September 2017

VETERANS HEALTH CARE

Additional Actions Could Further Improve Policy Management

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Why GAO Did This Study

GAO was asked to conduct a management review of VHA; this is the sixth report in the series. In this review of VHA's policy management, GAO examines the extent to which (1) VHA has implemented its new definitions for national policy and guidance documents; (2) VHA ensures that national policy and guidance documents are accessible to VISNs and VAMCs; (3) VHA collects information on local challenges with implementing national policy, including the exemptions granted when policy requirements cannot be met; and (4) local policies are developed and maintained by VISNs and VAMCs, and whether they are aligned with national policies.

GAO reviewed agency documentation, including VHA's revised directive on policy management. GAO also interviewed VHA officials involved with policy improvement efforts, as well as officials from a nongeneralizable sample of four national program offices, four VISNs, and eight VAMCs selected to provide geographic variation, among other factors.

What GAO Recommends

GAO is making six recommendations to VHA, which include clarifying national policy and guidance documents, ensuring access to guidance documents, incorporating local feedback into national policy, establishing a process to approve and track policy exemption waivers, and ensuring alignment of local and national policy. VHA generally concurred with GAO's recommendations.

What GAO Found

The Veterans Health Administration (VHA)—within the Department of Veterans Affairs (VA)—is taking steps to align existing national policy documents with newly revised definitions that streamline and clarify document use. According to the new definitions in its June 2016 directive on policy management, directives and notices are now the sole documents for establishing national policy; other types of documents, such as program office memos, are considered guidance. VHA is reviewing about 800 existing national policy documents to eliminate those that no longer meet its new definitions, and to rescind or recertify those that are outdated. At this time, VHA is not planning to review guidance documents, such as program office memos and standard operating procedures, to assess whether they align with its updated directive, because there is no central repository for these documents and it would be too resource intensive to locate all of them. Further, GAO's review found—contrary to VHA's updated directive—that program offices are continuing to use memos to issue policy. The continued use of program office memos to establish national policy undermines VHA's efforts to improve its policy management.

VHA has a standard process for making national policy documents accessible to VA medical centers (VAMC) and the Veterans Integrated Service Networks (VISN) to which the medical centers report, but lacks a process for making guidance documents accessible. VHA makes national policy documents accessible to all organizational levels through a publications website and e-mail distribution list as outlined in its June 2016 directive. However, GAO found that VHA has not established a similar process for program offices to make guidance documents accessible at the local level. Specifically, there is no central repository, such as a publications website, for guidance documents, and the program offices do not track or consistently disseminate the guidance documents they issue. Without a standard process for consistently maintaining and disseminating guidance, VHA lacks assurance that staff receive and follow the same guidance, as intended.

VHA does not routinely collect information on local challenges with national policy implementation or on exemption waivers. The four VISNs and eight VAMCs in GAO's review reported various challenges they face when implementing national policy, such as resource constraints and undefined time frames. In instances where VAMCs cannot meet policy requirements, program offices may approve policy exemption waivers on an ad hoc basis. However, GAO found that VHA lacks complete information on approved policy exemption waivers because it does not have a standard process for approving, tracking, and reassessing them. In recognition of this issue, VHA established a committee to develop a waiver process in June 2017.

VISNs and VAMCs in GAO's review develop and maintain various local policies, but VHA does not ensure that they align with national policies. Specifically, GAO found that VHA does not have a process for program offices to systematically ensure that local policies align with national policies. Without such a process, VHA may continue to experience inconsistent policy implementation across its health care system.

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Within the Department of Veterans Affairs (VA), the Veterans Health Administration (VHA) operates one of the nation's largest health care systems comprised of 18 regional networks called Veterans Integrated Service Networks (VISN), which include 170 VA medical centers (VAMC) and more than 1,000 outpatient facilities. To help carry out its mission to provide timely and high-quality health care to the nation's veterans, it is important that VHA develop and communicate national policies throughout the organization and ensure their appropriate implementation. VHA policies cover every aspect of care delivery, such as purchasing care in the community and scheduling outpatient medical appointments. At the national level, VHA has used a variety of document types to establish policy or to provide guidance to its facilities on implementation. Locally, VISNs and VAMCs may also establish regional- or facility-specific policies.

Our work, along with that of VA's Office of Inspector General and others, has cited longstanding concerns about VA's oversight of its health care

system.[1] These concerns, which include ambiguous policies and inconsistent processes, contributed to the addition of VA health care to GAO's High-Risk List in 2015.[2] Specifically, we found that ambiguous policies have led to inconsistencies in the way VAMCs operate at the local level, posing risks for veterans' access to health care and for the quality and safety of that care.

In addition, in 2014, Congress mandated both an independent assessment, and, separately, the establishment of a Commission on Care, to make recommendations for improving VA's health care system, including its management.[3] The report from the independent assessment was released in September 2015, and the report from the Commission on Care was released in July 2016. Both reports included recommendations to improve communication and implementation of VHA policies at the local level, as well as recommendations to improve policy development coordination among VHA's program offices.

Recently, VHA has taken a number of steps to improve its policy management. In June 2016, for example, VHA updated its directive on

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[1]For example, see GAO, *VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement,* GAO-13-130 (Washington, D.C.: Dec. 21, 2012), and *VA Health Care: Improvements Needed in Processes Used to Address Providers' Actions That Contribute to Adverse Events,* GAO-14-55 (Washington, D.C.: Dec. 3, 2013). See also, for example, Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration, Review of the Implementation of the Veterans Choice Program,* Report No. 15-04673-333 (Washington, D.C.: Jan. 30, 2017).

[2]GAO maintains a high-risk list to focus attention on government agencies and programs 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. GAO, *High-Risk Series: An Update,* GAO-15-290 (Washington, D.C.: Feb. 11, 2015).

[3]The Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, §§ 201(a)(1) and 202(a)(1), 128 Stat. 1754, 1769-71, 1773. The independent assessment included 12 specific assessment areas and, according to VA, resulted in 188 recommendations for reforming VHA. See Centers for Medicare & Medicaid Services Alliance to Modernize Healthcare, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs* (Sept. 1, 2015). The Commission on Care was required to, among other things, strategically examine how best to organize VHA, locate health resources, and deliver health care to veterans during the next 20 years. The commission's report to the President included 18 recommendations. See Commission on Care, *Final Report of the Commission on Care* (Washington, D.C.: June 30, 2016).

national policy management.[4] The updated VHA Directive 6330 provides new definitions for national policy and guidance to streamline the number of, and provide clearer instruction about, the document types the organization will use. For example, the directive included fewer national policy document options by eliminating previous document types. As part of implementing the updated directive, VHA plans to review its existing policies and ensure they align with its new definitions. The updated VHA Directive 6330 also describes the communication process for new or changed policy, and details the related roles and responsibilities for each level of the organization. In addition, VA submitted an action plan to us in August 2016 on how it plans to address the issues raised in the high-risk report, including its policy management activities. However, in our 2017 high-risk update, we reported that previously identified issues for policy management continue, in part, because VA lacks the capacity to effectively address this area of concern.[5]

Based on concerns about VHA's ability to manage its health care system, you asked us to conduct a management review of VHA that includes, among other issues, its oversight of core functions and internal communication mechanisms. We have previously issued several reports that addressed specific aspects of VHA's management, including those pertaining to its organizational structure, strategic planning, and human capital management.[6] This report examines the extent to which

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[4]Veterans Health Administration, *Controlled National Policy/Directives Management System*, VHA Directive 6330 (June 24, 2016).

[5]Specifically, VA has not met one of our criteria, the capacity criterion, because of significant gaps between its stated goals and the resources available to achieve them. GAO, *High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others*, GAO-17-317 (Washington D.C.: Feb. 15, 2017).

[6]See GAO, *VA Health Care: Processes to Evaluate, Implement, and Monitor Organizational Structure Changes Needed*, GAO-16-803 (Washington D.C.: Sept. 27, 2016); *Veterans Health Care: Improvements Needed in Operationalizing Strategic Goals and Objectives*, GAO-17-50 (Washington D.C.: Oct. 21, 2016); *Veterans Health Administration: Management Attention Is Needed to Address Systemic, Long-standing Human Capital Challenges*, GAO-17-30 (Washington D.C.: Dec. 23, 2016); *Veterans Affairs: Improved Management Processes Are Necessary for IT Systems That Better Support Health Care*, GAO-17-384 (Washington D.C.: June 21, 2017); and *VA Health Care: Improvements Needed in Data and Monitoring of Clinical Productivity and Efficiency*, GAO-17-480 (Washington D.C.: May 24, 2017). We have additional ongoing work related to VHA's use of contracts and other arrangements, such as those used to operate its community-based outpatient clinics.

- VHA has implemented its new definitions for national policy and guidance documents;

- VHA ensures that national policy and guidance documents are accessible to VISNs and VAMCs;

- VHA collects information on local challenges with implementing national policy, including the exemptions granted when policy requirements cannot be met;

- local policies are developed and maintained by VISNs and VAMCs, and whether they are aligned with national policies.

To determine the extent to which VHA has implemented its new definitions for national policy and guidance documents, we reviewed relevant VHA documentation. Specifically, this documentation included: 1) the 2008 and revised 2016 version of its national policy management directive, VHA Directive 6330; 2) VHA's plans for policy management improvement efforts, as well as VA's action plan for addressing the ambiguous policies and inconsistent processes area of concern identified in our high-risk report; and 3) internal reports quantifying the total number of VHA national policy documents, as well as detailing the length of time for developing these documents. We interviewed VHA officials who were leading policy management improvement efforts to assess how their activities are meeting the needs of each level of the organization, as well as addressing the high-risk concerns we have previously identified. To examine VHA's efforts in more detail, we selected a non-generalizable sample of four national policies based on issues identified in past GAO work with variation in policy expiration dates and responsible VHA program offices.[7] We selected

- VHA Directive 1230 on outpatient scheduling processes and procedures,[8]

- VHA Directive 1601 on non-VA medical care,[9]

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[7]A responsible program office is the office that develops and manages a particular policy. It can be a high-level office, such as the Office of Organizational Excellence, or one of its subordinate offices, such as the Office of Health Equity.

[8]Veterans Health Administration, *Outpatient Scheduling Processes and Procedures*, VHA Directive 1230 (July 15, 2016).

[9]Veterans Health Administration, *Non-VA Medical Care Program,* VHA Directive 1601 (Jan. 23, 2013).

- VHA Directive 2012-002 on re-engaging veterans with serious mental illness in treatment,[10] and

- VHA Directive 2010-008 on standards for mental health coverage in emergency departments and urgent care clinics in VHA facilities.[11]

We also interviewed officials from the responsible program offices for each of the four selected policies to obtain information on their policy management practices, and to determine the extent to which their offices adhere to VHA's new policy and guidance definitions. In addition, we selected and interviewed officials from four VISNs and two VAMCs from each of these VISNs to gain their perspectives on VHA's policy management practices. The four VISNs and eight VAMCs were selected to provide variation in geographic dispersion and facility complexity level.[12] Information from our interviews is not generalizable to all facilities. Specifically, we selected

- VISN 1 (Bedford, Mass.): Manchester VAMC (Manchester, N.H.), and White River Junction VAMC (White River Junction, Vt.);

- VISN 7 (Duluth, Georgia): Carl Vinson VAMC (Dublin, Georgia), and Central Alabama Veterans Health Care System (Montgomery, Ala.);

- VISN 22 (Long Beach, Calif.): Greater Los Angeles Healthcare System (Los Angeles, Calif.), and Phoenix VA Health Care System (Phoenix, Arizona); and

- VISN 23 (Eagan, Minn.): Omaha VAMC (Omaha, Neb.), and Royal C. Johnson Veterans Memorial Medical Center (Sioux Falls, S.D.).

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[10]Veterans Health Administration, *Re-engaging Veterans with Serious Mental Illness in Treatment*, VHA Directive 2012-002 (Jan. 10, 2012).

[11]Veterans Health Administration, *Standards for Mental Health Coverage in Emergency Departments and Urgent Care Clinics in VHA Facilities*, VHA Directive 2010-008 (Feb. 22, 2010). VHA subsequently rescinded Directive 2010-008 during our review and incorporated the content into a broader directive on emergency medicine. See Veterans Health Administration, *Emergency Medicine*, VHA Directive 1101.05 (2) (Sept. 2, 2016). In light of the rescission, we continued to include questions about Directive 2010-008 to better understand how officials were planning to implement, or were implementing, the new directive.

[12]VHA categorizes medical centers according to complexity level, determined on the basis of the characteristics of the patient population, clinical services offered, educational and research missions, and administrative complexity. There are three VAMC complexity levels with level 1 representing the most complex facilities, level 2 moderately complex facilities, and level 3 the least complex facilities. Level 1 is further subdivided into categories 1a - 1c.

We asked officials from our selected VISNs and VAMCs about how effectively VHA manages national policy and guidance documents, and any consequences of its actions at the local level. We also asked them about VHA's management of our four selected national policies.

To determine the extent to which VHA ensures that national policy and guidance documents are accessible to VISNs and VAMCs, we reviewed relevant documentation from VHA on its communication mechanisms, including VHA Directive 6330 and its policy distribution process. We interviewed VHA officials who are leading policy improvement efforts to assess how their activities affect the agency's policy and guidance communication practices. We also interviewed officials from responsible program offices for each of our four selected policies to obtain information on their communication practices. Specifically, we assessed the standards they follow and the mechanisms used to ensure the accessibility of their policy and guidance documents. In addition, we interviewed officials from our selected VISNs and VAMCs to gain their perspectives on the effectiveness of the communication mechanisms used for national policy and guidance documents. Finally, we evaluated VHA's actions against federal internal control standards related to communication.[13]

To determine the extent to which VHA collects information on local challenges with implementing national policy, including the exemptions granted when policy requirements cannot be met, we reviewed relevant documentation and spoke to officials from each level of VHA about their practices. To identify policy implementation challenges, we interviewed officials from our selected VISNs and VAMCs to gain their perspectives, including whether there were processes in place at the national level to help mitigate their challenges. To determine the extent to which processes have been established to address policy implementation challenges, we reviewed VHA documentation, including VHA Directive 6330, its internal plans for policy improvement efforts, and its action plan for addressing the ambiguous policies and inconsistent processes area of concern identified in our high-risk report. For our four selected national policies, we interviewed officials from the responsible program offices on how they help local facilities implement national policy, such as by

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[13]Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. GAO, *Standards for Internal Control in the Federal Government,* GAO-14-704G (Washington, D.C.: September 2014).

identifying time frames and resource requirements, as well as the extent to which they grant exemption waivers when facilities are unable to meet these requirements. Finally, we evaluated VHA's actions against standards for internal control in the federal government related to control activities, communication, and monitoring.[14]

To determine the types of local policies that are developed and maintained by VISNs and VAMCs and the extent to which they are aligned with national policies, we reviewed relevant documentation and spoke to officials from each level of VHA. At the local level, we interviewed officials from our selected VISNs and VAMCs on their policy management practices. We also obtained local policy document lists and information on where these policies are maintained. To assess the extent to which local policies are aligned with national policies, we reviewed relevant documentation from VHA, including VHA Directive 6330 and its action plan for addressing the ambiguous policies and inconsistent processes area of concern identified in our high-risk report. We assessed whether these documents identified the roles and responsibilities for monitoring policies at each level of VHA. Additionally, we interviewed officials from key program offices who are leading VHA's policy management improvement efforts about their activities to better understand local policy management. We also discussed with them how they plan to use this information to address local policy needs and high-risk concerns. Finally, we evaluated VHA's actions against standards for internal control in the federal government related to monitoring.[15]

We conducted this performance audit from June 2016 to September 2017 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.

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[14]GAO-14-704G.

[15]GAO-14-704G.

Background

VHA's Organizational Structure and Responsibilities for Policy Management

At the local level, VHA's delivery system is organized into 18 VISNs, each responsible for overseeing VAMCs within a defined geographic area.[16] VISN directors report to the Deputy Under Secretary for Health (USH) for Operations and Management who oversees VHA's field operations. The Deputy USH for Operations and Management also serves as the focal point between VHA's central office and the VISNs and VAMCs.

Within VHA's central office, policy management roles are divided between multiple offices. VHA's central office is responsible for national policies developed by individual program offices—approximately 145 program offices as of May 2017. These program offices may have clinical or administrative functions and vary in the number of policies that they develop and manage.

To help standardize national policy processes and reduce the burden on program office subject matter experts, VHA's Office of Regulatory and Administrative Affairs (ORAA) manages the national policy development and review process. As of June 2017, ORAA had about four full-time-equivalent staff assigned to national policy management.[17] These staff are primarily responsible for shepherding documents through the policy review process, providing policy-writing expertise, and working with relevant VHA subject matter experts within individual program offices to develop or update policies. Through its policy-development process, ORAA aims to reduce variability, simplify the process, and ensure any issues are identified and vetted prior to final approval. ORAA advises responsible program offices about their policies, but does not have the authority to require their compliance to complete policy-related tasks. ORAA also tracks and reports policy, procedural, and timeliness requirements, and is responsible for ongoing process improvement. It collaborates with the Office of Policy and Services on policy management activities and with the Office of Organizational Excellence on high-risk

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[16]VAMCs manage outpatient facilities located within their respective medical centers; these outpatient facilities include community-based outpatient clinics and health care centers. For the purpose of this report, we use the term VAMCs to refer to all of its components.

[17]ORAA also had seven contractors assigned to national policy management as of June 2017.

areas of concern. See figure 1 for VHA's key leadership positions related to policy management.

Figure 1: Selected Leadership Positions within the Veterans Health Administration (VHA), May 2016
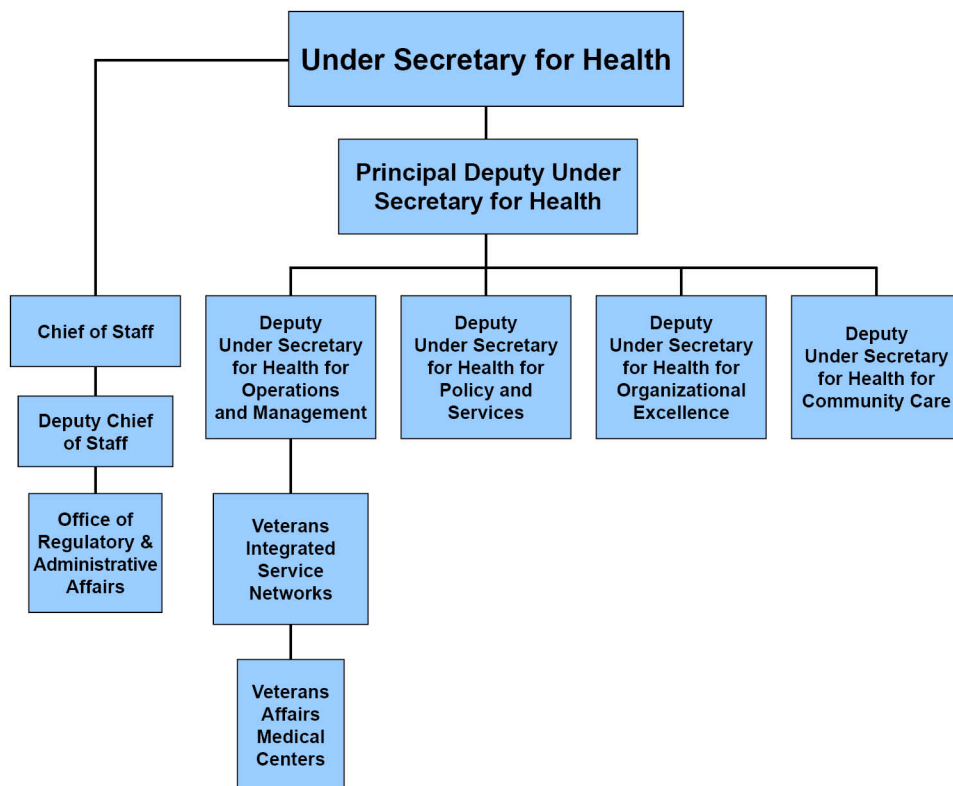
Source: GAO analysis of VHA documents. | GAO-17-748

Note: In addition to the Deputy Under Secretary positions shown in this figure, the following positions also report to the Under Secretary for Health: Chief Officer Readjustment Counseling Service, Executive Director of Research Oversight, and Chief Nursing Officer. Also, the Chief Financial Officer and Director of Strategic Integration report to the Principal Deputy Under Secretary for Health.

VHA Directive 6330

VHA Directive 6330 governs the organization's policy management; the June 2016 revisions established clearer definitions for national policy and guidance documents. It also updated VHA's policy drafting and submission processes, as well as its requirements for policy issuance and recertification. Specifically, the revised directive defines national policy as a document that "establishes a definite course of action for VHA and assigns responsibilities for executing that course to identifiable individuals

or groups." The directive stipulates that two primary document types are to be used for national policy—directives and notices:

- Directives are to be used to establish national policy and contain certain types of information, such as the roles and responsibilities for each component of the organization.

- Notices are to be used to communicate information about a one-time event (e.g., rescinding a current national policy) or to establish interim policy until a directive can be developed.

The directive also states that a memo signed by the USH can be used to establish policy for VHA's central office, but not for VISNs and VAMCs.

Additionally, VHA Directive 6330 states that guidance is not national policy and defines guidance as "recommendations that inform strong practices within the organization and are supported by evidence, legal requirements, national policy, or organizational priorities." It states that guidance includes recommendations for implementing statutes, regulations, or national policy. Guidance documents include program office memos, standard operating procedures, and other such documents that are not signed by the USH.[18]

VHA Directive 6330 establishes a 5-year recertification date for directives, while notices have an automatic 1-year expiration period.[19] VHA has not established recertification time frames for guidance documents.

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[18]Program offices can use memos that may have different levels of senior executive signature. For example, VHA has issued several program office memos signed by the Deputy USH for Operations and Management related to the agency's mental health programs, including identification and management of mental health conditions.

[19]ORAA officials explained that the 5-year time frame for recertification is based on the department-level VA Directive 6330.

VHA Has Taken Steps to Align Existing National Policy Documents with New Definitions, but It Continues to Use Program Office Memos to Issue Policy

## VHA Is Aligning Existing Policy Documents with Its New Definitions

We found that VHA is in the process of reviewing existing national policy documents to align with its new policy definitions as outlined in Directive 6330. It began reviewing documents in October 2015 in response to our high-risk concerns related to policy management, and this effort has evolved over time. Specifically, ORAA initiated a process of reviewing 788 documents previously issued as national policy—directives, handbooks, manuals, and information letters—the majority of which were outdated.[20] However, existing guidance documents, such as program office memos, have not been included in this review because there is no central repository that would facilitate their identification, and the number of these documents is unknown. In addition, ORAA officials told us that they do not have enough staff to review these additional documents.[21] (See figure 2.)

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[20]ORAA officials explained that the policy documents prioritized for review are mostly based on the readiness of the responsible program office and where the policies fall in its queue of documents waiting for its review.

[21]ORAA officials told us that they may review and assess future guidance documents submitted by program offices to provide assistance on choosing an appropriate document type, if their staff have availability to do so.

Figure 2: Documents Included in, and Excluded from, the Veterans Health Administration's (VHA) Transition to New Policy and Guidance Definitions, as of October 2015
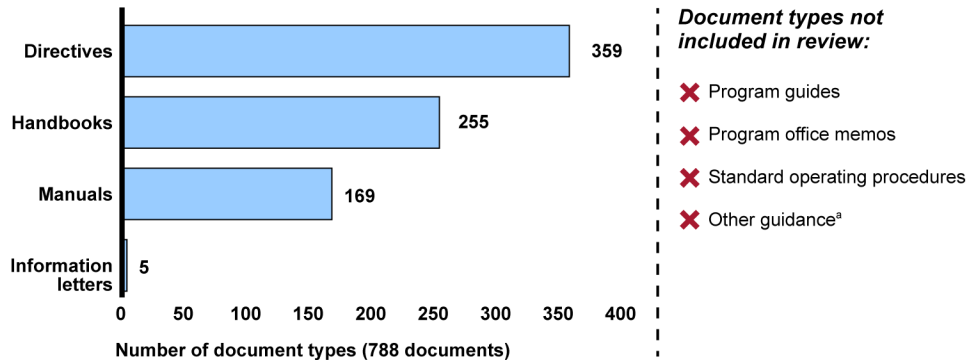
Source: GAO analysis of VHA documents. | GAO-17-748

Note: Although notices and memos signed by the Under Secretary for Health are also types of national policy documents according to the updated VHA Directive 6330, none of these documents existed at the time that VHA's Office of Regulatory and Administrative Affairs started reviewing existing policy documents in October 2015.

[a]Per VHA Directive 6330, other guidance may include e-mail, conference calls, SharePoint sites, or intranet sites. VHA uses Microsoft's SharePoint software to store, organize, share, and access information sites. SharePoint is only accessible through VHA's intranet.

Through its review process, ORAA intends to streamline the number and types of policy documents used by the organization. (See table 1.) ORAA is eliminating handbooks, manuals, and information letters, although they will continue to function as national policy until rescinded. As part of this effort, ORAA plans to move any relevant content to other policy and guidance documents as appropriate. For example, ORAA is incorporating handbooks into their related directives.[22] VHA noted that this consolidation should help reduce any redundancy and inconsistency when multiple documents articulate different aspects of a single policy. This will also help VHA ensure that when national policy is updated, the update will also include a review of relevant information currently found in other policy documents. Officials from many of the VISNs and VAMCs in our review agreed that a single document source for policy information

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[22]This process will eliminate stand-alone handbooks, although ORAA has made some exceptions for documents that were already far along in the review process. For example, ORAA officials told us that the Office of Ethics policy handbook has been held up in VHA's concurrence process for years. Because of the length of time in review, they determined that it was more important to maintain the integrity of the document rather than to align it with the national policy definition changes in VHA Directive 6330.

would be helpful. ORAA officials noted that the definitions for what constitutes national policy and guidance documents are still evolving.

Table 1: List of Veterans Health Administration (VHA) National Policy and Guidance Document Types

Document type	National policy documents	National policy documents to be eliminated	Guidance documents
Directives	✓	—	—
Notices	✓	—	—
Memos signed by the Under Secretary for Health	✓[a]	—	—
Handbooks	—	✓	—
Information letters	—	✓	—
Manuals	—	✓	—
Program guides	—	—	✓
Program office memos[b]	—	—	✓
Standard operating procedures	—	—	✓
Other guidance[c]	—	—	✓

Legend:

✓ Document type is included in this category.

— Document type is not included in this category.

Source: GAO analysis of VHA documents. | GAO-17-748

Note: This table does not include local policy documents.

[a]A memo signed by the Under Secretary for Health can be used to establish policy only for VHA's central office.

[b]Program offices can use memos that may have different levels of senior executive signature. For example, VHA has issued several program office memos signed by the Deputy Under Secretary for Health for Operations and Management related to the agency's mental health programs, including identification and management of mental health conditions.

[c]Per VHA Directive 6330, other guidance may include e-mail, conference calls, SharePoint sites, or intranet sites. VHA uses Microsoft's SharePoint software to store, organize, share, and access information sites. SharePoint is only accessible through VHA's intranet.

According to our review of ORAA information, almost 60 percent of the 788 policy documents identified for transition under the new definitions were outdated in October 2015. As part of its transition, ORAA is taking outdated documents and either rescinding them or recertifying the ones that are still relevant. VHA's recertification process involves assessing whether a national policy document still serves a purpose and should be updated accordingly, or is no longer needed and should be rescinded or
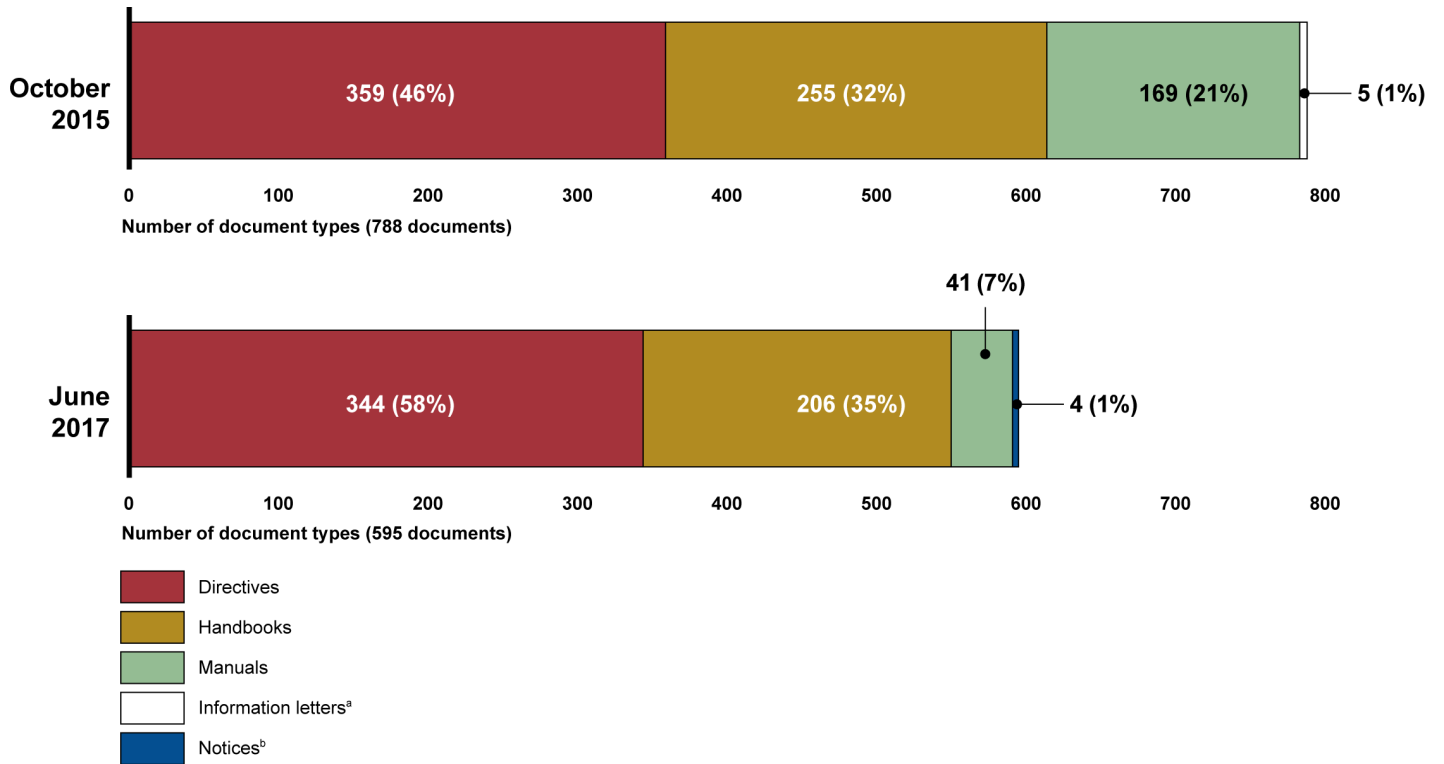
combined with another policy. Officials from most VISNs and VAMCs in our review told us that unless a policy has been rescinded, they continue to follow it, even if past its recertification date. This practice is consistent with requirements in the revised VHA Directive 6330 and a memo signed by the USH in June 2016.[23]

ORAA officials expect that transitioning VHA's existing policy documents will take about 5 years. As of June 2017, ORAA reduced the total number of documents identified for transition by 193 (from 788 to 595), and 43 percent of these remaining documents (256 of 595) are outdated. (See figure 3.) Much of the reduction has been driven by rescinding manuals and information letters. The number of directives and handbooks has not changed substantially; this is due, in part, to the continuation of policies reaching their recertification dates and the publication of new or changed policies. ORAA officials said that its limited progress is also due to resource constraints, such as insufficient staffing, funding, and inadequate information technology capability. Because ORAA does not own the policies, officials noted that they must rely on the responsible program offices to comply with policy-related tasks.

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[23]Under Directive 6330's certification requirements, national policy that has not been superceded or rescinded is considered to be current. VHA, *Controlled National Policy/Directives Management System*, VHA Directive 6330 (June 24, 2016), and *Validity of VHA Policy Document (VAIQ #7712168)*, VHA Memorandum (June 29, 2016).

Figure 3: Veterans Health Administration (VHA) Progress in Transitioning Existing Policy Documents, October 2015 to June 2017

October 2015

| 359 (46%) | 255 (32%) | 169 (21%) | 5 (1%) |

0   100   200   300   400   500   600   700   800

Number of document types (788 documents)

June 2017

41 (7%)

| 344 (58%) | 206 (35%) | | 4 (1%) |

0   100   200   300   400   500   600   700   800

Number of document types (595 documents)

- ⬛ Directives
- ⬛ Handbooks
- ⬛ Manuals
- ⬜ Information letters[a]
- ⬛ Notices[b]

Source: GAO analysis of VHA documents | GAO-17-748

[a]Information letters were previously used as policy documents at the time VHA's Office of Regulatory and Administrative Affairs (ORAA) started its review in October 2015 and were completely phased out in August 2016.

[b]Notices were added as a type of national policy under the updated VHA Directive 6330 in June 2016. There were no notices at the time that ORAA started reviewing existing policy and guidance documents in October 2015.

VHA Continues to Issue National Policy through Program Office Memos That Lack Vetting and Are Not Subject to Recertification

Contrary to the new national policy definitions in VHA Directive 6330, program offices continue to issue policy using memos—an issue we also noted in our high-risk update in 2017.[24] Officials from every program office in our review told us that they have continued to use memos to issue policy quickly. ORAA officials stated this may be due to the lengthy national policy review process, which they said took an average of 317 days in fiscal year 2016.[25] Program offices use memos for a variety of purposes, including clarifications or updates to issued directives, data collection requests, information about policies or procedures while a directive is under development, and the provision of training information. Memos signed by the Deputy USH for Operations and Management— referred to as "10N" memos—are the most common type of program office memo we identified in our review. Historically, VHA has primarily used 10N memos to communicate with VISNs and VAMCs because the Deputy USH for Operations and Management oversees local operations.[26]

ORAA officials stated that program office memos were never intended to serve as national policy. Specifically, VHA Directive 6330 states that a notice should be used to establish interim policy until a directive can be developed. However, VHA has mostly used notices to issue rescissions of previous policy documents, and memos continue to be used to establish policy. For example, we identified a 10N memo that instructed VAMCs to immediately implement changes to ongoing professional practice evaluations and peer review requirements for VAMC chiefs of staff. In another instance, officials at one VAMC noted that, at the time of our visit, they had already received 32 changes to the Veterans Choice

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[24]See GAO-17-317.

[25]VHA recently instituted a revised policy development, review, and approval process in December 2016 that has a 120-day (or 4-month) goal from start to finish. Its revised process includes faster publication of lower-risk policies and eliminates some of the barriers to timely approval. For example, the new process now requires all VHA program offices to simultaneously review the draft policy in the same time frame and approve or comment at that time.

[26]Officials from other VHA program offices told us that they seek signature and distribution of their memos through the Deputy USH for Operations and Management, even though they do not report to that position. These program offices include the Deputy USH for Policy and Services and the Deputy USH for Organizational Excellence.

Program since 2014 through non-policy documents, including memos.[27] Using program office memos—instead of the appropriate policy vehicle—to issue policy is problematic in light of VHA's new policy and guidance document definitions. Additionally, unlike national policy, program office memos are not internally vetted and are not subject to recertification, as described below.

Lack of internal vetting. Memos are not subject to a formal review process and can be issued quickly once signed. VHA noted in its high-risk action plan that 10N memos are the predominant source of guidance documents, and have been used to create policy without being vetted by other agency offices or VA's labor management relations group. Without such a vetting process, VHA leadership and other officials in the organization do not always have input on or even awareness of the potential impact of policy issued through these memos. Further, some of the VISNs and VAMCs in our review cited concerns about contradictory information among related program office memos.

Not subject to recertification. Unlike national policy documents, memos are not subject to recertification and are therefore typically not rescinded. Officials from some of the VISNs and VAMCs in our review described challenges when outdated memos are not rescinded, including questions about whether the memo should still be applied to local practices. For example, one VAMC wanted to use a certain non-VA care option for radiation oncology services, but a memo that was over a year old instructed local facilities to use a different non-VA care option. Since that memo had not been rescinded, VAMC officials said that they could not use their preferred non-VA care option to avoid delays in care.

ORAA is taking steps to address program offices' use of memos to issue policy, but it is only focusing on 10N memos at this time. ORAA officials told us they have agreed with the Deputy USH for Operations and Management to have a 5-year recertification date for 10N memos, although this has yet to go into effect. They are also reviewing and assessing guidance documents submitted by program offices to see whether the content should be in a different document type, such as a

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[27]The Veterans Access, Choice, and Accountability Act of 2014, as amended, provides authority and funding for veterans to obtain health care services from non-VA community providers to address long wait times, lengthy travel distances, or other challenges accessing care at VAMCs. Pub. L. No. 113-146, 128 Stat. 1754 (2014), as amended. Under this authority, VA introduced the Veterans Choice Program in November 2014.

directive. However, ORAA officials noted that they are not sure whether they have sufficient staff to sustain these reviews. Without further steps to clarify how and when program office memos should be used, the continued use of these memos by program offices may undermine VHA's efforts to implement new policy and guidance definitions, as intended. Furthermore, VHA cannot ensure that VISNs and VAMCs have a clear understanding of which policies to follow.

VHA Has a Standard Process for Making National Policy Documents Accessible to VISNs and VAMCs, but Lacks Such a Process for Guidance Documents

VHA Has a Standard Process to Make National Policy Documents Accessible to VISNs and VAMCs

As a part of its updated Directive 6330 on national policy management, VHA established a standard process to make national policy documents accessible to VISNs and VAMCs.[28] Specifically, ORAA's Publications Control Officer is responsible for ensuring national policy documents are disseminated to each level of the organization by maintaining the VHA publications website and distribution list, according to VHA Directive 6330.

Once a national policy document is finalized, the Publications Control Officer posts it to VHA's publications website. However, officials from two of the VISNs and most of the VAMCs in our review stated that the documents are difficult to search for on this website because it requires specific wording to locate them. As a result, some officials told us that they often search for national policy documents using other online search engines such as Google. ORAA officials told us that making the VHA

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[28]In addition to VISNs and VAMCs, the standard mechanism established in Directive 6330 also includes dissemination of national policy to VHA program offices.

publications website more user-friendly is dependent upon their ability to obtain the appropriate technical capability.

The Publications Control Officer is also responsible for distributing issued national policy no later than 2 business days after it is signed by the USH. To do so, this individual uses a national e-mail group—the VHA distribution list—as the standard mechanism to distribute the policy document to each component of the organization.[29] The distribution list includes groups of staff from program offices and key VISN and VAMC staff. According to ORAA officials, staff can be added to or removed from the distribution list on an ad hoc basis.

Many VISN and VAMC officials in our review were satisfied with the use of the distribution list to disseminate national policy documents. VHA program offices may also provide copies of the documents to VISNs and VAMCs to inform them of forthcoming policy or policy changes. Officials from several VISNs and VAMCs told us that receiving a national policy document from various sources ensures that it is disseminated to the right people at the local level.

ORAA officials told us that they recently conducted a survey and learned that it is not always clear which VAMC staff position is responsible for policy implementation. For example, officials from one VAMC in our review were unsure who within their facility was receiving national policy documents from the distribution list. In the future, ORAA officials said that they plan to update the distribution list process and e-mail contacts to ensure that the appropriate VISN and VAMC staff members are receiving the information. ORAA officials also said they plan to continue exploring which staff positions are responsible for managing policy at the local level to determine if there are any gaps that need to be filled. ORAA officials said that their ability to identify and address these gaps is contingent on competing priorities and staffing.

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[29]ORAA also uses the distribution list to disseminate changes to or rescissions of national policy.

VHA Does Not Have a Process to Consistently Make Guidance Documents Accessible to VISNs and VAMCs

Unlike with national policy documents, there is no standard process used to ensure guidance documents issued by various VHA program offices are consistently made accessible to VISNs and VAMCs. As a result, we found that guidance documents can be difficult to find, and there is no assurance that VISNs and VAMCs receive them and are all following the same guidance. Specifically, guidance documents are not part of a central repository, are not tracked, and are not consistently disseminated to VISNs and VAMCs.

Lack of a central repository. Guidance documents, such as program office memos, that do not go through the formal VHA review process are not posted on VHA's publications website and are maintained in different ways by the program offices that develop them. For example, 3 of the 4 VHA program offices in our review told us they maintain memos on various internal websites, while the remaining program office does not maintain copies of its memos once sent to the local level. ORAA officials noted that while a central repository with all VHA guidance would be ideal, they do not have sufficient staff and resources to accomplish this. However, they would like to establish a location on the VHA intranet, where ORAA could post future 10N memos. Officials said they do not have the capacity to identify and add previously issued 10N memos due to staff limitations.

Not systematically tracked. In general, guidance documents are not typically assigned tracking numbers and, as a result, are difficult to identify and quantify. For example, as previously mentioned, most VHA program offices in our review said that identifying and quantifying the total number of their memos would be difficult because they do not systematically track them. As a result, program offices do not know whether some of these documents are duplicative or whether they conflict with one another or with other policy documents. At the local level, officials from three VISNs and five VAMCs in our review noted difficulties with finding program office memos. Officials explained that they sometimes rely on staff's institutional knowledge to find a specific memo, or they may contact the relevant program office. ORAA officials told us they would like to work with the Deputy USH for Operations and Management to assign tracking numbers to 10N memos so that they can be referenced and searched.

Inconsistent dissemination. VHA program offices may disseminate guidance to VISN staff for distribution to VAMCs or to both VISN and VAMC staff at the same time. Each program office in our review told us

they maintain their own e-mail groups for communication with the local level.[30] However, officials from one VAMC expressed concern that receiving guidance depends on staff being included in a specific program office's e-mail group.

According to standards for internal control in the federal government, management should internally communicate the necessary quality information to achieve the entity's objectives.[31] In doing so, management selects appropriate methods to communicate internally and considers how that information will be made readily available to its staff when needed. Without a standard process for consistently maintaining and disseminating guidance documents to VISNs and VAMCs, the agency lacks assurance that staff members receive and follow the same guidance, as intended.

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[30]Program offices may also disseminate guidance to VISNs and VAMCs via other communication mechanisms like conference calls and e-mails, which may not always be documented. VHA program office officials told us that these calls are informal and are structured to be open discussions between program offices and the local level.

[31]GAO-14-704G.

VHA Does Not Routinely Collect Information on Local Challenges with National Policy Implementation and Lacks Information on Policy Exemption Waivers for VAMCs

VHA Does Not Consistently Collect Information on the Challenges VISNs and VAMCs Face in Implementing National Policy

VHA has not consistently solicited input on national policies either prior to issuance or after implementation from VISNs and VAMCs. Officials from the four VISNs and eight VAMCs in our review outlined a variety of challenges they face when implementing national policy, including insufficient or undefined time frames and conflicting policies on the same topic.

Insufficient or undefined time frames. Officials from most of the VISNs and VAMCs in our review told us that it is difficult to implement policies with insufficient or undefined time frames. For example, officials from one VAMC told us that a national policy sometimes does not specify required implementation time frames, and as a result, the expectations for when VAMCs should complete implementation are not clear. VHA officials told us that there is no VHA-wide standard for specifying time frames for completing implementation of national policy.

Resource constraints. Officials from most of the VISNs and VAMCs in our review identified resource constraints as an implementation challenge for certain policies, such as those with stringent staffing and building space requirements. For example, officials from one VISN told us that its facilities were required to have a certain type of surgeon available, which proved challenging to recruit and retain for smaller, more rural VAMCs. Additionally, officials from another VAMC said that one national policy required mental health patients to have access to a safe outdoor space, which would be difficult to implement without major construction and at least 5 years to plan. Officials said that to comply with this policy, they plan to have staff walk patients outside. However, this reduces the

available staff on the mental health unit during this time. Because local situations may vary, VHA program office officials told us that it is difficult to specify resource needs in national policy that applies across all VISNs and VAMCs.

Not specific to VAMC complexity level. Officials from most of the VISNs and VAMCs in our review noted that the lack of tailoring for a facility's complexity level makes national policy implementation difficult. As a result, officials stated that level 2 (medium complexity) and 3 (low complexity) VAMCs are often expected to adhere to the same policy requirements as level 1 (high complexity) VAMCs. For example, officials noted that policies requiring 24-hour physician coverage for specialties such as emergency medicine, women's health, and suicide prevention are challenging for complexity level 2 and 3 VAMCs, which may not have sufficient patient volume or staffing resources. Officials from one program office explained that complexity level is not addressed in national policy, but may be addressed in a standard operating procedure or local policy. Officials from VHA's Office of Organizational Excellence told us that national policies are intended to be written broadly for VAMCs of all complexity levels. However, other VHA officials acknowledged that policies are written for facilities that fully operate a service or program, and have the capability to implement all of its accompanying policy requirements, which are usually level 1 (high complexity) facilities.

Conflicting policies on the same topic. A few VISNs and VAMCs in our review noted implementation challenges when more than one program office has responsibility for the same policy area, and they do not collaborate when issuing policies on the same topic. For example, officials from one VAMC told us that they were unsure what humidity levels they should follow for sterile processing services when the national policy from one program office stated that the humidity level must be at 60 percent, which was contradictory to a national policy from another program office that stated humidity levels must be at 55 percent.

Officials from some of the VISNs and VAMCs in our review told us that obtaining input on national policy prior to issuance—particularly from those responsible for policy implementation—could help VHA to identify and mitigate many of the challenges that impede local policy implementation. For example, officials from three VISNs and two VAMCs told us that the terminology changes to VHA's updated scheduling policy issued in July 2016 caused confusion for staff. Additionally, officials from one VISN and one VAMC told us that terminology changes led to different

interpretations and variation in implementation across VAMCs, which may have been mitigated through prior feedback discussions.

In December 2016, ORAA instituted a new process to obtain comments on draft national policy that includes posting policy documents for a 2-week period on a SharePoint site.[32] All VHA officials, including those in VISNs and VAMCs, have access to the site and are able to comment.[33] In addition, ORAA has plans to develop a pre-policy form that would require program offices to provide information on the policy's purpose, whether it conflicts with other VHA policy, metrics to measure implementation, identification of any new resources needed, a cost analysis, and a communications plan for VISNs and VAMCs.[34] VHA officials told us that the pre-policy form could be another mechanism to collect information on potential implementation challenges. However, VHA officials have yet to finalize it.

Officials from several VISNs and VAMCs in our review said it also would be helpful for VHA to collect feedback from them after policy implementation to identify and address any unanticipated difficulties. Some program offices in our review already collect feedback on their own policies after implementation; however, this is not done systematically. According to standards for internal control in the federal government, management should internally communicate the necessary quality information to achieve the entity's operational objectives.[35] In doing so, management can obtain relevant information from reliable internal sources. Without a way to systematically obtain local feedback on national policies, VHA may lack the relevant information that would allow it to mitigate potential implementation challenges and resolve any unexpected problems to ensure policies are being implemented as intended.

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[32]VHA uses Microsoft's SharePoint software to store, organize, share, and access information sites. SharePoint is only accessible through VHA's intranet.

[33]According to ORAA officials, input on national policy has steadily increased as a part of this new process. As of August 2017, an average of 69 comments had been made by VHA staff on each policy listed on the SharePoint site.

[34]The pre-policy form will also include the legal authority for the policy and the potential impact on unions.

[35]GAO-14-704G.

VHA Lacks Information on Approved Policy Exemption Waivers Because It Has Not Established a Process for Approving, Tracking, and Reassessing Them

In certain cases, when VAMCs may be unable to comply with all or part of a national policy, program offices may approve policy exemption waivers on an informal and ad hoc basis. However, we found that VHA lacks information on these policy exemption waivers because it has not established a standard process for program offices to use for waiver submissions and approvals and does not centrally track those that have been granted. Furthermore, program offices are not required to reassess approved waivers to determine whether they are still warranted.

No standard submission or approval process. VHA does not have an established waiver exemption process that would standardize how program offices manage the submission and approval of waivers. As a result, program offices managed waiver submission and approval on an ad hoc basis, although certain national policies may specify a process for how VAMCs should submit a waiver.[36] If a process for submitting waivers is not specified for a policy, it is up to a VAMC to create and submit one for its facility's needs. For example, one VAMC had a waiver approved through e-mail and a conference call, and another VAMC had a waiver approved after a site visit.

No central tracking. VHA does not centrally track approved policy exemption waivers, and as a result, it does not know how many local facilities are not implementing national policy as intended. Additionally, several program offices in our review did not know how many waivers their offices had approved.

No reassessment requirement. There is no VHA requirement for program offices to reassess issued policy exemption waivers to determine whether they are still needed. Officials in some program offices told us that their waivers have an expiration date, and officials from another program office told us that time limits for waivers depends on the policy. Nevertheless, waivers are not routinely reassessed to determine whether they are still needed.

In June 2017, VHA's Office of Organizational Excellence established a committee comprised of subject matter experts and representatives from VHA, VISNs, and VAMCs to standardize the policy exemption waiver

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[36]Officials from program offices in our review told us they may also identify certain VAMCs that may be unable to meet a policy requirement and proactively provide a waiver to these facilities.

process.[37] According to its charter, the committee will assess the challenges local facilities experience when there are issues complying with a national policy and develop a process that will be used to pursue a waiver.[38] Under this process, officials explained that a VAMC would submit a proposal to its VISN, which would then submit it to the VHA waiver committee for approval.

According to standards for internal control in the federal government, management should design control activities, such as procedures, to achieve objectives and respond to risks.[39] In doing so, management designs appropriate procedures to help it fulfill responsibilities and address identified risks. Additionally, internal control standards state that management should establish and operate activities to monitor the internal control system and evaluate the results. In doing so, management considers using quality information to evaluate the agency's performance and make informed decisions. Without processes in place to systematically approve, track, and reassess policy waivers, VHA does not know which facilities are not implementing certain policies, the reasons why they are unable to do so, and whether these reasons continue to be valid.

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[37]VHA officials told us the committee will decide on an ad hoc basis which subject matter experts will serve on the waiver committee.

[38]VHA officials told us the waiver committee will also review all submitted waivers for a policy to identify if the exemption may apply to other similar VAMCs. If so, the waiver committee will determine if a waiver is needed for other VAMCs even if they have not requested one.

[39]GAO-14-704G.

VISNs and VAMCs in Our Review Develop and Maintain Various Local Policies, but VHA Does Not Ensure That They Align with National Policies

VISNs and VAMCs in Our Review Develop Their Own Policies That Are Maintained Locally

Almost all of the VISNs and VAMCs in our review told us that they had developed their own local policies.

- Officials from all four VISNs in our review told us they generally try to limit the number of regional policies so as not to overburden their VAMCs. Their regional policies are usually focused on administrative issues (for example, staff telework and records management) and overarching areas of responsibility (for example, sterile processing of medical equipment services and utilization management). The number of policies these four VISNs developed ranged from none to 88. VISNs vary in how often they renew their regional policies. Officials from one VISN told us they renew their policies every 2 to 3 years, while officials from another VISN told us they do so every 5 years.

- Officials from the eight VAMCs in our review told us that they generally issue facility-wide local policies (for example, policy management and medical appointment scheduling) and service-line-specific standard operating procedures for front line clinical care. These VAMCs generally develop local policies for different reasons, including when more specificity is needed for national policy implementation or to meet Joint Commission requirements.[40] VAMCs might also create a policy for a local circumstance, such as transportation or building issues. The number of local policies for the eight VAMCs ranged from 151 to 561. Officials from all eight VAMCs told us they generally renew their local policies every 3 years due to

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[40]The Joint Commission is an independent, not-for-profit organization that accredits and certifies health care organizations and programs in the United States.

Joint Commission requirements or as needed. Ad hoc updates to local policies may be due to newly issued national policy.

The VISNs and VAMCs in our review maintain local policies on a variety of websites, such as on SharePoint or intranet sites. The majority of VISN and VAMC officials said that they used SharePoint sites as the primary or only place for maintaining local policies. VHA officials generally do not have access to local SharePoint sites unless specifically requested. As a result, VHA officials are not necessarily aware of the number or types of local policies.

VHA Does Not Have a Process to Systematically Ensure That Local Policies Are Aligned with National Policies

VHA has not established a process for systematically ensuring that local policies are aligned with national policies, which increases the risk of inconsistent policy implementation across VAMCs—one of the primary reasons that VA health care was placed on our high-risk list. In recent years, we and others have reported various instances of VAMCs' differences in implementing national policy, most notably with its policy for scheduling medical appointments.[41] More recently, in February 2017, we reported weaknesses in the way VAMCs were implementing their controlled substance inspection programs because local policies at most of the VAMCs in our review did not include all nine VHA program requirements as outlined in the national policy.[42]

Officials from each level of the organization told us about ad hoc efforts to assess local policies:

- Officials from each of the VAMCs in our review generally told us that they assess their local policies to ensure they are consistent with issued national policy. VAMC officials also told us that VISNs and national program offices periodically assess whether specific local policies follow national policies during periodic site visits.

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[41]See GAO, *VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement*, GAO-13-130 (Washington, D.C.: Dec. 21, 2012). 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*.

[42]GAO, *VA Health Care: Actions Needed to Ensure Medical Facility Controlled Substance Inspection Programs Meet Agency Requirements*, GAO-17-242 (Washington, D.C.: Feb. 15, 2017).

- Officials from the VISNs in our review noted that their overall monitoring activities are primarily focused on evaluating local compliance with national policy and not on assessing local policy for alignment with national policy.

- None of the officials from the program offices in our review told us they have a standard process for assessing whether local and national policies are aligned. However, program offices may check the alignment of local policies on a case-by-case basis. For example, officials from a national program office told us about a recent assessment they conducted of local policies for a same-day access initiative to ensure certain national requirements were met.

VHA has recently outlined plans for additional oversight in response to our high-risk report that includes assessing whether local policies are aligned with national policies. According to the plan, VHA's Office of Integrity will conduct risk-based internal audits where senior VHA leadership would set priorities for audit areas (e.g., suicide prevention), and staff would then review local policies in those areas. A VHA official in the Office of Integrity explained that both the national program offices and VISNs may have responsibility for ensuring alignment of local and national policies under VHA's plans, but there is currently no consensus for designating this responsibility. VHA also plans to include standards, such as internal controls, in every new or revised policy to allow officials to determine whether the policy is being appropriately implemented and meets objectives. However, VHA is still in the early stages of putting its plans in place.

According to standards for internal control in the federal government, management should perform ongoing monitoring of its activities to help ensure its objectives are carried out as outlined in policy.[43] In doing so, management can build in continual monitoring into its internal control system through separate, periodic evaluations. Without a standard process to ensure local policy alignment with national policy, VHA may continue to experience inconsistent practices across its health care system.

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[43]GAO-14-704G.

Conclusions

As one of the largest health care delivery systems in the nation, it is important for VHA to ensure that its facilities consistently implement national policies as intended to ensure timely, high-quality care for the nation's veterans. VHA has taken a number of steps to improve its policy management; however, this is a substantial undertaking, and much work remains that will require a sustained focus to remedy a number of issues. In addition, appropriately allocating the necessary resources will be critical to VHA's ability to continue making improvements in this area as resource constraints continue to be an overarching impediment.

A number of systemic problems have contributed to the inconsistent implementation of national policy at the local level. Most notably, despite its newly revised directive on policy management, VHA's program offices continue to issue policy through mechanisms such as memos that are not defined as policy vehicles. Policy issued in such a manner can also be contradictory or outdated because it is not subject to a formal review process or periodically recertified. Additionally, VISNs and VAMCs may not be receiving or following the same memos and other issued guidance because VHA lacks a standard dissemination process or central repository for these documents. Furthermore, VHA does not have the ability to identify concerns associated with local implementation of national policies because it does not systematically collect information about challenges, before or after implementation. It also has not established a standard process for issuing and managing policy exemption waivers that may be granted to VAMCs. Compounding these problems is the lack of a process, including designated oversight roles, to ensure that the myriad of local policies established by VISNs and VAMCs are appropriately aligned with national policies. Collectively, if these issues persist, VHA will be unable to ensure that its policies are being consistently and effectively implemented as intended at the local level, potentially impacting veterans' access to timely, safe, and high-quality care.

Recommendations for Executive Action

We are making the following six recommendations to VHA:

- The Under Secretary for Health should further clarify when and for what purposes each national policy and guidance document type should be used, including whether guidance documents, such as program office memos, should be vetted and recertified. (Recommendation 1)

- The Under Secretary for Health should develop standard processes for consistently maintaining and disseminating guidance documents to each level of the organization. (Recommendation 2)

- The Under Secretary for Health should systematically obtain information on potential implementation challenges from VISNs and VAMCs and take the appropriate actions to address challenges prior to policy issuance. (Recommendation 3)

- The Under Secretary for Health should establish a mechanism by which program offices systematically obtain feedback from VISNs and VAMCs on national policy after implementation and take the appropriate actions. (Recommendation 4)

- The Under Secretary for Health should establish a standard policy exemption waiver process and centrally track and monitor approved waivers. (Recommendation 5)

- The Under Secretary for Health should establish a standard process, including designated oversight roles, to periodically monitor that local policies established by VISNs and VAMCs align with national policies. (Recommendation 6)

Agency Comments and Our Evaluation

VHA provided written comments on a draft of this report. In its comments, reproduced in appendix I, VHA concurred with all of our recommendations except one, which it concurred with in principle citing that the recommendation is no longer needed because VHA has already taken steps to address it.

Specifically, VHA requested that we close our recommendation that the agency systematically obtain information on potential implementation challenges with national policy because ORAA has instituted new policy development processes that allow VHA employees and program offices to provide feedback on national policy prior to issuance or recertification. However, VHA added that its pre-policy form—which would require program offices to provide key information on draft national policies—will not be rolled out until January 2019 due to the need to ensure that sufficient systems are in place to obtain cost and performance data and to conduct an implementation analysis. The pre-policy form will serve as a mechanism to systematically collect information about national policies prior to issuance and will require program offices to provide information on a policy's purpose, whether it conflicts with other VHA policy, implementation metrics, resources needed, a cost analysis, and a communications plan for VISNs and VAMCs. While VHA's more recent

efforts to obtain feedback on national policies are a step in the right direction, these efforts are not systematic because they rely on employee and program office participation. Consequently, we cannot close this recommendation until the pre-policy form has been implemented.

VHA also provided specific information about implementing each of the remaining recommendations and stated that its target completion date for implementing these recommendations is the third quarter of fiscal year 2018. However, VHA noted challenges related to its ability to implement our recommendations regarding guidance documents as it has never attempted a systematic effort to align national guidance under a single process or gather these documents in a central location. In addition, VHA stated that adequate staffing continues to be an obstacle and that information technology needs must be met to ensure the proper dissemination and maintenance of these documents. As we have noted in our high-risk work, capacity and resource allocation challenges continue to impede VHA's ability to address our concerns, and will continue to act as barriers until they are adequately addressed. VHA also provided a technical comment, which we incorporated.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Veterans Affairs, the Under Secretary for Health, and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, 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 report. GAO staff who made key contributions to this report are listed in Appendix II.

Debra A. Draper
Director, Health Care

Appendix I: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

August 31, 2017

Ms. Debra A. Draper
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Draper:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, *"VETERANS HEALTH CARE: Additional Actions Could Further Improve Policy Management"* (GAO-17-748).

The enclosure provides our general and technical comments and sets forth the actions to be taken to address the GAO draft report recommendations.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

Gina S. Farrisee
Deputy Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
**"VETERANS HEALTH CARE: Additional Actions Could Further Improve
Policy Management"**
(GAO-17-748)

General Comments:

The Veterans Health Administration (VHA) appreciates the opportunity to review the
draft report. VHA is strongly committed to making all of the improvements noted in your
recommendations, and transforming our policy development process to ensure the
delivery of the best health care for our nation's Veterans. We would also like to thank
the individuals involved in drafting this report, who displayed unparalleled
professionalism and made every effort to ensure that it is accurate and well-researched.

Regarding Recommendation 1, to clarify the purposes of national policy and guidance
documents, we have already made significant progress. We have undertaken a review
of all of VHA's existing national policy documents, some of which date back to the
1950s, to determine whether those documents can be rescinded or incorporated into
newer Directives. Thus far, we have reduced our overall policy inventory by 26 percent
since June 2016. The goal of this effort is to simplify policy for the field and our
stakeholders by ensuring that there is only one national document for each important
policy or goal where, historically, the various documents cited above all were used to
support an overarching policy. This effort is critical to the future of VHA, but requires
staff of multiple offices to perform thorough substantive and technical review and
revision to over 800 policies. It has put significant strain on the Office of the Deputy
Under Secretary for Health for Policy and Services, which is responsible for almost half
of all VHA policies, and on the Office of Regulatory and Administrative Affairs, which
manages the policy development process. There are even greater challenges to
meeting the recommendations about "guidance documents." VHA has never attempted
a systematic effort to align all national guidance under a single process or procedure, or
to gather these documents in a central location. We are making efforts to address the
most prevalent type of these guidance documents, but adequate staffing continues to
be an obstacle, and there are information technology hurdles to ensure their proper
dissemination and maintenance. Nevertheless, we believe the data above shows that
we have made significant progress, and we are committed to continuing along this path.

In your interviews and discussions during the development of your report, your staff
expressed interest in the "Pre-Policy form" that is discussed in our response to
Recommendation 3, and which we do not intend to roll out until January 2019. We
acknowledge that this is a long time, but individual aspects of the work will be
completed well before that date. Before we can require our program offices to do this
additional, important work, we must ensure that we have systems to support the
requirement for costing, providing performance data, and implementation analysis.

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VHA will use GAO's findings to continue to make improvements and fulfill VA's mission
of honoring America's Veterans by providing exceptional health care that improves their
health and well-being.

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<u>GAO Recommendation 1.</u> **The Under Secretary for Health should further clarify
when and for what purposes each national policy and guidance document type
should be used, including whether guidance documents, such as program office
memos, should be vetted and recertified.**

<u>VA Comment:</u> Concur. As noted in the Report, the types and purposes of the
Veterans Health Administrations (VHA) controlled national policy (CNP) are set forth in
VHA Directive 6330 (D6330), which was updated in June 2016 to allow only two types
of CNP: Directives and Notices. Regarding guidance documents, which are not national
policy, footnote 18 of the Report correctly notes that the most prevalent are memoranda
signed by the Deputy Under Secretary for Health for Operations and Management
(DUSHOM) ("10N Memos"). Our response to this recommendation will address national
policy first, and then 10N Memos and "other" guidance documents.

1. <u>Controlled National Policies.</u>

The June 2016 revision of D6330 eliminated several former policy vehicles, the most
common being Handbooks. Concurrently, VHA prioritized ensuring timely policy
recertification (i.e., every five years). This requires VHA Central Office (VHACO)
Program Offices under all of the Deputy Under Secretaries to reexamine the need for all
of their existing policies. VHA has made great progress, eliminating more than 200
policies and reducing overall policy inventory by 26 percent. This effort addresses the
recommendation above, GAO's findings in the High Risk Report concerning out-of-date
national policies, and GAO findings in both Reports that VHA's CNP inventory is vast
and confusing for the field.

Although we believe that revised D6330 does in fact clarify the purposes of each CNP
type, we acknowledge that we can do better. VHA's Office of Regulatory and
Administrative Affairs (ORAA) is currently finalizing technical amendments to D6330
that will provide additional guidance on the proper uses of, and alternatives to, national
policy.

We are conducting a full review and recertification of D6330. This review will include
feedback from many sources.

First, it will reflect lessons learned since August 2016, when VHA senior leadership
endorsed a five-year plan to transform VHA policymaking and began piloting a new
process. Since then, senior leaders at the Principal Deputy Under Secretary and
Deputy Under Secretary levels convene twice a month to address ongoing challenges in

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policy development. Concepts and practices from these meetings will inform the recertification of D6330.

Second, the planned revision will include feedback gathered from the field and VHACO through the newly revised review process, which enables full field participation in policy development. ORAA also meets frequently with program office leaders, and works daily with program office staff, gathering specific and broad suggestions for improvement.

Finally, VHA is convening a field-based advisory group in December 2017 that will provide detailed feedback on the effects of national policy on the field, with concrete suggestions for D6330. This field-advisory group input will also inform our efforts to address 10N Memos and other guidance documents under this recommendation.

2. 10N Memos and other guidance documents.

The recertification of D6330 described in detail above will clarify the proper uses of non-policy documents, to include 10N Memos.

In addition, as noted in the Report, 10N and ORAA are working together to develop recertification or rescission requirements for 10N Memos. These efforts are ongoing.

Regarding the recommendation to vet guidance documents, as of recently, 10N Memos with potential policy or regulatory impact must be substantively reviewed by ORAA prior to publication. We believe the recommendation to vet these documents has been met, and that recertification of D6330 will address the rest of this recommendation. The status is in process with a target completion date of Quarter 3 fiscal year (FY) 2018.

GAO Recommendation 2. **The Under Secretary for Health should develop standard processes for consistently maintaining and disseminating guidance documents to each level of the organization.**

VA Comment: Concur. We concur with your analysis that VHA relies on non-policy documents to communicate to the field, and field compliance is hampered by a lack of a centralized library of these documents. ORAA is working with the DUSHOM to develop an on-line library for 10N Memos, which will improve their accessibility and improve dissemination across the organization. We believe this will resolve this recommendation as it relates to 10N Memos. In addition, the field advisory group on policy described in Recommendation 1 will be charged with suggestions for improvement regarding VHACO guidance documents, and will not be limited to a

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discussion of 10N Memos. The status is in process with a target completion date of
Q3FY18.

Recommendation 3. **The Under Secretary for Health should systematically obtain
information on potential implementation challenges from VISNs and VAMCs and
take the appropriate actions to address challenges prior to policy issuance.**

VA Comment: Concur in principle. ORAA has instituted a new policy development
process that enables all VHA employees to provide feedback prior to the promulgation
or recertification of a national policy. We are receiving responses from the field at an
average rate of 69 comments per policy. Feedback on new policies often addresses
anticipated barriers to implementation, while feedback on recertification reflects the
field's past experience under the policy. Requests for feedback on policies that are in
the SharePoint process are sent to Veterans Affairs Medical Center (VAMC) and
Veteran Service Integrated Network (VISN) leaders across the system, including all
VHACO senior leaders and their executive assistants, as well as all VISN directors and
VHA Quality Managers in the field. Policy revisions take into account issues raised by
the field regarding implementation issues.

VHA program offices are also asked to review and concur in national policy, and their
participation rate averages 81 percent. These VHA program office reviews produce
valuable information about conflicts between programs that would otherwise not
necessarily be identified prior to implementation. The amendments to D6330 that will
be published this year will further emphasize and clarify the duty of responsible program
offices to address these comments. This was completed in July 2017. VA requests
closure of this recommendation.

Recommendation 4. **The Under Secretary for Health should establish a
mechanism by which program offices systematically obtain feedback from VISNs
and VAMCs on national policy after implementation and take the appropriate
actions.**

VA Comment: Concur. There are several ongoing improvements in this area, which,
when taken together, provide the recommended feedback system.

(1) The new concurrence process for recertification offers VHA program offices, VISNs,
and VAMCs the opportunity to provide information about challenges to implementation
of existing policies.

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(2) The SharePoint previously discussed will require responsible program offices to take appropriate action in response to implementation feedback before a policy is submitted for recertification. These changes will institute post-implementation data gathering at least once every five years (when the policy must be recertified).

(3) The field-based advisory group (described in our response to Recommendation 1), above, is charged with providing specific recommendations for a formal "real time" feedback process on national policy.

(4) ORAA will join a quarterly Network Director's call to solicit feedback on policies published in the previous quarter to elicit direct feedback on published policy and its implementation.

(5) Implementation issues also are reflected when there is inconsistency between national policy and local policy, as well as barriers to effective local implementation. On March 1, 2017, ORAA and 10N issued a memo requesting responses to a "Facility Policy Questionnaire" via SharePoint. The questions sought insight into national and local opportunities and strengths and barriers to effective local implementation. Over 1,200 data points were elicited from the 130 responses. As follow up, ORAA is conducting a qualitative evaluation of policy development, dissemination, and implementation at the facility level. Each VISN was asked to designate a facility to participate in a structured interview with ORAA to better understand what success looks like for a policy, how policy is being communicated, and how VHACO can better support policy implementation in the field.

(6) ORAA conducts at least two site visits to VAMCs and VISNs each year, during which ORAA examines policy implementation at the local level using the "tracer methodology" that is also used by The Joint Commission. Information from these visits is used generally to improve policy development and promulgation, as well as specifically when individuals at the sites identify specific issues with specific policies. The status is in process with a target completion date of Q3FY18.

<u>**Recommendation 5.**</u> **The Under Secretary for Health should establish a standard policy exemption waiver process and centrally track and monitor approved waivers.**

<u>**VA Comment:**</u> Concur. VHA concurs with the findings that in certain cases medical centers may be unable to comply with all or part of national policy for reasons that may include –

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➢ Insufficient or undefined timeframes
➢ Resource constraints
➢ Not specific to VAMC complexity level
➢ Conflicting policies on the same topic

As a result, program offices may approve policy exemption waivers on an informal and
ad hoc basis. Program offices requesting waiver submission and approval on an ad hoc
basis do not have a process outlining how a medical center should submit a waiver.
Additionally, VHA acknowledges that program offices may not know how many waivers
their offices have approved. VHA does not currently track waiver submissions that have
been granted and thus does not have a process to reassess approved waivers to
determine whether they are still warranted.

The Deputy Under Secretary for Health for Organizational Excellence (DUSHOE) has
established a committee comprised of subject matter experts and representatives from
VHA program offices, VISNs, and VAMCs to standardize the policy exemption waiver
process. The work of this committee will include:

➢ Assessing the challenges facilities experience in determining whether they have
impediments to compliance or implementation with VHA policy by:
  ○ Identifying criteria that must be met before submitting a waiver request.
  ○ Determining methods to be utilized to assess the validity of a waiver
    request.
  ○ Confirming whether the facility has explored all options and alternatives to
    policy implementation without a waiver request.
➢ Developing a process that can be initiated by VISN and facility leadership to
pursue a waiver which will include:
  ○ The application process to review and grant the waiver.
  ○ Establish a timeline for re-evaluating the continued need for the waiver.
  ○ Providing feedback to VHA program offices to consider in policy
    modification.

DUSHOE has initiated actions to mitigate risk by establishment of a Policy Waiver
Committee which met in July 2017 to begin working on this recommendation. The
status is in process with a target completion date of Q3FY18.

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Recommendation 6. **The Under Secretary for Health should establish a standard
process, including designated oversight roles, to periodically monitor that local
policies established by VISNs and VAMCs align with national policies.**

VA Comment: Concur. The Office of the Principal Deputy Under Secretary for Health
(PDUSH)will establish and oversee the standard process by which VHA program offices
that are responsible for national policies review a sample of local policies for alignment
against the national policy. The standard process will include:

1. Location where program offices can identify the policies for which they are
   responsible;
2. Criteria for determining the sample of local (i.e., facility or VISN) policies that will
   be reviewed;
3. Frequency for reviewing local policies (e.g., yearly, quarterly);
4. Standards for assessing alignment with national policy;
5. Responsibilities of the Program Officials, VISN Directors, Facility Directors, and
   others involved with policy development, oversight, or management;
6. Reporting of compliance with the standard process;
7. Other elements, as needed.

The PDUSH will coordinate with ORAA to leverage current data repositories for policy
oversight and ensure that this standard monitoring process smoothly integrates with
current efforts to improve policy ambiguity and process inconsistencies. The status is in
process with a target completion date of Q3FY18.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact	Debra A. Draper, (202) 512-7114 or draperd@gao.gov.
Staff Acknowledgments	In addition to the contact named above, Bonnie Anderson (Assistant Director), E. Jane Whipple (Analyst-in-Charge), and Ashley Dixon made key contributions to this report. Also contributing were Jennie F. Apter, Jacquelyn Hamilton, Vikki Porter, and Brian Schmidt.