United States Government Accountability Office

Report to Congressional Requesters

April 2017

VA REAL PROPERTY

VA Should Improve Its Efforts to Align Facilities with Veterans' Needs

GAO-17-349

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GAO Highlights

Highlights of GAO-17-349 a report to congressional requesters

Why GAO Did This Study

VA operates one of the largest health care systems in the United States, with 168 VA medical centers and more than 1,000 outpatient facilities. Many of these facilities are underutilized and outdated. A previous effort aimed at modernizing and better aligning facilities was not fully implemented.

GAO was asked to review the current alignment of VA medical facilities with veterans' needs. This report examines: (1) the factors that affect VA facility alignment with veterans' needs, (2) the extent to which VA's capital-planning process facilitates the alignment of facilities with the veteran population, and (3) the extent to which VA has followed best practices by integrating stakeholders in facility alignment decisions. GAO reviewed VA's facility-planning documents and data, and interviewed VA officials in headquarters and at seven medical facilities selected for their geographic location, population, and past alignment efforts. GAO also evaluated VA's actions against federal standards for internal control and best practices for capital planning.

What GAO Recommends

GAO made four recommendations, including that: VA improve SCIP's scoring and approval process among other limitations and discontinue or improve the utility of the VAIP facility master plans, and improve guidance to effectively communicate facility alignment decisions with stakeholders and to evaluate these efforts. VA partially concurred with the first recommendation and fully concurred with the other recommendations. GAO believes the recommendations are sound, as described in the report.

View GAO-17-349. For more information-contact David J. Wise at (202) 512-2834 or wised@gao.gov, or Debra A. Draper at (202) 512-7114 or draperd@gao.gov

What GAO Found

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

VA relies on the Strategic Capital Investment Planning (SCIP) process to plan and prioritize capital projects, but SCIP's limitations—including subjective narratives, long time frames, and restricted access to information—undermine VA's ability to achieve its goals. Although VA acknowledges many of these limitations, it has taken little action in response. Federal standards for internal control state that agencies should evaluate and determine appropriate corrective action for identified limitations on a timely basis. Without doing so, VA lacks reasonable assurance that its facility-alignment reflects veterans' needs.

A separate planning process—VA Integrated Planning (VAIP)—was designed to supplement SCIP and to provide planners with a more strategic vision for their medical facilities through the creation of facility master plans. However, GAO found limitations with this ongoing effort, which VA estimated to cost $108 million. Specifically, the facility master plans assume that all future growth in services will be provided directly through VA facilities without considering alternatives, such as purchasing care from the community. However, VA's use of care in the community has increased to an obligated $10.1 billion in fiscal year 2015. Federal capital-acquisition guidance identifies inefficient spending as a risk of not considering other options for delivering services. This consideration is particularly relevant as VA's data project that the number of enrolled veterans will begin to fall after 2024. Officials who oversee the VAIP process said that they were awaiting further analyses required by recently released VA guidance on the proportion of care and types of services to obtain from the community. As a result of this and other limitations, some local VA officials said that they make little use of the VAIP facility master plans and contract for their own facility master plans outside the VAIP process.

Although VA instructs local VA officials to communicate with stakeholders, its guidance is not detailed enough to conform to best practices. VA has not consistently followed best practices for effectively engaging stakeholders in facility consolidation efforts—such as in utilizing two-way communication early in the process and using data to demonstrate the rationale for facility alignment decisions. GAO found that when stakeholders were not always engaged consistently with best practices, VA's efforts to align facilities with veterans' needs were challenged. Also, VA officials said that they do not monitor or evaluate these communications efforts and, therefore, have little assurance that the methods used effectively disseminate information to stakeholders. This approach runs counter to federal standards for internal control, which instruct agencies to monitor and evaluate activities, such as communications methods.

Contents

Abbreviations

CARES	Capital Asset Realignment for Enhanced Services
CBOC	community-based outpatient clinic
Choice Act	Veterans Access, Choice, and Accountability Act of 2014
EHCPM	Enrollee Health Care Projection Model
HCPM	Health Care Planning Model
Independent Assessment	*Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*
OMB	Office of Management and Budget
SCIP	Strategic Capital Investment Planning
VA	Department of Veterans Affairs
VAIP	Department of Veterans Affairs Integrated Planning
VetPop2014	Veteran Population Projection Model 2014
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSO	veterans service organization

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

April 5, 2017

The Honorable Johnny Isakson
Chairman
The Honorable Jon Tester
Ranking Member
Committee on Veterans' Affairs
United States Senate

The Honorable David P. Roe
Chairman
Committee on Veterans' Affairs
House of Representatives

The Department of Veterans Affairs (VA) operates one of the largest health care systems in the United States, encompassing 168 VA medical centers and 1,053 outpatient medical facilities that provide care to more than 8.9 million veterans each year.[1] VA's total health care budget in fiscal year 2015 was nearly $51 billion. VA is also one of the largest federal property-holding agencies. As of September 2014, VA reported that its inventory included 6,091 owned buildings covering more than 151.5 million square feet and 1,586 leased buildings covering more than 16.6 million square feet and costing more than $340.6 million annually in rent.

As the veteran population has shifted in recent decades and the demand for the VA's health care services has changed, VA has recognized the need to improve planning and budgeting for modernizing its aging infrastructure and aligning its real property assets to veterans' needs and to provide accessible, high-quality, and cost-effective access to VA's services.[2] Specifically, VA initiated a process known as Capital Asset Realignment for Enhanced Services (CARES) to determine the future resources needed to provide health care to our nation's veterans. In

[1]Outpatient facilities include community-based outpatient clinics (CBOC) and health care centers. CBOCs are located in areas surrounding VA medical centers and provide primary care and some specialty care services that do not require a hospital stay. Health care centers, including ambulatory care centers, are large multi-specialty outpatient clinics that provide surgical services in addition to other health care services.

[2]See GAO, *Department of Veterans Affairs: Issues Related to Real Property Realignment and Future Health Care Costs,* GAO-11-877T (Washington, D.C.: July 27, 2011).

February 2004, the CARES Commission released its report recommending substantial changes to existing facilities but relatively few facility closures.[3] VA officials stated that as of June 2016, the CARES recommendations were not fully implemented and that the process was halted 8 years ago due to shifting priorities.

The need to align VA facilities in order to improve access to services is related to two of GAO's high risk areas. In 2015, GAO placed veterans' health care on its High Risk List due to persistent weaknesses and systemic problems with timeliness, cost-effectiveness, quality, and safety of the care provided to veterans.[4] In addition, federal real property management—including management of VA real property—has also been on GAO's High Risk List since 2003 due to long-standing challenges federal agencies face in several areas of real property management, including effectively disposing of excess and underutilized property.[5]

You asked us to review issues related to the current alignment of VA's medical facilities as they related to veterans' needs. In this report, we examine:

[3]See CARES Commission, *Capital Asset Realignment for Enhanced Services*, a report to the Secretary of Veterans Affairs (Washington, D.C.: February 2004). The 16 members of the independent CARES commission were appointed in December 2003. The commission issued recommendations to the Secretary on the basis of its review of the Draft National CARES Plan and related information obtained through public hearings, site visits, public meetings, written comments from veterans and other stakeholders, and consultations with experts.

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

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

1. The factors that affect VA's facility alignment efforts.
2. The extent to which VA's capital-planning process facilitates the alignment of medical facilities with the veteran population.
3. The extent to which VA has followed best practices by fully integrating stakeholders in facility alignment decisions.

To address these objectives, we reviewed relevant laws, regulations, policies, and other documents related to VA's real property management including, the 2004 CARES report and VA's annual budget submissions included in the President's *Budget of the United States Government for Fiscal Year 2017*.[6] We also interviewed officials from VA and VA's Veterans Health Administration (VHA) including from:

- VA's Central Office—including personnel from the Office of Asset Enterprise Management, Office of Construction & Facilities Management, and Office of Policy and Planning—and
- VHA's Central Office, including staff from its Office of Policy and Planning.

To obtain local perspectives on these objectives, we interviewed officials from a nongeneralizable sample of seven VA medical facilities within five different Veterans Integrated Service Networks (VISN) to learn more about how VA tries to align facilities with the veteran population, or "facility alignment."[7] VA medical facilities were chosen based on a review of the CARES recommendations, VA's veteran population data and projections, and geographic and veteran population variability.[8] We

[6]See CARES Commission, *Capital Asset Realignment for Enhanced Services*, *a report to the Secretary of Veterans Affairs* (Washington, D.C.: February 2004).

[7]VA organizes its system of care into regional networks called VISNs. Each VISN is responsible for managing and overseeing VA medical centers within a defined geographic area. At the VISN level, we met with the VISN planner and Capital Asset Manager, as well as VISN leadership at VISN 2 (New York), VISN 4 (Pennsylvania), VISN 10 (Ohio), and VISN 21 (California). In VISN 17 (Texas), we met with the VISN planner and engineering staff in lieu of meeting with the Capital Asset Manager.

[8]These were (1) the VA New York Harbor Health Care System (Brooklyn VA medical center, Manhattan VA medical center, and St. Albans Community Living Center); (2) VA Pittsburgh Health Care System (H.J. Heinz Campus and University Drive Campus); (3) Chillicothe, Ohio VA medical center; (4) Columbus, Ohio ambulatory care center; (5) the Central Texas Veterans Health Care System (Waco VA medical center, Temple VA medical center, and the Austin Outpatient Clinic); (6) the South Texas Veterans Health Care System (San Antonio VA medical center and Kerrville VA medical center); and (7) the VA Palo Alto Health Care System (Palo Alto Campus, Menlo Park Campus, and Livermore Campus).

conducted interviews (either in-person or via telephone or video conference) with officials at both the VISN and facility levels to discuss facility alignment resources, tools, and policies. At the facility level, we met with groups of individuals responsible for planning and making facility alignment decisions at seven VA medical facilities.[9] Results from our sample cannot be generalizable to all VISNs or VA medical facilities.

To determine the factors that affect the VA's facility-alignment efforts, we analyzed veteran population data from the Veteran Population Projection Model 2014 (VetPop2014) and interviewed officials at VA's Office of Policy and Planning who oversee the model regarding veteran population projections and trends.[10] We also reviewed data in the Enrollee Health Care Projection Model (EHCPM)—a VA model for estimating the amount of resources VA needs to meet the expected demand for most of the health care services it provides—and interviewed officials at VHA's Office of Policy and Planning who oversee the model regarding veteran population projections and trends.[11] We reviewed these models' methodologies, interviewed relevant officials, and determined that the data from both the VetPop2014 and EHCPM were sufficiently reliable for our audit objectives. We also interviewed planning officials at each of the five VISNs and seven VA medical facilities to obtain further information on factors related to making facility alignment decisions. Additionally, we reviewed specific sections within the *Independent Assessment of the Health Care Delivery Systems and Assessment Management Processes of the Department of Veterans Affairs* (hereafter referred to as the

[9]In many areas of the country, several medical centers and clinics may work together to offer services to area veterans as a health care system. By sharing services between or among medical centers, the aim is for VHA to provide veterans easier access to advanced medical care closer to their homes.

[10]VetPop2014 is an actuarial projection model —developed by the Office of the Actuary under VA's Office of Policy and Planning— for veteran population projections from fiscal year 2014 to 2043. The model provides living veteran counts by key demographic characteristics such as age, gender, period of service, and race/ethnicity at various geographic levels.

[11]The EHCPM was developed in 1998 by VA and Milliman, Inc. It helps supports the development of VA's budget estimate for health care and informs strategic and capital planning.

Independent Assessment).[12] Specifically, we reviewed its sections on demographics, health care capabilities, authorities and mechanisms for purchasing care, and facilities, and compared these assessments to our findings to determine whether there were similarities.[13] We reviewed the methodology of each of these assessments and found them to be sufficiently reliable for our audit objectives.

To determine the extent to which VA's capital-planning process facilitates the alignment of medical facilities with the veteran population, we reviewed relevant documentation about two processes VA uses to facilitate planning for medical facility needs, including construction projects. For the Strategic Capital Investment Planning (SCIP) process, we reviewed documentation and data on the SCIP process since fiscal year 2012 and interviewed officials with the Office of Asset Enterprise Management who oversee the process. For the Department of Veterans Affairs Integrated Planning (VAIP) process, we reviewed relevant documentation since the process's inception in fiscal year 2011, including the guiding principles and examples of plans that resulted from using the process, and interviewed officials with the Office of Construction & Facilities Management who oversee the process. To obtain further information on the usefulness of both of these processes we spoke with planning officials at each of the VISNs in our review. We also reviewed the findings and recommendations from the *Independent Assessment's* section related to facilities, and compared them to our findings to

[12]VA was required to contract for an independent assessment of health care services furnished in its facilities. Pub. L. No. 113-146, § 201(a)(1), 128 Stat. 1754, 1769 (2014). VHA contracted with the Centers for Medicare & Medicaid Services' Alliance to Modernize Healthcare (operated by MITRE Corporation, a private entity) and the Institute of Medicine to conduct the assessment. Parts of the evaluation were subcontracted to other organizations, including McKinsey & Company and the RAND Corporation. 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).

[13]See RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment A (Demographics)*, (Sept.1, 2015); See RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, (Sept.1, 2015); RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Authorities and Mechanisms for Purchasing Care)*, (Sept.1, 2015); and McKinsey & Company Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, (Sept.1, 2015).

determine whether there were similarities.[14] We also reviewed the methodology for this assessment and found it sufficiently reliable for our audit objectives. Further, we compared the two processes (SCIP and VAIP) to guidance outlined in the Office of Management and Budget's (OMB) *Circular No. A-11* and federal standards for internal control.[15]

To determine the extent to which VA has followed best practices by fully integrating stakeholders in facility alignment decisions, we compared VA guidance and local stakeholder communication efforts to GAO-identified best practices.[16] We interviewed VA officials, VISN and facility officials, national veterans' service organizations (VSO), and local veterans' organizations about their involvement in facility alignment decisions. To select national VSOs to interview, we chose organizations based on their participation in VA reform and planning efforts, and those that were recommended by VA officials or other VSOs as being knowledgeable with VA's efforts to align its medical facilities with the veteran population.[17] We spoke with national representatives from the American Legion, Disabled American Veterans, and Paralyzed Veterans of America. In addition, we asked the national VSOs for state and local chapter contacts. We reviewed each site's Health Care Planning Model (HCPM) list of external stakeholders and asked VA officials for local external stakeholder contacts. We did not always meet with the same stakeholder groups at each location.[18] We spoke to local chapters of the American Legion, Disabled American Veterans, Military Order of the Purple Heart, and

[14]See McKinsey & Company Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, (Sept.1, 2015).

[15]See OMB, *Circular No. A-11: Preparation, Submission, and Execution of the Budget*, July 2016, GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, DC: November 1999), and GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: September 2014).

[16]See GAO, *Streamlining Government: Questions to Consider When Evaluating Proposals to Consolidate Physical Infrastructure and Management Functions*, GAO-12-542 (Washington, D.C.: May 23, 2012).

[17]See RAND Corporation, *Veterans Access, Choice, and Accountability Act of 2014 Section 201: Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, (Sept.1, 2015).

[18]We did not speak to any local or state stakeholder group associated specifically with Livermore, CA as we did not receive any responses after several attempts to contact them.

Veterans of Foreign Wars, as well as some county veterans' service officers.

We conducted this performance audit from January 2016 to April 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.

Background

VA's System of Health Care

The mission of VA is to serve America's veterans and their dependents. All VA programs are administered through three major administrations—VHA, Veterans Benefits Administration, and the National Cemetery Administration.[19] VA provides medical services to various veteran populations—including an aging veteran population and a growing number of younger veterans returning from the military operations in Afghanistan and Iraq. In general, veterans must enroll in VA health care to receive VA's medical benefits package—a set of services that includes a full range of hospital and outpatient services, prescription drugs, and long-term care services provided in veterans' own homes and in other locations in the community. VHA is responsible for overseeing the delivery of care to enrolled veterans, as well as the health care professionals and support staff that deliver that care. VHA is also responsible for managing all VA medical facilities.

VA organizes its system of care into regional networks called VISNs. In September 2015, there were 21 VISNs nationwide, but VA is in the process of merging VISNs that will result in 18 VISNs when completed.[20]

[19]The Veterans Benefits Administration provides veterans, their dependents, and survivors with benefits and services such as compensation, pensions, fiduciary services, educational opportunities, vocational rehabilitation and employment services, and home ownership and insurance. The National Cemetery Administration inters eligible service members, veterans, and family members in VA national cemeteries and maintains the graves and their environs as national shrines; it also provides other burial benefits to veterans and their families, such as medallions and markers for headstones that signify veterans' service.

[20]This realignment is expected to be completed by the end of fiscal year 2018.

Each VISN is responsible for coordination and oversight of all administrative and clinical activities within its specified geographic region. Medical services are provided in inpatient/residential medical facilities and outpatient medical facilities, including:

Inpatient/residential care medical facilities as of January 2017:

- VA medical centers: A medical facility that provides at least two types of care, such as, inpatient, outpatient, residential, or institutional extended care. There are 168 VA medical centers.
- Extended care site (community living center): A medical facility that provides institutional care, such as nursing home beds, for extended periods of time. There are 135 community living centers.
- Residential care site: A medical facility that provides residential care, such as a domiciliary, for extended periods of time. There are 48 domiciliaries.

Outpatient care medical facilities as of October 1, 2016:

- Community-based outpatient clinics (CBOC): A medical facility that provides primary care and mental health services, and in some cases, specialty services such as cardiology or neurology, in an outpatient setting. There are 737 CBOCs.
- Health care center: A medical facility that provides the same services as CBOCs, but also ambulatory surgical procedures that may require moderate sedation. There are 22 health care centers.
- Other outpatient service: A medical facility that provides care to veterans but is not classified as a CBOC or health care center, such as a mobile treatment facility. There are 305 other outpatient services sites.

In order to meet the needs of the veterans it serves, VA is authorized to pay for veteran health care services from non-VA providers through both the Non-VA Medical Care Program and clinical contracts.[21] In fiscal year 2015, VA obligated about $10.1 billion to purchase care from non-VA providers. The Non-VA Medical Care Program, including the Choice Program and Patient-Centered Community Care, is referred to as “care in the community” by VA, and allows VA to offer care to veterans in non-VA

[21]VA uses the services of non-VA providers in non-VA facilities under the following statutory authorities: 38 U.S.C. §§ 1703, 1725, 1728, 8111, and 8153.

facilities, such as physicians' offices and hospitals in the community, and pay for this care using a fee-for-service arrangement.[22] Clinical contracts are used by VA to bring non-VA providers—such as physicians, pharmacists, and nurses—into VA facilities to provide services to veterans.

Current Efforts to Align Facilities with Veterans' Needs

SCIP Process

VA works with the VISNs, and medical facilities to manage its real property assets through VA's capital-planning process. The SCIP process—established in 2010 to assess and identify long-term capital needs—is VA's main mechanism for planning and prioritizing capital-planning projects, but is affected by the VA's budgetary resources, which will determine how many projects will be funded. The goal of SCIP is to identify the full capital need to address VA's service and infrastructure gaps, and to demonstrate that all project requests are centrally reviewed in an equitable and consistent way throughout VA, including across market areas within VA's health care system given competing capital needs.[23]

[22]The Choice Program was authorized under the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act), which provided new authorities, funding, and other tools to help with the reform of the VA health care system. Pub. L. No.113-146, 128 Stat. 1754. Through this Act, Congress appropriated $10 billion in additional funds to VA to under certain conditions expand its ability to provide non-VA medical care to certain veterans, such as veterans who are unable to receive an appointment with a VA provider within 30 days of either their preferred or clinically appropriate date, live more than 40 miles from the nearest VA facility, or experience certain excessive travel burdens. This funding is available until expended but only for Choice Program activities, which are only authorized through August 7, 2017, or until the funds are exhausted, whichever comes first. Patient-Centered Community Care is a nationwide VA program that established two nationwide contracts with Health Net and TriWest to establish networks of providers that can provide care through the Non-VA Medical Care Program in a number of specialties—including primary care, inpatient specialty care, and mental health care when VA may utilize non-VA medical care when a VA facility is unable to provide certain specialty care services, such as cardiology or orthopedics, or under other conditions.

[23]Each VISN is divided up into smaller geographic areas called market areas (usually on county lines), which consider travel and referral patterns, geographic dispersion of enrollees, and locations of medical facilities within the market. Each market area may have differing numbers of VA medical centers and other VA medical facilities. As of November 2016, VA had designated 98 market areas.

The SCIP process for that particular fiscal year's projects begins approximately 23 months before the start of the fiscal year with VA providing a set of guidelines to the VISNs and medical facilities. SCIP uses information from models to identify excesses and deficits in the services at the local level—called "gaps" within VA—and justify capital investments. For example, SCIP uses data from the EHCPM, a model for projecting veteran enrollment, utilization of VA health care, and the associated expenditures VA needs to meet the expected demand for most of the health care services it provides.[24]

VA officials at the VISNs and medical facilities play a major role in the capital-planning process. Each VISN has a Capital Asset Manager and a planner who are responsible for coordination and oversight of facility alignment activities, and work with individual facility planners and engineering staff. Annually, planners at the medical facilities develop a 10-year action plan for their respective facilities, which include capital or non-capital improvement projects to address gaps in service identified by the SCIP process.[25] According to VA, these long-range plans allow the department to adapt to changes in demographics, and health care and benefits delivery, while at the same time incorporating infrastructure enhancements. Medical facility officials then develop more detailed business plans for the capital improvement projects that are expected to take place in the first year of the 10-year action plan. These projects are validated, scored, and ranked centrally based on the extent to which they address the annual VA-approved SCIP criteria using the assigned

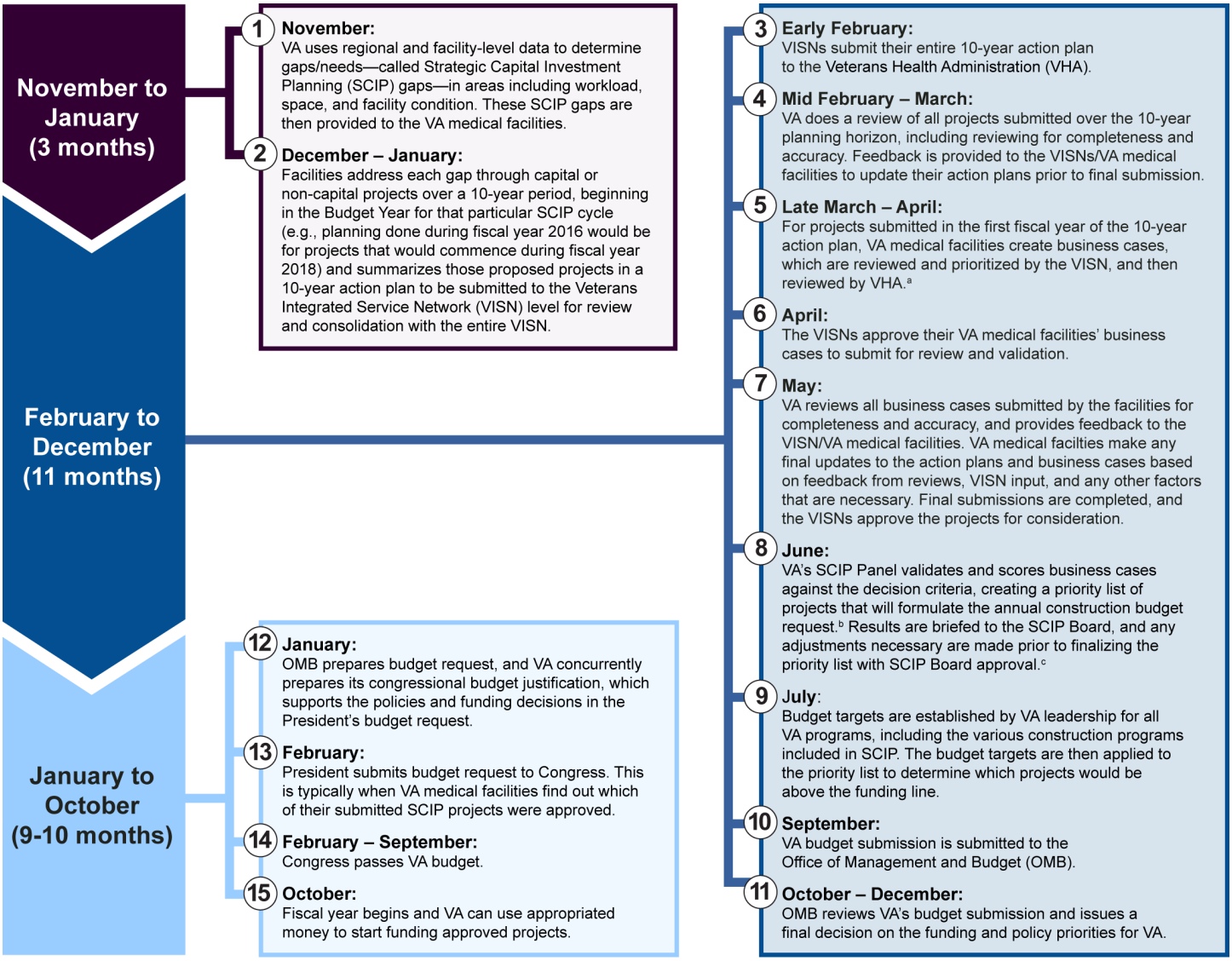
[24]The EHCPM projects the number of veteran enrollees and their utilization using several inputs, including from the VetPop2014 model, which provides living veteran projections by key demographic characteristics from fiscal year 2014 to 2043.

[25]The four types of capital investment programs are major construction, minor construction, leasing, and non-recurring maintenance. The major construction program funds construction projects estimated to cost more than $10 million. See 38 U.S.C. § 8104(a)(3)(A). The minor construction program funds construction projects estimated to cost $10 million or less. In general, non-recurring maintenance projects are repairs and renovations within the existing square footage of a facility that total more than $25,000. Non-recurring maintenance projects that are strictly meant to ensure facilities are in good working condition are limited to $10 million. However, non-recurring maintenance projects may include expansion of new space, but associated costs may not exceed $500,000.

weights.[26] (See fig. 1 for VA's capital decision-making process for evaluating and funding capital projects.)

[26]The scoring of submitted projects includes both narrative responses that are evaluated (about one-third of the overall score) and data-driven scoring based on gap closure (the remaining two-thirds of the overall score). SCIP decision criteria and priority weights are developed by the SCIP Board (comprised of nine senior level executives across VA who are not on the SCIP Panel) annually to address the various priorities of VA. Each criterion is given a scoring unit, scoring methodology, and relative weight which are grouped into six high level categories (for the fiscal year 2017 submission): (1) improve safety, compliance, and security; (2) fixing what we have; (3) increasing access; (4) right-sizing inventory; (5) ensure value of investment; and (6) strategic requirements.

Figure 1: Expected Timing and Process for Evaluating and Funding Capital Projects within the Department of Veterans Affairs (VA)



Source: GAO analysis of VA information. | GAO-17-349

Note: The process dates are expected dates, and not actual dates for each year.

[a]Business cases must include detailed cost estimates and explanations of how proposed projects align with decision criteria, such as reducing facility condition deficiencies.

[b]The SCIP Panel—comprised of nine representatives from across VA—scores all major, minor, leases, and non-recurring maintenance business cases against the decision criteria and priority weights. Each criterion is given a scoring unit, scoring methodology, and relative weight which are grouped into six high-level categories (for the fiscal year 2017 submission): (1) improve safety,

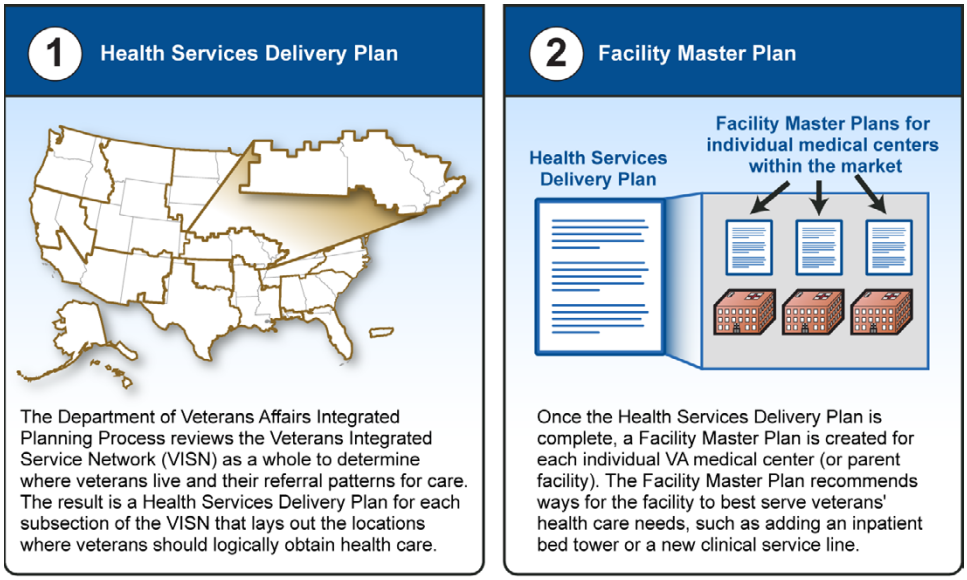
compliance, and security; (2) fixing what we have; (3) increasing access; (4) right-sizing inventory; (5) ensure value of investment; and (6) strategic requirements.

[c]The SCIP Board develops the decision criteria and priority weights annually—which are department-approved—to address the various priorities of VA. The Board is comprised of nine senior level executives from across VA who are not on the SCIP Panel.

VAIP Process

Another tool available for use by some VISNs and medical facilities is the VAIP Process, which was implemented in fiscal year 2011 as a pilot project. The goal was to identify the best distribution of health care services for veterans, where the services should be located based on the veterans' locations and referral patterns, and where VA should adapt services, facilities, and health care delivery options to better meet these needs as determined by locations and referral patterns. Data from the VAIP Process are designed to drive the VISNs' and VA medical facilities' operational decisions including costs, challenges, and local preferences, but the VAIP Process's findings can also result in future SCIP projects. The VAIP Process produces a market-level health services delivery plan for the VISN and a facility master plan for each medical facility within the VISN. (See fig. 2 for an overview of the VAIP Process.)

Figure 2: Overview of the Department of Veterans Affairs Integrated Planning (VAIP) Process



Source: GAO analysis of Department of Veterans Affairs (VA) information. | GAO-17-349

After completing a pilot of the program, VA officials began formally implementing the VAIP Process across VISNs and their medical facilities, utilizing multiple contractors. As of January 2017, VA officials told us they had mostly completed the VAIP Process in 6 of the 18 VISNs and had plans to start or complete the remaining VISNs by October 2018. According to officials who oversee the program, the entire cost of the VAIP process is expected to be about $108 million.

Prior Efforts to Align Facilities with Veterans' Needs

Over time, VA has recognized the need to modernize its facilities and align its real property portfolio to provide accessible, high-quality, and cost-effective access to services. In addition, VA has been the subject of several assessments focusing on facility alignment, and planning efforts to modernize its facilities. In 1999, VA initiated the CARES process to assess federally owned buildings and land ownership in response to changing veterans' inpatient and outpatient demand for care. CARES was the first comprehensive, long-range assessment of VA's health care capital-asset priorities since 1981 and was designed to assess the appropriate function, size, and location of VA facilities. In May 2004, VA issued the CARES Decision report to Congress and other stakeholders.[27] The decision report listed projects and actions that VA planned to take over the next 20 years, as well as the tools and principles that the agency planned to use to align its infrastructure and upgrade its facilities. VA officials told us that the implementation of CARES recommendations was monitored through fiscal year 2010. In July 2011, VA released an implementation and monitoring report on seven areas highlighted in the CARES report.[28] In this report, VA stated that excess space was reduced through mechanisms such as the demolition of vacant buildings and the realignment of underutilized space. VA also reported that since fiscal year 2009, 509,247 square feet of space was disposed. VA officials stated that as of June 2016, some of the CARES recommendations were not fully

[27]Department of Veterans Affairs, Office of the Secretary, *CARES Decision* (Washington, D.C.: May 2004).

[28]Department of Veterans Affairs, Veterans Health Administration, Office of Assistant Deputy Under Secretary for Health for Policy and Planning, *Implementation Monitoring Report on Capital Asset Realignment for Enhanced Services*, (Washington, D.C.: Jul 2011). The seven areas highlighted in this report include CBOCs, veteran rural access hospitals, improved access/modernizations, special disability programs, excess property, VA/Department of Defense collaboration and sharing, and collaborations between VHA, the Veterans Benefits Administration, and the National Cemetery Administration.

implemented, and the process was essentially replaced when the SCIP process was implemented in fiscal year 2012.

In a more recent effort, the Choice Act required VA to contract with a private entity to conduct an independent assessment of 12 areas of VA's health care delivery system and management processes, including its facilities in 2014.[29] Among the 12 areas, an assessment of facilities examined VA's processes for facility planning, funding, maintenance, and construction. The *Independent Assessment* identified four systemic findings:

1. A disconnect in the alignment of demand, resources, and authorities.
2. Varying bureaucratic operations and processes.
3. Non-integrated variations in clinical and business data and tools.
4. Leaders are not fully empowered due to a lack of clear authority, priorities, and goals.[30]

The Choice Act also established the Commission on Care to examine veterans' access to VA health care and to examine and report on how best to organize VA, locate health resources, and deliver health care to veterans during the next 20 years.[31] The Commission on Care assessed the results of the *Independent Assessment* as part of its work. The Commission on Care's report included 18 high-level recommendations,

[29]Pub. L. No. 113-146, § 201, 128 Stat. at 1769. VA commissioned the Centers for Medicare & Medicaid Services Alliance to Modernize Healthcare (operated by MITRE Corporation, a private entity) and the Institute of Medicine to conduct the assessment. Parts of the evaluation were subcontracted to other organizations, including the RAND Corporation. The *Independent Assessment's* 12 areas were (1) Assessment A: Demographics, (2) Assessment B: Health Care Capabilities, (3) Assessment C: Care Authorities, (4) Assessment D: Access Standards, (5) Assessment E: Workflow-Scheduling, (6) Assessment F: Workflow-Clinical, (7) Assessment G: Staffing/Productivity, (8) Assessment H: Health Information Technology, (9) Assessment I: Business Processes, (10) Assessment J: Supplies, (11) Assessment K: Facilities, (12) Assessment L: Leadership.

[30]In producing the *Independent Assessment*, the Mitre Corporation created a panel composed of experts from diverse health care and stakeholder backgrounds and engaged them in producing the *Integrated Report* and its findings and recommendations. The report provides operational, near-term strategies to improve clinical care for veterans and details remedies for root-cause problems that must be addressed both by Congress and the VA based on the *Independent Assessment* findings.

[31]Pub. L. No. 113-146, § 202, 128 Stat. at 1773.

and was submitted to the President on June 30, 2016.[32] For example, the one recommendation in the Commission on Care's report related to facility management was for the enactment of legislation, which would authorize a process similar to the Base Realignment and Closure process to facilitate facility realignment decisions.[33] While VA did not fully agree with the specifics of the recommendation, it did agree with the concept of a realignment commission to focus solely on VA's infrastructure needs once the mission services were determined.[34]

Facility Alignment Is Affected by Shifts in Veteran Population and Care Delivery, and an Aging Infrastructure

Long-standing factors, such as shifts in the veteran population and the delivery of care, as well as an aging infrastructure affect VA's efforts to fully align its real property portfolio with the veteran population.

Shifts in Veteran Population

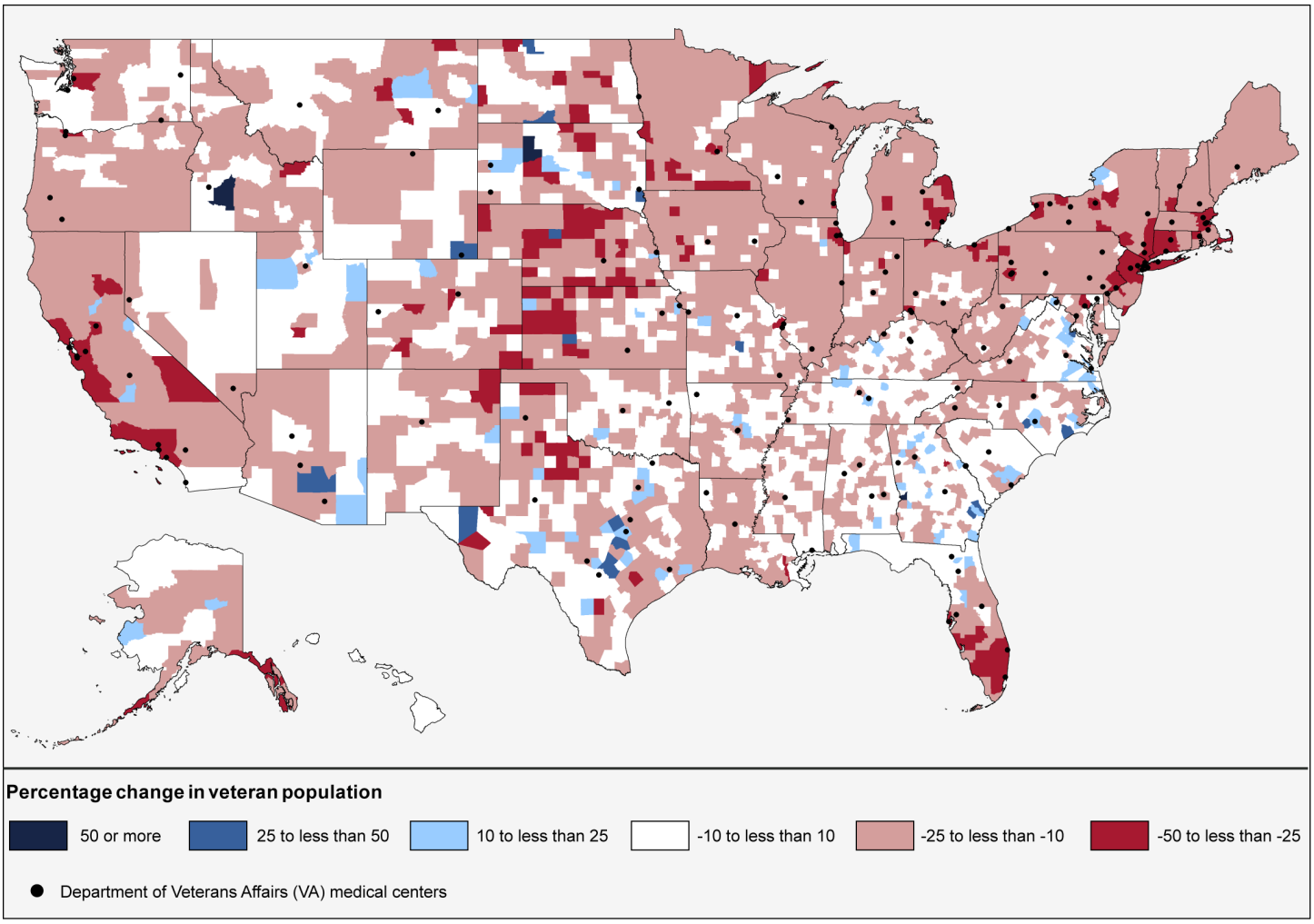
A decrease and a shift in the veteran population, impact the agency's ability to fully align its real property portfolio with veterans' needs. For example, VA's VetPop2014 projected a 14 percent decrease in the overall veteran population by 2024. It also projected a geographic shift with veterans continuing to migrate from the Northeast and Midwest areas of the United States to areas in the south and west. Figure 3 shows projected percentage population changes through 2024, by county.

[32]Commission on Care, *Final Report of the Commission on Care* (Washington, D.C.: June 30, 2016).

[33]The Base Realignment and Closure is a congressionally authorized process that has been used to reorganize the military base structure to more efficiently and effectively support U.S. forces and increase operational readiness.

[34]Department of Veterans Affairs, *Review of the Commission on Care* (Washington, D.C.: Aug. 2, 2016).

Figure 3: Projected Changes in Veteran Population in the United States, by County, from 2014 to 2024



Source: GAO analysis of VA information and Map Info (map). | GAO-17-349

These shifts in the veteran population—which also mirror general population trends—may result in a misalignment of services relative to veterans' needs and insufficient capacity in some locations and excess capacity in other locations. As the population continues to shift, VA will need to make decisions on how to best address these capacity issues. For example, planning officials from three medical facilities said that facilities located in areas with a declining veteran population—and thus,

most likely a general population decrease—may experience challenges recruiting and retaining certain types of specialty providers.[35] In addition, a planning official at one medical facility told us that in order for a facility's providers to maintain clinical proficiency, there needs to be sufficient patient volume. With such shifts, these areas could experience space that is underutilized because of a lack of veteran demand and health care providers.

Although there is a projected decrease in the overall veteran population, VA's EHCPM projects that nationally the number of enrolled veterans will increase through 2024, after which it will decline.[36] However, this trend varies by region, and generally mirrors the overall veteran population trends with decreases in the northeast and increases in the south.

In addition to a projected enrollment increase in the short term, enrollee demographics and acuity levels are also projected to change—which will affect the amount and type of health care VA is projected to provide. According to VA officials who oversee the EHCPM, the aging of enrolled veterans and the increasing prevalence of service-connected disabilities (either through these disabilities appearing later in life or through VA changing its scope for eligibility) are driving significant increases in projected utilization and financial expenditures. For example, Vietnam era veterans are expected to account for an increased utilization of long-term care services. In addition, these enrollees also tend to have increased rates of transition into the higher acuity priority groups for benefits.[37] Overall, the number of veterans in these higher acuity priority groups is projected to continue to increase and is a key driver of utilization for VA

[35]We have previously reported on the challenges VA faces in its recruitment and retention initiatives, including for example, a reduced pool of nurses with advanced training in certain locations. See GAO, *VA Health Care: Oversight Improvements Needed for Nurse Recruitment and Retention Initiatives*, GAO-15-794 (Washington, D.C.: Sept. 30, 2015).

[36]According to VA officials who oversee the EHCPM, total enrollment will begin to decline when enrollee mortality begins to outnumber new enrollment.

[37]VA's medical benefits package for enrollees is based on a set of priority groups to ensure health care benefits are readily available to all enrolled veterans. The priority groups consist of eight different levels (1 through 8), with priority group 1 typically being the most severely disabled (the highest acuity).

health care services, including in-home and community- based services.[38] As a result of this projected short-term growth in demand, followed by an eventual decline in veteran enrollment, VA must balance the expansion of services to meet the near-term demand with the potential excess capacity in the long-term.

Shifts in Care Delivery

Shifts in the type of care that VA provides and where its veterans obtain that care affect VA's efforts to align its facilities to meet the changing veteran population.

A Shift from Inpatient Care to Outpatient Care

Similar to trends in the health care industry overall, VA's model of care has shifted away from providing care in an inpatient setting, to that of an outpatient setting, which VA largely houses in converted inpatient space, or in a growing number of CBOCs.[39] This reflects, in part, the shift in demand from inpatient to outpatient services. According to the *Independent Assessment*, between 2007 and 2014, outpatient visits increased 41 percent while inpatient bed days declined 9 percent.[40] Further, it reported that inpatient bed days have dropped as much as 21 percent in some VISNs and, over the next 20 years, are expected to decline an additional 50 percent or more. This shift in the utilization of inpatient to outpatient services will likely result in underutilized space once used for inpatients, as a majority of VA medical facilities were originally designed for the delivery of inpatient care. Officials who oversee SCIP as well as some of the planners at medical facilities in our review told us that they can close portions of facilities that are underutilized. However, these planners also told us that the savings are small when compared to closing an entire building. For example, a medical facility in our review temporarily closed one of its inpatient wings due to decreased

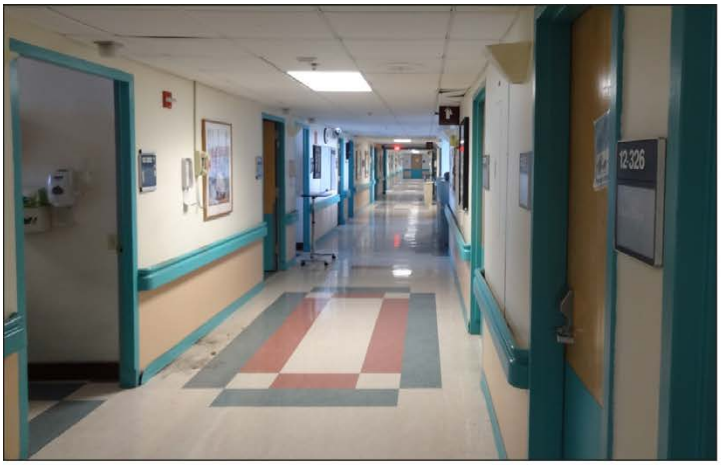
[38]VA offers adult day care, respite care, and other noninstitutional long-term care services as part of the medical benefits package it provides to all enrolled veterans. See 38 U.S.C. § 1710B. VA also provides some services that are not part of its medical benefits package, such as nursing home care. The population of veterans to whom VA is required to provide nursing home care is more limited than the population to whom VA is required to provide other health care services. VA is required by law to provide nursing home care to certain veterans needing such care who also have service-connected disabilities, and VA also makes nursing home care available to other veterans on a discretionary basis as resources permit.

[39]We have previously reported on VA's efforts to shift its real property portfolio toward more outpatient facilities, such as increases in leased space for CBOCs since the CARES Decision in 2004. See GAO-11-197.

[40]See McKinsey & Company Inc., *Assessment K (Facilities)*.

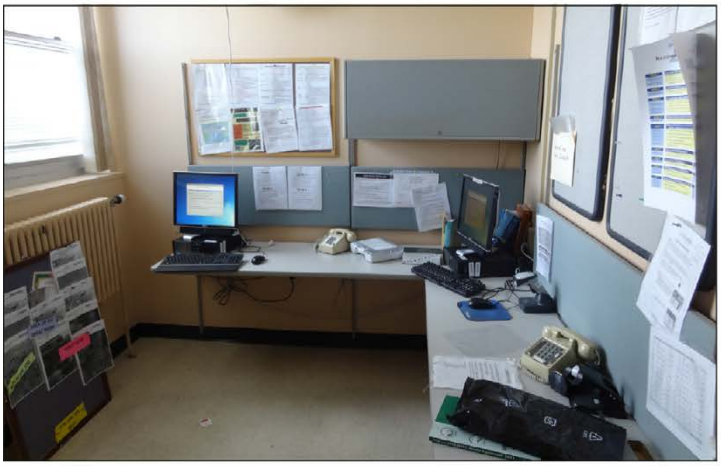
utilization. Although the unused space was technically closed, the wing still had beds and equipment, and used electricity and utilities, including lights in the hallways and power to operate computers. (See fig. 4.)

Figure 4: Example of Costs Still Accumulating in a Closed Inpatient Wing of a Department of Veterans Affairs' (VA) Medical Center, May 2016



Closed VA inpatient hallway of Brooklyn Medical Center utilizing electricity.

Unused medical equipment being stored in a vacant room.



Vacant office with various computers still turned on.

Vacant inpatient front desk with equipment utilizing the electricity.

Source: GAO. | GAO-17-349

Note: Brooklyn VA Medical Center, Brooklyn, New York: VA closed one of its inpatient wings of the facility in July 2015. The space was not being utilized by patients or staff. However, medical equipment was still there and electricity was still in use as can be seen, for example, by the various computers turned on in the closed wing.

Use of Care in the Community

In addition to shifts in the veteran population and the type of care provided, changes to VA's use of care in the community affect facility alignment. Although VA has traditionally provided care primarily through its own facilities, it has, and does also use its statutory authority to purchase care from providers in the community. VA's purchased care accounted for a small but growing proportion of VA's health care budget in the past decade.[41] For example, in fiscal year 2015, VA obligated about $10.1 billion for care in the community for about 1.5 million veterans. Three years earlier, in fiscal year 2012, VA spent about $4.5 billion on care in the community for about 983,000 veterans. VA officials who oversee the EHCPM told us that although under VA's care in the community programs, a portion of health care utilization may potentially move from VA facilities to community care, the costs of VA facilities—costs such as staffing, utilities, transportation, and laundry—do not decrease proportionally when this shift occurs. As a result, VA may be expanding care in the community while simultaneously operating underutilized and vacant space at its medical facilities. According to the *Independent Assessment*, if purchased care continues to increase then VA will need to realign resources by reducing its facilities.[42]

As VA expands its care in the community programs, questions remain regarding its impact on facility alignment. Planning officials at two of the seven medical facilities in our review told us that there is uncertainty surrounding the extent to which care in the community, as it currently exists, will continue in the future. These officials added that the uncertainty affects capital planning because capital projects are planned years in advance. For example, a planning official from one medical facility told us that in planning for future renovations to address SCIP utilization gaps, officials are hesitant to send entire clinical service lines to the community because if the Choice Act and its associated funds are not

[41]RAND Corporation, *Assessment C (Authorities and Mechanisms for Purchasing Care)*.

[42]RAND Corporation, *Assessment C (Authorities and Mechanisms for Purchasing Care)*.

re-authorized, the facility may be financially responsible for providing that service through non-VA providers.[43]

Aging Infrastructure

Aging infrastructure affects facility alignment because many VA facilities are no longer well suited to providing care in the current VA system, and VA will need to make decisions about how it can adapt to current needs. For example, the average VHA building is approximately 60 years old—five times older than the average building of a not-for-profit hospital. Planning officials at five of the seven medical facilities in our review told us it is often difficult and costly to modernize, renovate, and retrofit older facilities—including converting inpatient facilities into outpatient facilities. These challenges have contributed to the presence of vacant and underutilized buildings. VA reported in 2016 that its inventory includes 370 buildings that are vacant or less than 50 percent occupied, and 770 buildings that are underutilized, requiring it to expend funds designated for patient care to maintain more than 11.5 million square feet of unneeded or underutilized space costing $26 million annually to operate and maintain.[44]

As veterans continue to use more outpatient care and less inpatient care, VA's need to make decisions about its aging infrastructure and how it can adapt it to current needs will continue to grow. Planning officials from two VISNs and four medical facilities in our review told us that outdated building configurations—such as low ceilings and small distances between support columns—could prevent facilities from fully complying

[43]Pub. L. No.113-146, §§ 101(p)(2) and 802(d), 128 Stat. at 1754, 1763, 1802-1803. The Choice Act created a separate account, known as the Veterans Choice Fund, which can only be used to pay for VA obligations incurred for the Veterans Choice Program. The use of Choice funds for any other program requires legislative action. The Choice Act appropriated $10 billion to be deposited in the Veterans Choice Fund. Amounts deposited in the Veterans Choice Fund are available until expended and are available for activities authorized under the Veterans Choice Program. However, the Veterans Choice Program activities are only authorized through August 7, 2017 or until the funds in the Veterans Choice Fund are exhausted, whichever occurs first.

[44]Honorable Robert A. McDonald, Secretary, U.S. Department of Veterans Affairs, *U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2017*, testimony before the House Committee on Veterans' Affairs, 114th Cong., 2nd Sess., February 10, 2016.

with more recent VA health care delivery standards.[45] A planning official from one medical facility told us it is difficult to reconfigure a facility in accordance with these new standards after it is already built, and instead, these standards would have to be incorporated in the preliminary design phase. We observed at various locations where despite renovations, VA was unable to fully reconfigure existing spaces to meet newer care standards. See figures 5 and 6 for examples of these challenges to current health care delivery standards.

[45]Examples of these more recent standards are specific configurations for VA's new primary care model of care, called Patient Aligned Care Teams, and single occupancy rooms (as compared to double- or quadruple-occupancy rooms). Among other things, VA's primary care model established examination room privacy standards, such as space standards for women's health Patient Aligned Care Teams.

Figure 5: Example of Outdated Double Occupancy Room at a Department of Veterans Affairs' (VA) Medical Center, May 2016

Source: GAO. | GAO-17-349

Note: Manhattan VA Medical Center, New York, New York: In this example patients are housed in a double-occupancy room, which decreases their privacy. Current health care delivery standards call for single-occupancy rooms.

Figure 6: Examples of Outdated Building Configurations and Structural Barriers at a Department of Veterans Affairs' (VA) Medical Center, July 2016

Main building vacant with small distance between columns.

Ceiling height too low to meet current health care delivery standards.

Source: GAO. | GAO-17-349

Note: Waco VA Medical Center, Waco, Texas: These pictures are of the main building (which sat vacant at the time of our visit) and show the low ceilings and small distances between columns. Such conditions are inconsistent with current health care delivery standards.

We previously reported that the historic status of certain VA property can add to the complexity of converting or disposing of outdated facilities.[46] In 2014, VA reported having 2,957 historic buildings, structures, or land parcels—the third most in the federal government after the Department of Defense and the Department of the Interior. In some instances it may be more expensive to do renovations then it would be to demolish and rebuild. However, the option to demolish may not always be an option because of restrictions due to these buildings' designation as historic.[47]

[46]See GAO, *Federal Real Property: Progress Made in Reducing Unneeded Property, but VA Needs Better Information to Make Further Reductions*, GAO-08-939 (Washington, D.C.: Sept. 10, 2008).

[47]Under the National Historic Preservation Act, VA, like other federal agencies, is required to manage historic properties under its control and to take into account the effects of its action on historic preservation. VA consults with the relevant State Historic Preservation Office before taking any action, including demolition or construction, on a property that has been designated as historic. The Secretary of the Interior is responsible for establishing standards for all national preservation programs and advising federal agencies on the preservation of historic properties listed or eligible for listing on the National Register of Historic Places. 54 U.S.C. §§ 300101 et seq.

For example, planning officials at four of the medical facilities told us that state historic preservation efforts prevented them from demolishing vacant buildings, even though these buildings require upkeep costs and pose potential safety hazards. (See figs. 7-9.)

Figure 7: Example of Deteriorating Historic Vacant Buildings at a Department of Veterans Affairs' (VA) Medical Center, July 2016

Interior damage of Kerrville Medical Center.

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

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

Source: GAO. | GAO-17-349

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

Figure 8: Example of a Deteriorating Historic Vacant Building at a Department of Veterans Affairs' (VA) Medical Center, September 2016

Source: GAO. | GAO-17-349

Note: Chillicothe VA Medical Center, Chillicothe, Ohio: This vacant building has been designated as historic, but is in poor condition with broken windows and a neglected exterior.

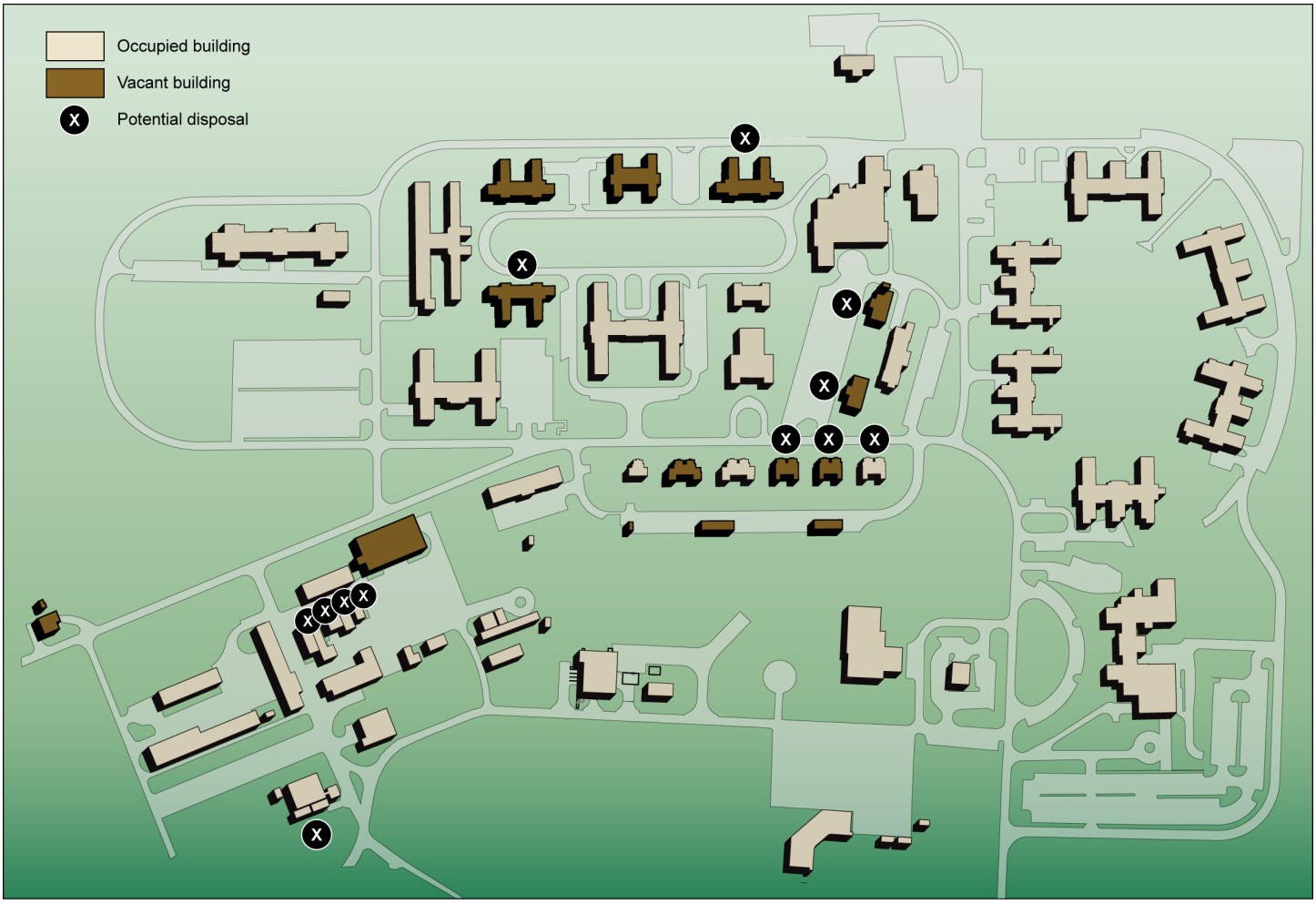
Figure 9: Unused Historic Structure That Faces Challenges to Demolition at a Department of Veterans Affairs' (VA) Medical Center, July 2016

Source: GAO. | GAO-17-349

Note: Waco VA Medical Center, Waco, Texas: At this facility, planning officials told us that the old water tower (brown) is unusable due to deteriorating conditions. Its repair would have been more expensive than building a new one (white), but the demolition of the old tower faced significant challenges due to its historic status. Because of its visibility; however, officials still paid to have it painted.

In addition, some VA medical facilities were built as large medical campuses with multiple unattached buildings. This configuration no longer meets modern health care delivery standards where services are more concentrated in one building or a series of attached buildings. For example, three facilities we visited had large campuses that included portions of vacant land and buildings designated as historic. Figure 10 illustrates the historic Chillicothe, Ohio VA medical center campus, which has numerous vacant buildings that the medical facility would like to dispose of.

Figure 10: Occupied, Vacant, and Buildings up for Potential Disposal on the Historic Chillicothe, Ohio, Department of Veterans Affairs' (VA) Medical Center Campus, December 2016



Source: GAO analysis of VA Medical Center data. | GAO-17-349

Limitations in the Capital-Planning Processes Impede VA's Alignment of Facilities with Veterans' Needs

VA's SCIP Has Limitations

SCIP has several limitations in the scoring and approval process, time frames, and access to information that can limit its utility to effectively facilitate the alignment of facilities with veterans' needs.

Limitations with SCIP's Scoring and Approval Process

Planning officials at VA medical facilities submit projects annually to SCIP, where they are centrally scored against a set of department-approved criteria and priority categories. To score high enough to be approved for funding, a project's narrative portion of the evaluation must demonstrate how it addresses predetermined VA priorities—this narrative portion represents about one-third of a project's overall score. Planning officials at two of the VISNs and three of the medical facilities in our review told us that the narrative portion is a limitation of the SCIP's project-scoring and approval process because it relies on facility planning officials' ability to write an accompanying narrative that addresses more of the priorities. This introduces subjectivity to the process, where the writer's ability to demonstrate how the project's narrative addresses more of the priorities can affect scoring independent of project merits. This can undermine SCIP's goal of ensuring all project requests are reviewed equitably and consistently. The *Independent Assessment* also found that some facilities have learned to place considerable emphasis on the ability to write a project's narrative tailored to perceived high value criteria—often using both in-house staff and consultants to try and maximize the scores.[48] For example, planning officials from one medical facility told us that they needed a SCIP project to expand a women's health center but did not think that it would score highly. Therefore, they told us they wrote the narrative carefully so that it linked back to more priority areas that they would not have originally thought of, such as "increasing patient privacy," in order for it to score higher.

[48]McKinsey & Company Inc., *Assessment K (Facilities)*.

In addition, another limitation to SCIP is that it allows facility planners to gain credit for closing service gaps by proposing capital projects that they have no intention of implementing. Specifically, planners at VA medical facilities must demonstrate within SCIP that they plan to address all service gaps within the 10-year action plan. However, planners can show that they are addressing a gap by including such a project in future or 'out' years of their 10-year plan but then continue to delay the project into future years without implementing the project or addressing the service gap. Such actions can undermine the department's goal of using SCIP to strategically manage its health care facilities. Although the extent to which this is occurring is unclear, facility planners at two of the facilities in our review told us that they routinely enter projects for future years that they have little or no intention of actually pursuing. For example, planning officials from one medical facility told us that in instances where they did not agree with the gaps that SCIP identified, they would include construction or demolition projects in the later years of their SCIP submission. They said they did this because (1) they could include a general project description without having to be too specific, and (2) demolition projects would most likely not score high enough to obtain funding. Planning officials from another medical facility told us that they continue to promote demolition projects to the out years of their SCIP plan as a way of appearing to address an excess space gap in SCIP plans without actually implementing the project.

Even though some facility-level planning officials told us they did not think demolition projects would score high enough to get funding, officials who oversee SCIP told us it is possible if the projects' narratives linked back to several different priority areas, such as "safety" or "reducing facility condition assessment deficiencies." As a result, they said facilities will only submit a demolition project in SCIP if it is part of a demolition-and-rebuild type project that links back to more priority areas.[49] Figure 11 shows an example of a non-clinical building on a medical facility campus that the facility's planning officials would like to demolish due to structural issues.

[49]As of September 2014 (the most recent information available), 704 of the 5,639 VHA-operated buildings (about 12 percent) were designated by VA as potential disposal candidates, representing about 6.5 million gross square feet (about 4.4 percent of the approximately 148.8 million gross square feet in VHA-operated buildings). The list consists of only those buildings owned by VA, and does not include leased facilities. (See app. I for a complete list of those VHA-operated buildings over 10,000 gross square feet in size that VA medical facilities have designated as potential disposal candidates.)

Figure 11: Example of a Non-Clinical Building at a Department of Veterans Affairs' (VA) Medical Center That Has Structural Damage, July 2016

Waco Medical Center's office for engineering staff with crumbling foundation.

Sinking foundation posing an eventual structural risk.

Source: GAO. | GAO-17-349

Note: Waco VA Medical Center, Waco, Texas: In this building, the foundation is sinking (about 6 inches as of July 2016). Planning officials at the medical facility told us that it is too expensive to fix, and demolishing the building would not score high enough in SCIP. According to these officials, although it cannot be used for patient care, the building, at present, is structurally sound and now houses the facility's engineering staff.

In addition, the SCIP scoring and approval process is limited in that it does not have a mechanism in place to correctly sequence projects. Specifically, planning officials at three of the seven medical facilities in our review told us that the SCIP approval process does not allow for, or ensure that projects will be approved in the chronological order they determined to be appropriate. For example, planning officials at one of the medical facilities said that they have been submitting projects in SCIP to try and collocate specialty outpatient clinics that were in separate areas of the campus. On several occasions, a project that needed to start after a predecessor project was finished was approved and funded first because the project addressed a higher priority area. Out of fear that they would lose the funding if they waited for the first project to get approved, these planning officials told us they changed the planned location of one clinic to a less desirable location instead of their initial goal of collocating the clinics. According to OMB guidance, improper funding of segments of

a project can lead to poor planning or higher costs.[50] VA officials told us that this problem could be addressed through better training for facility planners, but budget thresholds may also play a role. Specifically, VA officials told us, and the *Independent Assessment* reported that VA facility planners often divide a larger project into several smaller projects so that they stay under the statutorily-defined threshold for major medical facility projects ($10 million)—a threshold that the *Independent Assessment* recommended eliminating.[51]

Limitations with SCIP Time Frames

SCIP's lengthy project-development and approval timeframes can hinder capital project planning. Specifically, the time between when planning officials at VA medical facilities begin developing the narratives for projects that will be scored in SCIP and when they are notified that a project is funded has taken between 17 and 23 months over the past 6 fiscal-year SCIP submissions.[52] As such, facility planning officials routinely submit their next year's planned projects before knowing the outcomes of those from the previous year. In one instance, for example, facility planning officials were required to begin working on the narratives for the projects planned for fiscal year 2015 before they learned which projects for fiscal years 2013 or 2014 were approved for funding.[53] In another example, facility planning officials had to wait about 18 months to officially learn that VA only funded 2 of the 1,403 projects submitted for fiscal year 2017.[54] Officials who oversee the program told us that while they recognize that this is a concern, some information for unfunded projects is automatically loaded into the next year's SCIP submission, reducing rework. Long time frames can also exacerbate SCIP's inability to correctly sequence projects in the desired order. For example, under current time frames and SCIP guidelines, a facility planner may have to

[50]See OMB, *Circular No. A-11*.

[51]McKinsey & Company Inc., *Assessment K (Facilities)*.

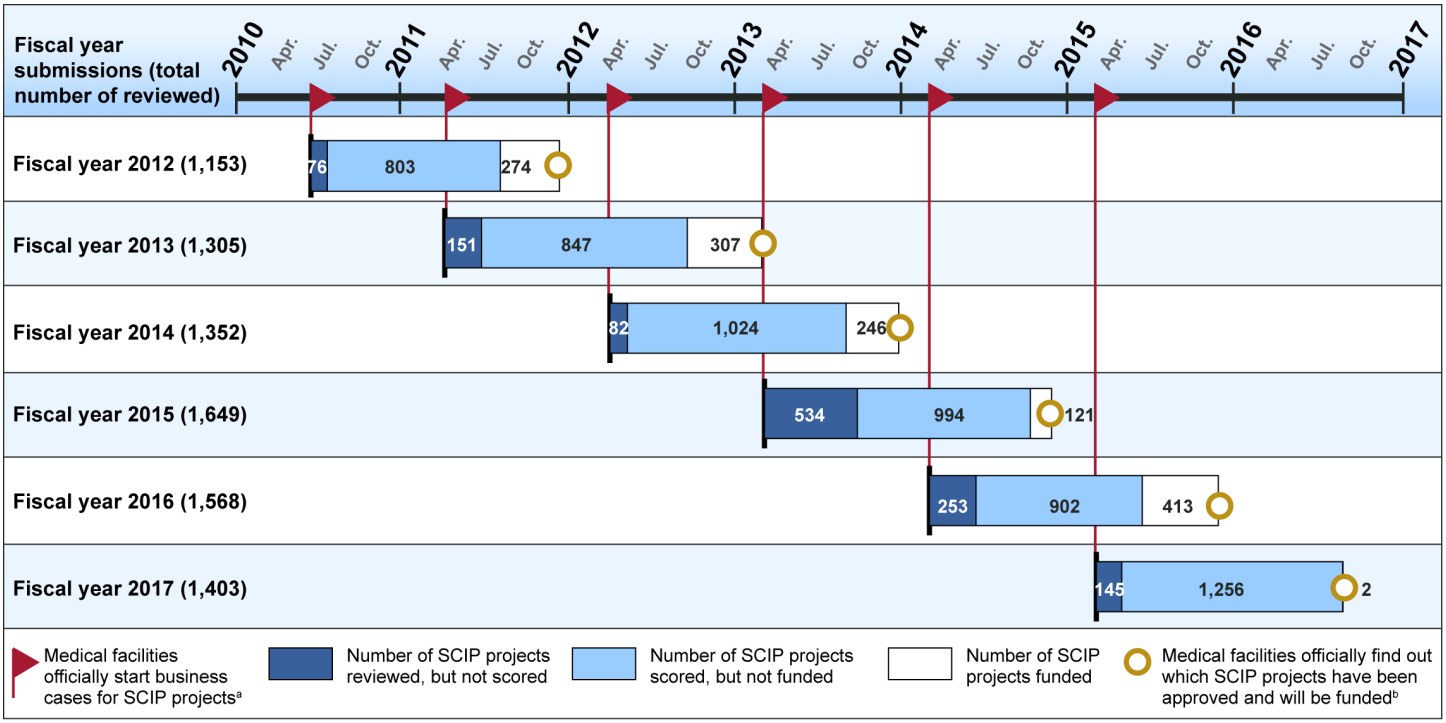
[52]Although planning officials at VA medical facilities obtain initial information from SCIP about what gaps they need to address, they typically do not begin developing the narratives until they receive a request from VA several months later to submit the projects for SCIP scoring and approval.

[53]Specifically, facility planning officials started working on the narratives for the fiscal year 2015 SCIP submissions in mid-March 2013, but did not officially learn about which projects were approved and funded from fiscal year 2013 and fiscal year 2014 until late March 2013 and mid-January 2014, respectively.

[54]According to VA officials, the only projects that were allowed to start in fiscal year 2017 were major construction projects with the National Cemetery Administration, due to the pending Commission on Care report and recommendations.

delay submitting subsequent projects in a sequenced group of projects for up to 2 years each while planners wait to ensure the predecessor project was funded. Figure 12 shows the overlapping timelines of the last 6 fiscal-year SCIP submissions. An official from the office that oversees SCIP told us that the timing of the budgeting process that is outside VA's control contributes to these delays.

Figure 12: Overlapping Timelines of the Last 6 Fiscal Years of the Strategic Capital Investment Program's (SCIP) Project Submissions and the Number of Submissions



Source: GAO analysis of Department of Veterans Affairs information. | GAO-17-349

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

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

While aspects of the process are outside VA's control, over the last 6 fiscal-years' SCIP submissions, VA has chosen to wait about 6 to 10

months to report the results of the SCIP scoring process to the medical facilities. This situation makes it difficult for local officials to understand the likelihood that their projects will receive funding. Federal standards for internal control note that agencies should ensure that quality information—such as information about approved projects—should be provided on a timely basis.[55] A VA official said that for future SCIP cycles, VA plans to release the scoring results for minor construction and non-recurring maintenance projects to local officials earlier in the process. At the time of our review, however, the official did not have a timeframe as to when this would be done.

Limitations Accessing SCIP Information

SCIP has limitations in its ability to provide planners with important information they need in the initial steps of planning capital needs. VA subdivides each VISN into a number of smaller "market areas." However, SCIP limits facility planners' access to the projects proposed by other markets and VISNs. According to federal standards for internal control, agencies should identify quality information and ensure that it is accessible.[56] Planning officials from four of the medical facilities told us that these access limitations to SCIP information make it difficult to obtain a comprehensive understanding of their needs for capital-planning purposes. For example, planning officials at one of the medical facilities told us that as a result of the lack of access to information about nearby projects, a VA medical facility in a neighboring VISN had plans for a new CBOC near its VISN boundary progress farther than it should have before VA officials determined that it would have been too close to an existing CBOC just over the VISN boarder.

VA Has Done Little to Address Known Limitations with the SCIP Process

VA is aware of many of the limitations of the SCIP process—as the *Independent Assessment* found many of the same limitations and made recommendations to address them—but has taken little action. Specifically, in 2015, the *Independent Assessment* found that SCIP's scoring and approval processes and time frames, among other things, undermined VA's capital-planning and prioritization process.[57] In addition, the *Independent Assessment* made several recommendations to address those limitations, including: (1) refining the SCIP processes to simplify

[55]See GAO-14-704G.

[56]See 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).

[57]McKinsey & Company Inc., *Assessment K (Facilities)*.

scoring methods; (2) strengthening the business case submission process; and (3) developing mechanisms to ensure projects met promised objectives. Officials who oversee SCIP told us that they were aware of, and mostly agreed with the *Independent Assessment's* findings in the facilities section. In order to address all of the *Independent Assessment's* recommendations, including most of the same SCIP limitations we found, VA created a task force called the Integrated Project Team, as we reported in September 2016.[58] According to VA officials, the task force identified several actions to enhance and restructure the department's infrastructure based on the facility section of the *Independent Assessment*. However, after 6 months of work, the task force disbanded before it developed an implementation plan for those initiatives. VA officials said that they were instead focused on addressing other priorities such as those in the Commission on Care's report—which built upon the *Independent Assessment*—and proposed legislation that could affect VHA operations. However, the Commission on Care did not address facility management issues on the level of the *Independent Assessment's* recommendations.[59] Not addressing important, known limitations runs counter to federal standards for internal control, which note that agencies should evaluate and determine appropriate corrective action for identified limitations and deficiencies on a timely basis.[60] In addition, managing federal real property is on GAO's High Risk List, and our High Risk report notes that agencies should have a corrective action plan with steps to implement solutions to recommendations in order to be removed from the list.[61] Without ensuring that recommendations from internal and external reviews are evaluated, decided upon, documented, and promptly acted on, VA does not have reasonable assurance that

[58]See GAO, *VA Health Care: Processes to Evaluate, Implement, and Monitor Organizational Structure Changes Needed*, GAO-16-803 (Washington, D.C.: Sept. 27, 2016).

[59]The Commission on Care report's "facility and capital assets" recommendation is that VA develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs. To accomplish this strategy, the report outlines several steps that will need to be undertaken, but notes that subsequent legislative action will need to take place before they can be addressed. Of the 41 facility-related recommendations within the *Independent Assessment* (*Assessment K (Facilities)*), not all were within the scope of this engagement.

[60]See GAO-14-704G.

[61]See 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).

SCIP can be used to identify the full capital needs to address VA's service and infrastructure gaps.

VAIP Facility Master Plans Have Limited Usefulness Because They Do Not Adequately Consider Care in the Community, among Other Weaknesses

VA's ongoing VAIP Process (estimated by VA officials to cost $108 million upon completion) was designed to provide a more strategic vision for aligning VA's medical facilities and services with veterans' needs. However, the facility master-planning process has several limitations, including that it assumes that all future growth in services will be provided directly through VA facilities without considering alternatives, including the status quo and purchasing care from the community. This assumption runs counter to VA guidance from November 2016 that notes the need for using taxpayer resources wisely by avoiding building facilities that create 100-year commitments if they could use community capacity. Nonetheless, facility master plans produced by the VAIP Process make construction recommendations that directly contradict this policy because the plans do not adequately consider care in the community, for example:

- To address one medical facility's master plan would require about $762 million to relocate and renovate spaces within a building, acquire adjacent land, demolish inadequate buildings, construct a new medical tower, and provide seven clinical services that are currently provided elsewhere. No analysis was done to determine if these services could be better or more cost effectively purchased through care in the community.
- Another medical facility's master plan indicated a need to construct five new structures estimated to cost about $100 million to provide clinical services that veterans were already obtaining elsewhere. Similarly, no cost-benefit analyses were done to consider care in the community as an option. This construction was recommended in addition to an unrelated major construction upgrade costing in excess of $366 million.

Because these plans do not consider that care could be provided in the community, if implemented, they increase the risk for spending more than necessary to provide the services. OMB's acquisition guidance notes that investments in major capital assets should be made only if no alternative private sector source can support the function at a lower cost.[62] Long-term costs for capital assets are particularly relevant for VA as its data project that the number of enrolled veterans will begin to fall after 2024.

[62]See OMB, *Circular No. A-11.*

VA officials told us that operations and maintenance represent 85 to 90 percent of the total life-cycle costs for VA health care facilities. Officials who oversee the VAIP Process told us that the facility master plans' lack of analyses regarding care in the community was because they were awaiting further guidance from VA on the proportion of care and types of services to obtain from the community versus in VA facilities. VA released this guidance in November 2016. That guidance requires individual analyses at the local level in order to determine the mix of services provided in VA facilities versus those in community care, a requirement that is not in the facility master-planning process.

We also identified other limitations that limit the utility of the VAIP Process:

- Lack of standardization: According to VA officials, they have mostly completed the VAIP Process for 6 of the 18 VISNs, but in part because it is conducted by several contractors, VA has not fully standardized the process across VISNs. As such, the results are also not comparable across VISNs. Officials who oversee the program said that they are proposing an enhancement to the Health Service Delivery Plan portion of the process that would allow for standardized analyses, planning, and reporting. But the proposal was still in its early stages, and at the time of our review, there was no timeline for completion.
- Lack of accountability for implementing VAIP recommendations: Officials who oversee the program told us that there is no requirement that the facilities or VISNs implement recommendations based on the VAIP Process's Health Services Delivery Plans or the facility master plans—although VA officials said there have been discussions about requiring this accountability in the future. As a result, there is no accountability for evaluating or responding to the VAIP recommendations.
- Incomplete cost estimates: The VAIP Process's facility master plans include estimates for construction and design, but do not include any long-term estimates for operating costs. OMB's *Capital Programming Guide* notes that these life-cycle costs, such as operations and maintenance, should be included in a credible life-cycle cost estimate.[63] As previously noted, VA officials said that operating and maintenance cost for VA medical facilities can represent 85 to 90

[63]See OMB, *Supplement to Circular No. A-11: Capital Programming Guide*.

percent of total facility costs. According to officials who oversee the program, the intent was only to provide costs for completing the identified projects.

The limitations of the VAIP Process's facility master plans reduce its utility for the VA's planning officials to the point where some local officials said that they do not use VAIP results and planning officials from five of the seven medical facilities in our review told us that they already contract for their own facility master plans, separate from VAIP. According to federal standards for internal control, agencies should take steps to identify, analyze, and respond to risks related to achieving the defined objectives, an approach that in this case, could reduce risks to the VAIP facility master plans' success.[64] Although officials who oversee the VAIP Process told us that the VAIP-produced master plans uniquely incorporate the Health Care Service Delivery Plan's recommendations from the first step of the process, and would therefore be different from the facilities' master-planning efforts, the potential for duplication exists as separate entities could be undergoing strategic planning for the same facility. The magnitude of these limitations and the potential for planning duplication raise questions about the need for and utility of the VAIP facility master plans as they are currently being developed.

Local Approaches to Stakeholder Involvement Vary due to a Lack of VA Guidance

VA Has Not Consistently Integrated Stakeholders into Facility Alignment Decisions

VA does not always include stakeholders in facility alignment decisions that affect veterans' health care. VA may align its facilities to meet veterans' needs by expanding or consolidating facilities or services. Stakeholders—including, veterans, local, state, and federal officials, VSOs, historic preservation groups, VA staff, and Congress—often view changes as working against their interests or those of their constituents, when services are eliminated or shifted from one location to another.

[64]See GAO-14-704G.

We have previously identified best practices for stakeholder involvement in facility consolidation actions and recommended agencies identify relevant stakeholders and develop a two-way communication strategy that begins well in advance of any facility changes and addresses concerns and conveys through data the rationale and overarching benefits behind decisions.[65] Failure to effectively engage with stakeholders in these ways can undermine or derail facility alignment. These best practices suggest that VA leadership should engage both external stakeholders, such as veterans groups and local politicians, and internal stakeholders, such as VA employees. However, we found that two-way communication did not always occur when VA engaged stakeholders.

External stakeholders: VA often takes steps to involve external stakeholders, but those efforts often fall short of the best practice of developing a two-way communication strategy. VA requires VISN leadership to hold quarterly town hall meetings with external stakeholders to promote ongoing communications.[66] Planning officials from each of the five VISNs and seven medical facilities in our review told us that they meet regularly with external stakeholder groups, usually through quarterly town hall meetings or roundtables. However, in speaking with external stakeholders, we found that, in large part, these meetings were for VA to communicate information, not necessarily to involve stakeholders in the decision-making process. For example, a local VA official said that the monthly stakeholder meetings were primarily a mechanism for VA officials to announce projects after decisions were made. Officials from two local veterans' organizations agreed with this characterization, and representatives from one stopped attending the meetings as a result. In one of these locations, the breakdown in two-way communication resulted in picketing when veterans' organizations opposed the closure of a facility.

We also found that when stakeholders were not always engaged consistently with best practices, VA's facility alignment efforts were challenged by external stakeholders. For example, one area that has a declining number of veteran enrollees also has three medical facilities within 25 miles of each other. According to the CARES report, the veteran

[65]See GAO-12-542.

[66]Department of Veterans Affairs, *Community Care, Including Veterans Choice Program (VCP), Town Halls,* (Washington. D.C.: May 10, 2016).

population and enrollment in this area did not justify multiple inpatient facilities. Based on the CARES recommendation, VA considered a consolidation of services. Officials from a local veterans group told us that due to the one-way nature of communication with VA officials, they did not fully trust that VA would follow through on plans to replace the services following the consolidation and feared this VA property would be sold or disposed of and not replaced with a new VA facility. This alignment proposal prompted members of Congress and of the city council and VSOs to conduct a campaign that resulted in all three facilities remaining operational 13 years after the CARES report was issued.

We found that local facility alignment efforts in which VA officials better followed best practices—building transparency by providing data-driven information and utilizing two-way communication strategies—with external stakeholders were more successful. For example, planning officials from one medical facility—which successfully implemented a CARES recommendation to consolidate inpatient beds in a neighboring facility—told us that they communicated with external stakeholder groups as far in advance as they could and presented data to support any proposed change. Planning officials from another medical facility were able to close an underutilized inpatient wing, a leased CBOC that had experienced decreased utilization and increased costs, and relocate a domiciliary from one campus to another. During this process, facility officials developed a communication plan and held meetings with external stakeholders to present their data and explain the reasoning behind the change.

Internal stakeholders: Best practices also include engaging internal stakeholders to build consensus for facility alignment actions. Facility alignment can mean job loss, relocation, or changes in the way employees perform their duties. VA officials told us that employees have sometimes challenged the facility alignment process and in some instances, affected the outcomes where these best practices were not incorporated. Specifically, effective communication with internal stakeholders can foster trust and an understanding of the planned changes, potentially defusing opposition while strengthening commitment to the effort. For example, as part of a consolidation and closure at one medical facility, planning officials addressed concerns, as well as presented data-driven information that highlighted the benefits and rationale to employees. Facility officials developed a communication plan and held a meeting with employees to present their data and explain the reasoning behind the change. In this meeting, they also addressed

employee concerns by reassuring them that no one was going to lose their job.

VA Lacks Guidance That Incorporates the Best Practice of Fully Engaging Stakeholders and Does Not Evaluate Communication Efforts

VA does not provide officials at VISNs and medical facilities with guidance that incorporates best practices on fully engaging both internal and external stakeholders about facility alignment decisions, or evaluate the effectiveness of local stakeholder engagement efforts. VA provides guidance on communicating changes to stakeholders, but this guidance does not conform to best practices in that it does not provide details about how and when to communicate. Without official guidance VA cannot be assured that the VISNs and medical facilities are consistently applying best practices that integrate stakeholders into the decision-making process in a way that better ensures the success of alignment efforts.

Further, existing VA guidance does not instruct VISNs and facilities to involve stakeholders throughout the decision-making process. Some of the guidance cites required notification procedures, but does not address general best-practice strategies for engaging and building consensus with stakeholders. For example, in April 2016, VA provided guidance to VISNs regarding notification procedures for any changes in clinical services. This memorandum includes direction to the VISN for a communication plan that includes creating congressional notification, patient notification letters, talking points, and a press release 30 days prior to opening a new facility. However, VA's guidance lacks specific directions on timelines, data, and the extent to which external stakeholders should be a part of the decision-making process. A VA official told us that they do not have such guidance because it is implicitly understood that local officials should engage stakeholders. However, this outcome is not always occurring due, in part, to this lack of specificity in the guidance, we described earlier in this report. We found variation both in the ways local officials engaged external and internal stakeholders in facility alignment efforts and in the results of those efforts.

In addition, VA officials stated that they do not monitor and evaluate their communication methods for best practices or for the methods' effectiveness in reaching their intended audiences. This runs counter to federal standards for internal control, which note that agencies should monitor and evaluate their activities.[67] We observed variation in the

[67]See GAO-14-704G.

involvement of stakeholders and the impact on facility alignment outcomes. As noted earlier, in some cases, we observed one-way communication that resulted in adversarial relationships that reduced VA's ability to better align facilities to the needs of the veteran population. In other areas, such as with the medical facility that was able to close an underutilized inpatient wing, close a leased CBOC, and relocate a domiciliary, two-way communication with stakeholders resulted in more productive relationships and effective alignment efforts.

Evaluating the effectiveness of stakeholder outreach efforts would help VA officials identify and internalize lessons for future activities. However, VA lacks a process for evaluating its stakeholder outreach efforts. Without guidance that adheres to best practices about fully integrating stakeholders and the lack of monitoring and evaluation about this process, VA increases its risk that stakeholders are not appropriately involved in its facility alignment efforts nor can it determine the effectiveness of its efforts, or learn lessons from previous efforts.

Conclusions

The shifts in veteran demographics and demand for health services combined with antiquated facilities create an imperative for VA to better align its medical facilities and services. However, some of the recommendations from VA's last major alignment effort—CARES—were not fully implemented and its current efforts to facilitate realignment—the SCIP and VAIP processes—are hindered by key limitations. For example, SCIP is unable to ensure that medical facilities are not adding projects in out years to address gaps that they do not intend to implement. In addition, relying on project narratives for one-third of the project score can introduce subjectivity into the process, a process that was intended to ensure that all projects are reviewed equitably and consistently. If these deficiencies remain, VA's SCIP process for prioritizing capital projects will continue to limit the agency's ability to effectively facilitate decisions to correctly align its medical facilities with veterans' needs and thereby deliver the best and most cost-effective health care to the veteran population.

The VAIP facility master plans also have significant limitations as a planning aid. If their trend toward not analyzing the benefits of utilizing medical capacity in the community is continued, the VAIP facility master plans' recommendations could result in spending more than necessary to provide the services. The level of potential overspending on VA medical centers will become an even more significant issue if the number of enrolled veterans begins to decline after the year 2024 as predicted.

Finally, because VA has not consistently followed best practices for effectively engaging stakeholders, stakeholders may not fully support alignment efforts—a situation that poses a risk to success. Also, VA does not have a process for monitoring and evaluating its communication methods, which runs counter to federal standards for internal control. Without this, VA does not know if the local officials are meaningfully or effectively engaging internal and external stakeholders in the capital alignment decisions that affect them.

Recommendations for Executive Action and Our Evaluation

To improve VA's ability to plan for and facilitate the alignment of its facilities with veteran needs, we recommend that the Secretary of Veterans Affairs direct the appropriate offices and administrations to take the following four actions:

1. Address identified limitations to the SCIP process, including limitations to scoring and approval, and access to information.
2. Assess the value of VAIP's facility master plans as a facility-planning tool. Based on conclusions from the review, either 1) discontinue the development of VAIP's facility master plans or 2) address the limitations of VAIP's facility master plans.
3. Develop and distribute guidance for VISNs and facilities using best practices on how to effectively communicate with stakeholders about alignment change.
4. Develop and implement a mechanism to evaluate VISN and facility communication efforts with stakeholders to ensure that these communication efforts are working as intended and align with guidance and best practices.

Agency Comments

We provided a draft of this report to VA for comment. Its written comments are reproduced in appendix II.[68] VA partially concurred with our first recommendation. Specifically, VA said that it generally concurred with the recommendation to address limitations in SCIP process, but limited its concurrence to addressing the limitations that are within VA's control. We edited our report to indicate that some parts of the process are outside VA's control and focused our findings on those elements for which VA does have control. VA fully concurred with the other three

[68]VA provided two identical letters with comments, with one addressed to Mr. Wise and the other to Ms. Draper. We only reproduced one of the letters in appendix II.

recommendations and outlined a plan to implement them. VA also provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the appropriate congressional committees and the Secretary of Veterans Affairs. 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 regarding this report, please contact David J. Wise at (202) 512-2834 or wised@gao.gov, or Debra A. Draper 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 III.

David J. Wise
Director
Physical Infrastructure

Debra A. Draper
Director
Health Care

Appendix I: Buildings Operated by the Veterans Health Administration (VHA) and Designated for Disposal, by State

Table 1 lists the 168 VHA-operated buildings over 10,000 square feet in size that, according to VA, had been designated for potential disposal at the end of fiscal year 2014, organized by state and medical center.[1]

Table 1: Buildings Operated by the Veterans Health Administration (VHA) and Designated for Disposal, by State, Fiscal Year 2014

State	Location	Building function	Total gross square feet
AL	Tuscaloosa		
	Building 39	Information technology/Salvation Army	**46,924**
	Building CC	Connecting corridors	**27,980**
	Building 145	Community center	**15,000**
	Tuskegee		
	Building 68	Administrative offices	**52,723**
AK	-	-	**-**
AZ	Phoenix		
	Building 31	Mental health	**28,202**
	Prescott		
	Building 70	Vacant	**20,685**
AR	North Little Rock		
	Building 76	Nutrition and food	**45,234**
	Building 26	Engineering shops, state veteran service organization	**13,594**
	Building 37	Human resources	**12,628**
	Building 80	Engineering, shops	**10,088**
CA	Long Beach		
	Building 5	Administrative offices	**32,030**
	Building 6	Engineering maintenance shop	**12,508**
	Building 5C	Police & engineering building	**10,080**
	Menlo Park		
	Building 321	Psychiatric outpatient	**42,461**
	Building 371	Warehouse	**29,500**
	Palo Alto		
	Building MVC 100	Administrative offices	**34,958**
	Building 9	Patient lodging	**34,000**
	Building 50	Warehouse	**26,200**

[1]The list consists of only those buildings under the custody and control of VA, and does not include leased facilities.

State	Location	Building function	Total gross square feet
	Building 42	Engineering shops	**15,748**
	Sacramento		
	Building 646	Consolidated outpatient surgical specialties	**19,000**
	Sepulveda		
	Building 23	Therapeutic gym	**24,432**
	West Los Angeles		
	Building 525	Distant patient lodging services	**15,000**
	Building 345	Radiation therapy	**14,217**
	Building 337	Research animal house	**12,941**
	Building 44	Engineering shops	**12,809**
	Building 46	Engineering shops	**11,034**
CO	-	-	**-**
CT	Newington		
	Building 2W	Business office	**18,228**
	Building 4	Vacant	**12,394**
DE	-	-	**-**
FL	Gainesville		
	Building 30	Fisher House	**15,943**
	Miami		
	Building 68	Fisher House	**13,559**
	Orlando		
	Building 7Nona	Central energy plant	**41,900**
GA	Augusta (Uptown)		
	Building 119	Fisher House	**14,024**
	Dublin		
	Building 34	Vacant	**30,857**
	Building 33	Vacant	**16,888**
	Building 42	Vacant	**16,649**
	Building 35	Vacant	**14,868**
HI	-	-	**-**
ID	Boise		
	Building 117	Research	**18,061**
IL	Danville		
	Building 14	Medical administrative service	**31,772**
	Building 49	Chapel	**16,621**
	Building 48	Carnegie library (vacant)	**14,290**
	Hines		

State	Location	Building function	Total gross square feet
	Building 37	Consolidated mail out pharmacy	**280,050**
	Building 800	Joliet community-based outpatient clinic	**60,000**
	Building 20	Supply depot, garage	**56,323**
	Building 8	Engineering shops, prosthetics, administrative	**42,095**
	Building 48	Laundry	**39,546**
	Building 2	Administrative offices	**34,906**
	Building 13	Mental health outpatient	**23,090**
	Building 16	Administrative offices	**22,187**
	Building 17	Office of Human Resources	**20,604**
	Building 12	Clinical exam space, employee fitness center	**18,702**
	Building 7	Engineering shops	**16,998**
	Building 9	Recreation, voluntary	**12,034**
	North Chicago		
	Building 135	Administrative, childcare	**69,963**
	Building 1	Research, logistics	**56,358**
	Building 48	Administrative offices, vacant space	**26,496**
	Building 46	Administrative	**19,141**
	Building 3	Administrative	**17,447**
	Building 5	Leased to crisis center	**13,872**
	Building 32	Engineering shops	**10,477**
IN	Indianapolis		
	Building 33	Warehouse, storage	**45,105**
	Building 5	Warehouse, storage	**24,073**
	Building 42	Veteran house	**21,708**
	Building 7	Prosthetics, home based health	**16,656**
	Marion		
	Building 79	Warehouse, storage	**24,697**
	Building 17	Nursing education	**18,471**
	Building CC	Connecting corridors	**13,600**
IA	-	-	**-**
KS	Leavenworth		
	Building 41	Warehouse, storage	**32,744**
	Building 54	Engineering shop	**12,365**
	Building 28	Engineering shop, storage	**10,919**
KY	Leestown		
	Building 28	Chapel, storage, vacant space	**49,758**
	Building 5	Administrative, lab (vacant)	**24,003**

State	Location	Building function	Total gross square feet
LA	-	-	**-**
ME	Togus		
	Building 21	Storage barn	**15,518**
MD	Loch Raven		
	Building 7	Research building	**15,500**
	Perry Point		
	Building 360	Old laundry facility. new warehouse	**40,619**
	Building 314B	Recreation	**18,686**
	Building 11H	Administrative offices	**11,027**
MA	Bedford		
	Building 19	Laundry, storage	**18,135**
	Building 21	Warehouse	**11,164**
	Brockton		
	Building 23	Gym, pool	**40,957**
	Building 25	Administrative offices, storage	**21,140**
	Building 24	Chapel	**15,720**
	Building 61	Administrative offices, computer rooms	**13,646**
	Jamaica Plains		
	Building 3A	Parking garage addition	**75,000**
	Building 1D	Radiation therapy	**25,000**
	Building 2	Patient lodging	**21,372**
	Building 1E	Cryogenics research	**15,000**
MI	Battle Creek		
	Building 6	Recreation, auditorium	**20,611**
	Building 8	Homeless veterans program (vacant)	**15,296**
	Building 1	Main administration	**10,484**
MN	Minneapolis		
	Building 222	Warehouse (Fort Snelling)	**61,969**
	Building 10	Lodging, Veterans Integrated Service Network support	**23,336**
	Building 224	Storage, general	**13,460**
MS	Biloxi		
	Building 1	Main hospital	**122,400**
	Building 2	Intermediate care	**76,170**
	Building 19	Mental health and rehabilitation	**76,170**
	Building 14	Blind rehabilitation center	**55,600**
	Building 26	Warehouse	**45,500**
	Building T103	Warehouse	**20,000**

State	Location	Building function	Total gross square feet
	Building 5	Surgical residents	**13,200**
MO	St. Louis (Jefferson Barracks)		
	Building 23	Shops, prosthetics	**21,300**
MT	-	-	**-**
NE	-	-	**-**
NV	Las Vegas		
	Building 5	Community living center	**109,748**
	Building 2	Energy plant	**34,005**
NH	-	-	**-**
NJ	-	-	**-**
NM	Albuquerque		
	Building 53	Behavioral health care	**17,607**
NY	Bath		
	Building 92	Recreation	**44,770**
	Building 33	Information systems	**12,962**
	Castle Point		
	Building 101	Storage	**10,000**
	Lyons		
	Building 55	Domiciliary (vacant)	**79,400**
	Building 9	Storage, vacant space	**44,100**
	Building 15	Linen distribution, engineering shops	**27,500**
	Building 5	Auditorium, gym, administrative offices	**16,661**
	Building 10	Administrative offices	**15,950**
	Building 11	Administrative offices	**15,000**
	Montrose		
	Building 5	Kitchen, dining hall	**58,511**
	Building 7	Storage, vacant space	**47,261**
	Building 2	Theater	**27,077**
	Building 16	Engineering administration, shops	**25,743**
	Building 26	Pool, gym	**23,842**
	Building 27	Chapel	**10,758**
	Northport		
	Building 88	Gym	**26,195**
	Building 37	Vacant	**21,468**
	Building 18	Vacant	**20,886**
	Building 13	Linen services	**19,173**

State	Location	Building function	Total gross square feet
	Building 15	Shops, fire department	**16,063**
	Building 89	Engineering shops (future)	**12,349**
	St. Albans		
	Building 65	Garage	**24,364**
NC	Asheville		
	Building 9	Nurses quarters (vacant)	**42,619**
	Salisbury		
	Building 43	Hospice	**18,459**
ND	-	-	**-**
OH	Chillicothe		
	Building 3	Rehab clinics	**23,922**
	Building 247	Gymnasium	**17,596**
	Building 4	Vacant	**15,418**
	Dayton		
	Building 409	Administrative building	**86,160**
	Building 116	Administrative building (vacant)	**11,495**
	Building 226	Freedom house, education	**10,729**
OK	-	-	**-**
OR	-	-	**-**
PA	Coatesville		
	Building 16	Administration	**21,700**
	Building 11	Research	**21,600**
	Building 15	Laundry	**16,300**
	Building 5	Great Hall, administration	**15,300**
	University Drive		
	Building 30	Research office building	**91,139**
SC	-	-	**-**
SD	Black Hills (Fort Meade)		
	Building T274	Vacant recreation hall	**17,706**
	Building 89	Engineering building	**13,051**
	Building 48	Facility management warehouse	**10,986**
	Building 109	Storage	**10,265**
TN	Murfreesboro		
	Building 4	Medical media	**18,653**
	Building 90	Storage	**13,103**
	Building CC	Connecting corridors	**12,700**
TX	Big Spring		

State	Location	Building function	Total gross square feet
	Building 22	Community living center	**21,500**
	Building 3	Engineering, emergency management	**16,910**
	San Antonio		
	Building 671FH	Fisher House	**13,006**
	Temple		
	Building 222	Information technology offices, storage, and server rooms	**28,453**
	Waco		
	Building 24	Engineering and environmental management offices	**10,630**
UT	-	-	**-**
VT	-	-	**-**
VA	Hampton		
	Building 50	Medical record files and vacant space	**23,236**
	Building 15	Boiler plant	**22,251**
	Building 31	Engineering shop	**10,674**
	Building 48	Chapel	**10,290**
WA	American Lake		
	Building 4	Domiciliary	**24,571**
	Walla Walla		
	Building 69	Patient call center, audiology, logistics	**48,195**
	Building 74	Clinical swing space, administrative offices, storage	**24,408**
WV	Huntington		
	Building 23R	Research	**35,154**
	Martinsburg		
	Building 314	Engineering	**18,255**
WI	Milwaukee		
	Building 2	Domiciliary, main mess hall (vacant)	**133,730**
	Building 6	Offices	**120,150**
	Building 20	Warehouse	**56,208**
	Building 102	Laundry	**31,000**
	Building 5	Great Lakes Service Center (Dom. Quarters)	**28,800**
	Building 41	Ward Memorial Theater (Vacant)	**21,986**
	Building 1	Offices (Dom. Administration)	**17,600**
	Building 108	Structural & machine shop	**10,248**
	Tomah		
	Building 40	Maintenance/repair and engineering shops	**13,999**
WY	-	-	**-**
Total		**168 buildings**	**4,955,946**

Appendix I: Buildings Operated by the Veterans Health Administration (VHA) and Designated for Disposal, by State

Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-17-349

Note: Data are as of the end of fiscal year 2014. The list consists of only those buildings under the custody and control of VA, and does not include leased facilities.

Appendix II: Comments from the Department of Veterans Affairs

Note: GAO comments supplementing those in the report text appear at the end of this appendix.

DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

March 22, 2017

Mr. David J. Wise
Director, Physical Infrastructure
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Wise:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report ***"VA REAL PROPERTY: VA Should Improve Its Efforts to Align Facilities with Veterans' Needs"*** (GAO-17-349).

VA understands that modifications to the Strategic Capital Investment Planning (SCIP) process would enhance the tool's effectiveness. To that end, VA concurs with the general premise of GAO's recommendations regarding SCIP, but many of the key driving factors are outside the Department's control, require external reform and the help of Congress to remove some of the limitations.

The SCIP process was initially developed in 2010, to demonstrate the full enterprise-wide capital needs for the Department, which it successfully achieved. While the goal of SCIP was achieved, additional factors, such as significantly lower than anticipated capital budget amounts, the continued aging of VA's infrastructure, and increased use of care in the community, have evolved and the Department recognizes that these factors should be more fully addressed in SCIP going forward.

See comment 1.

Many of the items noted in the draft GAO report mischaracterize the intended outcomes of the SCIP process, such as the fact that SCIP was not designed as a mechanism to force realignment of VA facilities, but rather as a way to implement realignment decisions that are made at the local level, and to prioritize the investments needed to enable those decisions based on a scored business case. The enclosure includes general comments and a plan of action to implement GAO's recommendations.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

Gina S. Farrisee
Deputy Chief of Staff

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
"VA REAL PROPERTY: VA Should Improve Efforts to Align Facilities with Veterans' Needs"
(GAO-17-349)

General Comments:

The Veterans Health Administration (VHA) appreciates the work of the Government Accountability Office (GAO). VHA will use GAO's findings and recommendations to continue to improve policies and processes in fulfilling our mission of honoring America's Veterans by providing exceptional health care that improves their health and well-being.

In early 2015, VA began working to reorganize the Department, guided by ideas and initiatives from Veterans, employees, and all of our other stakeholders. This reorganization is a part of the MyVA initiative and is designed to provide Veterans with a seamless, integrated, and responsive customer service experience.

As the Department announced its plan to realign its many organizational maps into one map with five districts to better serve Veterans – VHA joined in this effort by realigning existing Veterans Integrated Service Networks (VISN) – to fit with the five Department-level districts, and better align with state boundaries. The VISN realignment enhances efficiencies and Veteran experiences as they receive VA services. The implementation has had no adverse impact on their ability to access health care services through VA facilities. The realignment offers long term efficiencies, which will enhance Veteran experiences in accordance with MyVA and MyVA Access objectives. Throughout the process, VA worked closely with labor unions and directly with employees to ensure awareness, maintain two-way communication and minimize the potential for negative impact.

VHA is strongly committed to developing long-term solutions that mitigate risks to the timeliness, cost-effectiveness, quality and safety of the VA health care system. VHA is using the input from GAO and other advisory groups, to identify root causes and to develop critical actions.

GAO Recommendation: To improve VA's ability to plan for and align its facilities with veteran needs, we recommend that the Secretary of Veterans Affairs direct the appropriate offices and administrations to take the following four actions:

Recommendation 1: Address identified limitations to the SCIP process, including limitations to scoring and approval, accountability, and access to information.

VA Comment: Partially concur. VA generally concurs with GAO's recommendation that the Department should address limitations in the Strategic Capital Investment

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Planning (SCIP) process, but limits this concurrence to addressing the limitations that are within VA's control. The SCIP process was initially developed in 2010, to demonstrate the full enterprise-wide capital needs for the Department, which it successfully achieved. While the goal of SCIP was achieved, additional factors, such as significantly lower than anticipated capital budget amounts, the continued aging of VA's infrastructure, and increased use of care in the community, have evolved and should be more fully addressed in SCIP.

See comment 2

However, many of the items noted by GAO to be addressed through the SCIP process are outside of the SCIP program, and VA has limited ability to influence. SCIP was not designed as a mechanism to force realignment of VA facilities, but rather as a way to implement realignment decisions that are made at the local level, and to prioritize the investments needed to enable those decisions based on a scored business case. VA has acknowledged the need for a national realignment strategy, and began working towards that goal last fall. To enable SCIP to support that realignment, the full realignment study must be completed and accepted, and at that point SCIP can be refreshed and investments prioritized to support the realignment plan.

See comment 3.

The draft GAO report states that the SCIP process is limited, does not ensure that all service gaps are actually addressed, and that VA does not have a mechanism for ensuring that future-year projects are implemented. We believe that this is not an intentional limitation resulting from the SCIP process. It is an outcome stemming from VA not having enough capital to meet all of the needs identified in the SCIP plan. SCIP is a non-resource constrained plan that identifies the capital investments needed to close gaps. It does not guarantee whether or when necessary levels of funding that will be received or otherwise made available. When the SCIP process was developed, the assumption was that there would be significant investment in VA's capital portfolio. VA facility staffs cannot be held accountable for failure to implement SCIP plans, when sufficient funding is unavailable. In order to instill accountability throughout the process, VA provides training and guidance to planners stating that their projects and plans should be manageable and executable. While not specifically addressed in the report, it is important to note that VA also has taken steps to improve the disconnect between the budget formulation and execution processes. VA will continue to strengthen its SCIP guidance and look for ways to improve the process, to better support the facility planning process.

See comment 4.

The draft GAO report states that the SCIP development and approval timeframes can hinder capital planning. While VA agrees that the planning process is lengthy, the timeliness of the SCIP process is driven by the government-wide budget processes, set in place by the Office of Management and Budget for the Executive Branch and the

See comment 5.

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United States Congress for the Legislative Branch. VA has some limited ability to shift internal timelines, but has no ability to affect the overall timelines associated with the Federal budget process.

The report also portrays SCIP prioritization methodology as being highly based on narrative and/or subjective information. To the contrary, a majority of SCIP criteria weights are based on objective or hard data. For example, the top four criteria in the SCIP decision model are: Critical facility condition assessment, Seismic, Safety, and Utilization – in that order. All, but Safety, are 100 percent data-driven. The remaining criteria are based on the submitter's ability to develop a sound and cohesive business case that ties to the organization's strategic direction and goals. VA believes that the narrative component of the business case does not introduce subjectivity, but instead is an opportunity for planners to articulate the business need for the project, in line with any public or private sector organization's investment protocol.

To the extent possible, VA will implement changes to the SCIP process to support better access to project data, improve the visibility and prioritization of sequenced projects, minimize administrative burdens, and improve communication of SCIP results as early as possible in the process. In order to be able to make meaningful changes to the SCIP process, VA needs the support of Congress to deal with the limitations.

Recommendation 2: Assess the value of VAIP facility master plans as a facility planning tool. Based on conclusions from the review, either 1) discontinue the development of VAIP facility master plans, or 2) address the VAIP facility master plans limitations.

VA Comment: Concur. In order to address any limitations, future VA Integrated Planning (VAIP) facility master plans will embrace all recent and evolving guidance, especially regarding Community Care realignment opportunities. Where significant change in guidance is imminent, or otherwise anticipated VAIP facility master plans will either be postponed awaiting final determinations or structured to incorporate such changes. VA plans to his make this adjustment to facility master plans developed outside of VAIP.

Recommendation 3. Develop and distribute guidance for VISNs and facilities using best practices on how to effectively communicate with stakeholders about alignment change.

VA Comment: Concur. To ensure effective communication with stakeholders, the VHA Office of Communications has developed a template communications plan that is

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available to VISNs and facilities for use when rolling out alignment changes. The Office of Communications works closely with facility public affairs officers when requested, to develop and launch their local communications plans.

To ensure consistency in stakeholder engagement efforts, the Office of Communications will develop standard operating procedures (SOP) for all VISN and facility public affairs officers to follow when there is a mission change and/or realignment. The SOP will direct that the template communications plan, including timeline for notifications, target audiences, and example key messaging, will be utilized. In addition, the SOP will outline specific evaluation tools, such as effective after action reporting, as well as identification/sharing of best practices.

The SOP will be disseminated to facility and VISN leadership through a memorandum from the VHA Deputy Under Secretary for Health for Operations and Management. Target Completion Date: June 2017

Recommendation 4. Develop and implement a mechanism to evaluate VISN and facility communication efforts with stakeholders to ensure that they are working as intended, and align with guidance and best practices.

VA Comment: Concur. VISN and facility public affairs officers currently utilize after action reports (AAR) as an internal tool to evaluate the effectiveness of their communications efforts and determine best practices.

To ensure VISN and facility communication efforts with stakeholders are working as intended, and align with guidance and best practices, VHA's Office of Communication will provide public affairs officers with SOPs. The SOPs will outline specific evaluation tools, such as effective after action reporting, as well as identify/share best practices. The Office of Communications will review facilities' AARs monthly and provide feedback as appropriate. Best practices will be shared with all public affairs officers for implementation in moving forward with local communications. Target Completion Date: June 2017.

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The following are GAO's comments on the Department of Veterans Affairs letter dated March 22, 2017.

GAO's Comments

1. VA stated that many of the items noted in the draft report mischaracterized the intended outcomes of the SCIP process, such as the fact that SCIP was not designed as a mechanism to force realignment. We did not intend to characterize the SCIP process's intention as a mechanism to force realignment of VA facilities and clarified our report to reflect this approach.

2. VA stated that many of the items we found that needed to be addressed through the SCIP process were outside of the SCIP program and that VA had limited ability to influence. We agree and have edited the report: to reflect that some elements of the process are outside VA's control and to re-focus on the aspects that VA does control. Please see comments 3, 4, and 5 below for our responses. Regarding how we characterized the intention of the SCIP process, see comment 1.

3. In regard to our finding that the SCIP process does not have a mechanism in place for ensuring that future-year projects are implemented, VA stated that this was not an intentional limitation resulting from the SCIP process, but was instead an outcome stemming from VA not having enough capital to meet all of the needs identified in the SCIP plan. We agree and clarified the report. However, in our review, planners at two medical facilities told us that they enter projects for future years that they have little or no intention of actually pursuing—which is different than not having enough capital to pursue the project. As such, we continue to believe that SCIP has a limitation in that it does not have a mechanism in place to prevent facility planners from gaining credit for closing service gaps by proposing capital projects that they have no intention of ever implementing.

4. In regard to our finding that SCIP's development and approval timeframes can hinder capital planning, VA stated that it agrees that the planning process is lengthy, but added that the timeliness of the SCIP process is driven by the government-wide budget process, which is outside of VA's control. We agree that there are elements of the timeframes that are outside of VA's control and clarified our report to address this situation and focus on what is within VA's control. Specifically, over the last 6 fiscal-year SCIP submissions, VA has

chosen to wait about 6 to 10 months to report the results of the SCIP scoring process to the medical facilities.

5. In regard to our finding that the SCIP process's scoring and approval process relies on facility planning officials' ability to write an accompanying narrative that addresses more of the priorities, VA stated that it disagreed that the scoring was highly based on narrative and/or subjective information. We clarified our report to note that the narrative portion represents about one-third of a project's overall score, but as VA states, it relies on the planners' ability to articulate the business need for the project. GAO continues to believe that that relying on planners' abilities to articulate the business need for a project introduces subjectivity to the scoring process.

Appendix III: GAO Contacts and Staff Acknowledgments

GAO Contacts

David J. Wise at (202) 512-2834 or wised@gao.gov, or Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

Staff Acknowledgments

In addition to the contacts named above, Keith Cunningham, Assistant Director; Jeff Mayhew, Analyst-in-Charge; Colleen Taylor; Laurie F. Thurber; and Michelle Weathers made key contributions to this report. Also contributing were Jacquelyn Hamilton, John Mingus, Sara Ann Moessbauer, Malika Rice, and Crystal Wesco.