VA High Risk List Action Plan:

Managing Risks and Improving VA Health Care

March 2020

Department of Veterans Affairs

This page intentionally left blank

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

The Honorable Gene L. Dodaro
Comptroller General
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Dodaro:

In response to GAO report 15-290 High Risk Series An Update, I am pleased to submit the Department of Veteran Affairs (VA) High Risk List (HRL) Action Plan—Managing Risks and Improving VA Health Care report to the U.S. Government Accountability Office (GAO).

This report updates VA's approach to improving its overall management functions and identifies key metrics we will use to evaluate our success in resolving the issues identified by GAO in its 2015 High Risk Series Update. In addition, the report describes actions VA has already taken, both in its overall approach to the management of the Department, and more specifically how those actions have been incorporated into VA's modernization efforts. VA's modernization efforts are intended to streamline operations and focus attention on program improvements to move VA toward becoming a high reliability organization. Integrating foundational management practices will ensure these and future initiatives are positioned to have the right policies; staff with the right knowledge, skills, and abilities; receive the right IT support; obtain funding; and have management oversight.

Sincerely,

/s/Robert L. Wilkie

Enclosures

Executive Summary

This document is Department of Veterans Affairs' (VA) updated action plan for addressing the five broad management issues described by the Government Accountability Office (GAO) in its *2015 High-Risk List*[1] update. VA has embarked on a journey of self-improvement and rapid change. VA leaders and staff are motivated by a sincere commitment to transform the nation's largest health care system and are determined to address and resolve the five areas of concern (AOCs) GAO identified. The five AOCs are: (1) policies and processes, (2) oversight and accountability, (3) information technology (IT), (4) training and (5) resource allocation.

VA delivered its initial action plan to GAO in 2017; that action plan partially met GAO's expectations. Subsequently VA conducted a more thorough root cause analysis on each of the AOCs and reached mutual agreement with GAO on root causes, seven key outcomes, and twenty AOC-specific outcomes. The seven key outcomes establish core principles for VA's future state relative to the AOCs. The key outcomes are—

- Policy drives correct behavior and is implemented consistently
- Business processes are integrated and efficient
- Resources are used effectively and efficiently
- Systems are interoperable and meet business needs
- Data are available, accurate, reliable, complete and used to inform decisions
- Governance and oversight mechanisms provide reasonable assurance that requirements are met
- Targeted, standardized, and comprehensive training that supports policy or guidance and active field engagement

This updated action plan includes over 250 actions being undertaken throughout Veterans Health Administration and establishes nearly three dozen measures to monitor progress toward achieving the outcomes. The plan also identifies key transformational initiatives from *VHA's Plan for Modernization*[2] that complement or contribute to resolution of the areas of concern. VHA Modernization Lanes of Effort (LOEs) that integrate with high risk AOCs are:

- Commit to Zero Harm (become a High Reliability Organization)
- Organizational Improvement
- Develop Responsive Shared Services
- Engaging Veterans in Lifelong Health, Well-being, and Resilience
- Maintaining Internal Systems and Strengthening Integrated Outside (MISSION) Act Access to Care: Access Standards
- Modernize Electronic Health Records
- Transform Supply Chain

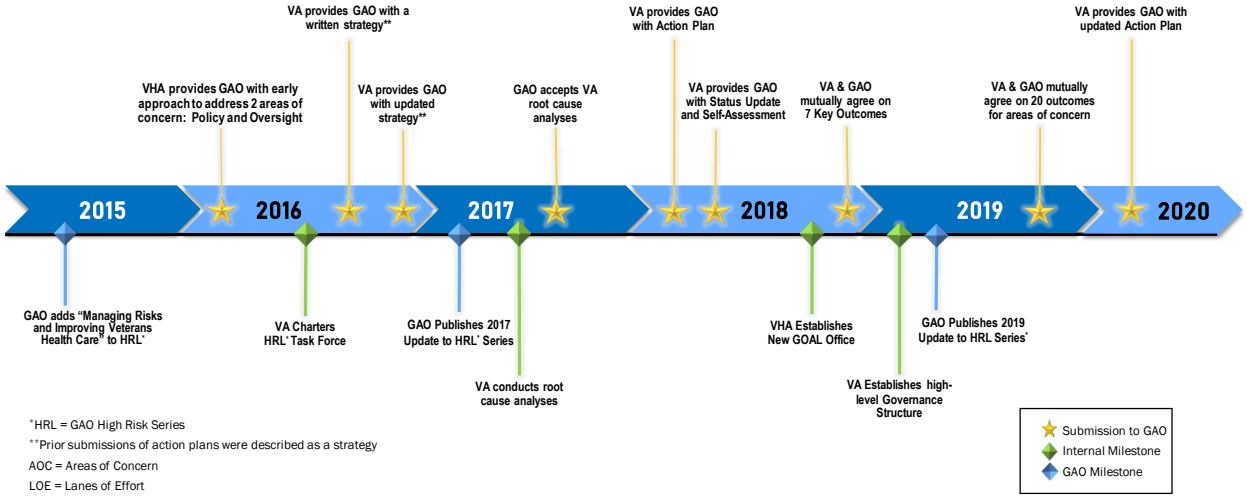
Attending to core management functions during planning and execution ensures large initiatives are reinforced by sound policy; are implemented by staff who have the right knowledge, skills, and abilities; receive the right IT support; identify and secure essential human and financial resources; have management oversight; and are accountable throughout planning, implementation, and reinforcement.

[1] GAO, *High-Risk Series: An Update*, GAO-15-290 (Washington, D.C.: February 2015).

[2] Department of Veterans Affairs, Veterans Health Administration, VHA Plan for Modernization (Washington D.C.: March 2019).

This report details VA's commitment to address management functions GAO highlighted in its 2015 report.

The timeline below highlights milestones in development of VA's action plan.



Key Milestones - 2015 to Present

VA's Progress on Resolving Areas of Concern – GAO Rating on Criteria for Removal

GAO uses five criteria to assess progress toward resolving the AOCs and ultimate removal from the High Risk List: (1) leadership commitment, (2) capacity, (3) action plan, (4) monitoring, and (5) demonstrated progress. GAO rates agencies on each criterion using the star diagram. Ratings are either "not met," "partially met," or "met." With this Action Plan, VA believes it will continue to make progress in all five AOCs to earn at least a "partially met" rating in each criterion for removal by 2021. These goals are graphically represented at the beginning of each area of concern section in Chapter 2. Key VA actions that were not part of GAO's most recent rating period[3] are briefly summarized below.

GAO's 2019 Rating of VA Health Care Progress

Removal Criterion 1 – Leadership Commitment

In fiscal year (FY) 2018, Secretary Wilkie strengthened leadership commitment by making business transformation a Departmental strategic priority. Secretary Wilkie also established a high-level governance structure to oversee the Department's high risk plans and actions. The high-level governance structure, managed through the Office of Enterprise Integration, consists of three decision-making bodies: VA Operations Board, Executive Advisory Board, and a Steering Committee supported by individual AOC work groups.

[3] GAO, *High-Risk Series: An Update*, GAO-19-157 SP (Washington, D.C.: March 2019).

In FY 2019, Dr. Richard Stone, Executive in Charge (EIC) for VHA, articulated that becoming a highly reliable organization means achieving the seven key outcomes articulated in the *VHA Plan for Modernization*.[4] At his request, modernization project teams met with GAO to receive input on their initiatives and included actions and measures relative to the AOCs in their operating plans. Dr. Stone also established a permanent program management office for GAO High-Risk Series work called the GAO-OIG Accountability Liaison (GOAL) Office. GOAL serves as VHA's primary liaison to GAO; leads portfolio management, change management, and risk management across the five AOC work groups; coordinates across transformational project teams; establishes strategic direction and plans; tracks and monitors planned actions; develops reports to senior leadership, GAO, and Congress; and chairs and staffs the Steering Committee. VHA leadership allocated funding and government staff to establish GOAL in FY 2019. Additional details on this office are included in Chapter 3 of this report.

VHA leadership also directly participates in high-level Departmental governance structures. The EIC is a member of the VA Operations Board; the VHA Principal Deputy Under Secretary for Health co-leads the Executive Advisory Board; the Deputy Under Secretary for Organizational Excellence is a member of the Executive Advisory Board. VA executive leaders have also allocated resources in the form of government employees or contract support for all five AOC work groups.

Removal Criterion 2 – Capacity Actions

In 2018 and 2019, VA built the management capacity needed to address the AOCs by dedicating government and contract staff; leveraging its federally funded research and development center and the private sector for best practices; supporting staff training for skill development; and allocating funds. VA trained GOAL staff in disciplines critical to long-term success – program/portfolio management, risk management, and change management – and VA allocated over $27 million in contract support. Nearly three dozen government personnel are actively involved in addition to dedicated contractor staff. VA expects dedicated staff and contract support will be needed through FY 2025. Stakeholder program offices use current funding and staff to support efforts to address GAO concerns. VA does not anticipate requesting additional funds to manage action plan activities in the upcoming budget cycle.

In FY 2018, VA established a manpower management office to develop and oversee position management, organizational structure, and validate analytic tools to determine workload-based staffing requirements. In FY 2019, VHA established an internal manpower management office to provide resource prioritization and oversight regarding funded positions and to implement manpower management policies established by the VA Manpower Management Policy directive published in October 2019. Skills and expertise in the VA manpower management offices contribute directly to VA's work to promote the most efficient and economical use of resources to meet the VA's mission. VHA also stood up a new risk management function that bears directly on VA's work to increase oversight through a risk management framework.

VA focused training efforts under the VHA Office of Client Services. This realignment brought both broader expertise and a more operational approach to planning. VA expects this change will spur more effective execution and progress.

VA's Office of Information and Technology (OIT) increased leadership and aligned responsible officials with work in the IT challenges area of concern. OIT retained its core team to promote integration across its five outcomes and to monitor action plan progress.

[4] Department of Veterans Affairs, Veterans Health Administration, VHA Plan for Modernization (Washington D.C.: March 2019). This is an internal VA Web site that is not available to the public.

Removal Criterion 3 – Action Plan

Chapter 2 of this document is VA's updated action plan for addressing the five AOCs on improving VA health care that GAO cited in its High-Risk Series. The updated action plan contains the following new elements—

- Root causes for each AOC, mutually agreed upon by VA and GAO
- Description of select initiatives from the *VHA Modernization Plan* and measures for ensuring applicable AOCs are part of planning, execution, and success of the initiatives (Chapter 1)
- Each area of concern action plan contains—
  - Outcome descriptions and alignment of outcomes to root causes
  - A description of progress made thus far for each outcome and progress toward meeting criteria for removal
  - Actions toward accomplishing the outcome, rectifying the root cause(s)
  - Key metrics and milestones for measuring progress in each outcome
  - Alignment of select outcomes to current transformational initiatives, as applicable
  - A high-level roadmap for each AOC
- Key VA and AOC level outcomes, mutually agreed upon by VA and GAO (Appendix A)
- A crosswalk aligning select planned actions to root causes (Appendix C)

VA and GAO agree this should be a dynamic action plan. Over time leadership priorities will evolve or change, which may bring about course corrections to VA's approach to the AOCs. Similarly, outcomes and initiatives may evolve, and metrics will evolve with them. Most important, VA is committed to a durable management structure for overseeing this work that persists through changes to VA leadership and Executive Branch administrations. With the action plan described in this document, VA can proceed with monitoring actions and demonstrating progress.

Removal Criterion 4 – Monitoring

In VA's 2016 and 2018 submissions, VA monitored planned actions using a general set of status categories: "in planning," "in progress," "completed," or "sustaining." VA determined these categories were appropriate for high-level reporting on the status of planned work. In 2019, VA created quantifiable metrics for outcomes in both the Modernization Lanes of Effort (Chapter 1) and AOC Action Plans (Chapter 2). A summary of key measures can be found in Appendix B. The GOAL Office, in collaboration with internal stakeholders, will implement a regular monitoring process in FY 2020.

Removal Criterion 5 – Demonstrated Progress

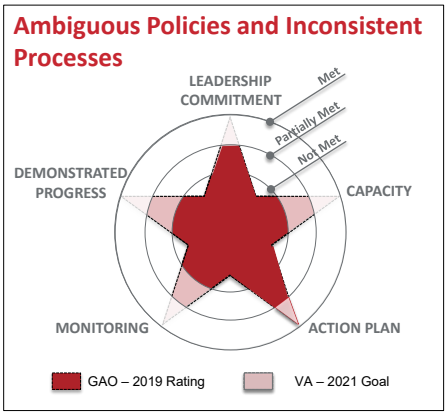
VA looks forward to monitoring progress on this action plan and providing GAO with evidence needed to rate VA on "Demonstrated Progress." The following brief descriptions of each area of concern highlight some of the progress that has already occurred. Additional details can be found in Chapter 2.

High Risk List Area of Concern Updates

The following brief descriptions of each area of concern highlight some of the progress that has already occurred. Additional details can be found in Chapter 2.

Area of Concern 1 – Policies and Processes

Over the past 5 years, VHA successfully built a robust foundation for developing, implementing, and maintaining national policy. Led by the VHA Chief of National Policy and the Senior Advisor, VHA Office of Regulatory and Administrative Affairs, the Policies and Processes (P&P) action plan sustains improved policy development processes and content standards; expands consolidation and clarification efforts of facility and regional policies; and plans development of a central repository for all policy and policy-related documents. Consistent execution of the action plan will result in clear, implementable VHA policy that incorporates industry best practices and stakeholder feedback, and enables VA to deliver high-quality, consistent care for Veterans at all VA medical facilities.

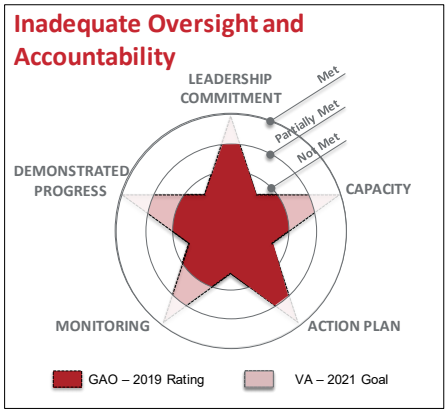


Policies and Processes 2021 Rating Goal

The P&P work group improved policy development and implementation in the following ways—

- Updated the VHA policy on the Controlled National Policy/Directives Management System to incorporate continuously improving VHA policy standards
- Streamlined and clarified the national policy inventory by reducing the number of national policy documents by 32% since 2015
- Required use of a pre-policy form for VHA program offices to ensure national policies are adequately resourced and capable of uniform implementation prior to publication
- Collected and hosting operational memoranda on the VHA Publications website to aid reference by VA Medical Center staff
- Launched a "Get to Zero" initiative to ensure national policies are current and have been appropriately reviewed and recertified within the prior 5 years
- Established business rules for policy development that empower local and regional leadership to streamline local policy inventory and will reduce time required for policymaking and policy administration by VA medical facility staff
- Implemented a bi-annual VA medical facility policy census to track local policy inventory reduction initiatives and improve alignment of national and local policies

Area of Concern 2 – Oversight and Accountability



Oversight and Accountability 2021 Rating Goal

The Oversight and Accountability action plan highlights the critical role modernization initiatives perform in addressing this area of concern. VA leadership recognizes oversight and accountability is pivotal to setting the foundation upon which mission services succeed. VA leadership commitment to this success is evidenced by the fact that several VHA modernization initiatives are focused on key oversight and accountability capabilities. Collectively, the Organization Improvement, Commit to Zero Harm, and Shared Services Lanes of Effort tackle critical oversight and accountability components such as decision making at the appropriate organizational level, aligning decision rights, standardizing services, improving vertical alignment, and fostering a culture of integrity and accountability.

Since 2015, VHA leadership took definitive actions to build new capacities and authorities that improve oversight and accountability functions. VHA leadership—

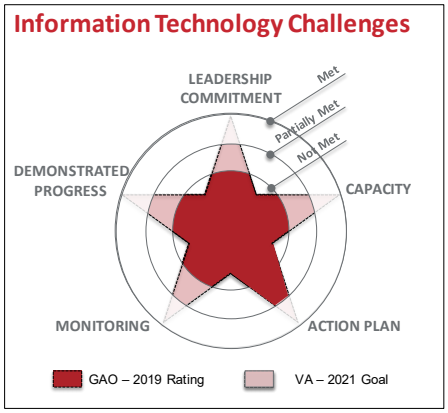
- Created a new Office of Integrity, headed by a new Assistant Deputy Under Secretary for Health for Integrity. This new office oversees previously unintegrated offices that conduct oversight activities – Office of Medical Inspector, Internal Audit, Compliance and Business Integrity, and Risk Management. It also oversees VHA's National Center for Ethics in Health Care, an essential component of a culture of integrity that is foundational to an accountable culture.
- Created a new VHA Internal Audit Office and hired an executive-level Chief Auditor and Deputy. The office is responsible for conducting internal audits on topics of interest to VHA.
- Created a governance structure, the Audit, Risk, & Compliance Committee (ARCC) and its Compliance subcommittee. This governance committee oversees internal audits, risk management, and compliance within VHA.
- Created a new VHA enterprise risk management function; hired a new risk manager
- Hired a new Senior Executive Service-level Chief Compliance and Business Integrity Officer and Deputy Officer
- Supported establishment a new VA Office of Accountability and Whistleblower Protection

Demonstrated progress toward improved oversight in VHA includes—

- Published a Code of Integrity that sets expectations for conduct for all VHA employees
- Established a new Risk Register and Risk Profile that is reviewed by a governance body (the Risk subcommittee of the ARCC)
- Increased collaboration across VHA program offices on the Statement of Assurance driven by newly issued requirements.

Area of Concern 3 – Information Technology

VA made significant strides in advancing IT modernization and fielding critical capabilities for VHA health care delivery. VA updated its action plan to reflect progress on major programs, attainment of key initial operating capability milestones, and improvements enhancing interoperability and availability of reliable data. Successful action plan execution will result in interoperable systems that meet business needs and data that is accurate, reliable, complete, and used to inform decisions. Delivering enhanced IT systems and services will enable VA to meet national commitments in Veteran care encompassed in key programs such as MISSION Act requirements, VHA modernization, and ongoing program improvement initiatives.



Information Technology 2021 Rating Goal

VA's OIT instituted Joint Business Plans (JBPs) in FY 2017 to focus on VHA's highest mission priorities. A JBP identifies a discrete set of high-profile work that OIT makes a special commitment to deliver including leadership attention and oversight. A JBP seeks balance across multiple VHA priorities. JBP actions that support VHA are highlighted in IT action plans with an initiative number (e.g., FY 2020 JBP-1 refers to the FY 2020 VHA and OIT JBP Initiative/Milestones and Metrics).

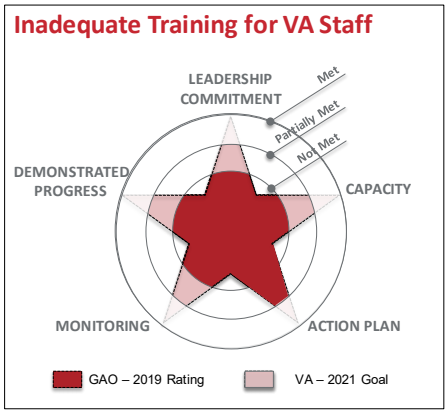
OIT integrates with all the VHA modernization efforts to ensure IT systems are underway and fully resourced. For example, OIT completed milestones in the FY 2020 JBP on Electronic Health Record Modernization. Additionally, OIT completed milestones in the FY 2020 JBP on Defense Medical Logistics Standard Support/LogiCole/Medcoi Implementation.

OIT improved IT delivery to achieve meaningful impact toward target IT AOC outcomes by—

- Delivering on-time, production ready incremental releases for major programs (30+)
- Integrating deployments to minimize transitional re-work and manage interdependencies
- Integrating 24×7 incident management teams to triage and resolve issues in real time
- Launching DevOps and Product Line Management transformation to deliver capabilities faster
- Establishing an office to steward Electronic Health Record Modernization at the Deputy Secretary level
- Empowering VA Interoperability leadership to seamlessly integrate and exchange health information/data/best practices across the Department of Defense, industry, and other partners
- Launching the Lighthouse open digital platform enabling rapid industry innovation for Veterans
- Aligning IT strategy with business goals through consistent IT governance processes

Area of Concern 4 – Training

VHA is actively developing comprehensive training policy and planning processes to address this AOC. Led by VHA's Deputy Chief Learning Officer and Director of Client Services, VA updated its action plan to reflect completed actions, expansion of leadership commitment, and development of supporting capabilities. Successful action plan implementation will result in a systematic approach to training delivery and management. This will drive implementation of an educational infrastructure throughout the organization. Targeted, standardized, and comprehensive training will support active field engagement while enhancing consistent Veteran care at all medical facilities.



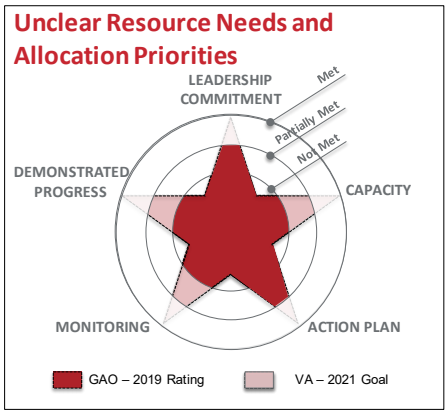
Training 2021 Rating Goal

The Training work group took action to achieve meaningful progress toward target outcomes by—

- Appointing a permanent VA Chief Learning Officer to lead the Talent Development Council
- Establishing the National Designated Learning Officer Community of Practice
- Implementing Learning Advisory Councils to provide training expertise, identify training resource needs, understand training needs, and review training outcomes in program offices across VA
- Establishing software to manage custom training development and delivery
- Aligning training priorities to support 18 priority operational strategies and Modernization LOEs
- Optimizing mandatory training to reduce demand on clinical staff time
- Upgrading the Learning Management System to a cloud-based platform
- Developing a systematic approach to training assignment, execution, and competency assessment

Area of Concern 5 – Resource Allocation

VA continues to increase capacity to manage within budget through new manpower policies and improved funds planning and management. This action plan reflects demonstrated progress of resource alignment to leadership priorities through evidence-based budget justifications, and enhanced reporting and decision-making capabilities. Successful action plan execution will result in defensible resource prioritization and allocation decisions informed by timely, robust data and reporting mechanisms. Consistently implemented practices will align resources with leadership priorities.



Resource Allocation 2021 Rating Goal

The Resource Allocation work group improved manpower, funds planning, and management practices by—

- Hiring leaders in Manpower, Finance, and Workforce Management and Consulting (WMC)
- Piloting a process to improve resource allocation and enhancing funding guidance to the field
- Establishing VA Manpower Management Service authority for overseeing VA's manpower management program, organizational and position structures
- Co-leading implementation of the Organizational Improvement LOE by WMC and Finance
- Implementing early controlled funds release to improve field funds planning and management
- Leveraging standing Chief Financial Officer teleconferences to address resource and budget allocation concerns
- Launching an initiative budget submission process prior to current and budget fiscal years
- Introducing evidence-based justifications to VHA Medical Care program budget requests
- In addition to leveraging the robust analytic capability for staffing and productivity provided in the Office of Productivity, Efficiency, and Staffing, the VA developed staffing models for critical programs such as police and VHA Caregiver Support Program

Conclusion: VA's Way Forward

Together, the AOC action plans, the GOAL Office, and VHA modernization initiatives establish the framework for an integrated strategy that will remediate, correct, and prevent future occurrence of the systemic foundational issues that have limited VA's business transformation with respect to health care delivery. VA's continued efforts to refine and advance this integrated strategy will further VA's goal of becoming a continuously learning and high reliability organization. The cumulative effect of this work will contribute to VA's ability to provide high-quality, safe, timely health care to Veterans, their families, and caregivers. This framework describes an iterative process that will continue to evolve over time.

Table of Contents

List of Tables

List of Figures

Overview

High Risk List Issue Summary

In 2015, the Department of Veterans Affairs (VA) embarked on a journey of self-improvement and rapid change. VA leaders and staff are motivated by a sincere commitment to transform the nation's largest health care system and are determined to address and resolve shortfalls the Government Accountability Office (GAO) identified in its High-Risk Series biennial reports. GAO's 2015 *High-Risk Series Update*[5] describes five broad management issues, referred to as areas of concern (AOCs) in this report. The five AOCs are: (1) policies and processes, (2) oversight and accountability (OA), (3) information technology (IT), (4) training, and (5) resource allocation.

The report lays out VA's approach and action plan for managing risks and improving VA Health Care. Chapter 1 describes how several large modernization initiatives incorporate management practices into planning and operations from the beginning. Timely attention to the AOCs ensures transformational efforts build policy clarity, oversight, IT solutions, effective training, and adequate resourcing into programmatic goals for success. Chapter 2 provides details on outcomes for each AOC and actions to achieve them. VA developed the outcomes after conducting thorough root cause analyses of GAO's concerns and other oversight findings across the organization. Reaching desired outcomes requires addressing underlying root causes; sustaining desired outcomes means VA will have transformed into an accountable organization with robust business practices. Chapter 3 describes the program management office that oversees the portfolio of projects related to this high risk listing. In the appendices, several key perspectives are covered, including a summary of the mutually agreed upon outcomes for each AOC (Appendix A), and a summary list of measures and metrics to track progress (Appendix B), and agreed upon root causes and a crosswalk to the action plan outcomes addressing them (Appendix C).

Historical Context on VA's Approach and Key Milestones

In 2015, GAO added VA Health Care to its High-Risk Series[1] for concerns related to VA's ability to deliver timely, cost-effective, high-quality, safe health care to Veterans. In the first year, Veterans Health Administration (VHA) sought to understand the scope of the AOCs and how they related to efforts already underway in VA. VHA initially took a phased approach and developed a plan that focused on policy and oversight improvements. GAO commented that this approach did not satisfy expectations in that GAO would need action plans on all five AOCs. On July 20, 2016, the Secretary of VA established the High Risk List (HRL) Task Force for Managing Risk and Improving VA Health Care as VA's early management structure for oversight of this high risk listing. The Task Force developed an initial strategy for approaching the five AOCs and linked AOC work to the former Secretary's "MyVA" initiative.

This first document earned VA a "partially met" rating for "Leadership Commitment" and "Action Plan" criteria for removal in 2017,[6] and set the stage for all subsequent work. GAO complimented the initial strategy as a good start but found that evidence of organizational understanding of the root causes underlying the AOCs was missing. VA devoted nearly the entirety of Fiscal Year (FY) 2017 to conducting thorough root cause analyses for each AOC while also moving forward on actions laid out in the initial strategy document and strengthening the nascent management structure. GAO accepted VA's analyses of root causes in late 2017 (Appendix C). VA then focused on updating the initial strategy, linking root causes to planned actions, highlighting actions underway or completed during FY 2017, and building in

[5] GAO, *High-Risk Series: An Update*, GAO-15-290 (Washington, D.C.: February 2015).
[6] GAO, *High-Risk Series: An Update*, GAO-17-317 (Washington, D.C.: February 2017).

planned actions through FY 2018. On March 15, 2018, VA presented GAO with the updated Integrated Action Plan and a written self-assessment a few months later. GAO found these efforts improved ratings for "Action Plan" in several of the AOCs but did not change VA's overall ratings in the *2019 High-Risk List*[7] update. GAO commented the Integrated Action Plan was a step in the right direction, but to be successful VA needed to identify outcomes and clear metrics for measuring progress.

Early in FY 2019, VA and GAO reached mutual agreement on key outcomes; these establish core principles for VA's future state relative to the AOCs. The key outcomes are—

- Policy drives correct behavior and is implemented consistently
- Business processes are integrated and efficient
- Resources are used effectively and efficiently
- Systems are interoperable and meet business needs
- Data are available, accurate, reliable, complete, and used to inform decisions
- Governance and oversight mechanisms provide reasonable assurance that requirements are met
- Targeted, standardized, and comprehensive training that supports policy or guidance and active field engagement

In March 2019, the Comptroller General voiced a preference to reach mutual agreement with VA on a specific set of outcomes for each AOC and for VA to then build its action plan addressing those agreed upon outcomes. In addition to the seven key outcomes, VA and GAO reached mutual agreement on 20 AOC-specific outcomes (Appendix B). VA expanded action plans for each outcome with information on progress made, metrics, integration with current Modernization Lanes of Effort, and planned actions. VA also continued taking previously planned actions while adding elements to the plan. This document contains those expanded plans.

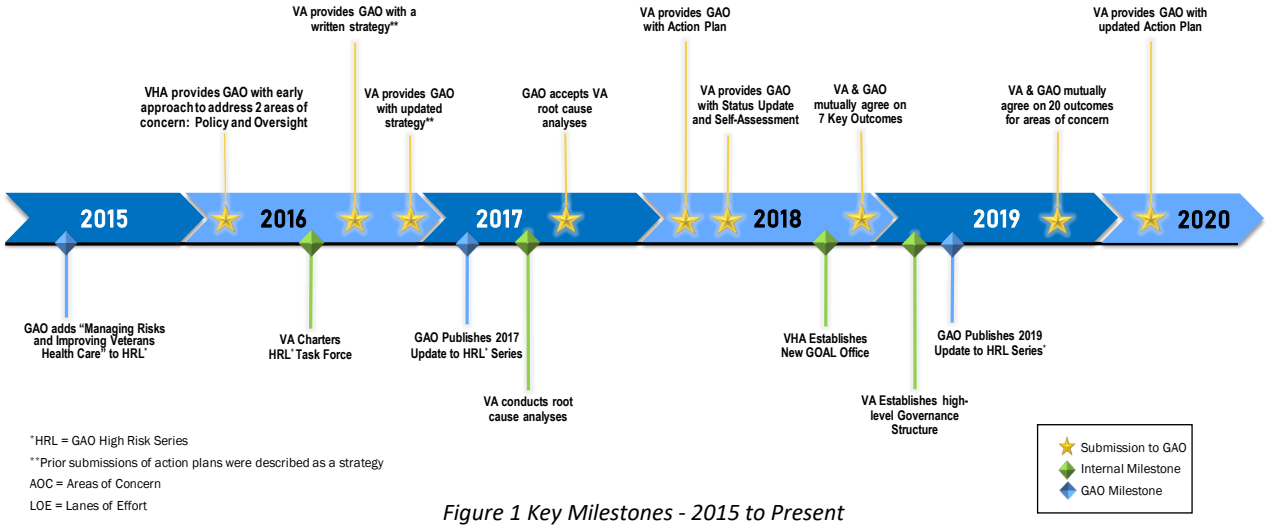


Figure 1 Key Milestones - 2015 to Present

[7] GAO, *High-Risk Series: An Update*, GAO-19-157 SP (Washington, D.C.: March 2019).

VA's Progress on Resolving Areas of Concern – GAO Rating on Criteria for Removal

GAO uses five criteria to assess progress toward resolving the AOCs and ultimate removal from the High Risk List: (1) leadership commitment, (2) capacity, (3) action plan, (4) monitoring, and (5) demonstrated progress. GAO rates agencies on each criterion using the star diagram; ratings are either "not met," "partially met," or "met." Key VA actions that were not part of GAO's most recent rating period are briefly summarized below.

Figure 2 GAO's 2019 Rating for VA Health Care

Removal Criteria 1 – Leadership Commitment

In FY 2018, Secretary Wilkie strengthened leadership commitment by making business transformation a Departmental strategic priority. Secretary Wilkie also established a high-level governance structure to oversee the Department's high risk plans and actions. The high-level governance structure, managed through the Office of Enterprise Integration (OEI), consists of three decision-making bodies: the VA Operations Board, the Executive Advisory Board (EAB), and a Steering Committee supported by individual AOC work groups.

1. **VA Operations Board.** The VA Operations Board (VAOB) is chaired by the Deputy Secretary for VA and staffed by OEI. Its membership consists of Assistant Secretaries and Under Secretaries. The VAOB reviews major programs and functional areas every two weeks. The VA Operations Board is briefed on status and progress toward resolving high risk listings, successes, risks, and resourcing. In 2019 the VAOB reviewed and approved the seven key outcomes that set an aspirational future state for VA relative to the AOCs (described above). It also reviewed and approved the creation of an Executive Advisory Board (EAB) to focus on GAO High Risk List responses. The EAB would guide VA's strategy for action plan development (per the Comptroller General's input), and the proposal to expand the scope of the governance structure to all high risk listings for the Department. In FY 2020, OEI is maturing the High Risk List processes, engaging stakeholders across the Department, and periodically brief the VAOB.

2. **VA High Risk List Executive Advisory Board (EAB)**. In FY 2019 by VAOB decision, VA established the EAB. The EAB is co-chaired by the Principal Deputy Assistant Secretary for OEI and VHA's Principal Deputy Under Secretary for Health. OEI provides staff support to the EAB. The Board's membership includes the Deputy Assistant Secretaries and Deputy Under Secretaries for each stakeholder office. In its first year, the EAB approved and recommended VAOB approval of the seven key outcomes and the proposed strategy for action plan development. The EAB oversees status and monitors progress toward resolution of the AOCs, makes decisions within the scope of authority of its membership, and makes recommendations to the VA Operations Board. The EAB receives input from the Steering Committee and other stakeholders.

3. **Steering Committee**. The Steering Committee (also referred to as HRL Task Force) is chaired by the Director of GAO-OIG Accountability Liaison (GOAL) Office. Steering Committee membership

is composed of the Executive Lead and Outcome Lead for each AOC work group, and representatives from OEI and the National Center for Organizational Development. Ad hoc attendees include representatives from the Office of Healthcare Transformation (OHT), and key representatives from stakeholder work groups. The Steering Committee is the core leadership structure that sets focus, vision, and direction; conducts strategic planning; assesses programmatic risks; oversees day-to-day operations across the five AOC work groups; briefs leadership; and makes recommendations to the EAB. This group—

- Proposed and developed establishment of the high-level governance structure
- Developed and gained approval of the seven key outcomes
- Developed and gained approval of the 20 AOC outcomes,
- Staffed and conducted the first EAB meeting
- Gained VA Operations Board approval for the strategic direction of the VA Health Care Action Plan
- Coordinated with the VA OEI and VHA modernization efforts to incorporate the AOCs into operational plans
- Coordinated with AOC and Modernization work groups to develop this action plan

4. **Area of Concern Work Groups**. AOC work groups inform the Steering Committee. Each AOC work group is led by an Outcome Executive and Outcome Lead and may have multiple Executive and Outcome Leads designated for individual outcomes. Work group membership varies depending on the scope of work, planned actions, and program office alignment. In FY 2019 the AOC work groups—
    - Implemented planned actions
    - Developed outcomes necessary to resolve each AOC
    - Expanded action plans toward achieving those outcomes
    - Developed metrics to measure progress toward those outcomes
    - Consulted with VHA modernization teams on measures related to each AOC
    - Integrated actions and communications with each other to build a unified approach to resolving risks to VA Health Care

VHA Leadership Commitment

In FY 2019 Dr. Richard Stone, Executive in Charge (EIC) for VHA, articulated that becoming a highly reliable organization means achieving the seven key outcomes articulated in the *VHA Plan for Modernization*.[8] At his request, modernization project teams met with GAO to receive input on their initiatives and they included actions and measures relative to the AOCs in their operating plans. Dr. Stone also established GOAL as a permanent program management office for GAO High-Risk Series work. GOAL serves as VHA's primary liaison to GAO; leads portfolio management, change management, and risk management across the five AOC work groups; coordinates across transformational project teams; establishes strategic direction and plans; tracks and monitors planned actions; develops reports to senior leadership, GAO, and Congress; and chairs and staffs the Steering Committee. VHA leadership allocated funding and government staff to establish GOAL in FY 2019 (Chapter 3).

VHA leadership directly participates in high-level governance structures. The EIC is a member of the VA Operations Board; the VHA Principal Deputy Under Secretary for Health co-leads the EAB; the Deputy Under Secretary for Organizational Excellence is a member of the EAB. VA executive leaders have also allocated resources in the form of government employees or contract support for all five AOC work groups.

Removal Criteria 2 – Capacity Actions

In 2018 and 2019 VA built the management capacity needed to address the AOCs by dedicating government and contract staff; leveraging its federally funded research and development center and the private sector for best practices; supporting staff training for skill development; and allocating funds. VA trained GOAL staff in disciplines critical to long-term success – program/portfolio management, risk management, and change management – and VA allocated over $27 million in contract support. Nearly three dozen government personnel are actively involved in addition to dedicated contractor staff. VA expects dedicated staff and contract support will be needed through FY 2025. Stakeholder program offices use current funding and staff to support efforts to address GAO concerns. VA does not anticipate requesting additional funds to manage action plan activities in the upcoming budget cycle.

In FY 2018, VA established a manpower management office to develop and oversee position management, organizational structure, and validate analytic tools to determine workload-based staffing requirements. In FY 2019, VHA established a Manpower Management Office (MMO) to provide resource prioritization and oversight regarding funded positions and to implement manpower management policies established by the VA Manpower Management Policy directive published in October 2019. Skills and expertise in the VA manpower management offices contribute directly to VA's work to promote the most efficient and economical use of resources to meet the VA's mission. VHA also stood up a new Risk Management function that bears directly on VA's work to increase oversight through a risk management framework.

VA focused training efforts under the VHA Office of Client Services. This realignment brought both broader expertise and a more operational approach to planning. VA expects this change will spur more effective execution and progress.

VA's Office of Information and Technology (OIT) increased leadership and aligned responsible officials with work in the IT challenges area of concern. OIT retained its core team to promote integration across its five outcomes and to monitor action plan progress.

As discussed under "VHA Leadership Commitment," VHA increased program management capacity by establishing the GOAL office. GOAL is supported by contracted experts in portfolio management, project management, risk management, change management, strategic planning, and technical writing. GOAL provides project management and administrative support to each of the AOCs. GOAL facilitates integration among AOC work groups and transformation efforts. Increased skills and expertise in GOAL will help ensure this action plan drives toward success.

Removal Criteria 3 – Action Plan

Chapter 2 of this document is VA's updated action plan for addressing the five AOCs on improving VA health care that GAO cited in its High-Risk Series. The updated action plan contains the following new elements—

- Description of select initiatives from the *VHA Modernization Plan* and measures for ensuring applicable AOCs are part of planning, execution, and success of the initiatives (Chapter 1)

- Each area of concern action plan (Chapter 2) contains—
  - Outcome descriptions and alignment of outcomes to root causes
  - A description of progress made thus far for each outcome and progress toward meeting criteria for removal
  - Actions toward accomplishing the outcome, rectifying the root cause(s)
  - Key metrics and milestones for measuring progress in each outcome
  - Alignment of select outcomes to current transformational initiatives, as applicable
  - A high-level roadmap for each AOC
- AOC outcomes, mutually agreed upon by VA and GAO (Appendix B)
- Root causes for each AOC, mutually agreed upon by VA and GAO
- A cross walk of root causes to AOC outcomes (Appendix C)

VA and GAO agree this should be a dynamic action plan. Over time leadership priorities will evolve or change, which may bring about course corrections to VA's approach to the AOCs. Similarly, outcomes and initiatives may evolve, and metrics will evolve with them. Most important, VA is committed to a durable management structure for overseeing this work that persists through changes to VA leadership and Executive Branch administrations. With the action plan described in this document, VA can proceed with monitoring actions and demonstrating progress.

Removal Criteria 4 – Monitoring

In VA's 2016 and 2018 submissions, VA monitored planned actions using a general set of status categories: "in planning," "in progress," "completed," or "sustaining." VA determined these categories were appropriate for high-level reporting on the status of planned work. In 2019, VA created quantifiable metrics for outcomes in both the Modernization Lanes of Effort (Chapter 1) and AOC Action Plans (Chapter 2). A summary of key measures can be found in Appendix B. The GOAL Office, in collaboration with internal stakeholders, will implement a regular monitoring process in FY 2020.

Removal Criteria 5 – Demonstrated Progress

Since GAO's High-Risk Series publication in 2015, VA has completed definitive actions toward addressing all five of the areas of concern. GAO rated VA as "not met" in the criterion of "Demonstrated Progress" in its 2017 and 2019 High-Risk List updates because GAO found VA's two prior submissions to be incomplete. Through more regular communications with GAO, in 2019 VA reached a clearer understanding of GAO's expectations for a complete action plan. This submission contains updated elements, with the understanding that some elements may evolve over time. VA looks forward to monitoring progress on this action plan and providing GAO with evidence needed to rate VA on "Demonstrated Progress."

Conclusion: VA's Way Forward

Together, the AOC action plans, the GOAL Office, and VHA modernization initiatives establish the framework for an integrated strategy that will remediate, correct, and prevent future occurrence of the systemic foundational issues that have limited VA's business transformation with respect to health care delivery. VA's continued efforts to refine and advance this integrated strategy will further VA's goal of becoming a continuously learning and high reliability organization (HRO). The cumulative effect of this work will contribute to VA's ability to provide high-quality, safe, timely health care to Veterans, their families, and caregivers. This framework describes an iterative process that will continue to evolve over time.

Chapter 1. Modernization Lanes of Effort

Introduction

Dr. Stone, the Veteran Health Administration's (VHA) Executive in Charge, prioritized a set of large modernization initiatives intended to streamline operations and focus attention on becoming a high reliability organization (HRO). These initiatives, called Lanes of Effort (LOEs), are fully described in *VHA's Plan for Modernization*. This chapter briefly describes the rationale and objectives for each LOE and integration points with related high risk areas of concern (AOCs) and applicable outcomes.

Attending to core business functions during planning and execution ensures large initiatives are reinforced by sound policy; are implemented by staff who have the right knowledge, skills, and abilities; receive the right IT support; identify and secure essential human and financial resources; have management oversight; and are accountable throughout change, implementation, and reinforcement.

Lane of Effort Support to Area of Concern Outcome Attainment

Some LOEs significantly assist in meeting some of the AOC outcomes. These contributions are vital even though they are managed separately from the AOC action plans. The connections are summarized below for the respective LOEs.

Table 1-1. VHA Modernization LOE Support to AOC Outcomes

VHA Modernization LOE *All initiatives are considered cross-cutting
The **Commit to Zero Harm LOE** supports the Oversight and Accountability AOC by encouraging and facilitating a culture of trust and accountability – foundational principles of a High Reliability Organization. This directly supports **Oversight and Accountability's Outcome 5** to create and ensure an organizational culture that fosters trust, integrity, learning, and collaboration. It supports the IT AOC by instilling greater reliability and transparency across VA's workforce. This directly supports **IT Outcome 3** to provide VHA with the tools and technology it needs to receive and evaluate information accurately and support informed decision making.
The **Organizational Improvement LOE** supports the Oversight and Accountability AOC by including efforts to ensure transparency, streamline decision making, and provide consistent support from VHA headquarters to the regions and medical facilities. In this way, this initiative directly supports **Oversight and Accountability Outcome 2** that decisions are made at the appropriate level of the organization. This initiative also ensures a long-term strategy is clearly defined, and resources and monitoring efforts are clearly aligned to the strategy. It directly supports **Oversight and Accountability Outcome 3** as it ensures governance and leadership decisions are focused on intended outcomes and aligned with strategic plans and VHA objectives. The Organizational Improvement LOE supports the Resource Allocation AOC by streamlining headquarters and revising governance processes to support the effective and efficient use of resources. This directly supports **Resource Allocation Outcome 2,** which uses a comprehensive strategic guidance process to ensure alignment of resources to leadership priorities. The initiative also aims to reduce unwanted variation across clinical service lines, focusing on a data-driven approach to inform decision making. Data-driven decision making directly supports **Resource Allocation Outcome 3** that relies on data and reporting to inform resourcing decisions.

VHA Modernization LOE
***All initiatives are considered cross-cutting**
The **Develop Responsive Shared Services LOE** supports the Policies and Processes action plan through its program focused on IT functions. This effort will address reorganizing oversight functions, providing consistent training and development, and standardizing position descriptions across multiple levels of VHA. Collectively, these efforts directly support **Policies and Processes Outcome 4** to increase transparency for all stakeholders for standards across VHA. This initiative also supports the Oversight and Accountability AOC by focusing on clear oversight and reporting structures consolidated at the regional level. These structures support **Oversight and Accountability Outcome 2** by ensuring decisions are made at the appropriate level of the organization and informed by reliable data. This initiative also supports the Training AOC with attention given to consistent training and development and standardized performance plans for staff. This supports **Training Outcome 2's** goal, an accurately identified audience is trained at the appropriate time to specific program/process requirements. This initiative also supports **Training Outcome 3,** using the most resource-efficient approach, training is planned and developed, coordinated and implemented, then evaluated and managed to achieve effective training outcomes. This Develop Responsive Shared Services LOE also supports the Resource Allocation AOC in two aspects – clear oversight and reporting structure consolidation at the regional level and modernizing Human Resources functions to allow resources to be allocated effectively and efficiently. This supports **Resource Allocation Outcome 3,** which aims to ensure that resources are allocated to the correct areas of the organization and are aligned to leadership priorities.
Engaging Veterans in Lifelong Well-being and Resilience – this LOE does not directly contribute to resolution of any specific AOC outcomes.
The **Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act LOE** supports the Policies and Processes Action Plan by standardizing enactment of Community Care and Urgent Care Benefits through policy, procedure, and oversight. This **supports Policies and Processes Outcome 4** by ensuring standards are transparent, accessible, and implemented consistently. This initiative also supports the Training AOC as it includes the launch of multiple training modules as well as an educational campaign on the national and network levels. This directly supports **Training Outcome 1** by aligning training with leadership priorities and ensuring training is delivered based on national standards. The MISSION Act also supports the Resource Allocation AOC through development of a staffing tool that estimates the number of clinical and administrative staff needed to support community care, directly supporting the goal of **Resource Allocation Outcome 3.** This outcome aims to use data and reporting mechanisms to evaluate and inform resource decisions.
The **Electronic Health Record Modernization (EHRM) LOE** supports the Oversight and Accountability Action Plan through promotion of accurate, reliable, and complete data to inform decisions. This strongly supports **Oversight and Accountability Outcome 2,** which ensures governance and management decisions are made at the appropriate level of the organization and informed by reliable data and are timely. The EHRM LOE also supports IT AOC outcomes by eliminating manual or electronic exchanges and reconciles data between health care providers and the Department of Defense (DOD) to support Veteran experiences across care sites. These capabilities directly support **IT Outcome 2** to improve system interoperability to execute core health care mission functions. Through standardized workflows and reporting processes as well as big data and predictive analytics, EHRM will be able to support **IT Outcome 3** in its efforts to provide governance oversight bodies with accurate, reliable, timely, and relevant information to support decision making. EHRM will replace over 130 separate electronic health records (EHRs), allowing VA to share a single EHR system with DOD and community care partners. This is a significant step toward attaining **IT Outcome 5** – reducing the number of duplicative IT systems and capabilities to support business needs. This initiative also supports the Resource Allocation AOC in that it will use standardized workflows and reporting mechanisms along with reliable data to better inform resource decisions. This supports **Resource Allocation Outcome 3** by ensuring adequate data and reporting mechanisms are used for making, evaluating, and informing resource planning and allocation decisions.
The **Transform Supply Chain LOE** supports IT AOC work in the aim to develop a new health care logistics system for VA, fully supporting **IT Outcome 4,** in reducing the number of legacy systems while continuing to meet business needs.

1. Commit to Zero Harm

Lane of Effort Leads:
Gerard Cox, MD, Deputy Under Secretary for Health for Organizational Excellence
William Patterson, MD, Network Director, VISN 15

Lane of Effort Objective

High Reliability focuses on a culture where identifying and correcting the smallest errors can lead to large improvements in patient safety, with the goal of ensuring that every patient receives excellent care every time. High reliability organizations (HROs) experience fewer than anticipated accidents or events of harm, despite operating in highly complex, high risk environments. The concept began in industries such as aviation, nuclear power, and naval operations where even small errors could lead to significant harm. The result of HRO efforts has been a significant decrease in accident rates within these industries.

American health care lags other complex industries in adopting HRO principles. In the U.S. health care system, medical errors are the third leading cause of death behind cancer and heart disease. The health care industry has worked to integrate HRO principles and practices into operations and to build a culture of safety and improvement that is committed to Zero Harm.

VHA benefits from a rich history of process improvement and patient focus. While VHA has led many successful initiatives to prevent harm, the organization lacked a coordinated effort. The commitment to Zero Harm requires that VHA transforms the workplace culture to empower VA's dedicated, compassionate employees. The overarching objectives of VHA's HRO journey and commitment to Zero Harm include the following:

- Build a Just Culture[9] of transparency and trust where HRO practices can thrive
- Empower employees to lead frontline improvement efforts and speak up for safety
- Improve system-wide performance across multiple domains (including safety, quality, access)
- Affirm trust with Veterans and VA's workforce through greater reliability and transparency

Background

VHA has long been a pioneer in patient safety. In 1999, VA established the National Center for Patient Safety (the Center). For over 15 years, the Center, working with patient safety officers and managers across VHA, developed a range of innovations including a methodology for root cause analysis that includes events that occurred and near-misses (one of the first methodologies of its kind in the health care industry).

To expand on this approach, VHA established an HRO Steering Committee in 2018 to adopt HRO principles based on leading VHA practices and industry best practices. In 2019, VHA began its HRO journey with a set of common HRO assessments, training, and improvement activities at 18 lead sites across each region. The 18 lead sites shaped transformation for the rest of VHA. Remaining sites (Cohort 2) joined the journey in 2020, incorporating lessons learned from the 18 lead sites. This phased approach has built a consistent national effort.

[9] Sculli GL,Hemphill R. *Culture of Safety and Just Culture.* VA National Center for Patient Safety. 2013. Available at: https://www.patientsafety.va.gov/about/approach.asp

In the future, HRO activities may be tailored to individual organizations (e.g., program office, region, medical facility, clinic), but will follow the same framework and sequence to help create change management progress. The major components in the VHA HRO journey are outlined below.

1. **Baseline HRO Curriculum:** Standard baseline training courses on HRO principles, Just Culture, everyday error management, and continuous process improvement are offered to the following audiences: executive leadership teams, supervisors/managers, and patient-facing staff.
2. **Site-Specific Assessments and Planning:** Regions and medical facilities complete a standardized, facilitated assessment process to understand their HRO maturity across the three pillars of HRO (leadership engagement, culture of safety, continuous process improvement) and create a site-specific HRO plan to move their site forward on the journey to Zero Harm.
3. **Clinical Team Training:** Training on team communications practices is based in reliability science and is applied by unit-level teams (starting with the 18 HRO lead sites and Cohort 2 HRO sites in calendar year 2020).
4. **Continuous Process Improvement:** Regions and medical facilities strategically build continuous process improvement capacity by expanding the bench strength of Lean belted professionals to lead improvement projects and coach improvement teams.
5. **HRO Leadership Coaching:** HRO coaches are matched with leaders from the 18 HRO lead sites and Cohort 2 HRO sites to assist in establishing standard HRO leadership practices (e.g., leader rounding, HRO huddle, safety forums, visual management) and progressing on the site-specific HRO plan.
6. **Experiential Learning:** Leading practices from the 18 HRO lead sites are identified, documented, and shared with Cohort 2 sites with the opportunity to visit a lead site to experience strong HRO practices in action.

Key Measures and Definitions

These measures, when taken as a whole, enable an iterative, systemic review and assessment of VHA's cultural shift to Zero Harm, and attainment of health care HRO status.

Key Measure for Policies and Processes: *All medical facilities have established a site-specific HRO roadmap informed by a standardized, facilitated HRO self-assessment with implementation of and progress against the HRO plan overseen by the region.*

In Q2FY20, VHA plans to publish a standardized, facilitated site-specific HRO assessment approved by the VHA HRO Steering Committee and Governance Board. The HRO assessment will include completion of the Joint Commission's Oro2.0™ HRO maturity assessment, which was evaluated as "the most comprehensive, rigorously developed, and applicable to VA's HRO initiative, given that its content validity has been evaluated at six VA hospitals" in the May 2019 *Evidence Brief: Implementation of High Reliability Organization Principles*,[10] prepared for the VHA Health Services Research and Development Service by the Evidence Synthesis Program. Additional HRO assessment metrics will be provided by the Patient Safety Assessment Tool developed by the VA National Center for Patient Safety and the continuous process improvement assessment developed by the VA Office of System Redesign and Improvement. As part of this effort, medical facilities will gather self-assessment feedback from a

[10] Veazie S, Peterson K, Bourne D. Evidence Brief: Implementation of High Reliability Organization Principles. Washington, DC: Evidence Synthesis Program, Health Services Research and Development Service, Office of Research and Development, Department of Veterans Affairs. VA ESP Project #09-199; 2019. Available at: https://www.hsrd.research.va.gov/publications/esp/reports.cfm.

representative sample of frontline staff, supervisors/managers, service line chiefs, and executive leadership team members at their facilities. Regional personnel, with support from VHA program office HRO subject matter experts, will be responsible for facilitating the self-assessment and overseeing the analysis of results. Upon analysis of the self-assessment, each medical facility will prepare or update a site-specific HRO roadmap to address gaps and targeted improvement areas revealed by the HRO assessment.

Metric: By December 2020, VHA standardized, facilitated HRO self-assessment is completed by all medical facilities, and all medical facilities have documented a site-specific HRO roadmap, verified by the regional office, that addresses key gaps and opportunities revealed by the assessment.

Metric Information:

- **Metric Definition:** Percentage of medical facility HRO site-specific HRO roadmaps developed and verified by the regional office
- **Calculation:** # of medical facilities that completed an HRO roadmap / total # of eligible medical facilities
- **Target:** 100% by December 31, 2020
- **Reporting Frequency:** Q1, Q2, Q3, Q4 until complete

Key Measure for Oversight and Accountability: *A patient safety culture demonstrates improved reporting of adverse events and close calls.*

This measure will be used to track the number of reports of adverse events and close calls at the medical facility, regional, and system-wide levels. An adverse event is a patient safety event that has resulted in harm to a patient. A close call (or "near miss" or "good catch") is a patient safety event that did not reach the patient.

In the early phase of HRO transformation, increased reporting of both adverse events and close calls should be evident. According to Barach and Small, "Studying close calls allows capture and analysis of recovery strategies that can help prevent harm."[11] From the National Institutes of Health, "Close calls occur more often in health care than events that cause actual harm and can provide valuable information to identify systemic flaws and recovery strategies. Reporting efforts should focus on both close calls and adverse events, because both can be used by health care organizations to make system changes that improve patient safety."[12]

Adverse events and close calls will be monitored at the medical facility, regional, and system-wide levels to identify systemic issues and target improvement efforts based on a risk analysis of reported issues based on likelihood and severity of patient harm.

Metric: By December 2020, all medical facilities have completed a standardized, facilitated self-assessment of their HRO culture, including reporting practices, and have established an annual baseline number of adverse events and close call reports upon which to measure the impact of HRO interventions. Within 1 year from the start of a medical facility's HRO roadmap, the percentage change of adverse event and close call reporting should represent an increase in reporting with evidence of a

[11] Barach P, Small SD. *Reporting and Preventing Medical Mishaps: Lessons from Non-Medical Near Miss Reporting Systems*. BMJ. 2000; 320:759-763

[12] Qu A, Marks C. *Close Calls in Patient Safety: Should We Be Paying Closer Attention?* CMAJ. 2013 Sep 17; 185(13): 1119–1120.doi: 10.1503/cmaj.130014

steady growth toward a reporting culture in which reported close calls consistently outnumber adverse events.

Metric Information:

- **Metric Definitions:** Change of adverse event reporting; change of close call reporting, measured at system-wide, regional, and medical facility levels
- **Calculation:** For adverse events: # adverse events reported / 10,000 unique veterans. For close calls reported: close calls / 10,000 unique veterans
- **Target:** Change in calendar year 2020 is positive
- **Reporting Frequency:** Q1, Q2, Q3, Q4

Key Measure for IT: *Data are available and accurate, reliable, complete, and used to inform decision making.*

This measure will focus on achieving results from continuous improvement efforts targeted on preventing harm. Stakeholders throughout VHA participated in a multi-step process to select measures that would demonstrate change at various stages on the path to becoming an HRO. As part of this effort, VHA created a Measurement Advisory Group composed of subject matter experts, program office leads, and administrators that reviewed over 120 HRO-relevant, currently collected metrics throughout VA. The Measurement Advisory Group reviewed literature from industry and academia to identify criteria for selecting HRO outcome measures related to reducing harm and compared selections against metrics used by top-performing HRO health care systems such as Memorial Hermann, Intermountain, and Cleveland Children's Hospital. The group followed several guiding principles to identify possible measures for inclusion, some of which are listed below.

- Data must be collected in a standardized fashion and produce valid and reliable performance results
- Measures must allow room for improvement (i.e., measures are not already as close to zero as possible)
- Measures must be systematically reviewed and prioritized by various VHA executives and program leads
- Measures must be able to evolve as the HRO journey proceeds (e.g., measures sunset as they trend to zero and new measures are introduced where progress is needed)

As part of this analysis, the Measurement Advisory Group selected five safety outcomes to focus on in the first years of the VHA HRO journey:

1. PSI 04 – Death among surgical inpatients with serious treatable complications
2. PSI 12 – Perioperative pulmonary embolism or deep vein thrombosis
3. PSI 13 – Postoperative sepsis
4. Clostridium difficile infection rate
5. Falls with any injury

Data captured on these five measures will be used at the medical facility, regional, and national levels to inform decision making about reducing harm throughout VHA.

Metric: By December 2022, positive trends will be identified in one or more of the metrics listed above.

Metric Information:

- **Metric Definitions:** Standard definitions for five inpatient patient safety indicators, reported at the enterprise level.
- **Calculation:**
  1. Rate PSI 04 = Death among surgical inpatients with serious treatable complications / 1,000 surgical discharges with serious treatable complications (further details outlined in the Agency for Healthcare Research and Quality (AHRQ) definition include detailed inclusion and exclusion criteria) (https://www.qualityindicators.ahrq.gov/Modules/PSI_TechSpec_ICD10_v2019.aspx)
  2. Rate PSI 12 = Number of perioperative patients with pulmonary embolism or deep vein thrombosis / 1,000 surgical discharges. Detailed inclusion and exclusion criteria available in the detailed AHRQ definition (https://www.qualityindicators.ahrq.gov/Modules/PSI_TechSpec_ICD10_v2019.aspx)
  3. Rate PSI 13 = Number of postoperative sepsis patients / 1,000 elective surgical discharges Detailed inclusion and exclusion criteria available in the detailed AHRQ definition (https://www.qualityindicators.ahrq.gov/Modules/PSI_TechSpec_ICD10_v2019.aspx)
  4. Rate of CDI = C difficile infections per 10,000 bed days of care
  5. Rate of falls with any injury = Total number of patient falls with injury / 1,000 bed days of care
- **Target:** Positive improvement trend in one or more of the five patient safety harm metrics, reported at the enterprise level with appropriate volume of eligible numerator cases, by December 2022
- **Reporting Frequency:** Q1, Q2, Q3, Q4

Key Measure for Training: *Training (field) drives effective behavior change consistent with HRO values, principles, and standards.*

This measure will assess training completion and then training evaluations by participants, their supervisors, and their leadership. Training evaluations assess the degree to which training participants acquire the intended knowledge, skills, and attitudes based on participation in training, and determine the degree to which participants apply what they learned during training. The evaluations will take place at pre-established intervals after they return to work. Baseline training will be delivered to audiences at the medical facility, regional, and VHA headquarters levels:

- Leaders
- Supervisors/managers
- Frontline staff

A cadre of training champions will be identified at each medical facility and region to sustain initial training and reinforcement activities during Phase 1 of the VHA HRO journey. By the end of calendar year 2021, the target goal is to have at least 80% of current staff trained in baseline HRO principles, daily practices, and behaviors (including Just Culture, error management, and continuous process improvement) and for a sustainable cadre of training champions to be established and maintained across the medical facilities with oversight, resourcing, and support from the region.

Many factors influence culture change within an organization. The failure to achieve the desired culture change is not necessarily a negative reflection on training, but rather may be an indicator of deeper, more systemic problems stemming from cultural issues that preclude installation and sustainable application of the desired behaviors. Therefore, the metric for the first year of the VHA HRO journey will focus on the process metric of training completed, along with participant training evaluation scores, to measure the building of HRO capacity that can lead to outcomes of reduced harm in a time period of 1 to 3 years after the implementation of common baseline training.

Metric: By Q2 FY 2022, 80% (or more) of existing VHA staff will have completed training in baseline HRO principles, practices, and behaviors.

Metric Information:

- **Metric Definitions:** Count of staff completing baseline HRO training. Measured at VHA headquarters, regional, and medical facility levels
- **Calculation:** # trained / total # of staff; (Talent Management System)
- **Target:** 80% (or more) staff complete training by Q2 FY 2022
- **Reporting Frequency:** Quarterly

Key Measure for Resource Allocation *Appropriate funds are prioritized and allocated across headquarters functions, regions, and facilities.*

This measure will be used to assess the effectiveness of resource allocation impacting patient safety culture during the current year. In calendar years 2020–2022, the majority of HRO resources are focused on education and training and organizational learning–continuous improvement across medical facilities, regions, and VHA headquarters.

Two patient safety culture measures from the All Employee Survey Employee Engagement Index score calculated by the National Center for Organizational Development will be used to assess employee perceptions of the appropriate prioritization of resources to support a high reliability culture:

- Education/Training/Resources
- Organizational Learning–Continuous Improvement

These measures will be tracked at medical facility, regional, and system-wide levels to assess year-over-year improvement from 2018 through 2022, with the target outcome of a trend in improvement at a system-wide level for these measures on the All Employee Survey (AES) in 2022. This target outcome would reflect effective use of education, training, and organizational learning resources in the early phase of the VHA HRO journey.

Metric: Year-to-year patient safety culture results on the AES should reflect a system-wide trend in improvement in Education/Training/Resources and Organizational Learning–Continuous Improvement.

Metric Information:

- **Metric Definitions:** Questions about availability and effectiveness of education and/or training and continuous improvement resources from the Patient Safety module of the AES provided to all VHA facility employees
    - Metric 1: Change in AES scores for Education/Training/Resources 2019–2022

- Metric 2: Change in AES scores for Organizational Learning–Continuous Improvement 2019–2022

- **Calculation:** Scale 0 - 5 with 0 being lower and 5 being higher performance
- **Target:** Positive improvement trend in enterprise level result from AES in categories of Education/Training/Resources and Organizational Learning – by September 2022.
- **Reporting Frequency:** FY Q1

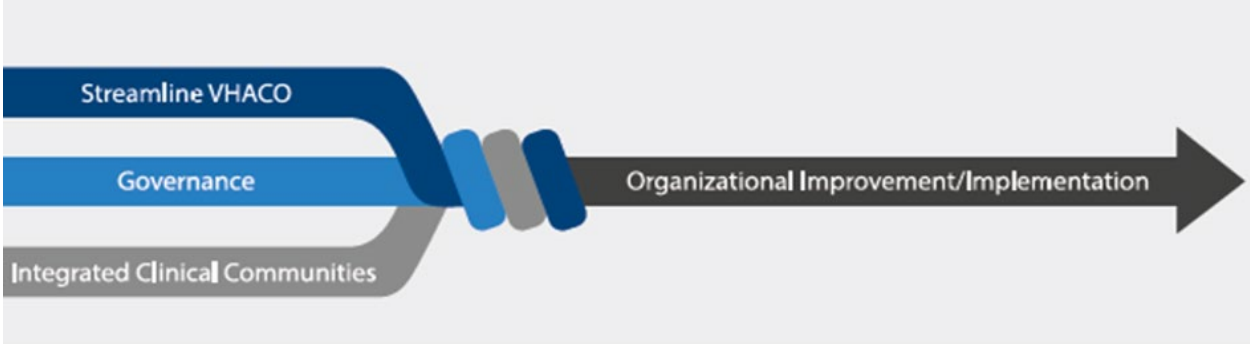
2. Organizational Improvement

Lane of Effort Leads:
Lucille Beck, PhD, Deputy Under Secretary for Health for Policy and Services
Skye McDougall, PhD, Network Director, VISN 16
David Fitchitt, Deputy Executive Director of Human Resources Operations Office
Rachel Mitchell, VHA Deputy Chief Financial Officer

Lane of Effort Objective

The Organizational Improvement portfolio comprises three Lanes of Effort (LOEs) – Streamline VHA Central Office (VHACO), Governance, and Integrated Clinical Communities (ICCs) – which address deficiencies in VHA's management and governance structures. Addressing these deficiencies will improve the alignment of VHA's programs, people, and resources to better support Veterans and allow VHA to become a matrixed, change-ready learning organization. Implementation of organizational improvements requires frequent and transparent communication, strong executive sponsorship, and detailed project management. The Executive Sponsorship Coalition (ESC) and the Implementation Integrated Project Team (IPT) are the entities responsible for supporting key areas of these changes. The following figure illustrates the integration of the three initiatives into a single IPT.

Figure 1-1 Illustration of the Organizational Improvement Implementation

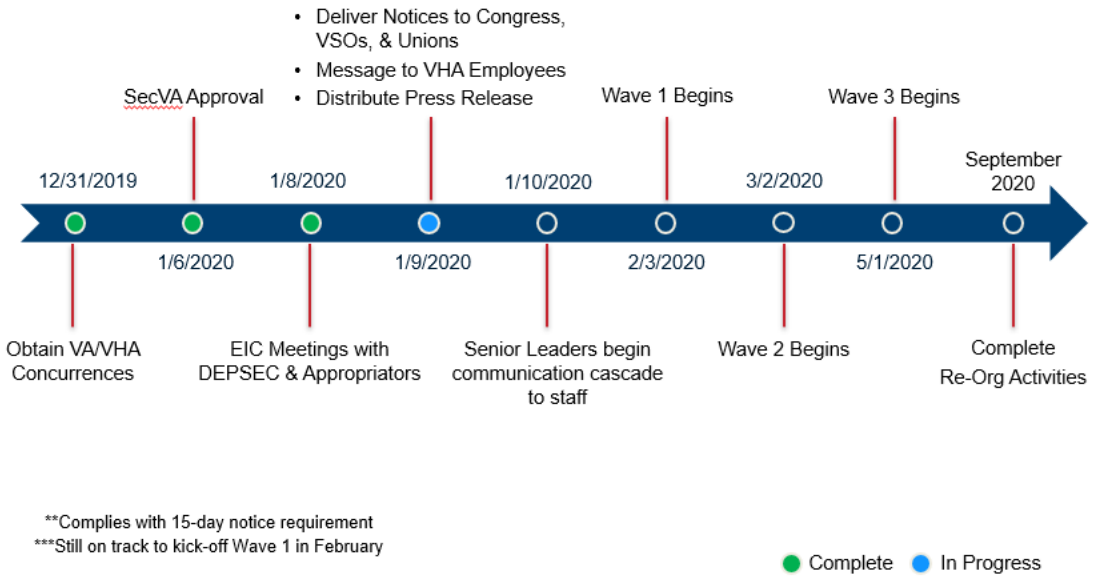


The ESC is critical to the execution of large-scale change. The ESC is chaired by the Deputy Under Secretary of Health for Policy and Services and the Director of VISN 16 with support from the Office of Healthcare Transformation (OHT) and the National Center for Organizational Development. The ESC will serve as change champions in providing guidance and institutional knowledge to reorganization efforts. The ESC is responsible for sponsoring change and executing a clear change management strategy, including frequent and transparent communication to internal and external stakeholders. The ESC will coordinate with the Implementation IPT and senior leadership throughout this organizational transformation.

The Implementation IPT, led by the VHA Office of Manpower Management and Consulting, and supported by OHT, are leading the tactical implementation of the new VHA headquarters organizational design. The purpose of the IPT is to reinforce our culture of continuous improvement so we can perform at our best and achieve the highest level of service for Veterans. The IPT will work with business function leads, coordinate with stakeholders, design a detailed project plan, ensure transparency, and address GAO's concerns regarding VA Health Care.

The timeline below provides key FY 2020 milestones and activities for the Organizational Improvement Implementation IPT.

Figure 1-2 Organizational Improvement Implementation Timeline



Background

Since 2015, external assessments – including the GAO,[13] Commission on Care,[14] and the Congressionally required Independent Assessments – have identified organizational and operational weaknesses and reported common criticisms of VHA's flaws in governance, decision rights, internal management structures, and accountability.

Specifically, the independent assessments found that VHA has uneven bureaucratic operations and processes, and that its leaders are not fully empowered due to a lack of clear authority, priorities, and goals. The Commission on Care[15] recommended that VHA transform its organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and spreading best practices. VHA's current organizational structure is complex, with overlap in some functions and uncertainty or gaps in management oversight and accountability. The inefficiencies created by VHACO's organizational structure overburden the field and contribute to confusion about roles, responsibilities, and authorities.

Throughout FY 2019, three VHA Modernization Lanes of Effort focused on planning and designing organizational improvements. Having completed this work, the VHA Executive in Charge (EIC) formally

[13] GAO High-Risk Series Report to Congressional Committees. (2019). Page 57. https://www.gao.gov/assets/700/697245.pdf
[14] Commission on Care Final Report. (2016). Page 12. https://www.stripes.com/polopoly_fs/1.417785.1467828140!/menu/standard/file/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf
[15] Commission on Care Final Report. (2016). Page 12. https://www.stripes.com/polopoly_fs/1.417785.1467828140!/menu/standard/file/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf

retired the Streamline VHACO work group, the Governance IPT, and the Integrated Clinical Service Lines IPT. VHA continues to make operational improvements by reorganizing VHA headquarters, revising its Governance functions, and creating ICCs. These efforts comprise the Organizational Improvement Portfolio and are represented by the following LOEs:

- ICCs
- Streamline VHACO
- Revise Governance Processes and Align Decision Rights

The changes implemented through these Modernization LOEs will drive continuous improvement and support VHA's transformation into a high reliability organization. Below is a summary of the goals, accomplishments, and a look ahead for each LOE.

Integrated Clinical Communities: The goal of integrating clinical communities (ICC) is to establish an enterprise-wide clinical framework with common structures, roles, and responsibilities at health care facilities, regions, and VHACO. Leveraging data analytics and strengths from existing models will inform our process improvement efforts, enable the rapid flow of information and communication, and drive a consistent, effective employee and Veteran experience.

The clinical service line structure supports continuous improvement, horizontal and vertical integration, and sharing of strong practices across the organization. The clinical service line structure supports VHA as a learning organization and facilitates success of other transformational efforts in VHA modernization that require an aligned clinical and operational team structure supported by common methods, metrics, and processes.

The FY 2019 plan for implementing ICCs did not change, but the timeline was adjusted to allow facilities and regions to focus on successfully implementing the MISSION Act.

VHA has accomplished the following:

- ICCs design approved for implementation
- Recommended roles, responsibilities, and processes developed by VISNs
- Analyzed gaps and developed an action plan defining support of VISN and facility-level structures completed by regions
- Analyzed gaps and developed an action plan to best support implementing ICCs completed by regions and VHACO work groups
- Briefed enterprise needs assessment to the Governing Board

VHA facilities, regions, and VHACO will implement individualized plans, supported by guidance and tools from an integrated clinical community team. Each region will adopt the six clinical communities into their organizational structure and governance. The six ICCs are: Mental Health, Primary Care, Surgical Care, Diagnostics, Rehab & Extended Care, and Specialty Care.

Regional clinical community leaders will develop processes with their facilities that are focused on communication, policies, and data. VHACO will have functional leaders and committees for each clinical community to support clinical operations throughout VHA. Subcommittees for specific clinical areas will be formed to provide input to the ICC Committee.

Streamline VHACO: VHA is redesigning its Central Office (headquarters) to consolidate many programs into fewer, clearly defined programs with related missions. These programs will be grouped and

categorized to avoid unnecessary overlap, redundancies, and fragmentation. Simply put, we are clearly defining the role of VHACO: to support operations at VA health care systems and regions.

There will be no reduction in force as a result of this reorganization. The Streamline VHACO effort will better align our talent and resources to support the delivery of exceptional health care that improves Veterans' health and well-being.

VHA developed a new VHACO framework with defined leadership levels and program office responsibilities. Looking ahead, Central Office leadership and project teams are modeling a new organizational design to consolidate programs where appropriate, facilitate decision making, and optimize resource management. Outreach through internal and external communication to stakeholders will be conducted for ongoing feedback. VHACO leadership and project teams will begin implementation in the second quarter of FY 2020, after communicating with key stakeholders, including Congress, unions, and Veterans Service Organizations. Changes will be prioritized and carried out in a phased approach, with changes affecting health care operations most likely to occur first. The goal is to complete the reorganization by the end of FY 2020.

Revise Governance Processes and Align Decision Rights: The development of an aligned and dedicated governance structure with clear roles, responsibilities, and decision rights creates opportunities for greater cross-organizational synergy. VHA's efforts over the last 4 years have positioned the organization to adopt changes to existing governance structures, focus on patient care priorities, and ensure proactive decision making. Both functional and structural change, with an emphasis on leadership engagement, a Just Culture, and continuous process improvement, are critical to change VHA's current structure.

The current VHA governance structure is being simplified to empower employees to make decisions at all levels and to be supported by consensus-driven roles, responsibilities, and accountability. A well-defined, transparent governance system will also allow us to better align authority and resources, and better support clinical operations and VHA priorities. Coordination is underway to carefully define decision rights and thresholds for governance and management. Decision rights will clarify when decisions are made as governance or management.

VHA's revised governance system proposal was approved by the EIC, creating the Governing Board consisting of senior VHACO leaders and all regional directors. The Governing Board meets monthly and has re-instituted use of executive decision memorandums to improve transparency and ensure input and buy-in from senior leaders; further, the Governing Board approved four Enterprise Councils that mirror the VISN Councils: Healthcare Delivery; Healthcare Operations; Organizational Health; and Quality, Safety, and Value.

VHA has identified the governing principles below to guide the governance restructuring, ensure proper oversight and accountability, and deliver optimal value for staff directly serving Veterans.

Table 1-2. VHA Governing Principles

VHA Governing Principles
Clear decision rights and appropriate delegation of authority
Standard defined process and approach that focuses on strategic priorities aligned to our core values
Agile structure that remains beyond leadership turnover
Transparent, disciplined, and accountable
Engages representation from all levels across the organization
Enterprise systems perspective that looks across silos
Delegate decisions to the appropriate level for maximum competence, cognizance, and commitment
Serving the Veteran by supporting those who care for Veterans

In FY 2020, VHA will have a well-functioning governance system comprised of the Executive Board, Governing Board, and Enterprise Councils. When in place, the governance structure will provide VHA employees and program offices access to governance at all levels of the organization, from the regions to VHACO. A more efficient, strategically aligned, and transparent decision-making process will also be visible throughout the coming year and beyond. The VHA Governance Office will provide additional analytical and administrative support to the Governing Board and the four Enterprise Councils. This office will be the focal point for requests appear before governing bodies and any questions related to the governance system.

In alignment with the Implementation IPT, the ESC plays a critical role in executing these changes by providing detailed, consistent, and ongoing communications with VHACO staff. Visible and engaged sponsorship is the most critical success factor for change as it creates credibility for the reorganization and shows VHA's commitment to change. Implementing a clear change management strategy and ensuring timely communications from leadership and management will minimize staff uncertainties and allow successful implementation of the new organization structure.

Together, the Implementation IPT and ESC support the following key outcomes:

- Policy drives correct behavior and is implemented consistently; business processes are integrated and efficient
- Governance and oversight mechanisms provide reasonable assurance that requirements are met
- Systems are interoperable and meet business needs
- Data is available, accurate, reliable, complete, and used to inform decisions
- Resources are used effectively and efficiently
- Adequate training for VA staff
- Clear, concise, and replicable change management plan that successfully guides the organization through the transition

Key Measures and Definitions

The current efforts of the Implementation IPT closely align to the actions of the Resource Allocation work group and create enabling steps for the achievement of the Resource Allocation AOC outcomes. The Resource Allocation action plan metrics in Chapter 2 demonstrate alignment with this initiative. Below are two sample measures to ensure the infrastructure to support the change is in place for the start of FY 2021.

Ensure the financial and human capital infrastructure is in place by the end of FY 2020 to ensure financial and human capital are easily tracked and monitored beginning in FY 2021.

- Establish and/or update station numbers for each Assistant Secretary line of authority to allow for tracking of financial and human capital resources
  - Measure: Station numbers are established, and accounting classification codes are funded for FY 2021 financial needs
- Review all employees assigned to organizational charts for VHACO ensuring all are identified under the appropriate Assistant Secretary line of authority
  - Measure: HR Smart records are updated to align to the new station number structure with all staff accounted for in the electronic system to provide current organizational charts for each office

3. Develop Responsive Shared Services

Lane of Effort Lead:
Jessica Bonjorni, MBA, Chief, Human Capital Management

Lane of Effort Objective

Responsive shared services will be implemented in VHA to meet Veterans' growing needs, while balancing quality and cost. Human Resources (HR) will be the first to adopt the Shared Services model. Lessons learned from the HR modernization will be leveraged to transform other VHA administrative services to Shared Services (e.g., IT, Contracting, Supply Chain). In implementing the Shared Services model, VHA will address the root causes of critical findings by the Commission on Care, GAO, and internal VA/VHA and other assessments.

Background

Shared Services modernization began in 2018 and is initially focused on transforming HR services to provide consistent, responsive, and cost-effective HR services for VHA headquarters, regions, and medical facilities. To achieve the objective, this initiative will provide—

- Clear oversight and reporting structures consolidated at the regional level
- Consistent HR training and development
- Standard position descriptions and performance plans for HR staff
- Standard Operating Procedures (SOPs) for all HR functional areas
- Reliable HR Information System data
- HR functional area governance

This initiative will consolidate over 150 facility-led HR offices to 18 regionally led HR Offices. By September 2020, all facility-based HR functions (i.e., Classification, Compensation, Compliance [Quality], Employee/Labor Relations [including Performance Management, Reasonable Accommodation, Work Life and Benefits], Suitability/PIV, HR Information System/Manpower, Recruitment & Placement, Training, and Worker's Compensation) will be fully consolidated and standardized at the regional level. Realigning HR functions from the facility to the region level will create a more streamlined HR function and will allow resources to be allocated to need. Standardized processes and performance metrics for all regional offices will eliminate confusion and variance in HR service provision. Leadership will monitor the modernization and its impacts on HR services through performance metrics and stakeholder feedback and will target HR staff training and development as needed.

VHA's HR modernization teams will include representatives with medical facility, region, and VHA headquarters perspectives and expertise, and be led by VHA headquarters executive leaders from the Office for Workforce Management and Consulting. Bringing these experts together will provide valuable insights and promote successful outcomes. Establishing SOPs, consistent performance measures, and enhanced HR staff training and development are key to achieving HR modernization.

This initiative supports the following key outcomes:

- Policy drives correct behavior and is implemented consistently; business processes are integrated and efficient
- Governance and oversight mechanisms provide reasonable assurance requirements are met

- Adequate training for VA staff

Key Measures and Definitions

Key Measures for Policies and Processes: *Standardized position descriptions (PDs), processes, accompanying SOPs, and performance plans across regions reduce variance in services delivery.*

The measure addresses the establishment of standardized PDs, processes, accompanying SOPs, and performance plans. This provides the means of assessing the degree and level of maturity to which processes, SOPs, and performance metrics have been designed, validated, and implemented for each HR functional area in the Shared Service Unit (SSU). This measure tracks activities required to standardize HR functional areas throughout VHA. The Office of Human Resources and Administration/Operations, Security and Preparedness, Office of the Chief Human Capital Officer (OCHCO) is supporting VHA's implementation of this measure through technology and policy. OCHCO is implementing enterprise-wide classification, employee relations, and performance management systems in FY 2020/2021. OCHCO is also updating all VA Directives and Handbooks related to recruitment and staffing, classification, employee relations and performance management in FY 2020. This will ensure all administrations and staff offices have current policy based on statute and regulation to effectively execute these human capital functions. OCHCO continues to make enhancements to VA's human resources system of records (HRSMART) to support manpower management and improve data integrity and reporting.

Measure of Performance:

Metric: Percentage of project position descriptions (PDs) standardized

Metric Information:

- **Metric Definition:** To enable efficiency and effectiveness, standardization in PDs for HR employees will ensure consistent expectations and drive uniform performance and improvement
- **Calculation:** # of standardized PDs implemented / total # of standardized PDs x 18 regions
- **Target:** 100% by September 30, 2020
- **Availability:** Monthly

Metric: Percentage of project performance plans standardized

Metric Information:

- **Metric Definition:** To enable efficiency and effectiveness, standardization in performance plans for HR employees will ensure consistent expectations and drive uniform performance and improvement. Standardized performance plans will be created per the HR Modernization design and implementation plan.
- **Calculation:** # of standardized performance plans implemented / total # of standardized performance plans x 18 regions
- **Target:** 100% by September 30, 2020
- **Availability:** Monthly

Metric: Percentage of project SOPs standardized

Metric Information:

- **Metric Definition:** To enable efficiency and effectiveness, VHA-wide HR SOPs will ensure consistent processes, driving uniform performance and improvement. SOPs will be created per the HR Modernization design and implementation will be reported as a percentage monthly.
- **Calculation:** # of VHA-wide SOPs implemented / total # of VHA-wide SOPs x 18 regions
- **Target:** 100% by September 30, 2020
- **Availability:** Monthly

Measure of Effectiveness:

Metric: Percentage of designated PDs standardized (classification modernization)

Metric Information:

- **Metric Definition:** To address HR customer concerns regarding the time it takes to classify a PD and inconsistency in grades across facilities, a repository of standardized PDs is being created for all VHA to use. PDs will be standardized in a prioritized sequence. When complete, customers will save time and have clarity into the grade of the position for which they are hiring.
- **Calculation:** # of PDs standardized / total # of PDs identified for standardization
- **Target:** 100% by December 31, 2022
- **Availability:** Monthly

Key Measure for Oversight and Accountability: *The target HR shared services reporting structure is standardized and fully implemented, including governance and oversight over shared services.*

To achieve this measure VHA will establish a new reporting structure, create the associated internal controls, and fully implement them. Once in place, VHA will measure results, track performance, and monitor trends to identify and address areas for improvement.

Measure of Performance:

Metric: Percentage of regional HR leadership consolidated

Metric Information:

- **Metric Definition:** To enable HR Modernization, over 150 facility-led HR offices are consolidated to 18 VISN-led HR offices. Regional HR leadership will be standardized for all regional offices.
- **Calculation:** # of regional leadership positions implemented (Chief HR Officer, Deputy HR Officer, Facility HR Officer, Employee Relations/Labor Relations Executive Support Unit) / (total # of regional leadership positions x 18 regions)
- **Target:** 100% by September 30, 2019
- **Availability:** Completed

Metric: Percentage SSUs at full operating capability (FOC)

Metric Information:

- **Metric Definition:** A measure reflecting percentage of implementation of HR Modernization. FOC is defined as all 18 regions consolidated into SSUs, and standardized documents and systems implemented.
- **Calculation:** # of VISNs FOC SSUs consolidated / 18 regions
- **Target:** 100% by September 30, 2020

- **Availability:** Monthly

Measure of Effectiveness:

Metric: Average number of days from hiring need validation to entry on duty (time to hire)

Metric Information:

- **Metric Definition:** A measure of how long it takes to bring on a new employee is needed as delays may impact ability of VHA to provide Veterans care. This measure reflects the average number of days it takes from the time a hiring need is validated to the entry on duty of the employee.
- **Calculation:** total # of aggregated days for all employees hired from hiring need validation to entry on duty / total number of employees hired
- **Target:** Title 5 and Hybrid Title 38: 80 days, Title 38: 100 days
- **Availability:** Monthly

Metric: Percentage of position inventory compared to authorized full time employee (FTE) (HR Data Quality)

Metric Information:

- **Metric Definition:** An indicator of organization resource management health and HR staff competency is to compare the current position inventory to the current authorized FTE. A difference of less than or equal to 1.5% reflects good position inventory management. Position inventory is tracked in HR Smart, the manpower system of record, and consists of validated positions that are budgeted and authorized.
- **Calculation:** total # of positions authorized / total number of positions active in HRSMART
- **Target:** Position inventory within +/- 1.5% of authorized FTE
- **Availability:** Monthly

Metric: Payroll errors per pay period (Payroll Quality)

Metric Information:

- **Metric Definition:** To gauge Payroll Quality, the measure will track the number of special pay requests each pay period. Special pay requests are submitted when an employee was not paid properly or on time through normal processes. Timely and accurate pay is critical for employee morale, satisfaction, and retention. Many employees will not stay in a job if they do not get paid for even one pay period.
- **Calculation:** Count: total # of special pay requests per specified pay period
- **Target:** TBD (Baseline data and therefore target is still being determined, but the goal will be to lower this over time and reach something close to 0)
- **Availability:** Per pay period

Metric: Employee Relations Quality (by complexity: number of cases and average case time)

Metric Information:

- **Metric Definition:** To gauge Employee Relations (ER) Quality, the LOE will track the number of ER cases, as well as the average time to resolve cases. Two categories of cases will be tracked:

Disciplinary and Adverse. Measuring the number of cases and average time to resolve cases is an indicator of the quality of relations with employees and how efficiently the organization is resolving real or perceived issues with the workforce when they arise.

- **Calculation:** Count: total # of Disciplinary employee relations cases per month
- **Calculation:** Count: total # of Adverse employee relations cases per month
- **Calculation:** Total # of aggregated days to resolve Disciplinary employee relations cases / # of Disciplinary employee relations cases
- **Calculation:** Total # of aggregated days to resolve Adverse employee relations cases / # of Adverse employee relations cases
- **Target:** TBD (Baseline data and target are still being determined, but the goal will be to lower both the number of cases in each complexity category as well as the average time to resolve.)
- **Availability:** Monthly

Metric: Customer Satisfaction (overall satisfaction score for leadership and managers/supervisors)

Metric Information:

- **Metric Definition:** To gauge customer satisfaction, the Shared Services LOE created a survey and distributed it to the field. The specific question used to report "Customer Satisfaction" asked respondents to answer: "How would you rate the overall service and support you receive from VHA HR?" In presenting the data for this metric, it will be broken down to present data based on a leadership score and a manager's/supervisor's score. Responses are on a Likert scale from 1 to 5.
- **Calculation:** Aggregated total value of Leadership scores (added together) / total # of Leadership score entries
- **Calculation:** Aggregated total value of Manager-Supervisor scores (added together) / total # of Manager-Supervisor score entries
- **Target:** TBD (On a scale of 1–5, higher is better. Baseline data and target are still being determined.)
- **Availability:** Annually

Key Measures for IT: *HR systems can meet HR shared services requirements*.

This measure evaluates HR Smart's (primary HR system of record) ability to provide effective and efficient service to HR SSUs. Fully integrated HR information systems allow tracking of recruitment from beginning to end.

Measure of Effectiveness:

Metric: Manager Self Service (MSS) fully deployed (Part of HRSMART); Recruitment Tracker in use to track status recruitment and staffing records in a unified system between HRSMART and USA Staffing data

Metric Information:

- **Metric Definition:** Integration between HR Smart, Manager Self Service, and the USA Staffing System (USAS) will result in elimination of manual data entry and duplicative trackers/systems. Currently HR staff must enter different portions of the recruitment process in multiple systems. HR Smart and USAS integration and enhancements are dependent on Department efforts to deploy VHA enhancement requests.

- **Calculation:** Count: # of instances recruitment step information is entered into HR IT systems
- **Target:** One by September 30, 2020
- **Availability:** TBD

Key Measure for Training: *HR Training is standardized and required for entry level through advanced competency levels.*

This measure establishes the basis for application of a lifecycle-driven, instructional systems design model for training standardized across the VHA. That model is based on the identification of competency requirements for the future state; a gap analysis between future requirements and existing competency; and designing and implementing training solutions to bridge the gap.

Measure of Effectiveness:

Metric: HR Workforce Quality (foundational training completion % for new hires [201s] within 1 year)

Metric Information:

- **Metric Definition:** A key to gauging the organization's adequacy of training is to ensure there are standard training programs operating at all regions. Without training programs available, there cannot be standard required training for employees. This measure will show how well the entire organization complies with national mandatory HR foundational training course requirements.
- **Calculation:** # of new hires in 201 series completing foundational training within 18 months of hire / total # of new 201 series hires
- **Target:** 80% of 201 series new hires complete foundational training within 18 months of hire. NOTE: Due to the current circumstances of COVID-19, the following two activities are in planning: 1. If the in person trainings cannot be converted to a useful workshop in addition to the virtual training done for NTDP, an exemption will be given to those surpassing 18 months; or 2) develop a virtual temporary final NTDP workshop in the interim to meet requirements. An exemption will 'exempt' those that were enrolled and planned to attend but were cancelled.
- **Availability:** Monthly

Key Measure for Resource Allocation: At this time, there is no VHA Resources measure needed.

4. Engaging Veterans in Lifelong Health, Well-being, and Resilience

Lane of Effort Leads:
David Carroll, PhD, Executive Director, Mental Health Operations
Laurie Phillips, Associate Director, Whole Health Implementation
Miguel Lapuz, MD, Network Director, VISN 8

Lane of Effort Objective

The health and well-being of the nation's Veterans is the highest priority at VA. VHA is expanding from a system designed around episodic points of clinical care primarily focused on disease management, to a partnership between Veterans and VHA over time, focused on Whole Health. Clinical encounters are essential, but not enough. Veterans need a health system focused not only on treatment, but also on health, well-being, and resilience for life. As a part of this effort, VHA is deploying a comprehensive mental health continuum of care including integrated, team-based stepped care within general mental health and primary care services. A team-based stepped care approach may include other services such as social workers, dietitians, specialists, family members, and others needed to help Veterans develop their health-for-life goals and become the center of their health management team, resulting in a more coordinated health care experience for Veterans.

VHA aims to meet these initiative goals through full implementation of the Whole Health approach at every VA Medical Center, including a comprehensive continuum of mental health care and suicide prevention resources. Through this effort, VHA will be better positioned to deliver a consistent experience of care across sites, integrate business processes, and increase efficiency by matching care intensity to care needs. Furthermore, resources be will effectively and efficiently utilized by shifting to a proactive Whole Health System of Care.

Background

Engaging Veterans in lifelong health, well-being, and resilience is an integral part of VHA's *Modernization Plan* and key to improving Veterans lives. Whole health is an approach to health care that empowers and equips Veterans to take charge of their health and well-being and to live their lives to the fullest. Within this redesigned system of care, VHA is also transforming the way it delivers mental health care and suicide prevention services. As the largest mental health care system in the nation, VA's mission is to ensure Veterans have access to a full range of proactive suicide prevention and mental health services that promote health and well-being.

The Whole Health System of Care requires three core components:

- **The Pathway:** Using peers to engage and empower Veterans
- **Well-being Programs**: Supporting self-care through well-being programs to equip Veterans
- **Whole Health clinical care:** Treating Veterans using Whole Health clinical approaches

In addition to implementing the Whole Health delivery system, mental health will—

- Deploy a full continuum of integrated care by training all qualified professionals to provide evidence-based psychotherapies and exploring innovative solutions to increase the number of mental health prescribing providers
- Use team-based stepped care in mental health and primary care, including virtual care and community partnership strategies

- Lead a public health approach to suicide prevention including primary, secondary, and tertiary interventions

Suicide is a national public health crisis and one that disproportionately affects the women and men who have served in uniform. It is the top clinical priority for VA. In June 2018, VA published the first-ever national strategy to prevent Veteran suicide. VA has worked internally within its own systems and with public and private partners to develop robust actions to prevent suicide, including training, outreach, standardized practices, data monitoring, and leadership involvement. Working with the White House, DOD, the Substance Abuse and Mental Health Services Administration, and the Department of Homeland Security, VA has led the implementation of one executive order on transitioning Service Member mental health, the creation of a Mayor's and Governor's Challenge program, and the first steps in launching a national, executive-order-driven effort to prevent the national tragedy of Veteran suicide. Suicide prevention is not only a mental health issue, but an issue with no single cause or solution, one that requires a coordinated effort from multiple groups and agencies. It is about engaging Veterans in health for life, keeping a healthy balance in risk and protective factors, developing resilience skills, and having lifelong supportive relationships—all of which are addressed through this initiative.

This Lane of Effort (LOE) overlaps and integrates with other LOEs within the *VHA Modernization Plan*. This initiative represents VA's brand of health care. It is supported by and reports through the governance body at every level of the organization, it incorporates and embodies the principles of being a high reliability organization (empowering staff, continuous improvement), and it utilizes the communication and collaboration enhancements afforded by the new EHR platform.
This effort will lead VHA toward its vision of providing exceptional, coordinated, and connected care, and engaging Veterans in lifelong health, well-being, and resiliency.

This initiative supports the following key outcomes:

- Policy drives correct behavior and is implemented consistently
- Business processes are integrated and efficient
- Governance and oversight mechanisms provide reasonable assurance that requirements are met
- Systems are interoperable and meet business needs; data are available, accurate, reliable, complete, and used to inform decisions
- Resources are used effectively and efficiently
- Training for VA staff

Key Measures and Definitions

Key Measure for Policies and Processes: *Lifelong health, well-being, and resilience expectations and standards are consistently applied at all medical facilities.*

This measure assesses how well the LOE's expectations and standards, as defined in forthcoming policy, are implemented in the field – at the medical facility level. Policy implementation will be important to achieve standardization of Whole Health clinical care integration throughout VHA.

This measure provides VHA with the ability to manage change for the LOE within the framework of an all-encompassing modernization change management plan.

Metric: Percentage of medical facility leadership identified via survey as indicating their full understanding of the forthcoming VHA directive that outlines the expectations, operating principles, and requirements for the integration of Whole Health clinical care within existing integrated care teams serving Veterans in primary care, primary care/mental health integration (PCMHI), and mental health

This metric will assess progress in understanding the Whole Health approach across VHA and enable VHA to facilitate challenges at individual medical facilities in doing so. Requirements for implementing the Whole Health approach will be: 1) developed in collaboration with VHA program offices that establish standards and set expectations for the integration of Whole Health clinical care and 2) published and distributed to regional and medical facility leadership by December 2021, 1 year following implementation at Whole Health flagship sites.

Metric Information:

- **Metric Definition:** Percentage of medical facility leadership survey responses confirming full understanding of the forthcoming VHA directive implementing the Whole Health approach (a survey of medical facility leadership will be solicited through regional leadership in January 2022, and annually thereafter, as necessary to ensure full understanding)
- **Calculation:** # of surveys indicating full understanding of directive / total # of survey responses received
- **Target:** By March 2023, 75% of medical facility responses indicate full understanding of the forthcoming directive defining the requirements for implementing the Whole Health approach
- **Reporting Frequency:** Annual survey solicited through regional leadership initially in January 2022 and reported March 2022

Key Measure for Oversight and Accountability: *Assignment of oversight and accountability to Regional Director and medical facility leadership through inclusion of an annual performance plan metric related to this LOE*

Metric: Percentage of regional and medical facility leadership demonstrating implementation of the Whole Health approach

Metric Information:

- **Metric Definition:** The percentage of regional and medical facility leaders that demonstrate success on annual performance objectives (e.g., the leader's annual performance plan, or other similar metrics)
- This objective and the corresponding performance criteria will reflect the requirements of the forthcoming directive and may include, for example: completion of required action plans for Whole Health programming, including a locally tailored and targeted suicide prevention implementation plan focused on gaps in key practices as outlined in the suicide prevention implementation guidance. With this metric, VHA will ensure all regions and medical facilities develop a proactive, community-integrated system of care to promote wellness and prevent suicide using a public health approach, a full mental health continuum of care, and a focus on each Veteran's personal goals and values.

- **Calculation:** # of regional and medical facility leaders being fully successful as defined in that year's annual performance plan or similar performance expectation / total # of regional and medical facility leaders
- **Target:** By December 2023, 100% of regional and medical facility leaders achieve full success
- **Reporting Frequency:** Annually following publication of the corresponding Whole Health policy

Key Measures for IT: *Integration of the Whole Health approach into patient EHRs to ensure care providers can address Whole Health objectives*

Success in this measure will facilitate integration of Whole Health clinical care with primary and mental health.

Metric: VA electronic data capture functions for Whole Health are translated, designed, and implemented in the new EHR.

This metric will assess progress to ensure the Whole Health design and build for the new EHR is available at initial operating capability (IOC). The objective is for the EHR to track the Whole Health (Clinic stops, CHAR 4, health factors, Personal Health Plan) in FY 2021.

Metric Information:

- **Metric Definition:** Percentage of target functionality for Whole Health data capture capabilities incorporated in the new EHR
- **Calculation:** # of functional Whole Health stop codes and CHAR 4 coding that can be captured at the facility, regional, and national levels / total # of Whole Health stop codes and CHAR 4 coding defined for target functionality (data will be generated by the Office of Electronic Health Record Modernization)
- **Target:** 75–100% of Whole Health data capture design and build for the new EHR is available at IOC (anticipated October 31, 2021)
- **Reporting Frequency:** TBD

Key Measures for Training: *Percentage of staff completing required Whole Health approach trainings within the targeted timeframes*

Initial required trainings will be specified in the forthcoming directive, and training requirements will be communicated to managers and staff. Metrics will demonstrate staff compliance with Whole Health training requirements and will enable follow-up action to ensure all appropriate staff are trained.

Metric: The percentage of staff completing required Whole Health approach trainings as documented in the Talent Management System (TMS) within 120 days of implementation.

Staff will complete Whole Health training, as required by pending VHA policy, within 120 days following initiation of implementation and within 120 days for new staff that are onboarded thereafter. Trainings specific to Whole Health systems and Whole Health clinical care have been developed and made available to staff across the country. Class completion is being recorded in TMS and can be retrieved by Employee Education System (EES) using VA organizational codes that delineate where the staff are currently serving (e.g., in primary care or mental health). For example, as of December 2019, Whole Health 102 (Whole Health Systems) has been completed by 1,004 staff at the 18 Whole Health flagship

sites and 2,120 staff have completed this training nationally. Whole Health 202 (Whole Health Clinical Care) has been completed by 142 staff serving in primary care and by 44 staff serving in mental health.

Metric Information:

- **Metric Definition:** Staff training requirements, as established through pending VHA policy for Integration of Whole Health clinical care within Primary Care/Mental Health Integration (PCMHI), will be met within 120 days following initiation of implementation. Thereafter, staff new to these areas will complete training requirements within 120 days of onboarding.
- **Calculation:** # of staff who have completed required training within 120 days of implementation per facility / # of staff required to complete the training (i.e., serving in primary care PCMHI, and mental health per facility)
- **Target:** 85–100% of staff serving in primary care, PCMHI, or mental health will complete required Whole Health training in the required timeframe; all staff new to primary care, PCMHI, and mental health will complete training within 120 days of onboarding
- **Reporting Frequency:** 120 days following implementation initiation of Whole Health clinical care into primary care, PCMHI, and mental health; bi-annually thereafter

Key Measures for Resource Allocation: *Resources are aligned with Lifelong Health, Well-Being, and Resilience priority needs as reflected in the increased participation of Veterans in Whole Health encounters.*

Metric: Whole Health Clinical Activity – participation in Whole Health services by Veterans

This metric will provide insight into Veterans' receipt of Whole Health services and enable management attention, as necessary, to increase that participation and improve Veteran health.

Metric Information:

- **Metric Definition:** The percentage of unique Veterans who had at least two Whole Health encounters as evidenced by Whole Health stop codes or CHAR 4 codes (These metrics will reflect degree of implementation and utilization at the regional level. Whole Health stop codes and CHAR 4 codes are available for encounter documentation currently; data will be obtained through the corporate data warehouse.)
- **Calculation:** # of unique Veterans who had at least two Whole Health encounters within a 12-month period / # of unique Veterans who engaged in VA services in the same 12-month period
- **Target:** The percentage of unique Veterans using Whole Health services for each region will increase by 10% in the first 2 years following implementation and then by 5% annually over the next 3 years
- **Reporting Frequency:** Quarterly

5. MISSION Act Access to Care: Access Standards

Lane of Effort Leads:
Kameron Matthews, MD, JD, Deputy Under Secretary for Health for Community Care
Cynthia Breyfogle, FACHE, Network Director, VISN 9

Lane of Effort Objective

VA operates one of the largest health care delivery systems in the world, servicing more than 9 million Veterans. Over the past several years VA has been undergoing a major transformation of not only health care delivery but also significant aspects of its operational processes. In many respects, this is a continuation of the transformative actions VA initiated since being placed on the GAO HRL for health care in 2015. This transformation of processes, policies, service delivery, and technology is best reflected in VA's implementation of the 2018 Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act legislation.

The MISSION Act includes five titles with more than 60 provisions that either create new laws or amend sections of existing laws. While implementing the MISSION Act, VA has demonstrated the maturation of processes and clear definition of policies for large-scale transformation, established clear lines of monitoring and accountability, and developed a collaborative IT decision making and project management infrastructure that puts end users at the center of the software development lifecycle. In fact, the first phase of MISSION Act, implementation of the new community care program, has given VA a proven operating model driving consistency, efficiency, accountability, and interoperability that is being replicated in other major VA initiatives. As future phases of MISSION Act are implemented, this report will be updated.

VA is taking a comprehensive approach to meet the MISSION Act's requirements, deliver on milestones, and modernize its health system to achieve high reliability. Later sections of this report will describe in detail the following outcomes that demonstrate VA's success in addressing the GAO identified risks through MISSION Act implementation and leveraging this success across VA. Some highlights include—

1. Clear, field-informed definition of policies and processes for standardized enactment of community care and urgent care benefits, including:
   - Established a new VHA Joint Operations Center (JOC) enabled coordination of national actions with regional offices, VHA program offices, and the Office of Information and Technology (OIT) and other Department offices. This continuing JOC function speeds communication across layers of hierarchy, bringing field voices directly into operations and plans and decreasing time to resolution of issues.
   - Convened Community Care Oversight Boards at regional level, helping to bring speed and consistency to key operations at medical centers.
   - Implemented interim Standardized Operating Procedures (SOPs) at regional level to bridge (and in many cases inform) the development and release of national policy guidance to facilities.
   - Conducted MISSION town halls hosted by facilities for Veterans and coordinated messaging across the country.
2. Establishment of oversight and accountability mechanisms within Veterans Care Agreements (VCAs), Community Care Network (CCN), Provider Exclusionary Management, and urgent care utilization, such as:

- Daily JOC teleconferences with VA Central Office Executive Leadership and regional executive leadership (twice daily in the days immediately leading up to June 6, 2019) facilitated oversight and issue resolution.
- Regions, in turn, established streamlined processes for communicating information from JOC calls into actionable priorities cascaded to regional and medical facilities staff.
- The Office of Community Care (OCC) deployed implementation tracking mechanisms to drive consistent oversight of implementation priorities.
- VHA continues to hold JOC teleconferences weekly, with VA Central Office Executive Leadership and all regional directors engaged. JOC teleconferences encompass a broad spectrum of oversight and accountability areas, including clinical and business operations, patient satisfaction, education/training, communications, and data trends.

3. Deployment of significant new IT capabilities including implementation of the Decision Support Tool (DST) for community care
   - Network Executive Leadership and regional IT Executive Leadership strengthened communication and engaged daily in the weeks leading up to and immediately following the MISSION Act start date (June 6, 2019). Joint collaborations tracked included—
     - Field IT issues encountered by facilities
     - Prioritization of remediation needs and level of action ownership (Regions, District IT, VA Central Office)
     - Communication back to the field regarding status of pending IT items
     - Dissemination of key timelines (IT patches, updates, help desk information, key points of contact, etc.) and points of contact for immediate troubleshooting needs
   - OIT prioritized MISSION Act IT issue tickets, which were labeled by facilities with the word "MISSION." OIT then engaged directly with facilities to resolve issues and spread solutions across all sites. The JOC tracked tickets and progress toward issue resolution. OIT operations and plans continue to be discussed in every weekly JOC call.
   - District IT now participates directly in regional governance (Healthcare Operations Committee) to ensure seamless coordination and communication. This was furthered by Regional IT Executive Leadership's participation directly in consortium (regional) governance meetings to ensure seamless coordination and communication across the regions.
4. Launch of multiple training modules and successful completion of more than 2 million training sessions by VA staff
   - VHA deployed an education campaign for all employees, including training and daily monitoring of training compliance at the network and national levels.
   - Leveraging the JOC, facility MISSION champions informed program offices before June 6, 2019, of any needs for just-in-time training, job aids, and specific communications tools; these were promptly addressed, and this process of issue elevation and action continues through the JOC and through twice monthly MISSION champions calls.
5. Expedited hiring processes and a staffing tool to evaluate demand for staffing large programs like Community Care, Caregiver Support Program (CSP) expansion, and other MISSION Act related activities.

Key Measures and Definitions

When the GAO added "Managing Risks and Improving VA Health Care" as one of its high risk areas, it identified five areas of concern (AOCs) about VA's delivery of health care. Through implementation of the MISSION Act, VA intends to address each AOC with the following metrics:

1. **Policies and Processes**
   - ***Metric:*** Number of regulations or directives that are regularly reviewed, approved, and actioned by VHA and field leadership through established governance processes
2. **Oversight and Accountability**
   - ***Metric:*** Number of key performance indicators developed through established governance processes that are regularly reviewed and actioned by VHA and field leadership
3. **IT**
   - ***Metric:*** Number of IT systems required to support the initiative that are developed and tested with relevant VA and VHA program offices and field subject matter expertise prior to national deployment
4. **Training**
   - ***Metric:*** Percentage of relevant employees who completed training prior to implementation of significant process changes
5. **Resource Allocation**
   - ***Metric:*** Resource needs and priorities for allocation are aligned with VA and VHA guiding documents (Strategic Plan and Long-Range Framework) and used to make decision aligned with resources and funding

Veterans Community Care Program

Background

With MISSION Act implementation, Veterans have additional options on where and when they receive care with the expansion of community care eligibility criteria and a new urgent care benefit. MISSION Act ended the Veteran Choice Program (VCP) and established a new community care program known as the Veterans Community Care Program (VCCP). VCCP has been implemented, in part, by creating a network of community providers through entering into the regional contracts to form the Community Care Network (CCN) and is being rolled out through a phased implementation. VA is also modernizing IT systems to replace old technology and manual processes, thereby speeding up many aspects of community care while also improving communication between Veterans, community providers, and VA staff.

VCCP was implemented on June 6, 2019, with the finalization of implementing regulations. At that time VCP officially ended, along with the traditional community care programs, known as the fee program under the pre-MISSION Act version of section 1703 of title 38 of the United States Code (U.S.C.).

VHA staff were provided robust and timely guidance via scripts, fact sheets, videos, tabletop exercises, and other materials to ensure awareness of changes to the community care program and everyday operations. Included below are bulleted overviews of changes to VA Community Care as mandated by MISSION Act, including new tools (e.g., DST), changes to standards and benefits (e.g., access, standards

for quality, and urgent care), and new processes (e.g., VCAs, provider exclusionary management, and medical service line remediation).

- **Eligibility Criteria:** Eligibility criteria expanded under MISSION Act to ensure Veterans have improved access and choice in health care received, whether at VA or in the community.
- **Decision Support Tool:** The DST is a software tool that helps standardize how VA providers and staff decide the appropriate location for a Veteran to receive care, whether in VA or in the community. The DST informs VA providers and staff about the availability of services within VA, and Veteran's eligibility for community care. Additionally, DST documents the outcome of the decision process by providing a standardized comment to the consult.
- **Access Standards:** VA's new access standards for community care eligibility are effective beginning June 6, 2019, per implementing regulations. These standards set criteria for when Veterans can seek care to meet their needs with community providers. Access standards are based on average drive time and appointment wait times, as shown below:

Table 1-3. MISSION Act Access Standards

Drive Times		Wait Times	
Primary/Mental Health/Non-Institutional Extended Care	Specialty Care	Primary/Mental Health/Non-Institutional Extended Care	Specialty Care
30 minutes	60 minutes	20 days	28 days

- **Veterans Care Agreements:** Under the MISSION Act, VA may enter into agreements with certain community providers to care for Veterans. VCAs are intended to be used in limited situations to ensure Veterans can get the care they need when a contracted provider is not available. VA verifies the credentials of licensed medical professionals providing care to Veterans by assessing their credentials and legitimacy to provide care. To do this, VA normally uses the Centers for Medicare and Medicaid Services (CMS) process to certify CMS-participating providers. Alternatively, VA can use its Interim Certifications Process to certify non-CMS participating providers for a VCA until VA establishes a national contract with a Credentials Verification Organization (CVO). The CVO reviews required provider and provider organization documentation and credentials the community providers based on established criteria.
- **Network Adequacy:** MISSION Act ended the VCP and created the VCCP to provide continuity of service to Veterans. VA now purchases care for Veterans either through its contracted networks, such as the Patient Centered Community Care network, or the CCN, or by establishing a VCA. These types of agreements, including those that utilize Third Party Administrators (TPAs), will provide Veterans with a sufficient number of in-network providers in order for the Veteran to have access to care in a timely fashion.

  Network Adequacy is evaluated utilizing both qualitative and quantitative measurements. Quantitative measures include appointment timeliness and drive-time as measured from the Veteran's residence to the community provider's office. Examples of qualitative measurements include confirmation that credentialing standards are met, licensing reviews, and excluding providers identified in VA's provider Exclusionary management process, such as those on the Office of Inspector General List of Excluded Individuals/Entities (LEIE). Providers who have signed VCAs are also required to meet these qualitative standards.

- **Provider Exclusionary Management:** The MISSION Act mandates that VA deny or revoke a community provider's eligibility to provide health care to Veterans if the provider was removed from VA employment with the Department of Veterans Affairs due to conduct that violated a policy of the Department relating to the delivery of safe and appropriate health care; or violated the requirements of medical license of the health care provider that resulted in the loss of such medical license. To meet these requirements, VA has established automated and manual processes to prevent excluded providers from receiving new authorizations from VA and conducting future appointments with Veterans until any and all exclusions have been lifted.
- **Urgent Care**: As of June 6, 2019, eligible Veterans can access urgent care in the community within VA's network of community urgent care providers. Urgent care is for non-life-threatening conditions that require treatment in a short period of time, such as pink eye or influenza. VA has a network of retail (walk-in) care and urgent care options in the community where Veterans can go without obtaining prior authorization. VA can pay for an urgent care claim only if the Veteran is eligible for the benefit, the urgent care provider is part of VA's contracted network of community providers, and the services are included in the benefit (preventative services and dental services are examples of services which are not in the benefit).
- **Prompt Payment:** The MISSION Act required VA to pay for or deny payment for services within 30 days of a clean electronic claim and 45 days of a clean paper claim. Claims that are not paid, denied, or made pending within the timeframe would be subject to interest payments and penalties. Prompt payment regulations are expected to be published in 2021.
- **Community Care Training Program:** The MISSION Act requires VA to develop a training program for VA employees and contractors on how to administer non-department health care programs and the management of prescription opioids. This program provided new training opportunities for facility community care office staff on the administration of the new program. Trainings have also been developed on all new MISSION Act requirements and benefits.
- **Opioid Safety:** In accordance with the MISSION Act, VHA requires community providers to review the Opioid Safety Initiative guidelines. This is accomplished through the external-facing training portal, VHA Training Finder Real-Time Affiliate Integrated Network (TRAIN). To ensure patient safety, community providers must submit medical history, records, and medications to VA. VA must establish a process to review the opioid prescribing practices of community providers and exclude or limit community providers found noncompliant with safe standards of care.
- **Competency Standards:** The MISSION Act requires VA to establish standards and requirements for non-department providers in clinical areas where VA has special expertise, including post-traumatic stress disorder, military sexual trauma-related conditions, and traumatic brain injuries.

Key Activities and Definitions

Key activities to address the five AOCs are identified below.

Policies and Processes: *Standardize business processes and field guidance across the Veteran Community Care Program to provide better access to care.*

Clear program policies will be distributed in a single community care program directive. This directive establishes policy for the implementation of the community care program to ensure compliance with

the laws and VA's regulations implementing the program. Operational guidance is provided to VA staff through a single guiding artifact called the Field Guidebook. The Field Guidebook defines systematic business and clinical processes for VA staff as they coordinate Veteran care. The Field Guidebook, as a living document, will be refined over time to incorporate newly implemented IT solutions or business processes that change community care.

Oversight and Accountability: *Monitor the quality and performance of the CCN and newly established VCAs.*

Key objectives are to monitor the quality and performance of the CCN related to timeliness, access, patient safety, clinical quality, and overall network performance; and identify preferred providers based on those criteria to allow Veterans the opportunity to choose a high-performing provider that is right for their health care needs.

At the facility level, trend analysis will be performed to observe changes in reporting results over time and to determine the root causes behind inadequate performance. VA staff will evaluate site performance reports to conduct audits and reviews of community care processes and functional areas. Evaluations of these processes and functional areas are essential components of managing community care and ensuring visibility and accountability.

IT: *Develop and modernize IT systems to address current community care challenges.*

This area optimizes key aspects of community care while improving communication between Veterans, community providers, and VA staff. For example, the DST is a software tool that helps standardize how VA providers and staff decide the appropriate location for a Veteran to receive care, whether in VA or in the community. The DST informs VA providers and staff about the availability of services within VA and Veterans' eligibility for community care. Additionally, DST documents the outcome of the decision process by providing a standardized comment to the consult.

Training: *Evaluate the effectiveness of the MISSION Act curriculum virtual training (eLearning and webinar) and in person workshop courses for both VA and contractor staff.*

This approach is used to identify training gaps, develop supplemental trainings, and update current trainings. Effectiveness and customer satisfaction of webinars is evaluated through approved surveys. Learner feedback is evaluated using evaluation forms. Learner knowledge retention is evaluated through pre- and post-tests. The number of learners is measured to ensure adequate training of VA staff.

Resource Allocation: *Align available resources to consistently execute established processes for the Veteran Community Care Program (VCCP).*

A staffing tool was developed that estimates the number of clinical and administrative staff needed to support community care processes at medical facilities. The purpose of the Staffing Tool is to identify the staffing needs and requirements for facilities under the new Office of Community Care (OCC) Operating Model. Information from the staffing tool is used to determine what optional tasks should be utilized by the CCN Third Party Administrator for a given facility.

By exercising the optional task, a medical facility's community care staff can delegate the scheduling of community care appointments to the CCN contractor. This support is intended to be an interim solution. VA's expectation is that these services will be performed by local VA staff when the contractor support ends. Using the staffing tool and optional tasks enables the appropriate resource allocation.

Demonstrated Progress

Policies & Field Guidance

- Published AQ45 "Veterans Care Agreements" regulation outlining the process and establishment of VCAs.
- Published AQ46 "Veterans Community Care Program" regulation governing the new VCCP.
- Published AQ47 "Veterans Community Walk-in Care" to establish procedures for the new urgent care benefit.
- Developing new policies and reviewed, edited, and updated existing guidance to facilitate consistent implementation. The VCCP Directive will be the authoritative source for field. Policy is in progress.
- Published Clean Claim Federal Register Notice in July 2019, soliciting requirements for a clean claim from the public and private industry. This information will feed into the prompt payment regulations.
- Prompt payment regulations are expected to be published as final in Spring 2021 to regulate the prompt payment standards within the MISSION Act.
- Published content in the OCC Field Guidebook: a regularly updated document available to VHA staff nationally that contains systematic clinical and business processes for MISSION Act implementation.

IT:

- Implemented the DST, the design of which assists in standard decision making and in data collection and oversight.
- National implementation of IT systems (e.g., DST) allows for reliable and standardized reporting to senior leadership for increased accountability.
- Ensured DST rollout included test environment and user acceptance testing to capture user feedback.
- Developed and implemented contingency plans that allowed the June 6 deployment of MISSION Act to occur with minimal impact on business operations.
- Published technical user guides, accessible to VA staff.
- New IT systems speed up all aspects of community care – eligibility, authorizations, appointments, care coordination, claims, payments – while improving overall communication between Veterans, community providers, and VA staff members. The following key systems were updated to meet MISSION requirements:
    - Provider Profile Management System: A repository of community provider information
    - HealthShare Referral Manager: A system-wide tool supporting community care used by facility community care staff to generate referrals and authorizations for Veterans receiving care in the community
    - Electronic Claims Administration and Management System: A web-based commercial-off-the-shelf system that can adjudicate, process, and pay health care claims submitted

by health care providers, on behalf of veterans' health needs, in accordance with industry standards.

Data Monitoring

- Building data dashboards and initiating new cross-functional collaboration processes to assist leadership with decisions on where best to apply available resources.
- Measuring and analyzing the effectiveness of the VCCP through performance metrics aligned to OCC's strategic goals.
- Submitted a Congressionally Mandated Report on June 6, 2019, describing the steps VA is taking to inform community providers of the safe opioid prescribing guidelines, as well as how VHA will monitor the opioids prescription practices of community providers.

Training and Communication

- MISSION Training Completion Summary:

Table 1-4. MISSION Act Training Completion Summary

MISSION Course	Completions Through 6/6/19	Completions Through 11/18/19
DST Complete Overview	269,550	301,608
Emergency Care Reimbursement 101	187,743	218,770
Provider Exclusionary Management (PEM)	39,962	56,225
Eligibility 101	278,615	324,047
Eligibility 201 (Detailed Process Training)	207,546	260,521
Urgent Care 101	259,280	288,532
Urgent Care 201	179,666	211,448
Veterans Care Agreements (VCA) 101	123,687	142,013
What's New in Community Care	255,499	285,724
An Overview of Community Care	54,098	64,228
Introduction to the Community Care Network - CCN 101	29,332	35,232
Total	**1,884,978**	**2,188,348**

- Communicated and trained staff on new processes across VHA.
- VA submitted a Congressionally Mandated Report in June 2019 outlining the approach to tracking training compliance and analyzing training effectiveness.
- Developed and published 10 MISSION related training courses for all VA staff, distributed via TMS, and tracked progress.
- Conducted multiple webinars on eligibility and DST to specialty groups such as Medical Support Assistants.
- Collaborated with Employee Education Service to conduct live training presentations.
- Conducted the Spring Forward workshop for 250 national participants (primarily from facilities and regions) on all aspects of the VCCP.
- Soliciting regular field leadership feedback on training adequacy and translating field staff questions into updated training modules.
- Developing webinar and guidance documents to inform the field of the process for reviewing opioid prescribing community providers.
- Published over 109 training courses for community providers, including the general community care training course, "Community Care Provider: A Perspective for Veteran Care," on VHA Training Finder Real-Time Affiliate Integrated Network.

- Established an internal intranet platform for all MISSION Act communications products, guidance, and staff resources.
- Established an external MISSION Act website: www.missionact.va.gov.
- Provided robust and timely guidance to VA staff via scripts, fact sheets, videos, tabletop exercises, and other materials to ensure awareness of changes to the community care program and daily operations.

Quality Standards

Background. VA's standards for quality support VA's commitment to provide Veterans with care that is timely, effective, safe, and Veteran-centered. These standards for quality were selected based on availability of comparative data for community providers and importance to Veterans, as determined through an extensive review of existing health care standards for quality and consultation with federal, regulatory, and public stakeholders through focus groups, meetings, and requests for information. These standards are supported by performance measures with availability of publicly reported results that evaluate clinical performance, when available:

Table 1-5. MISSION Act Quality Domains and Initial Measures

Quality Domains	Initial Quality Measures
Timely Care **is provided without inappropriate or harmful delays**	Patient-reported measures on getting timely appointments, care, and information
	Wait times for outpatient care
Effective Care **is based on scientific knowledge of what is likely to provide benefit to Veterans**	Risk-adjusted mortality rates for heart attack, pneumonia, heart failure, and chronic obstructive pulmonary disease
	Smoking and tobacco use cessation counselling
	Immunization for influenza
	Controlling high blood pressure
	Beta-blocker treatment after a heart attack
	Comprehensive diabetes care – blood pressure control and Hemoglobin A1c poor control
	Breast cancer and cervical cancer screening
	Improvement in function (short-stay skilled nursing facility patients)
	Newly received antipsychotic medications (short-stay skilled nursing facility patients)
Safe Care **avoids harm from care that is intended to help Veterans**	Catheter associated urinary tract infection rate
	Central line associated bloodstream infection rate
	Clostridium difficile infection rate
	Death rate among surgical patients with serious treatable complications
	New or worse pressure ulcer (short-stay skilled nursing facility patients)
	Falls with major injury (long-stay skilled nursing facility patients)
	Physical restraints (long-stay skilled nursing facility patients)
Veteran-Centered Care **anticipates and responds to Veterans' and their caregivers' preferences and needs and ensures that Veterans have input into clinical decisions**	Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) overall summary star rating
	HCAHPS Care Transition summary star rating
	Patient's overall rating of the provider on the Consumer Assessment of Health Providers and Systems (CAHPS) survey
	Patient's rating of coordination of care on the CAHPS survey

To facilitate the most effective partnership across the provider community caring for Veterans, VA is taking an iterative approach, proactively collaborating with federal partners at DOD and the Department of Health and Human Services, as well as community partners in the private sector, to remain in lockstep with the evolution of standards and measures for quality as the industry advances.

The Secretary is authorized to furnish care to Veterans through non-department providers for a VA medical service line designated as not providing care in a manner that complies with VA's standards for quality. Collaboration and coordination with the new community care program was essential to ensure seamless integration of this expanded eligibility for community care based on quality standards. For any designated VA medical service line, VA will engage in robust remediation processes and report its efforts (in alignment with the requirements of Section 109) to Congress to remediate VA's medical service line and ensure that Veterans are able to receive high-quality care from VA.

Key activities to address the five areas of concern are identified below.

Policies and Processes: *Standardized business processes are uniformly implemented across the health care delivery system.*

- The current quality measurement landscape continues to evolve rapidly necessitating VA's iterative approach to MISSION Act Quality Standards implementation. As a result, a formal directive is not appropriate at the current time; however, other tools and methodologies are being deployed to provide the requisite structure.
- Expert advice was sought from external parties (e.g., RAND Corporation, Special Medical Advisory Board) to confirm the necessity of the iterative approach described above.
- Established the foundational infrastructure and processes to support implementation.
- Developed Implementation Guide with related flow maps specific to MISSION Act Quality Standards and provided updates to the MISSION Act Field Guide to ensure consistency in messaging to the field.
- Developed and shared information in VA Health Care Options Brochure mailed to Veterans.
- Developed training for VHA key leaders in preparation for national implementation.
- Developed reference toolkit to be used by designated VA medical service lines.
- Selection of performance measures was predicated on those available through publicly available data sources to ensure that private and federal sector were using the same performance measures, consistent definitions, and comparable calculations for results.

Oversight and Accountability: *A structure for oversight and accountability helps ensure the consistency, objectivity, and effectiveness of the processes identified to implement the MISSION Act standards for quality as defined in Sections 101, 104, and 109.*

- Integrated the communication of the development and implementation of standards, measures, and key processes into the revised Governance Board structure for VHA.
- National Technical Advisory Group (TAG) established, composed of measurement and operations experts at multiple levels of the organization, to provide guidance and oversight of the data analysis processes. The Technical Advisory Group reports to the Principal Deputy Under Secretary for Health. The TAG reported its recommendations to the VHA Executive Committee.
- Regular meetings occurred with the following bodies: MISSION Act Project Management Office, Regional Directors responsible for the MISSION Act LOE; VHA Governance Board, Quality Work group; Strategic Planning Committee.
- Additional ad hoc meetings included the Special Medical Advisory Group, annual Strategic Planning Summit, consultative groups (e.g., RAND Corporation).

Area of Concern Level Outcomes Addressed:

- VHA oversight ensures governance and management decisions are implemented and focused on intended outcomes.
- Governance and management decisions are made at the appropriate level of the organization, are informed by reliable data, and are timely.
- VHA supports a Just Culture that fosters trust, integrity, learning, and collaboration.

IT: *IT and data reporting systems are designed to achieve objectives and ensure consistency across the enterprise.*

- Collaborated with technology, community care clinical integration, and quality teams to incorporate quality standards criterion into the DST, the design of which assists in standardizing documentation of the decision-making process for eligibility.
- Selection of performance measures that support the MISSION Quality Standards requirements was predicated on those available through publicly available data sources to ensure that the private and federal sectors were using the same performance measures, consistent definitions, and comparable calculations for results.
- Integrated MISSION quality measures into executive-level performance plans and online monitoring tool.

Training: *Employees affected by re-engineered or new business processes are effectively trained in new processes and areas of responsibility.*

- Provided targeted audiences with webinars and training sessions to ensure their feedback in the design process and keep them informed about the development and implementation process.
- Collaborated with Employee Education Service to develop national on-demand training presentation on establishing quality standards and measures and community care eligibility through the quality criterion.
- Monitored facility and regional leadership training using the above referenced educational module.

Resource Allocation: *Available resources are aligned*

- Multi-program implementation model developed and outlined in process flow design and Implementation Guide. Available resources were used in the design and execution except for resource reallocation of a partial position for the Health Operations Center.
- Existing programs, based on expertise and relevant functions, are being mobilized to support initial implementation and sustainment.
- Reviewed existing programs to identify opportunities to streamline and reduce redundancy.

Demonstrated Progress

Starting in August 2018, VA held multiple meetings on standards for quality with the Defense Health Administration of DOD and CMS. VA published a notice in the Federal Register on August 24, 2018, to

request feedback from the public to be considered in establishing VA's standards for quality. VA held a public meeting on September 24, 2018, to elicit feedback on establishing of standards for quality from federal and private sector entities.

VA proposed standards for quality in a March 12, 2019, report to Congress and officially established the standards for quality through an early Fall 2019 notice in the Federal Register. The need for a TAG was identified, and a charter was written and approved for a multidisciplinary group of measurement and operations experts representing the local, regional, and national health care delivery settings across VHA. Their purpose was to provide recommendations for designation of VA medical service lines based on an in-depth assessment by highly qualified experts on VA health care quality.

In August 2019, VA made education available through VA's TMS to VHA staff on VA's standards for quality. In September 2019, VA began the process of evaluating the quality of VA medical service lines using data from the annual CMS refresh and other sources; final analysis of those results is nearing completion.

A collaborative effort across OIT, Community Care, and the Quality work group is actively engaged in the refinement of the DST to incorporate the documentation and decision-making process to support the quality standards.

VHA is actively engaged with the Military Health System, CMS, and America's Health Insurance Plans in a collaborative effort to develop a meaningful set of core measures that can span the federal and private sector landscape.

VA has collaborated with the Military Health System, CMS, and Domestic Policy Council to outline critical elements of an evolving quality measurement landscape, which resulted in an Executive Order to the Department of Health and Human Services to develop a Health Quality Roadmap that aims to align and improve reporting on data and quality measures across federal health systems and programs, which shall include a strategy for establishing, adopting, and publishing common quality measurements; aligning inpatient and outpatient measures; and eliminating low-value or counterproductive measures.

The new evaluation process was initiated in September 2019 with results pending in Spring 2020.

Caregiver Support Program

Background

The John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act) was signed into law by President Donald Trump on June 6, 2018. The MISSION Act enables VA to continue the transformational efforts of its health care system, fulfill the President's commitment to provide Veterans with more choice in their health care providers, and prevent a funding shortfall in the current VCP. The MISSION Act mandates VA expand the Program of Comprehensive Assistance for Family Caregivers (PCAFC) which is part of the Caregiver Support Program (CSP), to include eligible Veterans and their family caregivers from all eras of military service. This expansion will strengthen VA's ability to support more caregivers with additional services to better care for themselves and the Veterans who depend on them.

Key Activities and Definitions

The MISSION Act mandates the following regarding PCAFC:

- Section 161 – Requires expansion of eligibility for PCAFC, new benefits for designated family caregivers of eligible Veterans, and other changes affecting program eligibility and VA's evaluation of PCAFC applications. PCAFC is currently provided to eligible Veterans who incurred or aggravated a serious injury in the line of duty or after September 11, 2001. Under the MISSION Act, expansion of PCAFC to eligible Veterans of earlier eras of service will occur in two phases:
    - Beginning on the date the Secretary submits to Congress a certification that the Department has fully implemented the IT system required by section 162 of the MISSION Act, PCAFC will be expanded to include eligible Veterans who incurred or aggravated a serious injury in the line of duty on or before May 7, 1975.
    - Two years after the date of the certification described above, PCAFC will be expanded to include eligible Veterans who incurred or aggravated a serious injury in the line of duty after May 7, 1975 and before September 11, 2001.
- Section 162 – Requires VA to implement an IT system that fully supports PCAFC and allows for data assessment and comprehensive monitoring, monitoring and assessment of PCAFC workload and any necessary modifications, and an initial and final report. The final report will include a certification that the IT system has been implemented, among other required elements.
- Section 163 – Modifies the annual reporting requirements for VA's Congressionally Mandated Report (CMR) on the PCAFC and the CSP, including a description of any barriers accessing and receiving care and services.
    - VA provided the annual CMR to Congress in April 2019 and May 2020.

Demonstrated Progress

Staffing

- VA increased the CSP workforce to support caregivers and Veterans, to build the infrastructure for expansion, increase governance and oversight, and centralize eligibility determinations at the region level.
    - In August 2019, over 680 new field-based CSP positions were approved for recruitment, which will bring the total CSP workforce to over 1,000 approved FTE. Positions cover a variety of necessary roles and range from GS 5s to medical doctors.
    - Designated and funded a dedicated VISN CSP lead position for every region to provide oversight and governance for medical facilities in each region. All regions are currently in the process of hiring this essential position, with 50% hired as of December 2019.

Caregiver Record Management Application

- VA vigorously pursued an IT system to fully support PCAFC with data assessment and comprehensive monitoring as required by the MISSION Act. This system is referred to as the Caregiver Record Management Application (CARMA).
- VA adopted a three-phase approach for the development and deployment of CARMA. The first release was successfully deployed on October 28, 2019 and is being used by Caregiver Support Coordinators (CSCs) nationwide to capture caregivers newly approved for the Program of General Caregiver Support Services, as well as new applications to the PCAFC.

- CARMA training of field-based users is ongoing. As of October 2019, there have been over 30 training sessions for VA staff expected to use CARMA inclusive of regional leads, CSCs and others supporting local caregiver support programming, and Health Eligibility Center staff.

Education and Training

CSP Calls and Training:

- The CSP Program Office provides ongoing education and training to field staff on four standing calls each month. In FY 2019, over 7,000 staff attended and participated in these calls.
- Specific education and training related to the expansion of CSP under the MISSION Act has been offered both through standing program office calls and in collaboration with VA EES.
- A training plan was developed targeting specific audiences (field staff, providers, caregivers, Veterans, etc.) and includes a variety of modalities: TMS webinars, in-person conferences, e-learning, and live training on CSC calls.
- CSP and EES have held two educational sequesters to facilitate the coordination of the education and training plan. The training plan is adjusted as needed and additional topics and opportunities added to the plan regularly to address identified needs.
- In FY 2020, CSP education and support planning rolls out coaching, skills training, peer support mentoring, and one-on-one caregiver support.

Webinars:

Four webinars have been recorded and are now available in TMS:

- CSP Program Overview
- CSP Directive
- PCAFC: Veteran Eligibility Criteria for Providers
- MISSION Act CSP Tool Kit Webinar

Other topics have been identified and are under development for TMS webinars.

Conferences – Current Plan:

- February 2020: CSP Regional Lead Training; approximately 40 staff attended
- July 2020: Clinical Eligibility Team (CET) Training; approximately 80 staff to attend
- August 2020: CSP Field Training; approximately 1,100 staff to attend

Centralized Eligibility and Appeals Teams

- The CSP is designing a centralized, clinical eligibility model to standardize eligibility and appeal determinations, to be made by a team of full-time, highly trained, multi-professional staff, based at VISNs, for Veterans participating in the PCAFC. One of the project's three master deliverables has been met. Two are slated for January and June releases, respectively:
    - Eight CEAT Functional Statements created and provided to the field September 2019 (i.e., Medical Doctor, Nurse Practitioner, Psychologist, Social Worker, Registered Nurse, Licensed Professional Mental Health Professional Counselor, Occupational Therapist, and Program Support Assistant)

- A CEAT SOP to be released fall 2020

Program of General Caregiver Support Services

To increase services and support to caregivers of Veterans of all eras, the CSP has expanded collaboration with—

- The Elizabeth Dole Foundation on a cultural transformation initiative called the Campaign for Inclusive Care. The campaign aims to integrate caregivers into the health care team. The Campaign for Inclusive Care will train providers via the Academy for Inclusive Care, with education modules addressing the following topics: Veteran caregivers, the role of caregivers, impact on caregiving, and how to include caregivers in the care team. The Campaign for Inclusive Care seeks to move from caregiver support to caregiver integration.
- The Office of Connected Care on the Annie App, a Short Message Service (SMS) text messaging capability that promotes self-care to caregivers of Veterans. The Memphis Caregiver Center, part of the CSP, has developed the text message protocols adapted from the successful REACH VA (Resources for Enhancing All Caregivers' Health) Program.
- The Office of Suicide Prevention to produce a toolkit for caregivers and family members and their role in the prevention of suicide. The toolkit educates and equips caregivers of Veterans to know the facts about suicide prevention and to know when and how to access VA assistance.

Regulations

- During the month of October 2019, the CSP led a cross-functional, multi-office regulation sequester to accelerate publication of proposed regulation (AQ48) that will facilitate MISSION Act implementation and PCAFC expansion.
- AQ48, Program of Comprehensive Assistance for Family Caregivers Improvements and Amendments Under the VA MISSION Act of 2018, was published on March 6, 2020. 85 Fed. Reg. 13356.

Section 106: Market Area Assessments

Background

The Market Area Health Systems Optimization project is an initiative to conduct market assessments for each of VA's 96 markets that will help VA provide the best health care for Veterans and their families. This work is also known as "market assessments."

In accordance with the VA MISSION Act of 2018, market assessments will assist VA's ongoing effort to develop high-performing networks of care that will improve access and quality of care for Veterans across the country. These networks include care provided by VA, as well as supplemental care provided by DOD, Federally Qualified Health Centers, other federal partners, teaching hospitals, and community providers across the country. VA will remain the integrator and coordinator of a Veteran's care throughout their lifetime.

Market assessment work will take place in three phases, assessing six regionals at a time. Phase 1 includes Veterans Integrated Service Networks (VISNs) 2, 4, 5, 6, 16, and 17. Phase 2 includes VISNs 1, 10, 12, 15, 19, and 23. Phase 3 includes VISNs (regions) 7, 8, 9, 20, 21, and 22.

Key Activities and Definitions

Section 106(a) requires that not less frequently than every 4 years, the Secretary of VA shall perform market area assessments regarding the health care services furnished under the laws administered by the Secretary.

Section 203(b)(3)(A)(iv) requires that the Secretary assess the capacity of each region and medical facility to furnish hospital care or medical services to veterans. Each assessment should include a commercial health care market assessment of designated catchment areas in the U.S. conducted by a non-governmental entity.

Demonstrated Progress:

- In Phase I the field work for 31 of the 96 market assessments occurred from late March to early May 2019.
- Phase II of the assessments included 32 markets and work was completed in December 2019.
- At present, market assessment work is delayed due to COVID-19 response. Phase II debriefs with VHA leadership are delayed as well as the remaining field work required for Phase.
- The completion of the field work does not incorporate national strategies. Market and VISN adjacencies as well as regional and national programs must be overlaid to produce a single view of the enterprise. This work will be completed in future phases.

Section 203: Procedure for Making Recommendation (Develop Criteria)

Background

The Criteria Development Work group is charged with developing the "criteria proposed to be used by VA in assessing and making recommendations regarding the modernization or realignment of facilities of the VHA" [MISSION Act (2018) §203(a)(1)]. The Secretary of VA shall provide a period of at least 90 days for public comment [§203(a)(2)] and publish in the Federal Register and transmit to the House Veterans Affairs Committee (HVAC) and Senate Veterans Affairs Committee (SVAC) the final criteria to be used in making recommendations regarding the closure, modernization, or realignment of facilities of the VHA [§203(a)(3)]. Maintaining alignment with §§ 106, 203, 208 (2018), the four-part criteria is the standard by which data from VA's Market Area Health Systems Optimization project will be applied. The application of this criteria is expected to yield the recommendations that the Secretary of VA – after concurrence – shall submit to the HVAC, SVAC, and Commission.

Key Activities and Definitions

- *Criteria* is defined as a principle and/or standard by which something is judged or decided.
- *Modernization* includes—
    - Any action, including closure, required to align the form and function of a facility of the Veterans Health Administration to the provision of modern-day health care, including utilities and environmental control systems
    - The construction, purchase, lease, or sharing of a facility of the Veterans Health Administration

  - Realignments, disposals, exchanges, collaborations between VA and other federal entities, and strategic collaborations between VA and non-federal entities, including tribal organizations

- *Realignment*, with respect to a facility of the VHA, includes—
  - Any action that changes the numbers of or relocates services, functions, and personnel positions
  - Disposes or exchanges services, functions, and personnel between VA and other Federal entities, including the DOD
  - Strategic collaborations between VA and non-Federal entities, including tribal organizations

Demonstrated Progress

- The work group held a kickoff event on August 29, 2019
- The work group is currently working on draft documents, including—
  - Timeline for the work implementing section 203 of the MISSION Act
  - Process map for the development of criteria as it relates to the life of the opportunities coming out of the market assessments
  - White paper
- Next steps include finalizing the above documents, briefing the larger work group to get reaction, and incorporating input from regional leadership as well as Veteran Service Organizations (as required)

Upcoming Milestones

- Develop criteria and gain approval across throughout VA
- Publish approved criteria in the Federal Register by February 2021
- Publish final criteria in the Federal Register by May 2021

6. Modernize Electronic Health Records

Lane of Effort Leads:
Charles Hume, FACHE, Assistant Deputy Under Secretary for Health Informatics
Michael J. Murphy, Network Director, VISN 20

Lane of Effort Objective

This initiative supports providing quality care, a positive Veteran experience, efficiency, safety, and innovation. Through Cerner, Electronic Health Record Modernization (EHRM) will allow VA to leverage the same commercial solution being deployed by DOD. This will achieve interoperability within VA, with DOD, and with community care providers. The following combine short- and long-term improvements that will continue:

- A single common system will replace over 130 separate EHRs, dramatically reducing maintenance and complexity (e.g., system updates), and variations across sites
- VA will share a single EHR system with DOD, facilitating innovation, security, and efficiency
- A common, shared solution across VA and DOD will facilitate the secure transfer of active duty service members' health data as they transition to Veteran status
- Standardized workflows and reporting support a common standard of health care throughout VA
- A single lifetime Veteran record and care plan available to all providers – VA, DOD, and community – will enable a continuum of care and care coordination
- Common capabilities for scheduling, refilling prescriptions, telehealth, care plans, and accessing health information will empower Veterans to take active roles in managing their health

Background

VA recognizes the problems facing Veterans today. Since 2015, numerous external assessments and GAO reports have identified organizational and operational weaknesses. The assessments identify common criticisms of VHA's strategy, leadership development and management, organizational structure, accountability and performance management, and culture. With Congressional and Presidential backing, VHA has been provided the necessary support to complete an organizational transformation that enables VA to provide seamless, high-quality, integrated, coordinated care, anytime and anywhere.

The VHA Plan for Modernization outlines the framework for developing a clinically integrated, community-supported, reliable system of care focused on providing the highest-quality and safest outcomes – and restoring trust among Veterans and their families, employees, and anyone who counts on VA's health care system. To accomplish this vision, the Secretary of VA established priorities to provide clarity and focus, ensure organizational improvements, and enable culture change. One of the four priorities is EHRM.

Modern systems represent one of the key components of an HRO. Evidence-based decisions and continuous learning will be enabled by the implementation of a modern EHR system and financial management platform. Furthermore, EHRM will provide the support that is required for medical centers to execute their missions.

This initiative supports the following key outcomes:

- Policy drives correct behavior and is implemented consistently; business processes are integrated and efficient
- Governance and oversight mechanisms provide reasonable assurance that requirements are met
- Systems are interoperable and meet business needs
- Data are available, accurate, reliable, complete, and used to inform decisions
- Resources are used effectively and efficiently

Key Measures and Definitions

Key Measure for Policies and Processes: *Uniform implementation, standardized business processes, and care across the health care delivery systems.*

This measure assesses the degree to which clear and standardized policies are implemented uniformly and provide a foundation to achieving high-quality care for every Veteran. It measures EHR implementation as an organizational transformation that standardizes business processes and implements best practices, while encouraging consistent evidence-based care.

Metric: This metric will directly measure the progress toward transformation to a high reliability organization with the premise the modernized EHR will facilitate the adoption of standardized clinical and business processes that are informed by best evidence and best use of the related IT systems. The desired outcome is to measure progress toward full adoption of standardized clinical and business processes by or before full operational capability.

Metric Information:

- **Metric Definition:** Percentage of standardized business processes that have been implemented across the VHA by full operational capability (FOC) (complete deployment of the EHRM)
- **Calculation:** # of clinical and business processes standardized / total # of end-to-end business processes as defined in the VHA business architecture
- **Target:** 100% / **Acceptable Threshold:** 80%. (More specificity will be added later. For instance, it may be decided that it is not necessary to standardize a complete end-to-end business process, but certain activities with an end-to-end process are expected to be standardized across VHA.) Target for each deployed site, within 1 year of go-live. VHA-wide: by FOC +1 year (FY29 per current approved schedule).
- **Reporting Frequency:** Measurement is expected to align to the wave (a set of medical facilities and associated Community-Based Outpatient Clinics deployment schedule, i.e., with each wave). For each wave, a current state clinical and business process assessment will be conducted pre go-live. A post go-live assessment will be conducted 12 months after go-live, to allow for adequate stabilization. Lights-on data, specifically to support the Value Management and Realization effort, will be measured not more than quarterly.

Key Measure for Oversight and Accountability: *Oversight and accountability controls assess the effectiveness of clinical and health care delivery support systems using EHRs.*

This measure examines the establishment of governance and accountability functions, data capture and reporting mechanisms, and implementation of review controls. Once established, the measure reports

on the effectiveness of the rollout, demonstrating the value of clinical and health care delivery systems using EHRs.

Metric: This measure indicates whether an EHR-specific governance has been established, has incorporated effective data capture and reporting mechanisms, has adequate review controls, and is inclusive of all necessary stakeholders (e.g., Office of Electronic Health Record Modernization [OEHRM], VHA, Federal Electronic Health Record Modernization [FEHRM] Program Office). The goal is to measure the effectiveness of the EHR-related governance process with an outcome of timely and actionable EHR-related governance decisions. The following provide specifics about the type and level of governance to be measured:

- The governance process is distinct from the *functional configuration management* process. The *functional issue resolution process* includes decisions that require a more deliberate governance process (i.e., to address investment or policy, or due to a complicated nature) and decisions specific to the configuration of the EHR within the bounds of the contract (i.e., not requiring enhancement to the EHR). This metric does not measure the latter.
- The four-tiered OEHRM governance structure includes the EHR Modernization Councils, the Functional Governance Board, a sister Technical Governance Board, a Governance Integration Board, and a Steering Committee. This metric focuses on the Functional Governance Board's decision making.
- This metric is limited to VA governance and does not specifically reference interagency governance, including Joint Executive Committee-related decision making and FEHRM-related decision making.

Metric Information:

- **Metric Definition:** Percentage of functional EHR-related governance decisions (e.g., new/change to policy, new/change/clarification to functional requirement) made within 60 days of identification
- **Calculation:** # of functional (EHR-related) governance decisions made within 60 days of identification / total # that enter the process during that period
- **Target**: 100% / **Acceptable Threshold** 80%
- **Reporting Frequency**: Quarterly; will start Q2FY20 and continue until it is no longer needed

Key Measures for IT: *EHRM eliminates current Veterans Information Systems and Technology Architecture (VistA) challenges and remedies lack of data due to non-interoperable systems (e.g., Defense Medical Logistics Supply Support, EHRM, Financial Management Business Transformation).*

This measure identifies how existing challenges (from both horizontal and vertical organizational aspects) in the VistA system are effectively addressed in the build and design of the EHRM plan. This measure identifies, monitors, and evaluates risks associated with transition from the VistA legacy system, and ensures key data are saved and, when applicable, pre-loaded into modernized systems to ensure minimal disruption to patient care and ultimately demonstrate improved quality of care.

Metric #1: This metric will measure the progress of pre-loading legacy data Notes/Documents and Reports into the EHR with the expectation this will ensure minimal disruption to patient care and

ultimately improved quality of care. The goal is to measure progress toward full legacy data migration with a desired outcome of minimal disruption to patient care and ultimately improved quality of care. The following parameters offer more detail:

- The metric does not address how existing challenges (from both horizontal and vertical organizational aspects) in the VistA system are effectively addressed in the build and design of the EHRM plan. This has already been accomplished through the EHRM council's work pre go-live to determine the workflows, content, and decision rules that will form the foundation of the EHR design.

Metric Information:

- **Metric Definition:** Percentage of legacy Data domains, Notes/Documents, and Reports (per requirement identified by the EHRM councils) migrated to HealtheIntent by 1) Spokane go-live, 2) Puget Sound go-live
- **Calculation**: # of complete legacy data domains, Notes/Documents, and Reports (per requirement identified by the EHRM councils) migrated / total # that are defined to be migrated
- **Target**: 100% / **Performance Threshold:** 100% of defined requirement not later than 1 week prior to 1) Spokane go-live, 2) Puget Sound go-live
- **Reporting Frequency**: Three months prior to Spokane go-live and monthly until complete

Metric #2: This metric will measure the degree to which existing challenges (from both horizontal and vertical organizational aspects) in the VistA system are effectively addressed in the build and design of the EHR. Workflows, Design Decision Matrices (DDMs), and Data Collection Workbooks collectively represent the configuration of the EHR. The goal is to measure progress toward (for initial operating capability [IOC] inclusive of Spokane and Puget Sound) configuration of EHR. The desired outcome is that the EHRM is configured to support the health care business of the VHA, incorporating lessons learned from past VA experience, DOD experience configuring Military Health Systems GENESIS, and best clinical practice.

Metric Information:

- **Metric Definition:** Percentage of Cerner workflows, DDMs, and DCWs that were approved by the EHRM councils during the eight National Workshops that are configured in the modernized EHR prior to functional testing
- **Calculation**: # of Cerner workflows, DDMs (list of specific design decisions), and DCWs (design decisions specific to content configuration and captures both enterprise and local configuration) that were configured in the modernized EHR / total # of workflows, DDMs, and DCWs that were approved by the EHRM councils
- **Target**: 100% / **Performance Threshold**: 100% of all approved workflows, DDMs, and DCWs prior to risk-based workflows and configuration validation
- **Reporting Frequency**: Weekly, post workshop 8, until complete. Expectation is that configuration will be completed by the time risk-based workflows and configuration validation are conducted.

Key Measure for Training: *Training plans address core competencies, competency gaps, and enhanced system functionality available in the modernized solution to reduce implementation variation.*

- This measure considers the effectiveness and completeness of training plans to train core competencies, tracks mandatory training, remedies competency gaps, and ensures employees are fully versed in enhanced system functionality available in the modernized solution. This measure reports on reductions to implementation variation. The measure also considers completion percentages to reflect employee completion of mandatory training.

Metric: This metric will measure end user completion of mandatory EHR training. The goal is to measure completeness of end user mandatory EHR training, with an outcome ensuring all EHR end users are fully trained according their role(s) prior to go-live. The following are additional considerations:

- This metric considers the effectiveness and completeness of training plans to train core competencies, measures mandatory training, remedy competency gaps, and ensure employees are fully versed in enhanced system functionality available in the modernized solution, as reflected in the OEHRM training and change management strategies and as executed through the tiered and blended training plan. It further assumes that because all end users will take the same training specific to their role(s) and reductions to implementation, variation is an inherent outcome.
- This metric does not specifically address sustainment training or continued education otherwise, but it does assume all new users will adhere to the initial training requirements.

Metric Information:

- **Metric Definition:** Percentage of end users trained at each of the 100, 200, 300, and 400 levels by date(s) in the OEHRM Integrated Master Schedule
- **Calculation**: # of site end users fully trained at each of the levels / # of site end users
- **Target**: 100% of end users / **Threshold:** 100% (i.e., no user will use the system until fully trained), per OEHRM training in Integrated Master Schedule
- **Reporting Frequency**: Per training in Integrated Master Schedule

Key Measure for Resource Allocation: *Resources are allocated and prioritized to support EHR implementation.*

This measure assesses the planning and prioritization of resource allocation for the transition from legacy to modernized systems, while considering common practices of transition planning (hardware and software, human capital, risk to budget from missing implementation timelines, changing staffing patterns, upstaffing during transition times, establishment of training teams, materials and facilities, training of end users, lost cost for project delays, contracts, and community care, etc.).

Metric #1: This metric will measure that site personnel necessary for the transition from the legacy to the modernized EHR have been onboarded in time for expected productivity loss due to training and implementation, with specific attention to upstaffing during transition times. The goal is to measure status of fully onboarding additional personnel necessary for the transition to the modernized EHR. The desired outcome is that all staff will be fully onboarded or otherwise available prior to go-live for each site, in time to meet expected productivity losses. The following provides additional specifics:

- This metric references the OHT VISN 20 IOC Productivity Plan as a proxy to encompass the wide scope of expectations described above. The metric assumes the number and competencies of increased facility personnel have been identified and that onboarding includes adequate VA and EHRM-specific training and competency validation.
- It is expected that upstaffing needs will decrease with future wave go-lives as lessons learned are incorporated.
- End user training is measured via the Key Measure for Training.
- This metric does not include long-term planning necessary to address resource allocation and prioritization needed for the full business process reengineering required to adopt end-to-end standardized clinical and business processes.

Metric Information:

- **Metric Definition:** Percentage of (additional) personnel that have been onboarded through each of 1) hires, 2) details, and 3) contracts at each of the go-live sites in time to meet expected productivity losses due to training or other identified impacts
- **Calculation**: # of personnel fully onboarded / # of personnel expected to be onboarded
- **Target**: 100% / **Acceptable Threshold:** 90% starting 3 months prior to go-live
- **Reporting Frequency**: Bi-weekly (twice monthly), starting 3 months prior to go-live

Metric #2: This metric will measure the status toward the planning, prioritization, and availability of space resource allocation for the transition from legacy to modernized EHR. The goal is to measure the status of the availability of space resource allocation necessary for the transition from legacy to modernized EHR. The desired outcome is that all identified additional spaces will be fully available for use prior to go-live at each of the sites. The following provides additional specifics:

- This metric references the OHT VISN 20 IOC Productivity Plan as a proxy to encompass the wide scope of expectations described above. The metric assumes the number and competencies of increased facility personnel have been identified and that onboarding includes adequate VA and EHRM-specific training and competency validation.
- This metric assumes additional space requirements have been identified and the decision to modify current space utilization and/or lease additional space has been made.
- It is expected that the requirement for additional space will vary among sites and with future waves of go-live as lessons learned are incorporated.

Metric Information:

- **Metric Definition:** Percentage of modified/additional space locations that are ready for use at each of the go-live sites prior to go-live at each of the sites
- **Calculation**: # of modified/additional space locations available / total # of modified/additional space locations identified as necessary
- **Target**: 100% / **Threshold:** 90% starting 3 months prior to go-live
- **Reporting Frequency**: Bi-weekly, starting 3 months prior to go-live

7. Transform Supply Chain

Lane of Effort Leads:
Tammy Czarnecki, MSOL, MSN, Assistant Deputy Under Secretary for Health for Administrative Operations
Robert McDivitt, FACHE, Network Director, VISN 23

Lane of Effort Objective

The mission of the VHA Procurement and Logistics Office is to provide a data-driven, resource-optimized, cost-effective, and clinically focused supply chain that ensures the delivery of the highest quality of care at the greatest value to the Veteran and the Veteran's family. VHA's current supply chain management systems and processes are outdated and create inefficiencies that limit VA's ability to fully realize this important mission. In response, a VHA Supply Chain Modernization framework has been built around three critical pillars: systems, strategic sourcing, and governance. Supply Chain Systems Modernization primarily implements the Defense Medical Logistics Standard Support (DMLSS) and the Supply Chain Master Catalog programs. Supply Chain Strategic Sourcing Modernization includes the Clinically Driven Strategic Sourcing program, Medical/Surgical Prime Vendor (MSPV) 2.0 program, National Equipment Catalog program, and developing partnerships with the Defense Logistics Agency (DLA). Finally, Supply Chain Governance Modernization includes training program initiatives, governance development, and policy and process programs.

Background

I. Supply Chain Systems Modernization Programs

A Supply Chain Strategy and Architecture Board framework is being developed by the Supply Chain Strategy and Architecture Board, which is responsible for developing requirements and monitoring overall cost, schedule, and performance of supply chain programs. It has final decision-making authority for changes affecting established project and program baselines. The Board's framework forms the basis of supply chain program performance and resources.

The **Veterans Administration Logistics Refresh** Program office is partnering with the DOD to implement its current health care supply chain management system, DMLSS, and its cloud-based successor, LogiCole. Implementing DMLSS/LogiCole aligns with VA's responsibility to Veterans and taxpayers and fulfills VA modernization requirements by replacing multiple costly and ineffective legacy supply chain management solutions. This is a major step forward in automating and integrating business processes for improved health care delivery.

The Supply Chain Master Catalog is a critical element in product oversight, visibility, and establishment of best practices. The catalog will integrate major functions and processes into a cohesive, standardized, and high-performing supply and demand management support system. It directly supports ERHM by providing a single item master record for which data will be shared among all facilities for each clinical item consumed.

II. Supply Chain Strategic Sourcing Modernization Programs

Clinically Driven Strategic Sourcing is a process that collects, monitors, and evaluates clinician input on commodities and equipment in partnership with supply chain professionals. Clinical analysis of commodities and equipment will be in coordination with local Clinical Product Review Committees and National Medical program offices. The impacts of clinically driven strategic sourcing will improve Veteran outcomes, increase clinical satisfaction, and decrease acquisition cycle time.

Modern systems represent one of the key components of a high reliability organization. High reliability requires the availability of clinical tools and supplies at the time Veterans require care. Improved supply chain methods and systems will advance high reliability objectives. Modern IT will support collaboration with other federal agencies and improve both employee and Veteran experiences; more reliable, efficient, and interoperable systems will allow employees to do their jobs better and improve customers' trust in VHA's ability to provide seamless care coordination.

Equipment Modernization provides a process to proactively plan and track equipment inventory and the procurement of replacements – helping the VHA efficiently deliver the items that clinicians and Veterans need. This effort also establishes a single National Equipment Catalog that will be the central source for all VHA equipment.

Medical/Surgical Supplies Modernization: the MSPV 2.0 process streamlines supply chain management for medical, surgical, dental, lab, and environmental medical supplies to create a national listing of available items to be integrated with DMLSS/LogiCole. VHA also is partnering with DOD to establish a joint MSPV product. VHA will conduct the DLA MSPV Pilot with DMLSS fielding in one region (VISN 20). In addition, VA began using DOD's Electronic Medical Catalog in January 2018 as the preferred method for end of fiscal year equipment purchases and to fill current MSPV-Next Generation gaps. Since then, Electronic Medical Catalog use has expanded to all 18 regions. These efforts will maximize VHA's purchasing power and reduce purchase card spending.

Key Measures and Definitions

Key Measure for Policies and Processes: *Updated and accurate policy and procedures to facilitate a lean and efficient supply chain*

VHA is completing a comprehensive review of all existing VA/VHA and related DOD policies to coincide with modernization efforts at all levels of the supply chain. VHA will leverage subject matter experts to develop and implement supply chain policies that reflect a supply chain system that enhances delivery of care to Veterans.

Metric*:* By the end of FY 2020, all applicable VA/VHA/DOD policies will be mapped to each process identified to support the DMLSS supply chain modernization pilot.

Metric Information:

- **Metric Definition:** Percentage of VA/VHA/DOD policies mapped to each process identified to support the modernization pilot
- **Calculation:** # of policies mapped / total number of identified, relevant policies
- **Target:** FY20-40%; FY21-60%; FY22-85%; FY23-100%

- **Reporting Frequency:** Q1, Q2, Q3, Q4

Metric: To effect supply chain modernization changes throughout VHA, by FY 2024 prepare 54 policy updates reflecting best practices in the supply chain modernization pilot.

Metric Information:

- **Metric Definition:** Percentage of VHA policy updates prepared
- **Calculation:** # of supporting policy updates prepared ahead of needed publication date / total # of updates required
- **Target:** FY21-10%; FY22-40%; FY23-70%; FY24-100%
- **Reporting Frequency:** Q2, Q3

The National Equipment Catalog is vital to Equipment and Supply Chain Modernization as it provides a formal process to proactively plan and track current equipment and replacement procurements. Adopting the National Equipment Catalog will limit unwarranted variation and leverage volume discounts and streamline procurements for regions and facilities.

Metric: Meeting VHA's clinical equipment needs and establishing a national catalog will require between 450 and 550 national contracts by the end of FY 2024. This metric measures progress toward awarding all the required contracts.

Metric Information:

- **Metric Definition:** Percentage of the total number of equipment contracts awarded
- **Calculation:** # contracts awarded / total # of contracts required
- **Target:** FY20-25%; FY21-35%; FY22-50%; FY23-75%; FY24-100%
- **Reporting Frequency:** Q2, Q4

Clinically driven strategic sourcing benefits VA by improving clinical care, enhancing supply protocols, increasing Veteran satisfaction, improving product safety, reducing product variation, eliminating non-value-added work, and identifying high-quality preferred items. Clinically driven strategic sourcing will help streamline and ensure quality products are available in the National Equipment Catalog. It will also provide data needed for evidentiary-based resourcing decisions and procurements.

Metric: Support initial operating capability rollout in FY 2020 by analyzing, recommending, and initiating procurement for 13 products, then continue the process for 20 products per year.

Metric Information:

- **Metric Definition:** Percent of initial products evaluated and recommended for procurement; percentage of products selected in clinically driven strategic sourcing sustainment evaluations
- **Calculation:** # products evaluated / total # products identified
- **Target:** Initial set: FY21-80%; FY22-100%. Second set: FY22-80%; FY23-100%
- **Reporting Frequency:** Q2, Q4

Metric: Decrease average acquisition/contracting cycle time for clinically driven strategic sourcing items.

Metric Information:

- **Metric Definition:** Percent decrease in average acquisition/contracting cycle time
- **Calculation:** # days decrease in acquisition time / baseline average # days in acquisition time
- **Target:** ≤300 days cycle time by end of FY21
- **Reporting Frequency:** Q4

MSPV VA (Next Generation/2.0) provides facilities with access to medical/surgical supplies via prime vendor (MSPV) distribution and supply management services contracts to meet medical/surgical supply needs. VA will develop a detailed strategy and implementation plan to transition VA's supplies program to a joint program with the DLA to increase cost avoidance and reduce overall resource requirements. The DLA MSPV Pilot VA will be implemented after DMLSS is fielded in one region (VISN 20). Finally, VA began using the Electronic Medical Catalog as the preferred mechanism for end of fiscal year equipment purchases and cover for MSPV-Next Generation service gaps in January 2018. Since then, electronic medical catalog use has expanded to all 18 regions.

Metric: VHA will begin the DLA MSPV Pilot in one region (VISN 20) in FY 2020, with the goal of increasing cost avoidance and reducing overall resource requirements. Upon evaluation of the effectiveness of the pilot, begin system-wide deployment.

Metric Information:

- **Metric Definition:** Percentage of facilities in which the DLA MSPV is operational
- **Calculation:** # of facilities with the DLA MSPV operational / total # of selected facilities
- **Target:** FY20-5%; FY21-15%; FY22-35%; FY23-50%; FY24-60%; FY28-100%
- **Reporting Frequency:** Q2, Q4

Key Measure for Adequate Oversight and Accountability: *Maturation of governance entities and ensuring compliance with policy to ensure a lean and efficient supply chain is in place*

Governance provides a standard defined process and approach that focuses on strategic priorities aligned to the 2018–2024 VA Strategic Plan. The Supply Chain Modernization Committee serves as the governance body under the Healthcare Operations Council of the VHA Governance Board. Accountability is fulfilled through quality control reviews conducted at the facility level. The Quality Control Reviews Checklist is agreed upon during an annual review by the Regional (VISN) Chief Supply Chain Officers to ensure facility logistics programs are compliant with applicable policies to ensure operational efficiency. Upon completion of the quality control reviews, the facility develops an action plan to address timely and effective remediation of all noncompliant issues discovered during the review.

Metric: By the end of FY 2020, assess inventory management by conducting all scheduled quality control reviews, and receive all needed corrective action plans; produce the FY 2021 Quality Control Review Checklist by Q4FY20.

Metric Information:

- **Metric Definition:** Percentage of scheduled quality control reviews conducted
- **Calculation:** # of reviews conducted / total scheduled reviews
- **Target:** 100% by end of FY20
- **Reporting Frequency:** Q1, Q2, Q3, Q4

Metric Information:

- **Metric Definition:** Percentage of corrective action plans received within and outside of standard timeframe
- **Calculation:** # action plans received within 60 business days / total # action plans required; # action plans received within 61–90 days / total # action plans required
- **Target:** 90% of action plans received within 60 days
- **Reporting Frequency:** Q1, Q2, Q3, Q4

Key Measures for IT: *Modernized IT systems eliminate current IT challenges and remedy lack of data interoperable systems. Data are available and accurate, reliable, complete, and used to inform decision making.*

To modernize VA's supply chain system, the Veterans Affairs Logistics Redesign Program Office is partnering with DOD to implement the DMLSS supply solution and its cloud-based successor, LogiCole. VA must have a fully integrated supply chain system to ensure the quality and safety of material critical for Veteran care. DMLSS/LogiCole will interface with EHRM and Financial Management Business Transformation (FMBT) solutions to provide an integrated supply chain system.

Metric: Beginning with the pilot in FY 2020, establish operational DMLSS and LogiCole in all selected VHA facilities. Finally upgrade all DMLSS early adopters with LogiCole in FY 2023. By FY 2024, all facilities use DMLSS/LogiCole and this system interfaces with EHRM.

Metric Information:

- **Metric Definition:** Percentage of facilities with Defense Medical Logistics Standard Support (DMLSS) or DMLSS/LogiCole deployed
- **Calculation:** # of facilities with the system / total # of facilities
- **Target:** FY20-DMLSS in 5%; FY21-DMLSS in 15%; FY22-DMLSS in 35%; FY23-DMLSS/LogiCole in 50%; FY24-DMLSS/LogiCole in 60%; FY28-LogiCole operational in 100% of facilities
- **Reporting Frequency:** Q2, Q4

Key Measure for Training: *Training and role standardization drive compliance, understanding, modernization, and a consistent product for clinicians and Veterans.*

VHA is conducting a comprehensive review of all existing education and training initiatives to coincide with the strategic modernization of supply chain efforts throughout VA. Underpinning these efforts is the standardization of position descriptions and organization structures, growth opportunities through

creation of a new professional series, succession planning facilitation, and regional workforce standardization. In addition, a required training program is being developed and will be ready for fielding in FY 2020. This effort will codify the training requirements listed in standardized position descriptions.

Metric: In FY 2020, complete standardization of position descriptions to target appropriate individual training; begin desktop training for supply chain transformation. By FY 2023, the functional workforce has completed required training in conjunction with systems implementation.

Metric Information:

- **Metric Definition:** Percentage of functional workforce that completed required training
- **Calculation:** # of staff completed training / # of staff that needs the training
- **Target:** FY20-10%; FY21-25%; FY22-55%; FY23-95%
- **Reporting Frequency**: Q2, Q4

Key Measure for Resource Allocation: *Appropriate funds are prioritized and allocated across functions. Resources are sufficient, prioritized, and allocated to support supply chain modernization.*

Defining and implementing more formal governance mechanisms involving appropriate leadership for arbitrating resource needs and program planning decisions that affect scope and milestones is a goal for FY 2020 and beyond using the maturing Supply Chain Management Strategy and Architecture Board (SSAB) framework. The SSAB is responsible for monitoring overall cost, schedule, and performance of supply chain programs and projects. The SSAB also has final decision-making authority for changes affecting established baselines.

Metric*:* Several measures will be used to efficiently and effectively manage the supply chain while ensuring good stewardship of resources. By the end of FY 2022, all programs and projects will be expected to maintain operating plans with integrated master schedules. These will be validated by the SSAB. By the end of FY 2020, programs and projects will maintain financial investment plans articulating current and future years' resource needs to allow appropriate programming and budgeting.

Metric Information:

- **Metric Definition:** Percentage of program and project operating plans with integrated master schedules
- **Calculation:** # of programs and projects with integrated master schedules / total # of program and project operating plans (16)
- **Target:** FY20-40%; FY21-90%; FY22-100%
- **Reporting Frequency:** Q1, Q3

Metric Information:

- **Metric Definition:** Percentage of financial investment plans that are reviewed and show evidentiary basis for investment for current and future years' resources and investment requirements
- **Calculation:** # of plans reviewed and complete / total # of plans

- **Target:** 100% by end of Q3FY20
- **Reporting Frequency:** Q1, Q3

Metric*:* Facilitate financial investment plans articulating current and future years' resources needs by reviewing information for 16 programs and projects to identify resources and investment requirements. All programs and projects will be reviewed by the end of FY 2020.

Metric Information:

- **Metric Definition:** Percentage of programs and projects reviewed
- **Calculation:** # of programs and projects reviewed / total # of programs and projects
- **Target:** FY20-100%
- **Reporting Frequency:** Q4

A foundation of validated modernization business requirements is necessary to define the functionality needed from supply chain systems. This modernization effort will guide process and system design and deployment actions as well as clarify supply chain operational needs.

Metric*:* To develop a comprehensive, validated list of business requirements, requirements must be developed for 14 VHA functional areas that have supply chain operational elements. By the end of FY 2023, all functional areas will have developed/validated business requirements. The outcome goal is to have no more than 8% of annual operating budgets in unfunded requirements.

Metric Information:

- **Metric Definition**: Percentage of functional areas that have developed/validated business requirements. All dates are by end of the fiscal year.
- **Calculation**: # of functional areas with validated business requirements / total # of functional areas
- **Target:** FY20-40%; FY21-80%; FY22-95%; FY23-100%
- **Reporting Frequency**: First quarter for prior fiscal year

Metric: Medical/Surgical Supplies Modernization products MSPV 2.0 and DLA MSPV will provide product lists that offer enhanced volume and variety of supplies to satisfy clinician requirements for patient care. As MSPV products are launched in FY 2021, reductions in purchase card use for medical supplies are expected.

Metric Information:

- **Metric Definition:** Percentage reduction in purchase card spending
- **Calculation:** 1 – (Current year dollars spent on purchase card to procure medical supplies / FY20 dollars spent [baseline] on purchase card to procure medical supplies) x 100
- **Target:** FY21-1%; FY22-1%; FY23-1%; FY24-1%
- **Reporting Frequency:** First quarter for prior fiscal year

Chapter 2. Addressing VA Health Care Areas of Concern

Introduction

This chapter describes action plans for addressing the five areas of concern (AOCs) that GAO identified for "Managing Risks and Improving VA Health Care" in its *2015 High-Risk List* update. The figure below shows the latest AOC ratings from the *2019 High-Risk List*[16] update.

Figure 2-1 GAO Rating for Each Area of Concern as of February 2019

Work groups for each AOC established a set of outcomes based on well-researched root causes. In 2019 VA and GAO agreed that these outcomes are substantive, strategic, forward thinking, and appropriate for driving future work. VA and GAO agree that long-term commitment toward achieving these outcomes will ultimately improve VA's ability to deliver quality health care.

Each outcome contains a general description, correlation to a root cause, metrics for measuring progress, a description of actions related to GAO's criteria for removal, a description of progress made, and a general description of key actions to achieve the outcome and their status (in planning, in progress, completed, sustaining). A list of the outcomes is in Table 2.1, below, and in Appendix B.

[16] Government Accountability Office, "Managing Risks and Improving VA Health Care," March 2019. 275-282.

Table 2-1. List of AOC Outcomes and Self-Assessed Ratings

Area of Concern Outcomes	Self-Assessed Rating
Policies and Processes ***Key Outcomes =*** Policy drives correct behavior and is implemented consistently; business processes are integrated and efficient	
Senior leaders of VHA programs and initiatives, including the Modernization Lanes of Effort, support the need for aligned, unambiguous policies and consistent policy implementation	In progress
VHA policy development, recertification, and amendment processes function with integrity according to VHA Directive 6330, including integration of a unified Risk Management Framework (RMF)	In progress
VHA applies standard business rules to determine when, what, and how to create uniform policy development and implementation processes across the agency that reflect VHA indices of policy quality	In progress
VHA standards and implementing processes are transparent and accessible to appropriate stakeholders	In progress
Oversight and Accountability ***Key Outcome =*** Governance and oversight mechanisms provide reasonable assurance that requirements are met	
VHA organizations and employees demonstrate timely and effective risk management in accordance with a unified RMF to support governance and oversight	In progress
Governance and management decisions are made at the appropriate level of the organization, are informed by reliable data, and are timely	In progress
VHA oversight ensures governance and management decisions are implemented and focused on intended outcomes	In progress
Leadership holds VHA organizations accountable to fulfill obligations imposed by decisions, regulations, and other requirements	In planning
VHA supports a Just Culture that fosters trust, integrity, learning, and collaboration	In progress
IT ***Key Outcomes =*** Systems are interoperable and meet business needs; data are available and accurate, reliable, complete, and used to inform decisions	
Deliver IT capabilities to support VHA-determined data and interoperability business needs	In progress
Improve system interoperability to execute core health care mission functions	In progress
Provide governance and oversight bodies with accurate, reliable, timely, and relevant information to support decision making	In progress
Reduce the number of legacy systems while continuing to meet business needs	In progress
Reduce the number of duplicative IT systems and capabilities to support business needs	In progress

Area of Concern Outcomes	Self-Assessed Rating
Training ***Key Outcome =*** Targeted, standardized, and comprehensive training that supports policy or guidance and active field engagement	
Training: Developed in response to priorities identified by senior VHA leadership (national and field); delivered to nationally specified standards; evaluated and reported by program office guidelines delineated in national policies	In progress
Accurately identified audience is trained at the appropriate time to specific program/process requirements	In progress
Using the most resource-efficient approach, training is planned and developed, coordinated and implemented, then evaluated and managed to achieve effective training outcomes	In progress
Resource Allocation ***Key Outcome =*** Resources are used effectively and efficiently	
Unified resource planning and allocation process is clearly documented and consistently applied	In progress
VHA utilizes a comprehensive strategic guidance process to ensure alignment of resources to leadership priorities	In progress
Adequate data and reporting mechanisms are used for making, evaluating, and informing resource planning and allocation decisions	In progress

1. Ambiguous Policies and Inconsistent Processes Area of Concern

Executive Summary

Over the past 5 years, VHA successfully built a robust foundation for developing, implementing, and maintaining national policy. Led by the VHA Chief of National Policy and the Senior Advisor, VHA Office of Regulatory and Administrative Affairs (ORAA), the Policies and Processes (P&P) action plan reflects sustainment of improved policy development processes and content standards, expanded consolidation and clarification of facility and regional policies, and planned development of a central repository for all policy and policy-related documents. Consistent execution of the action plan will result in clear, implementable VHA policy that incorporates industry best practices and stakeholder feedback, and enables VA to deliver high-quality, consistent care for Veterans at all VA medical facilities.

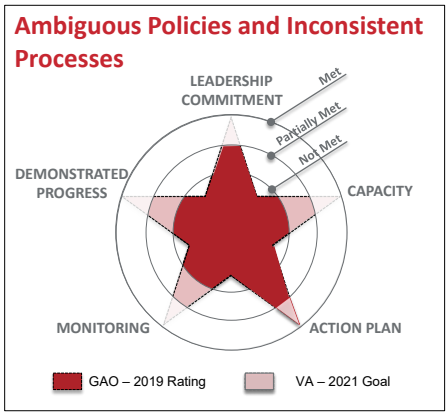


Figure 2-2 Policies and Processes 2021 Rating Goal

The Policies and Processes work group improved policy development and implementation and made progress toward target outcomes by—

- Updating the VHA policy on the Controlled National Policy/Directives Management System to incorporate continuously improving VHA policy standards
- Streamlining and clarifying the national policy inventory by reducing the number of national policy documents by 32% since 2015
- Requiring use of a pre-policy form for VHA program offices to ensure national policies are adequately resourced and capable of uniform implementation prior to publication
- Collecting and hosting operational memoranda on the VHA Publications website to aid reference by VA medical facility staff
- Launching a "Get to Zero" initiative to ensure national policies are current and have been appropriately reviewed and recertified within the prior 5 years
- Establishing business rules for policy development that empower local and regional leadership to streamline local policy inventory and reduce time required for policymaking and policy administration by VA medical facility staff
- Implementing a biannual VA medical facility policy census to track local policy inventory reduction initiatives and improve alignment of national and local policies

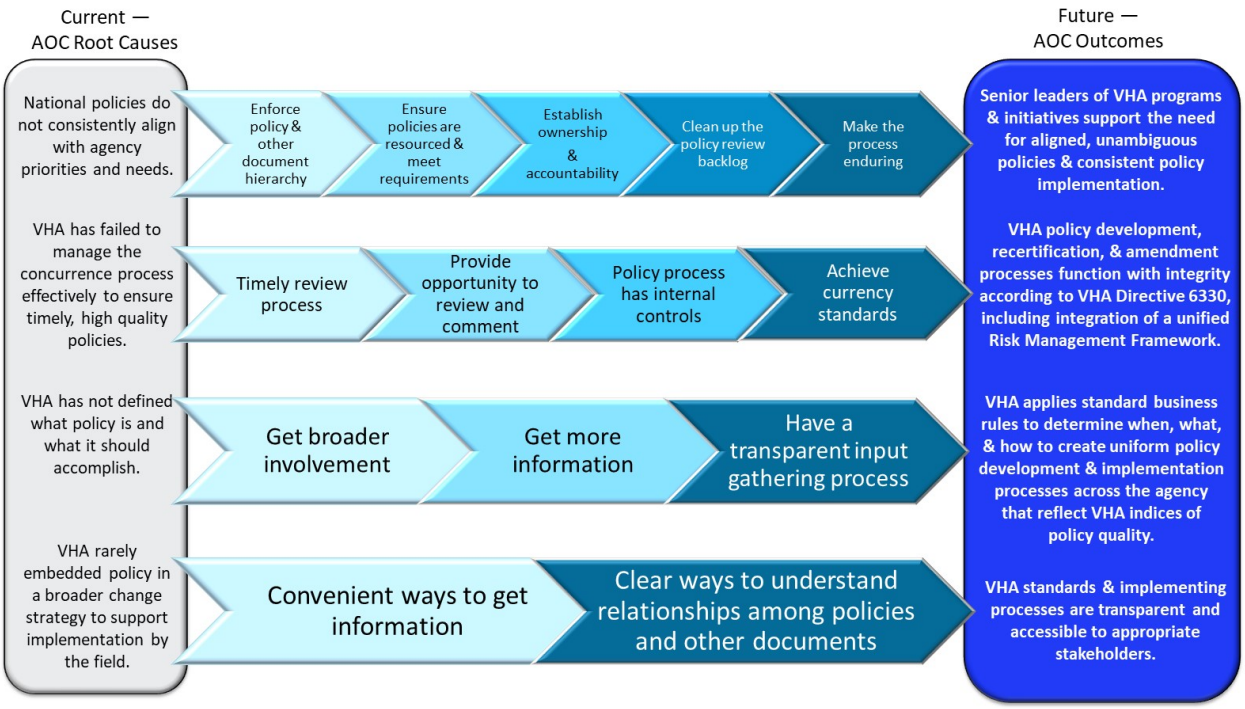
For direct navigation to a policy outcome and supporting action plan, click on the links below.

P&P-1: Senior leaders of VHA programs and initiatives, including the Modernization Lanes of Effort, support the need for aligned, unambiguous policies and consistent policy implementation
P&P-2: VHA policy development, recertification, and amendment processes function with integrity according to VHA Directive 6330, including integration of a unified Risk Management Framework

P&P-3: VHA applies standard business rules to determine when, what, and how to create uniform policy development and implementation processes across the agency that reflect VHA indices of policy quality
P&P-4: VHA standards and implementing processes are transparent and accessible to appropriate stakeholders

Highlights of the root causes, key actions, and outcomes for improving policy development and consistent implementation nationwide are outlined in the figure below.

Figure 2-3 Policies & Procedures Roadmap



The table below provides examples of how the policies and processes effort aligns with actions being undertaken to address the other areas of concern.

Alignment with Other Areas of Concern
Oversight and Accountability
Continued collaboration with the Oversight and Accountability work group is necessary to ensure VHA policy standards continue to align with VHA's Risk Management Framework protocols, and to ensure that VHA program offices can appropriately monitor implementation of national policy across VA medical facilities.
IT
Ongoing collaboration is necessary with other components of VA, especially with OIT, as subject matter experts for designing and operating a VHA policy document repository to house and link VHA national and local policy and policy-related documents, including implementation guidelines and human resources requirements.
Training

Alignment with Other Areas of Concern
Ongoing collaboration with the Training work group will ensure that VHA program offices continue to include required staff training in VHA policy as necessary and appropriate, and a Training committee reviews and approves training requirements prior to publication of a policy. The Policy and Processes and Training work groups will collaborate to develop a VHA directive that supports implementing standard VHA planning and oversight for training requirements.
Resource Allocation
Manpower Manpower consultation is necessary to develop and recertify VHA policies containing standards appropriate for staffing models and service line operation configurations at VA medical facilities. Manpower resources are also necessary to ensure continued work in policy areas, including actions described above. Additionally, VHA's Manpower Management Office is chartering and implementing a standard business support function by level of authority, which will require policy office coordination prior to publishing new guidance. **Finance** Finance consultation is necessary to develop and recertify VHA policies containing standards and operating guidelines that VA medical facilities can implement within existing and approved budgets. Resources are also necessary to ensure continued work in policy areas, including actions described above.

The table below provides examples of how work to resolve the policies and processes AOC aligns with applicable Modernization Lane of Effort initiatives.

Integration with Applicable Lanes of Effort
Commit to Zero Harm
A Co-Chair for the LOE serves on the VHA Policy Senior Leadership Committee that meets twice per month. The Regional Lead for the LOE serves on the ORAA Field Advisory Committee that meets quarterly.
Organizational Improvement
A Co-Chair for the LOE serves on the VHA Policy Senior Leadership Committee that meets twice per month.
MISSION Act
ORAA staff collaborate with the VHA Lead for the LOE to develop policy (directives and notices) necessary for effective implementation and monitoring of the MISSION Act across VHA.
Modernize Electronic Health Records
The Outcome Executive and Outcome Leads meet with Cerner and with the VA Office of Electronic Health Record Modernization (OEHRM) to manage policy-related changes for VA's transition to a modern EHR software platform. The Policy and Processes Outcome Executive and Lead also attend and provide updates to Joint Operational Command meetings on OEHRM, which align all components of VA. In addition, the Outcome Executive and Lead are forming a VHA headquarters work group to ensure coordination between EHR Councils, national policymakers, and policymakers at medical facilities designated as EHR early adopters.

Policies and Processes Outcome 1 (P&P-1)

Outcome Lead: Brian McCarthy, JD, MPH, Chief VHA National Policy
Outcome Executive: Ethan Kalett, JD, Senior Advisor, Office of Regulatory and Administrative Affairs

P&P-1 Outcome Statement: Senior leaders of VHA programs and initiatives, including the Modernization Lanes of Effort, support the need for aligned, unambiguous policies and consistent policy implementation

Key Outcome: Policy drives correct behavior and is implemented consistently

Root Cause: National policies do not consistently align with agency priorities and needs

In Planning | **In Progress** | **Complete** | **Sustaining**

P&P-1 Description & Status
To achieve this outcome, VHA must ensure collaborative policy development through processes and procedures and ensure adherence to published policy. Policy and process development must be VHA-wide activity that includes VHA's Modernization Lanes of Effort (LOEs), as each LOE's goals require unambiguous policy and a clear implementation plan. Chapter 1 shows that each LOE acknowledges the need for clear policies and processes. VHA streamlined its policy document vehicles to directives and notices and is steadily converting documents no longer issued as policy (handbooks and manuals) into updated policy documents. Directives and notices are 70% of VHA policy inventory, up from 47% in 2015.

The following table describes measures and metrics the work group uses to determine progress toward achieving P&P-1.

Table 2-2. P&P-1 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
All VHA policies, both newly developed and recertified, are reviewed for adequate implementation resources in existence or approved before policy publication	Percentage of total published policies with addressed resources as documented in the pre-policy form # published policies with addressed resources / total # published policies	Baseline = 0% in FY15 Milestone = 70% in FY20 Target = 100% of directives in FY24	Q1, Q2, Q3, Q4
100% of VHA's Publications website houses document types currently considered policy (i.e., directives and notices)	Percentage of documents on the VHA publication website that are directives and notices # of directives and notices / total # of entries	Baseline = 47% in FY15 Milestone = 70% in FY19 Target = 100% in FY22	Q2, Q4

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
VHA operational memoranda do not contain policy information when issued	Number of operational memoranda submitted by program offices for VHA's Publications website that contain policy information Count = # of existing operational memoranda on VHA's Publications website (less is better)	Baseline = 1,500 in FY19 start Milestone = 1,171 in FY19 Target = Minimal VHA memoranda with unapproved policy components in FY22	Q2, Q4

The following table describes actions the Policies and Processes work group identified to achieve P&P-1: Senior leaders of VHA programs and initiatives, including the Modernization Lanes of Effort, support the need for aligned, unambiguous policies and consistent policy implementation.

Table 2-3. P&P-1 Action Plan

Actions	Projected Date	Actual/Adjusted Date(s)	Status/Comments
All actions imply effective change management and training are a part of implementation			
(1.1) Establish a process for approving policy only with adequate resources for implementation across VHA		Q3FY18	**Sustaining**: VHA requires use of a pre-policy form (Chief of Staff Briefing Note) detailing required resources, risks, and communication plans. The action is ongoing and the process is modified for improvement.
(1.2) Develop a standard by which guidance is not confused for policy		Q4FY17	**Sustaining:** ORAA updated Directive 6330, which establishes directives and notices as the only forms of national policy documents. The action is ongoing: two notices for policy development business rules and a planned update of Directive 6330 will clarify document types at the local level.
(1.3) Convert documents that are no longer issued as policy (handbooks and manuals) into updated policy documents	Q4FY21		**In progress:** In May 2019 handbooks and manuals are 163 of 546 documents (30%), down from 53% of inventory in 2015.
(1.4) Clarify the role of operational memoranda	Q4FY19		**In progress:** In May 2018 ORAA conducted a data call for operational memoranda and posted them on the VHA Publications website. In April 2019, 329 operational memoranda were rescinded. In October 2019, VHA published a notice establishing operational memoranda standards of use.
(1.5) Establish a Senior Leader Committee composed of VHA senior leaders to oversee policies and processes		Q4FY16	**Sustaining:** The VHA Senior Leader Committee is established. It meets every 2 weeks.
(1.6) Identify responsibilities for policy implementation	Q4FY21		**In progress**: ORAA and the Field Advisory Work Group developed a medical facility quality manager and Regional Director survey to collect information about which

Actions	Projected Date	Actual/Adjusted Date(s)	Status/Comments
			organization is responsible for implementing and monitoring national and local policy.
(1.7) Establish a field work group that includes regional-level and medical facilities representatives to provide feedback on the policy development process		Q1FY18	**Sustaining:** The Field Advisory Work Group is established. It continues to meet quarterly.
(1.8) Ensure policies are clearly owned by a responsible entity and use the current numbering system	Q4FY21		**In progress:** ORAA identified orphan policies and sent queries to candidate responsible entities. The Field Advisory Work Group and ORAA are developing a strategy for a common numbering system.

The following table describes actions taken to address GAO's removal criteria.

P&P-1 Description of Actions Toward Removal Criteria
Leadership Commitment • The VHA Senior Leader Committee (SLC) was established in 2016 and is composed of the Principal Deputy Under Secretary for Health, each VHA Deputy Under Secretary for Health, the ORAA Executive Director, and the VHA Chief of National Policy. The SLC currently meets every 2 weeks to discuss governance, provide oversight, and approve enhancements to the policy development and implementation process. The SLC also ensures adequate resource alignment and ensures sub-offices establish and implement action plans for updating policies according to VHA Directive 6330, Controlled National Policy/Directives Management System. • The GAO High Risk Steering Committee was established in 2017 and is composed of representatives, including Outcome Leads, from each of the five AOCs. It meets every 2 weeks to identify interdependencies and discuss collaboration. The group conducted in-person meetings with key stakeholders in June 2018, August 2018, January 2019, and August 2019. In February 2019, the group met in person with LOE representatives to discuss VHA policies and processes and establish a framework for collaboration. • The VHA Field Advisory Work Group was established in 2017. Approximately 20 leaders from regional offices and VA medical facilities meet quarterly to provide feedback to the VHA Chief of National Policy regarding policy and process development.
Demonstrated Progress • The VHA Field Advisory Working Group made recommendations in May 2018 that informed and accelerated national policy improvements such as expanding pre-publication analysis to address funding new policies, reducing mandates of full-time employee positions, and clarifying the role of operational memoranda. • In August 2017, ORAA updated VHA Directive 6330, Controlled National Policy/Directives Management System, to define VHA policy documents only as directives and notices. VHA handbooks and manuals are no longer being published and are being gradually replaced. This ensures ongoing review and coordination with leadership direction. VHA Senior Leaders and Executive Assistants receive monthly reports regarding the status of non-policy documents that require either recertification in a policy document or rescission. As a result, VHA reduced the number of national policy documents by 32% since 2015 (805 documents to 546). • In 2018, VHA created a repository of operational memoranda to alleviate confusion between policy documents and memoranda and to aid reference of operational memoranda by VA field staff, further ensuring appropriate alignment. The VHA Chief of National Policy communicated the purpose and formation of the operational memoranda repository during information sessions with field stakeholders in 2017 and 2018 (see Outcome 3 below). Operational memoranda are now issued with clear expiration dates to ensure that they continue to align with current national priorities, and VHA is rescinding all operational memoranda not stored on the repository.
Capacity VHA supports ORAA to meet policy staffing needs with 8 FTE and 30 contractors. Senior leaders continue to assess capacity needs.
Monitoring • Starting in April 2018, ORAA requires each responsible entity developing a policy to complete the updated pre-policy form called the Chief of Staff Briefing Note. The current Chief of Staff Briefing Note expands the original 2016 format by requiring that the responsible entity explain resource needs (funding, space, personnel, IT), identify obstacles to uniform policy implementation, provide a risk assessment, and outline a communication plan for disseminating the policy upon publication. • The metrics and measures of this plan provide the mechanisms to assess and report progress to GAO. With the introduction of metrics and measures, monitoring processes and procedures will be formalized.

Policies and Processes Outcome (P&P-2)

Outcome Lead: Brian McCarthy, JD, MPH, Chief VHA National Policy
Outcome Executive: Ethan Kalett, JD, Senior Advisor, Office of Regulatory and Administrative Affairs

P&P-2 Outcome Statement: VHA policy development, recertification, and amendment processes function with integrity according to VHA Directive 6330, including integration of a unified Risk Management Framework (RMF)

Key Outcome: Policy drives correct behavior and is implemented consistently

Root Causes: VHA has failed to manage the concurrence process effectively to ensure timely, high-quality policies; the policy development process does not engage stakeholders to create shared understanding of the need for policy

In Planning | **In Progress** | **Complete** | **Sustaining**

P&P-2 Description & Status
To achieve this outcome, VHA national policies must be current, reviewed at least every 5 years, and developed or recertified using a sustainable and timely process. VHA standardized fundamental policy content requirements and development processes for national policy. ORAA set policy recertification timelines; monitors timeliness of all policies being recertified; solicits stakeholder feedback throughout development; and ensures each policy conforms to VHA Directive 6330, Controlled National Policy/Directives Management System, including publishing a comprehensive list of responsibilities and oversight requirements in accordance with VHA's RMF.

The following table describes the measures and metrics the work group uses to determine progress toward achievement of P&P-2.

Table 2-4. P&P-2 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
VHA policy development (writing new policies) and recertification (updating existing policies) occur within the standard timeframe	Average number of days from SharePoint field review to publication for all new policies and recertifications total # days for each processed policy (aggregated) / # of policies processed	Baseline = 334 days in FY15 Milestone = 190 days in FY19 Target ≤ 144 days in FY21	Q2, Q4
VHA policy development (writing new policies) and recertification (updating existing policies) include receiving stakeholder feedback from all appropriate service lines and program offices	Percentage of key stakeholders identified by VHA that respond per directive Per directive: # of stakeholders that respond / total # of stakeholders per directive identified by VHA	Target = 90% in FY20	Q1, Q2, Q3, Q4

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
VHA policies are current and have been reviewed and recertified in the prior 5 years (to the extent possible, e.g., pending regulations)	Percentage of policies that are overdue for recertification # of overdue policies / total # of policies per directive: # of stakeholders that respond / total # of stakeholders identified by VHA per directive	Baseline = 59% overdue in FY15 Milestone = 36% overdue in FY19 Target = functionally 0% overdue in FY21	Q1, Q2, Q3, Q4

The following table describes planned actions the Policies and Processes work group identified to achieve P&P-2: VHA policy development, recertification, and amendment processes function with integrity according to VHA Directive 6330, including integration of a unified RMF.

Table 2-5. P&P-2 Action Plan

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
All actions imply effective change management and training are a part of implementation			
(2.1) Develop a clear and concise process for policy development and management within a standard timeframe. The process will include receiving stakeholder feedback for policies in development.		Q1FY17	**Sustaining:** The standard development timelines apply to all new and recertified VHA policies; VHA posts policies in development to SharePoint for 2 weeks to receive feedback from VA staff.
(2.2) Pilot a process for policy development and recertification to ensure timely publication and ensure the process is sustainable upon completion of the pilot.		Q1FY17	**Complete:** VHA conducted the pilot process for 10 policies from July to December 2016 and then implemented the process for all VHA policies.
(2.3) Develop a process to identify when the Office of General Counsel review of new and revised policies is required.		Q4FY16	**Sustaining:** The Office of Regulatory and Administrative Affairs (ORAA) and the Office of General Counsel signed a Memorandum of Agreement in 2016: ORAA Regulatory Specialists review each policy based on ORAA's Regulatory Review Guide and determine if the policy requires Office of General Counsel review, excepting research policies, which require Office of General Counsel review.
(2.4) Develop a process that outlines the pre-policy analysis and appropriate internal controls consistent with the VHA RMF.		Q3FY18 (and ongoing)	**Sustaining:** VHA requires use of the Chief of Staff Briefing note, which includes a risk assessment, and Directive 6330 requires each policy contain a full chain of oversight and required staff training. The action is ongoing: the process is modified for improvement.
(2.5) Create a policy dashboard that demonstrates overall timeline expectations and days to completion for each policy in the process.		Q1FY17	**Sustaining:** VHA monitors all policies in the process through the dashboard and provides weekly updates to the SLC.
(2.6) Reach "functional zero," where, to the maximum extent possible, VHA policies are current and have been reviewed and recertified in the prior 5 years.	Q3FY20		**In progress:** In May 2019, VHA's policy inventory is 546 (down from 805 in 2015) and 36% are overdue (down from 59% in 2015).

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
(2.7) Employ a staff of writers to relieve the technical and administrative burdens required by the new, more robust collaborative process. Ensure staff vacancies are announced and filled in a timely manner, including reviewing potential unfilled positions that could be transferred to ORAA.		Q3FY16 (and ongoing)	**Sustaining**: VHA secured contractor support in 2016; VHA modified the contract in September 2019 to increase support for a total of 30 contractors. ORAA filled two FTE positions for a total of eight FTE supporting the policy development process.
(2.8) Review funding issues to ensure contracted staff remain active until otherwise determined by VHA senior leaders and ensure ORAA staff receive appropriate training.		Q3FY17	**Sustaining:** ORAA developed and continuously updates the Document Manager Review Guide to train new staff. In April 2019, contractors had an in-person training to learn responsibilities, roles, and project updates.

The following table describes actions taken to address GAO's removal criteria.

P&P-2 Description of Actions Toward Removal Criteria
Leadership Commitment The VHA SLC was established in 2016 and is composed of the Principal Deputy Under Secretary for Health, each VHA Deputy Under Secretary for Health, the ORAA Executive Director, and the VHA Chief of National Policy. The SLC currently meets every 2 weeks to discuss governance, provide oversight, and approve enhancements to the policy development and implementation process established in 2016. The SLC also ensures adequate resource alignment and ensures sub-offices establish and implement action plans for updating policies, including the appointment of policy status managers.
Demonstrated Progress • In FY 2019, VHA launched a "get to zero" initiative designed to ensure that to the maximum extent possible all national policies are current and have been appropriately reviewed and recertified within the prior 5 years. In cases where law, regulations, or other dependencies prevent timely recertification, there must be a plan in place to remedy the untimely recertification as soon as such dependencies are resolved. • In August 2017, ORAA updated VHA Directive 6330, Controlled National Policy/Directives Management System, to define VHA policy documents only as directives and notices. At the time of ORAA's most recent update in June 2018, Directive 6330 updated policy standards include: the requirement of a full chain of responsibilities and oversight from VHA senior leadership to field staff to align VHA policy with the RMF (in collaboration with the Oversight and Accountability work group); the requirement of a paragraph specifying required staff training (in collaboration with the Training work group); and the requirement of a Records Management paragraph. ORAA plans to convert Directive 6330 to Directive 0999 to align with VA's policy numbering system. • ORAA piloted a SharePoint review process for 10 policies in 2016 to solicit feedback from VA staff during the policy development process and implemented the SharePoint review for all VHA policies in 2017. VHA policies are posted to SharePoint for 2 weeks to enable staff from VA program offices, regions, and VA medical facilities to provide feedback on a policy, including identifying obstacles to uniform nationwide implementation. In 2018, the average number of SharePoint comments received per policy was 73. ORAA ensures that policy authors address field comments, which increases the transparency and integrity of policy development, and informs draft revisions to address medical facility needs prior to publication of a policy.
Monitoring ORAA created the VHA Policy Dashboard in 2016 and provides it to the SLC weekly through email. The SLC reviews the dashboard in person at its meeting every 2 weeks. The VHA Policy Dashboard provides a comprehensive status overview for policies in development, including each policy's current location and the time to completion for each development stage compared to the established policy development timeline of 140 days. In May 2018, ORAA also began distributing a monthly dashboard of published directives to the SLC, which also includes timeliness reports such as the number of days each Deputy Under Secretary for Health office took to concur for each policy. In May 2019, VHA's policy inventory is 546 (down from 805 in 2015) and 36% are overdue (down from 59% in 2015). ORAA created a SharePoint repository in 2017, composed of all policies posted for 2 weeks of field review, their Chief of Staff Briefing Notes, and their completed SharePoint comment logs that contain policy authors' responses to field comments. Starting February 2019, all VA employees can view and provide substantive feedback on documents located in the SharePoint repository. ORAA's SharePoint repository increased the transparency and integrity of the policy development process by providing an additional opportunity for all stakeholders to ensure national policy authors addressed concerns and suggestions from the field, which aligns with ORAA's actions to integrate VHA's RMF into all aspects of policy. The metrics and measures of this plan provide the mechanisms to assess and report progress to GAO. With the introduction of metrics and measures, monitoring processes and procedures will be formalized.

P&P-2 Description of Actions Toward Removal Criteria
Capacity VHA supports ORAA to meet its policy staffing needs. ORAA employs a staff of professional writers to assist program offices with the technical and administrative duties of policy development required by the robust and collaborative standardized process. In July 2016, ORAA added seven contractors to the document management staff, expanding to 12 contractors in May 2018. In August 2018, VHA transferred two unfunded positions to ORAA, which allowed ORAA to hire two additional document managers. In September 2019, VHA modified its contract to provide additional resources, for a total of 30 contractors and eight FTE supporting ORAA. Senior leaders continue to assess capacity needs.

Policies and Processes Outcome (P&P-3)

Outcome Lead: Brian McCarthy, JD, MPH, Chief VHA National Policy
Outcome Executive: Ethan Kalett, JD, Senior Advisor, Office of Regulatory and Administrative Affairs

P&P-3 Outcome Statement: VHA applies standard business rules to determine when, what, and how to create uniform policy development and implementation processes across the agency that reflect VHA indices of policy quality

Key Outcome: Policy drives correct behavior and is implemented consistently

Root Causes: VHA has not defined what policy is and what it should accomplish; VHA rarely embedded policy in a broader change strategy to support implementation by the field

In Planning | **In Progress** | **Complete** | **Sustaining**

P&P-3 Description & Status
To achieve this outcome all VHA stakeholders must understand and use policy development processes that result in clear, consistent VHA policy at all levels of the organization. VHA leaders will use the appropriate document type and dissemination method when establishing or updating standards, responsibilities, and processes. VHA program offices and medical facilities will have straightforward and integrated policies and processes that ensure national VHA policy systematically aligns with medical facility standards of practice. VHA must vastly reduce complexity and contradictions among policy and guidance documents. VHA must adopt standard definitions of national policy documents and use decision tools that enable medical facilities to implement and tailor national policies in an efficient manner. VHA must curate a site that is available to all VA staff and includes information about the policy development process, as well as policy and standards of practice decision tools and templates. The VHA Chief of National Policy and ORAA staff actively connect with VHA program offices and with leaders working at the regional level and medical facility leaders to discuss how to improve national policy to reduce the policy burden on VA medical facility staff and how to assist medical facility leaders in streamlining and aligning medical center policy and standards of practice with national policy. Implementing standard business rules for national and local policies and processes will simplify their development and facilitate their uniform implementation across VHA.

The following table describes the measures and metrics the work group uses to determine progress toward achievement of P&P-3.

Table 2-6. P&P-3 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Regular informational and educational sessions occur among ORAA and policy stakeholders	Number of engagements among ORAA, program offices, regions, and VA medical facilities Total # of events per FY	Milestone = 15 information sessions in FY18; monthly policy activity digest to VHA stakeholders Target = Quarterly meetings w/ regions and VA medical facilities; monthly policy activity digest to VHA stakeholders	Q2, Q4

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Reduced redundant and unnecessarily complex local policy for medical facilities	Percent reduction of local policies (# of local policies at baseline – current # of local policies) / # of local policies at baseline	Baseline = 55,000 local policies in FY19 Milestone = 10% reduction nationwide in FY21 Target = 25% reduction in FY23	Q2, Q4

The following table describes action plans Policies and Processes work group have identified to achieve P&P-3: VHA applies standard business rules to determine when, what, and how to create uniform policy development and implementation processes across the agency that reflect VHA indices of policy quality.

Table 2-7. P&P-3 Action Plan

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
All actions imply effective change management and training are part of implementation			
(3.1) Develop, implement, and follow a process for disseminating, monitoring, and evaluating policy implementation at the local level	Q3FY20		**In progress:** ORAA and the Field Advisory Work Group developed a center Quality Manager and VISN Director survey to collect information about who is responsible for implementing and monitoring national and local policy; VHA partners, including the Lanes of Effort, will be required for uniform implementation of identified monitoring and evaluation best practices.
(3.2) Identify field perspectives through primary research activities		Q3FY18 (and ongoing)	**Sustaining:** ORAA conducted 26 semi-structured interviews and four site visits in 2017–2018 to receive feedback and learn the field's policy needs. This action is ongoing: in 2019, ORAA replaced the semi-structured interviews with regional-level meetings to discuss the implementation of the policy business rules.
(3.3) Establish regular informational and educational sessions by which ORAA can disseminate updates about the policy development process and provide stakeholders an opportunity to discuss policy and the policy development process		Q3FY18 (and ongoing)	**Sustaining:** ORAA conducted 15 informational sessions with VHA, regional, and medical facility staff in 2018. This action is ongoing: ORAA emails a monthly policy activity digest to VHA stakeholders; the VHA Chief of National Policy meets with groups such as the Health Systems Committee and other stakeholders.
(3.4) Identify improvements to national policy to increase alignment with local policy and help reduce redundant and unnecessarily complex policy for medical facilities		Q3FY19 (and ongoing)	**Sustaining:** ORAA visited 10 sites in 2019 to identify alignment strategies and ways to reduce the local policy burden, and created a policy crosswalk of local policy concerns to address. ORAA staff are tracking local policy volume. ORAA is exploring a second round of site visits.

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
(3.5) Delineate the role of national and local policy	Q1FY20	Q1FY20	**In Progress:** In 2018–2019 ORAA conducted three medical center policy data calls to identify target areas for increased alignment and decreased redundancy with national policy. Two notices issuing business rules simplify policy structure and development at national and local levels. These business rules are incorporated into VHA Directive 6330/0999.
(3.6) Create a site that contains basic information about the policy development process, templates, and other tools as needed, that stakeholders can access to facilitate their participation	Q1FY20	Q1FY20	**In Progress:** In 2016, ORAA established a policy process information site. In 2019, ORAA created a SharePoint site to host policy and guidance templates and policy decision tools for VA staff.

The following table describes actions taken to address GAO's removal criteria.

P&P-3 Description of Actions Toward Removal Criteria
Leadership Commitment • In 2017, the VHA Chief of National Policy held 15 informational sessions and ORAA staff, including the Executive Director, visited four medical facilities to discuss the national policy development process and receive direct feedback from VHA, regional, and medical facility stakeholders about improvements to national policy and the policy development process. The field recommendations informed the agenda for ORAA and the Field Advisory Work Group's December 2017 in-person meeting. • In 2017 and 2018, the VHA Chief of National Policy conducted 26 semi-structured interviews with policy management staff from medical facilities in each region to discuss local policy development and gain insight about how national policy can ensure consistent implementation and oversight in medical facilities. ORAA shared reports of its key findings with the Field Advisory Work Group, and the interview feedback informed the selection of medical facilities for ORAA site visits in 2019.
Demonstrated Progress • In 2019, the VHA Chief of National Policy and ORAA staff visited 10 medical facilities to identify ways to better align national and medical facility policy (also known as medical center memoranda), and to identify best practices for medical facility policy and process development. ORAA requested proposals for national and local policy business rules that program offices and medical facilities must use to develop policy. ORAA issued the business rules in two notices. Upon publication of the notices, each medical facility will submit an action plan outlining how they will implement the business rules to address their most pressing policy needs, including the reduction of unnecessary medical center policies. • ORAA used information gathered from the site visits to create a local policy assessment and development tool to help medical facilities determine the appropriate course of action for implementing and tailoring national policy at the local level and development medical facility standards of practice. In addition to the standards of VHA Directive 6330, Controlled National Policy/Directives Management System, which defines what is and is not considered a national policy document, this tool will help medical facilities streamline local policy inventory and reduce confusion. Directive 6330 will become Directive 0999, Policy Management, and will incorporate information from two business rules notices that clarify what the policy documents are at the medical facility level. • In 2019, ORAA created a SharePoint site to facilitate the implementation of national and local policy business rules that program offices and medical facilities must use to develop policy. In addition to containing standard templates and decision tools for developing national and local policy, medical facilities will submit action plans to the site that outline how they will implement the business rules to address their most pressing policy needs, including the reduction of unnecessary medical center policies. • In 2017, ORAA initiated a biannual medical facility policy census to better understand the volume of local policy, establish benchmarks to track local policy reduction, and identify areas for improved alignment between national and local policy. • In 2018, VHA created a repository of operational memoranda, which have been noted as a source of confusion by GAO and internal stakeholders. The repository ensures that only current operational memoranda remain in effect. In addition, ORAA worked closely with field users to identify significant operational memoranda and is working to ensure that these memoranda are merged with the appropriate, overarching national policy, and all memoranda that do not contain current requirements are rescinded. • ORAA disseminates a monthly email digest across VHA at the beginning of each month which lists newly published VHA directives and notices and informs stakeholders about recent changes to VA and VHA policy and VHA forms. The digest provides information about the policy recertification process and includes a link for readers to provide direct feedback regarding specific policies, such as local implementation issues and improvement suggestions.
Monitoring – This plan's metrics and measures provide the mechanisms to assess and report progress to GAO. With the introduction of metrics and measures, monitoring processes and procedures will be formalized.

P&P-3 Description of Actions Toward Removal Criteria
Capacity – VHA supports ORAA to meet policy staffing needs with 8 FTE and 30 contractors. Senior leaders continue to assess capacity needs.

Policies and Processes Outcome (P&P-4)

Outcome Lead: Brian McCarthy, JD, MPH, Chief VHA National Policy
Outcome Executive: Ethan Kalett, JD, Senior Advisor, Office of Regulatory and Administrative Affairs

P&P-4 Outcome Statement: VHA standards and implementing processes are transparent and accessible to appropriate stakeholders

Key Outcome: Policy drives correct behavior and is implemented consistently

Root Cause: VHA rarely embedded policy in a broader change strategy to support implementation by the field

Initiated | **In Progress** | **Complete** | **Sustaining**

P&P-4 Description & Status
To achieve this outcome, VHA must have a national repository of publications that all appropriate stakeholders can access and easily navigate to find the right document at the right time. National and local policy will follow standard templates and a common numbering system. The national repository will link national policy with associated program office guidance, clinical practice guidelines, medical facility policy and standards of practice, related operational memoranda, and required training. VHA staff at all levels and sites of the organization will be able to easily understand their responsibilities and use policy and process documents to fulfil the requirements of their role.

The following table describes the measures and metrics the work group uses to determine progress toward achievement of P&P-4.

Table 2-8. P&P-4 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Current VHA policies are located in a single online repository that is available to all VA staff and has broad searchability	Percentage of local and national policy documents in the repository (Note: the online repository is planned to be a new document storage and access platform and will replace the VHA Publications website) # of local and national policy documents included in the online repository / total # of policy documents	Baseline = 0% policy availability (repository prototype in development) in FY19 Target = 100% policy availability in centralized repository in FY24	Q2, Q4

The following table describes action plans the Policies and Processes work group have identified to achieve P&P-4: VHA standards and implementing processes are transparent and accessible to appropriate stakeholders.

Table 2-9. P&P-4 Action Plan

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
All actions imply effective change management and training are a part of implementation			
(4.1) Create a VHA central repository of policy documents and include implementation documents, operational memoranda, local policies, clinical practice guidelines, and links to training resources	Q4FY24		**In progress:** ORAA added a repository of operational memoranda in 2018. In January and August 2019, ORAA met with the Office of Enterprise Integration (OEI), which is building a VA Business Reference repository, to discuss repository development.
(4.2) Create a standardized numbering system that links all related VHA documents (as applicable)	Q4FY24		**In progress:** The Field Advisory Work Group and ORAA are developing a strategy for a common numbering system.
(4.3) Co-locate VHA program office guidance websites on the VHA Forms and Publications website	Q4FY22		**In progress:** ORAA is requesting links from program offices that contain policy implementation guidance documents.

The table below describes actions taken to address GAO's removal criteria.

P&P-4 Description of Actions Toward Removal Criteria
Leadership Commitment – In 2019, the VHA Chief of National Policy established a collaboration with representatives from the Office of Enterprise Integration to develop a repository that meets organizational needs of VA and VHA.
Demonstrated Progress • Starting in 2017, ORAA reviews published national policy documents (directives and notices) for compliance with requirements of Section 508 of the Americans with Disabilities Act. As of February 2019, 76% of directives, notices, and handbooks on the VHA Publications website are 508 compliant, including documents that were published prior to 2017. • In 2018, ORAA added links to the VHA Publications website for VA/DOD clinical practice guidelines, VA publications including financial policies, and Veterans Benefits Administration (VBA), and National Cemetery Administration publications. In 2019, ORAA created a repository of operational memoranda on the VHA Publications website to alleviate field confusion between policy documents and memoranda and to aid reference of operational memoranda by VA field staff.
Monitoring - This plan's metrics and measures provide the mechanisms to assess and report progress to GAO. With the introduction of metrics and measures, monitoring processes and procedures will be formalized.
Capacity - VHA supports ORAA to meet policy staffing needs with 8 FTE and 30 contractors. Senior leaders continue to assess capacity needs.

2. Inadequate Oversight and Accountability Area of Concern

Executive Summary

The Oversight and Accountability action plan highlights the critical role modernization initiatives perform in addressing this area of concern. VA leadership recognizes oversight and accountability as pivotal to setting the foundation upon which mission services succeed. VA leadership commitment to this success is evidenced by the fact that several VHA modernization initiatives are focused on key oversight and accountability capabilities. Collectively, the Organization Improvement, Commit to Zero Harm and Shared Services LOE tackle critical oversight and accountability components such as decision making at the appropriate organizational level, aligning decision rights, standardizing services, improving vertical alignment, and fostering a culture of integrity and accountability.

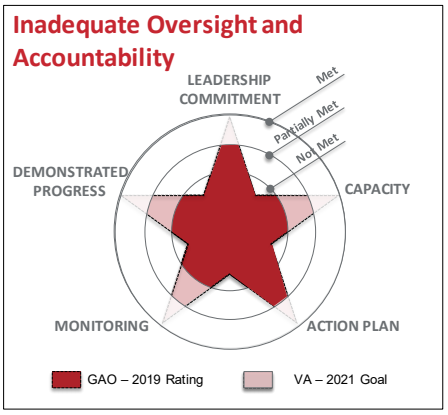


Figure 2-4 Oversight & Accountability 2021 Rating Goal

Since 2015, VHA leadership took definitive actions to build new capacity and authorities that improve oversight and accountability functions. VHA leadership—

- Created a new Office of Integrity, headed by a new Assistant Deputy Under Secretary for Health for Integrity. This new office oversees previously unintegrated offices that conduct oversight activities – Office of Medical Inspector (OMI), Internal Audit (IA), Compliance and Business Integrity (CBI), Risk Management. It also oversees VHA's National Center for Ethics in Health Care, an essential component of a culture of integrity that forms the foundation of an accountable culture.
- Created a new Internal Audit Office and hired new executive-level Chief Auditor and Deputy Chief Auditor for VHA. This office conducts internal audits on topics of interest to VHA.
- Created a governance structure, the Audit, Risk and Compliance Committee and its Compliance subcommittee. This governance committee oversees internal audits, risk management, and compliance within VHA.
- Created a new VHA enterprise risk management (ERM) function; hired a new risk manager.
- Hired a new executive-level Chief Compliance and Business Integrity Officer and Deputy Chief Compliance and Business Integrity Officer.
- Supported establishment of a new VA Office of Accountability and Whistleblower Protection.

Demonstrated progress toward improved oversight in VHA includes—

- Publishing a Code of Integrity that sets expectations for conduct for all VHA employees.
- Using a Risk Register and Risk Profile that is reviewed by a governance body (i.e., the Risk subcommittee of the Audit, Risk, and Compliance Committee [ARCC]).
- Increasing collaboration across VHA program offices on the Statement of Assurance driven by federal requirements.[17]

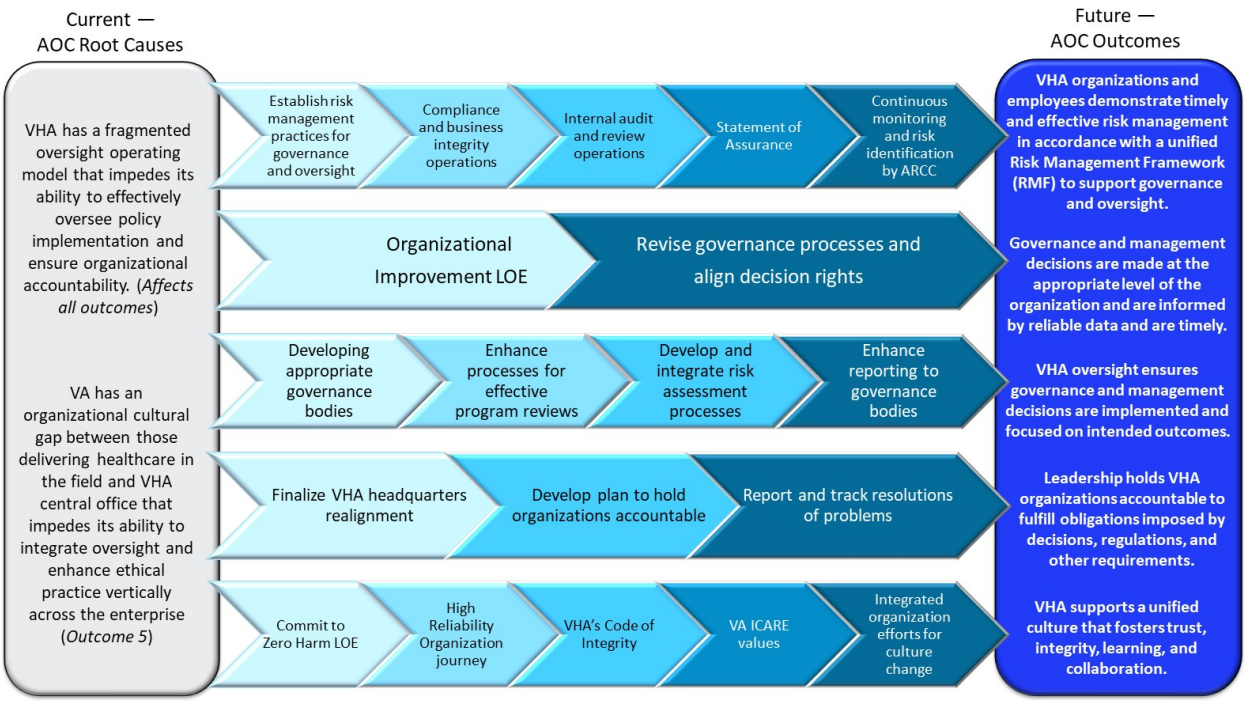
[17] Office of Management and Budget Circular No. A-123, Management's Responsibility for Enterprise Risk Management and Internal Control, July 15, 2016.

For direct navigation to Oversight and Accountability outcomes and supporting action plan, click on the links below.

OA-1: VHA organizations and employees demonstrate timely and effective risk management in accordance with a unified RMF to support governance and oversight
OA-2: Governance and management decisions are made at the appropriate level of the organization, are informed by reliable data, and are timely
OA-3: VHA oversight ensures governance and management decisions are implemented and focused on intended outcomes
OA-4: Leadership holds VHA organizations accountable to fulfill obligations imposed by decisions, regulations, and other requirements
OA-5: VHA supports a Just Culture that fosters trust, integrity, learning, and collaboration

Highlights of the root causes, key actions and outcomes for effective Oversight and Accountability are outlined in the following figure.

Figure 2-5 Oversight & Accountability Roadmap



The following table provides examples of Oversight and Accountability alignment with other AOCs.

Alignment with Other Areas of Concern
Policies and Processes
The Oversight and Accountability (OA) work group collaborates with the Policies and Process work group to ensure new policies on risk management and CBI adhere to standards for clarity. VHA published a Code of Integrity on June 30, 2019, to establish clear standards for integrity in a Just Culture.

Alignment with Other Areas of Concern
IT
IT systems are critical to the success of effective oversight and accountability. VHA must continue to work with OIT to determine and prioritize IT requirements and build them into the Joint Business Plan (JBP). IT assistance is needed for various elements, e.g., the development of the shared case management capability for Office of Medical Inspector (OMI)/Internal Audit/Compliance and Business Integrity that supports audits, investigations, and evaluations. Oversight and Accountability relies on IT support to ensure data are timely and reliable to inform sound decisions. Collaboration will help achieve a level 4 of 5 of the VA Data Governance Maturity Model. OIT's maintenance of Compliance Inquiry Reporting and Tracking Systems (CIRTS) is essential to CBI.
Training
The OA work group collaborates with the Training work group to develop needs-based trainings related to CIRTS, the "VHA Integrity" case management system, VHA's Code of Integrity, and any other oversight models, tools, or techniques that require training.
Resource Allocation
The OA work group supports the work of VHA's Manpower Management Office and VHA's Finance Office in creating standard staffing models across VHA programs to increase organizational accountability.

The following table provides examples of how Oversight and Accountability actions support the Modernization Lane of Effort initiatives.

Integration with Applicable Lanes of Effort
Commit to Zero Harm
Three activities under Outcome 5 support and supplement the LOE in encouraging and facilitating a culture of trust and accountability. • Publish Code of Integrity for VHA • Integrity, Commitment, Advocacy, Respect, Excellence (ICARE) training for all VA employees • Developing an effective collaborative approach for organizational entities involved in culture change (e.g., Veterans Experience Office, National Center for Organizational Development, Just Culture)
Organizational Improvement
The Oversight and Accountability action plan for Outcome 1 includes coordination of VHA's submission to the Statement of Assurance. The submission is a VHA-wide check on the effectiveness of VHA's system of internal control. The action plan for Outcome 4 includes an evaluation of whether current mechanisms or those that will be implemented with the Lanes of Effort are sufficient for leadership to hold VHA organizations accountable.

Oversight and Accountability Outcome (OA-1)

Outcome Leads: Matthew Tuchow, JD, Chief Compliance and Business Integrity Officer
Tracy Davis Bradley, PhD, Deputy Chief Compliance and Business Integrity Officer
Outcome Executive: David Chiesa, DDS, Assistant Deputy Under Secretary for Health for Integrity[18]

OA-1 Outcome Statement: VHA organizations and employees demonstrate timely and effective risk management in accordance with a unified risk management framework to support governance and oversight

Key Outcome: Governance and oversight mechanisms provide reasonable assurance that requirements are met

Root Cause: VHA has a fragmented oversight operating model that impedes its ability to effectively oversee policy implementation and ensure organizational accountability

In Planning | **In Progress** | **Complete** | **Sustaining**

OA-1 Description & Status
Description This outcome focuses on providing effective risk management practices to support governance and oversight. The following action plan establishes the ability for VHA organizations and employees to identify and manage risks in accordance with an established enterprise risk management (ERM) framework, such as from the Committee of Sponsoring Organization of the Treadway Commission (COSO), and the International Organization for Standardization 31000 (ISO 31000) series. The action plan includes— • A strong compliance program • An enterprise risk management function • An ability to conduct administrative investigations or audits • A governance structure for oversight of these compliance, enterprise risk management, and internal audit functions Risk management (RM) relies on existing permanent Departmental structures – Compliance and Business Integrity (CBI), RM, and Internal Audit, all guided by and coordinated through a central governance body, the Audit, Risk, and Compliance Committee (ARCC).
Status ***Compliance and Business Integrity*** A critical part of effective accountability and oversight is a compliance program that supports and monitors compliance laws, regulations, and policies. CBI's three main strategic goals are 1) promoting a culture of integrity, 2) assisting VHA to manage and mitigate legal and regulatory risk, and 3) providing a compliance framework with leadership and oversight to promote an integrated VHA-wide program. The elements of an effective compliance program include periodic compliance risk assessments, clear policies, communications (including a helpline for employees), training, audit/monitoring, appropriate enforcement or discipline, and adequate compliance resources. Working with the most senior executives of the VHA through formal governance (the ARCC), and partnering with other program offices and field leadership, the Chief Compliance

[18] The Oversight and Accountability Leads named above were newly appointed in January 2020 and were not involved in the creation of the action plans below but are looking forward to further developing the plans. We look forward to their leadership and vision.

OA-1 Description & Status
and Business Integrity Officer proposes to the ARCC key legal and regulatory compliance risk areas for national focus. Monitoring and risk identification support mitigation at the local level by Compliance and Business Integrity Officers in the facilities and program offices, as well as at the system-wide level. CBI identifies, tracks, and provides mitigation support of priority risks. ***VHA's Enterprise Risk Management*** A VHA ERM function is essential for streamlining, improving, and standardizing the risk assessment process, developing an integrated and forward-looking approach, and informing strategy and performance. The Enterprise Risk Manager is the steward of VHA's Risk Register; responsible for VHA's Risk Profile for annual submissions to the OEI's VA Risk Profile; responsible for the development, review, and approval of VHA's Risk Appetite Statement; and responsible for coordination, review, and approval of the VHA annual Statement of Assurance. VHA hired an Enterprise Risk Manager and is in the process of migrating identified risks to a centralized enterprise risk register to track reported risks and opportunities, as well as track risk and opportunity submissions from VA medical facilities, regional offices, and VHA program offices. The Statement of Assurance coordinates VA's assessment of and conclusion on the effectiveness of VHA's system of internal control. Success is minimal discrepancy between the VA Statement of Assurance and VA's external auditors' review of the Statement of Assurance as well as increasing participation of VA medical facilities, regional offices, and program offices, year-over-year. VHA ERM will track its level of maturity according to industry-standard maturity models such as the ones provided in the United States Chief Financial Officers Council's *Playbook: Enterprise Risk Management for the U.S. Federal Government*, dated July 29, 2016. VHA has adopted a risk management framework modeled after The Institute of Internal Auditors' (IIA's) Three Lines of Defense (3LD) framework. VHA is communicating this framework to all levels of the organization as a model for guiding effective risk management and assurance activities, ensuring a more cohesive and coordinated approach to enhance communications, clarifying roles and duties, and ultimately providing earlier identification and management of risks. To date, communications materials have been developed including a toolkit, fact sheet, list of frequently asked questions, MS PowerPoint slide show presentation, and video. The Office of Organizational Excellence and its respective program offices have socialized VHA's model to several audiences. The Deputy Under Secretary for Health for Organizational Excellence has focused on aligning the model with key initiatives such as High Reliability Organization and modernization. The effort developed additional resources including "personas" and incorporated the video into the Talent Management System. The model provides all employees a framework for effective risk management. ***Internal Audit (IA)*** After a full year with the Chief Audit Executive and Deputy Director in place, Internal Audit delivered its first audit and has an approved audit plan to conduct two more audits in FY 2020. Specific accomplishments include establishing of the Internal Audit office; the completion of benchmarking against commercial and federal organizations performing the internal audit function; development and socialization of a business case; completion of a Human Capital Plan and implementation plan; and a new organizational structure that provides for employee development and succession planning. IA is in the process of developing position descriptions and will implement the new organizational structure over 4 years. ***VHA Audit, Risk, and Compliance Committee*** The VHA Audit, Risk and Compliance Committee (ARCC) oversees risk management, audits and reviews, and compliance operations. This committee aims to improve— • Accountability • Trust with Veterans • Quality, efficiency, and consistency of VHA's operations and delivery of health care • Collaboration, communication, direction, and solution evaluations in VA and VHA senior leadership executive level forums • Governance oversight regarding major VHA risk and internal control initiatives

OA-1 Description & Status
Voting members include all Deputy Under Secretaries, two Regional Directors, two VA Medical Center Directors, the VHA Chief of Staff, and the Chief Nursing Officer. Ex officio members include the Chief Compliance and Business Integrity Officer; the Chief Audit Executive; the Assistant Deputy Under Secretary of Health for Workforce Services; Assistant Deputy Under Secretary of Health for Integrity; VHA Chief Financial Officer; Executive Director, Office of the Medical Inspector; Executive Director, Office of Research Oversight; Executive Director, Patient Advocacy Services; and Director, Office of Regulatory and Administrative Affairs. ARCC accomplishments include establishing a Compliance Subcommittee and a Risk Subcommittee, in addition to the ARCC meeting quarterly since 2018.

The following table describes the measures and metrics the work group uses to determine progress toward achievement of OA-1.

Table 2-10. OA-1 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
VHA's Enterprise Risk Manager coordinates VHA's submission to the annual Statement of Assurance	Consecutive years of successful submissions Count of consecutive years of successful submissions	Target = 3 consecutive years FY18 and FY19 are complete FY20 is in progress	Annual
Annual audits or reviews completed on a 3-year cycle (plan, execute, report)	Percentage completed of ARCC-approved audits or reviews # of audits or reviews completed / # of ARCC approved audits or reviews	Target = 100 % for 3 consecutive years FY18 complete	Annual
Corrective Actions in response to Internal Audit recommendations are completed by their negotiated implementation date	Percentage of corrective actions completed by their negotiated completion date = # of corrective actions completed by their negotiated completion date / total # corrective actions	Milestone = 50% in FY20 Target = 80% in FY21	Annual

The following table describes actions to achieve OA-1: VHA organizations and employees demonstrate timely and effective risk management in accordance with a unified risk management framework to support governance and oversight.

Table 2-11 OA-1 Action Plan

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
All actions imply change management and training needs are a part of implementation planning			
(1.1) Enterprise Risk Management process			

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
VHA's Enterprise Risk Manager coordinates VHA's submission to the annual Statement of Assurance and identifies internal control deficiencies, material weaknesses, and non-compliance with laws and regulation	Annual		**Sustaining**. VHA Risk Manager coordinated the submission for FY18 and FY19, FY20 submission is in progress.
Develop Enterprise Risk Register	Q3FY19	June 2019	**Complete**
Implements Office of Management and Budget (OMB) Circular No. A-123 and VA ERM policy	Q4FY20		**Complete.** OMB Circular No. A-123 has been implemented and continues to mature, year-over-year.
Communicates OMB's ERM and internal control policy	Q1FY19	December 2019	**Complete.** The OMB ERM policy (OMB Circular No. A-123, Management's Responsibility for Enterprise Risk Management and Internal Control) was distributed to all Deputy Undersecretary of Health (DUSH)-level offices. The responsibilities for compliance were published in VA Financial Policy, Volume 1, Chapter 5. VA's ERM and Internal Controls policy is underway.
(1.2) VHA Internal Audit (IA) and review function			
Adequate staffing level is achieved and maintained	Q4FY24		**In Progress**
OMI/IA/CBI Shared Investigation/Audit/Evaluation case management application ("VHA Integrity")	Q4FY20		**In Progress**
IA executes audit plans approved by ARCC for 3 consecutive years	Q4FY21		**In Progress.** FY 2019 audit plan approved and execution in progress. FY 2020 audit plan approved and execution in progress. FY 2021 audit in planning.
Develop and implement corrective action plan monitoring and reporting function (approved by ARCC Q1FY20)	Q4FY20		**In Progress**
(1.3) Audit, Risk, and Compliance Committee (ARCC)			
IA makes recommendation to ARCC for Corrective Action Plans Monitoring and Reporting	NA	Ongoing	**Sustaining** (track for at least 3 consecutive years). ARCC approved IA's recommendation for FY19.
FY19 Compliance Risk Assessment – Feeds VHA Consolidated Risk Assessment and gets reported VHA ERM, then to OEI	NA	Ongoing	**Sustaining** (track for at least 3 consecutive years)**.** Complete for FY19. Annual Compliance Risk Assessment helps identify priority areas for local VA medical facilities, and regional compliance programs.

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
FY19 Fraud Risk Assessment – Collaboration with VA Office of Business Oversight – Feeds VHA's enterprise risk register which will be vetted through a governance process before being submitted to OEI	NA	Ongoing	**Sustaining** (track for at least 3 consecutive years)**.** Complete for FY19. Support VA's Office of Business Oversight on VA Fraud Risk Assessment in alignment with OMB A-123 and Fraud Reduction Data Analytics Act.
Compliance Risk Mitigation tracking	NA	Ongoing	**Sustaining** (track for at least 3 consecutive years). Completed for FY19. Tracks Compliance Risk Mitigation activity for resolution; local medical facilities and regions report to VA headquarters on resolution.
Provide VHA Fraud, Waste, and Abuse Risk Mitigation Support	NA	Ongoing	**Sustaining** (track for at least 3 consecutive years). Completed for FY19. VHA CBI to hire a Senior Fraud, Waste, and Abuse Advisor and provide advice to field and program offices on mitigation activity.
ARCC meeting at least semiannually and preferably quarterly	NA	Ongoing	**Sustaining** (track for at least 3 consecutive years). Full year of quarterly meetings with minutes as of June 30, 2019.
ARCC Charter developed, coordinated, and signed	Q1FY19	Q3FY19	**Complete**
Establish and charter Compliance Subcommittee to coordinate compliance activities among similarly situated program offices.	Q1FY20	Q2FY19	**Complete.** Subcommittee established and functional as of March 31, 2019.
Establish and charter Risk Subcommittee	NA	Q2FY19	**Complete.** Subcommittee established and functional prior to charter signature March 31, 2019.
(1.4) Enterprise Risk Management Framework is communicated across VHA			
Communicate COSO's ERM framework across VHA as an option	Q3FY20		**In Progress**
Developed communications materials and plan	Q2FY20		**In Progress**
VHA leadership adopts a framework modeled from the Institute of Internal Auditors' (IIA) 3LD as an optional risk management framework	Q4FY16	August 2016	**Complete**
(1.5) Assess nationwide risk management involvement			

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
Determine mechanism for assessing program office and employee involvement in timely and effective risk assessment	TBD		**In Planning**

The following table describes actions that address GAO's HRL removal criteria.

OA-1 Description of Actions Toward Removal Criteria
Leadership Commitment Over the past several years, VHA leadership has supported the need to create and staff the new office of Internal Audit and the ERM function. VHA hired executive-level leaders to run these offices. VHA leadership has supported the growth of the CBI office including hiring in new Chief and Deputy CBI officers. Leadership committed to funding development of risk management communication materials.
Capacity VHA expanded capacity to integrate internal oversight functions within VHA by establishing the ARCC, the ARCC Compliance Subcommittee, and the ARCC Risk Subcommittee. The ARCC allowed leadership the forum and mechanism to direct a coordinated risk management function. VHA maintains adequate staffing levels for internal audit functions.
Monitoring The metrics and measures of this plan provide the mechanism to assess and report progress.
Demonstrated Progress The ARCC approved audit plans for FYs 2019 and 2020. IA executed the audit plan. By third quarter FY 2019 briefing to the ARCC, risk mitigation plans across all regions and medical facilities had been initiated. VHA developed communication materials for the ERM framework options.

Oversight and Accountability Outcome (OA-2)

Outcome Leads: Ethan Kalett, JD, Senior Advisor, Office of Regulatory and Administrative Affairs
Outcome Executives: Lucille Beck, PhD, Deputy Under Secretary for Health for Policy and Services
Skye McDougall, PhD, Network Director, VISN 16

OA-2 Outcome Statement: Governance and management decisions are made at the appropriate level of the organization, are informed by reliable data, and are timely

Key Outcome: Governance and oversight mechanisms provide reasonable assurance that requirements are met

Root Cause: VHA has a fragmented oversight operating model that impedes its ability to effectively oversee policy implementation and ensure organizational accountability

In Planning | **In Progress** | **Complete** | **Sustaining**

OA-2 Description & Status
Description The Organization Improvement Lane of Effort (described in Chapter 1) accomplishes the transformations necessary to achieve OA-2. **Revise Governance Processes and Align Decision Rights**: The development of an aligned and dedicated governance structure with clear roles, responsibilities, and decision rights creates opportunities for greater cross-organizational synergy. VHA's efforts over the past 4 years have positioned the organization to adopt changes to existing governance structures, focus on patient care priorities, and ensure proactive decision making. Functional and structural change, with an emphasis on leadership engagement, a Just Culture, and continuous process improvement, are critical to change VHA's current structure. The current VHA governance structure is being simplified to empower employees to make decisions at all levels and to be supported by consensus-driven roles, responsibilities, and accountability. A well-defined, transparent governance system will also allow us to better align authority and resources, and better support clinical operations and VHA priorities. Coordination is underway to carefully define decision rights and thresholds for governance and management. Decision rights will clarify when decisions are made through governance or management. Actions to address OA-2 are managed by the Organizational Improvement LOE.
Status VHA has a revised governance system proposal approved by the Executive in Charge and created a Governing Board of senior leaders in VHA headquarters and all Regional Directors, which has been stood up and is meeting monthly. It was instituted by an Executive Decision Memorandum to improve transparency, and to gain support from senior leaders. It also approved four councils that mirror regional councils: Healthcare Delivery; Healthcare Operations; Organizational and Veteran Health; and Quality, Safety, and Value. VHA has identified governing principles to guide governance restructuring, ensure proper oversight and accountability, and deliver optimal value for staff directly serving Veterans.

VHA Governing Principles
Clear decision rights and appropriate delegation of authority
Standard defined process and approach that focuses on strategic priorities aligned to core values

OA-2 Description & Status
 **Agile structure that remains beyond leadership turnover**  **Transparent, disciplined, and accountable**  **Engages representation from all levels across the organization**  **Enterprise systems perspective that looks across silos**  **Delegate decisions to the appropriate level for maximum competence, cognizance, and commitment**  **Serving the Veteran by supporting those who care for Veterans** In FY 2020, VHA will have a well-functioning governance system composed of the Executive Board, Governing Board, and Enterprise Councils. When in place, the governance structure will provide VHA employees and program offices access to governance at all levels of the organization, from the regions to VHA headquarters. A more efficient, strategically aligned, and transparent decision-making process will also be put in place starting in FY 2020. The VHA Governance Office will provide additional analytical and administrative support to the Governing Board and the four Enterprise Councils. This office will be the focal point for requests to brief governing bodies and any questions related to the governance system.

The following table describes the measures and metrics the work group uses to determine progress toward achievement of OA-2.

Table 2-12. OA-2 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Trend in AES scores for relevant questions (this measure is developed for this early phase and will likely evolve over time)	AES scores for the following questions: ○ I believe appropriate steps would be taken to hold me accountable for poor performance ○ I know what is expected of me on the job ○ I know how my work relates to the agency's goals ○ Managers communicate the goals of the organization ○ My direct supervisor communicates the reasoning (how and why) behind decision that impact my work ○ I have the appropriate supplies, materials, and equipment to perform my job well	Increasing scores	Annual

Actions to address OA-2 are managed by the *Organizational Improvement LOE.* The following table describes actions taken to address GAO's removal criteria.

OA-2 Description of Actions Toward Removal Criteria
Leadership Commitment The EIC chartered a VHA Governance Integrated Project Team (IPT) composed of senior leaders, that was convened in May 2018 to present a recommendation on a governance structure. The IPT established governing principles that will outlast leadership changes and, with the needs of the field in mind, the IPT will continue work on its two major priorities— • Develop and define a governing body with substantial field representation that focuses on the ongoing strategy, prioritization, and oversight of initiatives for VHA. Additionally, future-state governance may consider competency-based boards and committees with strong clinical and community representation. • Outline the VHA future state decision rights framework, starting with several sample decision processes and then extending to all major decision areas. Coordination of decision rights between VA and VHA will also be recommended.
Capacity The IPT, supported by the Office of Health Care Transformation, possesses the necessary staff, knowledge, and skills to execute the governance and decision rights transformation.
Monitoring The metrics and measures of this plan and the management reporting used by the LOE provide the mechanisms to assess and report progress.
Demonstrated Progress Since early in FY 2019, when the EIC established the Revise Governance Processes and Align Decision Rights LOE, the following actions have been completed. • Revised Governance system proposal approved by the Executive in Charge • First Governing Board meeting held, and enterprise councils chartered • Instituted use of the Executive Decision Memorandum to improve transparency in decision-making processes and ensure input and buy-in from senior leaders As of early FY 2020, this LOE is part of the new Organizational Improvement LOE.

Oversight and Accountability Outcome (OA-3)

Outcome Leads: Matthew Tuchow, JD, Chief Compliance and Business Integrity Officer
Tracy Davis Bradley, PhD, Deputy Chief Compliance and Business Integrity Officer
Outcome Executive: David Chiesa, DDS, Assistant Deputy Under Secretary for Health for Integrity[19]

OA-3 Outcome Statement: VHA oversight ensures governance and management decisions are implemented and focused on intended outcomes

Key Outcome: Governance and oversight mechanisms provide reasonable assurance that requirements are met

Root Cause: VHA has a fragmented oversight operating model that impedes its ability to effectively oversee policy implementation and ensure organizational accountability

In Planning | **In Progress** | **Complete** | **Sustaining**

OA-3 Description & Status
Description The ability for VHA to determine whether governance and management decisions are implemented is dependent on completion of organizational improvements that are underway. VHA already has a strong compliance program that will continue and may expand. Activities that support OA-3 include identifying needed mitigation to address corrective actions, risks, and audit findings or recommendations, monitoring the implementation of corrective actions, findings or recommendations and risk mitigation plans through completion, supporting a compliance hotline, and issuing a revised directive to clarify compliance requirements.
Status VHA has taken steps to update and improve the tracking of corrective actions and the mitigation of risks, CBI communicates on risk areas during monthly national calls with medical facilities and programs, distributes a monthly compliance newsletter, provides subject matter expertise on compliance and integrity and provides specific program guidance on risk-mitigating activities. A new policy on compliance is expected to be issued this fiscal year.

The following table describes the measures and metrics used to determine progress toward achievement of OA-3.

Table 2-13. OA-3 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Standardize compliance risk identification and tracking	Participation by all VHA compliance officers in risk assessment and mitigation efforts	Q4FY21 = 95%	Twice annually
Ensure minutes from ARCC are signed, approved and distributed with accountability on action items	Number of approved ARCC meetings/ Number of ARCC meetings	100%	Quarterly

[19] The Oversight and Accountability Leads named above were newly appointed in January 2020 and were not involved in the creation of the action plans below but are looking forward to further developing the plans. We look forward to their leadership and vision.

The following table describes actions to achieve OA-3: VHA oversight ensures governance and management decisions are implemented and focused on intended outcomes.

Table 2-14. OA-3 Action Plan

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
All actions imply effective change management and training are a part of implementation			
(3.1) Compliance with governance and management decisions			
Determine management approach for assessing compliance with governance and management decisions	TBD		**In Planning.** This action is dependent on full implementation of the Organizational Improvement LOE.
(3.2) Governance bodies sustain active tracking of corrective actions			
Corrective actions are monitored by the relevant governance bodies	Q4FY20	Ongoing	**Sustaining** (track for at least 3 consecutive years). Initial entered risk mitigation plans are being actively monitored.
(3.3) Compliance policy			
New compliance policy will define clear guidance and expectations of compliance-related oversight	Q3FY20	Q4FY20	**In Progress**

The following table describes actions taken to address GAO's removal criteria.

OA-3 Description of Actions Toward Removal Criteria
Leadership Commitment The EIC's commitment to organizational improvement by establishing the Governance Board has put in place the essential function for ensuring governance and management decisions are focused on intended outcomes.
Capacity The CBI office possesses the necessary expertise to advise VHA leadership on strong compliance programs that ensure oversight functions focus on intended outcomes.
Monitoring Examples of monitoring include review of corrective actions by the relevant governing bodies and VHA's use of the annual Statement of Assurance process to show effective internal control. The metrics and measures of this plan provide the mechanism to assess and report progress.
Demonstrated Progress The CBI office has been established, a compliance framework for managing risks has been implemented, and risk mitigation plans are being monitored.

Oversight and Accountability Outcome (OA-4)

Outcome Leads: Matthew Tuchow, JD, Chief Compliance and Business Integrity Officer
Tracy Davis Bradley, PhD, Deputy Chief Compliance and Business Integrity Officer
Outcome Executive: David Chiesa, DDS, Assistant Deputy Under Secretary for Health for Integrity[20]

OA-4 Outcome: Leadership holds VHA organizations accountable to fulfill obligations imposed by decisions, regulations, and other requirements

Key Outcome: Governance and oversight mechanisms provide reasonable assurance that requirements are met

Root Cause: VHA has a fragmented oversight operating model that impedes its ability to effectively oversee policy implementation and ensure organizational accountability

In Planning | In Progress | Complete | Sustaining

OA-4 Description & Status
Description VHA's governance functions include mechanisms for receiving reports from accountable entities on compliance with governance decisions, regulations, and other requirements (e.g., policies, guidance, standard operating procedures). Governance functions are aware of deviations from expected goals and have mechanisms for ensuring accountable entities exercise authority to drive course corrections. Accountable entities may be national program offices, regions VISNs, medical facilities, or others depending on the level of oversight for the decision, regulation, or other requirement.
Status Actions for this outcome are in the planning phase and most likely will be implemented when realignment of VHA headquarters is finalized and governance functions are fully implemented.

[20] The Oversight and Accountability Leads named above were newly appointed in January 2020 and were not involved in the creation of the action plans below but are looking forward to further developing the plans. We look forward to their leadership and vision.

The following table describes action plans to achieve OA-4: Leadership holds VHA organizations accountable to fulfill obligations imposed by decisions, regulations, and other requirements.

Table 2-15. OA-4 Action Plan

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
(4.1) Develop VHA governance function that ensures accountability			
OA workgroup identifies and collaborates with relevant stakeholders to develop actions, and other elements of the GAO Action Plan, to ensure VHA has accountability functionality built into its governance and oversight functions	Q420		**In Planning**

Oversight and Accountability Outcome (OA-5)

Outcome Lead: William Gunnar, MD, JD, Executive Director, National Center for Patient Safety
Outcome Executive: Gerard Cox, MD, Deputy Under Secretary for Health for Organizational Excellence

OA-5 Outcome Statement: VHA supports a Just Culture[21] that fosters trust, integrity, learning, and collaboration

Key Outcome: Governance and oversight mechanisms provide reasonable assurance that requirements are met

Root Cause: There is an organizational cultural gap between those delivering health care in the field and VHA headquarters that impedes VHA's ability to oversee and enhance ethical practice throughout the organization

In Planning | **In Progress** | **Complete** | **Sustaining**

OA-5 Description & Status
Description The Commit to Zero Harm Lane of Effort (described in Chapter 1) accomplishes many of the transformations necessary to achieve OA-5 by transforming VHA into a high reliability organization (HRO). The overarching objectives of VHA's HRO journey and commitment to Zero Harm include the following— • Build a Just Culture of transparency and trust where HRO practices can thrive • Empower employees to lead frontline improvement efforts and speak up for safety • Improve system-wide performance across multiple domains (including safety, quality, access) • Affirm trust with Veterans and VA's workforce through greater reliability and transparency Going forward, HRO activities may be tailored to individual organizations (e.g., program office, region, medical facility, clinic), but will follow the same framework and sequence to help move individuals along the change management path. The major components in the VHA HRO journey are outlined below. • **Baseline HRO Curriculum:** Standard baseline training courses on HRO principles, Just Culture, everyday error management, and continuous process improvement are offered to the following audiences: executive leadership teams, supervisors/managers, and patient-facing staff. • **Site-Specific Assessments and Planning:** Regions and medical facilities complete a standardized, facilitated assessment process to understand their HRO maturity across the three pillars of HRO (leadership engagement, culture of safety, continuous process improvement) and create a site-specific HRO plan to move their site forward on the journey to Zero Harm. • **Clinical Team Training:** Training on team communications practices is based in reliability science and is applied by unit-level teams (starting with the 18 HRO lead sites and Cohort 2 HRO sites in calendar year 2020). • **Continuous Process Improvement:** Regions and medical facilities strategically build continuous process improvement capacity by expanding the bench strength of Lean belted professionals to lead improvement projects and coach improvement teams. • **HRO Leadership Coaching:** HRO coaches are matched with leaders from the 18 HRO lead sites and Cohort 2 HRO sites to assist in establishing standard HRO leadership practices (e.g., leader rounding, HRO huddle, safety forums, visual management) and progressing on the site-specific HRO plan.

[21] Sculli GL,Hemphill R. *Culture of Safety and Just Culture.* VA National Center for Patient Safety. 2013. Available at: https://www.patientsafety.va.gov/about/approach.asp

OA-5 Description & Status
• **Experiential Learning:** Leading practices from the 18 HRO lead sites are identified, documented, and shared with Cohort 2 sites with the opportunity to visit a lead site to experience strong HRO practices in action. Two additional activities support OA-5— • VHA's Code of Integrity. The Code of Integrity creates a framework for behaviors and conduct in the workplace. The Code of Integrity supports VHA's risk management framework (described in OA-1). • VA's Organizational Values – ICARE. ICARE establishes the values for VA's culture and ensures staff are aware of those values. ICARE stands for Integrity, Commitment, Advocacy, Respect, and Excellence. These core values form the foundation of a Just Culture. Each year all employees recertify their commitment to the core values.
Status VHA has long been a pioneer in patient safety. In 1999, VA established the National Center for Patient Safety. For over 15 years, the Center, working with patient safety officers and managers across VHA, developed a range of innovations including a methodology for root cause analysis that includes events that occurred and close calls (one of the first methodologies of its kind in the health care industry). To expand on this approach, VHA established an HRO Steering Committee in 2018 to adopt HRO principles based on leading VHA practices and industry best practices. In 2019, VHA began its HRO journey with a set of common HRO assessments, training, and improvement activities at 18 lead sites across each region. The 18 lead sites shape transformation for the rest of VHA. Remaining sites (Cohort 2) join the journey in 2020, incorporating lessons learned from the 18 lead sites. This phased approach builds a consistent national effort. VHA's Code of Integrity was published on June 30, 2019. ICARE training reinforces VHA's core values with all VA employees.

The following table describes the measures and metrics used to determine progress toward achievement of OA-5. This metric is taken from the Commit to Zero Harm LOE described in Chapter 1.

Table 2-16. OA-5 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
A patient safety culture demonstrates improved reporting of adverse events and close calls	Metric definition and calculation: Change of adverse event reporting; change of close call reporting, measured at system-wide, regional, and medical facility levels Calculation = For adverse events: # adverse events reported / 10,000 unique veterans. For close calls reported: close calls / 10,000 unique veterans	Change in calendar year 2020 is positive	Q1, Q2, Q3, Q4

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
As part of this analysis, the Measurement Advisory Group selected five safety outcomes to focus on in the first years of the VHA HRO journey: 1. PSI 04 – Death among surgical inpatients with serious treatable complications 2. PSI 12 – Perioperative pulmonary embolism or deep vein thrombosis 3. PSI 13 – Postoperative sepsis 4. Clostridium difficile infection rate 5. Falls with any injury	Metric Definition and calculation: Standard definitions for five safety indicators reported at the enterprise level, as detailed in Chapter 1.	Sustain positive improvement in one or more of the five patient safety harm metrics reported at the enterprise level with appropriate volume of eligible numerator cases, by December 2022	Quarterly

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
The annual VA All Employee Survey (AES) includes a Patient Safety Culture Module. The 15 question Patient Safety Culture Module with 5 established AES questions comprise the Patient Safety Culture Survey as applied to the AES at regional and facility levels. The module shows perceptions around patient safety culture aligned to the following dimensions:	Metric Definition: Percent change trend in improvement in each unit of analysis by December 2021 Calculation = newest feedback value / baseline feedback value, for each unit of analysis These are the units of analysis: • Overall perceptions of patient safety • Communication, openness • Feedback and communication about error • Frequency of event reporting • Non-punitive response to error • Shame • Teamwork within hospital units • Teamwork across hospital units • Patient safety in comparison to other facilities • Perceptions of patient safety at your facility • Education/training resources • Organization learning, continuous improvement • Senior management awareness/actions in promoting safety • Job satisfaction	Change in calendar year 2020 is positive	Twice annually

The following table describes actions to achieve OA-5: VHA supports a Just Culture that fosters trust, integrity, learning, and collaboration.

Table 2-17. OA-5 Action Plan

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
All actions imply effective change management and training are a part of implementation			
(5.1) Commit to Zero Harm			
Actions managed by the Commit to Zero Harm LOE address OA-5			
(5.2) Code of Integrity and ICARE			
Publish Code of Integrity	Q3FY19	June 2019	**Complete.** The VHA Code of Integrity was published on June 30, 2019.
ICARE training for all VA employees		Ongoing	**Sustaining.** This annual requirement has been ongoing for the past 5 years.
(5.3) Integrate Efforts on Culture Change			
Identify organizational entities involved in organizational culture change (e.g., Veterans Experience Office, National Center for Organizational Development, Just Culture) and develop an effective collaborative approach	TBD		**In Planning**

The following table describes actions taken to address GAO's removal criteria.

OA-5 Description of Actions Toward Removal Criteria
Leadership Commitment VHA has long been a pioneer in patient safety. In 1999, VA established the National Center for Patient Safety. For over 15 years, the Center, working with patient safety officers and managers across VHA, developed a range of innovations. VHA established an HRO Steering Committee in 2018 to adopt HRO principles based on leading VHA practices and industry best practices. In 2019, VHA began its HRO journey with a set of common HRO assessments, training, and improvement activities at 18 lead sites across each region. The 18 lead sites shape transformation for the rest of VHA. Remaining sites (Cohort 2) join the journey in 2020, incorporating lessons learned from the 18 lead sites. This sustained leadership commitment builds a consistent national effort. The VHA Code of Integrity is another example of leadership commitment. It was published on June 30, 2019, with training and monitoring activities planned through 2022.

Capacity

HRO leadership capacity is fostered by HRO coaches, who are matched with leaders from the 18 HRO lead sites and Cohort 2 HRO sites to assist in establishing standard HRO leadership practices (e.g., leader rounding, HRO huddle, safety forums, visual management) and progressing on the site-specific HRO plan. In addition, a cadre of training champions will be identified at each medical facility and region to sustain initial training and reinforcement activities during Phase 1 of the VHA HRO journey. By the end of calendar year 2021, the target goal is to have at least 80% of current staff trained in baseline HRO principles, daily practices, and behaviors (including Just Culture, error management, and continuous process improvement) and for a sustainable cadre of training champions to be established and maintained across the medical facilities with oversight, resourcing, and support from the region.

Another example of building and training staff to accomplish the outcomes includes ICARE training, which is focused on the reaffirmation of VA Mission and Values.

Monitoring

The Commit to Zero Harm LOE will monitor its actions. Mandatory ICARE training is monitored through TMS.

Demonstrated Progress

The Measurement Advisory Group selected five safety outcomes to focus on in the first years of the VHA HRO journey:

1. PSI 04 – Death among surgical inpatients with serious treatable complications
2. PSI 12 – Perioperative pulmonary embolism or deep vein thrombosis
3. PSI 13 – Postoperative sepsis
4. Clostridium difficile infection rate
5. Falls with any injury

In addition, the Code of Integrity was published and ICARE training is partly complete.

3. Information Technology Challenges Area of Concern

Executive Summary

VA has made significant strides in advancing IT modernization and fielding critical capabilities for VHA health care delivery. VA updated its action plan to reflect progress on major programs, attainment of key initial operating capability milestones, and improvements enhancing interoperability and availability of reliable data. Successful action plan execution will result in interoperable systems that meet business needs and data that is accurate, reliable, complete, and used to inform decisions. Delivering enhanced IT systems and services will enable VA to meet national commitments in Veteran care encompassed in key programs such as MISSION Act requirements of 2018, VHA modernization, and ongoing program improvement initiatives.

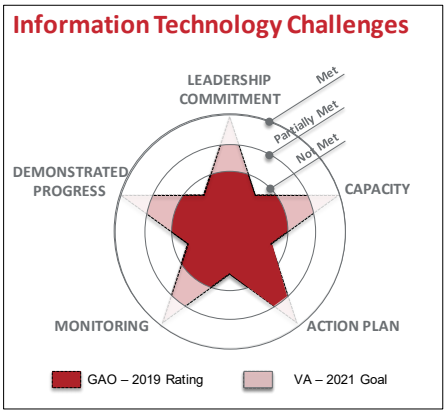


Figure 2-6 Information Technology 2021 Rating Goal

The Office of Information and Technology (OIT) is a critical partner to VHA for successful MISSION Act implementation. OIT stands shoulder-to-shoulder with VHA in fulfilling VA's promise to enhance community care for nearly 3.7 million Veterans. OIT personnel at VA facilities across the country worked around the clock to implement key MISSION Act requirements and deliver enhanced IT systems and services to customers and Veterans by June 6, 2019. In preparation, teams collaborated to embrace the DevOps mindset around MISSION Act – sharing and learning from one another, embracing the connection between business and IT, and offering an improved experience for internal and external customers, rather than just a service. OIT completed milestones in the FY 2020 Joint Business Plan (JBP) for Community Care Referral and Authorization System, Community Care Electronic Data Interchange, Caregiver Record Management Application, and State Prescription Drug Monitoring Program.

OIT instituted JBPs focused on VHA's highest mission priorities. A JBP identifies a discrete set of high-profile work that OIT makes a special commitment for delivery, leadership attention and oversight. JBPs seek balance across multiple VHA priorities. These were executed for FY 2017 through FY 2020. JBP actions that support VHA are highlighted in IT action plans with an initiative number (e.g., FY20 JBP-1 refers to the FY20 VHA and OIT JBP Initiative/Milestones and Metrics).

OIT integrates with all the VHA modernization efforts to ensure IT systems are underway and fully resourced. OIT completed milestones in the FY 2020 JBP on Electronic Health Record Modernization (EHRM). Additionally, OIT completed Supply Chain Modernization milestones in the FY 2020 JBP on DMLSS/LogiCole/Medcoi Implementation.

OIT improved IT delivery to achieve meaningful impact toward target IT AOC outcomes by—

- Delivering on-time, production-ready, incremental releases for major programs (30+)
- Integrating deployments to minimize transitional re-work and manage interdependencies
- Integrating 24×7 incident management teams to triage and resolve issues in real time
- Launching DevOps and Product Line Management transformation to deliver capabilities faster
- Establishing an office to steward EHRM at the Deputy Secretary level
- Empowering VA Interoperability leadership to seamlessly integrate and exchange health information, data and best practices across DOD, industry, and other partners
- Launching the Lighthouse open digital platform enabling rapid industry innovation for Veterans

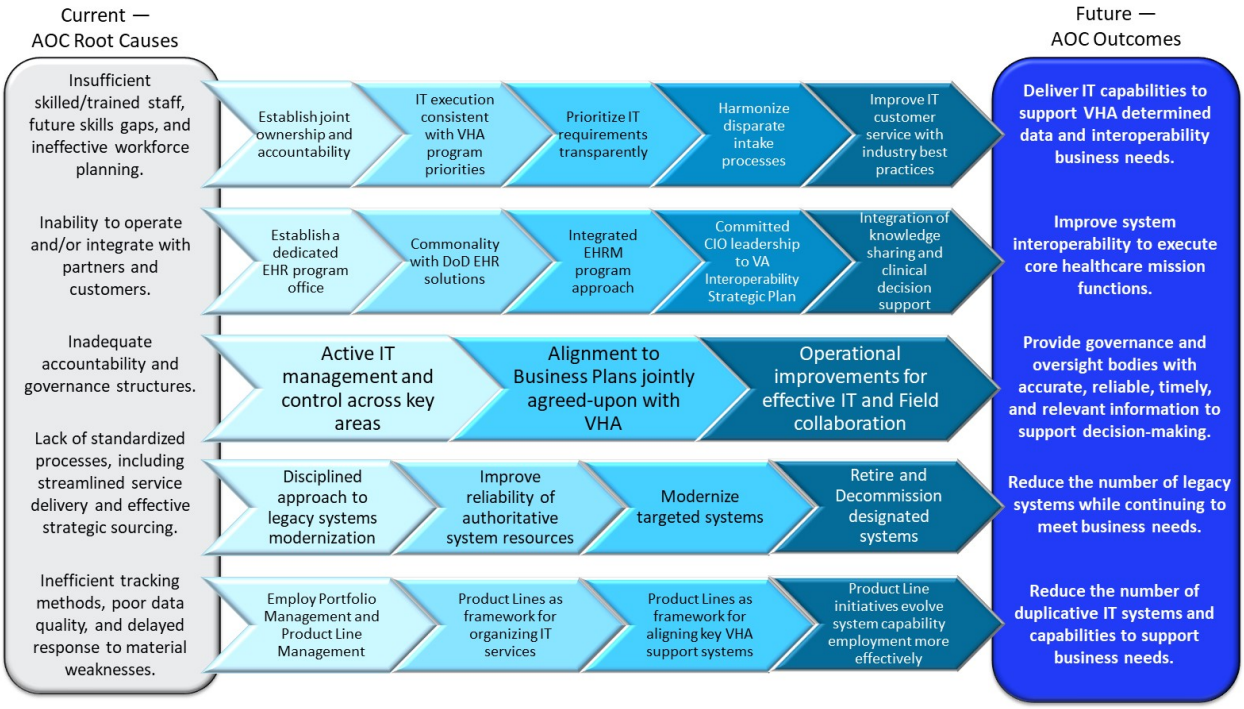
- Aligning IT strategy with business goals through consistent IT governance processes

For direct navigation to an IT Challenges outcome and supporting action plan, click on the links below:

IT-1: Deliver IT capabilities to support VHA-determined data and interoperability business needs
IT-2: Improve system interoperability to execute core health care mission functions
IT-3: Provide governance and oversight bodies with accurate, reliable, timely and relevant information
IT-4: Reduce the number of legacy systems while continuing to meet business needs
IT-5: Reduce the number of duplicative IT systems and capabilities to support business needs

Highlights of the root causes, key actions, and outcomes for IT Challenges are outlined in the following figure.

Figure 2-7 Information Technology Roadmap



Alignment with Other Areas of Concern
Policies and Processes
Ongoing collaboration with the Policies and Processes work group for designing and operating a VHA policy document repository that houses and links VHA national and local policy and policy-related documents, including implementation guidelines and human resources requirements.
Oversight and Accountability
IT systems are critical to the success of Oversight and Accountability. The IT work group will work with VHA to determine requirements to support Oversight and Accountability IT business needs. IT is supporting development of the shared Internal Audit–Compliance and Business Integrity case management capability.
Training

Alignment with Other Areas of Concern
OIT is collaborating with the Training work group to incorporate procedural changes and updates identified in the VHA training oversight directive into Business Intelligence Suite and Talent Management System (TMS) as needed.
Resource Allocation
As further progress is made in integrating manpower and financial management, the IT work group will coordinate with Resource work group to identify IT requirements. OIT is supporting upgrades to HR Smart, part of the Resource work group actions to decrease manpower reporting variance. OIT is also working to deploy a light electronic action framework (LEAF) system to track organizational and position change requests to improve manpower data transparency.

Information Technology Outcome (IT-1)

Outcome Lead: Katrina Tuisamatatele, Health Portfolio Director
Outcome Executive: Dan McCune, Executive Director, Enterprise Portfolio Management and Application

IT-1 Outcome Statement: Deliver IT capabilities to support VHA-determined data and interoperability business needs

Key Outcomes: Systems are interoperable and meet business needs. Data are available and accurate, reliable, complete, and used to inform decisions.

Root Causes: Insufficient skilled/trained staff, future skills gaps, and ineffective workforce planning; lack of standardized processes, including streamlined service delivery and effective strategic sourcing; inefficient tracking methods, poor data quality, and delayed response to material weaknesses; inability to operate and/or integrate with partners and customers

In Planning | **In Progress** | **Complete** | **Sustaining**

IT-1 Description & Status
Description To achieve this outcome, the Chief Information Officer (CIO) and Executive in Charge (EIC) collaborate to address risks and GAO recommendations, and develop the OIT and VHA JBP annually. Under and Assistant Secretaries direct action through Outcome Executives as necessary to mitigate or eliminate risk. OIT and VHA monitor and update progress throughout the fiscal year. A JBP identifies a discrete set of high-profile work that OIT makes a special commitment for delivery, leadership attention and oversight. A JBP seeks to balance across multiple VHA priorities. JBP actions that support this outcome are highlighted in the tables that follow, with an initiative number (e.g., FY20 JBP-1 refers to the FY20 VHA and OIT JBP Initiative/Milestones and Metrics). In addition to the JBP, internal customers are expected to use a single-entry point for IT requests to develop business epics for IT requirements.
Status • Delivered key requirements to support MISSION Act successful launch on June 6, 2019. OIT and VHA approved a JBP for FY 2017 through FY 2020. • In 2019 the VA IT Process Request portal (VIPR) went live and began receiving requests. The Enterprise Cloud Solutions Office is replacing its Enterprise Cloud Service Request form with the VIPR portal request, in accordance with the Unified OIT Intake Process. The new process provides a single-entry point for IT requests previously sent through multiple alternative entry points. • Improved help desk support to VHA, including support from Decision Support Tool development teams as part of delivering continuous improvement. **Examples of OIT Support for VHA Data and Business Needs:** An important example of OIT support for VHA business needs will be met when VHA business owners determine IT requirements are prioritized and underway, or fully resolved. The success of the June 6, 2019 launch of key requirements proved that OIT will deliver on MISSION Act no matter what issues may arise. Delivering a minimum viable product (MVP) does not mean that everything will work perfectly the first time, but OIT employees are ready to address any potential issue that may arise. Fulfilling JBP 1.2, OIT delivered a MVP supporting MISSION Act. Delivering a MVP is a highly complex task, and issues are to be expected, but OIT employees were trained and ready to quickly triage all incoming requests--fostering fluid, two-way communication between users and IT support. To better situate themselves to anticipate and respond to potential issues, the incident response teams conducted MISSION Act Daily Exercises.

IT-1 Description & Status
These scenario-based exercises took the teams through hypothetical resolution processes that required them to think, plan, and respond quickly. After each exercise, the teams discussed thoughts, comments, best practices, and lessons learned to better inform future crisis response scenarios. During go-live OIT's incident management teams from IT Operations and Services and the Enterprise Program Management Office (EPMO) – including the Enterprise Service Desk, Major Incident Management, and Decision Support Tool (DST) Development teams – working in concert with the VHA partners behind the scenes, manned the 24×7 issues bridge line, triaged help desk tickets, monitored problems and trends in real time, and called DST users to resolve their issues. Nearly all DST and MISSION Act-related help tickets were contacted immediately, leading to a smooth, rapid response that represents OIT's strong commitment to improved customer service. The current DST release began user acceptance testing on September 6, 2019. This release corrects Consult Toolbox and VistA defects and adds radiology order functionality. Caregiver Record Management Application (CARMA) continued progress toward Congressionally mandated expansion of the overall VHA Caregiver Support Program. The initial CARMA release in October 2019 replaced the Caregiver Assessment Tool (CAT), providing a new, enhanced case management system for the program. Release 2, released January 2020, automated the stipend process. Release 3, a major portion of which involved integration with and modernization Legacy System program is currently underway, OIT has worked closely with VHA business partners to identify requirements for legacy system modifications and awarded additional VHA Caregiver Support Program contracts. Development is underway to deliver Enrollment, Computerized Patient Record System, and Benefits Gateway Service enhancements to obtain eligibility, medical, and incarceration information for Veterans (FY18-JBP-8). The Account Management Office (AMO) for Health collaborated with other OIT pillars and VHA's Office of Healthcare Informatics, Office of Community Care (OCC), Office of Connected Care, and others to develop the annual VHA and OIT JBP. The initiative began in 2017 and is a component of VHA and OIT's strategy for improved customer service and effort to align to industry best practices. These include IT Infrastructure Library (Service Strategy), and Business Relationship Management Institute recommendations for communicating joint objectives.

The following table describes the measures and metrics the work group uses to determine progress toward achievement of IT-1.

Table 2-18. IT-1 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Consolidated Community Care (CCC) fully supported by modernized IT systems	Percentage of IT components modernized Percentage = total # of modernized CCC IT system components in FOC / total # of planned CCC modernized IT system components	Baseline = 49% Milestone = 65% completed at end of FY19 Target = 100% Q4 FY20	Q1, Q2, Q3, Q4
VIPR Addendum tab is reviewed by OIT AMO Intake Triage	Percentage of IT requests properly reviewed Percentage = total # of IT requests that were reviewed by the Intake Triage Team/ total # of IT requests	Target = 100% of the requests reviewed by the triage team and forwarded to the appropriate Intake team	Q1, Q2, Q3, Q4

The following table describes action plans the IT work group has identified to achieve IT-1: Deliver IT capabilities to support VHA-determined data and interoperability business needs.

Table 2-19. IT-1 Action Plan

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
All actions imply effective change management and training are part of implementation			
(1.1) OIT training programs in place to support this outcome – DevOps, Scaled Agile Framework, and Product Manager training has started. Q1 – Delivery of a minimum viable product for MISSION Act – Decision Support Tool (DST)	TBD		**In Progress.** Started in Q3FY19.
(1.2) FY20 JBP-3 Community Care Referral and Authorization System Q1 – Healthcare Referral Manager (HSRM) Release 8.0 Requirements Close, the IT completed priority and backlog grooming with stakeholders to define scope Q1 – HSRM Release 7.2 National Release Q1 – HSRM Release 7.3 National Release Q2 – HSRM Release 8.0 IOC Start Q2 – HSRM Release 8.0 National Release Q3 – HSRM Release 9.0 IOC Start Q3 – HSRM Release 9.0 National Release	Q3FY20		**In Progress**

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
(1.3) FY20 JBP-4 Community Care Electronic Data Interchange (EDI) Q1 – Deploy Fee Payment Processing System 2.0 (which will replace version 1.0, which is built on technology that is no longer Technical Reference Model compliant) Enterprise Program Reporting System 2.0, and Attachments Retrieval System 2.2 (add additional identified user stories functionality to current production system). Q2 – Deploy EDI Dashboard 1.0 (which allows for the monitoring of EDI transactions through the EDI Gateway), EDI Gateway 2.5 (added functionality that will move all non-compliant transactions off the existing EDI Gateway and have them run through Health Share), and Attachments Retrieval System 2.5. Q3 – Deploy EDI Dashboard 2.0 and EDI Gateway 3.0 (allow for the processing of 835 transactions and will complete the move of the EDI Gateway off the existing server located in the Health Administration Center. The old EDI Gateway bases on Sybase will then be decommissioned.). Q4 – Deploy EDI Dashboard 3.0 (which allows for the monitoring of EDI transactions through the EDI Gateway), enhancements to EDI Dashboard 2.0.	Q4FY20		**In Progress**
(1.4) FY20 JBP-5 Caregivers (CARMA) Q1 – Release 1 Q2 – Release 2 (Stipend and Financial Management Systems integration) Q4 – User Acceptance Training for Release 3 (legacy systems integration and 1010CG) Q4 – Certification	Q4FY20		**In Progress**
(1.5) FY20 JBP-6 State Prescription Drug Monitoring Program – IOC Q1 – Get long-term Prescription Drug Monitoring Program sustainment funding into the Multi-Year Planning. Q2 – Limited production release. Q3 – National release. Q4 – Funding needed for contract year 2.	Q4FY20		**In Progress**

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
(1.6) FY20 JBP-8 Implement DMLSS/LogiCole/ Medcoi Q1 – N. Chicago/FHCC Pilot testing completion 11/27/19 Q2 – VISN 20 Facilities and Cerner testing to begin 12/2/19 Q3 – North Chicago go-live 1/14/20, Spokane go-live 1/22/20, Puget Sound go-live 2/25/20. Q4 – VISN 22 Facilities go-live 3/1/20.	Q4FY20		**In Progress**
(1.7) FY20 JBP-10 Telephony/Call Center Modernization. Q1 – Identify and prioritize additional sites for Phase 2 modernization based on funding identified in FY20 for this purpose. Q2 – Identify the remaining contact center capabilities that will be standardized, to include costs for each capability. Q2 – Identify the data analytics system that will be installed for the enterprise and develop an implementation plan. Q3 – Award a contract for the remaining Phase 2 sites. Q4 – Install servers and routers (phase 2) at the 24 locations for which OIT we currently haves a contract.	Q1FY20 through Q4FY20		**In Progress**

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
(1.8) FY20 JBP-11 Suicide Prevention – Mental Health and Suicide Prevention IT Program Milestones. Q1 – Release new functionalities in the National Clozapine Registry (NCR); release Mental Health Assistant (MHA) with Kiosk capability; Release MHA Web/Mobile v.1, MHA Form Builder v.1, MHA Panel Management Tool v.1 with core functionalities; release Other Than Honorable button in the Computerized Patient Record System, allowing clinicians to identify veterans with this eligibility. Q2 – Release new functionalities in NCR (treatment overrides, blood monitoring forms); release OTH/high risk eligibility integration functionality with enrollment; Release Web/Mobile v.2, MHA Form Builder v.2, and MHA Panel Management v.2 with expanded functionalities; recoding REACHVET to work with Cerner Data complete; provider outreach role-play videos made available; Computerized Patient Record System (CPRS) Note templates available to providers. Q3 – Release clinical reminder for OTH-extended eligibility status; release enhanced treatment copay algorithm for high risk Veterans; release new functionalities for MHA Web/Mobile, including patient-facing plan with graphing and reports. Update predictor version from ~60 to a newly calibrated version with ~130 predictors; update system architecture to improve stability, performance, and maintenance of the system. Q4 – Release new functionalities for MHA Web/Mobile, including provider-facing assessment management tool; (NCR) registration/reporting graphical user interface (GUI) v.1; release OTH reporting dashboard; release methadone dispensing interface v.1.	Q1FY20 through Q4FY20		**In Progress**
(1.9) FY-20 JBP-13 Health Data and Analytics Product Line Platform Q1 – Kickoff meeting with appropriate stakeholders to achieve consensus on the product line objectives and platform needs. Series of meetings to finalize the product line scope such as database and analytics architypes (est December 2019). Q2 – Detailed requirement gathering and draft health data platform architecture diagram (est March 2020). If resources allow, a small pilot for one use case using MVP version or architecture. Q3 – Issue an RFI to solicit feedback from the industry, revise architecture, and establish vendor selection criteria (Est June 2020).	Q1FY20 through Q4FY20		**In Progress**

The following table describes actions taken to address GAO's removal criteria.

IT-1 Description of Actions Toward Removal Criteria
Leadership Commitment The OIT has forged a strong partnership with VHA. Like any business relationship, OIT's relationship with VHA must sustain and enhance mutual trust and must create recurring value in terms of additional capability, cost transparency and efficiency, and innovation. Through the JBPs, business partners in VHA and headquarters program offices help by prioritizing programs. They enable OIT apply DevOps concepts with clear business product ownership, backlog and requirements prioritization, early testing, and frequent and transparent communications.[22] OIT is undergoing a DevOps transformation to better position it to meet the needs of internal business partners, realigning staff to product lines to ensure that both development and operational maintenance needs are met for all products within a Product Line. OIT leadership met and approved of the GAO High Risk plan and actions in late September 2019.
Capacity OIT is undergoing a DevOps transformation to ensure better positioning and alignment to meet the needs of internal business partners, realigning staff to product lines to ensure that both development and operational maintenance needs are met for all products within a product line. During this transformation, OIT has trained staff on Scaled Agile Framework to ensure that all projects are using Agile with best practices for success. Additionally, this transformation is being undertaken using multiple work groups to ensure alignment with internal business partners and proper alignment of new and existing products within product lines.
Monitoring OIT has established an Enterprise Monitoring Strategy in which specific monitoring measures must be applied to all applications before an Authority to Operate will be granted. OIT instituted the Veteran-focused Integration Process (VIP), a lean-Agile Framework, to service the interest of Veterans through the efficient streamlining of IT activities that occur with the IT enterprise. VIP is a significant step forward for the VA, allowing for more frequent delivery of essential IT services, via a no-longer-than three month cadence. Additionally, OIT established regular program management reviews at multiple levels, including briefing executive leadership on schedule, scope, risk/issues, and budget. This plan's metrics and measures provide the mechanisms to assess and report progress to GAO. With the introduction of metrics and measures, monitoring processes and procedures will be formalized.
Demonstrated Progress OIT has made a continued commitment to ensure implementation of IT requirements meets the needs of VHA. Specifically, OIT continues to implement an IT system that fully supports VHA's Caregiver Program as recommended by GAO (14-675). OIT holds daily scrum meetings and program reviews, where key milestones for the critical path for release of each capability is discussed to ensure all roadblocks are identified and mitigated to ensure successful execution.

[22] Department of Veterans Affairs Office of Information Technology (OIT), Partnership is critical to VA's success, Chief Information Officer Messages, September 24, 2019

Information Technology Outcome (IT-2)

Outcome Lead/Executive: Helga Rippen, MD, Deputy Director, DOD/VA Interagency Program Office
Outcome Executive: Paul Tibbits, MD, Executive Director, Office of Technical Integration

IT-2 Outcome Statement: Improve system interoperability to execute core health care mission functions

Key Outcomes: Systems are interoperable and meet business needs; data are available and accurate, reliable, complete, and used to inform decisions

Root Causes: Lack of standardized processes, including streamlined service delivery and effective strategic sourcing; inadequate accountability and governance structures; inability to operate and/or integrate with partners and customers

In Planning | **In Progress** | **Complete** | **Sustaining**

IT-2 Description & Status
Description VA established the Office of Electronic Health Record Modernization (OEHRM), which reports directly to the Deputy Secretary of VA. OEHRM is responsible for ensuring VA successfully prepares for, deploys, and maintains the new EHR solution and the health IT tools dependent on it. OIT is currently finalizing the system interface plan for Electronic Health Record Modernization (EHRM). EHRM (FY20-JBP7) will give VA clinicians and physicians comprehensive access to patients' health records from their time in active duty through their status as a Veteran, improving care coordination between DOD and VA and ensuring seamless access to care. EHRM is a major business transformation led by OEHRM in support of the Veterans Health Administration. The modernization effort is adopting the same commercial EHR as DOD, which will improve interoperability, access to care, standardized provider workflows, infrastructure readiness, and return on investment. The EHRM effort has three major components, 1) modernize VA's legacy systems and associated infrastructure required to support a new industry-leading EHR solution; 2) provide Veterans and clinicians with a complete picture of patients' medical history, driving connections between military service and health outcomes through data analytics; and 3) implement a new EHR solution that is interoperable with DOD and community care providers, enabling the seamless sharing of records. VA is working with Cerner to achieve initial operating capability (IOC) of VA's new EHR solution in the Pacific Northwest, including three anchor locations: VA Puget Sound Health Care System–American Lake Division, VA Puget Sound Health Care System–Seattle Division, and Mann-Grandstaff VA Medical Center. As DOD has already deployed to this region, VA selected the Pacific Northwest to maximize efficiencies through DOD's lessons learned. This strategy also allows VA to leverage DOD's data hosting environment and adopt enhanced cybersecurity protocols to facilitate interoperability. To achieve this outcome, OIT and VHA collaborate to address risks and GAO recommendations, and develop the OIT and VHA JBP annually. Assistant and Under Secretaries direct action through Outcome Executives as necessary to mitigate or eliminate risk. OIT and VHA monitor and update progress throughout the fiscal year. Internal stakeholders will continue to develop and monitor the annual VHA and OIT JBPs. OIT and stakeholders address sustainability requirements to meet business needs on a continuous basis.
Status Full implementation at all VA facilities will be staggered over the next 10 years, during which VA will integrate every possible efficiency into the deployment process. VA Puget Sound Health System and Mann-Grandstaff VA Medical Center, part of Veterans Integrated Service Network (VISN) 20 in the Pacific Northwest, have been selected as IOC sites to deploy the new EHR. OEHRM has conducted current state reviews for these sites and staff began testing the new EHR in March 2020. Cerner Scheduling Program Management Resolved: OEHRM will supply the technical program management support for Cerner Standalone Scheduling Program Management. Once completed, the Cerner Scheduling

IT-2 Description & Status
Program will significantly improve the VA health care experience by giving thousands of clinicians and specialists ready access to a comprehensive view of their patients' records, resulting in streamlined scheduling, faster and more accurate diagnoses, and better treatment options. The VA Interoperability Leadership Team (VAIL) serves as a coordinated leadership body focused on ensuring all steps of the Veteran experience are seamlessly enabled through interoperability of the systems that support them. The activities of the Interoperability Leadership Team reach across the VA, the Federal Electronic Health Record Modernization (FEHRM), DOD, health care sector, and other partners' activities, governance, standards, tools, architecture, applications, policies, and processes related to the exchange of health information, data, and best practices for any purpose. The VA CIO is the lead executive sponsor who authorizes the establishment of the VAIL and empowers the VA Interoperability Leadership Team Chair to establish a charter and ensure conformance to the charter. Each Administration and Office impacted by health interoperability will also be executive sponsors that support the establishment of the VAIL and will provide the staffing and resources, as needed, to move forward the activities that align with their business needs. OIT will also support the operations of the VAIL. The VAIL represents all the stakeholders across VA that are impacted or have leadership roles relevant to health interoperability. The VAIL Executive Council consists of select members of VHA, VBA, OEI, OIT, Veteran Experience Office (VEO), OEHRM, and FEHRM/DOD/VA Interoperability Program Office. Lighthouse, formerly known as Digital Veterans Platform, is VA's Application Programming Interface (API) management platform. Lighthouse is a next generation open digital platform that enables rapid innovation in core VA functions by giving external developers access to the data and tools they need to build apps on a standard set of APIs designed for Veterans. Lighthouse is the "front door" to VA's vast data stores – giving developers the ability to design technology solutions that leverage data and serve Veterans. Lighthouse supports access to 600 back-end systems across VA and gives developers the tools they need to build applications on a standard set of APIs designed for Veterans. Micro purchases will play a big role in the development of the Lighthouse ecosystem – allowing developers to bid on short-term projects needed to build out a consistent architecture, security controls, strategy, roadmap, and outreach approach. The Defense Medical Logistics Standard Support System Integration team reviewed all functional file transactions. The Systems Integration Working Group continues the business architecture analysis based on input received from involved stakeholders. They are awaiting input from OEHRM to ensure a complete analysis. The AMO for Health collaborated with other OIT pillars and VHA's Office of Healthcare Informatics, Office of Community Care, Office of Connected Care, and others to develop the annual VHA and OIT JBP.

The following table describes the measures and metrics the work group uses to track progress toward achievement of IT-2.

Table 2-20. IT-2 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Initial electronic health record modernization (EHRM) deployment to regions	Percentage of the total regions that have modernized EHR = total # of regions with modernized EHR IOC / total # of planned modernized EHR IOC regional deployments	11% in FY20; 17% in FY21; 28% in FY22; 50% in FY23; 56% in FY24; 72% in FY25; 83% in FY26; 94% in FY27 Target = 100% in FY28	Q2, Q4

The following table describes actions the IT work group have identified to achieve IT-2: Improve system interoperability to execute core health care mission functions.

Table 2-21. IT-2 Action Plan

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
All actions imply effective change management and training are a part of implementation			
(2.1) VAIL serves as the single point of convergence and alignment for interoperability across the VA	TBD		**In Progress**
(2.2) VAIL adjudicates and addresses gaps in activities, governance, standards, tools, architecture, applications, policies, contract requirements, and processes relating to exchange of health information/data as needed	TBD		**In Progress**
(2.3) VAIL serves as the FEHRM's VA point of contact as it relates to DOD/VA health interoperability activities to ensure that VA's strategy, requirements and priorities guide their work; e.g., Joint DOD/VA Interoperability Strategic Plan Interagency Interoperability Technical Plan, standards development activities, and federal policy development	TBD		**In Progress**
(2.4) VAIL develops a VA Interoperability Strategic Plan and tracks progress through an interoperability maturity index	TBD		**In Progress**
(2.5) VAIL advises VA senior leadership on emerging technology to address interoperability issues requiring guidance and support	TBD		**In Progress**
(2.6) EHRM moves forward through IOC and beyond. • Interoperability with DOD and Private Sector • Internal Interoperability – Supply Chain RC3 infrastructure upgrades, VISTA Sustainment, VistA Scheduling Enhancements (VSE) and VA Online Scheduling Sustainment, Cerner Scheduling • Fast Health care Interoperability Resources (FHIR) – Next generation standards framework • Health Level Seven (HL7) International – Development of international health care informatics interoperability standards	Q3FY20		**In Progress.** Ongoing 10-year program.

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
(2.7) API development business epics submitted: • Integrate more effectively with outside health care community and generate greater opportunities for collaboration across the care continuum with private sector provider. • Effectively shift technology development to commercial EHR and administrative systems vendors that can integrate modular components in the IT enterprise through open APIs, allowing VA to adopt more efficient and effective management processes • Foster an interoperable, active, innovation ecosystem of solutions and services through APIs that contributes to the next generation of care and benefits models that are evidence-based, tiered, and connected across the continuum of engagement • Create open and accessible APIs that can be used not only for Veterans, but also for advanced knowledge sharing, clinical decision support, technical expertise, and process interoperability with organizations through the U.S. care delivery system	Q3FY18	TBD	**In Progress**
(2.8) Designate approved data sources through the Data Governance Council (DGC) Working Group: • Leverage best practices and analytics maturity frameworks to guide, develop, and implement an efficient and effective VA-wide analytics strategy • Provide a suggested continuum of training • Continually elevate awareness of the possibilities for high-end analytics throughout VA • Promote awareness of resources and tools to VA analysts	Q3FY19	TBD	**In Progress.** DGC to approve the implementation of a standing work group that combines elements of a Community of Practice and leverages them to advance VA's strategic objectives. Charter and governance to be determined.
(2.9) Business Process Re-Engineering (BPRE): • OEHRM conducts BPRE through monthly workshops at Cerner HQ in Kansas City. • Financial Management Business Transformation (FMBT) conducts BPRE sessions to improve business processes • DMLSS conducts BPRE to improve business processes			**Sustaining.** OEHRM meets monthly in Kansas City with Cerner. FMBT has already conducted several BPRE sessions. DMLLS BPRE is ongoing.

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
(2.10) FY20 JBP-7 Electronic Health Record Modernization (EHRM) Q1 – Groups 1-6 Interfaces Complete; Mann – Grandstaff: Superuser Training; Replicate Millennium Data to VA; JPIMS, SSOe, SSOI in Pre-Production; Technical Design Review Complete; IOC Go-Live Planning Complete; WAN Bandwidth Upgrades Complete; Printer and other Device Deployment Complete; Conduct Integration Validation Test Readiness Review; Integration Validation Test 1 MG Start; Clinical Workflows. Q2 – Develop EHRM interfaces as follows: IFCAP, BMS, Patient Record Flag (PRF), and PCMM Web; Remediate technical obsolescence and increase data handling capability of PCMM Web system; Mock go-Live (Clinical); Superuser training; Go-Live Readiness Determination; Complete implementation/Integration of Cybersecurity Operations Center (CSOC); IOC Medical Device ATC's Approved; Cerner Equipment Installation Complete; Data Integration Completed; Go-Live Mann-Grandstaff and WCPAC. Q3 – Post Go-Live Review. Q4 – Fiber Backbone Upgraded (American Lake Campus); ACQ1 Completion of Upgrade Telecomm, IT Closets/Fiber backbone, CAT 6A, Cable Management (Spokane).	Q1FY20 through Q4FY20		**In Progress**
(2.11) VA and DOD Federal Electronic Health Record Modernization (FEHRM) Implementation Plan. The FEHRM will be accountable to both DOD and VA Deputy Secretaries to make timely, authoritative decisions to efficiently manage technical, programmatic, and functional requirements in support of the Departments' EHR modernization objectives. The FEHRM will be an agile, coordinated decision-making management structure to accurately and efficiently implement a single, seamlessly integrated EHR. RC4, RC5.	Q3FY19	Implementation of FEHRM Delayed until FY20.	**In Progress.** Secretaries Wilkie (VA) and Mattis (DOD) signed a Joint Commitment Statement on September 28, 2018, pledging to align VA and DOD Strategies to implement an interoperable EHR system. The FEHRM is a result of a Joint EHR Modernization Work Group to assess modernization strategies and organizational structures.

The following table describes actions taken to address GAO's removal criteria.

IT-2 Description of Actions Toward Removal Criteria
Leadership Commitment In August 2018, OEHRM held a program kickoff hosted by Cerner Corporation. This event officially started the implementation of the Cerner Electronic Health Record solution for VA and generated tremendous enthusiasm and commitment. Over the course of this 3-day event, VA and Cerner senior leaders and EHRM partners engaged in variety of sessions and discussions on topics including— • Goals of interoperability and innovation • Veteran stories about how a modernized EHR will positively impact their VA health care experience • EHRM products and solutions in action These sessions were designed to give leadership a more comprehensive understanding of the program and implementation plan. The event was the first in a series to engage health care providers and other stakeholders in the development, deployment, and full implementation of the new EHR solution. Working together with all stakeholders, the EHRM team will ensure that program goals are achieved, and Veterans continue to have access to the high-quality health care they deserve.
Capacity The OEHRM will— • Standardize clinical and business processes across VA Enterprise • Ensure decision making and design are be driven by front-line and clinical staff • Drive toward rapid decision-making to keep the program on time and on budget • Design a flexible and open, single solution • Provide timely and complete communication, training, and tools to ensure successful deployment • Incorporate clinical business process reengineering, adoption, and implementation over technology • Build collaborative partnerships outside VA to advance national interoperability • Configure, not customize • Enable full Veteran engagement in their health care
Monitoring BPRE: • OEHRM conducts BPRE through monthly workshops at Cerner HQ in Kansas City. • FMBT conducts BPRE sessions to improve business processes. FMBT has already conducted several BPRE sessions. • DMLLS conducts BPRE to improve business processes. DMLLS BPRE is ongoing. • OEHRM meets monthly in Kansas City with Cerner. This plan's metrics and measures provide the mechanisms to assess and report progress to GAO. With the introduction of metrics and measures, monitoring processes and procedures will be formalized.
Demonstrated Progress Multiple teams across OEHRM are preparing for VA to go live with its new EHR solution at the IOC sites in the Pacific Northwest starting in March 2020. These preparations include updating the telecommunications infrastructure and assessing how ready the onsite staff are for the coming changes. Infrastructure upgrades: OEHRM's Technology and Integration Office infrastructure team worked with OIT, VHA, and the VA Office of Construction and Facilities Management to update the onsite telecommunications infrastructure, including servers, circuitry, equipment, devices, cables, fiber networks, and cooling and security systems.

Information Technology Outcome (IT-3)

Outcome Lead: Bonnie Walker, MBA Director, IT Enterprise Strategic Planning and Governance
Outcome Executive: Martha Orr, Deputy CIO, Quality, Privacy and Risk

IT-3 Outcome Statement: Provide governance and oversight bodies with accurate, reliable, timely, and relevant information to support decision making

Key Outcomes: Systems are interoperable and meet business needs; data are available and accurate, reliable, complete, and used to inform decisions

Root Causes: Inadequate accountability and governance structures; inability to operate and/or integrate with partners and customers

In Planning | **In Progress** | **Complete** | **Sustaining**

IT-3 Description & Status
Description The IT Governance Board (ITGB) serves as the IT senior-level leadership forum for IT governance within the Office of Information and Technology. The IT Governance Board's responsibility spans the culture, organization, policy, and practices that provide for IT management and control across five key areas: 1) Alignment, 2) Value Delivery, 3) Risk Management, 4) Resource Management, and 5) Performance Management. To achieve this outcome, ITGB will provide a final verdict, if necessary, on OIT Governance Board decisions, including acquisition-related decisions, when the Board and Councils are unable to come to a consensus. The ITGB will provide strategic direction of IT and the alignment of IT and the business with respect to services and projects, confirm that the IT/Business organization is designed to drive maximum business value from IT, and oversee the delivery of value by IT to the business and assess return on investment. ***Councils*** • Program & Acquisition Review Council: Co-Chairs • Standards & Architecture Council (SAC) • Organization & Workforce Council (OWC) ***Committees*** • Organizational Planning Committee • Transformation Committee • Budget, Programming and Acquisition Committee • Quality & Risk Committee • Operations and Portfolio Management Committee • Architecture and Data Management Committee • Information Security Committee • Analytics and Performance Management Committee • Talent Management Committee The Federal Electronic Health Record Modernization (FEHRM) Program will provide a single point of authority for VA and DOD. As such, the FEHRM directs each Department to execute joint decisions for technical, programmatic, and functions under its purview and has the authority to provide oversight regarding required funding and policy as necessary. The technical, programmatic, and functional joint organizational leads will coordinate within their VA and DOD respective communities to ensure requirements are executed.

IT-3 Description & Status
VHA is adopting the health care high reliability organization as its managerial framework for transformational change.[23] VHA will ground all initiatives in a broader set of foundational HRO principles, tools, and techniques – 1) management control, 2) risk control and compliance, and 3) independent assurance – to provide overall quality assurance. Clinical and administrative elements of the transformation will work to create a VHA in which governance and oversight mechanisms provide reasonable assurance that requirements are met. The Account Management Office for Health collaborated with other OIT pillars and VHA's Office of Healthcare Informatics, Office of Community Care, Office of Connected Care, and others to develop the annual VHA and OIT JBP.

The following table describes the measures and metrics the work group uses to determine progress toward achievement of IT-3.

Table 2-22. IT-3 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
ITGB provides direction for strategy and vision of VA OIT	Percentage of IT acquisitions over $15M approved = # acquisitions over $15M reviewed / total acquisitions over $15M Number OIT decisions reviewed by the ITGB Count = less is better	100% of IT acquisitions approved by ITGB in FY20 Less than 30 OIT decisions require review in FY20	Q2, Q4

[23] Department of Veterans Affairs Veterans Health Administration (VHA), *VHA Plan for Modernization: Every Patient. Every Time. Excellence.*, December 12, 2018

The following table describes action plans IT work group have identified to achieve IT-3: Provide governance and oversight bodies with accurate, reliable, timely, and relevant information to support decision making.

Table 2-23. IT-3 Action Plan

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
All actions imply effective change management and training are a part of implementation			
(3.1) ITGB provides direction for strategy and vision of VA OIT.	Ongoing	FY20	**Sustaining**. This is a regular function of the ITGB. • ITGB review/approve Chairs for Councils. • ITGB review and approve acquisitions greater than $15M • ITGB provide final verdict, if necessary, on OIT Governance Board decisions
(3.2) Provide for strategic direction of IT and the alignment of IT and the business with respect to services and projects.	Q4FY20		**Sustaining**. This is a regular function of the ITGB.
(3.3) FY20 JBP-2 VHA HRL – IT Challenges Q1 – Finalize outcome/measure content; submit IT Challenges Chapter 2 input to stakeholders for final review; VHA Executive in Charge review; Steering Committee review; VA Executive Board review; VA Operations Board review. IT Challenges Outcomes 1–5 execute Q1 action plans and Outcome Leads/Executives update the GOAL Office in accordance with the Change Management Plan. Q2 – Review changes to Chapter 2 IT Challenges and submit final update to GOAL Office; VA submits final update to GAO; VA OPS Board review. IT Challenges Outcomes 1–5 execute Q2 action plans and Outcome Leads/Executives update the GOAL Office in accordance with the Change Management Plan. Q3 – IT Challenges Outcomes 1–5 execute Q3 action plans and Outcome Leads/Executives update the GOAL Office in accordance with the Change Management Plan. Q4 – IT Challenges Outcomes 1–5 execute Q4 action plans and Outcome Leads/Executives update the GOAL Office in accordance with the Change Management Plan.	Q1FY20 through Q4FY20		**In Progress.** OIT Outcome Executives and Leads monitor progress of action plans throughout FY20.

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
(3.4) FY20 JBP-1 Addressing FY20 Budget Realities Q1 – Develop initial FY20 funding capability gap assessment and funding risk profile. Monthly – Status updates to stakeholders (CIO, VHA Senior Leadership, VA Senior Leadership).	Q1FY20 through Q4FY20		**In Progress**
(3.5) Governance & Accountability Boards & Councils (Program & Acquisition Review Council [PARC], Standards & Architecture Council [SAC], and Organization & Workforce Council [OWC]): • Establish IT Governance Framework • Provide for strategic direction of IT and the alignment of IT and the business with respect to services and projects. • Confirm that the IT/Business organization is designed to drive maximum business value from IT. Oversee the delivery of value by IT to the business and assess return on investment. • Risk Management – Ascertain that processes are in place to ensure that risks have been adequately managed. Include assessment of the risk aspects of IT investments. • Resource Management – Provide high-level direction for sourcing and use of IT resources. Oversee the aggregate funding of IT at enterprise level. Ensure there is an adequate IT capability and infrastructure to support current and expected future business requirements. • Performance Management – Verify strategic compliance, i.e., achievement of strategic IT objectives. Review the measurement of IT performance and the contribution of IT to the business (i.e., delivery of promised business value).	Q4FY20	Ongoing	**In Progress.** Establishment of IT Governance Framework was completed

The following table describes actions taken to address GAO's removal criteria.

IT-3 Description of Actions Toward Removal Criteria
Leadership Commitment The OIT Enterprise Strategic Planning and Governance (ESPG) Team works with leaders and stakeholders across throughout VA and supporting administrations to develop the IT Strategic Plan and execute the plan through a mature governance framework. The ESPG team endeavors to coordinate activities and support key stakeholders to align and maintain the strategic goals with resources, funding, and organizational initiatives and deliver results. The VAIL will serve as a coordinated leadership body focused on ensuring all steps of the Veteran experience are seamlessly enabled through interoperability of the systems that support them. The activities of the Interoperability Leadership Team reach across the VA, FEHRM, DOD, health care sector, and other partner activities, governance, standards, tools, architecture, applications, policies, and processes related to the exchange of health information/data/best practices for any purpose.
Capacity The OIT Governance Framework aligns with OIT's strategic goals, enhances the core values of OIT customer service, and promotes interoperability and standardization in OIT. The Organization & Workforce Council develops competency requirements for IT staff and leadership, to maintain an agile workforce; to recruit and retain IT talent needed for VA's mission accomplishment; to create workforce policies, strategies, processes, and models; and to promote the necessary skills and experience for leadership to drive cultural change and reach the demonstrated maturity level. The Organization & Workforce Council— • Determines potential organizational asset needs, such as space and facilities, and human capital • Creates HR policies, core competencies, training, processes, and procedures aligned with Strategic Planning • Supports space and facility policies, training, processes, and procedures • Evaluates customer service and performance metrics
Monitoring IT Governance is putting processes and structures in place to align IT strategy with business goals. For OIT, this means implementing an IT Infrastructure Library-based framework and governance boards to replace less effective processes. The IT Enterprise Governance Framework does the following— • Enables VA and OIT's Strategic Plan • Ensures all initiatives are aligned with VA's mission and vision • Identifies decision owners and solidifies decision rights for OIT senior leadership, to make the right decisions, at the right time, with the right stakeholders • Aligns operations, policies, and procedures to increase cost savings • Positions OIT to efficiently manage and execute the budget • Provides sustainable support for VA's transformation priorities
Demonstrated Progress OIT established a Chief Risk Officer position to better serve and protect Veterans who have been involved with identifying and disseminating root cause analysis. OIT Quality, Performance, and Risk pillars have aggressively pursued processes and procedures for addressing GAO recommendations in VHA Health Care IT and developing plans to address IT challenges identified in this AOC.

Information Technology Outcome (IT-4)

Outcome Lead: Mark Ennis, Senior Solution Architect
Outcome Executive: Drew Myklegard, Executive Director, Project Special Forces

IT-4 Outcome Statement: Reduce the number of legacy systems while continuing to meet business needs

Key Outcome: Systems are interoperable and meet business needs; data are available and accurate, reliable, complete, and used to inform decisions

Root Causes: Lack of standardized processes, including streamlined service delivery and effective strategic sourcing; inability to operate and/or integrate with partners and customers

In Planning	In Progress	Complete	Sustaining

IT-4 Description & Status
Description
To execute this responsibility, the OIT Associate Deputy Assistant Secretary created and tasked the Legacy Systems Modernization (LSM) Working Group. The LSM Working Group Chairperson, identified and tasked by the Associate Deputy Assistant Secretary EPMO, is responsible for the development, implementation, and maintenance of this LSM Working Group Charter.[24] The LSM Working Group is charged with cataloging current plans for system modernization and/or decommission, and facilitating decision making about legacy systems for which plans do not yet exist. The LSM Working Group is also responsible for ensuring a consistent, up-to-date view of legacy system status reporting, strategic roadmap, and decision data across VA.
To achieve this outcome, the LSM Working Group will conduct thorough and complete evaluations and assessments, including functional, cost and schedule, technical, security, and operational characteristics for groups of systems. The LSM Working Group will document assessment process and results as an auditable record and a reference for future assessments.
An important business capability to achieve this outcome is the LSM Working Group's ability and authority to monitor subsequent activities regarding system disposition and report status to EPMO management on a regular basis.
Legacy system modifications status:
Conducted initial requirements meeting with IT points of contact (POCs) for legacy systems and the VHA Caregiver Support Program team to discuss requirements elaboration, prioritization, and preliminary schedule. Leveraged VIPR/Intake process. OIT collaborated with internal business partners performing analysis of alternatives on proposed commercial-off-the-shelf solutions supporting the requirements of the VHA Caregiver Support Program to implement the MISSION Act. Held in-person sessions of OIT, VHA Caregiver Support Program team, and business partners on July 16–19, 2019 to refine requirements, identify dependencies and risks, and develop preliminary systems modifications plans to support implementation of the IT system required by section 162 of the MISSION Act.
The Program of Comprehensive Assistance for Family Caregivers (PCAFC) is currently open only to eligible Veterans who incurred or aggravated a serious injury in the line of duty on or after September 11, 2001, and their family caregivers. By developing the Caregiver Record Management Application (CARMA), VA is establishing IT foundations to support the program's expansion under the MISSION Act. CARMA enables VA to process, track, and manage PCAFC applications; automates the stipend payment process; and improves existing reporting functionality. CARMA is a commercial-off-the-shelf (COTS) solution that leverages multiple processes

[24] Department of Veterans Affairs Office of Information and Technology, Legacy Systems Modernization Working Group (LSM Working Group) Charter, v.1.0, June 19, 2019, Page 5.

IT-4 Description & Status
to iteratively deliver a high-functioning product and allow for better oversight and future product updates to support PCAFC's expansion. Phase 1, which launched in fall 2019 replaced the legacy system with increased data integrity and allowed for improved oversight at the medical facility level. Phase 2, launched in January 2020, automated the stipend process. On January 16, 2018, OIT issued a memorandum on "Use of Enterprise Cloud (VAEC) to Host Applications." The memorandum clarifies and affirms VAEC for new applications development, testing, and production, including COTS solutions. Application developers should establish a development, test, and pre-production environment in the cloud that supports Agile development and sustainment. Plans are ongoing for migrating applications to the VAEC at a mutually agreed time frame by the Cloud Executive and the Enterprise Cloud Solutions Office. Exceptions to the use of VAEC for new development, test, and production will require CIO approval and the approval of the OIT Standards & Architecture Council. The VAEC is an evolving entity that is built through an ongoing collaborative effort between the VA's business and technology communities and the Office of Enterprise Architecture within OIT. As organizational goals, priorities, business needs, and plans change, the VAEC is updated to maintain its relevance as a transformation tool and authoritative information resource. The VA System Inventory (VASI) is the authoritative source for VA IT systems and identifies the stewards responsible for maintaining the accuracy, integrity, and availability of the information contained in VASI. VAEC serves as a strategic planning and management tool to help VA leadership execute transformation throughout VA. Enterprise cloud products are informed by and support the Department's business and operational visions, strategies, and mission. For VA to achieve its mission, the VAEC must be viewed as an authoritative source for the information it makes available to end users. The VAEC's integrated views of strategic goals, mission, support services, and data and IT provide the requisite information to enable it to serve as the authoritative reference for issues of ownership, management, resourcing, performance goals, and design and documentation of systems and services. The VA Technical Reference Model (VA TRM) is one component within the overall enterprise architecture that establishes a common vocabulary and structure for describing the IT used to develop, operate, and maintain enterprise applications. The VA TRM includes the standards profile and product list, serves as a technology roadmap, and is a tool for supporting OIT. The TRM site is used to determine the technical alignment of projects/programs as part of the Veteran-Focused Integration Process. This site includes directions for use as well as the process for submitting new technologies to be evaluated and included in future releases of the VA TRM. Users can search for technologies, generate reports, review forecasts, and access release history. Adhering to the VA TRM is essential to improving the technical environment at VA. Architecture & Engineering Services has overall responsibility for VA TRM.

The following table describes the measures and metrics the work group uses to determine progress toward achievement of IT-4.

Table 2-24. IT-4 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Conduct thorough and complete evaluations and assessments, including functional, cost and schedule, technical, security, and operational characteristics	Percentage of assessments completed = # of completed assessments that meet all information criteria / total # of assessments needed	Baseline/Completed FY19=15% Dev/In-progress FY20=24% Target FY20=40%	Q2, Q4

The following table describes action plans IT work group have identified to achieve IT-4: Reduce the number of legacy systems while continuing to meet business needs.

Table 2-25. IT-4 Action Plan

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
All actions imply effective change management and training are a part of implementation			
(4.1) LSM Working Group monitors subsequent activities regarding system disposition; reports status to EPMO management on a regular basis.	Ongoing		**In Progress**
(4.2) Conduct thorough and complete evaluations and assessments, including functional, cost and schedule, technical, security, and operational characteristics for groups of systems. Document assessment process and results as an auditable record and a reference for future assessments.	Ongoing		**In Progress:** Currently, VA enterprise architecture has quarterly major releases (October, January, April, and July). However, the VAEC development process supports interim releases that can be published on an as-needed basis. There are multiple mechanisms used to enable VAEC stakeholders to distinguish updates between releases.
(4.3) Catalog current plans for system modernization and/or decommission, and facilitating decision making about legacy systems for which plans do not yet exist.	Ongoing		**In Progress**
(4.4) Retire designated systems: Continue to manage system ONLY as emergency backup for target system; in coordination with all stakeholders, validate that the system can be turned off, and get approval to do so; initiate planning for decommissioning; consider reduction in support resourcing.	Initiated		**In Progress**
(4.5) Decommission designated systems: Turn system off; initiate system disposal activities, including removing system software from system infrastructure, unplugging/sanitizing/ dispositioning system hardware, archiving data, canceling maintenance agreements, and reassigning personnel; VASI Production Status changes to “Inactive.”	Initiated		**In Progress**

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
(4.6) Modernize: Reengineer/Redesign/Update (e.g., to address issues in Legacy system or adapt legacy system to other more modern platforms/infrastructure). This includes modifications needed to transfer capability from another system, or activating an existing, dormant capability that will subsequently perform this inherited function.	Ongoing		**In Progress**
(4.7) FY20 JBP-12 Cloud Migration/National Solutions/Enterprise Solution Q1 – Hold a dedicated offsite with all appropriate stakeholders to better understand issues and propose process updates to address these needs (December 2019). Q2 – Develop/establish the initial processes/process changes (Est. March 2020). Q3 – Communicate new process to the OIT and VHA organization (est June 2020). Q4 – Demonstrate initial use cases using new process model (est September 2020).	Q1FY20 through Q4FY20		**In Progress**

The following table describes actions taken to address GAO's removal criteria.

IT-4 Description of Actions Toward Removal Criteria
Leadership Commitment • Established Legacy Systems Modernization (LSM) Working Group charged with cataloging current plans for system modernization and/or decommission, and facilitating decision making about legacy systems for which plans do not yet exist. • Established long-term priorities and goals via VHA and OIT JBP. • Issuing policy directives to migrate legacy systems to VA Enterprise Cloud. OIT initiated a memorandum on "Use of Enterprise Cloud (VAEC) to Host Applications." This memorandum further clarifies and affirms the use of VAEC for new applications development, testing, and production. • Providing continuing oversight by leveraging the VA System Inventory (VASI) as the authoritative source for VA IT systems and identifying stewards responsible for maintaining the accuracy, integrity, and availability of information contained in VASI.
Capacity • Establishing contract and government staffs to support LSM Working Group with specific responsibilities • Establishing and maintaining LSM assessment methodology and performance dashboard • Improved collaboration with business and OIT • Providing guidance and training to staff and addressing skills gaps
Monitoring • Ensuring data quality/adequacy or using third-party assessments and validation • Holding frequent review meetings to assess status and performance • Reporting to senior managers on program progress and potential risks • Tracking performance measures and progress against goals • This plan's metrics and measures provide the mechanisms to assess and report progress to GAO; with the introduction of metrics and measures, monitoring processes and procedures will be formalized
Demonstrated Progress • Implementing GAO recommendations • Using data to show action on plan implementation • Showing high risk issues are being effectively managed and root causes are being addressed • Taking actions to ensure progress (or improvements) is sustained

Information Technology Outcome (IT-5)

Outcome Lead: Dan Higgins, Director of Agile Center of Excellence
Outcome Executive: Dan McCune, Executive Director, Enterprise Portfolio Management and Application

IT-5 Outcome Statement: Reduce the number of duplicative IT systems and capabilities to support business needs

Key Outcomes: Systems are interoperable and meet business needs; data are available and accurate, reliable, complete, and used to inform decisions

Root Causes: Lack of standardized processes, including streamlined service delivery and effective strategic sourcing; inadequate accountability and governance structures

In Planning | **In Progress** | Complete | Sustaining

IT-5 Description & Status
Description To achieve this outcome, the VA Chief Information Officer and the EIC collaborate to address risks, GAO health IT recommendations, and the JBP process in real time. Assistant and Under Secretaries direct action through their Outcome Executives as necessary to mitigate or eliminate risk, continue to develop and monitor the annual VHA and OIT JBP, and ensure sustainability to meet business needs on a continuous basis. OIT will identify duplicative systems and capabilities with services providers, AMO, and business customers. OIT will leverage LSM Working Group to identify and plan for system modernization and/or decommission. **Status:** To address reducing the number of duplicative IT systems and capabilities, VA is implementing Portfolio Management and Product Life-cycle Management (PLM). OIT is establishing the framework required to leverage DevOps, Scaled Agile Framework, Systems Thinking, Human-Centered Design, Digital Innovation, and Site Reliability Engineering. These are complementary principles and approaches that require product teams to have end-to-end accountability. OIT is working with end users to understand requirements; to analyze business requirements and needs through the Unified Intake Process and VA IT Process Requests (VIPRs); to document requirements in user stories; to develop digital solutions; to automate testing and deployment; to support end users after deployment; to address system defects, and to ensure products perform as expected. OIT is adopting these practices to improve the Veteran's experience. VA product lines are the "functional groupings" of like VA IT products (systems). Product lines are grouped based on OIT portfolios and composition of IT systems supporting each product line. The product lines will be formalized, and system relationships/roadmaps are validated by the product line owners. The establishment of DevOps (combining Development and Operations) under OIT Deputy Assistant Secretary leadership is an OIT customer-focused strategy that will enable 1) rapid flow data-driven services to customers where a cross-functional teams will deliver services/capabilities in small batches, 2) maximized customer feedback to all OIT teams with actionable data from customer behaviors with reduced cycles, 3) continual learning, testing of hypotheses, and 4) improving, and maximizing agility/learning to deliver a continuously improving customer experience. OIT established change teams to help transform the organization migrating toward PLM and DevOps concepts. The goals of the change teams are to— • Establish product lines as the framework for organizing all IT services • Transform culture to one of empathy, accountability, and innovation • Rethink business operations (finance/acquisition) • Prepare the environment to receive and support DevOps value streams

IT-5 Description & Status
• Refine and integrate processes to fit VA (Scaled Agile Framework, DevOps, IT Infrastructure Library, and supporting processes) • Adopt human-centered design, modern DevOps tools, and performance monitoring • Establish architecture at the product line level • Establish, promote, and manage platforms • Become a strategic partner that proactively solves business problems using technology The VA System Inventory is the authoritative source for VA IT systems and identifies the stewards responsible for maintaining the accuracy, integrity, and availability of the information contained in VASI. The mission of VAEC is to serve as a strategic planning and management tool to help VA leadership execute transformation throughout the organization. VAEC products are informed by and support the Department's business and operational visions, strategies, and mission. For the VA to achieve its mission, the VAEC must be viewed as an authoritative source for the information it makes available to its end users. The VAEC's integrated views of strategic goals, mission, support services, and data and IT provide the requisite information to enable it to serve as the authoritative reference for issues of ownership, management, resourcing, performance goals, and design and documentation of systems and services. The VA Enterprise Architecture Repository provides a wealth of valuable information that describes VA business operations, capabilities, systems, services, and the IT capabilities that serve them. VA leadership, staff, and stakeholders can access this authoritative information to help improve service delivery, increase interoperability, and make better use of resources.

The following table describes the measures and metrics the work group uses to determine progress toward achievement of IT-5.

Table 2-26. IT-5 Measures/Metrics

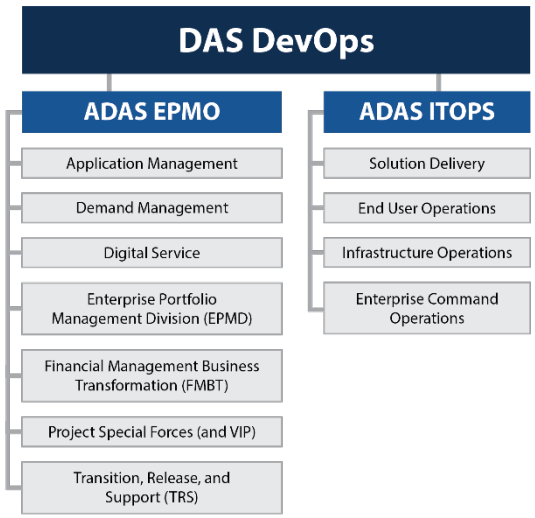
Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Reduce duplicative IT systems and capabilities	Number of legacy systems providing duplicate capabilities and functionality Count = # of IT systems providing duplicative capabilities and functionality (less is better)		Q2, Q4

The following table describes action IT work group have identified to achieve IT-5: Reduce the number of duplicative IT systems and capabilities to support business needs.

Table 2-27. IT-5 Action Plan

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
All actions imply effective change management and training are part of implementation			
(5.1) VHA and OIT identify duplicative systems and capabilities	Ongoing	Ongoing	**Sustaining.** Service provider, AMO, and Business Customer Ongoing.

The following table below describes actions taken to address GAO's removal criteria.

IT-5 Description of Actions Toward Removal Criteria
Leadership Commitment The CIO implemented a program to drive aggressive progress toward VA's IT modernization by implementing a true DevOps environment to address material weaknesses and stabilize and streamline OIT's core processes and platforms. Supported by Agile and Lean practices, DevOps is a culture-based software engineering approach that aims at unifying software development and software operation, and mandates collaboration between business and the IT organizations that develop, deliver, and manage applications for that business. The value of DevOps is measured based on customer value delivered at the cadence required to meet mission objectives. The CIO created a new position within OIT called the Deputy Assistant Secretary for Development and Operations (DAS DevOps). The DAS DevOps role will unify the Enterprise Project Management Office (EPMO) and IT Operations and Services led by Associate Deputy Assistant Secretaries. The following reorganization supports all five AOC and VHA's LOEs—    DevOps has been fully established and improves OIT customers' experience, enables OIT to deploy new systems and update existing systems more quickly and frequently, and lowers costs by leveraging industry best practices and innovation. The DevOps team has established high-level governance structures, established long-term priorities and goals, improved collaboration with stakeholders and customers, and supported continuing oversight and accountability.
Capacity DevOps employed a product line management structure to manage five portfolios and 27 product lines with over 700 products (Systems and Applications). One portfolio is Health Services and it includes Medical Care, Health Care Administration, Provider and Telehealth, Medical Research, Education, and Public Health, Community Care, and Supply Chain Management. This structure helps DevOps allocate or reallocate funds or staff; establish and maintain procedures or systems; establish work groups with specific responsibilities; improve collaboration with other agencies, stakeholders, and the private sector; and provide guidance and training to staff that addresses skills gaps. OIT will ensure employees are aware of the transition to DevOps. Training for executives and practitioners in Scaled Agile Framework, product line management, and other relevant topics will be required. Mentors and coaches will be available for projects choosing to adopt Agile and DevOps practices. OIT also will assign product line managers and lead engineers for select pilot product lines and portfolios.

IT-5 Description of Actions Toward Removal Criteria
Monitoring Divisions under the DevOps umbrella take responsibility for what is delivered to the customer. By simplifying IT architecture, DevOps will make data more accessible and understandable. DevOps has improved monitoring activities by— • Ensuring data quality/adequacy or using third-party assessments and validation • Holding frequent review meetings to assess status and performance • Reporting to senior managers on program progress and potential risks • Tracking performance measures and progress against goals This plan's metrics and measures provide the mechanisms to assess and report progress to GAO. With the introduction of metrics and measures, monitoring processes and procedures will be formalized.
Demonstrated Progress In 2017, OIT established a legacy system modernization and decommissioning strategy that continues to deliver the following outcomes for duplicative systems as well: • A reliable account of legacy systems and associated modernization plans with ongoing tracking and automated reporting of retirement and decommissioning activities • A repeatable process of discovery, analysis, and collaborative decision making to examine portfolios of systems to develop or confirm existing action plans for modernization, sustainment, or retirement • A standard process and checklist of activities required when retiring a system • Portfolio roadmaps that afford OIT the visibility to recapture resources, and re-program freed resources toward priority business as an element of lifecycle management of VA IT systems • Operational performance improvements in VA's business and technical systems

4. Inadequate Training for VA Staff Area of Concern

Executive Summary

VHA is actively developing comprehensive training policy and planning processes to address this area of concern (AOC). Led by VHA's Deputy Chief Learning Officer and Director of Client Services, VA updated its action plan to reflect completed actions, expansion of leadership commitment, and development of supporting capabilities. Successful action plan implementation will result in a systematic approach to training delivery and management. This will drive implementation of an educational infrastructure throughout the organization. Targeted, standardized, and comprehensive training will support active field engagement while enhancing consistent Veteran care at all medical facilities.

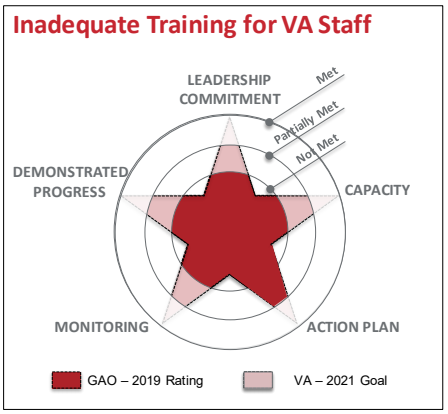


Figure 2-8 Training 2021 Rating Goal

Additionally, the Training work group took action to achieve meaningful progress toward target outcomes by—

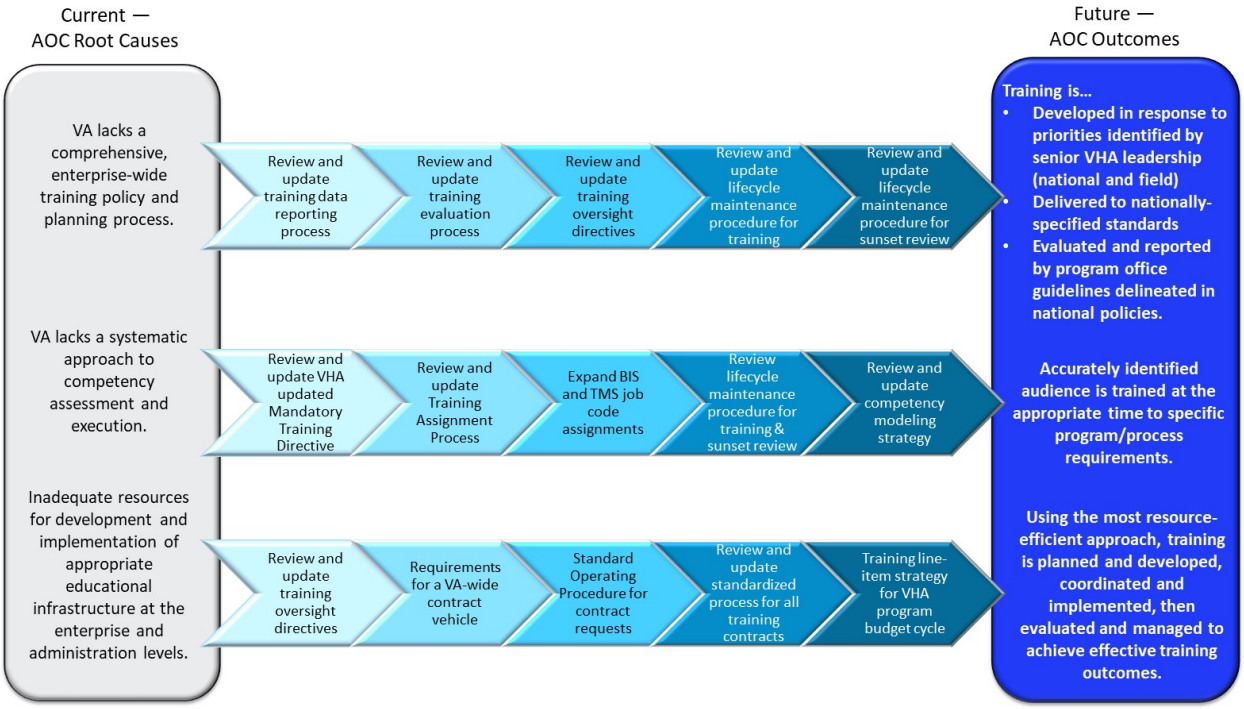
- Appointing a permanent VA Chief Learning Officer to lead the Talent Development Council
- Establishing the National Designated Learning Officer Community of Practice
- Implementing Learning Advisory Councils to provide training expertise, identify training resource needs, understand training needs, and review training outcomes in program offices across VA
- Establishing software to manage custom training development and delivery
- Aligning training priorities to support 18 priority operational strategies and the Modernization Lanes of Effort
- Optimizing mandatory training to reduce demand on clinical staff time
- Upgrading the Learning Management System to a cloud-based platform
- Developing a systematic approach to training assignment, execution, and competency assessment

For direct navigation to a Training outcome and supporting action plan, click on the links below:

T-1: Training is developed in response to priorities identified by senior VHA leadership (national and field), delivered to nationally specified standards, and evaluated and reported by program office guidelines delineated in national policies
T-2: Accurately identified audience is trained at the appropriate time to specific program/process requirements
T-3: Using the most resource-efficient approach, training is planned and developed, coordinated and implemented, then evaluated and managed to achieve effective training outcomes

Highlights of the root causes, key actions, and outcomes for Training are outlined in the following figure.

Figure 2-9 Training Roadmap



Alignment with Other Areas of Concern
Policies and Processes
The Training work group collaborates with the Policies and Processes work group to develop a policy that supports VHA's implementation of standardized oversight and training planning process for all training (Outcomes 1 and 3).
Oversight and Accountability
The Training work group collaborates with the Oversight and Accountability work group to develop policies and processes that support VHA's implementation of standardized oversight and training planning process for all training (Outcomes 1, 2, 3).
IT
The Training work group collaborates with the IT work group to incorporate procedural changes/updates identified in the VHA training oversight directive into Business Intelligence Suite and TMS as needed (Outcome 1), and to incorporate updated job codes into Business Intelligence Suite and TMS as needed (Outcome 2).
Resource Allocation
The Training work group collaborates with the Resource Allocation work group to— • Develop a staffing model that identifies additional FTE required to support VHA's implementation of standardized oversight and training planning process for all training (Outcome 1 and 3) • Review the current training assignment process and identify more defined role-specific job codes to target appropriate training participants via HR Smart, with all stakeholders (Outcome 2) • Generate the budget required to support VHA's implementation of standardized oversight and training planning process for all training (Outcome 1) • Identify the budget required to support VHA's update training assignment process (Outcome 2)

Alignment with Other Areas of Concern
• Develop budget required to support VHA's implementation of standardized oversight and training planning process for all training (Outcome 3)

Integration with Applicable Lanes of Effort
Commit to Zero Harm
Trainings supporting this effort include the e-Learning Course "High Reliability Organization 201," VA Central Office in-person and virtual training, and Systematic Review High Reliability Organization collaboration sessions.
Organizational Improvement
VHA Modernization Clinical Service Lines meeting was held Sept 2019.
Engaging Veterans in Lifelong Health, Well-Being, and Resilience
In-person conference support requested for "How Mental Health Leadership Can Support Veterans in a Life Worth Living."
MISSION Act
To include multiple webinar trainings for Section 121 of the VA MISSION Act.
Modernize Electronic Health Records (EHRM)
EHRM workshops, assessments, road shows, technical training for IT, end user training, and VITAL.
Transform Financial Management System
VA Office of Finance – 60+ support courses in audit, core competencies, and system usage offered in FY19 with >10,000 completions.
Transform Supply Chain
Technical integration of the Defense Medical Logistics Standard Support/LogiCole application with VA legacy systems (10-15 courses needing to be 508 compliant).

Training Outcome (T-1)

Outcome Lead: Robert Harrison, Director, Client Services
Outcome Executive: Elizabeth James, PhD, Acting Chief Learning Officer

T-1 Outcome Statement: Training:

- Developed in response to priorities identified by senior VHA leadership (national and field)
- Delivered to nationally specified standards
- Evaluated and reported by program office guidelines delineated in national policies

Key Outcome: Targeted, standardized, and comprehensive training that supports policy or guidance and active field engagement

Root Cause: VA lacks a comprehensive, enterprise-wide training policy and planning process

In Planning | **In Progress** | **Complete** | **Sustaining**

T-1 Description & Status
Description To achieve this outcome, VA and VHA must develop, implement, and confirm adherence to a comprehensive training oversight directive and planning process. Updates to the training policies and processes must include input from other AOC work groups, lane of effort work groups, and active field engagement. This action plan includes developing and implementing a training oversight policy that ensures the oversight and standardization of all developed training. The policy will include requirements to develop training with input, review, and post-training evaluation. The policy will provide guidance to VHA program offices to develop training plans for training initiatives and will include criteria related to resource needs, implementation, and evaluation planning to assess compliance with policy, process, and/or procedure. Through this policy, the Executive in Charge will establish an oversight and accountability role to ensure compliance. Training will be delivered to the intended audience through a variety of modalities and then evaluated to determine if training delivery meets participants' needs. VHA will work to ensure— • Consistency of the training content with best practices • Clarity of communication (to determine if the training delivery meets the participants' needs) • Evaluation to gauge the participants' comprehension of the training material and ability to execute the policy, process, or procedure The Employee Education System (EES) is the training component of the VHA and will help support VHA in accomplishing the above tasks.
Status The VA Chief Learning Officer (CLO) and VHA Training work group are reviewing and updating a training reporting procedure and policy (including lifecycle maintenance and sunset review processes, a proficiency assessment process, and a leadership-to-field communications process). These processes will be developed and piloted within EES and expanded across VHA.

The following table describes the measures and metrics the work group uses to determine progress toward achievement of T-1.

Table 2-28. T-1 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Training data reporting process	Percentage of EES (or VHA)-produced training that complies with training reporting process # of EES (or VHA)-produced training in compliance with training reporting process / total # of EES-produced training	Milestone = 50% of EES training by Q3FY21 Target = 90% by FY21 Milestone = 50% of VHA training by Q1FY22 Target = 90% by FY24	Quarterly
Training Evaluation Process Training accomplishes the initial objectives of the training sponsor and is validated through evaluation of the learners and reported back to the sponsor	Percentage of EES (or VHA) training evaluated based on standards or desired outcomes and reported to sponsor # of EES (or VHA) trainings evaluated based on standards or desired outcomes/ total # of trainings	Milestone = 50% of EES training by Q3FY20 Target = 90% of EES training by FY21 Milestone = 50% of VHA training by Q2FY21 Target = 90% of VHA training by FY23	Quarterly
Trainees demonstrate required knowledge and proficiency	Percentage of trainees that pass end-of-course proficiency standards # of trainees that demonstrate proficiency on training post-tests based on training proficiency standards / total # of trainees taking post-tests	Milestone = 50% of trainees by Q2FY21 Target = 90% of trainees by FY23	Quarterly

The following table describes action plans the Training work group have identified to achieve T-1: Training is—

1. Developed in response to priorities identified by senior VHA leadership (national and field)
2. Delivered to nationally specified standards
3. Evaluated and reported by program office guidelines delineated in national policies

Table 2-29. T-1 Action Plan

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
All actions imply effective change management and training needs are part of implementation			
(1.1) Training data reporting process Review and update training reporting process to assess achievement of intended training outcomes (Outcomes 1b and 1c; Q1FY20): • Draft EES Training Reporting Process (Q1FY20) • Draft VHA Training Reporting Process (Q1FY20)	Q1FY20		**In Progress**
(1.2) Monitor and provide input on VHA Managing Mission Critical Programs (Q2FY20)	Q2FY20		**In Progress:** The internal policy for the mission critical programs is being developed by the Executive Board team.
(1.3) Training oversight policy Review and update training proficiency assessment directive, for training associated with national processes, policies, and procedures (Outcome 1b, 1c): • Draft EES assessment process (Q1FY20) • Draft VHA assessment process (Q2FY20)	Q2FY20		**In Progress:** Revision required to enhance evaluation process and includes feedback process. This requires collaboration with the VA CLO, Resource Allocation work group, the Business Intelligence Suite and TMS teams, and oversight accountable entities.
(1.4) Review and update leadership-to-VHA communication process (Outcome 1a): • Draft EES communication process (Q1FY20) • Draft VHA communication process (Q3FY20)	Q3FY20		**In Progress:** Process for VHA senior leadership (national and field) to communicate training priorities to VHA Need process established through the Office of the Under Secretary of Health to ensure compliance and oversight across VHA.

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
(1.5) Review and update training oversight directive/process (Outcomes 1a, 1b, and 1c): • Draft internal EES training oversight policy/process (Q2FY20) • Draft VHA training oversight policy (Q4FY20)	Q4FY20		**In Progress:** VHA requires an overarching national training directive specifically for VHA to oversee all national-level training requirements to be effective in delivering training. This will include collaboration with the VA, CLO, VA Talent Development Council (TDC), Senior VHA Leadership, Policy and Oversight and Accountability work groups: • Office of Finance • Organizational training program • Deputy Secretary/Assistant Secretary/Deputy Under Secretary for Health for Operations and Management • Plan for assessing the performance gaps • Office of the Under Secretary for Health requirement for program offices to assess training objectives and reassess after training to ensure intended outcome is addressed • Requirement for program offices to assess performance to determine training gaps, develop comprehensive training plan and post-implementation evaluation assessment to determine effectiveness at a Kirkpatrick Level 3 or higher for all training-related endeavors
(1.6) Review and update lifecycle maintenance procedure for training process (Outcomes 1b and 1c)	Q3FY21		**In Planning:** Lifecycle maintenance procedures for VHA policies are conducted with VHA Office of Regulatory and Administrative Affairs and the Mandatory Training Subcommittee; other processes will be developed concurrently with policy approval and release.
(1.7) Review and update process to evaluate and update lifecycle maintenance procedure for sunset review process (Outcome 1a, 1b, and 1c)	Q4FY21		**In Planning:** Process is in place and further developments are being made, particularly for accredited courses, and reporting has been determined for EES-managed courses.

The following table describes actions taken to address GAO's removal criteria.

T-1 Description of Actions Toward Removal Criteria
Leadership Commitment The Training work group was established by the VHA GAO High Risk List Steering Committee to— • Support the design, development, and recommendation of an effective and efficient national training program. (Outcomes 1a, 1b, and 1c) • Provide support to the GOAL Office to provide a comprehensive and integrated series of responses for all the AOCs and the VHA Modernization Strategy. This ensures a coordinated and consistent approach of responding to GAO's high risk concerns. (Outcomes 1a, 1b, and 1c) VA appointed a permanent Chief Learning Officer (CLO) in March 2019. The VA CLO leads the Talent Development Council (TDC) of which the VHA CLO is the current rotating co-chair (Outcome 1a). The TDC is comprised of learning executives across the VA enterprise, with the purpose of reviewing, recommending, and establishing VA enterprise-wide policies, standards, metrics, and development and training activities. The TDC serves to promulgate VA enterprise-wide leadership and learning. VA appointed a permanent VA Chief Learning Officer in March 2019. The VA Chief Learning Officer leads the Talent Development Council (formerly the Training Leaders Council or TLC) of which the VHA Chief Learning Officer is the current rotating co-chair (Outcome 1a). The Talent Development Council makes, recommends, establishes, and implements VA corporate-wide training and development policy, metrics, recording, and reporting standards. The VHA EES is the education and training VHA headquarters program office, the training component of the VHA, and will help support VHA in accomplishing the above tasks. EES established the National Designated Learning Officer (DLO) Community of Practice and dedicated a full-time staff member to coordinate the activities and take the lead in creating a culture of learning and education to address the new VHA workforce. The DLO Community of Practice manages communication of training needs between the field (facilities, regions); creates contract vehicles (including blanket purchase agreements) to provide faster, easier, and cost-efficient training in the field; and provides feedback for training delivery lessons learned (Outcome 1a). In 2016, EES began developing Learning Advisory Councils, composed of designated training representatives from each VHA headquarters program office, to work with EES Learning Consultants, who provide training expertise and assist with identifying training resource needs, to understand training needs and review training outcomes. The Learning Advisory Councils review Kirkpatrick Level 2[25] training outcomes and report to respective program offices to ensure training outcomes are met (Outcomes 1a, 1b, and 1c). The National Coordinator for the DLOs conducts assessments of regional education and training initiatives and provides links to educational activities and long-term strategic goals such as the delivery of high-quality, patient-centered care. The National Coordinator acts as a liaison between EES and the field by facilitating communication to and from the field, identifying training needs and reviewing policies that impact the field. This includes the active integration of Regional Learning Consultants and an Associate Director (Outcomes 1a and 1c).

[25] A Kirkpatrick Level 2 evaluation measures learning through either a written or practical exam using a test before and after attendance in a course or through instructor observation. A Kirkpatrick Level 3 evaluation measuring individual performance or behavior is measured through a post-learning activities questionnaire for the learner and follow-up questions for the learner's manager, comparing the learner's assessment to the manager's observation of the application of the training. A Kirkpatrick Level 4 evaluation measuring organizational performance is measured through intended outcomes established prior to developing training (e.g., customer satisfaction increase, cost reduction), and methodology is determined on a case-by-case basis.

T-1 Description of Actions Toward Removal Criteria
Capacity To address GAO's training concerns, VHA leadership established the Training work group and approved contracts that support— • The design, development, and recommendation of an effective and efficient national training program (Outcomes 1a, 1b, and 1c) • The VHA GOAL Office requirements for providing comprehensive and integrated series of responses for the Training AOC and its overlap with the VHA Modernization Plan to be a High Reliability Organization (Outcomes 1a, 1b, and 1c) The National DLO Community of Practice, in collaboration with regional leadership, medical facility DLOs, other educational program directors, and program offices, coordinates the conception, design, development, implementation, and evaluation of the learning programs and ensures alignment with the overall organizational mission and vision for the future (Outcome 1a).
Monitoring In March 2018, VHA updated its process for developing evaluation for training development. The requirement to conduct a minimum Kirkpatrick Level 2 assessment for all accredited and non-accredited training was added. VHA began implementing this process in FY 2019, which allows the Training work group the ability to monitor and evaluate training effectiveness (Outcome 1c). This plan's metrics and measures provide the mechanisms to assess and report progress to GAO. With the introduction of metrics and measures, monitoring processes and procedures will be formalized.
Demonstrated Progress The Business Intelligence Suite was established in the Employee Education System to enable receiving, processing, and monitoring requests for customized training to be developed by VHA internally, to communicate the requirements across a broad area of production modalities, to track the development of training, and to deliver training products (Outcome 1b). In 2016, the Training work group developed and implemented a standardized training planning model within VHA. The process mandates content analysis and evaluative tools to assess effectiveness of training and utilizes Kirkpatrick Level 2 or above evaluation for VHA-wide training efforts. This training model has been enhanced to support the Training work group's planning efforts (Outcome 1c). In early 2019, VHA Deputy Under Secretaries for Health identified training priorities across VHA and designated training to support the 18 VHA Operational Strategies or four Secretary priorities. As of October 2, 2019, 99% (N = 1668) of all current internal VHA training requests aligned to the 18 VHA Operational Strategies or Secretary priorities per the Deputy Under Secretary for Health community (Outcome 1a). In March 2018, VHA updated its policy on the appropriate and effective use of trainings required to be completed by VHA employees via VHA Directive 1052 (Appropriate and Effective Use of VHA Employee Mandatory and Required Training). This directive outlines the policy regarding the appropriate processes for initiating, renewing, consolidating, expanding, substituting, and discontinuing required trainings for VHA employees, and therefore helps address GAO's concerns of burdensome training (Outcome 1a). For VHA national required training, the Learning Organization Transformation Mandatory Training Subcommittee conducts an annual review and recertification of existing mandatory training for VHA employees when such training is left to VHA to develop and implement but specifics are clearly directed by statute, executive order, or the Secretary of Veterans Affairs. To consistently track and report training outcomes, VHA conducts coordinated reporting for national initiatives. VHA leadership received monthly reports to address a 2015 White House memorandum to ensure opioid prescribing providers had the required training, which resulted in 99% completing the training and a continued sustained compliance rate of 93% in FY 2018. VHA compliance reporting in FY 2018 indicated a 95% compliance rate for suicide prevention training.

T-1 Description of Actions Toward Removal Criteria
During MISSION Act implementation in FY 2019, VHA had approximately 2 million completions of MISSION Act related training and reached its goal for the aggregate required VA completions (Outcomes 1a, 1b, and 1c). In support of the MISSION Act, VHA collaborated across responsible and supporting program offices to develop and deliver trainings that delineated national standards, policies, and processes to both VHA staff and external community care providers. This effort, which replaced the Choice Act, directly supports the VHA Operational Priorities and demonstrates VHA's ability to quickly and efficiently meet legislative requirements while preventing service disruptions for Veterans (Outcome 1a and 1b). In 2017, VHA conducted a series of site visits at 10 VA medical facilities of varying complexity, including hospitals and clinics. The site visits focused on the impact of burdensome training requirements and benchmarks of successful educational operations and barriers that have inhibited successful educational operations. Findings presented to the Office of the Deputy Under Secretary for Health for Operations and Management included— • Variation in VA education service configurations must be modernized particularly related to the DLO role, optimizing coordination to reduce mission overlap between facility departments, and leadership best practices to champion education • Mandatory training should be assigned with longer compliance times with annual refresh to maintain required status • VHA national program offices should define required clinical competencies to eliminate disparities (Outcome 1a)

Training Outcome (T-2)

Outcome Lead: Robert Harrison, Director, Client Services
Outcome Executive: Elizabeth James, PhD, Acting Chief Learning Officer

T-2 Outcome Statement: Accurately identified audience is trained at the appropriate time to specific program/process requirements

Key Outcome: Targeted, standardized, and comprehensive training that supports policy or guidance and active field engagement

Root Cause: VA lacks a systematic approach to competency assessment and execution

In Planning | **In Progress** | **Complete** | **Sustaining**

T-2 Description & Status
Description VHA must develop, implement, and confirm adherence to a systematic approach to competency assessment and execution. The new training assignment process will ensure that targeted audiences are trained according to specific program/process requirements. Integration with the other AOCs and modernization initiatives are identified in the action plan outlined below. The Training work group will define and draft the process to ensure a systematic approach to competency assessment and execution. Outcome 2 includes action items related to identifying the appropriate audience and delivering training with approved content to them. This will ensure standardized execution and implementation across VHA. EES will continue to support its clients by identifying and/or clarifying training needs and developing and delivering training products that address identified skill or knowledge gaps.
Status The Training work group is planning to update a mandatory training policy, a training assignment procedure (including lifecycle maintenance process), the training sunset review procedure, and a competency modeling strategy. These processes will be developed and piloted within EES and expanded system-wide.

The following table describes the measures and metrics the work group uses to determine progress toward achievement of T-2.

Table 2-30. T-2 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Compliance with training assignment process (This will allow accurate identification of individuals who need certain training)	Percentage of facilities and program offices that comply with use of job code assignments and HR Smart # of facilities and program offices that comply with new job codes, HR Smart / total # of facilities and program offices	Milestone = 50% of facilities and program offices by FY21 Target = 90% of facilities and program offices by FY22	Quarterly

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Compliance with lifecycle maintenance procedure and sunset review process	Percentage of duplicative or outdated training courses deleted from TMS # of duplicative or outdated training courses deleted from TMS / baseline # of duplicative or outdated training courses	Milestone = determination of baseline; 50% of duplicative or outdated training courses by FY22; Target = 90% of duplicative or outdated training courses by FY24	Quarterly

The table below describes actions the Training work group identified to achieve T-2: Accurately identified audience is trained at the appropriate time to specific program/process requirements.

Table 2-31. T-2 Action Plan

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
All actions imply effective change management and training are a part of implementation			
(2.1) Review and update VHA Mandatory Training Directive	Q2FY20		**In Progress:** Expand job code assignment via HR Smart and TMS. System currently exists but requires revision to further specify/define job codes and service lines within Business Intelligence Suite and TMS. This requires working with HR and links to HR Smart and TMS teams.
(2.2) Review and update training assignment process (e.g., process linking appropriate audience to appropriate training): • Tech process (with VHA Manpower Management Office) • Collaboration to develop training assignment process • Finalize draft of training assignment process	Q2FY20		**In Progress:** Process of linking appropriate audience to appropriate training; process exists but requires revision to further specify/define target audience and provide feedback process.
(2.3) Create functionality within Business Intelligence Suite and TMS to expand job code assignments	Q3FY20		**In Progress:** Training work group has begun collaboration with Business Intelligence Suite program manager and will meet with Business Intelligence Suite and TMS teams to schedule updates once updated job codes are finalized.
(2.4) Review and update lifecycle maintenance procedure for VHA Training Assignment Process (see 2.1 for process)	Q4FY21		**In Progress:** Lifecycle maintenance procedure for assessing new job codes, includes a process to update job codes and a process to review current job code assignments in TMS. This requires collaboration with HR and TMS teams.
(2.5) Review and update lifecycle maintenance procedure for the training sunset review process	Q4FY21		**In Progress:** Requires collaboration with VHA EES TMS team.
(2.6) Review and update competency modeling strategy	Q4FY21		**In Planning:** Initial discussions were explored with Workforce Management and Consulting. Additional work is in planning.

The following table describes actions taken to address GAO's removal criteria.

T-2 Description of Actions Toward Removal Criteria
Leadership Commitment As a result of leadership commitment, VA with the collaboration of all three administrations, reconfigured and upgraded its learning management system titled Talent Management System (TMS) to TMS 2.0 and made it a cloud-based platform in 2018. This update allows TMS to systematically monitor training execution, outcomes, and competency assessments (e.g., requiring a minimum of Kirkpatrick Level 2 evaluations for all training). It also allows for a systematic approach for retiring trainings (e.g., the sunset process). In VA's draft FY18–24 Strategic Plan, leadership commits to Business Strategy 4.2.1 and cites a new learning management solution: "VA will move toward a single learning platform to disseminate human capital policies and learning throughout the Department." Advances to the Human Resource Management Information System will allow training positions codes and competencies to be aligned to targeted learning participants, and it will synchronize with a single learning management platform. The Training work group collaborated with the Mandatory Training Subcommittee, a subcommittee of the Learning Organization Transformation subcommittee, to revise the mandatory training review process to streamline the process and then accurately differentiate between mandatory and non-mandatory training and appropriately allocate resources. An internal EES training evaluation policy document was completed, approved, and implemented in March 2018 (EES Directive 777-DCLO-EVAL-02).
Capacity VHA developed a systematic approach to training assignment, execution, and competency assessment. This approach identifies TMS Program Managers, Learning Consultants, and training production Project Managers as designated roles to assign training to appropriate audiences.
Monitoring TMS is a tool that provides the capability to monitor specific target audiences and completion rates, assign training to specific targeted audiences, and compile evaluation data. This supports the systematic monitoring of VHA training outcomes. This plan's metrics and measures provide the mechanisms to assess and report progress to GAO. With the introduction of metrics and measures, monitoring processes and procedures will be formalized.
Demonstrated Progress In 2017, EES added the capability to identify participant groups to trigger later assignment by TMS. Identifying the target audience early in production of the training reduces the burden of training for nontargeted VHA employees. This is an example of a process that may be expanded to include externally contracted training development by VHA Enterprise. Training is now assigned to participants via TMS by— • Automatic process utilizing HR Smart tools • Allowing supervisors to select individual employees based on individual learning plans • TMS administrators who can add a course to staff learning plans (at National Level or field facility), by User ID, Occupation, Service/Business Line or Facility Organization, or other demographic information provided by HR Smart, VA's human resources system of record

Training Outcome (T-3)

Outcome Lead: Robert Harrison, Director, Client Services
Outcome Executive: Elizabeth James, PhD, Acting Chief Learning Officer

T-3 Outcome Statement: Using the most resource-efficient approach, training is planned and developed, coordinated and implemented, then evaluated and managed to achieve effective training outcomes

Key Outcome: Targeted, standardized, and comprehensive training that supports policy or guidance and active field engagement

Root Cause: Inadequate resources for development and implementation of appropriate educational infrastructure at the enterprise and administration levels

In Planning | **In Progress** | **Complete** | **Sustaining**

T-3 Description & Status
Description The outcome includes action items related to the development of policy to ensure appropriate oversight of all training developed internally and externally. The policy will include requirements to develop training that includes input, review, and post-training evaluation. The plan for all national VHA training addressing a directive, process, or procedure must have an implementation plan along with follow-up to ensure adherence. To achieve this outcome, VHA must allocate adequate resources to develop, implement, and maintain an appropriate educational infrastructure. This section outlines how VHA will develop and implement a process to allocate resources to sustain such an educational structure.
Status The Training work group is helping develop VHA policy to provide oversight of all training, training cost reviews, and unnecessary training development costs. The Training work group is coordinating with the Resource Allocation work group to establish dedicated training resources within VHA's annual budget. In addition to developing training policy, the Training work group is drafting business and operational requirements for a VA-wide contract vehicle (for training development and delivery) and standardized procedures for vetting and executing training contracts (internal and external).

The following table describes the measures and metrics the work group uses to determine progress toward achievement of T-3.

Table 2-32. T-3 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Compliance with resource/budget reduction strategy	Percentage of externally contracted training reduced (demonstrates resource efficiency) # of externally contracted trainings / # of total trainings	Milestone = Annual (10%) reduction of externally contracted training (each year going forward) by FY23 Target = 20% of VHA training budget used for externally purchased training by FY25	Quarterly

The following table describes action plans Training work group have identified to achieve T-3: Using the most resource-efficient approach, training is planned and developed, coordinated and implemented, then evaluated and managed to achieve effective training outcomes.

Table 2-33. T-3 Action Plan

Actions	Projected Date	Actual/ Adjusted Date	Status
All actions imply effective change management and training are a part of implementation			
(3.1). Review and update training oversight policy/process (Outcomes 1a, 1b, and 1c): • Draft internal EES training oversight policy/process (Q2FY20) • Draft VHA training oversight policy (Q4FY20)	Q4FY20		**In Progress:** Directive required to identify oversight, governance, and evaluation standards.
(3.2) Review and update business and operational requirements for a VA-wide contract vehicle (for training delivery and development)	Q4FY21		**In Progress:** This requires collaboration with the Office of Acquisitions, Logistics, and Construction.
(3.3) Review and update Standard Operating Procedure (SOP) for vetting proposed training contract requests (for internal and external training requests)	Q4FY21		**In Progress**: This requires collaboration with the Office of Acquisitions, Logistics, and Construction.
(3.4) Review and update SOP for all training contracts	Q4FY21		**In Progress**: Process reduces redundant training contracts, provides standardized contracting language, and provides measure of compliance across VHA through the established business and operational processes and/or VA-wide contract vehicle.
(3.5) Develop strategy to consider guidelines for including a training line-item within the VHA Program Budget for the budget cycle	Q4FY22		**In Progress:** This requires collaboration with Office of Acquisitions, Logistics, and Construction; VHA Office of Finance; and the Office of the Under Secretary of Health.

The following table describes actions taken to address GAO's removal criteria.

T-3 Description of Actions Toward Removal Criteria
Leadership Commitment VHA has hired a contractor team of five FTE, to support the revitalization of VHA training. VHA has assigned high-level leadership to improve VHA training (Senior Executive Service sponsor, GS15 Director, and GS14 Deputy Director).
Capacity EES has dedicated resources of 30.0 full time equivalent employees (FTEEs) to consult with both VHA national subject matter experts and leadership and field leadership to identify training priorities. All VHA program offices and regions are assigned a Learning Consultant to provide training expertise and assist with identifying training resource needs. Learning Consultants— • Chair and co-chair Learning Councils across VHA program offices • Work with the client and instructional system designers to determine best delivery modality to meet specific training needs • Meet regularly with clients to review training outcomes
Monitoring This plan's metrics and measures provide the mechanisms to assess and report progress to GAO. With the introduction of metrics and measures, monitoring processes and procedures will be formalized.
Demonstrated Progress In accordance with EES Directive 777-DCLO-EVAL-02, VHA conducted Kirkpatrick Level 2, 3, and 4 evaluations for Q2FY18 for VHA (EES) internally developed training. This directive supports the implementation of an educational infrastructure to systematically evaluate training outcomes.

5. Unclear Resource Needs and Allocation Priorities Area of Concern

Executive Summary

VHA continues to increase capacity to manage within budget through new manpower policies and improved funds planning and management. This action plan reflects demonstrated progress of resource alignment to leadership priorities through evidence-based budget justifications, and enhanced reporting and decision-making capabilities. Successful action plan execution will result in defensible resource prioritization and allocation decisions informed by timely, robust data and reporting mechanisms. Consistently implemented practices will align resources with leadership priorities.

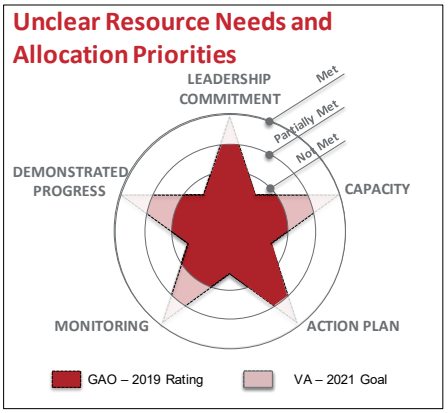


Figure 2-10 Resource Allocation 2021 Rating Goal

The Resource Allocation work group improved manpower, funds planning, and management practices to achieve meaningful impact toward target outcomes by—

- Filling leadership positions in Manpower, Finance, and Workforce Management & Consulting (WMC)
- Piloting a process to improve resource allocation and enhancing funding guidance to the field
- Establishing Manpower Management Office authority for organizational and position structures
- Co-leading implementation of the Organizational Improvement LOE by WMC and Finance
- Implementing early controlled funds release to improve field funds planning and management
- Leveraging standing Chief Financial Officer teleconferences to address resource and budget allocation concerns
- Introducing evidence-based justifications to the VHA Medical Care program budget request process
- Launching an initiative budget submission process prior to current and budget fiscal years
- In addition to leveraging the robust analytic capability for staffing and productivity provided in the Office of Productivity, Efficiency, and Staffing (OPES), VA developed staffing models for critical programs such as police and VHA Caregiver Support Program

For direct navigation to the Resource Allocation (RA) outcome and supporting action plan, click on the links below:

RA Outcome 1: Unified resource planning and allocation process is clearly documented and consistently applied

RA Outcome 2: VHA utilizes a comprehensive strategic guidance process to ensure alignment of resources to leadership priorities

RA Outcome 3: Adequate data and reporting mechanisms are used for making, evaluating, and informing resource planning and allocation decisions

Highlights of the root causes, key actions, and outcomes for improving resource allocation are outlined in the following figure.

Figure 2-11 Resource Allocation Roadmap

Alignment with Other Areas of Concern
Policies and Processes
As VHA refines its resource allocation processes and procedures, revisions to existing policies and issuance of new policies will be accomplished through collaboration with the Policies and Processes work group. The VHA Office of Finance is establishing a process to update annual VHA funding guidance and will coordinate with the policy office to meet new procedural requirements for promulgation. The VHA Manpower Management Office (MMO) is chartering and implementing a standard business support function at level of authority, which will require policy office coordination prior to publishing the new guidance. Over the next 3–5 years, the Resource Allocation work group will coordinate with the policy office for any new or revised policies as needed. MMO and the VHA Office of Finance will update guidance and policies as system advancement occurs, ensuring compliance with federal regulations. This guidance will be maintained on central repositories and updated regularly as advancements continue.
Oversight and Accountability
As VHA continues to improve its manpower management and resource allocation processes, both documentation and adherence to new business processes will need governance bodies to approve, monitor, and enforce desired behaviors. The VHA Office of Finance will coordinate with the VHA governance structure to assist with ensuring that management allocates resources in line with leadership priorities based on evidence-based justification. VHA MMO is consolidating oversight in the Office of the VHA Chief of Staff.
IT
As further progress is made in integrating manpower and financial management, additional IT requirements will be coordinated with IT counterparts.

Alignment with Other Areas of Concern
Both VHA MMO and the VHA Office of Finance are deploying improved management systems that enhance reporting and executive visibility/transparency of human and financial resources. Deploying these systems includes ensuring high data accuracy levels and reliability to populate the new systems. Examples of Manpower enhancements include deployment of a light electronic action framework (LEAF) to track organizational and position change requests while the Department develops the Manpower Module within HR Smart. The updated HR Smart Module will be a second key IT deliverable.
Training
As part of managing risk associated with resource prioritization and allocation, VHA will collaborate with the Training work group to verify and validate associated mandatory training and will adhere to VHA requirements for functional staff training development and implementation. The VHA MMO and the VHA Office of Finance are collaborating with the Training work group and other stakeholders to review the current training assignment process and identify more defined role-specific job codes to target appropriate training participants via HR Smart.

The following table provides examples of how Oversight and Accountability actions support the Modernization Lane of Effort initiatives.

Integration with Applicable Lanes of Effort
Organizational Improvement
Manpower coordination with this Lane of Effort (LOE) is essential to ensure consistency as decisions are made regarding the functions and structures necessary to accomplish program objectives. The VHA MMO and VHA Office of Finance partnered on the Integrated Product Team (IPT) to implement recommendations from the LOE. The VHA MMO provides full-time employee equivalent analysis and implementation leadership in support of this LOE. The VHA MMO is leading an Integrated Product Team to standardize and implement the business support function across the VHA. Manpower analysis provides criteria-based decision making on functions and workload, and manpower required to carry out work. The VHA MMO strives to standardize manning and prioritize fills. Conducting this work requires coordination with the LOE. Provision of manpower analysts at the regional level will improve the ability to make appropriate decisions. The manning document is a tool that leaders can use to gain needed information about valid workload-based requirements. The requirements inform workforce planning and budgets.

Resource Allocation Outcome (RA-1)

Outcome Leads: Ellen Bradley, MA, Director, Information Management & Reporting
Shane Walker, MBA, Management and Program Analyst, Manpower Management Office

Outcome Executives: Ogbeide Oniha, MA, Director, VHA Financial Management & Accounting Policy
Elizabeth Lowery, MA, Director, Manpower Management Office

RA-1 Outcome Statement: Unified resource planning and allocation process is clearly documented and consistently applied

Key Outcome: Resources are aligned to leadership priorities

Root Causes: The Department of Veterans Affairs (VA) lacks consistent resource management, oversight, and execution plans

RA-1 Description & Status
Description The intent of this outcome is to increase corporate capability to manage within budget through new manpower policies and improved funds planning and management.
Status The VHA Office of Finance will establish plans to support increased and well-timed access to mission-related funds. The controlled release of funds earlier in the fiscal year provides the field greater opportunity to improve funds planning and management. In FY 2019, the Office of Finance piloted a new process to improve resource allocation and management and looks to refine those processes in FY 2020 with enhanced funding guidance and outreach to the field. Manpower management improvement throughout VHA continues with several initiatives completed in FY 2019 including fully resourcing the VHA MMO to improve manpower allocation. In FY 2020, the VHA MMO has a continued focus on change management for organizational and position structure and validation of current VHA manpower requirements and undertaking several initiatives that align with leadership priorities.

The following table describes the measures and metrics the work group uses to determine progress toward achievement of RA-1.

Table 2-34. RA-1 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Decrease in unfunded requirements (UFRs)	Percentage decrease in number of UFRs from the baseline year = number UFRs in current FY / number UFRs in FY19	Baseline will be developed after the initial measurement in FY20	Annual
Increase in timely release of program funds.	Percentage of total funded budget released to regions and programs = amount of funding released on time / total amount of funding	Q1FY20=20% Q2FY20=35% Q3FY20=60%	Quarterly

The following table describes action plans Resource Allocation work group have identified to achieve RA-1: Unified resource planning and allocation process is clearly documented and consistently applied.

Table 2-35. RA-1 Action Plan

Actions	Projected Date	Actual/ Adjusted Date	Status
All actions imply effective change management and training are part of implementation			
(1.1) VHA Office of Finance and VHA MMO jointly review program missions with respect to program support and draft guidance for program offices.	Q4FY20		**In Planning**
(1.2) GA0 19-670 – Recommendation 1 VHA Comments: If an enacted budget is passed after the start of quarter two of the current fiscal year, Veterans Equitable Resource Allocation model will be re-run to reallocate funds based on prior year workload data. Note that this may cause internal fund recessions at the Veterans Integrated Service Network, medical facility, and program office levels for re-allocation of funds.	Q1FY20		**Complete**
(1.3) GA0 19-670 – Recommendation 2 VHA Comments: VHA's Chief Financial Officer will update guidance to establish a formal process to document the review of regions adjustments to medical facility allocations.	Q1FY20	TBD	**Complete**
(1.4) GA0 19-670 – Recommendation 3 VHA Comments: VHA's Chief Financial Officer will revise guidance to require regions to provide information on how they determined adjustments to medical facility allocation levels. VHA's Chief Financial Officer will require this justification prior to processing.	Q2FY20	TBD	**In Progress**
(1.5) GA0 19-670 – Recommendation 5 VHA Comments: All transfers of funds between regions will require review by the Associate Chief Financial Officer for Resource Management prior to processing to ensure adequate explanations are included. In addition, a monthly report will be provided to VHA's Chief Financial Officer identifying all transfers between medical facilities within a region that exceed 1.5% of the region's overall funding allocation.	Q4FY20	TBD	**In Progress**
(1.6) Release mission-related funds to the field by the start of Q4FY20 to assist with proper funds management and planning.	Q4FY20		**In Planning**
(1.7) VHA Office of Finance identify 3% of funds for potential transfer from Specified Program to General Program.	Q1FY20		**Complete**
(1.8) Publish VHA MMO policy.	Q1FY20		**Complete**
(1.9) Publish Executive in Charge Memorandum identifying VHA MMO as owner of VHA headquarters and regional office organizational structure.	Q2FY20		**In Progress**

Actions	Projected Date	Actual/ Adjusted Date	Status
(1.10) Publish VHA MMO SOP for frontline staff.	Q1FY20		**Complete**

The following table describes actions taken to address GAO's removal criteria.

RA-1 Description of Actions Toward Removal Criteria
Leadership Commitment The VHA leadership is committed to a unified resource planning and allocation process that is clearly documented and consistently applied across all programs, regions, and medical facilities. The focus of this action plan is on leveraging the increased capacity provided by the newly formed VHA MMO and refined budgeting processes of the VHA Office of Finance to clearly document and consistently apply a budgeting and allocation process. Leadership commitment is evidenced by the continued investment in VHA MMO and the development and enhancement of funding and allocation processes that give the regions, medical facilities, and program offices greater flexibility to leverage their respective resources to deliver quality services to Veterans.
Capacity The VHA has taken several actions to ensure the capacity to achieve desired results. In FY 2019, the VHA established the VHA MMO as the authority for the VHA's organizational and position structure and implemented new procedures to oversee the VHA position inventory. The VHA Office of Finance successfully recruited and hired the final member of the senior leadership team with a focus on improving the integration of financial and resource management processes throughout all sections, improving execution of resources to serve Veterans.
Monitoring Finance subject matter experts leverage the standing regional and medical facility Chief Financial Officer teleconferences to address resource and budget allocation process concerns. The VHA Finance Office reports on budget execution, reviewing and ensuring proper execution of VHA program office and regional operating plans. The VHA MMO is monitoring functional alignment and organizational hierarchy to improve organizational effectiveness and efficiency. This plan's metrics and measures provide the mechanisms to assess and report progress to GAO. With the introduction of metrics and measures, monitoring processes and procedures will be formalized.
Demonstrated Progress The VHA continuously reviews processes and identifies initiatives to improve the allocation of resources throughout the system. In FY 2020, the VHA Office of Finance is focusing on ensuring funds are in the medical facility budgets by reallocating funds to the field and focusing on ensuring current data are available for informed decision making. In FY 2019, the VHA MMO implemented the VHA position management policy and internal controls to improve position and vacancy workforce data, partnered with stakeholders to improve resource allocation for mission and function changes to include the VHA Caregiver Support Program, and actively managed VHA headquarters' manpower validation process by overseeing changes to organizational charts, position management, approval of change requests, and responding to stakeholder inquiries on organizational and position structure.

Resource Allocation Outcome (RA-2)

Outcome Leads: Ellen Bradley, MA, Director, Information Management & Reporting
Shane Walker, MBA, Management and Program Analyst, Manpower Management Office

Outcome Executives: Ogbeide Oniha, MA, Director, VHA Financial Management & Accounting Policy
Elizabeth Lowery, MA, Director, VHA Manpower Management Office

RA-2 Outcome Statement: VHA utilizes a comprehensive strategic guidance process to ensure alignment of resources to leadership priorities

Key Outcome: Resources are aligned to leadership priorities

Root Cause: VA lacks a streamlined, integrated, comprehensive strategic guidance process to develop resourcing decisions aligned with department goals and mission requirements

In Planning | **In Progress** | **Complete** | **Sustaining**

RA-2 Description & Status
Description The intent of this action plan is to ensure alignment to leadership priorities by providing evidence-based justifications for funding requests and to minimize reporting variances.
Status In FY 2019, the VHA Office of Finance held an Initiative Budget Call for initiatives to be considered for the 2021 President's Budget (PB). This budget submission call allowed VHA headquarters program offices and regions to communicate resource requirements for new initiatives supporting and aligning to key leadership priorities with the introduction of evidence-based justifications to the VHA Medical Care program budget request process. The VHA MMO established staffing models for Dental Service, VHA Caregiver Support Program, Health Information Management national scanning workload, and Environmental Management. The VHA MMO established standard procedures for requesting recruitments and organizational changes within VHA headquarters and regional offices.

The following table describes the measures and metrics the work group uses to determine progress toward achievement of RA-2.

Table 2-36. RA-2 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Initiative budget submissions from DUSHs and regions that contain evidence-based justifications	Percentage of regional and DUSHs budget submissions containing supporting evidence # of submissions with evidence / total # of submissions	Baseline = Determine baseline in FY21 Milestone = 50% in FY23 PB Target = TBD	Q4
VHA has validated approach to FTE staffing levels	Percentage of VHA organizations with standard approach for FTE staffing # of organizations using std approach / total # of organizations	Baseline = Determine baseline in FY21 Milestones = 25% in FY22, 50% in FY23, 98% in FY24	Q2, Q4

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Organizations have standardized support staff by grade according to organizational level	Percentage of Level of Authority (LOA) compliant organizations # of LOA compliant orgs / total # of orgs.	Baseline = Determine baseline in FY21 Milestone = 25% by end of FY22, 50% in FY23, 98% by end of FY24 Target = 98% in FY24	Q2, Q4

The following table describes action plans Resource Allocation work group have identified to achieve RA-2: VHA utilizes a comprehensive strategic guidance process to ensure alignment of resources to leadership priorities.

Table 2-37. RA-2 Action Plan

Actions	Projected Date	Actual/ Adjusted Date	Status
All actions imply effective change management and training are part of implementation			
(2.1) Review the documents provided for the initiative budget submission request process in FY19 and identify updates to the document	Q2FY20	Q1FY20	**Complete**
(2.2) Send out the Initiative Budget Call memorandum to the program offices and the regions	Q3FY20		**In Planning**
(2.3) Identify one program to implement VA's approach to Evidence—Based Policymaking in the 2021 Presidential Budget	Q1FY20	Q4FY19	**Complete**
(2.4) VHA organizational chart updated and signed identifying Level of Authority 3	Q2FY20		**In Progress**
(2.5) Begin socializing a manning document that supports VHA's ability to align resources with priorities	Q3FY20		**In Progress**
(2.6) Standard Business Support Function: Charter, and develop a standard Business Support Function at LOA	Q2FY20		**In Progress**
(2.7) Implement "Streamline VACO LOE" recommendations	Q2FY21		**In Progress**
(2.8) VHA Employees Covered by Staffing approach: Environmental scan	Q2FY20		**In Planning**
(2.9) VHA Employees Covered by Staffing approach: Inventory of current approaches and prioritization of gaps	Q4FY20		**In Progress**

The following table describes actions taken to address GAO's removal criteria.

RA-2 Description of Actions Toward Removal Criteria
Leadership Commitment The VHA leadership is committed to ensuring alignment of resources to leadership priorities. In this outcome, the VHA MMO will focus on increasing coverage of employees by a staffing approach and increasing the number of LOA 3 organizations with standard business support functions. The VHA Office of Finance will require high-visibility medical program initiative budget submissions to include evidence-based justifications.
Capacity The VHA has already taken several actions to ensure the capacity to achieve desired results. In FY 2019, VHA established the VHA MMO as the authority for the VHA's organizational structure. The VHA Office of Finance began the initiative budget submission process in FY 2019 to identify initiatives prior to the current and budget fiscal years. The implementation of these two initiatives in FY 2019 will allow program offices and regions to be better prepared for FY 2020 requirements and allow for more capacity to respond to requests.
Monitoring VHA is monitoring actions taken to ensure efforts achieve defined leadership priorities. For example, the VHA Office of Finance subject matter experts have leveraged the standing regional and medical facility Chief Financial Officer calls to address resource and budget allocation process concerns. The VHA Office of Finance holds budget execution meetings to review and ensure proper execution of VHA program office and regional operating plans. The VHA MMO is reviewing staffing approaches as part of an environmental scan to verify the current state of staffing approach utilization across VHA. The VHA MMO regularly meets with VHA leadership to review and discuss desired changes to authorized positions, onboard personnel, and workload-based requirements. The VHA MMO is working to support comparative analysis between similar functions to inform resource allocation. This plan's metrics and measures provide the mechanisms to assess and report progress to GAO. With the introduction of metrics and measures, monitoring processes and procedures will be formalized.
Demonstrated Progress The FY 2019 Initiative Budget Call memorandum provided an opportunity for VHA headquarters program offices and regions to ensure funding requirements align to leadership priorities. The VHA Office of Finance refined funding guidance by adding a new process for program offices and regions to report the reallocation of funds. In FY 2019, the VHA MMO implemented VHA position management policy and internal controls to improve position and vacancy workforce data, partnered with stakeholders to improve resource allocation for mission and function changes to include the VHA Caregiver Support Program, and actively manages the VHA headquarters' manpower validation process by overseeing changes to organizational charts, position management, approval of change requests, and responding to stakeholder inquiries on organizational and position structure.

Resource Allocation Outcome (RA-3)

Outcome Leads: Ellen Bradley, MA, Director, Information Management & Reporting
Shane Walker, MBA, Management and Program Analyst, Manpower Management Office

Outcome Executives: Ogbeide Oniha, MA, Director, VHA Financial Management & Accounting Policy
Elizabeth Lowery, MA Director, VHA Manpower Management Office

RA-3 Outcome Statement: Adequate data and reporting mechanisms are used for making, evaluating, and informing resource planning and allocation decisions

Key Outcome: Resources are aligned to leadership priorities

Root Cause: The VHA has insufficient, ineffective, and disjointed databases resulting in a lack of useful data for modeling and forecasting resource needs

In Planning | **In Progress** | **Complete** | **Sustaining**

RA-3 Description & Status
Description The intent of this outcome is to ensure alignment to leadership priorities by minimizing reporting variances across the VHA.
Status The VHA continues to leverage the existing systems and enhance reporting, resource planning, and decision making through continuous refinement of reports and identification of enhancements that can be made until new systems are implemented. In FY 2019, the VHA MMO was established and fully staffed. It now provides analytical capabilities and managerial oversight, overseeing work to validate positions in VHA and update HR databases. In FY 2020, VHA MMO will complete an environmental scan and validation of organizational staffing approaches. VHA MMO is also expanding VHA headquarters oversight of office organization charts and adding shared services to completed VHA headquarters and regional organization charts. The VHA Office of Finance will use this work and incorporate it into finance resource reporting.

The following table describes the measures and metrics the work group uses to determine progress toward achievement of RA-3.

Table 2-38. RA-3 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Reduce variance in FTE reporting within budgeting systems and HR IT system of record (HR Smart)	Alignment of HR Smart and Fiscal FTE Data Percentage = Variance (HR Smart FTE Data – Fiscal FTE Data) / HR Smart FTE Data	Baseline: Determine baseline in Q2FY21 Target: <25% Variance Q2FY22	Q2, Q4

The following table describes action plans Resource Allocation work group have identified to achieve RA-3: Adequate data and reporting mechanisms are used for making, evaluating, and informing resource planning and allocation decisions.

Table 2-39. RA-3 Action Plan

Actions	Projected Date	Actual/ Adjusted Date	Status
All actions imply effective change management and training are part of implementation			
(3.1) Identify and pull FTE reports from the VHA Office of Finance and Manpower and identify variances	Q4FY20		**In Planning**
(3.2) VHA Manpower oversees and maintains approved structure at VHA headquarters and regional offices	Q1FY20		**Completed**
(3.3) Position Transparency Initiative: Monthly monitoring of variance.		Q1FY19	**Sustaining**
(3.4) Position Transparency Initiative: Increase communications to Portfolio Management population	Q1FY20		**Complete**
(3.5) Position Transparency Initiative: Increase consultations as needed	Q2FY20		**Complete**
(3.6) Implement LEAF system to track/report on Manpower requirements	Q2FY20		**Complete**
(3.7) Implement HR Smart Manpower Module to track/report Manpower requirements	Q2FY21		**In Progress**

The following table describes actions taken to address GAO's removal criteria.

RA-3 Description of Actions Toward Removal Criteria
Leadership Commitment The VA has committed to improving the databases used in planning and forecasting allocation decisions through the implementation of HR Smart. VA leadership highlights improved manpower management in the VA draft Strategic Plan FY18–24 as a critical element to VA's success, and Secretary Wilkie has identified manpower management as a key priority. The Refreshed FY18–24 VA Strategic Plan, Business Strategy 4.2.4, is to "Institute manpower management to optimize human capital resources." VHA MMO is responsible for implementing and sustaining a uniform organizational structure. VA is currently implementing a new financial system throughout the Department that will enhance the budget formulation and execution data available.
Capacity Through the commitment to implement the new systems, VA is continuing to advance the capacity of the Department to provide more detailed and structured reports. With the establishment of the VHA MMO as the authority for VHA's organizational structure, VHA is recruiting for manpower analysts at the regional level to support the initiative and provide position structure reporting at the field level, enhancing the capacity for data reporting. This structure will provide more detailed information in the creation of staffing forecasts for budgetary reports.
Monitoring The VHA is monitoring actions taken to ensure efforts achieve the intended progress. VHA MMO staff have been invited to speak to finance staff at standing regional and medical facility Chief Financial Officer calls to share the capabilities of the manpower system for local use in budget forecasting. The VHA MMO now reviews proposed changes to organizational structure and makes recommendations for approval by the Chief of Staff for all structure changes in VHA headquarters and the regional offices. This plan's metrics and measures provide the mechanisms to assess and report progress to GAO. With the introduction of metrics and measures, monitoring processes and procedures will be formalized.
Demonstrated Progress In FY 2019, the VHA MMO implemented VHA position management policy and internal controls to improve workforce position and vacancy data. VHA MMO partnered with stakeholders to improve resource allocation for mission and function changes to include the VHA Caregiver Support Program. VHA MMO actively manages the VHA headquarters manpower validation process by overseeing changes to organizational charts, position management, approval of change requests, and responding to stakeholder inquiries on organizational and position structure. The information derived from these manpower reviews will be incorporated into future budget documents as justification for VA budget requests.

Chapter 3. The GOAL Office

The GAO-OIG Accountability Liaison (GOAL) Office was established at the start of FY 2019 to oversee VA's response and actions to GAO's high risk listing on VA health care. GOAL reports on GAO high risk program management to the Deputy Under Secretary for Health for Organizational Excellence. VHA increased GOAL's program management capacity by leveraging existent staff who had experience working with GAO, adding support staff to the office, and allocating funds for contract support. GOAL's responsibilities include—

- Serving as VHA's primary liaison to GAO and VA's Office of the Inspector General
- Setting Department strategic and operational direction for addressing the areas of concern (AOCs)
- Tracking and monitoring action plans
- Reporting to senior leadership on risks, challenges, and resources
- Ensuring integration with select VA and VHA transformational initiatives
- Coordinating across work groups involved in addressing the AOCs

Fiscal Year 2019 Accomplishments

In FY 2019, GOAL—

- Developed senior leadership commitment in high risk list efforts and coordinated stakeholder engagement across the five area of concern work groups and key program offices
- Led the Steering Committee in strategic planning and setting direction for VA's actions to address GAO concerns. GOAL built collaboration among siloed work groups by convening and facilitating multiple intensive in-person working sessions to strengthen engagement, integrate action plans, generate vision and outcomes, and develop measures for success
- Coordinated with the Department's Office of Enterprise Integration (OEI) to establish a high-level governance structure in VA for oversight of GAO High Risk List work
- Obtained Departmental approval of key outcomes for the action plan and facilitated mutual agreement between VA and GAO on key outcomes
- Developed VA's action plan to the high risk listing, in collaboration with work groups, leaders of current transformational initiatives, and senior leadership
- Tracked, analyzed, and reported on progress across all HRL-related efforts (e.g., AOC Action Plans, GAO findings, root causes, outcomes, milestones) and reported to the Executive Advisory Board and VA Operations Board (Outcome Executives and Leads for each AOC work group and crosscutting transformational initiative leads will monitor progress on their respective action plans according to their own internal processes and report progress to GOAL upon request)
- Improved Departmental business processes by incorporating AOCs into VA's operating plans, in collaboration with OEI
- Established a strategic communications work group and built a communications plan to enhance leadership and stakeholder awareness and manage reporting and briefings
- Secured funding for needed contract support

- Collaborated with OEI on lessons learned and approaches to other VA high risk listings
- Developed a change management strategy for implementation in FY 2020
- Developed a strategic management approach for implementation in FY 2020 and beyond

GOAL's work improved the coordination, collaboration, decision making, rigor, and effectiveness of VA's efforts to address the high risk listing on VA health care.

Fiscal Year 2020 Plans

For FY 2020, GOAL plans to expand its program management functionality by—

- Expanding executive sponsorship and leadership commitment by increasing Executive Advisory Board functionality and building regularized reporting to senior leadership
- Implementing portfolio management to oversee and assess integration across the multiple projects described in the AOC action plans
- Advancing an organizational change management strategy to effectively accomplish and sustain necessary changes relative to GAO's areas of concern
- Applying risk management; specifically, identifying risks to successful execution of planned actions and developing risk responses
- Monitoring and reporting on action plan progress
- Facilitating and improving collaboration among AOC work groups and the Modernization Lanes of Effort

In so doing, GOAL expects to guide and support VA's continued progress toward managing risks and improving Veterans' health care.

In 2018 and 2019, VA built the management capacity needed to address the AOCs by dedicating government and contract staff; leveraging its federally funded research and development center and the private sector for best practices; supporting staff training for skill development; and allocating funds. VA trained GOAL staff in disciplines critical to long-term success – program/portfolio management, risk management, and change management – and VA allocated over $27 million in contract support. Nearly three dozen government personnel are actively involved in addition to dedicated contractor staff. VA expects dedicated staff and contract support will be needed through FY 2025. Stakeholder program offices use current funding and staff to support efforts to address GAO concerns. VA does not anticipate requesting additional funds to manage action plan activities in the upcoming budget cycle.

GOAL Capacity

Table 3-1. GOAL Staff

GS Level	Position	Full-time Equivalent
Title 38, Physician	Director	0.5
GS 14	Program Analysts	1.25
GS 13	Program Analysts	0.75
GS 11	Staff Assistant	0.75

Table 3-2. Contracted Resources for GAO HRL Actions

Organization	FY 19 ($M)	FY 20 ($M)
GOAL	$2.98	$5.90
DUSH for Organizational Excellence (OE)	$0.12	$0.075
Oversight & Accountability	$4.78	$0.029
Policy	$3.60	$7.20
Training	$1.16	$1.18
Resource Allocation	$0.046	$ 0.21
Total	**$12.69**	**$14.60**
Total FY19 & FY20	**$27.29**	

Appendix A. Summary of Key Outcomes and VA Health Care Area of Concern Outcomes

Table A-1 Mapping of Key Outcomes to AOC Outcomes

ID	Area of Concern Outcome Statement	Self-Assessed Rating
Policies and Processes (P&P) **Key Outcomes:** Policy drives correct behavior and is implemented consistently; business processes are integrated and efficient		
P&P-1	Senior leaders of VHA programs and initiatives, including the Modernization Lanes of Effort, support the need for aligned, unambiguous policies and consistent policy implementation	In progress
P&P-2	VHA policy development, recertification, and amendment processes function with integrity according to VHA Directive 6330, including integration of a unified risk management framework	In progress
P&P-3	VHA applies standard business rules to determine when, what, and how to create uniform policy development and implementation processes across the agency that reflect VHA indices of policy quality	In progress
P&P-4	VHA standards and implementing processes are transparent and accessible to appropriate stakeholders	In progress
Oversight and Accountability (OA) **Key Outcome:** Governance and oversight mechanisms provide reasonable assurance that requirements are met		
OA-1	VHA organizations and employees demonstrate timely and effective risk management in accordance with a unified risk management framework to support governance and oversight	In progress
OA-2	Governance and management decisions are made at the appropriate level of the organization, are informed by reliable data, and are timely	In progress
OA-3	VHA oversight ensures governance and management decisions are implemented and focused on intended outcomes	In progress
OA-4	Leadership holds VHA organizations accountable to fulfill obligations imposed by decisions, regulations, and other requirements	In planning
OA-5	VHA supports a Just Culture that fosters trust, integrity, learning, and collaboration	In progress
Information Technology (IT) **Key Outcomes:** Systems are interoperable and meet business needs; data are available and accurate, reliable, complete, and used to inform decisions		
IT-1	Deliver IT capabilities to support VHA-determined data and interoperability business needs	In progress
IT-2	Improve system interoperability to execute core health care mission functions	In progress
IT-3	Provide governance and oversight bodies with accurate, reliable, timely, and relevant information to support decision making	In progress
IT-4	Reduce the number of legacy systems while continuing to meet business needs	In progress
IT-5	Reduce the number of duplicative IT systems and capabilities to support business needs	In progress

ID	Area of Concern Outcome Statement	Self-Assessed Rating
Training (T) **Key Outcome:** Targeted, standardized and comprehensive training that supports policy or guidance and active field engagement		
T-1	Training: 1. Developed in response to priorities identified by senior VHA leadership (national and field) 2. Delivered to nationally specified standards 3. Evaluated and reported by program office guidelines delineated in national policies	In progress
T-2	Accurately identified audience is trained at the appropriate time to specific program/process requirements	In progress
T-3	Using the most resource-efficient approach, training is planned and developed, coordinated and implemented, then evaluated and managed to achieve effective training outcomes	In progress
Resource Allocation (RA) **Key Outcome:** Resources are used effectively and efficiently		
RA-1	Unified resource planning and allocation process is clearly documented and consistently applied	In progress
RA-2	VHA utilizes a comprehensive strategic guidance process to ensure alignment of resources to leadership priorities	In progress
RA-3	Adequate data and reporting mechanisms are used for making, evaluating, and informing resource planning and allocation decisions	In progress

Appendix B. Area of Concern and Lane of Effort Success Measures and Metrics

Area of Concern Success Measures and Metrics
Policies and Processes
P&P-1: Senior leaders of VHA programs and initiatives, including Modernization Lanes of Effort, support the need for aligned, unambiguous policies and consistent policy implementation
Measure: All VHA policies, both newly developed and recertified, demonstrate adequate implementation resources are in existence or approved before policy publication ***Metric:*** Percentage of total published policies with addressed resources as documented in the pre-policy form
Measure: 100% of VHA's publications website is vehicles currently considered policy (i.e., directives and notices) ***Metric:*** Percentage of documents on the VHA publication website that are directives and notices
Measure: VHA operational memoranda do not contain policy information when issued ***Metric:*** Number of operational memoranda submitted by program offices for VHA's publications website that contain policy information
P&P-2: VHA policy development, recertification, and amendment processes function with integrity according to VHA Directive 6330, including integration of a unified Risk Management Framework
Measure: VHA policy development (writing new policies) and recertification (updating existing policies) occur within the standard timeframe ***Metric:*** Average number of days from SharePoint field review to publication for all new policies and recertifications
Measure: VHA policy development (writing new policies) and recertification (updating existing policies) processes include receiving stakeholder feedback from all appropriate service lines and program offices ***Metric:*** Percentage of key stakeholders identified by VHA that respond per directive
Measure: VHA policies are current and have been reviewed and recertified in the prior 5 years (to the extent possible, e.g., pending regulations) ***Metric:*** Percentage of policies that are overdue for recertification
P&P-3: VHA applies standard business rules to determine when, what, and how to create uniform policy development and implementation processes across the agency that reflect VHA indices of policy quality
Measure: Regular informational and educational sessions occur between ORAA and policy stakeholders ***Metric:*** Number of engagements among ORAA, program offices, regions, and VA medical facilities
Measure: Reduced redundant and unnecessarily complex local policy for medical facilities ***Metric:*** Percentage reduction of local policies
P&P-4: VHA standards and implementing processes are transparent and accessible to appropriate stakeholders
Measure: Current VHA policies are located in a single online repository that is available to all VA staff and has broad searchability ***Metric:*** Percentage of local and national policy documents in the repository
Oversight and Accountability * The Oversight and Accountability Leads were newly appointed in January 2020 and were not involved in the creation of the action plans but are looking forward to further developing the plans. We look forward to their leadership and vision.
OA-1: VHA organizations and employees demonstrate timely and effective risk management in accordance with a unified RMF to support governance and oversight
Measure: VHA's Enterprise Risk Manager coordinates VHA's submission to the annual Statement of Assurance ***Metric:*** Count of consecutive years of successful submissions
Measure: Annual audits or reviews completed on a 3-year cycle (plan, execute, report) ***Metric:*** Percentage completed of ARCC-approved audits or reviews

Area of Concern Success Measures and Metrics
Measure: Corrective Actions in response to Internal Audit recommendations are completed by their negotiated implementation date ***Metric:*** Percentage of corrective actions completed by their negotiated completion date
OA-2: Governance and management decisions are made at the appropriate level of the organization, are informed by reliable data, and are timely
Measure: Trend in AES scores for relevant questions ***Metric:*** AES scores for the following questions: • I believe appropriate steps would be taken to hold me accountable for poor performance • I know what is expected of me on the job • I know how my work relates to the agency's goals • Managers communicate the goals of the organization • My direct supervisor communicates the reasoning (how and why) behind decisions that impact on my work • I have the appropriate supplies, materials, and equipment to perform my job well
OA-3: VHA oversight ensures governance and management decisions are implemented and focused on intended outcomes
Measure: Standardize compliance risk identification and tracking ***Metric:*** Participation by all VHA compliance officers in risk assessment and mitigation efforts
Measure: Ensure minutes from ARCC are signed, approved and distributed with accountability on action items ***Metric:*** Number of approved ARCC meetings/ Number of ARCC meetings
OA-4: Leadership holds VHA organizations accountable to fulfill obligations imposed by decisions, regulations, and other requirements
Measure: TBD ***Metric:*** TBD
OA-5: VHA supports a Just Culture that fosters trust, integrity, learning, and collaboration
Measure: A patient safety culture demonstrates improved reporting of adverse events and close calls ***Metric:*** Change of adverse event reporting; change of close call reporting, measured at system-wide, regional, and medical facility levels
Measure: A Serious Safety Event results in harm that ranges from moderate to severe patient harm or death from hospital-acquired conditions (HACs) (details in Chapter 1 of VA HRL Action Plan) ***Metric:*** Standard definitions for five safety indicators reported at the enterprise level with a target to sustain positive improvement in one or more of the five patient safety metrics reported at the enterprise level with appropriate volume of eligible numerator cases, by December 2022.
Measure: The annual VA All Employee Survey (AES) includes a Patient Safety Culture Module. The 15 question Patient Safety Culture Module with 5 established AES questions comprise the Patient Safety Culture Survey as applied to the AES at regional and facility levels. ***Metric:*** Percent change trend in improvement in each unit of analysis by December 2021
IT Challenges
IT-1: Deliver IT capabilities to support VHA-determined data and interoperability business needs
Measure: Consolidated Community Care fully supported by modernized IT systems ***Metric:*** Percentage of IT components that are modernized
Measure: VIPR Addendum tab is reviewed by the OIT AMO Intake Triage ***Metric:*** Percentage of IT requests properly reviewed
IT-2: Improve system interoperability to execute core health care mission functions
Measure: Initial EHRM deployment to regions ***Metric:*** Percentage of the total regions that have modernized EHR

Area of Concern Success Measures and Metrics
IT-3: Provide governance and oversight bodies with accurate, reliable, timely, and relevant information to support decision making
Measure: The IT Governance Board provides direction for strategy and vision of VA OIT ***Metric:*** Percentage of IT acquisitions over $15M approved
IT-4: Reduce the number of legacy systems while continuing to meet business needs
Measure: Conduct thorough and complete evaluations and assessments, including functional, cost and schedule, technical, security, and operational characteristics ***Metric:*** Percentage of assessments completed
IT-5: Reduce the number of duplicative IT systems and capabilities to support business needs
Measure: Duplicative IT systems and capabilities ***Metric:*** Number of IT systems providing duplicative capabilities and functionality (less is better)
Training
T-1: Training is developed in response to priorities identified by senior VHA leadership (national and field); delivered to nationally specified standards; and evaluated and reported by program office guidelines delineated in national policies
Measure: Training data reporting process (percentage of training that complies with the training reporting process) ***Metric:*** Percentage of Employee Education System (or VHA)-produced training that complies with training reporting process
Measure: Training Evaluation Process: Training accomplishes the initial objectives of the training sponsor and is validated through evaluation of the learners and reported back to the sponsor ***Metric:*** Percentage of Employee Education System (or VHA) training evaluated based on standards or desired outcomes and reported to sponsor
Measure: Trainees demonstrate required knowledge and proficiency ***Metric:*** Percentage of trainees that pass end-of-course proficiency standards
T-2: Accurately identified audience is trained at the appropriate time to specific program/process requirements
Measure: Compliance with training assignment process (This will allow accurate identification of individuals who need certain training) ***Metric:*** Percentage of facilities and program offices that comply with use of job code assignments & HR Smart
Measure: Compliance with lifecycle maintenance procedure and sunset review process ***Metric:*** Percentage of duplicative or outdated training courses deleted from Talent Management System
T-3: Using the most resource-efficient approach, training is planned and developed, coordinated and implemented, then evaluated and managed to achieve effective training outcomes
Measure: Compliance with resource/budget reduction strategy (percent of externally contracted training reduced) ***Metric:*** Percentage of externally contracted training reduced (demonstrates resource efficiency)
Resource Allocation
RA-1: Unified resource planning and allocation process is clearly documented and consistently applied
Measure: Decrease in unfunded requirements (UFR) ***Metric:*** Percentage decrease in number of UFRs from the baseline year
Measure: Increase in timely release of program funds ***Metric:*** Percentage of total funded budget released to regions and programs
RA-2: VHA utilizes a comprehensive strategic guidance process to ensure alignment of resources to leadership priorities

Area of Concern Success Measures and Metrics
Measure: Initiative budget submissions from each Deputy Under Secretary for Health and region that contain evidence-based justifications ***Metric:*** Percentage of regional and Deputy Under Secretary for Health budget submissions that contain supporting evidence
Measure: VHA has validated approach to FTE staffing levels ***Metric:*** Percentage of VHA organizations with standard approach for FTE staffing
Measure: Organizations have standardized support staff by grade according to organizational level ***Metric:*** Percentage of LOA compliant organizations
RA-3: Adequate data and reporting mechanisms are used for making, evaluating, and informing resource planning and allocation decisions
Measure: Reduce variance in FTE reporting within budgeting systems and HR IT system of record (HR Smart) **Metric:** Alignment of HR Smart and Fiscal FTE Data

Lane of Effort Success Measures and Metrics that support AOCs
Commit to Zero Harm LOE
Policies and Processes Measure*:* All medical facilities have established a site-specific high reliability organization (HRO) roadmap informed by a standardized, facilitated HRO self-assessment with implementation of and progress against the HRO plan overseen by the region
Metric: Percentage of medical facility HRO site-specific high reliability organization roadmaps developed and verified by the region
Oversight and Accountability Measure*:* A patient safety culture demonstrates improved reporting of adverse events and close calls
Metric: Change of adverse event reporting; percent change of close call reporting, measured system-wide, at regional and medical facility levels
IT Measure*:* Data are available and accurate, reliable, complete, and used to inform decision making (Specific measures focus on preventing harm within the HRO context, as to be recommended by the Measurement Advisory Group)
Metric: By December 2022, positive trends will be identified in one or more of the five safety outcomes identified to focus on in the first years of the VHA HRO journey (standard definitions for five inpatient patient safety indicators, reported at the enterprise level)
Training Measure: Training (field) drives effective behavior change consistent with HRO values, principles, and standards
Metric: By December 2022, 80% (or more) of existing VHA staff will have completed training in baseline HRO principles, practices, and behaviors
Resource Allocation Measure: Appropriate funds are prioritized and allocated across headquarters functions, regions, and facilities
Metric: Year-to-year patient safety culture results on the AES should reflect a system-wide trend in improvement in Education/Training/Resources and Organizational Learning–Continuous Improvement
Organizational Improvement
The current efforts of the Implementation IPT closely align to the actions of the Resource Allocation work group and create enabling steps for the achievement of the Resource Allocation AOC outcomes. The Resource Allocation action plan metrics in Chapter 2 demonstrate alignment with this initiative.
Shared Services
Policies and Processes Measure: Standardized position descriptions, processes, accompanying SOPs, and performance plans across regions reduce variance in services delivery

Lane of Effort Success Measures and Metrics that support AOCs
Metric: Percentage of project position descriptions standardized; percentage of project performance plans standardized; percentage of project SOPs standardized; percent of designated position descriptions standardized (classified modernization)
Oversight and Accountability Measure: The target HR shared services reporting structure is standardized and fully implemented, including governance, and oversight over shared services
Metric: Percentage of regional HR leadership consolidated; percentage of regional-level shared services units at final operating capability; average number of days from hiring need validation to entry on duty (time to hire); percentage of position inventory compared to authorized full time employee (FTE) (HR Data Quality); payroll errors per pay period (Payroll Quality); Employee Relations Quality (by complexity: number of cases and average case time); Customer Satisfaction (overall satisfaction score for leadership and managers/supervisors)
IT Measure: HR systems can meet HR shared services requirements
Metric: Manager Self Service (MSS) fully deployed (Part of HRSMART); Recruitment Tracker in use to track status recruitment and staffing records in a unified system between HRSMART and USA Staffing data
Training Measure: HR Training is standardized and required for entry level through advanced competency levels
Metric: HR Workforce Quality (foundational training completion % for new hires [201s] within 1 year)
Resource Allocation Measure: At this time, there is no VHA Resources measure needed
Engaging Veterans in Lifelong Health, Well-Being, and Resilience
Policies and Processes Measure: Lifelong health, well-being, and resilience expectations and standards are consistently applied at all medical facilities
Metric: Percentage of medical facility leadership survey responses confirming full understanding of the forthcoming VHA directive implementing the Whole Health approach
Oversight and Accountability Measure: Assignment of oversight and accountability to Regional Director and medical facility leadership through inclusion of an annual performance plan metric related to this Lane of Effort
Metric: The percentage of regional and medical facility leaders demonstrating implementation of the Whole Health approach
IT Measure: Integration of the Whole Health approach into patient electronic health records to ensure care providers can address Whole Health objectives
Metric: VA electronic data capture functions for Whole Health are translated, designed, and implemented in the new electronic health record health record
Training Measure: Percentage of staff completing required Whole Health approach trainings within the targeted timeframes
Metric: Percentage of staff completing required Whole Health approach trainings as documented in TMS within 120 days of implementation
Resource Allocation Measure: Resources are aligned with Lifelong Health, Well-Being, and Resilience priority needs as reflected in the increased participation of Veterans in Whole Health encounters
Metric: Whole Health Clinical Activity – the percentage of unique Veterans who had at least two Whole Health encounters as evidenced by Whole Health stop codes or CHAR 4 codes
MISSION Act
Policies and Processes Measure: Standardize business processes and field guidance across the Veteran Community Care Program to provide better access to care
Metric: Number of regulations or directives that are regularly reviewed, approved, and actioned by VHA and field leadership through established governance processes
Oversight and Accountability Measure: Monitor the quality and performance of the CCN and newly established VCAs
Metric: Number of key performance indicators developed through established governance processes that are regularly reviewed and actioned by VHA and field leadership
IT Measure: Develop and modernize IT systems to address current community care challenges

Lane of Effort Success Measures and Metrics that support AOCs
Metric: Number of IT systems required to support the initiative that are developed and tested with relevant VA and VHA program offices and field subject matter expertise prior to national deployment
Training Measure: Evaluate the effectiveness of the MISSION Act curriculum virtual training (eLearning and webinar) and in person workshop courses for both VA and contractor staff
Metric: Percentage of relevant employees who completed training prior to implementation of significant process changes
Resource Allocation Measure: Align available resources to consistently execute established processes for the Veteran Community Care Program
Metric: Resource needs and priorities for allocation are aligned with VA and VHA guiding documents (Strategic Plan and Long-Range Framework) and used to make decision aligned with resources and funding
Modernize Electronic Health Records
Policies and Processes Measure: Uniform implementation, standardized business processes, and care across the health care delivery systems
Metric: Percentage of standardized business processes that have been implemented across the VHA by full operational capability (complete deployment of EHRM)
Oversight and Accountability Measure: Oversight and accountability controls assess the effectiveness of clinical and health care delivery support systems using electronic health records
Metric: Percentage of functional (electronic health record-related) governance decisions (e.g., new/change to policy, new/change/clarification to functional requirement) made within 60 days of identification
IT Measure: EHRM eliminates current VistA challenges and remedies lack of data due to non-interoperable systems (e.g., Defense Medical Logistics Supply Support, EHRM, Financial Management Business Transformation)
***Metrics*:** Percentage of legacy Data domains, Notes/Documents, and Reports (per requirement identified by the EHRM councils) migrated to HealtheIntent by 1) Spokane go-live and 2) Puget Sound go-live; percent of Cerner workflows, DDMs, and DCWs that were approved by the EHRM councils during the eight National Workshops that are configured in the modernized EHR prior to functional testing
Training Measure: Training plans address core competencies, competency gaps, and enhanced system functionality available in the modernized solution to reduce implementation variation
Metric: Percentage of end users trained at each of the 100, 200, 300, and 400 levels by date(s) in the VA Office of Electronic Health Record Modernization Integrated Master Schedule
Resource Allocation Measure: Resources are allocated and prioritized to support EHR implementation
Metrics: Percentage of (additional) personnel that have been onboarded through each of 1) hires, 2) details, and 3) contracts at each of the go-live sites in time to meet expected productivity losses due to training or other identified impacts; percentage of modified/additional space locations that are ready for use at each of the go-live sites prior to go-live at each of the sites
Transform Supply Chain
Policies and Processes Measure: Updated and accurate policy and procedures to facilitate a lean and efficient supply chain
Metric: Percentage of VA/VHA/DOD policies mapped to each process identified to support the modernization pilot; percentage of VHA policy updates prepared; percentage of the total number of equipment contracts awarded; percentage of initial products evaluated and recommended for procurement; percentage of products selected in clinically driven strategic sourcing sustainment evaluations; percent decrease in average acquisition/contracting cycle time; percent of facilities in which Defense Logistics Agency Medical/Surgical Prime Vendor is operational
Oversight and Accountability Measure: Maturation of governance entities and ensuring compliance with policy to ensure a lean and efficient supply chain is in place
Metric: Percentage of scheduled quality control reviews conducted; percentage of corrective action plans received within and outside of standard timeframe

Lane of Effort Success Measures and Metrics that support AOCs
IT Measure: Modernized IT systems eliminate current IT challenges and remedy lack of data interoperable systems; data is available and accurate, reliable, complete, and used to inform decision making
Metric: Percentage of facilities with Defense Medical Logistics Standard Support/LogiCole deployed
Training Measure: Training and role standardization drive compliance, understanding, modernization, and a consistent product for clinicians and Veterans
***Metric*:** Percentage of functional workforce that completed required training
Resource Allocation Measure: Appropriate funds are prioritized and allocated across functions; resources are sufficient, prioritized, and allocated to support supply chain modernization
Metric: Percentage of programs and projects operating plans with integrated master schedules; percentage of financial investment plans reviewed and show evidentiary basis for investment for current and future years' resources and investment requirements; percentage of programs and projects reviewed; percentage of functional areas that have developed/validated business requirements; percent reduction in purchase card spending

Appendix C. Area of Concern Level Outcomes and Activities that Address Root Causes

To address GAO's concerns, the underlying root causes of VA health care's management challenges must be addressed, and the corresponding outcomes related to each root cause must be achieved. Table C-1 summarizes the relationships between the outcomes planned for each area of concern (AOC) and the root causes they address. Table C-2 provides brief descriptions of the progress to date and planned activities that will achieve the intended outcomes and fully address the root causes.

Table 0-1. Summary of Root Causes and AOC Outcomes Addressed

Root Cause Number	Root Cause	AOC Outcome ID
Policies and Processes		
1	National policies do not consistently align with agency priorities and needs	**P&P-1**
2	VHA has failed to manage the concurrence process effectively to ensure timely, high-quality policies	**P&P-2**
3	The policy development process does not engage stakeholders to create shared understanding of the need for policy	**P&P-2**
4	VHA has not defined what policy is and what it should accomplish	**P&P-3**
5	VHA rarely embedded policy in a broader change strategy to support implementation by the field	**P&P-3; P&P-4**
Oversight and Accountability		
1	VA has a fragmented oversight operating model that impedes its ability to effectively oversee policy implementation and ensure organizational accountability	**OA-1; OA-2; OA-3; OA-4**
2	VA has an organizational cultural gap between those delivering health care in the field and VHA headquarters staff that impedes its ability to integrate oversight and enhance ethical practice vertically throughout the organization	**OA-5**
IT Challenges		
1	VA suffers from insufficiently skilled/trained staff, future skills gaps, and ineffective workforce planning	**IT-1**
2	Lack of standardized processes, including streamlined service delivery and effective strategic sourcing, inhibit IT delivery	**IT-1; IT-2; IT-4; IT-5**
3	Inefficient tracking methods, poor data quality, and delayed response to material weaknesses challenge management effectiveness	**IT-1**
4	Inability to operate and/or integrate with partners and customers detracts from service delivery	**IT-1; IT-2; IT-3; IT-4**
5	Inadequate accountability and governance structures impair IT management	**IT-2; IT-3 IT-5**
Training		
1	VA lacks a comprehensive, enterprise-wide training policy and planning process	**T-1**

Root Cause Number	Root Cause	AOC Outcome ID
2	VA lacks a systematic approach to competency assessment and execution	**T-2**
3	Inadequate resources for development and implementation of appropriate educational infrastructure at the enterprise and administration levels	**T-3**
Resource Allocation		
1	The VA lacks consistent resource management, oversight, and execution plans	**RA-1**
2	VA lacks a streamlined, integrated, and comprehensive strategic guidance process to develop resourcing decisions aligned with Department goals and mission requirements	**RA-2**
3	VHA has insufficient, ineffective, and disjointed databases, resulting in a lack of useful data for modeling and forecasting resource needs	**RA-3**

Table 0-2. Synthesis of Area of Concern Outcome Action Plans and Activities Addressing Root Causes

Action Plan Activities Addressing Root Causes
Policies and Processes
Policies and Processes Root Cause 1: National policies do not consistently align with agency priorities and needs. **Policies and Processes Outcome Addressing Root Cause:** Senior leaders of VHA programs and initiatives, including the Modernization Lanes of Effort, support the need for aligned, unambiguous policies and consistent policy implementation (P&P-1).
The VHA Senior Leader Committee (SLC) was established and is composed of the Principal Deputy Under Secretary for Health, each VHA Deputy Under Secretary for Health, the Office of Regulatory and Administrative Affairs (ORAA) Executive Director, and VHA Chief of National Policy. The SLC meets every 2 weeks to ensure that policies reflect SLC governance and policy decisions and current VHA standards, including alignment with current priorities and needs. The VHA Field Advisory Work Group was established and is composed of approximately 20 leaders from regions and VA medical facilities (i.e., the field). The Group meets quarterly to provide feedback to the VHA Chief of National Policy to ensure policy decisions align with the field needs. In addition, ORAA requires each responsible entity developing a policy to complete the updated pre-policy form called the Chief of Staff Briefing Note. The current Briefing Note requires explanations of the need being met by the policy and expands the original 2016 format by requiring that the responsible entity explain the availability of resources necessary for policy implementation (e.g., funding, space, staffing, IT, contract support, training), identify obstacles to uniform policy implementation, provide a risk assessment, and outline a communications plan for disseminating the policy upon publication.
Policies and Processes Root Cause 2: VHA has failed to manage the concurrence process effectively to ensure timely, high-quality policies. **Policies and Processes Outcome Addressing Root Cause:** VHA policy development, recertification, and amendment processes function with integrity according to VHA Directive 6330, including integration of a unified Risk Management Framework (P&P-2).
To fully address this root cause VHA national policies must be current, reviewed at least every 5 years, and developed or recertified using a sustainable and timely process. VHA standardized policy content requirements and development processes for national policy to better manage the concurrence process and effectively to ensure timely, high-quality policies. ORAA sets policy recertification timelines; monitors timeliness of all policies being recertified; solicits stakeholder feedback throughout development; and ensures each policy conforms to VHA Directive 6330, Controlled National Policy/Directives Management System, including setting forth a comprehensive list of responsibilities and oversight requirements in accordance with VHA's RMF. Specific actions include the following: • ORAA oversees the following actions: the requirement of a full chain of responsibilities and oversight from VHA senior leadership to field staff to align VHA policy with the risk management framework (in collaboration with the Oversight and Accountability work group); the requirement to specify required staff training (in collaboration with the Training work group); and the requirement of a Records Management paragraph.

Action Plan Activities Addressing Root Causes
• ORAA created the VHA Policy Dashboard and provides an updated version to SLC weekly through email. The SLC reviews the dashboard every 2 weeks. The VHA Policy Dashboard provides a comprehensive status overview for policies in development, including each policy's current location and the time of completion for each review/approval stage compared to the established policy timeline of 140 days. • ORAA piloted a SharePoint review process to solicit feedback from VA staff during the policy development process and implemented the SharePoint review for all VHA policies in 2017. Pending VHA policies are posted to SharePoint to enable staff from VA program offices, regions, and VA medical facilities to provide feedback on the policy, including identifying obstacles to uniform nationwide implementation. ORAA employs a staff of professional writers to assist program offices with the technical and administrative duties of policy development required by the robust and collaborative standardized process. In July 2016, ORAA added seven contractors to the document management staff, expanding to 12 contractors in May 2018. In August 2018, the Office of Policy and Services transferred two unfunded positions to ORAA, allowing ORAA to hire two more document managers. In April 2019, VHA modified its contract to provide for a total of 30 contractors and eight full-time employees supporting ORAA. Senior leaders continue to assess and adjust resource needs as appropriate.
Policies and Processes Root Cause 3: The policy development process does not engage stakeholders to create shared understanding of the need for policy. **Policies and Processes Outcome Addressing Root Cause:** VHA policy development, recertification, and amendment processes function with integrity according to VHA Directive 6330, including integration of a unified Risk Management Framework (P&P-2).
ORAA solicits stakeholder feedback throughout development and ensures each policy conforms to VHA Directive 6330, including a comprehensive list of responsibilities and oversight requirements in accordance with VHA's RMF. VHA policies are posted to SharePoint to enable staff from VA program offices, regions, and VA medical facilities to provide feedback on the policy, including identifying obstacles to uniform nationwide implementation. ORAA ensures that policy authors address field comments, which increases the transparency and integrity of policy development, and informs draft revisions to address medical facility needs prior to publication of a policy. ORAA disseminates a monthly email digest across VHA at the beginning of each month, which lists newly published VHA directives and notices, and informs stakeholders about recent changes to VA and VHA policy and VHA forms. The digest provides information about the policy recertification process and includes a link for readers to provide direct feedback regarding specific policies, such as local implementation issues and improvement suggestions. In 2017 and 2018, the VHA Chief of National Policy conducted 26 semi-structured interviews with policy management staff from medical facilities in each region to discuss local policy development and gain insight into how national policy can ensure consistent implementation and oversight in medical facilities. The Office of Regulatory and Administrative Affairs shared reports of its key findings with the Field Advisory Work Group. The feedback informed the selection of medical facilities for ORAA site visits in 2019. In 2019, ORAA used information gathered from 10 medical facility site visits to create a local policy assessment and development tool to help medical facilities determine the appropriate course of action for implementing and tailoring national policy at the local level and developing medical facility standards of practice. Specifically, VHA Directive 6330 defines what is, and is not, considered a national policy document. In addition to the standards of VHA Directive 6330, Controlled National Policy/ Directives Management System, VA created a tool to help medical facilities streamline local policy inventory and reduce confusion. In 2020, Directive 6330 will become Directive 0999, Policy Management, and will incorporate information from two business rules notices that clarify what are policy documents at the medical facility level.

Action Plan Activities Addressing Root Causes
Policies and Processes Root Cause 4: VHA has not defined what policy is and what it should accomplish. **Policies and Processes Outcome Addressing Root Cause:** VHA applies standard business rules to determine when, what, and how to create uniform policy development and implementation processes across the agency that reflect VHA indices of policy quality (P&P-3).
The VHA Chief of National Policy and ORAA staff actively connect with VHA program offices and with regional and VA medical facility leaders to discuss how to improve national policy to reduce the policy burden on VA medical facility staff and how to assist medical facility leaders in streamlining and aligning facility policy and standards of practice with national policy. Implementing standard business rules for national and local policies and processes will simplify development and facilitate uniform implementation across VHA. In August 2017, ORAA updated VHA Directive 6330, Controlled National Policy/Directives Management System, to define VHA policy documents only as directives and notices. At the time of ORAA's most recent update in June 2018 Directive 6330 updated policy standards include: the requirement of a full chain of responsibilities and oversight from VHA senor leadership to field staff to align VHA policy with the Risk Management Framework (in collaboration with the GAO Oversight and Accountability work group), the requirement of a paragraph specifying required staff training (in collaboration with the Training work group), and the requirement of a Records Management paragraph. In 2019, ORAA plans to convert Directive 6330 to Directive 0999 to align with the VA policy numbering system. In addition to the standards of VHA Directive 6330, Controlled National Policy/Directives Management System, this tool will help medical facilities streamline local policy inventory and reduce confusion. Directive 6330 will become Directive 0999, Policy Management, and will incorporate information from two "business rules" notices that clarify what are policy documents at the medical facility level. In 2018, VHA created a repository of operational memoranda, which have been noted as a source of confusion by GAO and internal stakeholders. The repository ensures that only current operational memoranda remain in effect. In addition, ORAA worked closely with field users to identify significant operational memoranda and is working to ensure that these memos are merged with the appropriate, overarching national policy and all memos that do not contain current requirements are rescinded. In 2019, ORAA used information gathered from 10 medical facility site visits to create a local policy assessment and development tool to help medical facilities determine the appropriate course of action for implementing and tailoring national policy at the local level and development medical facility standards of practice.
Policies and Processes Root Cause 5: VHA rarely embedded policy in a broader change strategy to support implementation by the field. **Policies and Processes Outcome(s) Addressing Root Cause:** VHA applies standard business rules to determine when, what, and how to create uniform policy development and implementation processes across the agency that reflect VHA indices of policy quality (P&P-3); VHA standards and implementing processes are transparent and accessible to appropriate stakeholders (P&P-4).
In 2017 and 2018, the VHA Chief of National Policy conducted 26 semi-structured interviews with policy management staff from medical facilities in each region to discuss local policy development and gain insight about how national policy can ensure consistent implementation and oversight in medical facilities. ORAA shared reports of its key findings with the Field Advisory work group, and the interview feedback informed the selection of medical facilities for ORAA site visits in 2019. Starting April 2018, ORAA requires each Responsible Entity (RE) developing a policy to complete the updated pre-policy form called the Chief of Staff (CoS) Briefing Note. The current CoS Briefing Note expands the original 2016 format by requiring that the RE explain resource needs (funding, space, personnel, IT),

Action Plan Activities Addressing Root Causes
identify obstacles to uniform policy implementation, provide a risk assessment, and outline a communication plan for disseminating the policy upon publication. The SLC was established in 2016 and comprises the Principal Deputy Undersecretary for Health, each VHA Deputy Undersecretary for Health, the ORAA Executive Director and VHA Chief of National Policy. The SLC currently meets every two weeks to discuss governance, provide oversight, and approve enhancements to the policy development and implementation process. The SLC also ensures adequate resource alignment and ensures sub-offices establish and implement action plans for updating policies according to VHA Directive 6330, Controlled National Policy/Directives Management System.
Oversight and Accountability
Oversight and Accountability Root Cause 1: VA has a fragmented oversight operating model that impedes its ability to effectively oversee policy implementation and ensure organizational accountability. **Oversight and Accountability Outcomes Addressing Root Cause:** VHA organizations and employees demonstrate timely and effective risk management in accordance with a unified risk management framework to support governance and oversight (OA-1); governance and management decisions are made at the appropriate level of the organization, are informed by reliable data, and are timely (OA-2); VHA oversight ensures governance and management decisions are implemented and focused on intended outcomes (OA-3); and leadership holds VHA organizations accountable to fulfill obligations imposed by decisions, regulations, and other requirements (OA-4).
VHA has established a new policy development and review process to, among other things, ensure that policies have effective oversight processes in place to ensure policies are implemented and there is accountability for compliance (see Chapter 2, Ambiguous Policies and Inconsistent Processes section for details on the development and review process and Chapter 2, Inadequate Oversight and Accountability section, especially Outcome 3, for oversight of implementation). Additionally, in the Oversight and Accountability action plan, the capacity to oversee operations is being improved by an expanded audit and review function, and expanded risk management and business integrity functions. VA will prevent fragmentation by coordinating oversight through the formation of ARCC and coordination through the risk management process. Corrective actions are followed up on after compliance officers document corrective action into the CIRTS tracking systems. The Organizational Improvement LOE also contributes importantly to resolving this root cause, with its components on governance processes and aligning decision rights, streamlining VHA headquarters, and vertical integration through Integrated Clinical Communities.
Oversight and Accountability Root Cause 2: VA has an organizational cultural gap between those delivering health care in the field and the VHA central office that impedes its ability to oversee and enhance ethical practice vertically throughout the organization. **Oversight and Accountability Outcome Addressing Root Cause:** VHA supports a Just Culture that fosters trust, integrity, learning, and collaboration (OA-5).
VHA is putting more emphasis on its devotion to cultural growth and has a major modernization Lane of Effort to enhance its standing as an HRO focusing on patient safety (Commit to Zero Harm). VA is pairing that commitment with a Just Culture program to foster the learning needed to both operate ethically and continually improve. VA is providing training in these perspectives (ICARE and others) and has issued a Code of Integrity. VA is also developing an effective collaborative approach for organizational entities involved in culture change (e.g., Veterans Experience Office, National Center for Organizational Development, Just Culture).
IT

Action Plan Activities Addressing Root Causes
IT Root Cause 1: Insufficient skilled/trained staff, future skills gaps, and ineffective workforce planning. **IT Outcome Addressing Root Cause:** Deliver IT capabilities to support VHA-determined data and interoperability business needs (IT-1).
A key test of successfully providing skilled/trained staff was the MISSION Act implementation, which also serves as an example of VA's enhanced approaches, mindsets and dedication to fielding knowledgeable and skilled staff. The Office of Information and Technology is a critical partner of VHA for successful MISSION Act implementation. OIT personnel at VA facilities across the country worked 24x7 to deliver enhanced IT systems and services to customers and Veterans by the June 6, 2019, milestone to implement key MISSION Act requirements. Leading up to that date, teams collaborated to embrace the DevOps mindset around MISSION Act – sharing and learning from one another, embracing the connection between business and IT, and offering an experience to internal customers rather than just a service. The success of the June 6 launch of key requirements has proved that OIT will deliver on MISSION Act needs no matter what issues may arise. To better situate themselves to anticipate and respond to potential issues, the incident response teams conducted MADE, or MISSION Act Daily Exercises. These scenario-based exercises took the teams through hypothetical resolution processes that required them to think, plan, and respond quickly. After each exercise, the teams discussed thoughts, comments, best practices, and lessons learned to better inform future crisis response scenarios. VA's ability to assess future needs is now driven by the improved planning possible because of the JBP. The JBP initiative began in 2017 and is a component of VHA and OIT's strategy for improved customer service and alignment with industry best practices. The Account Management Office for Health collaborated with other OIT pillars and VHA's Office of Healthcare Informatics (OHI), Office of Community Care, Office of Connected Care, and others to develop the annual VHA and OIT JBP. This concrete understanding of future business needs provides the basis for effective workforce planning.
IT Root Cause 2: Lack of standardized processes, including streamlined service delivery and effective strategic sourcing, inhibit IT delivery. **IT Outcomes Addressing Root Cause:** Deliver IT capabilities to support VHA-determined data and interoperability business needs (IT-1); improve system interoperability to execute core health care mission functions (IT-2); reduce the number of legacy systems while continuing to meet business needs (IT-4); and reduce the number of duplicative IT systems and capabilities to support business needs (IT-5).
VA is standardizing certain processes to streamline service delivery and make sourcing more effective. OIT established Change Teams to help transform the organization, migrating toward PLM and DevOps concepts. The goals of the Change Teams include the following: • Establish product lines as the framework for organizing all IT services • Transform culture to one of empathy, accountability, and innovation • Rethink business operations (finance/acquisition) • Prepare the environment to receive and support DevOps value streams • Refine and integrate processes to fit VA (Scaled Agile Framework, DevOps, IT Infrastructure Library, and supporting processes) • Adopt human-centered design, modern DevOps tools, and performance monitoring • Establish architecture at the product line level • Establish, promote, and manage platforms • Become a strategic partner that proactively solves business problems using technology

Action Plan Activities Addressing Root Causes
VA is standardizing on an open source Application Programming Interface management platform (Lighthouse), giving developers a standard set of APIs on which developers can build apps. Lighthouse is a next-generation open digital platform that enables rapid innovation in core VA functions and is the "front door" to VA's vast data stores – giving developers the ability to design technology solutions that leverage data and serve Veterans. Micro-purchases will play a big role in the development of the Lighthouse ecosystem – allowing developers to bid on short-term projects needed to build out a consistent architecture, security controls, strategy, roadmap, and outreach approach. Changes to the acquisition process will improve the speed-to-market delivery of approved products and service outcomes. VA will ensure costs, benefits, and the resultant value of all IT investments are estimated in advance and measured through acquisition, development, deployment, operations, and disposal.
IT Root Cause 3: Inefficient tracking methods, poor data quality, and delayed response to material weaknesses challenge management effectiveness. **IT Outcomes Addressing Root Cause:** Deliver IT capabilities to support VHA-determined data and interoperability business needs (IT-1).
To improve tracking methods, data quality, and responsiveness, Joint OIT and VHA teams are now collaborating to embrace the DevOps mindset around the MISSION Act. The first method to improve tracking is to anticipate the likely problems that may develop and create a process to quickly resolve them. To better situate themselves to anticipate and respond to potential issues, the incident response teams conducted MADE. These scenario-based exercises take the teams through hypothetical resolution processes that require them to think, plan, and respond quickly. After each exercise, the teams discuss thoughts, comments, best practices, and lessons learned. OIT employees trained to be ready to address, communicate, and solve any potential issues that may arise before, during, and after launch. Because of this level of preparation, OIT's incident management teams from IT Operations and Services and the Enterprise Program Management Office (EPMO) staffed a 24×7 issues bridge line, triaging help desk tickets, monitoring problems and trends in real time, and calling Decision Support Tool (DST) users to resolve their issues. Nearly all DST and MISSION Act-related help tickets are contacted immediately, leading to a smooth, rapid response. To set priorities to ensure material weaknesses are addressed promptly, the AMO for Health collaborated with other OIT pillars and VHA's OHI, Office of Community Care, Office of Connected Care, and others to develop the annual VHA and OIT JBP . The JBP identifies a discrete set of high-profile work for which OIT makes a special commitment for delivery and leadership attention and oversight.
IT Root Cause 4: Inability to operate and/or integrate with partners and customers detract from service delivery. **IT Outcomes Addressing Root Cause:** Deliver IT capabilities to support VHA-determined data and interoperability business needs (IT-1); improve system interoperability to execute core health care mission functions (IT-2); provide governance and oversight bodies with accurate, reliable, timely, and relevant information to support decision making (IT-3); and reduce the number of legacy systems while continuing to meet business needs (IT-4).
VA is undergoing a cultural shift in how it relates to it partners and customers. Four of the five IT Outcome Action Plans include activities supporting this shift. Below are a few of the highlights of improvements underway to better integrate with partners and customers. • The JBP initiative began in 2017 and is a component of VHA's and OIT's strategy for improved customer service and alignment with industry best practices. The AMO for Health collaborated with other OIT pillars and VHA's OHI, Office of Community Care, Office of Connected Care, and others to develop the annual VHA and OIT JBP. • OIT is a critical partner of VHA for successful MISSION Act implementation. OIT personnel at VA facilities across the country worked 24x7 to deliver enhanced IT systems and services to customers and Veterans by the June 6, 2019, milestone to implement key MISSION Act requirements.

Action Plan Activities Addressing Root Causes
• External developers will gain access to the data and tools they need to build apps on a standard set of APIs designed for Veterans. Lighthouse is the "front door" to VA's vast data stores – giving developers the ability to design technology solutions that leverages VA data and serves Veterans. • The FEHRM Program Office will provide a single point of authority for VA and DOD. As such, the FEHRM directs each department to execute joint decisions for technical, programmatic, and operational functions under its purview, and has the authority to provide oversight regarding required funding and policy as necessary. The technical, programmatic, and operational joint organizational leads will coordinate within their VA and DOD respective communities to ensure requirements are executed. • The VA Interoperability Leadership (VAIL) team serves as a coordinated leadership body focused on ensuring all steps of the Veteran experience are seamlessly enabled through interoperability of the systems that support them. The activities of the Interoperability Leadership Team reach across the VA, the FEHRM, DOD, health care sector, and other partner activities, governance, standards, tools, architecture, applications, policies, and processes related to the exchange of health information/data/best practices for any purpose. • Each Administration and Office impacted by health interoperability will also be executive sponsors. The VAIL represents all the stakeholders throughout VA that are impacted or have leadership roles relevant to health interoperability. The VAIL Executive Council consists of select members of VHA, VBA, OEI, OIT, the VEO, OEHRM, and FEHRM/IPO (non-voting). The reduction in legacy systems requires extensive interaction with the customer base of existing systems. For example, VA conducted an initial requirements meeting with IT POCs for legacy systems and Caregivers Business Owner to discuss next steps for requirements elaboration, prioritization, and preliminary schedule. OIT leveraged VIPR/Intake process and collaborated with business performing.
IT Root Cause 5: Inadequate accountability and governance structures impair IT management. **IT Outcomes Addressing Root Cause:** Improve system interoperability to execute core health care mission functions (IT-2); provide governance and oversight bodies with accurate, reliable, timely, and relevant information to support decision making (IT-3); and reduce the number of duplicative IT systems and capabilities to support business needs (IT-5).
The key methods VA is using to improve accountability and its governance structures are to better integrate across VA organizations and cross-departmentally with DOD, and to create several new offices and functions to support performance. Internal routine governance is improved by a more integrated IT Governance Board (ITGB), which serves as the IT senior-level leadership forum for IT governance within OIT. The IT Governance Board's responsibility spans the culture, organization, policy, and practices that provide for IT management and control across five key areas: 1) Alignment, 2) Value Delivery, 3) Risk Management, 4) Resource Management, and 5) Performance Management. The structure it uses to govern includes the following Councils and Committees. Councils: • Program and Acquisition Review Council (PARC) • Standards & Architecture Council (SAC) • Organization & Workforce Council (OWC) Among other duties, these three Councils address IT— • Strategy – Provide strategic direction of IT to align IT and the business with respect to services and projects.

Action Plan Activities Addressing Root Causes
• Business Value – Ensure the IT/Business organization is designed to drive maximum business value from IT (e.g., business value, return on investment). • Implement Risk Management – Ascertain that processes are in place to ensure that risks have been adequately managed and risks are considered in IT investment decisions. • Improve Resource Management – Provide high-level direction for sourcing and use of IT resources, oversee the aggregate enterprise-level IT funding, and ensure adequate IT capability and infrastructure to support current and expected future business requirements. • Employ Performance Management – Verify strategic compliance (i.e., achievement of strategic IT objectives), including reviewing IT performance measures (i.e., contribution of IT to the business). Committees Supporting the Councils: • Organizational Planning Committee • Transformation Committee • Budget, Programming and Acquisition Committee • Quality and Risk Committee • Operations and Portfolio Management Committee • Architecture and Data Management Committee • Information Security Committee • Analytics and Performance Management Committee • Talent Management Committee To further the implementation of the strategic direction provided by the councils and committees, OIT is also establishing an operational integration effort, the VAIL team, which will— • Serve as the single point of convergence and alignment for interoperability across the VA. • Adjudicate and address gaps in activities, governance, standards, tools, architecture, applications, policies, contract requirements, and processes relating to exchange of health information/data as needed. • Act as the FEHRM's VA point of contact as it relates to joint DOD/VA health interoperability activities to ensure that VA's strategy, requirements, and priorities guide their work (e.g., Joint DOD/VA Interoperability Strategic Plan Interagency Interoperability Technical Plan, standards development activities, and federal policy development). The VAIL Executive Council consists of select members of VHA, VBA, OEI, OIT, VEO, OEHRM, and FEHRM/IPO (non-voting). To ensure clear accountability between DOD and VA, the FEHRM Program Office provides a single point of authority for VA and DOD that resolves and clarifies responsibilities. As such, the FEHRM directs each department to execute joint decisions for technical, programmatic, and functional actions under its purview and has the authority to provide oversight regarding required funding and policy as necessary. The technical, programmatic, and functional joint organizational leads coordinate within their VA and DOD respective communities to ensure requirements are executed.

Action Plan Activities Addressing Root Causes
To ensure there is accountability for implementation, VA established the Office of Electronic Health Record Modernization (OEHRM), which reports directly to the Deputy Secretary of VA. OEHRM is responsible for ensuring VA successfully prepares for, deploys, and maintains the new EHR solution and the health IT tools dependent on it. To help ensure the culture supports the governance structures and accountability becomes an organizational challenge – not just a personal challenge – VHA has adopted the health care HRO as its model for a managerial framework for transformational change. VHA will ground all initiatives in a broader set of foundational HRO principles, tools, and techniques, and apply the Three Lines of Defense (3LD) model (i.e., management control, risk control and compliance, and independent assurance) to provide overall quality assurance. Clinical and administrative elements of the transformation will work to create a VHA in which governance and oversight mechanisms provide reasonable assurance that requirements are met. VA is undergoing a cultural shift in how it relates to it partners and customers. Four of the five IT Outcome Action Plans include activities supporting this shift. Below are a few of the highlights of improvements underway to better integrate with partners and customers. • The JBP initiative began in 2017 and is a component of VHA's and OIT's strategy for improved customer service and alignment with industry best practices. The AMO for Health collaborated with other OIT pillars and VHA's OHI, Office of Community Care, Office of Connected Care, and others to develop the annual VHA and OIT JBP. • OIT is a critical partner of VHA for successful MISSION Act implementation. OIT personnel at VA facilities across the country worked 24x7 to deliver enhanced IT systems and services to customers and Veterans by the June 6, 2019, milestone to implement key MISSION Act requirements. • External developers will gain access to the data and tools they need to build apps on a standard set of APIs designed for Veterans. Lighthouse is the "front door" to VA's vast data stores – giving developers the ability to design technology solutions that leverage VA's data and serve Veterans. • The FEHRM Program Office will provide a single point of authority for VA and DOD. As such, the FEHRM directs each department to execute joint decisions for technical, programmatic, and operational functions under its purview, and has the authority to provide oversight regarding required funding and policy as necessary. The technical, programmatic, and operational joint organizational leads will coordinate within their VA and DOD respective communities to ensure requirements are executed. • The VAIL team serves as a coordinated leadership body focused on ensuring all steps of the Veteran experience are seamlessly enabled through interoperability of the systems that support them. The activities of the Interoperability Leadership Team reach across the VA, the FEHRM, DOD, health care sector, and other partner activities, governance, standards, tools, architecture, applications, policies, and processes related to the exchange of health information/data/best practices for any purpose. • Each Administration and Office impacted by health interoperability will also be executive sponsors. The VAIL represents all the stakeholders throughout VA that are impacted or have leadership roles relevant to health interoperability. The VAIL Executive Council consists of select members of VHA, VBA, OEI, OIT, VEO, OEHRM, and FEHRM/IPO (non-voting). The reduction in legacy systems requires extensive interaction with the customer base of existing systems. For example, VA conducted an initial requirements meeting with IT POCs for legacy systems and the VHA Caregivers Support Program to discuss next steps for requirements elaboration, prioritization, and preliminary schedule. OIT leveraged VIPR/Intake process and collaborated with business performing analysis of alternatives on proposed Commercial-Off-The-Shelf solutions supporting the requirements of the VHA Caregiver Support Program to implement the MISSION Act. OIT held in-person sessions with the VHA Caregiver Support Program team and business partners in Atlanta in July 2019, to refine requirements, identify dependencies and risks, and develop systems modifications to support implementation of the IT system required by section 162 of the MISSION Act.

Action Plan Activities Addressing Root Causes
Training
Training Root Cause 1: VA lacks a comprehensive, enterprise-wide training policy and planning process. **Training Outcome Addressing Root Cause:** Training: • Developed in response to priorities identified by senior VHA leadership (national and field) • Delivered to nationally specified standards • Evaluated and reported by program office guidelines delineated in national policies (T-1)
Since 2015 VHA has made significant progress in developing and implementing a comprehensive training policy and planning process. VA's Training Action Plan also identifies significant further improvements planned to fully address this root cause. These accomplishments and plans are: **Policy Improvements** In March 2018, VHA updated its policy on the appropriate and effective use of trainings required to be completed by VHA employees via VHA Directive 1052 (Appropriate and Effective Use of VHA Employee Mandatory and Required Training). This directive also outlined the policy regarding the appropriate processes for initiating, renewing, consolidating, expanding, substituting, and discontinuing trainings mandated for VHA employees. The Training work group is collaborating with the Policies and Processes work group to develop a VHA policy that supports VHA's implementation of a standardized oversight and training planning process for all national directives, processes, or procedures. This policy defines: roles and responsibilities, oversight authority for internal and external training requests, the process to manage the training component of major system initiatives, training evaluation standards and resource requirements, and process for field concurrence (e.g., policy review process) (Q2FY20). VA's Training Leaders Council (TLC) is currently drafting an update to VA Directive 5015 (the VA Training Policy). **Planning Improvements** In 2016, the Training work group developed and implemented a standardized training planning model within VHA. The process mandated content analysis and evaluative tools to assess effectiveness of training using Kirkpatrick Level 2 or above evaluation for VHA-wide training efforts. In March 2018, VHA updated the process for developing/evaluating training development. Updates included the requirement to conduct a minimum Kirkpatrick Level 2 assessment for all accredited and non-accredited training. This evaluation is conducted using data collected from the Talent Management System (TMS), Qualtrics® XM, and Training Finder Real-time Affiliate Integrated Network (TRAIN). The National DLO Community of Practice, in collaboration with regional leadership, Medical Center DLOs, other educational program directors, and program offices, coordinates the conception, design, development, implementation, and evaluation of the learning programs and ensure alignment with the overall organizational mission and vision for the future. Business Intelligence Suite also was established to enable receiving, processing, and monitoring requests for customized training to be developed by VHA internally, communicating the requirements across a broad area of production modalities and tracking the development of training and delivering training products. VHA conducted a series of site visits at 10 VA medical facilities of varying complexity. Key findings included—

Action Plan Activities Addressing Root Causes
• Variation in VA education service configurations must be modernized particularly related to the DLO role, optimizing coordination to reduce mission overlap between facility departments, and leadership best practices to champion education • Mandatory training should be assigned with longer compliance times with annual refresh to maintain required status • VHA national Program Offices should define required clinical competencies to eliminate disparities VA and VHA implemented further improvements to the training planning process, including the ability to better prioritize training, thus freeing up resources to address critical training needs, as described below. • VHA is continuing to improve its training policies and planning processes by: 1) developing and using an effective assessment process to measure the effectiveness of training plan implementation and the impact of training on the desired organizational goal; and 2) ensuring the training planning process is fully adopted across VHA • VHA will develop SOPs for vetting proposed training contract requests
Training Root Cause 2: VA lacks a systematic approach to competency assessment and execution. **Training Outcome Addressing Root Cause:** Accurately identified audience is trained at the appropriate time to specific program/process requirements (T-2).
To establish the foundation to address this root cause— • VA established the TLC to promote effective and efficient training, education, and professional development activities, opportunities, and standards to achieve optimum employee performance in support of VA's mission. VA Chief Learning Officer leads the TLC; EES is a voting member and rotating co-chair of the TLC. • VA appointed a permanent VA Chief Learning Officer in March 2019. • VHA EES established the National DLO Community of Practice and dedicated a full-time staff member to coordinate the activities and take the lead in creating a culture of learning and education to address the new VA workforce. • All VHA Program Offices and regions are assigned a Learning Consultant that provides training expertise and assists with identifying training resource needs. • EES has dedicated resources of 30 FTEE to consult with both VHA national and field leadership, and subject matter experts. VHA also implemented improvements to the training assignment process, including reducing unnecessary mandatory training, better prioritization of all training, and meeting unplanned priority training needs, as described below: • In 2015, VHA developed a systematic approach to prioritize training requests based on scale of audience, origination of the request (e.g., legislative mandate, White House Mandate), business metrics, and identified skill or knowledge gap. • In early 2019, VHA Deputy Under Secretaries of Health identified training priorities across the VHA and designated training to support the 18 VHA Operational Strategies. As of June 21, 2019, 91.2% (N = 1920) of all current internal VHA training requests aligned to the 18 VA Operational Strategies or Secretary priorities. • In mid-FY 2019, the Executive in Charge, in support of the VA's Secretary, refocused training priorities to align with the Lanes of Effort.

Action Plan Activities Addressing Root Causes
• In support of the MISSION Act, VHA collaborated across responsible and supporting program offices to develop and deliver trainings that reflected national standards, policies, and processes to both VHA staff and external community care providers. During MISSION Act implementation in FY 2019, VHA reported bi-daily aggregate reporting, helping management and staff to ensure completion of the targeted approximately 2 million MISSION Act-related trainings. • VHA compliance reporting in FY 2018 indicated a 93% compliance rate for critical training for opioid prescribers and a 95% compliance rate for suicide prevention training. VHA is continuing to take additional steps to improve training resource management and availability, including the following: • Developing a process and policy to include a training line-item in VHA's annual budget and to similarly align budget object codes • Establishing business and operational requirements for a VA-wide contract vehicle for training delivery and development • Reducing redundant training contracts and providing standardized contracting language to ensure the government's needs are met
Training Root Cause 3: Inadequate resources for development and implementation of appropriate educational infrastructure at the enterprise and administration levels. **Training Outcome Addressing Root Cause:** Using the most resource-efficient approach, training is planned and developed, coordinated and implemented, then evaluated and managed to achieve effective training outcomes (T-3).
In 2017, EES added the capability to identify participant groups to trigger later assignment by TMS. This is an example of a process that may be expanded to include externally contracted training development by VHA. In 2018, to enable application of competency-based training requirements, VA/VHA upgraded TMS to enable synchronization with the Human Resource Management Information System. This will allow training position codes and competencies to be aligned to targeted learning participants. This also has enabled training to be "pushed" to participants based on their learning plan, supervisor assignments, occupation, service/business line, facility organization, or other demographic information provided by HR Smart, VA's human resources system of record. The Training work group is collaborating with the Resource Allocation work group and other stakeholders to review current training assignments and determine if more defined role-specific job codes should be used in targeting training participants through HR Smart. VHA also will evaluate lifecycle maintenance processes for assessing new job codes and the impact of the updated mandatory training policy. VHA is collaborating across VA's Manpower Office, program offices, regions, LOEs, medical facilities, and other key stakeholders to enhance VHA's ability to target training most effectively. By the end of FY 2020, VHA will develop a competency modeling strategy. Consideration will be given to addressing the findings from VHA's recent facility site visits, including having program offices define critical clinical competencies to eliminate disparities.
Resource Allocation
Resource Allocation Root Cause 1: The VA lacks consistent resource management, oversight, and execution plans. **Resource Allocation Outcome Addressing Root Cause:** Unified resource planning and allocation process is clearly documented and consistently applied (RA-1).

Action Plan Activities Addressing Root Causes
VHA established a new headquarters-level manpower office with the capabilities and authority to provide oversight of the entire VHA, with decision authority resting in the VHA Chief of Staff. The VHA Manpower Management Office (MMO) is undertaking initiatives to document and standardize appropriate organizational structures based on the work performed and personnel supported. Second, the Manpower Office is validating every position in VHA's HR system of record. Third, the VHA MMO will reconcile job descriptions and corresponding knowledge, skills, and abilities (KSA) to ensure like jobs have like job descriptions throughout the organization. The VHA MMO also is training and placing manpower analysts at every region so leaders at that level can obtain the support services they need.
Resource Allocation Root Cause 2: VA lacks a streamlined, integrated, comprehensive strategic guidance process to develop resourcing decisions aligned with department goals and mission requirements. **Resource Allocation Outcome Addressing Root Cause:** VHA utilizes a comprehensive strategic guidance process to ensure alignment of resources to leadership priorities (RA-2).
The VHA governance boards and supporting work groups have undergone restructure and re-chartering to provide appropriate decision authority and guidance. VHA now requires all major plans and initiatives to incorporate risk mitigation for the AOCs (i.e., policy, IT, training, oversight, and resource allocation) in every proposal prior to the plan or proposal is reviewed, and each proposal must show how it links to leadership priorities. Further, VHA has significantly enhanced its strategic planning guidance for programming and budgeting purposes. The guidance now includes special initiative program reviews, and reviews of any function that requires significant variance from prior years – either up or down – to ensure appropriate return on investment and alignment with leadership priorities. Within the next 3 to 5 years, VHA plans to deploy iFAMS (the Integrated Financial & Asset Management System) to improve resource management through all phases of the budget planning to execution process.
Resource Allocation Root Cause 3: VA has insufficient, ineffective, and disjointed databases resulting in a lack of useful data for modeling and forecasting resource needs. **Resource Allocation Outcome Addressing Root Cause:** Adequate data and reporting mechanisms are used for making, evaluating, and informing resource planning and allocation decisions (RA-3).
VHA recognizes accurate and up-to-date data are required to improve its modeling and forecasting for both human and financial resources. VHA is working to reconcile its manpower structure on the ground with its manpower database to within 98.5% accuracy. The new Manpower Office is establishing administration-wide staffing models to decrease unjustified variance in staff FTEs, KSAs, and grades throughout the administration. Both these efforts will improve transparency and visibility of VHA's manpower assets. Finance is working to improve the accuracy and recency of the Veterans Experience Resource Allocation model, and the Medical Center Allocation System model. With a goal of completing in Q3FY20, the models will be made available on an internal website. Already in the first wave implementation of iFAMS, VHA is working to scrub and transfer historical financial data from old financial management systems to the new system.

Acronyms and Initialisms

Acronym/ Initialism	Definition
3LD	Three Lines of Defense
AHRQ	Agency for Healthcare Research and Quality
AMO	Account Management Office
AOC	Area of Concern
API	Application Programming Interface
ARCC	Audit, Risk, and Compliance Committee
BPRE	Business Process Re-Engineering
CARMA	Caregiver Record Management Application
CBI	Compliance and Business Integrity
CCN	Community Care Network
CIO	Chief Information Officer
CIRTS	Compliance Inquiry Reporting and Tracking Systems
CLO	Chief Learning Officer
CMS	Centers for Medicare and Medicaid Services
COSO	Committee of Sponsoring Organizations of the Treadway Commission
CSP	Caregiver Support Program
DDM	Design Decision Matrix
DLA	Defense Logistics Agency
DLO	Designated Learning Officer
DMLSS	Defense Medical Logistics Standard Support
DOD	Department of Defense
DST	Decision Support Tool
DUSH	Deputy Under Secretary of Health
EAB	Executive Advisory Board
EDI	Electronic Data Interchange
EES	Employee Education System
EHR	Electronic Health Record
EHRM	Electronic Health Record Modernization
EIC	Executive in Charge
EMR	Electronic Medical Record
EPMO	Enterprise Program Management Office
ERM	Enterprise Risk Management
FEHRM	Federal Electronic Health Record Modernization
FMBT	Financial Management Business Transformation
FOC	Full Operating Capability
FTE	Full Time Equivalent
FTEE	Full Time Equivalent Employee
FWA	Fraud, Waste and Abuse
FY	Fiscal Year
GAO	Government Accountability Office
GOAL	GAO Office of the Inspector General Accountability Liaison Office
HAC	Hospital-Acquired Condition
HR	Human Resources

Acronym/ Initialism	Definition
HRL	High Risk List
HSRM	HealthShare Referral Manager
HRO	High Reliability Organization
HVAC	House Veterans Affairs Committee
IA	Internal Audit
ICARE	Integrity, Commitment, Advocacy, Respect, Excellence
iFAMS	Integrated Financial & Asset Management System
ICC(s)	Integrated Clinical Community(ies)
IIA	Institute of Internal Auditors
IOC	Initial Operating Capability
IPT	Integrated Project Team
IT	Information Technology
ITGB	IT Governance Board
JBP	Joint Business Plan
JOC	Joint Operations Center
KSA	Knowledge, Skills, and Abilities
LOE	Lane of Effort
LSM	Legacy Systems Modernization
MHA	Mental Health Assistant
MISSION Act	Maintaining Internal Systems and Strengthening Integrated Outside Networks Act
MMO	Manpower Management Office
MSPV	Medical/Surgical Prime Vendor
OA	Oversight and Accountability
OCC	Office of Community Care
OCHCO	Office of the Chief Human Capital Officer
OEHRM	Office of Electronic Health Record Modernization
OEI	Office of Enterprise Integration
OHI	Office of Healthcare Informatics
OHT	Office of Healthcare Transformation
OIG	Office of the Inspector General
OIT	Office of Information and Technology
OMB	Office of Management and Budget
OMI	Office of Medical Inspector
ORAA	Office of Regulatory and Administrative Affairs
OTH	Other Than Honorable discharge
P&P	Policies and Processes
PCAFC	Program of Comprehensive Assistance for Family Caregivers
PCMHI	Primary Care/Mental Health Integration
PD	Position Description
PLM	Product Life-cycle Management
POC	Point of Contact
RA	Resource Allocation
RMF	Risk Management Framework
SLC	Senior Leader Committee

Acronym/ Initialism	Definition
SOP	Standard Operating Procedure
SSAB	Supply Chain Management Strategy and Architecture Board
SSU	Shared Service Unit
SVAC	Senate Veterans Affairs Committee
T	Training
TBD	To Be Determined
TDC	Talent Development Council
TMS	Talent Management System
TRAIN	Training Finder Real-Time Affiliate Integrated Network
TRM	Technical Reference Model
UFR	Unfunded Requirement
VA	Department of Veterans Affairs
VAEC	Veterans Affairs Enterprise Cloud
VAIL	VA Interoperability Leadership Team
VASI	Veterans Affairs System Inventory
VBA	Veterans Benefits Administration
VCA	Veterans Care Agreement
VCCP	Veteran Community Care Program
VEO	Veteran Experience Office
VHA	Veterans Health Administration
VHACO	Veterans Health Administration Central Offices
VIPR	VA IT Process Requests
VISN	Veterans Integrated Service Network
VistA	Veterans Information Systems and Technology Architecture
VSE	VistA Scheduling Enhancements
WMC	Workforce Management and Consulting