



September 2016

VA HEALTH CARE

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

GAO Highlights

Highlights of [GAO-16-803](#), a report to congressional requesters

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.

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

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.

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Abbreviations

ADUSH	Assistant Deputy Under Secretary for Health
Choice Act	Veterans Access, Choice, and Accountability Act of 2014
DUSH governance task force	Deputy Under Secretary for Health Task Force on Improving Effectiveness of VHA Governance
Independent Assessment	<i>Independent Assessment of the Health Care Delivery Systems and Assessment Management Processes of the Department of Veterans Affairs</i>
VA	Department of Veterans Affairs
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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September 27, 2016

The Honorable Jeff Miller
Chairman
The Honorable Mark Takano
Acting Ranking Member
Committee on Veterans' Affairs
House of Representatives

The Honorable Corrine Brown
House of Representatives

The Honorable Derek Kilmer
House of Representatives

The Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), operates one of the nation's largest health care systems, with 168 VA medical centers (VAMC), more than 1,000 outpatient facilities, and a total health care budget of nearly \$51 billion in fiscal year 2015.¹ VHA provided care to about 6.7 million veterans in fiscal year 2015 and the demand for its services is expected to grow in the coming years.

VHA's organizational structure—the operating units, processes, and other components used to achieve agency objectives—is governed by its senior leadership. This leadership team, which is led by the Under Secretary for Health, manages more than 40 clinical programs and administrative offices, including those that allow veterans to obtain care from a network of non-VA providers. It also oversees VHA's field operations, comprised of Veterans Integrated Service Networks (VISN) that manage networks of VAMCs and outpatient facilities.

¹Outpatient facilities include community-based outpatient clinics and health care centers. Community-based outpatient clinics are located in areas surrounding VAMCs and provide primary care and some specialty care services that do not require a hospital stay. Health care centers are large multi-specialty outpatient clinics that provide surgical services in addition to other health care services.

We and others have expressed significant concerns about VHA's management of its health care system, including VHA's ability to effectively provide and oversee timely access to health care for veterans.² In addition, in 2014, a series of events called into question the ability of veterans to gain timely access to care from VHA medical facilities.³ As a result of these and other systemic problems, we concluded that VA health care is a high-risk area and added it to our High Risk List in 2015.⁴

In response to criticism that VHA was not succeeding in providing timely health care services to veterans, VA announced a major organizational initiative in September 2014 called MyVA. As part of this initiative, the department established a single regional framework for its three administrations—VHA, the Veterans Benefits Administration, and the National Cemetery Administration—dividing the United States into five regions based on state boundaries.⁵ According to VA, this regional

²See, 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*.

³Reviews by GAO, the VA Office of Inspector General, and others substantiated allegations of extended wait times for veteran appointments at VHA medical facilities. We found that VHA employees responsible for scheduling appointments at certain facilities engaged in inappropriate practices to make wait times appear more favorable.

⁴GAO, *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.

⁵The Veterans Benefits Administration provides veterans, their families, 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 servicemembers, 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.

framework is intended to align the previously disparate organizational boundaries of VA's administrations in order to promote internal coordination and to support the rollout of a Veterans Experience office dedicated to enhancing customer service capabilities across the department. Following the MyVA initiative's implementation, VHA announced plans to realign and, in some cases, merge VISNs so that they are geographically aligned with MyVA's regional boundaries (hereafter referred to as the VISN realignment). In addition, Congress passed the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act) to, among other things, improve veterans' timely access to care by expanding veterans' ability to obtain care from non-VA providers.⁶

Based on questions about VHA's ability to oversee its health care system and provide timely care, you asked us to conduct a management review of VHA that encompassed several key organizational components, including its organizational structure.⁷ 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's central office monitored and provided guidance for its field operations implementing the VISN realignment.

To determine the extent to which VHA has a process for evaluating recommended organizational structure changes to determine actions needed and implementing them as appropriate, we reviewed relevant documentation from VHA, including organizational charts, directives, position descriptions, and memos to identify current policy and practice with regard to organizational structure changes. We also reviewed related internal and external assessments of VHA to determine deficiencies identified and recommendations made. Specifically, we reviewed two assessments that were required by the Choice Act—the *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs* (Independent

⁶Pub. L. No. 113-146, tit. I, 128 Stat. 1754, 1755.

⁷We have additional forthcoming work related to VHA strategic planning, human capital, and information technology.

Assessment) and the *Final Report of the Commission on Care*.⁸ We also reviewed a report produced by an internal VHA task force chartered by the then Interim Under Secretary for Health to evaluate VHA's governance structure, the Task Force on Improving Effectiveness of VHA Governance (which we will refer to as the governance task force hereafter).⁹ We interviewed VHA officials, including officials from VHA's National Leadership Council, other VHA senior leadership such as the Under Secretary for Health, and VISN and VAMC officials on their involvement in organizational structure changes.¹⁰ We evaluated VHA's actions against federal internal control standards related to monitoring.¹¹

To determine the extent to which VHA's central office provided monitoring and guidance to its field operations implementing the VISN realignment, we reviewed relevant documentation from VHA, VISN, and VAMC officials, including organizational charts, position descriptions, directives, and memos. We also reviewed related internal and external assessments of VHA's organizational structure. We interviewed VHA central office officials involved in the VISN realignment. We also interviewed directors from all 21 VISNs that existed prior to the VISN realignment, and directors from six selected VAMCs, about the extent to which their participation was solicited as part of recent organizational structure changes and to obtain their perspectives on organizational structure changes, such as the

⁸Centers for Medicare & Medicaid Services' Alliance to Modernize Healthcare Federally Funded Research and Development Center, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs: Volume I: Integrated Report* (Sept. 1, 2015). Commission on Care, *Final Report of the Commission on Care* (Washington, D.C.: June 30, 2016).

⁹VHA, *Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health* (Feb. 28, 2015). The current Under Secretary for Health was confirmed by the Senate in June 2015. Prior to his confirmation, a VHA official served as the Under Secretary for Health in an interim capacity.

¹⁰The National Leadership Council is the Under Secretary for Health's governance structure for all policies, plans, and procedures across the entire VHA system. It is comprised of officials in leadership positions from VHA's central office and VISNs.

¹¹GAO, *Standards for Internal Control in the Federal Government* [GAO-14-704G](#) (Washington, D.C.: September 2014).

VISN realignment.¹² The six VAMCs were selected to provide variation in (1) whether the VAMC was affected by the realignment; (2) whether the associated VISN was affected by the realignment; (3) geographic location; (4) tenure of the VAMC director; (5) tenure of the VISN director; and (6) facility complexity level.¹³ The six selected VAMCs were Huntington VAMC (Huntington, W.V.); Jerry L. Pettis Memorial Veterans' Hospital (Loma Linda, Calif.); John D. Dingell VAMC (Detroit, Mich.); Jonathan M. Wainwright Memorial VAMC (Walla Walla, Wash.); Nashville VAMC (Nashville, Tenn.); and Togus VAMC (Togus, Maine). The information from our VAMC interviews is not generalizable to all VAMCs. We evaluated the monitoring and guidance provided by VHA against federal internal control standards related to risk assessment and monitoring.¹⁴

We conducted this performance audit from September 2015 to September 2016 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.

¹²In some cases, officials had left their positions as VISN or VAMC directors at the time of our interviews (from January through April 2016), but were in a permanent or acting director role as of December 2015, when our interviewees were selected. For the purpose of this report, we refer to all acting or other temporarily assigned directors as directors.

¹³For the purpose of this review, we define (1) a VAMC as being affected by the realignment if the VAMC was changing VISNs and (2) a VISN as being affected by the realignment if the VISN gained or lost a VAMC in the realignment or merged with another VISN; 15 of the 21 VISNs were affected by the realignment. VHA categorizes medical centers according to complexity level, determined on the basis of the characteristics of the patient population, clinical services offered, educational and research missions, and administrative complexity.

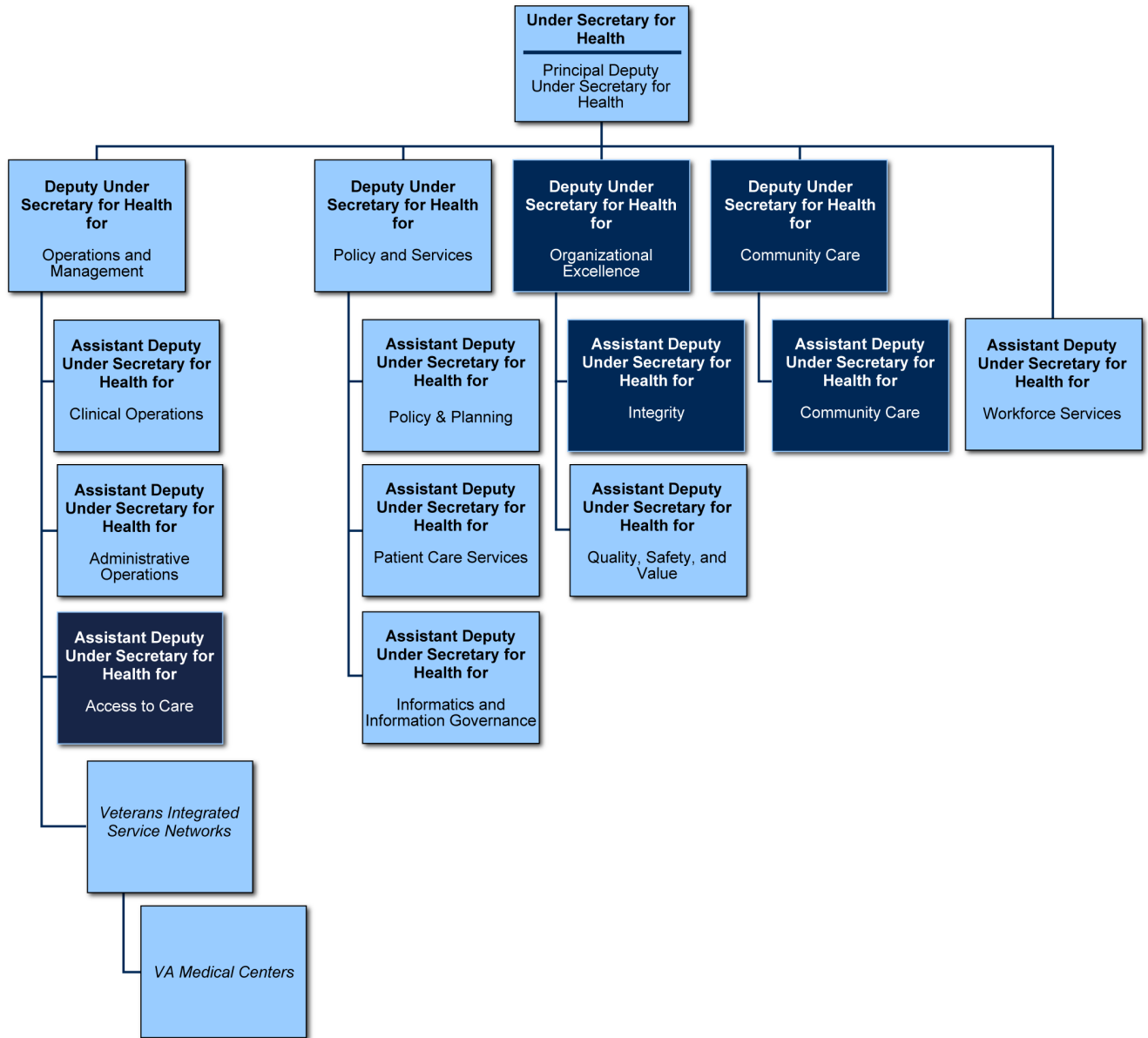
¹⁴See [GAO-14-704G](#).

Background

VHA Organizational Structure

The Under Secretary for Health is the head of VHA and is supported by the Principal Deputy Under Secretary for Health, four Deputy Under Secretaries for Health (DUSH), and nine Assistant Deputy Under Secretaries for Health (ADUSH). Five of these senior leadership positions have been added since 2015. (See fig. 1.)

Figure 1: Veterans Health Administration's (VHA) Organizational Chart, May 2016



Offices in place prior to 2015
 Offices added since 2015

Source: VHA. | GAO-16-803

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

Officer. Also, the Chief Financial Officer and Director of Strategic Integration report to the Principal Deputy Under Secretary for Health.

The four DUSH-level positions are

- **Operations and Management:** This official oversees VHA's field operations. All VISN directors report to the DUSH for Operations and Management; VISNs manage the day-to-day functions of VAMCs and outpatient facilities within their network. The Office of the DUSH for Operations and Management supports the VISNs by providing guidance and individual assistance to address operational challenges (such as personnel issues, adverse events at facilities, and implementation of legislation), and supporting the management of access to care (through the ADUSH for Access to Care position, added in 2016). The office also serves as the focal point for the flow of information and guidance between VHA central office and the VISNs and VAMCs.
- **Policy and Services:** This official oversees VHA offices focused on health care policy, information management, and research. The Office of the DUSH for Policy and Services is responsible for developing and promulgating VHA policies, employing information and informatics tools to improve patient outcomes, and measuring results to ensure continuous learning.
- **Organizational Excellence:** This official oversees program offices focused on assessing and improving quality and safety, providing VHA leadership with analytics to assess how VHA is performing as an organization, and addressing issues related to public trust and integrity. For example, the ADUSH for Integrity reports to the DUSH for Organizational Excellence and is responsible for the day-to-day management of offices focused on internal and external audits, compliance, and ethics. The Office of the DUSH for Organizational Excellence—created in 2015—serves as a hub to enable VHA to achieve the five priorities the Under Secretary of Health established in 2015, and to respond to our High Risk List designation.¹⁵

¹⁵In 2015, the Under Secretary for Health announced five priorities for VHA strategic action: (1) provide veterans timely access to health care; (2) create a work environment in which employees feel valued, supported, and encouraged to do their best; (3) ensure that veterans receive the highest level of care from VHA and non-VA providers; (4) use clinical best practices and best practices in research, education, and management; and (5) restore veterans' trust and confidence in VHA. For our High Risk List designation, see [GAO-15-290](#).

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- **Community Care:** This official oversees all VHA community care programs and business processes, such as determining veterans' eligibility to receive health care benefits and purchasing care from non-VA providers. The Office of the DUSH for Community Care was created in 2015 to implement provisions in the Choice Act that expanded veterans' access to non-VA health care services and directed VHA to consolidate the administration of payment for care from non-VA providers.¹⁶ Prior to the creation of this office, the administration of such care to veterans had been spread across VHA.

Internal and External Reviews of VHA Organizational Structure

Recent internal and external reviews of VHA operations have identified deficiencies in VHA's organizational structure and recommended changes that require significant restructuring to address, including eliminating and consolidating program offices and reducing VHA central office staff. For example, the Choice Act required VA to contract with a private entity to conduct an independent assessment of 12 areas of its health care delivery system and management processes, including VHA's leadership.¹⁷ The Independent Assessment report, which VHA reported cost \$68 million, was released in September 2015. It made recommendations across each of the 12 areas that support the report's four systemic findings of (1) a disconnect in the alignment of demand, resources, and authorities; (2) uneven bureaucratic operations and processes; (3) non-integrated variations in clinical and business data and tools; and (4) leaders not fully empowered due to a lack of clear authority, priorities, and goals.¹⁸ For example, to address the finding of uneven bureaucratic business operations and processes, the report includes a recommendation for VHA to develop a patient-centered operations model that balances local autonomy with appropriate standardization and employs best practices for high-quality health care. To accomplish this,

¹⁶Pub. L. No. 113-146, §§ 101(a), 106(a), 128 Stat. 1755, 1768.

¹⁷Pub. L. No. 113-146, § 201(a)(1), 128 Stat. 1769. 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.

¹⁸ According to VA, the report contains a total of 188 recommendations. See *Independent Assessment*, Volume I.

the report states that, among other things, VHA should reorient its central office to better support field operations in its delivery of care to veterans.

The Choice Act also established the Commission on Care, to be comprised of 15 members appointed by Congressional leaders or the President to examine, assess, and report on veterans' access to VA health care and to strategically examine how best to organize VHA, locate health resources, and deliver health care to veterans during the next 20 years.¹⁹ The commission was also required to evaluate, assess, and report its findings on the Independent Assessment, including any findings, data, or recommendations, and to report any of its own recommendations for legislative or administrative action.²⁰ The commission's June 2016 report to the President included 18 recommendations to improve veterans' access to care and, more broadly, to improve the quality and comprehensiveness of that care, in part by making large-scale organizational changes.²¹ For example, the commission recommended that VHA create local, networked systems of care that integrate traditional VHA and community care and remove restrictions to veterans seeking care from non-VA providers. It also recommended redesigning VHA's central office to better support field operations. The Choice Act required the President to submit a report to the Senate and House Committees on Veterans' Affairs and any other committees of Congress that the President considers appropriate within 60 days of the President's receipt of the commission report.^{22, 23} The report was required to include an

¹⁹The act required that members of the commission meet certain qualifications. For example, at least one member must represent an organization that represents veterans and at least one other member must have experience as senior management for a private integrated health care system with an annual gross revenue of more than \$50,000,000. Pub. L. No. 113-146, § 202(a)(b), 128 Stat 1773. Individuals selected to serve on the commission included decorated veterans, chief executive officers from major private health care systems, representatives from organizations that provide services to veterans, and health policy experts.

²⁰Pub. L. No. 113-146, § 202(b), 128 Stat. 1774.

²¹On August 2, 2016, the Secretary of Veterans Affairs stated that VA found 15 of the commission's 18 recommendations feasible and advisable.

²²Pub. L. No. 113-146, § 202(g), 128 Stat. 1776.

²³On September 1, 2016, the President concurred with 15 of the 18 recommendations and directed VA to implement any of the 15 recommendations that the department was not already working to implement.

assessment of the Commission on Care's recommendations and a description of the recommendations VHA is directed to implement.

In addition to the reviews required by the Choice Act, VHA initiated internal task forces to examine organizational structure changes and make recommendations. For example, VHA chartered its governance task force in December 2014, with the goal of making recommendations to improve operational effectiveness and efficiency, and to align the agency to strengthen business processes. According to the task force's charter, VHA needed to modify its governance structure to help address recent issues with substandard and inconsistent care delivery. The governance task force submitted a report in February 2015 with 21 recommendations.²⁴ For example, the task force recommended reorganizing VHA's central office around functional areas and establishing processes for regular review and revision of the VISN and VHA central office structures.

A governance task force recommendation to examine VISN staffing resulted in VHA chartering another task force, the VISN Staffing Task Force, in February 2015. In July 2015, this task force submitted a report to the DUSH for Operations and Management with recommendations for a new VISN staffing model. It included

- an option for reorganized VISN organizational structures;
- new positions focused on special populations (e.g., women's health, rural health), nursing, and communications; and
- staffing limits that would result in 95 fewer VISN full-time-equivalent staff nationally in fiscal year 2016 compared to fiscal year 2012.

In addition, VHA chartered a task force—the Integrated Project Team—in September 2015 to develop a detailed, time-limited, and organization-specific plan for, and initiate implementation of, selected recommendations from the Independent Assessment required by the Choice Act. According to the task force's charter, it was formed because, in a climate of intense public and congressional scrutiny, VHA needed to act quickly and could not afford to wait for the Commission on Care to

²⁴VHA Governance Task Force Report.

publish its recommendations, which were to incorporate the results of the Independent Assessment.

VHA Does Not Have a Process That Ensures Recommended Organizational Structure Changes Are Evaluated and Implemented

Despite several critical internal and external reviews, VHA does not have a process that ensures that recommendations resulting from these reviews are evaluated to determine appropriate actions and that any such appropriate actions are implemented. (See app. I for a table of recent internal and external reviews that examined VHA's organizational structure.) The lack of such processes is inconsistent with federal standards for internal control, which state that management should remediate identified internal control deficiencies on a timely basis.²⁵ This remediation may include evaluating the results of reviews to determine appropriate actions, and, once decisions are made, completing and documenting corrective actions on a timely basis.

We found instances where VHA task force actions in response to recent recommendations for organizational structure changes were incomplete, not documented, or not timely:

Governance task force. A senior VHA official on the task force—one of 10 senior officials who worked on the February 2015 report—told us that the Under Secretary for Health did not approve 13 of the 21 recommendations, so they would not be implemented.²⁶ Additionally, VHA officials stated that there was no documentation of the Under Secretary for Health's decisions on the recommendations because they were communicated verbally. Some of these 13 unimplemented recommendations focused on organizational structure changes that were later repeated in the Independent Assessment's recommendations.²⁷ For example, the

²⁵GAO-14-704G.

²⁶The 10-member governance task force was comprised of senior leadership from VA, VHA central office (including two ADUSH-level officials), VISNs, and VAMCs. The task force and its support staff conducted their work over 9 weeks, including one 2-day work session for the full task force and additional multiple, day-long work sessions for task force subgroups. According to the governance task force report, it was necessary for some members to meet on a nearly daily basis to ensure the task force was able to produce recommendations within its timeframes. *VHA Governance Task Force Report*.

²⁷*Independent Assessment*, Volume I.

Independent Assessment and the VHA governance task force reports both noted 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, and recommended restructuring and downsizing VHA central office. The Under Secretary for Health told us that his immediate priorities were to focus on improving access to care and hiring officials for vacant senior-level positions, and as a result he did not want to make significant changes to VHA’s organizational structure. Recommendations the Under Secretary for Health approved included those on improving the coordination and oversight of non-VA community care, restructuring the monthly meetings of VHA’s National Leadership Council, and establishing processes to develop and improve health care performance measures.

VISN Staffing Task Force. VHA officials told us that the DUSH for Operations and Management verbally communicated approval of the task force’s recommendations to change VISN staffing, which were developed over a week-long work session and incorporated input from all VISN directors.²⁸ VHA officials provided us a VISN organizational chart with revised VISN staffing limits as documentation of the DUSH’s approval, but did not provide documentation of the decision made on each task force recommendation. For example, the documentation did not include the DUSH’s decisions on the task force’s recommendations on whether larger VISNs should be allowed to establish deputy network director positions, or if certain staff positions could be shared across VISNs. It also did not include information on why one staffing model was chosen over another. Officials stated that the DUSH was responsible for implementing the new VISN staffing model, but had not developed a timeline for its implementation. VHA officials were not able to provide us with any updates on implementation and told us in May 2016 that the task force had been disbanded.

²⁸The eight-member task force included one ADUSH-level official and five VISN directors; their work session took place in April 2015. Other VISN directors not participating in the task force had the opportunity to provide input on the task force’s recommendations during an in-person meeting of all VISN directors in May 2015.

Integrated Project Team. The task force, made up of 18 senior VA and VHA officials, conducted its work over about 6 months but did not produce the detailed implementation plan of the Independent Assessment recommendations it was chartered to create, according to VHA officials.²⁹ A senior VHA official on the task force told us that the team planned to have a completed implementation plan in March 2016, and had identified senior-level VHA officials who would be responsible for ensuring implementation of the recommendations. The official also noted that the task force's work would be included in VHA's strategic planning summit in April 2016, at which point the task force would disband.³⁰ VHA officials later told us that although the Integrated Project Team developed eight topic areas that applied to the Independent Assessment's recommendations, and presented them at the strategic planning summit, they would not be moving forward with further work to develop and approve an implementation plan. In August 2016, VHA officials told us that since the strategic planning summit, they have been focused on addressing other priorities such as the Commission on Care report, proposed legislation that could affect VHA operations, and the Under Secretary for Health's five priorities for VHA.

VHA devoted significant time and effort to these different task forces, but then either did not act or acted slowly to implement recommendations. For example, all three task forces included senior officials from VHA's central office and VISNs, whose participation on the task forces created additional responsibilities beyond those related to their positions. In addition, all three sets of recommendations were available to VHA officials in 2015, but decisions on these recommendations were delayed by 6 months to 1 year after the report's completion, and in the case of the Integrated Project Team's work, decisions have not been made at all. One attribute of the federal internal control standard for timely remediation for identified deficiencies is assigning responsibility and

²⁹The team included seven ADUSH-level officials, VHA's Chief Financial Officer, and representatives from VA's offices for Information and Technology; Acquisition, Logistics, and Construction; and Human Resource Administration.

³⁰VHA held a strategic planning summit in April 2016. One of the objectives of the summit was to make decisions to guide the health care that VA provides or purchases over the following 3 years.

authority for carrying out corrective actions. The three task force charters did not require senior leadership to make decisions on the results of reviews within a certain time frame, or ensure implementation of agreed-upon recommendations. As a result, when officials retired (as did the chairs for all three task forces) or resumed their regular duties, there were no other individuals or offices responsible for ensuring that recommendations were acted on, or any documentation available to track progress made. VHA officials expressed frustration and confusion at the lack of response from central office to the findings and recommendations resulting from task forces. Without a process for ensuring that the recommendations resulting from internal and external reviews are evaluated, decisions documented, and promptly acted on, VHA will not be able to ensure that officials are accountable for taking actions that will resolve deficiencies. VHA also cannot ensure that it is making efficient use of internal resources allocated to developing and implementing recommendations.

VHA Central Office Has Provided Little Monitoring and Did Not Anticipate Challenges for a Recent and Significant Organizational Structure Change, the VISN Realignment

The VISN realignment is a significant change to VHA's organizational structure; it is the first large-scale reorganization of VISN boundaries since the VISNs were created in 1995.³¹ However, VISNs have been implementing this change with little monitoring from VHA's central office. In addition, VHA did not proactively identify and provide guidance to address challenges VISNs and VAMCs have encountered. These actions are inconsistent with federal standards for internal control concerning monitoring and risk assessment.³² Specifically, these controls state that management should establish monitoring activities, evaluate the results, and remediate identified deficiencies in a timely manner. This monitoring may include ongoing activities that are built into operations, as well as evaluations that provide feedback on the effectiveness of the monitoring and identify possible deficiencies that require corrective actions. In addition, these controls state management should identify, analyze, and respond to changes that could affect the system.

³¹A smaller-scale reorganization of VISNs occurred in 2002 when VISNs 13 and 14 were merged to create VISN 23.

³²[GAO-14-704G](#).

In October 2015, VHA began to implement a realignment of its VISN boundaries, with the goal of aligning them with MyVA regional boundaries. This involved decreasing the number of VISNs from 21 to 18 and reassigning some VAMCs to different VISNs. The governance task force evaluated several options for aligning VISN boundaries with MyVA regions and for aligning VISN boundaries better with state lines, and proposed an 18-VISN configuration. For example, the governance task force proposed reassigning West Virginia VAMCs so that they would all report to one VISN instead of four different VISNs. (See app. II for pre- and post-realignment VISN maps, and a table that shows the extent that each VISN is affected by the realignment.) VHA officials anticipate that the realignment will be completed, at the earliest, by the end of fiscal year 2018. Directors from the 15 VISNs affected by the realignment described a range of actions that needed to be completed as part of the realignment, including setting up new VISN governance structures; merging clinical and administrative functions; and assessing the operations in VAMCs that have been reassigned to a VISN to ensure they are in alignment with the VISN's practices, such as VAMCs' use of service contracts. According to VHA, the realignment is not expected to impact veterans' access to health care. For example, officials told us that the VISNs are expected to continue to honor historical geographical referral patterns for veterans—that is, to continue to refer veterans to the same VAMC or outpatient facility they were referred to prior to the realignment even if that VAMC or facility is part of a different VISN post-realignment.

VHA has provided little monitoring of VISNs' implementation efforts, and it has not provided adequate guidance in anticipation of implementation challenges. VHA chartered a task force—the VISN Realignment Workgroup—to implement the realignment across the VISNs. According to its charter, the task force is responsible for developing an implementation plan and timeline for the realignment, as well as identifying barriers and solutions to mitigate them. The task force is made up of VHA central office and VISN officials and led by the DUSH for Operations and Management and a VISN director. It meets monthly with VISNs affected by the realignment. Although these meetings provide a structure for VISN directors to share actions taken and challenges encountered in the realignment process, VHA has not taken an active role in implementing the realignment. VISN Realignment Workgroup officials told us that at the beginning of the realignment, the workgroup provided guidance in the form of a communication plan that answered frequently asked questions about the realignment's purpose, and made decisions about how the VISNs would be numbered. However, officials added that

they wanted to be facilitators, rather than directors or implementers, for the realignment, and that VISN directors were capable of implementing the realignment independently without the need for a close level of monitoring.

Directors from several VISNs affected by the realignment told us that they have made decisions independently about how to implement the realignment in their VISNs, and many also noted that they continue to face challenges with implementation, including

- **services and budgets.** Directors from 12 of the 15 VISNs affected by the realignment told us they continue to face challenges in managing services and budgets. The director of a VISN that gained a VAMC with after-hours call center services on site told us he faced an unexpected task of consolidating his VISN's existing call center services with those being provided at the VAMC. In addition, a VAMC director expressed concern about potentially having to re-start a VISN strategic planning exercise that the VAMC had participated in for 18 months because the VISN to which it had been reassigned had not done similar planning work. Finally, several VISN directors expressed concerns about how the realignment would affect their budgets, including one director who was concerned about losing a large VAMC that supplemented budget losses for other, smaller VAMCs in the VISN.
- **“double-encumbered” positions.** Six of the 15 VISNs affected by the realignment are in the process of merging, which has resulted in double-encumbered positions—two officials serving in the same position, such as two Chief Financial Officers. For example, one VISN director told us at the time of our interview (February 2016) that there were about 30 double-encumbered positions between two merging VISNs, which represented about one-third of their total staff. According to VHA, 23 positions remained double-encumbered in the merged VISN as of August 2016. Several VISN directors described challenges in resolving double-encumbered positions. For example, without authorization to offer Voluntary Separation Incentive Payments—also known as buyout authority—or specific instructions from central office, directors told us they were concerned that any actions they took (such as having officials compete for the position) would be inconsistent with other VISNs. VHA officials told us that they have been involved in helping VISNs address double-encumbered positions, such as assisting in finding staff new positions within VHA, but not all such situations had been resolved. Further, according to VHA, one merged VISN received central office approval to pursue

buyout authority, and two other merged VISNs were awaiting approval as of August 2016. VISN directors with double-encumbered staff expressed frustration at the lack of resolution of this issue and told us it has contributed to low staff morale. Double-encumbered positions were a VISN realignment challenge that VHA could have anticipated and made plans to address before the realignment started, but according to senior task force officials, the task force did not establish a subgroup on human resources until after the realignment began. As of August 2016, VHA reported there were 37 double-encumbered positions across the three merged VISNs.

- **information technology.** Six of the 15 directors from VISNs affected by the realignment told us that they continue to face information technology challenges, including having to manually reconstruct datasets to add or delete VAMCs that are still electronically associated with their former VISNs. One VISN director described difficulties in obtaining access rights to data from VAMCs that were reassigned to the VISN. Similarly, a VAMC director told us that the facility was no longer able to access its own data after changing VISNs because the data were located on their former VISN's server, requiring workarounds to gain access because there was no guidebook or plan for how to transfer VAMC data from one VISN to another.

VISN Realignment Workgroup officials told us they were aware of continued realignment challenges, but had no plans in place at the time of our review to expand their monitoring efforts to include an evaluation of the implementation of the realignment. Officials said that if they conducted an evaluation, the best time frame would be after the realignment is mostly complete because realignment actions are still in the process of being implemented. However, an evaluation may be useful to correct any identified implementation deficiencies. It can also help inform future organizational structure changes by offering VHA the opportunity to anticipate challenges and proactively provide guidance to address them. For example, the Under Secretary for Health told us he would be open to other VHA organizational structure changes in the future once he completes the process of filling vacant leadership positions within VHA.³³ In addition, the implementation of the Commission on Care

³³According to VHA, as of May 2016, there were vacancies in 4 of the 14 VHA central office senior leadership positions; 3 of the 18 VISN director positions that will exist after the realignment is complete; and 36 of the 168 total VAMC director positions.

report recommendations could result in large-scale organizational structure changes. VISN Realignment Workgroup officials told us they thought that an evaluation could also be useful for identifying any unintended consequences resulting from the realignment that bear examination.

Conclusions

VHA is aware that it is providing health care services to veterans in a time of significant scrutiny from us and others. This scrutiny comes in the wake of VHA's inability to provide timely health care services to veterans, which contributed to the placement of VA health care on our High Risk List. Although VHA has spent considerable resources—staff time and funds—on reviews and task forces that recommended improvements in its organizational structure, VHA lacks the processes needed to ensure that officials can evaluate those recommendations, document decisions, monitor and evaluate implementation, and hold staff accountable. In addition, without adequate monitoring, including a plan for evaluation, VHA cannot be certain it is effectively implementing the ongoing VISN realignment. VHA would also miss the opportunity to apply lessons learned from such an evaluation to future organizational structure changes, such as those it makes in response to the Commission on Care report's recommendations. Without processes for evaluating and implementing recommendations and actively monitoring major organizational structure changes, there is little assurance that VHA's delivery of health care to the nation's veterans will improve.

Recommendations for Executive Action

We recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following two actions:

1. Develop a process to ensure that organizational structure recommendations resulting from internal and external reviews of VHA are evaluated for implementation. This process should include the documentation of decisions and assigning officials or offices responsibility for ensuring that approved recommendations are implemented.
2. Conduct an evaluation of the implementation of the VISN realignment to determine whether deficiencies exist that need corrective actions, and apply lessons learned from the evaluation to future organizational

structure changes, such as possible changes to VISN staffing models or actions to implement Commission on Care recommendations.

Agency Comments

We provided a draft of this report to VA for comment. In its written comments, reproduced in appendix III, VA agreed with our conclusions and concurred with our recommendations. In its comments, VA stated that VHA plans to develop processes to ensure organizational structure changes are evaluated and implemented appropriately and to evaluate the implementation of the VISN realignment, with estimated completion dates for the development of these processes by March 2017 and September 2017, respectively. VA also stated that as the VISN realignment continues, VHA will strive to ensure a seamless flow of communication and execution of VHA's mission at all levels.

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies of this report to the appropriate congressional committees, the Secretary of Veterans Affairs, the Under Secretary for Health, and other interested parties. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at 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 IV.



Debra A. Draper
Director, Health Care

Appendix I: Recent External and Internal Reviews That Include an Examination of Veterans Health Administration's (VHA) Organizational Structure

Table 1: External and Internal Reviews That Include an Examination of Veterans Health Administration's (VHA) Organizational Structure, 2014-2016

Reviewer	Reason for review	Work produced and actions taken
<i>Reviews Conducted by External Entities</i>		
Centers for Medicare & Medicaid Services' Alliance to Modernize Healthcare and the Institute of Medicine ^a	The Veterans Access, Choice, and Accountability Act of 2014 (Choice Act) required the Department of Veterans Affairs (VA) to contract with a private entity to assess 12 areas of its health care delivery system and management processes, including VHA's leadership. ^b	In September 2015, the reviewers produced a report, <i>Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs</i> (Independent Assessment). ^c It made recommendations across each of the 12 areas that support the report's four systemic findings of (1) a disconnect in the alignment of demand, resources, and authorities; (2) uneven bureaucratic operations and processes; (3) non-integrated variations in clinical and business data and tools; and (4) leaders not fully empowered due to a lack of clear authority, priorities, and goals.
Commission on Care	The Choice Act established a commission to be appointed by Congressional leaders or the President to <ul style="list-style-type: none"> Evaluate, assess, and report on veterans' access to VA health care; Strategically examine how best to organize VHA, locate health resources, and deliver health care to veterans during the next 20 years; and Evaluate, assess, and report its findings on the Independent Assessment and to report any of its own recommendations for legislative or administrative action.^d 	In June 2016, the commission issued a report to the President with 18 recommendations to improve veterans' access to care and more broadly, to improve the quality and comprehensiveness of that care. ^e The Choice Act requires the President to produce, within 60 days of receiving the commission's report, a report that includes an assessment of the commission's recommendations and a description of the recommendations VHA is directed to implement. ^f
<i>Reviews Conducted by VHA Internal Task Forces</i>		
Task Force on Improving Effectiveness of VHA Governance	In December 2014, VHA chartered an internal task force to make recommendations to improve operational effectiveness and efficiency, and to align the agency to strengthen business processes.	In February 2015, the task force produced a report with 21 recommendations for improving VHA's governance structure. ^g For example, the task force recommended reorganizing VHA's central office around functional areas and establishing processes for regular review and revision of the Veterans Integrated Service Networks (VISN) and VHA central office structures. According to a VHA official, the Under Secretary for Health did not approve 13 of the 21 recommendations, but some actions were taken on other recommendations, including the task force's proposed structure for realigning the VISNs.
VISN Staffing Task Force	In February 2015, VHA chartered an internal task force to consider and recommend the appropriate mix and recommended staffing levels to effectively operate the 18 VISN structure, in response to a recommendation from the Task Force on Improving Effectiveness of VHA Governance to examine VISN staffing.	In July 2015, the task force produced a report with five recommendations for establishing a new VISN staffing model. VHA officials told us that the Deputy Under Secretary for Health for Operations and Management verbally communicated approval of the task force's recommendations, but as of May 2016, had not developed a timeline for implementation. ^h

Appendix I: Recent External and Internal Reviews That Include an Examination of Veterans Health Administration's (VHA) Organizational Structure

Reviewer	Reason for review	Work produced and actions taken
Integrated Project Team	In September 2015, VHA chartered an internal task force to develop a detailed, time-limited, and agency-specific plan for, and initiate implementation of, selected recommendations from the Independent Assessment.	According to VHA officials, the task force did not produce the detailed implementation plan of the Independent Assessment recommendations it was chartered to create. VHA officials told us that the task force developed eight topic areas that applied to the Independent Assessment's recommendations and presented them at VHA's 2016 strategic planning summit, but would not be moving forward with further work to develop and approve an implementation plan. As of August 2016, officials said they have been focused on addressing other priorities such as the Commission on Care report, proposed legislation that could affect VHA operations, and the Under Secretary for Health's five priorities for VHA.

Source: VHA. | GAO-16-803

^aVHA 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.

^bPub. L. No. 113-146, § 201(a)(1), 128 Stat. 1754, 1769 (2014).

^cCenters for Medicare & Medicaid Services' Alliance to Modernize Healthcare Federally Funded Research and Development Center, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs: Volume I: Integrated Report* (Sept. 1, 2015).

^dPub. L. No. 113-146, § 202(a)(b), 128 Stat 1773.

^eCommission on Care, *Final Report of the Commission on Care* (Washington, D.C.: June 30, 2016).

^fPub. L. No. 113-146, § 202(g)(2), 128 Stat. 1776.

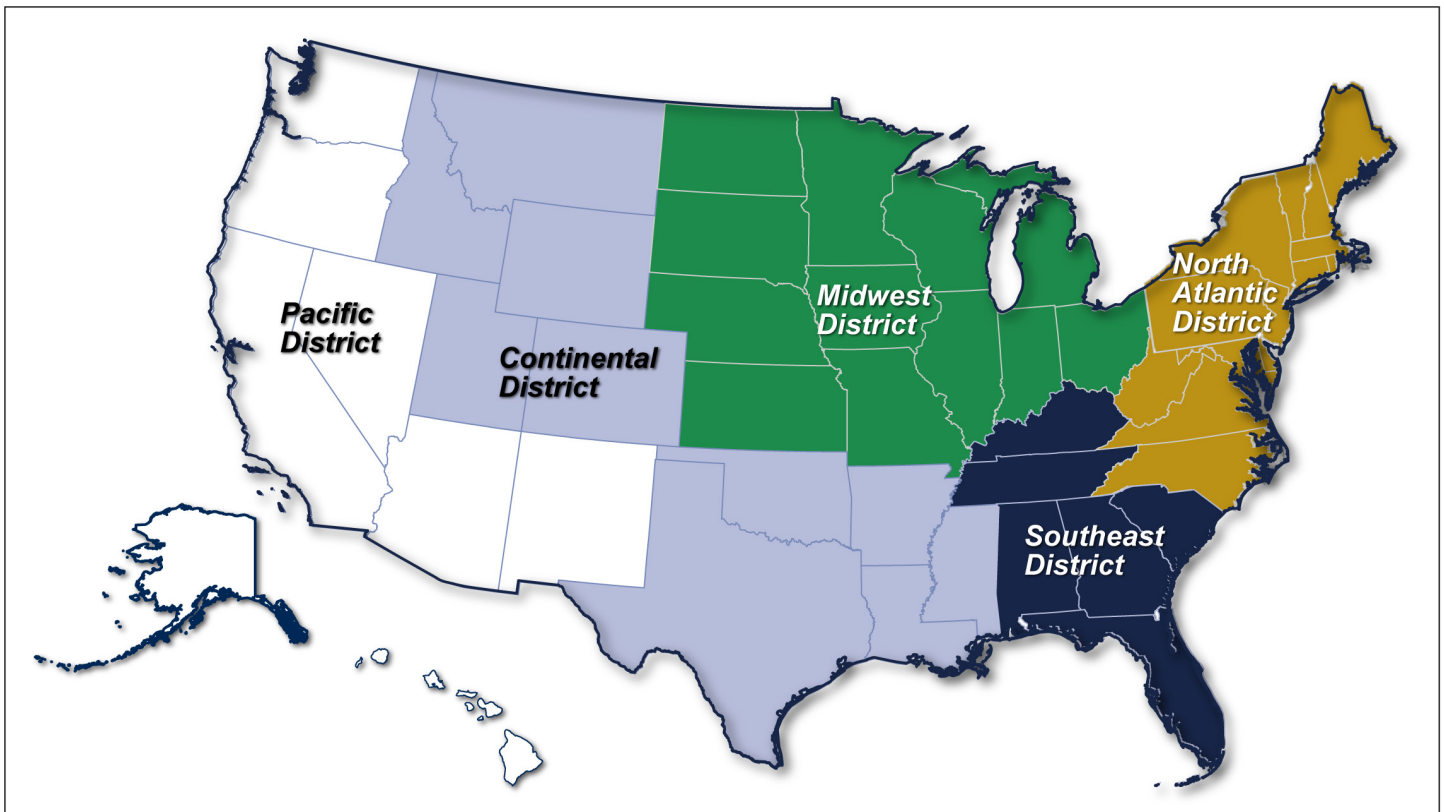
^gVHA, *Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health* (Feb. 28, 2015).

^hThe Deputy Under Secretary for Health for Operations and Management oversees VHA's field operations, comprised of VISNs that manage networks of VA medical centers and outpatient facilities.

Appendix II: Department of Veterans Affairs' (VA) MyVA Regions and the Veterans Health Administration's (VHA) Veterans Integrated Service Network (VISN) Realignment

VA announced a major organizational initiative in September 2014 called MyVA. As part of this initiative, the department established a single regional framework for its three administrations—VHA, the Veterans Benefits Administration, and the National Cemetery Administration—dividing the United States into five regions based on state boundaries.¹ (See fig. 2.)

Figure 2: Department of Veterans Affairs' (VA) MyVA Regional Map, 2015



Source: VA. Map Resources (map). | GAO-16-803

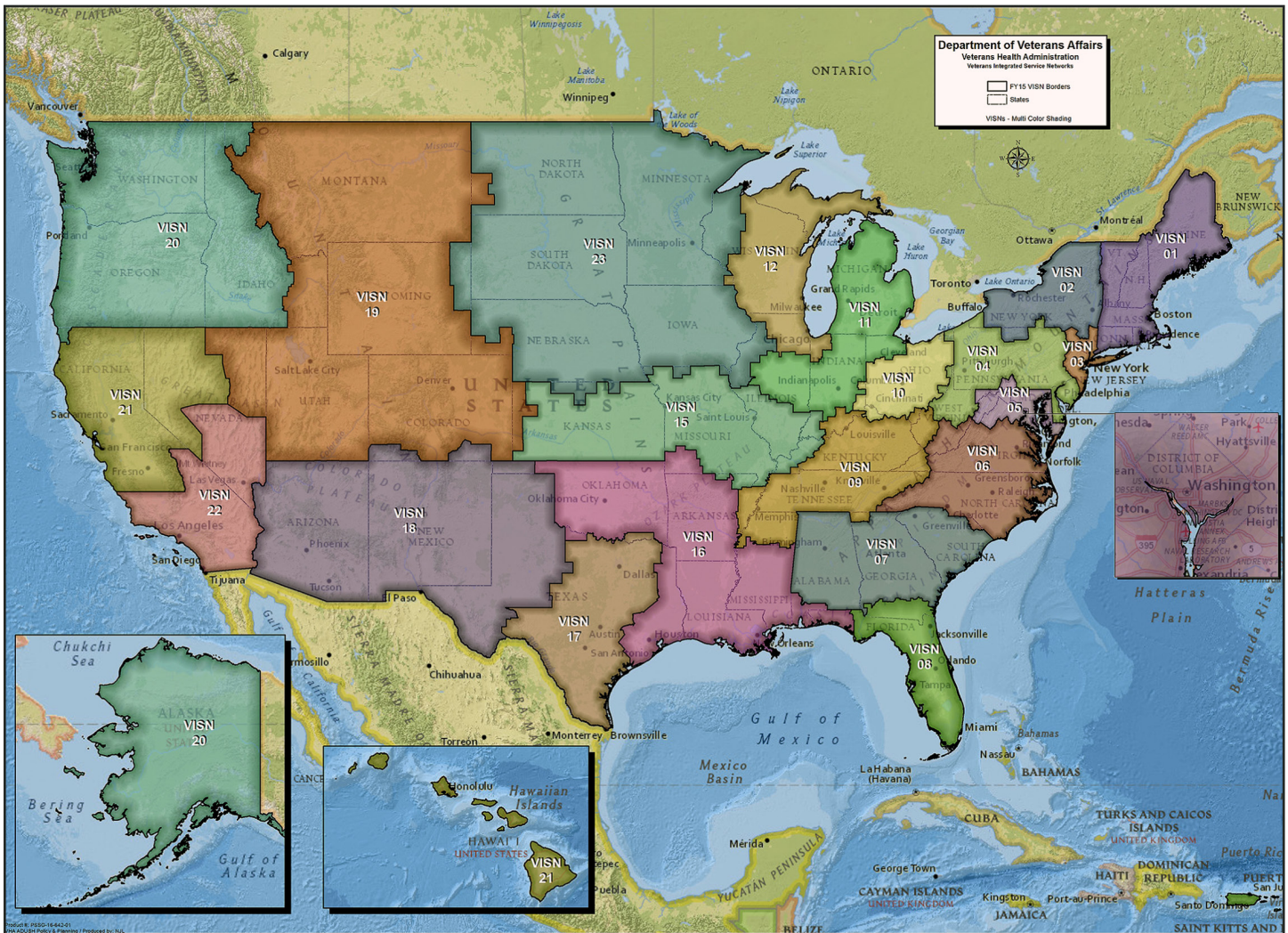
¹According to VA, the regional framework is intended to align the previously disparate organizational boundaries of VA's administrations in order to promote internal coordination and to support the rollout of a Veterans Experience office dedicated to enhancing customer service capabilities across the department.

**Appendix II: Department of Veterans Affairs'
(VA) MyVA Regions and the Veterans Health
Administration's (VHA) Veterans Integrated
Service Network (VISN) Realignment**

Following the MyVA initiative's implementation, VHA announced plans to realign, and in some cases, merge its VISNs—regional offices that oversee networks of VA medical centers (VAMC) and outpatient facilities—so that they geographically aligned with MyVA regional boundaries. (See figs. 3 and 4 for pre- and post-realignment VISN maps, respectively; and table 2 for information on the extent that each VISN is affected by the realignment.) The VISN realignment began in October 2015 and VHA officials anticipate it will be completed, at the earliest, by the end of fiscal year 2018.

Appendix II: Department of Veterans Affairs' (VA) MyVA Regions and the Veterans Health Administration's (VHA) Veterans Integrated Service Network (VISN) Realignment

Figure 3: Department of Veterans Affairs' (VA) Veterans Health Administration's (VHA) Veterans Integrated Service Network (VISN) Pre-Realignment Map, September 2015

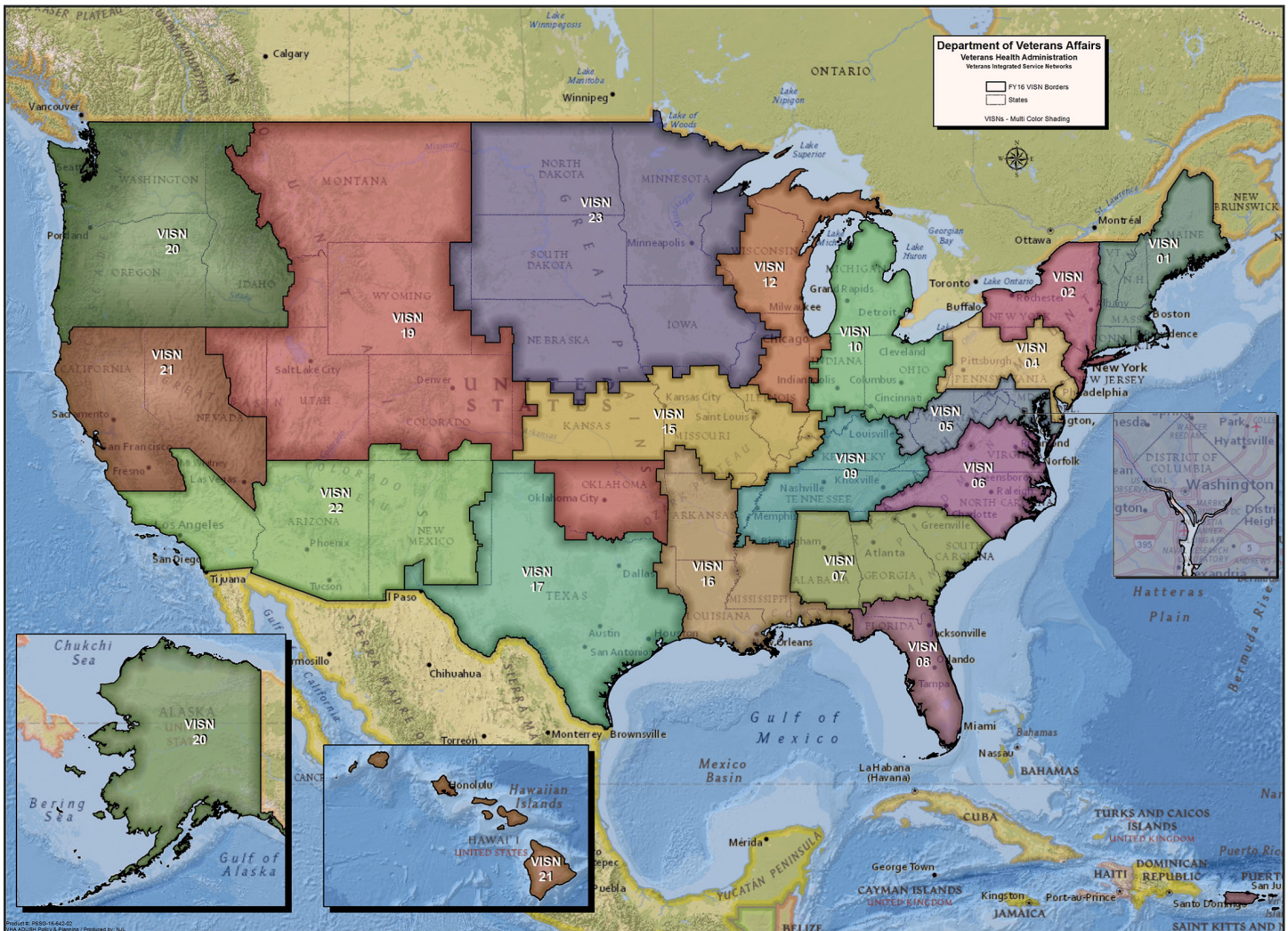


Source: VA. | GAO-16-803

Note: This map reflects the alignment of VISNs as of September 2015. In October 2015, VHA began a realignment of its VISNs—regional offices that oversee networks of VA medical centers and outpatient facilities—so that they are geographically aligned with the boundaries of five VA-established regions. VISNs are identified by numbers, which are not consecutive.

Appendix II: Department of Veterans Affairs' (VA) MyVA Regions and the Veterans Health Administration's (VHA) Veterans Integrated Service Network (VISN) Realignment

Figure 4: Department of Veterans Affairs' (VA) Veterans Health Administration's (VHA) Veterans Integrated Service Network (VISN) Map after the VISN Realignment Is Complete, Expected at the End of Fiscal Year 2018



Source: VA. | GAO-16-803

Notes: In October 2015, VHA began a realignment of its VISNs—regional offices that oversee networks of VA medical centers and outpatient facilities—so that they are geographically aligned with the boundaries of five VA-established regions. VISNs are identified by numbers, which are not consecutive.

As part of the realignment, three sets of VISNs are in the process of merging: VISNs 2 and 3; 10 and 11; and 18 and 22 (VISNs 13 and 14 were merged to create VISN 23 in 2002).

**Appendix II: Department of Veterans Affairs'
(VA) MyVA Regions and the Veterans Health
Administration's (VHA) Veterans Integrated
Service Network (VISN) Realignment**

Table 2: Veterans Integrated Service Network (VISN) Changes under the VISN Realignment, Expected at the End of Fiscal Year 2018

Pre-realignment VISN	Changes under the VISN realignment
VISN 1	Not affected
VISN 2	Gains all VISN 3 Veterans Affairs medical centers (VAMC)
VISN 3	Merges into VISN 2
VISN 4	Loses Clarksburg, WV VAMC (VISN 5)
VISN 5	Gains Clarksburg, WV (VISN 4); Beckley, WV (VISN 6); and Huntington, WV (VISN 9) VAMCs
VISN 6	Loses Beckley, WV VAMC (VISN 5)
VISN 7	Not affected
VISN 8	Not affected
VISN 9	Loses Huntington, WV VAMC (VISN 5)
VISN 10	Gains all VISN 11 VAMCs except for Danville, IL VAMC (VISN 12)
VISN 11	Merges into VISN 10
VISN 12	Gains Danville, IL VAMC (VISN 11)
VISN 15	Not affected
VISN 16	Loses Oklahoma City, OK and Muskogee, OK VAMCs (VISN 19); and Houston, TX VAMC (VISN 17)
VISN 17	Gains Amarillo, TX and El Paso, TX VAMCs (VISN 18); and Houston, TX VAMC (VISN 16)
VISN 18	Merges into VISN 22
VISN 19	Gains Oklahoma City, OK and Muskogee, OK VAMCs (VISN 16)
VISN 20	Not affected
VISN 21	Gains Las Vegas, NV VAMC (VISN 22)
VISN 22	Gains all VISN 18 VAMCs except for Amarillo, TX and El Paso, TX VAMCs (VISN 17); Loses Las Vegas, NV VAMC (VISN 21)
VISN 23	Not affected

Source: Veterans Health Administration (VHA). | GAO-16-803

Note: The VISN realignment began in October 2015. VHA officials anticipate that the VISN realignment will be completed, at the earliest, by the end of fiscal year 2018.

Some VISN borders will cross state lines and MyVA regional boundaries once the realignment is complete. VHA officials told us this reflects geographical referral patterns and the locations of outpatient clinics, which can be across state lines from their associated VAMCs. VHA officials told us that the VISNs are expected to continue to honor historical geographical referral patterns for veterans—that is, to continue to refer veterans to the same VAMC or outpatient facility they were referred to prior to the realignment even if that VAMC or facility is part of a different VISN post-realignment.

Appendix III: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

September 7, 2016

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

Dear Ms. Draper:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, "**VA HEALTH CARE: Processes to Evaluate, Implement, and Monitor Organizational Structure Changes Needed**" (GAO-16-803). VA agrees with GAO's conclusions and concurs with GAO's recommendations to the Department.

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

VA appreciates the opportunity to comment on your draft report.

Sincerely,

A handwritten signature in black ink that reads "Gina S. Farrissee".

Gina S. Farrissee
Deputy Chief of Staff

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***“VA HEALTH CARE: Processes to Evaluate, Implement, and Monitor
Organizational Structure Changes Needed”***
(GAO-16-803)

GAO Recommendation: GAO recommends that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following two actions:

Recommendation 1: Develop a process to ensure that organizational structure recommendations resulting from internal and external reviews of VHA are evaluated for implementation. This process should include the documentation of decisions and assigning officials or offices responsibility for ensuring that approved recommendations are implemented.

VA Comments: Concur. This recommendation is related to High Risk Area 1 (ambiguous policies and inconsistent processes). The Veterans Health Administration (VHA) will develop a consistent process to ensure that organizational structure changes are evaluated and implemented appropriately.

VHA's Office of Workforce Management and Consulting (WMC) will develop a structured, methodical process to assess the implementation progress and outcomes of organizational structural recommendations. VHA has undertaken recent structural changes to improve system responsiveness and oversight, including the development of organizations and programs responsible for organizational excellence and care in the community and the realignment of the Veterans Integrated Service Networks (VISN) and VA medical centers.

WMC will review existing practices for optimal organization design, approval, implementation, and evaluation. This effort will build upon transformative activities already underway, including MyVA. WMC will ensure appropriate administrative functions are integrated into reorganization efforts, and that the organization evaluation process is fully documented and approved by VHA leadership. The status is in process and the target completion date is March 2017.

Recommendation 2: Conduct an evaluation of the implementation of the VISN realignment to determine whether deficiencies exist that need corrective actions, and apply lessons learned from the evaluation to future organizational structure changes, such as possible changes to VISN staffing models or actions to implement Commission on Care recommendations.

VA Comments: Concur. This recommendation is related to High Risk Area 2 (inadequate oversight and accountability). By evaluating the implementation of the VISN realignment, VHA will ensure proper oversight and make corrections where necessary.

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***“VA HEALTH CARE: Processes to Evaluate, Implement, and Monitor
Organizational Structure Changes Needed”***
(GAO-16-803)

VHA’s WMC will evaluate the implementation of the VISN realignment to include the identification of deficiencies for correction, lessons learned, and potential changes to the VISN staffing models. The VISN Realignment Workgroup has been monitoring the implementation progress of various local realignment activities and will continue to make changes to the overall implementation plan based on conditions in the field. WMC will begin evaluation as the realignment activities near completion. At this point in time, several realignment processes and activities are in the beginning stages of implementation and too immature for evaluation. As the implementation activities near completion in fiscal year 2017, WMC will be better positioned to evaluate the effectiveness and efficiency of the VISN realignment processes. The status is in process and the target completion date is September 2017.

General Comments:

On January 26, 2015, VA announced that it was taking the first steps under the MyVA initiative to realign its many organizational maps into one map with five districts to better serve Veterans. As part of this Department-wide realignment, VHA began aligning existing VISN’s with the five Department level districts. This realignment is resulting in the consolidation of certain VISNs and the redistribution of some facilities to new VISNs.

VA is working to reorganize the Department for success, guided by ideas and initiatives from Veterans, employees, and all of our shareholders. This reorganization is a part of the MyVA initiative and is designed to provide Veterans with a seamless, integrated, and responsive customer service experience.

VHA has been carefully executing the VISN realignment, and assessing the results for both best practices and for lessons learned in support of future efforts. VHA has made considerable progress in consolidating VISNs 2 and 3, and VISNs 10 and 11. VHA currently has 19 VISNs, and will have 18 by the end of fiscal year 2017.

As the ongoing VISN realignment continues, VHA will integrate the VISN process with the overall VHA processes for organizational analysis and redesign. VHA will strive for a seamless flow of organization analysis and change – connecting the field, VISN and Central Office organizational structures into a coherent model that enables the flow of communication and mission execution at all levels.

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

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***“VA HEALTH CARE: Processes to Evaluate, Implement, and Monitor
Organizational Structure Changes Needed”***
(GAO-16-803)

develop critical actions. VHA is dedicated to sustained improvement in the high risk areas.

The content in this report applies to high risk areas 1 (ambiguous policies and inconsistent processes) and 2 (inadequate oversight and accountability). VHA recognizes the value of a structured, methodical approach to optimal organization design. VHA is integrating existing activities and expertise to ensure a focused effort; leading to an enhanced process for organization design and approval in fiscal year 2017.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Debra A. Draper, (202) 512-7114 or draperd@gao.gov.

Staff Acknowledgments

In addition to the contact named above, Janina Austin, Assistant Director; Malissa G. Winograd, Analyst-in-Charge; Amanda Cherrin; and Amanda Pusey made key contributions to this report. Also contributing were Jennie F. Apter, George Bogart, Muriel Brown, and Jacquelyn Hamilton.

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