September 2016

GAO Highlights

Highlights of GAO-16-803, a report to congressional requesters

VA HEALTH CARE

Processes to Evaluate, Implement, and Monitor Organizational Structure Changes Needed

Why GAO Did This Study

GAO and others have expressed concerns about VHA's management of its health care system. In response, VA initiated a new regional framework to improve internal coordination and customer service, and VHA initiated an effort to realign its VISNs.

GAO was asked to review VHA's organizational structure—the operating units, processes, and other components used to achieve agency objectives. This report examines the extent to which (1) VHA has a process for evaluating recommended organizational structure changes to determine actions needed and implementing them as appropriate; and (2) VHA monitored and provided guidance for implementing the VISN realignment. GAO reviewed VHA documents, reviewed internal and external assessments of VHA, and interviewed officials from VHA central office and all VISNs. GAO evaluated VHA's actions against relevant federal standards for internal control.

What GAO Recommends

GAO recommends that VHA (1) develop a process to ensure that organizational structure recommendations are evaluated for implementation; and (2) evaluate the implementation of the VISN realignment to determine and correct deficiencies, and apply lessons learned to future organizational structure changes, such as possible changes to VISN staffing models. VA concurred with GAO's recommendations.

View GAO-16-803. For more information, contact Debra Draper at (202) 512-7114 or draperd@gao.gov.

What GAO Found

Recent internal and external reviews of Veterans Health Administration (VHA) operations have identified deficiencies in its organizational structure and recommended changes that would require significant restructuring to address, including eliminating and consolidating program offices and reducing VHA central office staff. However, VHA does not have a process that ensures recommended organizational structure changes are evaluated to determine appropriate actions and implemented. This is inconsistent with federal standards for internal control for monitoring, which state that management should remediate identified internal control deficiencies on a timely basis. GAO found instances where VHA actions in response to recent recommendations for organizational structure changes were incomplete, not documented, or not timely. For example, VHA chartered a task force to develop a detailed plan to implement selected recommendations from the independent assessment of VHA's operations required by the Veterans Access, Choice, and Accountability Act of 2014; according to VHA, the assessment cost $68 million. It found, among other things, that VHA central office programs and staff had increased dramatically in recent years, resulting in a fragmented and "silo-ed" organization without any discernible improvement in business or health outcomes. It recommended restructuring and downsizing VHA's central office. The task force of 18 senior Department of Veterans Affairs (VA) and VHA officials conducted work over about 6 months, but did not produce a documented implementation plan or initiate implementation of recommendations. Without a process that documents the assessment, approval, and implementation of organizational structure changes, VHA cannot ensure that it is making appropriate changes, using resources efficiently, holding officials accountable for taking action, and maintaining documentation of decisions made.

VHA central office's monitoring of the Veterans Integrated Service Networks (VISN) realignment—a recent and significant organizational structure change—has been limited, and the office has provided little implementation guidance. In October 2015, VHA began to implement a realignment of its VISN boundaries, which involves decreasing the number of VISNs from 21 to 18 and reassigning some VA medical centers (VAMC) to different VISNs. VHA officials anticipate this process will be completed by the end of fiscal year 2018. VHA officials on the task force implementing the realignment told GAO they thought VISNs could implement the realignment independently without the need for close monitoring. VHA also did not provide guidance to address VISN and VAMC challenges that could have been anticipated, including challenges with services and budgets, double-encumbered positions (two officials in the same position in merging VISNs), and information technology. Further, VHA officials said they do not have plans to evaluate the realignment. VHA's actions are inconsistent with federal internal control standards for monitoring (management should establish monitoring activities, evaluate results, and remediate identified deficiencies) and risk assessment (management should identify, analyze, and respond to changes that could affect the system). Without adequate monitoring, including a plan for evaluating the VISN realignment, VHA cannot be certain that the changes being made are effectively addressing deficiencies; nor can it ensure lessons learned can be applied to future organizational structure changes.