAO maintains a high-risk program to focus attention on government operations that it identifies as high risk due to their greater vulnerabilities to fraud, waste, abuse, and mismanagement or the need for transformation to address economy, efficiency, or effectiveness challenges. See, for example, GAO, *VA Health Care: Actions Needed to Improve Newly Enrolled Veterans' Access to Primary Care*, [GAO-16-328](#) (Washington, D.C.: Mar. 18, 2016) and GAO, *VA Mental Health: Clearer Guidance on Access Policies and Wait-Time Data Needed*, [GAO-16-24](#) (Washington, D.C.: Oct. 28, 2015). See also, for example, Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration, Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*, Report No. 14-02603-267 (Washington, D.C.: Aug. 26, 2014) and VA, *Department of Veterans Affairs Access Audit, System-Wide Review of Access, Results of Access Audit Conducted May 12, 2014, through June 3, 2014*.

³See GAO, *High-Risk Series: Federal Real Property*, [GAO-03-122](#) (Washington, D.C.: January 2003).

Today I will summarize the findings from our April 2017 report including (1) the factors that affect VA facility alignment, (2) the extent to which VA's capital-planning process facilitates the alignment of facilities with the veteran population, and (3) the challenges VA faces in its alignment activities. In addition, I will highlight key actions that we recommended in our report that VA can take to improve its ability to plan for and facilitate the alignment of its facilities with veterans' needs.

For our report, we reviewed VA's facility-planning documents and data and interviewed VA officials in headquarters and at seven medical facilities selected for their geographic location, veteran population, and past alignment efforts. We also evaluated VA's actions against federal standards for internal control, federal capital-acquisition guidance, and GAO-identified best practices for capital planning.⁴ Additional information on our scope and methodology is available in our report. The work on which this testimony is based was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Facility Alignment Is Affected by Shifting Veteran Populations, Evolving Health Care Delivery, and an Aging Infrastructure

Geographic shifts in the veteran population, changes in health care delivery, and an aging infrastructure affect VA's efforts to align its services and real property portfolio to meet the needs of veterans. For example, a shift over time from inpatient to outpatient care will likely result in underutilized space once used for inpatient care. In such instances, it is often difficult and costly for VA to modernize, renovate, and retrofit these older facilities. In June 2017, VA reported that its facility inventory includes 430 vacant or mostly-vacant buildings that are, on average, more than 60 years old, and an additional 784 buildings are underutilized.

⁴See GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, DC: November 1999), and GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: September 2014), Office of Management and Budget, *Circular No. A-11: Preparation, Submission, and Execution of the Budget*, July 2016, and GAO, *Streamlining Government: Questions to Consider When Evaluating Proposals to Consolidate Physical Infrastructure and Management Functions*, [GAO-12-542](#) (Washington, D.C.: May 23, 2012).

The historic status of some VA facilities adds to the complexity of converting or disposing of them. In 2014, VA reported holding 2,957 historic buildings, structures, or land parcels—the third most in the federal government after the Department of Defense and the Department of the Interior. In some instances, it may be more expensive to renovate than demolish and rebuild outdated facilities. In other cases, however, there may not be an option to demolish if these buildings are designated as historic. For example, planning officials at four medical facilities in our review told us that state historic preservation efforts prevented them from demolishing vacant buildings, even though these buildings require upkeep costs and pose potential safety hazards. (See fig. 1.)

Figure 1: Example of a Deteriorating Historic Vacant Building at a Department of Veterans Affairs' (VA) Medical Center, July 2016



Interior damage of Kerrville Medical Center.



Portions of the ceiling have collapsed, spraying debris on to the floors and walls.



Exterior view of the building shows broken windows and missing bricks.

Source: GAO. | GAO-17-745T

Note: Kerrville VA Medical Center, Kerrville, Texas: These pictures show a dwelling formerly used for medical staff housing that has been designated as a historic building. The outside of the building shows broken windows, missing bricks, and gutters that have nearly detached from the building. On the inside, portions of the ceiling have collapsed, spraying debris onto the floors and walls.

Limitations in VA's Capital-planning Processes Impede Its Alignment of Facilities

Two of the planning processes VA uses to align its facilities—VA's Strategic Capital Investment Planning (SCIP) and the VA Integrated Planning (VAIP)—have limitations.⁵

SCIP Process

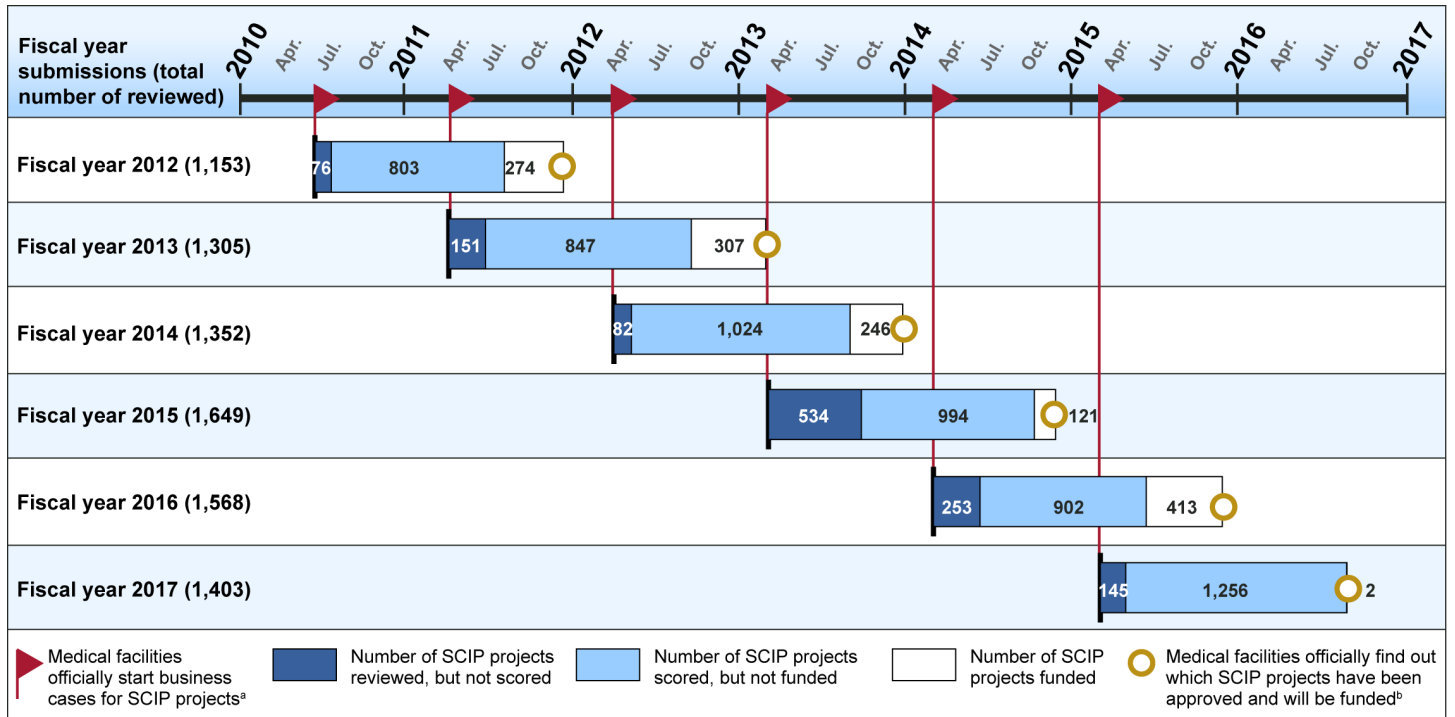
VA relies on the SCIP process to plan and prioritize capital projects system-wide, but SCIP's limitations—including subjective narratives, long timeframes, and restricted access to information—undermine VA's ability to achieve its goals. For example, the time between when planning officials at VA medical facilities begin developing the SCIP narratives and when they are notified that a project is funded has taken between 17 and 23 months over the past 6 fiscal-year SCIP submissions.⁶ (See fig. 2.) As such, VA routinely asks its facility planners to submit their next year's planned project narratives before knowing if their project submissions from the previous year have been funded.

⁵Established in 2010, the goal of SCIP is to identify the full capital needed to address VA's service and infrastructure gaps and to demonstrate that all project requests are centrally reviewed in an equitable and consistent way throughout VA, including across market areas within VA's health care system. Annually, planners at the medical facilities develop 10-year action plans for their respective facilities, which include projects to address gaps in service identified by the SCIP process. Medical facility officials then develop more detailed business plans for the capital improvement projects that are expected to take place in the first year of the 10-year action plan. These projects are validated, scored, and ranked centrally based on the extent to which they address the annual VA-approved SCIP criteria using the assigned weights.

Implemented in fiscal year 2011 as a pilot project, the VAIP process's goal was to identify the best distribution of health care services for veterans; where the services should be located based on the veterans' locations and referral patterns; and where VA should adapt services, facilities, and health care delivery options to better meet these needs as determined by locations and referral patterns.

⁶The scoring of submitted projects includes both narrative responses that are evaluated (about one-third of the overall score) and data-driven scoring based on gap closure (the remaining two-thirds of the overall score).

Figure 2: Overlapping Timelines of the Last 6 Fiscal Years of the Strategic Capital Investment Program's (SCIP) Project Submissions and the Number of Submissions



Source: GAO analysis of Department of Veterans Affairs information. | GAO-17-745T

^aAlthough planning officials at VA medical facilities obtain initial information from SCIP about what gaps they need to address, they do not officially start developing the narratives until they receive a request from VA to submit a project for SCIP scoring and approval. Officials from the office that oversees SCIP told us that facilities usually have access to the tools for submission about a week prior to the request date.

^bMedical facilities officially find out which major (over \$10 million) and minor construction (under \$10 million) SCIP projects are approved and will be funded when Congress passes the department's budget for that fiscal year. Non-recurring maintenance SCIP projects—repairs and renovations within the existing square footage of a facility that total more than \$25,000—are available for funding on the first day of the fiscal year for that project's submission because they have advance appropriations.

An official from the office that oversees SCIP told us that the timing of the budgeting process, which is outside VA's control, contributes to these delays. While these aspects are outside of its control, VA has chosen to wait about 6 to 10 months to report the results of the SCIP scoring process to the medical facilities. This situation makes it difficult for local officials to understand the likelihood that their projects will receive funding. A VA official said that for future SCIP cycles, VA plans to release the scoring results for minor construction and non-recurring maintenance projects to local officials earlier in the process. At the time of our review, however, the official did not have a timeframe for when VA would do this. Although VA acknowledges many of these limitations, it has taken little action in response. Federal standards for internal control state that agencies should evaluate and determine appropriate corrective action for identified limitations on a timely basis.⁷ If VA does not address known limitations with the SCIP process, it will not have reasonable assurance that SCIP can be used to accurately identify the capital necessary to address its service and infrastructure gaps. In our April 2017 report, we recommended that VA address identified limitations to the SCIP process, including limitations to scoring and approval, and access to information. VA partially concurred, noting that it generally concurred with the recommendation to address limitations in the SCIP process, but limited its concurrence to addressing the limitations that are within its control.

VAIP Process

The VAIP process produces a market-level health services delivery plan for each Veterans Integrated Service Network (VISN) and a facility master plan for each medical facility—which VA has estimated to cost \$108 million when fully complete.⁸ However, the VAIP process's facility master plans assume all future growth in services will be provided directly through VA facilities. This assumption is not accurate given that VA obligated about \$10.1 billion to purchase care from non-VA providers in fiscal year 2015. VA can provide care directly through its medical facilities or purchase health care services from non-VA providers through both the

⁷See [GAO-14-704G](#).

⁸VA organizes its system of care into regional networks (VISNs), which are responsible for coordination and oversight of all administrative and clinical activities within its specified geographic region. As of January 2017, VA officials told us they had mostly completed the VAIP process in 6 of the 18 VISNs and had plans to start or complete the remaining VISNs by October 2018.

Non-VA Medical Care Program (referred to as “care in the community” by VA) and clinical contracts.⁹

The Office of Management and Budget’s acquisition guidance notes that investments in major capital assets should be made only if no alternative private sector source can support the function at a lower cost.¹⁰ This consideration is particularly relevant as VA’s data projects that the number of enrolled veterans will begin to fall after 2024. Officials who oversee the VAIP process said that they were still awaiting other VA offices to complete analyses required by recently released VA guidance, but as a result of this and other limitations, some local VA officials said that they already bypass the VAIP process and contract for their own facility master plans. In our April 2017 report, we recommended that VA assess the value of the VAIP’s facility master plans as a facility-planning tool, and based on conclusions from the review, either (1) discontinue the development of VAIP’s facility master plans or (2) address the limitations of VAIP’s facility master plans. VA concurred with the recommendation and noted that all future VAIP facility master plans will embrace all recent and evolving guidance, especially regarding care in the community opportunities.

⁹VA uses the services of non-VA providers in non-VA facilities under the following statutory authorities: 38 U.S.C. §§ 1703, 1725, 1728, 8111, and 8153. The Non-VA Medical Care Program includes the Choice Program and Patient-Centered Community Care. The Choice Program was authorized under the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act), which appropriated \$10 billion for the furnishing of non-VA care when veterans’ access to VA health care does not meet applicable timeliness or travel requirements. Pub. L. No. 113-146, 128 Stat. 1754 (2014). VA may authorize Choice Program care until such funds are exhausted. Pub. L. No. 115-26, § 1, 131 Stat. 129 (2017). Patient-Centered Community Care is a nationwide program where VA may authorize non-VA care when a VA facility is unable to provide certain specialty care services, such as cardiology or orthopedics, or under other conditions. To implement the program, VA utilizes two contractors, Health Net and TriWest, to establish networks of providers in a number of specialties—including primary care, inpatient specialty care, and mental health care.

¹⁰See Office of Management and Budget, *Circular No. A-11*.

VA Has Faced Challenges When Not Fully Engaging Stakeholders in Its Facility Alignment Efforts

VA has encountered challenges to its facility alignment efforts, in part, because it has not consistently followed best practices for effectively engaging stakeholders. VA may align its facilities to meet veterans' needs by expanding or consolidating facilities or services. Stakeholders—including veterans; local, state, and federal officials; Veterans Service Organizations; historic preservation groups; VA staff; and Congress—often view changes as working against their interests or those of their constituents, especially when services are eliminated or shifted from one location to another.

We have previously identified best practices for stakeholder engagement in facility consolidation actions, recommending that stakeholder outreach begin well in advance of any facility changes and developing a two-way communication strategy to address concerns and explain the data, the rationale, and the overarching benefits behind decisions.¹¹ Failure to effectively engage with stakeholders about alignment changes can undermine or derail facility alignment. We found that VA has not consistently engaged stakeholders, and, in some cases, this resulted in adversarial relationships that reduced VA's ability to better align facilities with the needs of the veteran population. In other cases, we observed two-way communication with stakeholders that resulted in more productive relationships and effective alignment efforts, such as with a medical facility that successfully closed an underutilized inpatient wing, closed a leased community based outpatient clinic, and relocated a domiciliary.

This inconsistency in communication practices may result, in part, from a lack of VA guidance for incorporating best practices into stakeholder communication. Further, VA officials stated that they do not monitor and evaluate their communication methods for effectiveness in reaching their intended audiences. This runs counter to federal standards for internal control, which note that agencies should monitor and evaluate their activities.¹² Without guidance that adheres to best practices for fully integrating stakeholders and without monitoring and evaluation of this process, VA does not have reasonable assurance that its staff are meaningfully or effectively engaging stakeholders in the capital alignment decisions that affect them. In our April 2017 report, we recommended that

¹¹See [GAO-12-542](#).

¹²See [GAO-14-704G](#).

VA (1) develop and distribute guidance for VISNs and facilities using best practices on how to effectively communicate with stakeholders about alignment change, and (2) develop and implement a mechanism to evaluate VISN and facility communication efforts with stakeholders to ensure that these communication efforts are working as intended and align with guidance and best practices. VA concurred with our recommendations and outlined a plan to implement these recommendations.

Chairman Roe, Ranking Member Walz, and Members of the Committee, this concludes my prepared statement. I am happy to answer any questions related to our work on VA's efforts to align its medical facilities and services.

GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact me at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions to this testimony include Dave Wise, Director; Keith Cunningham, Assistant Director; Jacquelyn Hamilton; Jeff Mayhew; Malika Rice, Michelle Weathers; and Crystal Wesco.

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