VA High Risk List Action Plan - Update:

Managing Risks and Improving VA Health Care

Department of Veterans Affairs

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Executive Summary

The Department of Veterans Affairs (VA) is pleased to provide the Government Accountability Office (GAO) with our 2022 Action Plan submission for the Managing Risks and Improving VA Health Care GAO High-Risk Listing (HRL). This year's Action Plan contains an overview of accomplishments and documented progress made through March 2022, as well as a summary of VA's planned efforts to further address and resolve known areas of concern. Moreover, VA outlines future planned actions with detailed project milestones, refined goals and objectives, a resource assessment and a response to critiques made in GAO's 2021 High Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas (21-119SP).

VA Leadership continues to establish a unified vision for ensuring VA effectively takes action to address GAO's identified areas of concern and drives organizational accountability toward resolution of all high-risk listings. VA considers HRL-related work to be of utmost importance and, while encouraged by the progress that has been made in recent years, recognizes that continued improvements are needed to ensure department-wide changes are sustainable and in alignment with VA's enterprise roadmap.

In March 2021, GAO released an updated rating for each of the areas of concern in the five Removal Criteria. This Action Plan update represents progress VA has made towards further achieving HRL removal criteria since that time. VA intends for this Action Plan to not only increase the rating for the Action Plan Removal Criterion, but also to demonstrate the path forward for meeting the other four Removal Criteria.

VA is pleased with the progress represented in this Action Plan and continues to emphasize its commitment to work supporting HRL removal. While VA was encouraged with the progress made toward achieving "fully met" in many of GAO's Key Elements of an Action Plan following its 2021 submission, it recognizes that continued improvements are needed. This Action Plan demonstrates a more robust and complete approach to achieving VA's outcomes and will result in additionally increased ratings in more Key Elements.

Introduction

The information contained in this section of the Action Plan highlights significant changes undertaken by VA that impact HRL-related efforts, identifies major program management accomplishments and details how organizational and operational improvements made by the areas of concern impacted the VA's ability to respond to the coronavirus 2019 (COVID-19) pandemic. Upon the conclusion of this section, the Action Plan proceeds to provide in-depth updates for each of the areas of concern.

GAO identified VA's Managing Risks and Improving VA Health Care as a high-risk area in 2015. In the HRL-designation, GAO identifies five areas of concern that VA must address to be removed from the HRL. These five areas of concern include: ambiguous policies and inconsistent processes, inadequate oversight and accountability, information technology challenges, inadequate training for VA staff and unclear resource needs and allocation priorities. This is the fourth rating cycle for this HRL.

Figure 0.1, below, summarizes GAO's most recent rating for each of VA's abovementioned areas of concern.

Figure 0.1. GAO Rating for Each Area of Concern as of March 2021

VHA has codified an HRL governance structure, including an HRL Oversight Board and a Steering Committee. Throughout 2021, VA held strategic planning sessions, strengthened its risk and change management faculties, continued regular monitoring

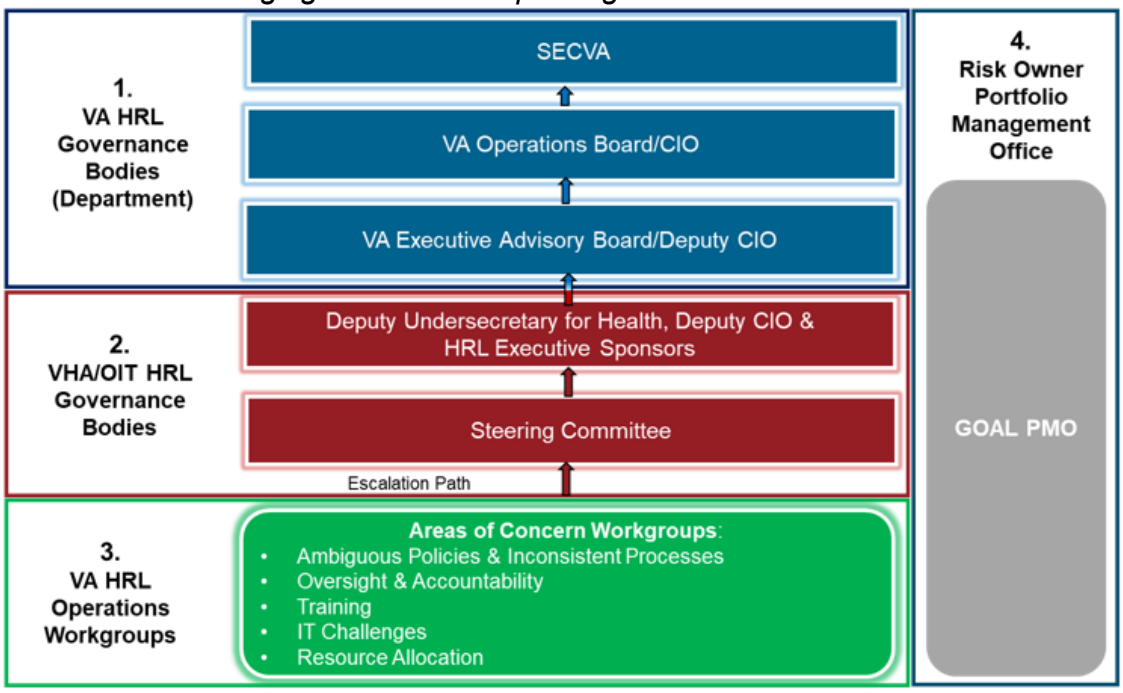
and reporting of metrics and leveraged an integrated operating platform for storing artifacts.

Portfolio Management

The ability of VA's senior leaders to inform and guide this HRL work continues to be supported at the operational level by a defined system of governance, centered around Area of Concern (AOC) workgroups. Each AOC workgroup is represented by an Outcome Lead who reports to an HRL Steering Committee. The Steering Committee, chaired by a Senior Advisor to the Deputy Under Secretary for Health (DUSH), reports to the HRL Oversight Board (HRL OVB) which is led by the DUSH and includes the Deputy Chief Information Officer (CIO) and HRL Outcome Executives for each AOC. The HRL OVB in turn reports to the VA Executive Advisory Board and VA Operations Board, both chaired by the VA Deputy Secretary.

This governance structure is graphically represented in Figure 0.2, below.

Figure 0.2. VA's Managing Risks and Improving VA Health Care Governance Structure



Each AOC workgroup continues to maintain a detailed roadmap that links individual actions to the resolution of root causes and key outcomes, which enables the refinement of goals and objectives. Additionally, AOC workgroups have been continuously evolving their set of metrics based on metrics development guidance. These metrics are moving towards outcome-based measures that will aid in understanding and communicating business benefits to stakeholders. VA also continues to note any intersection between VA transformational efforts and the AOCs.

In June 2021, the Acting Assistant USH for Community Care assumed the delegable duties of the DUSH, becoming the senior accountable official for VA's Healthcare High Risk Listing. The previous senior accountable official now performs the delegable duties of the USH. This transition benefited our HRL efforts by maintaining leadership continuity while broadening the senior leaders engaged with this work. Together, the Acting USH and Acting DUSH continue to ensure the Secretary has all information necessary to make critical decisions to further HRL efforts.

Portfolio Management Major Accomplishments June 2021 – March 2022

Consistent with the legislation S. 1550, the Program Management Improvement and Accountability Act of 2015 (PMIAA), the Government Accountability Office – Office of the Inspector General Liaison (GOAL) Office, the program office responsible for managing this high-risk listing within VHA, continues to contract experts in the field of portfolio, program, and project management to develop and institutionalize portfolio management functions that help to manage and coordinate efforts across the multiple areas of concern. In doing so, VA has been able to address many of the GAO removal criteria, which are intended to drive accountability and best practices in project and program management throughout the federal government. VA applies a portfolio management approach to monitor and track progress, coordinate with stakeholders to elevate identified risks to VA leadership and guide the necessary course corrections. VA developed and currently uses the following key management processes:

- The Change Control process ensures the integrity of the Action Plan and that any changes are documented and tracked. This process includes a Change Control Board to effectively coordinate proposed changes to key products and systems (changes from areas of concern, GAO, etc.).

- The Check Point process serves as the primary monitoring function driving consistency for how each AOC workgroup progresses from the planning phase to sustainment. Each phase is monitored against GAO criteria for removal.

- The Integrated Master Schedule (IMS) serves as the central logistics consolidation point across the portfolio of activities ensuring dates, milestones, resources, dependencies, and relationships do not conflict.

- The Artifact Repository serves as the central location for collecting, cataloging, and storing artifacts that demonstrate completion or sustainment of all actions identified in the Action Plan. The repository drives a level of standardization for how artifacts are named and stored.

- The Metrics Dashboard measures outcome-aligned progress toward stated milestones and targets for completion. The dashboard graphically depicts data, status, targets, and trends in a uniform format for knowledge-sharing and decision making. The dashboard allows for a straightforward interpretation of performance efforts and targeted course corrections. Understanding that metrics

may change, the dashboard was constructed with flexibility and scale in mind so that newly developed metrics can be easily incorporated.

- The Decision Log serves as the central repository for decisions impacting HRL response, ensuring leadership direction is applied consistently.

- The Risk Management process proactively identifies risks and issues threatening action plan implementation and allows VA to develop and apply appropriate management and mitigation strategies.

- Change Management activities support action plan implementation and success. Sponsor assessments, coaching and communications messaging is integrated into action items to support stakeholder understanding and promote leadership commitment to these efforts.

- The annual Communications Plan guides messaging including focused topics for the year and key themes and messages. GOAL hosts Strategic Communications meetings where the areas of concern present their long-term, mid-term and near-term communications plans.

COVID-19 Response

VA is extremely proud of the work conducted throughout the COVID-19 pandemic, specifically meeting the care needs of Veterans. In fiscal year (FY) 2021, VA provided the most outpatient care ever, with more than 78 million health care visits. This surpassed the previous record of 74.2 million visits in FY 2019. As business processes improvements have an immediate effect on Veterans' health care, VA continued to focus on addressing the HRL areas of concern throughout the pandemic. Improvements in the areas of IT, resource allocation, oversight and accountability, policy and training were paramount to VHA's successfully emergency response to the COVID-19 pandemic.

- The Office of Information Technology (OIT) increased network capacity to support 80,000 additional teleworking employees, rapidly scaled technology and supporting infrastructure and provided support to 150,000 caregivers and claims processors.
- Between March 1, 2020, and February 5, 2022, OIT-supported a 1,755% increase in telehealth sessions. Overall, use of telehealth services grew from approximately 1.3 million video visits in FY 2019 to more than 9 million in FY 2021.
- VHA added 92,812 new hires between March 2020 and March 2021, 18,088 of which were registered nurses and nurse practitioners.
- VHA utilized Coronavirus Aid, Relief, and Economic Stimulus (CARES) Act funds to support COVID-19 staffing surges, offering incentives and awards to help address staffing shortages at the local level.

- VA deployed personnel to more than 49 states and territories to support VA's Fourth Mission with direct patient clinical care, testing, education, and training.
- VHA rapidly adapted training processes, focusing on the cited GAO concerns, to deliver centrally vetted training to a specific training audience, based on specific COVID-19 related or impacted duties.
- Training, under Employee Education Services (EES), worked with the Office of Emergency Medicine and the Pharmacy Program Office to create and maintain up-to-date COVID-19 vaccine-related trainings. To allow clinicians to focus on patient care during the COVID-19 Delta variant surge, VHA Mandatory Training supported a 120-day Moratorium, which will be renewed as needed.
- Mandatory Training created an Interim Training Waiver Approval Process in FY21 to provide flexible and agile responses to the COVID-19 mission increase.
- VA expanded education and resources for families to be able to make informed decisions about their healthcare planning including difficult conversations around COVID-19 prognosis. Including decisional aids and interactive communication materials distributed to practitioners, caregivers, and Veterans.
- To improve the organization's ability to transparently communicate new and updated standards to stakeholders at all levels, Policy supported VHA's creation of a rapid process to review and publish COVID-19 Communications.

In December 2020, VA began distributing COVID-19 vaccines to eligible employees and Veterans, balancing site-specific resources, facility needs, vaccine availability and local pandemic statuses as well as the strict storage, handling and transportation requirements of available vaccines. Currently, 66.3% of Veteran users are vaccinated.

VA Health Care Areas of Concern Updates

1. Ambiguous Policies and Inconsistent Processes

Executive Sponsor: Ethan Kalett, JD, Senior Advisor, Office of Regulation, Appeals, and Policy

Executive Summary

Over the past seven years, VHA has streamlined the total number of national policies from 805 documents in FY 2015 to 474 by Q2FY22, while at the same time reducing the number of national policies overdue for recertification from 59% to 26%. In 2020, implemented business rules for policy development that empowered local and Veterans Integrated Service Network (VISN) leadership to streamline local policy inventory and reduce the time required for policymaking and policy administration by VA medical facility staff. As of February 2022, 129 VA medical facilities submitted an action plan update indicating that within the first year-and-a-half they'd achieved an average inventory reduction of 29%. VA medical facilities' ability to implement national policy without need for restatement or interpretation will reduce unnecessary administrative burdens and help provide consistently high-quality care at every point of service.

VHA has developed preliminary processes to ensure operational memos and guidance documents have integrity and a clear role as part of a broader policy framework. In addition, VHA continues to collaborate with VA partners to pilot a new policy library that establishes a single searchable source for VA policies and released an internal pilot site to solicit user feedback in 2021. Taken together, these initiatives are only possible because stakeholders increasingly trust the policies and guidance issued by VA; trust that has been earned by processes that facilitate policymakers' collaboration with front-line employees and skilled editors. The quality of VHA policy has unquestionably improved and VHA believes that our unambiguous policies and guidance, and consistent processes, are increasingly relied upon by facilities without the need for restatement or interpretation and will positively impact Veterans and those we serve by providing consistently high-quality care at every point of service.

Figure 1-1. Policies and Processes 2021 Rating Goal

VHA has successfully built a robust foundation for developing, implementing, and maintaining the national policy. Led by the VHA Chiefs of National Policy and the Senior Advisor, VHA Office of Regulations, Appeals and Policy (RAP), 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 initial development of a common library for all policy and

policy-related documents. Consistent execution of the action plan will result in a 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.

The P&P workgroup improved policy development and implementation in the following ways:

- Updated the VHA policy on the Controlled National Policy/Directives Management System Directive and supporting guidance to incorporate continuously improving VHA policy standards.

- Continued to improve the required Briefing Note (formally the pre-planning or Chief of Staff Briefing Note) that accompanies each policy document during concurrence for VHA program offices to ensure national policies are adequately resourced, capable of uniform implementation, and support VA priorities including diversity and equity before publication.

- Implemented a bi-annual VA medical facility policy census and continuous access to facility policy libraries to track local policy inventory reduction initiatives and improve the alignment of national and local policies.

- Reviewed and updated 150 national policies in less than six months to facilitate VA's rollout of a new national electronic health record software platform; continues to provide direct support to facilities as they update local policy inventory to enable Cerner implementation.

- Developed the framework for a pilot central repository that includes documents from VA, VHA, and VISN 4 policy and supporting documents and released a minimum viable product to solicit internal user feedback.

- Facilitated the implementation of VA's Supremacy Regulation, beginning February 2021, which will enable more than 40 health care professionals to establish national standards of practice through publication of national policy.

- Established a process for facilities to receive waivers from national policy, published approved waivers on a transparent intranet site, and provided semi-annual reports to VA CO leadership.

- Developed new standards and strengthened processes governing the development, review, publication of Operational Memoranda.

The section below provides examples of how the Policies and Processes area of concern effort aligns with actions being undertaken to address the other areas of concern.

Policy and Processes Alignment with Other Areas of Concern:

- **Policy and Processes Alignment with Oversight and Accountability:**
  - Continued collaboration with the Oversight and Accountability workgroup is necessary to ensure VHA policy standards continue to align with VHA's Risk Management Framework and to ensure that VHA program offices can appropriately monitor implementation of national policy across VA medical facilities.
    - The forthcoming VHA Directive 0999 (currently 6330) includes requirements to include oversight and accountability in all VHA policies. The responsibility for providing oversight must be written into policy at multiple levels of the organization: upper leadership, VHA program offices, Veterans Integrated Service Networks (VISN) and VA Medical Centers (VAMC).

    - Directive 1217, VHA Operating Units and 1217.01, VHA Governance, represent incremental steps to clarify roles and responsibilities for oversight and accountability in VHA. In addition, the Senior Advisor, Office of Regulation, Appeals, and Policy and the Chief, VHA National Policy Strategy are part of the Audit, Risk and Compliance Committee and Subcommittee, respectively.

  - Partnership in development of process to request waivers to VHA national policy. With publication of VHA Notice 2022-01, 10BRAP transitioned ownership of the process to 10OIC, with a corresponding change to email and website addresses. 10BRAP will assist 10OIC with development of a permanent waiver process via VHA directive.

- **Policy and Processes Alignment with 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.

- **Policy and Processes Alignment with Training:**
  - Ongoing collaboration with the Training workgroup will ensure that VHA program offices continue to include required staff training in VHA policy as necessary and appropriate.
    - Training committee reviews and approves training requirements prior to publication of a policy.

- The Policy and Processes and Training workgroups will collaborate to develop several VHA directives that support implementing standard VHA planning and oversight for training requirements.

- Policy will also collaborate with Training on waivers to VHA national policy – particularly training requirements – and a Training repository that includes direct links to the relevant VHA national policy.

- **Policy and Processes Alignment with 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. Policy will act on field requests to develop a common Position Description for policy managers in conjunction with VHA Manpower.

    - VHA's Manpower Management Office is chartering and implementing a standard business support function by level of authority, which will be consistent with Directive 1217 and 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.

Ambiguous Policies and Inconsistent Processes – Highlights

a. Key Actions Completed from March 2021 through March 2022; all initiatives are ongoing

- Continued right-sizing VHA national policy inventory from 554 to 474 and reduced the number of expired policies (now 26%) from 207 to 122 as part of VHA's goal to reach functional zero overdue national policies, helping to ensure VHA standards are communicated clearly, set forth in the appropriate vehicle and have adequate resources for uniform implementation.

- Successfully implemented policy development business rules designed to reduce unnecessary policy inventory and improve VHA's policy framework, leading to an average 24% reduction in local policy inventory in the first year from reporting VA medical facilities. Note: reduction measure reflects 124 facilities (89%) with

complete reporting data. Reducing unnecessary local policy inventory decreases unwanted variation between VA medical facilities and increases the time VA medical facility staff can devote to patient care rather than administrative activities.

- Local Policy Reduction - 133 VAMCs (95%) report a reduction of 10,809 MCPs (21%) or 81 MCPs on average per VAMC after one year (Feb. 2020- Jan. 2021). 129 VAMCs (92%) report a reduction of 14,424 MCPs (29%) or 112 MCPs on average per VAMC after one-and-a-half years (Feb. 2020- July 2021). Based on reported averages, a VHA-wide reduction of 21% (11,508 MCPs) after one year and a VHA-wide reduction of 29% (15,556 MCPs) after one-and-a-half years is estimated.

- Reduced local policy mandates written in national policy by 50% from November 2018 to March 2022, from 150 to 71. This reduced unnecessary administrative burdens and variation in policy implementation between VA medical facilities.

- Collaborated with VA, National Cemetery Administration (NCA), and VHA facility partners to pilot a new policy library that will ultimately host policy and policy-related documents in a central, searchable location, enabling all VA staff to conveniently access the policy information they need with full confidence the documents are up to date. The policy library's searchability and functionality measures were piloted (which did not exist last year), and significant progress has been made in integrating facility sites into the pilot site.

- Developed new standards and strengthened processes governing the development, review and publication of Review of Operational Memoranda VHA Notice 2021-12(1) to ensure VHA communicates standards and guidance in the appropriate communication vehicles.

- Assisted VHA program offices and VA medical facilities with reviewing and updating policy to enable the ongoing implementation of VA's new electronic health record software platform while maintaining VA medical facilities' capability to comply with VHA policy standards.

- Established a process for facilities to receive waivers from national policy, Waivers to VHA National Policy VHA Notice 2022-01, published approved waivers on a transparent intranet site, and provided semi-annual reports to VA leadership. The waiver process provides a structured pathway for VHA program offices to receive feedback on published policy and accounts for policy exceptions necessitated by current VA medical facility operational conditions. This established process is housed in OIC, part of the Oversight and Accountability Area of Concern.

- Supported VHA's creation of a rapid process to review and publish COVID-19 Communications to improve the organization's ability to transparently communicate new and updated standards to stakeholders at all levels.

b. Key Actions underway or planned through March 2023

- Facilitate implementation of VA's supremacy regulation to enable licensed and credentialed health care professions to establish national standards of practice to enhance VHA's uniform implementation of national policy.

- Support development of national standards of practice that will standardize practices and business operations across medical centers and maximize implementation of the Electronic Health Record (EHR) with Department of Defense (DoD).

- Facilitating sharing of best practices across VA medical facilities, including a position description (PD)for field-based policy managers with the goal of establishing a common PD.

- Strengthen leadership oversight and resource management by improving planning processes associated with policy development.

- Continue to reduce unnecessary administrative burdens and improve policy content clarity by providing direct support to Veterans Integrated Service Networks (VISN) and VA medical facilities to implement policy development business rules and align local and national policy inventories.

- Continue to reduce unnecessary administrative burdens by establishing a standardized definition of local implementing documents, including Standard Operating Procedures, created at VAMCs.

- Improve clarity and uniformity of policy content and standards by establishing standard definitions for clinical terminology used in VHA policy for Electronic Health Record (EHR) and National Standards of Practice.

Ambiguous Policies and Inconsistent Processes – Actions Taken to Address GAO's "Not Met" Removal Criteria 2021 Rating

Ambiguous Policies and Inconsistent Processes received a "not met" rating from GAO for the following removal criteria: Demonstrated Progress; Monitoring. The below list provides details on actions taken by the AOC workgroup since the GAO-21-119SP High Risk Series was published in response to these "not met" ratings:

a. Actions Taken to Address Demonstrated Progress "Not Met" Rating

- VHA has been continuously monitoring its activities associated with all the "in progress" and "sustaining" action items since March 2021. Observations from the monitoring activities have demonstrated progress in all the outcomes. As part of the new Action Plan format, the AOC workgroup created a new numbering

sequence which provides linkages between action items and performance measures.

- Additionally, the AOC workgroup meets twice a week to monitor the progress made on its performance measures and also presents the progress made to its leadership on a weekly basis.

b. Actions Taken to Address Monitoring "Not Met" Rating

- The AOC workgroup reviewed GAO's feedback to VHA's May 2021 policy action plan provided in GAO-21-119SP High Risk Series. As a result, VHA updated the format of the action plan to include interim milestones that support the actions and provide transparency around status, timelines, resources, risks etc.

- Please reference the above highlights section, the action items tables and roadmaps which provide further details that support these efforts.

Status Key

This Action Plan submission denotes the status of implementation for each metric, outcome, and action graphically. The following Key can be used to understand the status graphics:
○ – "Not Met." Few, if any, actions toward meeting GAO's criterion for removal have been taken.
◐ - "Partially Met." Some, but not all, actions necessary to meet GAO's criterion have been taken.
● – "Met." Actions have been taken that meet GAO's criterion for removal. There are no significant actions that need to be taken to further address the criterion.
▲ - New or revised Root Cause

Policies and Processes Outcome (P&P-1)

Outcome Executive: Ethan Kalett, JD, Senior Advisor, Office of Regulation, Appeals, and Policy

Outcome Lead: Laura Arcadipane, JD, Chief, VHA National Policy Strategy

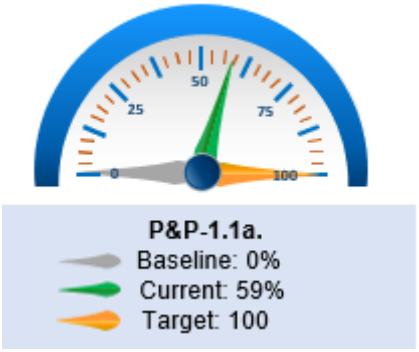
▲ **Root Cause**: National policies do not consistently align with agency priorities and needs, which means that the field cannot always follow policy and act consistently with priorities and needs.

◐ **P&P-1 Outcome Statement**: Senior leaders support the publication of implementable policy aligned to strategic objectives by adhering to procedural publication requirements and ensuring VHA stakeholders receive consistent messaging.

Status: Partially Met. VHA Senior Leaders demonstrate commitment to policy process improvement and policy implementation through monthly meetings of the Senior Leadership Committee, which have been ongoing since 2016 (see the Sustaining Measures paragraph below for the current strategic decisions). VHA mandates the use of the pre-policy form outlining resources required for implementation, which Senior Leaders review for each directive being recertified. VHA is on track to have 100% of published directives use the pre-policy form in FY 2024. Senior Leaders and RAP continue to make progress on consistently issuing operational information through the correct communication vehicles, as demonstrated by VHA Notice 2021-12(1), Review of Operational Memoranda, which outlines the required process for reviewing and issuing memoranda that do not contain policy information, as VHA does not consider memoranda to be Controlled National Policy.

◐ **P&P-1.1 Goal**: 100% of VHA directives in FY 2024 that are developed and recertified have been reviewed for adequate implementation resources and alignment to Department goals.

Status: Partially Met. VHA mandated use of a pre-policy form in Q3 FY 2018 and VHA continues to implement use of the pre-policy form as directives are recertified. The form requires information regarding implementation resources and alignment to VA and VHA's current strategic plans. VHA Senior Leaders review this form during the formal concurrence phase of directive recertification.



P&P-1.1a Metric: Percent of published policy with addressed resources as documented in the pre-policy form. Calculated as the number of published

directives using the pre-policy form divided by the total number of published directives. Reported quarterly. Partially met.

◐**P&P-1.1.1 Objective:** Continue reviewing all developed and recertified directives for implementation resources, ensuring that obstacles to consistent policy implementation are identified and addressed by VHA program office and senior leadership as appropriate.

Status: Partially Met. All VHA directives are required to have a pre-policy form, which VHA stakeholders and Senior Leaders review during recertification.

P&P-1.1.1a Metric: VHA Directives and Resources: All published VHA directives are reviewed for adequate implementation resources (in existence or approved). Reported quarterly.

◐**P&P-1.1.2 Objective:** Review 70% of directive inventory by the end FY 2021 to increase the number of directives that have clear alignment to current Department strategic goals and confirmed implementation resources (10% increase annually).

Status: Partially Met. In FY 2015 no published directives required use of a pre-policy form detailing implementation resources. 70% of published directives have been reviewed for addressed resources in FY 2021, with an additional 10% planned for review annually, to reach a target of 100% reviewed by end of FY 2024.

P&P-1.1.2a Metric: VHA Directives and Resources: All published VHA directives are reviewed for adequate implementation resources (in existence or approved). Reported annually.

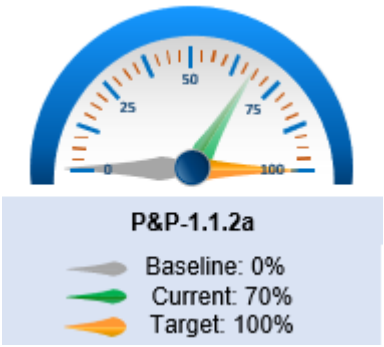


Table 1-1. P&P-1.1 actions

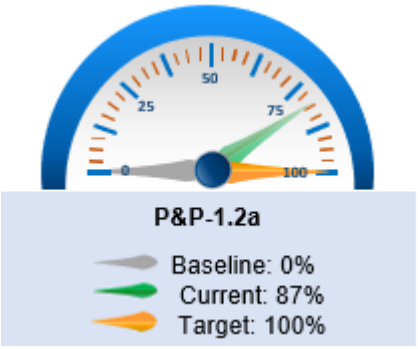
Act. #	Action Details	Projected Date	Actual Date
◐ **1.1.1.1 & 1.1.2.1**	100% of VHA directives in FY 2024 that are developed and recertified have been reviewed for adequate implementation resources.	Q4 FY24	TBD
IM-a:	Establish a process for approving policy only with adequate resources for implementation across VHA	Q3 FY18	Q3 FY18
IM-b:	Establish a Senior Leader Committee composed of VHA senior leaders to oversee policies and processes	Q4 FY16	Q4 FY16
IM-c:	Identify responsibilities for policy implementation	Q4 FY24	TBD
IM-d:	Establish a field workgroup that includes regional-level and medical facilities representatives to provide feedback on the policy development process	Q1 FY18	Q1 FY18
Risk:	If contract is not awarded this year, this action will be delayed until FY 2023		
Status:	IM-a: sustaining; IM-b: sustaining; IM-c: in progress; IM-d: sustaining		
Comments:	Sustaining as of Q3 FY 2018. VHA requires use of a planning document (a pre-policy form known as the Briefing Note) detailing required implementation resources, risks and field communication plans. The form is modified for improvement to ensure VHA directives align with current VA/VHA goals and resource capability. **IM-b**: Sustaining as of Q4 FY 2016. The VHA Senior Leader Committee is established and meets monthly. As of Q1 FY 2022, the Senior Leader Committee meets monthly to oversee policy development strategy and timelines. The SLC implemented a new process to expedite the Office of General Counsel (OGC) policy review phase: OGC now has two weeks to notify VHA of intent to comment on the policy rather than unlimited time. The SLC established an FY 2022 goal to refine and shorten their offices' concurrence processes and timelines, which had exceeded established benchmarks by three weeks in FY 2021. **IM-c**: In progress, targeted completion Q4 FY 2023. • RAP and its Field Advisory Workgroup developed a medical facility quality manager and Regional Director survey to collect information about which organization is responsible for implementing and monitoring national and local policy, whose results informed the Business Rules for policy development (originally published in 2020, currently issued as VHA Notice 2021-22, Mandatory Business Rules for Local Policy Development, and VHA Notice 2021-23, Mandatory Business Rules for VHA Program Offices). • VHA published VHA Directives 1217 and 1217.01 in Q4 FY 2021. Directive 1217 establishes responsibilities for operating units in VHA CO and Directive 1217.01 establishes responsibilities for VHA Governance Board and supporting entities. Directive 1217 will continue to be developed to include VISN and facilities and include systemwide oversight responsibilities. VHA is implementing VHA Directives 1217 and 1217.01 in FY 2022. The VHA Governance Board commenced meeting in		

Act. #	Action Details	Projected Date	Actual Date
	October 2021. Determinations have been rendered regarding the decision rights and delegation authority of each council. The VHA Governance Board Executive Committee Charter will be an appendix in VHA Directive 1217.01 and each Council Charter will be folded into the body of VHA Directive 1217.0		

◐ **P&P-1.2 Goal**: 100% of VHA's policy publications in FY 2023 website are vehicles currently considered policy by VHA Senior Leaders (directives and notices).

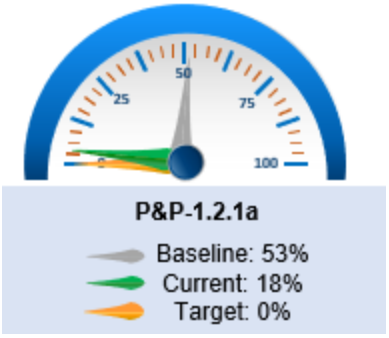
Status: Partially Met. VHA has steadily increased the percentage of directives and notices on the VHA publications site since FY 2015, further accelerated in FY 2020 with the launch of the USH's "Get to Zero" initiative (see P&P Outcome 2 for details). As part of this effort, VHA Senior Leaders must confirm ownership of all existing published policy, enforce the standards of policy development and maintenance set forth in VHA policy Business Rules, and conform to the standard of VHA 6330(4) and VHA Notice 2021-12(1) that operational information is issued through appropriate communication channels (see the Sustaining Measures paragraph below for details).

P&P-1.2a Metric: Percent of documents on the VHA publication website that are directives and notices. Calculated as the number of directives and notices divided by the total number of site entries. Reported Q2 and Q4 each FY. Partially met.



◐**P&P-1.2.1 Objective:** Eliminate handbooks and manuals, which VHA Senior Leaders deemed not proper policy vehicles.

Status: Partially Met. Handbooks and manuals comprise 18% of documents in FY 2020, down from 53% in FY 2015. Handbooks and manuals are either directly rescinded or replaced with a VHA directive upon its publication.



P&P-1.2.1a Metric: Policy Inventory: Streamline the policy inventory to directives and notices, eliminating handbooks and manuals. Reported quarterly.

◐**P&P-1.2.2 Objective:** Increase directives and notices to 100% of VHA policy inventory in FY 2023.

Status: Partially Met. Directives and notices comprise 82% of inventory in FY 2020, up from 47% in FY 2015, with an annual increase of 10% to reach a target of 100% of documents on the VHA publications website in FY 2023.

P&P-1.2.2a Metric: Policy Inventory: Streamline the policy inventory to directives and notices, eliminating handbooks and manuals. Reported quarterly.

Table 1-2. P&P-1.2 actions

Act. #	Action Details	Projected Date	Actual Date
◐ **1.2.1.1 & 1.2.2.1**	100% of VHA's policy publications in FY 2023 website are vehicles currently considered policy by VHA senior leaders (directives and notices).	Q4 FY26	TBD
IM-a:	Develop a standard by which guidance is not confused for policy	Q4 FY17	Q4 FY17
IM-b:	Convert documents that are no longer issued as policy (handbooks and manuals) into updated policy documents	Q4 FY23	TBD
IM-c:	Ensure policies are clearly owned by a responsible entity and use the current numbering system	Q4 FY26	TBD
Risk:	If contract is not awarded this year, this action will be delayed until FY2022		
Status:	**IM-a**: Sustaining as of Q4 FY17. RAP updated Directive 6330, which establishes directives and notices as the only forms of controlled national policy documents. In 2020 and 2021 VHA published two notices with business rules for policy development and a planned update of Directive 6330 (forthcoming 0999) will clarify document types at the local level to ensure VHA policymakers across the organization		

Act. #	Action Details	Projected Date	Actual Date
	have access to instructions for issuing operational information in the appropriate communication vehicle; **IM-b**: In progress, targeted completion Q4 FY23. In January 2020 handbooks and manuals are 97 of 514 documents (18%), down from 53% of inventory in 2015; **IM-c**: In progress, targeted completion Q4 FY26. • In FY21, RAP identified orphan policies and sent queries to candidate responsible entities. By Q4 FY22 RAP will confirm ownership of all VHA national policy on VHA publications site through program office and SLC discussion and rescind any unclaimed policy. There are currently 2 unowned policies (out of 446 directives and handbooks). • In FY20 RAP began meeting with VA, VHA, NCA, and IT partners to establish and collectively approve policy document name and number convention framework, with a completion goal of Q4 FY 2023. • By Q4 FY 2025 RAP will roll out the name and number framework for VHA policies at VHA, VISN, and VA medical facility levels (see P&P Outcome 4 for additional process details).		

●**P&P-1.3 Goal:** In FY 2023 minimal VHA operational memos issued by VHA program offices and Senior Leaders contain policy information when issued.

Status: Sustaining. VHA codified its prior Memoranda of Agreement regarding operational memoranda development as VHA Notice 2021-12(1), Review of Operational Memoranda, which outlines the required process for reviewing and issuing memoranda so that they do not contain policy information. In this process, designed to facilitate use of the correct communication channel for operational information, VHA Senior Leaders send memoranda to RAP for review prior to publication. In FY 2020, GAO closed Recommendation 2 of its 2017 17-748 report, which suggested VHA develop processes for consistent dissemination of guidance documents, based in part on the implementation of operational memoranda processes, as set forth in VHA Notice 2019-19, Maintaining VHA's Policy-Establishing Documents, and VHA Directive 2021-12(1).

P&P-1.3a Metric: RAP reviews 100% of operational memoranda sent to RAP to ensure policy content is not included prior to publication. Calculated by the number of operational memoranda reviewed by 10BRAP divided by the total number of operational memoranda sent to 10BRAP. This metric will develop over time as VHA's organizational

capacity to monitor and enforce the process increases. Reported Q2 and Q4 each FY. Sustained.

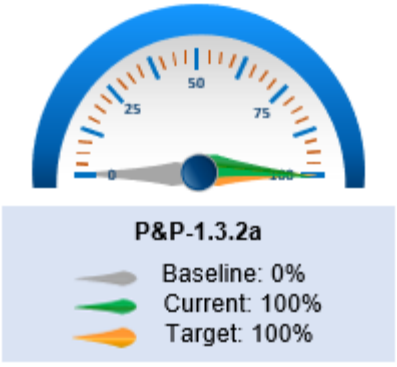
●**P&P-1.3.1 Objective:** Continue eliminating policy content from existing and future operational memoranda issued by VHA program offices and senior leaders.

Status: Sustaining. In 2019 VHA Senior Leaders and RAP established an operational memoranda review process to centralize and monitor field communication and enforce standards for use of appropriate communication channels. Following codification of that process in the form of Controlled National Policy (VHA Notice 2021-12(1)) RAP commenced formal review in the VIEWS document management system of operational memoranda prior to publication, and in FY 2021 reviews 100% of memoranda provided for review.

P&P-1.3.1a Metric: Operational Memoranda Reviews: RAP reviews all VHA operational memoranda for policy content prior to publication. Reported annually.

●**P&P-1.3.2 Objective:** Integrate policy content from memoranda into directives/notices in collaboration with VHA program offices and senior leaders.

Status: Sustaining. All VHA directives are required to have a pre-policy form, which VHA stakeholders and Senior Leaders review during recertification.



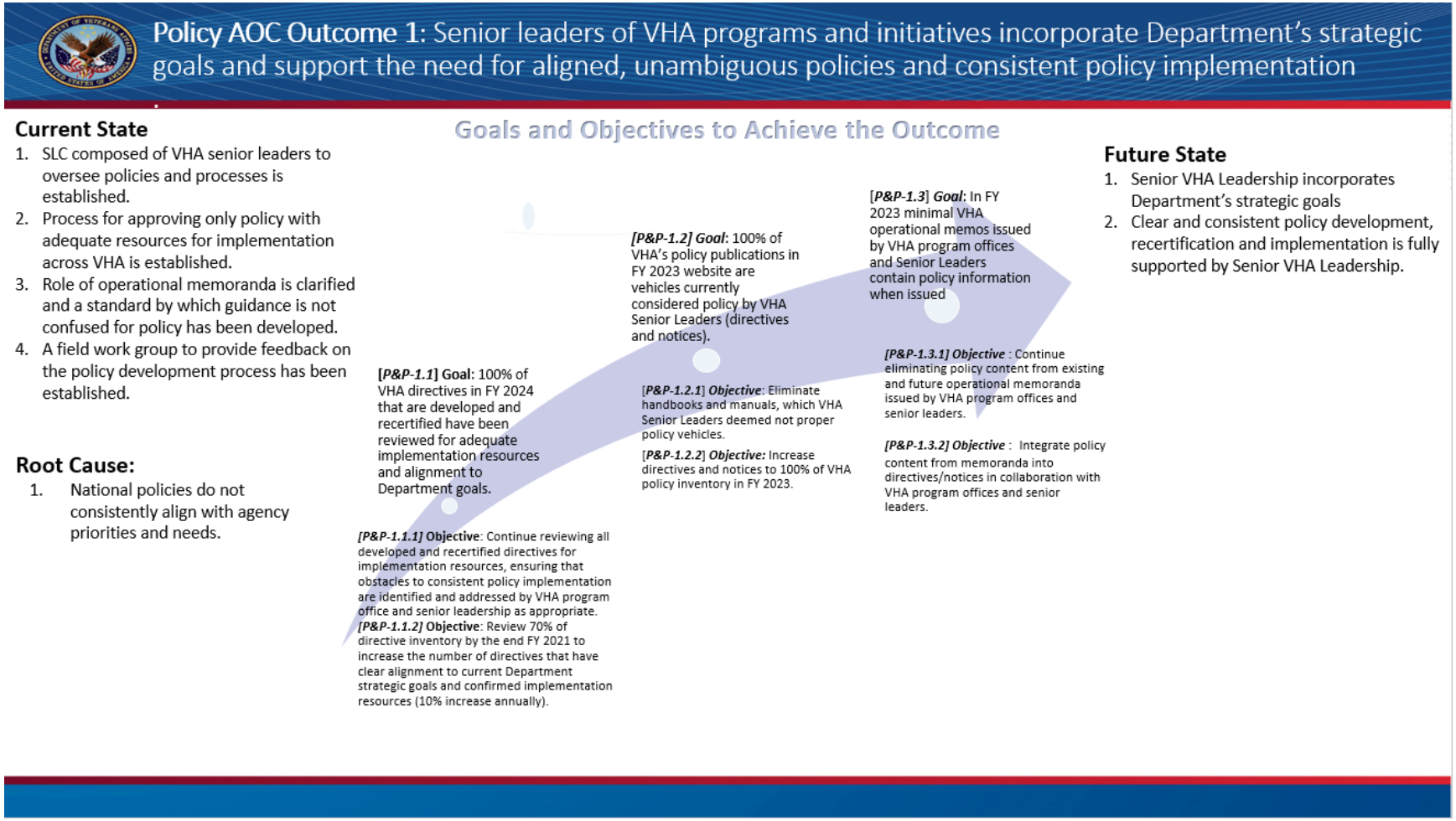
P&P-1.3.2a Metric: Operational Memoranda Reviews: Directive managers assist program offices in identifying applicable operational memoranda during the directive development process. Reported annually.

Table 1-3. P&P-1.3 actions

Act. #	Action Details	Projected Date	Actual Date
●**1.3.1.1**	In FY 2023 minimal VHA operational memos issued by VHA program offices and senior leaders contain policy information when issued	Q3 FY22	Q3 FY22
IM-a:	Clarify the role of operational memoranda	Q4 FY19	Q4 FY19
Risk:	If contract is not awarded this year, this action will be delayed until FY2022		
Status:	**IM-a**: Sustaining		
Comments:	The action item is completed and is expected to be in sustainment at least till Q3 FY22. In May 2018, RAP 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. In 2021, RAP collaborated with VHA CO to establish uniform standards for the development, concurrence, publication and rescission of the AUSH signed guidance documents. To continue VHA's progress toward policy content only existing in approved controlled national policy vehicles, operational memoranda are incorporated into VHA directives during development and recertification, when possible, which reduces the number of existing memoranda on the VHA publications site that contain policy information.		

Figure 1-2, below, visually presents the current state of this outcome, the desired future state of this outcome and the goals and supporting objectives that align and will contribute to the achievement of that future state.

Figure 1-2. P&P-1 Roadmap



P&P-1 Description of Actions Toward Removal Criteria

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

Leadership Commitment

- The VHA Senior Leader Committee (SLC) was established in 2016 and is composed of the DUSH, each VHA Assistant USH, the RAP Senior Advisor and the VHA Chiefs of National Policy. The SLC currently meets monthly 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 areas of concern. It meets monthly to identify interdependencies and discuss collaboration. The group conducted twice yearly in-person meetings with key stakeholders in 2018 and 2019. In August 2020, the group held a virtual summit to plan 2021-2022 goals and action steps, and came together in 2021 to guide the AOCs' metrics approach. The next meeting will be planned for summer 2022.

- A VHA Field Advisory Workgroup was established in 2017. Approximately 20 leaders from regional offices and VA medical facilities provided feedback to the VHA Chief of National Policy regarding policy and process development.

- In 2019 VHA chartered the VHA EHRM National Work Group with representation across Assistant USH offices, the EHRM office, VA medical facilities, including the initial operating site, and the VA Office of Enterprise Integration (OEI). In 2020, the workgroup met weekly to ensure that national policies and processes were updated to facilitate a smooth transition to VA's new electronic health record platform. In 2021, the workgroup continued to meet quarterly to ensure preparation for systemwide ongoing rollout.

Demonstrated Progress

- A VHA Field Advisory Working Group made recommendations in May 2018 that informed and accelerated national policy improvements such as expanding the 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, RAP 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 36% since 2015 (805 documents to 474). In 2021, VHA began recertifying VHA Directive 6330 and renumbered it VHA Directive 0999 to align with VA's numbering convention. We anticipate publication of VHA Directive 0999 in spring 2022.

- 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.

- In 2021, RAP partnered with VHA's Office of Health Equity to include a question in VHA's planning process (Briefing Note) designed to elicit dialogue to purposely review all policies for structural bias and support of Presidential, Departmental and VHA equity and diversity goals.

Capacity

- VHA supports RAP to meet policy staffing needs with eight FTE and 43 contractors. Senior leaders continue to assess capacity needs.

Monitoring

- Starting in April 2018, RAP required each responsible entity that developed a policy to complete the updated policy planning form called the Briefing Note. The current Briefing Note expands the original 2016 format by requiring that the responsible entity explain resource needs (e.g., funding, space, personnel, IT, etc.), 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 Executive: Ethan Kalett, JD, Senior Advisor, Office of Regulation, Appeals, and Policy

Outcome Lead: Laura Arcadipane, JD, Chief, VHA National Policy Strategy

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.

◐ **P&P-2 Outcome Statement**: VHA policy development, recertification, and amendment processes function with integrity according to VHA Directive 6330, including integration of Risk Management Framework (RMF) using an adaptable framework that enables policy development to conform to the enterprise risk management system established and updated by VHA Oversight and Accountability executives.

Status: Partially Met. VHA average policy development and recertification timelines have decreased 44% since 2016, enabling a 76% decrease in VHA national policies overdue for recertification. RAP's established Program Office relationships and engagement processes put VHA on track to reach functionally zero overdue policies for the first time. RAP Document Managers use a continuously updated VHA Policy Review Guide, developed with VHA partners including Oversight and Accountability and Educational Services, to support Program Offices with developing and updating policy content to meet current organizational structures and standards. The VHA policy development process includes periods for field review and AUSH concurrence, ensuring that all feedback is considered, and all required approval secured prior to policy publication.

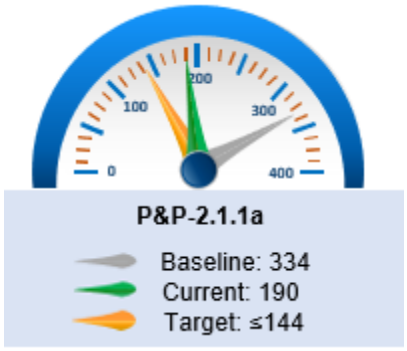
◐ **P&P-2.1 Goal**: VHA policy development (of new policies) and recertification (of existing policies) occur within a continuously improving timeframe according to VHA senior leadership and VHA Directive 6330.

Status: Partially Met. The average period in FY 2021 was 190 days, which is a 43% reduction from the FY 2015 baseline of 334 days, illustrating steady progress toward the current VHA Senior Leadership target of 144 days.

P&P-2.1a Metric: The average number of days from SharePoint field review to publication for all new policies and recertifications. Calculated as the total number of days for each process policy (aggregated) divided by

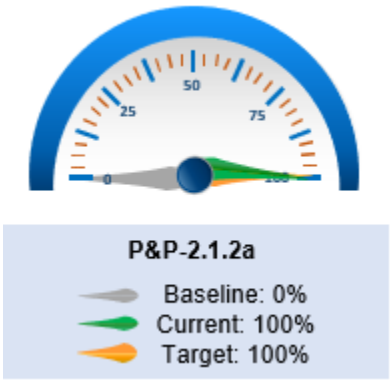
the number of policies processed. Reported in Q2 and Q4 each FY. Partially Met.

◐ **P&P-2.1.1 Objective:** Reduce average SharePoint field review to publication period from current of 190 days to 144 days by Q4 FY 2022.



P&P-2.1.1a Metric: Standard Timeframe for VHA policy development and recertification: VHA policy development (writing new policies) and recertification (updating existing policies) occur within the standard timeframe. Reported Q2 & Q4.

● **P&P-2.1.2 Objective:** Reassess whether 144 days is appropriate timeline and adjust, if necessary, by Q4 FY 2021.



P&P-2.1.2a Metric: Policy Development Timeline: assessed annually.

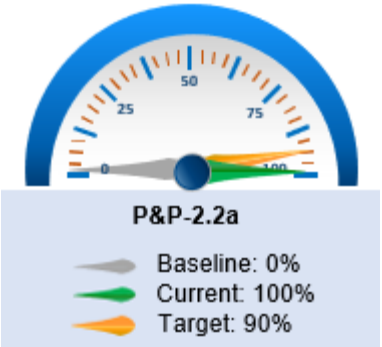
Table 1-4. P&P-2.1 actions

Act. #	Action Details	Projected Date	Actual Date
● **2.1.1.1 & 2.1.1.2**	VHA policy development (of new policies) and recertification (of existing policies) occur within the current standard timeframe according to VHA senior leadership and VHA Directive 6330.	TBD	TBD
IM-a:	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.	Q1 FY17	Q1 FY17
IM-b:	Pilot a process for policy development and recertification to ensure timely publication and ensure the process is sustainable upon completion of the pilot.	Q1 FY17	Q1 FY17
IM-c:	Develop a process to identify when the Office of General Counsel review of new and revised policies is required.	Q4 FY16	Q4 FY16
IM-d:	Develop a process that outlines the pre-policy analysis and appropriate internal controls consistent with the VHA RMF	Q3 FY18	Q3 FY18
Risk:	If contract is not awarded this year, this action will be delayed until FY2022		
Status:	• IM-a: sustaining; IM-b: complete; IM-c: sustaining; IM-d: sustaining		
Comments:	**IM-a:** Sustaining as of Q1 FY 2017. • VHA piloted a process for policy development and recertification to ensure timely publication and ensure		

Act. #	Action Details	Projected Date	Actual Date
	the process is sustainable upon completion of the pilot. VHA conducted the pilot process for ten policies from July to December 2016 and then implemented the process for all VHA policies. • The standard development timelines currently 144-day timeline applies to all new and recertified VHA policies to allow for sufficient stakeholder feedback without compromising development and publication efficiency. VHA posts policies in development to SharePoint for 2 weeks to receive feedback from VA staff. **IM-c:** Sustaining as of Q4 FY 2016. • RAP and the Office of General Counsel signed a Memorandum of Agreement in 2016: RAP Regulatory Specialists review each policy based on RAP'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. • In 2021, to increase review efficiency, RAP implemented a 2-week timeframe for OGC to indicate their intentions to provide comments for policies sent to OGC for review. **IM-d:** Sustaining as of Q3 FY 2018. VHA requires use of a pre-policy form (Briefing Note), which includes a risk assessment, and Directive 6330 requires each policy contain a full chain of oversight and required staff training. Each policy in development is reviewed to ensure the content aligns with current VHA authority structures and oversight standards.		

● **P&P-2.2 Goal**: VHA Senior Leadership, Program Offices, VISNs and VA medical facilities have the opportunity to provide pre-publication feedback on directives as set forth in current VHA policy development and recertification processes and VHA Directive 6330.

Status: Met. The directive development process contains a 2-week SharePoint field review period, in which anyone with a VA badge may provide feedback, following by a comment consolidation period during which the VHA Program Office responsible for the policy must review and document a response to all field comments. The directive development process also contains a final signature phase during which each AUSH office must provide concurrence using the VIEWS management system. During each of these reviews, policy stakeholders may provide comments or non-concur based on risk management factors



including individual responsibilities, oversight mechanisms, reporting requirements, auditing activities, and internal controls.

P&P-2.2a Metric: Percent of key stakeholders identified by VHA (i.e., AUSH offices) that concur for each directive. Calculated by the number of offices that concur divided by the total number of offices identified. Reported quarterly. Met.

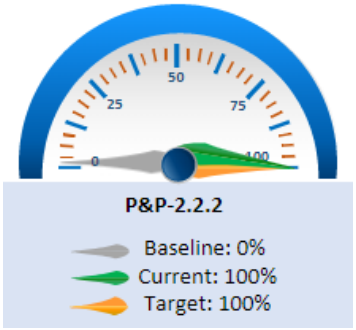
● **P&P-2.2.1 Objective:** Continue posting all VHA directives to SharePoint for field review to enable all VA staff an opportunity to provide feedback during the policy development process (prior to publication).

Status: Sustaining.

P&P-2.2.1a Metric*:* Stakeholder Feedback during VHA policy development: VHA policy development (writing new policies) and recertification (updating existing policies) include receiving stakeholder feedback from all appropriate service lines and program offices.
Reported Quarterly. Met Target=100% (In addition to the mandatory review period, which was extended from 2 to 3 weeks during the peak COVID-19 response period to enable continued participation, the weekly VHA policy dashboard sent to VHA stakeholders provides the percent participation of Program Offices, VISNs and VA medical facilities for each directive's field review period. The SharePoint Directive Repository contains a completed "Comment Log" of responses to field comments to enable stakeholders to review how their concerns were addressed.)

● **P&P-2.2.2 Objective:** Ensure 100% of policies in FY 2021 receive Assistant USH feedback prior to publication.

P&P-2.2.2a Metric*:* Stakeholder Feedback during VHA policy development: VHA policy development (writing new policies) and recertification (updating existing policies) undergo review by and receive concurrence from VHA Assistant USH in VIEWS. VHA policy is not published until AUSH non-concurrences are resolved, including enterprise-wide concerns for implementation, oversight, and risk management.



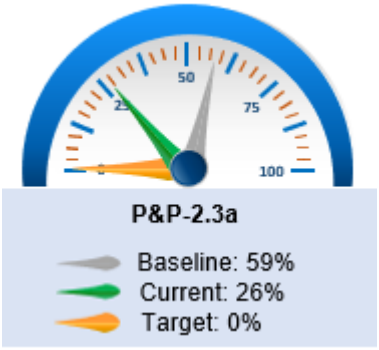
Reported Quarterly. Met Target=100%
(In FY 2020 100% of AUSH Offices concurred in VIEWS for VHA

directives and notices prior to publication (noting that the VHA reorganization affected the names and overall number of concurring offices). VHA policy is not published until AUSH non-concurs are resolved, to include enterprise-wide concerns for implementation, oversight, and risk management.)

◐ **P&P-2.3 Goal**: All VHA policies are current and have been reviewed and recertified in the prior 5 years (to the extent possible, e.g., pending regulations), thus ensuring all published VHA directives received feedback during the development or recertification process.

Status: In Progress. The VHA policy development process contains mandatory review periods for VHA directives and notices that enable appropriate VHA stakeholders to provide feedback and concurrence prior to publication. RAP Document Managers support Program Offices to develop and update content that meets current VHA standards for consistent implementation including clear oversight and accountability structures. VHA's consistent reduction in overdue policies since 2015 and regular Program Office outreach and engagement tactics place VHA in the "functional zero" range for the 5-year policy review cycle.

P&P-2.3a Metric: Percent of policies that are overdue for recertification. Calculated as the number of overdue policies divided by the total number of policies. Reported quarterly. Partially met.



◐ **P&P-2.3.1 Objective:** Reduce the number of policies overdue for recertification by 10% annually until 0% of policies are overdue for recertification or "functional" zero is reached, meaning any outstanding recertifications arise from factors beyond the scope of policy process and authority.

P&P-2.3.1a Metric: Percent of VHA policies overdue for recertification: VHA national policies are current and have been reviewed and recertified in the prior five years (to the extent possible, e.g., pending regulations). Reported quarterly.

Metric data: Baseline=59%, Milestone=26%, Target=0% (In Q4 FY 2021, VHA reached 25% overdue policy inventory, down from 59% in FY 2015, while also reducing the total VHA national policy inventory by 42%. Of the 25% overdue (115 out of 467 policies), 70% are in the recertification process and 6% are paused due to

pending regulation, putting RAP within reach of "functional zero" in FY 2022 based on prior annual decrease figures.)

● **P&P-2.3.2 Objective:** Continue existing monthly communication with program offices that have overdue policies and monthly reminders when policies are coming due to improve the likelihood policies are recertified according to established VHA policy development processes and timelines.

Status: Met. Policy Development Timelines: RAP provides an email to VHA Program Offices listing policies becoming overdue in the next 6 and 12 months to request an action plan for recertification. RAP provides VHA Senior Leaders with a list of overdue policies each month to enable leaders to inquire with Program Offices on progress. RAP Document Managers follow up with Program Offices at least every two weeks during the policy recertification process to ensure constant support and maintain engagement in order to meet development timelines.

Target is Met (In Q4 FY 2021, VHA reached 25% overdue policy inventory, down from 59% in FY 2015, while also reducing the total VHA national policy inventory by 42%. Of the 25% overdue (115 out of 467 policies), 70% are in the recertification process and 6% are paused due to pending regulation, putting RAP within reach of "functional zero" in FY 2022 based on prior annual decrease figures.)

Table 1-5. P&P-2.3 actions

Act. #	Action Details	Projected Date	Actual Date
◐**2.3.1.1**	All VHA policies are current and have been reviewed and recertified in the prior 5 years (to the extent possible, e.g., pending regulations), thus ensuring all published VHA directives received feedback during the development or recertification process.	Q4 FY23	TBD
IM-a:	Create a policy dashboard that demonstrates overall timeline expectations and days to completion for each policy in the process.	Q1 FY17	Q1 FY17
IM-b:	Reach "functional zero," where, to the maximum extent possible, VHA policies are current and have been reviewed and recertified in the prior five years.	Q4 FY23	TBD
IM-c:	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 RAP.	Q3 FY17	Q3 FY17
IM-d:	Review funding issues to ensure contracted staff remain active until otherwise determined by VHA senior leaders and ensure RAP staff receive appropriate training, which enables 10BRAP	Q3 FY17	Q3 FY17

Act. #	Action Details	Projected Date	Actual Date
	to support program offices to develop and recertify policies that meet the current VHA standards and timeframes established by VHA senior leaders and VHA Directive 6330		
Risk:	If contract is not awarded this year, this action will be delayed until FY2023		
Status:	IM-a: sustaining; IM-b: in progress; IM-c: sustaining; IM-d: sustaining		
Comments:	**IM-a:** Sustaining as of Q1 FY 2017. VHA monitors all policies in the process through the dashboard and provides updates to the SLC, which uses the data to improve its offices development processes and timeframes		

Figure 1-3 below, visually presents the current state of this outcome, the desired future state of this outcome and the goals and supporting objectives that align and will contribute to the achievement of that future state.

Figure 1-3. P&P-2 Roadmap

P&P-2 Description of Actions Toward Removal Criteria

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

Leadership Commitment

- The VHA SLC was established in 2016 and is composed of the DUSH, each VHA Assistant USH, the RAP Senior Advisor and the VHA Chief of National Policy.

- The SLC currently meets monthly 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. In 2021, SLC reviewed the timeline for policy concurrence.

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 five 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, RAP updated VHA Directive 6330, Controlled National Policy/Directives Management System, to define VHA policy documents only as directives and notices. At the time of RAP'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 workgroup); the requirement of a paragraph specifying required staff training (in collaboration with the Training workgroup); and the requirement of a Records Management paragraph. In 2021, VHA began recertifying Directive 6330 as Directive 0999 to align with VA's policy numbering system.

- RAP piloted a SharePoint review process for ten 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 two weeks (three weeks during pandemic response) 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 FY 2020, the average number of SharePoint comments received per policy was 69. RAP 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.

- In 2020, RAP collaborated with VHA program offices, Mann-Grandstaff VAMC, the Office of Electronic Health Record Modernization and Assistant Under Secretaries for Health to review 150 national policies to identify areas of critical revision ahead of VA's electronic health record software platform transition. VHA published 35 supplements to national policy to enable VA medical facilities to implement Cerner software and remain in national policy compliance.

- In 2020, VHA published Notice 2020-37, Waivers to VHA National Policy, to implement a systemic approach to reviewing and approving waiver requests from VISNs and VA medical facilities. In conjunction with responsible program offices, the notice establishes a uniform process for waiver requests, approvals and reporting through assigned responsibilities to VHA leadership at all levels of the organization.

Monitoring

- RAP 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 month. 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, RAP also began distributing a monthly dashboard of published directives to the SLC, which also includes timeliness reports such as the number of days each DUSH office took to concur for each policy. In May 2019, VHA's policy inventory is 496 (down from 805 in 2015) and 28% are overdue (down from 59% in 2015).

- RAP created a SharePoint repository in 2017, composed of all policies posted for two weeks of field review, their 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. RAP'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 10BRAP's actions to integrate VHA's RMF into all aspects of policy.

- In 2021, RAP implemented a VHA program office post-publication survey to solicit user feedback on the policy development process and identify opportunities to improve communication and efficiency. 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.

Capacity

- VHA supports RAP to meet its policy staffing needs. RAP 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, RAP added seven contractors to the document management staff, expanding to 12 contractors in May 2018. In August 2018, VHA transferred two unfunded positions to RAP, which allowed RAP to hire two additional document managers.

- In September 2019, VHA modified its contract to provide additional resources and in November 2020 secured continued support through May 2026 for a total of 30 contractors and eight FTE supporting 10BRAP. Senior leaders continue to assess capacity needs.

Policies and Processes Outcome (P&P-3)

Outcome Executive: Ethan Kalett, JD, Senior Advisor, Office of Regulation, Appeals, and Policy
Outcome Lead: Laura Arcadipane, JD, Chief, VHA National Policy Strategy

Root Cause: 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.

◐**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.

Status: Partially Met. 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 also 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 RAP 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.

◐ **P&P-3.1 Goal:** Ensure open and regular communication between VHA CO, VISNs, and VA medical facilities on policy matters to improve VHA's awareness of opportunities and ability to create uniform policy development and implementation processes.

◐ **P&P-3.1.1 Objective**: Hold at least quarterly "town halls" with VISN and VA medical facility representatives in FY 2021 focusing on improving communication about policy development processes and implementation.

◐ **P&P-3.1.2 Objective**: Ensure 48-hour response to policy development and implementation help requests from VHA, VISNs and VA medical facility stakeholders via the actions box.

Table 1-6. P&P-3.1 actions

Act. #	Action Details	Projected Date	Actual Date
◐3.1.1.1	Ensure open and regular communication between VHA CO, VISNs and VA medical facilities on policy matters to improve VHA's awareness of opportunities and ability to create uniform policy development and implementation processes.	Q3 FY25	TBD
IM-a:	Identify field perspectives through primary research activities	Q3 FY18	Q3 FY18
IM-b:	Establish regular informational and educational sessions by which RAP can disseminate updates about the policy development process and provide stakeholders an opportunity to discuss policy and the policy development process.	Q3 FY18	Q3 FY18
IM-c:	Identify improvements to national policy to increase alignment with local policy and help reduce redundant and unnecessarily complex policy for medical facilities	Q3 FY19	Q3 FY19
IM-d:	Delineate the role of national and local policy	Q2 FY21	Q2 FY21
IM-e:	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	Q1 FY20	Q1 FY20
Status:	IM-a: sustaining; IM-b: sustaining; IM-c: sustaining; IM-d: sustaining; IM-e: sustaining		

◐ **P&P-3.2 Goal:** All local policy (VISN and VA medical facility) is necessary, appropriate and accessible.

● **P&P-3.2.1 Objective**: Reduce redundant and unnecessarily complex local policy for medical facilities by 25% in FY 2023, which increases unnecessary administrative burdens on staff and unwanted variation in policy implementation across VA medical facilities

P&P-3.2.1a Metric: Reduction of local policies: Reduced redundant and unnecessarily complex local policy for medical facilities. Reported Q2 & Q4.

◐ **P&P-3.2.2 Objective**: Provide virtual or in-person policy inventory analyses to assist VISNs and VA medical facilities with local reductions and improve alignment to VHA national policy.

◐ **P&P-3.2.3 Objective**: Ensure ongoing communication about the local policy inventory reduction goal to ensure VHA CO, VISN and VA medical facility stakeholders are aware of and receive support needed to meet business rules requirements and VHA policy quality indices.

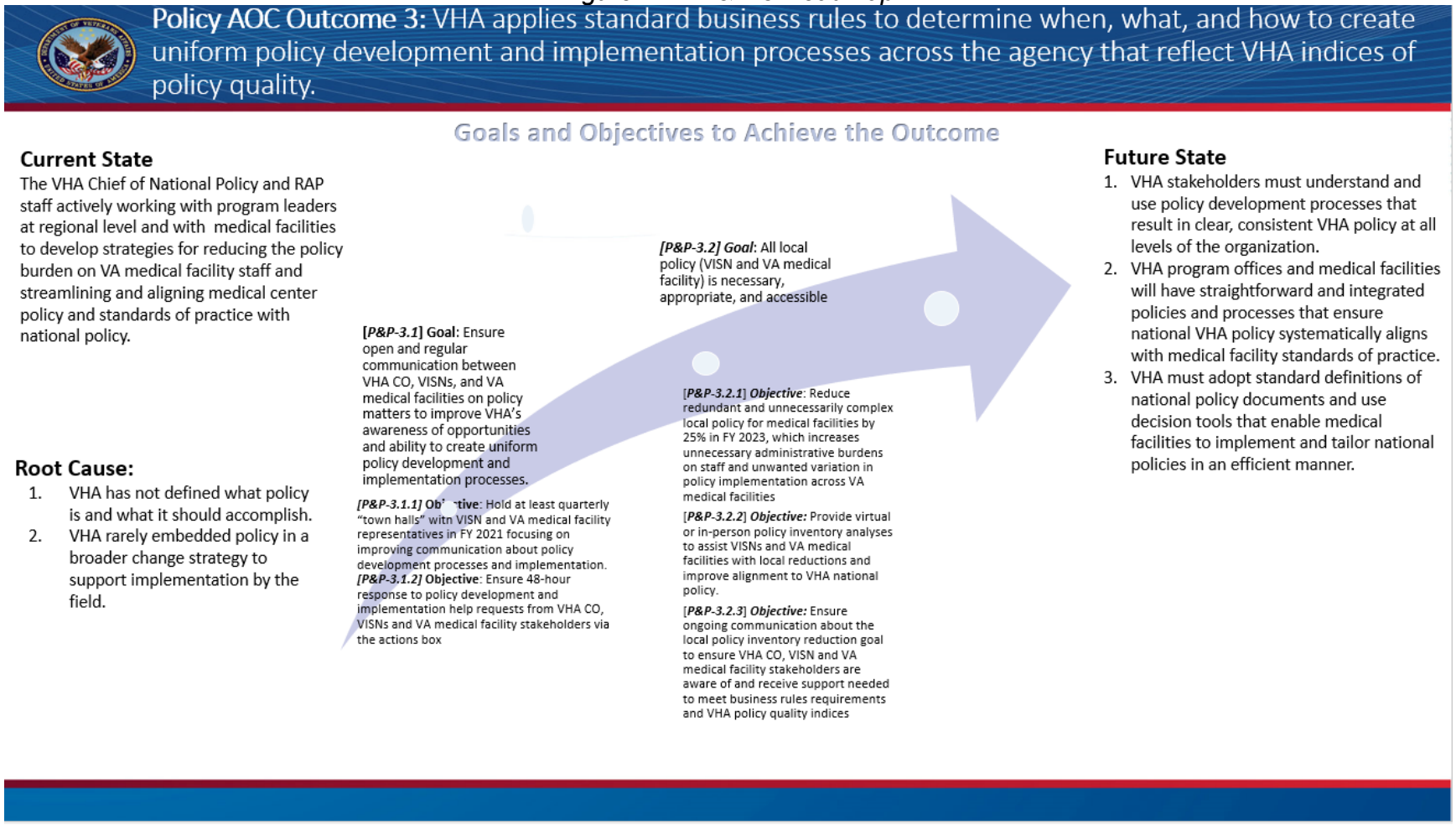
P&P-3.2.3a Metric: Engagement among stakeholders: Regular informational and educational sessions occur among RAP and policy stakeholders. Reported Q2 & Q4.
Metric data:
Baseline= Direct business rules implementation support to all VISNs and facilities in FY 2020 onward, Target = Quarterly meetings with field levels; Twice annual meetings to key VHA CO stakeholders.

Table 1-7. P&P-3.2 actions

Act. #	Action Details	Projected Date	Actual Date
◐3.2.1.1	All local policy (VISN and VA medical facility) is necessary, appropriate and accessible.	Q3 FY25	TBD
IM-a:	Develop, implement, and follow a process for disseminating, monitoring, and evaluating policy implementation at the local level.	Q4 FY22	TBD
Status:	IM-a: In Progress		
Comments:	RAP and the Field Advisory Workgroup 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 at the VA level, will be required for uniform implementation of identified monitoring and evaluation best practices. RAP is planning to Include a more robust summary of content and changes in the publication notification email.		

Figure 1-4, below, visually presents the current state of this outcome, the desired future state of this outcome and the goals and supporting objectives that align and will contribute to the achievement of that future state.

Figure 1-4. P&P-3 Roadmap



P&P-3: Description of Actions Toward Removal Criteria

Leadership Commitment

- In 2017, the VHA Chief of National Policy held 15 informational sessions and RAP 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 RAP and the Field Advisory Workgroup'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. RAP shared reports of its key findings with the Field Advisory Workgroup, and the interview feedback informed the selection of medical facilities for RAP site visits in 2019.

Demonstrated Progress

- In 2019, the VHA Chief of National Policy and RAP staff visited ten 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. RAP requested proposals for national and local policy business rules that program offices and medical facilities must use to develop policy. RAP issued the business rules in two notices. In accordance with the notices, each medical facility submits 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.

- RAP 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 develop 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. In 2021, VHA began recertifying Directive 6330 as Directive 0999, Policy Management, which will incorporate information from two business rules notices that clarify what the policy documents are at the medical facility level.

- In 2019, RAP 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, which averages over 1,000 unique visitors per month. In addition to containing standard templates and decision tools for developing national and local policy, medical facilities 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. At the initial reporting due date, January 2, 2021, 124 VA medical facilities (89%) submitted an action plan to reduce local policy inventory, indicating an average 24% inventory reduction achieved in the first year.

- In 2017, RAP 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 has 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, RAP 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.

- In 2020, RAP began disseminating 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.

- Since January 2020, RAP sends a monthly email to a Field Policy Managers email group to communicate important local policy updates, report deadlines and share best practices and answers to commonly asked policy questions.

- Starting in 2019, RAP hosts informational Q&A Sessions every other month with VISNs and VA medical facilities for the business rules. Sessions are recorded and posted for anyone within VHA to access at any later time. RAP offers additional informational sessions upon request to individual VISNs and VA medical facilities to provide tailored support for implementation of the local policy development business rules. Question topics include national policy, local policy implementation, electronic health record modernization, etc. Each session averages 90 participants.

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 RAP to meet policy staffing needs with eight FTE and 30 contractors. Senior leaders continue to assess capacity needs.

Policies and Processes Outcome (P&P-4)

Outcome Executive: Ethan Kalett, JD, Senior Advisor, Office of Regulation, Appeals, and Policy

Outcome Lead: Laura Arcadipane, JD, Chief, VHA National Policy Strategy

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

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

Status: Partially Met. 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.

◐ **P&P-4.1 Goal**: Locate 100% of VHA policies in a single online repository available to all VA staff and has broad searchability.

P&P 4.1a Metric: Percent of policies national and local that utilize the common numbering system.
Metric Data:
Baseline = 0% policy availability (repository prototype in development) in FY 2019

◐ **P&P- 4.1.1 Objective**: Assess the results of the FY 2021 repository prototype to confirm operational capability.

◐ **P&P- 4.1.2 Objective**: Secure continued funding for repository development.

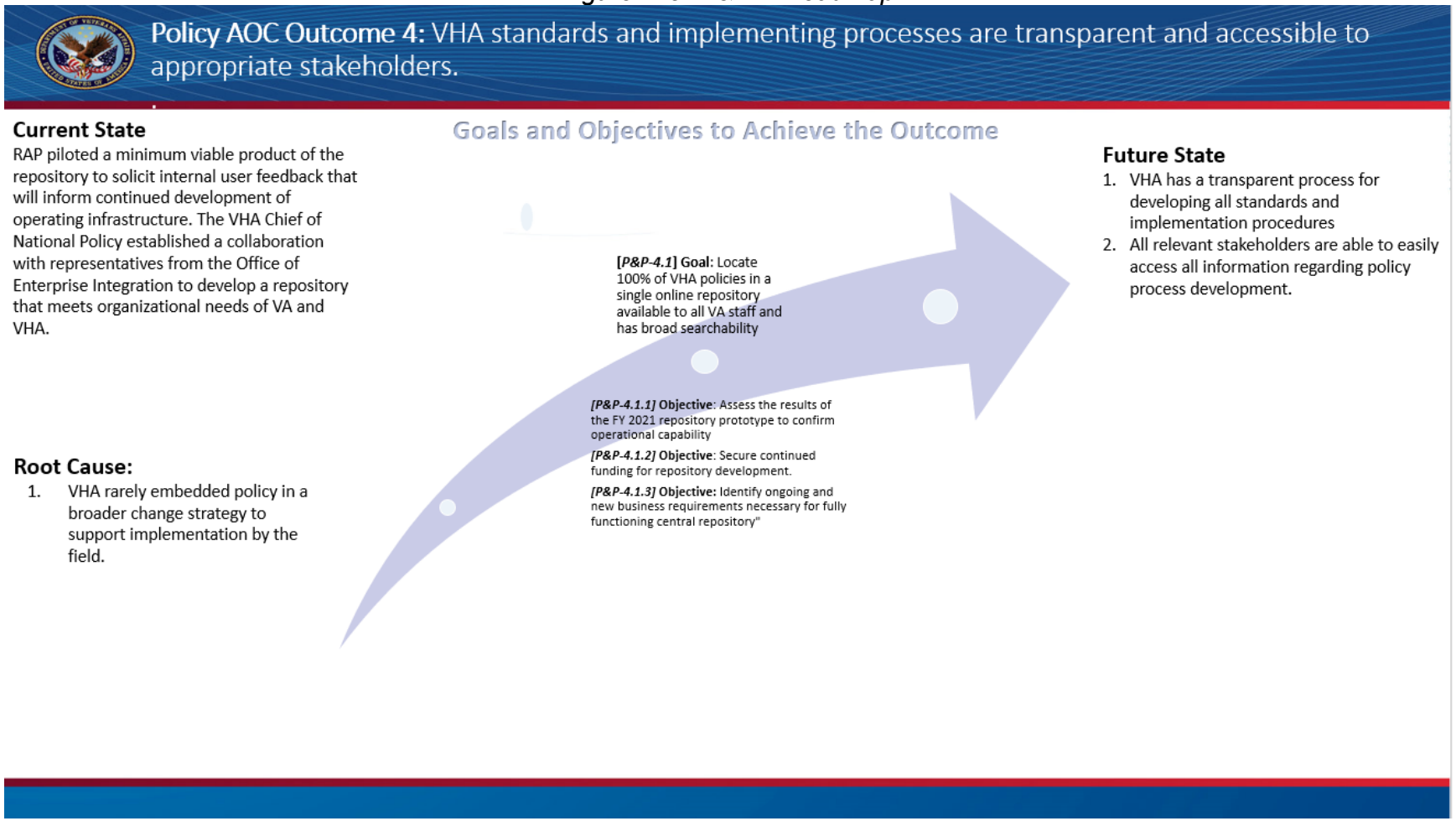
◐ **P&P- 4.1.3 Objective**: Identify ongoing and new business requirements necessary for fully functioning central repository.

Table 1-8. P&P-4.1 actions

Act. #	Action Details	Projected Date	Actual Date
◐ **4.1.1.1**	Locate 100% of VHA policies in a single online repository available to all VA staff and has broad searchability.	Q4 FY26	TBD
IM-a:	Create a VHA central repository of policy documents and include implementation documents, operational memoranda, local policies, clinical practice guidelines and links to training resources	Q4 FY26	TBD
IM-b:	Create a standardized numbering system that links all related VHA documents (as applicable)	TBD	TBD
IM-c:	Co-locate VHA program office guidance websites and supporting resources on the VHA Forms and Publications website	TBD	TBD
Risk:	If contract is not awarded this year, this action will be delayed until FY2023		
Status:	In Progress		

Figure 1-5, below, visually presents the current state of this outcome, the desired future state of this outcome and the goals and supporting objectives that align and will contribute to the achievement of that future state.

Figure 1-5. P&P-4 Roadmap



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

- In 2018, RAP added links to the VHA Publications website for VA/DOD clinical practice guidelines, VA publications including financial policies, and Veterans Benefits Administration (VBA) and NCA publications. In 2019, RAP 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.
- In 2020, RAP piloted a minimum viable product of the repository to solicit internal user feedback that will inform continued development of operating infrastructure.

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 RAP to meet policy staffing needs with eight FTE and 30 contractors. Senior leaders continue to assess capacity needs.

2. Inadequate Oversight and Accountability

Executive Sponsor: Tracy Davis Bradley, PhD, Executive Director, Office of Integrity and Compliance

Executive Summary

VHA is building the organizational tools, capacity and culture to ensure consistent organization-wide oversight and accountability across VHA, Veterans Integrated Service Networks (VISNs), VAMCs, Consolidated Patient Account Centers (CPACs) and every point of service VA provides, as well as care overseen by VHA in the community. VHA recognizes that, with its decentralized structure, consistent oversight and accountability requires a clear and strong institutional infrastructure to support oversight and accountability activities at all levels and areas of the organization, the connective tissue to provide organization-wide visibility and communication, as well as a culture of integrity. To achieve that, VHA's first phase strengthened the prior fragmented oversight model and focused on developing a comprehensive infrastructure through policy, processes, and training initiatives, cross-organization connections including systems, and cultural shift towards a culture of integrity. VHA implemented organizational changes to better ensure governance and management decisions are made at the appropriate level of the organization and create greater cross-organizational oversight, reporting, and accountability driven by interoperable high-quality data. VHA continues to strengthen its governance bodies, particularly the Governing Board and the Audit Risk and Compliance Committee and clarify their roles and responsibilities. Additionally, VHA established a High Reliability Organization (HRO) Steering Committee and program office to oversee HRO principles based on leading VHA and industry best practices.

Figure 0-1. Phased Approach to Establishing Consistent Oversight & Accountability

The current Oversight and Accountability action plan reflects a mix of both overarching and targeted initiatives responsive to each outcome and connect the infrastructure across the organization. Together, they enable VHA to develop organization-spanning oversight capabilities and provide the tools and environment for organization-wide accountability and learning:

1. The development of a risk informed oversight program in line with an oversight maturity model to define and guide the maturation of processes and systems across all dimensions of oversight for all VHA entities.

2. Implementation of an integrated framework for governance, compliance, evaluation and risk data to ensure coordinated oversight.
3. Initiate a systemic process for corrective action plans and monitoring to be used across VHA enabling organization-wide learning, follow-through and accountability.
4. Continue the transition towards a high reliability organization that fosters a culture of safety, integrity and accountability at all levels in the organization.

Source: GAO analysis. | GAO-21-119SP

Figure 0-2. Oversight & Accountability 2021 Rating Goal

The action plans for this outcome focus on strengthening oversight and accountability operations in key program offices and other organizational bodies, leveraging the broader capacity of the field for oversight activities, ensuring leadership engagement, optimizing monitoring capabilities and further deepening the culture of safety, integrity and accountability. VA leadership recognizes oversight and accountability, happening at all levels, as pivotal to setting the foundation upon which mission services succeed. VA leadership's continued commitment to this success is evidenced by using central resources with support from all VHA operating units to help stand up and support oversight activities across the organization, establish governance bodies and senior-level committees to monitor ongoing oversight and compliance activities and continuing to invest in fostering a culture of integrity, safety and accountability.

Oversight and Accountability are both critical components to effective risk management. VHA has utilized the principles found in GAO's Standards for Internal Control in the Federal Government and the Institute of Internal Auditors' Three Lines Model to inform the VHA Risk Management framework.

Figure 2-3: GAO Green Book Principles for Risk Management

Control Environment

1. The oversight body and management should demonstrate a commitment to integrity and ethical values.

2. The oversight body should oversee the entity's internal control system.

3. Management should establish an organizational structure, assign responsibility, and delegate authority to achieve the entity's objectives.

4. Management should demonstrate a commitment to recruit, develop, and retain competent individuals.

5. Management should evaluate performance and hold individuals accountable for their internal control responsibilities.

Risk Assessment

6. Management should define objectives clearly to enable the identification of risks and define risk tolerances.

7. Management should identify, analyze, and respond to risks related to achieving the defined objectives.

8. Management should consider the potential for fraud when identifying, analyzing, and responding to risks.

9. Management should identify, analyze, and respond to significant changes that could impact the internal control system.

Control Activities

10. Management should design control activities to achieve objectives and respond to risks.

11. Management should design the entity's information system and related control activities to achieve objectives and respond to risks.

12. Management should implement control activities through policies.

Information and Communication

13. Management should use quality information to achieve the entity's objectives.

14. Management should internally communicate the necessary quality information to achieve the entity's objectives.

15. Management should externally communicate the necessary quality information to achieve the entity's objectives.

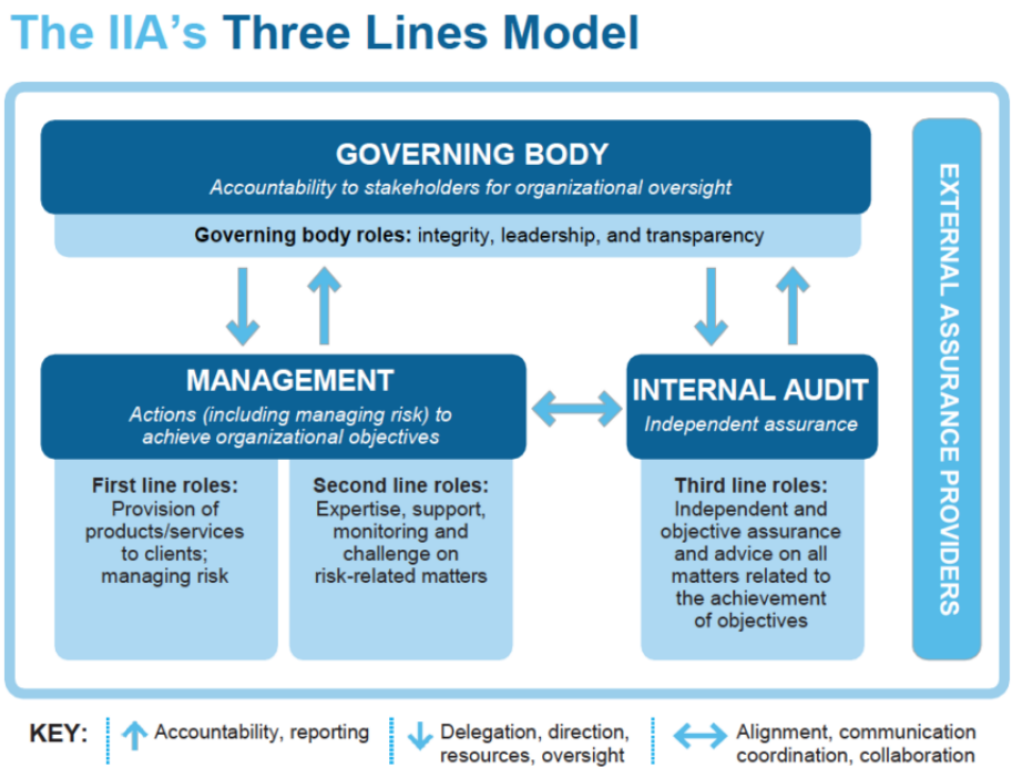
Monitoring

16. Management should establish and operate monitoring activities to monitor the internal control system and evaluate the results.

17. Management should remediate identified internal control deficiencies on a timely basis.

Source: GAO. | GAO-14-704G

Figure 2-4: Institute of Internal Auditors' Three Lines Model



The section below provides examples of how the Oversight and Accountability area of concern effort aligns with actions being undertaken to address the other areas of concern.

Oversight and Accountability Alignment with Other Areas of Concern

- **Oversight and Accountability Alignment with Policies and Processes:**
  - The Oversight and Accountability (OA) workgroup collaborates with the Policies and Procedures workgroup to ensure all policies under review receive a thorough and rigorous review and concurrence process, to ensure that all policies include an explanation of how the policy will be overseen and how programs will hold individuals accountable for following all aspects of the policy.
    - This includes strengthening VHA's policy on policy, current VHA Directive 6330 and future VHA Directive 0999, to require each policy to define roles and responsibilities and establish processes that strengthen accountability, establish internal controls, and propose oversight and monitoring plans for every program and for how to address non-compliance with the policy.

  - Policy owners (also known as responsible program offices) must ensure that policies are clear so they can be understood, have sufficient internal controls, and address the management of risk within the program or scope of policy.

  - Consistent with standard practice in corporate and government organizations, VHA published the VHA Code of Integrity on June 30, 2019 to create a common understanding of standards – internal and external to VHA - that define every employee's responsibilities towards establishing a culture of integrity. It is an umbrella document of standards that apply to VHA employees, organized under four larger categories (Integrity in the Workplace, Integrity in Care for Veterans and in Conduct of Research, Integrity in Financial Matters and Asset Protection and Integrity as a Federal Employee).

  - The VHA Code of Integrity provides each employee the necessary details to understand their reporting requirements as well as where to report and establishes clear expectations for fostering a Culture of Integrity.

  - VHA plans on utilizing the uniform policy naming convention as part of a tagging methodology that could be utilized across the Administration for the identification and resolution of identified risks and issues.

  - Collaboration in the development of a common policy library to unify disparate policy libraries into a single accessible site. This library, currently

in pilot phase, will allow any employee to have a single location where all facility, VISN, VHA and corporate policy will be able to be found. It will allow for program office and VISN oversight of facility standards where they differ from national by providing greater transparency. Combined with a strengthened waiver process that requires responsible program office's approval of any non-compliance.

- Collaboration with VHA's Office of Regulations, Appeals, and Policy to realign responsibility for establishing transparency and accountability for how VHA manages requests from the field to waive all or part of a VHA national policy to the Office of Integrity and Compliance (OIC).

- **Oversight and Accountability Alignment with IT:**
  - IT systems are critical to the success of effective oversight and accountability. VHA must continue to work with Office of Information and Technology (OIT) to determine and prioritize IT requirements.
  - IT assistance is needed for various elements, e.g., the development of the shared case management capability for VHA to provide adequate oversight, monitoring and accountability for policies, processes and decision made and executed at all levels of the organization.
  - OA relies on IT support to ensure data are timely and reliable to inform sound decisions.
  - OIT's maintenance of Compliance Inquiry Reporting and Tracking Systems (CIRTS) is essential for the OIC to track reports of non-compliance from identification to closure across the VHA enterprise.
  - Collaborating with IT and the Office of Electronic Health Record Modernization (EHRM) to ensure continuity of VHA's oversight capabilities.

- **Oversight and Accountability Alignment with Training:**
  - The OA workgroup collaborates with the Training workgroup to develop needs-based trainings related to oversight and accountability across VHA including training related to expectations for compliance with laws, regulation and policies, as well as high level expectation for Integrity and Safety in the Workplace.
    - Collaborate to utilize the Oversight and Accountability Reporting and Visualization Platform (OARVP) platform that currently hosts the Compliance Inquiry Reporting and Tracking Systems (CIRTS) to develop an additional interoperable module for the tracking and compliance requirements for training.

- **Oversight and Accountability Alignment with Resource Allocation:**
    - The OA workgroup 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 OA workgroup has collaborated in developing a uniform and transparent process for VA staffing requests through the Resource Validation Work Group.
        - The OA workgroup has worked to develop a uniform position description to elevate and harmonize the Integrity and Compliance Officer position at the facilities.

Inadequate Oversight and Accountability – Highlights

a. Key Actions Completed from March 2020 through December 2022

- VHA implemented organizational changes to better ensure governance and management makes decisions at the proper level of the organization and create greater cross-organizational oversight and accountability.

- To further align oversight and accountability, the Audit, Risk and Compliance Committee (ARCC), established a Compliance & Risk Subcommittee as well as a Fraud Waste and Abuse Subcommittee. In addition, the Compliance & Risk Subcommittee established a field based risk working group and risk management community of practice were also established in FY 2020 and FY 2021, respectively.

- The USH established the Office of Oversight, Risk and Ethics in 2020 (formerly the Office of Risk Management). This consolidated several oversight-focused offices and reports directly under the USH to align oversight functions as part of the larger VHA redesign (announced on January 1, 2020).

- VHA Enterprise Risk Management (ERM) analyzed and categorized previously disparate risk submissions to VA ERM thereby removing duplication and formulating a baseline Enterprise Risk Register.

- The OIC (formerly the Office of Compliance and Business Integrity (CBI) under the Office of Oversight, Risk and Ethics (ORE) deployed a Salesforce based platform to capture risk information from all VA medical facility and VISNs. The platform enables VA medical facility and VISN Compliance Officers to input and categorize risks, and input and track progress for responding to identified risks. OIC also developed and continues to refine a Risk Management Reporting Platform that will allow employees to better understand and respond to risks within their span of control.

- Over the past year, focused VHA efforts established authorities ensuring operating units make decisions at the appropriate levels. At the direction of the Acting USH, VHA published national directives that establish proper delegation of decisional authority. Directive 1217.01 delegates decisional authority to the previously established governance board and its councils and directive 1217 delegates decisional authority to VA operating units.

- VHA established a Governing Board, Enterprise Councils, and the Audit, Risk and Compliance Committee (ARCC) to modernize VHA's current governance structure. The Governing Board and Councils ensure leaders place the proper focus on governance and management decisions are informed by data and risk, and the ARCC provides oversight and accountability ensuring alignment with intended outcomes in alignment with Health and Human Services (HHS) Office of Inspector General's (OIG) guidance and Department of Justice (DoJ) Sentencing Guidelines on an effective compliance program.

- VHA implemented several modernization initiatives focused on improving key organizational oversight and accountability capabilities. Collectively, High Reliability Organization (HRO) and modernization efforts address critical oversight and accountability components such as decision making at the appropriate organizational level, aligning decision rights, improving vertical alignment and fostering a culture of integrity and accountability.

- VHA began to mandate the inclusion of oversight roles and responsibilities in all directives, which identifies the oversight mechanisms to be used by policy owners to which they and others are held accountable.

- CBI published Directive 1030, VHA Integrity and Compliance Program, in December 2020. This directive provides an enterprise-wide consistent and mandatory framework for all VHA compliance programs and requires VHA operational units (healthcare facilities, VISNs and VHA program offices to complete formal Causation and Corrective Action Plans in response to identified risk and issues.

- VHA focused on leadership development and staff training as they integrated 100% of its HRO Principles and Just Culture into all programs of the Office of Healthcare Leadership Institute (HLTI) and developed foundational HRO training that provides a common knowledge of HRO to employees at all levels of the organization supporting the promotion of VHAs transition to a high reliability organization. Over 90% of VISN and VAMC executive leaders completed this baseline training.

- The National Center for Ethics in Health Care has taken key steps to strengthen VA capacity to provide high quality healthcare ethics consultation and advising facility leadership on ethical issues that arise in healthcare delivery.

- VHA Designated Agency Ethics Official has established in concert with the Office of General Counsel a Government Ethics program that will place an Ethics Advisor at each Medical Center.

- VHA established uniform training for strengthen the VA's culture of integrity, this includes mandatory training on the Culture of Integrity, ICARE values, Own the Moment, Ethics, High Reliability Organization Principles, and other related topics.

b. Key Actions Planned through March 2023

- VHA Enterprise Risk Management (ERM) will establish a unified Integrated Risk Assessment and Management (IRM) model was necessary. An environmental scan, including interviews and surveys of key stakeholders at the program office and field level was completed. Data collected through this environmental scan will then inform the recommended IRM model.

- As a part of the risk management process, managers will develop and deploy improved oversight of the establishment of internal controls to align with the governance established for Risk Management. VHA anticipates that the ERM Environmental Scan will clarify where managers report programmatic risks, allowing VHA to clarify the reporting functions of risk. This clarification provides confidence in the ability to hold the assigned risk owner accountable for the ongoing response to the identified risk.

- VHA will continue to refine and adjust the governance structure and begin to address VHA operating units, to provide VHA employees and program offices access to governance at all levels of the organization, from the regions to VHA headquarters.

- The Office of Oversight, Risk and Ethics, is expanding program operations to reflect oversight and accountability needs at VHA. The office has begun socializing these changes with stakeholders engaged in oversight and accountability throughout the organization and has memorialized these changes in Directives, which received appropriate leadership approval.

Inadequate Oversight and Accountability – Actions Taken to Address GAO's "Not Met" Removal Criteria 2021 Rating

Inadequate Oversight and Accountability received a "not met" rating from GAO for the following removal criteria: Leadership Commitment; Demonstrated Progress; Monitoring; Action Plan; Capacity. The below list provides details on actions taken by the AOC workgroup since the GAO-21-119SP High Risk Series was published in response to these "not met" ratings:

a. Actions Taken to Address Leadership Commitment "Not Met" Rating

- President Biden has nominated Dr. Shereef Elnahal for the Under Secretary for Health and has robust efforts to fill Senior Leadership positions across the Department.

- The VHA Governance Board has been strengthened; five councils have been established nationally with a fractal structure in each VISN.

- The Audit Risk and Compliance Committee has been established to address strategic risks and accountability.

- Decision rights for VACO operational units have been established.

- VA's Strategic Plan has been updated and published.

- Policy and processes have improved, accurately representing the standards that govern the organization and facilitating high quality care regardless of where a Veteran enters the system.

- VA leadership supports VHA's Code of Integrity, ICARE values, High Reliability Organization to help set a positive tone at the top and support the clinical and government ethics programs.

- Leadership has endorsed an oversight and accountability framework that honors GAO's Standards for Internal Control in the Federal Government and the Institute for Internal Auditors Three Lines Model.

b. Actions Taken to Address Demonstrated Progress "Not Met" Rating

- The Action Plan provides additional detail consistent with improving capacity for oversight and accountability.

- Matured Integrated Risk Management and Enterprise Risk Management functions have been integrated into the Office of Integrity and Compliance.

c. Actions Taken to Address Monitoring "Not Met" Rating

- A uniform waiver process was established to proactively and transparently recognize where standards are not being met and establish corrective action plans and or accountability as appropriate.

- The coding audit has been broadened to include documentation reviews.

- Directive 0999 requires oversight and internal controls to be included in each policy submitted for concurrence after its publication.

d. Actions Taken to Address Action Plan "Not Met" Rating

- The AOC workgroup revisited VHA's response to reflect a broader and more comprehensive approach and consolidated efforts to respond to four mutually exclusive root causes. Those four root causes, taken together, establish roadmaps to improve VA's oversight capabilities, governance structure and processes, enhance the ability to monitor for quality and drive organizational and personal accountability and harmonize multiple efforts to improve enterprise-wide culture facilitating transparency and integrity.

- This Action Plan includes additional and more meaningful critical actions, milestones and performance measures across all outcomes.

e. Actions Taken to Address Capacity "Not Met" Rating

- Integrity and Compliance Directive 1030 was published and implemented.

- Risk University, a VHA-wide level setting of key risk and compliance training and standards, has been piloted and is set to be rolled out.

- VA's inquiry and allegation reporting module has been developed and launched.

- VHA has developed and continues to strengthen VHA's Risk Management Reporting Platform.

Status Key

This Action Plan submission denotes the status of implementation for each metric, outcome, and action graphically. The following Key can be used to understand the status graphics:
○ – "Not Met." Few, if any, actions toward meeting GAO's criterion for removal have been taken.
◐ - "Partially Met." Some, but not all, actions necessary to meet GAO's criterion have been taken.
● – "Met." Actions have been taken that meet GAO's criterion for removal. There are no significant actions that need to be taken to further address the criterion.
▲ - New or revised Root Cause.

Oversight and Accountability Outcome (O&A-1)

Outcome Executive: Tracy Davis Bradley, PhD, Executive Director, Office of Integrity and Compliance

Outcome Lead: Brian McCarthy, JD, MPH, Deputy Executive Director, Office of Integrity and Compliance

Root Cause: VHA has a fragmented oversight operating model that impedes on VHA's ability to effectively communicate across program offices, oversee policy implementation and ensure organizational accountability.

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

O&A-1a Metric: Percentage of operating units updating risks in a timely fashion. To be reported quarterly starting in FY23 calculated by number of risks responses and associated internal controls updated by due date over the total number of risks requiring updates.

O&A-1b Metric: Elapsed days between formal submission of candidate risk to Risk Working Group and approval or rejection by Risk Subcommittee. To be reported annually based on the number of candidate risk submissions. Elapsed time between submission to the Risk Working group and Risk Subcommittee decision not to exceed 120 days.

O&A-1c Metric: Percentage of principle offices with at least one active risk on the VHA ERR. To be reported quarterly to the Audit, Risk and Compliance Committee starting in Q3FY22 once a revised baseline VHA ERR has been approved by the Risk Subcommittee. Calculation = number of principle offices with ownership of listed risks over total number of principle offices.

O&A-1d Metric: Percentage of operating units actively participating in Integrated Risk Management. To be reported annually with a goal of 100%.

◐ **O&A-1.1 Goal**: VHA has formalized risk governance (GAO Components – Control Environment and Risk Assessment and Information and Communication).

◐ **O&A-1.1.1 Objective:** Establish and implement an organizational structure that promotes oversight and accountability.

O&A-1.1.1a Metric: Annual review of charters for each major risk governance body established. To be reported annually with a summary of major changes to each charter.

◐ **O&A-1.1.2 Objective:** Establish and implement committees, subcommittees and working groups to facilitate systematic risk management.

O&A-1.1.2a Metric: Audit, Risk and Compliance Committee, Risk Subcommittee and Oversight and Compliance Committee to meet quarterly each FY.

◐ **O&A-1.1.3 Objective:** Promote a risk-informed culture across VHA.

O&A-1.1.3a Metric: Percentage of VHA key stakeholders reporting that they understand VHA's risk governance structure and risk management framework is expected to reach 75% by end of FY 2023. The data will be reported annually beginning in FY 2022.

O&A-1.1.3b Metric: Attendance of representatives at risk related governance meetings. Governance groups include Audit, Risk and Compliance Committee; Risk Subcommittee; Oversight and Compliance Subcommittee. Target – end of FY2022 assigned representatives or approved delegate attend ≥50% of meetings. Target – end of FY2023 assigned representatives attend ≥75% of meetings.

○ **O&A-1.1.4 Objective:** Based on maturity evaluations (Goal 1.3), continue to enhance and define resource (e.g., funding, manpower, technology, etc.) needs for supporting field and program oversight, as well as governance bodies.

Table 2-1. O&A-1.1 actions

Act. #	Action Details	Projected Date	Actual Date
◐1.1.1.1	Realign VHA CO to promote oversight and accountability: establish ORE so that the Chief Risk Officer directly reports to USH consistent with DoJ Sentencing Guidelines and HHS OIG guidance.	Q2 FY20	TBD
Status:	In Progress		
◐1.1.1.2	Draft a policy to adopt the Three Lines Model across the Administration and clarify office roles and streamlining responsibilities to eliminate fragmentation, overlap and duplication.	Q1 FY23	TBD
Resources: **Risk:** **Status:** **Comments:**	Dr. Tracy Davis Bradley, Office of Integrity and Compliance If the Three Lines Model is not adopted by VHA then there will continue to be ongoing confusion regarding who has oversight and authority throughout the organization. In Progress On January 1, 2020, VA announced the redesign of the VHA CO to directly address oversight and accountability by consolidating several oversight focused offices under common leadership		
◐1.1.1.3	To promote oversight and accountability, ensure the IA Chief and Deputy Audit Executive positions are auditors as required	Q2 FY22	TBD

Act. #	Action Details	Projected Date	Actual Date
	by GAO Audit Standards and meet GSA requirements for auditor career field.		
Resources:	Robert McMillian, Office of Internal Audit		
Status:	In Progress		
Comments:	VHA IA Chief and Deputy Audit Executives are both auditors		
○**1.1.1.4**	Realign existing staff providing non-operational oversight from operational units.	Q3 FY25	TBD
IM-a:	Clarify and implement comprehensive reporting pathways	Q1 FY22	TBD
IM-b:	Establish core performance criteria	Q3 FY22	TBD
IM-c:	Submit proposal for resource reallocation	Q3 FY22	TBD
Resources:	No loss or gain of FTE but alignment changes potentially resulting in change in grade or supervisory status		
Risk:	If not completed, there will continue to be duplicative efforts, lack of transparency and damage to external reputation		
Status:	In Planning		
○**1.1.1.5**	VA offices support VISN, facilities, and program offices to establish responsive internal controls and monitors to ensure mission success.	Q3 FY23	TBD
IM-a:	Establish a revised baseline VHA ERR	Q3 FY22	TBD
IM-b:	Develop and implement expectations, templates and processes for candidate risk submission based on verified data and approved ownership	Q4 FY22	TBD
IM-c:	Develop and implement closure criteria for active risks rooted in tested internal controls and align reporting with the Statement of Assurance	Q3 FY23	TBD
Resources:	Organized and engaged governance structure, staff to support ERM functions and Statement of Assurance Functions, training and education regarding implementation and testing of internal controls		
Risk:	If not completed, risk-based decisions will not be anchored by evidence nor meet the standard necessary to validate mitigation of the risk areas		
Status:	In Planning		
Comments:	ERM functions moved to the Office of Integrity and Compliance in January 2022. Statement of Assurance kicked off in February 2022 and ERR revised as a step of improving the ICA process		
◐**1.1.1.6**	Properly resource (e.g., permanent personnel, contracting, etc.) VHA's oversight and accountability functions.	Q4 FY24	TBD
IM-a:	Examine the necessary requirements to properly resource program offices to execute its oversight and accountability functions		
IM-b:	Submit a proposal for resource allocation		
IM-c:	Obtain approval for resource reallocation and initiate implementation		
Resources:	Funding for FTE, approval from accountable official(s), staff with appropriate competencies		
Risk:	If resources are not appropriately reallocated then there will continue to be duplication of efforts, conflicting response plans to identified cross-functional risks and resources will be wasted leading to potential negative impact to veterans		
Status:	In Progress		

Act. #	Action Details	Projected Date	Actual Date
○**1.1.1.7**	Develop requirements, adequately resource and build unified and integrated risk reporting and monitoring system to ensure success of Goals 1.2 and 1.3.	Q3 FY24	TBD
IM-a:	Allocate resources to build a unified risk reporting and monitoring system	Q2 FY23	TBD
IM-b:	Identify requirements to build a unified risk reporting and monitoring system	Q3 FY23	TBD
IM-c:	Implement Risk Management Module of the OARVP system with expanded access to key process owners	Q3 FY24	TBD
Resources:	IT funds required to support system enhancement and build (approximately $1M/year for enhancement and $1M/year for sustainment)		
Risk:	If funding not secured, the oversight platform cannot be completed nor be optimized to better support risk informed decision making at all three levels of oversight.		
Status:	In Planning		
Comments:	Task cannot be started until resources are allocated and requirements are identified.		
◐**1.1.1.8**	Define oversight as a core responsibility of VHA operational units as defined in VHA Directive 1217.	Q3 FY25	TBD
IM-a:	Definition of oversight standards drafted and presented to Audit, Risk and Compliance Committee for adoption.	Q4 FY22	TBD
IM-b:	Standards resourced and implemented.	Q2 FY24	TBD
IM-c:	VACO operational units comply with oversight and reporting requirements found in Directive 1217	Q2 FY24	TBD
Resources:	Ethan Kalett, Lucille Beck, Office of Integrity and Compliance		
Status:	In Progress		
Comments:	Roll out implementing guidance		
● **1.1.2.1**	Charter and begin recurring Risk Working Group (RWG) meetings as an element of integrated risk management governance	Q2 FY20	Q2 FY20
Status:	Sustaining		
Comments:	The Risk Working Group (RWG) Core Team was established in FY 2021 to facilitate systematic risk management. The Risk Working Group provides input to candidate risks prior to submission for approval to the VHA ERR which is given by the Risk Subcommittee.		
◐**1.1.2.2**	Implement an annual review of RSC and RWG membership and charter	Q3 FY22	TBD
IM-a:	RSC and RWG membership to be reviewed in Q2 and adjusted as necessary	Q2 FY22	TBD
IM-b:	RSC charter and RWG addendum to be reviewed simultaneously with the membership	Q3 FY22	TBD
IM-c:	All vacancies to be filled on both groups by end of FY2022	Q4 FY22	TBD
Resources:	Engaged FTE from identified operational units		
Risk:	If governance for risk is not correctly established and membership not engaged, then the oversight of risk will be a paper exercise with no value behind it leading to misdirected decisions by the organization.		
Status:	In Progress		
Comments:	RWG membership review initiated in January 2022		

Act. #	Action Details	Projected Date	Actual Date
● 1.1.3.1	Establish an Enterprise Risk Community of Practice (CoP) to promote enterprise risk management knowledge and capabilities.	Q1 FY21	TBD
Status:	Completed		
Comments:	Monthly VHA ERM CoP meeting began in February 2021.		
◐1.1.3.2	Deploy a Risk Management Portal that provides key knowledge artifacts and resources to VHA personnel.	Q2 FY22	TBD
IM-a:	Deploy Risk Management Portal	Q3 FY21	Q3 FY21
IM-b:	Release Version 2.0 of the portal with additional stakeholders from associated program offices	Q3 FY22	TBD
Resources:	Contract support for initial build in MS PowerApps system		
Risk:	If funding not secured for contract support, the risk management portal cannot undergo required updates and enhancements to meet the needs of the end users.		
Status:	In Progress		
Comments:	The Risk Management Portal was deployed in FY 2021 and will be updated on an ongoing basis. VHA continues to make this portal a valuable reference for decisionmakers. The portal will migrate to the OARVP platform in FY24 – see 1.1.1.6		
◐1.1.3.3	Develop an education and communications effort to increase awareness of VHA's risk management framework, the connections between risk management and oversight, risk management best practices and available resources in order to inform VHA Program Offices, VA medical facility and VISN leadership and key stakeholders. Principles of risk management are also integrated into larger efforts like High Reliability Organization (HRO), Culture of Integrity, etc. to improve awareness.	Q1 FY23	TBD
IM-a:	Establish Risk University Advisory Board to be made up of cross-program SMEs	Q2 FY22	Q2 FY22
IM-b:	Pilot test Risk University with select cohort of volunteers	Q3 FY22	TBD
IM-c:	Formally announce availability for Risk University 2.0 to all VHA program office, VISN and VAMC staff	Q4 FY22	TBD
IM-d:	Deploy Risk University to all appropriate end users with a defined registration and approval process. Hold first official cohort.	Q1 FY23	TBD
Resources:	SMEs to lead Risk University, access to and knowledge of live instructor led facilitation systems, capacity of attendees to participate, tone at the top messaging from leadership		
Risk:	If VHA SMEs cannot all reach a baseline competency level for risk management efforts and processes, then we will continue to have fragmented and competing risk management efforts leading to a waste of resources.		
Status:	In Progress		
Comments:	VHA Enterprise Risk Community of Practice established. Risk University being led by SME on detail to OIC and Advisory Group kicked off in January 2022 with representation from clinical and non-clinical operational units.		
○1.1.4.1	Establish a risk management maturity model for VHA.	Q4 FY28	TBD
IM-a:	Proposals developed for review.	Q4 FY25	TBD
IM-b:	Maturity model adopted	Q4 FY26	TBD
IM-c:	Maturity model implemented	Q4 FY28	TBD
Resources:	Dr. Tracy Davis Bradley, Office of Integrity and Compliance		

Act. #	Action Details	Projected Date	Actual Date
Status:	In Planning		
○**1.1.4.2**	Utilize information from the IRM initiative and risk maturity assessments to inform decision making.	Q1 FY22	TBD
IM-a:	Determine where gaps in maturity of risk management programs exist and target for Risk University Training	Q4 FY22	TBD
IM-b:	Formally connect IRM practices with Strategic Planning Operations, Project Risk Management and Risk Governance	Q2 FY23	TBD
IM-c:	Establish a cadence of reporting on IRM trends to inform recommended enhancements to the risk governance structure	Q3 FY23	TBD
Resources:	Requires adoption of consistent risk management principals and collaboration between program and principal offices		
Risk:	If not completed, then there will continue to be significant variation in the ability of diverse groups to collect, analyze and act on risk-based information.		
Status:	In Planning		
Comments:	Dependent on the completion of the baseline and subsequent maturity assessments – target for baseline is FY 2021 / FY 2022.		
○**1.1.4.3**	Utilize the information from the IRM initiative and the maturity assessments to inform revised resource allocation and staffing models for those programs supporting risk management.	Q4 FY23	TBD
IM-a:	Build upon initial IRM environmental scan to collect detailed information on formally established RM oversight groups	Q4 FY22	TBD
IM-b:	Identify and spread best practices by advanced program offices, VISNs and VAMCs	Q4 FY23	TBD
Resources:	Training and education resources, FTE		
Risk:	If VHA SMEs cannot all reach a baseline competency level for risk management efforts and processes, then we will continue to have fragmented and competing risk management efforts leading to a waste of resources.		
Status:	In Planning		
Comments:	Will be dependent on resource availability and informed by the baseline maturity assessment that will completed at the end of FY 2021 and ongoing maturity assessment results.		
	All actions imply change management and training needs are a part of implementation planning.		

◐ **O&A-1.2 Goal**: VHA has a unified and integrated risk management framework (GAO Components – Risk Assessment and Control Activities) and it is understood and embraced by critical parties and that impacts agency priorities, decisions, resources, and facilitates the provision of safe and high-quality care.

◐ **O&A-1.2.1 Objective:** Deliver updated agency required oversight and accountability documentation and deliverables (e.g., Office of Management and Budget Circular No. A-123 required deliverables) for continued refinement to the governing bodies defined in OA-1.1 and to program and field leadership.

O&A-1.2.1a Metric: Accessible Units (AUs) reporting in a timely manner for the Internal Controls Assessment (ICA) with defined POCs. Percent compliant

calculated by number of AUs with all ICA entries completed by the VHA due date over total number of AUs. To be reported annually beginning in FY2022.

O&A-1.2.1b Metric: Internal Controls listed on the VA ERR show evidence of testing within one year of risk entry on the VA ERR. Percent of internal controls for risks on VA ERR for 12 or more months with testing documentation over total number of internal controls with qualifying risks.

◐ **O&A-1.2.2 Objective:** Catalogue baseline VHA risk management efforts and continue to mature processes.

O&A-1.2.2a Metric: Establishment of a uniform, high quality and reliable risk assessment process that is collaborative in nature. Calculated by the number of program offices collaborating on risk identification, assessment, and data collection. Target of six collaborating offices by Q4 FY2023

O&A-1.2.2b Metric: Establishment of a corporate compliance model to support business related risk identification and assessment at VAMCs. Percentage calculated by the number of VAMCs with a corporate compliance model over total number of VAMCs. Target of 25% of VAMCs with Corporate Model by end of FY2024.

◐ **O&A-1.2.3 Objective:** Develop and deploy Integrated Risk Management (IRM) process for aggregating and assessing risks identified across VHA.

O&A-1.2.3a Metric: Percentage of VISNs received vision is expected to reach 100% by Q4 FY2022. The data will be reported at the end of the FY to the ARCC.

O&A-1.2.3b Metric: Percentage of VISNs with identified liaison is expected to reach 100% by Q2 FY2023. The data will be reported on a bi-annual basis until the target is reached.

O&A-1.2.3c Metric: Percentage of VISN liaison's received training via Risk University is expected to reach 100% by Q2 FY2024. The data will be reported on a bi-annual basis until the target is reached.

O&A-1.2.3d Metric: Percentage of VISNs with dedicated IRM staff is expected to reach 75% by Q2 FY2024. The data will be reported on a bi-annual basis until the target is reached.

O&A-1.2.3e Metric: Percentage of VAMCs adopting an IRM model with the support of associated program offices (Goal 1.2) is expected to reach 10% by the end of FY2022 with an extended target of 50% by Q4 FY2026. The data will be reported on an annual basis until the target is reached.

O&A-1.2.3f Metric: Percentage of VISNs adopting an IRM model with the support of associated program offices (Goal 1.2) is expected to reach 10% by the end of FY2023 with an ultimate target of 100% by Q4 FY2025. The data will be reported on an annual basis until the target is reached.

○ **O&A-1.2.4 Objective:** Enhance the execution and utilization of the IRM process through improved processes and technology.

O&A-1.2.4a Metric: Percentage of operational units routinely cataloguing inquiries and allegations in an interoperable reporting system (CIRTS, PACERs, PATS-R, etc.). Target of 50% of operational units recording in an interoperable system by Q4FY22. Reporting with coordinated with the Data Governance Oversight Board on a cadence to be determined.

○ **O&A-1.2.5 Objective:** Establish an oversight framework for VHA modeled after the Three Lines Model.

Table 2-2. O&A-1.2 actions

Act. #	Action Details	Projected Date	Actual Date
● **1.2.1.1**	VHA's Chief Risk Officer uses the ARCC governance process to analyze and categorize risks assigned to VHA in VA's ERM Tool to form a baseline Enterprise Risk Register (ERR).	Q1 FY20	Q1 FY20
Status: **Comments:**	Completed The baseline VHA ERR was assembled during the fourth quarter of FY 2020 and is shared with the ARCC quarterly since FY 2021 Q1.		
● **1.2.1.2**	VHA's Chief Risk Officer submits VHA ERR baseline to VA following ARCC review.	Q2 FY21	Q2 FY21
Status: **Comments:**	Completed The baseline VHA ERR was submitted to the ARCC in December 2020. The VHA ERR will continually be updated and escalated to the VHA Chief Risk Officer as needed.		
◐**1.2.1.3**	VHA's Chief Risk Officer updates the Risk Profile and Internal Controls Assessment in collaboration with VHA operational units in accordance with OMB No. A-123.	Q4 FY22	TBD
IM-a: **IM-b:** **IM-c:** **Resources:** **Risk:** **Status:** **Comments:**	Identify primary and secondary POCs for the VHA Internal Controls assessment Establish a recurring cadence for updates to the VHA Risk Profile to be done annually Ensure that risks on the ERR are associated with well-defined controls FTE required to support ICA functions If the ICA is not better aligned with ERM functions then there will continue to be gaps in reporting between the two functions In Progress VHE ERM functions moved to the Office of Integrity and Compliance in Q2 FY2022 resetting some of the ICA and Statement of Assurance Functions.	Q2 FY22 Q4 FY22 Q4 FY22	Q2 FY22 TBD TBD

Act. #	Action Details	Projected Date	Actual Date
● 1.2.1.4	Deliver annual Statement of Assurances following assessment of internal controls and conclude on the effectiveness of controls consistent with OMB No. A-123 requirements.	Q4 FY21	Q4 FY21
Status:	Sustaining		
Comments:	VHE ERM functions moved to the Office of Integrity and Compliance in Q2 FY2022 resetting some of the ICA and Statement of Assurance Functions. Cadence for ICA and SOA reporting remains as required by federal regulations.		
◐1.2.1.5	Formalize the reporting of Accessible Units with identified Enterprise Risks will report annually through the Internal Controls Assessment on applicable internal monitoring, audits and reviews.	Q2 FY23	TBD
IM-a:	Crosswalk the Accessible Units with the identified Principal and Program Offices for each VA ERR risk.	Q2 FY22	TBD
IM-b:	Complete internal controls training with Risk POCs associated with the AUs and the oversight offices	Q1 FY23	TBD
IM-c:	Establish clear requirements for the ICA and VA ERR data inputs	Q2 FY23	TBD
Resources:	FTE to support the ICA and SOA, training and education for POCs		
Risk:	If there is disconnect between the ICA and the VA ERR then there will be errant reporting in the statement of assurance.		
Status:	In Progress		
Comments:	Monitoring, audit and review activities have been undertaken by VHA ORE entities. The assignment of such items will transition to be more risk-driven over time.		
◐ 1.2.2.1	Begin ongoing monitoring of VHA operational units for continuous improvement of risk, oversight and accountability practices.	Q4 FY22	TBD
IM-a:	Widely communication expectations for risk candidate submissions and regular reporting to governance bodies	Q2 FY22	TBD
IM-b:	Formalize submitting quarterly reports to the RSC to include successes, obstacles and matters requiring formal decisions.	Q3 FY22	TBD
IM-c:	Establish a cadence for program office reporting to the ARCC on risk, oversight and accountability actions under their purview.	Q4 FY22	TBD
Resources:	FTE and contract support to operationalize ERM functions to ensure that the VHA ERR is data driven and validated		
Risk:	If VHA ERM is not adequately supported through resources and tone at the top, then the VHA ERR will not be reflective of the true risks of VHA		
Status:	In Progress		
Comments:	With movement of VHA ERM under the Office of Integrity and Compliance, widespread coordination with related program offices has been initiated and risk submissions are in the process of being formalized.		
◐1.2.3.1	Leveraging formalized risk governance entities and considering the Environmental Scan inputs as well as GAO, OIG and authoritative methodologies, propose an IRM model that would serve to cohesively capture risk across VHA in a standardized manner.	Q2 FY22	TBD
IM-a:	Complete environmental Scan	Q1 FY22	Q1 FY22

Act. #	Action Details	Projected Date	Actual Date
IM-b:	Develop a communication cadence and process for risks identified at a national level to inform and reduce duplication of efforts occurring at a local level	Q3 FY22	TBD
IM-c:	Develop and implement an agreed upon process for escalating externally identified risks to all parties impacted by risk area.	Q4 FY22	TBD
Resources:	Clear reporting structures, FTE to support communication, widespread risk competency.		
Risk:	If risks are not able to be escalated upwards and downwards throughout the multiple levels of the organization, then VHA will lack transparency and waste resources by duplicating efforts to devoting time and resources to incorrectly prioritized risk areas.		
Status:	In Progress		
Comments:	Environmental scan completed, now taking the steps to develop a top risk list to be informed by external risk identification groups.		
◐**1.2.3.2**	Develop and implement the IRM Operational Plan that provides activities and milestones for deploying the IRM framework. Deploy to operational units by governing bodies	Q3 FY22	TBD
IM-a:	Adopted by governing bodies	Q2 FY22	TBD
IM-b:	Adopted by program offices	Q4 FY22	TBD
IM-c:	Adopted by VISNS and medical facilities	Q2 FY23	TBD
Resources:	Office of Integrity and Compliance, Enterprise Risk Management, ARCC; IT systems to support data collection		
Risk:	If governing bodies cannot agree upon an IRM operational plan, then IRM will continue to function in a wide variety of fashions or not at all at the other levels of the organization.		
Status:	In Progress		
Comments:	VHA ERM functions moved under OIC as of 1/19/22 allowing for a stronger connection between ERM and IRM functions. Risk University – anticipated for formal pilot in Q3 FY22 will provide the education required to support IRM operations.		
○**1.2.4.1**	VA improves and harmonizes data from pertinent quality, risk, issue, performance, culture databases for analysis and reporting. Key databases include: SAIL, RAMP, HEDIS, CDI, HOC, FACTS, PATS, and several others.	TBD	TBD
Status:	In Planning		
Comments:	Cannot be completed until previous actions are implemented.		
	All actions imply change management and training needs are a part of implementation planning.		

◐ **O&A-1.3 Goal**: VHA has a unified and integrated risk reporting and monitoring system (GAO Components – Information and Communication and Monitoring) and uses it for decision making and prioritization.

◐ **O&A-1.3.1 Objective:** Utilize data governance to ensure information is available, and performance metrics can be established and prioritized to support governance and oversight requirements.

O&A-1.3.1a Metric: Percentage of national policies with oversight standards and requirements included in policy document and associated processes is

expected to reach100% within 5 years of publication of 0999. Data will be reported on an annual basis.

◐ **O&A-1.3.2 Objective:** Assign and execute internal monitoring, audits and reviews based on VHA IRM prioritization.

O&A-1.3.2a Metric: IA conducts engagements the ARCC recommends and the USH approves via the current VHA Audit Plans. Calculated by the number of recommendations with follow up audits completed but IA. To be reported on an annual basis.

O&A-1.3.2b Metric: Percentage of corrective actions completed by their negotiated completion date is expected to reach 70% by end of fiscal year 2023. The data will be reported quarterly.

See O&A – 1.2.1a Metric

See O&A – 1.2.1b Metric.

○ **O&A-1.3.3 Objective:** Assign and execute corrective and preventive action plans based on VHA IRM information.

O&A 1.3.3a Metric: Percent of VHA ERR risks with risk mitigation plans initiated within 90 days of entry on the VHA ERR. To be reported annually.

O&A 1.3.3b Metric: Percent of risks with risk mitigation plans closed within 360 days of initiation. To be reported annually.

○ **O&A-1.3.4 Objective:** Monitor the performance and maturity of IRM; evaluate IRM tool inputs and effectiveness.

O&A 1.3.4a Metric: Submit annual reports effectiveness of implemented controls. Contrast differences between IRM sites and non-IRM sites. Compare AES scores and SAIL scores of IRM sites with non-IRM sites.

O&A 1.3.4b Metric: Percentage of risks with internal control effectiveness measures submitted within 180 days of completion of risk mitigation plan. To be reported annually through the Internal Controls Assessment

Table 2-3. O&A-1.3 actions

Act. #	Action Details	Projected Date	Actual Date
◐1.3.1.1	Enhance risk management platforms used as inputs for the VHA ERR.	Q4 FY23	TBD
IM-a:	Deploy Version 2.0 of Risk Management Portal	Q3 FY22	TBD
IM-b:	Complete discovery for migration of Risk Management Portal to OARVP	Q3 FY23	TBD

IM-c:	Develop and deploy Risk Management Module of the OARVP along with related analytics	Q4 FY23	TBD
Resources:	IT funding, VHA staffing capacity		
Risk:	If funding is not secured for the OARVP enhancement then the risk portal will have to remain locally maintained and be limited in its interoperability for analytics and reporting.		
Status:	In Progress		
Comments:	VHA OIC deployed a SharePoint platform during FY 2019 to capture risk and risk management information from VA medical facilities and VISNs. The tool has undergone numerous refinements, including significant updates during FY 2021. IT solutions are currently being reviewed.		
◐ 1.3.1.2	Consolidate issue and risk management platforms to include clinical, legal and regulatory, and operational to harmonize the collection, aggregation, and analysis of identified issues and VHA risks and risk response information. VA is working to establish broad interoperability standards that would facilitate the efficient and proactive use of siloed data.	Q4 FY23	TBD
IM-a:	Complete pilot with VHA OIC and VHA Strategic Planning Operations	Q4 FY22	TBD
IM-b:	Pilot collection of project-based risk in the Risk Management Portal	Q4 FY22	TBD
IM-c:	Monitor abandonment rates of entered risks, completion of mitigation plans and effectiveness of established controls	Q4 FY23	TBD
Resources:	Funding will be required to support staff and systems needs to execute this task		
Risk:	If risks and issues are captured and analyzed in a siloed manner then there will be no ability for VHA to track and trend emerging risks for rapid response in a manner that promptly identifies required responses		
Status:	In Progress		
Comments:	Coordinating efforts are in process to establish interoperability capability between the FACTS database and OARVP		
◐1.3.1.3	Establish a process in which potential risks are escalated to senior leadership review and previously identified risks are managed professionally consistent with the adopted risk management strategy.	Q4 FY21	TBD
Status:	In Progress		
Comments:	VHA is strengthening the competencies of Risk Working Group and Risk Subcommittee members to consistently review the entries elevated to the ARCC.		
◐1.3.1.4	Assign risk ownership to accountable entities so that all identified risks have accountable officials managing its risk response, VHA is ensuring that all risks have a clearly identified owner who understands their responsibilities regarding the risk. Future risk identification will require assignment of accountability.	Q4 FY22	TBD
IM-a:	Identify Principal Offices and Primary Owners for all current VHA ERR Risks	Q2 FY22	TBD
IM-b:	Require newly identified risks to have owner as part of ERM processes	Q3 FY22	TBD
IM-c:	Coordinate with identified Principal Offices and Primary Owners any proposals to archive or edit existing risks on the VHA ERR as of Q2 FY2022	Q3 FY22	TBD
Resources:	Engagement of governance representatives		

Risk:	If risks remain on the VHA ERR with no accountable owners then no meaningful action will be possible to implement, and the risks will remain unresolved.		
Status:	In Progress		
Comments:	VHA ERM is reviewing all current risks on the active VA ERR to determine validity of submission in the current environment. Primary and Secondary Program offices will then be assigned to each risk along with risk owners and points of contact for reporting purposes. Any risk that lacks a formal risk owner will be submitted to the ARCC to have a risk owner assigned. Candidate risks will not be allowed to move forward for consideration until ownership is agreed upon. This review of the current register was triggered by the movement of VHA ERM function to OIC		
◐1.3.2.1	VHA conducts regular coding audits to ensure the accuracy of coding and documentation. VHA plans to triple the number and expand from a limited sample to a national sample to allow for greater accuracy and more actionable recommendations that will ensure compliance and improve clinical documentation to support care providers with accurate and complete patient information.	Ongoing	TBD
IM-a:	Expand the number of national audits and samples for greater accuracy	Q2 FY22	TBD
IM-b:	Improve transparent reporting of results with internal oversight bodies that are cross functional in nature.	Q4 FY23	TBD
IM-c:	Clearly define when error rates require in a high level of oversight as defined by the three lines of defense model	Q4 FY24	TBD
Resources:	FTE to complete audits, access to information and related systems		
Risk:	If actions are not taken in response to known deficiency areas pertaining to coding and documentation, then there will continue to be negative impact on veterans and the organization as a whole.		
Status:	In Progress		
Comments:	Coding audits have been ongoing for several years. OIC has strengthened its collaboration with Quality and Patient Safety and Health Information Management to triple the resources allocated to this contract. OIC is currently reviewing processes and reports for quality and ensure efforts remain current and align with industry strong practice.		
◐1.3.2.2	VHA ERM functions to move under the Office of Oversight and Integrity, improving the connection between IRM and ERM and allowing for more comprehensive support to the field and program offices.	Q1 FY23	TBD
IM-a:	Transition all ERM functions to the Office of Integrity and Compliance	Q2 FY22	Q2 FY22
IM-b:	Revise position descriptions of those supporting the ERM functions for VHA	Q3 FY22	TBD
IM-c:	Obtain appropriate staffing levels in order to assure thorough oversight of ERM and ICA functions	Q1 FY23	TBD
Resources:	Funding for staffing, FTE, training and education		
Risk:	If ERM and IRM support is not resourced appropriate then risks will go unaddressed and internal controls will not be effective.		
Status:	In Progress		
Comments:	Initial transition completed in Q2 FY2022. OIC Risk Manager overseeing ERM functions until fully staffed and resourced.		
◐1.3.2.3	Execute the annual internal audit plan.	Ongoing	Ongoing

Status:	In Progress		
Comments:	From FY 2018 through FY 2020, the USH assigned VHA Internal Audit (under VHA ORE) 5 internal audits. For FY 2021, the ARCC recommended and the USH approved top five risks for internal audit engagements.		
○**1.3.3.1**	Institute a formal corrective action plan process for VHA enterprise risks.	Q2 FY24	TBD
IM-a:	Identify key stakeholders involved in corrective action oversight throughout VHA	Q4 FY22	TBD
IM-b:	Determine associated systems where corrective action information is collected and analyzed	Q1 FY23	TBD
IM-c:	Develop and implement a formal standardized process that can be used by multiple stakeholders throughout VHA to include closure of plans and monitoring effectiveness	Q2 FY24	TBD
Resources:	Collaboration between multiple offices, FTE to support development and implementation, funding for IT systems		
Risk:	If VHA does not implement a standardized approach to corrective action plans then there will be varying expectations and accountability for known issues resulting is chronic issues and risks for the organization.		
Status:	In Planning		
Comments:	Need was identified during the update to the GAO HRL response plan and will be built into the IRM Strategic Plan. This is being built into the risk submission and reporting process. Risk owners will be responsible for reporting on the status of said plans.		
○**1.3.4.1**	Develop a maturity model for VHA IRM. Assess IRM maturity at baseline and in follow-up to determine effectiveness of IRM.	Q4 FY23	TBD
IM-a:	Formally define and communicate IRM elements	Q4 FY22	TBD
IM-b:	Develop an assessment process for measuring maturity of IRM programs	Q3 FY23	TBD
IM-c:	Establish an annual review of maturity of known IRM programs	Q4 FY23	TBD
Resources:	Communication resources, assessment resources, staffing and funding to support assessment		
Risk:	If there is not a standard way to determine comprehensive maturity of each IRM program in VHA there will be no way to determine the validity level of risk submissions from the different inputs.		
Status:	In Planning		
Comments:	This step requires governance to oversee the determining of what is IRM.		
	All actions imply change management and training needs are a part of implementation planning.		

◐ **O&A-1.4 Goal**: Data required for the oversight of VA be made available to necessary parties. (GAO Components – Information and Communication)

◐ **O&A-1.4.1 Objective:** Support key data stewards sufficiently to allow for data necessary for oversight and accountability to be accessible.

◐ **O&A-1.4.2 Objective:** Develop a naming and tagging convention that can be utilized for the standards, processes, authorities that govern program implementation, identification of risks and issues, analysis, and response.

◐ **O&A-1.4.3 Objective:** Support the harmonization of management and oversight databases to facilitate interoperability for analysis and reporting.

See O&A-1.2.2a Metric

Table 2-4. O&A-1.4 actions

Act. #	Action Details	Projected Date	Actual Date
◐ **1.4.1.1**	Establish and implement the VHA Data Governance Council	Q4 FY22	TBD
IM-a:	Formalize proposal the VHA Data Governance Council	Q1 FY22	Q1 FY22
IM-b:	Define membership for the VHA Data Governance Council	Q2 FY22	TBD
IM-c:	Establish what will report up to the VHA Data Governance Council	Q4 FY22	TBD
Resources:	VHA Champion for Data and Analytics		
Risk:	If the VHA Data Governance Council is not established with agreed upon oversight and accountability then there will be a failure to reduce system duplication and improvement of information sharing		
Status:	In Progress		
◐ **1.4.2.1**	Implement a formalized naming convention for VHA documents that allows for alignment of data categorization and tagging throughout multiple systems.	Q1 FY23	TBD
Resources:	VHA Champion for Data and Analytics		
Status:	In Progress		
◐**1.4.3.1**	Develop and implement analytics systems and processes that can intake and digest information from multiple systems	TBD	TBD
IM-a:	In coordination with VA IT and other stakeholders, establish an inventory of data management systems and related elements	TBD	TBD
IM-b:	Propose a system in which segmented systems can communicate to better inform risk and issue data analytics	TBD	TBD
IM-c:	Determine ownership of analytics system and requirements for ongoing enhancements	TBD	TBD
Resources:	Funding for IT systems, staffing to support development		
Risk:	If VHA cannot streamline the analysis of risk and issue management with defined oversight responsible for responding and resolving any outlying areas identified, then VHA will be unable to make the best informed decisions to benefit veterans and stakeholders.		
Status:	In Progress		
Comments:	Initial discussions have been completed to discuss integration with other related projects throughout VA and VHA to collect the best knowledge management possible. In planning with initial stakeholder meeting underway.		

○ **O&A-1.5 Goal**: VHA attracts, develops, and retains oversight and compliance professionals with exceptional knowledge, skills, and abilities.

○ **O&A-1.5.1 Objective:** Support recruitment and training curriculum designed to prepare participants to be a successful compliance professionals.

O&A-1.5.1a Metric: Retention rate of compliance professionals. Measured by the turnover rate over a fiscal year. Goal of 80% retention rate year over year.

○ **O&A-1.5.2 Objective:** Provision of high-quality professional training and education materials.

O&A – 1.5.2a Metric – Principal Offices with two liaisons identified and trained through Risk University. Target of 100% by Q1 FY2023.

O&A – 1.5.2.b Metric – Compliance with Mandatory Compliance Training. Percentage of compliance with Compliance Mandatory Training nationally as recorded in TMS.

See O&A-1.2.3c

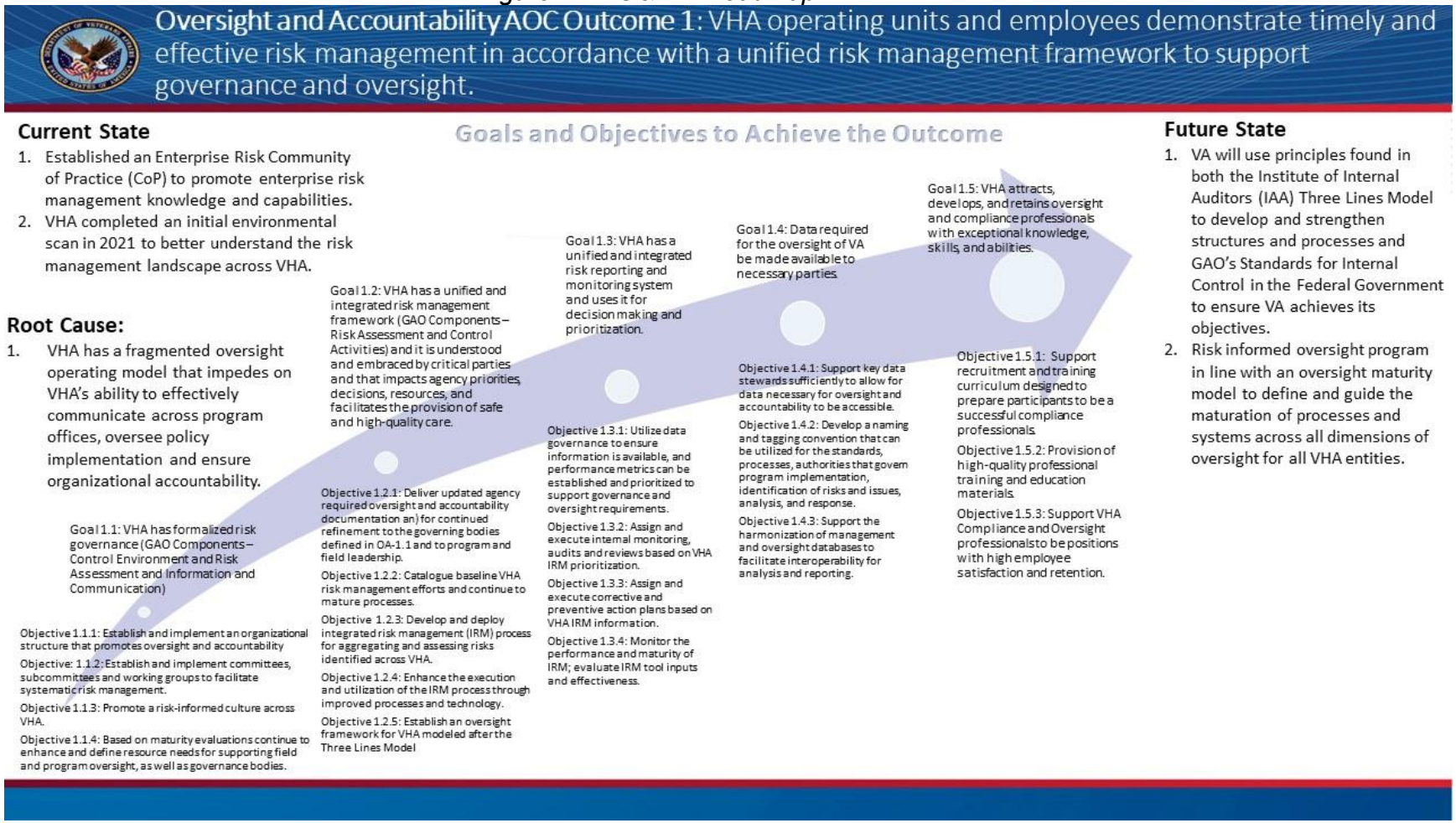
○ **O&A-1.5.3 Objective:** Support VHA Compliance and Oversight professionals to be positions with high employee satisfaction and retention.

O&A-1.5.3a Metric: Customer service satisfaction scores and program VA All Employee Survey (AES) scores.

O&A-1.5.3b Metric: Percentage of VAMC, VISN and Program ICOs satisfied or very satisfied with support provided.

Figure 2-7, below, visually presents the current state of this outcome, the desired future state of this outcome and the goals and supporting objectives that align and will contribute to the achievement of that future state.

Figure 2-7. O&A-1 Roadmap



O&A-1 Description and Status

Description

- This outcome focuses on providing effective risk and issue management practices to support governance and oversight. This action plan outlines how improving oversight requires coordinated and purposeful action at every level of the organization. To that end, this plan reflects a broadened scope to demonstrate the extensive work that is being done at every level of the Department and outlines ongoing efforts where VHA has strengthened its ability to work across silos to harmonize efforts between operational units and governing bodies to detect, identify, and respond to ensure VA provides the highest quality care to those we serve.

- Outlined in this section is how VA will use principles found in both GAO's Standards for Internal Control in the Federal Government and the Institute of Internal Auditors (IAA) Three Lines Model to develop and strengthen structures and processes and to ensure VA achieves its objectives. VA expects this framework to be applied across clinical and non-clinical programs will be operating under a common approach and understanding by all employees, regardless of position and station in the organization.

- Leading this effort are VA offices that provide subject matter expertise and support for oversight, quality, safety, and risk management functions for the operational units as demonstrated through membership and coordination of the Audit Risk and Compliance subcommittees and workgroup members.

- In addition, Coordination efforts are underway between representatives from the Office of Oversight, Risk, and Ethics, the Office of Quality and Patient Safety (QPS), Operations (15), and the newly established VHA Champion for Data and Analytics to strengthen the connections in data, risk and issue management, and to provide unified support to service driven program offices, VISNs, and senior leadership as each fulfills their management and oversight responsibilities.

- This action plan establishes key tasks that will support VHA organizations and employees to identify and manage risks in accordance with an established enterprise risk management (ERM) framework, specifically:
    - Development of sound quality and oversight mechanisms
    - Unified Risk Management Governance to include oversight of compliance, enterprise risk management and internal audit functions.
    - Development and deployment of an enterprise risk management model guided by the framework developed in GAO's Standards for Internal Control in the Federal Government.
    - An ability to conduct administrative reviews, investigations and audits.

- VHA Enterprise Risk Management (ERM) relies on all operational units and is led by the Chief Integrity and Compliance Officer and the VHA Enterprise Risk Manager with guidance and accountability coordinated through a central governance body, the ARCC. Functional duties of VHA ERM have been delegated to the OIC and efforts are spearheaded by the Chief Integrity and Compliance Officer and the assigned Enterprise Risk Manager.

- Strengthen the ability to provide subject matter expertise and collaboration among VHA operational units to harmonize quality, oversight and accountability efforts with operational units to identify new monitors and efforts that support a unified response to repeat findings and the management of known risks and issues.

Status

Three Lines Model

VA will use principles found in both the GAO's Standards for Internal Control in the Federal Government and the Institute of Internal Auditors (IAA) Three Lines Model to develop and strengthen structures and processes to ensure VA provides necessary oversight and independent, objective assurance of the delivery of healthcare to Veterans. Responsibility to achieve organizational objectives on the part of management comprises both first and second line roles. First line oversight and management roles are aligned with the delivery of products and/or services to clients of the organization and include the roles of support functions at the point of implementation. Second line roles provide assistance with managing risk and serve as subject matter experts in Privacy, Compliance, Risk Management, Internal Controls, and related fields and cannot be under the same supervisory structure as first line. Finally, the third line provides independent and objective assurance and advises on the adequacy and effectiveness of governance, internal controls and risk management. The third line must be independent of management and supervision in the first and second lines.

Determining these roles is often dependent on scenario. Regardless of scenario, it is paramount that integrity, the desire to minimize actual and perceived conflicts of interest, and professionalism drive individual and organizational understanding of how they or any of VA's operational units – individually and collectively - provide adequate oversight, assurance and accountability. To assist, VA offers additional guidance on how its system for oversight and internal controls must be understood: A) implementing operational units provide goods or direct services to those we serve, our partners, or other VA operational units and provide ongoing of oversight of the first line; B) the second line cannot be performed under the same supervisory structure as the first line; C) each individual and operational unit must design, implement, and operate within an effective internal control

system, based on GAO's Standards for Internal Control in the Federal Government to ensure VA's objectives are achieved; independent, objective assurance performed by the third line must operate and be supervised independent of the first and second lines in order to be effective and meet standards. VA believes the impact of implementing this oversight framework will be to honor a commitment to provide high quality, safe and effective care, and support VA's journey to become a High Reliability Organization that identifies and solves its known risks and issues and is accountable to those it serves.

Note: this action plan – due to its Administration-wide scope and consistent with VHA's organizational structure – views facilities as first line; VISNs and program offices, Operations, and oversight subject matter expert program offices as the second line; offices such as Internal Audit, Office of Research Oversight, etc. as the third line. Several bodies provide governance, these include the Governance Board which provides operational strategy; the Audit, Risk and Compliance Committee (ARCC) which provides strategic oversight and accountability. The Healthcare Operations Council (HOC) is not a governing body but oversees field management.

First Line: Implementing Operational Units

- First line roles are most directly aligned with the delivery of products and services to those we serve. All implementing staff have a responsibility to act with integrity. There work is immediately overseen by their manager and supervisor. As the largest integrated health care system in the United States, VHA has vast and varied program implementation strategies. There are four common scenarios:

  A) the facility service line delivering the product or service and owns the first line roles (and their employees, managers and supervisors own the first line functions). This scenario makes the second line functions to be jointly owned by: a) the in-facility management and quality, safety, compliance officers across multiple professions, b) VISNs, c) responsible program office(s), d) Operations (15) and e) Oversight SME Services.

  Note: this scenario's intra-facility perspective is consistent with VA's Modernization efforts to empower employees to better serve Veterans meant to empower effective internal controls and problem solving at the facility level. It does not minimize or remove the oversight function provided from operating units outside the facility.

  B) the facility, as a unit, delivers the product or service and owns the first line roles. This scenario makes the second line responsibilities to be jointly owned by: a) the VISN b) responsible program office(s), c) Operations and d) Oversight SME Services.

C) the VISN delivers the product or service and owns the first line roles. This scenario makes the second line responsibilities to be owned by the a) responsible program office(s), b) Operations, and c) Oversight SME Services.

D) the VA program office delivers the product or service and owns the first line roles. This scenario makes a) operations and b) VA oversight subject matter experts own the second line roles.

As stated above, VHA will roll out the three lines model with the above scenario B being the standard, but VHA acknowledges multiple scenarios.
Note: In all four scenarios, the third line is the independent, objective programs offices, including OMI, ORO and IA (see third line below).

Second Line (2A): Market and Service Focused Oversight

- The **Office of the Assistant USH for Operations** (AUSH-O) leads VHA operations and ensures it continues to be the benchmark for health care excellence and value through the clinical and administrative services we provide to care for Veterans and their families. The Office of the AUSH-O operates VHA health care systems, medical centers and outpatient sites of care. VHA's coverage area is divided into 18 VISNs, each a shared system of care working together to better meet local health care needs and provide Veterans greater access to care. The AUSH-O is responsible for ensuring VHA program policies and regulations are executed and supported to fulfill the operating needs of VHA field operations. Oversight responsibility lies with the AUSH-O and their delegees over the VISN Executive Directors and their respective VISN's performance.

- **Veterans Integrated Services Network:** The U.S. is divided into 18 Veterans Integrated Service Networks (VISNs) that are regional systems of care working together to better meet local health care needs and provides greater access to care. Each VISN provides operational oversight of several medical systems within their respective region. VISN oversight views medical systems performance, in their totality, as their span of control and oversight. Oversight responsibility lies with the Network Executive Director and their delegees over the various Medical Center Executive Directors and their respective facility's performance.

- **National Program Offices** are responsible for developing program standards, strategies, and providing tools to the field in support of national goals. Key responsibilities outlined in VHA Directive 1217, VHA Operating Units, include governance, expertise, leadership, and oversight. A National Program Office provides oversight of its program's performance at every point of delivery consistent with their span of control. A program office provides management and governance, and with exceptions, does not generally conduct direct operations. Any risk or issue identified by the program office's oversight at any VHA points of

operations, must be routed by processes established by VHA Senior Leadership to the appropriate Operating Units for response. For significant risks and issues, or the failure for an operational unit to establish or make progress on a negotiated and approved corrective action plan, must be reported to their Principal Officer and or the Audit, Risk, and Compliance Committee for purposes of accountability *(See OA-2 and 3).* Oversight responsibility lies with the chief or Principal Officer for the National Program Office to the appropriate service manager for each medical center, with communication and accountability following processes established by VHA Senior Leadership. Key National Program Office O&A Activities: Systemic oversight and resource allocation, including the management of professional standards within their span of control. Identifying emerging national issues, establishment of evidence based regulations, policies, guidance and best practices, and managing quality, compliance and risk by ensuring performance, promoting a culture of integrity within a high reliability organization, setting quality measures, performance measures and key indicators for performance and risk, evaluating effectiveness of outcomes, overseeing consistent implementation and systematically identifying risks and unintended variances, and reporting significant enterprise risks and issues to the VHA principal office.

Second Line (2B): VA Oversight Subject Matter Expert Services

Office of Oversight, Risk and Ethics (2B)

The Office of Oversight Risk and Ethics (ORE) has been tasked to coordinating VHA's Oversight functions. The USH established the Office of Oversight, Risk, and Ethics in 2020 (formerly the Office of Risk Management). This consolidated several oversight-focused offices and reports directly to the USH. The creation of this new office aligning oversight functions was part of the larger VHA CO redesign (announced on January 1, 2020). The goal of the redesign was to clarify office roles and streamline responsibilities to improve coordination across principal offices and their subordinate program offices, including eliminate fragmentation, contradictions, overlap and duplication for risk and issue reporting, management and governance for the Administration. Consistent with the Associate Deputy USH for Risk Management, consistent with their Chief Risk Officer's role and their leadership over the Audit Risk and Compliance Committee, and the OIC's role as the designated outcome lead for this area of concern, the Chief Integrity and Compliance Officer is facilitating collaboration among the various, and purposefully distinct, oversight functions.

- **Office of Integrity and Compliance.** OIC is charged with protecting Veterans' trust in VA healthcare by promoting a system-wide culture of integrity. OIC does this through our "boots on the ground" Integrity and Compliance Officers. OIC and all Integrity and Compliance officers, promote and implement a consistent framework with stakeholders at their facility, VISN, CPAC or program office to address non-ethical and non-compliant behavior. Compliance officers support

each facility to implement a local compliance program and help Veterans and staff report issues that arise when they see them. Independent and objective, they are trained to help leaders and staff identify and monitor high risk activities, as well as to understand the rules, regulations, and laws in place to reduce risk. This includes topics such as fraud, waste and abuse around billing, coding, procurement, prescriptions, to implementation of legislation or major initiatives. Integrity and Compliance officers promote a culture of Integrity by sharing training and education around the Code of Integrity, combating fraud, waste and abuse and maintaining the I CARE values in each employee's day-to-day work.

Quality and Patient Safety (2B)

- **Quality Management (QM)** (2B) division programs support the ongoing assessment and improvement of healthcare outcomes and healthcare delivery processes. The QM program offices help ensure VHA is hiring the right providers, identifying evidence-based practices, screening for deviations from standards of care, and keeping facilities in a continuous state of readiness and compliance with industry standards. QM includes the following programs:

    - **Center for Improvement Coordination** engages with networks, facilities, and program partners to support effective use of analytics, quality improvement and learning to strengthen care delivery processes and improve outcomes for Veterans.

    - **Clinical Risk Management** (CRM) oversees VHA's Clinical Risk Management Program, consisting of Risk Managers employed at every VA medical facility across the country. CRM's areas of responsibility in VA medical facilities include oversight of peer review for quality management, tort claim filings, and disclosure of adverse events (institutional disclosure). CRM consults and collaborates closely with quality management, ethics and patient safety professionals to integrate risk management strategies at all VA medical facilities and VISNs. CRM provides policy guidance on issues related to preventing malpractice and reducing harm to the patient or organization.

    - **Evidence-Based Practice** works to improve the overall health of Veterans and DOD patients by developing evidence-based recommendations for care that can be implemented throughout the VA and DOD healthcare systems, reducing variation in care and optimizing patient outcomes.

    - **External Accreditation** ensures sustained compliance with accepted industry standards for health care operations and quality through the management and oversight of three VHA national external accreditation contracts. The three contracts are: The Joint Commission (TJC),

Commission on Accreditation for Rehabilitation Facilities (CARF), and Healthcare Quality Assistance Group (current vendor for VHA National Survey Readiness contract).

- **Medical and Legal Affairs** coordinates the review and reporting of clinical malpractice in VA medical facilities in response to the Health Care Quality Improvement Act of 1986. OMLA oversight supports quality improvement in VA health care by communicating identified issues and deficiencies in patient care associated with poor patient outcomes, identifying licensed practitioners who rendered substandard care, reporting these providers to the National Practitioner Data Bank, and facilitating Regional Counsels' investigation of filed tort claims nationwide.

- **Medical Staff Affairs** has policy oversight for credentialing and privileging of health care providers, reporting to state licensing boards, and reporting to the National Practitioner Data Bank. The office is also responsible for the maintenance of the national electronic credentialing system.

- **Systems Redesign and Improvement** supports VHA's journey to become a High Reliability Organization by promoting a culture of continuous process improvement and providing the tools, principles and education to improve health care delivery. This is achieved through national improvement initiatives and enterprise learning opportunities, including training change agents in the science of improvement, Lean training programs, experiential learning opportunities, team-based improvement initiatives, focused academies, and targeted clinical and administrative process support and consultation. This program also provides knowledge management, consultation, and infrastructure support to facilitate VHA's high reliability organization implementation, cultural transformation, and sustainment efforts.

- The **National Center for Patient Safety (NCPS)** (2B) promotes best practices for safe patient care and optimal patient care utilization throughout the organization. Accordingly, NCPS guides the VHA and external stakeholders on policies and strategies to do the following: measure and mitigate harm to the Veteran and those who support their care; track utilization and address deficient patient admission and discharge practice; model characteristics of a High Reliability Organization including promotion of clinical team training and a just and safe culture; and evaluation of healthcare solutions, technology, and innovations from a patient safety and value-based perspective. The following program offices report to NCPS:
  - **Product Effectiveness (PE)** performs independent assessments and analyses on healthcare solutions to include technology, programs,

processes and services to ensure they are effective and meet the needs of the organization.

- **Utilization Management (UM)** provides vital tools to manage quality and resources. The program provides consultation services and evidence-based practices to ensure Veterans receive the right care, in the right setting, at the right time, for the right clinical reasons.

Office of Health Informatics (2B)

- The **Chief Health Technology Office** (CHTO/105CHTO) serves as the Administrations' principal advisor for the advancement of health technology, shaping VHA's future access and care delivery model as the enterprise transitions to a disintermediated model of consumer-driven digital delivery of care. CHTO identifies, analyzes, and effects implementation of emerging technologies, significantly enabling VHA's progress along the pathway to a true High Reliability Organization (HRO). Increasingly included in this portfolio are critical activities in the acquisition and site readiness spheres of the VA's adoption of the Cerner Millennium product pursuant to VA Electronic Health Record Modernization (EHRM).

- **Office of Nursing Informatics** (ONI/105CNI) supports Nurses throughout the care continuum to link science, technology and the use of electronic medical records, tools, and processes to improve health. Nurses are the largest group of healthcare professionals and the main users of technology and spend the most time with Veterans. VHA has over 113,000 licensed nurses to care for our nations Veterans throughout the care continuum making this the largest workforce using cutting edge technology to improve the lives of those we serve. Nurses are responsible for implementing evidence-based interventions to promote healthy lifestyles and use these interventions to guide care. ONI ensures providers can gain knowledge that reflects the best evidence of care practices to lead to the desired outcomes in care delivery and operational performance. ONI measures outcomes based on what Nurses caring for Veterans are experiencing and what solutions mean to Veterans. The ONI vision is to transform healthcare through Nursing Informatics by leveraging High Reliability Organization (HRO) principles to: Reduce unnecessary variation, reduce documentation burden, improve usability and EHR adoption.

- **Health Information Governance** (HIG/105HIG) serves as VHA's subject matter and policy expert regarding privacy, Freedom of Information Act (FOIA), library services, patient identity, health care security, health information management, records management, and on data contained in Veterans' Electronic Health Record (EHR) and in national data systems. HIG represents VA on national and international health care policy initiatives regarding Veterans' data. Other functions include compliance monitoring, management of national data systems, and provision of knowledge-based library services. HIG also develops and implements policy and regulations in accordance with FOIA, Privacy Act, Title 38

confidentiality statutes, and Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

- **Clinical Informatics and Data Management Office** (CIDMO/105CIDM) advances the enterprise standard of care and experience through improved data, tools, and the informatics workforce.

Third Line: Independent and Objective

- **Office of Internal Audit (IA).** The Office of Internal Audit provides independent and objective assurance to continuously improve VHA operations. Its functions and roles are defined in Directive 1370, VHA Internal Audit and Risk Assessment Program Office. IA brings expertise in audit standards, clinical care and operations, data analytics and statistics to help medical centers, VISNs and program offices identify vulnerabilities, and recommend opportunities for improvement. Specific accomplishments include establishing the IA office under ORE and funded basic staffing; 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 developing position descriptions and will implement the new organizational structure over four years.
- **Office of Research Oversight.** The Office of Research Oversight (ORO) is dedicated to promoting the responsible conduct of Department of Veterans Affairs (VA) research for the protection of Veterans and others who volunteer in VA research, and for the benefit of all Veterans whose health and well-being are improved by the discoveries made through a sound and ethically grounded VA research program. ORO monitors, reviews, and investigates matters of research compliance that involve VA research. Specifically, ORO provides oversight of compliance with VA and other Federal requirements for the protection of human research subjects, laboratory animal welfare, research safety, research laboratory security, research information security, and research misconduct. ORO also provides training to facility Research Compliance Officers (RCO) and oversight of RCO auditing programs.

  The creation of an "Office of Research Oversight" within VHA was mandated under legislation signed by the President on December 6, 2003, as Public Law 108-170. Consistent with the statute, ORO reports directly to the USH and serves as the primary VHA office for advising the Under Secretary on matters of research compliance. The statute further provides that ORO shall function independently of entities within VHA with responsibility for the conduct of medical research programs.

- **Office of the Medical Inspector (OMI).** The Office of the Medical Inspector assesses and reports on quality of health care issues within the Veterans Health Administration. In 1980, VA established the Office of the Medical Inspector to assess and report on quality-of-care issues within VHA. In 1988, through Public Law 100-322, Veterans Benefits and Services Act of 1988, Congress expanded the functions of the Office of the Medical Inspector to ensure its independence, objectivity, and accountability with the goal to monitor and improve the quality of services provided by VHA by investigating concerns raised by whistleblowers and Department of Veterans Affairs stakeholders.

External Assurance Providers

To provide a complete understanding of how VA intends to roll out its framework of oversight and accountability based on GAO's Standards for Internal Control in the Federal Government and the Institute of Internal Auditors (IAA) Three Lines Model, VA references here a brief list of the many external stakeholders that provide external assurance functions.

- **VA, OIG.** The VA OIG conducts meaningful independent oversight of the Department of Veterans Affairs.
- **GAO**. GAO is the supreme audit institution for the United States. Federal and state auditors look to GAO to provide standards for internal controls, financial audits, and other types of government audits.
- **Professional Accreditation Bodies.** Numerous accrediting bodies, including but not limited to, The Joint Commission, Commission on Accreditation of Rehabilitation Facilities, Long Term Care Institute, College of American Pathologists, and many others, provide external reviews of VHA programs.

Framework for Risk Management: Risk Assessment and Control Activities

- **Corporate Compliance Model:** The Corporate Compliance model of risk and issue management and mitigation is an emerging strong practice that harmonizes responsibility for identifying non-clinical organizational risks and issues for the consideration and action of executive leadership, specifically in the disciplines of Business Compliance & Integrity, Privacy, Research Compliance, Records Management, Conflict of Interest, Controlled Substance Inspections and Access Integrity. The goal of the Corporate Compliance model is to advise executive leadership of risks and failures; make recommendations to mitigate risks; and provide stewardship and accountability regarding the status of corrective action.

- **Integrated Risk Management**. VHA is developing an Integrated Risk Management (IRM) model to better ensure the collection of risk information from across VHA. The vision of Integrated Risk Management is to have a comprehensive framework and culture that allows for any risk, issue or concern, to be recognized and responded to no matter the environment in which it was

identified. Robust IRM will provide the necessary data for good management and governance (OA-2), compels the organization to be accountable (OA-3) and is consistent with VHA's culture of safety and integrity (OA-4). VHA completed an initial environmental scan in 2021 to better understand the risk management landscape across VHA. Completed in July of 2021, this effort included interviews and surveys of key stakeholders at the program office and field level. Data collected through this environmental scan will then inform the further development of VHA's IRM model. Understanding that IRM functions will inherently occur at the first and second lines of oversight, efforts are underway to collaborate with key program offices with key risk facilitators at the local level and program offices supporting locally identified risks. Current efforts within the IRM framework include the Office of Strategy's use of risk to inform and meet strategic plan development and implementation and the Office of Health Transformation recognizes that innovation always carries risk and they are working to identify and transparently manage their risk response as part of a unified approach to risk and issues. *See the VHA IRM Process and Strategic Plan figures below.*

- ***Enterprise Risk Management.*** VHA's Enterprise Risk Management (ERM) function aggregates the data from the Integrated Risk Management processes for VHA Senior Leadership review and action. ERM is essential for streamlining, improving, and standardizing the risk assessment process, developing an integrated and forward-looking approach, and informing strategy and performance. The Associate Deputy Under Secretary for Oversight, Risk, and Ethics established the Enterprise Risk Manager position to support their role as VHA's Chief Risk Officer. The Enterprise Risk Manager is the steward of VHA's Risk Register; responsible for VHA's Risk Profile for annual submissions to VA's Risk Profile that is managed by OEI; responsible for supporting the development of VA's Risk Appetite Statement; and responsible for coordination, review and approval of VHA's interim and annual Statement of Assurance. The VHA Enterprise Risk Manager utilizes a centralized enterprise risk register to track identified risks (opportunities and threats) and submissions from all Administration operating units. The Statement of Assurance coordinates VA's assessment of and conclusion on the effectiveness of VHA's system of internal controls. VHA ERM will track its level of maturity according to industry-standard maturity models.

- **VHA has a unified and integrated risk reporting and monitoring system** (GAO Components – Information and Communication and Monitoring).

  The OIC secured funding to initiate the development of the Oversight and Accountability Reporting and Visualization Platform which will include, when fully developed, modules for inquiry and allegation management, issue management and risk management. As each of these elements are intertwined in some nature, they will work in concert to informed overall oversight measures through Tableau CRM analytics. As of the writing of this plan, the inquiry and allegation module

(CIRTS) has been developed and deployed and includes over 1,200 entries in just 4 months of operation. Trending and analysis of this information will contribute to identifying potential risk areas at VAMCs and VISNs. The current Risk Management Portal and Dashboard will undergo one more enhancement in their current environment to accurately reflect the formal and organic processes in which risk is identified, assessed, and responded to at the local, regional and programmatic level. This system will then be migrated into the Oversight Platform allowing risk information to flow between modules and be available for deeper analysis. The enhancements to the Risk Management Portal has been informed by the IRM Environmental Scan and follow up discussions with risk facilitators and risk owners from facilities across the risk maturity spectrum.

Critical Actions Driving Oversight and Risk Management

Data:

- Strengthen the data sharing and interoperability between and among VHA quality, safety and oversight operational units to harmonize efforts with program offices and operational units to identify new monitors and efforts that support a unified response to repeat findings and the management of known risks, issues, and opportunities.

- VHA plans to establish a common naming and tagging convention for policy and risk and issue management that will facilitate operations, management, oversight, risk and issue management, quality and safety capacities.

Monitoring and Analytics:

- **Collaboration with the VA OIG.** VHA has strengthened its relationship with the VA OIG to include efforts to raise awareness of fraud, reporting capabilities, and non-case referrals for VHA action through the OIC. Other collaborative efforts include a uniform tagging and reporting convention for the identification and response to allegations and inquiries.

- **Coding Audits.** VHA OIC seeks to expand and improve its capacity to ensure that Administration coding and documentation is accurate and reflects the care provided. In FY22, VHA has tripled our capacity to conduct assessments on business processes and work in partnership with partners in Health Information Management to improve coding accuracy. VHA expects future audits and monitors to be better designed and drive actionable recommendations around provider productivity, accuracy of clinical documentation in the medical records that not only supports coding, staffing, but also future care provided to our patients.

- **Monitoring Activities.** Expand current monitoring operations to include second line support and oversight to key offices that include business functions across the Administration such as Part-Time Physicians and Separation of Duties monitors.

- **Realignment of Second- and Third-Line Functions:** Absent a clear standardized oversight model, VHA oversight functions were often embedded with their operational units. This is finally possible on account of the maturation of VHAs compliance framework and lack of independence and porous "firewall" limits the integrity of the necessary oversight and accountability. Concurrent with the broader oversight structure that will be guided by the IIA's Three Lines Model, VHA will systematically seek to realign second and third line functions currently embedded within the responsible service to an independent operational unit and chain of command.
    - **Finance Quality Assurance Review (FQAR) Program.** VHA seeks to realign the FQAR program under a VA program office to separate oversight functions from the implementation chain of command with the intent that the independence would strengthen the (FQAR) Program by providing independent second line quality assurance reviews used for the internal review and evaluation of financial management operating activities occurring within VHA.

- **Analytics Consultation.** Improve the capacity of VHA oversight and quality functions to be a consultative resource to provide trusted and responsive analytics to emerging issues as required by VHA operations and leadership.

- **VHA OIC Helpline** VHA operates a helpline for any stakeholder to report any concerns regarding compliance with established requirements or program implementation, report fraud or abuse of resources, or unusual attempts to gain personal information. Employees can contact their supervisor, and anyone can contact their local Integrity and Compliance Officer, or the Compliance Helpline. *Note: The OIC Helpline is in addition to the OIG Hotline, and both OIC and OIG makes the necessary referrals to respond properly to any report received.*

- **Fraud Waste and Abuse (FWA) –** VHA seeks to expand and improve its capacity to identify, investigate, and prevent cases of FWA across VHA business lines and with Administration partners. In FY22, VHA has strengthened our capacity to conduct assessments on business processes, improve data management, build investigative capacity, and statistical analysis that will facilitate remediation and provide recommendations to establish new processes tools and techniques to investigate underlying causes, detect connected cases, and understand overall impacts to Veterans and VA. It is in line with the vision to improve automation and machine learning as vehicles to strengthen the integrity and reduce the risk of VA's operational requirements.

- **Office of Medical Inspector.** The Office of Medical Inspector operates as an office of audit, compliance and investigation with ongoing responsibilities to utilize VHA Enterprise Risk Management Assessments to enable VHA's leaders

to identify and address risks and opportunities, more accurately report issues that need to be addressed, better assure compliance with laws and regulations, and reduce factors that interfere with accomplishing the goals, objectives and mission of the organization. ERM assessments will also drive OMI's annual quality review plan of organizational risks and include testing of critical control points in care delivery and organizational management processes. Finally, OMI has established an investigative process for responding to emergent "for cause" issues, hotline and whistleblower complaints. OMI functions as a rapid response team available to deploy on short notice at the USH's request to conduct quality of care investigations, based on clear triggers and mechanisms for responding to emergent or "for cause" issues, this includes systematic processes for investigating hotline and whistleblower reports. The above processes will also systematize the question of whether identified weaknesses represent isolated situations or systemic issues to be addressed.

Professional Development:

- **Risk University**. Risk University is an interdisciplinary employee education approach to introduce and disseminate Integrated Risk Management (IRM) principles, practices and toolkits to risk management professionals (clinical and non-clinical), leaders and other professionals across VHA. Risk University is an integral part of VHA's objective of integrating risk management and supports policy, technical and governance components of IRM. Risk University is under development with interdisciplinary input from a variety of program offices involved in risk identification and management at VAMCs and VISNs. Through this approach, VHA will move towards creating a baseline competency level in key risk staff in the field allowing for integrated efforts to move forward alongside the enhanced data collection systems supporting the process and information gathering elements. Risk University, as it is being deployed during the pandemic response, will initially be voluntary to participate in, however, it will target cohorts (multiple individuals from one location) to ensure that competency improvement will be across the entity and not reliant on one individual or role to serve as a train the trainer. As the program moves forward there is a possibility that different levels of VHA would mandate the training. Appropriate steps will be taken to ensure compliance with those requirements as needed.

- **Technical Career Field Program**. The Integrity and Compliance Officer position requires a specific skill set to respond to the complexity of VA Healthcare operations, Integrity and Compliance oversight functions and the wealth of information required in order to monitor healthcare functions. VHA has developed through the TCF program a curriculum designed to prepare participants to be a successful Integrity and Compliance officer. The TCF program has enabled the development of a robust onboarding program to effectively recruit and retain hard working, competent, and skilled compliance officers responsible for minimizing risk in the organization and assisting with high level initiatives such as reducing fraud, waste, and abuse. The ability for compliance professionals to be brought into the organization through an internship has created a steady stream of

trained and equipped compliance professionals to serve Veterans in medical centers around the United States.

- **Onboarding.** Integrity and Compliance Officers (ICO) in the facilities and VISNs are provided continuous touchpoints in the first six months in their position to uniformly understand their position. ICO ensures that within the first six months of assuming compliance duties they will be fully prepared.

- **Factfinding Training:** VHA OIC and Operations are jointly sponsoring employees to attend training provided by the VA Law Enforcement Training Center to provide attendees the knowledge, skills, and professional focus that is necessary when inquiring into allegations. At least forty attendees will annually be trained to prepare, appropriately coordinate, and conduct interviews to elicit factual information, as well as collect pertinent evidence to support and draw a conclusion that will substantiate or un-substantiate an alleged claim.

- **Integrity and Compliance Professional Development:** Training and communications within the OIC routinely provide training by internal (field and VA staff) and external experts, often in conjunction with Employee Education Service staff and resources, to provide world class professional development opportunities. Key activities include:
  The OIC's Annual National Conference; OIC's Annual National Awareness Campaign; and routine communications (Examples include tabletops, regular meetings, publications, and training modules)

- **Quality Professional Pathways**: The Quality Professional Pathway is a program available to quality professionals throughout the VHA designed to provide in-depth knowledge of the fundamentals and principles of analytics, QI, leadership and High Reliability Organizations. Additional information regarding Quality Professional

- **Patient Safety Program Academy:** The Patient Safety Program Academy is an educational program designed to provide VHA's patient safety professionals with in-depth knowledge of the fundamental principles and activities required for successful oversight and management of the facility patient safety program.

- **Advanced Fellowship in Patient Safety Program:** The Advanced Fellowship in Patient Safety Program is a one-year, full-time VHA trainee position for health care professionals from various specialties designed primarily to create PSMs, equipped with the best safety evidence and practices to help the VHA deliver the highest-quality care.

- **Chief Resident in Quality and Patient Safety Program:** The Chief Resident in Quality and Patient Safety (CRQS) Program is a post-residency, non-accredited Chief Resident year which relates to an accredited core physician residency training program with a design to provide in-depth knowledge of the

fundamentals and principles of a High Reliability Organization and related patient safety science.

Figure 2-5. VHA Integrated Risk Management (IRM) Process

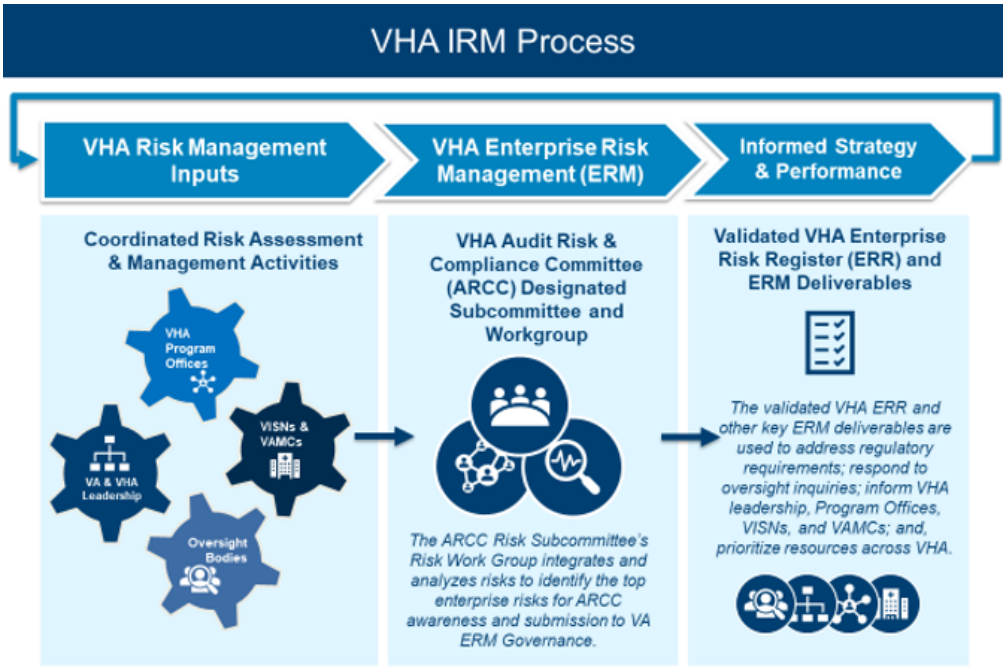
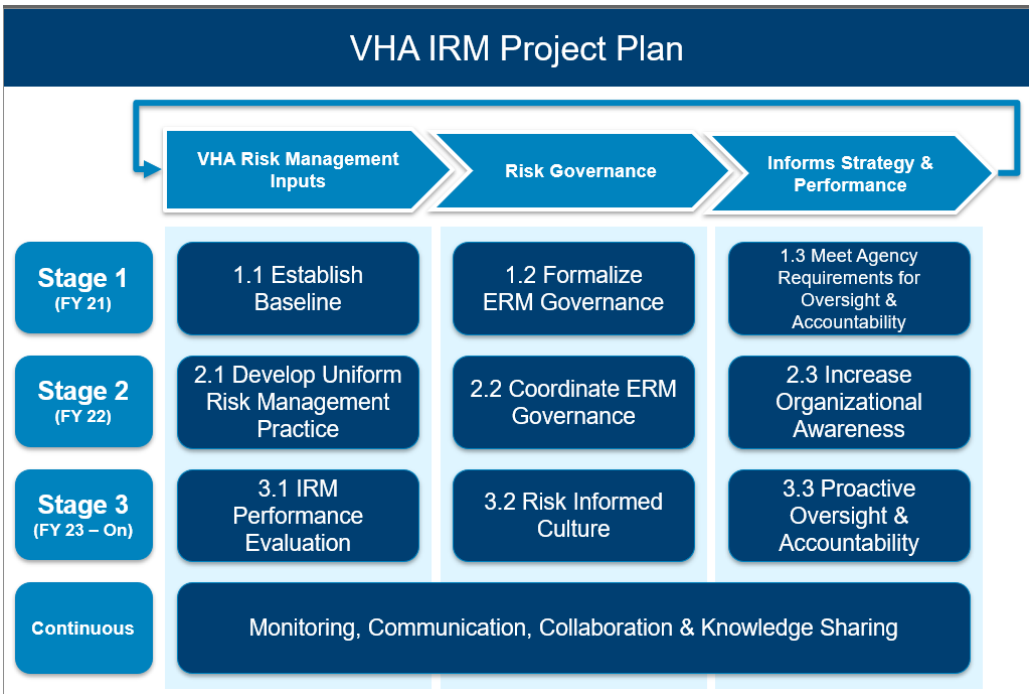


Figure 2-6. Integrated Risk Management (IRM) Strategic Plan



O&A-1 Description of Actions Toward Removal Criteria

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

Leadership Commitment

- Over the past several years, VHA leadership has supported the need to enhance oversight and accountability. Most notably, at the start of calendar year 2020, VHA reorganized the VHA CO.

- As part of this reorganization, the Office of Oversight, Risk and Ethics (ORE) was established (previously Office of Integrity). This office consolidated several bodies that performed oversight and accountability-based work into a single reporting structure.
    - Components of the VHA ORE include the Internal Audit, OIC, ERM, the Office of the Medical Inspector (OMI), the Office of Research Oversight (ORO) and the National Center for Ethics in Healthcare.

- Also, as part of the VHA CO realignment, the GOAL Office was aligned under the VHA Chief of Staff. This alignment enables GOAL to effectively facilitate the response to the GAO HRL.

- In addition, the Associate USH for Risk Management aligned Enterprise Risk Management functions under OIC to harmonize Integrated Risk and Enterprise Risk in a single location governed by the ARCC.

Demonstrated Progress

- The ARCC approved Internal Audit Plans and audits were conducted in FY 2018 – FY 2020. Corrective Actions were identified for each audit and program offices are working on addressing those items. The five highest risk areas were identified for internal audit engagements for FY 2021.

- The Risk Sub-Committee of the ARCC has instituted a review process for candidate risks to the VA ERM risk register as well as a review process to reflect on previously identified risks to ensure the information is accurate and that accountable risk owners are identified.

- OIC under the ORE deployed a Microsoft PowerApps and PowerBI based platform to capture risk information from all VA medical facility and VISNs. The platform enables VA medical facility and VISN Compliance Officers to input and categorize risks, for risk owners and process owners to directly input and track progress for responding to identified risks. Program offices are participating in multiple focus groups with the goal of streamlining risk reporting and oversight management of associated corrective action plans.

Capacity

- VHA expanded its capacity to integrate internal oversight functions within VHA by establishing the ARCC, the ARCC Oversight and Compliance Subcommittee and the ARCC Risk Subcommittee.

- The ARCC allowed leadership of the forum and mechanism to direct a coordinated risk management function. As part of the Risk Subcommittee, a Risk Working Group, a VHA Risk Appetite Working Group and VHA ERM CoP have all been initiated to bring key subject matter experts and key stakeholders together.

- Additionally, contract support has been obtained to support the increased scope of the VHA ERM initiatives. Resourcing requirements should be reviewed to ensure appropriate staffing and contract support meets the needs of the Action Plan.

Monitoring

- The metrics and measures of this plan provide the mechanism to assess and report progress.

- Additionally, the ARCC receives quarterly updates regarding ongoing efforts to from VHA, led by IA, OIC, ERM and other entities. The quarterly updates enable VHA leadership to monitor risk information captured at the VA medical facility and VISN level and the program office level; as well as updates on approved internal audits selected based on high-risk areas.

Oversight and Accountability Outcome (O&A-2)

Outcome Executives: Tracy Davis Bradley, PhD, Executive Director, Office of Integrity and Compliance

Lucille Beck, PhD, Senior Advisor, Office of the Deputy USH

Skye McDougall, PhD, Network Director, VISN 16

Ethan Kalett, JD, Senior Advisor, Office of Regulations, Appeals and Policy

Outcome Lead: Brian McCarthy, JD, MPH, Deputy Director, Office of Integrity and Compliance

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

◐ **O&A-2 Outcome Statement**: VHA oversight efforts support governance and management decisions are made at the appropriate level of the organization, are informed by reliable data, are timely implemented and focused on intended outcomes.

◐ **O&A-2.1 Goal**: Establish the decisional authority and accountability role for the governance bodies and operational units to make decisions at the appropriate level to ensure organizational accountability.

◐ **O&A-2.1.1 Objective:** The USH has formally approved an articulated matrix of levels of authority within VHA and/or has signed an official delegation of authority reflecting the same.

O&A-2.1.1a Metric*:* Publication and implementation of VA Directive 0000, Delegation of Authority which sets forth policies for issuing delegations of authority from the Secretary of Veterans Affairs, Deputy Secretary of Veterans Affairs, Chief of Staff, Assistant Secretaries, Under Secretaries, and Other Key Officials. VA Directive was published on November 14, 2018 and implemented. A list is maintained by the Enterprise Delegation Control Officer located in VA's Office of Enterprise Integration.

O&A-2.1.1b Metric: Publication and implementation of VHA Directive 0000, Delegation of Authority, establishing the delegation, from the USH to VHA Upper-level leadership, of signature, oversight, and decisional authority for national policy documents.

○ **O&A-2.1.2 Objective:** Develop new governance directives that articulate the approved levels of authority matrix, delegate specific actions for each level within VHA and respect these authorities as organizational principles and effectively implement new directives.

O&A-2.1.2a Metric*:* Publication and implementation of VHA Directive 1217, VHA Operating Units, specifically, that all covered operational units comply with oversight and reporting requirements found in Directive 1217. Defining "oversight" will be accomplished in a broad oversight directive that will shape operational units individual responsibilities but also how the existing and proposed systems are interoperable.

O&A-2.1.2b Metric*:* Publication and implementation of a VHA Directive that articulates the roles and responsibilities for operational units outside of VHA. The directive Is expected to be published by Q4F FY23.

O&A-2.1.2c Metric*:* Publication of VHA Directive 1217.01, VHA Governance Board that establishes the roles, responsibilities, and decisional authority of the Governance Board and its Councils as part of VHA's governance processes.

O&A-2.1.2d Metric: Establish regular and transparent communication between the ARCC and VHA Governance Board and VHA operational units to improve oversight, accountability, strategic planning and uniform implementation.

Table 2-5. O&A-2.1 actions

Act. #	Action Details	Projected Date	Actual Date
●2.1.1.1	Establish a VHA Governance Board to oversee activities related to the operational strategy (versus strategic – ARCC) to ensure recommendations are prioritized and consistent with the organization's mission and the strategic direction from the USH.	Q4 FY19	Q3 FY20
Resources: **Status:** **Comments:**	Accountable Officials: Ethan Kalett and Lucille Beck Completed The VHA Governance Board Charter was signed in June 2020 to review, discuss and make recommendations in key areas of enterprise-wide operations, post VERA resource allocation and strategy.		
● 2.1.1.2	Develop a VHA directive that will establish authority for governance board and its councils.	Q4 FY21	Q4 FY21
Resources: **Status:** **Comments:**	Accountable Official: Ethan Kalett and Lucille Beck Completed At the direction of the Executive in Charge, VHA published VHA Directive 1217.01 that establishes decisional authority within the governance board and its councils. Directive will be updated to include additional council and will be continuously monitored for effectiveness by the designated accountable officials.		
◐ 2.1.1.3	Develop a VHA Directive that will clarify the ARCCs responsibilities within the VHA governance ecosystem consistent with the ARCC's responsibility to oversee strategic (versus operational – Governance Board) activities and risks, ongoing enterprise risks to ensure organizational standards, responsible persons and entities, and efforts	Q4 FY23	TBD
IM-a: **IM-b:**	Submit proposed VHA Directive for review Publish directive	Q1 FY23 Q4 FY23	TBD TBD

Act. #	Action Details	Projected Date	Actual Date
Resources: **Status:** **Comments:**	Accountable Officials: Tracy Davis Bradley, Brian McCarthy, Robert McMillan In Progress The ARCC is currently chartered and functioning; this directive is proposed to complement Directive 1217.01 and clarify the distinct roles of the respective governance bodies.		
○ **2.1.2.1**	Develop and provide training, communications and processes related to new directives to ensure proper implementation and routine monitoring.	Q1 FY23	TBD
Resources: **Status:** **Comments:**	Governing Board Office, the OIC, and the designated leads, Ethan Kalett and Lucille Beck. In Planning Implementation to be coordinated by the Governing Board Office, the OIC, and the designated leads, Ethan Kalett and Lucille Beck.		

○ **O&A-2.2 Goal**: Establish governance processes (e.g., for escalation, appeals) and procedures for how each level of the organization interacts with and leverages the governance structure for timely decision-making.

○ **O&A-2.2.1 Objective:** Identify the organizational entity responsible for defining governance processes and procedures and ensure that processes are in place to implement and monitor that decisions are implemented as intended.

○ **O&A-2.2.2 Objective:** Establishing appropriate processes or data collection to ensure governance bodies have the information they need to make the appropriate decisions and that the decisions are implemented as intended to improve the functioning of the organization (see Goal 3.2).

Table 2-6. O&A-2.2 actions

Act. #	Action Details	Projected Date	Actual Date
○**2.2.1.1**	Clarify and strengthen field governance operating units and processes for escalating identified risks and issues (VISN, VAMC, CPAC, ICC)	TBD	TBD
IM-a: **IM-b:** **IM-c:** **Resources:** **Status:**	Data call for existing standards, principles, and processes of existing governance / management / decisional bodies. Draft policy supplementing or supporting VHA Directive 1217.01 establishing the roles and functions of field governance operating units within the VA governance ecosystem. Publish, implement and monitor AO: Dr. Tracy Davis Bradley, Ethan Kalett, Lucille Beck In Planning	Q4 FY23 Q4 FY24 Q2 FY25	TBD TBD TBD
○**2.2.2.1**	Survey submitted to governing entities (executive leadership) to determine what processes and data are required by decisionmakers.	TBD	TBD
IM-a: **IM-b:** **IM-c:**	Survey developed and submitted to Governance Board, ARCC, and Senior Leaders Recommendations presented for adoption Establish action plan based on leadership needs and data call results that is consistent with VA Data Plan.	Q4 FY24 Q4 FY24 Q2 FY25	TBD TBD TBD

Act. #	Action Details	Projected Date	Actual Date
Resources:	AO: Dr. Tracy Davis Bradley, Dr. Francine Sandrow, and Dr. Joseph Francis		
Status:	In Planning		

● **O&A-2.3 Goal**: Identify and assign a Senior Executive Service (SES)/Office reporting to a Senior VHA office (e.g., Chief Risk Officer and additional delegees) to provide appropriate oversight and ongoing monitoring and process improvement of the revised governance structure. (GAO Principle: The oversight body should oversee the entities internal controls system)

● **O&A-2.3.1 Objective:** Develop and implement monitoring and reporting procedures of the SES/Office to provide oversight and ensure future programmatic functions and initiatives are consistent with the matrixed delegations of authority.

Table 2-7. O&A-2.3 actions

Act. #	Action Details	Projected Date	Actual Date
●2.3.1.1	Submit a recommendation to the USH to identify and assign an SES/Office to provide oversight and ongoing monitoring of the revised governance structure.	Q3 FY25	Q3 FY19
Resources:	Ethan Kalett, Senior Advisor, Office of Regulations, Appeals, and Policy and Lucille Beck, Senior Advisor, USH		
Status:	Completed		
Comments:	Ethan Kalett, Senior Advisor, Office of Regulations, Appeals, and Policy and Lucille Beck, Senior Advisor, USH have been assigned leads for oversight and monitoring of the VHA governance structure. Dr. Tracy Davis Bradley has responsibility to ensure any specific initiative falls in line with the broader parameters of improved oversight and accountability.		

◐ **O&A-2.4 Goal**: Enhance VHA's governing bodies and governance mechanisms so that they have consistent, systematic processes and authorities to make management decisions.

◐ **O&A-2.4.1 Objective:** Define and clarify governing and oversight roles and responsibilities so that they can be applied to all stakeholders and embedded in policies.

O&A-2.4.1a Metric*:* The Audit Risk and Compliance Committee will establish a common menu aggregating mechanisms for organizational and individual accountability. Annually until published.

◐ **O&A-2.4.2 Objective:** Ensure that governing bodies have the appropriate oversight mechanisms that have clear designees for oversight activities to meet risk management and assurance needs.

○ **O&A-2.4.3 Objective:** Ensure decisions made by VHA Senior Leadership and Governing Bodies are transparently published and codified with the appropriate authority and oversight.

○ **O&A-2.4.4 Objective:** Strengthen governance processes across all VISN and facility operational units.

Table 2-8. O&A-2.4 actions

Act. #	Action Details	Projected Date	Actual Date
◐ **2.4.1.1**	Identify VHA governing bodies and clarify scope of authority. VHA directive 1217.01 sets forth the roles, responsibilities, and decision-making authorities for VHA Governance Board. The Audit Risk and Compliance Committee charter written in compliance with HHS OIG and DoJ standards.	TBD	TBD
IM-a:	Publish VHA directive 1217.01	Q4 FY21	Q4 FY21
IM-b:	Implement VHA directive 1217.01	Q4 FY23	TBD
Resources:	Ethan Kalett and Lucille Beck		
Risk:	If not resourced and additional policy and implementation guidance is not provided, this action will be delayed.		
Status:	In Progress		
Comments:	Planning in progress.		
◐ **2.4.1.2**	VHA Directive 1370: This VHA directive establishes the policies and assigns actions for an internal audit and risk assessment program for enterprise clinical and health care administrative operations.	TBD	TBD
Status:	In Progress		
Comments:	Approved in 2018, revision in progress by the Office of Internal Audit. Timeline for completion of policy revisions has not been established.		
●**2.4.1.3**	Publish and implement VHA Directive 1030. This VHA directive provides an enterprise-wide consistent and mandatory framework for integrity and compliance and defines the roles and responsibilities of VHA staff in implementing and maintaining an effective integrity and compliance program led by the Office of Integrity and Compliance.	Q1 FY20	Q1 FY20
Resources:	AO: Tracy Davis Bradley		
Status:	Completed		
Comments:	Policy was published December 29, 2020. Implementation over the course of Q2-Q3 FY21. The Office of Integrity and Compliance completed a complete refresh of the guidance documents or “chapters” found in Directive 1030.		
◐ **2.4.1.4**	Publish and implement VHA Directive 1217, setting forth the roles, responsibilities and decision-making authorities for VHA CO Operating Units.	Q4 FY23	TBD
IM-a:	Publish VHA Directive 1217	Q4 FY 21	Q4 FY21
IM-b:	Submit amendment to set forth the roles, responsibilities, and decision-making authorities for operational units outside of VHA CO	Q4 FY 22	TBD
IM-c:	Publish VHA directive with amendment	Q4 FY23	TBD
Resources:	Office of Integrity and Compliance		
Status:	In Progress		

Act. #	Action Details	Projected Date	Actual Date
Comments:	Amendment in development by the Office of Integrity and Compliance.		
◐ **2.4.1.5**	Publish VHA Oversight Directive**.** This policy will outline VHA's oversight framework consistent with the Three Lines Model and establish for risk and issue reporting requirements to management and governance bodies.	Q3 FY25	TBD
IM-a:	Submit VHA Oversight directive for review	Q4 FY22	TBD
IM-b:	Publish and implement directive	Q3 FY25	TBD
Resources:	Office of Integrity and Compliance, Oversight SME Services		
Status:	In Progress		
Comments:	Currently in development by VHA's Office of Integrity and Compliance		
◐ **2.4.1.6**	Publish VHA Directive 0999, Policy Management that will replace VHA Directive 6330, Controlled National Policy / Directives Management System. This policy is owned by VHA's Office of Regulation, Appeals and Policy, but includes requirements that responsibilities for oversight and quality to be included in each document and set benchmarks for accountability.	Q2 FY23	TBD
IM-a:	Submit draft of VHA Directive 0999 for review by VHA's Office of Regulations, Appeals and Policy	Q2 FY22	TBD
IM-b:	Publish VHA Directive 0999	Q2 FY23	TBD
Resources:	VHA's Office of Regulation, Appeals and Policy		
Status:	In Progress		
Comments:	Currently in development by VHA's Office of Integrity and Compliance. Draft submitted to VHA's Office of Regulations, Appeals and Policy Q3FY22.		
◐ **2.4.1.7**	Publish VHA Waiver Directive. This is an emerging program that VHA's Office of Integrity and Compliance is assuming ownership. The responsible oversight body will determine the disposition of any waiver request, OIC will publish and report to the Audit, Risk and Compliance Committee for appropriate action.	Q1 FY23	TBD
IM-a:	Submit draft of VHA waiver directive for review by VHA's Office of Regulations, Appeals and Policy	Q2 FY22	Q2 FY22
IM-b:	Publish directive	Q2 FY23	TBD
IM-c:	Directive fully implemented and monitored.	Q2 FY22	Q2 FY22
Resources:	VHA's Office of Regulation, Appeals and Policy, VHA's Office of Integrity and Compliance		
Status:	In Progress		
Comments:	Currently in development by VHA's Office of Integrity and Compliance. Draft submitted to VHA's Office of Regulations, Appeals and Policy Q2 FY22. VHA Notice 2022-01 was published February 10, 2022 that transferred responsibility for overseeing a waiver process to the Office of Integrity and Compliance.		
◐ **2.4.2.1**	Conduct environmental scan to identify governing entities with oversight responsibilities, decision-making processes, and decisional authorities at VHA. The sub-committees to the Audit Risk and Compliance Committee will review submitted recommendations for response. Action plan to be developed for implementation of approved recommendations and in line with published directives and the oversight directive that is under development.	TBD*	TBD

Act. #	Action Details	Projected Date	Actual Date
IM-a:	Conduct an Administration-wide survey of all governing and management committees.	Q4 FY22	TBD
IM-b:	ARCC subcommittees provide recommendations to ARCC	Q1 FY23	TBD
IM-c:	ARCC presents results to the Governing Board for guidance	Q2 FY23	TBD
IM-d:	Develop action plan for implementation of approved recommendations	Q4 FY23	TBD
Resources:	Office of Integrity and Compliance, ARCC, Governing Board		
Status:	In Progress		
Comments:	Multi-year activity. Environmental scan will be completed by 3/30/22 to better understand the universe of governing and management committees as a whole. *We have not yet determined all of the milestones that may be needed in the future.		
◐ **2.4.2.2**	Evaluate governing entities to determine if consistent and established systematic decision-making processes and decisional authority/rights exists. This includes an understanding of gaps and overlapping or duplicative efforts and authorities.	Q4 FY25	TBD
IM-a:	Administration-wide survey referenced in 2.4.2.1 conducted	Q4 FY22	TBD
IM-b:	ARCC subcommittees request additional process, authority, and effectiveness data from identified entities	Q2 FY23	TBD
IM-c:	ARCC presents *results to the Governing Board for recommendations*	Q4 FY24	TBD
IM-d:	Action plan developed consistent with approved recommendations.	Q4 FY25	TBD
Resources:	AO: Ethan Kalett, Lucille Beck, Dr. Tracy Davis Bradley; Office of Integrity and Compliance		
Risk:	*If contract is not awarded, this action will be delayed.*		
Status:	In Progress		
Comments:	Multi-year activity. This builds off the work in 2.4.2.1 but its focus is on the functioning of each governing and management entity and its evaluates its functioning.		

◐ ***O&A-2.5*** **Goal**: VHA governance and oversight mechanisms monitor the implementation of decisions and confirm that they have met intended outcome(s).

◐ ***O&A-2.5.1*** **Objective:** Develop monitoring and evaluation processes to ensure that desired outcomes of decisions made by governing bodies are achieved.

◐ ***O&A-2.5.2*** **Objective:** Provide regular reporting to key stakeholders regarding governing bodies' decisions and oversight functions.

○ ***O&A-2.5.3*** **Objective:** Develop and implement integrated system for monitoring and reporting oversight activities and associated data.

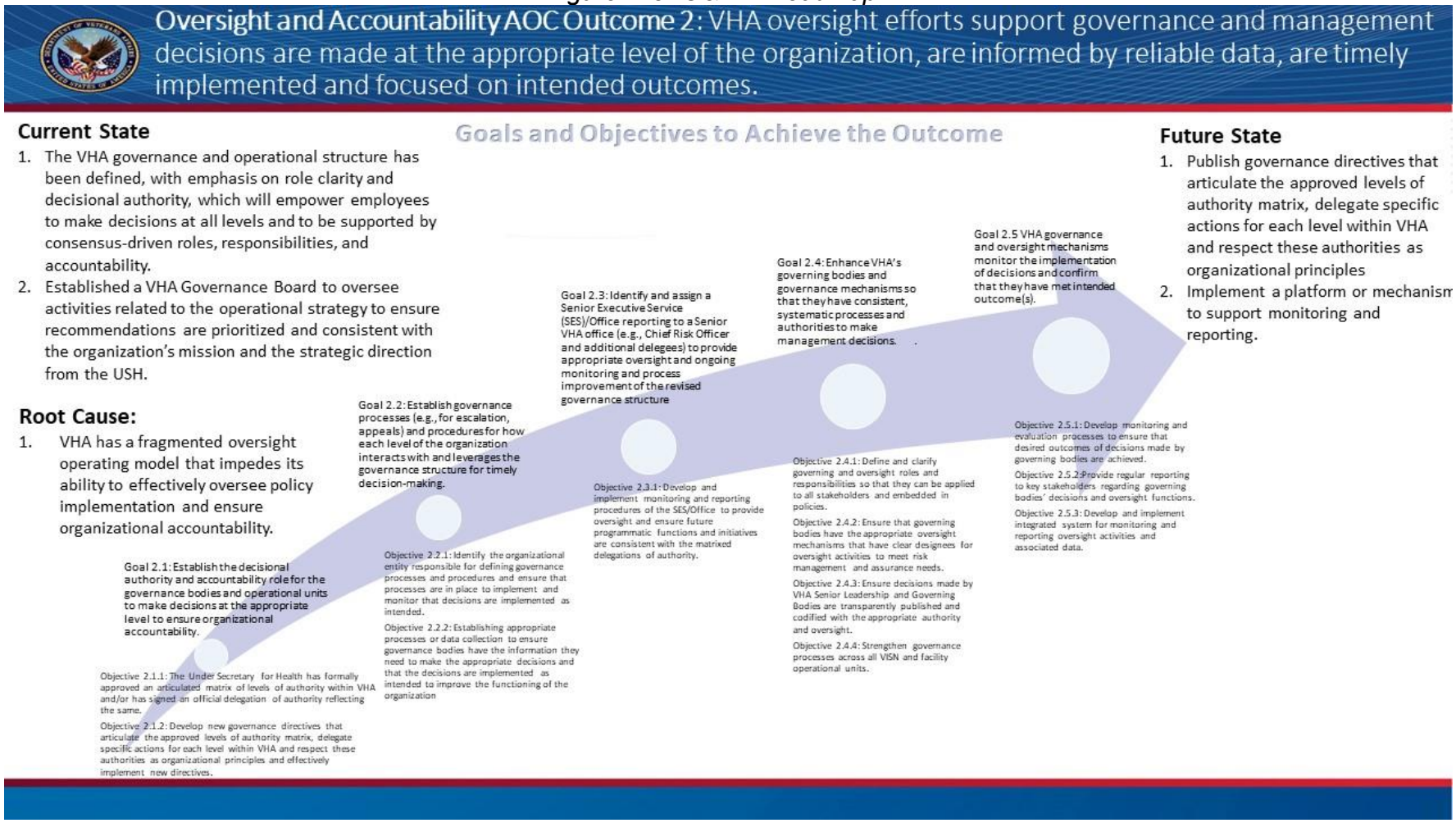
Table 2-9. O&A-2.5 actions

Act. #	Action Details	Projected Date	Actual Date
◐**2.5.1.1**	All supervisors and managers receive training on oversight and accountability of employees and programs within their span of control.	TBD	TBD

Act. #	Action Details	Projected Date	Actual Date
Status:	In Progress		
○**2.5.1.2**	Each decision, program, standard, risk, issue has an identified accountable official.	TBD	TBD
Status:	In Planning		
○**2.5.1.3**	Assess governing bodies monitoring and corrective action processes and results to determine its effectiveness.	TBD	TBD
Status:	In Planning		
○**2.5.1.4**	Evaluate effectiveness of monitoring and corrective action activities by governing bodies.	TBD	TBD
Status:	In Planning		
◐ **2.5.2.1**	Review formal documentation of governing bodies for information regarding communication and reporting for oversight responsibilities, decision-making processes and decisional authorities.	Q4 FY22	TBD
Status: **Comments:**	In Progress OA is collaborating with the Office of Regulation, Appeals and Policy, Office of Healthcare Transformation and the Governance Office, among other stakeholders, to complete this action.		
◐ **2.5.2.2**	Governance bodies activities set by the meeting agenda and decisions documented in the meeting minutes. The minutes memorializing decisional actions by the governance bodies are made readily available.	Q4 FY22	TBD
Status: **Comments:**	In Progress Activity underway		
○ **2.5.3.1**	Evaluate requirements/needs for specific platform or mechanism to support monitoring, oversight, reporting, and governance.	Q1 FY22	TBD
Status:	In Planning		
○ **2.5.3.2**	Perform assessment of adopted platform or mechanism.	TBD	TBD
Status:	In Planning		
○ **2.5.3.3**	Implement platform or mechanism to support monitoring and reporting.	TBD	TBD
Status:	In Planning		
○ **2.5.3.4**	Establish and improve data interoperability and reporting.	TBD	TBD
Status: **Comments:**	In Planning Collaboration with HOC, SAIL, FACTS		

Figure 2-8, below, visually presents the current state of this outcome, the desired future state of this outcome and the goals and supporting objectives that align and will contribute to the achievement of that future state.

Figure 2-8. O&A-2 Roadmap



O&A-2 Description and Status

Description

- The improved oversight capacity, structure, analysis and data outlines in OA-1 must be submitted for review and action by a functioning oversight and governance board.

- To achieve this outcome VHA will need to establish decisional authorities and governance processes for interaction within different levels of the organization. Once this is accomplished VHA will need to direct the Chief Risk and Compliance Officer to provide appropriate oversight and ongoing monitoring for the revised governance structure consistent with governance standards set by HHS OIG and DoJ Sentencing Guidelines. 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.

- VHA's governance mechanisms must be capable of documenting, tracking, and communicating decisions made by governing bodies (in alignment with their respective charters) to ensure actions are taken and have their intended outcomes. Risks associated with decisions should be prioritized and in alignment with the organization's mission and strategic direction. An integrated system has the potential to address this need and thus enhance VHA's ability to ensure oversight and accountability are established, transparent and effective across all reporting levels.

- To achieve this outcome, this action plan includes activities that establish:
    - Governing entities' oversight responsibilities, decision-making processes and decisional authorities.
    - Monitoring and evaluation process to ensure governing entities outcomes are achieved.
    - Regular communication process between impacted stakeholders and governing entities.
    - An integrated platform or mechanism for monitoring and reporting oversight data.

Revise Governance Processes and Align Decision Rights:

- In FY 2020, VHA implemented several modernization initiatives focused on improving key organizational oversight and accountability capabilities. Collectively, HRO and Modernization efforts address critical oversight and accountability components such as decision making at the appropriate organizational level, aligning decision rights, improving vertical alignment and fostering a culture of integrity and accountability.

- 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 four 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 and operational structure has been defined, with emphasis on role clarity and decisional authority, which will empower employees to make decisions at all levels and to be supported by consensus-driven roles, responsibilities, and accountability. A well-defined, transparent governance and operational structure will also enable VHA to establish clear processes and procedures, allow VHA to better align authority and resources and better support 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.

Status

Governing Board and Enterprise Councils

- VHA efforts over the past year have focused on establishing authorities for operating units to make decisions at the appropriate levels. At the direction of the AUSH, VHA has drafted national directives that will establish proper delegation of decisional authority. Directive 1217.01 delegates limited decisional authority to the previously established governance board and its councils. VHA has published Directive 1217 that delegates decisional authority to VA operating units.

- In FY 2020, VHA established a Governing Board and Enterprise Councils in an effort to modernize VHA's current governance structure. The Governing Board and Councils ensure governance and management decisions are focused on intended outcomes.

- VHA will continue to refine and adjust the governance board structure and begin to address VHA CO operating units, to provide VHA employees and program offices access to governance at all levels of the organization, from the VISNs to VHA headquarters. A more efficient, strategically aligned, and transparent decision-making process will also be developed starting in FY 2020. The VHA Governance Office provides administrative support to the Governing Board and the five Enterprise Councils; a data governance council was established in Q1FY22. This office will be the focal point for requests to brief governing bodies and any questions related to the governance board.

- VHA established a specific structure related to its governance board and oversight activities prioritizing the VHA operating model while addressing business risks across the organization. This will better assure governance and management decisions are made at the appropriate level of the organization and occurs through the creation and implementation of new governance bodies,

refinement of roles and decision rights at each level of authority and between the Governance Board and the modernized CO structures. These changes create opportunities for greater cross-organizational oversight and accountability.

Audit, Risk and Compliance Committee (ARCC)

- VHA has formalized risk governance and accountability functions under the Audit, Risk, and Compliance Committee which is led by its Chief Risk Officer, Dr. Alan Hirshberg assumed the role of Acting Associate DUSH, and directly reports and is accountable to the USH and leads the Audit Risk and Compliance Committee with Dr. Mark Upton, the Acting DUSH (GAO Components – Control Environment and Risk Assessment) and OMB Circular No. A-123. The VHA 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

- Established in 2018, the VHA ARCC oversees and provides accountability over VHA's clinical, administrative and business risks - in alignment with HHS OIG and DoJ Sentencing Guidelines - to make continuous improvements to VA's health care delivery system. ARCC's objectives are to improve accountability, build trust with Veterans and improve the quality, efficiency and consistency of VHA's operations and delivery of health care. ARCC provides VA and VHA Senior Leadership an executive-level forum for oversight and accountability through collaboration, communication, direction, solution evaluations and governance oversight of VHA risk and internal control. To further align oversight and accountability, VHA created two subcommittees of the ARCC that meet quarterly.

    - The Risk and Compliance Subcommittee reviews an integrated VHA Internal Controls and Risk Assessment for VHA and provides VHA programs and staff with support for compliance, oversight, and accountability matters, discuss coordination and collaboration and address shared challenges.

    - The Fraud, Waste and Abuse (FWA) subcommittee promotes greater coordination, communication and collaboration FWA activities and shares best practices to strengthen FWA prevention, detection and response efforts.

- The ARCC is primarily comprised of Assistant Under Secretaries and is chaired by the DUSH, enabling the ARCC to assign and realign resources based on the risk information presented.

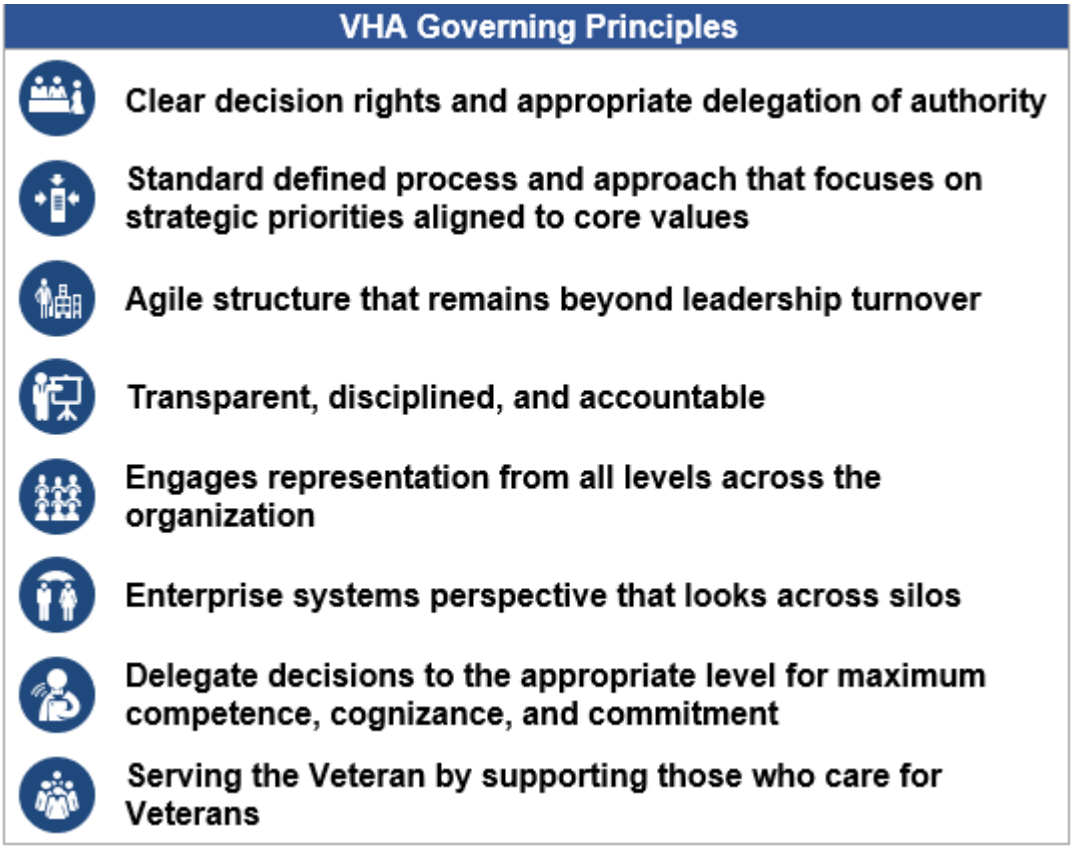
- The Office of Oversight, Risk and Ethics (ORE) was established in FY 2020 (as the Office of Risk Management) and is led by the Chief Risk Officer. The new office aligns oversight functions at VHA as part of the broader VHA CO redesign (announced on January 1, 2020). The ORE is in the process of significantly expanding their program to reflect oversight and accountability needs at VHA. The office has begun socializing these changes with stakeholders engaged in oversight and accountability throughout the organization and has memorialized these changes in Directives, which received appropriate leadership approval.

Field Governance

- **Fractal Governance Model.** Each facility and VISN has a governance structure that mirrors VA's governing bodies via all five Governing Board subcommittees. VHA is looking to standardize the reporting structure to reflect one of the two models that reflect the majority of facilities structures with the compliance committee reporting to the Heath care Operations Committee (HOC) with the ability to report directly to the Executive Director as necessary or directly the Governing Board.

- **Integrated Clinical Committees.** VHA is aligning clinical services into six Integrated Clinical Communities (ICCs) by creating common structures, roles, and responsibilities at facilities, Veteran Integrated Service Networks (VISNs) and VHA. Performance improvement will be driven by efficient and effective data analytics organized around the ICCs. Each facility will have designated leaders and multidisciplinary committees or workgroups for each ICC to allow for rapid two-way communication through VISNs and VHA. VISNs will have a common structure, with a VISN clinical leader and medical center director co-leading ICCs and Health Systems Specialist(s) to strengthen clinical and operational partnerships and better support facilities. VHA will align leadership roles and governance structures to the common VISN framework. The six ICCs are as follows: Mental Health, Primary Care, Diagnostics, Surgical Care, Rehabilitation and Extended Care, and Specialty Care. Integrated Services that support all ICCs include: Community Care, Nursing, Pharmacy, Care Management and Social Work, Caregiver Program, Chaplain, Sterile Processing Services, Physician Assistants, and Population Health.

Figure 2-9. OA-2 VHA Governing Principles



O&A-2 Description of Actions Toward Removal Criteria

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

Leadership Commitment

- The USH chartered a VHA Governance IPT composed of senior leaders that was convened in May 2018 to present a recommendation on a governance structure. The IPT in FY 2020 was reorganized as the Executive Sponsorship Coalition and established governing principles listed in chart XX above 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.

- VHA is modernizing to become a high reliability health care system. A critical element of a high reliability health care system is adequate enterprise governance of the organization's clinical, administrative and financial operations. Leadership commitment is critically important to affect the governance structure of VHA. Leadership behavior directly influences the relationship and actions of employees who support necessary changes and outcomes to improve the continuity of care for Veterans within VHA.

- Thus, to effectively exercise and demonstrate leadership commitment to this objective, and in order to enhance VHA's success, VHA implemented a six step approach: (1) identification of leadership needs, (2) identified knowledge and skill gaps, (3) created for engagement, (4) workplace supports to ensure that the developing leader is receiving ongoing guidance and quality feedback, (5) recognition leadership commitment and contribution to the organization and (6) aligned with the strategic goals of the organization.

- In FY 2020, VHA expanded on this approach and has demonstrated commitment to organizational improvement by enhancing the Governance Board structure and requirements and establishing the ARCC. Through the ARCC leadership commitment helps ensure governance and management decisions are focused on intended outcomes.

- Furthermore, VHA established the ARCC comprised primarily of VHA Assistant Under Secretaries. Voting members include the DUSH, all Assistant Under Secretaries, two VISN Directors, two VAMC Directors, the VHA Chief of Staff, Chief Financial Officer, Chief Informatics Officer, Chief Strategy Officer and Chief Human Capital Management Officer. Ex officio members include the Chief Advisor to the USH, Deputy Chief Counsel, Senior Advisor, Office of Regulatory and Administrative Affairs, Assistant Deputy Under Secretary of Health; Chief Compliance and Business Integrity Officer; the Chief Audit Executive; the Executive Director, Office of the Medical Inspector; and the Executive Director, Office of Research Oversight.

- The ARCC convenes quarterly and receives status updates, makes directional recommendations and decisional items from several VHA oversight and accountability entities.

- The ARCC recommends engagements to USH to be conducted by VHA IA and receives updates and final reports issued by IA. Based on IA reports, the USH tasks recommendation owners and ARCC oversees Corrective Action Plan (CAP) owners to address findings and recommendations. The ARCC also approved the establishment of a Risk Subcommittee (RSC) to meet at least quarterly and directly address and coordinate risk management activities.

Demonstrated Progress

- Since early in FY 2021, after the USH established the Revised Governance Processes and Align Decision Rights LOE, the following actions have been completed:

    - Revised Governance system proposal approved by the USH.
    - 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.
    - Developed directives establishing the decisional authority of the governance board and its councils, VA CO and VHA field offices.

- VHA has restructured its central office and is establishing a governance framework for managing oversight and accountability including various risk management activities that have been implemented across the VHA. VHA has established key goals, milestones, and key progress indicators to demonstrate progress of the enterprise.

Monitoring

- The metrics and measures of this plan and the management reporting used by the LOE provides the mechanism to assess and report progress.

- VHA is periodically monitoring and evaluating the process to determine the extent to which rules, regulations and policies are being followed, to include establishing a transparent waiver process.

- VHA is strengthening internal controls to identify whether procedures and corrective actions are working as intended, this includes reviewing and tracking (1) high-risk areas and (2) management decisions through documentation and related to those governing activities.

Capacity

- The IPT, supported by the Office of Health Care Transformation (OHT), possesses the necessary staff, knowledge and skills to execute the governance and decision rights transformation.

- The Audit, Risk and Compliance Committee (ARCC) is comprised of executive-level staff from across the VHA, including field offices. The Deputy USH or designee serves as the ARCC Chair. The committee consists of subject matter experts and senior executives from key program offices across VHA.

- VHA has actively worked to fill these pivotal leadership roles by appointing acting officers for key vacancies related to leadership positions including those that serve on governance councils and oversight committees and subcommittees. However, vacant leadership positions remain within VHA. The onset of the COVID-19 pandemic has placed a significant challenge to recruitment efforts and pandemic efforts has impacted VHA's immediate priorities to align with changes related to the pandemic.

- 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 provides leadership the forum and mechanism to direct a coordinated risk management function. As part of the Risk Subcommittee, a Risk Working Group, a VHA Risk Appetite Working Group and VHA Enterprise Risk Management (ERM) Community of Practice (CoP) have all been initiated to bring key subject matter experts and key stakeholders together.

Oversight and Accountability Outcome (O&A-3)

Outcome Executive: Tracy Davis Bradley, PhD, Executive Director, Office of Integrity and Compliance

Outcome Lead: Brian McCarthy, JD, MPH, Deputy Executive Director, Office of Integrity and Compliance

▲**Root Cause**: VHA has fragmented administrative functions that impede its ability to effectively respond to identified risks and issues to ensure organizational accountability and promote integrity.

◐**O&A-3 Outcome Statement**: Leadership holds VHA organizations accountable to fulfill obligations imposed by decisions, regulations, and other requirements.

◐**O&A-3.1 Goal**: Leadership ensures policies include oversight roles and responsibilities and that they are understood.

◐**O&A-3.1.1 Objective:** Require all accountable entities to include oversight roles and responsibilities in policies prior to approval.

○ **O&A-3.1.2 Objective:** Policy oversight roles and responsibilities are supported by change management capabilities and resources.

○ **O&A-3.1.3 Objective:** Policy oversight roles and responsibilities are properly funded and supported by VHA leadership.

Table 2-10. O&A-3.1 actions

Act. #	Action Details	Projected Date	Actual Date
●**3.1.1.1**	Leadership requires the inclusion of oversight roles and responsibilities in policies.	Q4 FY20	Q4 FY20
Status: **Comments:**	Completed VHA policy renewal process requires policy owners to include oversight roles and responsibilities upon writing review and concurrence of the policy		
○**3.1.2.1**	Leadership performs budgetary reviews, manpower assessments and develops manning documents to ensure adequate change management support.	Q1 FY23	TBD
Status: **Comments:**	In Planning Pending leadership acceptance and approval of action plan and allocation of funding		
○**3.1.3.1**	Leadership performs budgetary reviews, manpower assessments and develops manning documents to ensure adequate change management support.	Q1 FY23	TBD
IM-a:	Implementation of the policy national review to include key resource questions regarding the proposed policy.	TBD	TBD
IM-b:	Implementation of Resource Validation Workgroup to analyze central office resource requests.	TBD	TBD
IM-c:	Implementation of HR Smart as the system of record	TBD	TBD

Act. #	Action Details	Projected Date	Actual Date
Status: **Comments:**	In Planning Pending leadership acceptance and approval of action plan and allocation of funding		
○**3.1.3.2**	Develop requirements, adequately resource and build unified and integrated risk reporting and monitoring system to ensure success of Goals 1.2 and 1.3.	Q3 FY22	TBD
Status: **Comments:**	In Planning Task cannot be started until resources are allocated and requirements are identified.		

◐**O&A-3.2 Goal**: Leadership ensures the environment and processes are in place for occurrences of non-compliance or inappropriate activity to be reported and reviewed.

○ **O&A-3.2.1 Objective:** Leadership has a mechanism to receive reports of non-compliance or inappropriate activity.

◐ **O&A-3.2.2 Objective:** Entities receiving reports of non-compliance have a process in place for substantiating reports.

○ **O&A-3.2.3 Objective:** Leadership ensures that expectations are clear and promotes an environment that understands and supports just culture.

○ **O&A-3.2.4 Objective:** VHA has an escalation path through which leadership is made aware of substantiated and/or significant violations for action.

Table 2-11. O&A-3.2 actions

Act. #	Action Details	Projected Date	Actual Date
○**3.2.1.1**	Leadership enhances existing risk and compliance reporting mechanisms to develop a method by which it will receive aggregated routine reports of non-compliance.	Q2 FY23	TBD
Status: **Comments:**	In Planning Pending leadership acceptance and approval of action plan and allocation of funding		
◐**3.2.2.1**	Accountable entities develop a process where fact-finding is conducted and results accompany reports of non-compliance or inappropriate activity. VHA plans to increase the number and broaden the distribution of employees who have the necessary knowledge and skills to conduct preliminary fact finding through training provided by the VA Law Enforcement Training Center located in Little Rock, AR.	Q1 FY26	TBD
IM-a: **IM-b:** **IM-c:**	All Integrity and Compliance Officers received fact finding training; VHA expects each VISN will have two employees trained per year, notwithstanding turnover All VA designated oversight liaisons will receive fact finding training New hires will be expected to receive the training within 1 year of hire	Q1 FY26 Q1 FY26 Q1 FY26	TBD TBD TBD
Resources:	The Office of Integrity and Compliance funds approximately 40 field and VA employees to attend beginning in Q2 FY 2022.		

Act. #	Action Details	Projected Date	Actual Date
Status:	In Progress		
○**3.2.2.2**	VA improves and harmonizes data from pertinent quality, risk, issue, performance, culture databases for analysis and reporting. Key databases include: SAIL, RAMP, HEDIS, CDI, HOC, FACTS, PATS	TBD	TBD
Resources:	Office of Integrity and Compliance, Quality and Patient Safety and Operations (15)		
Status:	In Planning		
○**3.2.3.1**	Leadership develops universal oversight roles and responsibilities performance standards for inclusion in accountable entities' performance plans.	Q1 FY24	TBD
Status:	In Planning		
Comments:	Pending leadership acceptance and approval and allocation of funding		
○**3.2.3.2**	Leadership provides feedback on resolution, enforcement and disciplinary actions taken as a result of corrective actions taken.	Q4 FY23	TBD
Status:	In Planning		
Comments:	Pending leadership acceptance and approval and allocation of funding		
○**3.2.4.1**	A mechanism is developed enabling accountable entities with unfettered access to executive leadership to report substantiated and/or significant violations.	Q2 FY23	TBD
Status:	In Planning		
Comments:	Pending leadership acceptance and approval of action plan and allocation of funding		

○ **O&A-3.3 Goal**: Leadership ensures accountable entities take corrective action to resolve instances of non-compliance or improper activities.

○ **O&A-3.3.1 Objective:** Leadership has a process in place to determine if corrective actions were implemented within the time frame established by accountable entities.

○ **O&A-3.3.2 Objective:** Identified deficiencies and findings will be professionally managed by the organization.

Table 2-12. O&A-3.3 actions

Act. #	Action Details	Projected Date	Actual Date
○ **3.3.1.1**	Leadership develops a process or criteria to identify when options have been developed to resolve non-compliance or inappropriate activity.	Q3 FY23	TBD
Status:	In Planning		
Comments:	Pending leadership acceptance and approval of action plan and allocation of funding		
○ **3.3.1.2**	Leadership will develop a process to identify if corrective and preventative actions were taken as planned and able to be closed.	Q3 FY23	TBD
Status:	In Planning		
Comments:	Pending leadership acceptance and approval of action plan and allocation of funding		

○ **O&A-3.4 Goal:** VHA leadership reviews corrective action outcomes for effectiveness.

○ **O&A-3.4.1 Objective:** Leadership has a process in place to determine if corrective actions were implemented.

○ **O&A-3.4.2 Objective:** Leadership determines if the root cause has been identified and monitoring is put in place.

○ **O&A-3.4.3 Objective**: Leadership has an after-action analysis and reporting process to provide feedback to leaders of accountable entities.

Table 2-13. O&A-3.4 actions

Act. #	Action Details	Projected Date	Actual Date
○ **3.4.1.1**	Leadership will develop criteria to review outcomes of corrective actions.	Q3 FY23	TBD
Status: **Comments:**	In Planning Pending leadership acceptance and approval of action plan and allocation of funding		
○ **3.4.1.2**	Leadership develops mechanism to measure effectiveness and impact of corrective and preventative actions.	Q3 FY23	TBD
Status: **Comments:**	In Planning Pending leadership acceptance and approval of action plan and allocation of funding		
○ **3.4.1.3**	Leadership ensures there is a communication channel to provide program offices with feedback and recommendations, if any.	Q3 FY23	TBD
Status: **Comments:**	In Planning Pending leadership acceptance and approval of action plan and allocation of funding		
○ **3.4.1.4**	Leadership develops a process by which preventative actions are monitored for effectiveness.	Q3 FY23	TBD
Status: **Comments:**	In Planning Pending leadership acceptance and approval of action plan and allocation of funding		
○ **3.4.2.1**	Leadership adopts an after-action process where the detection of errors, corrective actions taken and outcomes are analyzed via a peer review mechanism to provide critical feedback and ensure clear accountability.	Q1 FY26	TBD
Status: **Comments:**	In Planning Pending leadership acceptance and approval of action plan		

○ **O&A-3.5 Goal**: VHA leadership ensures budgetary and resource requests from accountable entities are considered.

○ **O&A-3.5.1 Objective:** Leadership develops a mechanism by which resource requests are received, reviewed and responded to in a timely manner.

Table 2-14. O&A-3.5 actions

Act. #	Action Details	Projected Date	Actual Date

○ **3.5.1.1**	Leadership develops a mechanism by which resource requests are received, reviewed and responded to in a timely manner.	Q1 FY24	TBD
Status: **Comments:**	In Planning Pending leadership acceptance and approval of action plan and allocation of funding		

○ **O&A-3.6 Goal**: VHA leadership ensures accountable entities are held responsible for not responding appropriately to requests for action.

○ **O&A-3.6.1 Objective**: Leadership has a process to include accountability in performance standards.

○ **O&A-3.6.2 Objective:** Leadership outlines what constitutes accountability.

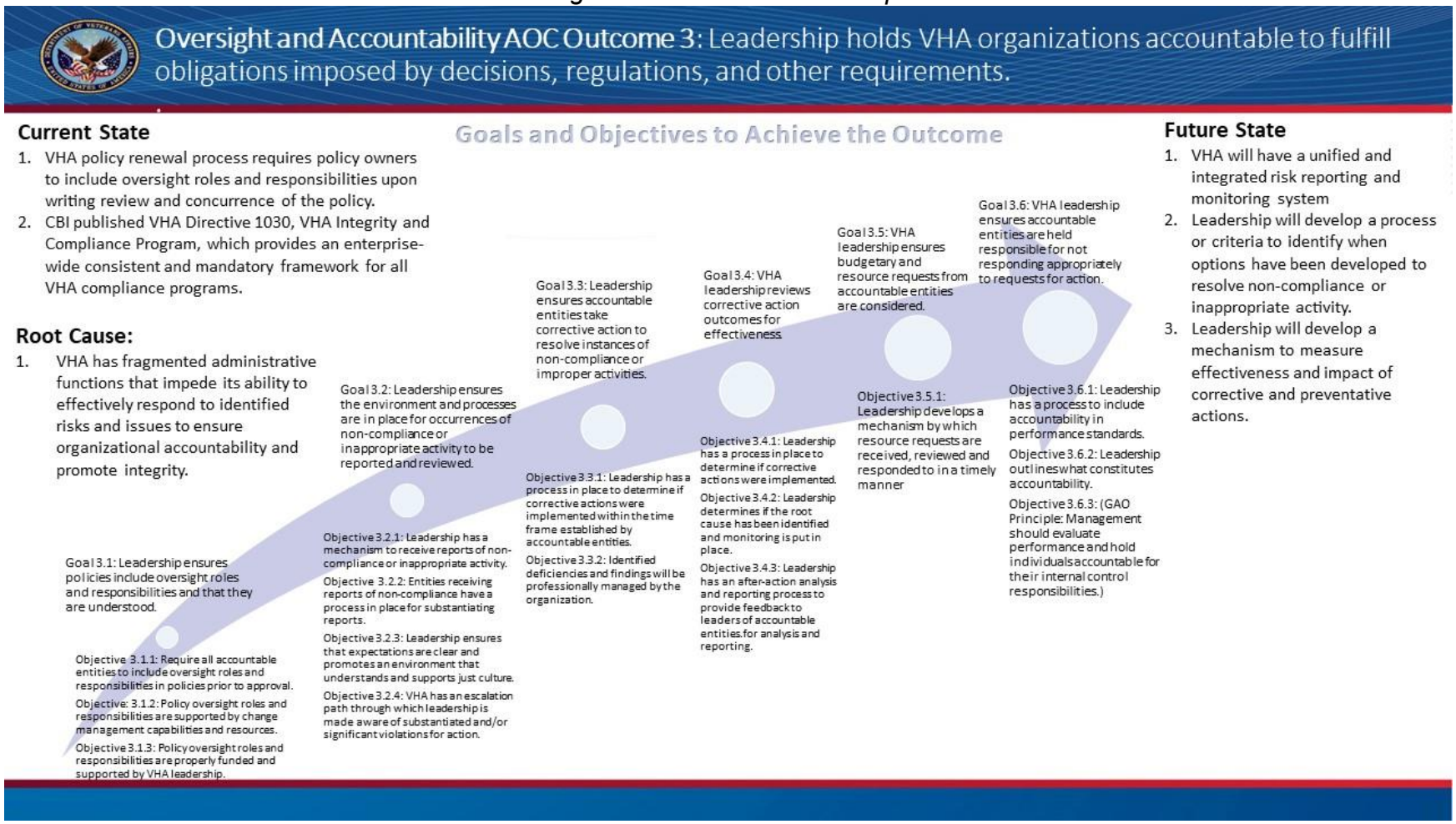
○ **O&A-3.6.3 Objective:** GAO Principle: Management should evaluate performance and hold individuals accountable for their internal control responsibilities.

Table 2-15. O&A-3.6 actions

Act. #	Action Details	Projected Date	Actual Date
○ **3.6.1.1**	Leadership develops universal oversight roles and responsibilities performance standards for inclusion in accountable entities' performance plans.	Q1 FY24	TBD
IM-a: **IM-b:** **IM-c:** **Status:** **Comments:**	Oversight directive published leadership outlines integrity for VHA leadership outlines accountability for VHA In Planning Pending leadership acceptance and approval of action plan and allocation of funding	Q4 FY23 Q4 FY23 Q4 FY23	TBD TBD TBD

Figure 2-10, below, visually presents the current state of this outcome, the desired future state of this outcome and the goals and supporting objectives that align and will contribute to the achievement of that future state.

Figure 2-10. O&A-3 Roadmap



O&A-3 Description and Status

Description

- VA's FY2022-28 Strategic Plan, Strategic Goal 3 commits VA to build and maintain trust with Stakeholders through proven stewardship, transparency, and accountability. This goal ensures that a strong culture of accountability drives ethical behavior across the organization and throughout the ecosystem of partners. Specifically, Strategic Objective 3.2, Internal and External Accountability, calls on VA to continue to promote and improve organization and individual accountability and ensure a just culture. VA is committed to ensuring that employees, contractors and third-party providers are properly trained and understand expectations for their performance and behavior and standards are fairly enforced internally and externally across the ecosystem of partners. Employees are confident VA will support their ability to speak up and swiftly and fairly hold individuals accountable for misconduct, fraud, waste and abuse and non-VA entities held accountable to strict criteria to protect Veterans and other beneficiaries. The links between OA-3 "accountability" and OA-4 "just culture" are inseparable, as there cannot be accountability in an organization where employees are able to identify risks, issues and be confident that the organization will address the root cause, but also that when there is a safe environment to disclose allegations of misconduct or other wrongdoing, employees feel protected from retaliation.

- Accountability, like all elements of VA's just culture (OA-4), starts with the tone at the top. VA's has and will continue to strengthen its oversight and quality internal controls (OA-1), combined with a strong and clearly defined governance (OA-2), sets a foundation in which the leaders have the necessary data to make the strategic decisions and ensure that those decisions are implemented with integrity. VA's leaders at every level of the organization hold themselves, others, and the organization as a whole, accountable for the provision of safe and high-quality care.

- Leadership sets the right tone of accountability and has a mechanism by which they can hold organizational entities accountable for decisions, regulations and other requirements (e.g., policies, guidance, standard operating procedures). VHA's governance functions include mechanisms for receiving reports from accountable entities on the status of compliance with requirements.

- 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, VISNs, VA medical facilities or others depending on the level of oversight for the decision, regulation or other requirements. The tone set by VHA also includes:
    - Adopting the HRO framework which highlights the importance of becoming a learning organization
    - Encouraging transparency via a mechanism that openly shares identified best practices and corrective actions

- Demonstrating lessons learned and standardizing a practice where process or decision- making errors are identified and resolved

- VHA will improve its capabilities to track mitigation plans, corrective action plans and performance improvement initiatives to completion. VHA will develop a structured, system-level capability for tracking progress and completion of critical remediation and performance improvement plans, particularly those related to high-risk areas; especially, VAMCs or VISNs with persistent performance challenges, or sites which have been non-responsive to risks and incidents.

Status

VHA realignment and name change for ORE has been finalized. With the implementation of an HRO framework, VHA is in the process of developing mechanisms to identify lessons learned and best practices. HRO provides a framework for all oversight entities to utilize practical tools and insight that enhance the ability to deliver optimal patient care in an environment focused on learning and quality improvement. VA has established a strategic goal in in its FY22-28 Strategic Plan that stakeholders trust VA through proven stewardship, transparency and accountability. As part of this goal, two strategic objectives were established. STRATEGIC OBJECTIVE 3.1: *(VA is transparent and trusted.)* VA is the trusted agent to improve quality of life and serve our Nations Heroes.

Patient-Centered Care Program / Veterans Experience. Many VA facilities have a leader who serves as the Patient-Centered Care

- Coordinator or a Veteran Experience Officer to oversee patient-driven care efforts with an intent of fostering greater collaboration, organizational alignment and integration of programs and services that impact the experience of Veterans. The use of Veteran and family feedback for quality improvement is built upon the foundation of the VA ICARE principles: Integrity, Commitment, Advocacy, Respect, and Excellence. This framework is based on a whole person approach which seeks to optimize health and well-being by placing the patient at the center of care. The VHA model of whole health care is personalized, proactive, patient-driven health care, delivered across the continuum from prevention through tertiary care and end of life.

- **Access to Care.** VA is committed to providing Veterans with the highest quality care when and where you need it, this includes providing information that is relevant and meaningful to help make more-informed health care decisions. VA information divided into distinct categories including, access to care at individual facilities; quality of care comparisons for VA and non-VA care; a search tool to find VA providers by location; patient satisfaction information provided by Veterans about their experience using VA health care; and information about overall access to care to within VA. https://www.accesstocare.va.gov/

Protecting Patient Data and Privacy. VHA affirms Veteran's trust in the Department by continuously protecting their privacy and health care security on data contained in Veterans' electronic health records (EHR) and in national data systems.

- **STRATEGIC OBJECTIVE 3.2:** *(Internal and external accountability.)* VA promotes and improves organizational and individual accountability and holds leaders, employees and external partners accountable for quality experiences and customer satisfaction.

- **Audit Risk and Compliance Committee (ARCC).** The ARCC is the governing body responsible for strategic risk and organizational accountability. Consistent with governance standards set by HHS OIG and DoJ Sentencing Guidelines, the ARCC is the only governance body that directly reports to USH and is comprised solely of VHA's senior accountable officials, which distinguishes it from the Governing Board. To this end, VHA is working to strengthen the ARCC and its processes to hold the organization, its operational units, and its employees responsible. The ARCC reviews the top risks to the organization, responses to internal and external audits, emerging risks, supports the governance of oversight activities and accountability across the Administration.

- **Policy Waiver Process.** VHA has established and plans to strengthen the process by which operating units request and establish a transparent record when national standards cannot be implemented. All records must be presented to the ARCC for review and disposition.

- **Governance Board –** The Governance Board is a recommending body to the USH for Administration-wide strategy and operational risks and issues. Lu Beck and Ethan Kalett are the accountable executives responsible for oversight and monitoring outcomes of Governance Board decisions. The Governance Board's roles, responsibilities, and has authority to assign responsibility to the executive over the operating Unit or to a voting member to ensure that Governance Board decisions are implemented in the desired manner and, if not, that the Governance Board provides strategic instruction or redirection as needed. The Governing Board also has authority to identifying and addressing key issues that affect VHA's national strategic goals or health care delivery. This authority includes the ability to recommend the establishment, sunsetting, or revision of VHA national programs consistent with an approved prioritization strategy for VHA.

- **Patient Advocates.** A facility's Patient Advocate manages the complaint and compliment process, including complaint resolution, data capture and

analysis of issues/complaints and communicate this information to facility leadership to help drive system improvements. Patient Advocates assist front line staff in resolving issues that occur at the point of service and address complaints that were not able to be resolved at the point of service. Facility Patient Advocates work directly with Service Chiefs and Service management to facilitate resolution to problems beyond the scope of front-line staff and participate in resolution of system problems by presenting the patient's perspective of the problem and desired resolution. The Patient Advocacy Program is an important aspect of patient satisfaction and significantly contributes to the VHA strategic goal of providing personalized, proactive, patient-driven health care.

- **VHA Clinical Risk Management.** VHA must report certain malpractice payments to the National Practitioner Data Bank (NPDB) and appropriate state licensing boards. These reports are required by the Health Care Quality Improvement Act of 1986 (42 U.S.C. §§ 11101-11152) which established the NPDB, and a Memorandum of Understanding (MOU) between VA and HHS. VHA's reporting requirements are set forth at Title 38 Code of Federal Regulations (CFR) Part 46 and are applicable to all VHA licensed health care practitioners involved in patient care who are employed, appointed, contracted for, or otherwise utilized under job titles listed in the NPDB document entitled "Occupation/Field of Licensure Codes." These regulations establish a malpractice payment reporting process, including a review panel which determines for whose benefit a claim for medical malpractice was made.

- **VHA Integrity and Compliance Program.** VHA's integrity and compliance program sets the standards by which enhance and preserve Veterans' trust by promoting a culture of integrity, assisting VHA to identify, assess and appropriately respond to compliance risks across the enterprise and to support oversight efforts throughout the organization through a standard program to address non-ethical and non-compliant behavior. Efforts include requires consolidated corrective action plan to known risks or issues for operational units, OIC Hotline, referrals to and from VA's Office of the Inspector General.

O&A-3 Description of Actions Toward Removal Criteria

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

Leadership Commitment
VHA is committed to:

- Changes necessary to define a culture of oversight and accountability for decisions and requirements issued by accountable entities.
- Encouraging learning from mistakes through after-action analysis and transparent reporting of errors and corrective actions.
- Acquiring necessary funding to obtain staff and technology to implement the action plan.
- Holding responsible parties accountable to compliance and oversight, which includes exercising disciplinary and punitive actions for gross non-compliance.

Demonstrated Progress

- In FY 2019, VHA required all staff to complete HRO training and started shifting toward implementation of the HRO framework.
- In FY 2020, VHA began to mandate the inclusion of oversight roles and responsibilities in all directives, which identifies the oversight mechanisms to be used by policy owners to which they and others are held accountable.
- In Q1 FY 2021, CBI published VHA Directive 1030, VHA Integrity and Compliance Program, which provides an enterprise-wide consistent and mandatory framework for all VHA compliance programs.
- Directive 1217
- Directive 1217.01
- VHA Directives 1370 and 1217 are also in the process of being revised.

Monitoring

- VHA will monitor and track implementation and activity related to actions as reported through senior leadership committees.
- The ARCC and its various subcommittees will receive and review monitoring reports in preparation for meetings to discuss VHA's progression toward a culture of oversight and accountability. VHA will monitor leadership engagement, resource allocation, implementation and completion of corrective and preventive action plans and organizational performance standards.

Capacity

- Members of the ARCC and its various subcommittees serve in dual capacity as senior leaders and ARCC members for the purpose of enhancing the culture of oversight and accountability in VHA. The duality of the members' roles offers a reciprocal relationship and mechanism for transmitting information between the ARCC and the respective program offices necessary for holding the organization and its employees accountable for actions.

- During the subcommittee meetings, members can bring their subject matter experts to the table to thoroughly analyze needs associated with creating a culture of oversight and accountability and resourcing (such as, staffing, funding, technology) all actions appropriately to support implementation.

- When additional resourcing needs are identified, members can report and escalate requests to the ARCC for review and decisional action.

Oversight and Accountability Outcome (O&A-4)

Outcome Executive: Tracy Davis Bradley, PhD, Chief Compliance and Business Integrity Officer

Gerard Cox, MD, Assistant USH for Quality and Patient Safety

Outcome Leads: Brian McCarthy, JD, MPH, Deputy Chief Compliance and Business Integrity Officer

Edward E. Yackel, DNP, FNP-C, FAANP, Acting Executive Director, National Center for Patient Safety

▲**Root Cause**: There are organizational cultural gaps between those delivering health care in the field and VHA that impedes VHA's ability to oversee and enhance ethical practice throughout the organization

◐ **O&A-4 Outcome Statement**: VHA supports a culture of safety and integrity that fosters trust, integrity, learning, and collaboration.

◐ **O&A-4.1 Goal**: Promote the transition of VHA to a high reliability organization incorporating a culture of safety.

◐ **O&A-4.1.1 Objective:** Establish high reliability and promote a culture of safety through leadership development and staff training.

O&A-4.1.1a Metric: ARCC develops recommendations standard options for program and operational unit accountability by Q1 FY2023. Decisions will be reported on an annual basis.

Table 2-16. O&A-4.1 actions

Act. #	Action Details	Projected Date	Actual Date
● **4.1.1.1**	ICARE training for all VA employees.	Ongoing	Ongoing
Status:	Completed		
Comments:	This annual requirement has been ongoing for the past five years.		
● **4.1.1.2**	Integrate HRO Principles and Just Culture into all Office of HLTI Programs.	Q1 FY20	Q1 FY20
Status:	Completed		
Comments:	HRO content is now included in 100% of HLTI programs: Technical Career Fields, Graduate Health Administration Training Program (GHATP), Explorations in Leadership (LeadX), Virtual Aspiring Supervisors Program (vASP), Leadership VA (LVA), Health Care Leadership Development Program (HCLDP), New Executive Training (NeXT), Senior Executive Service Candidate Development Program (SES CDP) and VHA Senior Executive Orientation.		
◐ **4.1.1.3**	Administration-wide mandatory Integrity and Compliance Awareness Training	Target 95%	Quarterly monitoring
Resources:	OIC		

Act. #	Action Details	Projected Date	Actual Date
Status:	In Progress		
Comments:	Revenue staff were only staff historically required to complete training. Starting in Q4 FY20, with the publishing of VHA Directive 1030, the scope of mandatory training expanded to all VHA employees. Systemwide training was launched in TMS in March 2021; As of August 2021, 351K employees were assigned and 308K have completed the training, a completion rate of 87%, VHA notes there is a temporary moratorium on training starting September 2021.		
◐ **4.1.1.4**	Own the Moment (OTM) is a principles-based approach to meet the needs of the Veteran and provide exceptional Veteran Patient Experience. Training defines VA's Customer Experience Principles.	TBD	TBD
Resources:	Veterans Experience Office		
Status:	In Progress		
	All actions imply effective change management and training are a part of implementation.		

◐ **O&A-4.2 Goal**: Promote VHA core values of integrity throughout the organization at all levels. (GAO Internal Principle: The oversight body and management should demonstrate a commitment to integrity and ethical values)

◐ **O&A-4.2.1 Objective:** Promote the importance of a culture of integrity through leadership commitment, policy, communications, and training.

O&A-4.2.1a Metric: Percentage of VHA staff completing HRO Baseline Training is expected to reach >80% by Dec 31, 2021. Data will be reported on a quarterly basis.

O&A-4.2.1b Metric: Number of sites with active cadre of CTT Master Trainers is expected to reach 139 VAMCs by end of FY 2023. Data will be reported on a quarterly basis.

O&A-4.2.1c Metric: Number of unit-level CTT participants is expected to reach >14,000 unit-level CTT participants system-wide by end of FY2022. Data will be reported on a quarterly basis.

O&A-4.2.1d Metric: Count of improvement projects tracked in CTT tracker is expected to be >1,400 CTT unit-level projects system-wide by end of FY 2023. Data will be reported on a quarterly basis.

Table 2-17. O&A-4.2 actions

Act. #	Action Details	Projected Date	Actual Date
◐**4.2.1.1**	Build a common body of knowledge by spreading foundational HRO training across the enterprise.	Q1 FY21	Q1 FY21
IM-a:	Develop and deploy standard curriculum for HRO Baseline Training	Q1 FY20	Q1 FY20

IM-b:	Certify VISN and VAMC HRO Baseline Trainers at all VISINs and sits	TBD	TBD
IM-c:	HRO Baseline Trainers will lead training sessions for all supervisors and front-line staff at their facilities.	TBD	TBD
Resources:	VISN and VAMC executive leadership team		
Status:	In Progress		
Comments:	Standard curriculum for HRO Baseline Training has been developed and deployed (both in-person and virtually). >90 % of VISN and VAMC executive leadership team members have completed HRO Baseline Training. VISN and VAMC HRO Baseline Trainers have been certified at all VISNs and 137 of 139 sites. From January to December 2021, HRO Baseline Trainers will lead training sessions for all supervisors and front-line staff at their facilities.		
◐ 4.2.1.2	Strengthen the organizational culture to facilitate ethical practice, transparency, and a culture of integrity.	TBD	TBD
IM-a:	Fraud Waste and Abuse Campaign	FY21	FY21
IM-b:	Integrity and Conflicts of Interest Campaign	FY22	FY22
Resources:	Dr. Tracy Davis Bradley		
Status:	In Progress		
◐ 4.2.1.3	Spread team-based training in error management tools that promote a culture of safety and integrity.	Q1 FY22	TBD
Resources:	National Center for Patient Safety		
Status:	In Progress		
Comments:	Evidence-based standard curriculum for HRO Clinical Team Training (CTT) has been developed and deployed (both in-person and virtually). CTT Master Trainers have begun to take training and receive coaching at 72 facilities through September 2021. Remaining 67 facilities will begin CTT Master and unit-level training through FY 2022.		
◐ 4.2.1.4	Strengthen a government ethics program to provide greater access and timely responses to ethics inquiries	Q4 FY21	TBD
IM-a:	Conclude government ethics advisors pilot	Q2 FY22	TBD
IM-b:	Recruit and train additional ethics advisors and begin monitoring and maintenance		
Resources:	Office of Integrity and Compliance		
Status:	In Planning		
Comments:	92 cases in FY21 41 ICOs and 11 VA OIC trained in first cohort; second cohort planned for Q2FY22		
◐4.2.1.5	All medical facilities will establish a site-specific HRO roadmap informed by a standardized, facilitated HRO assessment with implementation of and progress against the HRO plan overseen by the region. These HRO roadmaps will contain actions aimed at improving the culture of safety and integrity at each individual site.	Q1 FY22	TBD
Resources:	VISNs		
Status:	In Progress		
Comments:	HRO assessments have been performed and site-specific HRO roadmaps have been developed by 21 facilities. These HRO roadmaps have been tracked and supported by the VISNs. In FY 2021, 51 additional assessments will be completed resulting in 51 site-specific HRO roadmaps. Remaining sites will be assessment and complete site-specific HRO roadmaps in FY 2022.		

	All actions imply effective change management and training are a part of implementation.

◐ **O&A-4.3 Goal**: Employees demonstrate a culture of safety and integrity.

◐ **O&A-4.3.1 Objective:** Annually measure patient safety culture and culture of integrity through the All-Employee Survey.

O&A-4.3.1a Metric: All organizational entities scores of the Patient Safety Culture 15-item module of on the AES. The data is expected to be used as a trend analysis to observe year over year improvements in Patient Safety Culture Scores as HRO roadmaps are implemented across VHA. Data will be reported on an annual basis. Note: These metrics will be modified with the FY22 AES.

O&A-4.3.1b Metric: Score of AES measure, "I can disclose a suspected violation of any law, rule or regulation without fear of reprisal." Data will be reported annually.

O&A-4.3.1c Metric: All organizational entities scores of AES/FEVS/SAIL metric Organization Satisfaction: "Considering everything, how satisfied are you with your organization?" Data will be reported annually.

O&A-4.3.1d Metric: All organizational entities scores of AES/FEVS/SAIL Best Places to Work: "Best Places to Work". Data will be reported annually.

○ **O&A-4.3.2 Objective**: Management demonstrates a commitment to recruit, develop, and retain a stable and effective workforce.

Table 2-18. O&A-4.3 actions

Act. #	Action Details	Projected Date	Actual Date
◐ **4.3.1.1**	As part of their site-specific HRO roadmap, site leadership will monitor their Patient Safety Culture survey scores to determine areas for improvement to drive year-over-year improvement in the culture of safety and integrity items tracked on the AES.	Ongoing	Ongoing
Resources: **Status**: **Comments:**	Facility and VISN leaders In Progress Composite scores based on survey results for the Patient Safety Culture questions on the AES are displayed on HRO Measure Dashboard for each medical facility and VISN. Facility and VISN leaders will work together to include tactical actions on the HRO roadmap to foster continuous year-over-year improvement in targeted Patient Safety Culture survey results.		
	All actions imply effective change management and training are a part of implementation.		

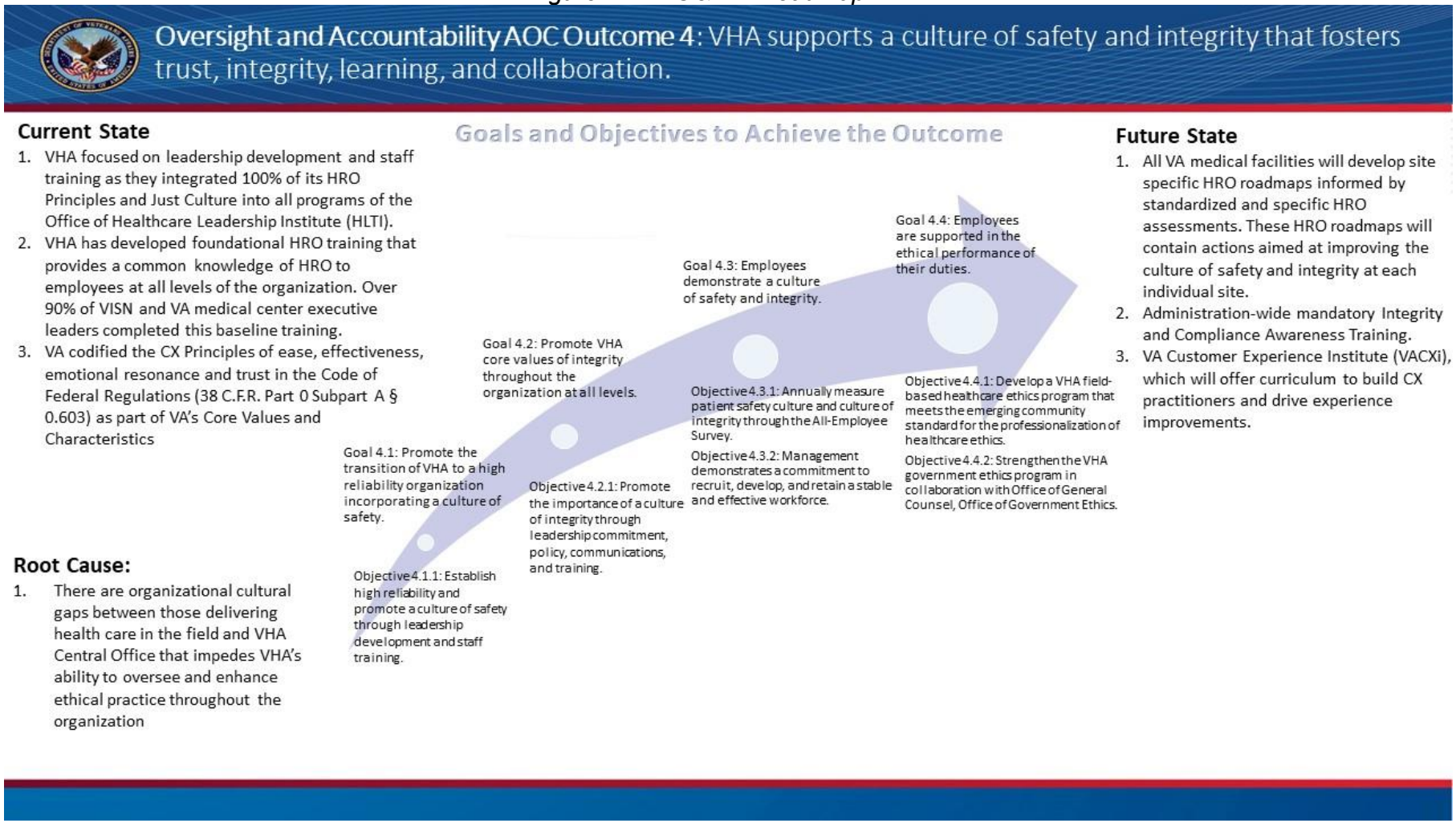
○ **O&A-4.4 Goal**: Employees are supported in the ethical performance of their duties.

- **O&A-4.4.1 Objective:** Develop a VHA field-based healthcare ethics program that meets the emerging community standard for the professionalization of healthcare ethics.

- **O&A-4.4.2 Objective:** Strengthen the VHA government ethics program in collaboration with Office of General Counsel, Office of Government Ethics.

Figure 2-11, below, visually presents the current state of this outcome, the desired future state of this outcome and the goals and supporting objectives that align and will contribute to the achievement of that future state.

Figure 2-11. O&A-4 Roadmap



O&A-4 Description and Status

Description:

- **ICARE**: VA's Core Values of Integrity, Commitment, Advocacy, Respect, and Excellence define who we are as VA employees and how we will fulfill our sacred obligation to care for Veterans, their families, caregivers, and survivors. They describe VA's culture and serve as the foundation for the way VA employees should interact with Veterans, fellow employees, and others outside the organization. I CARE Core Values and Characteristics are codified in our VA regulations at 38 C.F.R. Part 0.

- **VA's 2022-2027 Strategic Plan.** VA Secretary Denis McDonough established in the Department's 2022-2027 Strategic Plan a goal that "VA builds and maintains trust with stakeholders through proven stewardship, transparency, and accountability." Specifically, VA Strategic Objective 3.2 calls for internal and external accountability. Accordingly, VA will continue to hold leaders, employees and partners accountable for providing quality customer experiences and satisfaction and rewarding good performance to promote and improve organizational and individual accountability and ensure a just culture.

- **VA's Culture of Integrity** and no reprisal philosophy ensures individual and organizational accountability and proper stewardship of resources. Employees, contractors and third-party providers are properly trained and understand expectations for their performance and behavior and standards are fairly enforced internally and externally across the ecosystem of partners. VA provides a safe environment to disclose allegations of misconduct or other wrongdoing and employees feel protected from whistleblower retaliation. Employees are confident VA will support their ability to speak up and swiftly and fairly hold individuals accountable for misconduct, fraud, waste and abuse and non-VA entities held accountable to strict criteria to protect Veterans and other beneficiaries.

- The overarching goals of VHA's journey to support a culture of safety and integrity include the following:
    - Promote the transition of VHA to a high reliability organization incorporating a culture of safety.
    - Promote VHA core values of integrity throughout the organization at all levels.
    - Employees act with integrity.

- HRO activities may be tailored to individual organizations (e.g., program office, VISN, medical facility, clinic), but will follow the same framework and sequence to continually reinforce a culture of safety. The major components in the VHA HRO journey are outlined below.
- **Baseline HRO Curriculum:** Enterprise-wide training in HRO terminology, key concepts and daily error management tools.

- **Site-Specific Assessments and Planning:** Roadmaps VA of site-specific activities to address findings from the HRO assessments with the intent to drive continuous improvement.

- **Clinical Team Training:** Frontline unit-based training in safety behaviors and tools to detect human and system error before it causes harm.

- **Continuous Process Improvement:** Establish a method for tracking HRO related continuing process improvement activity.

- **HRO Leadership Coaching:** Quantitative and qualitative assessments of HRO cultural indicators in areas of leadership engagement, safety culture and continuous process improvement.

Status

High Reliability Organization

- VHA has long been a pioneer in patient safety. In 1999, VA established the National Center for Patient Safety. For over two decades, the Center, working with patient safety officers and managers across VHA, developed a range of innovations including a methodology for promoting medical team training, the collection of patient safety event and root cause analysis reports, and a framework for HRO called the High Reliability Hospital model.

- 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 and in 2019 began its HRO journey with a set of common HRO assessments, training, and improvement activities at 18 lead sites across each VISN. Using lessons learned from 18 HRO lead sites, VISNs and VAMCs have accelerated the use of HRO standard practices, such as safety huddles, leader rounding, safety forums and visual management.

- In FY 2020, VHA focused on leadership development and staff training as they integrated 100% of its HRO Principles and Just Culture into all programs of the Office of Healthcare Leadership Institute (HLTI). These include a range of programs within VHA such as Technical Career Fields, Graduate Health Administration Training Program (GHATP), Explorations in Leadership (LeadX), etc. The integration of these HRO principles and Just Culture into the HLTI programs support the promotion of VHAs transition to a high reliability organization because it provides leadership with the training and knowledge to understand the importance and incorporate a culture of safety and integrity within their daily activities.

- To establish high reliability within the enterprise, VHA has developed foundational HRO training that provides a common knowledge of HRO to employees at all levels of the organization. Over 90% of VISN and VAMCs

executive leaders completed this baseline training. In FY 2021, certified baseline trainers will lead training sessions for all supervisors and frontline staff at all medical facilities. VHA is aiming to have more than 80% of its staff complete baseline training in FY 2021.

- Similar to the integration of HRO principles and Just Culture to HLIT programs, this training provides a foundational understanding on how VHA is transforming itself into an enterprise-wide high reliability organization. Additionally, Clinical Team Training (CTT) has launched at 72 medical facilities – spreading safety behaviors and error management tools to unit-level teams, culminating in a 12-month project to institute an HRO practice to improve safety outcomes on the unit-level.

- In its journey to support a culture of integrity, all VA medical facilities will develop site specific HRO roadmaps informed by standardized and specific HRO assessments. These HRO roadmaps will contain actions aimed at improving the culture of safety and integrity at each individual site. Leadership will monitor their Patient Safety Culture survey scores to include tactical actions on the HRO roadmaps to foster continuous year-over-year improvement. As of FY 2021, 21 VA medical facilities have developed their HRO roadmaps that will be supported by the VISNs. The remaining medical facilities are expected to complete their roadmaps by FY 2022.

VHA's Integrity and Compliance Program

- OIC was established in 1999 by the USH in alignment with the US Sentencing Commission (USSC) Sentencing Guidelines and the HHS OIG compliance program model to reduce fraud, waste and abuse, and to promote high standards of business integrity and quality. In 2020, VHA OIC, with its administration wide oversight responsibilities, broadened the audience for mandatory Integrity and Compliance Awareness training beyond its historical scope of revenue operations to all VHA employees and has supported routine awareness training by annually celebrating Compliance and Integrity Awareness Week and Risk Awareness Week.

VHA Healthcare Ethics

- The National Center for Ethics in Health Care provides resources to address the complex ethical issues that arise in patient care, health care management, and research. VHA has a field-based healthcare ethics program that meets the emerging community standard for the professionalization of healthcare ethics, where practitioners have the education, demonstrated competency, and protected time to deliver the highest quality of healthcare ethics services to VA staff and Veterans.

Government Ethics Advisors

- VHA OIC has worked collaboratively with the OGC Ethics Specialty Team (EST) to designate ICOs who have received training to be designated Agency Advisors and are able to provide "safe harbor" guidance on identified specific subjects or

subject matter areas where VHA employees frequently ask questions (i.e. basic ethics advice, gifts, CFD/PFD filing rules and rationale, gifts of travel and conflicts of interest). Where questions arise, EST records clearly demonstrate that ICO's consult with EST colleagues to confirm or discuss their intended advice.

Veterans Experience Office

- Veterans Experience Office (VEO) supports VA as a shared service to partner with, support, and enable VA to provide the highest quality customer experience (CX) in the delivery of care, benefits and memorial services to Service members, Veterans, their families, caregivers and survivors. VEO applies CX best practices across its core capabilities of CX data, CX tools, CX technology and CX engagement to institutionalize the CX mission and ingrain CX into the fabric of the employee experience.

- VA codified the CX Principles of ease, effectiveness, emotional resonance and trust in the Code of Federal Regulations (38 C.F.R. Part 0 Subpart A § 0.603) as part of VA's Core Values and Characteristics and issued VA Directive 0010: VA Customer Experience highlighting the role every employee plays in creating excellent experiences for our customers. VEO also created New Employee Orientation training and updated the annual I CARE recommitment training (#3901227) to further identify how employees can put those CX principles into action.

- The VEO CX framework is built upon human-centered design (HCD) principles and puts the Veteran at the center for solution development. To that end, VA created "Own the Moment" (OTM) CX employee training to support and empower frontline employees with the knowledge and skills to deliver world-class Veteran experiences. OTM encourages the delivery of positive experiences by connecting emotionally with Veterans. This training is available through facilitated workshops or self-paced eLearning on TMS (#42980). VEO is also developing the VA Customer Experience Institute (VACXi), which will offer curriculum to build CX practitioners and drive experience improvements. VEO is currently piloting the concept through its patient experience curriculum with VHA.

O&A-4 Description of Actions Toward Removal Criteria

The following describes actions taken to address GAO's 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 ongoing.

Demonstrated Progress

- **High Reliability Organization.** Executive leadership teams at all medical facilities and VISNs have completed HRO Baseline Training, including training in use of the VHA Just Culture Decision Support Tool. As of January 2021, 72 facilities have an active cadre of Clinical Team Training Master Trainers. HRO roadmaps of site-specific activities to address findings from the HRO assessments have been developed by 21 facilities.

- **Government Ethics** VA's ethics program remains an effective prevention mechanism to guard against conflicts of interest and violations of ethical standards. OGE works to prevent corruption in the federal executive branch in partnership with officials across government and civil society. VHA OIC has established an Ethics Advisor's program with more than 80 Ethics Advisors in place with additional capability planned.

- **Medical Ethics** The National Center for Ethics in Health Care serves as VA's authoritative resource for addressing the complex ethical issues that arise in patient care, health care management, and research.

- **ICARE** VA's Core Values of Integrity, Commitment, Advocacy, Respect, and Excellence define who we are as VA employees and how we will fulfill our sacred obligation to care for Veterans, their families, caregivers, and survivors. They describe the organization's culture and serve as the foundation for the way VA employees should interact with Veterans, fellow employees, and others outside the organization. I CARE Core Values and Characteristics are codified in our VA regulations at 38 C.F.R. Part 0.

- **Code of Integrity** Code of Integrity emphasizes VHA's common culture of integrity and its responsibility to operate with the highest principles and ethical business standards both in the provision of health care, as well as our everyday interactions with one another.

- **Just Culture** A Just and Fair Culture is a necessary component of a Culture of Safety. A Just and Fair Culture is one that learns and improves by openly identifying and examining its own weaknesses; it is transparent in that those within it are as willing to expose weaknesses as they are to expose areas of excellence. In a Just Culture, employees feel safe and protected when voicing concerns about safety and have the freedom to discuss their own actions, or the actions of others in the environment, with regard to an actual or potential adverse event. Human error is not viewed as the cause of an adverse event, but rather a symptom of deeper trouble in an imperfect system. Leaders therefore do not rush to judge and punish employees involved in medical errors but seek first to examine the care delivery system as a whole in order to find hidden failures and vulnerabilities.

Monitoring

- This plan's metrics and measures provide the mechanisms to assess and report progress to GAO.

Capacity

- Every VISN, facility, CPAC, has an ICO.

- Every facility has a Clinical Risk Manager.

- Every employee must complete a mandatory culture of integrity training on an annual basis.

- Risk and Compliance & Integrity weeks efforts.

- 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.

- ICARE training is a reaffirmation of VA mission and values by empowering staff to accomplish outcomes that honor VA's mission and values.

3. Information Technology Challenges

Executive Sponsor: Martha Orr, Deputy CIO, Quality, Performance and Risk

Executive Summary

Since first being placed on the GAO HRL in 2015 as an Area of Concern under the Managing Risks and Improving VA Health Care listing, the Information Technology (IT) AOC has addressed the challenges of making incremental progress. In preparing the 2022 update to the Action Plan, a thorough review of the more recent GAO reports and previous HRL updates was conducted. Consistent themes from 2015, 2017, 2019 and most recently 2021 GAO updates were identified. As a result, the 2022 updated Action Plan for IT challenges has been focused on those themes, addressing needed improvements for each:

Figure 3-1. IT 2021 Rating

- The lack of VHA IT systems interoperability
- The ineffectiveness of some IT systems to support priority VHA operations at acceptable levels
- The lack of interoperability between DoD and VA Healthcare IT systems

This adjusted focus has resulted in a refinement of IT AOC outcomes, folding them into three from five with no loss of content or intent. The separate outcomes previously associated with governance IT -3, eliminate duplicate systems IT -5 and legacy systems retirement IT -4 have been blended into three revised outcomes.

In further support of their Action Plan realignment, the IT AOC workgroup continues efforts to refine and develop goals, objectives, and actions that directly align to GAO sited concerns and corresponding Root Causes. Outcome Leads and IT Leadership will continue to meet regularly between March and July to ensure all eight key elements of an action plan are robustly developed and reflected in their final August Action Plan submission.

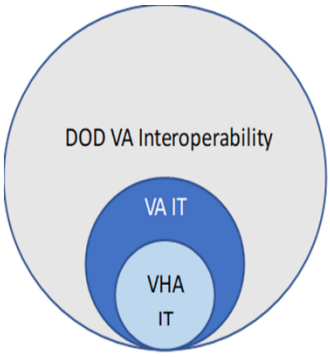
Outcome Focus and Alignment -

The focus and alignment of the IT AOC's outcomes and goals show a planned progression from a solid foundation of VHA interoperability, to integration of information technology modernization efforts throughout VA. Resulting in improved DoD and VA interoperability and integrated healthcare. This is not a "quick fix" effort and will require measured, aligned, deliberate, and monitored investment over the next decade to approach the desired state: integrated healthcare that best serves the VA.

IT -1 will demonstrate the VHA and IT commitment to promote interoperability through efforts like the creation of the VA Interoperability Liaison (VAIL)Team.

IT – 2 discusses the system improvement efforts to support prioritized VHA operational requirements. OIT's work led by the healthcare account management office to identified VHA prioritized needs and the implementation of product line management to effectively develop and deliver critical information technology systems to meet those prioritized needs.

Figure 3-2. IT-3



IT – 3 describes the long-term path to interoperability and integrated healthcare, addresses the stewardship of the Federal Electronic Health Record Modernization (FEHRM) for a common electronic health record and the multitude of other information sharing activities that are going on between DoD and VA.

To Achieve Interoperability

In this update, particular attention has been placed on outcomes, goals, objectives, and actions to ensure alignment with associated milestones and measures which enable greater oversight and accountability by IT leadership. Providing appropriate detail in planned actions and identifying measures which support leadership oversight are a primary goal of the Action Plan update.

While the IT AOC's Action Plan overhaul has required a significant effort on the part of the entire IT leadership team, it has resulted in an incremental roadmap to adequately address the IT challenges. It is clear this is a long-term journey. Systems that will require concerted leadership and interoperability focus. Removal from the high-risk list will not change the need for continuous change and continued improvement of information systems. The following discussion of each of the outcomes is not an end state but rather a significant milestone demonstrating progress along the way.

IT-1: Improve system interoperability (within VA across the VA enterprise) to facilitate effective delivery of core health care mission functions.

Discussion:

Established in FY 2019 the VAIL Team was chartered to serve as a single point of contact for the furtherance of VA interoperability. The VAIL seeks to:

1. Maintain the VA's interoperability roadmap, assess VA's interoperability maturity using a maturity index, and foster an interoperable culture
2. Serve as a conduit for information sharing, decision making, alignment, prioritization, advancement of interoperability adoption, compliance advancement and other initiatives critical for improving interoperability across VA and among its partners

3. Reach across the VA, the FEHRM, DoD and other government/non-government partners in supporting VA's mission
4. Reinforce the role of other governance bodies and strive to eliminate duplication of efforts

While relatively recent, the accomplishments of the VAIL demonstrate progress and on-going efforts to improve interoperability in VA healthcare and across VA. One example of the efforts so far is:

Referrals for care, otherwise known as "consults," may be internal to the facility (provider to provider), inter-facility (VA to VA), or external (VA to non-VA), and they are managed through a consult management process. To improve VA's ability to oversee consults and manage the process more effectively, VA developed the Consult Toolbox. The Consult Toolbox is a single consult that staff members can forward as needed to schedule a patient for an episode of care, rather than the current system where staff members are required to re-enter data for each new consult.

This enhancement to the current process makes it possible to document completed actions quickly and consistently, use consistent verbiage, and eliminate the need to take a second action or make a separate entry to track scheduling steps. Additionally, the consistent verbiage allows software analysis of records without needing to have software changes to Veterans Health Information Systems and Technology Architecture (VistA) or Computerized Patient Record System (CPRS). The Consult Toolbox will enable VA providers and community care staff to share statements for consults and track the Veteran through the community care experience.

IT-2: Modernize or replace VA IT systems, as necessary and as prioritized by VHA business partners, in cases where legacy systems do not support current VHA business needs.

Discussion:
To drive Digital Transformation, OIT worked with business partners to create the Department's Information Resource Management (IRM) Strategic Plan. This FY20–22 IT IRM strategic plan provides the foundation for moving forward with the transparency, accountability, innovation, and teamwork identified by OIT's guiding principles. This plan guides OIT's progress to become a world-class IT organization that provides a seamless, unified Veteran experience through the delivery of state-of-the-art technology at pace with the evolving digital world. VA must provide critical services to support its operations while continuing to innovate with new technologies and practices and remaining responsive to legislative requirements. A major objective in the modernization effort is to streamline interactions with business partners and align OIT activities and priorities with business partner objectives. To do this OIT has begun to:

1. Identify portfolio and product managers aligned to OIT business partners to improve collaboration

2. Become a trusted advisor to our business partners and help them understand the "art of the possible"
3. Improve our business partners' understanding of internal IT processes and decisions

VHA and OIT recognized that the current organizational interaction does not support the aim of becoming a high reliability, clinically integrated, and Veteran-driven organization. Improvements were needed in the delivery of services and benefits, diffusion of best practices, and enhanced employee engagement. VA's goal is to provide Veterans with the care they need at the right time, at the right place, and from the right provider. Accordingly, the Department is modernizing the way it delivers health care to over nine million Veterans by transitioning VHA from legacy IT systems to a modern, commercially focused suite of applications. The implementation of the Health Services Portfolio is a key component of this effort and provides advanced technology solutions to enable this transition and ensure modern, high-quality and efficient medical care delivery.

A second part of this modernization effort is establishing the Health Care Administration (HCA) Product Line. The HCA includes systems, applications, and capabilities that enable the interoperability of Veteran data between non-VA providers and VA, as well as between VistA and the Cerner Electronic Health Records (EHR) to ensure Veterans' EHRs remain current across providers. Additionally, continuous analysis and business intelligence on comprehensive data sets is being conducted to improve health care for all Veterans. As VA continues to implement the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act and transitions from VistA to the Cerner EHR over the next 10 years, VA will need to ensure that each Veteran's EHR is up to date, complete, and not fragmented while multiple EHR systems are in operation at the same time.

VHA and OIT cooperation to further the implementation of the Health Services Portfolio and the Health Care Administration product line are key to the progress made and ongoing efforts to improve modernization and the digital transformation of VA healthcare.

OIT's business model focuses on the continual improvement of customers' experience whether the customer is a Veteran using an OIT-built product, a VA employee logging in to a workstation, or a community partner working with VA to meet a business need. VA will deliver self-service tools on par with top private sector companies and have the best online experience in the Federal Government. OIT helps each administration provide an interactive experience for the Veteran that is consistent, easy, intuitive, and personalized through focus groups, customer journey mapping, design thinking, rapid prototyping, Agile development, and metrics. OIT will balance the end-user experience of the Veteran with security protocol and internal business partners' requirements so that the back-end functionality is as intuitive as the front-end experience.

IT-3: VA clinicians are able to access patient clinical data from DoD systems - Armed Forces Health Longitudinal Technology Application (AHLTA) and Cerner- through their EHR systems – VistA/Cerner

Discussion:
DOD and VA are working to align systems, software platforms, security procedures and data repositories to increase interoperability, improve information exchange and the use of information to provide seamless healthcare and benefits for Veterans and their beneficiaries. These efforts are built upon a shared vision of the health care and benefits ecosystem and a high degree of collaboration and coordination between the two departments. One of the major efforts towards interoperability is the implementation of a single, common EHR between DoD and VA.

To accomplish this, the Departments are supported by the FEHRM Office which serves as a single point of accountability in the delivery of a common electronic record that contributes to full interoperability of healthcare information between the Departments. The FEHRM Office has released the DoD/VA Interoperability Modernization Strategy, which outlines important goals to enable seamless care and empower service members and Veterans to own and control their health data. The strategy focuses on interoperability, but the vision is about seamless care and benefits.

VA's continued commitment to implementing modern and interoperable technologies to support health and benefits delivery presents tremendous opportunities. The use of the vast data stored in their systems will enhance the overall health of the beneficiary population, maximize access to earned benefits and improve the quality and safety of the care and services provided. While also driving down costs. Interoperable systems enable the identification of health trends, leading to earlier detection and treatment and improving beneficiary outcomes.

The DoD has begun the phased deployment and made progress on its new EHR system, called Military Health System (MHS) GENESIS. VA has begun deployment of its new health record system, called Electronic Health Record Modernization (EHRM) which has been successfully installed at the Mann-Grandstaff Medical Center. After a pause in the rollout, EHRM Reorganization plan was adopted in December 2021 and rollout is currently underway.

In addition to the EHR efforts, other actions have been taken to improve the exchange of health information between VA, DoD and community healthcare providers. The deployment of the Joint Longitudinal Viewer enables DoD and VA health care providers to view a patient's health record across both Departments. The Joint Health Information Exchange (HIE) allows data from participating community partners and health systems who treat DoD and VA beneficiaries to be integrated into the EHR. The FEHRM is leveraging VA's patient-facing video platform to develop a parallel platform for DoD to expand virtual health capabilities.

Response to the COVID-19 pandemic demonstrated the ability of the single, common federal EHR to quickly adapt to changing demands and support providers during the pandemic. When providers needed to order COVID-19 tests, and they didn't have that capability, VA was able to make those changes in four hours within four hours. The pandemic demanded a change in the healthcare delivery model and demonstrated virtual health as a priority. In response, the FEHRM Office pivoted toward accelerating the adoption of tools, platforms, and joint capabilities to deliver telemedicine solutions that meet the operational requirements driven by the pandemic.

VA is a leader in providing telehealth services and leverages technologies to provide care through three primary telehealth modalities: Clinical Video Telehealth, Home Telehealth, and Store and Forward Telehealth. In FY 2018, VA achieved more than one million video telehealth visits, a 19% increase in video telehealth visits over the prior year, and an 88–90% satisfaction rate. In the same year, more than 782,000 Veterans—or 13% of Veterans obtaining care at VA—had one or more telehealth episodes of care, which equates to more than 2.29 million telehealth episodes of care among 50+ primary and specialty areas. To enable Veterans to better control their health care records VA launched the Blue Button initiative and has now seen 38 million Blue Button downloads by Veterans since August 2010. The most recent feature launched on VA's portal allows Veterans to download their full imaging files, including the opportunity to burn a disc with their Digital Imaging and Communications in Medicine (DICOM) files as well as a viewer for these files.

In response to the pandemic, VHA worked closely with OIT to address and stay ahead of the anticipated increase in demand for virtual care. VA has seen over a 1,200% increase in video visits from home with 10,654 visits in the first week of March 2020 to 139,854 visits in the first full week of July 2020. In May 2020, VA recorded its first day with two million minutes of VA Video Connect (VVC) visits. This system has expanded to the VA Commercial Cloud, and VA continues to scale capacity to meet the exponential increase in demand for telehealth appointments. Since the emergence of the pandemic, VA has deployed 244 tele-Intensive Care Unit carts across 91 VAMCs, and every VA facility with intensive care beds is now equipped with 24/7 virtual access to critical care specialists.VA is working with DoD's Defense Health Agency (DoD DHA) to share the telemedicine capabilities it has developed to further the integration of healthcare.

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

IT Alignment with Other Areas of Concern

- **IT Alignment with Policies and Processes:**
    - Continue to work with the Policies and Procedures Workgroup to ensure ease of accessibility to VHA policy and policy-related documents, including implementation guidelines and human resources requirements.

        - As part of the IT AOC's efforts to improve interoperability, the IT Workgroup will collaborate with the Policies and Procedures Workgroup to ensure relevant VHA program offices are engaged and connected to outcome efforts.

- **IT Alignment with Oversight and Accountability:**
    - IT systems are critical to the success of Oversight and Accountability. The IT Workgroup will continue to collaborate with VHA to determine and support Oversight and Accountability's IT business needs.

- **IT Alignment with Training:**
    - As the reliance and use of teleservices continue to grow within VHA, OIT will collaborate with the Training Workgroup to ensure the availability and access to training materials, procedural changes, and other materials.

- **IT Alignment with Resource Allocation:**
    - As an enterprise-wide office, OIT will continue to collaborate with the Resource Allocation Workgroup to identify VHA's IT requirements and their relative prioritization for funding based on VHA's determinations of relative need given IT capacity and IT funding which are not unlimited.

Information Technology Challenges – Actions Taken to Address GAO's "Not Met" Removal Criteria 2021 Rating

Information Technology Challenges received a "not met" rating from GAO for the following removal criteria: Demonstrated Progress; Monitoring. The below list provides details on actions taken by the AOC workgroup since the GAO-21-119SP High Risk Series was published in response to these "not met" ratings:

a. Actions Taken to Address Demonstrated Progress "Not Met" Rating

- The IT AOC workgroup overhauled the entire Action Plan in preparation for the 2022 submission.
    - IT AOC workgroup leadership examined the Outcome Leads and Outcome Executives, ensuring that the appropriate people were leading the correct Outcomes.

    - The IT AOC workgroup has also rewritten all of the metrics and actions to ensure that they are relevant and can provide information to aid in the success of the AOC workgroup.

b. Actions Taken to Address Monitoring "Not Met" Rating

- The IT AOC workgroup leadership has a standing bi-weekly meeting to monitor progress.

- The IT AOC workgroup holds a monthly meeting with the Outcome Leads.
    - This meeting provides updates on Actions and Metrics.
    - This meeting also allows the IT AOC workgroup to stay ahead of any issues blocking progress.

Status Key

This Action Plan submission denotes the status of implementation for each metric, outcome, and action graphically. The following Key can be used to understand the status graphics:
○ – "Not Met." Few, if any, actions toward meeting GAO's criterion for removal have been taken.
◐ - "Partially Met." Some, but not all, actions necessary to meet GAO's criterion have been taken.
● – "Met." Actions have been taken that meet GAO's criterion for removal. There are no significant actions that need to be taken to further address the criterion.
▲ - New or revised Root Cause.

As part of the IT AOC workgroup's Action Plan overhaul, IT AOC workgroup leadership led a comprehensive review of its Actions and reported Metrics to ensure alignment and connectivity to newly developed and/or refined Outcomes and Root Causes. Upon completion, it was found that many of the previously reported actions no longer directly supported/aligned with their outcomes or had been reported as complete and sustaining long enough to support removal from the Action Plan.

While the IT AOC workgroup is pleased with updated content reflected in the following outcomes, it remains committed to continuing its overhaul process. Guided by a routinely updated projected timeline, IT AOC workgroup leadership continues to drive the Action Plan update process through the identification and development of supporting Actions as well as measurable metrics that demonstrate progress towards resolving root causes. As such, Outcome Leads meet at least weekly with their identified teams of subject matter experts to further build out their outcomes. As of March 2022, the IT AOC workgroup is on track to develop a robust and complete Action Plan by the August GAO submission deadline.

Information Technology Outcome (IT-1)

Outcome Lead: John Burke, Senior FAC-PPM

Outcome Executive: Helga Rippen, MD, PhD, Chief Interoperability and Veteran Access Officer

Root Cause: 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.

○ **IT-1 Outcome Statement**: Improve system interoperability to execute core health care mission functions.

○**IT-1.1 Goal**: Establish and promote a common vision, definition and understanding of interoperability principles within the VA and with our partners.

○**IT-1.1.1 Objective**: Provide a common definition and approach to measure progress of interoperability.

IT-1.1.1a Metric:
Title: Standardized Interoperability Process Development and Accountability Metric
Description: Yearly number of new Interoperability Maturity Assessment baselines conducted
Frequency: Yearly, reported in Q4 of same year
Data: Target = three-yearly

○**IT-1.1.2 Objective**: Demonstrate outcomes of interoperability.

IT-1.1.2a Metric:
Title: Standardized Interoperability Process Development and Accountability Metric
Description: Yearly number of new Interoperability Maturity Assessment baselines conducted
Frequency: Yearly, reported in Q4 of same year
Data: Target = three-yearly

○**IT-1.1.3 Objective**: Develop, implement, and maintain an enterprise-level interoperability roadmap.

IT-1.1 Actions Table to be inserted following the identification and development of planned actions

○**IT-1.2 Goal**: Optimize planning and investment in systems to improve interoperability to support VA healthcare mission.

○ **IT-1.2.1 Objective:** Define and prioritize VHA system interoperability improvement opportunities and integrate within OIT development and funding schedules.

IT-1.2.1a Metric: In Planning

○ **IT-1.2.2 Objective:** Expand capability and tools to enable interoperability.

IT-1.2.2a Metric*:* In Planning

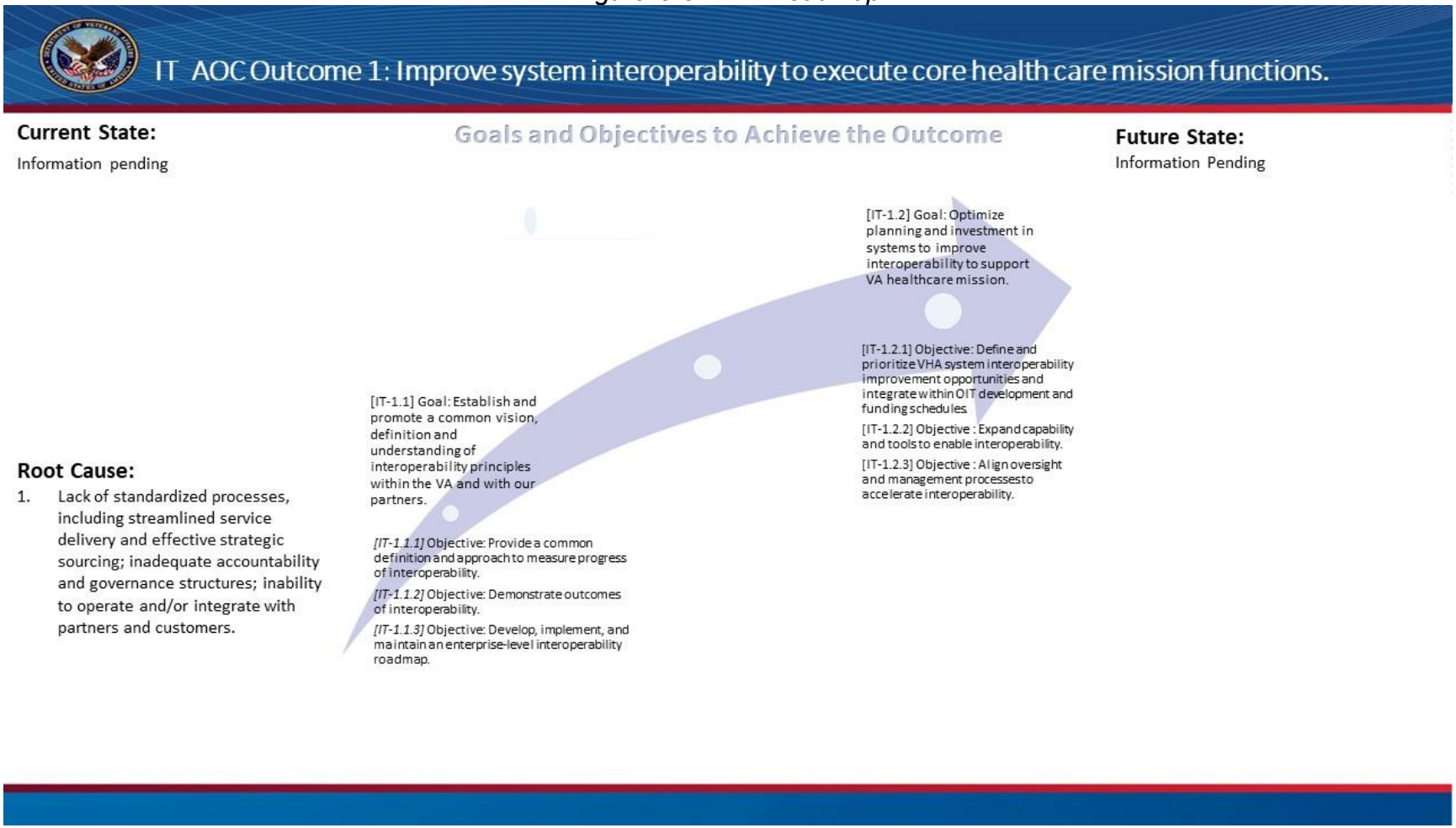
○ **IT-1.2.3 Objective:** Align oversight and management processes to accelerate interoperability.

IT-1.2.3a Metric*:* In Planning

IT-1.2 Actions Table to be inserted following the identification and development of planned actions

Figure 3-3, below, will be updated when information is available to reflect the identified current state of this outcome, the desired future state of this outcome and the goals and supporting objectives that align and will contribute to the achievement of that future state.

Figure 3-3. IT-1 Roadmap



IT-1 Description of Actions Toward Removal Criteria

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

- The term 'interoperability' means the ability of different information systems, devices, or applications to connect, regardless of the technology platform or the location where care is provided, in a coordinated and secure manner, within and across organizational boundaries, and across the complete spectrum of care, including all applicable care settings.

- As an IT outcome, seamless and secure interoperability is one of OIT's core goals. Interoperability requires alignment of three ecosystems: business, data, and technical systems.

- Need to address the planning, architecture and investment management aspects.

- Major IT modernization activities help accelerate interoperability, and support the needs of the VHA, (example, EHRM). To accelerate efforts to increase interoperability across the VA, OIT has created the position of Chief Interoperability and Veteran Access Officer (CIVAO). The role of the CIVAO is to facilitate coordination across the VA and our partners; establish an enterprise VA Interoperability Leadership Group; develop a VA interoperability strategy; and track progress of interoperability efforts. These three cornerstones highlight leadership commitment and alignment, expand and coordinate capacity with needs to achieve interoperability goals, develop and execute action plans, and establish metrics for monitoring.

- A major initiative of the VA is IT modernization. This includes not only major efforts like the EHRM and Defense Medical Logistics Standard Support (DMLSS) supply chain but also investing in solutions that enable interoperability capabilities to meet the needs of VHA and the enterprise. Middleware, such as Veterans Data Integration and Federation Enterprise Platform (VDIF-EP), and Lighthouse Application Programming Interface are examples that enable these capabilities.

- Lighthouse, also 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 internal and 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 in a safe and secure fashion.

- Middleware is software that lies between an operating system and the applications running on it, enabling communication and data management for distributed applications.

- VDIF-EP, is a standards-based, middleware platform that can support data exchange, in a standardized manner, between VistA and other applications.

- The VAIL promotes and reinforces a common vision of interoperability across the VA enterprise by providing direction, enabling alignment of activities, adjudicating interoperability issues, and addressing gaps.

- Internal VHA Innovation activities.

- To achieve this outcome, the VA Chief Information Officer (CIO) and the EiC (Evidence Intake Center) collaborate to address risks and GAO health IT recommendations in real time. Assistant and Under Secretaries direct action through their Outcome Executives as necessary to mitigate or eliminate risk and ensure sustainability to meet business needs on a continuous basis.

- OIT will identify duplicative systems and capabilities with services providers, Account Management Office (AMO) and business customers. OIT will leverage Legacy Systems Modernization (LSM) Working Group to identify and plan for system modernization and/or decommission.

- OIT is establishing the framework required to leverage Development and Operations (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 VHA 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 (within VHA there are X product lines) and composition of IT systems supporting each product line. The product lines will be formalized and system relationships and roadmaps validated by the product line owners.

Information Technology Outcome (IT-2)

Outcome Lead: Tobie Wethington, Business Relationship Manager, AMO

Outcome Executive: Howard Green, IT Account Manager, Health

▲**Root Cause**: Weaknesses in VA OIT solution delivery and large program management oversight impact VA ability to deliver the IT capabilities needed by VHA.

○ **IT-2 Outcome Statement**: To improve IT solution delivery and large program management oversight practices to effectively deliver business and veteran oriented solutions.

○ **IT 2.1 Goal**: Enhance collaboration with VHA partners to consistently provide timely IT solutions that will support VHA healthcare delivery processes.

○**IT-2.1.1 Objective:** Increase transparency amongst VHA and OIT partners using advanced project and program management tools and product line management practices.

IT-2.1.1a Metric: In Planning

○**IT-2.1.2 Objective:** Use a Product Line Maturity Rating Level approach to establish a baseline and monitor incremental improvements in delivery for OIT Product Lines.

IT-2.1.2a Metric: In Planning

○**IT-2.1.3 Objective:** Implementation of Investment Management and Capital Planning and Investment Control (CPIC).

IT-2.1.3a Metric: In Planning

IT-2.1 Actions Table to be inserted following the identification and development of planned actions

○ **IT-2.2 Goal**: Provide appropriate training to close knowledge gaps in best practices for IT professionals.

○ **IT-2.2.1 Objective:** Establish a comprehensive training strategy to consistently educate staff in best practices.

IT-2.2.1a Metric: In Planning

○ **IT-2.2.2 Objective:** Develop and implement training plans that educate staff in product line management (PLM).

IT-2.2.2a Metric: In Planning

○ **IT-2.2.3 Objective:** Develop and implement training plans that educate staff in Agile practices and SAFe.

IT-2.2.3a Metric: In Planning

- **IT-2.2.4 Objective:** Develop and implement training plans that educate staff in Development, Security, Ops (DevSecOps).

IT-2.2.4a Metric: In Planning

IT-2.2 Actions Table to be inserted following the identification and development of planned actions.

- **IT-2.3 Goal**: Implement Scaled Agile Framework (SAFe) and Investment management.

  - **IT-2.3.1 Objective:** Appropriate major program initiatives will reflect hybrid SAFe and Agile practices.

IT-2.3.1a Metric: In Planning

  - **IT-2.3.2 Objective:** The Capital Planning Investment Control (CPIC) governance process will be established.

IT-2.3.2a Metric: In Planning

IT-2.3 Actions Table to be inserted following the identification and development of planned actions

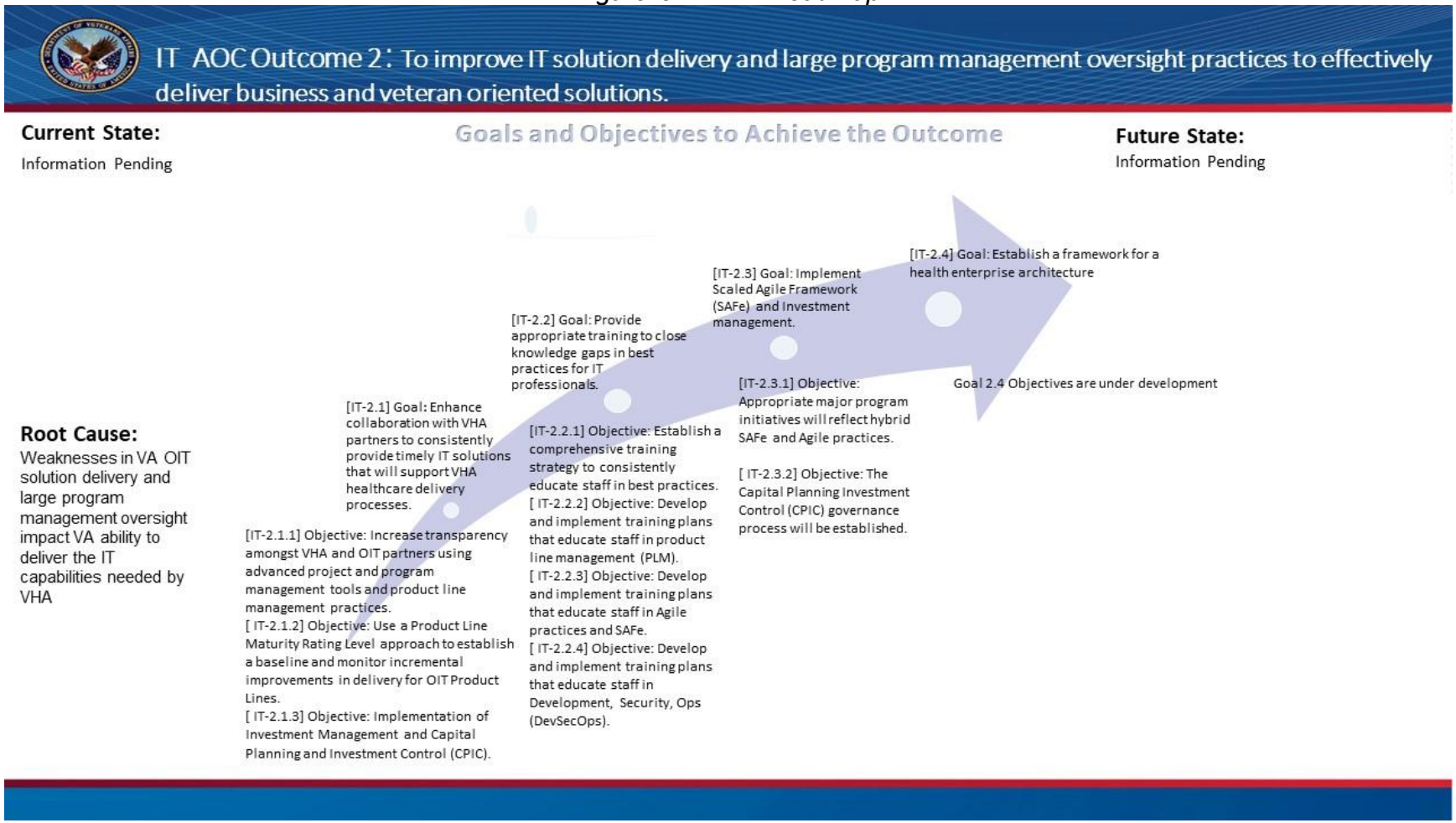
- **IT-2.4 Goal**: Establish a framework for a health enterprise architecture.

IT-2.4 Objectives are currently under development.

IT-2.4 Actions Table to be inserted following the identification and development of planned actions.

Figure 3-4, below, will be updated when information is available to reflect the identified current state of this outcome, the desired future state of this outcome and the goals and supporting objectives that align and will contribute to the achievement of that future state.

Figure 3-4. IT-2 Roadmap



IT-2 Description of Actions Toward Removal Criteria

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

- To achieve this outcome, the Chief Information Officer (CIO) and Executive in Charge (EiC) collaborate to address risks and GAO recommendations. 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. OIT will strive to have all Product Lines achieve a Product Line Maturity Level 1 which is an indicator of teams being more collaborative with VHA partners and consistent with their deliverables. Lastly, an Integrated Product Environment (IPE) will be established to help ensure any product deliverable is able to be tested for integration prior to being released into production. This will increase quality and delivery confidence once it is released into production.

- The VAIL promotes and reinforces a common vision of interoperability across the VA enterprise by providing direction, enabling alignment of activities, adjudicating interoperability issues, and addressing gaps.

- Innovation activities between VHA and OIT - VA IT Investment Board (ITIB) and its associated IT Investment Council (ITIC) has been established in the past six months to provide a governance forum for deliberation and decisions about VA's information technology investments to deliver maximum mission capabilities and business value for every dollar spent. The ITIB will advise the Secretary of VA through the Deputy Secretary and the CIO to ensure that the VA makes IT investment decisions consistent with the VA's mission, strategic plan, budget, and enterprise architecture and delegates to other governance bodies, as appropriate. The VA ITIB and ITIC consists of voting members from all VA administrations and VA staff offices.

- In addition to the VA OIT Governance Forums, the Oil's CIO co-chairs the DoD / VA Information Technology Executive Committee which is a governing forum under the DoDNA Joint Executive Committee for VA/ DoD implementation of healthcare improvement efforts and the FEHRM Office.

- To execute this responsibility, the OIT Associate Deputy Assistant Secretary created and tasked the LSM Working Group. The LSM Working Group Chairperson, identified and tasked by the Associate Deputy Assistant Secretary - Enterprise Program Management Office (EPMO), is responsible for the development, implementation, and maintenance of this LSM Working Group Chapter. 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 the 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.

- AMO collaborated with VHA's Office of Healthcare Informatics, Office of Community Care (OCC) and Office of Connected Care to institute portfolio product line management. 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's best practices. In 2020, the Community Care Program reorganized into a Product Line Management Model to better align with VHA OCC delivery teams, streamline delivery and increase transparency and collaboration across product teams. The sub-Product Lines withing Community Care are Clinical Integration, Delivery Operations, Medical Care Collection Funds Electronic Data Interchange (MCCF EDI), Payer Electronic Data Interchange and Revenue Operations.

- During 2020, the Integrated Billing and Accounts Receivable (IB/AR) product released multiple VistA patches supporting the VA COVID-19 response that improve veteran ability to manage debt with account level repayment plan and supported the ability to capture data and not charge for cancellations related to COVID-19.

- The Revenue Operations Workflow tool (ROWT) project implemented Robotic Process Automation to automatically validate when veteran has no third-party insurance to save insurance verification clerk’s time. ROWT also added Urgent Care, Inpatient and Outpatient data from community providers into the workflow tool; this enables VA to bill insurance companies for urgent care, inpatient care and outpatient care in the community.

Information Technology Outcome (IT-3)

Outcome Lead: Tim Masias, Director, Community Care Integration

Outcome Executive: Helga Rippen, MD, PhD, Chief Interoperability and Veteran Access Officer

▲ **Root Cause**: Limited DoD/VA agreement on approach, common IT infrastructure or data standards required to improve joint interoperability.

○ **IT-3 Outcome Statement**: VA clinicians and other authorized users are able to access patient clinical data from DoD systems (AHLTA/Cerner) through their EHR (VistA/Cerner).

○ **IT-3.1 Goal**: Develop & implement the DoD/VA common approach towards improving clinical interoperability.

○ **IT-3.1.1 Objective**: Develop joint interoperability DoD /VA senior leadership forum to improve clinical interagency interoperability.

IT-3.1.1a Metric: In Planning

○ **IT-3.1.2 Objective**: Develop a joint interoperability strategy.

IT-3.1.2a Metric: In Planning

IT-3.1 Actions Table to be inserted following the identification and development of planned actions

○ **IT-3.2 Goal**: Develop & implement DoD/VA agreed-upon joint clinical interoperability systems and standards approach.

○ **IT-3.2.1 Objective:** Development and implementation of Joint Legacy Viewer (JLV) to support access to clinical data across multiple joint systems.

IT-3.2.1a Metric*:* In Planning

○ **IT-3.2.2 Objective:** Develop and implement a joint HIE strategy to accelerate clinical data exchanged with community healthcare providers and made available to DoD/VA clinicians.

IT-3.2.2a Metric: In Planning

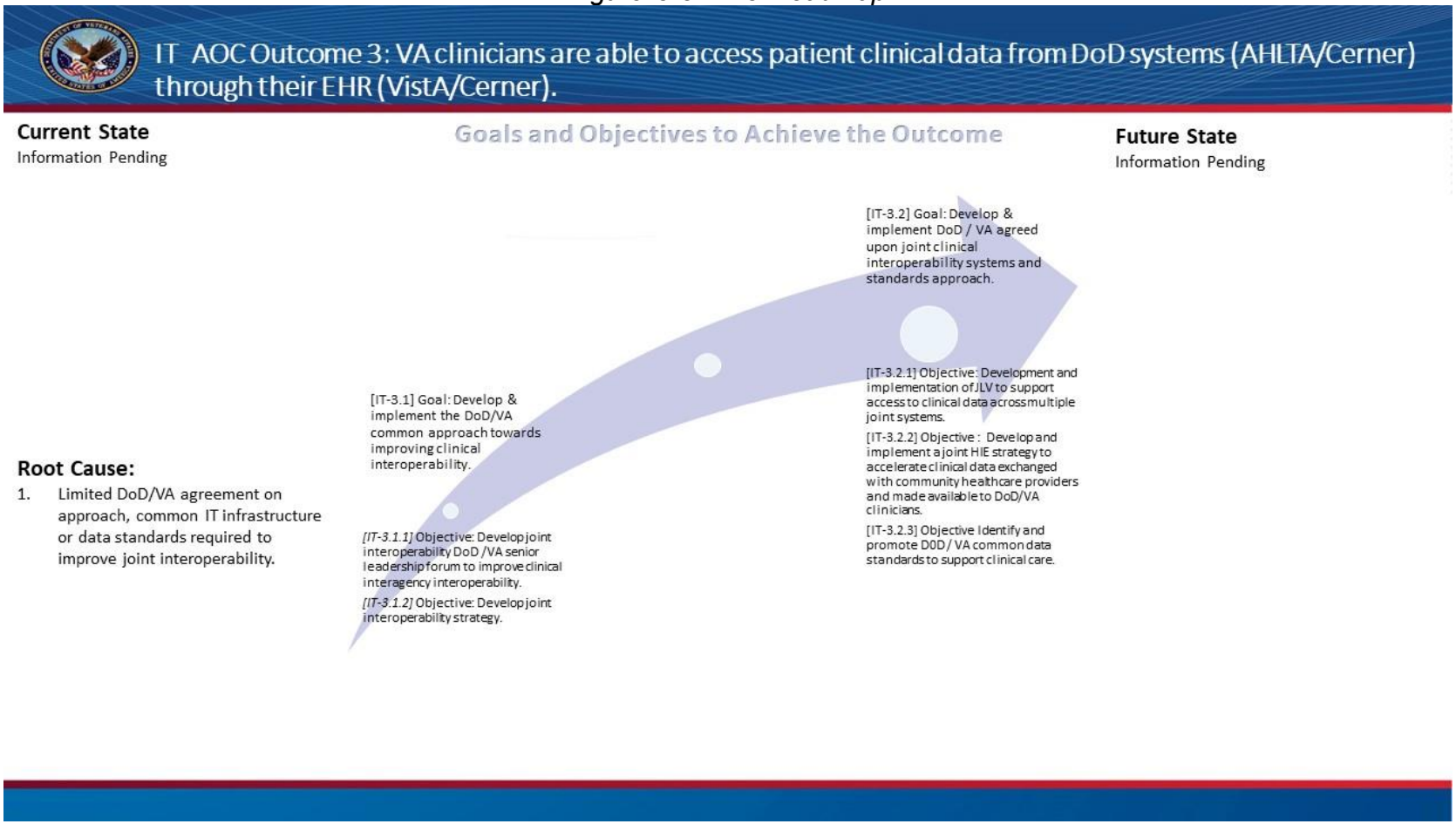
○ **IT-3.2.3 Objective:** Identify and promote DOD/VA common data standards to support clinical care.

IT-3.2.3a Metric*:* In Planning

IT-3.2 Actions Table to be inserted following the identification and development of planned actions

Figure 3-5, below, will be updated when information is available to reflect the identified current state of this outcome, the desired future state of this outcome and the goals and supporting objectives that align and will contribute to the achievement of that future state.

Figure 3-5. IT-3 Roadmap



IT-3 Description of Actions Toward Removal Criteria

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

- Removing interoperability as a barrier between DoD and VA EHRs and community partners.
- The Secretary of VA authorized the EHR contract award in May 2018, seeking to modernize VA's EHR system with a commercial solution to improve the delivery of quality health care to Veterans, enhance the provider experience and promote interoperability with the DoD, the U.S. Coast Guard and community care providers.
- Electronic Health Record Modernization Reorganization - December 2021
- OIT is currently finalizing the system interface plan for EHRM, which will give VA clinicians and physicians comprehensive access to patient's 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 effort led by the FEHRM Office in support of VHA. The modernization effort is adopting the same commercial EHR as DOD, which will improve interoperability, Veteran access to care, standardize provider workflows, promote infrastructure readiness and increase 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 patient's 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. This strategy also allows VA to share lessons learned with DoD and leverage DOD's data hosting environment while adopting enhanced cybersecurity protocols to facilitate interoperability. Additionally, the FEHRM Office works to align DOD and VA activities relating to the EHRM activities.

4. Inadequate Training for VA Staff

Executive Sponsor: Jessica L. Salyers, PhD, VHA Acting Chief Learning Officer (ACLO)

Executive Summary

The Training AOC has achieved an increased rating in leadership and capacity. The Training AOC recognizes the GAO feedback concerning the significant improvements in the training action plan and GAO's recommendations for managing risks and improving health care for our veterans.

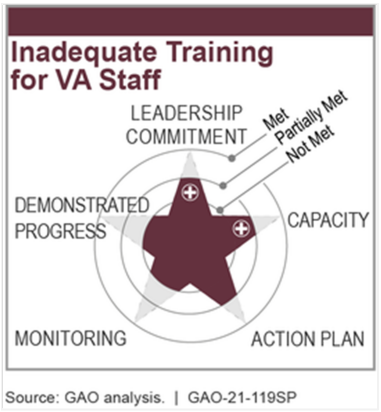


Figure 4-1. Training 2021 Rating Goal

The input provided plus lessons learned during the implementation of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act) and the COVID-19 management including the COVID-19 Vaccination and detailed analysis of the Electronic Health Record Modernization (EHRM) issues identified by both GAO and OIG, has allowed the Training AOC to significantly update the Training Action Plan. This Action Plan aims to comprehensively address GAO concerns and move VHA to a sustainable, effective, and efficient training system.

The Training AOC's overall goal is to establish and implement nationwide training standards across VHA, which will include policy and oversight of newly established/or implemented standardized training processes through compliance, auditing, and reporting.

In mid-FY 2021 Training Work Group (TWG), the Training AOC action arm, changed its operational name to VHA Training Modernization to better reflect the overall enterprise objectives.

1. VHA Training Modernization developed a more comprehensive plan that shows the need for extensive collaboration with subject matter experts (SMEs) and a broader range of stakeholders in the field, a quality management and continuous process improvement plan, auditing and compliance reporting, along with change and communications management for each Training Outcome through fiscal year (FY) 2025/2026.

2. To implement this Training Action Plan over the next four years, VHA Training Modernization is:

- Collaborating with VHA field and program offices to ensure the training processes and policies are co-developed and co-owned for application to field and program office training needs.

- Establishing a formal VHA Training Governance structure to guide the development, implementation, and sustainment of training standards, processes, and systems.

- Establishing a VHA Training Steering Committee to guide the implementation, sustainment, quality and continuous improvement of training standards, processes, and systems.

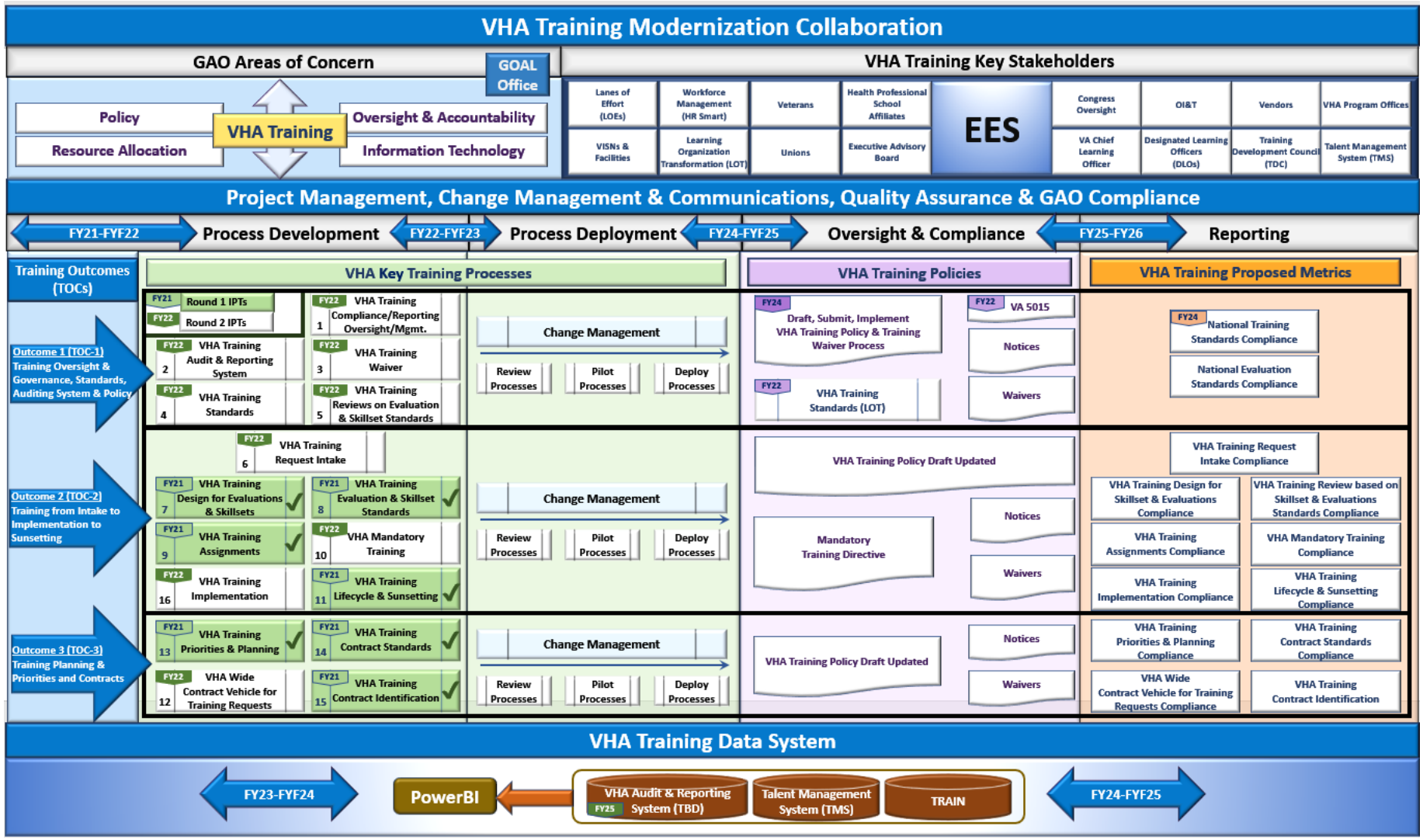
- Collaborating with the VA Chief Learning Officer (CLO) to develop an integrated approach to VA and VHA training directive development, to leverage VHA training standards and improve consistency in training guidance throughout VA and VHA.

3. VHA implemented several draft policies and procedures from the GAO Action Plan during the COVID-19 Pandemic. As a result, VHA rapidly prepared and executed urgently needed training targeted to specific staff, through a centralized process that ensured standardized application across the enterprise. Accurate and timely updates were provided based on constant changes directed by the Center for Disease Control and Prevention (CDC) and other governing bodies.

VHA Training Modernization undertook actions to achieve meaningful progress toward targeted outcomes:

- In FY 2020, while preparing to develop a comprehensive training policy and planning process to address this AOC, VHA Training Modernization attempted to use existing metric data available in VHA Employee Education Services (EES). The data was neither consistent nor reliable and, in many instances, could not be validated nor replicated. Based on this analysis, VHA Training Modernization developed a more comprehensive plan, which is represented in graphical form in Figure 4-2 below. This plan shows the need for extensive collaboration, process improvement, oversight and compliance, and reporting, along with project management, change management, communications and quality assurance required to fully issue a comprehensive and sustainable VHA Training Policy and Planning Process for each Training Outcome through FY 2024.

Figure 4-2. Training AOC Action Plan Overview



To implement the VHA Training Action Plan represented in Figure 4-2 above over the next four years, VHA Training Modernization:

- Established a VHA Training Steering Committee to guide the development and implementation of training standards, processes, and systems.

- Identified, defined, and chartered several Integrated Project Teams (IPTs) to develop and ensure the implementation of standard processes, clear training standards, and meaningful outcome metrics are consistently used across the VHA enterprise. All identified stakeholders in the Training AOC Action Plan Overview (Figure 4-2 above) will be represented in the IPTs, as well as the VHA Training Steering Committee. To measure progress while outcome metrics are being developed, VHA Training Modernization will provide routine status updates to the Executive Sponsor on the numerous processes under development by the IPTs. Once a process has been standardized, piloted, and released with an associated Training Outcome Metric across VHA, that metric will be reported instead of the status of the process development metric.

- Is developing, in conjunction with the GOAL Office and the Office of Change Management (OCM), a comprehensive change management and communication plan to implement the findings of the IPTs, collaborate with key stakeholders (facilities, VISNs and program offices) and implement the training standards, processes, and policies to the VHA Enterprise using a series of "Notices, pending the release of the final comprehensive VHA Training Policy.

- Is collaborating monthly with the VA Chief Learning Officer (CLO) and Training Development Council (TDC) to ensure that the VHA Training Policy that will be developed in FY 2024 is aligned with the VA 5015 Directive and VA 5015 Handbook that is awaiting publication.

- Used Job Roles to assign Mandatory Training in place of Job Codes for:

    - The Caregiver Support Program Core Elements Training. This process identified 77,367 staff that required the training and attained 94.3% completion with 72,935 completions in 2020.

    - COVID-19 Training for VHA Staff and Clinicians in Response to the Pandemic. Five courses were developed using a Subject Matter Expert (SME) from the Office of Emergency Medicine. The courses were assigned at the local facility level using Job Roles - rather than Job Codes - to reduce burdensome training across the VHA enterprise.

    - During the COVID-19 pandemic, VHA rapidly adapted training processes, focusing on the cited GAO concerns, to deliver centrally vetted training to

a specific training audience, based on specific COVID-19 related or impacted duties.

Employee Education Services (EES) undertook actions to achieve meaningful progress toward targeted outcomes in FY 2021, including:

- Contracted with Franklin Covey to provide an All-Access Pass to their training across the entire VHA enterprise, which will result in significant overall cost savings to VHA. In the past, facilities would contract individually for Franklin Covey training for their locations.

- Supporting the Regional Consortiums along with Academies (AO, Service Chief). (ongoing)

- Support to BPA and IDIQs (School at Work, Performax, Med Trainer, Medcom) to deliver training solutions. (ongoing)

The section below provides examples of how the Training area of concern effort aligns with actions being undertaken to address the other areas of concern.

Training Alignment with Other Areas of Concern

- **Training Alignment with Policies and Processes:**
  - VHA Training Modernization collaborates with Policy AOC to:
    - Solicit information regarding an automation system of record recently established by the Policy AOC. AOCs agree there is a need for integrated systems that includes necessary data points and alerts oriented to other AOCs.
    - Conduct deliberate review of recently published processes, tools, SharePoint location for the purpose of future implementation. Training AOC has initiated a policy review process with the Policy AOC to ascertain directed training requirements.
- **Training Alignment with Oversight and Accountability:**
  - VHA Training Modernization collaborated with Oversight and Accountability AOC to:
    - Enable Outcome leads to work collaboratively on a regular basis to develop an integrated approach towards future cross-over actions applicable to all AOCs.
    - Solicit information regarding the automation system of record recently established by the Compliance and Integrity element of the AOC. AOCs agree there is a need for integrated systems which will include necessary data points and alerts oriented to other AOCs.

- **Training Alignment with IT:**
  - VHA Training Modernization collaborated with Information Technology AOC which:
    - Provided guidance and established meetings with key points of contact and subject matter experts in support of the procurement of a future training automation system. This collaboration resulted in:
      - Receipt of funding for the active discovery and development of business requirements.
      - Approval for partial funding necessary for system development over the next five-year period.

- **Training Alignment with Resource Allocation:**
  - Nothing to report

Inadequate Training for VA Staff Area of Concern – Progress

- Met all projected FY 2021 milestones and on track to meet the additional FY 2022 requirements.
  - **Q2 FY 2021**: Recruitment and onboarding/orientation of 110 VHA personnel to support the implementation of seven Integrated Project Teams (IPTs). Of the 110 VHA personnel recruited and onboarded:
    - 50.5% to Facility Field Level
    - 45% to Employee Education System (EES)
    - 4.5% to Program Offices
  - **Q2 FY 2022**: Seven (Round 1) IPTs completed all tasks resulting in:
    - Identification of 34 “future state” key training processes
    - Process maps
    - Identification of key stakeholders
    - Organizational change management assessments
    - Process validation
    - Pilot recommendations

    - Standards, metrics, and potential scenarios for waivers

  - **Q2 FY 2022: Eight** IPTs (Round 2) began Phase 1, Kickoff.

  - **Q4 FY 2021:** (Ongoing) Conducting monthly collaborative lessons learned discussions with VA Chief Learning Officer to ensure future alignment with VA Directive 5015 and VA Handbook 5015.

  - **Q4 FY 2021:** (Ongoing) Training AOC Outcome Leads provided direct support to EES executive leadership during initial planning of EES Transformation

  - **Q2 FY 2022:** (Ongoing) VHA Training Modernization provided five consultants to EES working groups to share recent findings, artifacts, and information discovered throughout Round 1 IPTs which resulted in draft Functional Statements for the areas of: Governance and Oversight and Client Experience.

- Training AOC conducted deliberate engagements with VHA leaders to gather essential information oriented towards future planning and communications within the administration. Program offices included:

  - VHA Assistant Under Secretary for Health Operations (AUSH-O) – Discussed processes and procedures for communicating with and tasking the 18 VISNs

  - VHA Office of Healthcare Transformation (OHT) – Discussed methods of program management, operations, and planning communication

  - VHA Office of Chief Strategy Office (OSCO) – Discussed processes and procedures for proposal of new/additional requirements of VHA priority "Create a Learning Organization" and VHA Long Range Goals 3 & 4

- Training AOC conducted deliberate engagements with VHA learning leaders with the purpose of providing an overview of VHA Training Modernization and to solicit information regarding opportunities for improvement in VHA Training. These small groups included:

  - VHA Office of Mental Health and Suicide Prevention
  - VHA Mental Illness Research Education and Clinical Centers (MIRECCs) from VISN 22 and VISN 20

  - VHA War Related Illness and Injury Study Center

  - VHA Center of Excellence in Substance Addiction Treatment and Education

  - VA Center of Excellence for Suicide Prevention (VISN 2)
  - EES Learning Consultants, Program Managers
  - VHA Designated Learning Officers
  - Advisory Board for Learning and Education (ABLE)

- Conducting quarterly collaborative calls between VHA, NCA, and VBA Training Leaders for the purpose of sharing best practices and lessons learned

- Collaborated with VHA education leaders to gather best practices and lessons-learned information from the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (Veteran's MEGABUS Bill) and Electronic Health Records Modernization (EHRM) working groups

- Integrated Training AOC requirement of National Training Standards with the Learning Organization Transformation (LOT) subcommittee and the establishment of Training Standards subcommittee

- Compelled Workforce Committee to implement key goals and objectives from LOT Action Plan as FY 2022 focused effort

- Liaised with Office of Oversight and Accountability (O&A) and Office of Information Technology (OIT) regarding business requirements gathering for a future training governance, compliance, auditing, and reporting platform

- Integrated National Coordinator for Education Program Management, National Coordinator for Designated Learning Officers, Mandatory Training, Inter-Agency Shared Training, and the Learning Organization Transformation into VHA Training Modernization enterprise effort.

- Identified available enterprise-wide contract vehicles in the form of VHA's Integrated Healthcare Transformation (IHT) Indefinite Delivery Indefinite Quantity (IDIQ); VA's Veteran Enterprise Contracting for Transformation and Operational Readiness (VECTOR) contract; and OPM's Human Capital and Training Solutions (HCaTS) IDIQ and USALearning Education, Training Products, and Services (USAL) contract in support of Round 2: IPT 12, VHA Wide Contract Vehicle for Training Requests.

- Initiated discussions with VBA and NCA for the potential leveraging of their existing training solution contracts.

- During recent COVID-19 Delta variant surge, VHA Mandatory Training supported a 120-day Moratorium which allowed clinicians to focus on patient care which will be renewed as needed.

Inadequate Training for VA Staff Area of Concern – Highlights

a. Key Actions Completed from March 2021 through March 2022; all initiatives are ongoing

- Seven Round 1 IPTs initiated and completed the tasks defined in the 5-phase execution plan resulting in the identification of 34 key training processes and associated artifacts needed for future piloting and implementation.
    - Round 1 IPTs key training processes oriented towards:
        - **IPT 07**: VHA Training Design for Evaluations and Skillsets
        - **IPT 08**: VHA Training Evaluation and Skillset Standards
        - **IPT 09**: VHA Training Assignment
        - **IPT 11**: VHA Training Lifecycle Maintenance and Sunsetting
        - **IPT 13**: VHA Training Priorities and Planning
        - **IPT 14**: VHA Contracts Standardization
        - **IPT 15**: VHA Training Contract Identification
- Initiated Phase 1 (Kickoff) actions for 8 Round 2 IPTs.
    - Four IPTs in support of Training Oversight and Standards (TOC-1)
        - **IPT 01**: VHA Training Compliance, Reporting & Oversight Management
        - **IPT 03**: VHA Training Waiver Process
        - **IPT 04**: VHA Training Standards
        - **IPT 05**: VHA Training Evaluation and Skillset standards for review and design
    - Three IPTs in support of Training Assignments and Evaluation (TOC-2)

        - **IPT 06**: VHA Training Request Intake Process
        - **IPT 10**: VHA Mandatory Training
        - **IPT 16**: VHA Training Implementation
    - One IPT in support of Training Planning and Contracts (TOC-3)
        - **IPT 12:** VHA Wide Contract Vehicle for Training Request

- Essential Round 1 IPTs information/findings:
    - **IPT 07**: VHA Training Design for Evaluation and Skillsets, drafted an overarching process to support standardized design of training solutions and associated skillsets. This included design framework for clinical nursing practice and the design of simulation-based training.
    - **IPT 08:** VHA Training Evaluation and Skillset Standards, drafted a VHA standard process for evaluating and measuring training solutions based upon the New World Kirkpatrick Model to ensure the collection of credible evidence that establishes a "chain of impact" in the areas of measurable learner/organizational outcomes, transfers of skill, and return on expectations resulting in reduced burdensome training and improved Veteran care.
    - **IPT 09:** VHA Training Assignments, identified inconsistent data field integration between the Talent Management System (TMS) and HR Smart when attempting to properly assign training to different disciplines and/or different employee groups throughout VHA.
    - **IPT 11**, VHA Training Lifecycle and Sunsetting, identified a clear lack of standards, criteria, and timelines related to the hosting, sustainment, and archiving of training items.
    - **IPT 13**, VHA Training Planning and Prioritization found significant gaps shared prior to communication of organizational needs and potential for enterprise-wide leveraging resulting in substantial duplication of effort and expenditure of funds.
    - **IPT 14**, VHA Training Contract Standards found a lack of distributed standards for training product solicitation that would ensure compliance and operability.

- **IPT 15**, VHA Training Contract Identification, found essential differences in the requirements, templates, and tools in use by VA/VHA contract centers. Additionally, research recognized limited to nonexistent methodologies (e.g., budget object codes, contract line-item number, etc.) oriented towards the earmarking of funds utilized in the procurement of training.

- Training AOC identified a gap in the overarching action plan and created an additional IPT for Training Implementation (IPT16).

- Training AOC moved IPT 06, VHA Training Request Intakes from TOC-1 to TOC-2 to consolidate training infrastructure for future piloting efforts.

- Chartered authorities for the Mandatory Training Subcommittee are actively pursuing the mitigation and elimination of mandatory training burdens through collaborative work with Field and Program Offices. As of Feb 3rd, 2022, these efforts have resulted in a cost savings of $7,655,376 and a productivity saving of 12,156 hours.

- In support of IPT 02, VHA Training Audit & Reporting System, organizational funds in the amount of $548,866 have been approved for business requirements gathering, use case, and planned scope for the future Training Governance, Oversight, Compliance/Auditing, and Reporting system.

- Partial funding ($1M per year for 5 years starting in FY24) of the multi-year funding process for the future Training Governance, Oversight, Compliance/Auditing, and Reporting system (IPT 02) has been approved by the VHA Information Technology Committee to move forward toward further endorsement and action.

- Reviewed VA 5015 Directive and VA 5015 Handbook for alignment of identified key training processes for future implementation.

- Initiated discussions with VA Chief Learning Officer's (CLOs) office regarding the submission of potential department-wide recommendations through the VA Training Development Council (TDC) resulting in publication as a separate annex and further implementation into the VA 5015 Directive and VA 5015 Handbook.

- Established, implemented, and continuously revised a comprehensive Change Management Plan that regularly communicates newly identified VHA training process findings across the enterprise.

- Drafted extensive communications plan in conjunction with EES Transformation to ensure clear and concise messaging oriented towards VHA Training Modernization, the Training AOC, and the foundational framework for EES Transformation.

- Met with the EES Executive Board, LOT subcommittee, VHA Workforce Committee and the VHA Chief of Human Capital Management to gain full support and engagement for implementation of the FY 2021 Training AOC Action Plan. Provided regular and recurring updates.

- Continually engaged with GOAL Advisor/Project Managers to identify opportunities for collaboration across other areas of concern (AOCs) and identified stakeholders to help VHA Training Modernization with piloting VHA training standards and processes.

- Mandatory Training created an Interim Training Waiver Approval Process in FY21 to provide flexible and agile responses to the COVID-19 mission increase. VHA Training Modernization IPT 03, VHA Training Waivers, will incorporate the processes, standards, metrics, and lessons learned as essential artifacts for further key training process development.

- VHA National Designated Learning Officer (DLO) Coordinator in collaboration with VHA DLOs, addressed leadership and development (LEAD) training gap by partnering with the Franklin Covey and Vital Smarts Crucial Conversations vendors to develop comprehensive products in support of VHA Strategic Goals: Covey Leadership Development Framework (LDF) Guides, Covey HRO Playbook, Covey AES Dashboard Training Alignment.

b. Key Actions underway or planned through March 2023

- Formalization and distribution of Round 1 IPT key training processes, standards, and associated metrics.

- Drafting and publication of policies associated with the implementation of a limited number of Round 1 IPT findings.

- Implementation of a designated number of Round 1 IPT findings.

- In conjunction with VHA GAO OIG Accountability Liaison (GOAL) office, conduct active communications and engagement with VHA Governance Board and Councils for the incorporation of Training AOC identified priorities and goals.

- Initiation of communications with key department-level leaders in the functional areas of Fiscal and Acquisition to gain support for potential VA-level changes identified through the work of IPT 15 and others.

- Incorporation of newly developed VHA training governance function within the VHA Employee Education System (EES) transformation effort.

- Development of an integrated VHA Training/Funding/Planning cycle using the VHA Office of Chief Strategy Officer's planning framework, VA/VHA goals and priorities, and Training AOC future training processes developed in IPT 06, IPT13, and IPT 16.

- Execution and conclusion of eight Round 2 IPTs tasks and key training processes, process maps, identification of key stakeholders, organizational change management assessments, process validation, pilot recommendations, standards, metrics, and potential scenarios for waivers.

- Conduct deliberate communication and engagement plans with VHA leaders and Learning Leaders using targeted email distribution, presentations through large Communities of Practice (CoPs), and strategic and frequent planned messaging through the weekly leadership "hotline call" and bi-weekly Veterans Integrated Services Network (VISN) director's meetings.

- Planning and initiation of enterprise-wide pilots for three training outcomes (TOCs) to validate, update, and solicit adoption of key training processes and pending policy.

- Implementation and sustainment of an aggressive Change Management Plan to assist in gathering participation in the piloting of three TOC areas.

- Coordination with VA CLO and the VA Training Development Council (TDC) for potential inclusion/publication of key training process discoveries into VA 5015 Directive and VA 5015 Handbook.

- Developing a new and revised Mandatory/Required Training Function with the VHA National Coordinator for Mandatory Training (MT) leading a 10 member, VHA Mandatory Training IPT (IPT 10).

- Spearhead Healthcare Operations Council (HOC) reboot requirement to reduce VHA Employee Burnout through extensive mandatory training mitigation efforts and course re-design initiatives. Recommendations could become the standard for VA-level mandatory training approval and development.

- Develop and further refine the Mandatory Training Waiver process allowing for seamless execution of training priorities across VHA. The new process will result in an integrated solution that combines Learning Solutions Training Team (LST2) assignment and Mandatory Training Sub-Committee (MTSC) approval and coordination.

- Design a new National-Local MT vetting process to include new VHA infrastructure and processes to prioritize, approve, assign, and report on all local and nationally assigned mandatory and required training.

Inadequate Training for VA Staff – Actions Taken to Address GAO's "Not Met" Removal Criteria 2021 Rating

Inadequate Training for VA Staff received a "not met" rating from GAO for the following removal criteria: Demonstrated Progress; Monitoring. The below list provides details on actions taken by the AOC workgroup since the GAO-21-119SP High Risk Series was published in response to these "not met" ratings:

a. Actions Taken to Address Demonstrated Progress "Not Met" Rating

- VHA has been continuously monitoring its activities associated with all the "in progress" action items since March 2021. As part of the new Action Plan format, the Training AOC workgroup has created a new numbering sequence which provides linkages between action items and performance measures.

- Additionally, the Training AOC workgroup meets on a weekly basis to monitor the status of its IPTs and the progress metrics and also presents the progress made by the IPTs and the VHA Training Modernization effort to its leadership on a bi-weekly basis and monthly basis respectively. The Training AOC workgroup is continuously monitoring progress towards meeting the intended outcomes of the Training Action Plan.

b. Actions Taken to Address Monitoring "Not Met" Rating

- The Training AOC workgroup reviewed GAO's feedback to VHA's May 2021 Training Action Plan provided in GAO-21-119SP High Risk Series. As a result, VHA has updated the format of the Action Plan to include interim milestones (progress, process and performance/outcome metrics) that support the actions and provide transparency around status, timelines, resources, risks, and so forth).

- Please reference the above highlights section, the action items tables and the roadmaps which provide further details that support all of these efforts.

Status Key

This Action Plan submission denotes the status of implementation for each metric, outcome, and action graphically. The following Key can be used to understand the status graphics:

○ – "Not Met." Few, if any, actions toward meeting GAO's criterion for removal have been taken.

◐ - "Partially Met." Some, but not all, actions necessary to meet GAO's criterion have been taken.

● – "Met." Actions have been taken that meet GAO's criterion for removal. There are no significant actions that need to be taken to further address the criterion.

▲ - New or revised Root Cause.

Training Outcome (TOC-1)

Outcome Leads:

- **Rebecca Goodson,** Associate Director, Enterprise Project Management Office (EPMO), Employee Education System (EES)
- **David Lusk, PhD,** Deputy Director, Client Services, Employee Education System (EES)

▲**Root Cause**: VA lacks a comprehensive, enterprise-wide training policy and oversight process.

◐ **TOC-1 Outcome Statement**: Training is:

- Developed in response to priorities identified that align with VHA mission and goals.
- Delivered to nationally specified standards.
- Evaluated based on performance measurements and results that align with VHA mission and goals.

TOC Outcome Metrics: Defined by: Q3 FY 2024; Reported by: Q4 FY 2025

◐ **TOC-1.1 Goal:** Implement a VHA comprehensive, enterprise-wide training policy and planning process where training is developed in response to priorities identified by senior VHA leadership and in alignment with VHA mission and goals; delivered to nationally specified standards; and evaluated based on performance measurements and results that align with VHA mission and goals. (*Q2 FY 2023*).

TOC- 1.1a Metric: Defined by: Q3 FY 2024; Reported by: Q4 FY 2025

◐ **TOC-1.1.1 Objective:** Identify, design, develop, validate, and document Key Training Processes for VHA Training Policy and Training Reviews based on Training Evaluation/Skillset Standards, VHA Training Modernization has formed the following IPTs: (*Q2 FY 2023*)
IPT 05: VHA Training Reviews based on Training Evaluation/Skillset Standards Processes (*Q2 FY 2023*)
IPT 04: VHA Training Standards (*Q2 FY 2023*)
IPT 03: VHA Training Policy and Waiver Processes (*Q2 FY 2023*)

Table 4-1. TOC-1.1.1 actions

Act #	Action Details	Projected Date	Actual Date
◐ 1.1.1.1	**IPT 05: VHA Training Reviews based on evaluation and skillset standards Processes**	**Q2 FY23**	**TBD**
●	**Phase 1**: Kick Off	Q3 FY22	Q3 FY22
◐	**Phase 2**: Design and Develop Key Training Processes	Q4 FY22	TBD
○	**Phase 3**: Document and Validate Key Training Processes	Q1 FY23	TBD
○	**Phase 4**: Develop Key Training Process Measures/Standards/ Waiver Requirement Scenarios	Q2 FY23	TBD
○	**Phase 5**: Key Training Processes Work Completed and Accepted by VHA TRN MOD	Q2 FY23	TBD
Progress Metrics	***In Progress*** Started: Q2 FY22 Milestone: 50% by Q4 FY22 Target: 100% by Q2 FY23		
Process Metric	Defined by: Q2 FY23 Manual Reporting: Q4 FY24		
Resources:	IPT members and artifacts from IPT 07: VHA Training Design of Evaluations and Skillsets and IPT 08: VHA Training Evaluation and Skillset Standards.		
Status:	In Progress (As of 03/07/2022)		
Comments:	IPT 05: VHA Training Reviews based on evaluation and skillset standards kicked off in March 2022 and will take the Key Training Processes finalized in Round 1's IPT 07: VHA Training Design of Evaluations and Skillsets and IPT 08: VHA Training Evaluation and Skillset Standards and begin to define what criteria will be utilized to ensure that training is effective and measurable. ***The projected date to complete this action has accelerated to Q2FY23 from the May 2021 version where it was projected for completion in Q4FY23.**		
Act #	**Action Details**	**Projected Date**	**Actual Date**
◐ 1.1.1.2	**IPT 04: VHA Training Standards**	**Q2 FY23**	**TBD**
●	**Phase 1**: Kick Off	Q3 FY22	Q3 FY22
◐	**Phase 2**: Design and Develop Key Training Standards	Q4 FY22	TBD

Act #	Action Details	Projected Date	Actual Date
○	**Phase 3**: Document and Validate Key Training Standards	Q1 FY23	TBD
○	**Phase 4**: Develop Key Training Measures/Waiver Requirement Scenarios	Q2 FY23	TBD
○	**Phase 5**: Key Training Standards Work Completed and Accepted by VHA TRN MOD	Q2 FY23	TBD
Progress Metrics	***In Progress*** Started: Q2 FY22 Milestone: 50% by Q4 FY22 Target: 100% by Q2 FY23		
Process Metrics	Defined by: Q2 FY23 Manual Reporting: Q4 FY24		
Resources:	IPT members, Industry Training Standards, Other agencies regulations, artifacts from other IPTs		
Risk:	Potential conflict between newly developed VHA Training Standards and future publication of VA 5015 Directive and VA 5015 Handbook		
Status:	In Progress (As of 03/07/2022)		
Comments:	IPT 04: VHA Training Standards has begun to gather and quantify the standards gathered by Round 1 IPTs and work with Round 2 IPTs to pull in additional, required Training standards required. ***The projected date to complete this action has accelerated to Q2FY23 from the May 2021 version where it was projected for completion in Q4FY23.**		

Act #	Action Details	Projected Date	Actual Date
◐ 1.1.1.3	**IPT 03: VHA Training Policy and Waiver Processes**	**Q2 FY23**	**TBD**
●	**Phase 1**: Kick Off	Q3 FY22	Q3 FY22
◐	**Phase 2**: Design and Develop Key Training Processes	Q4 FY22	TBD
○	**Phase 3**: Document and Validate Key Training Processes	Q1 FY23	TBD
○	**Phase 4**: Develop Key Training Process Measures/Standards/ Waiver Requirement Scenarios	Q2 FY23	TBD
○	**Phase 5**: Key Training Processes Work Completed and Accepted by VHA TRN MOD	Q2 FY23	TBD

Act #	Action Details	Projected Date	Actual Date
Progress Metrics	***In Progress*** Started: Q2 FY22 Milestone: 50% by Q4 FY22 Target: 100% by Q2 FY23		
Process Metrics	Defined by: Q2 FY23 Manual Reporting: Q4 FY24		
Resources:	IPT Members, usable IPT artifacts, current policies and standards, VA 5015 Directive and VA 5015 Handbook		
Risk:	Potential conflict between newly developed VHA Training Standards and future publication of VA 5015 Directive and VA 5015 Handbook		
Status:	In Progress (As of 03/07/2022)		
Comments:	IPT 03: VHA Training Policy and Training Waiver Process has begun to gather scenarios from Round 1 IPTs to determine when Training Waivers are required. In addition, the VHA Training Policy and Training Waiver Processes need to align with the VA 5015 Directive and VA 5015 Handbook that is currently in review and set to be released in Q4 FY 2022. VHA Training Modernization's goal is to build the infrastructure with processes, standards, and systems oversight over the next three years to fully and adequately standardize VHA Training. ***The projected date to complete this action has accelerated to Q2FY23 from the May 2021 version where it was projected for completion in Q4FY23.**		

Act #	Action Details	Projected Date	Actual Date
○ **1.1.1.4**	**Draft and Implement VHA Training Policy**	**Q2 FY25**	**TBD**
○	**Phase 1**: Draft Policy	Q2 FY24	TBD
○	**Phase 2**: Submit Policy for Concurrence	Q1 FY25	TBD
○	**Phase 3**: Draft Communications/Release Policy	Q2 FY25	TBD
Progress Metrics	***In Progress*** Started: Q2 FY23 Milestone: 50% by Q1 FY24 Target: 100% by Q3 FY25		
Process Metrics	None		

Act #	Action Details	Projected Date	Actual Date
Resources:	Usable IPT artifacts, VA 5015 Directive and VA 5015 Handbook, current policies and standards		
Risk:	Lengthy process to get policy approved. Requires 100% Concurrence.		
Status:	In Planning		
Comments:	VHA Training Policy and Training Waiver Process has begun to gather scenarios from Round 1 IPTs to determine when Training Waivers are required. In addition, the VHA Training Policy and Training Waiver Processes need to align with the VA 5015 Directive and VA 5015 Handbook that is currently in review and set to be released in Q4 FY22. VHA Training Modernization's goal is to build the infrastructure with processes, standards, and systems oversight over the next three years to fully and adequately standardize VHA Training.		

The below graphics reflect the action-level metric data represented in the above table:

Graphic

1.1.1.1 Progress Metric for IPT 05: VHA Training Reviews based on Evaluation and Skillset Standards Processes

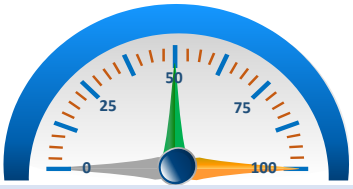
Current: Start Q2 FY22
Milestone: 50% by Q4 FY22
Target: 100% by Q2 FY23

1.1.1.2 Progress Metric for IPT 04: VHA Training Standards

Current: Start Q2 FY22
Milestone: 50% by Q4 FY22
Target: 100% by Q2 FY23

1.1.1.3 Progress Metric for IPT 03: VHA Training Policy and Waiver Processes

Current: Start Q2 FY22
Milestone: 50% by Q4 FY22
Target: 100% by Q2 FY23



1.1.1.4 Progress Metric for: Draft and Implement VHA Training Policy

Current: Start Q2 FY23
Milestone: 50% by Q1 FY24
Target: 100% by Q3 FY25

◐ **TOC-1.1.2 Objective:** Coordinate with VA CLO on the VA 5015 Training Directive and VA 5015 Handbook to ensure VHA compliance with VA Training standards. (*Q4 FY23*)

Table 4-2. TOC-1.1.2 actions

Act #	Action Details	Projected Date	Actual Date
◐ 1.1.2.1	**Establish National Training Standards within the VA 5015 Directive and VHA Training Standards Steering Committee**	**Q4 FY23**	**TBD**
◐1.1.2.1a	Work with VA CLO on the VA 5015 Directive and VA 5015 Handbook updates to incorporate National Training Standards	Q4 FY23	TBD
●1.1.2.1b	Work with VHA VA CLO to create a VHA Training Standards Steering Committee for Oversight and Governance	Q1 FY22	Q2FY22
Progress Metrics	None		
Process Metrics	None		
Resources:	Current "Draft" of new 5015 under review		
Risk:	Lack of authority to enforce new policies. Length of time to get new policies approved. Conflicts with VA 5015 Directive and VA 5015 Handbook.		
Status:	In Progress		
Comments:	Currently the VA 5015 Directive and VA 5015 Handbook is undergoing the VIEWS comment review/acceptance process and is being routed next to the Office of Enterprise Integration and the Office of General Counsel. VHA Training Modernization conducts a monthly meeting with the VA CLOs Office to discuss information and findings oriented towards additions or improvements of the VA 5015 Directive and VA 5015 Handbook. VHA Training will align with, follow, or augment the VA 5015 Directive VA 5015 Handbook. At this time, VHA Training Modernization is focused on ensuring newly recommended key training processes and associated standards are in alignment with training at the VA level. The VA 5015 Handbook and Directive is working towards publication by Q4 FY 2022. **1.1.2b** Completed the integration of a VHA training standards workgroup (to serve as the VHA Training Standards Oversight and Governance) within the VHA Learning Organization Transformation (LOT) subcommittee reporting to the VHA Workforce Management Committee which		

Act #	Action Details	Projected Date	Actual Date
	reports to the VHA Healthcare Operations Council (Governance).		

◐ **TOC-1.2 Goal:** Establish a comprehensive and effective VHA Training Oversight, Governance, & Compliance Structure that aligns with VHA Training Standards and Policy. (*Q3 FY 2025*)

TOC-1.2a Metrics: Defined by: Q3 FY24; Reported by: Q4 FY25

◐ **TOC-1.2.1 Objective**: to identify, design, develop, validate, and document Key Training Processes for VHA Training Oversight Structure, Training Standards, and Auditing/Reporting System, VHA Training Modernization has formed the following IPTs: (*Q3 FY25*)

- **IPT 01**: VHA Training Compliance, Reporting, & Oversight Processes (*Q2 FY23*)
- **IPT 02**: VHA Training Audit & Data Reporting System (*Q3 FY25*)

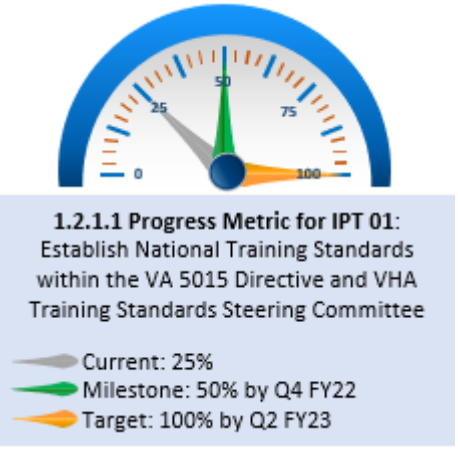
Table 4-3. TOC-1.2.1 actions

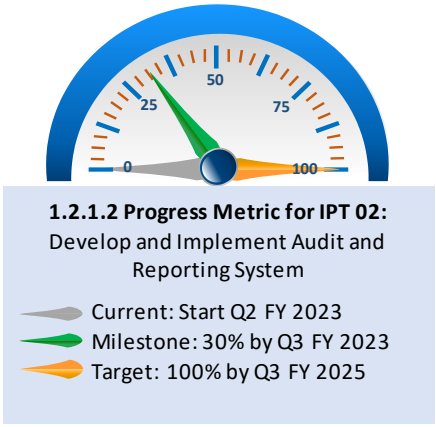
Act #	Action Details	Projected Date	Actual Date
◐ 1.2.1.1	**IPT 01: Design and Develop VHA Training Compliance, Reporting, & Oversight Management Processes**	**Q2 FY23**	**TBD**
●	**Phase 1**: Kick Off	Q3 FY22	Q3FY22
◐	**Phase 2**: Design and Develop Key Training Processes	Q4 FY22	TBD
○	**Phase 3**: Document and Validate Key Training Processes	Q1 FY23	TBD
○	**Phase 4**: Develop Key Training Process Measures/Standards/ Waiver Requirement Scenarios	Q2 FY23	TBD
○	**Phase 5**: Key Training Processes Work Completed and Accepted by VHA TRN MOD	Q2 FY23	TBD
Progress Metrics:	Restarting in Q2 FY22 Current Progress: 25% Milestone: 50% by Q4 FY 22 Target: 100% by Q2 FY23		
Process Metrics:	Defined by Q2 FY23 Manual Reporting Q4 FY24		
Resources:	IPT Team, Usable IPT artifacts, current policies and standards, EES Transformation		
Risk:	EES Transformation and Resistance to Change		
Status:	In Progress (As of 03/07/2022)		

Act #	Action Details	Projected Date	Actual Date
Comments:	Once the oversight and accountability governance structure has been defined and a VHA Training Standards Steering Committee is formed, a system will be developed to capture and report auditing data to produce the defined Training Outcome Metrics. An IPT has been formed to design and develop a process and then gather system, user, and reporting requirements for the existing data systems. ***The projected date to complete this action has accelerated to Q2FY23 from the May 2021 version where it was projected for completion in Q4FY23.**		
Act #	**Action Details**	**Projected Date**	**Actual Date**
○ **1.2.1.2**	**IPT 02: Develop and Implement Audit and Reporting System for Data**	**Q3 FY25**	**TBD**
○	**Phase 1:** Kick Off	Q2 FY23	TBD
○	**Phase 2:** Gather Requirements	Q3 FY23	TBD
○	**Phase 3:** Determine Solution	Q4 FY23	TBD
○	**Phase 4:** Configure System	Q3 FY24	TBD
○	**Phase 5:** Implement System	Q3 FY25	TBD
Progress Metrics	***In Planning*** Start: Q2 FY23 Milestone: 30% by Q4 FY23 Target: 100% by Q3 FY25		
Process Metrics:	Defined by: Q2 FY23 Manual Reporting: Q4 FY24		
Resources:	Organizational funds in the amount of $548,866 has been approved. Partial funding ($1M per year for 5 years starting in FY24) of the multi-year funding for the future Training Governance, Oversight, Compliance/Auditing, and Reporting system is in the approval process.		
Risk:	Length of time and cost to implement and sustain new software system		
Status:	In Planning		
Comments:	Once the oversight and accountability governance structure has been defined and a VHA Training Standards Steering Committee is formed, a system will be developed to capture and report auditing data to produce the defined Training Outcome Metrics. An IPT has been formed to design and develop a process and then gather system, user, and reporting requirements for the existing data systems.		

Act #	Action Details	Projected Date	Actual Date
	***Kick Off has been adjusted from Q2FY22 to Q2FY23 for the collection of business requirements, standards, and measures of Round 2 IPT work.**		

The below graphics reflect the action-level metric data represented in the above table:





◐**TOC-1.2.2 Objective:** Establish VHA Training Oversight and Governance function within Employee Educations System (EES) program office.
(*Q2 FY 2023*)

Table 4-4. TOC-1.2.2 actions

Act #	Action Details	Projected Date	Actual Date
◐ 1.2.2.1	**Designs and Deploy the VHA Training Governance Function**	**Q2 FY25**	**TBD**
◐	**Phase 1:** Defining and developing the key training processes for the VHA Training Governance Functions	Q2 FY23	TBD
○	**Phase 2:** Piloting key training processes for the VHA Training Governance Functions	Q1 FY24	TBD
○	**Phase 3:** Determine Resources to support VHA Training Governance Functions	Q3 FY24	TBD
○	**Phase 4:** Align staff to VHA Training Governance Functions	Q4 FY23	TBD
○	**Phase 5:** Deploy Key Training Processes for the VHA Training Governance Functions	Q2 FY25	TBD
Progress Metric:	EES Transformation: In Progress Current Progress: 10% Q2 FY22 Milestone: 45% Q1 FY23		

Act #	Action Details	Projected Date	Actual Date
	Target: 100% by Q2 FY25		
Process Metric:	None		
Resources:	IPT Team, Consultants, Artifacts, findings, and other information related to "Deep Dive" efforts		
Risk:	Lack of differentiation and resulting confusion between EES Transformation and VHA Training Modernization may impact future adoption and implementation of a greater VHA Training Strategy. Future involvement of key SMEs and Team members may be impacted.		
Status:	In Progress		
Comments:	Actively participating and supporting five EES Transformation "deep dive" working groups. VHA Training Modernization is providing 5 team members as Change Champions in support of EES Transformation. Working with EES Transformation in joint messaging and presentations in small group (CoP, partner/client) settings. Additionally, working an integrated Communications Plan that supports joint messaging.		

The below graphic reflects the action-level metric data represented in the above table:

◐ **TOC-1.3 Goal:** Ensure seamless deployment of TOC-1 developed processes. (*Q1 FY 2026*)

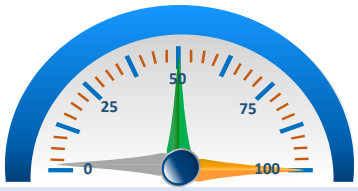
TOC-1.3a Metrics: Defined by: Q3 FY 2024; Reported by: Q4 FY 2025

◐**TOC-1.3.1 Objective:** To ensure the processes developed in TOC-1 are adopted and a comprehensive change management plan established. (*Q2 FY 2025 - Ongoing*)

Table 4-5. TOC-1.3.1 actions

Act #	Action Details	Projected Date	Actual Date
◐ 1.3.1.1	**Define and Implement Change Management Plan for TOC-1**	**Q2 FY25**	**TBD**
◐	**Phase 1:** Define Change Management	Q3 FY22	TBD
◐	**Phase 2:** Prepare for Change	Q2 FY23	TBD
○	**Phase 3:** Manage Change	Q2 FY25	TBD
○	**Phase 4:** Evaluate/Revise Change	Q2 FY25	TBD
○	**Phase 5:** Reinforce Change	Q2 FY25	TBD
Progress Metrics	Change Management: In Progress Current Progress: 5% Q3 FY22 Milestone: 50% by Q2 FY23 Target: 100% by Q4 FY25		
Process Metrics	None		
Resources:	VHA Change Management Practitioner (PROSCI) trained members, AMSG contractors, and available Change Management tools		
Risk:	Resistance to change, lack of change agents and/or change champions.		
Status:	In Progress		
Comments:	Training AOC assessed our change impacts, organizational attributes, and sponsor leadership and support, which were used to complete our change management assessment analysis. The Training Action Plan will require a significant amount of change management and socialization across VHA Program Offices, VISNs, and the field. This is a major, on-going effort that VHA Training Modernization is including in a comprehensive Change Management Plan, to include quality compliance and reporting guidelines incorporated into each of the processes as they are implemented.		

The below graphic reflects the action-level metric data represented in the above table:



1.3.1.1 Progress Metric for:
Define and Implement Change Management Plan for TOC-1

Current: 5% by Q3 FY 2022
Milestone: 50% by Q2 FY 2023
Target: 100% by Q4 FY 2025

○**TOC-1.3.2 Objective:** Review of TOC-1 Key Training Processes, Lessons Learned, After Action Reports, and Artifacts in preparation for Pilot. (*Q2 FY 2023*)

Table 4-6. TOC-1.3.2 actions

Act #	Action Details	Projected Date	Actual Date
○ 1.3.2.1	**Review of TOC-1 Round 2 Processes**	**Q2 FY23**	**TBD**
○	**Phase 1:** Review IPT Artifacts and Deliverables for completion and clarity using checklist and summarize overall state of Key Training Processes and requirements to finalize.	Q2 FY23	TBD
○	**Phase 2:** Work with IPT Leads to mitigate issues and requirements to finalize artifacts.	Q2 FY23	TBD
Progress Metrics	Review: Not Started Start: Q2 FY23 Milestone: 40% by Q2 FY23 Target: 100% by Q3 FY23		
Process Metrics:	None		
Resources:	Artifacts from Round 1 IPTs		
Risk:	Rework might be required before Pilot starts		
Status:	In Planning		
Comments:	Once the IPTs have completed the designing/developing/validation of the Key Training Processes, they are turned over the VHA Training Modernization Team to do a thorough review and analysis to for any gaps or modifications that needed to be made prior to piloting the Key Training Processes		

The below graphic reflects the action-level metric data represented in the above table:

1.3.2.1 Progress Metric for:
Review of TOC-1 Round 2 Processes

Current: Start by Q2 FY 2023
Milestone: 40% by Q2 FY 2023
Target: 100% by Q3 FY 2023

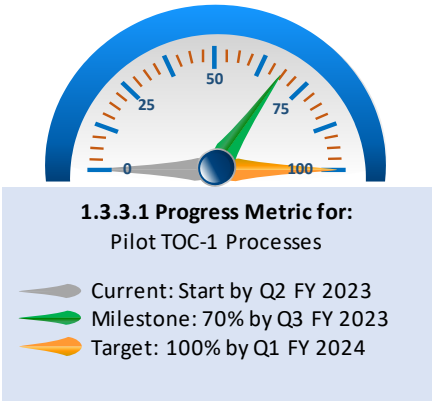
○ **TOC-1.3.3 Objective:** To ensure the processes developed functionally support VHA Training Oversight Structure, VHA Training Standards, and Audit/Reporting in TOC-1 by piloting processes developed by IPTs: IPT 01, IPT 03, IPT 04, IPT 05. (*Q1 FY 2024*)

Table 4-7. TOC-1.3.3 actions

Act #	Action Details	Projected Date	Actual Date
○ 1.3.3.1	**Pilot TOC-1 Processes**	**Q1 FY24**	**TBD**
○	**Phase 1:** Pilot Change Management/Comms Strategy	Q2 FY23	TBD
○	**Phase 2:** Create Test Plan for Processes to be piloted	Q3 FY23	TBD
○	**Phase 3:** Conduct Pilot of Processes using change management tactics	Q4 FY23	TBD
○	**Phase 4:** Assess Pilot Results	Q4 FY23	TBD
○	**Phase 5:** Document and Rework Processes and change management tactics	Q1 FY24	TBD
○	**Phase 6:** Processes Adopted and Integrated	Q1 FY24	TBD
Progress Metrics	Pilots: Not started Start: Q2 FY23 Milestone: 70% by Q4 FY23 Target: 100% by Q1 FY24		
Process Metrics	None		
Resources:	Change Management Plan, Stakeholder Analysis, Artifacts from Round 1 & 2 IPTs		
Risk:	Recruiting a large enough sample to test out the Key Training Processes		
Status:	In Planning		

Act #	Action Details	Projected Date	Actual Date
Comments:	Originally the IPTs were going to pilot the Key Training Processes they developed. VHA Training Modernization determined it would be more efficient to hold three pilots: one for each TOC that piloted the processes for that TOC. This also allowed us to ensure that a complete test is performed.		

The below graphic reflects the action-level metric data represented in the above table:



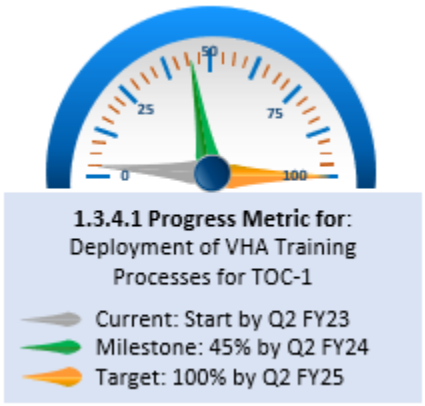
○ **TOC-1.3.4 Objective:** To collectively achieve VHA's planned objectives by deploying processes, standards, and systems developed in TOC-1. (*Q2 FY 2025*)

Table 4-8. TOC-1.3.4 actions

Act #	Action Details	Projected Date	Actual Date
○ **1.3.4.1**	**Deployment of VHA Training Processes for TOC-1**	**Q2 FY25**	**TBD**
○	**Phase 1:** Assess Organization and Identify Change Resistance	Q3 FY23	TBD
○	**Phase 2:** Implement Closed-Loop Change Management Comms	Q3 FY23	TBD
○	**Phase 3:** Plan Deployment of Processes	Q4 FY23	TBD
○	**Phase 4:** Finalize all materials required for Deployment of Processes	Q2 FY24	TBD
○	**Phase 5:** Execute Deployment of Processes	Q1 FY24	TBD
○	**Phase 6:** Evaluate and Revise Deployment of Processes	Q2 FY25	TBD
Progress Metrics	Processes Deployment: Not Started Start: Q2 FY23 Milestone: 45% by Q2 FY24 Target: 100% by Q2 FY25		
Process Metrics	None		

Act #	Action Details	Projected Date	Actual Date
Resources:	Change Management Plan, Pilot Results		
Risk:	Enterprise reluctance to change		
Status:	In Planning		
Comments:	Once all the processes have been piloted, policy and handbooks drafted, then the deployment of the processes will begin across VHA.		

The below graphic reflects the action-level metric data represented in the above table:



- **TOC-1.3.5 Objective**: To make evidence-based decisions on known VHA requirements and outcomes implement compliance auditing and measurement reporting. (*Q1 FY 2026*)

Table 4-9. TOC-1.3.5 actions

Act #	Action Details	Projected Date	Actual Date
○ 1.3.5.1	**Determine VHA Training Reporting and Compliance for TOC-1 Processes**	**Q3 FY23**	**TBD**
○	**Phase 1:** Determine what metrics will be captured for TOC-1	Q2 FY23	TBD
○	**Phase 2:** Determine how to capture the data	Q2 FY23	TBD
○	**Phase 3:** Determine what the targets will be	Q3 FY23	TBD
○	**Phase 4:** Add Metric to the VHA Training Dashboard	Q3 FY23	TBD
○	**Phase 5:** Document metrics and add to the VHA Training Compliance/Reporting/Mgmt. Process	Q3 FY23	TBD
Progress Metrics	Reporting Compliance: Not Started Start: Q4 FY23 Milestone: 75% by Q3 FY23 Target: 100% by Q3 FY23		
Process Metrics	None		
Resources:	Pilot Results and Analysis		
Risk:	None		
Status:	In Planning		
Comments:	As the processes are deployed, measurement of process and policy effectiveness will be developed and monitored.		

Act #	Action Details	Projected Date	Actual Date
○ 1.3.5.2	**Implement VHA Training Compliance Reporting for TOC-1 Sustainment**	**Q1 FY26**	**TBD**
○	**Phase 1:** Collect Data against metrics quarterly	TBD	TBD
○	**Phase 2:** Track and Trend data against targets	TBD	TBD
○	**Phase 3:** Validate Data	TBD	TBD
○	**Phase 4:** Analyze Data	TBD	TBD
○	**Phase 5:** Report Quarterly Summary	TBD	TBD
○	**Phase 6:** Develop corrective action plans	TBD	TBD
○	**Phase 7:** Implement Corrective action plans	TBD	TBD
○	**Phase 8:** Track Improvement	TBD	TBD
Progress Metrics	None		
Process Metrics	None		

Act #	Action Details	Projected Date	Actual Date
Resources:	Training Reporting and Compliance data from deployment		
Risk:	New system/software may be required.		
Status:	In Planning		
Comments:	Auditing compliance and reporting will be done manually until automated data systems are in place. Analysis and improvement measures will be ongoing.		

The below graphic reflects the action-level metric data represented in the above table:

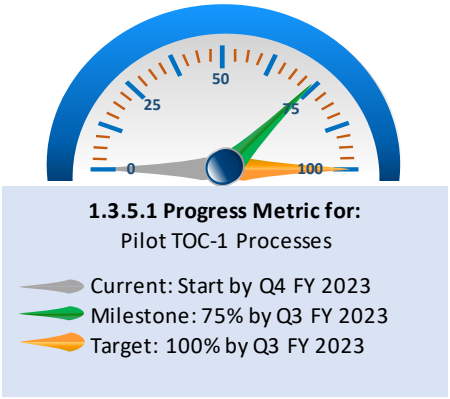
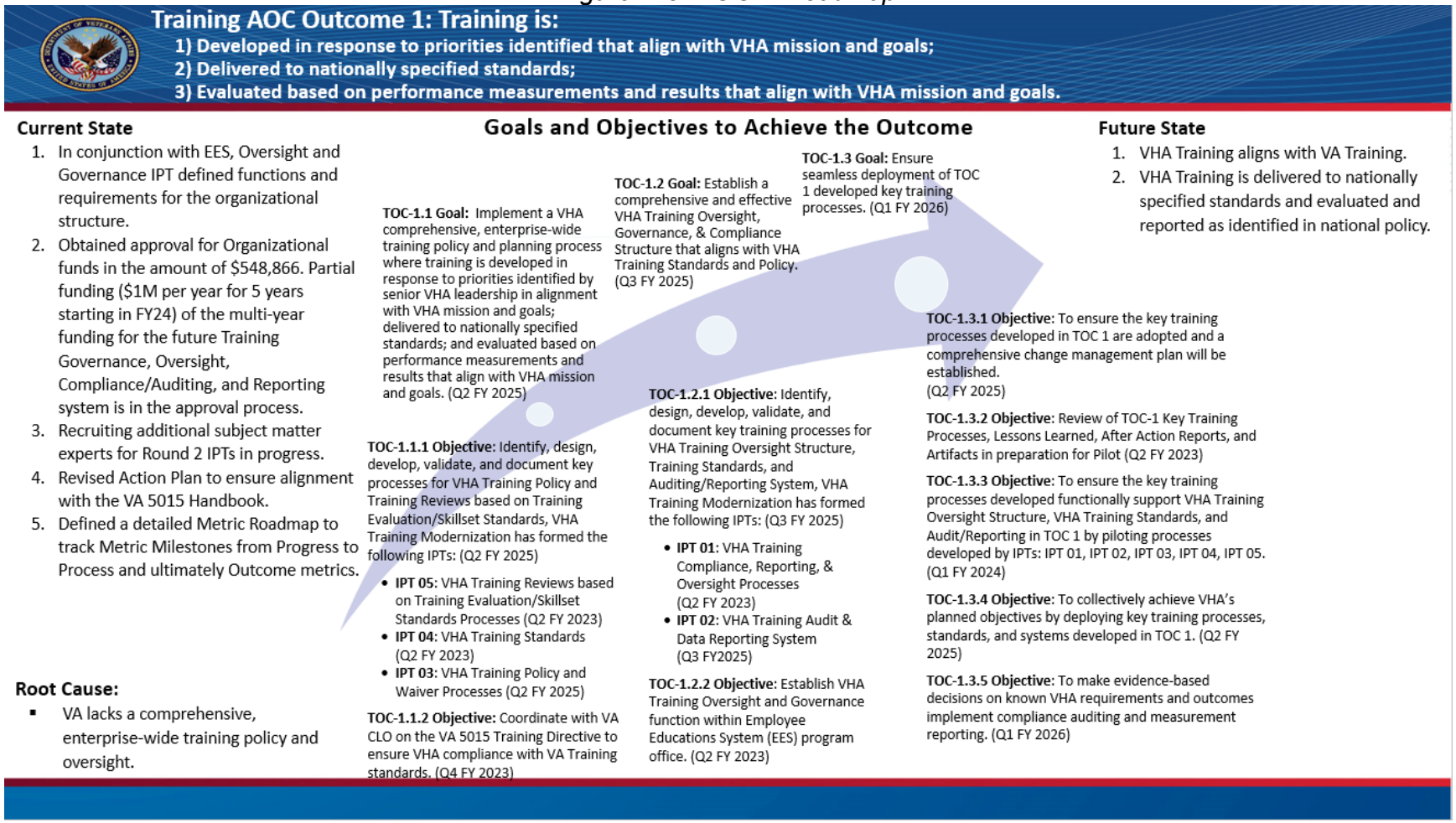


Figure 4-3, below, visually presents the current state of this outcome, the desired future state of this outcome and the goals and supporting objectives that align and will contribute to the achievement of that future state.

Figure 4-3. TOC-1 Roadmap



TOC-1 Description of Actions Toward Removal Criteria

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

Leadership Commitment

- **FY 2015, EES is the education and training authority for the VHA headquarters program office** supporting VHA in addressing concerns identified by GAO in 2014 that have the potential to adversely affect Veteran care. The VHA GAO HRL Task Force established the Training AOC in 2015 in partnership with EES.
    - Support the design, development, and recommendation of an effective and efficient national training program. (Outcomes 1a, 1b, and 1c)
    - Provide support to the Task Force 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)
- **FY 2014, EES established and sustained the National Designated Learning Officer (DLO) Community of Practice** and dedicated a full-time staff member to coordinate its activities and take the lead in creating a more robust culture of learning and education for 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 more cost-efficient training to the field; and provides feedback for training delivery lessons learned (Outcome 1a).
    - **FY 2019,** the National Coordinator for the DLOs conducted assessments of regional education and training initiatives and provided links to educational activities and long-term strategic goals, such as 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. (Outcomes 1a and 1c).
    - **FY 2022**, the National Coordinator for the DLOs and the DLO Community of practice has moved under the VHA / EES Training Governance and Oversight function.
    - **FY 2016, EES began developing Learning Advisory Councils**, composed of designated training representatives from each VHA headquarters program office, to work with EES Learning Consultants. They provide training expertise and help identify training resource needs, understand training needs, and

review Training Outcomes. Only 4 of the 197 Program Offices have adopted the Learning Advisory Council. Some have similar functions but are not standardized. (Outcomes 1a, 1b, and 1c)

- In **FY 2022**, the intent is to develop one concept of Learning Leaders across the VHA enterprise that will work locally to implement and sustain training processes and standards.

- **FY 2019, to support VHA Training Modernization's efforts**, EES contracted a designated support team (VHA Training Modernization: formerly Training Work Group) to assist in this work - contributing $1.2 million annually to this effort.

    - **FY 2021** expanded the support by engaging over 100 VHA staff from across the VHA enterprise along with 6.7 contract staff and 15 full time VHA EES Staff. Contract is in its second year and expected to run at a minimum one additional year at $1.3 million.

- **FY 2019**, **VA appointed a permanent CLO**. The VA CLO leads the Talent Development Council (TDC) (Outcome 1a). The TDC is comprised of learning executives across the VA enterprise to review, recommend, and establish VA enterprise-wide policies, standards, metrics, and development/training activities. The TDC promulgates VA enterprise-wide leadership and learning. The VA CLO along with the TDC began a major review and revision of the VA 5015 Directive and VA 5015 Handbook, which directs all VA Training including VHA. VHA Training Modernization collaborates with the TDC to incorporate standards and processes, that will be developed by the IPTs, into the VA 5015 Directive and VA 5015 Handbook.

    - **FY 2021, VA CLO position was vacated** and is currently staffed by VA SES on 120-day detail. Training Management is working with VA Training office and VA Assistant Secretary for Human Resources Administration

- **In FY 2020, VHA Training Modernization performed a comprehensive review of all training processes and procedures along with evaluation of available training metric data.** It was determined that most of the existing processes and procedures could not be applied across VHA, and that training data was unreliable and could not be validated. VHA Training Modernization is standing up 16 IPTs consisting of VHA staff and leadership that will establish training standards, develop processes, and produce a VHA Training Policy that clearly delineates duties, roles, and responsibilities.
- **FY 2021, The Executive Sponsorship for the Training Area of Concern shifted from the Deputy Chief Learning Officer to the Chief Learning Officer.** Briefings to several VHA governing committees have already been

completed to establish an operable VHA training governance framework that demonstrates VHA leadership commitment. Working with VA Training Office and providing briefings to VA Assistant Secretary for Human Resources and Administration (ASHRA) to collaborate VHA Training Modernization efforts.

- **FY 2021/FY 2022**, **Learning Organization Transformation (LOT)** is a standing subcommittee that reports to the VHA Workforce Committee (WC) and provides an avenue for the Governance and Oversight body to brief senior VHA leadership. Actions taken to date:

    - Charter reviewed and approved (November 2020)
    - LOT asked for concurrence on establishment of VHA Training Modernization IPTs to address GAO High Risk List. Additionally, requested members. WC approved and provided suggested nominations to serve. (March 2021)
    - Revised FY 2021 LOT Charter to include updated Vision and Mission Statement, goals and objectives, and membership. New LOT Charter submitted to Workforce Committee for approval (Approved November 2021).
    - VHA Communities of Practice Guidebook developed, approved, and communicated with approved memorandum to leadership, TDC, Health Care Leadership Talent Institute (HLTI), WC, DLO COP and various other communities of practice. (July 2021) Although not always formally called "Communities of Practice," CoPs exist across disciplines and entities within VHA and serve to support VHA as a learning organization through transformation. CoPs are often formed to create, expand, and exchange knowledge and can develop individual community member capabilities. The VHA CoP Guidebook offers information and examples to make a CoP successful. While the use of this guide is not mandatory, it serves as a resourceful tool to CoPs across VHA. The use of the guide will result in standardized, efficient and effective CoPs that support VHA priorities and mission. Effective and efficient communication of the guide is critical to a successful socialization of the tool. This tool will support the Field and program offices.
    - **FY 2021 / FY 2022,** DLO Survey rolled out in November 2020, which was administered to all DLOs. A strong, representative sample was obtained (approximately 50% of DLO pool responded).
        - **In summary**: Results demonstrated that -on average- DLOs are new to their jobs and are not aware of the published competencies required for their positions, even though they are confident about their responsibilities required of them as DLOs; however, their reporting structure and job duties are highly variable.

        - **Results**: Oversaw the re-validation, update, and communication of the DLO Learning Leaders Competency Model.

    - **FY 2022,** Provided VHA Training Modernization goals, priorities, and objectives to Workforce Committee (WC) for inclusion in the WC Charter.

- **FY 2021,** Compiled and distributed a GAO Executive Summary oriented to the challenge of "Inadequate Training for VA Staff".

- **FY 2021 (Ongoing),** Integrated the Executive Sponsor through involvement within the bi-weekly IPT Lead meeting, in addition to Phase completion back-briefs.

- **FY 2022 (Ongoing),** Initiated recurring, collaborative discussion/information sessions with the office of the VA Chief Learning Officer (CLO) and the Talent Development Council (TDC).

Capacity

- **FY 2014, the National DLO Community of Practice**, in collaboration with regional leadership, medical facility DLOs, other educational program directors, and program offices, will coordinate the conception, design, development, implementation, and evaluation of the learning programs and ensure alignment with the overall organizational mission and vision for the future. (Outcome 1a)

    - **FY 2022/FY 2023, Transition of DLO Community of Practice to Learning Leaders** and will encompass both field and headquarters training areas of operations.

- **FY 2019, VHA leadership established VHA Training Modernization** and approved contract support consisting of 6.71 FTEs, 100+ IPT VHA staff and seven government FTEs to address the concern of “inadequate and burdensome training” that can lead to poor healthcare delivery to our nation’s veterans:

    - Design, develop, and recommend an effective and efficient national training program (Outcomes 1a, 1b, and 1c)

    - Draft action plan requirements for providing a comprehensive and integrated series of responses for VHA Training Modernization - and its overlap with the VHA Modernization Plan - to create a High Reliability Organization (Outcomes 1a, 1b, and 1c)

- **FY 2021, A sustainment division consisting of designated FTE staff** to manage, maintain and ensure compliance with VHA training processes, procedures and policies is required. An IPT has been identified to design and recommend the sustainment division to EES Leadership and Manpower. (Outcome 1)

- **FY 2022, Work has begun under EES Transformation initiative.** Functional areas have been identified but full-time staffing and total capacity will not be possible until all IPTs have identified the capacity required to support the processes being designed/developed.

- **FY 2021, A functional work unit** will be required to review and evaluate all contracted training solutions/products in VHA to ensure efficiencies, adherence to training standards and compliance to training policy. An IPT has been identified to design and recommend the tasks required for the review of contractual training to EES Leadership and Manpower. A long-term process will include changes to the VA Contract policy. Short-term interim processes are being developed. (Outcome 1)

- **FY 2021, Expanded the breadth and scope of the Action Plan** with the subsequent launch of the interactive VHA Training Modernization SharePoint, which provides access for all our tools and resources.

- **FY 2021,** Conducted analysis and developed draft Functional Statement and Draft Functional Charts in support of a future VHA Training and Governance structure.

- **FY 2021 (Ongoing),** Collaborated with adjacent HRL AOCs to support shared lessons learned and gain efficiencies in the overarching VHA GAO efforts.

- **FY 2021 (Ongoing),** Engaged with VHA Strategic partners (OCSO, AUSH-O, OHT, OOA, OIT, etc.) to gain information and to establish foundational relationships for future governance efforts. – include both vertical and horizontal collaboration.

- **FY 2021 (Ongoing),** Conducted fact finding/best practice engagement with academia, private sector, and other federal partners (KP, Rutgers etc.).

- **FY 2021 (Ongoing),** Initiated Communications with VISN and Facility Directors through briefings and memoranda distribution. - OCM/Collaboration.
- **FY 2021 / FY 2022**, Initiated requirements gathering through a business requirements document (BRD) for future resourcing and development of an oversight, auditing, compliance, and reporting system.

- **FY 2021 / FY 2022,** Integrated VHA Training Modernization and EES Transformation to ensure joint work efforts towards common end-state objectives/outcomes. Cohesive integration with EES Transformation for the establishment of EES Governance and Oversight Infrastructure (Functions).
    - 2 consultants to each of working groups
    - 2 consultants to leadership teams
    - Artifacts/Lessons learned

- **FY 2022**, Provided consultants/facilitators to EES Transformation Client Experience (CE), Innovations, Business Support Operations, Design and Development, and Training Governance & Oversight (TG&O) Working Groups.

Action Plan

- **In FY 2021, Developed deliberate cross walk of GAO** Guide 04-546G, "A Guide for Assessing Strategic Training and Development Efforts in the Federal Government" to use as baseline criteria directing VHA Training Modernization work efforts. Conducted extensive review of all GAO findings and recommendations attributed to "inadequate training for VA Staff. Conducted initial VHA Training Modernization maturity assessment using the specifics found in the GAO Guide 04-546G, "A Guide for Assessing Strategic Training and Development Efforts in the Federal Government".

- **FY 2021 (Ongoing),** Conducted deliberate review of draft VA 5015 Directive and VA 5015 Handbook to ensure synchronization of policies, standards, and future governance efforts.

- **FY 2021 (Ongoing),** Continued the maturation and integration of Organizational Change Management efforts at the IPT and Key Training Process level; as well as with EES Transformation.

Monitoring

- **FY 2018**, per the Employee Education System Evaluation Policy (777-DCLO-EVAL-02), VHA required a minimum Kirkpatrick Level 2 assessment for all VHA training. (Outcome 1c). A Kirkpatrick Level 2 evaluation can provide overall training analytical data, but it does not indicate whether training participants have achieved an acceptable level of understanding, nor does it indicate a competency skill level for any course. As a result, a training course outcome evaluation and monitoring process will need to be developed and implemented. An IPT Lead has been identified to develop this process with VHA staff and leadership from across the VHA Enterprise.
- **FY 2021, The goal of this plan's metrics is to provide the mechanisms needed to assess and report progress to GAO and VHA Leadership** on training viability which will ultimately enhance veteran's care. With the development of a reportable evaluation process and the introduction of improved metrics, measures and monitoring processes will be significantly enhanced.

- **FY 2021,** Conducted alignment analysis of the VHA eight lanes of effort and the characteristics of High Reliability Organization (HRO) with that of VHA Training Modernization work streams.

Demonstrated Progress

- **FY 2016, VHA Training Modernization developed and implemented a standardized training planning model within VHA**. The model provides

content analysis and evaluation tools that assess VHA-wide training effectiveness, utilizing a Kirkpatrick Level 2 or above evaluation, and has been enhanced to support VHA Training Modernization's planning efforts. (Outcome 1c) Further review of this model during FY20 indicated that the training planning model is effective for only training items requested by VHA to be produced by EES and does not capture training resource needs being met outside of EES Production (<4% of all VHA training). Additionally, it was determined that the current required evaluation level (Kirkpatrick Level 2) effectively analyzes training implementation at the field level, but it does not effectively analyze the learners' demonstrated mastery of individual content matter or skillset competency. As a result, a need for an IPT has been identified to review and recommend a more formal process for evaluations and skillset assessments, i.e., to improve, monitor, and report training outcomes. All identified stakeholders in the Training AOC Action Plan Overview (Figure 2-10) will be represented in IPTs as well as the VHA Training Standards Steering Committee.

- **FY 2017, VHA conducted a series of site visits to ten VA medical facilities** of varying complexity, including hospitals and outpatient clinics. The site visits focused on the impact of burdensome training requirements, as well as benchmarks of successful educational operations and barriers that have inhibited successful educational operations. Findings presented to the Office of the DUSH for Operations and Management included:

    - Variations in VA education service configurations must be modernized, particularly in relation to the DLO role, with coordination optimized to reduce mission overlap between facility departments, and development/promulgation of leadership best practices to champion education and employee development.

    - Mandatory training should be assigned with longer compliance times and must include an annual refresh to maintain the required status.

    - VHA national program offices should define required clinical competencies to eliminate disparities. (Outcome 1a)

- **FY 2018, VHA updated its policy on the appropriate and effective use of trainings** that must be completed by VHA employees via VHA Directive 1052 (Appropriate and Effective Use of VHA Employee Mandatory and Required Training). This directive outlines policy regarding the appropriate processes for initiating, renewing, consolidating, expanding, substituting, and discontinuing required trainings for VHA employees, which helps address GAO's concerns of burdensome training. (Outcome 1a)

- **FY 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. (Outcome 1a)

- In FY 2019, 99% (N = 1668) of all current internal VHA training requests aligned to the 18 VHA Operational Strategies or Secretary priorities per the DUSH community.

- In FY20, 98% (N = 14,320) of all current internal VHA training requests aligned to the 18 VHA Operational Strategies or Secretary priorities per the DUSH community.

    - **FY 2022, This process is no longer valid.** IPT 13: VHA Training Planning and Priorities IPT is working on developing a new and improved process to put in its place.

- **FY 2019, for VHA national required training, the Learning Organization Transformation (LOT) Mandatory Training Subcommittee** conducted an annual review and recertification of existing mandatory training for VHA employees, when such training is left to VHA to develop and implement, but specific requirements are clearly directed by statute, executive order, or the Secretary of Veterans Affairs.

- **FY 2018, Reached a sustained compliance rate of 93%** for Opioid Prescribing Training for providers. This addresses a 2015 White House memorandum to ensure that opioid prescribing providers had the required training.

- **FY 2018, VHA compliance reporting indicated a 95% compliance rate** for taking mandatory suicide prevention training. 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)

- **FY 2019, 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 meet legislative requirements while preventing Veteran's service disruptions quickly and efficiently. (Outcome 1a and 1b)

- **FY 2020, a review of training systems indicates a need to develop a system** for VHA training oversight, compliance, and reporting. A need for an IPT has been identified to determine system requirements based on developed training standards that can capture all training resource needs in VHA, including vendor purchased or developed training.

    - **FY 2021, IPT 01: Oversight and Governance** has kicked off to determine infrastructure and reporting systems required.

- **FY 2021,** VHA is collaborating with Policy, OIT and the Oversight and Accountability AOCs to develop infrastructure to include resources, systems, and policy required to support Oversight Management Compliance and Reporting of VHA Training in an ongoing effort.

- **FY 2021 (Ongoing),** Expanded communications and collaborations with VHA GOAL Office. Worked closely with the GOAL Office to provide best practices in the areas of Project Management, Metrics, Templates, Communications, and graphical representations.

- **FY 2021 / FY 2022,** Developed metrics roadmap for Progress, Process, and Performance Metrics associated with the near, mid, and long-term efforts of VHA Training Modernization.

Training Outcome (TOC-2)

Outcome Leads:

- **Rebecca Goodson,** Associate Director, Enterprise Project Management Office (EPMO), Employee Education System (EES)
- **David Lusk, PhD,** Deputy Director, Client Services, Employee Education System (EES)

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

◐**TOC-2 Outcome Statement:** Accurately identified audience is trained at the appropriate time to specific programs/process requirements.

Outcome Metrics: Defined by: Q3 FY 2024; Reported by: Q4 FY 2025

◐**TOC-2.1 Goal:** Develop and implement a VHA systematic approach to competency assessment and execution for VHA training products and services to get the right training to the right people at the right time and to ensure that training is effective and current using training skillset assessments along with lifecycle maintenance and sunsetting. (*Q2 FY 2023*)

TOC-2.1a Metrics: Defined by: Q3 FY 2024; Reported by: Q4 FY 2025

◐**TOC-2.1.1 Objective:** To identify, design, develop, validate, and document Key Training Processes for the Execution of VHA Training, VHA Training Modernization formed seven IPTs. (*Q2 FY 2023*)

- **IPT 06:** VHA Training Request Intake Processes (*Q2 FY 2023*)
- **IPT 07:** VHA Training Design of Evaluation and Skillsets Processes (*Q2 FY 2022*)
- **IPT 08:** VHA Training Evaluation and Skillset Standards (*Q2 FY 2022*)
- **IPT 09:** VHA Training Assignments Processes (*Q2 FY 2022*)
- **IPT 10:** VHA Mandatory Training Processes (*Q2 FY 2023*)
- **IPT 11:** VHA Training Lifecycle Maintenance and Sunsetting Processes (*Q2 FY 2022*)
- **IPT 16:** VHA Training Implementation Processes (*Q2 FY 2023*)

Table 4-10. TOC-2.1.1 actions

Act #	Action Details	Projected Date	Actual Date
◐ 2.1.1.1	**IPT 06: VHA Training Request Intake Processes**	**Q2 FY23**	**TBD**
●	**Phase 1**: Kick Off	Q3 FY22	TBD
◐	**Phase 2**: Design and Develop Key Training Processes	Q4 FY22	TBD
○	**Phase 3**: Document and Validate Key Training Processes	Q1 FY23	TBD
○	**Phase 4**: Develop Key Training Process Measures/Standards/ Waiver Requirement Scenarios	Q2 FY23	TBD
○	**Phase 5**: Key Training Processes Work Completed and Accepted by VHA TRN MOD	Q2 FY23	TBD
Progress Metrics	Started: Started 03/07/22 Start: Q2 FY22 Milestone: 50% by Q4 FY22 Target: 100% by Q2 FY23		
Process Metrics	Defined by: Q2 FY23 Manual Reporting: Q4 FY24		
Resources:	IPT Team Members, Current processes, Lessons learned		
Risk:	Reluctance to change. Missing key information during intake		
Status:	In Progress (As of 03/07/2022)		
Comments:	There currently is not a standard intake process in place for training requests across VHA. EES is facilitating an IPT to look at a VHA wide intake process for training requests. Once that process is defined, along with additional training standards, a standardized VHA Training Request process will be established and implemented. An IPT has been formed to design and develop the process, determine standards, define outcome metrics, and training waivers needed. IPT 06 was originally in TOC-1 but was moved to TOC-2 where all Training Deliverable processes are from Intake to Archival (sunsetting). ***The projected date to complete this action has accelerated to Q2FY23 from the May 2021 version where it was projected for completion in Q4FY23.**		
Act #	**Action Details**	**Projected Date**	**Actual Date**
● 2.1.1.2	**IPT 07: VHA Training Design of Evaluation and Skillsets Processes**	**Q2 FY22**	**Q2 FY22**

Act #	Action Details	Projected Date	Actual Date
●	**Phase 1**: Kick Off	Q3 FY21	Q3 FY21
●	**Phase 2**: Design and Develop Key Training Processes	Q4 FY21	Q4 FY21
●	**Phase 3**: Document and Validate Key Training Processes	Q1 FY22	Q1 FY22
●	**Phase 4**: Develop Key Training Process Measures/Standards/ Waiver Requirement Scenarios	Q2 FY22	Q2 FY22
●	**Phase 5**: Key Training Processes Work Completed and Accepted by VHA TRN MOD	Q2 FY22	Q2 FY22
Progress Metrics	IPT 07: Complete Current Progress: 100% Q2 FY22 Milestone: 50% Q4 FY21 Target: 100% by Q2 FY22		
Process Metrics	Defined by: Q2 FY22 Manual Reporting: Q4 FY24		
Resources:	Artifacts turned over to VHA Training Modernization for Review and Analysis		
Risk:	Some rework might be required		
Status:	Complete		
Comments:	IPT 07 has finalized the key training processes for the design of training evaluations and skillsets. All documentation has been turned over to VHA Training Modernization Team to further refine and prepare to pilot.		

Act #	Action Details	Projected Date	Actual Date
● **2.1.1.3**	**IPT 08: Design and Develop VHA Training Evaluation and Skillset Standards**	**Q2 FY22**	**Q2 FY22**
●	**Phase 1**: Kick Off	Q3 FY21	Q3 FY21
●	**Phase 2**: Design and Develop Key Training Processes	Q4 FY21	Q4 FY21
●	**Phase 3**: Document and Validate Key Training Processes	Q1 FY22	Q1 FY22
●	**Phase 4**: Develop Key Training Process Measures/Standards/ Waiver Requirement Scenarios	Q2 FY22	Q2 FY22
●	**Phase 5**: Key Training Processes Work Completed and Accepted by VHA TRN MOD	Q2 FY22	Q2 FY22
Progress Metrics:	IPT 08: Complete Current Progress: 100% Q2 FY22 Milestone: 50% Q4 FY21		

Act #	Action Details	Projected Date	Actual Date
	Target: 100% by Q2 FY22		
Process Metrics:	Defined by: Q2 FY22 Manual Reporting: Q4 FY24		
Resources:	Artifacts turned over to VHA Training Modernization for Review and Analysis		
Risk:	Some rework might be required		
Status:	Complete		
Comments:	IPT 08 has finalized the key training processes and standards for training evaluations and skillsets. All documentation has been turned over to VHA Training Modernization Team to further refine and prepare to pilot.		
● **2.1.1.4**	**IPT 09: Design and Develop VHA Training Assignments Processes**	**Q2 FY22**	**Q2 FY22**
●	**Phase 1**: Kick Off	Q3 FY21	Q3 FY21
●	**Phase 2**: Design and Develop Key Training Processes	Q4 FY21	Q4 FY21
●	**Phase 3**: Document and Validate Key Training Processes	Q1 FY22	Q1 FY22
●	**Phase 4**: Develop Key Training Process Measures/Standards/ Waiver Requirement Scenarios	Q2 FY22	Q2 FY22
●	**Phase 5**: Key Training Processes Work Completed and Accepted by VHA TRN MOD	Q2 FY22	Q2 FY22
Progress Metrics	IPT 09: Complete Current Progress: 100% Q2 FY22 Milestone: 50% Q4 FY21 Target: 100% by Q2 FY22		
Process Metrics	Defined by: Q2 FY22 Manual Reporting:		
Resources:	Artifacts turned over to VHA Training Modernization for Review and Analysis		
Risk:	Some rework might be required. HR Smart job codes do not adequately define the roles needed for assigning training. IPT 09 will be losing their EHRM participants to other priorities very soon meaning they may not be available later for any Key Process mitigation or Pilot findings updates.		
Status:	Complete		
Comments:	IPT09 has finalized the key training processes for training assignments. All documentation has been turned over to VHA Training		

Act #	Action Details	Projected Date	Actual Date
	Modernization Team to further refine and prepare to pilot.		
Act #	**Action Details**	**Projected Date**	**Actual Date**
◐ 2.1.1.5	**IPT 10: Design and Develop VHA Mandatory Training Processes**	**Q4 FY23**	**Q2 FY23**
●	**Phase 1**: Kick Off	Q3 FY22	Q3 FY22
◐	**Phase 2**: Design and Develop Key Training Processes	Q4 FY22	TBD
○	**Phase 3**: Document and Validate Key Training Processes	Q1 FY23	TBD
○	**Phase 4**: Develop Key Training Process Measures/Standards/ Waiver Requirement Scenarios	Q2 FY23	TBD
○	**Phase 5**: Key Training Processes Work Completed and Accepted by VHA TRN MOD	Q2 FY23	TBD
Progress Metrics	IPT 10: Started 03/07/22 Start: Q2 FY22 Milestone: 50% by Q4 FY22 Target: 100% by Q2 FY23		
Process Metrics	Defined by: Q2 FY23 Manual Reporting: Q4 FY24		
Resources:	IPT Team Members, Current processes, Mandatory training directives, Lessons learned		
Risk:	None		
Status:	In Progress (As of 03/07/2022)		
Comments:	IPT 10 has kicked off and will work with the VHA Directive 1052, Mandatory Training Directive that currently exists. This directive will be dependent on the development of the VHA Training Assignment process to ensure that (1) Mandatory Training is being assigned to the correct personnel and (2) the Evaluation and Skillset processes/standards being developed are evaluating training effectiveness. An IPT has been formed to design and develop the processes, determine standards, define outcome metrics and identify training waivers needed. ***The projected date to complete this action has accelerated to Q2FY23 from the May 2021 version where it was projected for completion in Q4FY23.**		
Act #	**Action Details**	**Projected Date**	**Actual Date**

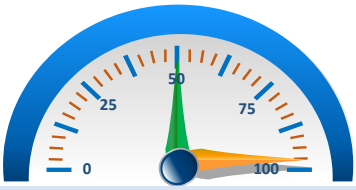
Act #	Action Details	Projected Date	Actual Date
◐ 2.1.1.6	**IPT 16: Design and Develop VHA Training Implementation Processes**	**Q2 FY 2023**	**TBD**
●	**Phase 1**: Kick Off	Q3 FY22	Q3 FY22
◐	**Phase 2**: Design and Develop Key Training Processes	Q4 FY22	TBD
○	**Phase 3**: Document and Validate Key Training Processes	Q1 FY23	TBD
○	**Phase 4**: Develop Key Training Process Measures/Standards/ Waiver Requirement Scenarios	Q2 FY23	TBD
○	**Phase 5**: Key Training Processes Work Completed and Accepted by VHA TRN MOD	Q2 FY23	TBD
Progress Metrics:	IPT 16: Started 03/07/22 Start: Q2 FY22 Milestone: 50% Q4 FY22 Target: 100% by Q2 FY23		
Process Metrics:	Defined by: Q2 FY23 Manual Reporting: Q4 FY24		
Resources:	IPT Team formed		
Risk:	None		
Status:	In Progress (As of 03/07/2022)		
Comments:	After reviewing our Action Plan against the GAO Evaluation Guide (GAO-04-546G) VHA Training Modernization realized there was not a consistent process for implementing VHA Training. A new IPT was added to address VHA Training Implementation processes. ***The projected date to complete this action has accelerated to Q2FY23 from the May 2021 version where it was projected for completion in Q4FY23.**		
Act #	**Action Details**	**Projected Date**	**Actual Date**
● 2.1.1.7	**IPT 11: Design and Develop VHA Training Lifecycle Maintenance and Sunsetting Processes**	**Q2 FY22**	**Q2 FY22**
●	**Phase 1**: Kick Off	Q3 FY21	Q3 FY21
●	**Phase 2**: Design and Develop Key Training Processes	Q4 FY21	Q4 FY21
●	**Phase 3**: Document and Validate Key Training Processes	Q1 FY22	Q1 FY22

Act #	Action Details	Projected Date	Actual Date
●	**Phase 4**: Develop Key Training Process Measures/Standards/ Waiver Requirement Scenarios	Q2 FY22	Q2 FY22
●	**Phase 5**: Key Training Processes Work Completed and Accepted by VHA TRN MOD	Q2 FY22	Q2 FY22
Progress Metrics	IPT 11: Complete Current Progress: 100% Q2 FY22 Milestone: 50% Q4 FY21 Target: 100% by Q2 FY22		
Process Metrics	Defined by: Q2 FY22 Manual Reporting: Q4 FY24		
Resources:	Artifacts turned over to VHA Training Modernization for Review and Analysis		
Risk:	Rework might be required once turned over to VHA Training Modernization for review and analysis		
Status:	Complete		
Comments:	IPT 11 to develop detailed criteria, standards, and metrics in support of the full training solution/product lifecycle from initiation to sunsetting (archiving).		

The below graphics reflect the action-level metric data represented in the above table:

2.1.1.1 Progress Metric for IPT 06:
VHA Training Request Intake Processes

Current: Start Q2 FY 2022
Milestone: 50% by Q4 FY 2022
Target: 100% by Q2 FY 2023



2.1.1.2 Progress Metric for IPT 07:
VHA Training Design of Evaluation and Skillsets Processes

Current: 100% by Q2 FY 2022
Milestone: 50% by Q4 FY 2021
Target: 100% by Q2 FY 2022

2.1.1.3 Progress Metric for IPT 08:
Design and Develop VHA Training Evaluation and Skillset Standards

Current: 100% by Q2 FY 2022
Milestone: 50% by Q4 FY 2021
Target: 100% by Q2 FY 2022

2.1.1.4 Progress Metric for IPT 09:
Design and Develop VHA Training Assignments Processes

Current: 100% by Q2 FY 2022
Milestone: 50% by Q4 FY 2021
Target: 100% by Q2 FY 2022

2.1.1.5 Progress Metric for IPT 10:
Design and Develop VHA Mandatory Training Processes

Current: Start Q2 FY22
Milestone: 50% by Q4 FY22
Target: 100% by Q2 FY 2023

2.1.1.6 Progress Metric for IPT 16:
Design and Develop VHA Training Implementation Processes

Current: Start Q2 FY 2022
Milestone: 50% by Q4 FY 2022
Target: 100% by Q2 FY 2023

◐**TOC-2.2 Goal:** Ensure seamless deployment of TOC-2 developed processes. (*Q1 FY 2026*)

TOC-2.2a Metrics: Defined by: Q3 FY 2024; Reported by: Q4 FY 2025

◐**TOC-2.2.1 Objective:** To ensure the processes developed in TOC-2 are adopted and a comprehensive change management plan will be established.
(*Q2 FY 2025 - Ongoing*)

2.1.1.7 Progress Metric for IPT 11:
Design and Develop VHA Training Lifecycle Maintenance and Sunsetting Processes

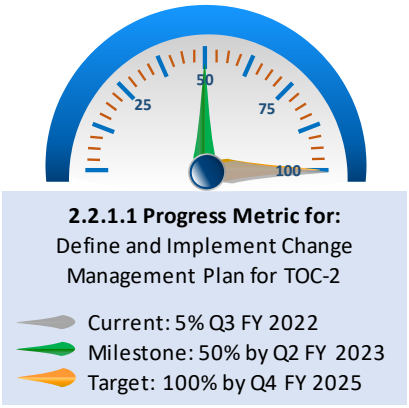
Current: 100% Q2 FY 2022
Milestone: 50% by Q4 FY 2021
Target: 100% by Q2 FY 2022

Table 4-11. TOC-2.2.1 actions

Act #	Action Details	Projected Date	Actual Date
◐ 2.2.1.1	**Define and Implement Change Management Plan for TOC-2**	**Q2 FY25**	**TBD**
◐	**Phase 1:** Define Change Management	Q3 FY22	TBD
◐	**Phase 2:** Prepare for Change	Q2 FY23	TBD
○	**Phase 3:** Manage Change	Q2 FY25	TBD
○	**Phase 4:** Evaluate/Revise Change	Q2 FY25	TBD
○	**Phase 5:** Reinforce Change	Q2 FY25	TBD
Progress Metrics	Change Management: In Progress Current Progress: 5% Q3 FY22 Milestone: 50% by Q2 FY23 Target: 100% by Q4 FY25		
Process Metrics	None		
Resources:	VHA Change Management Practitioner (PROSCI) trained members, AMSG contractor, and available Change Management tools		
Risk:	Resistance to change, lack of change agents and change champions.		
Status:	In Progress		
Comments:	Training AOC assessed our change impact, organization attributes, and sponsor leadership and support, which was used to complete our change management assessment analysis. The Training Action Plan will require a significant amount of change management and socialization across VHA Program Offices, VISNs, and the field. This is a major on-going effort that VHA Training Modernization is working on a comprehensive change management plan, to include quality		

Act #	Action Details	Projected Date	Actual Date
	compliance, and reporting guidelines incorporated into each of the processes as they are being implemented.		

The below graphic reflects the action-level metric data represented in the above table:



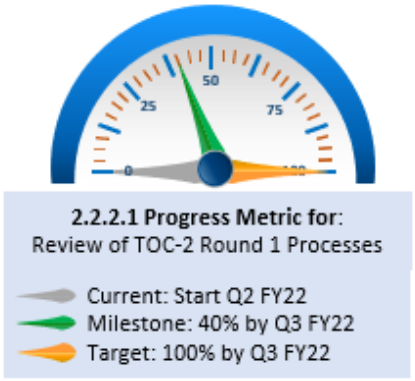
- **TOC-2.2.2 Objective:** Review of TOC-2 Key Training Processes, Lessons Learned, After Action Reports, and Artifacts in preparation for Pilot. (*Q2 FY 2023*)

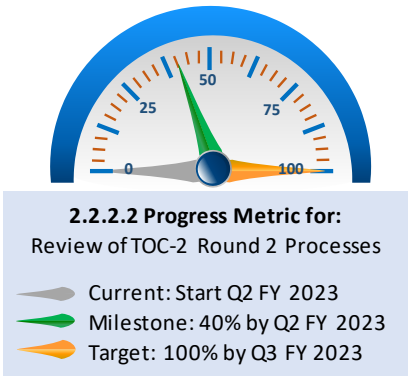
Table 4-12. TOC-2.2.2 actions

Act #	Action Details	Projected Date	Actual Date
◐ 2.2.2.1	**Review of TOC-2 Round 1 Processes**	**Q3 FY23**	**TBD**
◐	**Phase 1:** Conduct Review of IPT Artifacts and Deliverables for completion and clarity using Check list and summarize overall state of Key Training Processes and requirements to finalize.	Q3 FY22	TBD
○	**Phase 2:** Work with IPT Leads to mitigate issues and requirements to finalize artifacts.	Q3 FY22	TBD
Progress Metrics:	Review: In Progress Start: Q2 FY22 Milestone: 40% by Q3 FY22 Target: 100% by Q3 FY22		
Process Metrics:	None		
Resources:	Artifacts from Round 1 IPTs		
Risk:	Rework might be required before Pilot starts		
Status:	In Planning		
Comments:	Once the IPTs have completed the designing/developing/validating of the Key Training Processes they are turned over the VHA Training Modernization Team to do a thorough review and analysis to determine any gaps or modifications that need to be made prior to piloting the Key Training Processes.		
Act #	**Action Details**	**Projected Date**	**Actual Date**
○ 2.2.2.2	**Review of TOC-2 Round 2 Processes**	**Q2 FY23**	**TBD**
○	**Phase 1:** Conduct Review of IPT Artifacts and Deliverables for completion and clarity using Check list and summarize overall state of Key Training Processes and requirements to finalize.	Q2 FY23	TBD
○	**Phase 2:** Work with IPT Leads to mitigate issues and requirements to finalize artifacts.	Q2 FY23	TBD
Progress Metrics:	Review: Not started Start: Q2 FY23 Milestone: 40% by Q2 FY23 Target: 100% by Q4 FY23		
Process Metrics:	None		
Resources:	Artifacts from Round 1 IPTs		

Act #	Action Details	Projected Date	Actual Date
Risk:	Rework might be required before Pilot starts		
Status:	In Planning		
Comments:	Once the IPTs have completed the designing/developing/validating of the Key Training Processes they are turned over the VHA Training Modernization Team to do a thorough review and analysis to determine any gaps or modifications that need to be made prior to piloting the Key Training Processes.		

The below graphics reflect the action-level metric data represented in the above table:





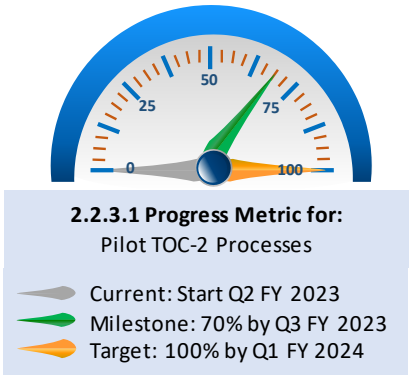
○**TOC-2.2.3 Objective:** To ensure the processes developed functionally support VHA Training from Intake to Sunsetting (Archiving) within the lifecycle in TOC-2 by piloting processes developed by IPTs: IPT 06, IPT 07, IPT 08, IPT 09, IPT 10, IPT 11, IPT 16. (*Q1 FY 2024*)

Table 4-13. TOC-2.2.3 actions

Act #	Action Details	Projected Date	Actual Date
○ **2.2.3.1**	**Pilot TOC-2 Processes**	**Q1 FY24**	**TBD**
○	**Phase 1:** Pilot Change Management/Comms Strategy	Q2 FY23	TBD
○	**Phase 2:** Create Test Plan for Processes to be piloted	Q3 FY23	TBD
○	**Phase 3:** Conduct Pilot of Processes using change management tactics	Q4 FY23	TBD
○	**Phase 4:** Assess Pilot Results	Q4 FY23	TBD
○	**Phase 5:** Document and Rework Processes and change management tactics	Q1 FY24	TBD
○	**Phase 6:** Processes Adopted and Integrated	Q1 FY24	TBD

Act #	Action Details	Projected Date	Actual Date
Progress Metrics:	Pilots: In planning Start: Q2 FY23 Milestone: 70% by Q4 FY23 Target: 100% by Q1 FY24		
Process Metrics:	None		
Resources:	Change Management Plan, Stakeholder Analysis, Artifacts from Round 1 & 2 IPTs		
Risk:	Recruiting a large enough sample to test out the Key Training Processes		
Status:	In Planning		
Comments:	Originally the IPTs were going to pilot the Key Training Processes they developed. VHA Training Modernization determined it would be more efficient to hold three pilots: one for each TOC that piloted the processes for that TOC. This also allowed us to test the processes that were related to ensure a complete test is performed.		

The below graphic reflects the action-level metric data represented in the above table:

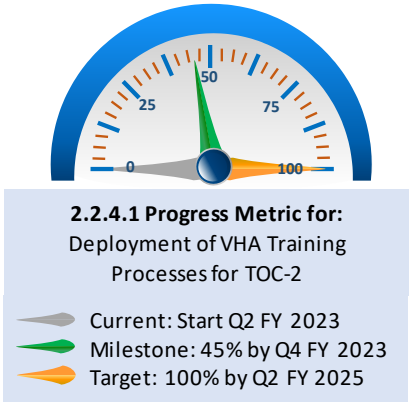


- **TOC-2.2.4 Objective:** To collectively achieve VHA's planned objectives by deploying processes, standards, and systems developed in TOC-2. (*Q2 FY 2025*)

Table 4-14. TOC-2.2.4 actions

Act #	Action Details	Projected Date	Actual Date
○ 2.2.4.1	**Deployment of VHA Training Processes for TOC-2**	**Q2 FY25**	**TBD**
○	**Phase 1:** Assess Organization and Identify Change Resistance	Q3 FY23	TBD
○	**Phase 2:** Implement Closed Loop Change Management Comms	Q3 FY23	TBD
○	**Phase 3:** Plan Deployment of Processes	Q4 FY23	TBD
○	**Phase 4:** Finalize all materials required for Deployment of Processes	Q2 FY24	TBD
○	**Phase 5:** Execute Deployment of Processes	Q1 FY24	TBD
○	**Phase 6:** Evaluate and Revise Deployment of Processes	Q2 FY25	TBD
Progress Metrics	Process Deployment: In Planning - Not Started Start: Q2 FY23 Milestone: 45% by Q4 FY23 Target: 100% by Q2 FY25		
Process Metrics:	None		
Resources:	Change Management Plan, Pilot Results		
Risk:	Enterprise reluctance to change		
Status:	In Planning		
Comments:	Once all the processes have been piloted, policy and handbooks drafted, then the deployment of the processes will begin across VHA.		

The below graphic reflects the action-level metric data represented in the above table:



○**TOC-2.2.5 Objective**: To make evidence-based decisions on known VHA requirements and outcomes implement compliance auditing and measurement reporting. (*Q1 FY 2026*)

Table 4-15. TOC-2.2.5 actions

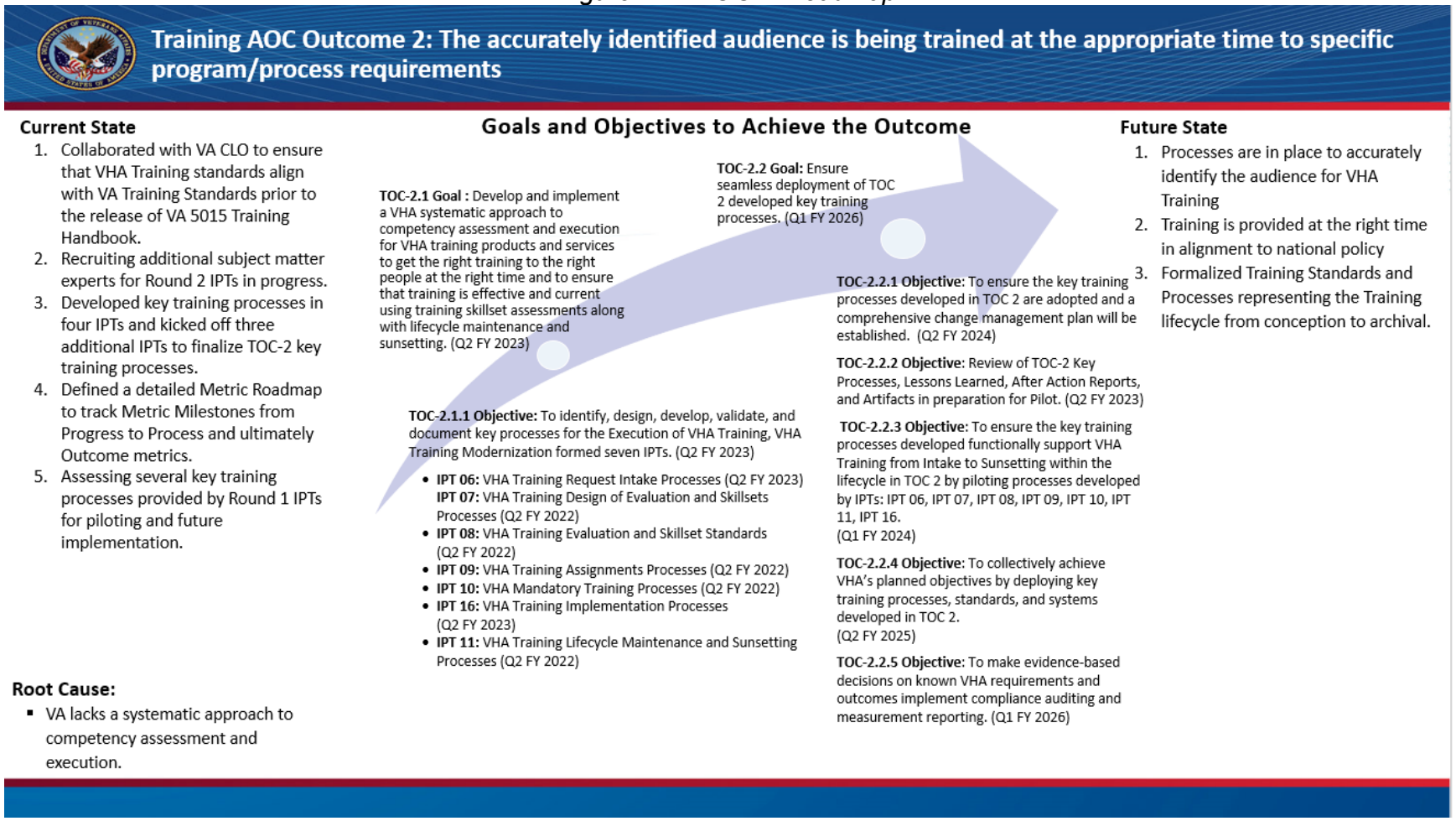
Act #	Action Details	Projected Date	Actual Date
○ **2.2.5.1**	**Determine VHA Training Reporting and Compliance for TOC-2 Processes**	**Q3 FY23**	**TBD**
○	**Phase 1:** Determine what metrics will be captured for TOC-1	Q2 FY23	TBD
○	**Phase 2:** Determine how to capture the data	Q2 FY23	TBD
○	**Phase 3:** Determine what the targets will be	Q3 FY23	TBD
○	**Phase 4:** Add Metric to the VHA Training Dashboard	Q3 FY23	TBD
○	**Phase 5:** Document metrics and add to the VHA Training Compliance/Reporting/Mgmt. Process	Q3 FY23	TBD
Progress Metrics:	Reporting Compliance: In Planning Start: Q2 FY23 Milestone: 75% by Q3 FY23 Target: 100% by Q3 FY23		
Process Metrics:	None		
Resources:	Pilot Results and Analysis		
Risk:	None		
Status:	In Planning		
Comments:	As the processes are deployed, how we measure the effectiveness of the processes and the policy will be developed and monitored.		
Act #	**Action Details**	**Projected Date**	**Actual Date**
○ **2.2.5.2**	**Implement VHA Training Compliance Reporting for TOC-2 Sustainment**	**Q1 FY26**	**TBD**
○	**Phase 1:** Collect Data against metrics quarterly	TBD	TBD
○	**Phase 2:** Track and Trend data against targets	TBD	TBD
○	**Phase 3:** Validate Data	TBD	TBD
○	**Phase 4:** Analyze Data	TBD	TBD
○	**Phase 5:** Report Quarterly Summary	TBD	TBD
○	**Phase 6:** Develop corrective action plans	TBD	TBD
○	**Phase 7:** Implement Corrective action plans	TBD	TBD
○	**Phase 8:** Track Improvement	TBD	TBD
Progress Metrics:	None		

Act #	Action Details	Projected Date	Actual Date
Process Metrics:	None		
Resources:	Training Reporting and Compliance data from deployment		
Risk:	New system or software maybe required		
Status:	In Planning		
Comments:	Auditing compliance and reporting will be done manually until data systems are in place. Constant analysis and improvement measures will also be ongoing.		

The below graphic reflects the action-level metric data represented in the above table:

Figure 4-4, below, visually presents the current state of this outcome, the desired future state of this outcome and the goals and supporting objectives that align and will contribute to the achievement of that future state.

Figure 4-4. TOC-2 Roadmap



TOC-2 Description of Actions Toward Removal Criteria

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

Leadership Commitment

- FY 2018, VA, with the collaboration of all three administrations (VHA, VBA, and NCA), and with leadership commitment, reconfigured and upgraded its learning management system, titled TMS, to TMS 2.0 and made it a cloud-based platform. 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 outdated training (e.g., the sunset review process). Upon closer evaluation and analysis by VHA Training Modernization, there is no documented process for reviewing training catalogs across the VHA enterprise. There are over 88,000 courses within TMS without a consistent expected outcome, periodic review, or process to remove outdated items not created or placed in TMS outside of EES produced training. As a result, VHA Training Modernization has recommended, and EES Production Directors have committed to, the development of processes and standards using VHA leaders and staff in an IPT, to remove outdated, duplicative training, and establishing a process for assigning training to a more targeted audience.

- In VA's draft FY 2018–2024 Strategic Plan, leadership has committed 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 position codes and competencies to be aligned to targeted learning participants, and it will synchronize with a single learning management platform.

    - FY 2019, Published and Released

- FY 2019, analysis of training evaluation demonstrates that EES does have a process for using Kirkpatrick Evaluation methods for training developed and delivered by EES but does not have the same process or ability to identify non-EES produced training and ensure the same standards are applied across the enterprise. EES has assembled and chartered an IPT to develop a more in-depth process for determining learners course comprehension and skill competency at the completion of training based upon clear identified standards for all courses delivered across the VHA enterprise. The same IPT will recommend a process for monitoring course outcomes and compliance with these processes and procedures.

    - FY 2021, IPT 07: VHA Training Design of Evaluation and Skillsets Processes, IPT 08: VHA Training Evaluation and Skillset Standards, and IPT 05: VHA Training Reviews based on evaluation and skillset standards Processes have been formed to address the issues.

- FY 2019, VHA Training Modernization collaborated with the Mandatory Training Subcommittee of the Training Development Council (TDC) to upgrade the training review process to accurately differentiate between mandatory vs. non-mandatory training and then allocate resources appropriately.

- FY 2018, an internal EES training evaluation policy document was completed, approved, and implemented (EES Directive 777-DCLO-EVAL-02) that could be leveraged across VHA.

    - FY 2022, this evaluation policy is being incorporated into the VA 5015 Directive and VA 5015 Handbook.

- FY 2021 (Ongoing), Integrated the Executive Sponsor through involvement within the bi-weekly IPT Lead meeting in addition to Phase completion back-briefs.

Capacity

- FY 2021, VHA began developing a systematic approach to training assignment, execution, and competency assessment. This approach empowers TMS Program Managers, Learning Consultants, and training production Project Managers to assign training to appropriate audiences. More detailed steps need to be established across VHA to ensure that training is targeted to the appropriate staff so that burdensome training is reduced. IPT 09: VHA Training Assignments was formed to determine consistent processes to be used for assigning training across VHA.

- FY 2021 / FY 2022, Operationalized 7 of 16 Integrated Project Teams oriented to a 5-phase plan to support the identification, validation, and communications necessary for the future implementation of 34 enterprise-wide key training processes.

Monitoring

- FY 2021, TMS is a tool that provides the capability to assign and monitor completion rates for specific target audiences and then compile evaluation data being assessed. These capabilities support the systematic monitoring of VHA training outcomes. To improve the quality of training, whether EES-produced or vendor produced, EES will establish standard training outcome expectations from which to measure training completions. The IPT Lead has been identified to begin this additional monitoring requirement.

Demonstrated Progress

- FY 2017, EES added the capability to identify participant groups as targets for later assignments by TMS. However, FY20 analysis indicated that the participant

groups identified were much too broad and did not remedy burdensome training, as they did not adequately distinguish between targeted versus non-targeted staff. Accurate identification of a target audience early in training production is essential to reduce unnecessary training for VHA staff. This is an example of a process that will be upgraded and expanded to encompass all VHA training. An IPT Lead has been identified to begin this work using VHA leadership and staff.

- FY 2019, The Caregiver Support Program Core Elements Training was assigned according to job role for Mandatory Training to 77,367 staff and attained 94.3% completion with 72,935 completions in 2020. In addition, the Caregiver Support Program Expansion and Overview Course, which was congressionally mandated, was assigned to 268,077 individuals and achieved a 96.8% completion rate with 259,464 completions. An IPT has been formed to develop Training Assignment standards and processes that can be applied to all VHA training.

- FY 2020, Training was assigned to participants via TMS by:

    - Automatic process utilizing HR Smart tools which is only about 60% effective.

    - Allowing supervisors to select individual employees based on individual training plans.

    - TMS administrators 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.

    - In FY 2021, an IPT has been established to refine and establish standards VHA wide for training assignments.

- FY 2020, COVID-19 Training for VHA Staff and Clinicians in Response to Pandemic. Five courses were developed using a SME from the Office of Emergency Medicine. The courses were assigned at the local facility level using Job Roles rather than Job Codes to reduce burdensome training across the VHA enterprise.

- FY 2021, EES EPMO Division led an EES Process Mapping EES Functions Process Mapping IPT team which created 94 process flow maps.

- FY 2021, Training Test-Out Revised Language Presented to the WC and TDC approved to be included in VA 5015 Directive and VA 5015 Handbook (Q4 FY 2022) Providing an option for staff to test out of a required training will reduce the amount of burdensome training by reducing the time spent training.

- FY 2021 / FY 2022, Collective and regular collaboration with VHA/EES Electronic Health Records Modernization (EHRM) action team to gather information and provide support in the areas of: Lessons Learned, Best Practices, After Action Reviews, Development of Standards, Development of Metrics. VHA Training Modernization is interacting with EHRM to recommend standards and outcomes for EHRM Training Outcomes.

Training Outcome (TOC-3)

Outcome Leads:

- **Rebecca Goodson,** Associate Director, Enterprise Project Management Office (EPMO), Employee Education System (EES)
- **David Lusk, PhD,** Deputy Director, Client Services, Employee Education System (EES)

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

◐ **TOC-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.

Outcome Metrics: Defined by: Q3 FY 2024; Reported by: Q4 FY 2025

◐ **TOC-3.1 Goal:** Develop and implement a VHA systematic approach to competency assessment and execution for VHA training products and services to get the right training to the right people at the right time and ensure that training is effective and current using training skillset assessments, along with lifecycle maintenance and sunsetting. (*Q2 FY 2023*)

◐ **TOC-3.1.1 Objective:** To identify, design, develop, validate, and document Key Training Processes for the Execution of VHA Training, VHA Training Modernization formed seven IPTs. (*Q2 FY 2023*)

- **IPT 13:** Design and Develop VHA Training Priorities and Training Plan Processes (*Q2 FY 2022*)
- **IPT 12:** Design and Develop VHA-wide Contract Vehicle for Training Requests Processes (*Q2 FY 2023*)
- **IPT 14:** Design and Develop VHA Training Contracts Standardization Processes (*Q2 FY 2022*)
- **IPT 15:** Design and Develop VHA Training Contract Identification Processes (formerly Budget Object Codes) (*Q2 FY 2022*)

Table 4-16. TOC-3.1.1 actions

Act #	Action Details	Projected Date	Actual Date
● **3.1.1.1**	**IPT 13: Design and Develop VHA Training Priorities and Training Plan Processes**	**Q2 FY22**	**Q2 FY22**
●	**Phase 1**: Kick Off	Q3 FY21	Q3 FY21
●	**Phase 2**: Design and Develop Key Training Processes	Q4 FY21	Q4 FY21

Act #	Action Details	Projected Date	Actual Date
●	**Phase 3**: Document and Validate Key Training Processes	Q1 FY22	Q1 FY22
●	**Phase 4**: Develop Key Training Process Measures/Standards/ Waiver Requirement Scenarios	Q2 FY22	Q2 FY22
●	**Phase 5**: Key Training Processes Work Completed and Accepted by VHA TRN MOD	Q2 FY22	Q2 FY22
Progress Metrics:	IPT 13: Complete Current Progress: 100% Q2 FY22 Milestone: 50% Q4 FY21 Target: 100% by Q2 FY22		
Process Metrics:	Defined by: Q2 FY22 Manual Reporting: Q4 FY24		
Resources:	IPT Team, current standards, regulations, mandatory training requirements and IPT artifacts		
Risk:	Competing priorities across the enterprise. No planning and priorities process available at the VA/VHA top levels. Policies vary significantly between all facility levels. Lack of standardization.		
Status:	Complete		
Comments:	IPT 13 has finalized the key training processes VHA Training Planning and Priorities. All documentation has been turned over to VHA Training Modernization Team to further refine and prepare to pilot.		
Act #	**Action Details**	**Projected Date**	**Actual Date**
◐ 3.1.1.2	**IPT 12: Design and Develop VHA-wide Contract Vehicle for Training Requests Processes**	**Q2 FY23**	**TBD**
●	**Phase 1**: Kick Off	Q3 FY22	Q3 FY22
◐	**Phase 2**: Design and Develop Key Training Processes	Q4 FY22	TBD
○	**Phase 3**: Document and Validate Key Training Processes	Q1 FY23	TBD
○	**Phase 4**: Develop Key Training Process Measures/Standards/ Waiver Requirement Scenarios	Q2 FY23	TBD
○	**Phase 5**: Key Training Processes Work Completed and Accepted by VHA TRN MOD	Q2 FY23	TBD
Progress Metrics:	**IPT 12:** Started 03/07/22 **Start:** Q2 FY22 **Milestone:** 50% by Q4 FY22 **Target:** 100% by Q2 FY23		

Act #	Action Details	Projected Date	Actual Date
Process Metrics:	**Defined by:** Q2 FY23 **Manual Reporting:** Q4 FY24		
Resources:	IPT Team, current regulations, contract examples and templates		
Risk:	Differences in contracting offices across VA. New training contract identification process (and appropriate language standards must be accepted by senior VHA leadership and then socialized throughout the VHA enterprise and will require certain actions by VA contracting to implement.		
Status:	In Progress (As of 03/07/2022)		
Comments:	Currently VHA Program Offices, VISNs, and the field can purchase or contract out development of training which can be very redundant, duplicative, and costly. There are no standards in place for training contracts, which hinders consistency in training content and alignment to VHA priorities. To reduce cost and ensure uniformity, a VHA-wide contract vehicle for training requests needs to be developed and implemented. An IPT will be formed to design and develop the process, determine standards, define outcome metrics, and identify training waivers needed. ***The projected date to complete this action has accelerated to Q2FY23 from the May 2021 version where it was projected for completion in Q4FY23.**		

Act #	Action Details	Projected Date	Actual Date
● 3.1.1.3	**IPT 14: Design and Develop VHA Training Contracts Standardization Processes**	**Q2 FY22**	**Q2 FY22**
●	**Phase 1**: Kick Off	Q3 FY21	Q3 FY21
●	**Phase 2**: Design and Develop Key Training Standards	Q4 FY21	Q4 FY21
●	**Phase 3**: Document and Validate Key Training Standards	Q1 FY22	Q1 FY22
●	**Phase 4**: Develop Key Training Measures/Waiver Requirement Scenarios	Q2 FY22	Q2 FY22
●	**Phase 5**: Key Training Standards Work Completed and Accepted by VHA TRN MOD	Q2 FY22	Q2 FY22
Progress Metrics:	IPT 14: Complete Current Progress: 100% Q2 FY22 Milestone: 50% Q4 FY21 Target: 100% by Q2 FY22		
Process Metrics:	Defined by: Q2 FY22		

Act #	Action Details	Projected Date	Actual Date
	Manual Reporting: Q4 FY24		
Resources:	Current regulations, Other agencies templates, Artifacts created by IPT		
Risk:	Differences in contracting offices across VA. New training contract identification process (and appropriate language standards must be accepted by senior VHA leadership and then socialized throughout the VHA enterprise and will require certain actions by VA contracting to implement.		
Status:	Complete		
Comments:	IPT 14 has finalized the key training processes and standards for VHA Training Contracts. All documentation has been turned over to VHA Training Modernization Team to further refine and prepare to pilot.		
● **3.1.1.4**	**IPT 15: Design and Develop VHA Training Contract Identification Processes**	**Q2 FY22**	**Q2 FY22**
●	**Phase 1**: Kick Off	Q3 FY21	Q3 FY21
●	**Phase 2**: Design and Develop Key Training Processes	Q4 FY21	Q4 FY21
●	**Phase 3**: Document and Validate Key Training Processes	Q1 FY22	Q1 FY22
●	**Phase 4**: Develop Key Training Process Measures/Standards/ Waiver Requirement Scenarios	Q2 FY22	Q2 FY22
●	**Phase 5**: Key Training Processes Work Completed and Accepted by VHA TRN MOD	Q2 FY22	Q2 FY22
Progress Metrics:	IPT 15: Complete Current Progress: 100% Q2 FY22 Milestone: 50% Q4 FY21 Target: 100% by Q2 FY22		
Process Metrics:	Defined by: Q2 FY22 Manual Reporting: Q4 FY24		
Resources:	Current regulations, Other agencies templates, Artifacts created by IPT, VA/VHA Finance Policies, VA/VHA Finance and Acquisition SMEs, VHA Policy Staff, OPAL Websites, VBA Training Staff		
Risk:	Differences in contracting offices across VA. New training contract identification process (and appropriate language standards must be accepted by senior VHA leadership and then socialized throughout the VHA enterprise and will require certain actions by VA contracting to implement. Budget Object Codes (BOCs) are currently very limited in number and cannot adequately		

Act #	Action Details	Projected Date	Actual Date
	distinguish between the many forms of training within VHA.		
Status:	In Planning		
Complete:	IPT 15 has finalized the key training processes for VHA Training Contract Identification. All documentation has been turned over to VHA Training Modernization Team to further refine and prepare to pilot. This was renamed to be VHA Training Contract Identification instead of VHA Training Budget Object Codes. IPT 15 initiated a sub-work group directed towards the potential "stand-up" of sub-BOC codes with the VA/VHA fiscal functions. This work supports the overarching implementation of IPT 15 initiatives.		

The below graphics reflect the action-level metric data represented in the above table:

3.1.1.1 Progress Metric for IPT 13: Design and Develop VHA Training Priorities and Training Plan Processes

- Current: 100% Q2 FY 2022
- Milestone: 50% by Q4 FY 2021
- Target: 100% by Q2 FY 2022

3.1.1.2 Progress Metric for IPT 12: Design and Develop VHA-wide Contract Vehicle for Training Requests Processes

- Current: Start Q2 FY 2022
- Milestone: 50% by Q4 FY 2022
- Target: 100% by Q2 FY 2023

3.1.1.3 Progress Metric for IPT 14: Design and Develop VHA Training Contracts Standardization Processes

- Current: 100% Q2 FY 2022
- Milestone: 50% by Q4 FY 2021
- Target: 100% by Q2 FY 2022

3.1.1.4 Progress Metric for IPT 15: Design and Develop VHA Training Contract Identification Processes

- Current: 100% Q2 FY 2022
- Milestone: 50% by Q4 FY 2021
- Target: 100% by Q2 FY 2022

◐**TOC-3.2 Goal:** Ensure seamless deployment of TOC-2 developed processes. (*Q1 FY 2026*)

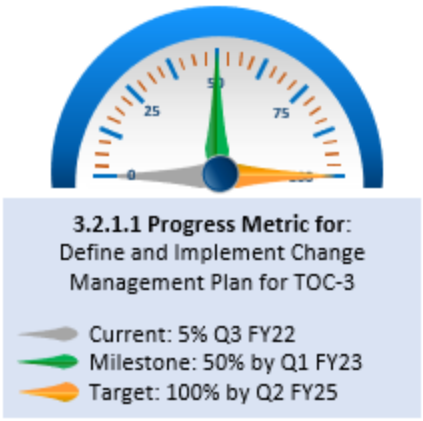
TOC-3.2a Metrics: Defined by: Q3 FY 2024; Reported by: Q4 FY 2025

◐ **TOC-3.2.1 Objective:** To ensure the processes developed in TOC-2 are adopted and a comprehensive change management plan will be established.
(*Q2 FY 2025 - Ongoing*)

Table 4-17. TOC-3.2.1 actions

Act #	Action Details	Projected Date	Actual Date
◐ 3.2.1.1	**Define and Implement Change Management Plan for TOC-3**	**Q2 FY25**	**TBD**
◐	**Phase 1:** Define Change Management	Q3 FY22	TBD
◐	**Phase 2:** Prepare for Change	Q2 FY23	TBD
○	**Phase 3:** Manage Change	Q2 FY25	TBD
○	**Phase 4:** Evaluate/Revise Change	Q2 FY25	TBD
○	**Phase 5:** Reinforce Change	Q2 FY25	TBD
Progress Metrics:	Change Management: In Progress Current Progress: 5% Q3 FY22 Milestone: 50% by Q1 FY23 Target: 100% by Q2 FY25		
Process Metrics:	None		
Resources:	VHA Change Management Practitioner (PROSCI) trained members, ASMG contractor, and available Change Management tools		
Risk:	Resistance to change, lack of change agents and change champions.		
Status:	In Progress		
Comments:	Training AOC assessed our change impact, organization attributes, and sponsor leadership and support, which was used to complete our change management assessment analysis. The Training Action Plan will require a significant amount of change management and socialization across VHA Program Offices, VISNs, and the field. Eventually, this effort will extend into VA Acquisition Policy. This is a major on-going effort that VHA Training Modernization is working on a comprehensive change management plan, to include quality compliance, and reporting guidelines incorporated into each of the processes as they are being implemented.		

The below graphic reflects the action-level metric data represented in the above table:



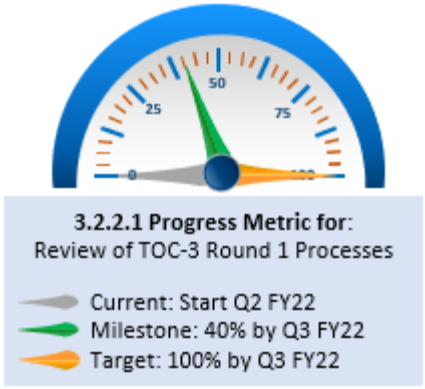
○**TOC-3.2.2 Objective:** Review of TOC-3 Key Training Processes, Lessons Learned, After Action Reports, and Artifacts in preparation for Pilot. (*Q2 FY 2023*)

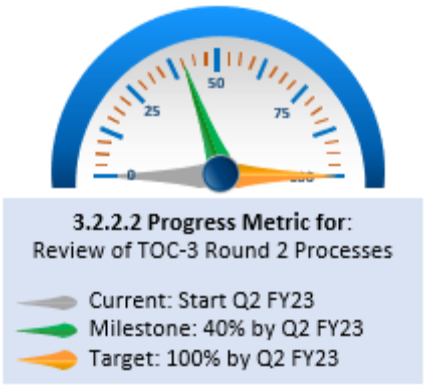
Table 4-18. TOC-3.2.2 actions

Act #	Action Details	Projected Date	Actual Date
◐ 3.2.2.1	**Review of TOC-3 Round 1 Processes**	**Q3 FY22**	**TBD**
◐	**Phase 1:** Conduct Review of IPT Artifacts and Deliverables for completion and clarity using Check list and summarize overall state of Key Training Processes and requirements to finalize.	Q3 FY22	TBD
○	**Phase 2:** Work with IPT Leads to mitigate issues and requirements to finalize artifacts.	Q3 FY22	TBD
Progress Metrics:	Review: In Progress Start: Q2 FY22 Milestone: 40% by Q3 FY22 Target: 100% by Q3 FY22		
Process Metrics:	None		
Resources:	Artifacts from Round 1 IPTs		
Risk:	Rework might be required before Pilot starts		
Status:	In Planning		
Comments:	Once the IPTs have completed the designing/developing/validating of the Key Training Processes they are turned over the VHA Training Modernization Team to do a thorough review and analysis to determine any gaps or modifications that need to be made prior to piloting the Key Training Processes.		

Act #	Action Details	Projected Date	Actual Date
Act #	Action Details	Projected Date	Actual Date
○ 3.2.2.2	**Review of TOC-3 Round 2 Processes**	**Q2 FY23**	**TBD**
○	**Phase 1:** Conduct Review of IPT Artifacts and Deliverables for completion and clarity using Check list and summarize overall state of Key Training Processes and requirements to finalize.	Q2 FY23	TBD
○	**Phase 2:** Work with IPT Leads to mitigate issues and requirements to finalize artifacts.	Q2 FY23	TBD
Progress Metrics:	Review: Not Started Start: Q2 FY23 Milestone: 40% by Q2 FY23 Target: 100% by Q2 FY23		
Process Metrics:	None		
Resources:	Artifacts from Round 1 IPTs		
Risk:	Rework might be required before Pilot starts		
Status:	In Planning		
Comments:	Once the IPTs have completed the designing/developing/validating of the Key Training Processes they are turned over the VHA Training Modernization Team to do a thorough review and analysis to determine any gaps or modifications that need to be made prior to piloting the Key Training Processes.		

The below graphics reflect the action-level metric data represented in the above table:





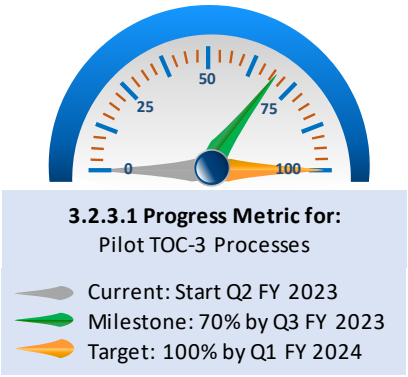
○**TOC-3.2.3 Objective:** To ensure the processes developed functionally support VHA Training Standards for Contracting and

the Training Priorities and Planning in TOC-3 by piloting processes developed by IPTs: IPT 12, IPT 13, IPT 14, IPT 15. (*Q1 FY 2024*)

Table 4-19. TOC-3.2.3 actions

Act #	Action Details	Projected Date	Actual Date
○ **3.2.3.1**	**Pilot TOC-3 Processes**	**Q1 FY24**	**TBD**
○	**Phase 1:** Pilot Change Management/Comms Strategy	Q2 FY23	TBD
○	**Phase 2:** Create Test Plan for Processes to be piloted	Q3 FY23	TBD
○	**Phase 3:** Conduct Pilot of Processes using change management tactics	Q4 FY23	TBD
○	**Phase 4:** Assess Pilot Results	Q4 FY23	TBD
○	**Phase 5:** Document and Rework Processes and change management tactics	Q1 FY24	TBD
○	**Phase 6:** Processes Adopted and Integrated	Q1 FY24	TBD
Progress Metrics:	Pilots: In Planning - Not Started **Start:** Q2 FY23 **Milestone:** 70% by Q4 FY23 Target: 100% by Q1 FY24		
Process Metrics:	None		
Resources:	Change Management Plan, Stakeholder Analysis, Artifacts from Round 1 & 2 IPTs		
Risk:	Recruiting a large enough sample to test out the Key Training Processes		
Status:	In Planning		
Comments:	Originally the IPTs were going to pilot the Key Training Processes they developed. VHA Training Modernization determined it would be more efficient to hold three pilots: one for each TOC that piloted the processes for that TOC. This also allowed us to test the processes that were related to ensure a complete evaluation is performed.		

The below graphic reflects the action-level metric data represented in the above table:

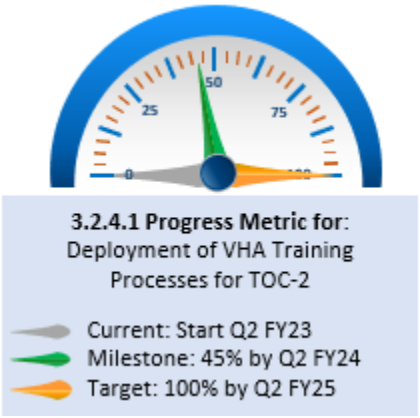


○**TOC-3.2.4 Objective:** To collectively achieve VHA's planned objectives by deploying processes, standards, and systems developed in TOC-3.
(*Q2 FY 2025*)

Table 4-20. TOC-3.2.4 actions

Act #	Action Details	Projected Date	Actual Date
○ 3.2.4.1	**Deployment of VHA Training Processes for TOC-2**	**Q2 FY25**	**TBD**
○	**Phase 1:** Assess Organization and Identify Change Resistance	Q3 FY23	TBD
○	**Phase 2:** Implement Closed Loop Change Management Comms	Q3 FY23	TBD
○	**Phase 3:** Plan Deployment of Processes	Q4 FY23	TBD
○	**Phase 4:** Finalize all materials required for Deployment of Processes	Q2 FY24	TBD
○	**Phase 5:** Execute Deployment of Processes	Q1 FY24	TBD
○	**Phase 6:** Evaluate and Revise Deployment of Processes	Q2 FY25	TBD
Progress Metrics:	**In Planning:** Not Started **Start:** Q2 FY23 **Milestone:** 45% by Q2 FY24 Target: 100% by Q2 FY25		
Process Metrics:	None		
Resources:	Change Management Plan, Pilot Results		
Risk:	Enterprise resistance to change		
Status:	In Planning		
Comments:	Once all the processes have been piloted, policy and handbooks drafted, then the deployment of the processes will begin across VHA.		

The below graphic reflects the action-level metric data represented in the above table:



○**TOC-3.2.5 Objective**: To make evidence-based decisions on known VHA requirements and outcomes implement compliance auditing and measurement reporting. (*Q1 FY 2026*)

Table 4-21. TOC-3.2.5 actions

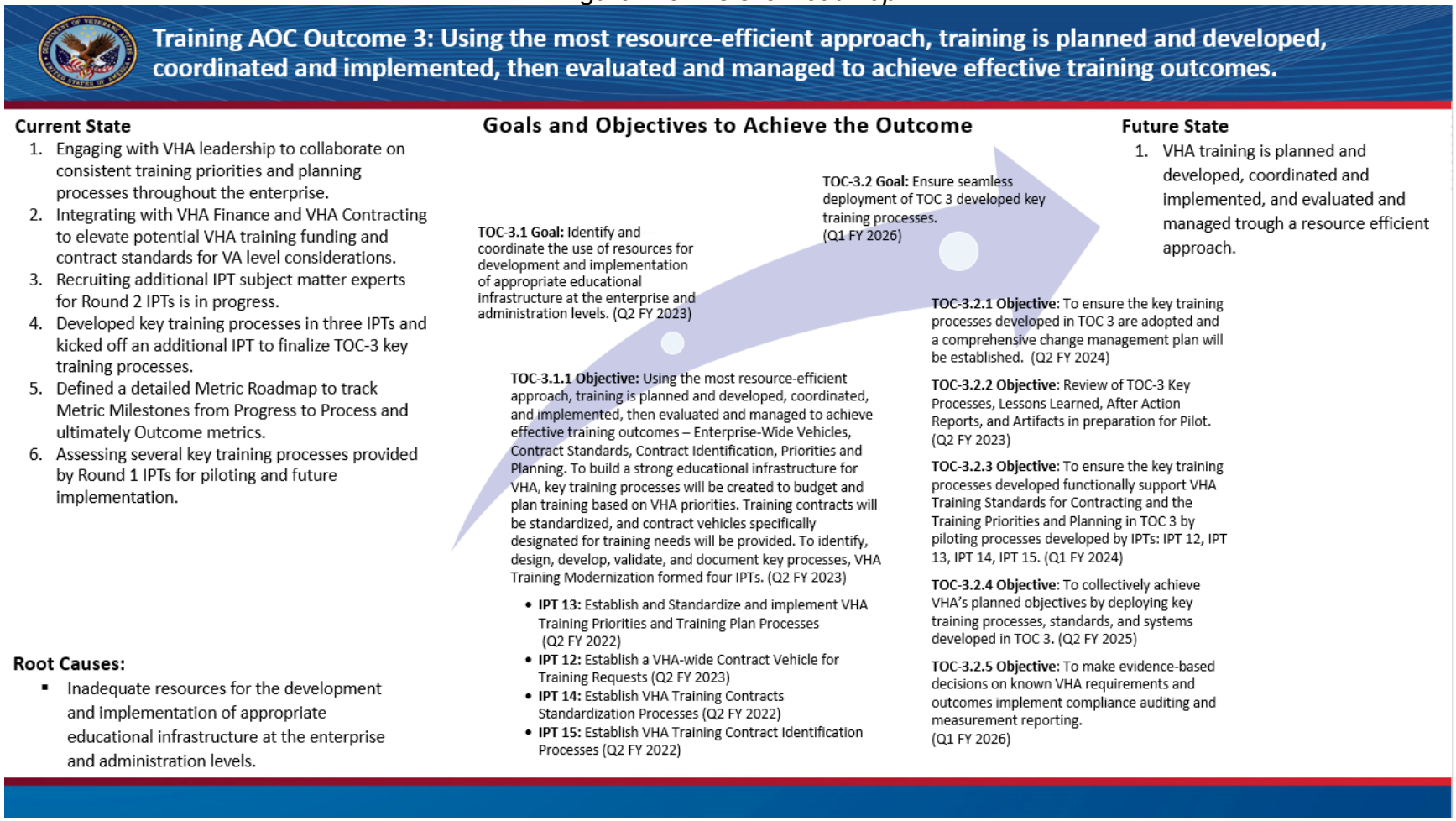
Act #	Action Details	Projected Date	Actual Date
○ 3.2.5.1	**Determine VHA Training Reporting and Compliance for TOC-3 Processes**	**Q3 FY23**	**TBD**
○	**Phase 1:** Determine what metrics will be captured for TOC-1	Q2 FY23	TBD
○	**Phase 2:** Determine how to capture the data	Q2 FY23	TBD
○	**Phase 3:** Determine what the targets will be	Q3 FY23	TBD
○	**Phase 4:** Add Metric to the VHA Training Dashboard	Q3 FY23	TBD
○	**Phase 5:** Document metrics and add to the VHA Training Compliance/Reporting/Mgmt. Process	Q3 FY23	TBD
Progress Metrics:	Reporting Compliance: In Planning - Not Started Start: Q2 FY23 Milestone: 75% by Q3 FY23 Target: 100% by Q3 FY23		
Process Metrics:	None		
Resources:	Pilot Results and Analysis		
Risk:	None		
Status:	In Planning		
Comments:	As the processes are deployed, how we measure the effectiveness of the processes and the policy will be developed and monitored.		

Act #	Action Details	Projected Date	Actual Date
Act #	Action Details	Projected Date	Actual Date
○ 3.2.5.2	**Implement VHA Training Compliance Reporting for TOC-3 Sustainment**	**Q1 FY26**	**TBD**
○	**Phase 1:** Collect Data against metrics quarterly	TBD	TBD
○	**Phase 2:** Track and Trend data against targets	TBD	TBD
○	**Phase 3:** Validate Data	TBD	TBD
○	**Phase 4:** Analyze Data	TBD	TBD
○	**Phase 5:** Report Quarterly Summary	TBD	TBD
○	**Phase 6:** Develop corrective action plans	TBD	TBD
○	**Phase 7:** Implement Corrective action plans	TBD	TBD
○	**Phase 8:** Track Improvement	TBD	TBD
Progress Metrics:	None		
Process Metrics:	None		
Resources:	Training Reporting and Compliance data from deployment		
Risk:	New system/software may be required.		
Status:	In Planning		
Comments:	Auditing compliance and reporting will be done manually until data systems are in place. Analysis and improvement measures will also be ongoing.		

The below graphic reflects the action-level metric data represented in the above table:

Figure *4-5, below, visually presents the current state of this outcome, the desired future state of this outcome and the goals and supporting objectives that align and will contribute to the achievement of that future state.*

Figure 4-5. TOC-3 Roadmap



TOC-3 Description of Actions Toward Removal Criteria

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

Leadership Commitment

- FY 2019, to support the revitalization of the training function, VHA has hired a dedicated contractor team with expertise in Program and Project Management, Training Management, Change Management, Communications, Business Process Improvement, VHA Field Operations and Policy Development/Management.

    - FY 2021, the dedicated contractor team was instrumental in developing the overall action plan that is currently in place, as well as supporting the active IPTs with facilitation, development of materials, and metrics.

- FY 2019, VHA has assigned five high-level leadership representatives to improve VHA training (Chief Learning Officer to serve as Executive Sponsor, a GS-15 Executive Advisor, and two GS-14s as Outcome Lead and Subject Matter Expert, and two Project Managers.

    - FY 2022, Operational alignment of Training Functions into future organizational structure.
        - Training governance and oversight
            - LOT
                - Mandatory Training Workgroup
                - Learning Leaders Initiative
            - Quality Management (performance improvement, auditing, and compliance)
            - Reporting
            - Training Policy, Standards, and Waivers
        - Mandatory Training and Training Assignments
        - Training Contracts

    - FY 2021, EES Executive Leadership has committed, assignment of an IPT Lead to work with the Chief Financial Officer, to develop a process of identifying training resource requirements during contracting to review contracts and ensure standards are emphasized and contract meets training requirements.

Capacity

- FY 2014, 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 client and instructional system designers to determine the best delivery modality to meet specific training needs
    - Meet regularly with clients to review training outcomes

- FY 2021, EES has dedicated resources, including six staff and 16 IPT Leads, to consult with both VHA subject matter experts and leadership within VA and the field, to develop standards, processes and systems that will address training issues in the areas of contracting, contract review staff recommendation (future) and training governance oversight.

Monitoring

- FY 2024, this plan's metrics and measures will provide the mechanisms to assess and report progress to GAO once the processes are established and implemented.

- FY 2021, VHA Training Modernization developed a comprehensive Metric Roadmap to show the progression of the Training AOC metrics from Progress Metrics to Process Metrics and, ultimately, Outcome Metrics.

Demonstrated Progress

- FY 2019, the eLearning Division of EES offered to assist clients with contract development by reviewing contracts for training development to ensure they are SCORM Compliant and meet VA 508, platform, and copyright requirements. An IPT is being formed to design and develop the process, determine standards, define outcome metrics, and identify training waivers needed.

- FY 2021, EES was able to contract with Franklin Covey to provide an "All Access Pass" to their training for enterprise wide VHA, which resulted in significant overall cost savings to VHA. Previously, facilities would contract individually for Franklin Covey training for their locations at significantly higher seat license pricing.

5. Unclear Resource Needs and Allocation Priorities Area of Concern

Executive Sponsors: Jessica Bonjorni, Chief, Human Capital Management
Rachel Mitchell, Deputy Chief Financial Officer

Executive Summary

Figure 5-1 Resource Allocation 2021 Rating Goal

VHA continues to demonstrate progress in prioritization and allocation of resources through transformation of business processes, system modernization and a focus on the administrative and clinical staff that support our more than 9,000,000 enrolled veterans. VA Secretary Denis McDonough recently stated, "the lifeblood of a well-run, well-functioning organization or agency is timely, accurate information." We could not agree more. To continue addressing unclear resource needs and allocation priorities, the VHA Office of Finance and VHA Workforce Strategy and Standardization (WSS), previously Manpower Management Office (MMO), continue to champion leadership commitment towards enterprise improvements that address root causes, modernize technologies, and align with the GAO HRL removal criteria. As seen in the 2022 Action Plan, VHA continues to strengthen initiatives focused on providing transparent & standardized processes, aligning resources and providing training to better position the organization to accomplish its mission.

One specific example of this is the continued partnership between Finance and WSS to review VHA hiring and change requests, ensuring the most efficient and effective use of resources to accomplish the mission. In FY 2022, Finance and WSS launched a Staffing and Vacancy Transparency IPT. The IPT identified milestones and timelines to implement a standardized national policy and procedures for the documentation and communication of staffing level approvals at VAMCs. The standardized national procedures for documentation and communication of staffing levels approvals at VAMCs has been developed as an input to the Resource Management Committee (RMC) process. Future work will include review and standardization of RMC processes and outputs to further align resource prioritization and allocation across the enterprise.

To meet the evolving needs of our customers and stakeholders, the Resource Allocation AOC workgroup continues to lead the development and implementation of improvements in VHA's resource prioritization and allocation process by:

- Filling leadership positions in Finance and WSS.

- Developing and conducting a recurring budget reporting program with leadership from program offices to improve transparency around budget needs and allow for an open line of communication throughout the organization and enhance funding guidance.

- Sustaining WSS authority for organizational and position structures.

- Continuing to advance technology to support data driven resource allocation decisions.

- Implementing early controlled funds release to improve planning and management of field funding

- Leveraging standing Chief Financial Officer teleconferences to address resource and budget allocation concerns.

- Realizing increases in recruitment of VA trainees through the National VHA Training and Education Program, utilization of the VA-Trainee Recruitment Event (VA-TRE) automated solution, and an increase in the number of participating medical centers.

- Strengthening leadership commitment by developing and implementing a VHA CO Resource Board, made up of AUSH level leadership, with the goal of unifying resource allocation and funding decisions across VHA CO.

- Providing training to the Manpower Community of Practice on organizational structure and staffing levels.

- Introducing evidence-based justifications to the VHA Medical Care program budget request process.

- In addition to leveraging the robust analytic capability for staffing and productivity provided in the Office of Productivity, Efficiency and Staffing (OPES), VHA will develop and implement staffing models for HR functions and other critical programs.

- Provided key data cleansing efforts in the implementation of Integrated Financial Acquisition Management System (iFAMS).

The section below provides examples of how the Resource Allocation area of concern effort aligns with actions being undertaken to address the other areas of concern.

Resource Allocation Alignment with Other Areas of Concern

- **Resource Allocation Alignment with Policies and Processes:**
    - The VHA Office of Finance has established a process to update annual VHA funding guidance and has coordinated with the policy office to meet new procedural requirements for promulgation. The VHA WSS has chartered and developed business support function standards. This

standardization will improve VHAs ability to manage and accomplish the mission. Over the next three to five years, the Resource Allocation workgroup will coordinate with the policy office for any new or revised policies as needed.

- 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 workgroup.

- WSS and the VHA Office of Finance will continue to update guidance and policies as system technology advancement occurs, ensuring compliance with federal regulations. This guidance will be maintained on central repositories and updated regularly as advancements continue.

- **Resource Allocation Alignment with Oversight and Accountability:**
  - As VHA continues to improve its manpower management and resource allocation processes, both documentation and adherence to new business processes will require governance to approve, monitor and enforce desired behaviors. Oversight will reinforce leadership's ability to prioritize and allocate resources. Utilizing HR Smart derived organizational charts, HR Smart being the workforce system of record (SOR), will ensure enterprise accuracy of data while improving the ability to view real-time status and trends.

  - The VHA Office of Finance has begun coordinating with the VHA governance structure to assist with ensuring that management allocates resources in line with leadership priorities based on evidence-based justification. VHA WSS is working closely with the Office of the VHA Chief of Staff to ensure hiring and position change requests meet manpower guidelines to maximize the efficiency and effectiveness of our organizational structure and staffing levels.

- **Resource Allocation Alignment with IT:**
  - As further progress is made in integrating manpower and financial management technologies, additional IT requirements will be coordinated with IT counterparts.

  - Both VHA WSS and the VHA Office of Finance have begun to deploy improved management systems that enhance reporting and executive visibility/transparency of human and financial resources. These systems improve the accuracy and timeliness of data used in analysis and decision making. Examples of manpower technology enhancements include the deployment of a light electronic action framework (LEAF) to track organizational and position change requests while the Department has

developed a Manpower Module within HR Smart. The updated HR Smart Module is a key IT deliverable.

- **Resource Allocation Alignment with Training:**
  - As part of managing risk associated with resource prioritization and allocation, VHA will continue to collaborate with the Training workgroup to verify and validate associated mandatory training and will adhere to VHA requirements for functional staff training development and implementation. The VHA WSS and the VHA Office of Finance are collaborating with the Training workgroup 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.

  - In FY 2021 – FY 2022, the Office of Workforce Management and Consulting continues expanding the health professional trainee (HPT) placement initiative by leveraging the VA-TRE model to connect, match and place HPTs in critical vacancies. VHA WSS will be rolling out additional HR Smart training for Managers to build awareness, promote adoption and reinforce utilization of system functionality like Manager Self-Service (MSS).

Unclear Resource Needs and Allocation Priorities – Actions Taken to Address GAO's "Not Met" Removal Criteria 2021 Rating

Unclear Resource Needs and Allocation Priorities received a "not met" rating from GAO for the following removal criteria: Demonstrated Progress; Monitoring. The below list provides details on actions taken by the AOC workgroup since the GAO-21-119SP High Risk Series was published in response to these "not met" ratings:

a. Actions Taken to Address Demonstrated Progress "Not Met" Rating

- VHA implemented a strategy to demonstrate progress that includes developing and executing processes that oversee and align to the Action Plan's strategic approach.

- VHA continuously reviews processes and identifies initiatives to improve the allocation of resources throughout the system. VHA developed an artifact collection process to collect and demonstrate the completion or sustainment of actions and share with GAO through agreed upon processes and cadence.

- In addition, VHA increases the transparency and accountability of progress by having the Action Plan published to the Federal Register.

- Furthermore, VHA developed an annual cycle for Action Plan updates to ensure content is current and documents all remediation activities occurring across VHA

Office of Finance and WSS. VHA increased leadership involvement, collaboration, and communication to ensure the GAO HRL Action Plan is a priority for all stakeholders.

- The FY 2021 Initiative Budget Call memorandum provided an opportunity for VHA program offices and regions to ensure funding requirements align to leadership priorities. The budget call program is being run again in FY 2022 and beyond. The VHA Office of Finance refines funding guidance by updating processes for program offices and regions to report the reallocation of funds. VHA took steps to refine the budget policy-making process using Evidence-Based Policymaking which was adopted and implemented beginning in the 2021 President's Budget.

- In FY 2021 – FY 2022, VHA WSS continued to refine VHA position management policy and internal controls to improve workforce position and vacancy data. VHA WMC actively manages the VHA workforce resources validation process by overseeing changes to organizational charts, position management, approval of change requests and responding to stakeholder inquiries on organizational and position structure. In FY 2021, VHA introduced staffing and vacancy transparency initiatives, including standardizing an RMC cover sheet and plans to further standardize the RMC process.

b. Actions Taken to Address Monitoring "Not Met" Rating

- VHA is implementing a strategy for monitoring that includes developing and implementing metrics that are aligned to root cause issues and demonstrate progress towards overall outcomes, overseeing the implementation, sustainment and change management which occurs as a result of the Action Plan and proactively reviewing metrics to ensure they are aligned to key Action Plan elements and give an accurate assessment of progress.

- VHA implemented standardized processes to monitor and report out on high priority resourcing. In addition, VHA is developing metrics that establish baselines and allow for progress tracking as the Action Plan is executed. The Action Plan's metrics and measures have been reported quarterly since Q3 FY 2020 and provide the data to assess and report progress to GAO. With the continued refinement and expansion of metrics and measures, monitoring processes, procedures and improvement throughout VHA will be increasingly robust and representative of progress.

- 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 WSS regularly meets with VHA leadership to review and discuss desired changes to authorized positions, onboard personnel and workload-based requirements. The VHA WSS is supporting comparative analysis between similar functions to inform resource allocation. A major accomplishment in FY 2020 was the execution of the VHA Redesign streamlining VHA and aligning like functions within the organization. In FY 2022-2023, enhanced resource monitoring is taking shape around resource boards at VHA and VAMCs.

- This Action Plan's metrics and measures have been assessed quarterly since Q3 FY 2020 and provide the data to assess and report progress to GAO. With the continued identification and refinement of metrics and measures, the monitoring of processes, procedures and improvement throughout VHA will be increasingly robust and representative of progress.

- The VHA is monitoring actions taken to ensure efforts achieve the intended progress. WSS has implemented a LEAF system to support the review and approval of position recruitment and change actions prior to updating HR Smart. Additionally, VHA has begun a Staffing and Vacancy Transparency Initiative to further standardize staffing level approvals. WSS and the VHA Resource Board (RB) will partner to review and resource proposed changes to organizational structure and staffing levels.

Status Key

This Action Plan submission denotes the status of implementation for each metric, outcome, and action graphically. The following Key can be used to understand the status graphics:
○ – "Not Met." Few, if any, actions toward meeting GAO's criterion for removal have been taken.
◐ - "Partially Met." Some, but not all, actions necessary to meet GAO's criterion have been taken.
● – "Met." Actions have been taken that meet GAO's criterion for removal. There are no significant actions that need to be taken to further address the criterion.
▲ - New or revised Root Cause.

Resource Allocation Outcome (RA-1)

Outcome Leads: Frank Costa, Resource Operation Officer

Shane Walker, PMP, MBA, Supervisor, Workforce Resources

Outcome Executives: Ogbeide Oniha, MA, Director, VHA Financial Management & Accounting Policy

Elizabeth Lowery, MA, Director, Manpower Management Office

Root Causes: VA lacks consistent resource management, oversight and execution plans.

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

RA-1a Metric: VHA will implement standard organizational structure codes (OSC) in HR Smart for all VHA positions. The metric is defined by the number of VHA positions in compliance with organizational structure code standards divided by the number of VHA positions. *The metric is to be reported during Q1 annually. The targets for this metric include:*

Q1 FY 2020 = 80%
Q2 FY 2023 = 90%
Q3 FY 2024 = 95%

RA-1b Metric: The success measure for this metric is defined by there being accurate and timely flow of information between HR and Financial Systems. The metric calculation is defined by the number of data elements integrated between HR Smart, iFAMS and other complementary systems. The metric is to be reported during Q1 annually starting in Q1 FY 2025.

RA-1c Metric: The success measure for this metric is defined by the number of HR staffing models implemented. The metric calculation is defined by implementing position management and classification staffing models. The metric is to be reported during Q1 annually starting in Q4 FY 2023.

- ***These Actions were developed prior to Goals and Objectives and are still aligned to the outcome.***

Table 5-1: RA-1 actions

Act. #	Action Details	Projected Date	Actual Date
◐ **1.0.0.1**	VHA Office of Finance and VHA WSS will continue to jointly lead the Resource Allocation Area of Concern through the FY 2023 submission	Q2 FY23	TBD
Status:	In Progress		
●**1.0.0.2**	**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 (VERA) 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.	Q1 FY20	Q1 FY20
Status: **Comments:**	Complete The budget was passed, and the VERA model was re-run to ensure appropriate allocation of funding based on workload data.		

Act. #	Action Details	Projected Date	Actual Date
●1.0.0.3	**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.	Q1 FY20	Q3 FY20
Status:	Complete		
Comments:	VHA CFO updated and issued guidance on the implemented process for reviewing medical facility allocations.		
●1.0.0.4	**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.	Q2 FY20	Q3 FY20
Status:	Complete		
Comments:	The implementation of this step has benefited VHA's CFO office by providing a valuable level of transparency and allowing for a more refined and accelerated processing structure by cutting down on the amount of follow ups needed between VHA CFO and Regions.		
●1.0.0.5	**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.	Q4 FY20	Q4 FY20
Status:	Complete		
Comments:	The implementation of this step has benefited VHA's CFO office by increasing transparency of transfer requests and justifications while standardizing the request and reporting processes.		
●1.0.0.6	Release mission-related funds to the field by the start of to assist with proper funds management and planning.	Q4 FY20	Q4 FY20
Status:	Complete		
Comments:	VHA Office of Finance released mission-related funds as scheduled ensuring medical centers and program offices have appropriate funding to continue providing healthcare to Veterans.		
●1.0.0.7	VHA Office of Finance will identify 3% of funds for potential transfer from Specified Program to General Program.	Q1 FY20	Q1 FY20
Status:	Complete		
Comments:	VHA Office of Finance completed a thorough analysis of both programs and identified the 3% threshold of funds for potential transfer.		
●1.0.0.8	Publish VA MMS Directive.	Q1 FY20	Q1 FY20
Status:	Complete		
Comments:	VA MMS Directive 5010 "Manpower Management Policy" HO WSS Policy has been published on October 28, 2019.		
●1.0.0.9	Publish Executive in Charge Memorandum identifying VHA WSS as owner of VHA headquarters and regional office organizational structure.	Q2 FY20	Q2 FY20
Status:	Complete		
Comments:	The EIC Memorandum titled "Maintenance of VA and VISN Office Organizational Structure" has been published to identify VHA WSS		

Act. #	Action Details	Projected Date	Actual Date
	as an owner which allows WSS insight and authority over organizational structures.		
●1.0.0.10	Publish VHA WSS SOP for frontline staff.	Q1 FY20	Q1 FY20
Status:	Complete		
Comments:	VHA WSS SOP on Hiring Requests and Change Requests has been published		

● **RA-1.1 Goal:** Deliver timely and transparent resource decisions.

● **RA-1.1.1 Objective:** VA will oversee VHA CO hiring requests through a Resource Validation Process.

Table 5-2. RA-1.1.1 actions

Act. #	Action Details	Projected Date	Actual Date
●1.1.1.1	VHA WSS will develop and communicate standard operating procedures to support efficient and effective resourcing decisions through the manpower validation process.	Q2 FY21	Q2 FY21
Status:	Complete		
Comments:	This new policy has been implemented. VHA WSS continues to develop and socialize SOPs to improve and integrate manpower management processes.		
●1.1.1.2	Hiring requests are tracked via the Workforce Resources Validation LEAF system.	Q3 FY20	Q3 FY20
Status:	Complete		
Comments:	The Workforce Resources Validation LEAF system has been implemented and VHA CO hiring requests are now tracked through the system increasing visibility into resource requirements.		
●1.1.1.3	VHA WSS will provide focused training to improve stakeholder knowledge and reinforce positive behaviors.	Q3 FY21	Q3 FY21
Status:	Complete		
Comments:	WSS utilizes the VHA Manpower monthly Community of Practice (CoP) to build and maintain awareness, desire, and knowledge (training) of our stakeholders to promote efficient prioritization of hiring and position change requests.		

● **RA-1.1.2 Objective:** VA will prioritize utilization of incentives and awards to meet human capital needs.

Table 5-3. RA-1.1.2 actions

Act. #	Action Details	Projected Date	Actual Date
●1.1.2.1	Report annual spend of Recruitment, Retention, and Relocation funds towards VHA top shortage occupations by VISN and healthcare system in VHA Workforce and Succession Strategic Plan.	Q2 FY22	Q2 FY22
Status:	Complete		

● **RA-1.1.3 Objective:** VA will continue to expand the health professions trainee (HPT) placement initiative by leveraging the new VA-Trainee Recruitment Event (VA-TRE) model to connect, match and place HPTs in critical vacancies.

Table 5-4. RA-1.1.3 actions

Act. #	Action Details	Projected Date	Actual Date
● **1.1.3.1**	Standardize training/education materials for recruitment and hiring processes for HPTs.	Q2 FY20	Q2 FY20
Status: **Comments:**	Complete VHA Workforce Management and Consulting (WMC) conducted a review of recruitment training/education materials and produced a standardized version of the materials.		
●**1.1.3.2**	Diffuse standardized training/materials for recruitment and hiring process for HPTs in the Field.	Q2 FY20	Q2 FY20
Status: **Comments:**	Sustaining The new standardized training/materials continue to be utilized by the field. Protocols have been established to socialize training/materials as needed during the recruitment and hiring process.		
●**1.1.3.3**	Develop, test, and implement the VA-TRE automated solution, HPT Placement Solutions. VHA will increase the number of facilities participating in VA-TREs.	Q1 FY22	Q1 FY22
Status:	Complete		
●**1.1.3.4**	VHA will increase HPT accepted offers annually.	Q2 FY22	Q2 FY22
Status:	Complete		

● **RA-1.1.4 Objective:** VHA will reduce Time to Hire and assure for flexibilities for recruitment of candidates and retention of staff.

Table 5-5. RA-1.1.4 actions

Act. #	Action Details	Projected Date	Actual Date
●**1.1.4.1**	VHA will conduct post COVID-19 Assessments on the utilization of authorities/flexibilities in compensation, staffing and ER/LR, to reduce time to hire.	Q1 FY23	Q3 FY21
Status:	Complete		

◐ **RA-1.2 Goal:** Support leadership managing their own resources.

◐ **RA-1.2.1 Objective:** VA leaders will have oversight and accountability of their manpower and financial resources to execute the mission.

Table 5-6. RA-1.2.1 actions

Act. #	Action Details	Projected Date	Actual Date
◐ **1.2.1.1**	AUSH and Chief Officer organizations will have an approved org chart based on their HR Smart derived manning document.	Q4 FY23	TBD
Status:	In Progress		
●**1.2.1.2**	VHA will conduct a bottom-up review of program office budgets.	Q4 FY21	Q4 FY21

Act. #	Action Details	Projected Date	Actual Date
Status:	Complete		

◐ **RA-1.2.2 Objective:** VA leaders will have real time access to human resources data.

Table 5-7. RA-1.2.2 actions

Act. #	Action Details	Projected Date	Actual Date
◐**1.2.2.1**	Build awareness and desire to use MSS and reissue technical training for HR Smart Manager Self-Service.	Q1 FY23	TBD
Status:	In Progress		
◐**1.2.2.2**	Reissue HR Smart technical training.	Q1 FY23	TBD
Status:	In Progress		
●**1.2.2.3**	Create dashboards to support business analysis for manager utilization of recruitment data.	Q4 FY22	Q4 FY22
Status:	Complete		

◐ **RA-1.3 Goal:** Standardize VHA resource planning and allocation processes.

◐ **RA-1.3.1 Objective:** VHA will develop a Staffing model for position managers.

Table 5-8. RA-1.3.1 actions

Act. #	Action Details	Projected Date	Actual Date
◐**1.3.1.1**	Conduct a review of position manager data quality.	Q1 FY22	TBD
Status:	In Progress		
◐**1.3.1.2**	Collaborate with VISNs to improve accuracy of HR Smart data.	Q2 FY22	TBD
Status:	In Progress		
◐**1.3.1.3**	Conduct HR Smart data cleansing.	Q3 FY22	TBD
Status:	In Progress		
◐**1.3.1.4**	Develop HR Staffing models.	Q4 FY22	TBD
Status:	In Progress		
○**1.3.1.5**	Implement HR Staffing models.	Q1 FY23	TBD
Status:	In Planning		

◐ **RA-1.3.2** Objective**:** VHA will build standardized organization charts and position descriptions.

Table 5-9. RA-1.3.2 actions

Act. #	Action Details	Projected Date	Actual Date
●**1.3.2.1**	Review Position Manager and Manpower Analysts (PDs) – standardized positions in the field.		Q4 FY21
Status:	Complete		
◐**1.3.2.2**	VHA will continue HR modernization efforts through the combined standardization of organizational structure and position descriptions.	TBD	TBD
Status:	In Progress		

● **RA-1.3.3 Objective:** VHA will improve oversight processes within VHA CFO on Specific Purpose Funding at the field and central office levels.

Table 5-10. RA-1.3.3 actions

Act. #	Action Details	Projected Date	Actual Date
●1.3.3.1	Standardize Program Office operating plans.	Q4 FY21	Q4 FY21
Status:	Complete		
●1.3.3.2	Monitor Medical Center funding allocations.		Pending Confirmation
Status: **Comments:**	Sustaining This action is in sustainment. We are confirming sustainment date.		
●1.3.3.3	Monitor execution of VHA CO station funds as it relates to operating plan.		Pending Confirmation
Status: **Comments:**	Sustaining This action is in sustainment. We are confirming sustainment date.		

○ **RA-1.3.4 Objective:** VHA will define policy and procedure to further standardize staffing level approvals.

Table 5-11. RA-1.3.4 actions

Act. #	Action Details	Projected Date	Actual Date
○1.3.4.1	VHA will review staffing level approval processes in VHA and the field.	Q2 FY23	TBD
Status:	In Planning		

◐ **RA-1.4 Goal:** Establish a board to centralize governance over the prioritization and allocation of VHA CO financial and human capital resources and continually work to identify ways to efficiently utilize resources.

◐ **RA-1.4.1 Objective:** VHA will maintain alignment of VHA CO human capital resources with organizational priorities to ensure Program Offices and initiatives have the human capital resources necessary to succeed.

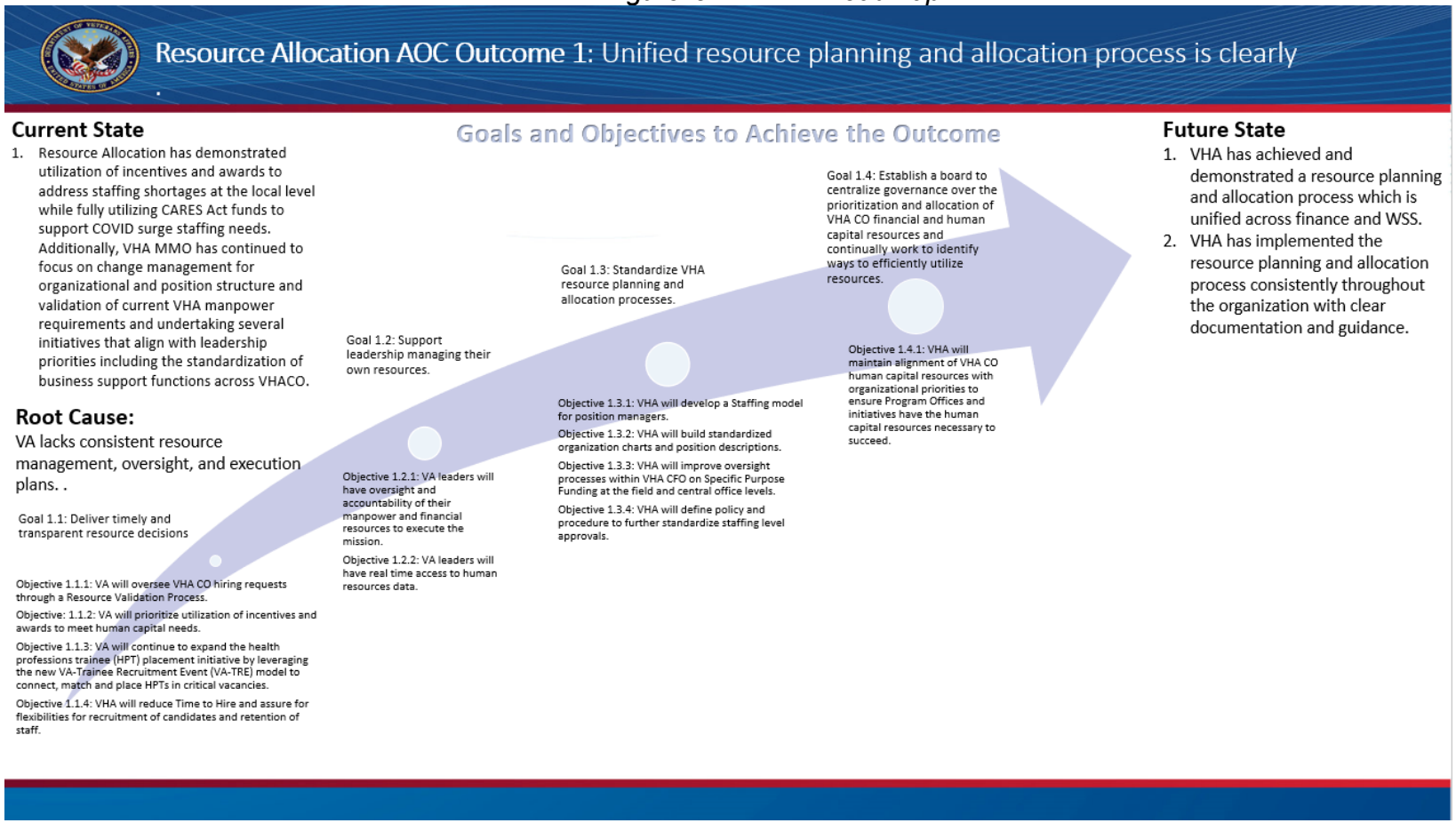
Table 5-12. RA-1.4.1 actions

Act. #	Action Details	Projected Date	Actual Date
●1.4.1.1	VHA will establish a board aligned under the VHA Chief of Staff, reporting to the VHA USH and ensure members of the board have the knowledge necessary to make specific recommendations according to VHA Strategic priorities.	Q1 FY22	Q1 FY22
Status:	Complete		
●1.4.1.2	VHA will develop the Board's mission and objectives to assess and address developing priorities and areas of concern.	Q3 FY22	Q1 FY22
Status:	Complete		

Act. #	Action Details	Projected Date	Actual Date
●1.4.1.3	VHA will create and sign the VHA CO Resources Board charter.	Q1 FY22	Q1 FY22
Status:	Complete		
◐1.4.1.4	VHA will realign financial and/or workforce resources to support new and changing priorities.	Q4 FY22	TBD
Status:	In Progress		
◐1.4.1.5	VHA will utilize SMEs from finance, human resources, governance, and other specialized fields to ensure best in class decisions are made.	Q4 FY22	TBD
Status:	In Progress		

Figure 5-2, below, visually presents the current state of this outcome, the desired future state of this outcome and the goals and supporting objectives that align and will contribute to the achievement of that future state.

Figure 5-2. RA-1 Roadmap



RA-1 Description of Actions Toward Removal Criteria

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

Leadership Commitment

- 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. VHA leadership takes advantage of the GAO HRL action plan to highlight and monitor initiatives that are critical to resource prioritization and allocation. Leadership commitment is evidenced by increased collaboration between Finance and WSS to ensure stakeholder buy-in on all action plan efforts. In addition, WSS and Finance leadership are identifying and communicating the linkage between GAO findings and organizational priorities, goals, and required actions, to program offices and field leaders.

Capacity

- VHA created a strategy that supports capacity goals by identifying and supporting work that addresses high-risk list findings. This includes reallocating and reprioritizing resources to achieve strategic priorities or goals and implementing change management approaches around relevant initiatives.

- VHA has taken several actions to ensure the capacity to achieve desired results. WSS reviews vacancies (backfills) on behalf of the VHA CO. The WSS and Finance Office stood up a resource board under the VHA Chief of Staff. In addition, VHA is leveraging relationships with stakeholders and program offices beyond Finance and WSS offices to support high-risk list activities. VHA currently partners with Oversight and Accountability and Policy Areas of Concern on numerous efforts in the action plan and will collaborate with other areas of concern as needed. VHA is incorporating change management and trainings into actions, objectives, and goals to ensure understanding and execution of requirements across all levels of the organization.

Monitoring

- VHA is implementing a strategy for monitoring that includes developing and implementing metrics that are aligned to root cause issues and demonstrate progress towards overall outcomes, overseeing the implementation, sustainment, and change management which occurs as a result of the action plan, and proactively reviewing metrics to ensure they're aligned to key Action Plan elements and give an accurate assessment of progress.

- VHA implemented standardized processes to monitor and report out on high priority resourcing. In addition, VHA is developing metrics that establish baselines and allow for progress tracking as the action plan is executed. The action plan's metrics and measures have been reported quarterly since Q3 FY 2020 and provide the data to assess and report progress to GAO. With the continued refinement and expansion of metrics and measures, monitoring

processes, procedures, and improvement throughout VHA will be increasingly robust and representative of progress.

Demonstrated Progress

- VHA implemented a strategy to demonstrate progress that includes developing and executing processes that oversee and align to the action plan's strategic approach.

- VHA continuously reviews processes and identifies initiatives to improve the allocation of resources throughout the system. VHA developed an artifact collection process to collect and demonstrate the completion or sustainment of actions and share with GAO via agreed upon processes and cadence. In addition, the publication of the Action Plan to the Federal Register to increase transparency and accountability. VHA continues to develop metrics collection process to collect and report on metrics quarterly. Furthermore, VHA developed an annual cycle for Action Plan updates to ensure content is current and documents all remediation activities occurring across finance and WSS. VHA increased leadership involvement, collaboration, and communication to ensure the GAO HRL action plan is a priority for all stakeholders.

Resource Allocation Outcome (RA-2)

Outcome Leads: Frank Costa, Resource Operation Officer

Shane Walker, PMP, MBA, Manager, Resource Management

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

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

RA-2a Metric: The success measure description for RA Outcome Metric 1 involves the initiative budget submissions from DUSHs and regions that contain evidence-based justifications. The metric is defined by the percent of regional and DUSH budget submissions containing support evidence. The calculation is defined by the number of submissions with evidence divided by the total number of submissions. Our baselines will be determined in FY21 and will be reported out on annually in Q4.

RA-2b Metric: The success measure for this metric is defined by a decrease in UFRs. The metric is defined by the percent decrease in number of UFRs from the baseline year. This will equal the number of UFRs in current FY divided by the number of UFRs in FY19. Our baseline was developed in FY20 and is currently undergoing refinement in FY22. This metric will be reported on annually in Q1.

RA-2c Metric: The success measure for this metric is defined by the percent of AUSH/CO organizations with an approved manning document. The metric is defined by the number of AUSH/CO organizations with an approved manning document divided by the number of AUSH/CO organizations. The milestone for this metric is FY21=10%. This metric will be reported on annually in Q2.

RA-2d Metric: The success measure for this metric is the percent of AUSH/CO organizations with an approved manpower assessment baseline. The metric for this is the number of AUSH/CO organizations with an approved manpower assessment baseline divided by the number of AUSH/CO organizations (18). The baseline will be determined in FY21 and will be reported on annually in Q1.

These Actions were developed prior to Goals and Objectives and are still aligned to the outcome.

Table 5-13. RA-2 actions

Act. #	Action Details	Projected Date	Actual Date
●2.0.0.1	Review the documents provided for the initiative budget submission request process in FY19 and identify updates to the document.	Q2 FY20	Q1 FY20
Status:	Complete		
Comments:	VHA Office of Finance reviewed and made refinements to the initiative budget submission to ensure appropriate budget requests were submitted.		
●2.0.0.2	Send out the Initiative Budget Call memorandum to the program offices and the regions.	Q3 FY20	Q3 FY20
Status:	Complete		
Comments:	VHA Office of Finance provided the Initiative Budget Call to all Program offices in a timely manner to allow adequate time to develop complete and accurate budget submissions.		
●2.0.0.3	Identify one program to implement VA's approach to Evidence-Based Policymaking in the 2021 Presidential Budget.	Q1 FY20	Q3 FY20
Status:	Complete		
Comments:	The Opioid Abuse Prevention Program Expansions was identified and completed this task.		
●2.0.0.4	VHA organizational chart updated and signed identifying Level of Authority 3.	Q2 FY20	Q3 FY20
Status:	Complete		
Comments:	The VHA organizational chart has been updated, signed, and made available to all stakeholders.		
●2.0.0.5	Begin socializing a manning document that supports VHA's ability to align resources with priorities.	Q3 FY20	Q3 FY20
Status:	Complete		
Comments:	A manning document has been developed and socialized to continue the effort to align resources with staffing priorities		
●2.0.0.6	Standard Business Support Function: Charter and develop a standard Business Support Function for VHA CO.	Q2 FY20	Q2 FY20
Status:	Complete		
Comments:	VHA standard Business Support Function has been chartered and developed.		

◐ **RA-2.1 Goal**: Align resources to leadership priorities

●**RA-2.1.1 Objective:** VA will improve organizational alignment of VHA

Table 5-14. RA-2.1.1 actions

Act. #	Action Details	Projected Date	Actual Date
●2.1.1.1	Implement "Streamline VHA LOE" recommendations.	Q2 FY21	Q1 FY21
Status:	Complete		
Comments:	These recommendations were implemented and assisted with streamlining VHA CO.		
●2.1.1.2	Establish organization specific station numbers for clearer lines of accounting, tracking, reporting and increased resource transparency.	Q1 FY21	Q1 FY21
Status:	Complete		

Act. #	Action Details	Projected Date	Actual Date
Comments:	Station numbers have been established and implemented which increase the visibility and transparency for station accounting tracking and reporting.		
●**2.1.1.3**	Review approximately 10,000 records in HR Smart on a reoccurring basis to enhance data integrity during the reorganization.	Q1 FY21	Q1 FY21
Status: **Comments:**	Complete WSS established the best practice of reviewing HR Smart records on an ongoing basis, which has assisted in providing stability during reorganizations.		
●**2.1.1.4**	Coordinate with Financial Service Center (FSC), Defense Finance Accounting Service (DFAS) and HR Information Systems (HRIS) to perform system updates.	Q1 FY21	Q1 FY21
Status: **Comments:**	Complete Lines of communication have remained strong across the various stakeholders as system updates continue to occur.		
●**2.1.1.5**	Accurately process Personnel Action Requests (PARs) for all impacted employees aligning them to the appropriate organizational structure.	Q1 FY21	Q1 FY21
Status: **Comments:**	Complete Completed the alignment of employees to appropriate organizational structures in accordance with PARs.		
●**2.1.1.6**	After action reviews (AAR) revealed successful realignment with minimal errors or pay issues to impacted employees.	Q1 FY21	Q1 FY21
Status: **Comments:**	Complete The AAR was completed and reviewed. The results showed that there were minimal errors or pay issues to impacted employees.		

◐ **RA-2.1.2 Objective:** VA will conduct an assessment of VHA CO position inventory by program office

Table 5-15. RA-2.1.2 actions

Act. #	Action Details	Projected Date	Actual Date
●**2.1.2.1**	VHA will update the VA Functional Organization Manual (FOM) annually, to accurately reflect current program office mission functions and tasks.	Q4 FY21	Q4 FY21
Status:	Sustaining		
◐**.2.1.2.2**	VHA will have its first approved manning document.	Q4 FY22	TBD
Status:	In Progress		
◐**2.1.2.3**	VHA will review same grade reporting and supervisory span of control.	Q3 FY23	TBD
Status:	In Progress		
○**2.1.2.4**	WSS will collect and analyze contract dollars/functions/FTE equivalents.	Q3 FY23	TBD
Status:	In Planning		
◐**2.1.2.5**	The Manpower Estimation Model (MEM) Tool will be utilized to capture baseline workload date for all VHA program offices.	Q3 FY23	TBD
Status:	In Progress		
○**2.1.2.6**	WSS will kick-off the triennial review process.	Q1 FY24	TBD
Status:	In Planning		

Act. #	Action Details	Projected Date	Actual Date
○**2.1.2.7**	WSS will conclude the first triennial review effort	Q2 FY27	TBD
Status:	In Planning		

● **RA-2.1.3 Objective:** VA will strengthen its Strategic Planning Process

Table 5-16. RA-2.1.3 actions

Act. #	Action Details	Projected Date	Actual Date
●**2.1.3.1**	Publish updates to VHA Directive 1075 of the strategic-operational planning processes.	Q4 FY20	Q4 FY20
Status: **Comments:**	Complete An update to the VHA Directive 1075 has been published to assist VHA organizations with long-range planning.		
●**2.1.3.2**	VA will implement a new electronic system to facilitate the annual strategic-operational planning process.	Q2 FY21	Q2 FY21
Status:	Complete		
●**2.1.3.3**	VA will utilize change management practices to enhance use of the strategic-operational planning process.	Q4 FY21	Q4 FY21
Status:	Complete		

◐ **RA-2.1.4 Objective:** VA will reduce the number of annual unfunded requests (UFR).

Table 5-17. RA-2.1.4 actions

Act. #	Action Details	Projected Date	Actual Date
◐**2.1.4.1**	Measure unfunded requests (UFR) annually and identify opportunities to minimize out of cycle resource needs.	Q3 FY22	TBD
Status:	In Progress		
○ **2.1.4.2**	Identify program offices that frequently submit UFRs.	Q2 FY22	TBD
Status:	In Planning		
○ **2.1.4.3**	Work with program offices to manage within budget.	Q4 FY22	TBD
Status:	In Planning		

◐ **RA-2.2 Goal**: Integrating VHA WSS Management Functions.

◐ **RA-2.2.1 Objective:** VA will integrate manpower management into routine operations to promote efficient and economical use of resources.

Table 5-18. RA-2.2.1 actions

Act. #	Action Details	Projected Date	Actual Date
○**2.2.1.1**	Liaisons are clearly identified for each AUSH/CO (LOA III) organization.	Q1 FY23	TBD
Status:	In Planning		
○**2.2.1.2**	Liaisons are competent and confident executing WSS policies and procedures.	Q4 FY23	TBD
Status:	In Planning		

Act. #	Action Details	Projected Date	Actual Date
●2.2.1.3	WSS will provide guidance and training to position managers, classifiers, and other stakeholders in the HR community.	Q2 FY21	Q2 FY21
Status:	Complete		
●2.2.1.4	VHA Finance will incorporate WSS into the annual President's Budget process.	Q3 FY21	Q3 FY21
Status:	Sustaining		

◐ **RA-2.2.2 Objective:** WSS will review VHA CO and VISN Office organizational structure.

Table 5-19. RA-2.2.2 actions

Act. #	Action Details	Projected Date	Actual Date
●2.2.2.1	Maintain organization chart review process for VISN offices.	Q2 FY20	Q2 FY20
Status:	Sustaining		
Comments:	VISN organization charts are reviewed and updated on an annual basis or as needed.		
●2.2.2.2	Ongoing monitoring of VHA CO organizational change process.	Q2 FY20	Q2 FY20
Status:	Sustaining		
Comments:	A process to monitor the VHA CO organization change process has been implemented.		
○2.2.2.3	WSS will create a Standard Operating Procedure for organizational change in VHA CO that aligns with VA Directive 0213.	Q2 FY23	TBD
Status:	In Planning		

◐ **RA-2.2.3 Objective:** WSS will standardize the organizational structure and approval of change requests for Medical Center Quad/Pentad positions.

Table 5-20. RA-2.2.3 actions

Act. #	Action Details	Projected Date	Actual Date
◐2.2.3.1	VHA will develop and implement standard organizational structure codes within the system of record HR Smart, to ensure Medical Center functions are aligned in a consistent fashion within similar organizational components across the enterprise.	Q4 FY21	TBD
Status:	In Progress		
●2.2.3.2	Publish SOP on process to request additional Senior Leadership positions at VAMCs.	Q1 FY21	Q1 FY21
Status:	Sustaining		
Comments:	The SOP on how to request additional Senior Leadership positions has been reviewed, published and communicated to VAMCs.		

◐ **RA-2.3 Goal**: VHA will align executive performance goals to resource and leadership priorities.

◐ **RA-2.3.1 Objective:** VHA will incorporate executive performance goals on resource prioritization and allocation.

Table 5-21. RA-2.3.1 actions

Act. #	Action Details	Projected Date	Actual Date
◐2.3.1.1	VHA will develop a standardized strategic plan/process for updating annual performance plans to align with VHA Strategic goals and priorities.	Q1 FY23	TBD
Status:	In Progress		
●2.3.1.2	WMC will launch a pilot program to improve the development of annual performance plans to align with VHA strategic goals and priorities.	Q4 FY22	Q2 FY22
Status:	Complete		
◐2.3.1.3	WMC will create and publish a SOP on annual updates for performance plans.	Q4 FY22	TBD
Status:	In Progress		
◐2.3.1.4	WMC will create a mechanism to monitor the development and completion of performance plans that align with VHA Strategic goals and priorities.	Q1 FY23	TBD
Status:	In Progress		

◐ **RA-2.3.2 Objective:** VHA will conduct training on finance processes to ensure education standards for new leaders at the facility level.

Table 5-22. RA-2.3.2 actions

Act. #	Action Details	Projected Date	Actual Date
●2.3.2.1	Establish a workgroup to manage and oversee the identification of training areas and the development of trainings.	Q1 FY22	Q1 FY22
Status:	Complete		
◐2.3.2.2	Align training goals with Leadership goals.	Q2 FY22	TBD
Status:	In Progress		
●2.3.2.3	Identify outdated or erroneous resource allocation training and sunset.		Pending Confirmation
Status: **Comments:**	Sustaining This action is in sustainment. We are confirming sustainment date.		
●2.3.2.4	Identify and implement best practices to ensure standardization across trainings and robust education standards are developed.		Pending Confirmation
Status: **Comments:**	Sustaining This action is in sustainment. We are confirming sustainment date.		
○2.3.2.5	Recruit SMEs to develop trainings.	Q3 FY22	TBD
Status:	In Planning		
○2.3.2.6	Implement Trainings.	Q4 FY22	TBD
Status:	In Planning		
○2.3.2.7	Create a feedback loop to measure benefits of training.	Q4 FY22	TBD
Status:	In Planning		

◐ **RA-2.4 Goal**: Standardizing and formalizing training and guidance for Financial Processes.

◐ **RA-2.4.1 Objective:** VHA will develop a standardized training and education program to train field users on budget processes.

Table 5-23. RA-2.4.1 actions

Act. #	Action Details	Projected Date	Actual Date
●2.4.1.1	VHA will conduct a field assessment to identify and prioritize budget training areas.	Q2 FY22	Q2 FY22
Status:	Complete		
◐2.4.1.2	VHA will identify SMEs to develop training curriculum and deliver training programs.	Q4 FY22	TBD
Status:	In Progress		
◐2.4.1.3	VHA will monitor & measure the effectiveness of training. VHA will perform reviews and to measure effectiveness & ensure education quality standards are met.	Q4 FY22	TBD
Status:	In Progress		

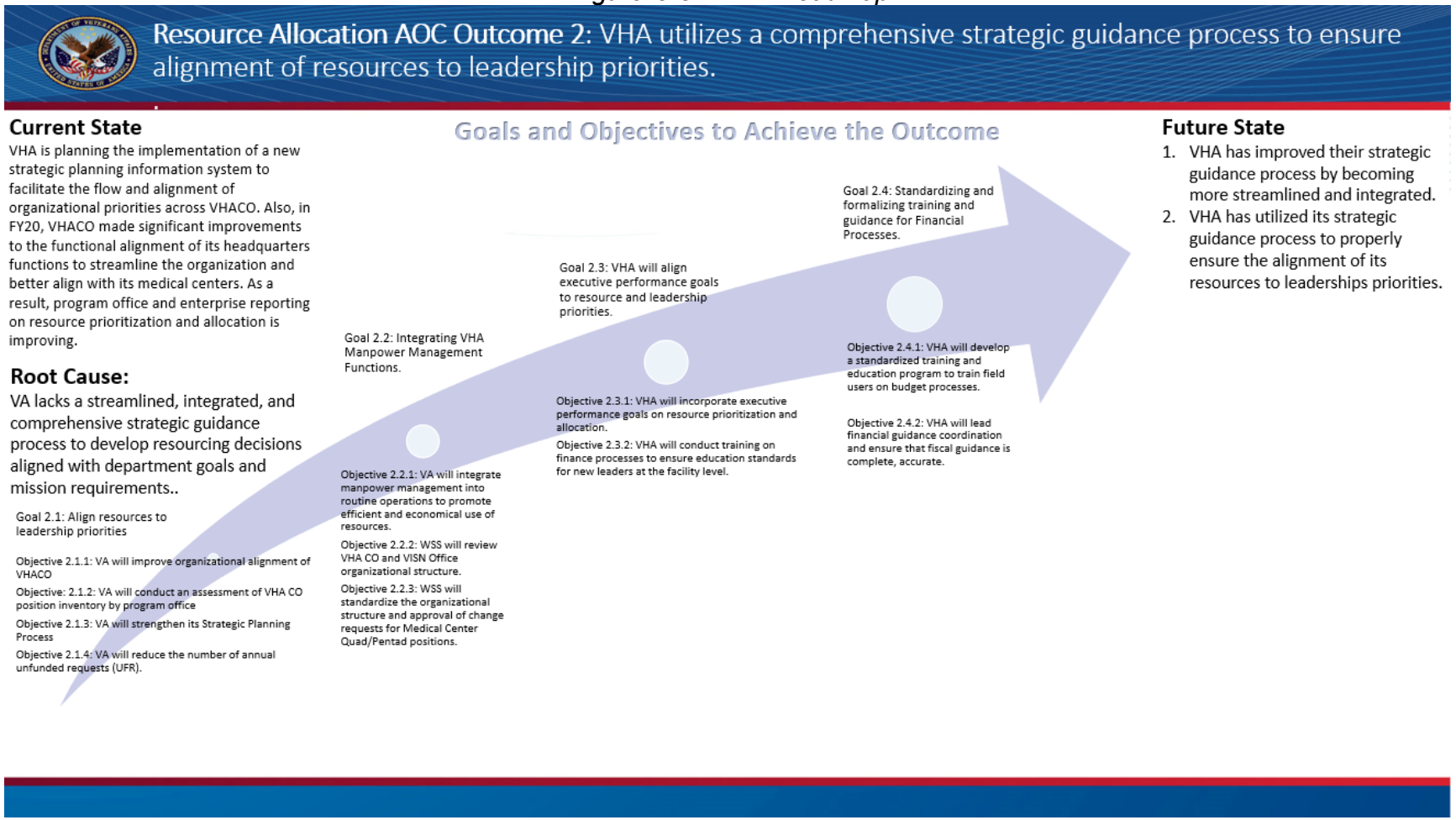
● **RA-2.4.2 Objective:** VHA will lead financial guidance coordination and ensure that fiscal guidance is complete, accurate.

Table 5-24. RA-2.4.2 actions

Act. #	Action Details	Projected Date	Actual Date
●2.4.2.1	VHA will improve the streamlining of guidance to the field regarding IVC implementation.	Q3 FY22	TBD
Status:	Sustaining		
Comments:	Projected date reflects end of sustainment period.		
●2.4.2.2	VHA will ensure policies align with VA policy.	Q4 FY22	TBD
Status:	Sustaining		
Comments:	Projected date reflects end of sustainment period.		
●2.4.2.3	VHA will collaborate with Medical Centers to refine the policy development process.	Q4 FY22	TBD
Status:	Sustaining		
Comments:	Projected date reflects end of sustainment period.		
●2.4.2.4	VHA will communicate policy changes to stakeholders on a routine basis.	Q4 FY22	TBD
Status:	Sustaining		
Comments:	Projected date reflects end of sustainment period.		
●2.4.2.5	VHA will maintain and promote tools set in place (SharePoint site) to assist with guidance dissemination and the addressment of field inquiries.	Q2 FY23	TBD
Status:	Sustaining		
Comments:	Projected date reflects end of sustainment period.		
●2.4.2.6	VHA will conduct periodic assessments of policy by SMEs and other resources. Place each guidance article through robust stages of review.	Q2 FY23	TBD
Status:	Sustaining		
Comments:	Projected date reflects end of sustainment period.		

Figure 5-3, below, visually presents the current state of this outcome, the desired future state of this outcome and the goals and supporting objectives that align and will contribute to the achievement of that future state.

Figure 5-3. RA-2 Roadmap



RA-2 Description of Actions Toward Removal Criteria

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

Leadership Commitment

- The VHA leadership is committed to ensuring alignment of resources to leadership priorities. In FY 2020, VHA identified standard business support functions. Additionally, VHA began the socialization of a manning document strategy that supports VHA's ability to align resources with priorities. In FY 2022-2023, WSS will focus on the utilization of staffing model data to further inform resourcing decisions. The VHA Office of Finance will require high-visibility medical program initiative budget submissions to include evidence-based justifications.

Capacity

- The VHA continues to take action to ensure the capacity to achieve desired results. In FY 2019, VHA established the VHA (WSS) as the authority for 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 2020 has allowed program offices and regions to be better prepared for future requirements and allow for more capacity to respond to requests. Also, in FY 2020, VHA WSS partnered with various VHA CO Program Offices to charter and define the core business support functions (BSF) that support VHA CO Program Offices in completing their mission. To be specific they are Financial Management, Administrative, Communications, Correspondence, Manpower, Contract Liaison and HR Liaison.

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 WSS regularly meets with VHA leadership to review and discuss desired changes to authorized positions, onboard personnel, and workload-based requirements. The VHA WSS is supporting comparative analysis between similar functions to inform resource allocation. A major accomplishment in FY 2020 was the execution of the VHA CO Redesign streamlining VHA CO and aligning like functions within the organization. In FY 2022-2023, enhanced resource monitoring is taking shape around resource boards at VHA CO and medical centers.

- This plan's metrics and measures have been reported quarterly since Q3 FY 2020 and provide the data to assess and report progress to GAO. With the

continued identification and refinement of metrics and measures, monitoring processes, procedures, and improvement throughout VHA will be increasingly robust and representative of progress.

Demonstrated Progress

- The FY 2021 Initiative Budget Call memorandum provided an opportunity for VHA CO program offices and regions to ensure funding requirements align to leadership priorities. The budget call program is being run again in FY2022 and beyond. The VHA Office of Finance refines funding guidance by updating processes for program offices and regions to report the reallocation of funds. VHA took steps to refine the budget policy making process using Evidence-Based Policymaking which was adopted and implemented beginning in the 2021 President's Budget.

Resource Allocation Outcome (RA-3)

Outcome Leads: Frank Costa, Resource Operation Officer

Shane Walker, PMP, MBA, Manager, Resource Management

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

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

RA-3a Outcome Metric: The success measure for this metric will be a reduction in variance in VAMC department codes within HR Smart. The metric is defined by the clean-up of approximately 12,000 department titles. The metric calculation, as a percentage, is defined by the total number of VHA Medical Center departments with a standard code divided by the total number of VHA Medical Center departments. The target for Q3FY21 is <5% non-compliant department codes, (Q4FY21, Q4FY22). The reporting period is annual in Q1.

RA-3b Outcome Metric: The success measure for this metric is the completion of PIAA testing and complete reviews. The metric is defined by the quarterly reduction on the percent of review left to complete PIAA testing. The baseline is Q3FY21 reduction by 25% through FY22, Q1 Q2 Q3. This will be reported on quarterly.

- ***These Actions were developed prior to Goals and Objectives, these actions are still aligned to the outcome***

Table 5-25. RA-3 actions

Act. #	Action Details	Projected Date	Actual Date
●3.0.0.1	Identify and pull FTE reports from the VHA Office of Finance and WSS and identify variances.	Q3 FY20	Q3 FY20
Status:	Complete		
Comments:	VHA WSS and Finance collaborated to identify and put into place, policies, and protocols for addressing FTE variances.		
●3.0.0.2	VHA WSS reviews and maintains approved structure at VHA headquarters and regional offices.	Q1 FY20	Q1 FY20
Status:	Sustaining		
Comments:	VHA WSS continues to review and maintain approved structures to ensure accurate representation of resources across VHA and VISNs.		
●3.0.0.3	Position Transparency Initiative: Monthly monitoring of variance.	Q1 FY19	Q1 FY19
Status:	Sustaining		
Comments:	VHA WSS continues to conduct monthly monitoring of variances.		
●3.0.0.4	Position Transparency Initiative: Increase communications to Position management population.	Q1 FY20	Q1 FY20
Status:	Complete		
Comments:	VHA WSS has strengthened and sustained lines of communication with the Position management population.		
●3.0.0.5	Position Transparency Initiative: Increase consultations as needed.	Q2 FY20	Q2 FY20
Status:	Complete		
Comments:	As per the Initiative, VHA WSS is working with stakeholders to conduct more frequent consultations as needed.		
●3.0.0.6	Implement LEAF system technology to track/report on manpower requirements.	Q2 FY20	Q2 FY20
Status:	Complete		
Comments:	The LEAF system technology has been implemented and provides data utilized to track and report on manpower requirements.		
○3.0.0.7	Implement HR Smart Manpower Module to track/report manpower requirements.	Q4 FY22	TBD
Status:	In Planning		

◐ **RA-3.1 Goal**: Develop internal controls to ensure accuracy of HR Smart data.

◐ **RA-3.1.1 Objective:** VA will make systemic enhancements to improve the accuracy of HR Smart data.

Table 5-26. RA-3.1.1 actions

Act. #	Action Details	Projected Date	Actual Date
●3.1.1.1	Recommend policy requirements around role access in HR Smart.	Q2 FY22	Q2 FY22
Status:	Sustaining		
◐3.1.1.2	VA will implement standard department codes in HR Smart.	Q4 FY21	TBD
Status:	In Progress		

● **RA-3.1.2 Objective:** VA will implement a Manpower Analyst function across the VHA enterprise.

Table 5-27. RA-3.1.2 actions

Act. #	Action Details	Projected Date	Actual Date
●3.1.2.1	VHA WSS will stand up a formal Manpower Analysis Program to govern the VISN and medical center manpower function.	Q3 FY21	Q3 FY21
Status:	Sustaining		
Comments:	Work continues to define policy, procedure, and tools for VISN Manpower staff and VHA support necessary to sustain this function		
●3.1.2.2	VHA WSS will conduct monthly CoP calls to build awareness and desire while reinforcing knowledge of the manpower analyst function.	Q1 FY20	Q1 FY20
Status:	Sustaining		
Comments:	CoP Calls are continuing to occur on a monthly basis to address stakeholder concerns and spread best practices		
●3.1.2.3	VHA will conduct an annual Manpower Analyst supervisor summit to build awareness and increase supervisory competency of the newly implemented function.	Q4 FY22	Q3 FY21
Status:	Complete		
Comments:	Complete VISN Manpower Summit conducted June 15-17, 2021. Agenda sent via email 02/10/22 for documentation		

○ **RA-3.1.3 Objective:** VHA will establish a training platform for enhanced proficiency and proper data entry.

Table 5-28. RA-3.1.3 actions

Act. #	Action Details	Projected Date	Actual Date
○3.1.3.1	On-demand technology training will be available for Manpower Analysts on an as-needed basis.	Q4 FY22	TBD
Status:	In Planning		
Comments:	Manpower Analyst training will be available on demand		

○ **RA-3.1.4 Objective:** VHA will define and disseminate manpower terminology.

Table 5-29. RA-3.1.4 actions

Act. #	Action Details	Projected Date	Actual Date
○3.1.4.1	VHA WSS will consolidate a draft glossary of terms with definitions.	Q4 FY22	TBD
Status:	In Planning		
○3.1.4.2	Collaborate with VA Manpower Management Service and SMEs to conduct a variance analysis and identify material differences.	Q2 FY23	TBD
Status:	In Planning		
○3.1.4.3	Disseminate approved manpower technology.	Q4 FY23	TBD
Status:	In Planning		

◐ **RA-3.2 Goal**: Modernize Financial Management Systems.

◐ **RA-3.2.1 Objective:** Conduct the VHA Configuration Validation Pre-Wave Activities for VHA's iFAMS implementation.

Table 5-30. RA-3.2.1 actions

Act. #	Action Details	Projected Date	Actual Date
●**3.2.1.1**	Determine VHA Funding Allocation between Specific Purpose and General-Purpose Funding.	Q4 FY21	Q4 FY21
Status:	Complete		
●**3.2.1.2**	Allocate funding in financial system by October 1.	Q1 FY22	Q1 FY22
Status:	Complete		
○**3.2.1.3**	In collaboration with the VA FMBTS team, VHA will develop a Pre-Wave Implementation Plan (WIP).	Q2 FY22	TBD
Status:	In Planning		
○**3.2.1.4**	In collaboration with the VA FMBTS team, VHA will develop baseline system configuration and system process flaws by the end of Q2 FY23 to meet its common end goal of VHA's iFAMS implementation.	Q2 FY23	TBD
Status:	In Planning		
○**3.2.1.5**	In collaboration with the VA FMBTS team, VHA will define its operating model, standardize business process, and prioritize capabilities across VISNs by end of Q2FY23 to meet its common goal of VHA's iFAMS implementation.	Q2 FY23	TBD
Status:	In Planning		
○ **3.2.1.6**	In collaboration with the VA FMBTS team, VHA will develop a Pre-Wave Test Plan	Q2 FY22	TBD
Status:	In Planning		

◐ **RA-3.2.2 Objective:** VA will conduct data cleansing and data conversion activities to prepare for VHA iFAMS implementation.

Table 5-31. RA-3.2.2 actions

Act. #	Action Details	Projected Date	Actual Date
●**3.2.2.1**	In collaboration with the VA FMBTS team, VHA will develop and approve a data cleansing strategy.	Q1 FY22	Q1 FY22
Status:	Complete		
●**3.2.2.2**	VHA will coordinate with VISNs, program Offices, CPACs, & CMOCs to assemble data SMEs.	Q2 FY22	Q2 FY22
Status:	Complete		
○**3.2.2.3**	In collaboration with the VA FMBTS team, VHA will develop a Pre-Wave Data Conversion Project Management Plan	Q3 FY22	TBD
Status:	In Planning		
○**3.2.2.4**	In collaboration with the VA FMBTS team, VHA will develop a Data Cleanse Plan.	Q4 FY22	TBD
Status:	In Planning		
○**3.2.2.5**	In collaboration with the VA FMBTS team, VHA will develop a Conversion Design Plan including Epics, Features and User Stories.	Q2 FY23	TBD
Status:	In Planning		

○ **RA-3.2.3 Objective:** VHA will conduct project planning and execution activities to prepare for VHA's implementation of iFAMS.

Table 5-32. RA-3.2.3 actions

Act. #	Action Details	Projected Date	Actual Date
○**3.2.3.1**	In collaboration with the VA FMBTS team, VHA will develop a Stakeholder Analysis Plan.	Q2 FY22	TBD
Status:	In Planning		
○**3.2.3.2**	In collaboration with the VA FMBTS team, VHA will develop a Program Level Project Management Plan (PMP)	Q3 FY22	TBD
Status:	In Planning		
○**3.2.3.3**	In collaboration with the VA FMBTS team, VHA will develop an Interface Development Project Management Plan	Q3 FY22	TBD
Status:	In Planning		
○**3.2.3.4**	In collaboration with the VA FMBTS team, VHA will develop a System Integration Plan (SIP)	Q4 FY22	TBD
Status:	In Planning		
○**3.2.3.5**	In collaboration with the VA FMBTS team, VHA will develop a OCM and Operational Readiness Plan.	Q4 FY22	TBD
Status:	In Planning		
○**3.2.3.6**	In collaboration with the VA FMBTS team, VHA will develop a Training Plan.	Q1 FY23	TBD
Status:	In Planning		
○**3.2.3.7**	In collaboration with the VA FMBTS team, VHA will develop a Communications Management Plan.	Q1 FY23	TBD
Status:	In Planning		

○ **RA-3.2.4 Objective:** VHA will implement iFAMS.

Table 5-33. RA-3.2.4 actions

Act. #	Action Details	Projected Date	Actual Date
○**3.2.4.1**	VHA will conduct multi-wave implementation.	Q2 FY25	Q2 FY28
Status	In Planning		

◐ **RA-3.3 Goal**: Implementing transparent and standardized processes.

◐ **RA-3.3.1 Objective:** VA will update and streamline budget distribution and reporting efforts.

Table 5-34. RA-3.3.1 actions

Act. #	Action Details	Projected Date	Actual Date
◐**3.3.1.1**	VHA program offices will conduct ongoing Budget briefs to VHA Leadership.	Q4 FY22	TBD
Status	In Progress		
●**3.3.1.2**	VHA will develop timely and effective communication to support resource planning and allocation decisions.	Q4 FY22	Q1 FY22
Status	Sustaining		

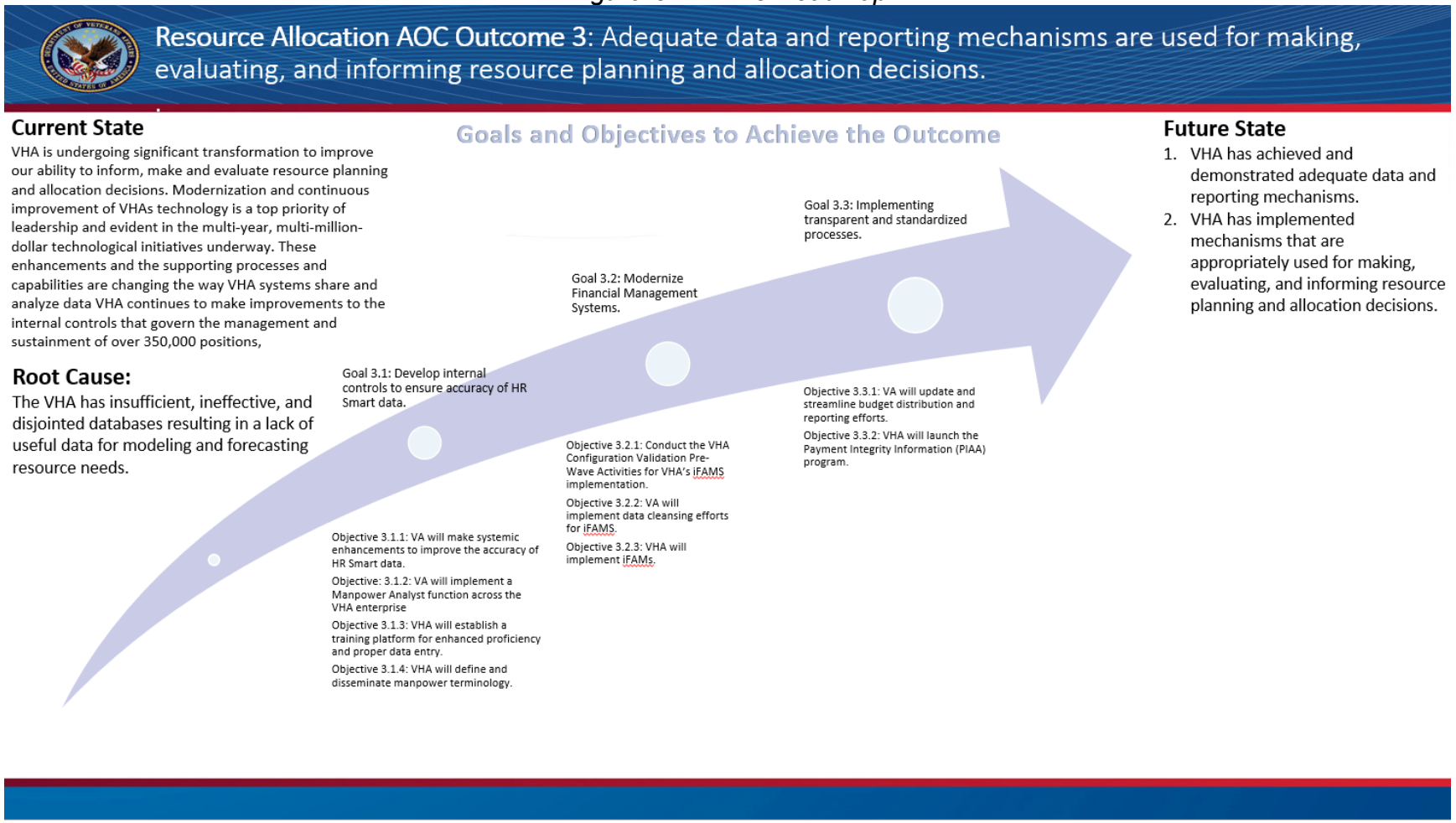
◐ **RA-3.3.2 Objective:** VHA will launch the Payment Integrity Information (PIAA) program.

Table 5-35. RA-3.3.2 actions

Act. #	Action Details	Projected Date	Actual Date
●3.3.2.1	VHA will conduct data extraction and mapping	Q1 FY22	Q1 FY22
Status	Complete	Q4 FY16	Q4 FY16
◐3.3.2.2	VHA will conduct risk assessments and produce statistical sampling and estimation methodology plans for High-Risk programs.	Q4 FY22	TBD
Status	In Progress		
◐3.3.2.3	VHA will update test plans and conduct PIAA testing.	Q3 FY22	TBD
Status:	In Progress		
○3.3.2.4	VHA will compile updates to formulate CAPs.	Q1 FY23	TBD
Status:	In Planning		
○3.3.2.5	VHA will complete High-Priority Reporting.	Q1 FY23	TBD
Status:	In Planning		

Figure 5-4, below, visually presents the current state of this outcome, the desired future state of this outcome and the goals and supporting objectives that align and will contribute to the achievement of that future state.

Figure 5-4. RA-3 Roadmap



RA-3 Description of Actions Toward Removal Criteria

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

Leadership Commitment

- VA leadership commitment has resulted in improved manpower management capabilities outlined in the VA draft Strategic Plan FY 2018 –FY 2024 as a critical element to VA's success, and SECVA has identified manpower management as a key priority. The Refreshed FY 2018 – FY 2024 VA Strategic Plan, Business Strategy 4.2.4, is to "Institute manpower management to optimize human capital resources." VHA WSS is responsible for implementing and sustaining a uniform organizational structure. VHA currently oversees and maintains the approved structure at VHA CO and VISN offices.

Capacity

- VHA continues to expand its capacity to monitor and improve data and reporting mechanisms that drive resource prioritization and allocation. This is evident in the rollout of new manpower and financial functionality. As well as governance like the VHACO Resource Board to oversee the optimization of human capital resources as defined in the VA Strategic Plan FY2018-2024.

Monitoring

- The VHA is monitoring actions taken to ensure efforts achieve the intended progress. WSS has implemented a LEAF system to support the review and approval of position recruitment and change actions prior to updating HR Smart. Additionally, VHA has begun a Staffing and Vacancy Transparency Initiative to further standardize staffing level approvals. WSS and the VHA RB will partner to review and resource proposed changes to organizational structure and staffing levels.

- This plan's metrics and measures have been reported quarterly since Q3 FY 2020 and provide the data to assess and report progress to GAO. With the continued identification and refinement of metrics and measures, monitoring processes, procedures, and improvement throughout VHA will be increasingly robust and representative of progress.

Demonstrated Progress

- In FY 2021 – FY 2022, VHA WSS continued to refine VHA position management policy and internal controls to improve workforce position and vacancy data. VHA WMC actively manages the VHA CO workforce resources validation process by overseeing changes to organizational charts, position management, approval of change requests, and responding to stakeholder inquiries on organizational and position structure. In FY 2021, VHA introduced staffing and vacancy transparency initiatives, including standardizing an RMC cover sheet and plans to further standardize the RMC process.

6. Portfolio Management Office - GAO-OIG Accountability Liaison Office

In October 2018, the GOAL Office was charged with overseeing VA's response to GAO's high-risk listing on VA Health Care. GOAL reports on GAO high-risk portfolio management activities to the DUSH. VHA increased GOAL's portfolio management capacity by leveraging existing 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.
- Driving portfolio management functions for VHA HRL efforts.
- Tracking and monitoring action plans.
- Reporting to senior leadership on risks, challenges and resources.
- Coordinating across work groups involved in addressing the areas of concern.
- Ensuring integration with select VA and VHA transformational initiatives.
- Congressionally Mandated Report and Congressional Tracking Report management for VHA.

Consistent with the Program Management Improvement and Accountability Act of 2015 (PMIAA), the GOAL Office continues to implement portfolio, program and project management to develop and institutionalize these functions that help to manage and coordinate efforts on this GAO high risk listing. In doing so, GOAL has been able to address many of the GAO removal criteria, which are intended to drive accountability and best practices in project and program management throughout the federal government.

To address the areas of concern and ultimately be removed from the HRL, VHA executives, managers and staff will have to commit to and sustain organizational change. Incorporating effective organizational change management (OCM) strategies into each area of concern action plan early in the process increases the likelihood that employees will be prepared to embed the changes needed to successfully transform. The GOAL Office has contracted experts in the field of OCM to develop a change management strategy, communications products, and other materials. The OCM team incorporates four key elements including leadership and stakeholder engagement, communications, workforce impact and training.

Status Key

This Action Plan submission denotes the status of implementation for each metric, outcome, and action graphically. The following Key can be used to understand the status graphics:

○ – "Not Met." Few, if any, actions toward meeting GAO's criterion for removal have been taken.

◐ - "Partially Met." Some, but not all, actions necessary to meet GAO's criterion have been taken.

● – "Met." Actions have been taken that meet GAO's criterion for removal. There are no significant actions that need to be taken to further address the criterion.

GOAL Office Action Plan

◐ **GOAL Office-1 Outcome Statement:** GOAL Office provides portfolio and program management to support resolving the areas of concern according to GAO's five criteria for removal (1) Leadership Commitment, (2) Capacity, (3) Action Plan, (4) Monitoring, and (5) Demonstrated Progress.

Status: Partially Met

GOAL Office-1a Outcome Metric: GAO's overall star rating for the listing Managing Risk and Improving VA Health Care.

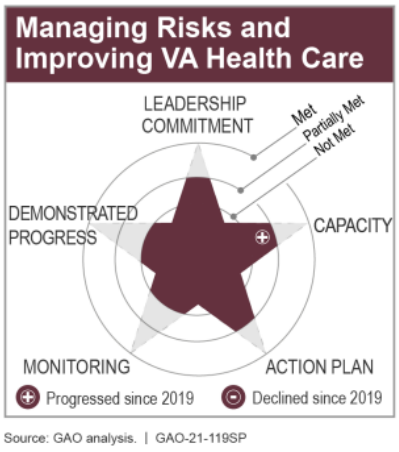


Figure 6-1: Managing Risks and Improving VA Health Care, 2021 Rating Goal

◐ **GOAL Office-1.1 Goal**: GOAL Office provides portfolio and program management to support Leadership Commitment criterion.

Status: Partially Met

◐ **GOAL Office-1.1.1 Objective:** Establish and maintain high-level governance structure

Status: In progress. VHA established the Health Care Listing Steering Committee in December 2020. In 2021, the GOAL Office restructured the Steering Committee to become agile and more decision oriented and then established and finalized a charter for how it operates and identified key executives to fulfill the role of the Chair. The Steering Committee meets monthly to discuss best practices, risks and issues, and schedules.

The HRL OVB first met in February 2021 and meets on a monthly basis. VHA and OIT Senior accountable officials meet with executive sponsors to continue to set expectations and goals for oversight of GAO HRL.

◐ **GOAL Office-1.1.2 Objective:** Establish and maintain organizational change and communications initiatives

Status: In progress. Change management and communications activities support action plan implementation and success. Sponsor assessments, coaching and communications messages are integrated into action items to support stakeholder understanding and promote leadership commitment to these efforts.

◐ **GOAL Office-1.1.3 Objective:** Improve collaboration through establishing networks within VA and with other federal agencies

Status: In progress. GOAL plans and executes strategy sessions with AOC workgroup leadership to coordinate planning efforts and share best practices for HRL removal strategies. GOAL is an active participant with OEI and Office of Management and Budget (OMB) that fosters inter-agency HRL work.

GOAL shares best practices, provides input and guidance on strategic direction, etc. To facilitate this collaboration, GOAL and Office of Acquisition, Logistics, and Construction (OALC) leadership attend regular meetings specific to the HRL to share best practices, provide input, and guidance on strategic direction.

◐ **GOAL Office-1.1.4**: Responding to legislation by submitting content to OEI for Congressionally Mandated Report (CMR) for 8 years

Status: In Progress. Section 7007 of the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020, enacted in January 2021, requires VA to submit to Congress a plan addressing certain high risk areas and provide annual updates on its progress, which provides an important oversight mechanism for VA's high-risk efforts. VA provided its first report to congress, July 2021. This reporting requirement is completed in July 2028, or sooner if VA is removed from the HRL.

Table 6-1. GOAL Office-1 Leadership Commitment actions

Act. #	Action Details	Projected Date	Actual Date
◐**1.1.1.1**	Establish and maintain High-level Governance Structure	Q4 FY25	TBD
IM-a:	Establish and operationalize Steering Committee	Q3 FY21	Q3 FY21
IM-b:	Selected Steering Committee Chairperson	Q3 FY21	Q3 FY21
IM-c:	Steering Committee Charter Signed	Q4 FY21	Q4 FY21
IM-d:	Established and operationalized Oversight Board	Q2 FY21	Q4 FY21
IM-e:	Selected Oversight Board Chairperson	Q3 FY21	Q1 FY22
IM-f:	Oversight Board Charter Signed	Q3 FY21	Q2 FY22
IM-g:	Maintain high level governance structure FY23	Q4 FY23	TBD
IM-i:	Maintain high level governance structure FY24	Q4 FY24	TBD
IM-j:	Maintain high level governance structure FY25	Q5 FY25	TBD
Resources:	GOAL		
Status:	In progress		
◐**1.1.2.1**	Establish and maintain organizational change and communications initiatives	Q4 FY25	TBD
IM-a:	Weekly consultations with Executive Director, NCOD	Q1 FY19	On-going
IM-b:	Execute Change Management Workshops (May 2019)	Q3 FY19	Q3 FY19
IM-c:	Conduct Sponsor Assessment	Q3 FY19	Q3 FY19
IM-d:	Establish GAO HRL Strategic Communications group	Q1 FY19	Q1 FY19
IM-e:	Develop meeting and briefing communication materials	Q1 FY19	On-going

Act. #	Action Details	Projected Date	Actual Date
IM-f:	Develop and distribute monthly GOAL Post (newsletter)	Q3 FY19	On-going
IM-g:	Maintain organizational change and communications initiatives	Q4FY25	TBD
Resources:	GOAL, NCOD		
Status:	In progress		
◐1.1.3.1	Improve collaboration through establishing networks within VA and with other federal agencies	Q4 FY22	TBD
IM-a:	Execute strategic planning sessions for AOC workgroups (5/6 total)	Q4 FY21	TBD
IM-b:	Initiate intra & interagency partnerships (OEI, DOD, ONDCP, OMB)	Q1 FY19	Q4FY21
IM-c:	Maintain collaboration with OALC counterparts	Q4 FY21	On-going
IM-d:	Initiate collaboration with OALC counterparts (MOU)	Q4 FY21	Q4 FY21
IM-e:	Plan and execute Drug Misuse Workshop	Q2 FY22	Q2 FY22
IM-f:	Facilitated interagency panel	Q4 FY21	Q4 FY21
IM-g:	Share HRL playbook with federal agency partners	Q4 FY21	Q4 FY21
IM-h:	Maintain collaboration for 5 years	Q4 FY25	TBD
Resources:	GOAL		
Status:	In progress		
◐1.1.4.1	Submit content to OEI for annual CMR	Q3 FY28	TBD
IM-a:	Develop template to align to legislative requirements	Q2 FY21	Q2 FY21
IM-b:	Complete action plan updates	Q3 FY21	Q3 FY21
IM-c:	First submission of content to OEI for annual CMR	Q3 FY21	Q3 FY21
IM-d:	Provide CMR Content to OEI FY22	Q3 FY22	Q3 FY22
IM-e:	Provide CMR Content to OEI FY23	Q3 FY23	TBD
IM-f:	Provide CMR Content to OEI FY24	Q3 FY24	TBD
IM-g:	Provide CMR Content to OEI FY25	Q3 FY25	TBD
IM-h:	Provide CMR Content to OEI FY26	Q3 FY26	TBD
IM-i:	Provide CMR Content to OEI FY27	Q3 FY27	TBD
IM-j:	Provide CMR Content to OEI FY28	Q3 FY28	TBD
Resources:	AOC workgroups and GOAL		
Status:	In Progress		

◐ **GOAL Office-1.2 Goal**: GOAL Office provides portfolio and program management to support Capacity criterion.

Status: Partially Met

● **GOAL Office-1.2.1 Objective:** Establish workgroups with specific responsibilities

Status: Complete. VA chartered a "task force" in 2016 but later determined that a more formal steering committee with dedicated area of concern workgroups was necessary to adequately address the major business functions. VA established the GAO HRL Steering Committee with 5 distinct workgroups for each area of concern. GOAL office developed and encouraged the use of individual AOC workgroup charters to further identify roles and responsibilities.

GOAL staffs and supports leadership and 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.

● **GOAL Office-1.2.2 Objective:** Provide guidance and training to staff and address skills gaps

Status: Complete. VA trained GOAL staff in disciplines critical to long-term success – program/portfolio management, risk management and change management. GOAL promulgated VA's designated change management approach, Prosci, through workshops and dedicated change management support. As requested, GOAL will provide additional guidance or support with respect to program and portfolio management.

◐ **GOAL Office-1.2.3 Objective:** Conduct Annual Resource Assessment for 5 years

Status: In progress. GOAL conducts an annual resource assessment to collate the universe of expenditures necessary to execute HRL actions and reporting and to identify any resource gaps. Three of 5 have been completed.

◐ **GOAL Office-1.2.4 Objective:** Conduct Annual Self-Assessment on GOAL's Program Management for 5 years

Status: In progress. GOAL conducts an annual self-assessment on program management to improve their ability to support the areas of concern workgroups by identifying and prioritizing improvement areas. Two of 5 have been completed.

◐ **GOAL Office-1.2.5 Objective:** Secure resources (funding or staff) to establish and maintain GOAL program management office (PMO) functionality

Status: In progress. Between 2018 and 2019, VA built the management capacity needed to address the areas of concern 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.

Table 6-2. GOAL Office-1 Capacity actions

Act. #	Action Details	Projected Date	Actual Date
● **1.2.1.1**	Establish workgroups with specific responsibilities	Q3 FY21	Q1 FY22
IM-a:	Establish HRL Task Force	Q4 FY16	Q4 FY16
IM-b:	Establish Steering Committee	Q4 FY19	Q4 FY20

Act. #	Action Details	Projected Date	Actual Date
IM-c:	AOC workgroups provide signed charters to Executive Oversight Board	Q2 FY21	Q4 FY21
IM-d:	Executive Oversight Board approves workgroup charters	Q3 FY21	Q1 FY22
Comment:	Actions taken before FY19 were performed by PMO prior to assignment to GOAL		
Resources:	GOAL		
Status:	Complete		
● **1.2.2.1**	Provide guidance and training to staff and address skills gaps	Q3 FY19	Q3 FY19
IM-a:	GOAL staff trained in Prosci	Q2 FY19	Q2 FY19
IM-b:	Conduct AOC workgroup Change Management workshop	Q3 FY19	Q3 FY19
IM-c:	Provide access to professional change manager to all AOC workgroups	Q1 FY19	Ongoing
IM-d:	Piloted AOC workgroup-specific change management plans	Q3 FY19	Q4 FY19
Resources:	GOAL and NCOD staff		
Status:	Complete		
◐ **1.2.3.1**	Conduct annual resource assessment for 5 years	Q4 FY24	TBD
IM-a:	Develop, distribute, and publish resource assessment FY20	Q4 FY20	Q1 FY21
IM-b:	Develop, distribute, and publish resource assessment FY21	Q4 FY21	Q4 FY21
IM-c:	Develop, distribute, and publish resource assessment FY22	Q4 FY22	TBD
IM-d:	Develop, distribute, and publish resource assessment FY23	Q4 FY23	TBD
IM-e:	Develop, distribute, and publish resource assessment FY24	Q4 FY24	TBD
Resources:	AOC workgroups and GOAL		
Status:	In Progress		
◐ **1.2.4.1**	Conduct annual self-assessment for GOAL PMO 5 years	Q4 FY25	TBD
IM-a:	Develop, distribute, and analyze the annual self-assessment FY20	Q4 FY20	Q4 FY20
IM-b:	Develop, distribute, and analyze the annual self-assessment FY21	Q4 FY21	Q4 FY21
IM-c:	Develop, distribute, and analyze the annual self-assessment FY22	Q4 FY22	TBD
IM-d:	Develop, distribute, and analyze the annual self-assessment FY23	Q4 FY23	TBD
IM-e:	Develop, distribute, and analyze the annual self-assessment FY24	Q4 FY24	TBD
Resources:	AOC workgroups and GOAL		
Status:	In Progress		
◐ **1.2.5.1**	Secure resources to establish and maintain GOAL program management function	Q4 FY27	TBD
IM-a:	Assume responsibility for active contracts in 2019	Q1 FY19	Q1 FY19
IM-b:	Close-out contracts at end of performance period	Q4 FY19	Q4 FY19
IM-c:	Obtain program management guidance from VHA Office of Healthcare Transformation	Q1 FY19	Q1 FY19
IM-d:	Consolidate and secure contract support for GOAL program management	Q4 FY22	TBD

Act. #	Action Details	Projected Date	Actual Date
IM-e:	Develop and obtain approval for transition plan to establish permanent PMO in GOAL	Q1 FY23	TBD
IM-f:	Initiate transition plan to permanent PMO	Q4 FY27	TBD
IM-g:	Complete transition plan to permanent PMO Q1 FY20	Q1 FY20	TBD
Resources:	GOAL		
Status:	In progress		
◐ 1.2.6.1	Establish and ensure continued project management support to AOC workgroups for 5 years	Q4 FY21	TBD
IM-a:	Assign project managers to support each AOC workgroup	Q1 FY19	Q1 FY19
IM-b:	Stand-up strategic communications group with representatives from each AOC workgroup	Q1 FY19	Q1 FY19
IM-c:	Support change management efforts for each AOC workgroup	Q1 FY19	Q1 FY19
IM-d:	Support change control process for each AOC workgroup	Q4 FY21	Q4 FY21
IM-e:	Support metrics collection process for each AOC workgroup	Q2 FY20	Q2 FY20
IM-f:	Support artifact collection process in IOP for each AOC workgroup	Q1 FY21	Q1 FY21
IM-g:	Support resource assessment for each AOC workgroup	Q4 FY20	Q1 FY21
IM-h:	Support action plan updates with technical and subject-matter expertise for each AOC workgroup	Q2 FY20	Q2 FY20
IM-i:	Provide administrative support for routine AOC workgroup meetings	Q1 FY19	Q1 FY19
IM-j:	Support ad-hoc workgroup-specific conferences (for example, Training, Drug Misuse)	Q3 FY21	Q3 FY21
IM-k:	Support development of briefing and reporting materials for each AOC workgroup	Q2 FY19	Q2 FY19
IM-l:	Support development of the IMS for each AOC workgroup	Q4 FY20	Q4 FY20
IM-m:	Ensure each AOC workgroup has project management support	Q4 FY21	Q4 FY21
IM-n:	Ensure each AOC workgroup has project management support	Q4 FY22	TBD
IM-o:	Ensure each AOC workgroup has project management support	Q4 FY23	TBD
IM-p:	Ensure each AOC workgroup has project management support	Q4 FY24	TBD
IM-q:	Ensure each AOC workgroup has project management support	Q4 FY25	TBD
Resources:	GOAL		

◐ **GOAL OFFICE-1.3 Goal**: GOAL Office provides portfolio and program management to support action plan criterion.

Status: Partially Met

● **GOAL Office-1.3.1 Objective:** PMO facilitated root cause analyses for each AOC

Status: Complete. In 2017, VA conducted a root cause analysis for each AOC which was accepted by GAO in 2018.

● **GOAL Office-1.3.2 Objective:** Obtain Departmental approval of outcomes for each AOC and facilitate mutual agreement between VA and GAO

Status: Complete. In 2019, GAO directed VA to clarify outcomes for each AOC and to work with GAO to achieve mutual agreement of those outcomes. GOAL facilitated and finalized those outcomes and achieved mutual agreement near the end of calendar year 2019.

● **GOAL Office-1.3.3 Objective:** Guide and facilitate establishment of goals and objectives for each outcome

Status: Complete. GOAL provided guidance to the AOC workgroups on establishing goals and objectives for each outcome. All 5 AOC workgroups established goals and objectives that are reflected in the action plan. Each AOC workgroup developed a roadmap that links goal and objectives to each outcome.

◐ **GOAL Office-1.3.4 Objective:** Provide PMO support for AOC workgroups to develop an integrated action plan with clear milestones and metrics

Status: In Progress. Subsequent to GAO's rating in 2021, VA focused on developing clear milestones and metrics for each outcome in the published action plan. GOAL developed guidance for metrics development to aid in understanding and communicating business benefits to stakeholders. AOC workgroups continue to refine actions and incremental milestones that contribute toward achieving objectives. Each AOC continues to develop performance metrics for each outcome.

GAO and VA established a regular meeting cadence to evaluate the action plan for essential elements. These regular meetings ensure VA and GAO are working according to a common understanding so the action plan will meet GAO's expectations during its upcoming rating cycle (FY23). VA and GAO meet bi-monthly throughout March 2022.

◐ **GOAL Office-1.3.5 Objective:** Establish, implement, and maintain a Change Control process for 5 years

Status: In Progress. The Change Control process was developed and implemented in FY19. The Change Control process ensures the integrity of the action plan, and any changes are documented and tracked. This process includes a Change Control Board (CCB) to effectively coordinate proposed changes to key products and systems (changes from areas of concern, GAO, etc.). The Change Control process was used to manage revisions to the 2021 updated action plan. The process is being used to manage revisions to the 2022 action plan. Sustainment for 5 years demonstrates a standardized process.

◐ **GOAL Office-1.3.6 Objective:** Make VA's action plan accessible and transparent

Status: In Progress. GOAL first posted VA's Action Plan to the Federal Register on December 18, 2020 and continues to do so on an annual basis. This regular process includes obtaining Secretary concurrence along with the requisite organizations within VA prior to publishing on the Federal Register. GOAL also makes the action plan available on the public-facing website: VA Plans, Budget & Performance.

Table 6-3. GOAL Office-1 actions

Act. #	Action Details	Projected Date	Actual Date
● **1.3.1.1**	PMO facilitated root cause analyses for each AOC	Q1 FY17	Q2 FY18
IM-a:	Conduct listening sessions with field staff	Q2 FY16	Q4 FY16
IM-b:	Brief senior leaders on root causes and obtain approval	Q3 FY16	Q4 FY16
IM-c:	Achieved mutual agreement from GAO on root causes for each AOC	Q1 FY17	Q2 FY18
Comment:	Actions taken before FY19 were performed by PMO prior to assignment to GOAL. This work was delayed due to PMO changes in the Office of Organizational Excellence.		
Resources:	AOC workgroups and GOAL		
Status:	Complete		
● **1.3.2.1**	Obtain Departmental approval of outcomes for each AOC and facilitate mutual agreement between VA and GAO	Q1 FY18	Q2FY19
IM-a:	HRL Task Force Workshop to develop outcomes	Q3 FY17	Q3 FY18
IM-b:	Brief and obtain senior leader approval for outcomes	Q4 FY17	Q4 FY18
IM-c:	Brief GAO on outcomes	Q1 FY18	Q2 FY19
Comment:	Actions taken before FY19 were performed by PMO prior to assignment to GOAL		
Status:	Complete		
● **1.3.3.1**	Guide and facilitate establishment of goals and objectives for each outcome	Q4 FY20	Q4 FY21
IM-a:	Develop guidance for goals and objectives	Q1 FY20	Q2 FY20
IM-b:	Provide guidance and conduct workshops to AOCs	Q2 FY20	Q2 FY20
IM-c:	Publish action plan with goals, objectives and roadmaps for AOC outcomes	Q4 FY20	Q4 FY21
Comment:	This work was delayed due to COVID-19 pandemic		
Resources:	AOC workgroups and GOAL		
Status:	Complete		
◐ **1.3.4.1**	Provide PMO support for AOC workgroups to develop an integrated action plan with clear milestones and metrics	Q3 FY21	TBD
IM-a:	Metric guidance development	Q1 FY20	Q2 FY20
IM-b:	Metric-consult workshops	Q1 FY20	Q1 FY20
IM-c:	Incorporate AOC workgroup metrics into revised FY20 action plan	Q2 FY20	Q2 FY20
IM-d:	Publish action plan that contains metrics for outcomes, goals or objectives	Q4 FY20	Q1 FY21
IM-e:	AOC workgroup's revised metrics and submitted for incorporation in FY21 action plan	Q2 FY21	Q2 FY22
IM-f:	Publish action plan that contains updated metrics	Q4 FY21	Q4 FY21
IM-g:	GOAL directed metrics workshops to develop clearer outcome milestones and outcome metrics	Q4 FY21	Q4 FY21

Act. #	Action Details	Projected Date	Actual Date
IM-h:	Incorporated revised metrics into FY22 action plan	Q2 FY22	Q2 FY22
IM-i:	Publish action plan that contains updated metrics	Q4 FY22	TBD
Comment:	The PMO process for revising and publishing metrics in the action plan has been consistent for 2 years and is sustained		
Resources:	AOC Workgroups and GOAL		
Status:	In Progress		
◐ **1.3.5.1**	Establish, implement, and maintain a Change Control process for 5 years	Q4 FY25	TBD
IM-a:	Draft change control process	Q2 FY20	Q2 FY20
IM-b:	Brief OVB and SC on change control process	Q2 FY21	Q1 FY21
IM-c:	Draft CCB charter and obtain approval	Q2 FY21	Q2 FY21
IM-d:	Change Control Board Meeting	Q4 FY22	TBD
IM-e:	Implement change control process for updated action plan FY21	Q4 FY21	Q4 FY21
IM-f:	Implement change control process for updated action plan FY22	Q4 FY22	TBD
IM-g:	Implement change control process for updated action plan FY23	Q4 FY23	TBD
IM-h:	Implement change control process for updated action plan FY24	Q4 FY24	TBD
IM-i:	Implement change control process for updated action plan FY25	Q4 FY25	TBD
Resources:	GOAL		
Status:	In Progress		
◐ **1.3.6.1**	Make action plan accessible and transparent	Q4 FY24	TBD
IM-a:	Provide GAO high risk list written strategy	Q4 FY16	Q4 FY16
IM-b:	Provide GAO with updated action plan	Q2 FY18	Q2 FY18
IM-c:	Post action plan to the external VA performance website and Federal Register for 5 years FY 20	Q4 FY20	Q1 FY21
IM-d:	Post action plan FY 21	Q4 FY21	Q4 FY21
IM-e:	Post action plan FY 22	Q4 FY22	TBD
IM-f:	Post action plan FY 23	Q4 FY23	TBD
IM-g:	Post action plan FY24	Q4 FY24	TBD
Comment:	Actions taken before FY19 were performed by PMO prior to assignment to GOAL		
Resources:	GOAL		
Status:	In Progress		

◐ **GOAL Office-1.4 Goal**: GOAL Office provides portfolio and program management to support Monitoring criterion.

Status: Partially Met

◐ **GOAL Office-1.4.1 Objective:** Develop and test checkpoint process

Status: In Progress. The check point process serves as the primary monitoring function driving consistency for how each AOC workgroup progresses from the planning phase to sustainment. Each phase is monitored

against GAO criteria for removal. GOAL has developed the process and next steps are to test it to determine if its value added.

◐ **GOAL Office-1.4.2 Objective**: Establish and maintain metrics dashboard for 5 years

Status: In Progress. The metrics dashboard measures individual action item progress toward stated milestones and targets for completion. The dashboard graphically depicts data, status, targets, and trends in a uniform format for knowledge-sharing and decision making. The dashboard allows for straightforward interpretation of performance efforts and targeted course corrections. Understanding that metrics may change, the dashboard was constructed with flexibility and scale in mind so that newly developed metrics can be easily incorporated. GOAL has developed the dashboard and captured results. Metrics are briefed to the OVB and reviewed for course corrections and changes. VA provides GAO with the metrics results and has shared 6 quarters of metric results with GAO since 2020.

◐ **GOAL Office-1.4.3 Objective**: Implement and maintain risk management for 5 years

Status: In Progress. The risk management framework to proactively identify risks and issues threatening HRL removal success and develop timely actions to mitigate those risks. The OVB holds regular review meetings to assess status and performance; senior officials report on program progress and potential risks. The risk management process is actively used across the portfolio. High severity risks and issues are brought to the attention of the OVB.

◐ **GOAL Office-1.4.4 Objective:** Implement and maintain an Integrated Master Schedule (IMS) for 5 years

Status: In Progress. The IMS serves as the central logistics consolidation point across the portfolio of activities ensuring dates, milestones, resources, dependencies and relationships do not conflict. Schedules from areas of concern are consolidated within the IMS. GOAL is consistently reviewing.

Table 6-4. GOAL Office-1 Monitoring actions

Act. #	Action Details	Projected Date	Actual Date
◐1.4.1.1	Develop and test checkpoint process	Q3 FY27	TBD
IM-a:	Develop checkpoint process	Q1 FY21	Q2 FY21
IM-b:	Create training materials	Q2 FY21	Q2 FY21
IM-c:	Test checkpoint process	Q3 FY22	TBD
Resources:	GOAL		
Status:	In Progress		
◐1.4.2.1	Establish and maintain metrics dashboard for 5 years	Q4 FY20	TBD
IM-a:	Create metrics dashboard	Q2 FY20	Q2 FY20

Act. #	Action Details	Projected Date	Actual Date
IM-b:	Obtain Initial metrics data from AOC workgroups	Q3 FY20	Q3 FY20
IM-c:	Submit initial metric data to GAO	Q4 FY20	Q4 FY20
IM-d:	Complete first cycle of dashboard with publication to IOP	Q1 FY21	Q1 FY21
IM-e:	*Collect metrics data and maintain metrics dashboard FY21	Q1 FY22	Q1 FY22
IM-f:	*Collect metrics data and maintain metrics dashboard FY22	Q1 FY23	TBD
IM-g:	*Collect metrics data and maintain metrics dashboard FY23	Q1 FY24	TBD
IM-h:	*Collect metrics data and maintain metrics dashboard FY24	Q1 FY25	TBD
Comments:	*"Maintaining the metrics dashboard" means: collecting metrics data from AOC workgroups regularly, updating the IOP, briefing OVB and incorporating executive input, submitting metrics data to GAO, incorporating metrics data in the updated action plan.		
Resources:	GOAL		
Status	In Progress		
◐1.4.3.1	Implement and maintain risk management for 5 years	Q4 FY24	TBD
IM-a:	Create risk management framework	Q1 FY19	Q1 FY19
IM-b:	Training AOC workgroups on risk management framework	Q3 FY19	Q3 FY19
IM-c:	Report area of concern risks to the Steering Committee (Quad Charts)	Q4 FY19	Q1 FY20
IM-d:	Report risks to the OVB	Q4 FY20	Q4 FY20
IM-e:	Maintain risk management across the portfolio FY21	Q4 FY21	Q4 FY21
IM-f:	Maintain risk management across the portfolio FY22	Q4 FY22	TBD
IM-g:	Maintain risk management across the portfolio FY23	Q4 FY23	TBD
IM-h:	Maintain risk management across the portfolio FY24	Q4 FY24	TBD
Resources:	GOAL		
Status:	In Progress		
◐1.4.4.1	Implement and maintain the IMS for 5 years	Q4 FY24	TBD
IM-a:	Develop list of activities and projected dates	Q1 FY20	Q1 FY20
IM-b:	Identify and link dependencies	Q2 FY20	Q2 FY20
IM-c:	Verify IMS with stakeholders	Q4 FY20	Q4 FY20
IM-d:	Maintain the IMS FY21	Q4 FY21	Q4 FY21
IM-e:	Maintain the IMS FY22	Q4 FY22	TBD
IM-f:	Maintain the IMS FY23	Q4 FY23	TBD
IM-g:	Maintain the IMS FY24	Q4 FY24	TBD
Resources:	GOAL		
Status:	In Progress		

◐ **GOAL OFFICE-1.5 Goal**: GOAL Office provides portfolio and program management to support Demonstrated Progress criterion.

Status: Partially Met.

● **GOAL Office-1.5.1 Objective:** Establish Artifact Management Process

Status: Complete. GOAL implemented this process for collecting, cataloging, and storing artifacts that demonstrate completion or sustainment of all area of concern actions identified in the action plan. This process drives a level of standardization for how artifacts are named and stored. GOAL reviewed the

process with GAO and the HRL Steering Committee in May 2020. The process is actively being utilized.

● **GOAL Office-1.5.2 Objective:** Establish Artifact Repository

Status: Complete. The artifact repository serves as central location for collecting, cataloging and storing artifacts that demonstrate completion or sustainment of all actions identified in the action plan. The repository drives a level of standardization for how artifacts are named and stored. The Integrated Operating Platform (IOP) houses the artifacts associated with the HRL portfolio.

◐ **GOAL Office-1.5.3 Objective**: Maintain Artifact Management Process for 5 years

Status: In Progress. To ensure progress and improvements are sustained, GOAL will collect and verify artifacts support completed and sustained area of concern actions. Upon request GOAL can deliver artifacts to GAO. GOAL has developed the standard operating procedure.

◐ **GOAL Office-1.5.4 Objective**: Establish and maintain Integrated Operating Platform (IOP) for 5 years

Status: In Progress. The IOP houses the artifacts associated with the HRL portfolio. This includes but is not limited to communications materials, metrics dashboards, charters, meeting notes and historical documents.

Table 6-5. GOAL Office-1 Demonstrated Progress actions

Act. #	Action Details	Projected Date	Actual Date
●1.5.1.1	Establish Artifact Management Process	Q3 FY20	Q3 FY20
IM-a:	Develop artifact management process	Q1 FY20	Q1 FY20
IM-b:	Brief process to HRL Steering Committee	Q2 FY20	Q2 FY20
IM-c:	Brief process to GAO	Q3 FY20	Q3 FY20
Resources:	GOAL		
Status:	Complete		
●1.5.2.1	Establish the Artifact Repository	Q3 FY20	Q3 FY20
IM-a:	Collect requirements from stakeholders	Q1 FY20	Q1 FY20
IM-b:	Develop artifact repository	Q2 FY20	Q2 FY20
Resources:	AOC workgroups and GOAL		
Status:	Complete		
◐1.5.3.1	Maintain Artifact Management Process for 5 years	Q4 FY24	TBD
IM-a:	Develop standard operating procedure for artifact process	Q2 FY20	Q2 FY20
IM-b:	Initiate collection of artifacts from AOC workgroups which demonstrate action sustainment	Q3 FY20	Q3 FY20
IM-c:	Verify artifacts support sustainment	Q4 FY20	Q4 FY20
IM-d:	Maintain artifact management process FY21	Q4 FY21	TBD
IM-e:	Maintain artifact management process FY22	Q4 FY23	TBD
IM-f:	Maintain artifact management process FY23	Q4 FY24	TBD

Act. #	Action Details	Projected Date	Actual Date
IM-g:	Maintain artifact management process FY24	Q4 FY25	TBD
Resources:	AOC workgroups and GOAL		
Status:	In progress		
◐1.5.4.1	Establish and Maintain IOP for 5 years	Q4 FY24	TBD
IM-a	Collect requirements from stakeholders	Q1 FY20	Q1 FY20
IM-b:	Work with developers to clarify and implement requirements	Q2 FY20	Q2 FY20
IM-c:	Release IOP for use	Q4 FY20	Q4 FY20
IM-d:	Maintain IOP FY21	Q4 FY21	Q4 FY21
IM-e:	Maintain IOP FY22	Q4 FY22	TBD
IM-f:	Maintain IOP FY23	Q4 FY23	TBD
IM-g:	Maintain IOP FY24	Q4 FY24	TBD
Resources:	GOAL		
Status:	In Progress		

Capacity – VA Resources Involved in GAO HRL Efforts

Table 6-6. VA Resources Involved in GAO HRL Efforts

Managing Risks and Improving Health Care

Area of Concern	Estimated Government FTE (#)	Estimated Contract Support ($)
Policies and Process	9	$657,000
Training	10	$1,250,000
Oversight and Accountability	37	$2,375,000
Resource Allocation	20	$2,000,000
GOAL	4	$3,274,920.00
TOTAL	**80 FTE**	**$9,556,920**

7. Appendices

Table 7-1. List of Area of Concern Outcomes and Self-Assessed Ratings

Area of Concern Outcomes	Self-Assessed Status
Policies and Processes	
P&P-1: Senior leaders support the publication of implementable policy aligned to strategic objectives by adhering to procedural publication requirements and ensuring VHA stakeholders receive consistent messaging	In progress
P&P-2: VHA policy development, recertification, and amendment processes function with integrity according to VHA Directive 6330, including integration of Risk Management Framework (RMF) using an adaptable framework that enables policy development to conform to the enterprise risk management system established and updated by VHA Oversight and Accountability executives	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-1: VHA operating units 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: VHA oversight efforts support governance and management decisions are made at the appropriate level of the organization, are informed by reliable data, are timely implemented and focused on intended outcomes	In progress
OA-3: Leadership holds VHA organizations accountable to fulfill obligations imposed by decisions, regulations, and other requirements	In progress
OA-4: VHA supports a culture of safety and integrity that fosters trust, integrity, learning, and collaboration	In progress
Information Technology	
IT-1: Improve system interoperability to execute core health care mission functions	In planning

Area of Concern Outcomes	Self-Assessed Status
IT-2: To improve IT solution delivery and large program management oversight practices to effectively deliver business and veteran oriented solutions	In planning
IT-3: VA clinicians are able to access patient clinical data from DoD systems (AHLTA/Cerner) through their EHR (VistA/Cerner)	In planning
Training	
TOC-1: Training is …. • Developed in response to priorities that align with VHA mission and goals • Delivered to nationally specified standards. • Evaluated based on performance measurements and results that align with VHA mission and goals.	In progress
TOC-2: Accurately identified audience is trained at the appropriate time to specific program/process requirements	In progress
TOC-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-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

Table 7-2. List of Root Causes and AOC Outcomes Addressed

Root Cause ID	New/Revised /Unchanged	Root Causes	Outcome ID
	Policies and Processes		
1	Revised	National policies do not consistently align with agency priorities and needs, which means that the field cannot always follow policy and act consistently with priorities and needs	**P&P-1** Senior leaders support the publication of implementable policy aligned to strategic objectives by adhering to procedural publication requirements and ensuring VHA stakeholders receive consistent messaging
2	Unchanged	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	**P&P-2** VHA policy development, recertification, and amendment processes function with integrity according to VHA Directive 6330, including integration of Risk Management Framework (RMF) using an adaptable framework that enables policy development to conform to the enterprise risk management system established and updated by VHA Oversight and Accountability executives
3	Unchanged	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	**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

Root Cause ID	New/Revised /Unchanged	Root Causes	Outcome ID
4	Unchanged	VHA rarely embedded policy in a broader change strategy to support implementation by the field	**P&P-4** VHA standards and implementing processes are transparent and accessible to appropriate stakeholders
	Oversight and Accountability		
1	Unchanged	VHA has a fragmented oversight operating model that impedes on VHA's ability to effectively communicate across program offices, oversee policy implementation and ensure organizational accountability	**OA-1** VHA operating units and employees demonstrate timely and effective risk management in accordance with a unified risk management framework to support governance and oversight
2	Unchanged	VHA has a fragmented oversight operating model that impedes its ability to effectively oversee policy implementation and ensure organizational accountability	**OA-2** VHA oversight efforts support governance and management decisions are made at the appropriate level of the organization, are informed by reliable data, are timely implemented and focused on intended outcomes
3	New	VHA has fragmented administrative functions that impede its ability to effectively respond to identified risks and issues to ensure organizational accountability and promote integrity	**OA-3** Leadership holds VHA organizations accountable to fulfill obligations imposed by decisions, regulations, and other requirements
4	New	There are organizational cultural gaps between those delivering health care in the field and VHA that impedes VHA's ability to oversee and enhance ethical practice throughout the organization	**OA-4** VHA supports a culture of safety and integrity that fosters trust, integrity, learning, and collaboration

Root Cause ID	New/Revised /Unchanged	Root Causes	Outcome ID
	Information Technology Challenges		
1	Unchanged	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	**IT-1** Improve system interoperability to execute core health care mission functions
2	Revised	Weaknesses in VA OIT solution delivery and large program management oversight impact VA ability to deliver the IT capabilities needed by VHA.	**IT-2** Integrate VHA systems modernization with VA wide IT modernization efforts to reduce VHA reliance on legacy systems which do not support their business needs
3	New	Limited DoD/VA agreement on approach, common IT infrastructure or data standards required to improve joint interoperability	**IT-3** VA clinicians are able to access patient clinical data from DoD systems (AHLTA/Cerner) through their EHR (VistA/Cerner)
	Training		

Root Cause ID	New/Revised /Unchanged	Root Causes	Outcome ID
1	Revised	VA lacks a comprehensive, enterprise-wide training policy and oversight process	**TOC-1** Training is: • 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
2	Unchanged	VA lacks a systematic approach to competency assessment and execution	**TOC-2** Accurately identified audience is trained at the appropriate time to specific program/process requirements.
3	Unchanged	Inadequate resources for development and implementation of appropriate educational infrastructure at the enterprise and administration levels	**TOC-3** Using the most resource-efficient approach, training is planned and developed, coordinated, and implemented, then evaluated and managed to achieve effective training outcomes
	Resource Allocation		
1	Unchanged	VA lacks consistent resource management, oversight and execution plans.	**RA-1** Unified resource planning and allocation process is clearly documented and consistently applied.

Root Cause ID	New/Revised /Unchanged	Root Causes	Outcome ID
2	Unchanged	VA lacks a streamlined, integrated, and comprehensive strategic guidance process to develop resourcing decisions aligned with department goals and mission requirements.	**RA-2** VHA utilizes a comprehensive strategic guidance process to ensure alignment of resources to leadership priorities.
3	Unchanged	The VHA has insufficient, ineffective, and disjointed databases resulting in a lack of useful data for modeling and forecasting resource needs.	**RA-3** Adequate data and reporting mechanisms are used for making, evaluating, and informing resource planning and allocation decisions.

Table 7-3. Metrics for Assessing Progress by AOC and AOC Outcome

Metric ID	Metric Description
Policies and Processes	
P&P-1: Senior leaders of VHA programs and initiative incorporate Department's strategic goals and support the need for aligned, unambiguous policies and consistent policy implementation	
P&P-1.1a	Percent of published policy with addressed resources as documented in the pre-policy form. Calculated as the number of published directives using the pre-policy form divided by the total number of published directives. Reported quarterly.
P&P-1.1.1a	VHA Directives and Resources: All published VHA directives are reviewed for adequate implementation resources (in existence or approved). Reported quarterly.
P&P-1.1.2a	VHA Directives and Resources: All published VHA directives are reviewed for adequate implementation resources (in existence or approved). Reported annually.
P&P-1.2a	Percent of documents on the VHA publication website that are directives and notices. Calculated as the number of directives and notices divided by the total number of site entries. Reported Q2 and Q4 each FY.
P&P-1.2.1a	Policy Inventory: Streamline the policy inventory to directives and notices, eliminating handbooks and manuals. Reported quarterly.
P&P-1.2.2a	Policy Inventory: Streamline the policy inventory to directives and notices, eliminating handbooks and manuals. Reported quarterly.
P&P-1.3a	RAP reviews 100% of operational memoranda sent to RAP to ensure policy content is not included prior to publication. Calculated by the number of operational memoranda reviewed by 10BRAP divided by the total number of operational memoranda sent to 10BRAP. This metric will develop over time as VHA's organizational capacity to monitor and enforce the process increases. Reported Q2 and Q4 each FY.

Metric ID	Metric Description
P&P-1.3.1a	Operational Memoranda Reviews: RAP reviews all VHA operational memoranda for policy content prior to publication. Reported annually.
P&P-1.3.2a	Operational Memoranda Reviews: Directive managers assist program offices in identifying applicable operational memoranda during the directive development process. Reported annually.
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 (RMF).	
P&P-2.1a	The average number of days from SharePoint field review to publication for all new policies and recertifications. Calculated as the total number of days for each process policy (aggregated) divided by the number of policies processed. Reported in Q2 and Q4 each FY.
P&P-2.1.1a	Standard Timeframe for VHA policy development and recertification: VHA policy development (writing new policies) and recertification (updating existing policies) occur within the standard timeframe. Reported Q2 & Q4.
P&P-2.1.2a	Policy Development Timeline: assessed annually.
P&P-2.2a	Percent of key stakeholders identified by VHA (i.e., AUSH offices) that concur for each directive. Calculated by the number of offices that concur divided by the total number of offices identified. Reported quarterly.
P&P-2.2.1a	Stakeholder Feedback during VHA policy development: VHA policy development (writing new policies) and recertification (updating existing policies) include receiving stakeholder feedback from all appropriate service lines and program offices. Reported Quarterly.

Metric ID	Metric Description
P&P-2.2.2a	Stakeholder Feedback during VHA policy development: VHA policy development (writing new policies) and recertification (updating existing policies) undergo review by and receive concurrence from VHA Assistant USH in VIEWS. VHA policy is not published until AUSH non-concurs are resolved, to include enterprise-wide concerns for implementation, oversight, and risk management. Reported Quarterly.
P&P-2.3a	Percent of policies that are overdue for recertification. Calculated as the number of overdue policies divided by the total number of policies. Reported quarterly.
P&P-2.3.1a	Percent of VHA policies overdue for recertification: VHA national policies are current and have been reviewed and recertified in the prior five years (to the extent possible, e.g., pending regulations). Reported quarterly.
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-3.2.1a	Reduction of local policies: Reduced redundant and unnecessarily complex local policy for medical facilities. Reported Q2 & Q4.
P&P-3.2.3a	Engagement among stakeholders: Regular informational and educational sessions occur among RAP and policy stakeholders. Reported Q2 & Q4.
P&P-4: VHA standards and implementing processes are transparent and accessible to appropriate stakeholders	
P&P-4.1a	Number of VAMCs and health care sites connected to the central repository / total number of VAMCs and health care sites.
P&P-4.1b	Percent of policies national and local that utilize the common numbering system

Metric ID	Metric Description
Oversight and Accountability	
OA-1: VHA operating units and employees demonstrate timely and effective risk management in accordance with a unified risk management framework to support governance and oversight	
OA-1a	Percentage of operating units updating risks in a timely fashion. To be reported quarterly starting in FY23 calculated by number of risks responses and associated internal controls updated by due date over the total number of risks requiring updates.
OA-1b	Elapsed days between formal submission of candidate risk to Risk Working Group and approval or rejection by Risk Subcommittee. To be reported annually based on the number of candidate risk submissions. Elapsed time between submission to the Risk Working group and Risk Subcommittee decision not to exceed 120 days.
OA-1c	Percentage of principle offices with at least one active risk on the VHA ERR. To be reported quarterly to the Audit, Risk and Compliance Committee starting in Q3FY22 once a revised baseline VHA ERR has been approved by the Risk Subcommittee. Calculation = number of principle offices with ownership of listed risks over total number of principle offices.
OA-1d	Percentage of operating units actively participating in Integrated Risk Management. To be reported annually with a goal of 100%
OA-1.1.1a	Annual review of charters for each major risk governance body established. To be reported annually with a summary of major changes to each charter.
OA-1.1.2a	Audit, Risk and Compliance Committee, Risk Subcommittee and Oversight and Compliance Committee to meet quarterly each FY.

Metric ID	Metric Description
OA-1.1.3a	Percentage of VHA key stakeholders reporting that they understand VHA's risk governance structure and risk management framework is expected to reach 75% by end of FY 2023. The data will be reported annually beginning in FY 2022.
OA-1.1.3b	Attendance of representatives at risk related governance meetings. Governance groups include Audit, Risk and Compliance Committee; Risk Subcommittee; Oversight and Compliance Subcommittee. Target – end of FY2022 assigned representatives or approved delegate attend ≥50% of meetings. Target – end of FY2023 assigned representatives attend ≥75% of meetings.
OA-1.2.1a	Accessible Units (AUs) reporting in a timely manner for the Internal Controls Assessment (ICA) with defined POCs. Percent compliant calculated by number of AUs with all ICA entries completed by the VHA due date over total number of AUs. To be reported annually beginning in FY2022.
OA-1.2.1b	Internal Controls listed on the VA ERR show evidence of testing within one year of risk entry on the VA ERR. Percent of internal controls for risks on VA ERR for 12 or more months with testing documentation over total number of internal controls with qualifying risks.
OA-1.2.2a	Establishment of a uniform, high quality and reliable risk assessment process that is collaborative in nature. Calculated by the number of program offices collaborating on risk identification, assessment, and data collection. Target of six collaborating offices by Q4 FY2023
OA-1.2.2b	Establishment of a corporate compliance model to support business related risk identification and assessment at VAMCs. Percentage calculated by the number of VAMCs with a corporate compliance model over total number of VAMCs. Target of 25% of VAMCs with Corporate Model by end of FY2024.

Metric ID	Metric Description
OA-1.2.3a	Percentage of VISNs received vision is expected to reach 100% by Q4 FY2022. The data will be reported at the end of the FY to the ARCC.
OA-1.2.3b	Percentage of VISNs with identified liaison is expected to reach 100% by Q2 FY2023. The data will be reported on a bi-annual basis until the target is reached.
OA-1.2.3c	Percentage of VISN liaison's received training via Risk University is expected to reach 100% by Q2 FY2024. The data will be reported on a bi-annual basis until the target is reached.
OA-1.2.3d	Percentage of VISNs with dedicated IRM staff is expected to reach 75% by Q2 FY2024. The data will be reported on a bi-annual basis until the target is reached.
OA-1.2.3e	Percentage of VAMCs adopting an Integrated Risk Management model with the support of associated program offices (Goal 1.2) is expected to reach 10% by the end of FY2022 with an extended target of 50% by Q4 FY2026. The data will be reported on an annual basis until the target is reached.
OA-1.2.3f	Percentage of VISNs adopting an Integrated Risk Management model with the support of associated program offices (Goal 1.2) is expected to reach 10% by the end of FY2023 with an ultimate target of 100% by Q4 FY2025. The data will be reported on an annual basis until the target is reached.
OA-1.2.4a	Percentage of operational units routinely cataloguing inquiries and allegations in an interoperable reporting system (CIRTS, PACERs, PATS-R, etc.). Target of 50% of operational units recording in an interoperable system by Q4FY22. Reporting with coordinated with the Data Governance Oversight Board on a cadence to be determined.
OA-1.3.1a	Percentage of national policies with oversight standards and requirements included in policy document and associated processes is expected to reach100% within 5 years of publication of 0999. Data will be reported on an annual basis.

Metric ID	Metric Description
OA-1.3.2a	IA conducts engagements the ARCC recommends and the USH approves via the current VHA Audit Plans. Calculated by the number of recommendations with follow up audits completed but IA. To be reported on an annual basis.
OA-1.3.2b	Percentage of corrective actions completed by their negotiated completion date is expected to reach 70% by end of fiscal year 2023. The data will be reported quarterly.
OA-1.3.3a	Percent of VHA ERR risks with risk mitigation plans initiated within 90 days of entry on the VHA ERR. To be reported annually.
OA-1.3.3b	Percent of risks with risk mitigation plans closed within 360 days of initiation. To be reported annually.
OA-1.3.4a	Submit annual reports effectiveness of implemented controls. Contrast differences between IRM sites and non-IRM sites. Compare AES scores and SAIL scores of IRM sites with non-IRM sites.
OA-1.3.4b	Percentage of risks with internal control effectiveness measures submitted within 180 days of completion of risk mitigation plan. To be reported annually through the Internal Controls Assessment
OA-1.5.1a	Retention rate of compliance professionals. Measured by the turnover rate over a fiscal year. Goal of 80% retention rate year over year.
OA-1.5.2a	Principal Offices with two liaisons identified and trained through Risk University. Target of 100% by Q1 FY2023.
OA-1.5.2b	Compliance with Mandatory Compliance Training. Percentage of compliance with Compliance Mandatory Training nationally as recorded in TMS.
OA-1.5.3a	Customer service satisfaction scores and program VA All Employee Survey (AES) scores.
OA-1.5.3b	Percentage of VAMC, VISN and Program ICOs satisfied or very satisfied with support provided.

Metric ID	Metric Description
OA-2: VHA oversight efforts support governance and management decisions are made at the appropriate level of the organization, are informed by reliable data, are timely implemented and focused on intended outcomes	
OA-2.1.1a	Publication and implementation of VA Directive 0000, Delegation of Authority which sets forth policies for issuing delegations of authority from the Secretary of Veterans Affairs, Deputy Secretary of Veterans Affairs, Chief of Staff, Assistant Secretaries, Under Secretaries, and Other Key Officials. VA Directive was published on November 14, 2018 and implemented. A list is maintained by the Enterprise Delegation Control Officer located in VA's Office of Enterprise Integration.
OA-2.1.1b	Publication and implementation of VHA Directive 0000, Delegation of Authority, establishing the delegation, from the USH to VHA Upper-level leadership, of signature, oversight, and decisional authority for national policy documents.
OA-2.1.2a	Publication and implementation of VHA Directive 1217, VHA Operating Units, specifically, that all covered operational units comply with oversight and reporting requirements found in Directive 1217. Defining "oversight" will be accomplished in a broad oversight directive that will shape operational units individual responsibilities but also how the existing and proposed systems are interoperable.
OA-2.1.2b	Publication and implementation of a VHA Directive that articulates the roles and responsibilities for operational units outside of VHA. The directive Is expected to be published by Q4F FY23.
OA-2.1.2c	Publication of VHA Directive 1217.01, VHA Governance Board that establishes the roles, responsibilities, and decisional authority of the Governance Board and its Councils as part of VHA's governance processes.

Metric ID	Metric Description
OA-2.1.2d	Establish regular and transparent communication between the ARCC and VHA Governance Board and VHA operational units to improve oversight, accountability, strategic planning and uniform implementation.
OA-2.4.1a	The Audit Risk and Compliance Committee will establish a common menu aggregating mechanisms for organizational and individual accountability. Annually until published.
OA-3: Leadership holds VHA organizations accountable to fulfill obligations imposed by decisions, regulations, and other requirements	
OA-4: VHA supports a culture of safety and integrity that fosters trust, integrity, learning, and collaboration	
OA-4.1.1a	ARCC develops recommendations standard options for program and operational unit accountability by Q1 FY2023. Decisions will be reported on an annual basis.
OA-4.2.1a	Percentage of VHA staff completing HRO Baseline Training is expected to reach >80% by Dec 31, 2021. Data will be reported on a quarterly basis.
OA-4.2.1b	Number of sites with active cadre of CTT Master Trainers is expected to reach 139 VAMCs by end of FY 2023. Data will be reported on a quarterly basis
OA-4.2.1c	Number of unit-level CTT participants is expected to reach >14,000 unit-level CTT participants system-wide by end of FY2022. Data will be reported on a quarterly basis.
OA-4.2.1d	Count of improvement projects tracked in CTT tracker is expected to be >1,400 CTT unit-level projects system-wide by end of FY 2023. Data will be reported on a quarterly basis.

Metric ID	Metric Description
OA-4.3.1a	All organizational entities scores of the Patient Safety Culture 15-item module of on the AES. The data is expected to be used as a trend analysis to observe year over year improvements in Patient Safety Culture Scores as HRO roadmaps are implemented across VHA. Data will be reported on an annual basis. *Note: These metrics will be modified with the FY22 AES.*
OA-4.3.1b	Score of AES measure, "I can disclose a suspected violation of any law, rule or regulation without fear of reprisal." Data will be reported annually.
OA-4.3.1c	All organizational entities scores of AES/FEVS/SAIL metric Organization Satisfaction: "Considering everything, how satisfied are you with your organization?" Data will be reported annually.
OA-4.3.1d	All organizational entities scores of AES/FEVS/SAIL Best Places to Work: "Best Places to Work". Data will be reported annually.
Information Technology Challenges	
IT-1: Improve system interoperability to execute core health care mission functions	
IT-1.1.1a	Title: Standardized Interoperability Process Development and Accountability Metric Description: Yearly number of new Interoperability Maturity Assessment baselines conducted Frequency: Yearly, reported in Q4 of same year
IT-1.1.2a	Title: Standardized Interoperability Process Development and Accountability Metric Description: Yearly number of new Interoperability Maturity Assessment baselines conducted Frequency: Yearly, reported in Q4 of same year Data: Target = three yearly
IT-1.1.3a	In Planning
IT-1.2.1a	In Planning

Metric ID	Metric Description
IT-1.2.2a	In Planning
IT-1.2.3a	In Planning
IT-2: To improve IT solution delivery and large program management oversight practices to effectively deliver business and veteran oriented solutions	
IT-2.1.1a	In Planning
IT-2.1.2a	In Planning
IT-2.1.3a	In Planning
IT-2.1.4a	In Planning
IT-2.2.1a	In Planning
IT-2.2.2a	In Planning
IT-2.2.3a	In Planning
IT-3: VA clinicians are able to access patient clinical data from DoD systems (AHLTA/Cerner) through their EHR (VistA/Cerner)	
IT-3.1.1a	In Planning
IT-3.1.2a	In Planning
IT-3.2.1a	In Planning
IT-3.2.2a	In Planning
IT-3.2.3a	In Planning
Training	
TOC-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	
TOC-1.1.1.1	Progress Metric for IPT 05: VHA Training Reviews based on Evaluation and Skillset Standards Processes
TOC-1.1.1.2	Progress Metric for IPT 04: VHA Training Standards
TOC-1.1.1.3	Progress Metric for IPT 03: VHA Training Policy and Waiver Processes
TOC-1.1.1.4	Progress Metric for Draft and Implement VHA Training Policy

Metric ID	Metric Description
TOC-1.2.1.1	Progress Metric for IPT 01: Establish National Training Standards within the VA 5015 Directive and VHA Training Standards Steering Committee
TOC-1.2.1.2	Progress Metric for IPT 02: Develop and Implement Audit and Reporting System
TOC-1.2.2.1	Progress Metric for EES Transformation
TOC-1.3.1.1	Progress Metric for Define and Implement Change Management Plan for TOC-1
TOC-1.3.2.1	Progress Metric for Review of TOC-1 Round 2 Processes
TOC-1.3.3.1	Progress Metric for Pilot TOC-1 Processes
TOC-1.3.4.1	Progress Metric for Deployment of VHA Training Processes for TOC-1
TOC-1.3.5.1	Progress Metric for Pilot TOC-1 Processes
TOC-2: The accurately identified audience is being trained at the appropriate time to specific program/process requirements	
TOC-2.1.1.1	Progress Metric for IPT 06: VHA Training Request Intake Processes
TOC-2.1.1.2	Progress Metric for IPT 07: VHA Training Design of Evaluation and Skillsets Processes
TOC-2.1.1.3	Progress Metric for IPT 08: Design and Develop VHA Training Evaluation and Skillset Standards
TOC-2.1.1.4	Progress Metric for IPT 09: Design and Develop VHA Training Assignments Processes
TOC-2.1.1.5	Progress Metric for IPT 10: Design and Develop VHA Mandatory Training Processes
TOC-2.1.1.6	Progress Metric for IPT 16: Design and Develop VHA Training Implementation Processes
TOC-2.1.1.7	Progress Metric for IPT 11: Design and Develop VHA Training Lifecycle Maintenance and Sunsetting Processes
TOC-2.2.1.1	Progress Metric for Define and Implement Change Management Plan for TOC-2
TOC-2.2.2.1	Progress Metric for Review of TOC-2 Round 2 Processes
TOC-2.2.2.2	Progress Metric for Review of TOC-2 Round 2 Processes
TOC-2.2.3.1	Progress Metric for Pilot TOC-2 Processes

Metric ID	Metric Description
TOC-2.2.4.1	Progress Metric for Deployment of VHA Training Processes for TOC-2
TOC-2.2.5.1	Progress Metric for Determine VHA Training Reporting and Compliance or TOC-2 Processes
TOC-3: Using the most resource-efficient approach, training is planned and developed, coordinated, and implemented, then evaluated and managed to achieve effective training outcomes	
TOC-3.1.1.1	Progress Metric for IPT 13: Design and Develop VHA Training Priorities and Training Plan Processes
TOC-3.1.1.2	Progress Metric for IPT 12: Design and Develop VHA-wide Contract Vehicle for Training Requests Processes
TOC-3.1.1.3	Progress Metric for IPT 14: Design and Develop VHA Training Contracts Standardization Processes
TOC-3.1.1.4	Progress Metric for IPT 15: Design and Develop VHA Training Contract Identification Processes
TOC-3.2.1.1	Progress Metric for Define and Implement Change Management Plan for TOC-3
TOC-3.2.2.1	Progress Metric for Review of TOC-3 Round 1 Processes
TOC-3.2.2.2	Progress Metric for Review of TOC-3 Round 2 Processes
TOC-3.2.3.1	Progress Metric for Pilot TOC-3 Processes
TOC-3.2.4.1	Progress Metric for Deployment of VHA Training Processes for TOC-2
TOC-3.2.5.1	Progress Metric for Determine VHA Training Reporting and Compliance for TOC-3 Processes
Resource Allocation	
RA-1: Unified resource planning and allocation process is clearly documented and consistently applied	

Metric ID	Metric Description
RA-1a	VHA will implement standard organizational structure codes (OSC) in HR Smart for all VHA positions. The metric is defined by the number of VHA positions in compliance with organizational structure code standards divided by the number of VHA positions. *The metric is to be reported during Q1 annually.*
RA-1b	The success measure for this metric is defined by there being accurate and timely flow of information between HR and Financial Systems. The metric calculation is defined by the number of data elements integrated between HR Smart, iFAMS and other complementary systems. The metric is to be reported during Q1 annually starting in Q1 FY 2025.
RA-1c	The success measure for this metric is defined by the number of HR staffing models implemented. The metric calculation is defined by implementing position management and classification staffing models. The metric is to be reported during Q1 annually starting in Q4 FY 2023.
RA-2: VHA utilizes a comprehensive strategic guidance process to ensure alignment of resources to leadership priorities	
RA-2a	The success measure description for RA Outcome Metric 1 involves the initiative budget submissions from DUSHs and regions that contain evidence-based justifications. The metric is defined by the percent of regional and DUSH budget submissions containing support evidence. The calculation is defined by the number of submissions with evidence divided by the total number of submissions. Our baselines will be determined in FY21 and will be reported out on annually in Q4.

Metric ID	Metric Description
RA-2b	The success measure for this metric is defined by a decrease in UFRs. The metric is defined by the percent decrease in number of UFRs from the baseline year. This will equal the number of UFRs in current FY divided by the number of UFRs in FY19. Our baseline was developed in FY20 and is currently undergoing refinement in FY22. This metric will be reported on annually in Q1.
RA-2c	The success measure for this metric is defined by the percent of AUSH/CO organizations with an approved manning document. The metric is defined by the number of AUSH/CO organizations with an approved manning document divided by the number of AUSH/CO organizations. The milestone for this metric is FY21=10%. This metric will be reported on annually in Q2.
RA-2d	The success measure for this metric is the percent of AUSH/CO organizations with an approved workload assessment baseline. The metric for this is the number of AUSH/CO organizations with an approved manpower assessment baseline divided by the number of AUSH/CO organizations (18). The baseline will be determined in FY21, and will be reported on annually in Q1.
RA-3: Adequate data and reporting mechanisms are used for making, evaluating, and informing resource planning and allocation decisions	
RA-3a	The success measure for this metric will be a reduction in variance in VAMCs department codes within HR Smart. The metric is defined by the clean-up of approximately 12,000 department titles. The metric calculation, as a percentage, is defined by the total number of VHA Medical Center departments with a standard code divided by the total number of VHA Medical Center departments. The target for Q3FY21 is <5% non-compliant department codes, (Q4FY21, Q4FY22). The reporting period is annual in Q1

Metric ID	Metric Description
RA-3b	The success measure for this metric is the completion of PIAA testing and complete reviews. The metric is defined by the quarterly reduction on the percent of review left to complete PIAA testing. The baseline is Q3FY21 reduction by 25% through FY22, Q1 Q2 Q3. This will be reported on quarterly.

Table 7-4. Summary of Progress by AOC and Key Outcomes

Policies and Processes (P&P)
• Right-sized VHA national policy inventory from 554 to 493 and reduced the number of expired policies from 207 to 144 as part of VHA's goal to reach functional zero overdue national policies, helping to ensure VHA standards are communicated clearly, set forth in the appropriate vehicle and have adequate resources for uniform implementation. • Successfully implemented policy development business rules designed to reduce unnecessary policy inventory and improve VHA's policy framework, leading to an average 24% reduction in local policy inventory in the first year from reporting VA medical facilities. Note: reduction measure reflects 124 facilities (89%) with complete reporting data. Reducing unnecessary local policy inventory decreases unwanted variation between VA medical facilities and increases the time VA medical facility staff can devote to patient care rather than administrative activities. • Reduced local policy mandates written in national policy by 50% from November 2018 to March 2021, from 150 to 75. This reduced unnecessary administrative burdens and variation in policy implementation between VA medical facilities. • Collaborated with VA, National Cemetery Administration (NCA) and VHA facility partners to pilot a new policy library that will ultimately host policy and policy-related documents in a central, searchable location, enabling all VA staff to conveniently access the policy information they need with full confidence the documents are up to date. • Developed new standards and strengthened processes governing the development, review and publication of Operational Memoranda to ensure VHA communicates standards and guidance in the appropriate communication vehicles. • Assisted VHA program offices and VA medical facilities with reviewing and updating policy to enable the ongoing implementation of VA's new electronic health record software platform while maintaining VA medical facilities' capability to comply with VHA policy standards. • Established a process for facilities to receive waivers from national policy, publish approved waivers on a transparent intranet site, and provide semi-annual reports to VA leadership. The waiver process provides a structured pathway for VHA program offices to receive feedback on published policy and account for policy exceptions necessitated by current VA medical facility operational conditions. • Supported VHA's creation of a rapid process to review and publish COVID-19 Communications to improve the organization's ability to transparently communicate new and updated standards to stakeholders at all levels.

Oversight and Accountability (OA)

- VHA implemented organizational changes to better ensure governance and management makes decisions at the proper level of the organization and create greater cross-organizational oversight and accountability.
- To further align oversight and accountability, the Audit, Risk and Compliance Committee (ARCC), established a Compliance & Risk Subcommittee as well as a Fraud Waste and Abuse Subcommittee. In addition, the Compliance & Risk Subcommittee established a field-based risk working group and risk management community of practice were also established in FY 2020 and FY 2021, respectively.
- The USH established the Office of Oversight, Risk and Ethics in 2020 (formerly the Office of Risk Management). This consolidated several oversight-focused offices and reports directly under the USH to align oversight functions as part of the larger VHA redesign (announced on January 1, 2020).
- VHA Enterprise Risk Management (ERM) analyzed and categorized previously disparate risk submissions to VA ERM thereby removing duplication and formulating a baseline Enterprise Risk Register.
- The OIC (formerly the Office of Compliance and Business Integrity (CBI) under the Office of Oversight, Risk and Ethics (ORE) deployed a Salesforce based platform to capture risk information from all VA medical facility and VISNs. The platform enables VA medical facility and VISN Compliance Officers to input and categorize risks, and input and track progress for responding to identified risks. OIC also developed and continues to refine a Risk Management Reporting Platform that will allow employees to better understand and respond to risks within their span of control.
- Over the past year, focused VHA efforts established authorities ensuring operating units make decisions at the appropriate levels. At the direction of the Acting USH, VHA published national directives that establish proper delegation of decisional authority. Directive 1217.01 delegates decisional authority to the previously established governance board and its councils and directive 1217 delegates decisional authority to VA operating units.
- VHA established a Governing Board, Enterprise Councils, and the Audit, Risk and Compliance Committee (ARCC) to modernize VHA's current governance structure. The Governing Board and Councils ensure leaders place the proper focus on governance and management decisions are informed by data and risk, and the ARCC provides oversight and accountability ensuring alignment with intended outcomes in alignment with HHS OIG guidance and DoJ Sentencing Guidelines on an effective compliance program.
- VHA implemented several modernization initiatives focused on improving key organizational oversight and accountability capabilities. Collectively, High Reliability Organization (HRO) and modernization efforts address critical oversight and accountability components such as decision making at the

appropriate organizational level, aligning decision rights, improving vertical alignment and fostering a culture of integrity and accountability.

- VHA began to mandate the inclusion of oversight roles and responsibilities in all directives, which identifies the oversight mechanisms to be used by policy owners to which they and others are held accountable.
- CBI published Directive 1030, VHA Integrity and Compliance Program, in December 2020. This directive provides an enterprise-wide consistent and mandatory framework for all VHA compliance programs and requires VHA operational units (healthcare facilities, VISNs, and VHA CO Program Offices to complete formal Causation and Corrective Action Plans in response to identified risk and issues.
- VHA focused on leadership development and staff training as they integrated 100% of its HRO Principles and Just Culture into all programs of the Office of Healthcare Leadership Institute (HLTI) and developed foundational HRO training that provides a common knowledge of HRO to employees at all levels of the organization supporting the promotion of VHAs transition to a high reliability organization. Over 90% of VISN and VAMC executive leaders completed this baseline training.
- The National Center for Ethics in Health Care has taken key steps to strengthen VA capacity to provide high quality healthcare ethics consultation and advising facility leadership on ethical issues that arise in healthcare delivery.
- VHA Designated Agency Ethics Official has established in concert with the Office of General Counsel a Government Ethics program that will place an Ethics Advisor at each Medical Center.
- VHA established uniform training for strengthen the VA's culture of integrity, this includes mandatory training on the Culture of Integrity, ICARE values, Own the Moment, Ethics, High Reliability Organization Principles, and other related topics.

Information Technology (IT)

- Reviewed and realigned HRL work and action plan elements to ensure IT workgroup efforts targeted to GAO sited concerns
- Sunset metrics found to be complete/sustaining and/or didn't fully align to GAO sited concerns
- Reviewed and revised planned actions to further drive organizational change and improved service delivery

Training (T)

- Seven Round 1 IPTs initiated and completed the tasks defined in the 5-phase execution plan resulting in the identification of 34 key training processes and associated artifacts needed for future piloting and implementation.
    - Round 1 IPTs key training processes oriented towards:

- **IPT 07**: VHA Training Design for Evaluations and Skillsets
- **IPT 08**: VHA Training Evaluation and Skillset Standards
- **IPT 09**: VHA Training Assignment
- **IPT 11**: VHA Training Lifecycle Maintenance and Sunsetting
- **IPT 13**: VHA Training Priorities and Planning
- **IPT 14**: VHA Contracts Standardization
- **IPT 15**: VHA Training Contract Identification

- Initiated Phase 1 (Kickoff) actions for 8 remaining Round 2 IPTs.
  - Five IPTs in support of Training Oversight and Standards (TOC-1)
    - **IPT 01**: VHA Training Compliance, Reporting & Oversight Management
    - **IPT 03**: VHA Training Waiver Process
    - **IPT 04**: VHA Training Standards
    - **IPT 05**: VHA Training Evaluation and Skillset standards for review and design
  - Three IPTs in support of Training Assignments and Evaluation (TOC-2)
    - **IPT 06**: VHA Training Request Intake Process
    - **IPT 10**: VHA Mandatory Training
    - **IPT 16**: VHA Training Implementation
  - One IPT in support of Training Planning and Contracts (TOC-3)
    - **IPT 12**: VHA Wide Contract Vehicle for Training Request

- Essential Round 1 IPTs information/findings:
  - **IPT 07**, VHA Training Design for Evaluation and Skillsets, drafted an overarching process to support standardized design of training solutions and associated skillsets. This included design framework for clinical nursing practice and the design of simulation-based training.
  - **IPT 08**, VHA Training Evaluation and Skillset Standards, drafted a VHA standard process for evaluating and measuring training solutions based upon the New World Kirkpatrick Model to ensure the collection of credible evidence that establishes a “chain of impact” in the areas of measurable learner/organizational outcomes, transfers of skill, and return on expectations resulting in reduced burdensome training and improved Veteran care.
  - **IPT 09**, VHA Training Assignments, identified inconsistent data field integration between the Talent Management System (TMS) and HR Smart when attempting to properly assign training to different disciplines and/or different employee groups throughout VHA.

- **IPT 11**, VHA Training Lifecycle and Sunsetting, identified a clear lack of standards, criteria, and timelines related to the hosting, sustainment, and archiving of training items.
- **IPT 13**, VHA Training Planning and Prioritization found significant gaps shared prior to communication of organizational needs and potential for enterprise-wide leveraging resulting in substantial duplication of effort and expenditure of funds.
- **IPT 14**, VHA Training Contract Standards found a lack of distributed standards for training product solicitation that would ensure compliance and operability.
- **IPT 15**, VHA Training Contract Identification, found essential differences in the requirements, templates, and tools in use by VA/VHA contract centers. Additionally, research recognized limited to nonexistent methodologies (e.g., budget object codes, contract line-item number, etc.) oriented towards the earmarking of funds utilized in the procurement of training.
- Training AOC identified a gap in the overarching action plan and created an additional IPT for Training Implementation (IPT16).
- Training AOC moved IPT 06, VHA Training Request Intakes from TOC-1 to TOC-2 to consolidate training infrastructure for future piloting efforts.

- Chartered authorities for the Mandatory Training Subcommittee are actively pursuing the mitigation and elimination of mandatory training burdens through collaborative work with Field and Program Offices. As of Feb 3rd, 2022, cost savings of 12,156 hours and $7,655,376.
- In support of IPT 02, VHA Training Audit & Reporting System, organizational funds in the amount of $548,866 have been approved for business requirements gathering, use case, and planned scope for the future Training Governance, Oversight, Compliance/Auditing, and Reporting system.
- Partial funding ($1M per year for 5 years starting in FY24) of the multi-year funding process for the future Training Governance, Oversight, Compliance/Auditing, and Reporting system (IPT 02) has been approved by the VHA Information Technology Committee to move forward toward further endorsement and action.
- Reviewed VA 5015 Directive and VA 5015 Handbook for alignment of identified key training processes for future implementation.

- Initiated discussions with VA Chief Learning Officer's (CLOs) office regarding the submission of potential department-wide recommendations through the VA Training Development Council (TDC) resulting in publication as a separate annex and further implementation into the VA 5015 Directive and VA 5015 Handbook.
- Established, implemented, and continuously revised a comprehensive Change Management Plan that regularly communicates newly identified VHA training process findings across the enterprise.
- Drafted extensive communications plan in conjunction with EES Transformation to ensure clear and concise messaging oriented towards VHA Training Modernization, the Training AOC, and the foundational framework for EES Transformation.
- Met with the EES Executive Board, LOT subcommittee, VHA Workforce Committee and the VHA Chief of Human Capital Management to gain full support and engagement for implementation of the FY 2021 Training AOC Action Plan. Provided regular and recurring updates.
- Continually engaged with GOAL Advisor/Project Managers to identify opportunities for collaboration across other areas of concern (AOCs) and identified stakeholders to help VHA Training Modernization with piloting VHA training standards and processes.
- Mandatory Training created an Interim Training Waiver Approval Process in FY21 to provide flexible and agile responses to the COVID-19 mission increase. VHA Training Modernization IPT 03, VHA Training Waivers, will incorporate the processes, standards, metrics, and lessons learned as essential artifacts for further key training process development.
- VHA National Designated Learning Officer (DLO) Coordinator in collaboration with VHA DLOs, addressed leadership and development (LEAD) training gap by partnering with the Franklin Covey and Vital Smarts Crucial Conversations vendors to develop comprehensive products in support of VHA Strategic Goals: Covey Leadership Development Framework (LDF) Guides, Covey HRO Playbook, Covey AES Dashboard Training Alignment.

Resource Allocation (RA)
• Filling leadership positions in Finance and WSS. • Developing and conducting a recurring budget reporting program with leadership from program offices to improve transparency around budget needs and allow for an open line of communication throughout the organization and enhance funding guidance. • Sustaining WSS authority for organizational and position structures. • Continuing to advance technology to support data driven resource allocation decisions. • Implementing early controlled funds release to improve planning and management of field funding • Leveraging standing Chief Financial Officer teleconferences to address resource and budget allocation concerns. • Realizing increases in recruitment of VA trainees through the National VHA Training and Education Program, utilization of the VA-Trainee Recruitment Event (VA-TRE) automated solution, and an increase in the number of participating medical centers. • Strengthening leadership commitment by developing and implementing a VHA CO Resource Board, made up of AUSH level leadership, with the goal of unifying resource allocation and funding decisions across VHA CO. • Providing training to the Manpower Community of Practice on organizational structure and staffing levels. • Introducing evidence-based justifications to the VHA Medical Care program budget request process. • In addition to leveraging the robust analytic capability for staffing and productivity provided in the Office of Productivity, Efficiency and Staffing (OPES), VHA will develop and implement staffing models for HR functions and other critical programs such as public affairs. • Provided key data cleansing efforts in the implementation of Integrated Financial Acquisition Management System (iFAMS).

Table 7-5. Major Necessary Technology Components by AOC

Area of Concern	Technology Component(s)
Policies and Process	Centralized repository
Oversight and Accountability	Integrated platform for governance, compliance, evaluation, and risk data (Objective OA-2.5.3)
Information Technology	Chapter 3. Information Technology Challenges
Training	A single, integrated Training Governance, Oversight, Compliance/Auditing, and Reporting system
Resource Allocation	• Light Electronic Action Framework (LEAF) system • Strategic planning information system • HR Smart • Integrated Financial and Acquisition Management System (iFAMS) • Financial Management System • Veterans Equitable Resource Allocations (VERA) model • Recruitment Tracker • Achievelt • USA Staffing • Functional Organizational Manual (FOM) Application • Intelliwork