



June 2019

VA REAL PROPERTY

Improvements in Facility Planning Needed to Ensure VA Meets Changes in Veterans' Needs and Expectations

Accessible Version

GAO Highlights

Highlights of [GAO-19-440](#), a report to congressional requesters

Why GAO Did This Study

VA provides for care to over 9-million veterans in its health care system, including 172 VAMCs. As veterans' demographics shift, such as by age or gender, their needs for health care and their expectations for how they receive that care may also change. Along with the VA MISSION Act of 2018, which requires VA to assess its facilities for realignment and modernization, these changes could have implications for VA's capital-planning efforts.

GAO was asked to review how VA incorporates veterans' changing needs and expectations into facility planning. This report examines: (1) VA's efforts to assess trends in veterans' future needs and expectations; (2) VA's efforts to help VAMCs address these changes through facility planning; and (3) how VAMCs use VA's process for identifying facilities' future space needs.

GAO surveyed all VAMCs, visited nine VAMCs, reviewed VA's planning documents and data, and interviewed officials from VA and veterans service organizations. GAO's survey response rate was 99 percent.

What GAO Recommends

GAO recommends VA: (1) assess changes in veterans' expectations; (2) instruct facility planners on how to incorporate veterans' changing needs and expectations; (3) clarify foundational health services implementation; and (4) assess concerns with the SCIP process and make needed adjustments. VA agreed with GAO's recommendations.

View [GAO-19-440](#). For more information, contact Andrew Von Ah at (202) 512-2834 or vonaha@gao.gov, or Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

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What GAO Found

The Department of Veterans Affairs (VA) analyzes demographic trends to assess veterans' future health-care needs, such as the need for more long-term care or women's health care services. VA does not, however, systematically collect data concerning whether demographic groups differ in their expectations for how they will receive care, such as whether some groups expect different levels of privacy. VA officials said they gauge expectations by surveying veterans and talking to veterans service organizations. GAO's review, however, found the amount of information VA collected through these methods is limited. Without robust data about veterans' expectations and assessing how changes would affect facilities' space needs, VA cannot readily anticipate and adapt to meet veterans' changing expectations—a goal in its *FY 2018–2024 Strategic Plan*.

In addition to identifying meeting veterans' changing needs and expectations as a national strategic goal, VA defined a national set of VA-delivered core medical services called "foundational health services" to, in part, meet veterans' expectations of consistent care offerings across VA medical centers (VAMC) and also to focus VA's resources on its highest priority services. However, based on GAO's survey of VAMCs and discussions with selected facility-planning officials, GAO found that VA did not clearly instruct VAMCs in how to apply VA's strategic goal or foundational health services to facility planning. Accordingly, more than three quarters of VAMC facility-planning officials responding to GAO's survey indicated additional instruction from VA for the strategic goal and foundational health services would be useful. Without providing clear instruction, VA increases its risk that its strategic goal and foundational health services are not meeting their objective to incorporate veterans' changing needs and expectations.

Most facility-planning officials had concerns with using estimated space needs derived from VA's Strategic Capital Investment Planning (SCIP) process, which converts estimated needs for veterans' health care into future space needs for the VAMCs. Specifically, the officials (1) did not understand how the SCIP process converts health care needs into physical space and (2) questioned how accurately the space estimates reflected the future health-care needs for local facilities. For example, 72 percent of facility-planning officials responding to GAO's survey reported that at least one of SCIP's 12 space category estimates was "generally inaccurate" at reflecting projected space needs for their facility. As a result, instead of relying on SCIP's space estimates as a starting point to incorporate veterans' changing needs into facility planning, VAMC facility planners told GAO that they may instead use locally identified health care needs and priorities to determine space needs. Without a process for VA to understand and address concerns about the SCIP process, VAMCs may spend time and resources on capital projects that do not necessarily meet veterans' future needs as VA intended. This approach may therefore impede VA's ability to respond to veterans needs as this population changes.

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Abbreviations

SCIP	Strategic Capital Investment Planning
VA	Department of Veterans Affairs
VAMC	VA medical center
VetPop2016	Veteran Population Projection Model 2016
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSO	veterans service organization

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June 13, 2019

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

The Honorable Jerry Moran
United States Senate

The Department of Veterans Affairs (VA) operates one of the largest health care systems in the country. VA provides for care at 172 VA medical centers (VAMC) and 1,069 outpatient sites to over 9 million veterans enrolled in the VA health care program.¹ VA provides medical services to various veteran populations, including an aging veteran population and a growing number of younger veterans returning from military operations in Afghanistan and Iraq. These and other demographic shifts in the population served by VA are expected to drive changes in veterans' needs for care and in their expectations for how their care will be delivered. These changes will have implications for VA's capital-planning efforts that are primarily undertaken by the VAMCs, and can take 4–9 years to complete.² This is in addition to recent requirements under the VA MISSION Act of 2018 for VA to establish criteria for

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

²In 2013, GAO reported on four major construction projects for VAMCs, noting that the estimated time frames for completion were between 4 and 9 years without any delays. According to VA, the estimated completion dates are from the initial budget prospectus, which assumed receipt of all requested construction funding within 1 to 2 years after the budget submission. See GAO, *VA Construction: Additional Actions Needed to Decrease Delays and Lower Costs of Major Medical-Facility Projects*, [GAO-13-302](#) (Washington, D.C.: Apr. 4, 2013).

assessing and making recommendations on the modernization and realignment of VA facilities.³

The need for VA to align its capital planning to veterans' changing demographics, and the resultant changes in their needs and expectations, is related to two high-risk areas GAO identified. One is veterans' health care, which has had systemic and persistent problems with timeliness, cost-effectiveness, quality, and safety of the care that veterans receive.⁴ The other is federal real property management, which includes VA's management of its real property assets—including the effective disposal of excess and underutilized VA property.⁵

You asked us to review issues related to how VA incorporates changing veterans' needs and expectations into facility planning. In this report, we examine:

1. The extent to which VA assesses trends in veterans' future needs and expectations.
2. VA's efforts to help VAMCs address veterans' changing needs and expectations in their facility planning.

³The criteria shall include the preferences of veterans regarding health care furnished by VA. An independent commission, the Asset and Infrastructure Review Commission, will review and analyze VA's recommendations and report its findings and conclusions to the President. VA MISSION Act of 2018. Pub. L. No. 115-182, tit. II, § 203, 132 Stat. 1393, _ (2018).

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. See, for example, GAO, *VA Health Care: Actions Needed to Improve Oversight of Community-Based Outpatient Clinics*, [GAO-18-375](#) (Washington, D.C.: Apr. 12, 2018) and GAO, *VA Health Care: Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns*, [GAO-18-63](#) (Washington, D.C.: Nov. 15 2017). See also, for example, Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration, Comprehensive Healthcare Inspection Program Review of the Washington DC VA Medical Center*, Report No. 17-01757-50 (Washington, D.C.: Jan. 28, 2019) and VA, *Veterans Health Administration, Patient and Radiation Safety Concerns at the John D. Dingell VA Medical Center, Detroit, Michigan*, Report No. 18-02210-19 (Washington, D.C.: Nov. 27, 2018).

⁵See GAO, *High-Risk Series: Federal Real Property*, [GAO-03-122](#) (Washington, D.C.: January 2003) and GAO, *VA Real Property: Clear Procedures and Improved Data Collection Could Facilitate Property Disposals*, [GAO-19-148](#) (Washington, D.C.: Jan. 9, 2019).

3. How VAMCs use VA's planning process for identifying future need for space in VA's facilities to address veterans' changing needs in facility planning.

To address these objectives, we reviewed relevant laws, regulations, policies, and VA's planning documents and interviewed officials from VA and a broad range of national veterans' service organizations (VSO). To obtain local perspectives on the objectives, we surveyed those officials who are responsible for planning and making facility-planning decisions (hereafter referred to as "facility-planning officials") at all VAMCs across the country. The survey addressed VA's efforts to assess trends in veterans' needs and expectations and incorporate the information in facility planning, and VA's Strategic Capital Investment Planning (SCIP) process. We administered our web-based survey between November 2018 and January 2019 and received a 99 percent response rate.⁶ See appendix I for more information about our methodology and appendix II for the survey questions and summarized responses. For more detailed information to supplement the survey, we visited a nongeneralizable sample of nine VAMCs located in four Veterans Integrated Service Networks (VISN) in August 2018 and September 2018.⁷ We chose the nine VAMCs because they had relatively high future-space needs based on fiscal year 2019 data from VA's SCIP process and geographic proximity to each other. We interviewed facility-planning officials at both the VISN and VAMC levels to discuss facility-planning resources, tools, and policies, and reviewed relevant documentation provided by these officials. Even though we visited nine VAMCs, we only met with eight

⁶We received responses from 137 of the 139 facility-planning officials, representing 159 of the 162 VAMCs. Although there are 172 VAMCs, a VA official who oversees SCIP told us that VA combines several VAMC's SCIP space gap estimates as part of the SCIP planning process. As a result, VA attributes SCIP data to 162 VAMCs.

⁷VA organizes its system of care into regional networks called VISNs. Each VISN is responsible for managing and overseeing VA medical centers within a defined geographic area. We met with the planning officials at VISN 5 (District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia), VISN 6 (North Carolina and Virginia), VISN 8 (Florida, Georgia, Puerto Rico, and the U.S. Virgin Islands), and VISN 17 (Texas).

groups of facility-planning officials because two of the VAMCs share a common set of facility-planning officials.⁸

To determine the extent to which VA assesses trends in veterans' needs and expectations, we reviewed documentation of the Enrollee Health Care Projection Model—a VA model for estimating the amount of resources VA needs to meet the expected demand for most of the health care services it provides—and interviewed officials at VHA's Office of Policy and Planning who oversee the model to discuss projections of veterans' populations and trends.⁹ We reviewed the model's documentation related to its purpose and structure and interviewed relevant officials, and determined that the data from the Enrollee Health Care Projection Model were sufficiently reliable for our audit objectives.¹⁰ We also coordinated with VHA officials and relevant VAMC officials to identify 127 surveys that VA had been administering. In reviewing survey titles and coordinating with relevant survey points of contact, we narrowed down the 127 surveys to a list of 14 surveys by identifying those that could (1) potentially help VA understand veterans' needs and/or expectations in facility planning and (2) be attributed to different veteran population demographics (e.g., gender, age, race, etc.). We then reviewed these 14 survey instruments to determine the extent to which they included measures that specifically asked about veterans' expectations. Further, we compared VA's efforts to assess trends in veterans' needs and expectations to federal standards for internal control for use of quality information and relevant control activities.¹¹

To identify what national efforts VA has initiated to help VAMCs address veterans' changing needs and expectations in facility planning, we

⁸Two of the VAMCs we visited, the Baltimore VAMC and Perry Point VAMC, are part of the VA Maryland Healthcare System and, as a result, have the same facility-planning officials. In many areas of the country, several medical centers and clinics may work together to offer services to area veterans as a health care system. According to VA, by sharing services between or among medical centers, the aim is for VHA to provide veterans easier access to advanced medical care closer to their homes.

⁹The Enrollee Health Care Projection Model was developed in 1998 by VA and its consultant. It helps supports the development of VA's budget estimates for health care and informs strategic and capital planning.

¹⁰A review of the underlying assumptions of the Enrollee Health Care Projection Model and the accuracy of model projections was outside the scope of this review.

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

reviewed VA documents and interviewed VA officials. To obtain local perspectives on these efforts, we spoke with the facility-planning officials at each of the VISNs and VAMCs from our nine site visits and included questions about VA's instructions to VAMCs to implement these efforts in our national survey of facility planners. Further, we compared VA's national efforts to federal standards for internal control for communicating internally and relevant control activities.¹²

To determine how facility-planning officials at VAMCs use VA's process for identifying future facilities' space needs to address veterans' changing needs and expectations in their facility planning, we used information collected from our survey and interviews with facility-planning officials at VISNs and VAMCs. We also analyzed variation in SCIP's 10-year estimates of facilities' space needs for all VAMCs across 4 years of SCIP data (SCIP fiscal years 2017, 2018, 2019, and 2020 estimates).¹³ To assess the reliability of these data, we

- performed electronic testing of relevant data elements,
- reviewed existing information about the data and the system that produced them, and
- interviewed agency officials knowledgeable about the data.

We determined that these data were sufficiently reliable for presenting the estimates across the 4-year period. Further, we compared how VAMCs are using VA space estimates in their facility planning to federal standards for internal control for use of quality information and relevant control activities.¹⁴

We conducted this performance audit from April 2018 to June 2019 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

¹²See [GAO-14-704G](#).

¹³A given fiscal year's SCIP data are based on information collected 4 years prior. For example, SCIP data for fiscal year 2020 are based on information collected in fiscal year 2016, while SCIP data for fiscal year 2019 are based on information collected in fiscal year 2015.

¹⁴See [GAO-14-704G](#).

conclusions based on our audit objectives. Further details on our scope and methodology can be found in appendix I.

Background

VA's Organization

VA's mission is to serve America's veterans, and one of the ways it accomplishes this mission is by providing veterans with medical services. In general, veterans must enroll in VA health care to receive VA's medical benefits package—a set of services that includes a full range of hospital and outpatient services, prescription drugs, and long-term care services. In addition to care provided at VA medical facilities, veterans may also obtain services from non-VA providers in the community—known as community care—through one of several community-care programs aimed at helping ensure veterans receive timely and accessible care. The VA MISSION Act of 2018 has introduced new eligibility criteria that could lead veterans to make increased use of community care, which may in turn affect veteran's future needs and expectations.¹⁵

VHA is responsible for overseeing the delivery of care to enrolled veterans, as well as overseeing the health care professionals and support staff who deliver that care. VHA is also responsible for managing all VA medical facilities across 18 regional networks, known as VISNs, which are structured to manage and allocate resources to VA's health care facilities. Each VISN is also responsible for the coordination and oversight of all administrative and clinical activities within its specified region of the country.

VA's Projection Models and Health Care Planning

VA's FY 2018–2024 Strategic Plan calls for VA to continuously adapt its benefits and health care offerings to meet veterans' changing needs and expectations.¹⁶ VA expects that veterans' health care needs and expectations will change due to changes in veteran demographics, and VA uses several models to estimate these demographic changes. One of

¹⁵VA MISSION Act of 2018. Pub. L. No. 115-182, tit. I, 132 Stat. 1393 (2018).

¹⁶See Department of Veterans Affairs, *FY 2018–2024 Strategic Plan* (February 2018).

these models is VetPop2016, which estimates the number and key demographic characteristics of the total veterans' population—such as age, gender, period of service, and race/ethnicity—over the next 30 years. Another model that VA uses to estimate future veteran demographic characteristics is the Enrollee Health Care Projection Model—which VA told us was updated almost annually. Based on a set of assumptions, including future enrollee demographics, this model estimates the number of enrolled veterans, as well as the extent to which they will rely on VA health care and utilize services over the next 20 years.¹⁷ As part of its health care planning, the Enrollee Health Care Projection Model makes a number of adjustments to projections for VA's health care services to account for the characteristics of VA health care and enrolled veterans. For example, the Enrollee Health Care Projection Model includes adjustments to account for enrollees' reliance on VA health care; in other words, the extent to which enrolled veterans choose to access health care services through VA instead of obtaining services through the community. Additionally, the Enrollee Health Care Projection Model includes adjustments to incorporate the age, gender, priority level, and geographic location of enrolled veterans. The information obtained from VA's health care planning is relevant to VA's capital planning.

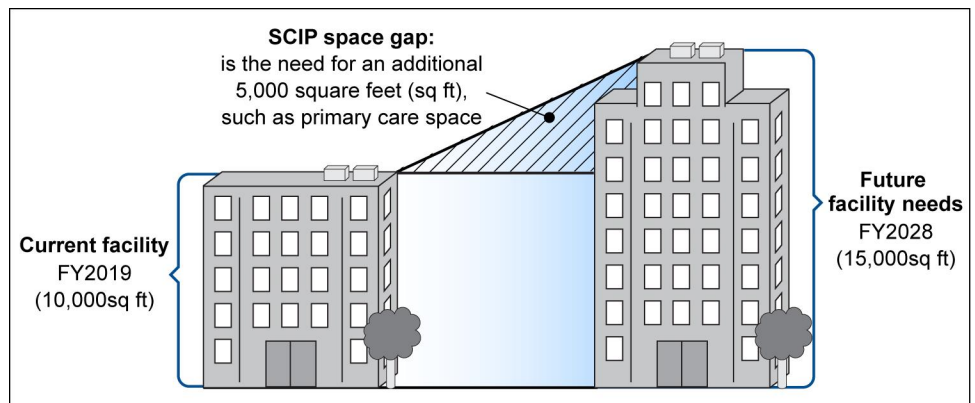
Capital Planning at the VA Level

VA's main mechanism for identifying and prioritizing capital-planning projects is the annual SCIP process. SCIP—first used in fiscal year 2010—is used not only to identify the capital required to meet VA's service and space needs but also to ensure that all project requests are centrally reviewed in an equitable and consistent way throughout the system. As part of the SCIP process, VA utilizes VAMC-level data from models (including VetPop and the Enrollee Health Care Projection Model) to determine “gaps” between the current state and the strategic capital goal. A SCIP “gap” is the difference between a current facility's square footage and its estimated future space needs. These data are updated and distributed annually to local VAMC staff for the development of plans

¹⁷In determining estimates using the Enrollee Health Care Projection Model, VA uses different sets of assumptions for future years, called “scenarios,” to model the impact of changes such as new policies, regulations, or legislation. For example, one scenario might assume that the percentage of veterans' care at the VA and in the community should remain at present levels and another might assume that a larger percentage of future care will be provided in the community. According to VA officials, VA management decides which scenarios to use in determining estimates for a given year.

for “closing” the gaps (i.e., reducing the gaps). The SCIP process calculates both positive (needs additional capacity) and negative (has excess capacity) gaps between current and future space needs for 12 different categories of clinical and non-clinical space.¹⁸ (See fig. 1.)

Figure 1: Illustration of Strategic Capital Investment Planning (SCIP) “Gaps”



Source: GAO. | GAO-19-440

Note: A SCIP “gap” is the difference between a current facility’s square footage and its estimated future space needs.

Capital Planning at the VISN and VAMC level

VA officials at the VISNs and VAMCs play a major role in the capital-planning process. Each VISN has a Capital Asset Manager and planning staff who are responsible for coordination and oversight of capital-planning activities and who work with the individual VAMCs’ facility-planning officials. The capital-planning process includes several tools for the facility-planning officials to use, including the Enrollee Health Care Projection Model, the Health Systems Planning Application, and SCIP.¹⁹

¹⁸The 12 SCIP space gap categories are: (1) Acute Care: Acute Inpatient Medicine & Surgery; (2) Acute Care: Acute Special Programs; (3) Acute Care: Inpatient Mental Health; (4) Ambulatory Care: Ancillary/Diagnostic; (5) Ambulatory Care: Mental Health; (6) Ambulatory Care: Primary Care; (7) Ambulatory Care: Specialty Care; (8) Long Term Care: CLC/Hospice; (9) Non-Clinical Space: Administration; (10) Non-Clinical Space: Common/Vacant/Construction; (11) Non-Clinical Space: Research; and (12) Non-Clinical Space: Support.

¹⁹According to VA officials, the Health Systems Planning Application is a tool that facility planners can use to, among other things, help close their facility’s gaps. These officials also noted that the tool collects and displays additional data, including health care utilization projections from the Enrollee Health Care Projection Model and mapping tools.

VA officials said that after the estimates from the Enrollee Health Care Projection model are prepared, facility-planning officials should undertake a health care planning process to better inform the SCIP process.

Through the SCIP process, VA encourages VAMC facility-planning officials to develop 10-year plans to address 95 percent of projected space needs, on an annual basis. According to VA, the department uses these plans to adapt its budget for infrastructure projects to changes in demographics that affect health care and benefits delivery. VAMC facility-planning officials then develop plans for the capital improvement projects that are expected to take place in the first year of the 10-year plan.

VA Assesses Trends in Veterans' Future Needs but Lacks a Process for Assessing Veterans' Changing Expectations

VA analyzes information about the needs of different veterans' groups and their demographic data to assess veterans' future needs for care. However, it lacks sufficient information to similarly assess how veterans' expectations for care may change over time. One of the VA officials responsible for the development of VA's strategic plan told us that veterans'

- needs refer to the care, benefits and support services veterans require to support their well-being and quality of life, and
- expectations refer to how veterans would like to receive the care, benefits, or support services that address their needs.²⁰

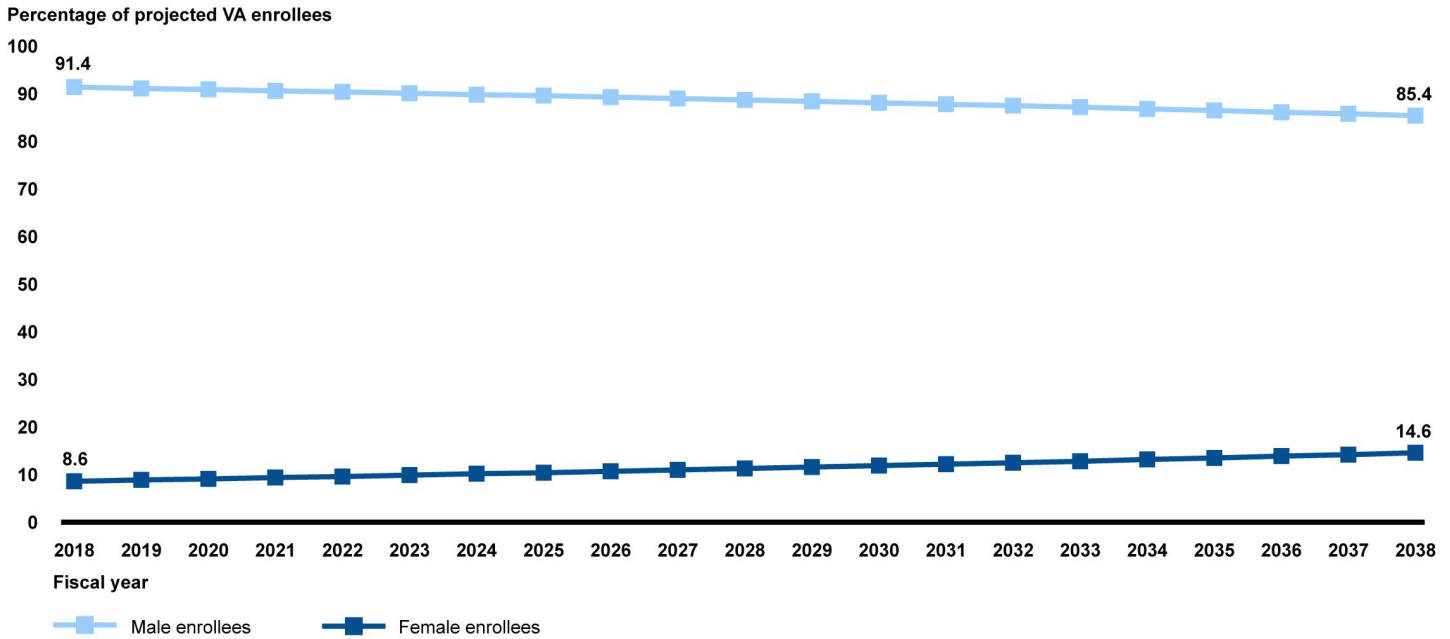
Assessing needs: VA expects that demographic changes will affect both veterans' health care needs and expectations. Using the abovementioned definition, we found that VA assesses some aspects of veterans' needs at the national level, a practice that may help VAMC facility planning officials avoid replication of efforts. For example, female veterans or those who served in specific military operations may have some similar health care needs regardless of where they are located, so it would not be necessary for multiple VAMCs to design and conduct separate studies of these populations. VA generates an overall depiction of how changes in

²⁰VA did not provide a definition of "needs" and "expectations" in its *FY 2018–2024 Strategic Plan*. However, VA provided these definitions when we asked them.

veterans’ demographics—including gender, service-connected disabilities, or age—will affect veterans’ needs.²¹ For example:

- Gender: According to VA, female veterans of recent conflicts—such as the Gulf War and Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn—make up over half of the female veterans who use VA services. Whereas the number of male enrolled veterans is estimated to decrease by almost 100,000 (8.03 million in fiscal year 2017 to 7.93 million by fiscal year 2027), the number of female enrolled veterans is expected to grow, increasing from 736,000 in fiscal year 2017 to 979,000 by fiscal year 2027. VA also estimates that the percentage of enrolled veterans who are female will continue to grow through fiscal year 2038. (See fig. 2.)

Figure 2: Department of Veterans Affairs’ (VA) Projected Demographic Changes among VA Enrollees, by Gender (Fiscal Years 2018 through 2038)



Source: GAO analysis of VA data. | GAO-19-440

Note: These data are drawn from VA’s Enrollee Health Care Projection Model from fiscal year 2017.

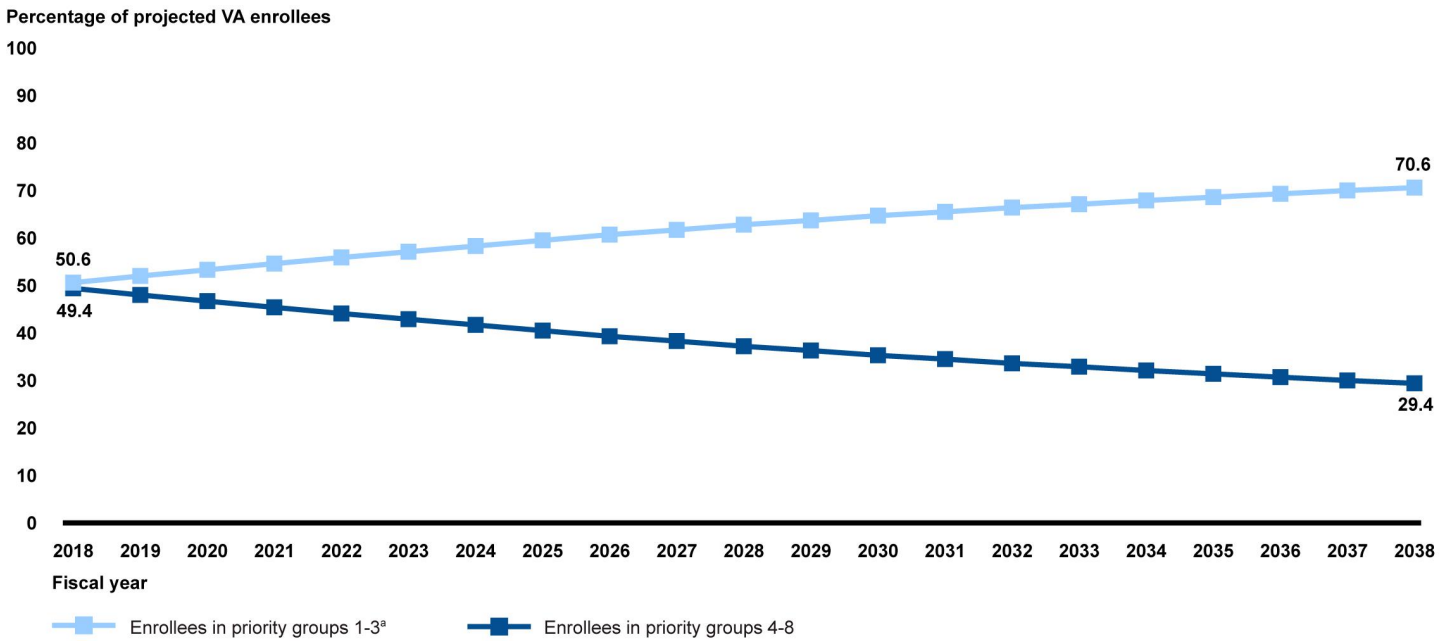
²¹VA’s enrollment system for enrollees is based on a set of 8 priority groups to ensure health care benefits are readily available to all enrolled veterans.

As the number of female veterans grows, VA estimates that there may be an increasing demand within VA for types of care specific to women, such as obstetrics.

- **Service-Connected Disabilities:** According to VA, veterans with service-connected disabilities rely on VA services to a significantly greater degree than do their counterparts without such disabilities. VA estimates that there will be an increase in the percentage of enrollees with service-connected disabilities in coming years. VA's enrollment system is based on 8 priority groups, and veterans' enrollment in priority groups 1 through 3 is based on service-connected disabilities.²² The number and percentage of VA enrollees in groups 1-3 is currently about the same as those in groups 4-8 (those who do not have service-connected disabilities). As figure 3 shows, however, VA estimates significant growth in the percentage of veterans who will be enrolled in priority groups 1-3 by fiscal year 2038.

²²Priority group 1 is typically the most severely disabled (the highest acuity). There are also income requirements for certain veterans, including those who do not have a VA-rated service connected disability, which may influence which priority level they are placed in.

Figure 3: Department of Veterans Affairs' (VA) Projected Demographic Changes among VA Enrollees, by Priority Group (Fiscal Years 2018 through 2038)



Source: GAO analysis of VA data. | GAO-19-440

Notes: VA's enrollment system is based on 8 priority groups, with priority group 1 typically having the highest acuity or severity of disability.

These data are drawn from VA's Enrollee Health Care Projection Model from fiscal year 2017.

^aVA combines priority groups 1-3 because enrollment in them is dependent on service-connected disabilities.

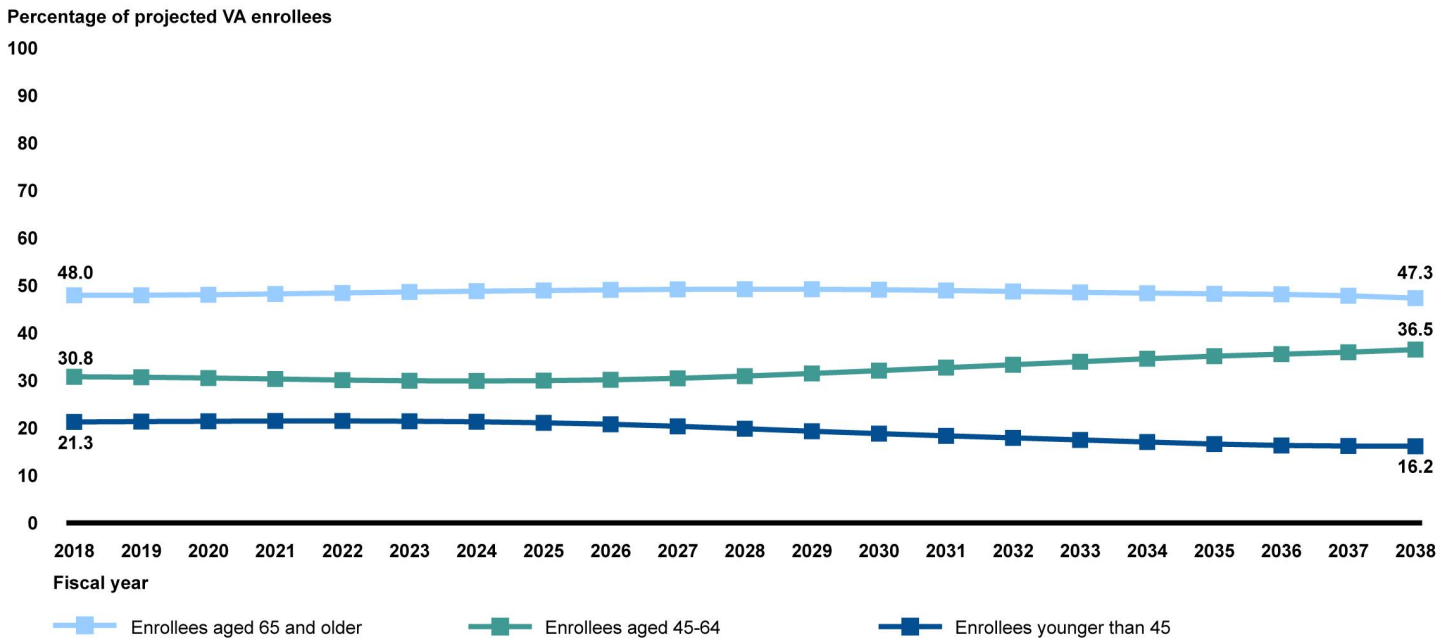
According to VA, the growth in priority groups 1 through 3 is a key driver of demand for VA health care services. As enrollees transition into these groups, their reliance on VA health care significantly increases relative to those in other priority groups. Growth in these priority groups also affects specific VA services more than others, including home and community based care, outpatient mental-health services, and prosthetics.

- Age: VA also predicts that veterans' needs will change as younger cohorts enroll and older cohorts' reliance on VA services decreases as they become eligible for enrollment in the Medicare program.²³ This is in part because different cohorts have different needs. For example, VA officials told us that the cohort of veterans who entered

²³According to VA, veterans' reliance on VA health care decreases beginning at age 65 as enrollees become eligible for Medicare coverage.

military service immediately after the Vietnam War have a higher need for VA mental health services compared to other cohorts. According to VA, as older veterans' reliance on VA decreases, the needs of younger veterans of recent conflicts will have a larger effect on VA's health care services. Currently younger veterans make up a smaller proportion of VA enrollees than do older veteran cohorts. For example, at the end of fiscal year 2018, about 1.9-million VA enrollees were under the age of 45, about 2.7 million between the ages of 45–64, and about 4.2 million aged 65 or older. However, VA estimates that the percentage of enrolled veterans who are between 45–64 will increase over the next 20 years. (See fig. 4.)

Figure 4: Department of Veterans Affairs' (VA) Projected Demographic Changes among VA Enrollees, by Age (Fiscal Years 2018 through 2038)



Source: GAO analysis of VA data. | GAO-19-440

Note: These data are drawn from VA's Enrollee Health Care Projection Model from fiscal year 2017. According to VA, reliance on VA health care tends to decrease beginning at age 65, as enrollees become eligible for Medicare coverage. Conversely, veterans may still rely on VA for certain types of services after age 65, and age drives growth in long-term care services and support, and other services generally not covered by private insurance or Medicare, such as hearing aids. VA officials told us that World War II enrollees are currently the highest users of long-term care services and

support, with Vietnam Era enrollees projected to be an increased driver of demand for those services as they age.

Assessing expectations: While VA uses information about the needs of different groups in combination with demographic data to assess trends in veterans' future needs, it does not systematically collect data concerning how, if at all, demographic groups differ in their expectations for how they would like to receive care. Without this information, VA cannot provide VAMCs with national assessments of the expectations of different groups of veterans, as it does for their needs. VSOs, literature, and VAMC facility-planning officials have noted that demographic shifts may be driving changes in veterans' expectations for the care they receive from VA. According to literature and these VSOs and planning officials, these expectations can be relevant to facility planning and include:

- Convenience of care: Some younger veterans may prioritize “telehealth” more than older veterans.
- Privacy of care: Some younger veterans may expect to receive care in single-occupancy rooms rather than multi-occupancy. Additionally, female veterans may prefer to receive certain types of care in gender-separated environments.
- Scope of care: Some age groups may have a greater expectation for a holistic approach to their care, such as that promoted by VA's Whole Health initiative.²⁴

VA officials told us that they learn about veterans' changing expectations through surveys and conversations with VSOs. We found, however, that the information VA collects through these efforts may be limited based on our review of VA's surveys and our discussions with five VSOs. Using the definition of veterans' expectations provided by VA, we analyzed the 14 surveys identified through our VA-coordinated review and determined that five surveys potentially included survey questions that specifically asked about veterans' expectations.²⁵ The amount of information that VA can ascertain about veterans' expectations from these five surveys, however, is limited because of the surveys' scope. Specifically:

²⁴The Whole Health initiative is intended to provide a holistic approach to health care that takes into consideration many life factors that can affect veterans' health, such as work environment, relationships, diet, and sleep patterns.

²⁵The need to be able to link the responses to the respondent's demographic characteristics is key for being able to determine expectations for specific veterans' characteristics.

- Two of the five surveys were about specific services (i.e., retinal therapy and dermatology). Although each asked a question about the veteran's preference for receiving care via telehealth versus driving long distances, the surveys were focused primarily on veterans' satisfaction with receiving this care via telehealth.²⁶ An official told us that VA has expanded this survey to additional services, but further review of the survey instrument showed that there are no longer any questions that specifically ask about veterans' expectations.
- The third survey—an annual survey of enrolled veterans' use of VA services—asks veterans about their experiences with VA health care, their reasons for choosing to seek care outside of VA, and the extent to which they use VA for their health care needs. However, our review found only one question that specifically asked about veterans' expectations, which asked the primary way veterans' expect to use VA in the future (e.g., as their primary source of health care, for prescriptions, etc.).²⁷
- Finally, the last two surveys were administered in January and October 2015, respectively—and are no longer being conducted and only ask questions about five of the many types of VA health care.²⁸ These surveys were part of studies that asked veterans' about their expectations for how they receive primary or specialty care (i.e., appointment timeliness, type of provider, face-to-face vs. telehealth, distance traveled, etc.), and basic demographic characteristics, including gender, age, ethnicity, education, and health status.

Although VA officials told us they learn about veterans' expectations from discussions with VSOs, officials from three of the five VSOs we met with told us that they do not think that VA has a good understanding of the expectations of veterans as a whole, or certain groups of veterans. In addition, officials from the remaining two VSOs told us that they thought VA was collecting this information through veteran surveys. However, as we previously noted, the amount of information VA can ascertain on veterans' expectations from these surveys is limited.

²⁶The two surveys that focus on specific service lines are: VA's Teleretinal Patient Satisfaction Survey and VA's Tele-Dermatology Imaging Patient Satisfaction Survey.

²⁷VA's Survey of Veteran Enrollees' Health and Use of Health Care.

²⁸Specifically, the surveys asked questions about primary care in general and about four types of specialty care: orthopedics, oncology, endocrinology, and cardiology. These two surveys were part of VA's Primary Care Access Conjoint Study and VA's Specialty Care Conjoint Study, which have since been completed.

VA's FY 2018–2024 Strategic Plan notes the need for VA to solicit veteran feedback and to continuously adapt benefits and care offerings to meet their changing needs and expectations. In addition, federal standards for internal control state that agencies should use quality information to achieve their objectives.²⁹ These standards specify that management identifies information requirements in an iterative and ongoing process and obtain relevant data from reliable internal and external sources in a timely manner. VA told us it uses surveys and interactions with VSOs to obtain information about veterans' satisfaction with aspects of their care. Our review of VA's surveys, however, found that VA may be limited in its ability to systematically assess trends in veterans' expectations due to the lack of explicit questions and measures of expectations for many types of VA health-care services—based on the definition of expectations provided by VA. Further, our discussions with VSOs suggest that VA may not be effectively collecting information from the VSOs on their members' expectations for care. Also, federal standards for internal control state that management should externally communicate necessary quality information. Management obtains quality information from external stakeholders—which in VA's case would be information from veterans—using established reporting lines that provide methods of communication that can flow down, across, up, and around the organizational structure.³⁰ This information includes significant matters relating to risks, changes, or issues that, in this case, affect VA's ability to meet its objective regarding veterans' changing expectations. We found that although VA understands how future shifts in veteran demographics will affect veterans' needs, VA lacks sufficient information about how these shifts will impact veterans' expectations over time. As a result, VA is at risk of:

- not accomplishing its strategic goal of meeting veterans' changing expectations by providing services in the way veterans want them provided, and
- VAMCs replicating each other's efforts to assess changes to veterans' expectations.

²⁹See [GAO-14-704G](#).

³⁰See [GAO-14-704G](#).

VA Has Made Addressing Veterans' Changing Needs and Expectations in Facility Planning a Priority but Lacks Instructions for Its Implementation

VA Established Meeting Veterans' Changing Needs and Expectations as a Strategic Goal but Did Not Provide VAMCs Instructions on How to Meet It

VA made soliciting and using veterans' changing needs and expectations a strategic goal. However, VA has not provided instruction to VAMC facility-planning officials on how to assess veterans' needs and expectations or incorporate them into their facility planning. For example, VA could identify certain resources or tools and direct VAMCs to use them. Federal standards for internal control state that management should internally communicate the necessary quality information to achieve the entity's objectives, i.e., implementing its strategic goal.³¹

During our site visits, it was clear that the facility-planning officials from the eight VAMCs we visited had not received instruction from VA on how to assess changes to veterans' needs and expectations. VA officials told us that they did not provide such instruction to the regional level (VISNs) or to the local level (VAMCs) because they believed most people understand what is meant by needs and expectations. However, we found during our site visits that there is a lack of consistent interpretation of what these terms mean among facility-planning officials, a lack that was illustrated by the different approaches they used in assessing the changing needs and expectations of the veterans they serve. For example:

- **Needs:** In addition to using VA's health-care workload projection data, facility-planning officials at one VAMC we visited told us they use surveys and historical workload trends to assess changes to veterans' needs. Facility-planning officials at another VAMC told us they use surveys, town halls, focus groups, and meetings with VSOs and other stakeholders.

³¹See [GAO-14-704G](#).

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- **Expectations:** Facility-planning officials at one VAMC told us they use patient satisfaction data from surveys and information collected on patients' expectations in the private sector to assess changes to veterans' expectations. Facility-planning officials at another VAMC told us they use veterans' feedback, including information from VSOs and interactions between their facility's leadership with veterans.

Facility-planning officials' use of different approaches to assessing veterans' needs and expectations may not be concerning—different approaches may provide valuable information. However, without instruction on this from VA, VAMCs may miss out on opportunities to use other identified approaches for collecting this information as part of their facility planning efforts.

In addition, VA has not instructed facility planners on how to incorporate information about veterans' needs and expectations into facility planning. Although 71 percent of facility-planning officials responded in our survey that VA's expectations for incorporating veterans' demographics and the associated changes in their needs or expectations are moderately or very clear, about 87 percent responded that instructions from VA would be moderately or very useful. One survey respondent suggested that through such instruction, VA provide a "clear and concise direction" and another respondent suggested the instruction include "clearly established and communicated goals, objectives, and targets that are cascaded to VAMCs through VISNs." Without clear, internal communication explaining how it expects its stated goals to be achieved, VA cannot reasonably ensure that VAMCs' future facility plans are designed to meet veterans' changing needs and expectations.

VA Identified Foundational Health Services to Meet Some of Veterans' Expectations but Did Not Provide Clear Instruction on How to Implement the Effort

At the national level, VA selected a set of core medical services called "foundational health services," in part, according to VA officials, to meet veterans' expectations of consistent care offerings across VAMCs, and also to focus its resources on its highest priority services. However, based on our survey of VAMCs and discussions with selected facility-planning officials, we found that VA did not provide VAMC facility-planning officials with clear instruction on how to implement this effort. According to VA guidance, foundational health services focus on:

- the management of military disorders where care access is limited in the private market, such as a spinal cord injury and prosthetics, or
- care across the veterans’ lifespan, including their primary care and geriatric care.³²

Department of Veterans Affairs’ (VA) Foundational Health Services

According to VA’s FY 2018–2024 Strategic Plan, VA’s foundational health services are:

- Primary care,
- Urgent care,
- Mental health,
- Geriatrics and extended care,
- Rehabilitation,
- VA care coordination-such as case management,
- Post Deployment Health Services and War Related Illness and Injury Study Centers, and
- Pain management and opioid safety.

Source: VA’s FY 2018–2024 Strategic Plan. | GAO-19-440

VA’s FY 2018–2024 Strategic Plan states “VA’s emphasis on foundational services ensures veterans receive quality care for those conditions most attributed to military services and best provided by VA that optimizes their health, well-being, and quality of life.” As for those services not defined as foundational (i.e., non-foundational services), a VA official responsible for leading VA’s foundational services effort told us those services are still part of its health benefits package, but may or may not be provided at the VAMCs. VA’s guidance further states that the decision to provide a non-foundational service is made locally, by individual VAMCs.

A VA official responsible for leading VA’s foundational services effort told us that foundational health services are the services that veterans can expect at each medical center. The list of these services is identified in VA guidance to VISNs and VAMCs. However, facility-planning officials at four of the VAMCs we visited during our site visits told us they did not know if the services VA specified were required to be delivered at each facility or if each facility could make changes to the list. Further, we found through our survey and site visits that VAMC facility-planning officials had defined different sets of foundational services for their facility. Specifically, approximately 10 percent of survey respondents said that their VAMC considers at least one VA-identified foundational health service to be non-foundational. In addition, officials from one of the VAMCs we visited told us they considered only six of VA’s foundational health services to be foundational at their facility, while officials from another VAMC told us they only considered four (see table 1).

Table 1: Examples of Department of Veterans Affairs’ (VA) Medical Centers with Differing Lists of Foundational Health Services (February 2019)

VA’s foundational health services	Foundational health services at one VA medical center (VAMC)	Foundational health services at another VAMC
Primary care	Yes	Yes
Urgent care	Yes	Yes

³²VA’s Memorandum on Foundational Services dated August 18, 2017.

VA's foundational health services	Foundational health services at one VA medical center (VAMC)	Foundational health services at another VAMC
Mental health	Yes	Yes
Geriatrics and extended care	Yes	No
Rehabilitation	Yes	No
VA care coordination	Yes	No
Post Deployment Health Services and War Related Illness and Injury Study Centers	No	No
Pain management and opioid safety	No	Yes

Source: GAO analysis. | GAO-19-440

Note: According to a VA official responsible for leading VA's foundational services effort, foundational health services are services that veterans can expect at each medical center.

Based on our survey of VAMCs and discussions with selected facility-planning officials, we found that VA did not provide clear instruction to facility planners on how to incorporate foundational and non-foundational health services into their facility planning.

- Foundational health services: In our survey, 42 percent of facility-planning officials reported that VA's expectations for how their facility should plan for foundational health services was "slightly" or "not at all" clear. A VA official responsible for leading VA's foundational services effort told us that the intent is for VA to provide all of the care for the foundational services at the VAMCs and not purchase any through community providers.³³ However, in our discussions with facility-planning officials at five of the VAMCs we visited, it was clear that VA had not provided them with this information because they were unsure as to whether they could plan to obtain foundational services from community providers. Facility-planning officials at one of the VAMCs we met with told us their understanding was that some of the care for foundational health services could be provided by community providers. In contrast, facility-planning officials from another VAMC told us that their understanding was that none of the care for foundational health services could be provided by community providers.

³³This official told us that there may be some rare exceptions to providing foundational health services at the medical centers, but did not provide an example of a rare exception.

- Non-foundational health services: Facility-planning officials from four of the VAMCs we visited told us they were unsure about how to plan for non-foundational health services and suggested a need for further clarification. This perspective was also shared by 12 facility planning officials who responded to our open-ended survey question that asked how, if at all, the information received from VA on the foundational services could be improved to help them prioritize their planning efforts.³⁴ For example, one survey respondent reported that “VA is not very clear on how to plan for these non-foundational services,” and another wrote about the need to “understand what, if anything, is going to occur with non-foundational services.”

In addition, facility-planning officials at five of the VAMCs we visited told us that they are unsure whether the foundational health services will continue to be a priority under current leadership—a concern that VHA officials also shared with us.³⁵ Accordingly, facility-planning officials told us that further instruction on the future implementation of foundational health services would be helpful. Specifically, in our survey, nearly four in five respondents (79 percent) reported that additional instruction from VA regarding incorporating foundational health services would be moderately or very useful. For example, one respondent noted that the instruction should be “concise, clear, and more explicit,” and another that “communication [of foundational health services] needs to funnel down to the facilities better.” Federal standards for internal control state that management should internally communicate the necessary quality information to achieve the entity’s objectives.³⁶

Although VA has issued guidance for foundational health services, it does not address how facility-planning officials should plan for foundational and non-foundational services. Foundational health services have important consequences for VA’s facility planning, as VA’s desire to prioritize which health care services should be offered consistently across VAMCs must be compatible with a constrained fiscal environment. However, based on

³⁴A total of 80 facility planning officials responded to this question. As the question was an open-ended survey question, respondents had the opportunity to list areas where they thought additional clarification was needed. In addition to suggesting further clarification on non-foundational health services, facility-planning officials also discussed needing clarification on what is included for each foundational service and explaining how the foundational services relate to the SCIP approval process.

³⁵The foundational health services were established in late 2017 under the previous VA administration.

³⁶See [GAO-14-704G](#).

our survey of VAMCs and discussions with selected facility-planning officials, we found that VA has not provided clear instruction regarding these services and has not told facility-planning officials whether the foundational health services remain a priority—guidance that would be an example of quality information. Moreover, VA increases the risk that it may not accomplish its goal of planning for the concept of foundational health services. This has further implications for meeting veterans' expectations of consistent care offerings across VAMCs and increases its risk that VAMCs are not focusing their resources on VA's highest priority services. Without this instruction, VAMC facility-planning officials may not successfully implement this effort through their facility planning—including the SCIP process, leaving VA at risk for VAMCs not focusing their resources on VA's highest priority services.

VAMC Facility Planners Are Concerned about VA's Process for Identifying Future Needs for Space in Facilities and Thus May Instead Rely on Locally Defined Priorities

VAMC Facility Planners Have Concerns about How SCIP's Estimated Space Needs Are Determined and Also Question The Estimates' Reliability and Usefulness

Although VA uses its SCIP process to identify facilities' future needs for space, we found that VAMC facility-planning officials have concerns about the SCIP estimates. VA annually provides VAMC facility-planning officials with 10-year estimates of future space needs for their facilities based on VA's estimates of veterans' future health-care needs. Specifically, VA uses facility-level utilization data from the Enrollee Health Care Projection Model to convert predicted utilization of VA health care services into future square footage needs with the SCIP process. However, in speaking to and surveying facility-planning officials at VAMCs, we found most do not fully understand the calculation of the

Of those respondents to GAO's survey who believed a particular Strategic Capital Investment Planning (SCIP) space gap—the difference between a current facility's square footage and estimated future space needs—was generally inaccurate in reflecting the projected space needs for the facility, 37 percent believed they actually needed less space than the estimate suggested.

Nearly half of the survey's respondents (49 percent) noted that they did not know enough about how the space gaps were determined to understand what actually caused what they perceived as inaccuracies in the SCIP estimates. When asked to identify what they perceived as having contributed to the inaccuracies, facility planners most often responded that it was changing veteran needs and expectations or standards of care (56 percent) and inaccuracies with the actual demographic or workload estimates (54 percent).

Source: GAO survey of Department of Veterans Affairs' medical center facility-planning officials. | GAO-19-440

SCIP space estimates, and to some extent questioned their reliability and usefulness.

- **Calculation of SCIP's space estimates:** VAMC facility-planning officials reported difficulties understanding how SCIP's space estimates are calculated from projected workload estimates. Specifically, 70 percent responded that this process was either slightly or not at all clear. In addition, 89 percent responded that further clarification about this process from VA would be moderately or very useful to their facility's planning efforts. Further, nearly 7 in 10 facility planner respondents (69 percent) responded that it was somewhat or very difficult to determine which of the 71 space categories (that they are more familiar with at their local level) to allocate the projected space changes from the 12 SCIP categories.³⁷ VA officials told us that they have included information about how these 71 space categories relate to the 12 SCIP space categories in a "crosswalk" they provided to the VAMCs. However, it does not include information on how to determine which of the 71 categories to allocate specific space needs to from a particular SCIP gap.
- **Reliability of SCIP space estimates:** VAMC facility-planning officials believe that some SCIP space estimates do not accurately reflect the projected needs for their facilities, and some have reported large annual variations in the estimates. Specifically, facility planners at 72 percent of the facilities reported the estimated space needs for their facility as generally inaccurate in reflecting their facility's projected space needs for at least 1 of the 12 SCIP space categories.³⁸ Further, over half (51 percent) responded that estimates for 3 or more of the SCIP space categories were generally inaccurate in reflecting the projected space needs for their facility. The SCIP space categories most cited for inaccuracies were "Inpatient Mental Health," followed by "Administration" and "Acute Inpatient Medicine & Surgery."³⁹ For

³⁷At the facility level, VAMC officials categorize their square footage into 71 space categories in the Capital Asset Inventory database. These 71 categories are more granular than SCIP's space categories, and each facility is required to annually validate that their space is accurately recorded.

³⁸Across the 12 SCIP space categories, ratings of "generally inaccurate" range from 14 percent to 43 percent.

³⁹Nearly half of the respondents (43 percent) reported that they thought the "Inpatient Mental Health" SCIP space category was generally inaccurate in reflecting the projected needs for their facilities, followed by over one-third (34 percent) for the "Administration" category and (31 percent) for the "Acute Inpatient Medicine & Surgery" category.

example, at one VAMC we visited, the SCIP process estimated an Inpatient Mental Health surplus of approximately 29,000 square feet. Facility-planning officials at the VAMC told us they disagreed with the estimate, saying that they anticipate growth in this area due to an increased focus on suicide prevention and a related VA policy change.⁴⁰ As such, they expect needing more space—not having a surplus of it. When asked about this particular concern, VA officials who oversee SCIP explained that the policy change took place after that year’s SCIP space estimates had been calculated.⁴¹ They acknowledged that there may also be specific instances where it is necessary to allow the facility planners to have some flexibility to deviate from the SCIP space estimates, and told us that facility-planning officials are encouraged to report any perceived inaccuracies to SCIP officials.⁴²

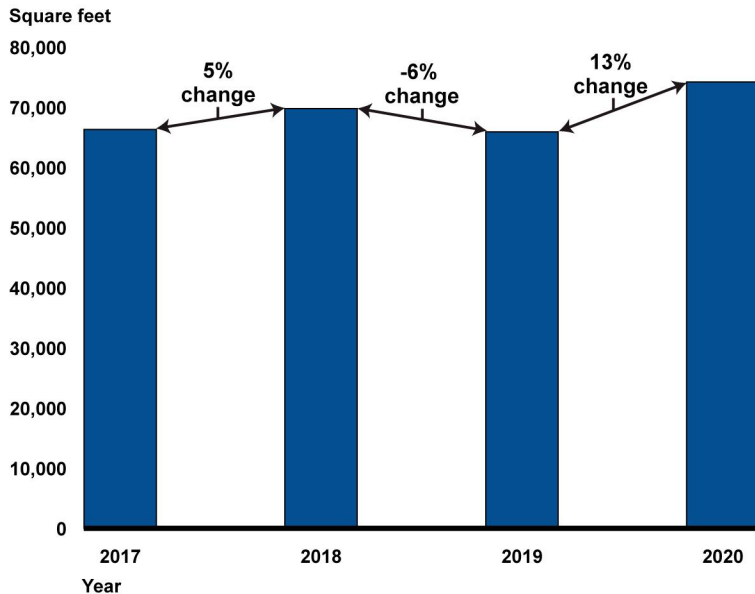
Facility planning officials at two of the VAMCs we visited told us that they observed large variations in their facility’s SCIP space estimates from year to year, which can make it difficult for planning purposes. In addition, one survey respondent noted that the “huge swings in gaps from year to year make it extremely challenging to put in valid projects for more than 1 or 2 years out.” To better understand these views, we reviewed the 4 most-recent years of SCIP space estimates and found some annual variations. For example, for a given SCIP space category, we found that the median SCIP space estimates of what facilities would need in 10 years increased by 13 percent from the fiscal year 2019 SCIP space estimates to the fiscal year 2020 estimates. (See fig. 5)

⁴⁰In 2018, VA identified suicide prevention as its highest clinical priority in its strategic plan for fiscal years 2018 through 2024 and, under a recent policy change allows for mental health treatment for veterans with other-than- honorable discharges.

⁴¹According to officials who oversee SCIP, the initial space projection was done in January 2017. The policy change was announced in July of 2017.

⁴²SCIP officials told us that they did not receive feedback from this particular VAMC regarding this particular SCIP space estimate.

Figure 5: Changes in the Median Estimated Space Need from the Strategic Capital Investment Planning (SCIP) Process, SCIP's Fiscal Year Estimates 2017, 2018, 2019, and 2020



Source: GAO analysis of Department of Veterans Affairs data. | GAO-19-440

Note: The median SCIP space estimate represents the median projected 10-year space needs for a given SCIP space category.

When we asked VA officials who oversee the Enrollee Health Care Projection Model and the SCIP process about these annual variations, they told us that the variations are primarily due to the Enrollee Health Care Projection Model's scenarios that VA applies to estimate how much veteran care will be outsourced to the community. VA officials who oversee the Enrollee Health Care Projection Model further stated that they communicate information about changes to the model annually to the VISNs and facilities through training classes. Officials at the VISNs we visited confirmed to us that VAMC planners are invited to these annual training classes and included on emails.

- Usefulness of SCIP space estimates: VAMC facility-planning officials also questioned the usefulness of the process for closing out SCIP gaps. Specifically, more than half of the facility planners (52 percent) responded that they thought the overall process of closing SCIP gaps was slightly or not at all useful to address the future needs and expectations of their local veteran population. Further, in order to close the SCIP space gaps on an annual basis, facility-planning officials at seven of the VAMCs we visited told us they frequently put in a project (that they may or may not actually have realistic plans to

complete) in the out-years of the 10-year planning process called a “lump sum project.” The facility planners told us they would use these projects to close whatever SCIP space gaps they did not think were correct or important to address.⁴³ For example, facility-planning officials at a VAMC with a reported space deficit for “common/vacant/construction” space in the hundreds of thousands of square feet said that they did not agree with this gap and had no intention of adding this much common space.⁴⁴ Nonetheless, they told us they added a lump-sum project to SCIP that suggests they would add hundreds of thousands of square feet of circulation space in order to close out the SCIP gap. Another facility planner echoed this sentiment by responding to the survey that the SCIP process “becomes an exercise of zeroing out numbers with lump sum out-year projects,” and another noted that “gaps closed in out-year projects rarely come to fruition and certainly don’t address current needs”.

VA Facility Planners May Rely on Local Priorities Rather Than Using SCIP’s Estimated Space Needs

Instead of using SCIP space estimates as a starting point to incorporate veterans’ changing needs, VAMC facility planners may instead rely on local priorities, such as those identified by VAMC management or through feedback from local veterans. Specifically, due, in part, to their concerns with the SCIP process, facility-planning officials at five of the VAMCs we visited told us that instead of using the SCIP gaps to assist them in identifying what their future space needs are, they instead base these decisions on what they or their local management think are what the facility needs. For example, one VAMC we visited had—based on the SCIP process—an estimated 10-year surplus of approximately 4,000 square feet of inpatient mental health space. However, facility-planning officials at this VAMC told us that because their inpatient mental health beds are always at capacity, they are actually submitting projects to increase their space, and not decrease it.

In reference to not always using the Strategic Capital Investment Planning (SCIP) space gaps—the difference between a facility’s current square footage and estimated future space needs—as a starting point to determine needs and instead using local priorities, one survey respondent noted that: “The SCIP process often becomes fitting projects we need into filling the gaps,” and “as with many centrally controlled processes, SCIP has become more of a ‘how can we get our projects funded’ tool than a ‘this helps us plan’ tool.”

Source: GAO survey of Department of Veterans Affairs’ medical center facility-planning officials. | GAO-19-440

⁴³In a January 2019 memorandum about the fiscal year 2021 SCIP process, VA notes that those out-year projects that are entered into SCIP must be projects that the facility has an intent to complete—and thus must be a “real and justifiable” project.

⁴⁴For this particular VAMC, the facility planning officials told us that closing this particular SCIP space gap would require them to increase the current size of the entire facility by approximately 40 percent.

We also found that officials at VAMCs collect veterans' feedback through a variety of mechanisms and incorporate some of this information into their facility-planning efforts. For example, facility-planning officials from four of the VAMCs we visited told us that they obtain feedback from veterans on their needs and expectations through VA's national level satisfaction surveys, and incorporate this feedback into facility planning decisions. However, as we report above, the amount of information that VA can ascertain about veterans' expectations from these surveys is limited.

Of the different methods available to collect feedback from veterans' on their needs and expectations, the method most cited by survey respondents was town halls (88 percent), followed by feedback from veterans' comments to providers/VA staff (85 percent), and then feedback from VSOs (80 percent).⁴⁵ Facility-planning officials use information from these efforts to inform their decisions. For example, facility-planning officials at one VAMC we visited told us that they coordinate with a particular VSO when considering changes to the Spinal Cord Injury or Polytrauma areas, as that VSO has knowledge of veterans' unique requirements in these areas. However, these methods for collecting information on veterans' needs and expectations are not consistent across VAMCs, making it even more important for VAMC facility planners to supplement their efforts with information on veterans' needs from the SCIP space estimates. For example, while town hall meetings can provide valuable feedback, they may not capture changing demographics and may only represent the most vocal veteran participants in attendance.

Federal standards for internal control state that management should use quality information to achieve the entity's objectives.⁴⁶ For example, this includes obtaining quality information through relevant data from reliable sources. Relevant data have a logical connection with the information

⁴⁵In our survey of facility-planning officials, we asked which of the following sources of veteran's feedback they used as part of the facility planning process: VA-administered nationally representative surveys of veterans; VAMC- or VISN-administered surveys of only the veterans that go to your facilities or are in your VISN; town halls or other formal discussions with veterans; feedback from veterans' comments (e.g., comments to providers/VA staff, patient advocates, comment boxes, social media, etc.); feedback from VSOs, third party reports (e.g., VSO reports, RAND, etc.); or other sources. See appendix II for the survey questions.

⁴⁶See [GAO-14-704G](#).

requirements, and reliable data faithfully represent what it is purported to represent. Reliable sources include internal stakeholders. Further, the information needed is best identified in an iterative and ongoing process to address any risks identified in determining whether all the relevant information is obtained. VA expends significant effort on the SCIP process and expects VAMC facility-planning officials to use SCIP space estimates as starting points for incorporating veterans' changing needs into their facility planning, and then make local adjustments as necessary. However, VAMC facility-planning officials—citing confusion with the process and concerns about the reliability of some of the space gaps—are sometimes reluctant to use the SCIP estimates as the starting point for determining their future facility needs. These concerns can result in inconsistent use of SCIP estimates across the VAMCs and diminish the ability to equitably and systematically assess needs. Unless VA officials work with the VAMC facility-planning officials to understand and address their concerns with the SCIP process, VA may not have all the necessary information and the facility-planning officials may continue to miss out on an opportunity to incorporate veterans' changing needs. As a result, their planning may not sufficiently address veterans' changing needs and expectations. Moreover, VAMCs may spend time and resources to build something they may not need (resulting in excess capacity) or not focus these resources where additional capacity is needed (resulting in shortages).

Conclusions

VA's efforts to assist VAMCs in planning for shifts in veteran demographics, reflecting changing needs and expectations may only be partly successful and may lead to excess capacity in some facilities, and shortages in others. Over the next 10 to 20 years, an increasing percentage of veterans who are female and the aging of different wartime groups are just two of the many demographic shifts among veterans for which VA must prepare its medical facilities. Advance planning for the effects changes in veterans' needs and expectations will have on VAMCs' services and facilities is important as, for example, a construction project on a VAMC campus can take many years to complete. VA assesses how these shifts affect facility planning for veterans' needs but has not conducted an effort to assess the potential effects of veterans' changing expectations. Further, VA has not communicated to local VAMCs how to incorporate its strategic goal for addressing veterans' needs and expectations as part of their service and facility planning. Without a national effort to assess trends in veterans' changing expectations (as

they have done for veterans' needs) or common instructions from VA, individual VAMCs may potentially replicate each other's efforts (e.g., in designing surveys) or use varying methods to assess how changes to their local veterans' population might alter their services and facilities. Moreover, without VA leadership fully explaining to VAMCs how to implement the concept of foundational health services, VA increases the risk that it may not accomplish its strategic goal of meeting veterans' expectations of consistent care across VAMCs, and that VAMCs are not focusing resources on high priority services. In addition, VAMC planning officials are not confident that the SCIP process is accurately converting veterans' future health-care needs into where appropriate space will be needed and at times are reluctant to use SCIP data as a starting point for decision-making. Without a systematic process in place for VA to identify and address concerns with the SCIP process, VAMC facility-planning officials may build space in facilities they will not need—or fail to build space they do need.

Recommendations for Executive Action

To improve VA's ability to plan for and align its facilities with estimated changes to veterans' needs and expectations, we recommend that the Secretary of Veterans Affairs ensure the appropriate offices and administrations take the following four actions:

Develop and implement a process to assess veterans' changing expectations and disseminate this information to VAMCs.
(Recommendation 1)

Instruct VAMCs on how to meet VA's strategic goal of incorporating veterans' changing needs and expectations into facility planning, such as by identifying certain resources or tools and directing VAMCs to use them. (Recommendation 2)

Provide additional instruction to VAMCs on how to incorporate the concept of foundational health services into facility planning.
(Recommendation 3)

Systematically gather feedback from facility planners and address (as necessary) their concerns with the reliability of the SCIP process, including providing additional information on how SCIP's space estimates are derived. (Recommendation 4)

Agency Comments and Our Evaluation

We provided a draft of this report to VA for comment. Its written comments are reproduced in appendix III. VA concurred with our four recommendations. In response to our recommendation that VA develop and implement a process to assess veterans' changing expectations and disseminate this information to VAMCs, VA stated that it has already developed and implemented effective systems for obtaining veterans' input in facility planning. We have reviewed all materials that VA provided and continue to believe that they do not yet align with VA's definition of expectations. We will continue to monitor VA's efforts in this area and will close the recommendation when VA develops and implements a process to assess veterans' changing expectations, as defined by VA. Regarding our fourth recommendation, VA agreed to improve training for facility-planning officials. We still believe VA should also create a process for gathering and assessing legitimate concerns related to the SCIP process and make changes where appropriate. VA also provided technical comments, which we incorporated as appropriate, including a resulting clarification to our third recommendation. As a general comment, VA stated that we did not include information on its health care planning process, and we have added this information to our final report.

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

If you or your staff have any questions regarding this report, please contact Andrew Von Ah at (202) 512-2834 or vonaha@gao.gov, or Debra A. Draper at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on

the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.

A large, stylized handwritten signature in black ink, appearing to read 'Andrew Von Ah'.

Andrew Von Ah
Director
Physical Infrastructure

A smaller, stylized handwritten signature in black ink, appearing to read 'Debra A. Draper'.

Debra A. Draper
Director
Health Care

Appendix I: Objectives, Scope, and Methodology

This report examines: (1) the extent to which the Department of Veterans Affairs (VA) assesses trends in veterans' future needs and expectations; (2) VA's efforts to help VA medical centers (VAMC) address veterans' changing needs and expectations in planning VA's facilities; and (3) how VAMCs use VA's planning process for identifying future need for space in VA's facilities to address veterans' changing needs and expectations in facility planning.

To address these objectives, we reviewed relevant laws, regulations, policies, and VA's planning documents, including VA's FY 2018–2024 Strategic Plan.¹ We also interviewed officials from VA and VA's Veterans Health Administration (VHA) including from:

- VA's Central Office—including personnel from the Office of Asset Enterprise Management—and
- VHA's Central Office, including staff from its Office of Policy and Planning and Office of the Assistant Deputy Under Secretary for Health for Clinical Operations.²

In addition, we interviewed representatives from a broad range of national veterans' service organizations (VSO), including The American Legion, Vietnam Veterans of America, Disabled American Veterans, Iraq and Afghanistan Veterans of America, and Wounded Warrior Project.

To obtain local perspectives on the objectives, we surveyed those officials who are responsible for planning and making facility-planning decisions (hereafter referred to as "facility-planning officials") from all VAMCs. The survey addressed VA's efforts to assess trends in veterans' needs and expectations and incorporate the information in facility planning, and VA's SCIP process. We developed the survey based on our audit objectives,

¹See Department of Veterans Affairs, *FY 2018–2024 Strategic Plan* (Washington, D.C.: February 2018).

²VHA operates VA's health care system, which includes VA medical centers and community-based outpatient clinics.

prior GAO work, and discussions with facility-planning officials. We pretested the survey with facility-planning officials at six VAMCs.³ We administered our web-based survey between November 2018 and January 2019. One hundred thirty-seven individuals (of 139) responded to the survey (118 of the 119 facility-planning officials at single VAMCs and 19 of the 20 facility-planning officials that oversee multiple VAMCs), for an overall response rate of about 99 percent.⁴ See appendix II for the survey questions and the summarized responses.

For more detailed information to supplement the survey, we visited a nongeneralizable sample of nine VAMCs located in four Veterans Integrated Service Networks (VISN) in August 2018 and September 2018.⁵ (See table 2.) We chose the nine VAMCs because they had relatively high needs for future space based on fiscal year 2019 data from VA's Strategic Capital Investment Planning (SCIP) process and geographic proximity to each other. We conducted interviews with facility-planning officials at both the VISN and VAMC levels to discuss facility-planning resources, tools, and policies, and reviewed relevant documentation provided by these officials. At these nine VAMCs, we met with eight groups of facility-planning officials, because two of the VAMCs

³We pretested the survey with VAMC facility-planning officials at the following six facilities that we selected based on future space needs (high and low) based on fiscal year 2020 data from VA's Strategic Capital Investment Planning (SCIP) process: (1-2) the VA Maryland Health Care System (Baltimore VAMC, Perry Point VAMC, and Loch Raven VAMC); (3) the Bay Pines VA Healthcare System (Bay Pines, Florida); (4) the James A. Haley Veterans' Hospital (Tampa, Florida); (5) the Cleveland VAMC (Cleveland, Ohio); (6) the Corporal Michael J. Crescenz VAMC (Philadelphia, Pennsylvania); and the Phoenix VA Health Care System (Phoenix, Arizona).

⁴We received responses from 137 of the 139 facility planning officials, representing 159 of the 162 VAMCs. Although there are 172 VAMCs, a VA official who oversees SCIP told us that VA combines several VAMC's SCIP space gap estimates as part of the SCIP planning process. As a result, VA attributes SCIP data to 162 VAMCs.

⁵VA organizes its system of care into regional networks called VISNs. Each VISN is responsible for managing and overseeing VA medical centers within a defined geographic area. We met with the planning officials at VISN 5 (District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia); VISN 6 (North Carolina and Virginia); VISN 8 (Florida, Georgia, Puerto Rico, and the U.S. Virgin Islands); and VISN 17 (Texas).

share a common set of facility-planning officials.⁶ Results from our sample of site visits are not generalizable to all VISNs or VAMCs.

Table 2: Department of Veterans Affairs' (VA) Medical Centers Visited by GAO

VA medical center (VAMC)	Location	Veteran Integrated Service Network (VISN)
Baltimore VAMC	Baltimore, Maryland	VISN 5
Perry Point VAMC	Perry Point, Maryland	VISN 5
Hunter Holmes McGuire VAMC	Richmond, Virginia	VISN 6
Bay Pines VA Healthcare System	Bay Pines, Florida	VISN 8
Malcolm Randall VAMC	Gainesville, Florida	VISN 8
James A. Haley Veterans' Hospital	Tampa, Florida	VISN 8
Dallas VAMC	Dallas, Texas	VISN 17
Olin E. Teague Veterans' Medical Center	Temple, Texas	VISN 17
Audie L. Murphy VA Hospital	San Antonio, Texas	VISN 17

Source: GAO. | GAO-19-440

Note: The Baltimore VAMC and Perry Point VAMC are part of the VA Maryland Healthcare System and, as a result, have the same facility-planning officials.

To determine the extent to which VA assesses trends in veterans' needs and expectations, we reviewed documentation of the Enrollee Health Care Projection Model—a VA model for estimating the amount of resources VA needs to meet the expected demand for most of the health care services it provides—and interviewed officials at VHA's Office of Policy and Planning who oversee the model to discuss veteran population projections and trends.⁷ We reviewed the model's documentation related to its purpose and structure and interviewed relevant officials, and determined that the data from the Enrollee Health Care Projection Model were sufficiently reliable for our audit objectives.⁸ We also coordinated

⁶Two of the VAMCs we visited, the Baltimore VAMC and Perry Point VAMC, are part of the VA Maryland Healthcare System and, as a result, have the same facility-planning officials. In many areas of the country, several medical centers and clinics may work together to offer services to area veterans as a health care system. According to VA, by sharing services between or among medical centers, the aim is for VHA to provide veterans easier access to advanced medical care closer to their homes.

⁷The Enrollee Health Care Projection Model was developed in 1998 by VA and its consultant. It helps supports the development of VA's budget estimates for health care and informs strategic and capital planning.

⁸A review of the underlying assumptions of the Enrollee Health Care Projection Model and the accuracy of model projections was outside the scope of this review.

with VHA officials and relevant VAMC officials to identify 127 surveys that VA had been administering. In reviewing survey titles and coordinating with relevant survey points of contact, we narrowed down the 127 surveys to a list of 14 surveys by identifying those that could (1) potentially help VA understand veterans' needs and/or expectations in facility planning and (2) be attributed to different veteran population demographics (e.g., gender, age, race, etc.). We then reviewed these 14 survey instruments to determine the extent to which they included measures that specifically asked about veterans' expectations. Further, we compared VA's efforts to assess trends in veterans' needs and expectations to federal standards for internal control for use of quality information and relevant control activities.⁹

To identify what national efforts VA has initiated to help VAMCs address veterans' changing needs and expectations in facility planning, we reviewed VA documents, including its FY 2018–2024 Strategic Plan and relevant documentation about VA's foundational health services. We also interviewed officials from VHA's Office of Policy and Planning and Office of the Assistant Deputy Under Secretary for Health for Clinical Operations. To obtain local perspectives on these efforts, we spoke with the facility-planning officials at each of the VISNs and VAMCs from our site visits and included questions about VA's instructions to VAMCs to implement these efforts in our national survey of facility planners. Further, we compared VA's national efforts to federal standards for internal control for communicating internally and relevant control activities.¹⁰

To determine how VAMCs use VA's process for identifying future facilities' space needs to address veterans' changing needs and expectations in facility planning, we spoke with the facility planning-officials at each of the VISNs and VAMCs from our site visits and included questions about the SCIP process (including its perceived reliability and usefulness) in our national survey of facility planners. Further, we analyzed SCIP data on estimates of facilities' needs for space in 10 years. Specifically, we analyzed variation in SCIP's estimate 10-year needs for space for all VAMCs across 4 years of SCIP data (SCIP fiscal

⁹GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: September 2014).

¹⁰See [GAO-14-704G](#).

years 2017, 2018, 2019, and 2020 estimates).¹¹ To assess the reliability of these data, we (1) performed electronic testing of relevant data elements; (2) reviewed existing information about the data and the system that produced them; and (3) interviewed agency officials knowledgeable about the data. We determined that these data were sufficiently reliable for presenting the estimates across the 4-year period. Further, we compared how VAMCs are using VA space estimates in their facility planning to federal standards for internal control for use of quality information and relevant control activities.¹²

We conducted this performance audit from April 2018 to June 2019 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.

¹¹A given fiscal year's SCIP data are based on information collected 4 years prior. For example, SCIP data for fiscal year 2020 are based on information collected in fiscal year 2016, while SCIP data for fiscal year 2019 are based on information collected in fiscal year 2015.

¹²See [GAO-14-704G](#).

Appendix II: Results of GAO's Survey of Department of Veterans Affairs' Medical Center (VAMC) Facility-Planning Officials

In this appendix, we include all questions asked in our survey and results of responses to the closed-ended questions. Narrative answers to open-ended text questions are not displayed to prevent the identification of individual respondents. Percentages may not always sum to 100 percent because of rounding of decimal figures.

We administered our web-based survey between November 2018 and January 2019 to VAMC facility-planning officials. As noted in appendix I, 137 individuals representing 159 VAMCs responded to the survey (118 of the 119 facility-planning officials at single VAMCs and 19 of the 20 facility-planning officials that oversee multiple VAMCs), for an overall response rate of about 99 percent.¹ Because question-specific response rates varied in cases where individual questions were not answered, we show the total number of respondents for each question. Questions 11–22 ask about the facility planning officials' views on the accuracy of Strategic Capital Investment Planning (SCIP) process's 10-year projected space estimates for the officials' VAMC (or for each of the officials' VAMCs if they oversee multiple VAMCs). Of the 162 VAMCs' SCIP estimates that the survey asked about, facility-planning officials responded to the questions about their accuracy for 154 or 155 VAMCs (depending on the specific SCIP space category question).

¹We received responses from 137 of the 139 facility-planning officials, representing 159 of the 162 VAMCs. Although there are 172 VAMCs, a VA official who oversees SCIP told us that VA combines several VAMC's SCIP space gap estimates as part of the SCIP planning process. As a result, VA attributes SCIP data to 162 VAMCs.

**Appendix II: Results of GAO's Survey of
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Facility Planning Resources

1. Please indicate to what extent your facility uses the Health Systems Planning Application in its facility planning process. Then, please indicate if your facility has experienced any of the following issues with the Health Systems Planning Application.

Use of the Health Systems Planning Application

Use to a large extent	Use to some extent	Use to a slight extent	Do not use	Total number of respondents
13%	36%	29%	21%	135

Notes: There were 137 possible respondents for this question. These percentages do not include those who did not respond to the question.

Problems identified with the Health Systems Planning Application

Relevancy	Accuracy	Completeness	"User friendly"	Other	No problems
19	25	22	29	32	43

Notes: There were 137 possible respondents for each question. Due to higher item non-response and the check-all-that-apply format, only counts of respondents who selected these answers are presented, rather than percentages.

If "Other" types of problems, please specify: *[text data intentionally not reported]*

**Appendix II: Results of GAO's Survey of
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2. For each of the following types of data in the VHA Support Service Center Capital Assets portal/Pyramid, please indicate to what extent your facility uses each in its facility planning process. Then, please indicate if your facility has experienced any problems with these data.

Use of data in the VHA Support Service Center Capital Assets portal/Pyramid

	Use to a large extent	Use to some extent	Use to a slight extent	Do not use	Total number of respondents
a. Enrollee Health Care Projection Model data within the VHA Support Service Center Capital Assets portal/Pyramid	59%	32%	4%	4%	136
b. Data other than the Enrollee Health Care Projection Model available in the VHA Support Service Center Capital Assets portal/Pyramid that is nationally collected and available at the facility level	56%	29%	10%	6%	136

Notes: There were 137 possible respondents for each question. These percentages do not include those who did not respond to the question.

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Problems identified with the data in the VA Support Service Center Capital Assets
portal/Pyramid

	Relevancy	Accessibility	Completeness	"User friendly"	Other	No Problems
a. Enrollee Health Care Projection Model data within the VHA Support Service Center Capital Assets portal/Pyramid	7	31	6	33	28	55
b. Data other than the Enrollee Health Care Projection Model available in the VHA Support Service Center Capital Assets portal/Pyramid that is nationally collected and available at the facility level	8	17	11	28	18	59

Notes: There were 137 possible respondents for each question. Due to higher item non-response and the check-all-that-apply format, only counts of respondents who selected these answers are presented, rather than percentages.

If "Other" types of problems, please specify: [text data intentionally not reported]

**Appendix II: Results of GAO's Survey of
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3. For each of the following sources of veteran feedback, please indicate to what extent your facility uses each in its facility planning process. Then, please indicate if your facility has experienced any of the following problems with the sources of veteran feedback. (Please respond for each source of feedback.)

Use of sources of veteran feedback

	Use to a large extent	Use to some extent	Use to a slight extent	Do not use	Don't know	Total number of respondents
a. VA-administered nationally representative surveys of veterans	34%	37%	15%	8%	6%	135
b. VAMC- or Veterans Integrated Service Network (VISN)-administered surveys of only the veterans that go to your facilities or are in your VISN	27%	32%	10%	18%	13%	135
c. Town halls or other formal discussions with veterans	56%	33%	10%	1%	1%	135
d. Feedback from veterans' comments (e.g., comments to providers/VA staff, patient advocates, comment boxes, social media, etc.)	58%	26%	12%	3%	1%	136
e. Feedback from veterans service organizations (VSO)s	45%	35%	17%	1%	1%	135
f. Third party reports (e.g., VSO reports, RAND, etc.)	13%	43%	21%	11%	12%	134

Notes: There were 137 possible respondents for each question. These percentages do not include those who did not respond to the question.

3g. Does your facility use any other sources of veteran feedback that are not listed above?

	Yes	No	Total number of respondents
	45%	55%	136

Notes: There were 137 possible respondents for each question. These percentages do not include those who did not respond to the question.

If "Yes", please describe the other sources: *[text data intentionally not reported]*

**Appendix II: Results of GAO's Survey of
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Problems identified with different sources of veteran feedback

	Relevancy	Accessibility	Not conducted	Other	No problems
a. VA-administered nationally representative surveys of veterans	20	19	NA	35	60
b. VAMC- or VISN-administered surveys of only the veterans that go to your facilities or are in your VISN	7	6	7	17	73
c. Town halls or other formal discussions with veterans	21	NA	0	21	83
d. Feedback from veterans' comments (e.g., comments to providers/VA staff, patient advocates, comment boxes, social media, etc.)	16	NA	0	17	85
e. Feedback from VSOs	13	NA	1	15	85
f. Third party reports (e.g., VSO reports, RAND, etc.)	11	13	NA	16	65

Notes: There were 137 possible respondents for each question. Due to higher item non-response and the check-all-that-apply format, only counts of respondents who selected these answers are presented, rather than percentages.

If "Other" types of problems, please specify: *[text data intentionally not reported]*

Facility Planning and Veterans' Changing Demographics

4. How clear, if at all, are VA's expectations regarding how to incorporate veterans' changing demographics and the associated changes in their needs or expectations into your facility planning?

Very clear	Moderately clear	Slightly clear	Not at all clear	Total number of respondents
29%	41%	18%	12%	136

Notes: There were 137 possible respondents for each question. These percentages do not include those who did not respond to the question.

**Appendix II: Results of GAO's Survey of
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5. How useful, if at all, would instructions from VA regarding how to incorporate veterans' changing needs or expectations into facility planning be to your facility?

Very useful	Moderately useful	Slightly useful	Not at all useful	Total number of respondents
61%	26%	11%	2%	137

Notes: There were 137 possible respondents for each question. These percentages do not include those who did not respond to the question.

VA's Foundational Health Services

6. Facility foundational health services and VA's list of foundational health services

	Yes	No	Don't know	Total number of respondents
a. Does your facility consider any additional services, not included on VA's list, to be foundational?	57%	37%	6%	137
b. Does your facility consider any services (1 or more) included on VA's list to be not foundational?	10%	86%	4%	136

Notes: There were 137 possible respondents for each question. These percentages do not include those who did not respond to the question.

7. To what extent, if at all, does your facility plan for foundational services (as identified either by VA or your facility) differently from non-foundational services as part of its facility planning process?

To a large extent	To some extent	To a slight extent	Not at all	Total number of respondents
33%	47%	12%	9%	137

Notes: There were 137 possible respondents for each question. These percentages do not include those who did not respond to the question.

8. How clear, if at all, are VA's expectations for how your facility should plan for foundational services (as identified either by VA or your facility) versus non-foundational services?

Very clear	Moderately clear	Slightly clear	Not at all clear	Total number of respondents
24%	35%	24%	18%	136

Notes: There were 137 possible respondents for each question. These percentages do not include those who did not respond to the question.

**Appendix II: Results of GAO's Survey of
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9. How useful, if at all, would additional instruction from VA regarding incorporating foundational services (as identified either by VA or your facility) into facility planning be for your facility?

Very useful	Moderately useful	Slightly useful	Not at all useful	Total number of respondents
51%	28%	17%	4%	135

Notes: There were 137 possible respondents for each question. These percentages do not include those who did not respond to the question.

10. To what extent, if at all, has the information you have received from VA regarding planning for foundational services (as identified either by VA or your facility) helped you to prioritize your facility planning efforts?

To a large extent	To some extent	To a slight extent	Not at all	Total number of respondents
27%	44%	21%	8%	137

Notes: There were 137 possible respondents for each question. These percentages do not include those who did not respond to the question.

10a. How, if at all, could the information you received from VA on the foundational services (as identified either by VA or your facility) be improved to help you prioritize your facility planning efforts?

[text data intentionally not reported]

**Appendix II: Results of GAO's Survey of
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VA's SCIP Process Space Gaps

11a – 22a: As you were closing out your fiscal year (FY) 2020 SCIP space gaps, was this projection generally accurate or generally inaccurate at reflecting the projected needs for your facility?

	Generally accurate	Generally inaccurate	Don't know	Total number of respondents
11a. Acute Care: Acute Inpatient Medicine & Surgery	55%	31%	14%	154
12a. Acute Care: Acute Special Programs	71%	14%	15%	154
13a. Acute Care: Inpatient Mental Health	43%	43%	14%	154
14a. Ambulatory Care: Ancillary/Diagnostic	61%	25%	14%	154
15a. Ambulatory Care: Mental Health	57%	30%	13%	155
16a. Ambulatory Care: Primary Care	68%	22%	10%	155
17a. Ambulatory Care: Specialty Care	66%	20%	14%	154
18a. Long Term Care: CLC/Hospice	57%	28%	15%	155
19a. Non-Clinical Space: Administration	50%	34%	16%	154
20a. Non-Clinical Space: Common/Vacant/Construction	56%	23%	20%	154
21a. Non-Clinical Space: Research	65%	20%	15%	154
22a. Non-Clinical Space: Support	63%	21%	16%	155

Notes: These questions were asked at the facility level, and as a result, there were 159 possible respondents for each question. These percentages do not include those who did not respond to the question. Although there were 137 possible survey respondents, 19 of the possible survey respondents were facility-planning officials for more than one VAMC.

**Appendix II: Results of GAO's Survey of
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11b – 22b: If "Generally inaccurate:" Which of the following best describes any inaccuracies of the projected space gap for this category?

	More space needed	Less space needed	Total number of respondents
11b. Acute Care: Acute Inpatient Medicine & Surgery	67%	33%	49
12b. Acute Care: Acute Special Programs	86%	14%	21
13b. Acute Care: Inpatient Mental Health	69%	31%	65
14b. Ambulatory Care: Ancillary/Diagnostic	42%	58%	38
15b. Ambulatory Care: Mental Health	63%	37%	46
16b. Ambulatory Care: Primary Care	82%	18%	33
17b. Ambulatory Care: Specialty Care	40%	60%	30
18b. Long Term Care: CLC/Hospice	62%	38%	42
19b. Non-Clinical Space: Administration	88%	12%	52
20b. Non-Clinical Space: Common/Vacant/Construction	38%	62%	37
21b. Non-Clinical Space: Research	62%	38%	29
22b. Non-Clinical Space: Support	53%	47%	32

Notes: These questions were asked at the facility level, and as a result, there were 159 possible respondents for each question. These percentages do not include those who did not respond to the question. Although there were 137 possible survey respondents, 19 of the possible survey respondents were facility-planning officials for more than one VAMC.

Overall SCIP Questions

23. When closing each of 12 SCIP space gaps, how easy or difficult is it to determine which of the 71 Capital Asset Inventory categories to allocate the changes in space to?

Very easy	Somewhat easy	Somewhat difficult	Very difficult	Total number of respondents
8%	23%	56%	14%	133

Notes: There were 137 possible respondents for each question. These percentages do not include those who did not respond to the question.

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24. Do any of the following issues contribute to inaccuracies with the SCIP space gaps?

	Yes	No	Don't know	Total number of respondents
a. Inaccuracies in our facility's Capital Asset Inventory	43%	40%	17%	136
b. Inaccuracies with projections (e.g., demographics, workload, etc.)	54%	21%	24%	136
c. Inaccuracies with the translation of the projections into square footage	49%	24%	27%	136
d. Inaccuracies due to changing veteran needs and expectations and/or standards of care	56%	21%	22%	135
e. Don't know enough about how the gap was calculated to understand what caused the error	49%	33%	19%	135
f. Other	42%	27%	31%	95

Notes: There were 137 possible respondents for each question. These percentages do not include those who did not respond to the question.

If "Yes" for "Other", describe any additional issues regarding the accuracy of SCIP space gaps below: *[text data intentionally not reported]*

25. How clear, if at all, is the process that VA uses to translate projected utilization into square footage for the SCIP space gap projections for the 12 categories?

Very clear	Moderately clear	Slightly clear	Not at all clear	Total number of respondents
8%	22%	40%	29%	136

Notes: There were 137 possible respondents for each question. These percentages do not include those who did not respond to the question.

26. How useful, if at all, would further clarification about this process from VA be to your facility planning efforts?

Very useful	Moderately useful	Slightly useful	Not at all useful	Total number of respondents
65%	25%	8%	2%	133

Notes: There were 137 possible respondents for each question. These percentages do not include those who did not respond to the question.

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(VAMC) Facility-Planning Officials**

27. As part of your facility planning, how useful do you find the overall process of closing SCIP gaps in order to address future needs and expectations of your local veteran population?

Very useful	Moderately useful	Slightly useful	Not at all useful	Total number of respondents
19%	29%	38%	15%	136

Notes: There were 137 possible respondents for each question. These percentages do not include those who did not respond to the question.

27a. What was your reasoning for how you answered about the usefulness of the overall process of closing out SCIP gaps?

[text data intentionally not reported]

28. VAMC officials are required to annually close out all of their SCIP gaps by submitting projects based on a 10-year planning cycle through SCIP. How useful is it to your facility to submit projects across a full 10-year SCIP planning cycle?

Very useful	Moderately useful	Slightly useful	Not at all useful	Total number of respondents
13%	25%	40%	21%	136

Notes: There were 137 possible respondents for each question. These percentages do not include those who did not respond to the question.

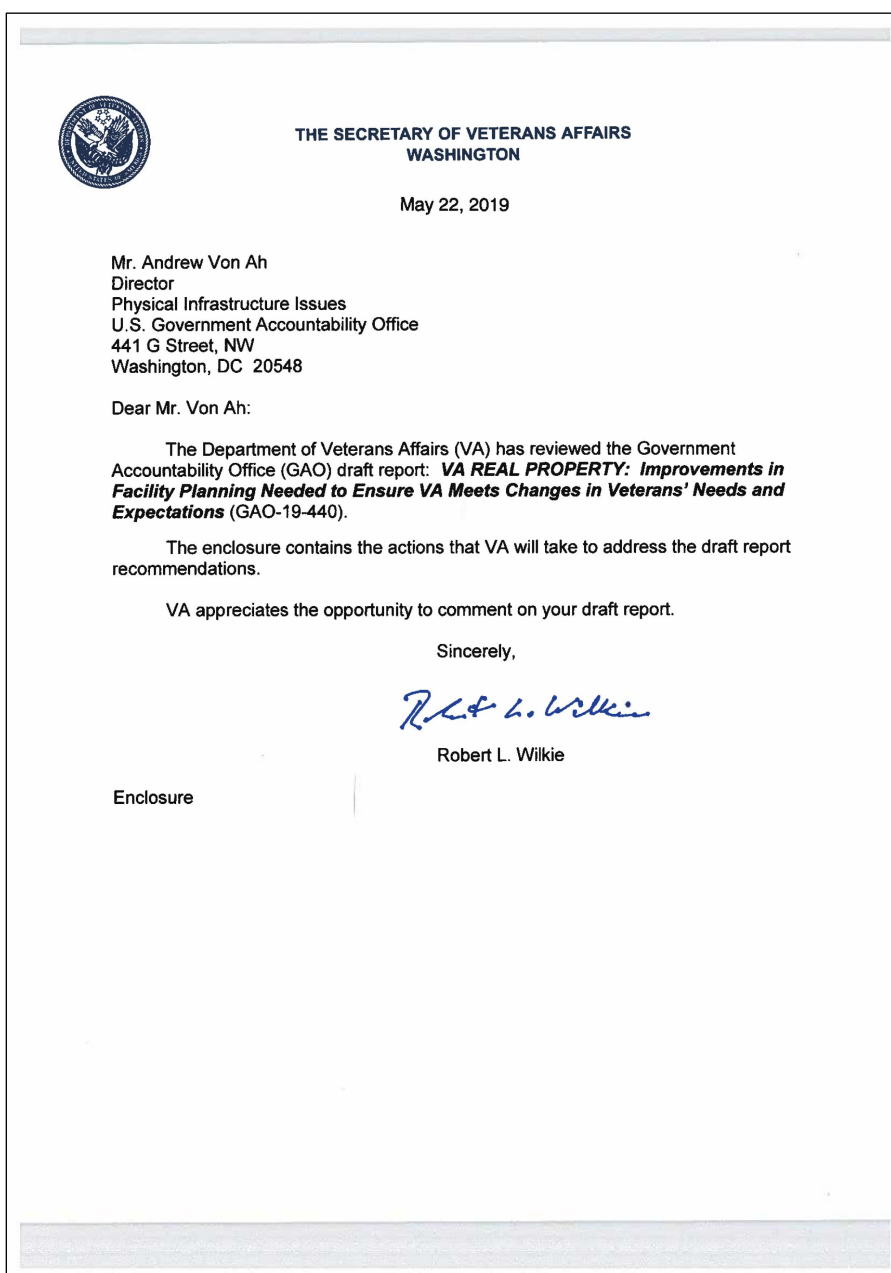
28a. What was your reasoning for how you answered about the usefulness of submitting projects across a full 10-year SCIP planning cycle?

[text data intentionally not reported]

29. What, if anything, would help you better plan for the changing needs and expectations of veterans?

[text data intentionally not reported]

Appendix III: Comments from the Department of Veterans Affairs





THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

May 22, 2019

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

Dear Ms. Draper:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: ***VA REAL PROPERTY: Improvements in Facility Planning Needed to Ensure VA Meets Changes in Veterans' Needs and Expectations*** (GAO-19-440).

The enclosure contains the actions that VA will take to address the draft report recommendations.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

A handwritten signature in blue ink that reads "Robert L. Wilkie".

Robert L. Wilkie

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***VA REAL PROPERTY: Improvements in Facility Planning Needed to Ensure VA
Meets Changes in Veterans Needs and Expectations***
(GAO-19-440)

General Comment:

As discussed with GAO at the exit conference, the report does not address the health care planning process that the Veterans Health Administration (VHA) utilizes. That health care planning process is the missing step for facility planners to develop both capital and non-capital solutions to address the workload projections that are derived from the Enrollee Health Care Projection Model (EHCPM). That health care planning process is designed to occur after the EHCPM estimates are generated--but before the Strategic Capital Investment Plan (SCIP) process is initiated--to better inform the inputs the facility will need to put into SCIP. While the inclusion of this health care planning process may not change the recommendations GAO has made, it would ensure the process VA utilizes is properly and accurately explained in the report.

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
**VA REAL PROPERTY: Improvements in Facility Planning Needed to Ensure VA
Meets Changes in Veterans Needs and Expectations**
(GAO-19-440)

**Recommendation 1: Develop and implement a consistent process to assess
veterans' changing expectations and disseminate this information to VAMCs.**

VA Comment: Concur. VHA has already developed and implemented effective systems for obtaining Veterans' input in facility planning. Depending on the project, VHA uses multiple modalities for obtaining this input, such as: townhalls, focus groups, demographic based surveys, Veterans signals (Vsignals), data from the Office of Policy and Planning, and general public comment. Vsignals allows each service such as pharmacy, imaging, or even location such as a Community Based Outpatient Clinic to see in real time the feedback that their Veterans have given them. This means that each team can review their performance routinely and make quick corrective actions based on that feedback. They have access to the right information at the right time. Veterans Integrated Service Networks (VISN) and VA Medical Centers (VAMC) use these mechanisms to ensure local needs and expectations are understood and addressed in facility planning. VHA uses an electronic system to collect and store Veterans' input from feedback surveys. VA feels this system is effective and consistent and has been in place for some time. Should VHA determine that a facility planning requirement gained from the input systems be implemented nationwide, it would be incorporated into national standards. For example, standard construction specifications and facility design are used throughout VA. VHA finds actions on this recommendation to be completed and requests GAO consider closure of this recommendation.
Status: Complete

**Recommendation 2: Instruct VAMCs on how to meet VA's strategic goal of
incorporating veterans' changing needs and expectations into facility planning,
such as identifying certain resources or tools and directing VAMCs to use them.**

VA Comment: Concur. VHA's Office of Capital Asset Management Engineering and Support (OCAMES) agrees that refreshing the requirement to use the Vsignals system data to assist in planning and updates will help ensure Veterans input is incorporated where appropriate. OCAMES will provide guidance to VAMCs in conjunction with the Office of Asset Enterprise Management's annual call memo for the SCIP program to remind VISNs and VAMCs to ensure that Vsignals data is used in preparation for SCIP planning process.
Target Completion Date: September 2019

Enclosure

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Recommendation 3: Assess the extent to which its concept of foundational services is still a priority and communicate the results to VAMCs, and if still a priority, include additional instruction to VAMCs on how to incorporate into facility planning.

VA Comment: Concur. VHA appreciates GAO's finding that VAMCs have variable understanding of national guidance on foundational services. We define our vision for a modernized VHA as "Consistent delivery of excellent-quality care and customer service for every patient, every time." Our plan for modernization encompasses ten lanes of effort that, when taken together, enable VHA to function as an integrated high reliability organization. The ten lanes of effort are:

- Commit to Zero Harm
- VA MISSION Act: Improve Access to Care
- Engaging Veterans in Lifelong Health, Well-being, and Resilience
- Reduce Unwarranted Variation Across Integrated Clinical and Operational Service Lines
- Streamline VHA Central Office
- Revise Governance Processes and Align Decision Rights
- Develop Responsive Shared Services
- Modernize Electronic Health Records
- Transform Financial Management System
- Transform Supply Chain

The Office of the Deputy Under Secretary for Health for Operations and Management will clarify prior guidance on foundational services for Medical Centers. VHA looks forward to improving Veterans health care through modernization.
Target Completion Date: June 2019

Recommendation 4: Increase the value and reliability of the Strategic Capital Investment Planning (SCIP) process for facility planners by systematically gathering feedback from facility planners and addressing their concerns with the SCIP process (as necessary), including providing additional information on how SCIP space estimates are derived.

VA Comment: Concur. VA's training for the SCIP process will be modified to include additional explanation on how SCIP space estimates are derived. Training will specify how both clinical and non-clinical space is generated and how it relates to projected

Enclosure

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station workloads. Training will also specify what is expected in terms of gap closure for both clinical and non-clinical space estimates.

Additionally, VA will develop a survey to be released after training to ensure that users understand key concepts. It will also survey if users would like additional training on the SCIP Automation tool, how their gaps (including space estimates) are generated, and other topics related to the SCIP process. Staff will use the results of those surveys to either schedule individual or small-group training to address those users concerns and/or develop improvements to the SCIP process as needed.
Target Completion Date: May 2020

Agency Comment Letter

Text of Appendix III: Comments from the Department of Veterans
Affairs

Page 1

May 22, 2019

Mr. Andrew Von Ah
Director
Physical Infrastructure Issues
U.S. Government Accountability Office
441 G Street, NW

Washington, DC 20548

Dear Mr. Von Ah:

The Department of Veterans Affairs (VA) has reviewed the Government
Accountability Office (GAO) draft report: VA REAL PROPERTY: Improvements in
Facility Planning Needed to Ensure VA Meets Changes in Veterans' Needs and
Expectations (GAO-19-440).

The enclosure contains the actions that VA will take to address the draft report
recommendations.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

Robert L. Wilkie

Enclosure

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May 22, 2019

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

Dear Ms. Draper:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: VA REAL PROPERTY: Improvements in Facility Planning Needed to Ensure VA Meets Changes in Veterans' Needs and Expectations (GAO-19-440).

The enclosure contains the actions that VA will take to address the draft report recommendations.

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Sincerely,

Robert L. Wilkie

Enclosure

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Office (GAO) Draft Report
VA REAL PROPERTY: Improvements in Facility Planning Needed to Ensure VA
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{GAO-19-440}**

General Comment:

As discussed with GAO at the exit conference, the report does not address the health care planning process that the Veterans Health Administration (VHA) utilizes. That health care planning process is the missing step for facility planners to develop both capital and non-capital solutions to address the workload projections that are derived from the Enrollee Health Care Projection Model (EHCPM). That health care planning process is designed to occur after the EHCPM estimates are generated--but before the Strategic Capital Investment Plan (SCIP) process is initiated--to better inform the inputs the facility will need to put into SCIP. While the inclusion of this health care planning process may not change the recommendations GAO has made, it would ensure the process VA utilizes is properly and accurately explained in the report.

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Recommendation 1:

Develop and implement a consistent process to assess veterans' changing expectations and disseminate this information to VAMCs.

VA Comment: Concur. VHA has already developed and implemented effective systems for obtaining Veterans' input in facility planning. Depending on the project, VHA uses multiple modalities for obtaining this input, such as: townhalls, focus groups, demographic based surveys, Veterans signals (Vsignals), data from the Office of Policy and Planning, and general public comment. Vsignals allows each service such as pharmacy, imaging, or even location such as a Community Based Outpatient Clinic to see in real time the feedback that their Veterans have given them. This means that each team can review their performance routinely and make quick corrective actions based on that feedback. They have access to the right information at the right time.

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Status: Complete

Recommendation 2:

Instruct VAMCs on how to meet VA's strategic goal of incorporating veterans' changing needs and expectations into facility planning, such as identifying certain resources or tools and directing VAMCs to use them.

VA Comment: Concur. VHA's Office of Capital Asset Management Engineering and Support (OCAMES) agrees that refreshing the requirement to use the Vsignals system data to assist in planning and updates will help ensure Veterans input is incorporated where appropriate. OCAMES will provide guidance to VAMCs in conjunction with the Office of Asset Enterprise Management's annual call memo for

the SCIP program to remind VISNs and VAMCs to ensure that Vsignals data is used in preparation for SCIP planning process.

Target Completion Date: September 2019

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Recommendation 3:

Assess the extent to which its concept of foundational services is still a priority and communicate the results to VAMCs, and if still a priority, include additional instruction to VAMCs on how to incorporate into facility planning.

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The Office of the Deputy Under Secretary for Health for Operations and Management will clarify prior guidance on foundational services for Medical Centers. VHA looks forward to improving Veterans health care through modernization.

Target Completion Date: June 2019

Recommendation 4:

Increase the value and reliability of the Strategic Capital Investment Planning (SCIP) process for facility planners by systematically gathering feedback from facility planners and addressing their concerns with the SCIP process (as necessary), including providing additional information on how SCIP space estimates are derived.

VA Comment: Concur. VA's training for the SCIP process will be modified to include additional explanation on how SCIP space estimates are derived. Training will specify how both clinical and non-clinical space is generated and how it relates to projected station workloads. Training will also specify what is expected in terms of gap closure for both clinical and non-clinical space estimates.

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Additionally, VA will develop a survey to be released after training to ensure that users understand key concepts. It will also survey if users would like additional training on the SCIP Automation tool, how their gaps (including space estimates) are generated, and other topics related to the SCIP process. Staff will use the results of those surveys to either schedule individual or small-group training to address those users concerns and/or develop improvements to the SCIP process as needed.

Target Completion Date: May 2020

Appendix IV: GAO Contacts and Staff Acknowledgments

GAO Contacts

Andrew Von Ah at (202) 512-2834 or vonaha@gao.gov, or Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

Staff Acknowledgments

In addition to the contacts named above, Keith Cunningham, Assistant Director; Jeff Mayhew, Analyst-in-Charge; Adam Gomez; Jacquelyn Hamilton; Serena Lo; Matt Nattinger; Jerry Sandau; Michelle Weathers; Crystal Wesco; and Elizabeth Wood made key contributions to this report. Also contributing were Cathy Colwell and Malika Rice.

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