



January 2017

FEDERAL HEALTH CARE CENTER

VA and DOD Need to Develop Better Information to Monitor Operations and Improve Efficiency

Accessible Version

GAO Highlights

Highlights of [GAO-17-197](#), a report to congressional committees

Why GAO Did This Study

The National Defense Authorization Act for Fiscal Year 2010 (NDAA 2010) authorized VA and DOD to establish a 5-year demonstration to integrate their medical facilities in North Chicago, Ill. The NDAA 2010 also required VA and DOD to submit a report of their evaluation of the demonstration and their recommendation as to whether it should continue operating as a fully integrated facility after 5 years. In July 2016, VA and DOD submitted a report to Congress recommending that the FHCC continue operating as an integrated facility.

The NDAA 2015 included a provision for GAO to assess VA and DOD's evaluation to Congress. In this report, GAO assesses VA and DOD's approach for evaluating the FHCC and making the determination to continue operating it as an integrated facility. To do this, GAO reviewed the report to Congress and relevant supporting documents, and interviewed officials about the evaluation. In analyzing the evaluation, GAO used as criteria its prior work on planning practices, evaluating physical infrastructure, and management consolidation initiatives, as well as the Office of Management and Budget's (OMB) capital programming guide.

What GAO Recommends

GAO recommends that the Secretaries of VA and DOD collaborate to establish time frames and interim milestones for tracking the implementation of the jointly recommended improvements and to conduct a cost-effectiveness analysis for the FHCC. VA and DOD concurred with GAO's recommendations.

View [GAO-17-197](#). For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

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VA and DOD Need to Develop Better Information to Monitor Operations and Improve Efficiency

What GAO Found

The Department of Veterans Affairs (VA) and the Department of Defense's (DOD) evaluation to determine whether the Captain James A. Lovell Federal Health Care Center (FHCC) should continue operating as an integrated facility or revert to a "joint venture" included conducting both separate and joint reviews. As an integrated facility, the FHCC has a unified governance structure, workforce, and budget. As a joint venture, the departments would continue sharing medical facility space, but would manage their operations with separate governance structures, workforces, and budgets. VA and DOD's joint review team concluded that converting the FHCC to a joint venture was not advisable or achievable because the Navy hospital had been demolished and money to replace it was used to expand the VA facility. In addition, returning the civilian employees from VA's to DOD's personnel system would require complex negotiations that could result in job reclassifications and salary changes. As a result, officials recommended continuing the FHCC as an integrated facility with the implementation of specific recommended improvements with the caveat that no similar integration efforts be undertaken until they "get it right" at the FHCC.

In the report to Congress, VA and DOD outlined 17 recommended improvements for the FHCC but did not include time frames for implementing them. As GAO has previously reported, leading practices for planning call for results-oriented organizations to develop plans that provide tools to assure accountability, such as time frames and interim milestones that could be used to monitor progress, hold staff accountable for achieving desired results, and make mid-course corrections, if needed. Although officials routinely track each improvement through twice monthly meetings, and use a spreadsheet to monitor status and next steps, they have not specified time frames and interim milestones. Without this information, officials cannot ensure that they will implement the recommended improvements in a timely and efficient manner.

The letter that accompanied the report to Congress stated that the FHCC's costs were "very high" and not in keeping with the initial goal of delivering more cost-effective health care. VA and DOD officials told GAO that this statement was based on their contractor's evaluation of the facility, which found that the FHCC was not more cost-effective than a joint venture. Officials told GAO that their contractor's analyses used cost data that ended in fiscal year 2014, and since that time, the FHCC has made improvements they believe would positively impact cost savings. However, officials said that they did not have sufficient time for the contractor to update the analysis after receiving the contractor's report in September 2015, and that one additional year of data would not likely have changed their conclusions or recommendations. According to OMB's capital programming guide, at many key decision points, a cost-effectiveness analysis of operations would be useful to help make decisions. Without an updated cost-effectiveness analysis for the FHCC, officials will not have a baseline from which to measure and track the FHCC's future efficiency, including the effect of the recommended improvements, once implemented.

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Abbreviations

DOD	Department of Defense
FHCC	Captain James A. Lovell Federal Health Care Center
IT	information technology
MTF	Military Treatment Facility
NDAA	National Defense Authorization Act
OMB	Office of Management and Budget
VA	Department of Veterans Affairs

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January 23, 2017

Congressional Committees:

In October 2010, the Departments of Veterans Affairs (VA) and Defense (DOD) expanded their efforts to share health care resources through a 5-year demonstration to more fully integrate their medical facilities in North Chicago, Ill. As authorized by the National Defense Authorization Act for Fiscal Year 2010 (NDAA 2010), VA and Navy facilities in North Chicago were integrated into a first-of-its-kind facility known as the Captain James A. Lovell Federal Health Care Center (FHCC). The 5-year demonstration was intended to create a national model for the joint delivery of health care that would be more accessible and less expensive than operating two federal medical centers serving VA and DOD beneficiaries in the same area.¹ It was also expected to inform decision makers about whether this model of care would be effective if replicated at other VA and DOD locations.

The Secretaries of VA, DOD, and the Navy signed an Executive Agreement, effective October 1, 2010, which defined the departments' roles in operating and overseeing the FHCC and outlined requirements in specific "integration areas," such as governance, workforce management, and facility operations, including information technology (IT).² According to the agreement, the FHCC was intended to meet the health care missions of both departments—including DOD's operational readiness mission—by integrating services previously provided by the former North Chicago VA Medical Center and the Naval Health Clinic Great Lakes into

¹VA beneficiaries include veterans of military service and certain dependents and survivors. DOD beneficiaries include active duty servicemembers (including Navy recruits) and their dependents, medically eligible National Guard and Reserve servicemembers and their dependents, and military retirees and their dependents and survivors. Active duty personnel also include Reserve members on active duty for at least 30 days. Military retirees are dually eligible for both VA and DOD benefits.

²The NDAA 2010 authorized the Secretaries of VA and Defense to execute an Executive Agreement to combine medical facilities. Pub. L. No. 111-84, § 1701(a), 123 Stat. 2190, 2567 (2009).

a single facility.³ The agreement also specified that the FHCC was designed to improve the access, quality, and cost-effectiveness of care, while providing FHCC leadership with the ability to adopt the most efficient of the clinical and administrative processes used by VA and DOD.

The NDAA 2010, as amended by the NDAA for Fiscal Year 2012, included a provision for us to assess and report on the departments' progress in implementing the Executive Agreement and the effects of the Executive Agreement on the provision of care and operation of the facility at specified times.⁴ We issued reports in response to this provision in 2011, 2012, and 2016.⁵ Overall, we found that although the departments had made progress in implementing areas of the Executive Agreement, difficulties with the integration still remained in areas such as IT and workforce planning. As a result, we made a number of recommendations to the departments. (See appendix I for an outline of the status of those recommendations.)

The NDAA 2010 also required the departments to submit a report to the appropriate committees of Congress no later than 180 days after 5 years of executing the Executive Agreement (or by March 2016), to include a comprehensive evaluation of the demonstration and a recommendation as to whether the FHCC should continue as a fully integrated facility.⁶ To

³ DOD's operational readiness mission includes ensuring that Navy recruits are medically ready to accomplish military duties and deployments and ensuring that active duty providers develop and maintain clinical skills necessary to serve at military treatment facilities and in combat environments.

⁴ NDAA 2010—Pub. L. No. 111-84, § 1701(e), 123 Stat. 2190, 2568 (2009)—required GAO to report annually beginning one year after the Executive Agreement was executed; NDAA for Fiscal Year 2012—Pub. L. No. 112-81, § 1098, 125 Stat. 1298, 1609 (2011)—amended that reporting requirement to include two more reports, resulting in GAO reports in 2011, 2012, and 2016.

⁵ GAO, *VA and DOD Health Care: First Federal Health Care Center Established, but Implementation Concerns Need to Be Addressed*, [GAO-11-570](#) (Washington, D.C.: July 19, 2011); GAO, *VA/DOD Federal Health Care Center: Costly Information Technology Delays Continue and Evaluation Plan Lacking*, [GAO-12-669](#) (Washington, D.C.: June 26, 2012); and GAO, *Federal Health Care Center: VA and DOD Need to Address Ongoing Difficulties and Better Prepare for Future Integrations*, [GAO-16-280](#) (Washington, D.C.: Feb. 29, 2016).

⁶ See Pub. L. No. 111-84, § 1701(d)(2), 123 Stat. 2190, 2568 (2009).

address this requirement, VA and DOD submitted a report of their evaluation to Congress in July 2016. In the letter that accompanied the report to Congress, the departments recommended maintaining the FHCC as an integrated facility with periodic reviews and the implementation of specific recommended improvements. The departments also stated that they would not recommend any similar demonstration projects until they “get it right” at the FHCC.

The Carl Levin and Howard P. “Buck” McKeon National Defense Authorization Act for Fiscal Year 2015 (NDAA 2015) included a provision for us to assess the departments’ evaluation for Congress on the FHCC.⁷ In this report, we examine VA and DOD’s approach for evaluating the FHCC and making the determination to continue operating it as an integrated facility.

To address our objective, we reviewed VA and DOD’s report to Congress, including the documents departmental officials reviewed and created in preparing their report. We interviewed VA, DOD, and FHCC officials to obtain information on their methodologies, including how they selected and assessed specific areas of the FHCC and how they identified the recommended improvements. We also spoke with these officials about the implementation of the recommended improvements that were outlined in the report to Congress and reviewed documents related to these efforts. Finally, we assessed the extent to which VA and DOD’s methodology aligned with our identified best practices for planning, the Office of Management and Budget’s (OMB) capital programming guide, and our previous work on evaluating physical infrastructure and management consolidation initiatives.⁸

⁷ Pub. L. No. 113-291, § 1413, 128 Stat. 3292, 3609-3610 (2014).

⁸ In past reports, we have identified best practices in planning. For example, see GAO, *Combating Terrorism: Evaluation of Selected Characteristics in National Strategies Related to Terrorism*, [GAO-04-408T](#) (Washington, D.C.: Feb. 3, 2004) and GAO, *Social Security Disability: Additional Performance Measures and Better Cost Estimates Could Help Improve SSA’s Efforts to Eliminate Its Hearings Backlog*, [GAO-09-398](#) (Washington, D.C.: Sept. 9, 2009); and GAO, *Streamlining Government: Questions to Consider When Evaluating Proposals to Consolidate Physical Infrastructure and Management Functions*, [GAO-12-542](#) (Washington, D.C.: May. 2012). See also Office of Management and Budget, *Capital Programming Guide, Supplement to Office of Management Budget Circular A-11, Planning, Budgeting, and Acquisition of Capital Assets*. (Washington, D.C.: 2015).

We conducted this performance audit from December 2015 to January 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

Although VA and DOD have shared resources at some level since the 1980s, the FHCC is the first integrated health care center with a unified governance structure, workforce, and budget.⁹ In fiscal year 2015, the FHCC provided care to about 100,000 patients at a total cost of \$474 million.

The Executive Agreement, signed by the Secretaries of VA, DOD, and the Navy, defines the departments' sharing relationship at the FHCC and contains key provisions to be met in 12 integration areas. (See table 1 for the key provisions in the Executive Agreement.)

Table 1: Twelve Executive Agreement Integration Areas for the Captain James A. Lovell Federal Health Care Center (FHCC)

Executive Agreement integration area	Key provisions
Governance structure	FHCC leadership structure and advisory bodies
Access to health care at FHCC	Patient priority system and eligibility of members of the uniformed services for care
Research	Institutional Review Board approval and policy for the protection of human subjects
Contracting	Department of Veterans Affairs (VA) and Defense (DOD) responsibility for contracting support
Quality assurance	Accreditation and oversight from external entities and credentialing and privileging of health care providers
Contingency planning	Emergency and disaster management and security
Integration benchmarks	Completion of 15 integration benchmarks may occur before 2015

⁹The Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act was enacted in 1982. See 38 U.S.C. § 8111. The Department of Veterans Affairs was previously known as the Veterans Administration.

Workforce management and personnel	Staffing, training, and the transfer of DOD civilian personnel to VA
Property	Construction, transfer of property, and physical plant management
Reporting requirements	VA and DOD reports to congressional committees and Comptroller General reviews
Fiscal authority	Budgeting, joint funding authority, and reconciliation
Information technology (IT)	Administrative and clinical IT, including efforts to achieve interoperability between VA and DOD systems

Source: GAO analysis of FHCC and DOD Information | GAO 17-197

According to the governance structure established in the Executive Agreement, the FHCC is accountable to both VA and DOD, with VA serving as the lead department. The FHCC director, a VA executive, is accountable to VA for the fulfillment of the FHCC mission, while the deputy director, a Navy Captain who rotates approximately every 2 years, is accountable to the Navy and, ultimately, DOD.

Also in accordance with the Executive Agreement, staff from the Naval Health Clinic Great Lakes and the North Chicago VA Medical Center merged to create a single, joint workforce. This included the transfer of DOD civilian staff employed by the Department of the Navy to VA's personnel system. As of November 2016, the FHCC's workforce included approximately 3482 civilian, active duty, and contract staff. Civilians comprised 69 percent (about 2396) of the facility's overall workforce, while 26 percent (about 907) were active duty servicemembers, and 5 percent (about 179) were contract staff.

The NDAA 2010 established the Joint DOD-VA Medical Facility Demonstration Fund (Joint Fund) as the funding mechanism for the FHCC, with VA and DOD both making transfers to the Joint Fund from their respective appropriations. As authorized in the NDAA 2010, the Executive Agreement requires a financial reconciliation process that permits VA and DOD to identify their contributions to the Joint Fund each year. These contribution proportions are determined based on the proportion of shared care provided by each department, as well as the amount each department spent for mission-specific services provided to its beneficiaries.

**VA and DOD’s
Evaluation of the
FHCC Involved
Multiple Reviews, but
Had No Time Frames
for Implementing
Recommended
Improvements or an
Updated Cost-
Effectiveness
Analysis**

VA and DOD’s approach for evaluating the FHCC involved both separate and joint reviews that included the identification of recommended improvements in their report to Congress. However, the report did not include time frames for implementing these improvements. Additionally, although the departments acknowledged the “very high” costs of operating the FHCC, there was no updated cost-effectiveness analysis included that would provide a baseline for measuring efficiency.

**VA and DOD’s Evaluation
of the FHCC Included
Both Separate and Joint
Reviews**

VA and DOD’s approach for evaluating the FHCC included conducting both separate and joint reviews to determine whether it should continue operating as an integrated facility with a unified governance structure, workforce, and budget or revert to a “joint venture.” Under a joint venture arrangement, the departments would continue sharing medical facility space, but would manage their operations with separate governance structures, staff, and budgets.¹⁰

VA and DOD initially conducted separate reviews of the FHCC with their own subject matter teams. VA established 9 subject matter teams that began their reviews in August 2015, and DOD established 11 subject matter teams that began their reviews in June 2015. Officials told us that the issues selected for review by the subject matter teams were based on the functional areas of the FHCC, the Executive Agreement, and requirements in the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (NDAA 2009) that provided guidelines for

¹⁰“Joint ventures” are joint efforts to construct or share medical facilities that focus on mutual benefit and shared risk and may include collaboration in providing multiple health care services as well as joint operations in specific clinical areas.

establishing the demonstration.¹¹ According to officials, each team reviewed the following documents:

- the FHCC evaluation conducted by VA and DOD's contractor,¹²
- the FHCC IT evaluation conducted by the Veterans Health Administration Product Effectiveness group,¹³
- and other relevant reports, including reviews by GAO and the Institute of Medicine, as well as the mission and purpose of the facility.¹⁴

Based on their assessments, each team was asked to recommend whether the FHCC should continue as an integrated facility or revert to a joint venture. While the majority of VA's teams recommended that the FHCC should continue operating as an integrated facility, the DOD/Navy teams did not have an overall consensus. (See table 2.) According to a Navy official, the teams' recommendations were prioritized based on DOD's determination of the importance of their particular area. Specifically, recommendations of the governance and budget teams were given a higher priority than the other subject matter teams. As a result,

¹¹While the NDAA 2010 authorized the demonstration, the NDAA 2009 provided guidelines to the departments for planning the demonstration. See Pub. L. No. 110-417, § 706, 122 Stat. 4356, 4500 (2008).

¹²In its September 2015 report, the departments' contractor, Knowesis, found that the overall benefits resulting from the FHCC demonstration project were not inherently superior to those that could be achieved by a joint venture. The report stated that continuation of the FHCC as an integrated facility was feasible if the departments implemented its recommendations, as well as the recommendations identified in the 2012 Institute of Medicine report (see Institute of Medicine, *Evaluation of the Lovell Federal Health Care Center Merger: Findings, Conclusions, and Recommendations* (Washington, D.C.: National Academies Press, 2012)). The departments paid Knowesis approximately \$3 million for this evaluation.

¹³ The Veterans Health Administration Product Effectiveness evaluation assessed the effectiveness of the joint-funded IT components, identified challenges and unintended consequences of the common services Information Management/Information Technology model implemented at the FHCC, and provided VA and DOD leadership with information for improved decision making in future integrated endeavors. The report found that the demonstration at FHCC had not shown evidence of efficient or cost-effective operations on a consistent basis.

¹⁴[GAO-11-570](#), [GAO-12-669](#), and [GAO-16-280](#). *IOM. Evaluation of the Lovell FHCC* (2012).

their recommendations to continue operating the FHCC as an integrated facility had more weight in DOD's final determination.

Table 2: Department of Veterans Affairs (VA) and Department of Defense (DOD) Subject Matter Teams' Recommendations on Whether the Captain James A. Lovell Federal Health Care Center (FHCC) Should Continue Operating as an Integrated Facility

Subject Matter Teams' Recommendations for the FHCC			
Teams	Continue as an Integrated Facility	Remained Neutral	Revert to a Joint Venture
VA Teams			
Governance	Yes	No	No
Acquisition and Contracting	No	Yes	No
Manpower	Yes	No	No
Quality Assurance ^a	Yes	No	No
Budget	Yes	No	No
Education and Training	Yes	No	No
Facilities	No	Yes	No
Business Operations ^b	Yes	No	No
Clinical Informatics ^c	Yes	No	No
DOD Teams			
Governance	Yes	No	No
Acquisition and Contracting	No	No	Yes
Manpower	No	Yes	No
Quality Assurance	No	Yes	No
Budget	Yes	No	No
Education and Training	No	No	Yes
Facilities	No	No	Yes
Information Technology ^b	No	Yes	No
Credentialing and Privileging ^a	No	Yes	No
Active Duty Personnel ^d	No	Yes	No
Medical Readiness ^d	No	Yes	No

Source: GAO Analysis | GAO-17-197

Note: While the subject matter teams addressed all 12 integration areas of the Executive Agreement, there was not a separate team for each area.

^aVA officials told us that they discussed the issue of credentialing within their quality assurance team, whereas DOD established two separate teams, one for quality assurance, and one for credentialing and privileging.

^bVA officials told us that the business operations team discussed billing, reimbursement, and disability evaluations.

^cVA officials told us that they established a clinical informatics team to review the use of information technology.

^dActive duty personnel and medical readiness are DOD-specific issues that VA did not address.

VA and DOD officials met jointly in October 2015 to determine the future of the FHCC. They reviewed the work of the subject matter teams, including the teams' recommendations related to whether the FHCC should continue operating as an integrated facility as well as specific improvements the teams recommended implementing if the FHCC continued to operate as an integrated facility. They also studied the implications of either operating the FHCC as an integrated facility or converting it to a joint venture, and concluded that the latter was not advisable or achievable for two main reasons:

- The former Naval Hospital Great Lakes had been demolished, and funding for the replacement facility was used to expand the former North Chicago VA Medical Center as part of the demonstration.
- Returning all or some of the 470 civilian employees from VA to DOD's personnel system would require complex negotiations and could result in job reclassifications and salary changes.

As a result, the departments jointly recommended continuing the FHCC as an integrated facility with periodic reviews and the implementation of 17 recommended improvements that had been identified by the subject matter teams¹⁵ (See table 3.)

¹⁵Most of the recommended improvements are clearly linked to the team's area of expertise with the exception of pharmacy and performance metrics. According to DOD officials, pharmacy was discussed by their acquisitions and contracting team and performance metrics was not discussed in any of their teams. According to VA officials, pharmacy was discussed in their clinical informatics team and performance metrics was discussed in their quality assurance team.

Table 3: Department of Veterans Affairs (VA) and Department of Defense (DOD) Recommended Improvements to the Captain James A. Lovell Federal Health Care Center (FHCC) by Functional Area

Functional Area	Recommended Improvement
Governance	1) Revise the reporting structure to make it less burdensome for local FHCC leadership ^a
	2) Conduct an extensive review and revision of the Executive Agreement and associated executive decision memoranda with the goal of reducing redundancies and clarifying interagency governance roles, responsibilities, and activities, as well as conflict resolution procedures.
	3) Conduct a review to minimize or eliminate duplicate VA and DOD reporting policies and procedures at FHCC.
	4) Revise the FHCC's Advisory Board charter to re-define its evolved role of a more high-level, monitoring, and decision-focused body. ^b
Acquisitions & Logistics	5) Continue to identify ways to make logistics and facilities management operations more efficient and effective.
Manpower	6) Jointly conduct a total force review (review of total staff) to validate the FHCC manpower requirements and revise the relevant VA and DOD documents accordingly.
Quality Assurance	7) Develop a detailed quality assurance executive decision memorandum that outlines a timely quality assurance inquiry review and response process between VA and DOD.
Budget/Funding	8) Explore options to develop a performance-based budget—leveraging the work in performance reporting and metrics (see 15 and 16 below)—to optimize cost efficiency and productivity.
	9) Continue efforts to develop an automated budget reconciliation tool (an information technology tool to help VA and DOD reconcile the budget in a timely manner).
	10) Explore options for the best future funding mechanism.
Education & Training	11) Undertake a staffing study to optimize the FHCC workforce and address patient volume and workload
	12) Improve involvement with the clinical resident and student programs to provide a richer learning environment.
Military Readiness	13) Implement a plan to optimize the use of military staff by establishing and monitoring military clinical currency measures (measures on clinical staff in order to ensure the maintenance of skills), increasing clinical opportunities both internally and through external partnerships, establishing specific guidelines for enhanced utilization of corpsmen (Navy servicemembers), and eliminating duplicate VA and DOD training requirements.
Information Management/Information Technology (IT)	14) Review “Plans of Actions” and milestones developed by VA and DOD to perform a gap analysis (an analysis to identify gaps in the IT systems) and make recommendations to improve the IT model in both its current and future states.
Performance Reporting and Metrics	15) Continue integration/normalization of VA and DOD data and develop meaningful metrics for use by FHCC leaders and managers.
	16) Provide data to support development of a performance-based budget.
Pharmacy	17) Continue to improve pharmacy formulary and drug pricing processes.

Source: GAO Analysis | GAO-17-197

^aThe current reporting structure requires that the FHCC report to its Veteran Integrated Service Network as a VA facility, as well as to the Navy, the FHCC Advisory Board, and the VA/DOD Health Executive Committee/Joint Executive Committee. The Health Executive and Joint Executive Committees are groups that help VA and DOD plan and carry out joint efforts.

^bThe FHCC's Advisory Board is responsible for ensuring that the VA and DOD missions are met by monitoring the FHCC and handling issues that are not resolved at the local level. It is co-chaired by representatives of both departments and meets on at least a quarterly basis to discuss the FHCC's progress and recommendations.

VA and DOD Did Not Provide Time Frames for Implementing the Recommended Improvements for the FHCC in Their Report to Congress

Although the departments' report to Congress outlined a number of recommended improvements for the FHCC as part of their decision to continue operating it as an integrated facility, the report did not include time frames for implementing them. VA and DOD officials have been routinely tracking each of the recommended improvements through meetings held twice monthly, and have developed a spreadsheet that includes information on status and next steps.¹⁶ However, officials have not identified time frames as part of their routine tracking efforts. As we have previously reported, leading practices for organizational planning call for results-oriented organizations to develop comprehensive plans that provide tools to ensure accountability, among other things.¹⁷

Although officials have defined goals and identified activities for implementing the recommended improvements, the lack of time frames and interim milestones suggests they do not have all of the tools needed to ensure accountability. Time frames and interim milestones could be used to monitor progress, hold staff accountable for achieving desired results, and make mid-course corrections, if needed. DOD officials acknowledged that although a majority of the recommended improvements do not have this information, the timing for implementing some improvements is outside their control, such as approval and funding for IT enhancements. (See recommended improvement 14 in table 3.) Additionally, according to these officials, the recommendation to conduct an extensive review and revision of the FHCC Executive Agreement and associated executive decision memoranda to reduce redundancies will be

¹⁶Officials also said that they are tracking the status of the recommendations from our most recent report on the FHCC. [GAO-16-280](#).

¹⁷In past reports, we have identified best practices in planning. For example, see [GAO-04-408T](#) and [GAO-09-398](#). To identify these best practices, we consulted numerous sources, including the Government Performance and Results Act of 1993, general literature on strategic planning and performance, and guidance from the Office of Management and Budget. See also, [GAO-14-704G](#) and [GAO/AIMD-00-21.3.1](#).

a monumental undertaking, and until this review is under way, officials will not know how much time will be needed to complete these efforts. (See recommended improvement 2 in table 3.) Furthermore, DOD officials informed us that two of the recommended improvements do have time frames, although this is not reflected in the tracking spreadsheet. Specifically, DOD officials stated that the joint staffing study has a completion goal of February 2017, and the proposal for future funding for the FHCC is due to be presented at the April 2017 Advisory Board meeting.¹⁸ (See recommended improvements 6 and 10, respectively, in table 3.) Both VA and DOD officials told us that they believe their current tracking efforts of the recommended improvements are sufficient. However, without time frames and interim milestones for most of the recommended improvements, VA and DOD officials are unable to ensure that these improvements will be implemented in a timely and efficient manner.

Despite Acknowledging the Demonstration's High Costs, VA and DOD Did Not Include an Updated Cost-Effectiveness Analysis of the FHCC in Their Report to Congress

In the letter that accompanied the report to Congress, both departments acknowledged that the costs associated with the demonstration project were "very high" and not in keeping with the initial goal of delivering more cost-effective health care. The letter further noted that the increased costs were due, in part, to the departments' inability to appropriately downsize staff, as well as efforts to integrate their separate information systems.¹⁹ VA and DOD officials informed us that their statement about the high costs of the FHCC was based on the FHCC evaluation conducted by their contractor, Knowesis, which was referenced as an appendix in their report to Congress. Specifically, the contractor found that integration was not more cost-effective than a joint venture and that the FHCC was not

¹⁸The Advisory Board is responsible for ensuring that the VA and DOD missions are met by monitoring the FHCC and handling issues that are not resolved at the local level. It is co-chaired by representatives of both departments and meets on at least a quarterly basis to discuss the FHCC's progress and recommendations.

¹⁹Officials told us that this referred to separate electronic health record systems.

consistently performing as well as the separate VA and Navy facilities were before integration.²⁰

The contractor's analyses of the FHCC's cost-effectiveness used cost data that ended in fiscal year 2014. Since that time, the FHCC has had a change in leadership and has made additional improvements that VA and DOD officials believe would positively impact cost-savings. Consequently, VA and DOD officials informed us that they considered asking the contractor to update its analyses, but ultimately decided against it due to time constraints and the need to enter into a new contract as the prior one had expired. Officials also noted that although the FHCC's costs had decreased, another analysis with one additional year of data would likely not have changed the contractor's conclusions or recommendations.

In addition, VA and DOD officials stated that they did not have sufficient time to conduct their own analysis with updated cost data to include in the report to Congress after receiving the contractor's final report in September 2015. Instead, officials told us they discussed the increase in costs that would occur if the integrated facility was converted into a joint venture, which would result in the establishment of duplicative services that would be less efficient than the current arrangement. For example, officials said that the facility would need to have two infection control programs and two credentialing programs that would have to be staffed accordingly, resulting in additional costs.

According to OMB's capital programming guide, at many key decision points, a cost-benefit or cost-effectiveness analysis of operations would be useful to help make decisions.²¹ Additionally, based on our prior work on evaluating physical infrastructure and management consolidation initiatives, the goals and likely costs and benefits of a consolidation are

²⁰Prior to the establishment of the FHCC in February 2009, VA and DOD had conducted a cost-benefit analysis and found significant savings, including the potential for \$19.7 million savings in operating costs and an avoidance of \$67 million as a one-time construction cost. However, the departments' contractor, Knowesis, did not discuss this initial analysis in its report.

²¹Office of Management and Budget, *Capital Programming Guide, Supplement to Office of Management Budget Circular A-11, Planning, Budgeting, and Acquisition of Capital Assets*. (Washington, D.C.: 2015).

key questions to consider.²² Without an updated cost-effectiveness analysis, VA and DOD do not know the extent to which they are achieving their initial goal of delivering more cost-effective health care. Such an analysis would provide a baseline from which to measure and track the FHCC's future efficiency, including the effect of the recommended improvements, once implemented. It may also help facilitate the identification of any additional improvements and inform other future efforts to integrate VA and DOD facilities.

Conclusions

VA and DOD's recommendation to continue operating the FHCC as an integrated facility acknowledged the shortcomings and high costs of the demonstration and recommended not initiating similar efforts until they are able to "get it right." However, despite the departments' recommended improvements to overcome these shortcomings, deficiencies in monitoring and accountability may impede their ability to improve future operations and ensure cost efficiency. Specifically, the lack of time frames and interim milestones limits the departments' efforts to ensure the timely and efficient implementation of their recommended improvements. Additionally, without an updated cost-effectiveness analysis, the departments lack the necessary information to know to what extent they are achieving their original goal of more cost-effective care, as well as whether their recommended improvements are contributing to this goal. Until these deficiencies are addressed, the departments cannot assure whether they will actually "get it right" at the FHCC, and whether this integrated model of care could or should be replicated in the future.

Recommendations for Executive Action

We recommend that the Secretaries of Veterans Affairs and Defense collaborate to take the following actions:

- develop time frames and interim milestones for tracking and implementing each of their jointly developed recommended improvements; and
- conduct a cost-effectiveness analysis for the FHCC to establish a baseline for measuring the facility's efficiency over time.

²²GAO, *Streamlining Government: Questions to Consider When Evaluating Proposals to Consolidate Physical Infrastructure and Management Functions*, [GAO-12-542](#) (Washington, D.C.: May 2012).

Agency Comments

VA and DOD each provided written comments on a draft of this report. In their comments, both departments concurred with our recommendations. In VA's written comments, reproduced in appendix II, VA provided additional information related to implementing each of our recommendations. Specifically, VA stated that the Veterans Health Administration would work jointly with DOD to develop time frames and milestones for the recommended improvements with a target completion date of April 2017. VA also stated that FHCC officials are working with both departments to define a methodology to conduct a cost-effectiveness analysis using existing FHCC data. Once a methodology has been defined, VA stated that FHCC officials will work with both departments to complete the analysis with a target completion date of June 2018. DOD's written comments, reproduced in appendix III, did not provide any additional information about implementing our recommendations. DOD also provided technical comments that we incorporated, as appropriate.

We are sending copies of this report to the Secretary of Defense, Secretary of Veterans Affairs, and appropriate congressional committees. In addition, the report will be available at no charge on GAO's 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 Office of Congressional Relations and Office of Public Affairs can be found on the last page of this report. Other major contributors to this report are listed in appendix IV.



Debra A. Draper
Director, Health Care

List of Committees

Chairman
Ranking Member
Committee on Armed Services
United States Senate

Chairman
Ranking Member
Committee on Veterans' Affairs
United States Senate

Chairman
Ranking Member
Committee on Armed Services
House of Representatives

Chairman
Ranking Member
Committee on Veterans' Affairs
House of Representatives

Appendix I: Status of Prior GAO Recommendations

The Captain James A. Lovell Federal Health Care Center’s (FHCC) Executive Agreement defines the sharing relationship and roles of the Department of Veterans Affairs (VA) and Department of Defense (DOD) and contains key provisions to be met in 12 integration areas. In 2011 and 2012, we reported on the implementation status of the FHCC’s Executive Agreement integration areas and made a number of recommendations.¹ Additionally, in 2016, we reported on the ongoing difficulties that continued at the FHCC and made additional recommendations.² See table 4 for our previous recommendations and the status of their implementation.

Table 4: Status of Prior GAO Recommendations Related to the Captain James A. Lovell Federal Health Care Center (FHCC), as of November 2016

Recommendations from	Agency concurrence	Status
VA and DOD Health Care: First Federal Health Care Center Established, but Implementation Concerns Need to Be Addressed, GAO-11-570 (Washington, D.C.: July 19, 2011)		
The Secretary of Defense should seek a legislative change to designate the FHCC as a military treatment facility (MTF).	DOD disagreed with the recommendation to pursue an MTF designation for the FHCC ^a	Closed – not implemented
The Secretaries of Veterans Affairs and Defense should direct FHCC leadership to conduct further evaluation of the scorecard reporting tool and its methodology and make revisions that will better ensure the transparency and accuracy of the information reported.	General concurrence	Closed – implemented
Recommendations from		
VA/DOD Federal Health Care Center: Costly Information Delays Continue and Evaluation Plan Lacking, GAO-12-669 (Washington, D.C.: June 26, 2012)		
The Secretaries of Veterans Affairs and Defense should determine the costs associated with the workarounds required because of delayed information technology (IT) capabilities at the FHCC for each year of the demonstration, including the costs of hiring additional staff and of managing the administrative burden caused by the workarounds.	General concurrence	Closed – implemented

¹See GAO, *VA and DOD Health Care: First Federal Health Care Center Established, but Implementation Concerns Need to Be Addressed*, [GAO-11-570](#) (Washington, D.C.: July 19, 2011), and GAO, *VA/DOD Federal Health Care Center: Costly Information Delays Continue and Evaluation Plan Lacking*, [GAO-12-669](#) (Washington, D.C.: June 26, 2012).

²GAO, *Federal Health Care Center: VA and DOD Need to Address Ongoing Difficulties and Better Prepare for Future Integrations*, [GAO-16-280](#) (Washington, D.C.: February 29, 2016).

**Appendix I: Status of Prior GAO
Recommendations**

The Secretaries of Veterans Affairs and Defense should develop plans with clear definitions and specific deliverables, including time frames for two IT capabilities—documentation of patient care to support medical and dental operational readiness and outpatient appointment enhancements—and formalize these plans, for example, by incorporating them into the Executive Agreement.	General concurrence, however agencies did not agree that formalization should be incorporated in the Executive Agreement	Open
The Secretaries of Veterans Affairs and Defense should expeditiously develop and agree to an evaluation plan, including the performance measures and standards, such as target scores, to be used to evaluate the FHCC demonstration, and formalize the plan, for example, by incorporating it into the Executive Agreement.	General concurrence, however agencies did not agree that formalization should be incorporated in the Executive Agreement	Closed – implemented
The Secretaries of Veterans Affairs and Defense should establish measures related to the cost-effectiveness of the FHCC’s care and operations to be included as a part of the evaluation plan.	General concurrence	Closed – implemented
Recommendations from <i>Federal Health Care Center: VA and DOD Need to Address Ongoing Difficulties and Better Prepare for Future Integrations</i>, GAO-16-280 (Washington, D.C.: February 29, 2016)		
The Secretaries of Veterans Affairs and Defense should collaborate to establish FHCC-specific selection criteria for the FHCC facility director and deputy director positions that include responsibilities and leadership competencies for effective collaboration.	General concurrence	Open
The Secretaries of Veterans Affairs and Defense should collaborate to ensure that the evaluation of the leadership performance at the FHCC is carried out jointly between VA and DOD.	General concurrence	Open
The Secretaries of Veterans Affairs and Defense should collaborate to perform data-driven strategic workforce planning prior to implementing any future integration efforts.	General concurrence	Open
The Secretaries of Veterans Affairs and Defense should collaborate to determine how best to fill the FHCC’s short-term staffing needs, including any additional statutory authorities that might be necessary to implement the desired approach.	General concurrence	Open
The Secretaries of Veterans Affairs and Defense should collaborate to resolve differences in IT network security standards to the extent possible prior to implementing any future integration efforts.	General concurrence	Open
The Secretary of Veterans Affairs should take steps to ensure that the FHCC is able to systematically monitor the reasons for referrals to non-VA medical care.	General concurrence	Closed-implemented
The Secretaries of Veterans Affairs and Defense should direct FHCC leadership to provide routine training to civilian managers, who supervise active duty staff on the West Campus, on how to effectively utilize such staff, particularly Navy hospital corpsmen.	General concurrence	Open
The Secretaries of Veterans Affairs and Defense should direct FHCC leadership to provide additional guidance on the patient priority system to all staff responsible for approving consults and ensure that the monthly capability and capacity reports include information on all categories of FHCC patients defined by the patient priority system.	General concurrence	Open

Source: GAO. | GAO-17-197

**Appendix I: Status of Prior GAO
Recommendations**

^a According to DOD officials, as the FHCC stabilized and matured, the confusion due to the lack of an MTF designation would diminish. Additionally, officials told us that an MTF designation would introduce additional operational requirements and challenges to the FHCC, including financial management and quality assurance requirements, which would outweigh the benefits associated with such a designation.

Appendix II: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

December 21, 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, "**FEDERAL HEALTH CARE CENTER: VA and DOD Need to Develop Better Information to Monitor Operations and Improve Efficiency**" (GAO-17-197).

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

VA appreciates the opportunity to comment on your draft report.

Sincerely,

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

Gina S. Farrisee
Deputy Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***“FEDERAL HEALTH CARE CENTER: VA and DOD Need to Develop Better
Information to Monitor Operations and Improve Efficiency”***
(GAO-17-197)

General Comments:

The Captain James A. Lovell Federal Health Care Center (JALFHCC) five-year demonstration project provided the Department of Veterans Affairs (VA) and Department of Defense (DoD) with a unique opportunity to create an integrated healthcare facility serving both Veterans and military beneficiaries.

Our learning has been iterative over the past five years as we sorted through duplicative and, at times, disparate processes, policies and statutory requirements. Under current legislative authorities, we were unable to create a facility that would operate under a single line of authority. Instead, we had to create duplicative governance systems which, in turn, led to an overly complex oversight and reporting structure with multiple standards and reporting requirements.

The costs associated with this demonstration project were very high and not in keeping with our initial goal to deliver more cost-effective healthcare. Part of the increased costs was due to the inability to appropriately downsize facility staff. Other high operating costs were due to efforts to integrate information systems at JALFHCC.

We believe health resource sharing between DoD and VA is a vital part of both our health systems and we wholeheartedly support continuing the JALFHCC demonstration project as a unique optimally integrated facility. Furthermore, it is essential to continue to provide health services, including inpatient capability, for the Navy Recruit Training Command at Great Lakes, to ensure a medically ready force.

However, we have more work to do to realize our vision of an integrated facility designed to improve access, quality and the cost effectiveness of healthcare delivery to our Veterans and military beneficiaries.

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***"FEDERAL HEALTH CARE CENTER: VA and DOD Need to Develop Better
Information to Monitor Operations and Improve Efficiency"***
(GAO-17-197)

GAO Recommendation: GAO recommends that the Secretaries of Veterans Affairs and Defense collaborate to take the following actions:

Recommendation 1: Develop time frames and interim milestones for tracking and implementing each of their jointly developed recommended improvements.

VA Comment: Concur. This recommendation is related to High Risk Area 2 (inadequate oversight and accountability).

The Veterans Health Administration (VHA) will work jointly with the Department of Defense (DOD) to develop time frames and milestones for tracking and implementing recommended improvements. The status is in progress and the target completion date is April 2017.

Recommendation 2: Conduct a cost-effectiveness analysis for the FHCC to establish a baseline for measuring the facility's efficiency over time.

VA Comment: Concur. This recommendation is related to High Risk Area 2 (inadequate oversight and accountability).

The Captain James A. Lovell Federal Health Care Center (JALFHCC) is in the process of working with VA and DoD to define the methodology to conduct a cost-effectiveness analysis using existing JALFHCC data. The initial analysis will establish a baseline for measuring the facility's efficiency over time. Once the methodology is defined, the site will work jointly with the agencies to conduct the analysis. The status is in progress and the target completion date is June 2018.

Appendix III: Comments from the Department of Defense



HEALTH AFFAIRS

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, DC 20301-1200

DEC 21 2016

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

Dear Ms. Draper:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) Draft Report, GAO-17-197, 'FEDERAL HEALTH CARE CENTER: VA and DOD Need to Develop Better Information to Monitor Operations and Improve Efficiency,' dated November 21, 2016 (GAO Code 100493).

Thank you for the opportunity to review the GAO #17-197 (GAO Code 100493) draft report. I concur with the report's findings and conclusions. My specific comments to the report's recommendations are attached, as well as technical comments to the draft report.

Again, thank you for your informative review and the opportunity to comment on the draft report. Thank you for your interest in the health and well-being of our Service members, Veterans, and their families.

My points of contact are Ms. Sylvia Farias (703) 275-6067 or via email at sylvia.n.farias.civ@mail.mil and Ms. Joyce Forrest (Audit Liaison) at (703) 681-6741 or via email at joyce.forrest2.civ@mail.mil.

Sincerely,

A handwritten signature in blue ink, appearing to read "Karen S. Guice".

Karen S. Guice, M.D., M.P.P.
Principal Deputy, Performing the Duties of the
Assistant Secretary of Defense for Health
Affairs

Attachments:
As stated

GAO DRAFT REPORT DATED November 21, 2016
GAO-17-197 (GAO CODE 100493)

**“FEDERAL HEALTH CARE CENTER: VA and DOD Need to Develop Better
Information to Monitor Operations and Improve Efficiency”**

**DEPARTMENT OF DEFENSE COMMENTS
TO THE GAO RECOMMENDATIONS**

RECOMMENDATION: GAO recommends that the Secretaries of Veterans Affairs and Defense develop time frames and interim milestones for tracking and implementing each of their jointly developed recommended improvements.

DoD RESPONSE: DoD concurs with this recommendation.

RECOMMENDATION: GAO recommends that the Secretaries of Veterans Affairs and Defense conduct a cost-effectiveness analysis for the Federal Health Care Center (FHCC) to establish a baseline for measuring the facility’s efficiency over time.

DoD RESPONSE: DoD concurs with this recommendation.

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, Bonnie Anderson, Assistant Director; Danielle Bernstein, Analyst-in-Charge; Jennie Apter; and Linda Galib made key contributions to this report. Also contributing were Jacquelyn Hamilton and David Wise.

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