VA High Risk List Action Plan - Update:

Managing Risks and Improving VA Health Care

May 2021

Department of Veterans Affairs

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Table of Contents

List of Tables

List of Figures

Executive Summary

The Department of Veterans Affairs (VA) is pleased to provide the Government Accountability Office (GAO) documentation of recent progress made since VA's March 2020 Action Plan. In this update, VA provides status on actions taken from March 2020 through May 2021, future planned actions with detailed project milestones, refined goals and objectives, a resource assessment, information on work related to the coronavirus disease 2019 (COVID-19) pandemic 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) published March 2, 2021. VA is pleased to achieve an increased rating for capacity and recognizes there is more work needed to resolve the areas of concern. In the 2021 update, VA provides additional level of detail with the recent progress made in the High Risk List (HRL) activities. VA's new Secretary, Denis McDonough, anticipates a continued commitment to the work related to high risk related activities despite transitions in various leadership roles. He looks forward to collaborating with GAO to make VA's HRL a part of the commitment of "being a leader who will fight relentlessly for the Veterans."

Leaders in the Veterans Health Administration's (VHA), in partnership with the Office of Information Technology (OIT), continue to establish a unified vision for ensuring VA effectively takes action to address the five areas of concern and drives organizational accountability toward resolution of the high-risk listing. In February 2021, Dr. Steven Lieberman, Acting Deputy Under Secretary for Health (DUSH), was named as the senior accountable official for the "Managing Risks and Improving VA Health Care" GAO High-Risk Listing.

VA has worked to establish a management structure that will endure over time and across leadership changes. VA has developed and matured its HRL governance structure to set the strategic direction of its efforts and to oversee the status of progress toward the HRL removal criteria to achieve desired outcomes. At the operational level of the governance structure are the Area of Concern (AOC) workgroups. The workgroups report to the HRL Steering Committee, which is comprised of Outcome Leads from each AOC. The Steering Committee reports to the HRL Oversight Board for this listing, which is led by the Deputy Undersecretary for Health and includes the Deputy Chief Information Officer (CIO) and the HRL Outcome Executives for each AOC. The HRL Oversight Board reports to the VA Operations Board, which is chaired by the VA Deputy Secretary.

Dr. Lieberman and VHA's Acting Under Secretary for Health (USH), Dr. Richard Stone, have been at the helm of VHA for the past four years, providing continued support and resources to VA's High Risk-List effort. Both Dr. Lieberman and Dr. Stone have worked to establish a management structure that will endure over time and across leadership changes and ensuring that VA's new Secretary, Denis McDonough, has the necessary information to make critical and necessary decisions to further our efforts.

Throughout the COVID-19 pandemic, VA continued to address the HRL areas of concern; improving fundamental business processes had an immediate effect on

Veterans' health care during the early stages of the crisis. Our work on IT, resource allocations and training were paramount to VHA's emergency response to the COVID-19 pandemic.

- For example, IT increased network capacity to support 80,000 additional employees teleworking, rapidly scaled technology and supporting infrastructure and provided support to 150,000 caregivers and claims processors.
- IT also enabled a 1000% increase in daily video telehealth sessions allowing VA to conduct nine million more sessions year-to-date over last year.
- VA's ability to allocate resources effectively and efficiently opened the way to recruit more than 20,000 new hires, including 3,500 nurses and 500 physicians.
- Just-in-time training was available to the new hires, clinicians and airway management staff treating Veterans with COVID-19 were able to use targeted, standardized and comprehensive training that was supported by policy.
- Policy work continued improvements with some delays (open field period extended from two to three weeks temporarily) and otherwise continued with established deadlines

In December 2020, VA began distributing vaccines to eligible employees and Veterans. It is our goal is to vaccinate all eligible Veterans and employees who want to be vaccinated in 2021. VA's COVID-19 vaccination strategy balances site-specific resources, facility needs, vaccine availability and status of the pandemic locally, as well as strict storage, handling and transportation requirements of available vaccines.

- Policy 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.
- VHA has a heightened sense of awareness of opportunities to meet human capital needs of today and tomorrow. This is apparent through our demonstrated utilization of incentives and awards to address staffing shortages at the local level while fully utilizing Coronavirus Aid, Relief, and Economic Stimulus (CARES) Act funds to support COVID-19 surge staffing needs. As part of this effort VHA had 92,812 new hires between March 2020 and March 2021, 18,088 of which are registered nurses and nurse practitioners.
- VA has 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 will conduct post COVID-19 Assessments on the utilization of authorities/flexibilities in compensation, staffing and employee relations/labor relations (ER/LR), to reduce time to hire.
- Five training courses were developed using a Subject Matter Expert (SME) from the Office of Emergency Medicine, in Response to the COVID-19 Pandemic. The courses were assigned at the local facility level using Job Roles rather than Job Codes to reduce burdensome training, and ensure assignment was based on COVID-19 related duties, across the VHA enterprise. This resulted in nearly 170,000 staff and clinician training completions of these 5 COVID-19 related trainings.

- Training under Employee Education Services (EES) has been working with the Office of Emergency Medicine and the Pharmacy Program Office to create and maintain updates of all Vaccine-related training from all manufacturers, information from the CDC and National Institutes of Health. Updates to training and training requirements are made as they are received.

GAO recognized that our action plan contained key components and serves as an important foundational document to build upon in greater detail. We recognize there is much work to be done and feel this Action Plan Update demonstrates a more sophisticated and complete roadmap to monitor progress and achieve stated outcomes. We have instituted annual strategic planning, risk management, change management, regular monitoring on metrics, an integrated operating platform for storing artifacts, a robust Steering Committee and sharing strong practices with our partner program offices.

Each AOC workgroup has begun developing a roadmap that links individual actions to the resolution of root causes and eventually, key outcomes. This work is closely tied to refining goals and objectives. Workgroups are establishing a more near-term vision of identifying incremental milestones that contribute towards the eventual outcome.

Additionally, VA developed guidance for metrics development that will aid in understanding and communicating business benefits to stakeholders. VA also decoupled certain Modernization Lanes of Effort (LOE) that do not directly contribute towards the outcomes of the HRL areas of concern. VA will continue to monitor the LOE activities to determine if/when an intersection occurs.

Portfolio Management Major Accomplishments March 2020 – March 2021
Consistent with the legislation S. 1550, the Program Management Improvement and Accountability Act of 2015 (PMIAA), the GAO-OIG Accountability Liaison (GOAL) office, which is the program office responsible for managing this high risk listing within VHA, has contracted 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 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 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 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 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.

- VA's 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 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. VA is also committed to sharing our progress with Congress and the public through Federal Register postings and making action plans accessible on VA's website: https://www.va.gov/performance/.

VA Made Progress Across Each of the Areas of Concern

Policy AOC:

1. 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.

2. From 2015 – 2021, VHA reduced national policy by 300 and overdue national policy by 50% while increasing the quality of policy content and the efficiency of policy development.

3. VHA provides direct support to VA medical facilities to reduce unnecessary policy inventory by building on best practices learned through local policy analyses, including on electronic health record modernization, leading to an average 24% reduction in local policies in 2020.

Oversight and Accountability AOC:

1. 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 Under Secretary for Health to align oversight functions as part of the larger Veterans Health Administration Central Office (VHACO) redesign (announced on January 1, 2020).

2. Reorganized the VHA Governance Integrated Project Team in FY20 as the Executive Sponsorship Coalition and established governing principles that will outlast leadership changes and, with the needs of the field in mind, the IPT continue to work on its major priorities.

3. Implementation of a comprehensive compliance and integrity program to strengthen accountability, grounded in continuous improvement, system-wide VHACO, Veterans Integrated Service Networks (VISN), Consolidated Patient Account Center (CPAC) and facility leadership, and Compliance and Business Integrity Officers located at all 18 VISNs, 8 CPACs and 140 Medical Centers.

4. Identified metrics that will provide meaningful indication of progress towards achieving its goals and objectives and fulfilling the ultimate desired outcomes of the effort.

OIT AOC:

1. The OIT AOC met in November 2020 with all Outcome Leads and stakeholders to establish a Plan of Actions and Milestones (POAM) to drive further linkage and accountability across the outcomes.

2. Additionally, the OIT AOC is working to identify goals and objectives for each outcome to better address gaps and is working with VHA on how best to integrate into HRL governance structures.

3. Lastly, the AOC is revisiting current root causes to ensure their applicability and alignment.

Training AOC:

1. The Training Workgroup (TWG) developed a more comprehensive plan that shows the need for extensive collaboration with subject matter experts in the field, continuous process improvement, oversight and compliance reporting along with change and communications planning for each Training Outcome through fiscal year (FY) 2024.

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

- Collaborating with the field and program offices to ensure that the training processes and policies developed account for critical field and program office needs.

- Establishing a VHA Training Steering Committee to guide the development and implementation 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, including timely and accurate updates based on constant changes directed by the Center for Disease Control and Prevention (CDC) and other governing bodies.

Resource Allocation (RA) AOC:

1. Established collaboration between the Manpower Management Office (MMO) and Finance at the working group and leadership level to coordinate remediation activities. Continuing to focus on strengthening and expanding the collaboration across program offices, working groups, and areas of concern to demonstrate forward progress in executing the action plan.

2. Improve and refine the action plan, timelines and metrics based on the continued identification of root causes driving high risks and link actions to outcomes.

3. Refine training, communication, monitoring and oversight methodologies to ensure remediation actions are successfully implemented and sustained across the field and program offices.

4. Identified interim improvement efforts that can assist with remediating risks while long-term systems implementation efforts are ongoing.

Figure 1-0. GAO Rating for Each Area of Concern as of March 2021

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

Each outcome contains a general description, correlation to a root cause, metrics for measuring progress, a description of actions related to GAO's criteria for removal, a description of progress made and a general description of key actions to achieve the outcome and their status (e.g., in planning, in progress, completed, sustaining). A list of the outcomes is in Table 1, below.

Table 1-0. List of AOC Outcomes and Self-Assessed Ratings

AOC Outcomes	Self-Assessed Status
Policies and Processes ***Key Outcomes* =** Policy drives correct behavior and is implemented consistently; business processes are integrated and efficient	
P&P-1: Senior leaders of VHA programs and initiatives incorporate the Department's strategic goals and support the need for aligned, unambiguous policies and consistent policy implementation	In progress

AOC Outcomes	Self-Assessed Status
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)	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 ***Key Outcome* =** Governance and oversight mechanisms provide reasonable assurance that requirements are met	
OA-1: VHA organizations and employees demonstrate timely and effective risk management in accordance with a unified RMF to support governance and oversight	In progress
OA-2: Governance and management decisions are made at the appropriate level of the organization, are informed by reliable data, and are timely	In progress
OA-3: VHA oversight ensures governance and management decisions are implemented and focused on intended outcomes	In progress
OA-4: Leadership holds VHA organizations accountable to fulfill obligations imposed by decisions, regulations, and other requirements	In progress
OA-5: VHA supports a Just Culture that fosters trust, integrity, learning, and collaboration	In progress
Information Technology ***Key Outcomes* =** Systems are interoperable and meet business needs; data are available and accurate, reliable, complete, and used to inform decisions	
IT-1: Deliver IT capabilities to support VHA-determined data and interoperability business needs	In progress
IT-2: Improve system interoperability to execute core health care mission functions	In progress
IT-3: Provide governance and oversight bodies with accurate, reliable, timely, and relevant information to support decision making	In progress
IT-4: Reduce the number of legacy systems while continuing to meet business needs	In progress

AOC Outcomes	Self-Assessed Status
IT-5: Reduce the number of duplicative IT systems and capabilities to support business needs	In progress
Training ***Key Outcome* =** Targeted, standardized, and comprehensive training that supports policy or guidance and active field engagement	
T-1: Training developed in response to priorities identified by senior VHA leadership (national and field); delivered to nationally specified standards; evaluated and reported by program office guidelines delineated in national policies	In progress
T-2: Accurately identified audience is trained at the appropriate time to specific program/process requirements	In progress
T-3: Using the most resource-efficient approach, training is planned and developed, coordinated and implemented, then evaluated and managed to achieve effective training outcomes	In progress
Resource Allocation ***Key Outcome* =** Resources are used effectively and efficiently	
RA-1: Unified resource planning and allocation process is clearly documented and consistently applied	In progress
RA-2: VHA utilizes a comprehensive strategic guidance process to ensure alignment of resources to leadership priorities	In progress
RA-3: Adequate data and reporting mechanisms are used for making, evaluating, and informing resource planning and allocation decisions	In progress

Highlights

1. Ambiguous Policies and Inconsistent Processes

a. Key Actions Completed from March 2020 through March 2021; all initiatives are ongoing

- 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 Central Office (VACO) 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.

b. Key Actions underway or planned through March 2022

- 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.
- Further improve VHA's uniform implementation of national policy by facilitating implementation of VA's supremacy regulation to enable licensed and credentialed health care professions to establish national standards of practice.
- Continue to reduce unnecessary administrative burdens by establishing a baseline for Standard Operating Procedures created at VA medical facilities.
- Improve clarity and uniformity of policy content and standards by establishing standard definitions for clinical terminology used in VHA policy.
- Support VA medical facility policy oversight capabilities by establishing a common position description for field-based policy managers.
- Increase alignment and transparency of policy across levels of the organization by establishing a uniform numbering system for VHA policy documents.
- Strengthen leadership oversight and resource management by improving planning processes associated with policy development.

2. Inadequate Oversight and Accountability

a. Key Actions Completed from March 2020 through March 2021

- 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 and accountability.
- To further align oversight and accountability, the Audit, Risk and Compliance Committee (ARCC), established a Compliance Subcommittee, Fraud Waste and Abuse Subcommittee and a Risk Subcommittee. As a part of the Risk Subcommittee, a risk working group and enterprise risk management community of practice were also established in FY 2020 and FY 2021, respectively.
- The Office of Oversight, Risk and Ethics was established 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 VHACO 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 Office of Compliance and Business Integrity (CBI) under the Office of Oversight, Risk and Ethics (ORE) deployed a Microsoft SharePoint 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.

- 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 has drafted national directives that will establish proper delegation of decisional authority. Directive 1217.01 will delegate decisional authority to the previously established governance board and its councils and directive 1217 will delegate decisional authority to VACO operating units.
- VHA established a Governing Board and Enterprise Councils to modernize VHA's current governance structure. The Governing Board and Councils ensure governance and management decisions are focused on intended outcomes.
- 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.
- In quarter 1 (Q1) FY 2021, CBI published Directive 1030, VHA Integrity and Compliance Program, which provides an enterprise-wide consistent and mandatory framework for all VHA compliance programs.
- 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 VA medical center executive leaders completed this baseline training.

b. Key Actions Planned through March 2022

- VHA ERM will establish a unified Integrated Risk Assessment and Management (IRM) model was necessary. As of Q1 FY 2021, an environmental scan, including interviews and surveys of key stakeholders at the program office and field level was initiated. Data collected through this environmental scan will then inform the recommended IRM model.
- As a part of the risk management process, improved oversight of the establishment of internal controls will be developed and deployed to align with the governance established for Risk Management. It is anticipated that the ERM Environmental Scan will clarify where programmatic risks are reported, allowing VHA to clarify the reporting functions of risk. This will provide confidence in the ability to hold the assigned risk owner accountable for the ongoing response to the identified risk.
- In FY 2021, VHA will refine and adjust the governance board structure and begin to address VHA Central Office 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 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.
- In FY 2021, certified baseline trainers will lead HRO training sessions for all supervisors and frontline staff at all medical facilities. VHA is aiming to have more than 80% of its staff complete foundational HRO training in FY 2021.

3. Information Technology Challenges

a. Key Actions Completed from March 2020 through March 2021

- Delivered a minimum viable product (MVP) for supporting the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018.
- Launching DevOps and Product Line Management transformation to manage five portfolios and 27 products lines with over 700 products (including systems and applications).
- Continued support of IT infrastructure upgrades required for Electronic Health Records Management (EHRM).
- Empowering VA Interoperability leadership to seamlessly integrate and exchange health information, data and best practices across the Department of Defense (DoD) and other partners.
- Aligning strategy with business goals; cataloguing current plans for modernization, decommission and facilitating decision making.
- By June 2020, the Legacy System Modernization workgroup completed 24% of assessments on VA systems to determine their disposition and funding status for future years.
- National Release of Community Care Referral and Authorization System – HealthShare Referral Manager (HSRM).
- Deployed Community Care Electronic Data Interchange (EDI) Dashboard 3.0, allowing for the monitoring of EDI transactions through the EDI Gateway.
- Finalized Federal Electronic Health Record Modernization (FEHRM) Charter establishing DoD/VA Interagency Program Office.
- Developed initial FY 2020 funding capability gap assessment.
- Completed user acceptance testing (UAT) for CARMA Initiative (Caregiver Program).
- National Release of Prescription Drug Monitoring Program (PDMP).

- Designated approved data sources though Data Governance Council (DGC) working group.
- Launched EHR in the Pacific Northwest and Las Vegas, Nevada.
- Stood up VA Interoperability Leadership Team (VAIL) and other workgroups (e.g., Data Standards, VISP, Interoperability, Innovations).
- Established Governance and Accountability Boards and Councils.
- Communicated and supported new process to the OIT and VHA organizations regarding the IT-non-IT Working Groups (ITW) decision for allowing certain non-IT funding for VA Enterprise Cloud (VAEC) cloud capacity and services; identified initial use case (Behavioral Health Laboratories) using new process model.

b. Key Actions Planned through March 2022

- Continue updating VA's Interoperability Strategy (VAIS) and conducting interoperability maturity assessment baselines.
- Continue Cerner EHR wave deployments.
- Coordinate and flag important gaps in standards alongside the FEHRM.
- Approve implementation of a standing workgroup combining elements of a Community of Practice to advance VA's strategic objectives.
- Continue Legacy System Modernization (LSM) assessments for all remaining product lines.
- Catalog current plans for system modernization and/or decommission, retire designated systems and address legacy system issues to enable transfer of capabilities from another system.

4. Inadequate and Burdensome Training for VA Staff

a. Key Actions Completed from March 2020 through March 2021

- Updated and submitted the Training Action Plan, which addresses GAO concerns and VHA's commitment to shift VHA to a sustainable, effective and efficient training system.
- Continued to draft training related directive that defines oversight, accountability, roles and responsibilities, training definitions and supporting processes.
- Continued to assign training effectively and efficiently across the enterprise to the targeted population, and to the requisite standard during the COVID-19 pandemic and used many of the draft processes to support VA's 4th Mission effectively.
- Collaborated with the VA CLO to align the VA 5015 Training Directive revision with the draft VHA Training Policy.
- Reexamined previous March 2020 Training Action Plan, conducted a thorough current state analysis and identified additional gaps in processes and standards thought to already exist.

- Met with Employee Education Services (EES) Executive Board, Learning Organization Transformation (LOT) Committee, VHA Workforce Management (WFM) Committee, and the VHA Chief of Human Capital Management to inform them of the VHA Training Modernization effort, the Training Action Plan, upcoming events and gain their support for the 15 Integrated Project Teams (IPTs) to define training standards and processes for FY 2021 Training AOC Action Plan.
- Met with GAO OIG Accountability Liaison (GOAL) Advisors and Project Managers to identify opportunities for collaboration across other areas of concern and identify stakeholders that the TWG can work with to beta test new EES processes and procedures.
- Delivered training to VHA staff to address emergent work related to VHA's new Caregiver Program and the COVID-19 pandemic.

b. Key Actions Planned through March 2022

- Continue to review and align draft VHA Training Policy to the VA 5015 Training Directive.
- Establish and implement the initial nine training processes identified and listed below using IPTs. The remaining six processes will be developed once these are complete, due to dependencies.

    1. VHA Training Compliance, Reporting & Oversight Management
    2. VHA Training Waiver Process
    3. VHA Training Standards
    4. VHA Training Evaluation and Skillset standards for review and design
    5. VHA Training Assignment
    6. VHA Training Lifecycle Maintenance and Sunsetting
    7. VHA Training Priorities and Planning
    8. VHA Contracts Standardization
    9. VHA Training Budget Object Codes

- Continue to draft and update the VHA Training Policy as each training process has been completed.
- Establish and implement a comprehensive Change Management Plan that will socialize newly developed VHA Training Processes across the enterprise.
- Meet with the EES Executive Board, LOT Committee, VHA WFM 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 and provide routing updates.
- Continue to work with GOAL Advisor/Project Managers to identify opportunities for collaboration across other areas of concern and identify stakeholders that the TWG can work with to beta test VHA training standards and processes.

5. Unclear Resource Needs and Allocation Priorities

a. Key Actions Completed from March 2020 through March 2021

- VHA Finance allocated the FY2021 budget using the longstanding Veterans Equitable Resource Allocation (VERA) model ensuring a timely distribution to all medical centers and programs instrumental in Veteran healthcare with no interruption to care.
- VHA Finance and Manpower Management offices co-led a yearlong realignment of VHA Central Office, reallocating approximately 10,000 positions and creating a new accounting station structure. This realignment enables leadership to more effectively and efficiently make and report resource allocation decisions.
- While combatting a world-wide pandemic, VHA prioritized leadership stability as a key tool in this fight sustaining a 96% Medical Center Director fill rate. This fill rate provided critical leadership and oversight in implementing and maintaining compliant effective operations holding VHA healthcare as a leader in the fight against COVID-19.
- Throughout the pandemic, VHA identified modifications to pre-pandemic processes in the manpower and financial arenas to streamline processing, mitigate risk to Veterans and employees, and meet the changing healthcare environment. This streamlining resulted in significantly shorter onboarding process, collaborative pandemic guidance, and a significant technology usage providing real time communication to field leadership allowing for key operation decision making.
- VHA advanced HR Smart technology by coordinating with program office and medical center human resources staff to improve data quality and reporting capabilities. The continued advancement of HR Smart technology integrates with the VA Financial Management and Business Transformation initiative upgrading the financial and acquisition technology. The implementation of these new technologies will integrate multiple systems and allow for VA compliance with laws and regulations.
- VHA Manpower Management Office (MMO) continued the foundation work of updating established standard operating procedures regarding recruitment and annual reviews of Network organizational charts. This work is a key tool in improving technological advances in HR Smart and the financial report process.

b. ***Key Actions Planned through March 2022***

- VHA will implement a standard organizational structure to improve HR Smart and prepare VHA for the transition to iFAMS. This structure will reflect the functional organizational alignment and promote accurate data reporting and staffing analysis. Standard organizational structure codes is an infrastructure advancement supporting both HR Smart and iFAMS technologies to support leadership decision making regarding the allocation of VHA assets.
- VHA Manpower will complete initial Organization Modernization Assessment workstreams creating HR Smart derived organizational charts and manning documents for each AUSH/CO organization.

- VHA Finance will prepare for the FY 2024 implementation of iFAMS through data cleanup and procedure restructuring. The new system will provide current technology instituting a VA financial and acquisition system compliant with federal laws and regulations.
- VHACO will continue reorganization with the standardization of business support functions implementing best practices and procedures. This standardization will minimize variation in business support services and positively impact the ability of VHACO Program Offices to accomplish their mission.
- VHA will expand its Manpower Management Program to include VISN Manpower Analysis supporting the most efficient and effective use of organizational structure and staffing levels to support the needs of the local Veteran population.
- VA will deploy the Manpower Module within HR Smart as an internal control in the oversight and management of position and organizational structure improving the accuracy and availability of position inventory.
- VHA will submit legislative proposals based on temporary changes during the pandemic to improve the onboarding process at all levels of the organization.

VA Health Care Areas of Concern Updates

1. Ambiguous Policies and Inconsistent Processes Area of Concern

Executive Summary

Over the past five years, the total number of VHA national policies has been streamlined from 805 documents in FY 2015 to 493 Q 2F 2021 and reduced the total number of national policies overdue for recertification from 59% to 28%. In 2020, VHA implemented nationwide policy business rules designed to reduce unnecessary policy inventory and improve VHA's policy framework. By January 2, 2021, 123 VA medical facilities submitted an action plan update indicating an average 23% inventory reduction achieved in the first year. 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 VHA Central Office; trust that has been earned by processes that facilitate policy makers 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.

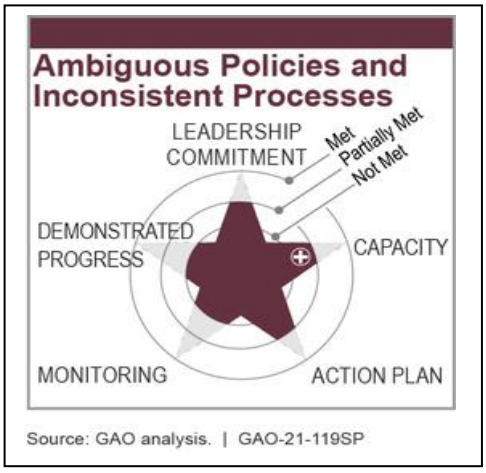


Figure 1-1. Policies and Processes 2021 Rating Goal

VHA has successfully built a robust foundation for developing, implementing and maintaining 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 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.
- Streamlined and clarified the national policy inventory by reducing the number of national policy documents by 36% since 2015.
- 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 prior to publication.
- Executed the “Get to Zero” initiative to ensure national policies are current and have been appropriately reviewed and recertified within the prior five years, with overdue national policies reduced to 28% and continuing to trend downward.
- Implemented business rules for policy development that empowered local and VISN leadership to streamline local policy inventory and reduce time required for policymaking and policy administration by VA medical facility staff.
- 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 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 professions 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.

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

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

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

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

Table 1-1. Policy Alignment with Other Areas of Concern

Alignment with Other Areas of concern
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. 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. A link to a point of contact for oversight and accountability will be provided in Policy's welcome email for policy development.
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 closely collaborated with the OEHRM to review and update more than 150 national policies to help VHA prepare for the implementation of a new electronic health record platform in 2020. A link to a point of contact for IT will be provided in Policy's welcome email for policy development.
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, and a 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 directive that supports implementing standard VHA planning and oversight for training requirements. A link to a point of contact for training will be provided in Policy's welcome email for policy development. Policy is also collaborating 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.

Alignment with Other Areas of concern
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. Additionally, 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. A link to a point of contact for manpower will be provided in Policy's welcome email for policy development. **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. A link to a point of contact for finance will be provided in Policy's welcome email for policy development.

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 (Commenced March 2021)

Brian McCarthy, JD, MPH, Chief VHA National Policy (Prior to March 2021)

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

P&P-1 Outcome Statement: 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-1.1 GOAL: 100% of VHA directives in FY 2024 that are developed and recertified have been reviewed for adequate implementation resources.

Objective 1: 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.

Objective 2: 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).

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).

Objective 1: Eliminate handbooks and manuals, which VHA senior leaders deemed not proper policy vehicles.

Objective 2: Increase directives and notices to 100% of VHA policy inventory in FY 2023.

P&P-1.3 GOAL: In FY 2022 minimal VHA operational memos issued by VHA program offices and senior leaders contain policy information when issued.

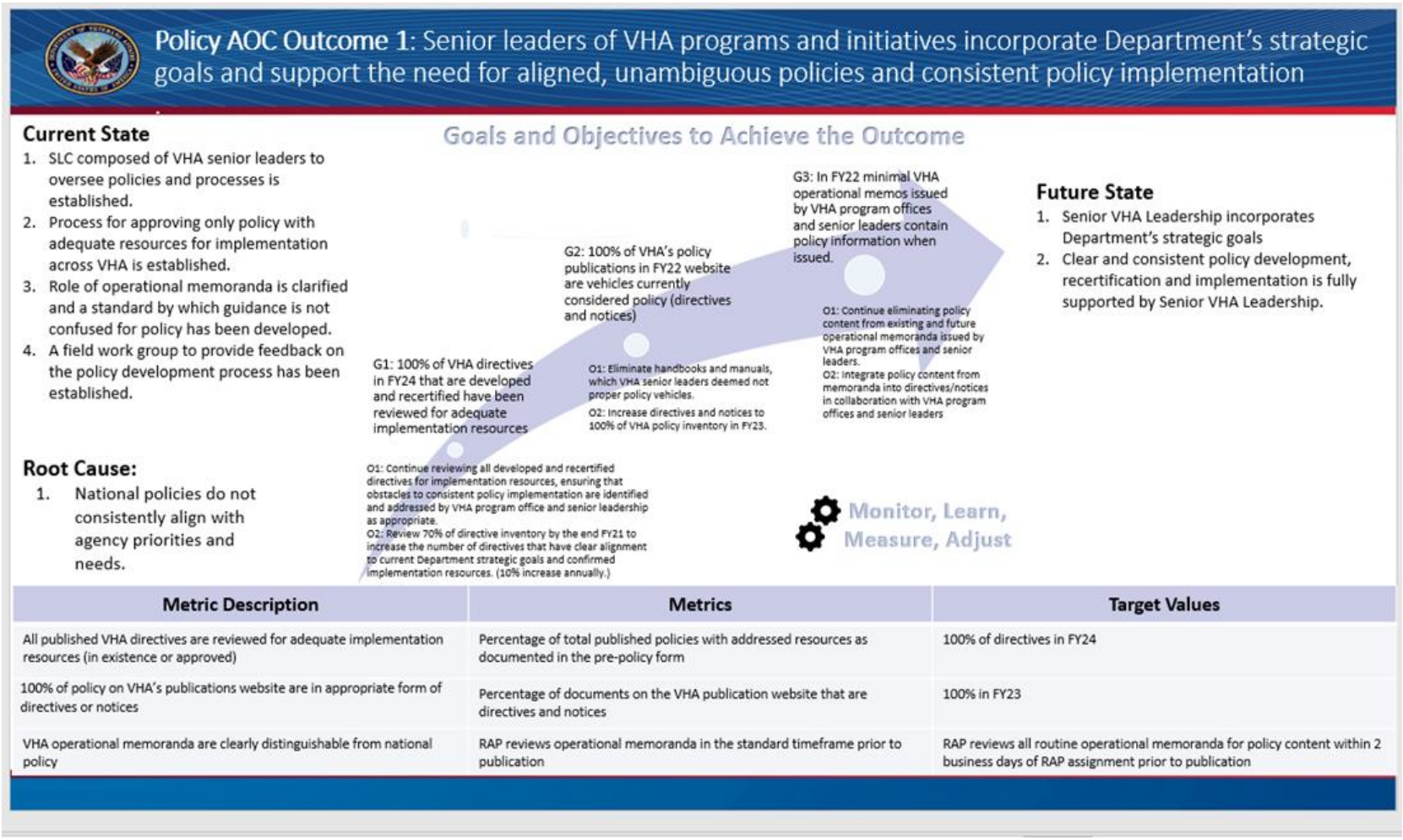
Objective 1: Continue eliminating policy content from existing and future operational memoranda issued by VHA program offices and senior leaders.

Objective 2: Integrate policy content from memoranda into directives/notices in collaboration with VHA program offices and senior leaders.

Table 1-2. P&P-1 Description & Status

In Planning	In Progress	Complete	Sustaining

P&P-1 Description & Status
• To achieve this outcome, VHA must ensure collaborative policy development through processes and procedures and ensure adherence to published policy. Policy and process development must be VHA-wide activity that includes VHA's Modernization LOEs, as each LOE's goals require unambiguous policy and a clear implementation plan. • VHA streamlined its policy document vehicles to directives and notices and is steadily converting documents no longer issued as policy (handbooks and manuals) into updated policy documents. Directives and notices are 88% (Q2 FY 2021) of VHA policy inventory, up from 47% in 2015.



Metric Description	Metrics	Target Values
All published VHA directives are reviewed for adequate implementation resources (in existence or approved)	Percentage of total published policies with addressed resources as documented in the pre-policy form	100% of directives in FY24
100% of policy on VHA's publications website are in appropriate form of directives or notices	Percentage of documents on the VHA publication website that are directives and notices	100% in FY23
VHA operational memoranda are clearly distinguishable from national policy	RAP reviews operational memoranda in the standard timeframe prior to publication	RAP reviews all routine operational memoranda for policy content within 2 business days of RAP assignment prior to publication

Figure 1-2. P&P-1 Roadmap

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

Table 1-3. P&P-1 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
All published VHA directives are reviewed for adequate implementation resources (in existence or approved)	Percent of total published policies with addressed resources as documented in the pre-policy form Number of published policies with addressed resources / total number published policies	Baseline = 0% in FY 2015 Milestone = 60% in FY 2020; additional 10% of directives reviewed in Q4 of FY 2022 – FY 2024 Target = 100% of directives in FY 2024	Q1, Q2, Q3, Q4
100% of policy on VHA's publications website are in appropriate form of directives or notices	Percent of documents on the VHA publication website that are directives and notices number of directives and notices / total number of entries	Baseline = 47% in FY 2015 Milestone = 80% in FY 2020; increase directives/notices by 10% FY 2021 – FY 2023 Target = 100% in FY 2023	Q2, Q4

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
VHA operational memoranda are clearly distinguishable from national policy	RAP reviews operational memoranda in the standard timeframe prior to publication Count = number of business days to review operational memoranda	Baseline = RAP reviews operational memos when received and within time requested by program office Milestone = RAP re-issues MOU with VHA senior leaders to ensure RAP reviews all operational memos to determine if VHA national policy needs to be updated Target = RAP reviews all routine operational memoranda for policy content within two business days of RAP assignment prior to publication	Q2, Q4

The following table has examples of the actions the Policies and Processes workgroup identified to achieve 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.

Table 1-4. P&P-1 Action Plan

*All actions in this table imply effective change management and training are a part of implementation.

Actions*	Projected Date	Actual/ Adjusted Date(s)	Status/Comments
P&P-1.1 GOAL: 100% of VHA directives in FY 2024 that are developed and	*Objective 1*: Continue reviewing all developed and	*Objective 2*: Review 70% of directive inventory by the end FY 2021 to increase the number of directives that have clear	

Actions*	Projected Date	Actual/ Adjusted Date(s)	Status/Comments
recertified have been reviewed for adequate implementation resources.	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.	alignment to current Department strategic goals and confirmed implementation resources (10% increase annually.)	
(1.1) Establish a process for approving policy only with adequate resources for implementation across VHA		Q3 FY 2018	**Sustaining**: VHA requires use of a planning form (Briefing Note) detailing required resources, risks and communication plans. The action is on-going and the process is modified for improvement.
(1.5) Establish a Senior Leader Committee composed of VHA senior leaders to oversee policies and processes		Q4 FY 2016	**Sustaining:** The VHA Senior Leader Committee is established and meets monthly.
(1.6) Identify responsibilities for policy implementation		Q4 FY 2023	**In progress**: RAP and the Field Advisory Workgroup developed a medical facility quality manager and Regional

Actions*	Projected Date	Actual/ Adjusted Date(s)	Status/Comments
			Director survey to collect information about which organization is responsible for implementing and monitoring national and local policy, results included in Business Rules. 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.
(1.7) Establish a field workgroup that includes regional-level and medical facilities representatives to provide feedback on the policy development process		Q1 FY 2018	**Sustaining:** The Field Advisory Workgroup will be re-established and plans on meeting three times annually.
P&P-1.2 GOAL: 100% of VHA's policy	*Objective 1*: Eliminate handbooks	*Objective 2*: Increase directives and notices to	

Actions*	Projected Date	Actual/ Adjusted Date(s)	Status/Comments
publications in FY 2023 website are vehicles currently considered policy by VHA senior leaders (directives and notices).	and manuals, which VHA senior leaders deemed not proper policy vehicles.	100% of VHA policy inventory in FY 2023.	
(1.2) Develop a standard by which guidance is not confused for policy		Q4 FY 2017	**Sustaining:** RAP updated Directive 6330, which establishes directives and notices as the only forms of national policy documents. The action is ongoing: in 2020 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.
(1.3) Convert documents that are no longer issued as policy (handbooks and manuals) into updated policy documents	Q4 FY 2023		**In progress:** In January 2020 handbooks and manuals are 97 of 514 documents (18%), down from 53% of inventory in 2015.
(1.8) Ensure policies are clearly owned by a responsible entity and use the current	Q4 FY 2026		**In progress:** RAP identified orphan policies and sent queries to candidate responsible entities. RAP is

Actions*	Projected Date	Actual/ Adjusted Date(s)	Status/Comments
numbering system			developing a strategy for a common numbering system and establishing a temporary workgroup to develop business requirements necessary for the implementation of the national policy library.
P&P-1.3 GOAL: In FY 2022 minimal VHA operational memos issued by VHA program offices and senior leaders contain policy information when issued.	*Objective 1*: Continue eliminating policy content from existing and future operational memoranda issued by VHA program offices and senior leaders.	*Objective 2*: Integrate policy content from memoranda into directives/notices in collaboration with VHA program offices and senior leaders.	
(1.4) Clarify the role of operational memoranda		Q4FY 2019	**Sustaining:** 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.

Actions*	Projected Date	Actual/ Adjusted Date(s)	Status/Comments
			In 2021, RAP collaborated with VHA CO to establish uniform standards for the development, concurrence, publication and rescission of the AUSH signed guidance documents.

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

Table 1-5. P&P-1 Description of Actions Toward Removal Criteria

P&P-1 Description of Actions Toward Removal Criteria
Leadership Commitment • The VHA Senior Leader Committee (SLC) was established in 2016 and is composed of the Deputy Under Secretary for Health, each VHA Assistant Under Secretary for Health, 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 there is a planned meeting in March 2021. • 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 Under Secretary for Health 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 continues to meet quarterly to ensure preparation for systemwide on-going rollout.

P&P-1 Description of Actions Toward Removal Criteria
Demonstrated Progress • A VHA Field Advisory Working Group made recommendations in May 2018 that informed and accelerated national policy improvements such as expanding pre-publication analysis to address funding new policies, reducing mandates of full-time employee positions and clarifying the role of operational memoranda. • In August 2017, 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 493). In 2021, VHA began recertifying VHA Directive 6330 and renumbered it VHA Directive 0999 to align with VA's numbering convention. • 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 supports Presidential, Department and VHA's equity and diversity policy and strategic goals. • Starting in 2021, VHA will include additional contacts in the policy development welcome email to facilitate planning conversations with key stakeholders in resources, workforce management, IT, oversight and accountability and education.
Capacity • VHA supports RAP to meet policy staffing needs with eight FTE and 30 contractors. Senior leaders continue to assess capacity needs.

P&P-1 Description of Actions Toward Removal Criteria
Monitoring • Starting in April 2018, RAP requires each responsible entity developing 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 (Commenced March 2021)

Brian McCarthy, JD, MPH, Chief VHA National Policy (Prior to March 2021)

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 a unified Risk Management Framework (RMF).

P&P-2.1 GOAL: 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.

Objective 1: Reduce average SharePoint field review to publication period from current of 187 days to 180 days by Q4 FY 2022, as set forth in current VHA policy development and recertification processes.

Objective 2: Reassess whether 144 days is appropriate timeline and adjust if necessary, by Q4 FY 2021.

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.

Objective 1: 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).

Objective 2: Ensure 100% of policies in FY 2021 receive Assistant Under Secretary for Health feedback prior to publication.

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.

Objective 1: Reduce number of policies overdue for recertification by 10% annually until 0% of policies are overdue for recertification.

Objective 2: Continue existing monthly communication with program offices that have overdue policies and monthly reminders when policies are coming due to

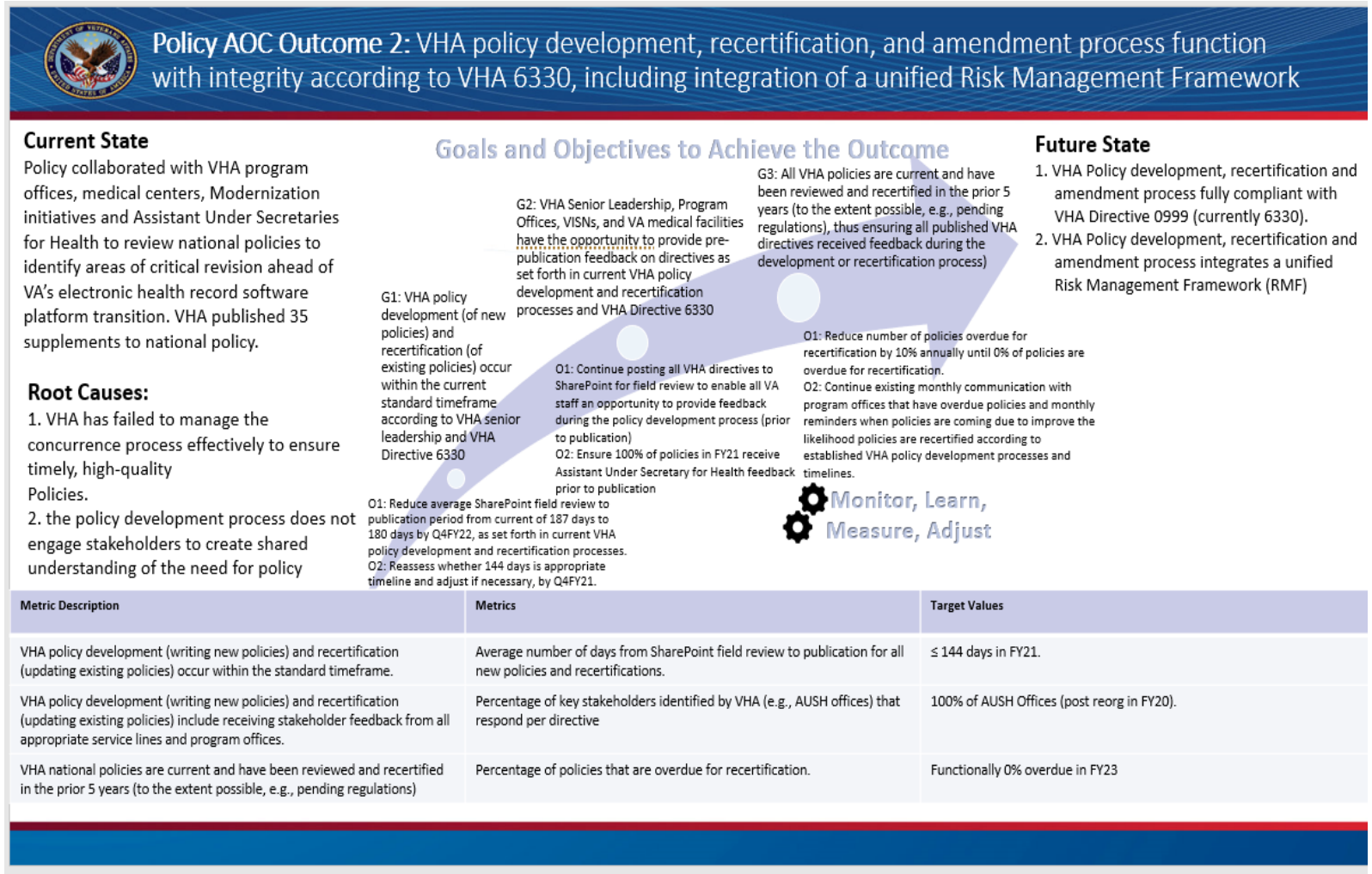
improve the likelihood policies are recertified according to established VHA policy development processes and timelines.

Table 1-6. P&P-2 Description & Status

In Planning	In Progress	Complete	Sustaining

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

Figure 1-3. P&P-2 Roadmap



Metric Description	Metrics	Target Values
VHA policy development (writing new policies) and recertification (updating existing policies) occur within the standard timeframe.	Average number of days from SharePoint field review to publication for all new policies and recertifications.	≤ 144 days in FY21.
VHA policy development (writing new policies) and recertification (updating existing policies) include receiving stakeholder feedback from all appropriate service lines and program offices.	Percentage of key stakeholders identified by VHA (e.g., AUSH offices) that respond per directive	100% of AUSH Offices (post reorg in FY20).
VHA national policies are current and have been reviewed and recertified in the prior 5 years (to the extent possible, e.g., pending regulations)	Percentage of policies that are overdue for recertification.	Functionally 0% overdue in FY23

The following table describes measures and metrics the workgroup uses to determine progress toward achieving P&P-2.

Table 1-7. P&P-2 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
VHA policy development (writing new policies) and recertification (updating existing policies) occur within the standard timeframe.	Average number of days from SharePoint field review to publication for all new policies and recertifications Total number days for each processed policy (aggregated) / number of policies processed	Baseline = 334 days in FY 2015 Milestone = 187 days in FY 2020 Target ≤ 144 days in FY 2021	Q2, Q4
VHA policy development (writing new policies) and recertification (updating existing policies) include receiving stakeholder feedback from all appropriate service lines and program offices	Percent of key stakeholders identified by VHA (e.g., AUSH offices) that respond per directive Per directive: number of stakeholders that respond / total number of stakeholders per directive identified by VHA	Target (achieved): 100% of AUSH offices (post-reorg) in FY 2020	Q1, Q2, Q3, Q4
VHA national policies are current and have been reviewed and recertified in the prior five years (to the extent possible, e.g., pending regulations)	Percent of policies that are overdue for recertification Number of overdue policies / total number of policies	Baseline = 59% overdue in FY 2015 Milestone = Reduce policies overdue for recertification 10% annually in FY 2021 – FY 2023; 28% overdue in May 2019 Target = functionally 0% overdue in FY 2023	Q1, Q2, Q3, Q4

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

Table1-8. P&P-2 Action Plan

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

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
P&P-2.1 GOAL: 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.	***P&P-2.1 GOAL; Objective 1***: Reduce average SharePoint field review to publication period from current of 187 days to 180 days by Q4FY 2022, as set forth in current VHA policy development and recertification processes. ***Objective 2:*** Reassess whether 144 days is appropriate timeline and adjust if necessary, by Q4FY 2021.	**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.	**P&P-2.2 GOAL; *Objective 1*:** 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). ***Objective 2***: Ensure 100% of policies in FY 2021 receive Assistant Under Secretary for Health feedback prior to publication.
(2.1) Develop a clear and concise process for policy development and management within a standard timeframe. The process will include receiving stakeholder feedback for policies in development.		Q1 FY 2017	**Sustaining:** The standard development timelines apply to all new and recertified VHA policies; VHA posts policies in development to SharePoint for two weeks to receive feedback from VA staff. In April 2020, VHA extended this

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
			period to three weeks to enable continued stakeholder participation while VHA responded to the COVID-19 pandemic.
(2.2) Pilot a process for policy development and recertification to ensure timely publication and ensure the process is sustainable upon completion of the pilot.		Q1 FY 2017	**Complete:** VHA conducted the pilot process for ten policies from July to December 2016 and then implemented the process for all VHA policies.
(2.3) Develop a process to identify when the Office of General Counsel review of new and revised policies is required.		Q4 FY 2016	**Sustaining:** The Office of Regulation, Appeals, and Policy (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.
(2.4) Develop a process that		Q3 FY 2018 (and ongoing)	**Sustaining:** VHA requires use of the

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
outlines the pre-policy analysis and appropriate internal controls consistent with the VHA RMF.			Briefing Note, which includes a risk assessment, and Directive 6330 requires each policy contain a full chain of oversight and required staff training. The action is ongoing: the process is modified for improvement.
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.	*Objective 1*: Reduce number of policies overdue for recertification by 10% annually until 0% of policies are overdue for recertification.	*Objective 2*: 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.	
(2.5) Create a policy dashboard that demonstrates overall timeline expectations and days to completion for each policy in the process.		Q1 FY 2017	**Sustaining:** VHA monitors all policies in the process through the dashboard and provides weekly updates to the SLC.
(2.6) Reach "functional zero," where, to the maximum extent possible, VHA policies are current	Q4 FY 2023		**In progress:** In May 2019, VHA's policy inventory is 493 (down from 805 in 2015) and 28% are overdue

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
and have been reviewed and recertified in the prior five years.			(down from 59% in 2015).
(2.7) Employ a staff of writers to relieve the technical and administrative burdens required by the new, more robust collaborative process. Ensure staff vacancies are announced and filled in a timely manner, including reviewing potential unfilled positions that could be transferred to RAP.		Q3 FY 2016 (and ongoing)	**Sustaining**: VHA secured contractor support in 2016; VHA secured an extension of support in November 2020 until May 2026. In 2020 RAP filled two FTE positions for a total of eight FTE supporting the policy development process.
(2.8) Review funding issues to ensure contracted staff remain active until otherwise determined by VHA senior leaders and ensure RAP staff receive appropriate training, which enables 10BRAP 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.		Q3 FY 2017	**Sustaining:** RAP developed and continuously updates the Document Manager Review Guide to train new staff. In 2020, the training was redesigned to ensure seamless operation in a virtual operating environment.

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

Table 1-9. P&P-2 Description of Actions Toward Removal Criteria

P&P-2 Description of Actions Toward Removal Criteria
Leadership Commitment • The VHA SLC was established in 2016 and is composed of the Deputy Under Secretary for Health, each VHA Assistant Under Secretary for Health, 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.

P&P-2 Description of Actions Toward Removal Criteria

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 VA Medical Center, 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.

P&P-2 Description of Actions Toward Removal Criteria
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 Deputy Under Secretary for Health 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 (Commenced March 2021)

Brian McCarthy, JD, MPH, Chief VHA National Policy (Prior to March 2021)

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

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.

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.

Objective 1: 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.

Objective 2: Ensure 48- hour response to policy development and implementation help requests from VHA CO, VISNs and VA medical facility stakeholders via the actions box.

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

Objective 1: 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

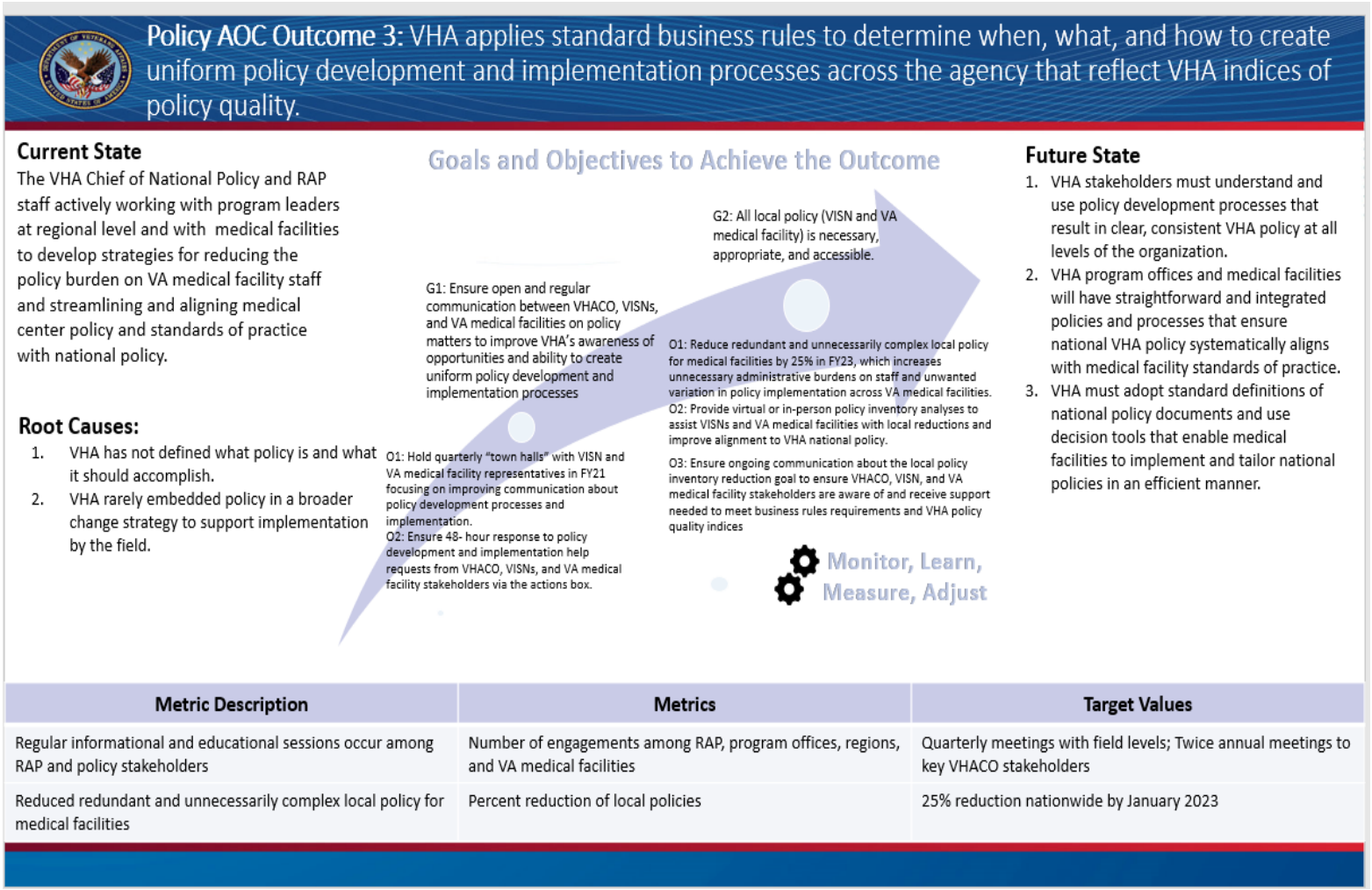
Objective 2: Provide virtual or in-person policy inventory analyses to assist VISNs and VA medical facilities with local reductions and improve alignment to VHA national policy.

Objective 3: 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.

Table 1-10. P&P-3 Description & Status

In Planning	In Progress	Complete	Sustaining

P&P-3 Description & Status
• To achieve this outcome all VHA stakeholders must understand and use policy development processes that result in clear, consistent VHA policy at all levels of the organization. VHA leaders will use the appropriate document type and dissemination method when establishing or updating standards, responsibilities and processes. VHA program offices and medical facilities will have straightforward and integrated policies and processes that ensure national VHA policy systematically aligns with medical facility standards of practice. • VHA must vastly reduce complexity and contradictions among policy and guidance documents. VHA must 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.



Metric Description	Metrics	Target Values
Regular informational and educational sessions occur among RAP and policy stakeholders	Number of engagements among RAP, program offices, regions, and VA medical facilities	Quarterly meetings with field levels; Twice annual meetings to key VHACO stakeholders
Reduced redundant and unnecessarily complex local policy for medical facilities	Percent reduction of local policies	25% reduction nationwide by January 2023

Figure 1-4. P&P-3 Roadmap

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

Table 1-11. P&P-3 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Regular informational and educational sessions occur among RAP and policy stakeholders	Number of engagements among RAP, program offices, regions and VA medical facilities Total number of events per FY	Milestone = 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	Q2, Q4
Reduced redundant and unnecessarily complex local policy for medical facilities	Percent reduction of local policies Number of local policies at baseline – current number of local policies) / number of local policies at baseline	Baseline = 55,000 local policies in FY 2019 Milestone = 10% reduction in FY 2021 Target = 25% reduction nationwide by January 2023	Q2, Q4

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

Table 1-12. P&P-3 Action Plan

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

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
P&P-3.2 GOAL: All local policy (VISN and VA medical facility) is necessary, appropriate, and accessible.	***Objective 1***: 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	***Objective 2***: 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.	

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(3.1) Develop, implement, and follow a process for disseminating, monitoring, and evaluating policy implementation at the local level	Q4 FY 2022		**In progress:** 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.
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	***Objective 1***: Hold quarterly "town halls" with VISN and VA medical facility representatives in FY 2021 focusing on improving communication about policy development processes and implementation	***Objective 2***: Ensure 48- hour response to policy development and implementation help requests from VHA CO, VISNs, and VA medical facility stakeholders via the actions box.	**P&P-3.1 GOAL;** ***Objective 3***: 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.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(3.2) Identify field perspectives through primary research activities		Q3 FY 2018 (and ongoing)	**Sustaining:** RAP conducted 26 semi-structured interviews and four site visits in 2017–2018 to receive feedback and learn the field's policy needs. This action is ongoing: in 2019 and 2020, RAP replaced the semi-structured interviews with VISN- and facility-level meetings to discuss the implementation of the policy business rules. RAP will conduct virtual site visits with field leadership in 2021 to assess business rules implementation and again identify strategies for improvement and future action plans. Site visits complete Q4 FY 2021, report and action plan updates projected for Q2 FY 2022. RAP will continue to research best practices in academia, healthcare organizations, federal departments, and the private sector. Research complete Q4 FY 2021, report and action plan updates projected for Q2 FY 2022.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(3.3) 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 FY 2018 (and ongoing)	**Sustaining:** RAP conducted 15 informational sessions with VHA, regional, and medical facility staff in 2018. This action is ongoing: RAP emails a monthly policy activity digest to VHA stakeholders; the VHA Chief of National Policy meets with groups such as the Health Systems Committee and other stakeholders. In 2020, RAP held monthly Q&A sessions to support VA medical facility business rules implementation; they are held at least quarterly going forward.
(3.4) Identify improvements to national policy to increase alignment with local policy and help reduce redundant and unnecessarily complex policy for medical facilities		Q3 FY 2019 (and ongoing)	**Sustaining:** RAP visited ten sites in 2019 to identify alignment strategies and ways to reduce the local policy burden and initiated actions to address local policy concerns. RAP staff are tracking local policy volume. By Q1 FY 2022, RAP will establish a permanent committee of field representatives to meet at least three times a year to receive ongoing feedback and consultation on continuous policy improvement.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(3.5) Delineate the role of national and local policy		Q2 FY 2021	**Sustaining:** In 2018–2019 RAP conducted three medical center policy data calls to identify target areas for increased alignment and decreased redundancy with national policy. Two notices issuing business rules simplify policy structure and development at national and local levels. These business rules will be incorporated into VHA Directive 0999 (currently 6330). RAP will conduct ten facility and VISN analyses in 2021. Starting in 2021 RAP is synthesizing findings from the MCP analyses at facilities and VISNs to understand trends at the national and local level.
(3.6) Create a site that contains basic information about the policy development process, templates and other tools as needed, that stakeholders can access to facilitate their participation	Q1 FY 2020	Q1 FY 2020	**Sustaining:** In 2016, RAP established a policy process information site. In 2019, RAP created a SharePoint site to host policy and guidance templates and policy decision tools for VA staff. The site has received 9,473 unique users and 131,267 site visitors to date.

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

Table 1-13. P&P-3 Description of Actions Toward Removal Criteria

P&P-3 Description of Actions Toward Removal Criteria
Leadership Commitment • In 2017, the VHA Chief of National Policy held 15 informational sessions and 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 development medical facility standards of practice. In addition to the standards of VHA Directive 6330, Controlled National Policy/Directives Management System, which defines what is and is not considered a national policy document, this tool will help medical facilities streamline local policy inventory and reduce confusion. 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 have been noted as a source of confusion by GAO and internal stakeholders. The repository ensures that only current operational memoranda remain in effect. In addition, 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

P&P-3 Description of Actions Toward Removal Criteria
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.
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 (Commenced March 2021)

Brian McCarthy, JD, MPH, Chief VHA National Policy (Prior to March 2021)

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

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

Objective 1: Assess the results of the FY 2021 repository prototype to confirm operational capability.

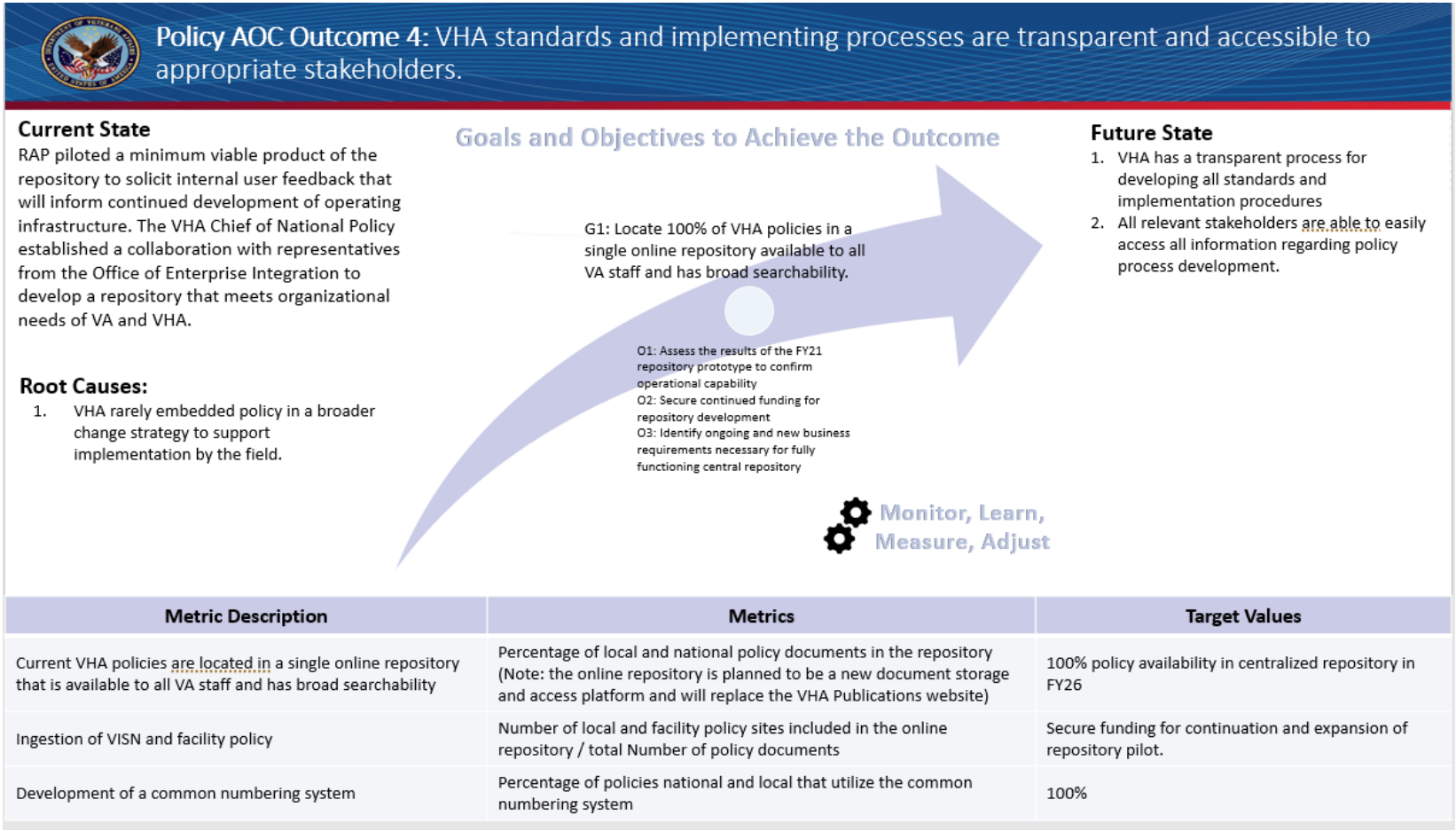
Objective 2: Secure continued funding for repository development

Objective 3: Identify ongoing and new business requirements necessary for fully functioning central repository

Table 1-14. P&P-4 Description & Status

Initiated	In Progress	Complete	Sustaining

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



Metric Description	Metrics	Target Values
Current VHA policies are located in a single online repository that is available to all VA staff and has broad searchability	Percentage of local and national policy documents in the repository (Note: the online repository is planned to be a new document storage and access platform and will replace the VHA Publications website)	100% policy availability in centralized repository in FY26
Ingestion of VISN and facility policy	Number of local and facility policy sites included in the online repository / total Number of policy documents	Secure funding for continuation and expansion of repository pilot.
Development of a common numbering system	Percentage of policies national and local that utilize the common numbering system	100%

Figure 1-5. P&P-4 Roadmap

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

Table 1-15. P&P-4 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Current VHA policies are located in a single online repository that is available to all VA staff and has broad searchability	Percent of local and national policy documents in the repository (Note: the online repository is planned to be a new document storage and access platform and will replace the VHA Publications website)	Baseline = 0% policy availability (repository prototype in development) in FY 2019 Milestone: 100% national VHA policy availability in centralized repository in FY 2022 Target = 100% policy availability in centralized repository in FY 2026	Q2, Q4
Ingestion of VISN and facility policy	Number of local and facility policy sites included in the online repository / total number of policy documents	Secure funding for continuation and expansion of repository pilot	Q4
Development of a common numbering system	Percent of policies national and local that utilize the common numbering system	Baseline: zero Pilot + five years: 100%	Q4

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

Table 1-16. P&P-4 Action Plan

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

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
P&P-4.1 GOAL: Locate 100% of VHA policies in a single online repository available to all VA staff and has broad searchability.	***Objective 1***: Assess the results of the FY 2021 repository prototype to confirm operational capability.	***Objective 2***: Secure continued funding for repository development.	***Objective 3***: Identify ongoing and new business requirements necessary for fully functioning central repository.
(4.1) Create a VHA central repository of policy documents and include implementation documents, operational memoranda, local policies, clinical practice guidelines and links to training resources	Q4 FY 2026		**In progress:** RAP added a repository of operational memoranda in 2018. In January and August 2019, RAP met with OEI, which is building a VA Business Reference repository, to discuss repository development.
(4.2) Create a standardized numbering system that links all related VHA documents (as applicable)	Q4 FY 2026		**In progress:** RAP is developing a strategy for a common numbering system and establishing a temporary workgroup to develop business requirements necessary for the implementation of the national policy library.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(4.3) Co-locate VHA program office guidance websites and supporting resources on the VHA Forms and Publications website	Q4 FY 2026		**In progress:** RAP is requesting links from program offices that contain policy implementation guidance documents.

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

Table 1-17. P&P-4 Description of Actions Toward Removal Criteria

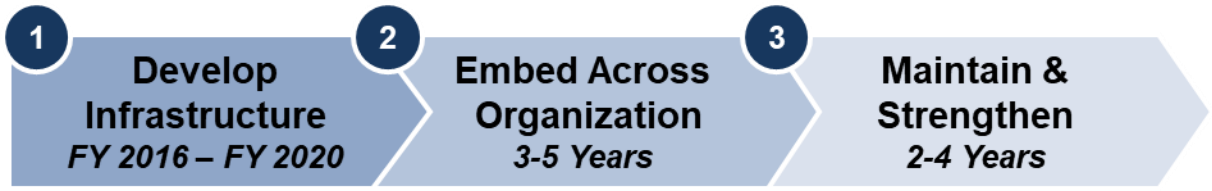
P&P-4 Description of Actions Toward Removal Criteria
Leadership Commitment • In 2019, the VHA Chief of National Policy established a collaboration with representatives from the Office of Enterprise Integration to develop a repository that meets organizational needs of VA and VHA.
Demonstrated Progress • 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 Area of Concern

Executive Summary

VHA is building the organizational tools, capacity and culture to ensure consistent organization-wide oversight and accountability across VHA CO, VISNs, VAMCs, Consolidated Patient Account Centers (CPACs) and Community-Based Outpatient Clinics (CBOCs). 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 and training initiatives, cross-organization connections including systems, and cultural shift. 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 and accountability. Additionally, VHA expanded the role of its oversight and accountability programs by improving coordination of essential stakeholders, created a committee of the senior leadership – the Audit, Risk and Compliance Committee (ARCC) – and three associated subcommittees (Risk, Compliance, and Fraud, Waste and Abuse (FWA)) and established a High Reliability Organization (HRO) Steering Committee and program office to oversee HRO principles based on leading VHA and industry best practices. With this base infrastructure now operational, the focus pivots towards creating the connective systems, tools and processes that span the infrastructure and leverage the infrastructure to embed consistent oversight activities and behavior across the organization.

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 VHA 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 platform for governance, compliance, evaluation and risk data to ensure coordinated oversight.
3. Initiate a systemic process for After-Action Reports to be used across VHA enabling organization-wide learning, follow-through and accountability.
4. Continue the transition towards a high reliability organization creating a culture of safety, integrity and accountability at all levels in the organization.

Figure 0-2. Oversight & Accountability 2021 Rating Goal

The outcome action plans focus on rolling out 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 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.

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

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

Oversight and Accountability are both critical components to effective risk management. The COSO Internal Controls Framework/GAO Green Book Principles inform the VHA Risk Management framework.

Figure 2-3. OA COSO Internal Controls Framework / GAO Green Book Principles for Risk Management

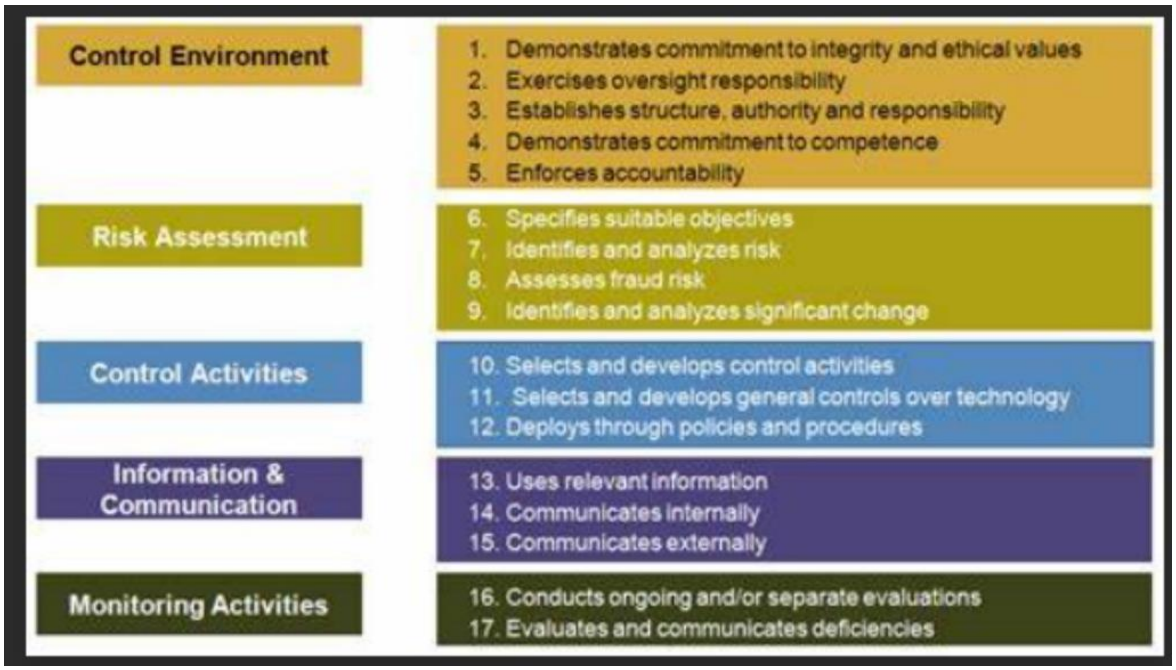


Figure 2-4. OA Compliance Program Elements

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

Table 2-1. OA Alignment with Other Areas of Concern

Alignment with Other Areas of Concern
Policies and Procedures
• The Oversight and Accountability 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 written policy requirements to define accountability roles, internal controls that exist for the policy, oversight and monitoring plans for the policy and plans for how to address non-compliance with the policy. • Policy owners (aka program offices) must ensure that policies are clear so they are not misunderstood and must address the management of risk within the program. • Given the complex policy environment within VHA, CBI stewarded the development of the VHA Code of Integrity (published on June 30, 2019) to create an umbrella document that helped simplify all of the policies that apply to VHA employees 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 as provides a section for requirements for reporting as well as where to report and establishes clear expectations for fostering a Culture of Integrity.
IT
• IT systems are critical to the success of effective oversight and accountability. VHA must continue to work with OIT to determine and prioritize IT requirements and build them into VA's operational and strategic planning efforts, including the Joint Business Plan (JBP). • 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. • Oversight and Accountability relies on IT support to ensure data are timely and reliable to inform sound decisions. • IA is facilitating collective discussions across VHA and VA program offices to develop the VHA roadmap that will increase data management maturity in VHA. Collaboration will help achieve a level 4 of 5 of the VA Data Governance Maturity Model. • For example, OIT's maintenance of Compliance Inquiry Reporting and Tracking Systems (CIRTS) is essential to for the Office of Compliance and Business Integrity to track reports of non-compliance from identification to closure across the VHA enterprise.
Training

Alignment with Other Areas of Concern
• 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 laws, regulation and policies, as well as high level expectation for Integrity and Safety in the Workplace.
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.

Oversight and Accountability Outcome (OA-1)

Outcome Executive: Erica Scavella[1], MD, Associate Deputy Under Secretary for Health for Oversight, Risk and Ethics

Outcome Leads: Tracy Davis Bradley, **PhD,** Acting Chief Compliance and Business Integrity Officer
Brian McCarthy, JD, MPH, Acting Deputy Chief Compliance and Business Integrity Officer (Starting March 2021)

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.

OA-1.1 GOAL: VHA has formalized risk governance (GAO Components – Control Environment and Risk Assessment and Information and Communication)

Objective 1.1.1: Establish and implement an organizational structure that promotes oversight and accountability.

Objective 1.1.2: Establish and implement committees, subcommittees and working groups to facilitate systematic risk management.

Objective 1.1.3: Promote a risk-informed culture across VHA.

Objective 1.1.4: 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.

OA-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.

Objective 1.2.1: 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.

Objective 1.2.2: Catalogue baseline VHA risk management efforts and continue to mature processes.

Objective 1.2.3: Develop and deploy integrated risk management (IRM) process for aggregating and assessing risks identified across VHA.

Objective 1.2.4: Enhance the execution and utilization of the IRM process through improved processes and technology.

[1] Dr. Erica Scavella assumed responsibility as the Outcome Executive in January 2021.

OA-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.

Objective 1.3.1: Utilize data governance to ensure information is available, and performance metrics can be established and prioritized to support governance and oversight requirements.

Objective 1.3.2: Assign and execute internal monitoring, audits and reviews based on VHA IRM prioritization.

Objective 1.3.3: Assign and execute corrective and preventive action plans based on VHA IRM information.

Objective 1.3.4: Monitor the performance and maturity of IRM; evaluate IRM tool inputs and effectiveness.

Table 2-2. OA-1 Description & Status

In Planning	In Progress	Complete	Sustaining

OA-1 Description & Status

Description
• This outcome focuses on providing effective risk management practices to support governance and oversight. The following action plan establishes the ability for VHA organizations and employees to identify and manage risks in accordance with an established enterprise risk management (ERM) framework, such as from the Committee of Sponsoring Organization of the Treadway Commission (COSO), and the International Organization for Standardization 31000 (ISO 31000) series. The action plan includes:
  ○ 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.
  ○ An ability to conduct administrative reviews, investigations or audits.
• Risk management (RM) relies on existing permanent Departmental structures –CBI, ERM and Internal Audit, all guided by and coordinated through a central governance body, the ARCC.

Status
• ***VHA has formalized risk governance (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

OA-1 Description & Status

        - Governance oversight regarding major VHA risk and internal control initiatives
    - Voting members include the Deputy Under Secretary for Health, all Assistant Under Secretaries, two VISN Directors, two VA Medical Center 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 Under Secretary for Health, 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.
    - ARCC's accomplishments include establishing a Compliance Subcommittee, Fraud Waste and Abuse Subcommittee and a Risk Subcommittee, in addition to meeting quarterly since 2018 for risk management decision making. As a part of the Risk Subcommittee, a risk working group and enterprise risk management community of practice were also established in FY 2020 and FY 2021, respectively.
    - The Office of Oversight, Risk, and Ethics was established in 2020 (formerly the Office of Risk Management). This consolidated several oversight-focused offices and reports directly under the Under Secretary for Health. The creation of this new office to align 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 program offices, including eliminate fragmentation, contradictions, overlap and duplication.
- ***VHA has a unified and integrated risk management framework (GAO Components – Risk Assessment and Control Activities).*** A VHA ERM function is essential for streamlining, improving, and standardizing the risk assessment process, developing an integrated and forward-looking approach, and informing strategy and performance. The Enterprise Risk Manager is the steward of VHA's Risk Register; responsible for VHA's Risk Profile for annual submissions to the OEI's VA Risk Profile; responsible for the development, review and development of VHA's Risk Appetite Statement; and responsible for coordination, review and approval of VHA's interim and annual Statement of Assurance.
    - VHA hired an Enterprise Risk Manager and is in the process of migrating identified risks to a centralized enterprise risk register to track reported threats and opportunities, as well as track risk (opportunities and threats) and submissions to include but not limited to VA medical facilities, regional offices and VHA program offices. The Statement of Assurance coordinates VA's assessment of and conclusion on the effectiveness of VHA's system of internal control. VHA ERM will track its level of maturity according to industry-standard maturity models such as

OA-1 Description & Status
the ones provided in the United States Chief Financial Officers Council's *Playbook: Enterprise Risk Management for the U.S. Federal Government*, dated July 29, 2016. ○ Working in conjunction with VA ERM, VHA ERM analyzed and categorized previously disparate risk submissions to VA ERM; thereby remove duplication and formulate a baseline Enterprise Risk Register. To better ensure the collection of risk information from across VHA, VHA ERM, with the support of CBI and IA, determined that a unified IRM model was necessary. As of Q1 FY 2021, an environmental scan, to include interviews and surveys of key stakeholders at the program office and field level was initiated. Data collected through this environmental scan will then inform the recommended IRM model. *See the VHA IRM Process and Strategic Plan figures below.* • ***VHA has a unified and integrated risk reporting and monitoring system (GAO Components – Information and Communication and Monitoring).*** Specific accomplishments include establishing the IA office under ORE; 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. ○ The ARCC recommended the USH approved Audit Plans and internal audits were conducted in FY 2018 – FY 2020. Corrective and Preventive Actions were identified for each audit and program offices are working on addressing those items. Additionally, the five highest ranked risks were recommended by ARCC and approved by the USH for FY 2021 Internal Audit engagements. ○ The CBI under the ORE deployed a Microsoft SharePoint based platform to capture risk information from all VA medical facilities 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. ○ As a part of the risk management process, improved oversight of the establishment of internal controls will be developed and deployed to align with the governance established for Risk Management. It is anticipated that the ERM Environmental Scan will clarify where programmatic risks are reported, allowing VHA to clarify the reporting functions of risk. This will provide confidence in the ability to hold assigned risk owners accountable for the ongoing response to the identified risk.

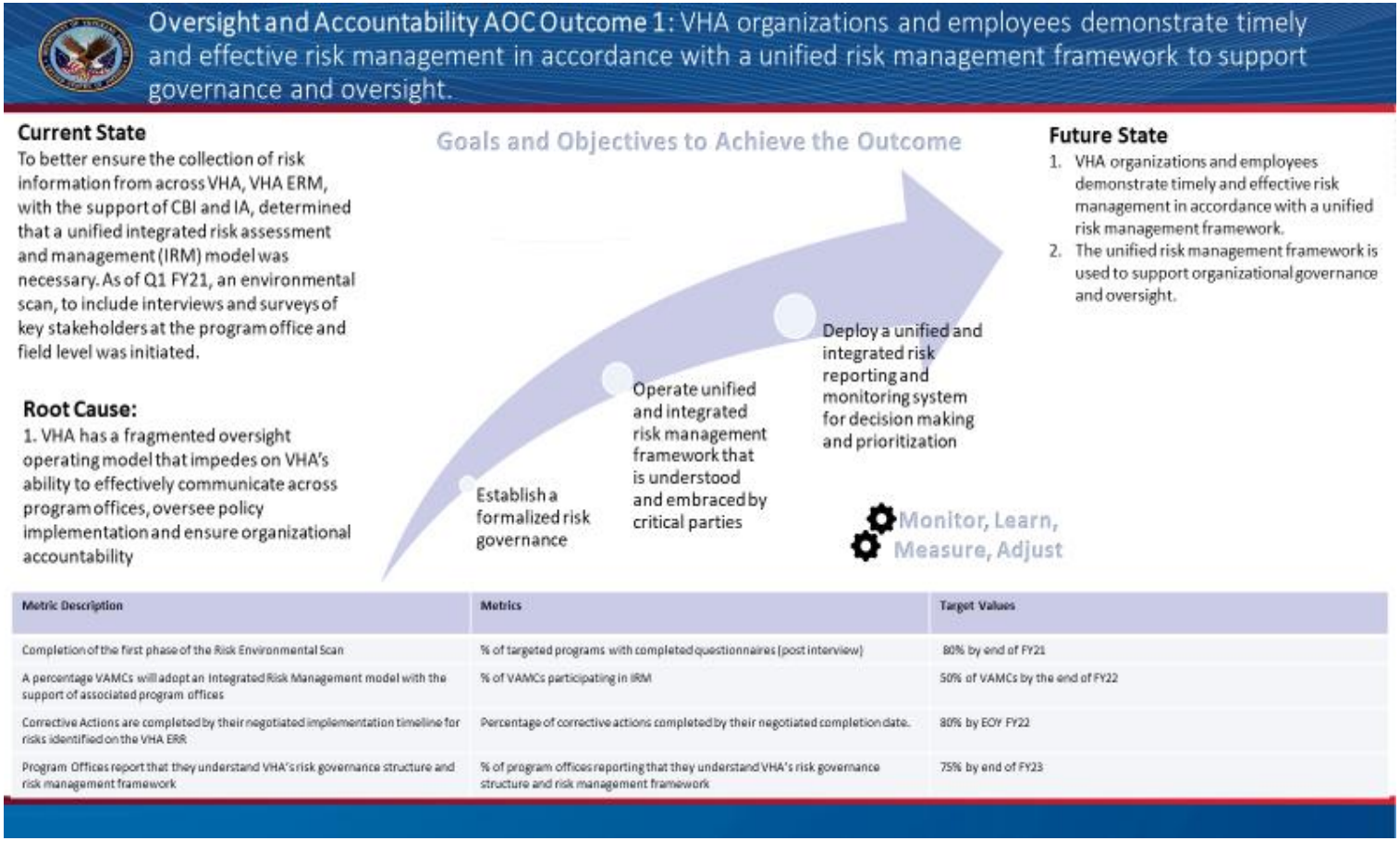


Figure 2-5. OA-1 Roadmap

Figure 2-6. VHA Integrated Risk Management (IRM) Process

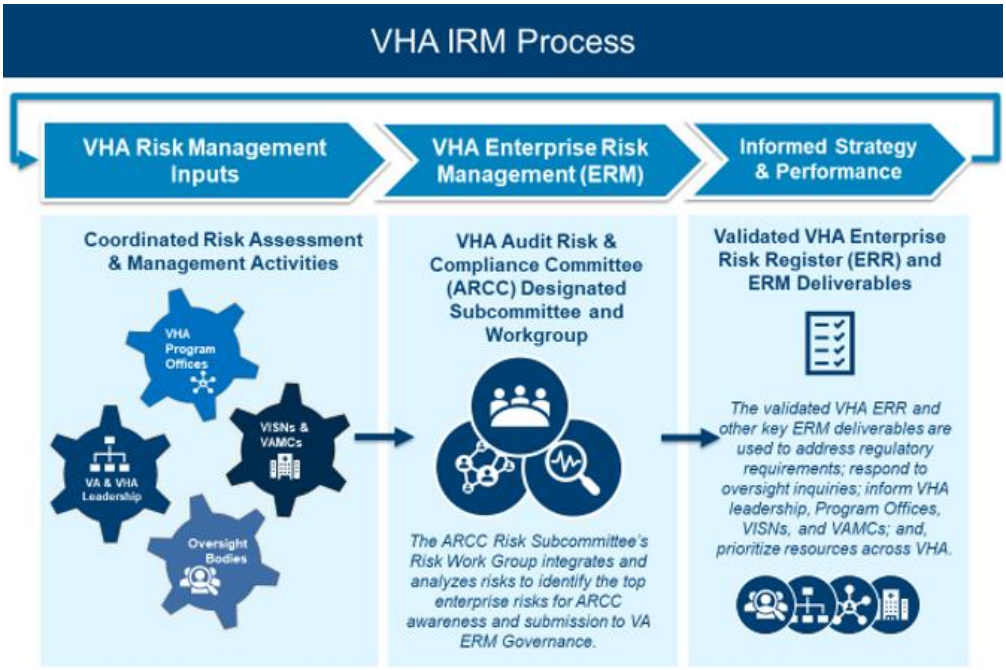


Figure 2-7. Integrated Risk Management (IRM) Strategic Plan

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

Table 2-3. OA-1 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
ARCC member risk awareness and opportunities for improved oversight and accountability (Goal 1.1) Survey will be initially administered beginning in 2021.	Level of member risk awareness as reported in ARCC member survey, as well as recognition of opportunities for improved oversight and accountability.	Milestone = TBD Target = TBD	Semiannual
Key stakeholders across VHA report that they understand VHA's risk governance structure and risk management framework (Goal 1.1) Survey to be initially administered to program offices in 2021	Percent of VHA key stakeholders reporting that they understand VHA's risk governance structure and risk management framework = Number of program offices reporting that they agree/strongly agree to survey questions about risk management / total program offices surveyed	VHA Milestone = 50% by end of FY 2022 VHA Target = 75% by end of FY 2023	Annually beginning in FY 2022
Timely submission of a complete VHA Enterprise Risk Register to VA Enterprise Risk Governance entities (Goal 1.2)	All newly identified risks submitted to VA ERM within 30 days following review by ARCC	Milestone = 75% by end of FY 2021 Target = 100% by end of FY 2022	Annually
Completion of the first phase of the Risk Environmental Scan (Goal 1.2)	Percent of targeted programs with completed questionnaires (post interview) = Number of programs that responded to questionnaire/ total number distributed	Milestone = 50% by end of Q2 Target = 80% by end of FY 2021	Quarterly in FY 2021

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Percentage of VAMCs adopting an Integrated Risk Management model with the support of associated program offices (Goal 1.2)	Percent of VAMCs participating in IRM = Number of VAMCs participating in IRM / total number of VAMCs	Milestone = 15% of VAMCs by end of FY 2021 Target = 50% of VAMCs by the end of FY 2022	Annually
Timely submission of internal control updates and risk scoring for current VHA risks existing on the VA Risk Register (Goal 1.3)	By end of Q2 FY 2022 all submitted risks will have an updated risk owner, risk scores, and internal controls information including status of controls	Target = 100% by Q2 FY 2022	Annually
Corrective Actions assigned by the Office of Oversight, Risk and Ethics based on monitoring activities, audits and reviews are completed by their negotiated implementation date (Goal 1.3)	Percent of corrective actions completed by their negotiated completion date. = Number of corrective actions completed by their negotiated completion date / total number corrective actions	Milestone = 50% by EOY FY 2022 Target = 70% by EOY FY 2023 Dates may be renegotiated to adjust for unforeseen circumstances like COVID-19 priorities	Annual
Corrective Actions are completed by their negotiated implementation timeline for risks identified on the VHA ERR (Goal 1.3)	Percent of corrective actions completed by their negotiated completion date. = Number of corrective actions completed by their negotiated completion date / total number corrective actions	Milestone = 60% by EOY FY 2021 Target = 80% by EOY FY 2022	Annual

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

Table 2-4. OA-1 Action Plan

*All actions imply change management and training needs are a part of implementation planning.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
OA- 1.1 Goal: VHA has formalized risk governance (Greenbook Principles 1-6, 14-15) [2]	**Objective 1.1.1**: Establish and implement an organizational structure and systems that promote oversight and accountability		
(1.1) Realign VHA CO to promote oversight and accountability	Q2 FY 2020	Q2 FY 2020	**Complete.** On January 1, 2020, VA announced the redesign of the VHA CO to directly address oversight and accountability by clarifying office roles and streamlining responsibilities to eliminate fragmentation, overlap, and duplication.
(1.2) Established the ORE	Q2 FY 2020	Q2 FY 2020	**Complete.** ORE consolidates several oversight-focused offices and reports directly to the Office of the USH.

[2] GAO, *Standards for Internal Control in the Federal Government*, GAO -14-70G, (Washington, D.C.: March 2014)
Greenbook Principle 1 – Demonstrate Commitment to Integrity and Ethical Values
Greenbook Principle 12 – Exercise Oversight Responsibility
Greenbook Principle 13 – Establish Structure, Responsibility, and Authority
Greenbook Principle 14 – Demonstrate Commitment to Competence
Greenbook Principle 15 – Enforce Accountability
Greenbook Principle 16 – Define Objectives and Risk Tolerances
Greenbook Principle 114 – Communicate Internally
Greenbook Principle 115 – Communicate Externally

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(1.3) Align the GOAL Office to effectively direct the HRL response.	Q2 FY 2020	Q2 FY 2020	**Complete.** The GOAL Office is located within the Office of the Chief of Staff, which reports directly to the USH.
(1.4) Establish a VHA Governance Board to oversee activities related to the operational strategy to ensure decisions are prioritized and consistent with the organization's mission and the strategic direction from the USH.	Q4 FY 2019	Q3 FY 2020	**Complete.** 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.
(1.5) Properly resource (e.g., permanent personnel, etc.) ORE to achieve its oversight and accountability functions.	Q4 FY 2024		**In Progress.** VHA and ORE are planning to fully resource program offices to properly execute its oversight and accountability functions.
(1.6) Develop requirements, adequately resource and build unified and integrated risk reporting and monitoring system to ensure success of Goals 1.2 and 1.3.	Q4 FY 2024		**In Planning.** Task cannot be started until resources are allocated and requirements are identified.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
	Objective 1.1.2: Establish and implement committees, subcommittees and working groups to facilitate systematic risk management		
(1.7) Establish the ARCC	Q3 FY 2019	Q3 FY 2019	**Complete.** The ARCC Charter was signed by the VHA Executive in Charge (EIC) in May 2019. The ARCC convenes quarterly.
(1.8) Establish the ARCC Risk Subcommittee (RSC) and RSC sub-working groups	Q3 FY 2019	Q3 FY 2019	**Complete.** The ARCC-RSC Charter was signed by the ARCC Chairperson in May 2019. The ARCC-RSC convenes quarterly.
(1.9) Determine key stakeholders in risk management across VHA and begin recurring Risk Working Group (RWG) meetings as an element of integrated risk management governance	Q2 FY 2020	Q2 FY 2020	**Complete.** The RSC Risk Working Group (RWG) Core Team was established in FY 2021 to facilitate systematic risk management.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(1.10) Establish direct lines of communication between the ARCC and the VHA Governance Board.	Q4 FY 2021		**In Progress.** The ARCC and VHA Governance Board have numerous individuals that serve as members of both committees. These members' dual roles allow for current and relevant information to be communicated during convened meetings. The ARCC was established prior to the Chartering of the VHA Governance Board, and its alignment to the VHA Governance Board still requires clarification.
	Objective 1.1.3: Promote a risk informed culture across VHA		
(1.11) Establish an Enterprise Risk Community of Practice (CoP) to promote enterprise risk management concepts and awareness.	Q2 FY 2021		**In Progress.** Monthly VHA ERM CoP meeting began in February 2021.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(1.12) Deploy a Risk Management Portal that provides key knowledge artifacts and resources to VHA personnel.	Q3 FY 2021		**In Progress.** The Risk Management Portal is scheduled to be deployed in conjunction with the initial VHA ERM COP meeting in FY 2021. The Risk Management Portal will then be updated on an ongoing basis.
(1.13) Develop an education and communications efforts 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 HRO, Culture of Integrity, etc. to improve awareness.	Q3 FY 2022		**In Progress.** Groups within VHA ORE are establishing partnerships to support formal RWG and CoP meetings to promote risk management. Examples include one-on-one meetings, direct outreach to program offices and email communication.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
	Objective 1.1.4: Based on maturity evaluations (Goal 1.3) continue to enhance and define resource needs (e.g., funding, manpower, technology, etc.) for supporting and program oversight, as well as governance bodies.		
(1.14) In pursuit of continuous improvement and becoming a high reliability organization, utilize the information from the IRM initiative and risk maturity assessments to recommend enhancements to the governance and oversight process for risk management.	Q1 FY 2021		**In Planning –** Dependent on the completion of the baseline and subsequent maturity assessments – target for baseline is FY 2021 / FY 2022.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(1.15) In pursuit of continuous improvement and becoming a high reliability organization, 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.	Q1 FY 2021		**In Planning –** 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.
OA-1.2 Goal: VHA has a unified and integrated risk management framework and it is understood and embraced by critical parties. (Greenbook Principles 7-12)[3]	**Objective 1.2.1**: Deliver updated agency required oversight and accountability documentation and deliverables (e.g., Office of Management and Budget Circular A-123 required deliverables) for continued refinement to the governing bodies defined in OA-1.1 and to program and field leadership.		

[3] Greenbook Principle 7 – Identify, Analyze, and Respond to Risks
Greenbook Principle 8 – Assess Fraud Risk
Greenbook Principle 9 – Identify, Analyze and Respond to Change
Greenbook Principle 10 – Design Control Activities
Greenbook Principle 11 – Design Activities for the Information System
Greenbook Principle 12 – Implement Control Activities

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(1.16) Using the ARCC governance process, analyze and categorize risks assigned to VHA in VA's ERM Tool to form a baseline Enterprise Risk Register (ERR).	Q1 FY 2020	Q1 FY 2020	**Complete.** The baseline VHA ERR was assembled during the fourth quarter of FY 2020 and shared with the ARCC during the FY 2021 Q1 and Q2 meeting.
(1.17) Submit VHA ERR baseline to VA following ARCC review.	Q2 FY 2021	Q2 FY 2021	**Complete.** The baseline VHA ERR was submitted to the Risk Subcommittee and ARCC in December, 2020 and to the RWG and Risk Subcommittee in February 2021.
(1.18) Deliver updated Risk Appetite Statement, Risk Profile and Internal Controls Assessment in collaboration with VHA Program Offices and/or Workgroups in accordance with OMB No. A-123.	Q4 FY 2021		**In Progress.** The VHA Enterprise Risk Manager (under VHA ORE) is facilitating the assembly of updated OMB No. A-123 requirements.
(1.19) Deliver updated Statement of Assurance following assessment of internal controls and conclude on the effectiveness of controls.	Q4 FY 2021		**In Progress.** The VHA Enterprise Risk Manager (under VHA ORE) is facilitating the assembly of updated OMB No. A-123 requirements.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
	Objective 1.2.2: Catalogue baseline VHA risk management efforts and continue to mature processes.		
(1.20) Develop a Risk Management Environmental Scan methodology to identify existing VHA risk assessment and risk management efforts conducted locally, regionally, and nationally, including VA medical facilities, VISNs and VHA program offices.	Q1 FY 2021	Q1 FY 2021	**Complete**
(1.21) Execute the initial phase of the Integrated Risk Management Environmental Scan by conducting stakeholder identification and outreach.	Q2 FY 2021		**In Progress.** VHA ERM is currently conducting interviews and collecting questionnaires from key stakeholders.
(1.22) Execute a subsequent phase of the Integrated Risk Management Environmental Scan through a formalized survey and other methods of data collection.	Q2 FY 2021		**In Planning.** Task cannot be started until the previous actions are completed.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(1.23) Consolidate and catalog information captured in the Integrated Risk Management Environmental Scan to generate a baseline of risk management activities conducted across VHA.	Q3 FY 2021		**In Planning.** Task cannot be started until the previous actions are completed.
	Objective 1.2.3: Develop and deploy an integrated risk management (IRM) process for aggregating and assessing risks identified across VHA		
(1.24) 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.	Q4 FY 2021		**In Progress.** Being informed by the Environmental Scan currently in progress
(1.25) Develop an IRM Operational Plan that provides activities and milestones for deploying the IRM framework.	Q1 FY 2021		**In Planning.** Task cannot be started until the previous actions are completed.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(1.26) Communicate the IRM Framework and Operational Plan to formalized risk governance entities.	Q1 FY 2021		**In Planning.** Task cannot be started until the previous actions are completed.
(1.27) Deploy the IRM Framework to VHA program offices.	Q1 FY 2021		**In Planning.** Task cannot be started until the previous actions are completed. Dependent on leadership support and competencies of involved staff.
(1.28) Deploy the IRM Framework to VISNs and medical facilities.	Q1 FY 2021		**In Planning.** Task cannot be started until the previous actions are completed. Dependent on leadership support and competencies of involved staff.
	Objective 1.2.4: Enhance the execution and utilization of the IRM processes and technology		

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(1.29) Enhance risk management platforms used as inputs for the VHA ERR.	Q2 FY 2022		**In Progress.** VHA CBI deployed a Microsoft 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.
(1.30) Consolidate risk management platforms to expedite the collection, aggregation, and analysis of VHA risks and risk response information.	Q2 FY 2022		**In Planning.** Funding will be required to support staff and systems needs to execute this task.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
OA-1.3 Goal: VHA has unified and integrated risk reporting and monitoring system and uses it for decision making and prioritization (Greenbook Principles 5, 13-17)[4]	***Objective 1.3.1***: Utilize data governance to ensure information is available, and performance metrics can be established and prioritized to support governance and oversight requirements.		
(1.31) Establish a cadence for reviewing VHA risks and identifying VHA enterprise risks.	Q4 FY 2021		**In Progress.** RWG and Risk Subcommittee are establishing the competencies of the members to consistently review the entries elevated to the ARCC.

[4] Greenbook Principle 13 – Use Quality Information
Greenbook Principle 14 – Communicate Internally
Greenbook Principle 15 – Communicate Externally
Greenbook Principle 16 – Perform Monitoring Activities
Greenbook Principle 17 – Evaluate Issues and Remediate Deficiencies
Greenbook Principle 5 – Enforce Accountability

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(1.32) Update the VHA ERR monthly.	Ongoing		**In Progress.** Initial updates to the VHA ERR and subsequently to the VA ERR were initiated in December 2020. It was identified that this would need to be done on an ongoing basis and would rely on the appropriate identification of the risk owners. This will be an ongoing task as risks will have continuing efforts to establish controls as long as they remain within appropriate risk tolerance levels.
(1.33) Assign risk ownership to accountable entities.	Ongoing		**In Progress.** VHA ERM has generated a list of potential program offices who own risks currently on the VA ERR. Specific risk owners are in the process of being identified, notified and provided with explanation of their responsibilities. This will be an ongoing task as new risks are identified.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
	Objective 1.3.2: Assign and execute internal monitoring, audits and reviews based on VHA IRM prioritization		
(1.34) Annually assign internal monitoring, audits and reviews to responsible offices based on prioritized VHA enterprise risks.	Ongoing		**In Progress.** 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.
(1.35) Execute the annual internal audit plan.	Ongoing		**In Progress.** 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.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(1.36) Develop corrective action plans based on internal monitoring, audit and review results.	Ongoing		**In Progress.** VHA ORE is currently working with risk owners, as they are identified, to define clear action plans to address the risk at hand including monitors that determine if implemented controls are effective. This process is also being mirrored at the field level through CBI initiatives.
(1.37) Execute corrective action plans developed to address internal monitoring, audit and review results.	Ongoing		**In Progress.** As reviews are completed, recommendations for corrective action are provided to the impacted entities. This will remain ongoing as reviews continue. The process for corrective actions plans will continue to be enhanced and matured.
	Objective 1.3.3: Assign and execute corrective action plans based on VHA IRM information		

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(1.38) Institute a formal corrective action plan process for VHA enterprise risks.	Ongoing		**In Planning.** Need was identified during the update to the GAO HRL response plan and will be built into the IRM Strategic Plan.
(1.39) Monitor progress against corrective action plans.	Ongoing		**In Planning.** Need was identified during the update to the GAO HRL response plan and will be built into the IRM Strategic Plan.
	Objective 1.3.4: Monitor the performance and maturity of IRM; evaluate IRM tool inputs and effectiveness		
(1.40) Distribute questionnaire to key users of IRM to determine usability, adoption and general sentiment towards VHA IRM framework.	Q4 FY 2022		**In Planning.** This step cannot be taken until the IRM model has been fully implemented with the targeted users.
(1.41) Analyze the risks input into the IRM tool for relevance, completeness and accuracy; work with stakeholders to understand areas of opportunity for the IRM tool.	Start by Q4 FY 2021 Ongoing		**In Planning.** This step cannot be taken until the IRM model has been fully implemented with the targeted users.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(1.42) Assess IRM maturity at baseline and in follow-up to determine effectiveness of IRM.	Q4 FY 2021		**In Planning.** This step cannot be taken until VHA ERM is prepared to roll out the IRM model as this is a pre- and post-test.

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

Table 2-5. OA-1 Description of Actions Toward Removal Criteria

OA-1 Description of Actions Toward 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 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 IA, CBI, 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. • Furthermore, VHA established the ARCC) comprised primarily of VHA Assistant Under Secretaries. 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.
Capacity • VHA expanded capacity to integrate internal oversight functions within VHA by establishing the ARCC, the ARCC Compliance Subcommittee and the ARCC Risk Subcommittee. • The ARCC allowed leadership the forum and mechanism to direct a coordinated risk management function. 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 needs of Action Plan.

OA-1 Description of Actions Toward Removal Criteria
Monitoring • The metrics and measures of this plan provide the mechanism to assess and report progress. • Additionally, the ARCC receives quarterly updates from IA, CBI, ERM and other entities, as necessary. 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. • The ARCC is primarily comprised of Assistant Under Secretaries and is chaired by the Principal Deputy Under Secretary for Health (PDUSH), enabling the ARCC to assign and realign resources based on the risk information presented.
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. • The CBI under the ORE deployed a Microsoft SharePoint 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. Program offices are participating in multiple focus groups with the goal of streamlining risk reporting and oversight management of associated corrective action plans.

Oversight and Accountability Outcome (OA-2)

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

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

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

OA-2.1 GOAL: Establish the decisional authority and accountability role for the governance bodies to make decisions at the appropriate level to ensure organizational accountability.

Objective 2.1.1: 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.

Objective 2.1.2: 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.

OA-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.

Objective 2.2.1: 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.

Objective 2.2.2: 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).

OA-2.3 GOAL: Identify and assign a Senior Executive Service (SES)/Office reporting to a Senior VHA office (e.g., Chief of Staff) to provide appropriate oversight and ongoing monitoring and process improvement of the revised governance structure.

Objective 2.3.1: 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 2-6. OA-2 Description & Status

In Planning	In Progress	Complete	Sustaining

OA-2 Description & Status
Description • 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 establish an office to provide appropriate oversight and ongoing monitoring for the revised governance structure. 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. **Revise Governance Processes and Align Decision Rights**: • The development of an aligned and dedicated governance structure with clear roles, responsibilities, and decision rights creates opportunities for greater cross-organizational synergy. VHA's efforts over the past 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 is being 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 clinical operations and VHA priorities. Coordination is underway to carefully define decision rights and thresholds for governance and management. Decision rights will clarify when decisions are made through governance or management.
Status • 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 will delegate decisional authority to the previously established governance board and its councils. VHA has also drafted directive 1217 that will delegate decisional authority to VA central office operating units. Before these directives are published, they will undergo a rigorous concurrence process and be signed by the Undersecretary. Once signed and concurred these directives will become national policies and implemented across the organization. • In FY 2020, VHA established a Governing Board, and Enterprise Councils. In FY 2021, VHA will 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 regions 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 will provide administrative support to the Governing Board

OA-2 Description & Status
and the four Enterprise Councils. This office will be the focal point for requests to brief governing bodies and any questions related to the governance board.

Figure 2-8. OA-2 VHA Governing Principles

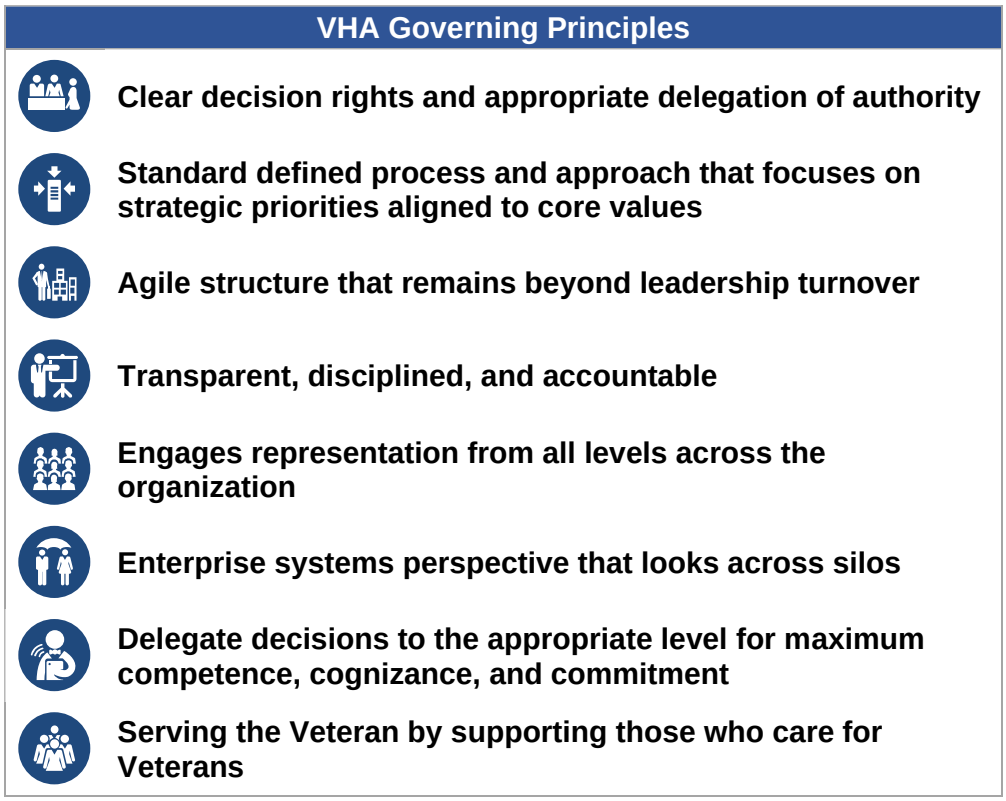
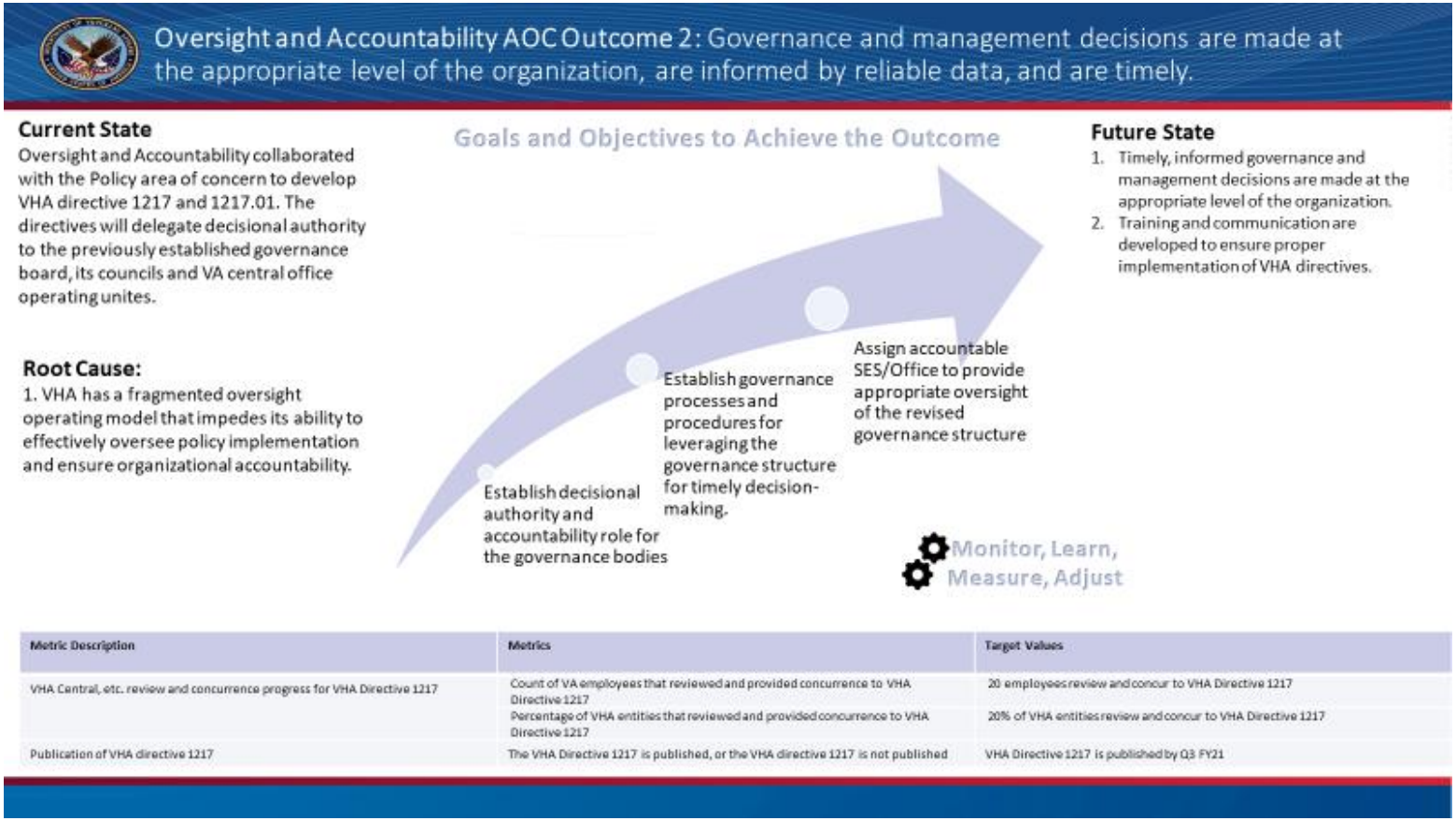


Figure 2-9. OA-2 Roadmap



Metric Description	Metrics	Target Values
VHA Central, etc. review and concurrence progress for VHA Directive 1217	Count of VA employees that reviewed and provided concurrence to VHA Directive 1217	20 employees review and concur to VHA Directive 1217
	Percentage of VHA entities that reviewed and provided concurrence to VHA Directive 1217	20% of VHA entities review and concur to VHA Directive 1217
Publication of VHA directive 1217	The VHA Directive 1217 is published, or the VHA directive 1217 is not published	VHA Directive 1217 is published by Q3 FY21

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

Table 2-7. OA-2 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
VHA Central, etc. review and concurrence progress for VHA Directive 1217.	Projected to be submitted for national review and formal concurrence	Submitted for national review in SharePoint	Quarterly, until publication
Publication of VHA directive 1217.	Metric: VHA Directive 1217 is published, or VHA Directive 1217 is not published	Milestone: VHA Directive receives concurrence from the office of Labor Management and Relations Target: VHA Directive 1217 is published by Q3 FY 2021	Quarterly, until publication

Table 0-8. OA-2 Action Plan

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
OA-2.1 Goal: Establish the decisional authority and accountability role for the governance bodies to make decisions at the appropriate level to ensure organizational accountability.	***Objective 2.1.1***: 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.		

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(2.1) Develop a VHA directive that will establish authority for governance board and its councils: • Obtain feedback from senior leadership (Q3 FY 2021) • Obtain signature from Undersecretary (Q4 FY 2021) • Publish directive (Q1 FY 2022)	Q3 FY 2022		**In progress.** At the direction of the Executive in Charge the Executive Sponsorship Collation drafted VHA Directive 1217.01 that will establish decisional authority within the governance board and its councils.
	Objective 2.1.2: 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.		
(2.2) Develop and provide training, communications and processes related to new directives to ensure proper implementation and routine monitoring.	Q1 FY 2022		**In Planning**

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
OA-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.	***Objective 2.2.1***: 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.		
(2.3) Develop a VHA directive that will establish decisional authority of VA central office operating units. • Obtain feedback from senior leadership (Q3 FY 2021) • Obtain signature from the Undersecretary (Q4 FY 2021) • Publish directive (Q1 FY 2022)	Q3 FY 2022		**In progress.** At the direction of the Executive in Charge VHA Directive 1217 has been drafted to establish the decisional authority of VA central office operating units.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
	Objective 2.2.2: 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.		
Actions are under development			
OA-2.3 Goal: Identify and assign a SES/Office reporting to a Senior VHA Office (e.g., COS) to provide appropriate oversight and ongoing monitoring and process improvement of the revised governance structure.	***Objective 2.3.1***: 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.		

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(2.4) Submit a recommendation to the Executive Sponsorship Coalition (ESC) to identify and assign an SES/Office to provide oversight and ongoing monitoring of the revised governance structure.		Q1 FY 2021	**Complete.**

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

Table 2-9. OA-2 Description of Actions Toward Removal Criteria

OA-2 Description of Actions Toward 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 that will outlast leadership changes and, with the needs of the field in mind, the IPT will continue work on its two major priorities:
  ○ Develop and define a governing body with substantial field representation that focuses on the ongoing strategy, prioritization, and oversight of initiatives for VHA. Additionally, future-state governance may consider competency-based boards and committees with strong clinical and community representation.
  ○ Outline the VHA future state decision rights framework, starting with several sample decision processes and then extending to all major decision areas. Coordination of decision rights between VA and VHA will also be recommended.

Capacity • The IPT, supported by the Office of Health Care Transformation (OHT), possesses the necessary staff, knowledge and skills to execute the governance and decision rights transformation.
Monitoring • The metrics and measures of this plan and the management reporting used by the LOE provide the mechanisms to assess and report progress.
Demonstrated Progress

OA-2 Description of Actions Toward Removal Criteria

• Since early in FY 2021, after the USH established the Revise 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.

Oversight and Accountability Outcome (OA-3)

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

Brian McCarthy, JD, MPH, Acting Deputy Chief Compliance and Business Integrity Officer (starting March 2021)

Outcome Executive: Erica Scavella[5], MD, Associate Deputy Under Secretary for Health for Oversight, Risk and Ethics

Root Cause: VHA has a fragmented oversight operating model that can impede its ability to effectively oversee every item related to implementation/execution that ensures organizational accountability.

OA-3 Outcome Statement: VHA oversight efforts ensure that governance and management decisions are implemented and focused on intended outcomes.

OA-3.1 GOAL: Enhance VHA's governing bodies and governance mechanisms so that they have consistent, systematic processes and authorities to make management decisions.

Objective 3.1.1: Define and clarify governing and oversight roles and responsibilities so that they can be applied to all stakeholders and embedded in policies.

Objective 3.1.2: Ensure that governing bodies have the appropriate oversight mechanisms that have clear designees for oversight activities to meet risk management and assurance needs.

OA-3.2 GOAL: VHA governance and oversight mechanisms monitor the implementation of decisions and confirm that they have met intended outcome(s).

Objective 3.2.1: Develop monitoring and evaluation processes to ensure that desired outcomes of decisions made by governing bodies are achieved.

Objective 3.2.2: Provide regular reporting to key stakeholders regarding governing bodies' decisions and oversight functions.

Objective 3.2.3: Develop and implement integrated system for monitoring and reporting oversight activities and associated data.

Table 2-10. OA-3 Description & Status

[5] Dr. Erica Scavella assumed responsibility as the Outcome Executive in January 2021.

OA-3 Description & Status

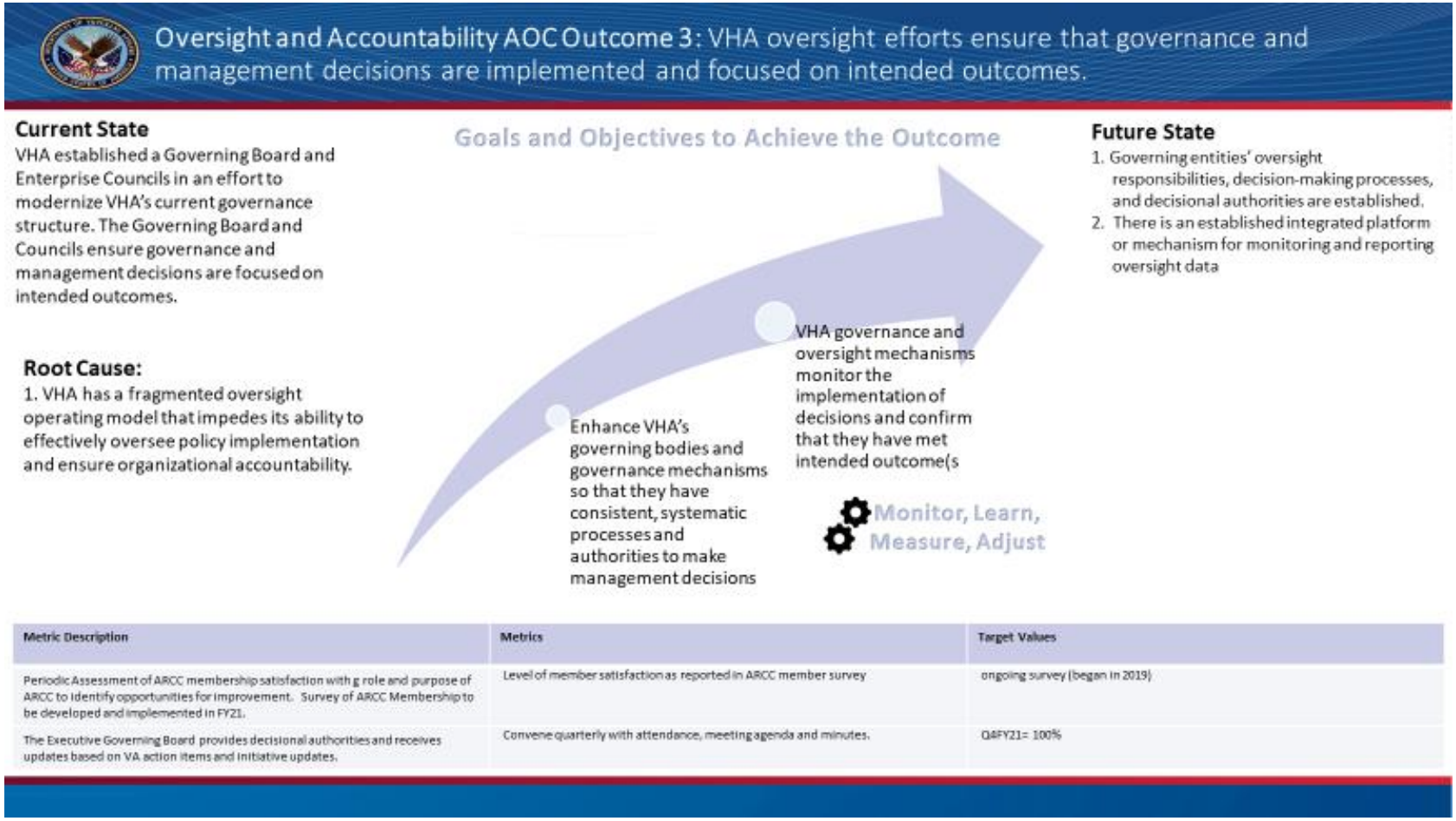
Description
• VHA's governance mechanisms must be capable of documenting and tracking decisions made by governing bodies (in alignment with their respective charters) to ensure actions are taken and have their intended outcomes. Risks associated with decisions should be prioritized and in alignment with 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.

Status

- 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.
- VHA established a specific structure related to its executive 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.
- Specifically, the VHA ARCC oversees VHA's clinical, administrative and business risks 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 collaboration, communication, direction, solution evaluations and governance oversight of VHA risk and internal control. To further align oversight and accountability, VHA created three subcommittees of the ARCC.
    - The Compliance Subcommittee 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 Risk Subcommittee (RSC) reviews an integrated VHA Internal Controls and Risk Assessment for VHA.
- Moreover, 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. There are additional governance councils being chartered.
- The ORE was established in FY 2020 (as the Office of Risk Management). 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

OA-3 Description & Status
organization and has memorialized these changes in Directives, which received appropriate leadership approval.

Figure 2-10. OA-3 Roadmap



The following table describes the measures and metrics used to determine progress toward achievement of OA-3: VHA oversight ensures governance and management decisions are implemented and focused on intended outcomes.

Table 2-11. OA-3 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Periodic Assessment of ARCC membership satisfaction with role and purpose of ARCC to identify opportunities for improvement. Survey of ARCC Membership to be developed and implemented in FY 2021.	Level of member satisfaction as reported in ARCC member survey	Milestone = Survey on 9/30/21 Target = ongoing survey (began in 2019)	Annually
The Executive Governing Board provides decisional authorities and receives updates based on VA action items and initiative updates.	Convene quarterly with attendance, meeting agenda and minutes	Q4 FY 2021= 100%	Quarterly

The following table describes actions to achieve OA-3 management decisions are implemented and focused on intended outcomes. All actions imply effective change management and training are a part of the implementation.

Table 2-12. OA-3 Action Plan

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
OA-3.1 Goal: Enhance VHA's governing bodies and governance mechanisms so that they have consistent, systematic processes and authorities to make management decisions.	***Objective 3.1.1***: Define and clarify governing and oversight roles and responsibilities so that they can be applied to all stakeholders and embedded in policies.		

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
(3.1) Identify VHA governing bodies and clarify scope of authority.	Q4 FY 2022		**In Progress.** VHA directive 1217 will set forth the roles, responsibilities, and decision-making authorities for VHA CO Operating Units.
(3.2) 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.	Q2 FY 2018	Q2 FY 2018	**In Progress:** Approved in 2018, revision in progress.
(3.3) Publish VHA Directive 1030.	Q1 FY 2020	Q1 FY 2020	**Complete.** This VH) 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.

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
(3.4) Publish VHA Directive 1217.	Q3 FY 2022		**In progress.** This VHA directive sets forth the roles, responsibilities and decision-making authorities for VHA CO Operating Units.
	Objective 3.1.2: Ensure that governing bodies have the appropriate oversight mechanisms that have clear designees for oversight activities to meet risk management and assurance needs.		
(3.5) Conduct environmental scan to identify governing entities with oversight responsibilities, decision-making processes, and decisional authorities at VHA.	Q2 FY 2022		**In progress.** Environmental scan will be completed by 3/30/22
(3.6) Evaluate governing entities to determine if consistent and established systematic decision-making processes and decisional authority exists.	Q1 FY 2023		**In Progress.** Multi-year activity

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
(3.7) Identify gaps and areas of opportunity regarding the governing entities' authorities, overlapping and/or duplicative efforts, and authorities.	Q1 FY 2024		**In Progress.** Multi-year activity
(3.8) Identify specific improvements to ensure governing entities have clear oversight responsibilities, decision-making processes.	Q3 FY 2021		**In progress.** Activities underway
OA-3.2 Goal: VHA governance and oversight mechanisms monitor the implementation of decisions and confirm that they have met intended outcome(s).	***Objective 3.2.1***: Develop monitoring and evaluation processes to ensure that desired outcomes of decisions made by governing bodies are achieved.		
(3.9) Assess governing bodies monitoring and corrective action activities to determine its effectiveness.	TBD		**In Planning.**
(3.10) Evaluate effectiveness of monitoring and corrective action activities by governing bodies.	TBD		**In Planning.**

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
	Objective 3.2.2: Provide regular reporting to key stakeholders regarding governing bodies' decisions and oversight functions.		
(3.11) Review formal documentation of governing bodies for information regarding communication and reporting for oversight responsibilities, decision-making processes and decisional authorities.	Q4 FY 2022		**In Progress.** Oversight and accountability is collaborating with the other areas of concern to complete this action.
(3.12) 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 FY 2022	TBD	**In Progress.** Activity underway

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
	Objective 3.2.3: Develop and implement integrated system for monitoring and reporting oversight activities and associated data.		
(3.13) Determine how a specific platform or mechanism can support reporting of oversight data for governance and oversight activities.	Q1 FY 2022	TBD	In Planning.
(3.14) Evaluate requirements/needs for specific platform to support monitoring and reporting.	TBD		In Planning.
(3.15) Perform testing of specific platform or mechanism and incorporate key stakeholder feedback.	TBD		In Planning.
(3.16) Implement specific platform or mechanism to support monitoring and reporting.	TBD		In Planning.
(3.17) Monitor the effectiveness of the specific platform or mechanism to support monitoring and reporting.	TBD		In Planning.

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
*All actions imply effective change management and training are a part of the implementation.			

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

Table 2-13. OA-3 Description of Actions Toward Removal Criteria

OA-3 Description of Actions Toward Removal Criteria
Leadership Commitment • 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. [6] • In FY 2020, VHA expanded on this approach and has demonstrated commitment to organizational improvement by enhancing the Executive 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. Since the inception of the ARCC, leadership commitment has demonstrated to be predictive of positive attitudes and performance in VHA surrounding the constituting a solidified governance structure.

[6] The Relationship Among Leadership Commitment, Organizational Performance, and Employee Engagement, Boonyada Nasomboon.

OA-3 Description of Actions Toward Removal Criteria
Capacity • The 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.
Monitoring • VHA is periodically monitoring and evaluating the process to determine the extent to which rules, regulations and policies are being followed and to identify whether procedures and corrective actions are working as intended. VHA is reviewing and tracking (1) high-risk areas and (2) management decisions through documentation and related to those governing activities.
Demonstrated Progress • VHA has restructured its central office and is establishing a governance framework for managing oversight and accountability including various risk management activities that has been implemented across the VHA. VHA has established key goals, milestones, and key progress indicators to demonstrate progress of the enterprise.

Oversight and Accountability Outcome (OA-4)

Outcome Executive: Erica Scavella[7], MD, Associate Deputy Under Secretary for Health for Oversight, Risk and Ethics

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

Brian McCarthy, JD, MPH, Acting Deputy Chief Compliance and Business Integrity Officer (starting March 2021)

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

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

OA-4.1 GOAL: Leadership ensures policies include oversight roles and responsibilities and that they are understood.

Objective 4.1.1: Require all accountable entities to include oversight roles and responsibilities in policies prior to approval.

Objective 4.1.2: Policy oversight roles and responsibilities are supported by change management capabilities and capacity.

Objective 4.1.3: Policy oversight roles and responsibilities are properly funded and supported by VHA leadership.

OA-4.2 GOAL: Leadership ensures the environment and processes are in place for occurrences of non-compliance or inappropriate activity to be reported and reviewed.

Objective 4.2.1: Leadership has a mechanism to receive reports of non-compliance or inappropriate activity.

Objective 4.2.2: Entities receiving reports of non-compliance have a process in place for substantiating reports.

Objective 4.2.3: Leadership ensures that expectations are clear and promotes an environment that understands and supports just culture.

Objective 4.2.4: VHA has an escalation path through which leadership is made aware of substantiated and/or significant violations for action.

OA-4.3 GOAL: Leadership ensures accountable entities take corrective action to resolve instances of non-compliance or improper activities.

Objective 4.3.1: Leadership has a process in place to determine if corrective actions were implemented in a timely manner by accountable entities.

OA-4.4 GOAL: VHA leadership reviews corrective action outcomes for effectiveness.

Objective 4.4.1: Leadership has a process in place to determine if corrective actions were implemented.

[7] Dr. Erica Scavella assumed responsibility as the Outcome Executive in January 2021.

Objective 4.4.2: Leadership has an after-action analysis and reporting process to provide feedback to leaders of accountable entities.

OA-4.5 GOAL: VHA leadership ensures budgetary and resource requests from accountable entities are considered.

Objective 4.5.1: Leadership develops a mechanism by which resource requests are received, reviewed and responded to in a timely manner.

OA-4.6 GOAL: VHA leadership ensures accountable entities are held responsible for not responding appropriately to requests for action.

Objective 4.6.1: Leadership has a process to include accountability in performance standards.

Table 2-14. OA-4 Description & Status

In Planning	In Progress	Complete	Sustaining

OA-4 Description & Status

Description
• 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, regions 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
  ○ Standardizing a practice where mistakes are identified and resolved

Status • VHA realignment has been finalized and ORE is awaiting final approval of the official name change. With the implementation of an HRO framework, VHA is in the process of developing mechanisms to identify lessons learned and best practices. HRO offers practical tools and insight that enhance the ability to deliver optimal patient care in an environment focused on learning and quality improvement.

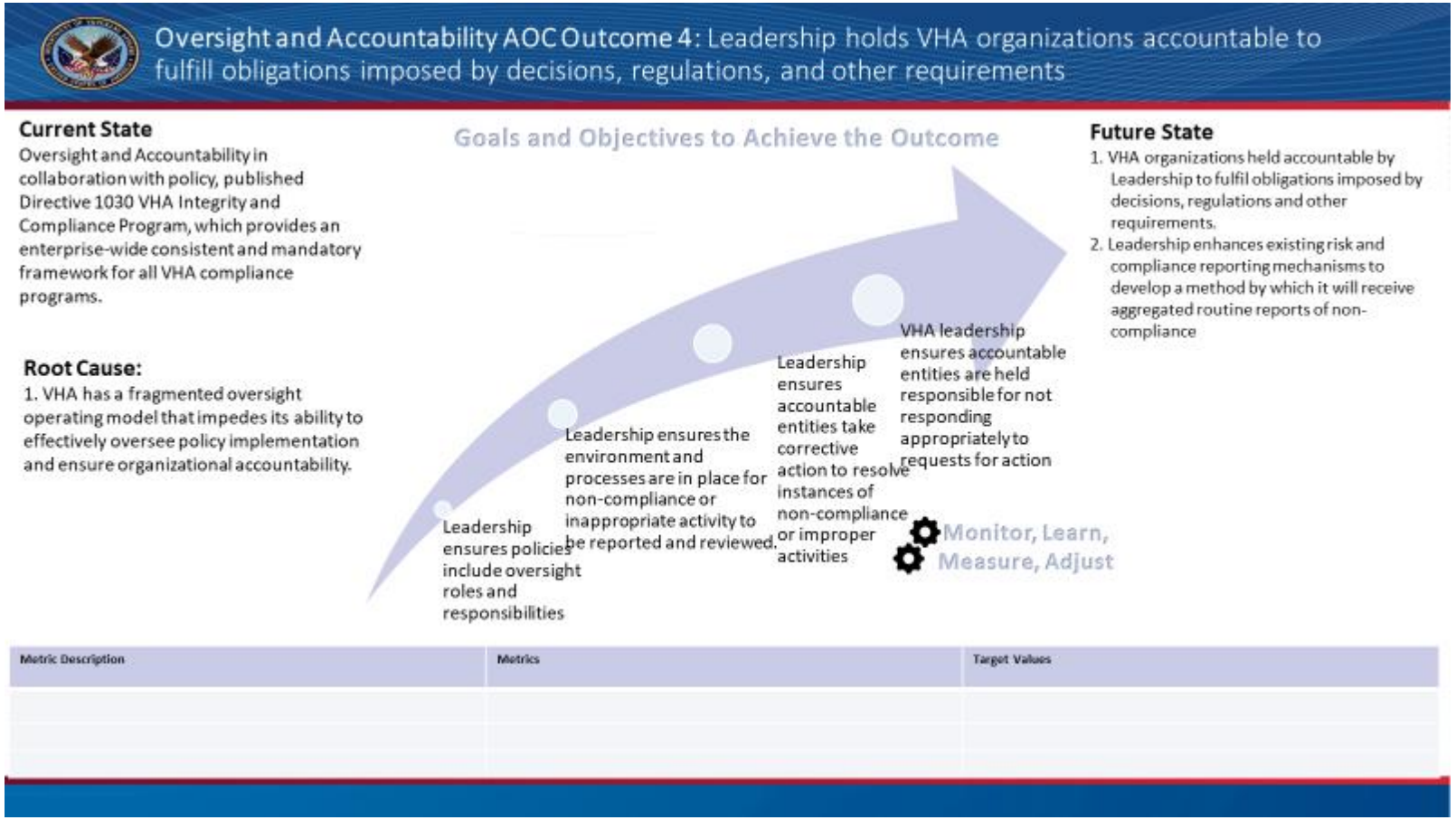


Figure 2-11: OA-4 Roadmap

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

Table 2-15. OA-4 Action Plan

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
OA-4.1 Goal: Leadership ensures policies include oversight roles and responsibilities and that they are understood	***Objective 4.1.1***: Require all accountable entities to include oversight roles and responsibilities in policies prior to approval		
(4.1) Leadership requires the inclusion of oversight roles and responsibilities in policies.	Q4 FY 2020	Q4 FY 2020	**Complete.** VHA policy renewal process requires policy owners to include oversight roles and responsibilities upon writing review and concurrence of the policy
	Objective 4.1.2: Policy oversight roles and responsibilities are supported by change management capabilities and capacity		
(4.2) Leadership performs budgetary reviews, manpower assessments and develops manning documents to ensure adequate change management support.	Q1 FY 2023	Q1 FY 2023	**In Planning.** Pending leadership acceptance and approval of action plan and allocation of funding

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
	Objective 4.1.3: Policy oversight roles and responsibilities are properly funded and supported by VHA leadership		
(4.3) Leadership develops a process by which oversight roles and responsibilities are evaluated for resource needs.	Q1 FY 2023	Q1 FY 2023	**In Planning.** Pending leadership acceptance and approval of action plan and allocation of funding
OA-4.2 Goal: Leadership ensures the environment and processes are in place for occurrences of non-compliance or inappropriate activity to be reported and reviewed	***Objective 4.2.1***: Leadership has a mechanism to receive reports of non-compliance or inappropriate activity.		
(4.4) Leadership enhances existing risk and compliance reporting mechanisms to develop a method by which it will receive aggregated routine reports of non-compliance.	Q2 FY 2023	Q2 FY 2023	**In Planning.** Pending leadership acceptance and approval of action plan and allocation of funding
	Objective 4.2.2: Entities receiving reports of non-compliance have a process in place for substantiating reports.		

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
(4.5) Accountable entities develop a process where fact-finding is conducted and results accompany reports of non-compliance or inappropriate activity.	Q1 FY 2023	Q1 FY 2023	**In Planning.** Pending leadership acceptance and approval of action plan and allocation of funding
	Objective 4.2.3: Leadership ensures that expectations are clear and promotes an environment that supports just culture.		
(4.6) Leadership develops universal oversight roles and responsibilities performance standards for inclusion in accountable entities' performance plans.	Q1 FY 2024	Q1 FY 2024	**In Planning.** Pending leadership acceptance and approval of action plan and allocation of funding
(4.7) Leadership provides feedback on resolution, enforcement and disciplinary actions taken as a result of corrective actions taken.	Q4 FY 2023	Q4 FY 2023	**In Planning.** Pending leadership acceptance and approval of action plan and allocation of funding

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
	Objective 4.2.4: VHA has an escalation path through which leadership is made aware of substantiated and/or significant violations for action.		
(4.8) A mechanism is developed enabling accountable entities with unfettered access to executive leadership to report substantiated and/or significant violations.	Q2 FY 2023	Q2 FY 2023	**In Planning.** Pending leadership acceptance and approval of action plan and allocation of funding
OA-4.3 Goal: Leadership ensures accountable entities take corrective action to resolve instances of non-compliance or improper activities.	***Objective 4.3.1***: Leadership has a process in place to determine if corrective actions were implemented in a timely manner by accountable entities.		
(4.9) Leadership develops a process or criteria to identify when options have been developed to resolve non-compliance or inappropriate activity.	Q3 FY 2023	Q3 FY 2023	**In Planning.** Pending leadership acceptance and approval of action plan and allocation of funding

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
(4.10) Leadership will develop a process to identify if corrective and preventative actions were taken as planned.	Q3 FY 2023	Q3 FY 2023	**In Planning.** Pending leadership acceptance and approval of action plan and allocation of funding
OA-4.4 Goal: VHA leadership reviews corrective action outcomes for effectiveness	***Objective 4.4.1***: Leadership has a process in place to determine if corrective actions were implemented.		
(4.11) Leadership will develop criteria to review outcomes of corrective actions.	Q3 FY 2023	Q3 FY 2023	**In Planning.** Pending leadership acceptance and approval of action plan and allocation of funding
(4.12) Leadership develops mechanism to measure effectiveness and impact of corrective and preventative actions.	Q3 FY 2023	Q3 FY 2023	**In Planning.** Pending leadership acceptance and approval of action plan and allocation of funding
(4.13) Leadership ensures there is a communication channel to provide program offices with feedback and recommendations, if any.	Q3 FY 2023	Q3 FY 2023	**In Planning.** Pending leadership acceptance and approval of action plan and allocation of funding
(4.14) Leadership develops a process by which preventative actions are monitored for effectiveness.	Q3 FY 2023		**In Planning.** Pending leadership acceptance and approval of action plan and allocation of funding

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
	Objective 4.4.2: Leadership has an after-action analysis and reporting process to provide feedback to leaders of accountable entities.		
(4.15) 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 FY 2026	Q1 FY 2026	**In Planning.** Pending leadership acceptance and approval of action plan
OA-4.5 Goal: VHA leadership ensures budgetary and resource requests from accountable entities are considered.	***Objective 4.5.1***: Leadership develops a mechanism by which resource requests are received, reviewed, and responded to in a timely manner.		
(4.16) Leadership develops a mechanism by which resource requests are received, reviewed and responded to in a timely manner.	Q1 FY 2024	Q1 FY 2024	**In Planning.** Pending leadership acceptance and approval of action plan and allocation of funding

Actions	Projected Date	Actual/ Adjusted Date	Status/Comments
OA-4.6 Goal: VHA leadership ensures accountable entities are held responsible for not responding appropriately to requests for action.	***Objective 4.6.1***: Leadership has a process to include accountability in performance standards.		
(4.17) Leadership develops universal oversight roles and responsibilities performance standards for inclusion in accountable entities' performance plans.	Q1 FY 2024	Q1 FY 2024	**In Planning.** Pending leadership acceptance and approval of action plan and allocation of funding

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

Table 2-16. OA-4 Description of Actions Toward Removal Criteria

OA-4 Description of Actions Toward Removal Criteria
Leadership Commitment VHA is committed to: 1. Changes necessary to define a culture of oversight and accountability for decisions and requirements issued by accountable entities. 2. Encouraging learning from mistakes through after-action analysis and transparent reporting of errors and corrective actions. 3. Acquiring necessary funding to obtain staff and technology to implement the action plan. 4. Holding responsible parties accountable to compliance and oversight, which includes exercising disciplinary and punitive actions for gross non-compliance.

OA-4 Description of Actions Toward Removal Criteria
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 (i.e. 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.
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.
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. • VHA Directives 1370 and 1217 are also in the process of being revised.

Oversight and Accountability Outcome (OA-5)

Outcome Executive: Gerard Cox, MD, Assistant Under Secretary for Health for Quality and Patient Safety

Outcome Lead: William Gunnar, MD, JD, Executive Director, National Center for Patient Safety

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

OA-5 Outcome Statement: VHA supports a culture of safety and integrity that fosters trust, integrity, learning, and collaboration.

OA-5.1 GOAL: Promote the transition of VHA to a high reliability organization incorporating a culture of safety.

Objective 5.1.1: Establish high reliability and promote a culture of safety through leadership development and staff training.

OA-5.2 GOAL: Promote VHA core values of integrity throughout the organization at all levels.

Objective 5.2.1: Promote the importance of culture of integrity through leadership commitment, policy, communications and training.

OA-5.3 GOAL: Employees demonstrate a culture of safety and integrity.

Objective 5.3.1: Annually measure patient safety culture and culture of integrity through the All-Employee Survey.

Table 2-17. OA-5 Description & Status

In Planning	**In Progress**	Complete	Sustaining

OA-5 Description & Status

Description:
• 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, region, 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.

OA-5 Description & Status
• **Site-Specific Assessments and Planning:** Roadmaps 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 • 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 region. Using lessons learned from 18 HRO lead sites, VISNs and VA medical centers 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 level, 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 VA medical center 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

OA-5 Description & Status
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.

Figure 2-12. OA-5 Roadmap

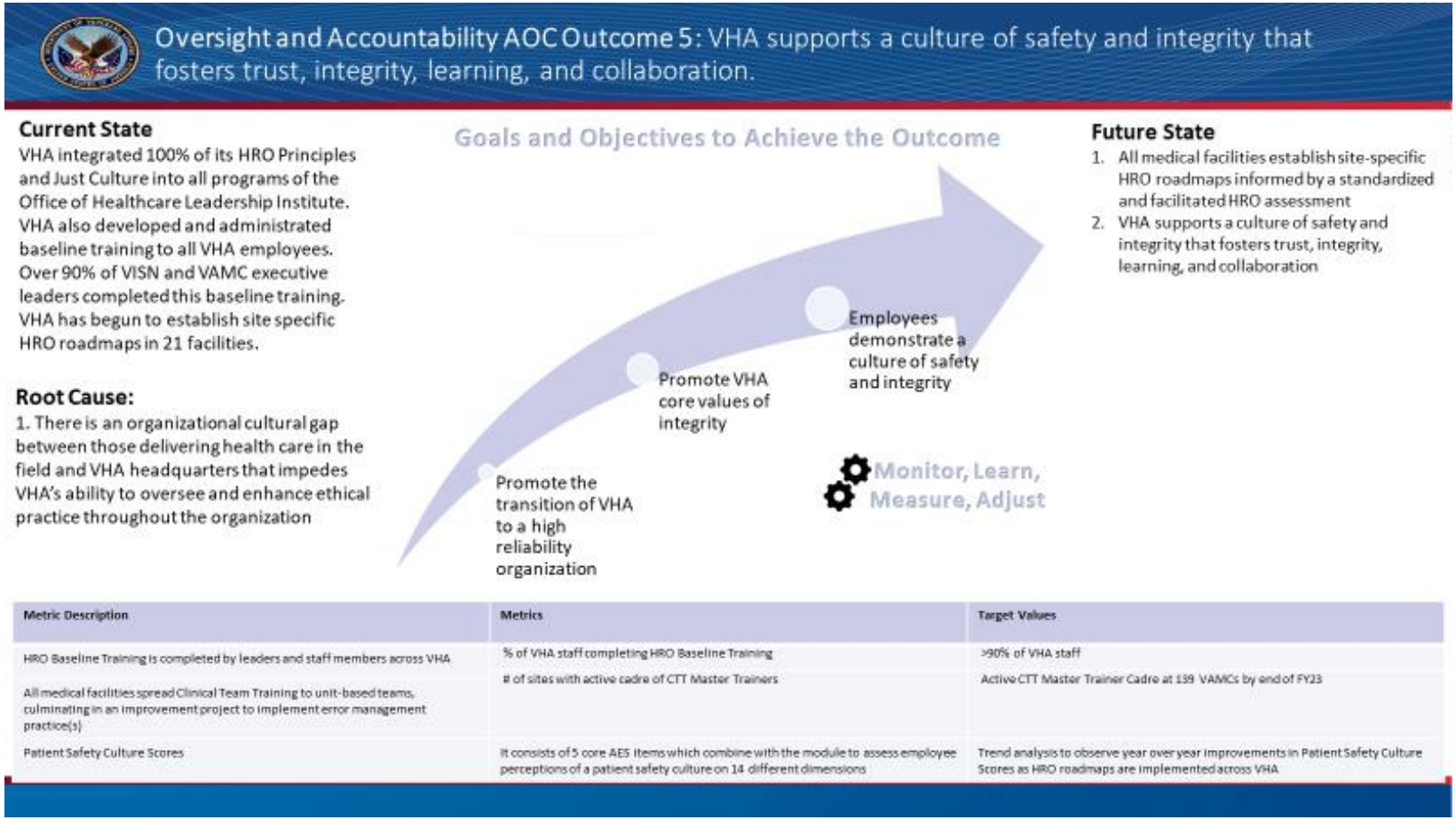


Table 2-18. OA-5 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
HRO Baseline Training is completed by leaders and staff members across VHA: • VISN ELT: TMS 40637 • VISN/VAMC Train-the-Trainer: TMS 42184 • Supervisors: TMS 40880 • Front Line: TMS 40879	Metric: percent of VHA staff completing HRO Baseline Training Calculation: Number Attendees of Baseline training trained (Co leads dashboard) / number of Full Time VHA Employees (WMC Quarterly Data)	Milestone: >80% by Dec 31, 2021 Target: >90% of VHA staff	Quarterly
All medical facilities spread Clinical Team Training to unit-based teams, culminating in an improvement project to implement error management practice(s)	Metric: Number of sites with active cadre of CTT Master Trainers Calculation: Count of facilities with CTT Master Trainers (TMS 405430)	Milestone: CTT is spread to all facilities by Dec 31, 2022 Target: Active CTT Master Trainer Cadre at 139 VA medical centers by end of FY 2023	Quarterly
	Metric: Number of unit-level CTT participants Calculation: Count of unit-level CTT participants (TMS 41465)	Milestone: Unit-level CTT participants system-wide (at facilities with Active CTT Master Trainers) by Dec 31, 2022 Target: >14,000 unit-level CTT participants system-wide	

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
	Metric: Number of tracked CTT projects Calculation: Count of improvement projects tracked in CTT tracker	Milestone: CTT unit-level improvement projects system-wide (at facilities with Active CTT Master Trainers) by Dec 31, 2022 Target: >1,400 CTT unit-level projects system-wide by end of FY 2023	
Patient Safety Culture Scores	Metric: It consists of five core AES items which combine with the module to assess employee perceptions of a patient safety culture on 14 different dimensions Calculation: Patient Safety Culture comes from a 15-item module on the AES developed by the NCPS. National Center for Organization Development (NCOD) calculates results.	Milestone: N/A Target: Trend analysis to observe year over year improvements in Patient Safety Culture Scores as HRO roadmaps are implemented across VHA	Annually
Culture of Integrity Measurement and Tracking (Culture of Integrity in already a part of VISN and Facility medical director performance standards and is measured as part of the AES survey. In FY 2021, a composite measure will be developed.	Composite metrics and individual measures have been identified and will be reported after the FY 2021 AES survey is administered.	Target – All organizational entities will receive a Culture of Integrity score.	Annually

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

Table 2-19. OA-5 Action Plan

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

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
OA-5.1 GOAL: Promote the transition of VHA to a high reliability organization incorporating a culture of safety.	***Objective 5.1.1***: Establish high reliability and promote a culture of safety through leadership development and staff training.		
(5.1) ICARE training for all VA employees.		Ongoing	**Complete.** This annual requirement has been ongoing for the past five years.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(5.2) Integrate HRO Principles and Just Culture into all Office of HLTI Programs.		Q1 FY 2020	**Complete.** 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.
OA-5.2 Goal: Promote VHA core values of integrity throughout the organization at all levels.	***Objective 5.2.1***: Promote the importance of culture of integrity through leadership commitment, policy, communications, and training.		

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(5.3) Build a common body of knowledge by spreading foundational HRO training across the enterprise.	Q1 FY 2021		**In progress.** Standard curriculum for HRO Baseline Training has been developed and deployed (both in-person and virtually). >90 % of VISN and VA medical center executive leadership team members have completed HRO Baseline Training. VISN and VA medical center 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.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(5.4) Spread team-based training in error management tools that promote a culture of safety and integrity.	Q1 FY 2022		**In progress.** 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.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(5.5) 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 FY 2022		**In progress.** 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.
OA-5.3 GOAL: Employees demonstrate a culture of safety and integrity.	***Objective 5.3.1:*** **Annually measure patient safety culture and culture of integrity through the All-Employee Survey.**		

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(5.6) 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	**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.

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

Table 2-20. OA-5 Description of Actions Toward Removal Criteria

OA-5 Description of Actions Toward Removal Criteria
Leadership Commitment • VHA has long been a pioneer in patient safety. In 1999, VA established the National Center for Patient Safety. For over 15 years, the Center, working with patient safety officers and managers across VHA, developed a range of innovations. VHA established an HRO Steering Committee in 2018 to adopt HRO principles based on leading VHA practices and industry best practices. • In 2019, VHA began its HRO journey with a set of common HRO assessments, training, and improvement activities at 18 lead sites across each region. The 18 lead sites shape transformation for the rest of VHA. Remaining sites (Cohort 2) join the journey in 2020, incorporating lessons learned from the 18 lead sites. This sustained leadership commitment builds a consistent national effort. • The VHA Code of Integrity is another example of leadership commitment. It was published on June 30, 2019, with training and monitoring activities planned through FY 2023.
Capacity • HRO leadership capacity is fostered by HRO coaches, who are matched with leaders from the 18 HRO lead sites and Cohort 2 HRO sites to assist in establishing standard HRO leadership practices (e.g., leader rounding, HRO huddle, safety forums, visual management) and progressing on the site-specific HRO plan. In addition, a cadre of training champions will be identified at each medical facility and region to sustain initial training and reinforcement activities during Phase 1 of the VHA HRO journey. • By the end of calendar year 2021, the target goal is to have at least 80% of current staff trained in baseline HRO principles, daily practices, and behaviors (including Just Culture, error management, and continuous process improvement) and for a sustainable cadre of training champions to be established and maintained across the medical facilities with oversight, resourcing and support from the region. • Another example of building and training staff to accomplish the outcomes includes ICARE training, which is focused on the reaffirmation of VA mission and values.
Monitoring • This plan metrics and measures provide the mechanisms to assess and report progress to GAO.

Demonstrated Progress

- 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.

3. Information Technology Challenges Area of Concern

Executive Summary

OIT, a critical partner for VHA health care delivery, instituted plans focusing on VHA's highest mission priorities to address AOC outcomes by: (1) delivering a minimum viable product for supporting the MISSION ACT; (2) launching DevOps and Product Line Management transformation to deliver capabilities faster; (3) supporting the IT infrastructure upgrades required for EHRM; (4) empowering VA Interoperability leadership to seamlessly integrate and exchange health information, data and best practices across the DoD, industry and other partners; (5) aligning IT strategy with business goals through consistent IT governance processes; and (6) cataloguing current plans for modernization, decommission and facilitating decision making about legacy systems for which plans do not yet exist. The Legacy System Modernization workgroup collaborated with various stakeholders and as of early December2020, it had completed 35% of assessments on VA systems to determine their disposition and funding status for upcoming FYs.

The IT AOC has been working towards correcting interoperability issues across VHA.

The IT-1 Outcome is focused on delivering IT capabilities to support VHA-determined data and interoperability business needs. To effectively support the delivery of VHA business needs (and all other business stakeholders needs), the Account Management Office (AMO) is also working with OEI to map, group and align OIT products to Product Lines that enable primary business capabilities as defined in the Business Reference Model (BRM). Examples of this partnership include continued development of the Community Care Referral and Authorization System, which include national quarterly releases during FY 2021. Additionally, OIT will continue to build and refine Caregiver Record Management Application (CARMA) functionality through the end of FY 2021 according to priorities set forth by the Caregiver Support Program as they prepare for the next phase of expansion. CARMA enables VA to process, track and manage applications for the Program of Comprehensive Assistance for Family Caregivers (PCAFC); automates the stipend payment process; and improves existing reporting functionality. OIT is also working on implementing the Defense Medical Logistics Standard Support (DMLSS) at Puget Sound, Spokane and Roseburg by the end of FY 2021.

Figure 3-1. Information Technology 2021 Rating Goal

The IT AOC is also focused on improving system interoperability to execute core health care mission functions and the EHRM rollout has been a critical objective to this end for OIT in recent years. In addition to launch at the Mann-Grandstaff VA Medical Center and its four community-based outpatient clinics located, VA has also began using the new system at the West Consolidated Patient Account Center, the VA business

operations facility in Las Vegas, Nevada that supports billing for the Pacific Northwest. Over the next ten years, EHRM will move forward through initial operating capability (IOC) and beyond by increasing external interoperability with DoD and Private Sector, and internal interoperability, which includes supply chain RC3 infrastructure upgrades, VistA Sustainment and scheduling enhancements (VSE), standing update framework for Fast Health care Interoperability Resources (FHIR) and the development of Health Level Seven (HL7) interoperability standards. By removing interoperability as a barrier between DoD and VA EHRs and community partners, OIT increases scheduling efficiency and provider productivity and ensures Veterans' timely access to care.

OIT also leverages the Lighthouse API platform, which offers developers secure access to the VA data they need to build helpful tools and services for Veterans. OIT continues to work with Health and Medical Informatics Office Knowledge Based Systems (KBS) to ensure VA-wide consistency in Vista and Cerner to FHIR mappings, HL7 alignment. Adoption of ONC Cures act, including R4 and US Core IG.

The IT AOC will also continue leveraging the VA System Inventory (VASI) as the authoritative source for VA IT systems and to identify the stewards responsible for maintaining the accuracy, integrity, and availability of the information contained in VASI. Relatedly, OIT also leverage the VA Enterprise Cloud (VAEC) as a strategic planning and management tool to help VA leadership execute transformation throughout VA. The VAEC's integrated views of strategic goals, mission, support services, and data and IT provide the requisite information to enable it to serve as the authoritative reference for issues of ownership, management, resourcing, performance goals and design and documentation of systems and services.

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

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

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

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

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

IT-3: Provide governance and oversight bodies with accurate, reliable, timely and relevant information.

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

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

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

Table 3-1. IT Alignment with Other Areas of Concern

Alignment with Other Areas of concern
Policies and Processes
• Ongoing collaboration with the Policies and Processes workgroup for designing and operating a VHA policy document repository that houses and links VHA national and local policy and policy-related documents, including implementation guidelines and human resources requirements.
Oversight and Accountability
• IT systems are critical to the success of Oversight and Accountability. The IT workgroup will work with VHA to determine requirements to support Oversight and Accountability IT business needs. IT is supporting development of the shared Internal Audit–Compliance and Business Integrity case management capability.
Training
• OIT is collaborating with the Training workgroup to incorporate procedural changes and updates identified in the VHA training oversight directive into Business Intelligence Suite and Talent Management System (TMS) as needed.
Resource Allocation
• As further progress is made in integrating manpower and financial management the IT workgroup will coordinate with Resource workgroup to identify IT requirements. OIT is supporting upgrades to HR Smart, part of the Resource workgroup actions to decrease manpower reporting variance. • OIT is also working to deploy a light electronic action framework (LEAF) system to track organizational and position change requests to improve manpower data transparency.

Information Technology Outcome (IT-1)

Outcome Lead: Niriksha Patel, Director, Community Care

Outcome Executive: Dan McCune, Executive Director, Enterprise Portfolio Management and Application

Root Causes: Problems we face to deliver IT Capabilities come from a wide range of topics such as: Insufficient skilled/trained staff, future skills gaps to adopt Scaled Agile Framework – Enterprise, potential lack of funding, competing priorities, bad reporting/data and poor communication.

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

IT-1 Goal: Enhance collaboration with VHA partners to provide consistent deliverables (90 days or less per project) of IT solutions that will support VHA business needs.

Objective 1: Increase Transparency amongst VHA and OIT partners on IT products using project tools.

Objective 2: Obtain Product Line Maturity Rating Level 1 by September 2021 for all OIT Product Lines.

Objective 3: Establish an Integrated Product Environment (IPE) for testing purposes.

Table 3-2. IT-1 Description & Status

In Planning	In Progress	Complete	Sustaining

IT-1 Description & Status
Description • To achieve this outcome, the Chief Information Officer (CIO) and Executive in Charge (EIC) collaborate to address risks and GAO recommendations. 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 IPE will be established to help ensure any product deliverable is able to be tested for integrations prior to being released into production. This will increase quality and confidence the deliverable will succeed once releases into production.
Status • The AMO for Health collaborated with other OIT pillars and VHA's Office of Healthcare Informatics, Office of Community Care (OCC) and Office of Connected Care. The initiative began in 2017 and is a component of VHA and OIT's strategy for improved customer service and effort to align to industry best practices. As part of developing a more comprehensive engagement with the

business offices, AMO has also initiated the Information Technology Investment Board (ITIB) to ensure traceability of all requirements and funding through the enterprise. As part of this effort, AMO conducted a portfolio assessment of the Office of Community Care to inform leadership of the findings. These findings will be utilized to provide process improvement recommendations and report enterprise level risks and mitigations.

- In 2020 the Community Care Program organized into a Product Line Management Model to better align with VHA Office of Community Care (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 EDI and Revenue Operations.
- The Community Care Clinical Integration Team's Consult Toolbox (CTB) expedited a COVID-19 release which allowed the VA to triage, track and group consults to offset appointment conflicts of Veteran care that was profoundly impacted by COVID-19. The Claims Processing and Eligibility system team delivered enhancements that contributed to a 90% reduction in the Office of Community Care Veteran and Veteran Beneficiary claims backlog. VHA Business Owners' needs are now being more effectively met through OIT's collaboration with business partners to prioritize and determine when a requirement is fully resolved. The rapid delivery of the Central Authorized Emergency Care (CAEC) public web portal (a tool that enables retroactive reimbursements for emergency care to replace the previous manual process) demonstrates this rapid adjustment to changing business needs.

Additional examples of OIT and VHA collaboration include:

Clinical Integration

- During 2020, Clinical Integration Sub-Product Line met key Office of Community Care needs and fulfilled legislative commitments tied to CHOICE Act, MISSION Act and CARE Act. Consult Toolbox (CTB) expedited a COVID-19 release which allowed the VA to triage, track and group consults to offset appointment conflicts of Veteran care that was profoundly impacted by COVID-19. Legacy Veteran Health Information Exchange (VHIE) created a COVID-19 build that allowed the Department of Veterans Affairs to fulfill it's 'Fourth MISSION' in times of national emergencies and disasters by expanding care to non-Veterans.
- Furthermore, VHIE directly contributed to VA fulfilling the OPT-OUT MISSION ACT commitment enabling record sharing of over 220 clinical partners to the Cerner Joint Health Information Exchange (JHIE) solution and this served as VA's first successful Cerner Electronic Health Records Management (EHRM) accomplishment. Finally, Provider Profile Management System (PPMS) supported the MISSION Act by implementing a large and comprehensive physician profile that enabled clinicians to coordinate community care for a Veteran.

IT-1 Description & Status
Delivery Operations: • During 2020, the Delivery Operations Sub-Product Line met key Office of Community Care needs and fulfilled legislative commitments tied to the MISSION Act. The Community Care Claims and Reimbursement System (CCRS) team delivered critical functionality over numerous releases to enable the payment and accurate tracking of COVID-19 related claims. The Program Integrity Tool (PIT) system was migrated to the cloud improving performance and extensibility and the PIT team delivered numerous enhancements to continue to improve fraud, waste and abuse analytics and reporting on Community Care claims. • The Eligibility and Claims Modernization team began support for a high visibility project to migrate Veteran Family Member (VFMP) claims processing to a new SaaS solution which will transform the way that the VFMP program manages claims. **Payer EDI:** • In January 2020 a Community Care Provider complained that VHA was not providing payment remittance advice statements in a timely manner compared to payments, up to 24 days later than payments, complicating their ability to reconcile, and well beyond the mandated three days. • OIT Community Care, in partnership with VHA Office of Community Care and ITOPS identified the source as a $1.1 million transaction backlog in processing remittance advice notices. The teams collaborated and eliminated the backlog and the delayed Remittance Advice Problem within 180 days. In addition, the team improved overall system performance by increasing transaction processing throughput from 1,200/day to 72,000/day. • The team also completed upgrade of a critical database from a non-supported version to current version (Oracle 12c to Oracle 19). **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.

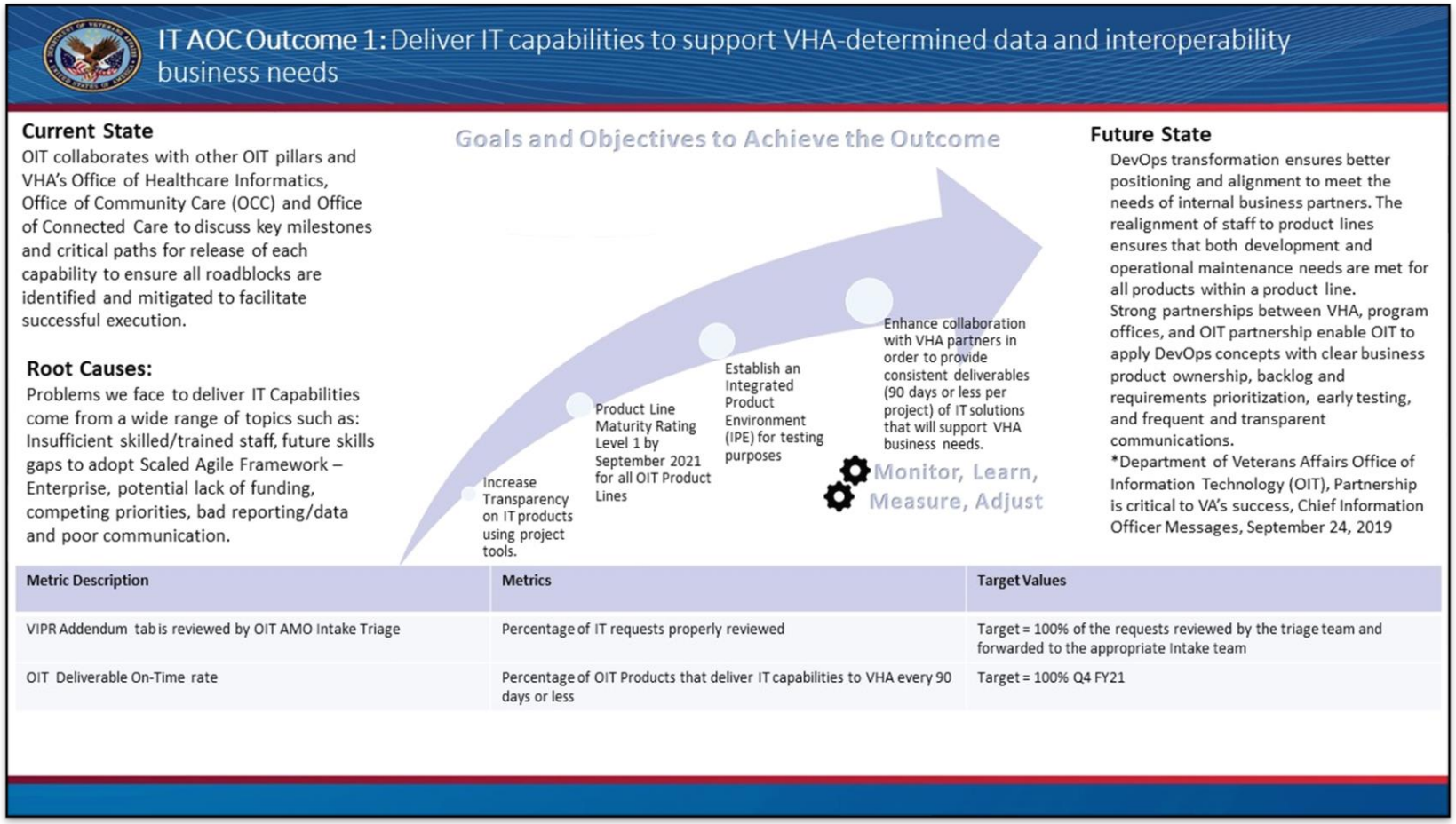


Figure 3-2. IT-1 Roadmap

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

Table 3-3. IT-1 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
VIPR Addendum tab is reviewed by OIT AMO Intake Triage	Percent of IT requests properly reviewed Percent = total number of IT requests that were reviewed by the Intake Triage Team / total number of IT requests	Target = 100% of the requests reviewed by the triage team and forwarded to the appropriate Intake team	Q1, Q2, Q3, Q4
OIT Deliverable On-Time rate	Percent of OIT Products that deliver IT capabilities to VHA every 90 days or less	Target = 100% Q4 FY 2021	Q1, Q2, Q3, Q4

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

Table 3-4. IT-1 Action Plan

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

These actions were developed prior to the aforementioned goals and objectives. Future actions will be aligned to goal(s) and objective(s)			
Actions*	**Projected Date**	**Actual/ Adjusted Date**	**Status/Comments**
(1.1) OIT training programs in place to support this outcome – DevOps, Scaled Agile Framework, and Product Manager training has started. Q1 – Delivery of a minimum viable product for MISSION Act – Decision Support Tool (DST).	Q1 FY 2021		**Complete**
(1.2) Community Care Referral and Authorization System – FY 2021 Milestones Q1 – HealthShare Referral Manager (HSRM) National Release 11.0 and Millennium IOC Q1 – MVP CAEC portal delivery and enhancements to the emergency care Q2 – HSRM National Release 12.0 containing Clinical Viewer Q3 – HSRM National Release 13.0 Q4 – HSRM National Release 14.0	Q4 FY 2021		**Sustaining**

These actions were developed prior to the aforementioned goals and objectives. Future actions will be aligned to goal(s) and objective(s)			
Actions*	**Projected Date**	**Actual/ Adjusted Date**	**Status/Comments**
(1.3) Community Care Electronic Data Interchange (EDI) Q1 – Deploy Fee Payment Processing System 2.0 (which will replace version 1.0, which is built on technology that is no longer Technical Reference Model compliant) Enterprise Program Reporting System 2.0, and Attachments Retrieval System 2.2 (add additional identified user stories functionality to current production system). Q2 – Deploy EDI Dashboard 1.0 (which allows for the monitoring of EDI transactions through the EDI Gateway), EDI Gateway 2.5 (added functionality that will move all non-compliant transactions off the existing EDI Gateway and have them run through Health Share), and Attachments Retrieval System 2.5. Q3 – Deploy EDI Dashboard 2.0 and EDI Gateway 3.0 (allow for the processing of 835 transactions and will complete the move of the EDI Gateway off the existing server located in the Health Administration Center. The old EDI Gateway bases on Sybase will then be decommissioned. Q4 – Deploy EDI Dashboard 3.0 (which allows for the monitoring of EDI transactions through the EDI Gateway), enhancements to EDI Dashboard 2.0.	Q4 FY 2020		**Complete**

These actions were developed prior to the aforementioned goals and objectives. Future actions will be aligned to goal(s) and objective(s)			
Actions*	**Projected Date**	**Actual/ Adjusted Date**	**Status/Comments**
(1.4) Caregivers (CARMA) – FY 2021 Milestones Q1 – Prioritize bug fixes and new capabilities for development release throughout the FY. Q3 – Support VHA development and submission of final report to Congress on Caregiver IT systems implementation. Continuous throughout FY: IT System releases throughout the FY to address system defects and implement new capabilities based on prioritization and using VA's agile methodology.	Q3 FY 2021		**In Progress**
(1.5) State Prescription Drug Monitoring Program – IOC– FY 2021 Milestones Q1 – Start National Deployment of State Prescription Drug Monitoring Program (PDMP). Q2 – Quarter Finish National Deployment of State Prescription Drug Monitoring Program (PDMP). Q3 – Quarter Improve functionality of the MVP by reducing manual processes with automated processes (i.e. Batch Processing). Q4 – Quarter Develop roadmap for transition from Vista CPRS to Cerner.	Q4 FY 2021		**In Progress**
(1.6) Implement DMLSS/LogiCole/ Medcoi – FY 2021 Milestones Q1 – Implementation at Puget Sound Q2 – Implementation at Spokane and Columbus Q3 & Q4 – Implementation at Walla Walla and White City	Q4 FY 2020	Q4 FY 2021	**In Progress**

These actions were developed prior to the aforementioned goals and objectives. Future actions will be aligned to goal(s) and objective(s)			
Actions*	**Projected Date**	**Actual/ Adjusted Date**	**Status/Comments**
(1.7) Suicide Prevention – Mental Health and Suicide Prevention IT Program Milestones – FY 2021 Milestones Q1 – Integrate and coordinate Veteran suicide prevention activities across multiple sectors and settings. Implement research-informed communication efforts designed to prevent Veteran suicide by changing knowledge, attitudes and behaviors. Q2 – Increase knowledge of the factors that offer Veterans protection from suicidal behaviors and that promote their wellness and recovery. Q3 – Promote responsible media reporting of Veteran suicide, accurate portrayals of Veteran suicide and mental illnesses in the entertainment industry, and the safety of online content related to Veteran suicide. Q4 – Develop, implement, and monitor effective programs that promote wellness and prevent Veteran suicide and related behaviors.	Q1 FY 2021	Q4 FY 2021	**In Progress**

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

Table 3-5. IT-1 Description of Actions Toward Removal Criteria

IT-1 Description of Actions Toward Removal Criteria
Leadership Commitment • The OIT has forged a strong partnership with VHA. Like any business relationship, OIT's relationship with VHA must sustain and enhance mutual trust and must create recurring value in terms of additional capability, cost transparency and efficiency, and innovation. Through the business partners in VHA and headquarters program offices help by prioritizing programs. They enable OIT apply DevOps concepts with clear business product ownership, backlog and requirements prioritization, early testing, and frequent and transparent communications.[8] • OIT is undergoing a DevOps transformation to better position it to meet the needs of internal business partners, realigning staff to product lines to ensure that both development and operational maintenance needs are met for all products within a Product Line. • In August 2020, the VA submitted the 2020 Action Plan and metrics data to GAO.
Capacity • OIT is undergoing a DevOps transformation to ensure better positioning and alignment to meet the needs of internal business partners, realigning staff to product lines to ensure that both development and operational maintenance needs are met for all products within a product line. • During this transformation, OIT has trained staff on Scaled Agile Framework to ensure that all projects are using Agile with best practices for success. Additionally, this transformation is being undertaken using multiple workgroups to ensure alignment with internal business partners and proper alignment of new and existing products within product lines.
Monitoring • OIT has established an Enterprise Monitoring Strategy in which specific monitoring measures must be applied to all applications before an Authority to Operate will be granted. • OIT instituted the Veteran-focused Integration Process (VIP), a lean-Agile Framework, to service the interest of Veterans through the efficient streamlining of IT activities that occur with the IT enterprise. VIP is a significant step forward for the VA, allowing for more frequent delivery of essential IT services, via a no-longer-than a three-month cadence. Additionally, OIT established regular program management reviews at multiple levels, including briefing executive leadership on schedule, scope, risk/issues and budget. • This plan's metrics and measures provide the mechanisms to assess and report progress to GAO. With the introduction of metrics and measures, monitoring processes and procedures will be formalized.

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

IT-1 Description of Actions Toward Removal Criteria
Demonstrated Progress • OIT has made a continued commitment to ensure implementation of IT requirements meets the needs of VHA. Specifically, OIT continues to implement an IT system that fully supports VHA's Caregiver Program as recommended by GAO (14-675). • OIT holds daily scrum meetings and program reviews, where key milestones for the critical path for release of each capability is discussed to ensure all roadblocks are identified and mitigated to ensure successful execution.

Information Technology Outcome (IT-2)

Outcome Lead: John Burke**,** Senior FAC-PPM

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

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

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

IT-2.1 GOAL: VA optimizes investments in systems to accelerate interoperability.

Objective 2.1: EHRM: Removing interoperability as a barrier between DoD and VA EHRs and community partners.

Objective 2.2: Expanding capability and tools to enable interoperability

IT-2.2 GOAL: The VA Interoperability Leadership Team (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.

Objective 2.2.1: Providing a common understanding of interoperability and a way to measure it.

Objective 2.2.2: Developing, implementing and maintaining an enterprise-level Interoperability Strategy.

Objective 2.2.3: Governance and processes to accelerate interoperability and enable alignment.

Table 3-6. IT-2 Description & Status

In Planning	In Progress	Complete	Sustaining

IT-2 Description & Status
• Interoperability is the ability to enable the right information and services to securely and reliably reach the right person at the right time in the best manner to make a timely, informed decision and enable an action. As an IT outcome, seamless and secure interoperability is one of OIT's core goals. Interoperability requires alignment of three ecosystems: business, data, and systems. • Major IT modernization activities help accelerate interoperability, and supporting the needs of the VHA, (e.g., 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. • What is noted below, under Status, demonstrates the progress made. This report has been reformatted to account for a strategic approach to align activities with the major goals that support addressing the challenges identified by the GAO.
Goal 1: VA optimizes investments in systems to accelerate interoperability. A. EHRM: 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. • VA established the Office of Electronic Health Record Modernization (OEHRM) to ensure VA successfully prepares for, deploys, and maintains the new EHR solution and the health IT tools dependent upon it. OEHRM reports directly to VA Deputy Secretary and works in close coordination with other VA offices, including VHA and OIT. • OIT is currently finalizing the system interface plan for EHRM, which will give VA clinicians and physicians comprehensive access to patients' health records from their time in active duty through their status as a Veteran, improving care coordination between DOD and VA and ensuring seamless access to care. EHRM is a major business transformation effort led by the OEHRM 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.

IT-2 Description & Status
• The EHRM effort has three major components, 1) modernize VA's legacy systems and associated infrastructure required to support a new industry-leading EHR solution; 2) provide Veterans and clinicians with a complete picture of patients' medical history, driving connections between military service and health outcomes through data analytics; and 3) implement a new EHR solution that is interoperable with DOD and community care providers, enabling the seamless sharing of records. 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 works to align DOD and VA activities relating to the EHRM activities. • OIT and VHA collaborate to address risks and GAO recommendations. Assistant and Under Secretaries direct action through Outcome Executives as necessary to mitigate or eliminate risk. OIT and VHA monitor and update progress throughout the fiscal year. OIT and stakeholders address sustainability requirements to meet business needs on a continuous basis. B. Expanding capability and tools to enable interoperability. • A major initiative of the VA is IT modernization. This includes not only major efforts like the EHRM and supply chain (DMLSS) but also investing in solutions that enable interoperability capabilities to meet the needs of VHA and the enterprise. Middleware (VDIF) and Lighthouse (API capability) 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.

IT-2 Description & Status
• Veteran Data Integration and Federation – Enterprise Platform – VDIF-EP, is a standards-based, middleware platform that can support data exchange, in a standardized manner, between VistA and other applications. Goal 2: The VA Interoperability Leadership Team (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. A. Providing a common understanding of interoperability and a way to measure it. • For the VA to be successful in accelerating interoperability, it is critical that there is an understanding of the factors that impact interoperability (interoperability organizational framework), a common lexicon, and a consistent method to measure interoperability maturity. The CIVAO, with the support of the VAIL, will be responsible for ensuring the integrity of this framework and maturity index. B. Developing, implementing and maintaining an enterprise-level Interoperability Strategy • The CIVAO, through the VAIL, is responsible for the development and maintenance of the VA Interoperability Strategy (VAIS), which is updated every four years with yearly updates that track progress, reports on additional efforts, and expands impact. C. Governance and processes to accelerate interoperability and enable alignment • The FEHRM enables alignment between DoD and VA relating to EHRM activities. The VAIL serve as a coordinated leadership body focused on ensuring all steps of the Veteran journey are seamlessly enabled through interoperability of the ecosystems supporting them. The VAIL Executive Council made up of SESs across Administrations and offices, along with liaisons from the FEHRM and DoD, ensure alignment across the VA enterprise. The VAIL reinforces the roles of other governance bodies and is focused on maintaining the VAIS, measuring progress, enabling alignment, identifying opportunities and addressing gaps.

IT-2 Description & Status
Status Goal 1: VA optimizes investments in systems to accelerate interoperability. A. EHRM: Removing interoperability as a barrier between DoD and VA EHRs and community partners. • In October 2020, VA successfully launched the new EHR solution to Mann-Grandstaff VA Medical Center, its associated Community Based Outpatient Clinics and the West Consolidated Patient Center. In August 2020, VA successfully launched the Centralized Scheduling Solution, which increases scheduling efficiency and provider productivity and ensures Veterans' timely access to care. OEHRM endeavors to remain agile in the unpredictable COVID-19 environment, while ensuring the safety of the VA Medical Center and program office staff. • The FEHRM has been formally chartered and the Executive Director and Executive Deputy Directors are in place. The Joint-HIE has gone live with eHealthExchange and CommonWell. These metrics are reported to Congress every three months. B. Expanding capability and tools to enable interoperability. • Cerner Scheduling Program Management Resolved: OEHRM will supply the technical program management support for Cerner Standalone Scheduling Program Management.
IT-2 Description & Status

- Once completed, the Cerner Scheduling Program will significantly improve the VA health care experience by giving thousands of clinicians and specialists ready access to a comprehensive view of their patients' records, resulting in streamlined scheduling, faster and more accurate diagnoses and better treatment options. It has been successfully deployed to Columbus, Ohio.
- The Defense Medical Logistics Standard Support System Integration team reviewed all functional file transactions. The Systems Integration Working Group continues the business architecture analysis based on input received from involved stakeholders. They are awaiting input from OEHRM to ensure a complete analysis.
- Lighthouse supports access to 600 back-end systems across VA and gives developers the tools they need to build applications on a standard set of APIs designed for Veterans.
- VDIF-EP has been successfully deployed to the cloud and to support the Joint Health Information Exchange in providing VistA data to community partners (MISSION Act). It has demonstrated its ability to quickly (less than three months) enable interoperability in support of COVID-19 vaccination requirements by bringing together three different data streams (VistA, Occupational Health Record System and Cerner data) and reporting updates to the CDC.

Goal 2: 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.

A. Providing a common understanding of interoperability and a way to measure it.

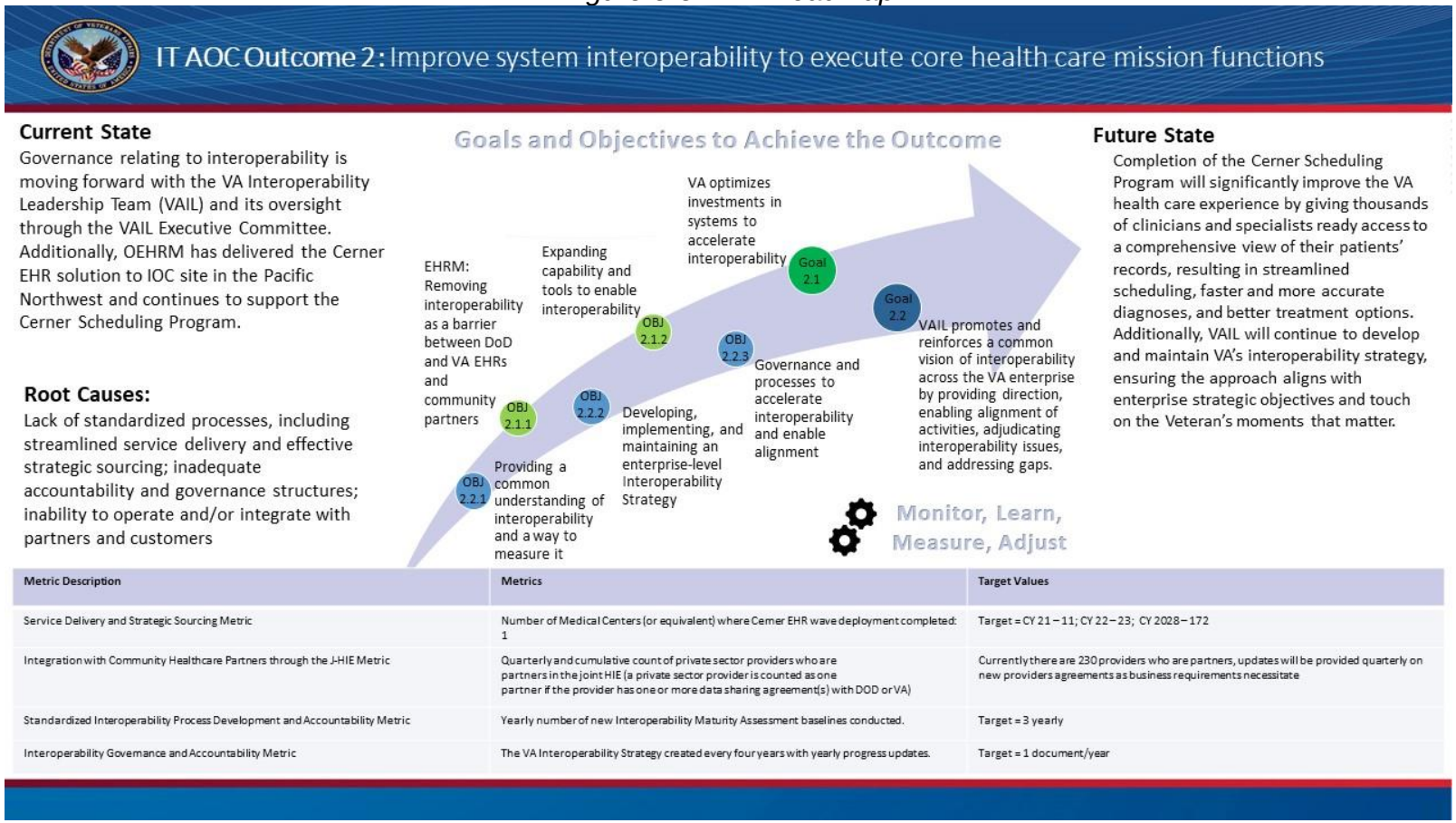
- The VAIL has developed an interoperability organizational framework that captures all the core pillars and foundational elements that impact interoperability with definitions. Moreover, an interoperability maturity index has been developed and vetted through internal and external reviews. Since December 2020, seven interoperability maturity assessments have been completed. Moreover, a formal Change Control Board has been chartered and is in operation. This ensures the integrity of the interoperability maturity index.

B. Developing and implementing an Interoperability Strategy.

- The activities of the Interoperability Leadership Team reach across the VA, FEHRM, DOD, health care sector and other partners' activities, governance, standards, tools, architecture, applications, policies and processes related to the exchange of health information, data and best practices for any purpose. The VAIL and the FEHRM operate in a close partnership to identify opportunities to advance initiatives in support of VA and interagency interoperability goals and objectives.
- The VAIL's purpose is to enable the mission of the VA through interoperability; the VAIS serves as the primary mechanism to accomplish this. The VAIS 2020-2024 provides VA an approach to address interoperability that aligns with its strategic objectives and touch on the Veteran's moments that matter. By focusing on business use cases, it enables incremental improvements at a use case level, provides insights into common challenges that can be addressed at

IT-2 Description & Status
the enterprise level, and promotes the building of foundational capabilities. This strategy also includes a yearly update to track progress on use cases, add new use cases and address enterprise opportunities. C. Governance and processes to accelerate interoperability and enable alignment. • The VA CIO is the lead executive sponsor who authorized the establishment of the VAIL (Q1 FY 2019) and empowers the VA Interoperability Leadership Team Chair to establish a charter and ensure conformance to the charter. • The Charter is currently being formalized to enable an enterprise reach. The VAIL Executive Council has been established with SES level representatives from VHA, VBA, NCA, VEO, OM, OALC, HRA/OSP, OEHRM, OIT, FEHRM, DHA and decision rights of the VAIL and Working Groups established. OIT will support the operations of the VAIL. • The VAIL represents all the stakeholders across VA that are impacted or have leadership roles relevant to interoperability. Current standing working groups of the VAIL are operational include: VISP, Data, Organizational Framework, External Federal Coordination, Interoperability Innovations, Occupational Health/COVID-19, Data Ethics and Standards. • The VAIL governance structure reinforces the role of the DGC and the OIT governance bodies, reporting to them the findings of the VAIL and deferring to these bodies and other governance bodies as appropriate.

Figure 3-3. IT-2 Roadmap



Metric Description	Metrics	Target Values
Service Delivery and Strategic Sourcing Metric	Number of Medical Centers (or equivalent) where Cerner EHR wave deployment completed: 1	Target = CY 21 – 11; CY 22 – 23; CY 2028 – 172
Integration with Community Healthcare Partners through the J-HIE Metric	Quarterly and cumulative count of private sector providers who are partners in the joint HIE (a private sector provider is counted as one partner if the provider has one or more data sharing agreement(s) with DOD or VA)	Currently there are 230 providers who are partners, updates will be provided quarterly on new providers agreements as business requirements necessitate
Standardized Interoperability Process Development and Accountability Metric	Yearly number of new Interoperability Maturity Assessment baselines conducted.	Target = 3 yearly
Interoperability Governance and Accountability Metric	The VA Interoperability Strategy created every four years with yearly progress updates.	Target = 1 document/year

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

Table 3-7. IT-2 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Service Delivery and Strategic Sourcing Metric	Number of Medical Centers (or equivalent) where Cerner EHR wave deployment completed: 1 Number of Health Care Systems where Cerner EHR wave deployment scheduled for completion but not achieved (excluding re-scheduling necessary to support COVID-19): 0	Aggregate: CY 21 – 11; CY 22 – 23; CY 2028 – 172 due to COVID-19 response these targets may change they are as of December 2020 Targets provided 2 years out based on the OEHRM quarterly update to Congress	Quarterly
Integration with Community Healthcare Partners through the J-HIE Metric	Quarterly and cumulative count of private sector providers who are partners in the joint HIE (a private sector provider is counted as one partner if the provider has one or more data sharing agreement(s) with DoD or VA)	Currently there are 230 providers who are partners, updates will be provided quarterly on new providers agreements as business requirements necessitate	Quarterly
Standardized Interoperability Process Development and Accountability Metric	Yearly number of new Interoperability Maturity Assessment baselines conducted	Target = three yearly	Yearly, reported in Q4 of same year
Interoperability Governance and Accountability Metric	The VA Interoperability Strategy created every four years with yearly progress updates	Milestone: VAIS or update document, Target one document/year	Yearly, reported in Q4 of same year

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

Table 3-8. IT-2 Action Plan

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

These actions were developed prior to the aforementioned goals and objectives. Future actions will be aligned to goal(s) and objective(s)			
Actions*	**Projected Date**	**Actual/Adjusted Date**	**Status/Comments**
(2.1) VAIL serves as the single point of convergence and alignment for interoperability across the VA.	Q2 FY 2019	Q2 FY 2019	**Sustaining.** The VAIL has been in place since Q2 FY 2019, the VAIL EC kicked-off Q4 FY 2020 to enable alignment.

These actions were developed prior to the aforementioned goals and objectives. Future actions will be aligned to goal(s) and objective(s)			
Actions*	**Projected Date**	**Actual/Adjusted Date**	**Status/Comments**
(2.2) VAIL adjudicates and addresses gaps in activities, governance, standards, tools, architecture, applications, policies, contract requirements and processes relating to exchange of health information/data as needed.	Q2 FY 2019	Q2 FY 2019	**Sustaining.** Addressed a gap resulting in a VA Secretary approved Ethical Principles for Access and Use of Veteran Data; developed set of interoperability principles; interoperability questions part of the FITARA process. Assessing use case results to identify gaps; Shared findings of use cases to DGC and ADMC co-chairs relating to data/information and system/technology respectively. The VAIL was chartered Q2 FY 2019 and has sustained continuous operation.
(2.3) VAIL serves as the FEHRM's VA point of contact as it relates to DOD/VA health interoperability activities to ensure that VA's strategy, requirements and priorities guide their work; e.g., Joint DOD/VA Interoperability Strategic Plan Interagency Interoperability Technical Plan, standards development activities and federal policy development.	Q1 FY 2020	Q1 FY 2020	**Sustaining.** Meet with the FEHRM on a regular basis; participate in meetings; coordinate and flag important gaps in standards. FEHRM chartered Q1 FY 2020, VAIL Chartered Q2 FY 2019

These actions were developed prior to the aforementioned goals and objectives. Future actions will be aligned to goal(s) and objective(s)			
Actions*	**Projected Date**	**Actual/Adjusted Date**	**Status/Comments**
(2.4) VAIL develops a VA Interoperability Strategy and tracks progress through an interoperability maturity index. *This action recurs annually*	Q3 FY 2021		**In Progress.** VA Interoperability Strategy 2020-2024 is in VIEWS. 2021 Annual update being drafted. Change Control Board Charter signed and established. Six interoperability maturity assessments completed
(2.5) VAIL advises VA senior leadership on emerging technology to address interoperability issues requiring guidance and support.	Q1 FY 2021	Q1 FY 2021	**Completed.** Interoperability Innovations WG established. Operational cadence established; meetings are conducted on a bi-weekly basis. Deliverables being assessed.
(2.6) EHRM moves forward through IOC and beyond. • Interoperability with DoD and Private Sector • Internal Interoperability – Supply Chain RC3 infrastructure upgrades, VISTA Sustainment, VistA Scheduling Enhancements (VSE) and VA Online Scheduling Sustainment and Cerner Scheduling • Fast Health care Interoperability Resources (FHIR) – Next generation standards framework • Health Level Seven (HL7) International – Development of international health care informatics interoperability standards	IOC Q3 FY 2020 (Projected FOC: ten years)	IOC Q3 FY 2020	**In Progress.** Ongoing ten year program.

(2.7) API development business epics submitted: • Integrate more effectively with outside health care community and generate greater opportunities for collaboration across the care continuum with private sector provider • Effectively shift technology development to commercial EHR and administrative systems vendors that can integrate modular components in the IT enterprise through open APIs, allowing VA to adopt more efficient and effective management processes • Foster an interoperable, active, innovation ecosystem of solutions and services through APIs that contributes to the next generation of care and benefits models that are evidence-based, tiered and connected across the continuum of engagement • Create open and accessible APIs that can be used not only for Veterans, but also for advanced knowledge sharing, clinical decision support, technical expertise and process interoperability with organizations through the U.S. care delivery system	Q3 FY 2018	Q1 FY 2022	**In Progress.** Lighthouse API platform offers developers secure access to the VA data they need to build helpful tools and services for Veterans. Our library consists of APIs for Benefits, Health, Facilities and Veteran Verification information. We have six private sector providers integrating with our API (and a few more in our sandbox) to provide innovative ecosystem of solutions and services for Veterans. Lighthouse currently has 60 applications in production, 30 of which are external. Lighthouse is an active participant in CARIN alliance. Clinical decision support, PGD and Bulk FHIR API to be determined. Working with Health and Medical Informatics Office Knowledge Based Systems (KBS) to ensure VA-wide consistency in Vista and Cerner to FHIR mappings, HL7 alignment. Adoption of ONC Cures act, including R4 and US Core IG.

(2.8) Designate approved data sources through the Data Governance Council (DGC) Working Group: • Leverage best practices and analytics maturity frameworks to guide, develop and implement an efficient and effective VA-wide analytics strategy • Provide a suggested continuum of training • Continually elevate awareness of the possibilities for high-end analytics throughout VA • Promote awareness of resources and tools to VA analysts	Q3FY 2019	TBD	**In Progress.** DGC to approve the implementation of a standing workgroup that combines elements of a CoP and leverages them to advance VA's strategic objectives. The DGC, under the leadership of VA's Chief Data Officer, coordinated the development of the VA Data Management Directive until its publication on December 8, 2020. In addition, on January 19, 2021, VA published the VA Data Strategy. The strategy intends to strengthen VA as a learning enterprise. Using a federated, matrixed approach with five goals, the strategy intends to improve the current data and analytics capacity and capability building in VA. The goals are supported by 13 initial priority objectives rooted in VA mission and business imperatives that have identifiable data-related challenges.
(2.9) Business Process Re-Engineering (BPRE): • OEHRM conducts BPRE through monthly workshops at Cerner HQ in Kansas City, Missouri.	Ongoing	Ongoing	**Sustaining.** OEHRM meets monthly in Kansas City with Cerner. FMBT has already

These actions were developed prior to the aforementioned goals and objectives. Future actions will be aligned to goal(s) and objective(s)			
Actions*	**Projected Date**	**Actual/Adjusted Date**	**Status/Comments**
• FMBB conducts BPRE sessions to improve business processes • DMLSS conducts BPRE to improve business processes			conducted several BPRE sessions. DMLLS BPRE is ongoing.
(2.10) Electronic Health Record Modernization (EHRM) Q1 – Groups 1-6 Interfaces Complete; Mann – Grandstaff: Superuser Training; Replicate Millennium Data to VA; JPIMS, SSOe, SSOI in Pre-Production; Technical Design Review Complete; IOC Go-Live Planning Complete; WAN Bandwidth Upgrades Complete; Printer and other Device Deployment Complete; Conduct Integration Validation Test Readiness Review; Integration Validation Test 1 MG Start; Clinical Workflows Q2 – Develop EHRM interfaces as follows: IFCAP, BMS, Patient Record Flag (PRF), and PCMM Web; Remediate technical obsolescence and increase data handling capability of PCMM Web system; Mock go-Live (Clinical); Superuser training; Go-Live Readiness Determination; Complete implementation/Integration of Cybersecurity Operations Center (CSOC); IOC Medical Device ATC's Approved; Cerner Equipment Installation Complete; Data Integration Completed; Go-Live Mann-Grandstaff and WCPAC Q3 – Post Go-Live Review Q4 – Fiber Backbone Upgraded (American Lake Campus); ACQ1 Completion of Upgrade Telecomm, IT Closets/Fiber backbone, CAT 6A, Cable Management (Spokane)	Q1 FY 2020 through Q4 FY 2020		**In Progress**

These actions were developed prior to the aforementioned goals and objectives. Future actions will be aligned to goal(s) and objective(s)			
Actions*	**Projected Date**	**Actual/Adjusted Date**	**Status/Comments**
(2.11) VA and DoD FEHRM Implementation Plan. The FEHRM will be accountable to both DOD and VA Deputy Secretaries to make timely, authoritative decisions to efficiently manage technical, programmatic, and functional requirements in support of the Departments' EHR modernization objectives. The FEHRM will be an agile, coordinated decision-making management structure to accurately and efficiently implement a single, seamlessly integrated EHR. RC4, RC5.	Q3 FY 2019	Q1 FY 2020	**Completed.** The FEHRM was chartered on Dec 4, 2019 by the Deputy Secretary of VA and the Deputy Secretary of Defense. The FEHRM delivered and received approval on the Interoperability Modernization strategy in September 2020 and the Healthcare Interagency Interoperability Technology package (I2TP) in April 2020. The FEHRM Implementation plan was completed on October 8, 2020 and is a living internal document updated as needed by FEHRM Leadership

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

Table 3-9. IT-2 Description of Actions Toward Removal Criteria

IT-2 Description of Actions Toward Removal Criteria
Leadership Commitment • In August 2018, OEHRM held a program kickoff hosted by Cerner Corporation. This event officially started the implementation of the Cerner Electronic Health Record solution for VA and generated tremendous enthusiasm and commitment. The OEHRM, under the Deputy Secretary of the VA, has demonstrated leadership commitment. This senior level commitment reaches across through the FEHRM and the DoD. This commitment has resulted in close collaboration between DoD and VA, sharing of lessons learned, and moving forward on a shared infrastructure. • This leadership commitment also reaches across other interoperability needs. VA OIT's major goals are related to IT modernization and interoperability. Interoperability is one of OIT's goals. VA OIT has a SES Chief Interoperability and Veteran Access Officer (CIVAO). Senior leaders across the VA are participating as members of the VAIL Executive Council, ensuring alignment.
Capacity • OEHRM, VHA and OIT continue to build capability to support EHRM activities and interoperability. • VA's OIT has a SES-level CIVAO and has established an Interoperability arm of the Office of Technical Integration.
Monitoring • OEHRM conducts BPRE through monthly workshops at Cerner HQ in Kansas City, Missouri. • FMBT conducts BPRE sessions to improve business processes. FMBT has already conducted several BPRE sessions. • DMLLS conducts BPRE to improve business processes. DMLLS BPRE is ongoing. • OEHRM meets monthly in Kansas City with Cerner. This plan's metrics and measures provide the mechanisms to assess and report progress to GAO. With the introduction of metrics and measures, monitoring processes and procedures will be formalized. • FEHRM is working with DoD and VA to develop metrics to track progress (outcomes focused). • VAIL is tracking interoperability maturity index results and progress on the VAIS roadmap.
Demonstrated Progress • Multiple teams across OEHRM have delivered the Cerner EHR solution to IOC site in the Pacific Northwest. This work began in March 2020. These preparations include updating the telecommunications infrastructure, assessing how ready the onsite staff are for the coming changes and training them as needed.

IT-2 Description of Actions Toward Removal Criteria
• Infrastructure upgrades: OEHRM's Technology and Integration Office infrastructure team worked with OIT, VHA and the VA Office of Construction and Facilities Management to update the onsite telecommunications infrastructure, including servers, circuitry, equipment, devices, cables, fiber networks and cooling and security systems. • J-HIE community partners able to exchange veteran data has reached record numbers (230 and growing) and a standardized process to expand. The Joint Longitudinal Viewer (JLV) is providing the VA and DoD the capability to access clinical records from J-HIE partners, DoD Cerner, VA Cerner, DoD Alta and VA VistA. • Governance relating to interoperability is moving forward with VAIL and its oversite through the VAIL Executive Committee.

Information Technology Outcome (IT-3)

Outcome Lead: Bonnie Walker, Director, IT Enterprise Strategic Planning and Governance

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

Root Causes: Inadequate governance structures to ensure organizational accountability for acquisition-related decisions, IT strategic direction and alignment of the IT and business services and projects.

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

IT-3: Goals and Objectives development are underway.

Table 3-10. IT-3 Description & Status

In Planning	In Progress	Complete	Sustaining

IT-3 Description & Status
Description • The IT Governance Board (ITGB) serves as the IT senior-level leadership forum for IT governance within the Office of Information and Technology. The IT Governance Board's responsibility spans the culture, organization, policy, and practices that provide for IT management and control across five key areas: 1) Alignment, 2) Value Delivery, 3) Risk Management, 4) Resource Management and 5) Performance Management. • To achieve this outcome, ITGB will provide a final verdict, if necessary, on OIT Governance Board decisions, including acquisition-related decisions, when the Board and Councils are unable to come to a consensus. The ITGB will provide strategic direction of IT and the alignment of IT and the business with respect to services and projects, confirm that the IT/Business organization is designed to drive maximum business value from IT and oversee the delivery of value by IT to the business and assess return on investment. ***Councils*** • Program & Acquisition Review Council (PARC) • Standards & Architecture Council (SAC) • Organization & Workforce Council (OWC) ***Committees*** • Organizational Planning Committee • Transformation Committee • Budget, Programming and Acquisition Committee • Quality & Risk Committee • Operations and Portfolio Management Committee • Architecture and Data Management Committee • Information Security Committee • Analytics and Performance Management Committee • Talent Management Committee

IT-3 Description & Status
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 in service to our Nation's Veterans. 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 OIT's CIO co-chairs the DoD/VA Information Technology Executive Committee which is a governing forum under the DoD/VA Joint Executive Committee for VA / DoD implementation of the Federal Electronic Health Record Modernization efforts.

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

Table 3-11. IT-3 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
An OMB defined TechStat is an intervention into a Major Investment to correct program or project failures. OMB defines requirement for a TechStat if an investment is in a high-risk status for three months.	Percent of OMB IT Investment TechStats (intervention) performed by ITGB = Number of IT TechStats Performed by ITGB / number Investment Reviews by IT Performance Review Team	Target: 10% or less of IT TechStats performed by ITGB in FY 2020 **Results:** 0% TechStats performed in FY 2021	Q2, Q4

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Quality of Decisions made	Number of decisions deferred vs. number of decisions made	Target 90% Decision Rate **Results:** In FY 2021, there was a 96% quality decision rate. Of 93 Decisional topics for 13 Governance Board only four decisions where deferred.	Q2, Q4

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

Table 3-12. IT-3 Action Plan

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

Goals, objectives, and additional actions will be developed prior to the next rating period			
Actions*	**Projected Date**	**Actual/ Adjusted Date**	**Status/Comments**
(3.1) ITGB provides direction for strategy and vision of VA OIT.	Ongoing	FY 2020	**Complete**. This is a regular function of the ITGB. • IT Governance Framework – Oversight of IT Strategic Plan, Goals and Objectives • ITGB perform IT TechStat as required • ITGB provides final verdict, if necessary, on OIT Governance Framework escalation of decisions
(3.2) Provide for strategic direction of IT and the alignment of IT and the business with respect to services and projects.	Q4 FY 2020		**Sustaining**. This is a regular function of the ITGB.

Goals, objectives, and additional actions will be developed prior to the next rating period			
Actions*	**Projected Date**	**Actual/ Adjusted Date**	**Status/Comments**
(3.3) VHA HRL – IT Challenges Q1 – Finalize outcome/measure content; submit IT Challenges Chapter 2 input to stakeholders for final review; VHA Executive in Charge review; Steering Committee review; VA Executive Board review; VA Operations Board review. IT Challenges Outcomes 1–5 execute Q1 action plans and Outcome Leads/Executives update the GOAL Office in accordance with the Change Management Plan. Q2 – Review changes to Chapter 2 IT Challenges and submit final update to GOAL Office; VA submits final update to GAO; VA OPS Board review. IT Challenges Outcomes 1–5 execute Q2 action plans and Outcome Leads/Executives update the GOAL Office in accordance with the Change Management Plan. Q3 – IT Challenges Outcomes 1–5 execute Q3 action plans and Outcome Leads/Executives update the GOAL Office in accordance with the Change Management Plan. Q4 – IT Challenges Outcomes 1–5 execute Q4 action plans and Outcome Leads/Executives update the GOAL Office in accordance with the Change Management Plan.	Q1 FY 2020 through Q4 FY 2020		**Complete**
(3.4) Addressing FY 2020 Budget Realities Q1 – Develop initial FY 2020 funding capability gap assessment and funding risk profile. Monthly – Status updates to stakeholders (CIO, VHA Senior Leadership, VA Senior Leadership).	Q1 FY 2020 through Q4 FY 2020		**Complete**

Goals, objectives, and additional actions will be developed prior to the next rating period			
Actions*	**Projected Date**	**Actual/ Adjusted Date**	**Status/Comments**
(3.5) Governance and Accountability Boards and Councils (Program & Acquisition Review Council [PARC], Standards & Architecture Council [SAC], and Organization & Workforce Council [OWC]): • Establish IT Governance Framework • Provide for strategic direction of IT and the alignment of IT and the business with respect to services and projects. • Confirm that the IT/Business organization is designed to drive maximum business value from IT. Oversee the delivery of value by IT to the business and assess return on investment. • Risk Management – Ascertain that processes are in place to ensure that risks have been adequately managed. Include assessment of the risk aspects of IT investments. • Resource Management – Provide high-level direction for sourcing and use of IT resources. Oversee the aggregate funding of IT at enterprise level. Ensure there is an adequate IT capability and infrastructure to support current and expected future business requirements. • Performance Management – Verify strategic compliance, i.e., achievement of strategic IT objectives. Review the measurement of IT performance and the contribution of IT to the business (i.e., delivery of promised business value).	Q4 FY 2020	Ongoing	**Complete**

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

Table 3-13. IT-3 Description of Actions Toward Removal Criteria

IT-3 Description of Actions Toward Removal Criteria
Leadership Commitment • The OIT Enterprise Strategic Planning and Governance (ESPG) Team works with leaders and stakeholders across throughout VA and supporting administrations to develop the IT Strategic Plan and execute the plan through a mature governance framework. The ESPG team endeavors to coordinate activities and support key stakeholders to align and maintain the strategic goals with resources, funding, and organizational initiatives and deliver results. • The activities of the IT Governance Framework reach across the VA, FEHRM, DoD, health care sector and other partner activities, governance, standards, tools, architecture, applications, policies and processes related to the exchange of health information/data/best practices for any purpose.
Capacity • The OIT Governance Framework aligns with OIT's strategic goals, enhances the core values of OIT customer service, and promotes interoperability and standardization in OIT. • The Organization & Workforce Council develops competency requirements for IT staff and leadership, to maintain an agile workforce; to recruit and retain IT talent needed for VA's mission accomplishment; to create workforce policies, strategies, processes and models; and to promote the necessary skills and experience for leadership to drive cultural change and reach the demonstrated maturity level. The Organization & Workforce Council: o Determines potential organizational asset needs, such as space and facilities, and human capital o Creates HR policies, core competencies, training, processes and procedures aligned with Strategic Planning o Supports space and facility policies, training, processes and procedures o Evaluates customer service and performance metrics
Monitoring • IT Governance is putting processes and structures in place to align IT strategy with business goals. For OIT, this means implementing an IT Infrastructure Library-based framework and governance boards to replace less effective processes. The IT Enterprise Governance Framework does the following: o Enables VA and OIT's Strategic Plan o Ensures all initiatives are aligned with VA's mission and vision o Identifies decision owners and solidifies decision rights for OIT senior leadership, to make the right decisions, at the right time, with the right stakeholders o Aligns operations, policies, and procedures to increase cost savings o Positions OIT to efficiently manage and execute the budget o Provides sustainable support for VA's transformation priorities

IT-3 Description of Actions Toward Removal Criteria
Demonstrated Progress • OIT established a Chief Risk Officer position to better serve and protect Veterans who have been involved with identifying and disseminating root cause analysis. OIT Quality, Performance and Risk pillars have aggressively pursued processes and procedures for addressing GAO recommendations in VHA Health Care IT and developing plans to address IT challenges identified in this AOC.

Information Technology Outcome (IT-4)

Outcome Lead: Curtis Dunson, Program Analyst, EPMO

Amy Smart, IT Specialist, EPMO

Outcome Executive: Drew Myklegard, Executive Director, Project Special Forces

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

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

IT-4: Goal(s) and Objective(s) development are underway.

Table 3-14. IT-4 Description & Status

In Planning	In Progress	Complete	Sustaining

IT-4 Description & Status

Description

- To execute this responsibility, the OIT Associate Deputy Assistant Secretary created and tasked the Legacy Systems Modernization (LSM) Working Group. The LSM Working Group Chairperson, identified and tasked by the Associate Deputy Assistant Secretary EPMO, is responsible for the development, implementation, and maintenance of this LSM Working Group Charter.[9] The LSM Working Group is charged with cataloging current plans for system modernization and/or decommission, and facilitating decision making about legacy systems for which plans do not yet exist. The LSM Working Group is also responsible for ensuring a consistent, up-to-date view of legacy system status reporting, strategic roadmap and decision data across VA.
- To achieve this outcome, the LSM Working Group will conduct thorough and complete evaluations and assessments, including functional, cost and schedule, technical, security, and operational characteristics for groups of systems. The LSM Working Group will document assessment process and results as an auditable record and a reference for future assessments.
- An important business capability to achieve this outcome is the LSM Working Group's ability and authority to monitor subsequent activities regarding system disposition and report status to EPMO management on a regular basis.

Legacy System Modernization status:

- Completed assessments of all products within the following product lines: Community Care, Supply Chain Management, Digital Experience, Education Veteran Readiness and Employment, EHRM and Provider Systems. Assessments currently in progress in the following product lines: APM, FM, HC, Contact Center, SCLA and MREPH. This represents 213 of completed

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

IT-4 Description & Status
assessments and initiated or in progress 198 assessments. As of January, 25, 2021 there are 531 products remaining to assess in VASI. • Conducted initial requirements meeting with IT points of contact (POCs) for legacy systems and the VHA Caregiver Support Program team to discuss requirements elaboration, prioritization, and preliminary schedule. Leveraged VIPR/Intake process. OIT collaborated with internal business partners performing analysis of alternatives on proposed commercial-off-the-shelf solutions supporting the requirements of the VHA Caregiver Support Program to implement the MISSION Act. • Held in-person sessions of OIT, VHA Caregiver Support Program team, and business partners on July 16–19, 2019 to refine requirements, identify dependencies and risks, and develop preliminary systems modifications plans to support implementation of the IT system required by section 162 of the MISSION Act. • The Program of Comprehensive Assistance for Family Caregivers (PCAFC) is currently open only to eligible Veterans who incurred or aggravated a serious injury in the line of duty on or after September 11, 2001, and their family caregivers. By developing CARMA, VA is establishing IT foundations to support the program's expansion under the MISSION Act. CARMA enables VA to process, track, and manage PCAFC applications; automates the stipend payment process; and improves existing reporting functionality. CARMA is a commercial-off-the-shelf (COTS) solution that leverages multiple processes to iteratively deliver a high-functioning product and allow for better oversight and future product updates to support PCAFC's expansion. Phase 1, which launched in fall 2019 replaced the legacy system with increased data integrity and allowed for improved oversight at the medical facility level. Phase 2, launched in January 2020, automated the stipend process. • On January 16, 2018, OIT issued a memorandum on "Use of Enterprise Cloud (VAEC) to Host Applications." The memorandum clarifies and affirms VAEC for new applications development, testing, and production, including COTS solutions. Application developers should establish a development, test and pre-production environment in the cloud that supports Agile development and sustainment. Plans are ongoing for migrating applications to the VAEC at a mutually agreed time frame by the Cloud Executive and the Enterprise Cloud Solutions Office. Exceptions to the use of VAEC for new development, test, and production will require CIO approval and the approval of the OIT Standards & Architecture Council. • The VAEC is an evolving entity that is built through an ongoing collaborative effort between the VA's business and technology communities and the Office of Enterprise Architecture within OIT. As organizational goals, priorities, business needs and plans change, the VAEC is updated to maintain its relevance as a transformation tool and authoritative information resource. VASI is the authoritative source for VA IT systems and identifies the stewards responsible for maintaining the accuracy, integrity, and availability of the information contained in VASI. VAEC serves as a strategic planning and

IT-4 Description & Status
management tool to help VA leadership execute transformation throughout VA. Enterprise cloud products are informed by and support the Department's business and operational visions, strategies, and mission. For VA to achieve its mission, the VAEC must be viewed as an authoritative source for the information it makes available to end users. The VAEC's integrated views of strategic goals, mission, support services and data and IT provide the requisite information to enable it to serve as the authoritative reference for issues of ownership, management, resourcing, performance goals and design and documentation of systems and services. • The VA Technical Reference Model (VA TRM) is one component within the overall enterprise architecture that establishes a common vocabulary and structure for describing the IT used to develop, operate and maintain enterprise applications. The VA TRM includes the standards profile and product list, serves as a technology roadmap, and is a tool for supporting OIT.The TRM site is used to determine the technical alignment of projects/programs as part of the Veteran-Focused Integration Process. This site includes directions for use as well as the process for submitting new technologies to be evaluated and included in future releases of the VA TRM. Users can search for technologies, generate reports, review forecasts, and access release history. Adhering to the VA TRM is essential to improving the technical environment at VA. Architecture & Engineering Services has overall responsibility for VA TRM.

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

Table 3-15. IT-4 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Conduct thorough and complete evaluations and assessments, including functional, cost and schedule, technical, security and operational characteristics	Number of Legacy System Modernization (LSM) assessments completed	Baseline/Completed: • FY 2019=75 • FY 2020=87 • FY 2021=51 to date In-progress FY 2021=198 Remaining products=531	Q2, Q4

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

Table 3-16. IT-4 Action Plan

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

Goals, objectives, and additional actions will be developed prior to the next rating period			
Actions*	**Projected Date**	**Actual/ Adjusted Date**	**Status/Comments**
(4.1) LSM Working Group monitors subsequent activities regarding system disposition; reports status to EPMO management on a regular basis.	Q1 FY 2022		**In Progress**
(4.2) Conduct thorough and complete evaluations and assessments, including functional, cost and schedule, technical, security and operational characteristics for groups of systems. Document assessment process and results as an auditable record and a reference for future assessments.	Q1 FY 2022		**In Progress:** Currently, VA enterprise architecture has quarterly major releases (October, January, April, and July). However, the VAEC development process supports interim releases that can be published on an as-needed basis. There are multiple mechanisms used to enable VAEC stakeholders to distinguish updates between releases.
(4.3) Catalog current plans for system modernization and/or decommission, and facilitating decision making about legacy systems for which plans do not yet exist.	Q1 FY 2022		**In Progress**

Goals, objectives, and additional actions will be developed prior to the next rating period			
Actions*	**Projected Date**	**Actual/ Adjusted Date**	**Status/Comments**
(4.4) Retire designated systems: Continue to manage system ONLY as emergency backup for target system; in coordination with all stakeholders, validate that the system can be turned off, and get approval to do so; initiate planning for decommissioning; consider reduction in support resourcing.	Initiated		**In Progress**
(4.5) Decommission designated systems: Turn system off; initiate system disposal activities, including removing system software from system infrastructure, unplugging/sanitizing/ dispositioning system hardware, archiving data, canceling maintenance agreements and reassigning personnel; VASI Production Status changes to “Inactive.”	Initiated		**In Progress**
(4.6) Modernize: Reengineer/Redesign/Update (e.g., to address issues in Legacy system or adapt legacy system to other more modern platforms/infrastructure). This includes modifications needed to transfer capability from another system, or activating an existing, dormant capability that will subsequently perform this inherited function.	Q2 FY 2022		**In Progress**

Goals, objectives, and additional actions will be developed prior to the next rating period			
Actions*	**Projected Date**	**Actual/ Adjusted Date**	**Status/Comments**
(4.7) Cloud Migration/National Solutions/Enterprise Solution Q1 – Hold a dedicated offsite with all appropriate stakeholders to better understand issues and propose process updates to address these needs (December 2019) Q2 – Develop/establish the initial processes/process changes (est. March 2020) Q3 – Communicate new process to the OIT and VHA organization (est. June 2020) Q4 – Demonstrate initial use cases using new process model (est. September 2020)	Q1 FY 2020 through Q4 FY 2020		**Complete**

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

Table 3-17. IT-4 Description of Actions Toward Removal Criteria

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

Information Technology Outcome (IT-5)

Outcome Lead: Matthew Zullo, Deputy Director, Agile Center of Excellence

Outcome Executive: Dan McCune, Executive Director, Enterprise Portfolio Management and Application

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

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

IT-5: Goal(s) and Objective(s) development are underway.

Table 3-18. IT-5 Description & Status

In Planning	In Progress	Complete	Sustaining

IT-5 Description & Status
Description • To achieve this outcome, the VA CIO and the EIC 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, AMO and business customers. OIT will leverage LSM Working Group to identify and plan for system modernization and/or decommission. **Status:** • To address reducing the number of duplicative IT systems and capabilities, VA is implementing Portfolio Management and Product Life-cycle Management (PLM). • OIT is establishing the framework required to leverage DevOps, Scaled Agile Framework, Systems Thinking, Human-Centered Design, Digital Innovation and Site Reliability Engineering. These are complementary principles and approaches that require product teams to have end-to-end accountability. OIT is working with end users to understand requirements; to analyze business requirements and needs through the Unified Intake Process and VA IT Process Requests (VIPRs); to document requirements in user stories; to develop digital solutions; to automate testing and deployment; to support end users after deployment; to address system defects, and to ensure products perform as expected. OIT is adopting these practices to improve the Veteran's experience. VA product lines are the "functional groupings" of like VA IT products (systems). Product lines are grouped based on OIT portfolios and composition of IT systems supporting each product line. The product lines will be formalized and system relationships/roadmaps are validated by the product line owners. • The establishment of DevOps (combining Development and Operations) under OIT Deputy Assistant Secretary leadership is an OIT customer-focused

IT-5 Description & Status

strategy that will enable: 1) rapid flow data-driven services to customers where a cross-functional teams will deliver services/capabilities in small batches, 2) maximized customer feedback to all OIT teams with actionable data from customer behaviors with reduced cycles, 3) continual learning, testing of hypotheses and 4) improving, and maximizing agility/learning to deliver a continuously improving customer experience.
• OIT established change teams to help transform the organization migrating toward PLM and DevOps concepts. The goals of the change teams are to:
  ○ Establish product lines as the framework for organizing all IT services.
  ○ Transform culture to one of empathy, accountability and innovation.
  ○ Rethink business operations (finance/acquisition).
  ○ Prepare the environment to receive and support DevOps value streams.
  ○ Refine and integrate processes to fit VA (Scaled Agile Framework, DevOps, IT Infrastructure Library and supporting processes).
  ○ Adopt human-centered design, modern DevOps tools and performance monitoring.
  ○ Establish architecture at the product line level.
  ○ Establish, promote and manage platforms.
  ○ Become a strategic partner that proactively solves business problems using technology.
• VASI is the authoritative source for VA IT systems and identifies the stewards responsible for maintaining the accuracy integrity, and availability of the information contained in VASI. The mission of VAEC is to serve as a strategic planning and management tool to help VA leadership execute transformation throughout the organization. VAEC products are informed by and support the Department's business and operational visions, strategies, and mission. For the VA to achieve its mission, the VAEC must be viewed as an authoritative source for the information it makes available to its end users. The VAEC's integrated views of strategic goals, mission, support services and data and IT provide the requisite information to enable it to serve as the authoritative reference for issues of ownership, management, resourcing, performance goals and design and documentation of systems and services.
• The VA Enterprise Architecture Repository provides a wealth of valuable information that describes VA business operations, capabilities, systems, services and the IT capabilities that serve them. VA leadership, staff and stakeholders can access this authoritative information to help improve service delivery, increase interoperability and make better use of resources.

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

Table 3-19. IT-5 Measures/Metrics

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

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

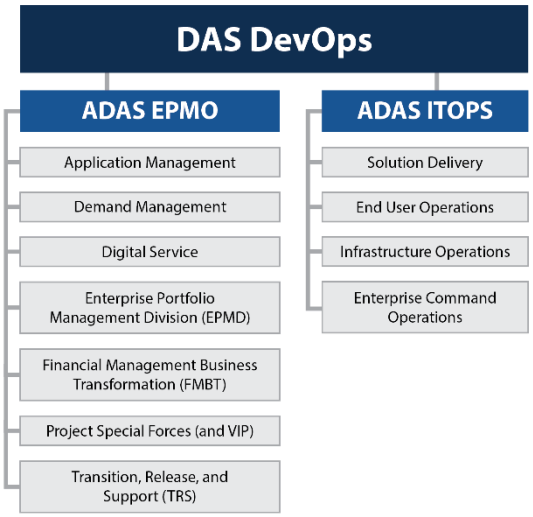
Table 3-20. IT-5 Action Plan

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

Goals, objectives, and additional actions will be developed prior to the next rating period			
Actions*	**Projected Date**	**Actual/ Adjusted Date**	**Status/Comments**
(5.1) VHA and OIT identify duplicative systems and capabilities	Ongoing	Ongoing	**Sustaining.** Service provider, AMO and Business Customer Ongoing.

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

Table 3-21. IT-5 Description of Actions Toward Removal Criteria

IT-5 Description of Actions Toward Removal Criteria
Leadership Commitment • The CIO implemented a program to drive aggressive progress toward VA's IT modernization by implementing a true DevOps environment to address material weaknesses and stabilize and streamline OIT's core processes and platforms. Supported by Agile and Lean practices, DevOps is a culture-based software engineering approach that aims at unifying software development and software operation, and mandates collaboration between business and the IT organizations that develop, deliver, and manage applications for that business. The value of DevOps is measured based on customer value delivered at the cadence required to meet mission objectives. • The CIO created a new position within OIT called the Deputy Assistant Secretary for Development and Operations (DAS DevOps). The DAS DevOps role will unify the Enterprise Project Management Office (EPMO) and IT Operations and Services led by Associate Deputy Assistant Secretaries. The following reorganization supports all five areas of concern and VHA's LOEs: *Figure 3-4. IT-5 DAS DevOps*    • DevOps has been fully established and improves OIT customers' experience, enables OIT to deploy new systems and update existing systems more quickly and frequently, and lowers costs by leveraging industry best practices and innovation. The DevOps team has established high-level governance structures, established long-term priorities and goals, improved collaboration with stakeholders and customers, and supported continuing oversight and accountability.
Capacity • DevOps employed a product line management structure to manage five portfolios and 27 product lines with over 700 products (systems and applications). One portfolio is Health Services and it includes Medical Care,

IT-5 Description of Actions Toward Removal Criteria
Health Care Administration, Provider and Telehealth, Medical Research, Education and Public Health, Community Care, and Supply Chain Management. This structure helps DevOps allocate or reallocate funds or staff; establish and maintain procedures or systems; establish workgroups with specific responsibilities; improve collaboration with other agencies, stakeholders, and the private sector; and provide guidance and training to staff that addresses skills gaps. • OIT will ensure employees are aware of the transition to DevOps. Training for executives and practitioners in Scaled Agile Framework, product line management, and other relevant topics will be required. Mentors and coaches will be available for projects choosing to adopt Agile and DevOps practices. OIT also will assign product line managers and lead engineers for select pilot product lines and portfolios.
Monitoring • Divisions under the DevOps umbrella take responsibility for what is delivered to the customer. By simplifying IT architecture, DevOps will make data more accessible and understandable. DevOps has improved monitoring activities by: o Ensuring data quality/adequacy or using third-party assessments and validation. o Holding frequent review meetings to assess status and performance. o Reporting to senior managers on program progress and potential risks. o Tracking performance measures and progress against goals. • This plan's metrics and measures provide the mechanisms to assess and report progress to GAO. With the introduction of metrics and measures, monitoring processes and procedures will be formalized.
Demonstrated Progress • In 2017, OIT established a legacy system modernization and decommissioning strategy that continues to deliver the following outcomes for duplicative systems as well: o A reliable account of legacy systems and associated modernization plans with ongoing tracking and automated reporting of retirement and decommissioning activities. o A repeatable process of discovery, analysis, and collaborative decision making to examine portfolios of systems to develop or confirm existing action plans for modernization, sustainment or retirement. o A standard process and checklist of activities required when retiring a system. o Portfolio roadmaps that afford OIT the visibility to recapture resources, and re-program freed resources toward priority business as an element of lifecycle management of VA IT systems. o Operational performance improvements in VA's business and technical systems.

4. Inadequate Training for VA Staff Area of Concern

Executive Summary

The Training AOC received valuable feedback from GAO on its original Action Plan. That input, plus lessons learned during the implementation of the MISSION Act, COVID-19 and COVID-19 Vaccination Training allowed the Training AOC to significantly update the Training Action Plan. This update has been submitted to the GOAL office for inclusion in the VA Health Care Progress Report. This Action Plan aims to address GAO concerns and move VHA to a sustainable, effective, and efficient training system. Included in the root causes the Training AOC identified pertaining to the training issues across VHA, GAO cited that "VA lacks a comprehensive, enterprise-wide training directive and planning process." The Training AOC formed a Training Workgroup (TWG), a designated team specifically created to address the root causes and achieve the desired Training Outcomes (TOCs).

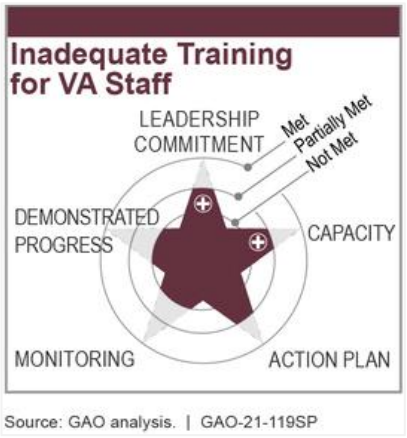


Figure 4-1. Training 2021 Rating Goal

The AOC's overall goal for VHA is to establish and implement VHA nation-wide training standards for all training across VHA to include oversight and policy that aligns with the VA 5015 Training Directive.

Objectives:

1. To address burdensome and inadequate training across VHA and reach the defined training outcomes to implement standardized training planning, development and design and training procurement procedures, the TWG must first establish and implement 15 processes for the three TOCs described below. These 15 processes will be established and implemented, using IPTs, before the supporting VHA Training Policy can be drafted and submitted for concurrence. This policy's purpose is to enforce adoption and compliance with new training processes and procedures. (Q2 FY 2021 through Q4 FY 2024)

TOC 1: To establish a comprehensive and effective Training Oversight Structure, Training Standards and Policy, the following six processes will be established and implemented:

- VHA Training Compliance, Reporting, & Oversight Management Process (Q4 FY 2022)
- VHA Training Audit & Reporting Data System (Q4 FY 2024)
- VHA Training Waiver Process (Q4 FY 2022)
- VHA Training Standards (Q4 FY 2022)
- VHA Training Reviews based on Training Evaluation/Skillset Standards Process (Q4 FY 2023)

- VHA Training Requests Intake Process (Q4 FY 2023)

TOC 2: 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, the following five processes will be established and implemented:

- VHA Training Evaluations/Skillset Design Process (Q4 FY 2022)
- VHA Training Evaluations/Skillset Standards (Q4 FY 2022)
- VHA Training Assignment Process (Q4 FY 2022)
- VHA Mandatory Training Process (Q3 FY 2023)
- VHA Training Lifecycle Maintenance and Sunsetting Process (Q4 FY 2022)

TOC 3: To build a strong educational infrastructure for VHA, processes will be created to efficiently budget and plan training based on VHA priorities. Training contracts will be standardized, and contract vehicles specifically designated for training needs will be provided. The following four Processes will be established and implemented:

- VHA-wide Contract Vehicle for Training Requests (Q4 FY 2023)
- VHA Training Priorities and Training Plan Process (Q4 FY 2022)
- VHA Training Contracts Standardization Process (Q4 FY 2022)
- VHA Training Budget Object Codes Process (Q4 FY 2022)

1. TWG will coordinate with VA CLO on the VA 5015 Training Directive to ensure VHA compliance with VA Training standards set within the Directive. (Q4 FY 2022)
2. Gain concurrence for the VHA Training Policy. (Q2 FY 2025)
3. Establish a comprehensive change management plan for each of the VHA Training Outcomes.
4. Establish quality compliance and reporting guidelines for each of the VHA Training Outcomes.

The TWG took several 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, the TWG attempted to use metric data available in VHA Employee Education Services (EES), but found that the data was neither consistent nor reliable and, in many instances could not be validated nor replicated. Based on this analysis, the TWG developed a more comprehensive plan, which is represented in Figure 2-10 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.

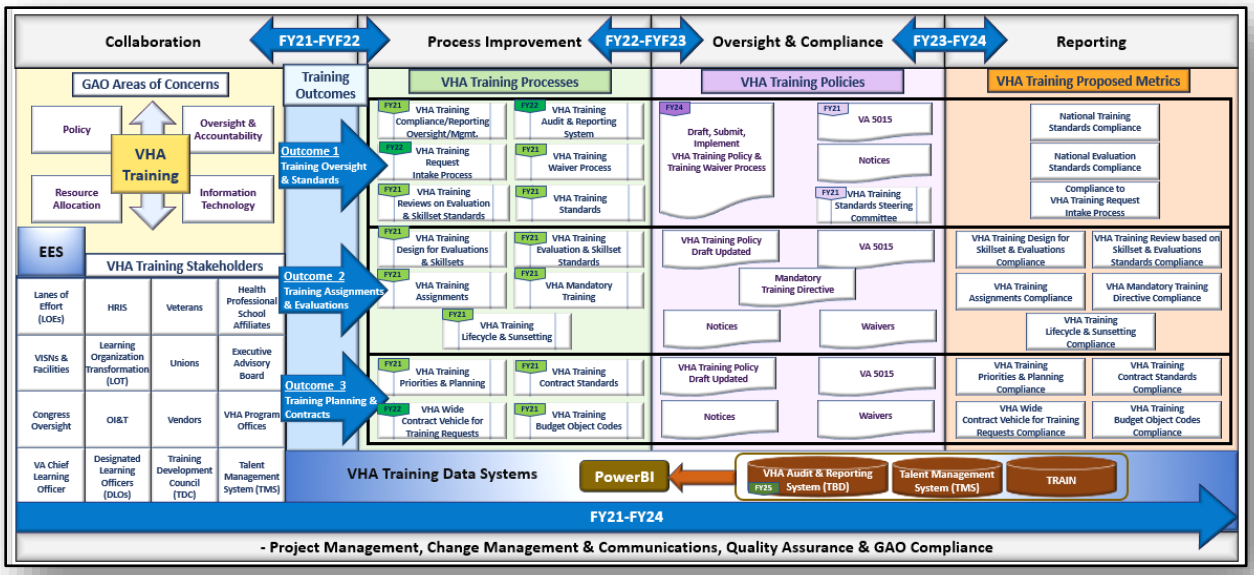


Figure 4-2. Training AOC Action Plan Overview

To implement this Training Action Plan over the next four years, the TWG:

- Is establishing a VHA Training Steering Committee to guide the development and implementation of training standards, processes and systems.
- Has identified, defined, and chartered several 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 2-10 above will be represented in the IPTs as well as the VHA Training Steering Committee. To measure progress while outcome metrics are being developed, the TWG will provide routine status updates on the numerous processes while 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 through the use of a series of “Notices”, pending the release of the final comprehensive VHA Training Policy.
- Is collaborating with the VA CLO and Training Development Council (TDC). The TWG is ensuring the VHA Training Policy is aligned with the VA 5015 Training Directive that is being rewritten and updated.

Job Roles were used to assign Mandatory Training instead 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 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 very specific training audience based on specific COVID-19 related or impacted duties.

In FY 2021, EES was able to contract 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.

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

- **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-2:** Accurately identified audience is trained at the appropriate time to specific program/process requirements.
- **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.

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

Table 4-1. Training Alignment with Other Areas of Concern

Alignment with Other Areas of Concern
Policies and Processes
The TWG collaborates with the Policies and Processes workgroup to: • Develop a VHA directive that supports VHA's implementation of standardized oversight and training planning process for all training. (Outcomes 1, 2, 3)
Oversight and Accountability
The TWG collaborates with the Oversight and Accountability workgroup to: • Develop a VHA directive that supports VHA's implementation of standardized oversight and training planning process for all training. (Outcome 1, 2, 3) • Develop a process that supports the standardized oversight and planning processes for VHA training. (Outcome 2)
IT

Alignment with Other Areas of Concern
The TWG collaborates with the IT workgroup to: • Incorporate procedural changes/updates identified in the VHA Training Oversight Directive into Business Intelligence Suite (BIS) and TMS as needed. (Outcome 1) • Incorporate updated job codes into BIS and TMS and other learning management systems as needed. (Outcome 2) • Assist with the development of a new VHA Training Audit and Reporting Data System. (Outcome 1)
Resource Allocation
The TWG collaborates with the Resource Allocation workgroup to: • Develop a staffing model to identify additional FTEs required to support VHA's implementation of standardized oversight and training planning process for all training. (Outcome 1, 2, 3) • Review the current training assignment process and define how training will be assigned based on skillset versus job codes. (Outcome 2) • Generate the designated budget required to support VHA's implementation of standardized oversight and training planning, assignment and evaluation process for all training. (Outcome 1, 2, 3) • Develop contracting standards and guidelines, for training procurements and establish a designated training contract vehicle for blanket purchase agreements. (Outcome 1, 2, 3)

Training Outcome (TOC-1)

Outcome Lead: Rebecca Goodson, Acting Director, Enterprise Project Management Office (EPMO), Employee Education Services (EES)

Outcome Executive: Margarita Devlin, VHA CLO

TOC-1 Root Cause: VA lacks a comprehensive, enterprise-wide training policy and planning process.

TOC-1 Outcome Statement:

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

T-1: Goal 1. Establish and implement effective Training Oversight Structure, Data Reporting Systems and Processes by Q4 FY 2024.

Objective 1: Establish and implement the VHA Training Compliance, Reporting & Oversight Management Process. (Q4 FY 2022)

Objective 2: Establish and implement a VHA Training Audit & Reporting Data System. (Q4 FY 2024)

T-1: Goal 2. Establish and implement training standard guidelines that not only define effective training and ensures that all training across VHA is consistent and compliant with defined quality standards by Q4 FY 2023.

Objective1: Establish and implement VHA training standard guidelines by working in conjunction with the VA CLO and the VA 5015 Training Directive to ensure VHA standards are leveraged and integrated. (Q4 FY 2022)

Objective 2: Establish and implement VHA training reviews based on an established training evaluation/skillset standards process. (Q4 FY 2023)

T-1: Goal 3. To ensure proper tracking and verification of training compliance, a Training Waiver Process will be needed, if, under certain circumstances the field is unable to comply with the VHA Training Policy. The Training Waiver Process will be in place by Q4 FY 2022.

Objective 1: Establish and implement a VHA Training Waiver Process. (Q4 FY 2022)

T-1: Goal 4. Establish and implement a Standard Training Request Intake to ensure consistent requirements gathering across VHA when creating or acquiring training by Q4 FY 2023.

Objective 1: Establish and implement a VHA training requests intake process. (Q4 FY 2023)

T-1: Goal 5. Establish and implement a comprehensive change management plan to ensure the VHA Training Action Plan is accepted across the VHA Enterprise by Q1 FY 2024.

Objective 1: Establish and implement a VHA change management plan for Training Outcome 1. (Q1 FY 2024)

T-1: Goal 6. Establish and implement a quality reporting and compliance plan to ensure the VHA Training Action Plan is accepted and complied with across the VHA Enterprise by Q4 FY 2024.

Objective 1: Establish and implement a VHA Audit System for Training Outcome 1. (Q4 FY 2024)

Table 4-2. T-1 Description & Status

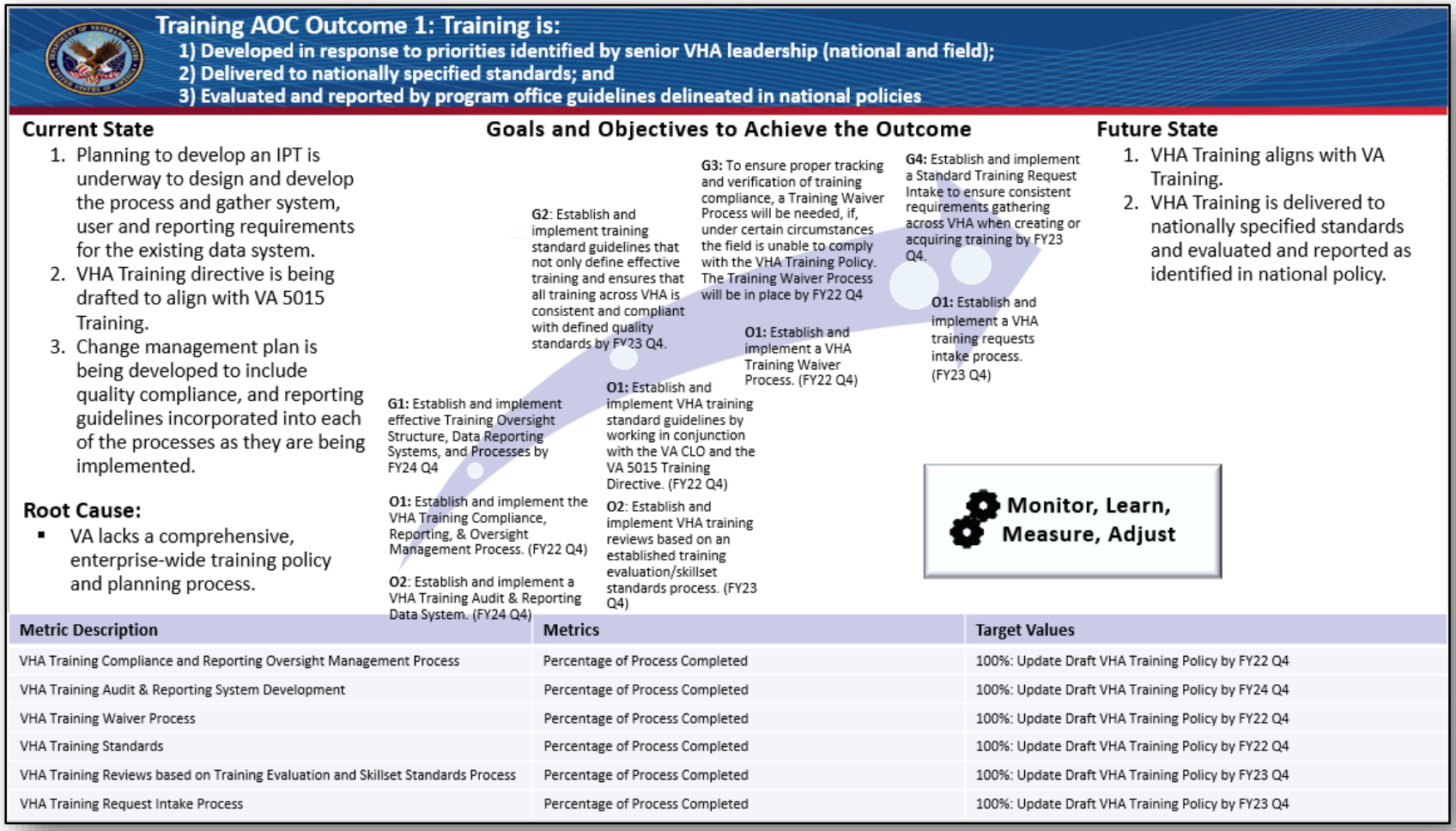
In Planning	In Progress	Complete	Sustaining

T-1 Description & Status

Description
• To ensure VHA is adequately positioned to achieve this training outcome, training oversight and standards must first be identified, and a nationwide comprehensive Training Oversight Policy established to enforce and ensure compliance. In its current state, VHA training remains burdensome and inadequate due to poorly defined training processes and standards in addition to unclear compliance, reporting and oversight requirements.
• For this Training Outcome, this Action Plan demonstrates how the TWG will establish national Training Oversight and Standards, supported by VHA Training Policy and leadership for:
  ○ VHA Training Compliance and Reporting, which will delineate clear roles and responsibilities and compliance requirements, in alignment with the VA 5015 Training Directive.
  ○ VHA Training Request and Intake Processes that detail training standards.
  ○ VHA Training Review, Evaluation and Skillset Standards.
  ○ VHA Training Audit and Reporting System, that defines business information and VHA training data systems and reporting requirements.
  ○ VHA Training Waiver Process, purpose, and justification requirements.
  ○ VHA Training Standards governance and oversight requirements.
• Additionally, reportable VHA Training Metrics will be developed, implemented and the data recorded to monitor efficacy and compliance for:
  ○ National Training Standards
  ○ National Evaluation and Skillset Standards

T-1 Description & Status
Status • The VHA CLO and Outcome Leads have chartered several IPTs which are designed to support the development of these standards, planning guidelines and oversight policy requirements and the piloting of new processes, prior to nation-wide implementation. Additionally, a VHA Training Standards Steering Committee is estimated to be established by Q1 FY 2022 to support the development and validation of national training standards and training processes.

Figure 4-3. T-1 Roadmap



Metric Description	Metrics	Target Values
VHA Training Compliance and Reporting Oversight Management Process	Percentage of Process Completed	100%: Update Draft VHA Training Policy by FY22 Q4
VHA Training Audit & Reporting System Development	Percentage of Process Completed	100%: Update Draft VHA Training Policy by FY24 Q4
VHA Training Waiver Process	Percentage of Process Completed	100%: Update Draft VHA Training Policy by FY22 Q4
VHA Training Standards	Percentage of Process Completed	100%: Update Draft VHA Training Policy by FY22 Q4
VHA Training Reviews based on Training Evaluation and Skillset Standards Process	Percentage of Process Completed	100%: Update Draft VHA Training Policy by FY23 Q4
VHA Training Request Intake Process	Percentage of Process Completed	100%: Update Draft VHA Training Policy by FY23 Q4

In FY 2020, the TWG attempted to use metric data and processes available in EES and found that the data was not consistent or reliable and, in many instances, could not be validated. In addition, the processes were not documented. Two issues related to metrics are:

1. There is no definition of what “training” is. Some areas of training might not be trackable or measurable “training” such as conferences. But all are being included when retrieving training reports.
2. Only EES Produced training could be tracked. Until all VHA produced training can be tracked and measured, including purchased and contractor developed training there will not be metrics for those events.

To measure our progress until the IPTs are completed and a VHA Training policy is released, the TWG will report the percent complete of each IPT to demonstrate the work being performed. This is a change in approach from the previous Action Plan.

The following table describes the measures and metrics the TWG is using to determine progress toward achievement of T-1.

Table 4-3. T-1 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
(1.1) VHA Training Compliance and Reporting Oversight Management Process	Percent of Process Completed	Milestone = 50%: Develop Process Standards, Metrics, Waivers by Q1 FY 2022 Target = 100%: Update Draft VHA Training Policy by Q4 FY 2022	Quarterly
(1.2) VHA Training Audit & Reporting System Development	Percent of Process Completed	Milestone = 20%: Requirements Gathered and Solutions for the development of the new System identified by Q4 FY 2022 Target = 100%: Update Draft VHA Training Policy by Q4 FY 2024	Quarterly
(1.3) VHA Training Waiver Process	Percent of Process Completed	Milestone = 50%: Develop Process Standards, Metrics, Waivers by Q1 FY 2022 Target = 100%: Update Draft VHA Training Policy by Q4 FY 2022	Quarterly

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
(1.4) VHA Training Standards	Percent of Process Completed	Milestone = 50%: Develop Standards, Metrics, Waivers by Q1 FY 2022 Target = 100%: Update Draft VHA Training Policy by Q4 FY 2022	Quarterly
(1.5) VHA Training Reviews based on Training Evaluation and Skillset Standards Process	Percent of Process Completed	Milestone = 50%: Develop Standards, Metrics, Waivers by Q1 FY 2023 Target = 100%: Update Draft VHA Training Policy by FY 2023 Q4	Quarterly
(1.6) VHA Training Request Intake Process	Percent of Process Completed	Milestone = 50%: Develop Process Standards/Metrics/Waivers by Q1 FY 2023 Target = 100%: Update Draft VHA Training Policy by Q4 FY 2023	Quarterly

The following table describes actions the TWG has identified to be completed to achieve T-1.
Training is:

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

Table 4-4. T-1 Action Plan

*All actions imply effective change management and training needs are part of implementation

Actions*	**Projected Date**	**Actual/ Adjusted Date**	**Status/Comments**
T-1 Goal 1: Establish and implement effective Training Oversight Structure, Data Reporting Systems, and Processes by Q4 FY 2024.	**Objective 1**: Establish and implement the VHA Training Compliance, Reporting, & Oversight Management Process. (Q4 FY 2022)	**Objective 2**: Establish and implement a VHA Training Audit & Reporting Data System. (Q4 FY 2024)	
1.1) Establish and implement structure for oversight and compliance of VHA Training Data, Audit and Reporting System **(1.1a)** Establish and implement structure for oversight and compliance of VHA Training Data	**Q4 FY 2024** ***Q4 FY 2022*** Q3 FY 2021		In Planning: After reviewing and analyzing existing data systems and oversight and compliance capabilities, a formalized structure to audit

▪ Design and develop process ▪ Pilot process ▪ Develop process standards/Metrics/Waivers ▪ Identify business requirements for system data ▪ Process work completed and accepted by TWG Leadership ▪ Implement process and release process notice ▪ Update draft VHA Training Policy **(1.1b)** Develop Audit and Reporting System for Data ▪ Gather Requirements ▪ Determine Possible Solutions ▪ Configure System Implement System	Q4 FY 2021 Q1 FY 2022 Q1 FY 2022 Q2 FY 2022 Q4 FY 2022 Q4 FY 2022 ***Q4 FY 2024*** Q3 FY 2022 Q4 FY 2022 Q4 FY 2023 Q4 FY 2024		and report Training Outcome Metrics will need to be defined once all the training processes identified have been established and implemented. 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 the process and gather system, user, and reporting requirements for

			the existing data system.
T-1 Goal 2: Establish and implement training standard guidelines that not only define effective training and ensures that all training across VHA is consistent and compliant with defined quality standards by Q4 FY 2023.	**Objective 1:** Establish and implement VHA training standard guidelines by working in conjunction with the VA CLO and the VA 5015 Training Directive. (Q4 FY 2022)		
(1.2) Establish National Training Standards within the VA 5015 Directive and VA Training Standards Steering Committee **(1.2a)** Work with VA CLO on the VA 5015 Directive updates to incorporate National Training Standards **(1.2b)** Work within VHA VA CLO to create a VHA Training Standards Steering Committee for Oversight and Governance	**Q1 FY 2022**		**In Progress:** Currently the VA 5015 Directive is being reevaluated and updated. The TWG has met with the VA CLO to discuss collaboration in the development of the VA 5015 Training Directive in conjunction with forming a VHA Training Standards Steering Committee. VHA Training will have to align with and

			follow the VA 5015 Training Directive. The TWG is focusing on ensuring specific training standards are in alignment with training at the VA level. The VA 5015 Training Directive is working towards completion by FY22 Q1.
	Objective 2: Establish and implement VHA training reviews based on an established training evaluation/skillset standards process. (FY23 Q4)		
(1.3) Establish and implement VHA Training Reviews based on evaluation and skillset standards ▪ Design and develop process ▪ Pilot process ▪ Develop process standards/Metrics/Waivers	**Q4 FY 2023** Q3 FY 2022 Q1 FY 2023 Q1 FY 2023		**In Planning:** Evaluations and Skillset standards must be defined before training review standards can be set up for evaluations and

▪ Identify business requirements for system data ▪ Process work completed and accepted by TWG Leadership ▪ Implement process and release process notice Update draft VHA Training Policy	Q1 FY 2023 Q2 FY 2023 Q3 FY 2023 **Q4 FY 2023**		skillsets. Once the evaluation and skillset design processes are defined, documents and the standards set, this task will begin to define what criteria will be utilized to ensure that training is effective and measurable. An IPT has been formed to design and develop the process, determine standards, define outcome metrics, and training waivers needed.
T-1 Goal 4: Establish and implement a Standard Training Request Intake to ensure consistent requirements gathering across VHA when creating or acquiring training by Q4 FY 2023.	**Objective:** Establish and implement a VHA training requests intake process. (Q4 FY 2023)		
(1.4) Establish and implement VHA Training Request process ▪ Design and develop process	**Q4 FY 2023** Q3 FY 2022		**In Planning:** There currently is not a standard intake process in

▪ Pilot process ▪ Develop process standards/Metrics/Waivers ▪ Identify business requirements for system data ▪ Process work completed and accepted by TWG Leadership ▪ Implement process and release process notice ▪ Update draft VHA Training Policy	Q4 FY 2022 Q1 FY 2023 Q1 FY 2023 Q2 FY 2023 Q3 FY 2023 Q4 FY 2023		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.
T-1 Goal 3: To ensure proper tracking and verification of training compliance, a Training Waiver Process will be needed, if, under certain circumstances the field is unable to comply with the VHA Training Policy. The Training	**Objective:** Establish and implement a VHA Training Waiver Process. (Q4 FY 2022)		

Waiver Process will be in place by Q4 FY 2022.			
(1.5) Establish and implement VHA Training Policy and Waiver Process **(1.5a)** Establish and implement Training Waiver Process ▪ Design and develop process ▪ Pilot process ▪ Develop process standards/Metrics/Waivers ▪ Identify business requirements for system data ▪ Process work completed and accepted by TWG Leadership ▪ Implement process and release process notice ▪ Update draft VHA Training Policy **(1.5b)** Gain Concurrence and implement VHA Training Policy ▪ Draft Policy ▪ Submit Policy for Concurrence ▪ Draft Communications Release Policy	**Q2 FY 2025** ***Q4 FY 2022*** Q3 FY 2021 Q4 FY 2021 Q1 FY 2022 Q1 FY 2022 Q2 FY 2022 Q4 FY 2022 Q4 FY 2022 ***Q2 FY 2025*** Q4 FY 2024 Q2 FY 2025 Q2 FY 2025 Q2 FY 2025		**In Progress:** The TWG has determined that many of the training processes and standards required to support the VHA Training Policy were believed to exist, but they do not. This assessment has required a plan that first ensures that all the training standards and processes required to meet the Training Outcomes and address Root Causes are developed before implementation of a VHA Training Policy and Waiver process can be completed. In addition, it needs to align with the VA 5015 Directive

			that is currently being revised. The TWG'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.
T-1: Goal 5. Establish and implement a comprehensive change management plan to ensure the VHA Training Action Plan is accepted across the VHA Enterprise by Q1 FY 2024. **T-1: Goal 6.** Establish and implement a quality reporting and compliance plan to ensure the VHA Training Action Plan is accepted and complied with across the VHA Enterprise by Q4 FY 2024.	**Goal 5; Objective 1:** Establish and implement a VHA change management plan for Training Outcome 1. (Q1 FY 2024) **Goal 6; Objective 1:** Establish and implement a VHA Audit System for Training Outcome 1. (Q4 FY 2024)		

(1.6) Establish change management, quality compliance and reporting guidelines for T- **(1.6a) Change Management**: ▪ Define Change Management ▪ Phase 1: Prepare for Change ▪ Phase 2: Manage Change ▪ Phase 3: Reinforce Change **(1.6b) Reporting and Compliance**: ▪ Determine outcome metrics for T-1 ▪ Determine data sources for outcome metrics ▪ Determine outcome metrics targets ▪ Add outcome metrics to the VHA Training Dashboard Document metrics and update VHA Training Compliance/Reporting Management Process	**On going** **<u>Q1 FY 2024</u>** Q2 FY 2021 Q2 FY 2021 Q4 FY 2022 Q1 FY 2024 **<u>Q4 FY 2024</u>**		**Completed:** Training AOC assessed our change impact, organization attributes, and sponsor leadership and support, which was used to complete our change management assessment analysis. **In Progress:** 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 the TWG 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 following table describes actions taken to address GAO's removal criteria.

Table 4-5. T-1 Description of Actions Toward Removal Criteria

T-1 Description of Actions Toward Removal Criteria

Leadership Commitment
• **FY 2015, EES is the education and training authority for the VHA headquarters program office** that supports VHA in addressing concerns identified by GAO in 2014 that can potentially adversely affect the care provided to our Veterans. The VHA GAO High Risk List (HRL) Steering Committee 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 GOAL Office to provide a comprehensive and integrated series of responses for all the AOCs and the VHA Modernization Strategy. This ensures a coordinated and consistent approach of responding to GAO's high-risk concerns. (Outcomes 1a, 1b, and 1c)
• **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 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 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. (Outcomes 1a, 1b, and 1c).
• **FY 2019, to support the TWG's efforts**, EES contracted a designated support team (Training Workgroup: TWG) to assist in this work - contributing $1.2 million annually to this effort.
• **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 Training Directive which directs all VA Training including VHA. The TWG collaborates with the TDC to incorporate several standards and processes that will be developed by the IPTs into the VA 5015 Training Directive.
• **FY 2019, the National Coordinator for the DLOs conducts assessments of regional education and training initiatives** and provides links to educational activities and long-term strategic goals such as delivering high-quality, patient-centered care. The National Coordinator acts as a liaison between EES and

T-1 Description of Actions Toward Removal Criteria
the field by facilitating communication to and from the field, identifying training needs and reviewing policies that impact the field. This includes the active integration of Regional Learning Consultants and an Associate Director (Outcomes 1a and 1c). • **In FY 2020, the TWG 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. The TWG is standing up 15 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 demonstrate VHA leadership commitment.
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 ensures alignment with the overall organizational mission and vision for the future. (Outcome 1a) • **FY 2019, VHA leadership established the TWG** and approved contract support consisting of 6.71 FTEs, along with four government FTEs to address the concern of “inadequate and burdensome training” that potentially leads to poor healthcare delivery to our nations’ veterans: o Design, develop, and recommend an effective and efficient national training program (Outcomes 1a, 1b, and 1c) o Draft VHA GOAL Office requirements for providing comprehensive and integrated series of responses for the TWG 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’s to EES Leadership and Manpower. (Outcome 1) • **FY 2021, a staff is required to review and evaluate all contractual training** 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. (Outcome 1)
Monitoring

T-1 Description of Actions Toward Removal Criteria
• **FY 2018**, per the Employee Education System Evaluation Policy (777-DCLO-EVAL-02), VHA required a minimum Kirkpatrick Level 2[10] assessment for all VHA training. (Outcome 1c). A Kirkpatrick Level 2 evaluation can provide overall training analytic 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. • **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 of 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.
Demonstrated Progress • **FY 2016, the TWG 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 the TWG'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, 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 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 and benchmarks of successful educational operations and barriers that have inhibited successful educational operations. Findings presented to the Office of the Deputy Under Secretary for Health for Operations and Management included:

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

T-1 Description of Actions Toward Removal Criteria

  - 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 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** required to be completed by VHA employees via VHA Directive 1052 (Appropriate and Effective Use of VHA Employee Mandatory and Required Training). This directive outlines the policy regarding the appropriate processes for initiating, renewing, consolidating, expanding, substituting, and discontinuing required trainings for VHA employees, 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 Deputy Under Secretary for Health 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 Deputy Under Secretary for Health community.
- **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

T-1 Description of Actions Toward Removal Criteria
ability to meet legislative requirements while preventing Veterans 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,** VHA is collaborating with Policy, OIT and the Oversight and Accountability AOCs to determine infrastructure to include resources, systems, and policy required to support Oversight Management Compliance and Reporting of VHA Training.

Training Outcome (TOC-2)

Outcome Lead: Rebecca Goodson, Acting Director, Enterprise Project Management Office (EPMO), Employee Education Services (EES)

Outcome Executive: Margarita Devlin, VHA CLO

TOC-2 Root Cause: VA lacks a systematic approach to competency assessment and execution.

TOC-2 Outcome Statement: The accurately identified audience is being trained at the appropriate time to specific program/process requirements.

T-2: Goal 1. Ensure Training Evaluations and Skillsets Standards are established and designed effectively to ensure Training effectiveness by Q4 FY 2022, through the development of the following two processes.

Objective 1: Establish and implement VHA Training Evaluation and Skillset Standards that will work for all training across VHA. (Q4 FY 2022)

Objective 2: Establish and implement VHA Training Evaluation and Skillset Design Process that will work for all training across VHA. (Q4 FY 2022)

T-2: Goal 2. Ensure the right people will receive appropriate training by Q3 FY 2023, through the development of the following two processes.

Objective 1: Establish and implement VHA Training Assignment Process that will work for all training across VHA. (Q4 FY 2022)

Objective 2: Enhance the VHA Mandatory Training Process to follow the new Training Assignment Process. (Q3 FY 2023)

T-2: Goal 3. Training is updated regularly and kept current by Q4 FY 2022 and beyond, through the development of the following process.

Objective 1: Establish and implement an effective VHA Training Lifecycle and Sunset Process that will work for all training across VHA. (Q4 FY 2022)

T-2: Goal 4. Establish and implement a comprehensive change management plan to ensure the VHA Training Action Plan is accepted across the VHA Enterprise by Q1 FY 2024.

Objective 1: Establish and implement a VHA change management plan for Training Outcome 1. (Q1 FY 2024)

T-2: Goal 5. Establish and implement a quality reporting and compliance plan to ensure the VHA Training Action Plan is accepted and complied with across the VHA Enterprise by Q4 FY 2024.

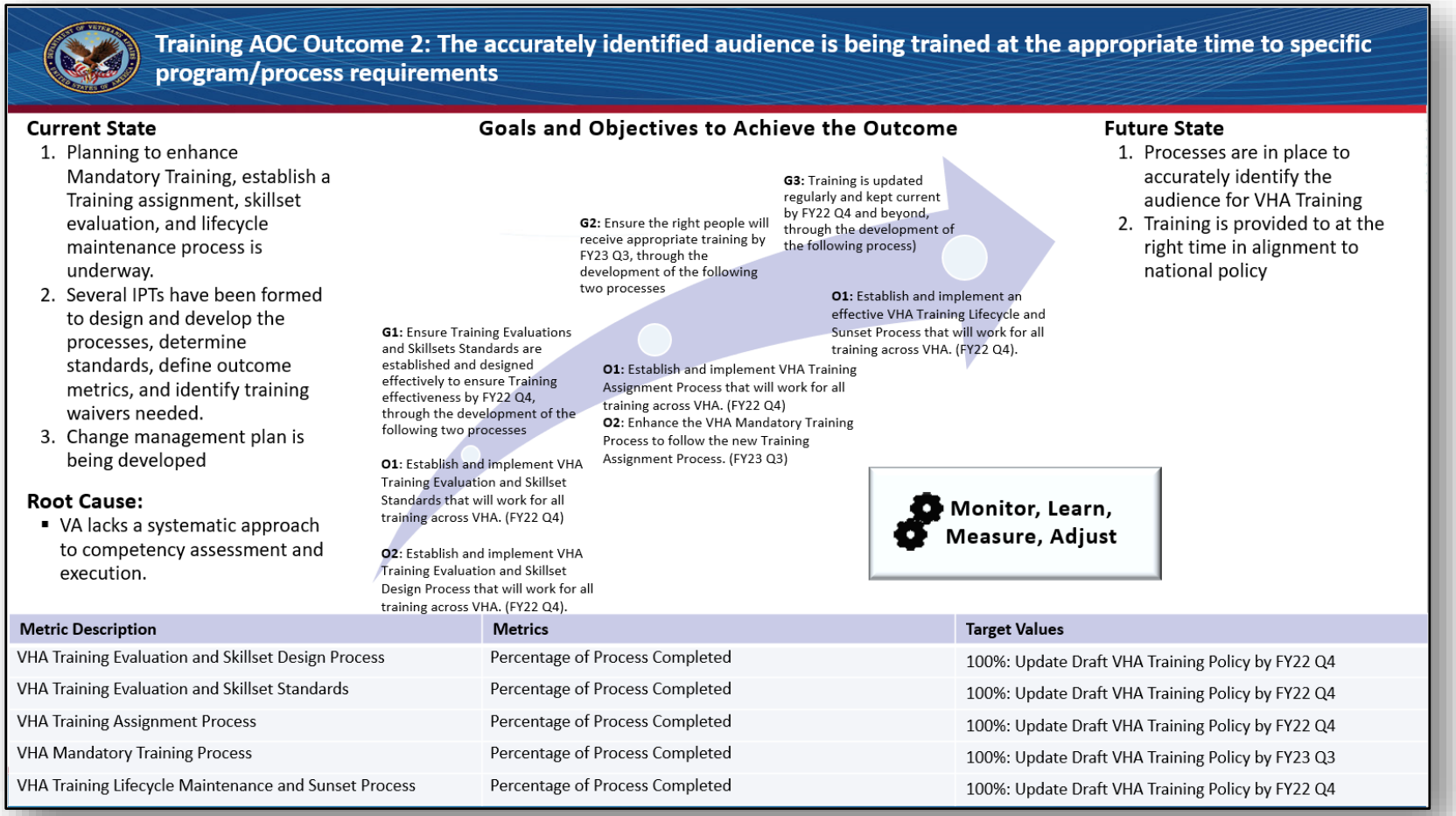
Objective 1: Establish and implement a VHA Audit System for Training Outcome 1. (Q3 FY 2023)

Table 4-6. T-2 Description & Status

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

T-2 Description & Status
Description • **The TWG has identified several operational gaps** in how VHA training is designed, evaluated, and assigned. For example, training developed outside of EES has been identified as inconsistent with the ADDIE Model, (analysis, design, development, implementation, evaluation), which is an industry standard and best practice for training development, as well as the preferred model for VHA. • **VHA training is not consistently evaluated in many cases**, nor is data accurately captured or reported to be able to assess training quality and deficiencies or discern if the training is effective. • **VHA Mandatory Training is inconsistently implemented across the enterprise**, often with unclear guidelines of what constitutes mandatory, versus required training and without the appropriate audiences identified. • **Systemic disparities exist across VHA Training Data Systems,** including the TMS. The inconsistencies are around management of training data elements, as well as loose functional user access across the enterprise. The issue creates misconceptions about which training is current versus outdated training and how they are to be managed. A thorough review and standardization of the training lifecycle and sunset review process will eliminate the inconsistencies that exist.
Status • **To ensure that VHA training is consistent and standardized**, the TWG worked with VHA Leadership to establish several IPTs tasked with establishing and implementing several key training processes that will address these disparities. The new processes will be piloted before implementation, supported by nationwide VHA Policy, and in accordance and alignment with the VA 5015 Training Directive and the Mandatory Training Directive. • **The TWG will identify key performance and quality metrics** that will enable VHA to monitor progress and compliance with new processes, standards, and policy.

Figure 4-4. T-2 Roadmap



Metric Description	Metrics	Target Values
VHA Training Evaluation and Skillset Design Process	Percentage of Process Completed	100%: Update Draft VHA Training Policy by FY22 Q4
VHA Training Evaluation and Skillset Standards	Percentage of Process Completed	100%: Update Draft VHA Training Policy by FY22 Q4
VHA Training Assignment Process	Percentage of Process Completed	100%: Update Draft VHA Training Policy by FY22 Q4
VHA Mandatory Training Process	Percentage of Process Completed	100%: Update Draft VHA Training Policy by FY23 Q3
VHA Training Lifecycle Maintenance and Sunset Process	Percentage of Process Completed	100%: Update Draft VHA Training Policy by FY22 Q4

In FY 2020, the TWG attempted to use metric data and processes available in EES and found that the data was not consistent or reliable and, in many instances, could not be validated. In addition, the processes were not documented. Two issues related to metrics are:

1. There is no definition of what “training” is. Some areas of training might not be trackable or measurable “training” such as conferences. But all are being included when retrieving training reports.
2. Only EES Produced training could be tracked. Until all VHA produced training can be tracked and measured, including purchased and contractor developed training there will not be metrics for those events.

To measure our progress until the IPTs are completed and a VHA Training policy is released, the TWG will report the percent complete of each IPT to demonstrate the work being performed. This is a change in approach from the previous Action Plan.

The following table describes the measures and metrics the TWG is using to determine progress toward achievement of T-2.

Table 4-7. T-2 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
(2.1) VHA Training Evaluation and Skillset Design Process	Percent of Process Completed	Milestone = 50%: Develop Process Standards, Metrics, Waivers by Q1 FY 2022 Target = 100%: Update Draft VHA Training Policy by Q4 FY 2022	Quarterly
(2.2) VHA Training Evaluation and Skillset Standards	Percent of Process Completed	Milestone = 50%: Develop Process Standards, Metrics, Waivers by Q1 FY 2022 Target = 100%: Update Draft VHA Training Policy by Q4 FY 2022	Quarterly

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
(2.3) VHA Training Assignment Process	Percent of Process Completed	Milestone = 50%: Develop Process Standards, Metrics, Waivers by Q1 FY 2022 Target = 100%: Update Draft VHA Training Policy by Q4 FY 2022	Quarterly
(2.4) VHA Mandatory Training Process	Percent of Process Completed	Milestone = 50%: Develop Process Standards, Metrics, Waivers by Q3 FY 2022 Target = 100%: Update Draft VHA Training Policy by Q3 FY 2023	Quarterly
(2.5) VHA Training Lifecycle Maintenance and Sunset Process	Percent of Process Completed	Milestone = 50%: Develop Process Standards, Metrics, Waivers by Q1 FY 2022 Target = 100%: Update Draft VHA Training Policy by Q4 FY 2022	Quarterly

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

Table 4-8. T-2 Action Plan

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

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
T-2 Goal 1: Ensure Training Evaluations and Skillsets Standards are established and designed effectively to ensure Training effectiveness by Q4 FY 2022, through the development of the following two processes.	**Objective 1:** Establish and implement VHA Training Evaluation and Skillset Standards that will work for all training across VHA. (Q4 FY 2022)		

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(2.1) Establish VHA Training evaluation and skillset standards ▪ Design and develop process ▪ Pilot process ▪ Develop process standards/metrics/waivers ▪ Identify business requirements for system data ▪ Process work completed and accepted by TWG Leadership ▪ Implement process and release process notice ▪ Update draft VHA Training Policy	**Q4 FY 2022** ▪ Q3 FY 2021 ▪ Q4 FY 2021 ▪ Q1 FY 2022 ▪ Q1 FY 2022 ▪ Q2 FY 2022 ▪ Q4 FY 2022 ▪ Q4 FY 2022		**In Progress:** Training evaluation and skillset standards are not consistent across VHA. Training developed internally by EES, training developed by VHA program offices or the field and contracted or purchased training are not held to the same standards. This effort will set the standards for evaluation and skillset assessments for all VHA training whether produced internally or contracted out. An IPT has been formed to design and develop the process, determine standards, define outcome metrics, and identify training waivers needed.
	Objective 2: Establish and implement VHA Training Evaluation and Skillset Design Process that will work for all training across VHA. (Q4 FY 2022)		

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(2.2) Establish and implement VHA Training design process for evaluations and skillsets ▪ Design and develop process ▪ Pilot process ▪ Develop process standards/metrics/waivers ▪ Identify business requirements for system data ▪ Process work completed and accepted by TWG Leadership ▪ Implement process and release process notice ▪ Update draft VHA Training Policy	**Q4 FY 2022** ▪ ▪ Q3 FY 2021 ▪ Q4 FY 2021 ▪ Q1 FY 2022 ▪ Q1 FY 2022 ▪ Q2 FY 2022 ▪ Q4 FY 2022 ▪ Q4 FY 2022		**In Progress:** Another process that varies across VHA is training evaluations and skillsets (assessment of ability to perform a specific task) design. This effort will first establish standards for evaluations and skillsets, then determine the process for designing them. An IPT has been established to design and develop the process, determine standards, define outcome metrics, and identify training waivers needed.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
T-2 Goal 2: Ensure the right people will receive appropriate training by Q3 FY 2023, through the development of the following two processes.	**Objective 1:** Establish and implement VHA Training Assignment Process that will work for all training across VHA. (Q4 FY 2022)		

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(2.3) Establish and implement VHA Training Assignment Process ▪ Design and develop process ▪ Pilot process ▪ Develop process standards/metrics/waivers ▪ Identify business requirements for system data ▪ Process work completed and accepted by TWG Leadership ▪ Implement process and release process notice ▪ Update draft VHA Training Policy	**Q4 FY 2022** ▪ Q3 FY 2021 ▪ Q4 FY 2021 ▪ Q1 FY 2022 ▪ Q1 FY 2022 ▪ Q2 FY 2022 ▪ Q4 FY 2022 ▪ Q4 FY 2022		**In Progress:** Previously it was determined that HR Smart's job codes could be used to ensure that training is assigned correctly. It was later determined, however, that there are many other factors that impact training assignments. For example, job codes may differ for certain functions in small vs large hospitals. Cleaning a scope in a large hospital may be done by a CNA but a Registered Nurse may fulfill that same function in a smaller institution. This process will need to consider all factors that affect the training assignments to determine a solution. An IPT has been formed to design and develop the process, determine standards, define outcome metrics, and identify training waivers needed.
Objective 2: Enhance the VHA Mandatory Training Process to follow the new Training Assignment Process. (Q3 FY 2023)			

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(2.4) Enhance Mandatory Training Process ▪ Design and develop process ▪ Pilot process ▪ Develop process standards/metrics/waivers ▪ Identify business requirements for system data ▪ Process work completed and accepted by TWG Leadership ▪ Implement process and release process notice ▪ Update draft VHA Training Policy	**Q4 FY 2023** ▪ ▪ Q1 FY 2022 ▪ Q3 FY 2022 ▪ Q3 FY 2022 ▪ Q4 FY 2022 ▪ Q4 FY 2022 ▪ Q3 FY 2023 ▪ Q4 FY 2023		**In Planning:** Mandatory Training Directive 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.
T-2 Goal 3: Training is updated regularly and kept current by Q4 FY 2022 and beyond, through the development of the following process.	**Objective:** Establish and implement an effective VHA Training Lifecycle and Sunset Process that will work for all training across VHA. (Q4 FY 2022)		

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(2.5) Establish and implement VHA Training Lifecycle Maintenance and Sunset Process ▪ Design and develop process ▪ Pilot process ▪ Develop process standards/metrics/waivers ▪ Identify business requirements for system data ▪ Process work completed and accepted by TWG Leadership ▪ Implement process and release process notice ▪ Update draft VHA Training Policy	**Q4 FY 2022** ▪ Q3 FY 2021 ▪ Q4 FY 2021 ▪ Q1 FY 2022 ▪ Q1 FY 2022 ▪ Q2 FY 2022 ▪ Q4 FY 2022 ▪ Q4 FY 2022		**In Progress:** While this was believed to have a defined process, it is not applied consistently across all VHA training. This effort will establish and implement a process to be used for all VHA Training including contracted and purchased training. An IPT has been formed to design and develop the process, determine standards, define outcome metrics and training waivers needed.

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
T-2: Goal 5. Establish and implement a comprehensive change management plan to ensure the VHA Training Action Plan is accepted across the VHA Enterprise by Q1 FY 2024.	***T-2: Goal 5; Objective 1*:** Establish and implement a VHA change management plan for Training Outcome 1. (Q1 FY 2024)		
T-2: Goal 6. Establish and implement a quality reporting and compliance plan to ensure the VHA Training Action Plan is accepted and complied with across the VHA Enterprise by Q4 FY 2024	***T-2: Goal 6; Objective 1:*** Establish and implement a VHA Audit System for Training Outcome 1. (Q3 FY 2023)		

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(2.6) Establish change management, quality compliance and reporting guidelines for T-2 **(2.6a) Change Management:** ▪ Define Change Management ▪ Phase 1: Prepare for Change ▪ Phase 2: Manage Change ▪ Phase 3: Reinforce Change **(2.6b) Reporting and Compliance**: ▪ Determine outcome metrics for T-2 ▪ Determine data sources for outcome metrics ▪ Determine outcome metrics targets ▪ Add outcome metrics to the VHA Training Dashboard ▪ Document metrics and update VHA Training Compliance/Reporting Management Process	**On going** ***Q1 FY 2024*** ▪ Q2 FY 2021 ▪ Q2 FY 2021 ▪ Q4 FY 2022 ▪ Q1 FY 2024 ***Q3 FY 2023***		**Completed:** Training AOC assessed our change impact, organization attributes, and sponsor leadership and support, which was used to complete our change management assessment analysis. **In Progress:** 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. The TWG is working on a comprehensive change management plan, to include quality compliance and reporting guidelines that will be a part of each of the implemented processes.

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

Table 4-9. T-2 Description of Actions Toward Removal Criteria

T-2 Description of Actions Toward Removal Criteria
Leadership Commitment • **FY 2018, VA with the collaboration of all three administrations** because of 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 the TWG there is not a 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 or EES produced training. As a result, the TWG 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. A lead for this IPT has been identified. • **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 positions codes and competencies to be aligned to targeted learning participants, and it will synchronize with a single learning management platform. • **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 2019, the TWG collaborated with the Mandatory Training Subcommittee of the LOT** to upgrade the training review process to accurately differentiate between mandatory and 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 possibly be leveraged across VHA.

T-2 Description of Actions Toward Removal Criteria
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. An IPT Lead has been identified to further address this need.
Monitoring • **FY 2021, a TMS is a tool that provides the capability to assign and monitor completion rates for specific target audiences** and then compile evaluation data is 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 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, and 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

T-2 Description of Actions Toward Removal Criteria

Course	Targeted Roles	Staff/Clinicians Completions
PPE and Respiratory Protection while Caring for COVID-19 Patients	Personnel that will come in direct contact with COVID-19 patients	30,907
Updated Course PPE and Respiratory Protection while Caring for COVID-19 Patients	Personnel that will come in direct contact with COVID-19 patients	36,540
Handoff Process and Software Training for Veteran Engagement Office Employees in Contact with COVID-19 Patients	VEO Call Enter Staff Tier 1 Agents	178
General COVID-19 Information for Non-Clinical Staff	Non-Clinical Staff	36,500
General COVID-19 Information for Clinical Staff	All Clinical Staff	64,813

Training Outcome (TOC-3)

Outcome Lead: Rebecca Goodson, Acting Director, Enterprise Project Management Office (EPMO), Employee Education Services (EES)

Outcome Executive: Margarita Devlin, VHA CLO

TOC-3 Root Cause: Inadequate resources for the 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.

T-3: Goal 1: Establish VHA-wide Contract Vehicle and Contracting Standards to ensure consistency and standards are included in procured training by Q4 FY 2023, through the development of the following two processes.

Objective 1: Establish and implement a VHA-wide Contract Vehicle for Training Requests. (Q4 FY 2023)

Objective 2: Establish and implement VHA Training Contracts Standardization Process. (Q4 FY 2022)

T-3: Goal 2: Establish effective Training budgeting and planning processes to better align to VHA priorities by Q4 FY 2022, through the development of the following two processes.

Objective 1: VHA Training Priorities and Training Plan Process. (Q4 FY 2022)

Objective 2: VHA Training Budget Object Codes Process. (Q4 FY 2022)

T-3: Goal 3. Establish and implement a comprehensive change management plan to ensure the VHA Training Action Plan is accepted across the VHA Enterprise by Q1 FY 2024.

Objective 1: Establish and implement a VHA change management plan for Training Outcome 1. (Q1 FY 2024)

T-3: Goal 4. Establish and implement a quality reporting and compliance plan to ensure the VHA Training Action Plan is accepted and complied with across the VHA Enterprise by Q4 FY 2024.

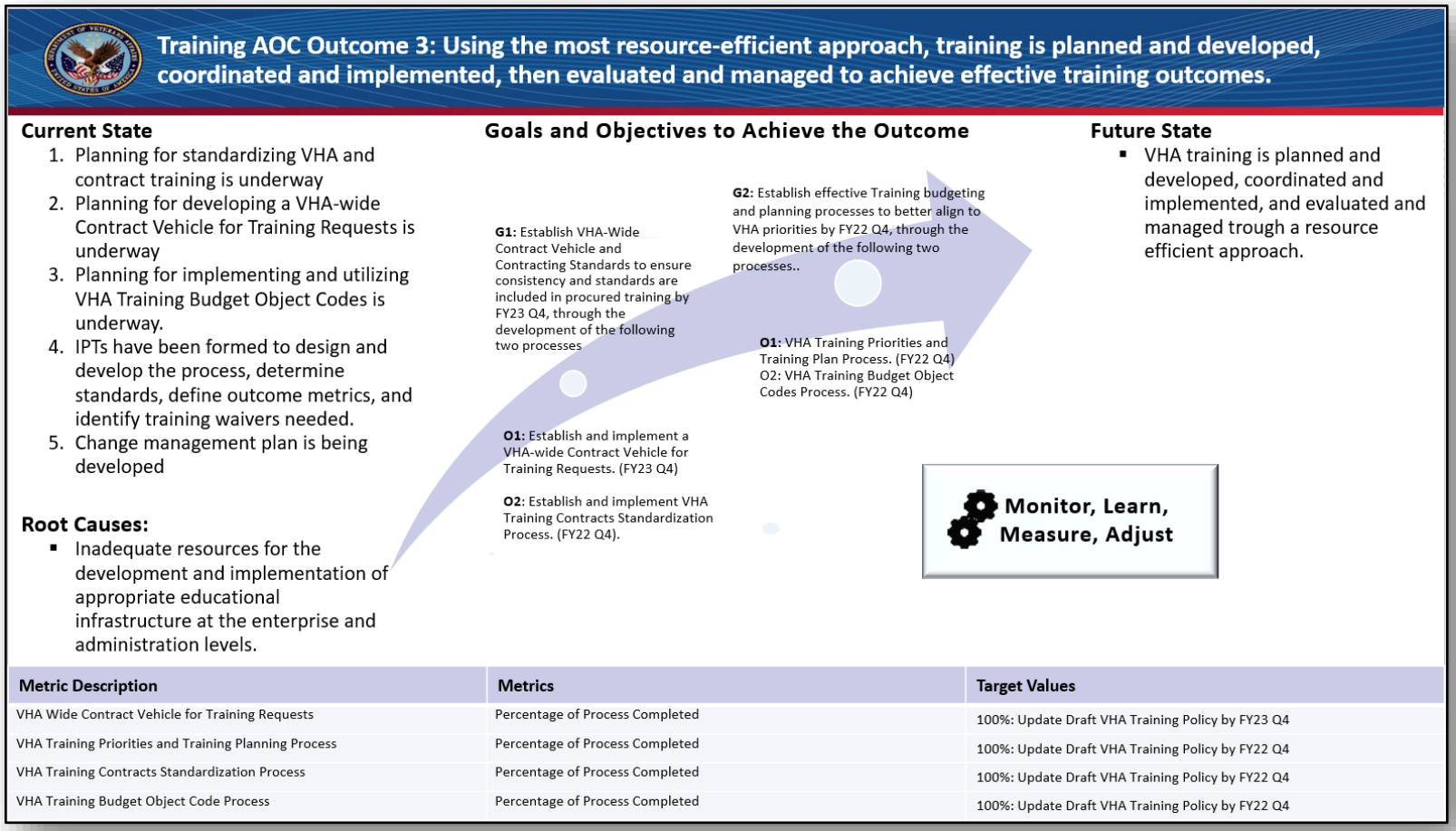
Objective 1: Establish and implement a VHA Audit System for Training Outcome 1. (Q1 FY 2024)

Table 4-10. T-3 Description & Status

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

T-3 Description & Status
Description • To achieve Training Outcome 3, the TWG has identified several areas of opportunity. VHA training priorities and planning are not part of a centralized process, and often necessary resources are not allocated to ensure these needs are met. Additionally, in the current state, Program Offices and the field have had unclear or non-existent annual budget line-items that designate funds allocated purely for training needs. • There currently is a lack of VHA Nation-wide policy that outlines how and under what circumstances training must be procured outside of the organization, leading to potential misallocation or inefficient use of funds and resources.
Status • To achieve this outcome, the TWG is employing a series of IPTs to create clear guidance and standards surrounding training procurement, budgeting and planning. • The TWG is also drafting business and operational requirements for a VHA-wide contract vehicle (for training development and delivery), along with standardized procedures for vetting and executing training contracts (both internal and external).

Figure 4-5. T-3 Roadmap



Metric Description	Metrics	Target Values
VHA Wide Contract Vehicle for Training Requests	Percentage of Process Completed	100%: Update Draft VHA Training Policy by FY23 Q4
VHA Training Priorities and Training Planning Process	Percentage of Process Completed	100%: Update Draft VHA Training Policy by FY22 Q4
VHA Training Contracts Standardization Process	Percentage of Process Completed	100%: Update Draft VHA Training Policy by FY22 Q4
VHA Training Budget Object Code Process	Percentage of Process Completed	100%: Update Draft VHA Training Policy by FY22 Q4

In FY 2020, the TWG attempted to use metric data and processes available in EES and found that the data was not consistent or reliable and, in many instances, could not be validated. In addition, the processes were not documented. Two issues related to metrics are:

1. There is no definition of what “training” is. Some areas of training might not be trackable or measurable “training” such as conferences. But all are being included when retrieving training reports.
2. Only EES produced training could be tracked. Until all VHA produced training can be tracked and measured, including purchased and contractor developed training there will not be metrics for those events.

To measure our progress until the IPTs are completed and a VHA Training policy is released, the TWG will report the percent complete of each IPT to demonstrate the work being performed. This is a change in approach from the previous Action Plan.

The following table describes the measures and metrics the TWG is using to determine progress toward achievement of T-3.

Table 4-11. T-3 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
(3.1) VHA-wide Contract Vehicle for Training Requests	Percent of Process Completed	Milestone = 50%: Develop Process Standards, Metrics, Waivers by Q1 FY 2023 Target = 100%: Update Draft VHA Training Policy by Q4 FY 2023	Quarterly
(3.2) VHA Training Priorities and Training Planning Process	Percent of Process Completed	Milestone = 50%: Develop Process Standards, Metrics, Waivers by Q1 FY 2022 Target = 100%: Update Draft VHA Training Policy by Q4 FY 2022	Quarterly

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
(3.3) VHA Training Contracts Standardization Process	Percent of Process Completed	Milestone = 50%: Develop Process Standards, Metrics, Waivers by Q1 FY 2022 Target = 100%: Update Draft VHA Training Policy by Q4 FY 2022	Quarterly
(3.4) VHA Training Budget Object Code Process	Percent of Process Completed	Milestone = 50%: Develop Process Standards, Metrics, Waivers by Q1 FY 2022 Target = 100%: Update Draft VHA Training Policy by FY Q4 2022	Quarterly

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

Table 4-12. T-3 Action Plan

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

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
T-3 Goal 1: Establish VHA-wide Contract Vehicle and Contracting Standards to ensure consistency and standards are included in procured training by Q4 FY 2023, through the development of the following two processes	**Objective 1**: Establish and implement a VHA-wide Contract Vehicle for Training Requests. (Q4 FY 2023)		

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(3.1) Develop and implement a VHA-wide Contract Vehicle for Training Requests ▪ Design and develop process ▪ Pilot process ▪ Develop process standards/metrics/waivers ▪ Identify business requirements for system data ▪ Process work completed and accepted by TWG ▪ Implement process and release process notice ▪ Update draft VHA Training Policy	**Q4 FY 2023** ▪ ▪ Q3 FY 2022 ▪ Q4 FY 2022 ▪ Q1 FY 2023 ▪ Q1 FY 2023 ▪ Q2 FY 2023 ▪ Q3 FY 2023 ▪ Q4 FY 2023		**In Progress:** Currently VHA Program Offices, VISNs, and the field can purchase or contract out development of training which can be very 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.
	T-3 Goal 1; Objective 2: Establish and implement VHA Training Contracts Standardization Process. (Q4 FY 2022)		

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(3.2) Standardize VHA Training Contract Process ▪ Design and develop process ▪ Pilot process ▪ Develop process standards/metrics/waivers ▪ Identify business requirements for system data ▪ Process work completed and accepted by TWG ▪ Implement process and release process notice ▪ Update draft VHA Training Policy	**Q4 FY 2022** ▪ Q3 FY 2021 ▪ Q4 FY 2021 ▪ Q1 FY 2022 ▪ Q1 FY 2022 ▪ Q2 FY 2022 ▪ Q3 FY 2022 ▪ Q4 FY 2022		**In Progress:** Currently VHA Program Offices, VISNs, and the field can purchase or contract out development of training. There are no standards in place for training contracts to ensure consistency in evaluations, skillset assessments, format, ownership, etc. An IPT has been formed to design and develop the process, determine standards, define outcome metrics, and identify training waivers needed.
T-3 Goal 2: Establish effective Training budgeting and planning processes to better align to VHA priorities by Q4 FY 2022, through the development of the following two processes	**Objective** 1: VHA Training Priorities and Training Plan Process. (Q4 FY 2022)		

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(3.3) Standardize VHA Training Priorities and Planning Process ▪ Design and develop process ▪ Pilot process ▪ Develop process standards/metrics/waivers ▪ Identify business requirements for system data ▪ Process work completed and accepted by TWG ▪ Implement process and release process notice ▪ Update draft VHA Training Policy	**Q2 FY 2023** ▪ Q3 FY 2021 ▪ Q4 FY 2021 ▪ Q1 FY 2022 ▪ Q1 FY 2022 ▪ Q2 FY 2022 ▪ Q3 FY 2022 ▪ Q4 FY 2022		**In Progress:** Another area that lacked consistency and requires a defined process is mapping of VHA training priorities into the training planning process. An IPT has been formed to design and develop the process, determine standards, define outcome metrics, and identify training waivers needed.
	Objective 2: VHA Training Budget Object Codes Process. (Q4 FY 2022)		

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(3.4) Implement and utilize VHA Training Budget Object Codes ▪ Design and develop process ▪ Pilot process ▪ Develop process standards/metrics/waivers ▪ Identify business requirements for system data ▪ Process work completed and accepted by TWG ▪ Implement process and release process notice ▪ Update draft VHA Training Policy	**Q4 FY 2022** ▪ Q3 FY 2021 ▪ Q4 FY 2021 ▪ Q1 FY 2022 ▪ Q1 FY 2022 ▪ Q2 FY 2022 ▪ Q3 FY 2022 ▪ Q4 FY 2022		**In Progress:** VHA training budget codes are not used consistently throughout VHA making it challenging to determine the cost and types of training acquired. An IPT has been formed to design and develop the process, determine standards, define outcome metrics, and identify training waivers needed.
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Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
T-3: Goal 3. Establish and implement a comprehensive change management plan to ensure the VHA Training Action Plan is accepted across the VHA Enterprise by Q1 FY 2024 **T-3: Goal 4.** Establish and implement a quality reporting and compliance plan to ensure the VHA Training Action Plan is accepted and complied with across the VHA Enterprise by Q4 FY 2024	**T-3: Goal 3; Objective 1:** Establish and implement a VHA change management plan for Training Outcome 1. (Q1 FY 2024) **T-3: Goal 4; Objective 1:** Establish and implement a VHA Audit System for Training Outcome 1. (Q1 FY 2024)		

Actions*	Projected Date	Actual/ Adjusted Date	Status/Comments
(3.5) Establish change management, quality compliance and reporting guidelines for T-3 **(3.5a) Change Management:** ▪ Define Change Management ▪ Phase 1: Prepare for Change ▪ Phase 2: Manage Change ▪ Phase 3: Reinforce Change **(3.5b) Reporting and Compliance**: ▪ Determine outcome metrics for T-3 ▪ Determine data sources for outcome metrics ▪ Determine outcome metrics targets ▪ Add outcome metrics to the VHA Training Dashboard ▪ Document metrics and update VHA Training Compliance/Reporting Management Process	**Ongoing** ***Q1 FY 2024*** ▪ Q2 FY 2021 ▪ Q2 FY 2021 ▪ Q4 FY 2022 ▪ Q1 FY 2024 ***Q1 FY 2024***		**Completed:** Training AOC assessed our change impact, organization attributes, and sponsor leadership and support, which was used to complete our change management assessment analysis. **In Progress:** 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. The TWG is working on a comprehensive change management plan, to include quality compliance and reporting guidelines that will be a part of each of the processes implemented.

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

Table 4-13. T-3 Description of Actions Toward Removal Criteria

T-3 Description of Actions Toward 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 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 in FY2019. • **EES Executive Leadership has committed by assigning an IPT Lead** to work with the Chief Financial Officer to develop a process of identifying training resource requirements at contracting to review contracts and ensure standards are emphasized and contract meets training requirements in FY2021

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 15 IPT Leads**, to consult with both VHA subject matter experts and leadership within VACO 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.
Demonstrated Progress • FY2019, the eLearn 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. • FY2021, EES was able to contract with Franklin Covey to provide and All Access Pass to their training for VHA enterprise wide, which will be a significant overall cost savings to VHA. In the past, facilities would contract individually for Franklin Covey training for their locations.

5. Unclear Resource Needs and Allocation Priorities Area of Concern

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 Manpower Management Office (MMO) are sustaining leadership commitment towards enterprise improvements that address root causes, modernize technologies and align with GAO HRL removal criteria. One specific example is the partnership between Finance and Manpower to review VHA CO hiring and change requests ensuring the most efficient and effective use of resources to accomplish the mission while monitoring the frequency and nature of requests for unfunded requirements.

The Resource Allocation workgroup improved manpower, funds planning and management practices to achieve meaningful impact toward target outcomes by:

- Filling leadership positions in Manpower, Finance and Workforce Management & Consulting (WMC)
- Piloting a process to improve resource allocation and enhancing funding guidance to the field
- Establishing Manpower Management Office authority for organizational and position structures
- Co-leading implementation of the Organizational Improvement LOE by WMC and Finance
- Advancing technology to support data driven resource allocation decisions
- Implementing early controlled funds release to improve field funds planning and management
- Leveraging standing Chief Financial Officer teleconferences to address resource and budget allocation concerns
- Introducing evidence-based justifications to the VHA Medical Care program budget request process

- Launching an initiative budget submission process prior to current and budget fiscal years
- In addition to leveraging the robust analytic capability for staffing and productivity provided in the Office of Productivity, Efficiency and Staffing (OPES), VA developed staffing models for critical programs such as police and VHA Caregiver Support Program

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

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

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

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

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

Table 5-1. Resource Allocation Alignment with Other Areas of Concern

Alignment with Other Areas of Concern
Policies and Processes
• As VHA refines its resource allocation processes and procedures, revisions to existing policies and issuance of new policies will be accomplished through collaboration with the Policies and Processes workgroup. • 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 MMO 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. • MMO 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.
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.

Alignment with Other Areas of Concern
• 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 MMO is working closely with the Office of the VHA Chief of Staff to ensure hiring and position change requests meet manpower guidelines to include same grade reporting and supervisory span of control.
IT
• As further progress is made in integrating manpower and financial management technologies, additional IT requirements will be coordinated with IT counterparts. • Both VHA MMO 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 ensure that high data accuracy levels and reliability are used to populate the new systems. 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 second key IT deliverable.
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 MMO 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 2020 – FY 2021, the Office of Workforce Management and Consulting is expanding the health professional trainee (HPT) placement initiative by leveraging the new established VA-Trainee Recruitment Event (VA-TRE) model to connect, match and place HPTs in critical vacancies. VHA MMO 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).

Resource Allocation Outcome (RA-1)

Outcome Leads: Frank Costa, Resource Operation Officer

Shane Walker, PMP, **MBA,** Manager, Resource Management

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.

Outcome 1 Goals and Objectives:

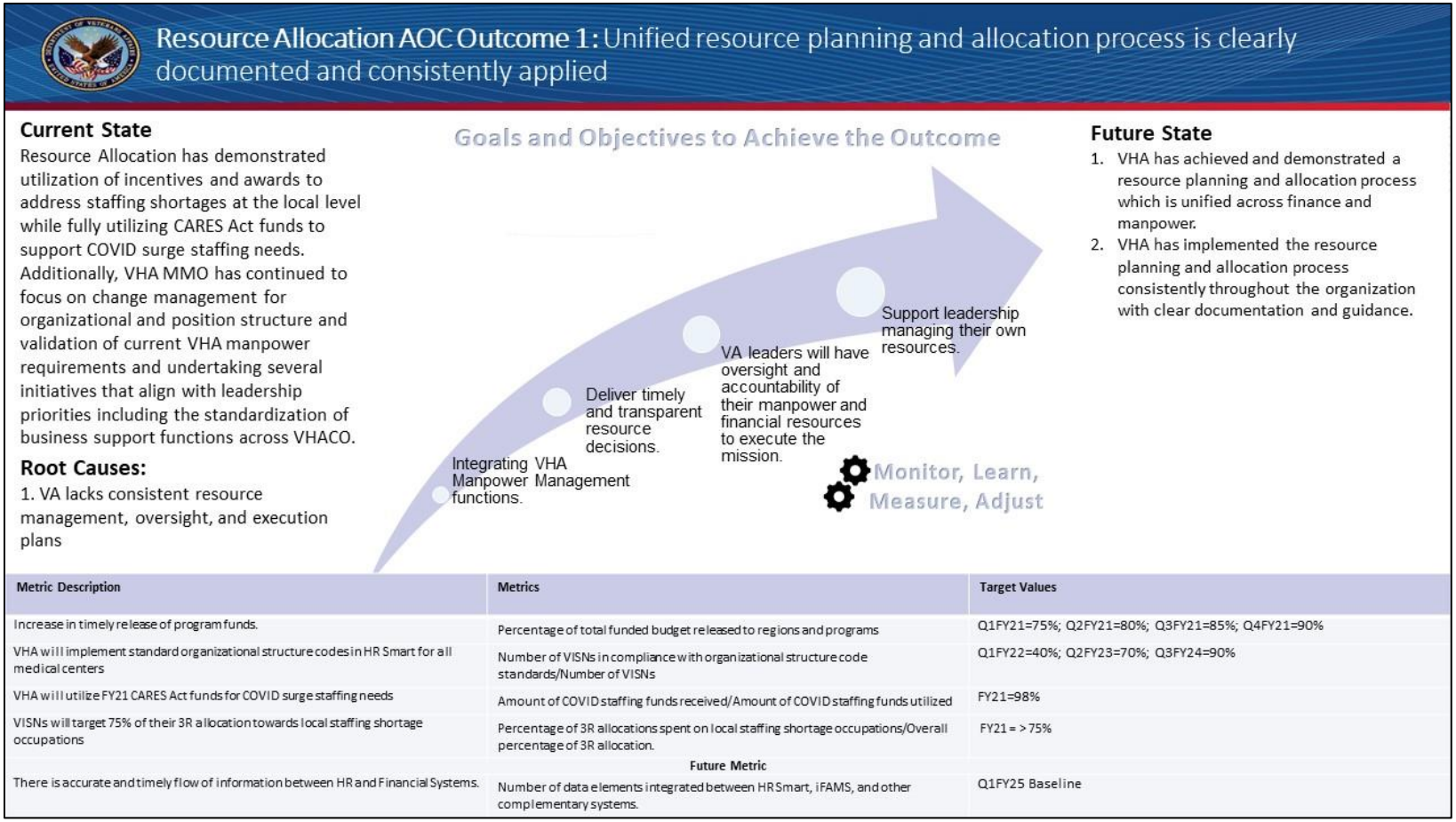
- **Goal 1:** Deliver timely and transparent resource decisions.
  - Objective 1.1: VA will oversee VHA CO hiring requests through a Resource Validation Process.
  - Objective 1.2: VA will streamline the Executive Decision Memorandum (EDM) process.
  - Objective 1.3: VA will prioritize utilization of incentives and awards to meet human capital needs.
  - Objective 1.4: 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.
  - Objective 1.5: VHA will reduce Time to Hire and assure for flexibilities for recruitment of candidates and retention of staff.
- **Goal 2:** Support leadership managing their own resources.
  - Objective 2.1: VA leaders will have oversight and accountability of their manpower and financial resources to execute the mission.
  - Objective 2.2: VA leaders will have real time access to human resources data.
  - Objective 2.3: VA will standardize and oversee VHA CO business support functions.
  - Objective 2.4: VA will sustain clinical productivity and efficiency reporting.
  - Objective 2.5: VHA will have oversight and accountability of CARES Act funding to respond to the COVID-19 pandemic.
- **Goal 3:** Integrating VHA Manpower Management functions.
  - Objective 3.1: VA will integrate manpower management into routine operations to promote efficient and economical use of resources.
  - Objective 3.2: VHA Manpower will review VHA CO and VISN office organizational structure.

- Objective 3.3: VHA Manpower will standardize the organizational structure and approval of change requests for Medical Center Quad/Pentad positions.

Table 5-2. RA-1 Description & Status

In Planning	In Progress	Complete	Sustaining

RA-1 Description & Status
Description • The intent for RA-1 is to plan and allocate both financial and manpower resources in alignment with leadership priorities.
Status • In FY 2020, the VHA has a heightened sense of awareness of opportunities to meet human capital needs of today and tomorrow. This is apparent through our demonstrated utilization of incentives and awards to address staffing shortages at the local level while fully utilizing CARES Act funds to support COVID-19 surge staffing needs. VHA MMO has continued to focus on change management for organizational and position structure and validation of current VHA manpower requirements and undertaking several initiatives that align with leadership priorities. One example of aligning initiatives to leadership priorities is the standardization of business support functions across VHA CO. This initiative includes defining the core business support functions that support VHAs ability to accomplish its mission. What we in VA call “the business of doing the business.” Finance and Manpower have partnered with HR, Correspondence, Administration and Communications to create and implement a standard organizational structure and best practices and procedures in support of this transformational initiative. VHA also developed and implemented a version of the LEAF web application to monitor and sustain day to day activities around resource validation and approval.



Metric Description	Metrics	Target Values
Increase in timely release of program funds.	Percentage of total funded budget released to regions and programs	Q1FY21=75%; Q2FY21=80%; Q3FY21=85%; Q4FY21=90%
VHA will implement standard organizational structure codes in HR Smart for all medical centers	Number of VISNs in compliance with organizational structure code standards/Number of VISNs	Q1FY22=40%; Q2FY23=70%; Q3FY24=90%
VHA will utilize FY21 CARES Act funds for COVID surge staffing needs	Amount of COVID staffing funds received/Amount of COVID staffing funds utilized	FY21=98%
VISNs will target 75% of their 3R allocation towards local staffing shortage occupations	Percentage of 3R allocations spent on local staffing shortage occupations/Overall percentage of 3R allocation.	FY21 = > 75%
	Future Metric	
There is accurate and timely flow of information between HR and Financial Systems.	Number of data elements integrated between HR Smart, iFAMS, and other complementary systems.	Q1FY25 Baseline

Figure 5-2. RA-1 Roadmap.

The following table describes measures and metrics the workgroup uses to determine progress toward achieving RA-1.

Table 5-3. RA-1 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Increase in timely release of program funds	Percent of total funded budget released to regions and programs = amount of funding released on time / total amount of funding	Q1 FY 2021=75% Q2 FY 2021=80% Q3 FY 2021=85% Q4 FY 2021=90%	Quarterly
VHA will implement standard organizational structure codes (OSC) in HR Smart for all VHACO positions	Number of VHACO positions in compliance with organizational structure code standards / number of VHACO positions	Q1 FY 2022=80% Q2 FY 2023=90% Q3 FY 2024=95%	Q1/Annual
VHA will utilize FY 2021 CARES Act funds for COVID-19 surge staffing needs	Amount of COVID-19 staffing funds received/Amount of COVID-19 staffing funds utilized	FY 2021=98%	Q2/Annual
VISNs will target 75% of their 3R allocation towards local staffing shortage occupations	Percent of 3R allocations spent on local staffing shortage occupations / overall percent of 3R allocation	FY 2021 = > 75%	Q2/Annual
Future Metrics			
There is accurate and timely flow of information between HR and Financial Systems	Number of data elements integrated between HR Smart, iFAMS and other complementary systems.	Q1 FY 2025 Baseline	Q1/Annual

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

Table 5-4. RA-1 Action Plan

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

Actions*	Projected Date	Actual/ Adjusted Date	Status
These Actions were developed prior to Goals and Objectives, these actions are still aligned to the outcome			
(1.1) VHA Office of Finance and VHA MMO will continue to jointly lead the Resource Allocation Area of Concern through the FY 2023 submission.	Q2 FY 2023		**In Progress**
(1.2) GA0 19-670 – Recommendation 1 VHA Comments: If an enacted budget is passed after the start of quarter two of the current fiscal year, Veterans Equitable Resource Allocation model will be re-run to reallocate funds based on prior year workload data. Note that this may cause internal fund recessions at the Veterans Integrated Service Network, medical facility and program office levels for re-allocation of funds.	Q1 FY 2020		**Complete.** The budget was passed and the Veterans Equitable Resource Allocation model was re-run to ensure appropriate allocation of funding based on workload data.
(1.3) GA0 19-670 – Recommendation 2 VHA Comments: VHA's Chief Financial Officer will update guidance to establish a formal process to document the review of regions adjustments to medical facility allocations.	Q1 FY 2020	Q3 FY 2020	**Complete.** VHA CFO updated and issued guidance on the implemented process for reviewing medical facility allocations.

Actions*	Projected Date	Actual/ Adjusted Date	Status
(1.4) GA0 19-670 – Recommendation 3 VHA Comments: VHA's Chief Financial Officer will revise guidance to require regions to provide information on how they determined adjustments to medical facility allocation levels. VHA's Chief Financial Officer will require this justification prior to processing.	Q2 FY 2020	Q3 FY 2020	**Complete.** 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.
(1.5) 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 FY 2020	Q4 FY 2020	**Complete.** 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.
(1.6) Release mission-related funds to the field by the start of Q4 FY 2020 to assist with proper funds management and planning.	Q4 FY 2020		**Complete.** 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.
(1.7) VHA Office of Finance will identify 3% of funds for potential transfer from Specified Program to General Program.	Q1 FY 2020		**Complete.** VHA Office of Finance completed a thorough analysis of both programs and identified the 3% threshold of funds for potential transfer.

Actions*	Projected Date	Actual/ Adjusted Date	Status
(1.8) Publish VA MMS Directive.	Q1 FY 2020		**Complete.** VA MMS Directive 5010 "Manpower Management Policy" HO MMO Policy has been published on October 28, 2019.
(1.9) Publish Executive in Charge Memorandum identifying VHA MMO as owner of VHA headquarters and regional office organizational structure.	Q2 FY 2020		**Complete.** The EIC Memorandum titled "Maintenance of VA Central Office and VISN Office Organizational Structure" has been published to identify VHA MMO as an owner which allows MMO insight and authority over organizational structures.
(1.10) Publish VHA MMO SOP for frontline staff.	Q1 FY 2020		**Complete.** VHA MMO SOP on Hiring Requests and Change Requests has been published.
RA Goal 1: Deliver timely and transparent resource decisions	**RA Objective 1.1:** VA will oversee VHA CO hiring requests through a Resource Validation Process		
(1.11) VHA Manpower will develop and communicate standard operating procedures to support efficient and effective resourcing decisions through the manpower validation process.	Q2 FY 2021		**Complete.** This new policy has been implemented. VHA Manpower continues to develop and socialize SOPs to improve and integrate manpower management processes.

Actions*	Projected Date	Actual/ Adjusted Date	Status
(1.12) Hiring requests are tracked via the Manpower Validation LEAF system.	Q3 FY 2020		**Complete.** The Manpower Validation LEAF system has been implemented and VHA CO hiring requests are now tracked through the system increasing visibility into resource requirements.
(1.13) VHA Manpower will provide focused training to improve stakeholder knowledge and reinforce positive behaviors.	Q3 FY 2021		**In Progress**
	Objective 1.2: VA will streamline the Executive Decision Memorandum (EDM) process.		
(1.14) 10BGOV will facilitate a workgroup to revise EDM guidance.	Q3 FY 2021		**In Progress**
	Objective 1.3: VA will prioritize utilization of incentives and awards to meet human capital needs		

Actions*	Projected Date	Actual/ Adjusted Date	Status
(1.15) 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 FY 2022		**In Planning**
(1.16) VISNs will fully utilize CARES Act funds in FY 2021 for COVID-19 surge staffing needs. FY 2021 COVID-19 hiring spend totals.	Q1 FY 2022		**In Progress**
	Objective 1.4: 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		

Actions*	Projected Date	Actual/ Adjusted Date	Status
(1.17) Standardize training/education materials for recruitment and hiring processes for HPTs.	Q2 FY 2020		**Complete.** VHA WMC conducted a review of recruitment training/education materials and produced a standardized version of the materials.
(1.18) Diffuse standardized training/materials for recruitment and hiring process for HPTs to the Field.	Q2 FY 2020		**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.
(1.19) Develop, test and implement the VA-TRE automated solution, HPT Placement Solutions. VHA will increase the number of facilities participating in VA-TREs.	Q1 FY 2022		**In Progress**
(1.20) VHA will increase HPT accepted offers annually.	Q1 FY 2022		**In Progress**
	Objective 1.5: VHA will reduce Time to Hire and assure for flexibilities for recruitment of candidates and retention of staff.		
(1.21) 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 FY 2023		**In Progress**

Actions*	Projected Date	Actual/ Adjusted Date	Status
RA Goal 2: Support leadership managing their own resources	**Objective 2.1**: VA leaders will have oversight and accountability of their manpower and financial resources to execute the mission		
(1.22) AUSH and Chief Officer organizations will have an approved org chart based on their HR Smart derived manning document.	Q4 FY 2023		**In Planning**
(1.23) VHA will conduct a bottom-up review of program office budgets.	Q4 FY 2021		**In Progress**
(1.24) VA leaders will use change management processes to ensure individual change is prioritized during modernization efforts.	Q3 FY 2021		**In Progress**
	Objective 2.2: VA leaders will have real time access to human resources data.		

Actions*	Projected Date	Actual/ Adjusted Date	Status
(1.25) Build awareness and desire to use MSS and reissue technical training for HR Smart Manager Self-Service,	Q4 FY 2021		**In Planning**
(1.26) Reissue HR Smart technical training.	Q2 FY 2022		**In Planning**
(1.27) Conduct business analysis in support of a metrics/dashboard for manager utilization.	Q4 FY 2022		**In Planning**
	Objective 2.3: VA will standardize and oversee VHA CO business support functions		
(1.28) VHA will standardize business support function organizational structure and best practices and procedures.	Q2 FY 2024		**In Progress**
	Objective 2.4: VA will sustain clinical productivity and efficiency reporting		
(1.29) VA will update and publish VHA Directive 1065.	Q1 FY 2021		**Complete**. The VHA Directive 1065 has been updated, published and communicated.

Actions*	Projected Date	Actual/ Adjusted Date	Status
(1.30) VA will close the fourth finding from GAO 17-480 report finding regarding clinical productivity and efficiency.	Q4 FY 2019		**Complete.** The fourth finding on clinical productivity and efficiency has been resolved. The status is closed – implemented.
(1.31) VA will systematically review medical center plans for addressing low clinical productivity and inefficiency.	Q4 FY 2019		**Sustaining.** A process has been implemented to continue performing the systematic reviews of medical center plans for addressing low clinical productivity and inefficiency.
	Objective 2.5: VHA will have oversight and accountability of CARES Act funding to respond to the COVID-19 pandemic.		
(1.41) Publish and maintain guidance to the field on utilizations of CARES Act funding.	Q3 FY 2020		**Complete.** Guidance on utilization is published and accessible to relevant stakeholders.
(1.42) Implement a process to allocate CARES Act funding and to review requests for additional funds.	Q3 FY 2020		**Complete.** Initial allocation completed in Q3 FY 2020.
(1.43) Oversee and report on CARES Act obligations and expenditures in order to reallocate and redistribute funds within VHA.	Q4 FY 2020		**In Progress**

Actions*	Projected Date	Actual/ Adjusted Date	Status
(1.44) Identify best practices from CARES Act allocations to guide implementation of future appropriations.	Q2 FY 2022		**In Progress**
RA Goal 3: Integrating VHA Manpower Management functions	**Objective 3.1**: VA will integrate manpower management into routine operations to promote efficient and economical use of resources.		
(1.32) HR Liaisons are clearly identified for each AUSH/CO (LOA III) organization.	Q4 FY 2022		**In Planning**
(1.33) HR Liaisons are competent and confident executing Manpower policies and procedures.	Q4 FY 2023		**In Planning**
(1.34) VHA Manpower will provide guidance and training to position managers, classifiers and other stakeholders in the HR community.	Q2 FY 2021		**In Progress**
(1.35) VHA Finance will incorporate Manpower into the annual President's Budget process.	Q3 FY 2021		**In Progress**

Actions*	Projected Date	Actual/ Adjusted Date	Status
	Objective 3.2: VHA Manpower will review VHA CO and VISN Office organizational structure.		
(1.36) Maintain organization chart review process for VISN Offices.	Q2 FY 2020		**Sustaining.** VISN organization charts are reviewed and updated on an annual basis or as needed.
(1.37) Ongoing monitoring of VHA CO organizational change process.	Q2 FY 2020		**Sustaining.** A process to monitor the VHA CO organization change process has been implemented.
(1.38) VHA Manpower will create a Standard Operating Procedure for organizational change in VHA CO that aligns with VA Directive 0213.	Q4 FY 2021		**In Planning**

Actions*	Projected Date	Actual/ Adjusted Date	Status
	Objective 3.3: VHA Manpower will standardize the organizational structure and approval of change requests for Medical Center Quad/Pentad positions.		
(1.39) 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 FY 2021		**In Progress**
(1.40) Publish SOP on process to request additional Senior Leader positions at VA Medical Centers.	Q1 FY 2021		**Sustaining.** The SOP on how to request additional Senior Leadership positions has been reviewed, published and communicated to VA Medical Centers.

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

Table 5-5. RA-1 Description of Actions Toward Removal Criteria

RA-1 Description of Actions Toward Removal Criteria
Leadership Commitment • The VHA leadership is committed to a unified resource planning and allocation process that is clearly documented and consistently applied across all programs, regions and medical facilities. The focus of this action plan is on leveraging the increased capacity provided by VHA MMO and refined budgeting processes of the VHA Office of Finance to clearly document and consistently apply a budgeting and allocation process. Leadership commitment is evidenced by the leadership from VHA's Chief Financial Officer providing guidance on establishing a formal process to document the review of VISN adjustments to medical center allocations. Additionally, in FY 2020, VA MMO Directive 5010 and VHA SOPs for frontline staff were published alongside of EIC Memos identifying VHA MMO as the owner of VHA CO and VISN Office Organizational Structure.
Capacity • VHA has taken several actions to ensure the capacity to achieve desired results. VHA has also taken steps to ensure that all transfer funds between VISNs require review by the Associate Chief Financial Officer for Resource Management prior to processing, ensuring adequate explanations. Additionally, mission-related funds were released to the field at the start of the fourth quarter in FY 2020, assisting with proper funds management and planning. The VHA EIC signed a memo requiring Manpower to review VHA CO and VISN Office organizational structure. VHA MMO issued standard operating procedures to monitor hiring and change requests as well.
Monitoring • Finance subject matter experts leverage the standing regional and medical facility Chief Financial Officer teleconferences to address resource and budget allocation process concerns. The VHA Finance Office reports on budget execution, reviewing and ensuring proper execution of VHA program office and regional operating plans. The VHA MMO continues to monitor functional alignment and organizational hierarchy to improve organizational effectiveness and efficiency. • 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 refinement and expansion of metrics and measures, monitoring processes, procedures and improvement throughout VHA will be increasingly robust and representative of progress.

RA-1 Description of Actions Toward Removal Criteria
Demonstrated Progress • The VHA continuously reviews processes and identifies initiatives to improve the allocation of resources throughout the system. In FY 2020, the VHA Office of Finance is focusing on ensuring funds are in the medical facility budgets by reallocating funds to the field and focusing on ensuring technology solutions provide current data that is readily available for informed decision making. In FY 2020, the VA MMO published a VA Directive 5010 Manpower Management Policy establishing the Manpower Management policies and responsibilities for ensuring the most effective and efficient use of organizational structure and staffing levels to accomplish the mission.

Resource Allocation Outcome (RA-2)

Outcome Leads: Frank Costa, Resource Operation Officer

Shane Walker, PMP, MBA, Manager, Resource Management

Outcome Executives: Ogbeide Oniha, MA, Director, VHA Financial Management & Accounting Policy

Elizabeth Lowery, MA, Director, VHA Manpower Management Office

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.

Outcome 2 Goals and Objectives:

- **Goal 4:** Align internal and external resources to leadership priorities.
  - Objective 4.1: VA will improve organizational alignment of VHA CO.
  - Objective 4.2: VA will conduct a VHA CO workload assessment to baseline and monitor manpower requirements.
  - Objective 4.3: VA will strengthen its Strategic Planning Process.
  - Objective 4.4: VA will reduce the number of annual unfunded requests (UFR).
- **Goal 5:** VA will align executive performance goals to resources and leadership priorities.
  - Objective 5.1: VA will develop guidance on decision authority at each level of the organization.

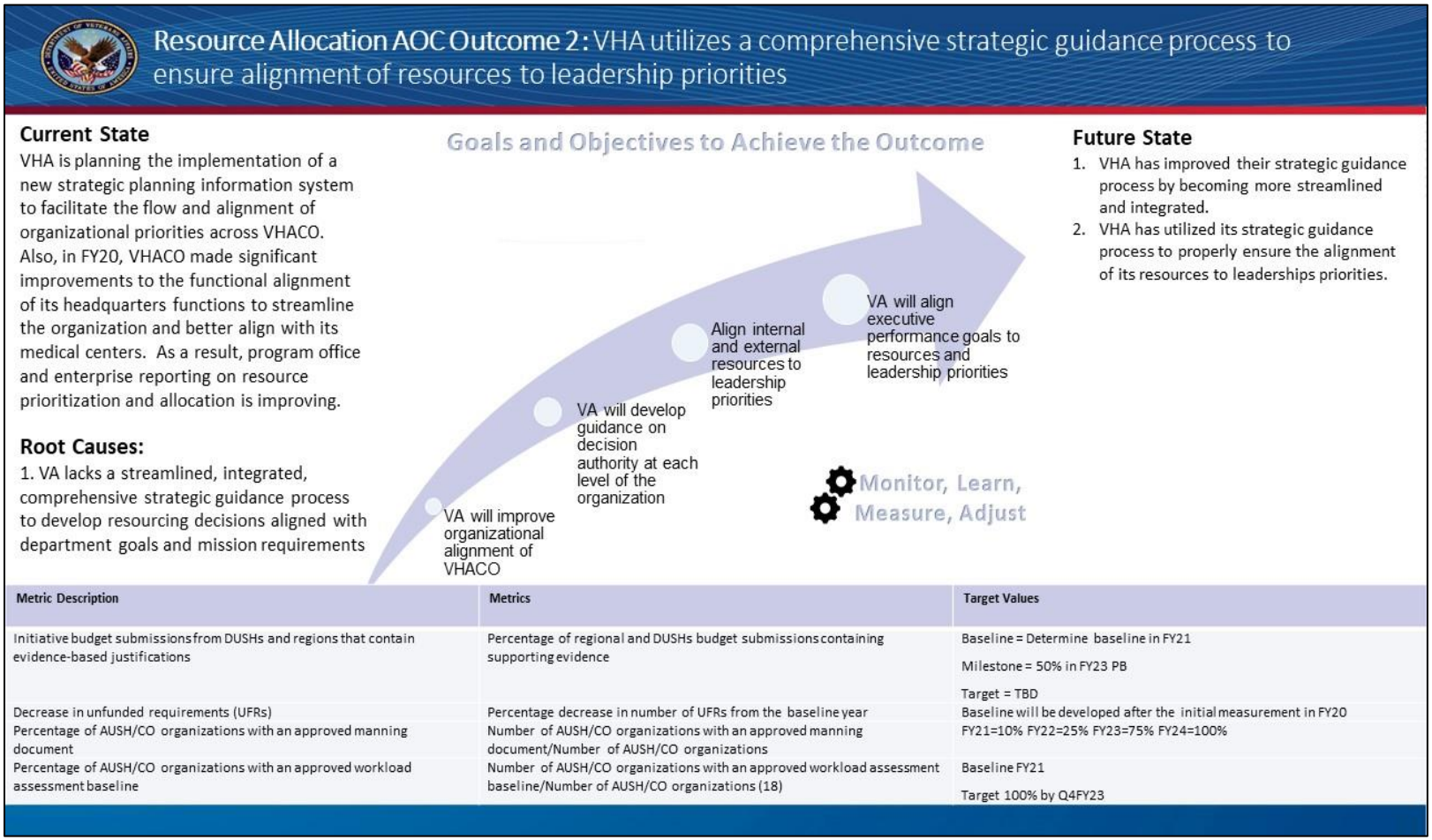
Table 5-6. RA-2 Description & Status

In Planning	In Progress	Complete	Sustaining

RA-2 Description & Status
Description • The intent is a streamlined and integrated approach to monitoring and adjusting financial and manpower allocations through workload and fiscal assessments and analysis.

RA-2 Description & Status
Status • In FY 2020, the VHA Office of Finance held a Budget Call for initiatives to be considered for the 2021 President's Budget (PB). This budget submission call allowed VHA headquarters program offices and regions to communicate resource requirements for new initiatives supporting and aligning to key leadership priorities with the introduction of evidence-based justifications to the VHA Medical Care program budget request process. • VHA is planning the implementation of a new strategic planning information system to facilitate the flow and alignment of organizational priorities across VHA CO. Also, in FY 2020, VHA CO made significant improvements to the functional alignment of its headquarters functions to streamline the organization and better align with its medical centers. As a result, program office and enterprise reporting on resource prioritization and allocation is improving. • In FY 2021, VHA Manpower will kick-off a VHA CO workload assessment to baseline manpower requirements. VHA Manpower created a module within its resource validation LEAF system to capture and analyze information gathered during the manpower assessments occurring through FY 2023. VHA MMO now oversees the management and sustainment of the VHA portion of the department level VA Functional Organization Manual (FOM). The FOM is the authoritative source that documents the current organization structure, missions, functions and tasks of the department and its organizations.

Figure 5.3. RA-2 Roadmap



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

Table 5-7. RA-2 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Initiative budget submissions from DUSHs and regions that contain evidence-based justifications	Percent of regional and DUSH budget submissions containing supporting evidence Number of submissions with evidence / total number of submissions	Baseline = Determine baseline in FY 2021 Milestone = 50% in FY 2023 PB Target = TBD	Q4/Annual
Decrease in UFRs	Percent decrease in number of UFRs from the baseline year = Number UFRs in current FY / number UFRs in FY 2019	Baseline will be developed after the initial measurement in FY 2020	Q1/Annual
Percent of AUSH / CO organizations with an approved manning document	Number of AUSH / CO organizations with an approved manning document / Number of AUSH / CO organizations	FY 2021=10% FY 2022=25% FY 2023=75% FY 2024=100%	Q2/Annual
Percent of AUSH / CO organizations with an approved workload assessment baseline	Number of AUSH / CO organizations with an approved workload assessment baseline / Number of AUSH / CO organizations (18)	Baseline FY 2021 Target 100% by Q4 FY 2025	Q1/Annual

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

Table 5-8. RA-2 Action Plan

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

Actions*	Projected Date	Actual/ Adjusted Date	Status
These Actions were developed prior to Goals and Objectives, these actions are still aligned to the outcome			
(2.1) Review the documents provided for the initiative budget submission request process in FY 2019 and identify updates to the document.	Q 2FY 2020	Q1 FY 2020	**Complete.** VHA Office of Finance reviewed and made refinements to the initiative budget submission to ensure appropriate budget requests were submitted.
(2.2) Send out the Initiative Budget Call memorandum to the program offices and the regions.	Q3 FY 2020	Q3 FY 2020	**Complete.** 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.
(2.3) Identify one program to implement VA's approach to Evidence—Based Policymaking in the 2021 Presidential Budget.	Q1 FY 2020	Q3 FY 2020	**Complete.** The Opioid Abuse Prevention Program Expansion was identified and completed this task.
(2.4) VHA organizational chart updated and signed identifying Level of Authority 3.	Q2 FY 2020	Q3 FY 2020	**Complete.** The VHA organizational chart has been updated, signed, and made available to all stakeholders.

Actions*	Projected Date	Actual/ Adjusted Date	Status
(2.5) Begin socializing a manning document that supports VHA's ability to align resources with priorities.	Q3 FY 2020	Q3 FY 2020	**Complete.** A manning document has been developed and socialized to continue the effort to align resources with staffing priorities.
(2.6) Standard Business Support Function: Charter and develop a standard Business Support Function for VHA CO.	Q2 FY 2020	Q2 FY 2020	**Complete.** VHACO's standard Business Support Function has been chartered and developed.
RA Goal 4: Align internal and external resources to leadership priorities	**Objective 4.1:** VA will improve organizational alignment of VHACO		
(2.7) Implement "Streamline VHACO LOE" recommendations	Q2 FY 2021	Q1 FY 2021	**Complete.** These recommendations were implemented and assisted with streamlining VHA CO.
(2.10) Establish organization specific station numbers for clearer lines of accounting, tracking, reporting and increased resource transparency.	Q1 FY 2021		**Complete.** Station numbers have been established and implemented which increase the visibility and transparency for station accounting, tracing and reporting.
(2.11) Review approximately 10,000 records in HR Smart on a reoccurring basis to enhance data integrity during the reorganization.	Q1 FY 2021		**Complete.** VHA Manpower established the best practice of reviewing HR Smart records on an ongoing basis, which has assisted in providing stability during reorganizations.

Actions*	Projected Date	Actual/ Adjusted Date	Status
(2.12) Coordinate with Financial Services Center (FSC), Defense Finance Accounting Service (DFAS) and HR Information Systems (HRIS) to perform system updates.	Q1 FY 2021		**Complete.** Lines of communication have remained strong across the various stakeholders as system updates continue to occur.
(2.13) Accurately process Personnel Action Requests (PARs) for all impacted employees aligning them to the appropriate organizational structure.	Q1 FY 2021		**Complete.** Completed the alignment of employees to appropriate organizational structures in accordance with PARs.
(2.14) After action reviews (AAR) revealed successful realignment with minimal errors or pay issues to impacted employees.	Q1 FY 2021		**Complete.** The AAR was completed and reviewed. The results showed that there were minimal errors or pay issues to impacted employees.
	Objective 4.2: VA will conduct a VHACO workload assessment to baseline and monitor manpower requirements		
(2.15) Improved accuracy of VHACO HR Smart data and the Functional Organization Manual (FOM).	Q2 FY 2022		**In Planning**
(2.16) VHACO will have its first approved manning document.	Q4 FY 2022		**In Progress**
(2.17) VHACO will review same grade reporting and supervisory span of control.	Q3 FY 2023		**In Progress**

Actions*	Projected Date	Actual/ Adjusted Date	Status
(2.18) VHA Manpower will collect and analyze contract dollars/functions/FTE equivalents.	Q3 FY 2023		**In Planning**
(2.19) The Manpower Estimation Model (MEM) Tool will be utilized to capture baseline workload data for all VHACO program offices.	Q3 FY 2023		**In Progress**
(2.20) VHA Manpower will kick-off the triennial review process.	Q1 FY 2024		**In Planning**
(2.21) VHA Manpower will conclude the first triennial review effort.	Q2 FY 2027		**In Planning**
	Objective 4.3: VA will strengthen its Strategic Planning Process		
(2.22) Publish updates to VHA Directive 1075 of the strategic-operational planning processes.	Q4 FY 2020		**Complete.** An update to the VHA Directive 1075 has been published to assist VHACO organizations with long-range planning.
(2.23) VA will implement a new electronic system to facilitate the annual strategic-operational planning process.	Q2 FY 2021		**In Progress**
(2.24) VA will utilize change management practices to enhance use of the strategic-operational planning process.	Q4 FY 2021		**In Progress**

Actions*	Projected Date	Actual/ Adjusted Date	Status
	Objective 4.4: VA will reduce the number of annual unfunded requests (UFR).		
(2.25) Measure unfunded requests (UFR) annually and identify opportunities to minimize out of cycle resource needs.	Q1 FY 2022		**In Progress**
(2.26) Identify program offices that frequently submit UFRs.	Q2 FY 2022		**In Planning**
(2.27) Work with program offices to manage within budget.	Q4 FY 2022		**In Planning**
RA Goal 5: VA will align executive performance goals to resources and leadership priorities	**Objective 5.1:** VA will develop guidance on decision authority at each level of the organization		
(2.28) VHA will develop and publish policy defining the roles, responsibilities, and decision rights for VHA CO Operating Units.	Q3 FY 2021		**In Progress**

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

Table 5-9. RA-2 Description of Actions Toward Removal Criteria

RA-2 Description of Actions Toward Removal Criteria
Leadership Commitment • The VHA leadership is committed to ensuring alignment of resources to leadership priorities. In FY 2020, VHA implemented standard business support functions, including a charter and development of Business Support Functions (BSF). Additionally, VHA began the socialization of manning documentation that supports the VHA's ability to align resources with priorities. VHA MMO will focus on increasing coverage of employees by a staffing approach and increasing the number of LOA 3 organizations with standard business support functions. The VHA Office of Finance will require high-visibility medical program initiative budget submissions to include evidence-based justifications.
Capacity • The VHA has already taken several actions to ensure the capacity to achieve desired results. In FY 2019, VHA established the VHA MMO as the authority for the VHA's organizational structure. The VHA Office of Finance began the initiative budget submission process in FY 2019 to identify initiatives prior to the current and budget fiscal years. The implementation of these two initiatives in FY 2020 will allow program offices and regions to be better prepared for FY 2021 requirements and allow for more capacity to respond to requests. Also, in FY 2020, VHA MMO 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.

RA-2 Description of Actions Toward Removal Criteria
Monitoring • VHA is monitoring actions taken to ensure efforts achieve defined leadership priorities. For example, the VHA Office of Finance subject matter experts have leveraged the standing regional and medical facility Chief Financial Officer calls to address resource and budget allocation process concerns. The VHA Office of Finance holds budget execution meetings to review and ensure proper execution of VHA program office and regional operating plans. The VHA MMO regularly meets with VHA leadership to review and discuss desired changes to authorized positions, onboard personnel, and workload-based requirements. The VHA MMO 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. • 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 refinement and expansion of metrics and measures, monitoring processes, procedures and improvement throughout VHA will be increasingly robust and representative of progress.
Demonstrated Progress • The FY 2019 Initiative Budget Call memorandum provided an opportunity for VHA headquarters program offices and regions to ensure funding requirements align to leadership priorities. The VHA Office of Finance refined funding guidance by adding a new process for program offices and regions to report the reallocation of funds. In FY 2020, VHA took steps to identify one program in which implementation of VA's approach to Evidence-Based Policymaking in the 2021 PB could be monitored.

Resource Allocation Outcome (RA-3)

Outcome Leads: Frank Costa, Resource Operation Officer

Shane Walker, PMP, **MBA,** Manager, Resource Management

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

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.

Outcome 3 Goals and Objectives:

- **Goal 6:** Develop internal controls to ensure accuracy of HR Smart data.
  - Objective 6.1: VA will make systemic enhancements to improve the accuracy of HR Smart data.
  - Objective 6.2: VA will implement a Manpower Analyst function across the VHA enterprise.
  - Objective 6.3: VHA will establish a training platform for enhanced proficiency and proper data entry.
- **Goal 7:** Modernize Financial Management Systems.
  - Objective 7.1: Annual funding allocations will be scheduled and distributed on-time to VHA CO and VISN Offices.
  - Objective 7.2: Conduct the VHA Configuration Validation Pre-Wave Activities for VHA's Integrated Financial and Acquisition Management System (iFAMS) Implementation.

Table 5-10. RA-3 Description & Status

In Planning	In Progress	Complete	Sustaining

RA-3 Description & Status
Description • The intent of this outcome is the enhancement, maintenance and utilization of HR Smart and our financial systems to better inform resourcing decisions at the local and enterprise levels.

RA-3 Description & Status
Status • VHA is undergoing significant transformation to improve our ability to inform, make and evaluate resource planning and allocation decisions. One example of this is the implementation of a standard organizational structure that will align functional data and subsequent reporting in HR Smart and iFAMS. This long-term goal will be a major milestone for VHA and a display of our commitment to improving the data and systems that drive our resource prioritization and allocation. Modernization and continuous improvement of VHAs technology is a top priority of leadership and evident in the multi-year, multi-million-dollar technological initiatives underway. These enhancements and the supporting processes and capabilities are changing the way VHA systems share and analyze data. VHA continues to make improvements to the internal controls that govern the management and sustainment of over 350,000 positions. This includes the implementation of a Manpower Analyst function at VHA CO headquarters level and the VISN level to oversee VISN and facility manpower activities.

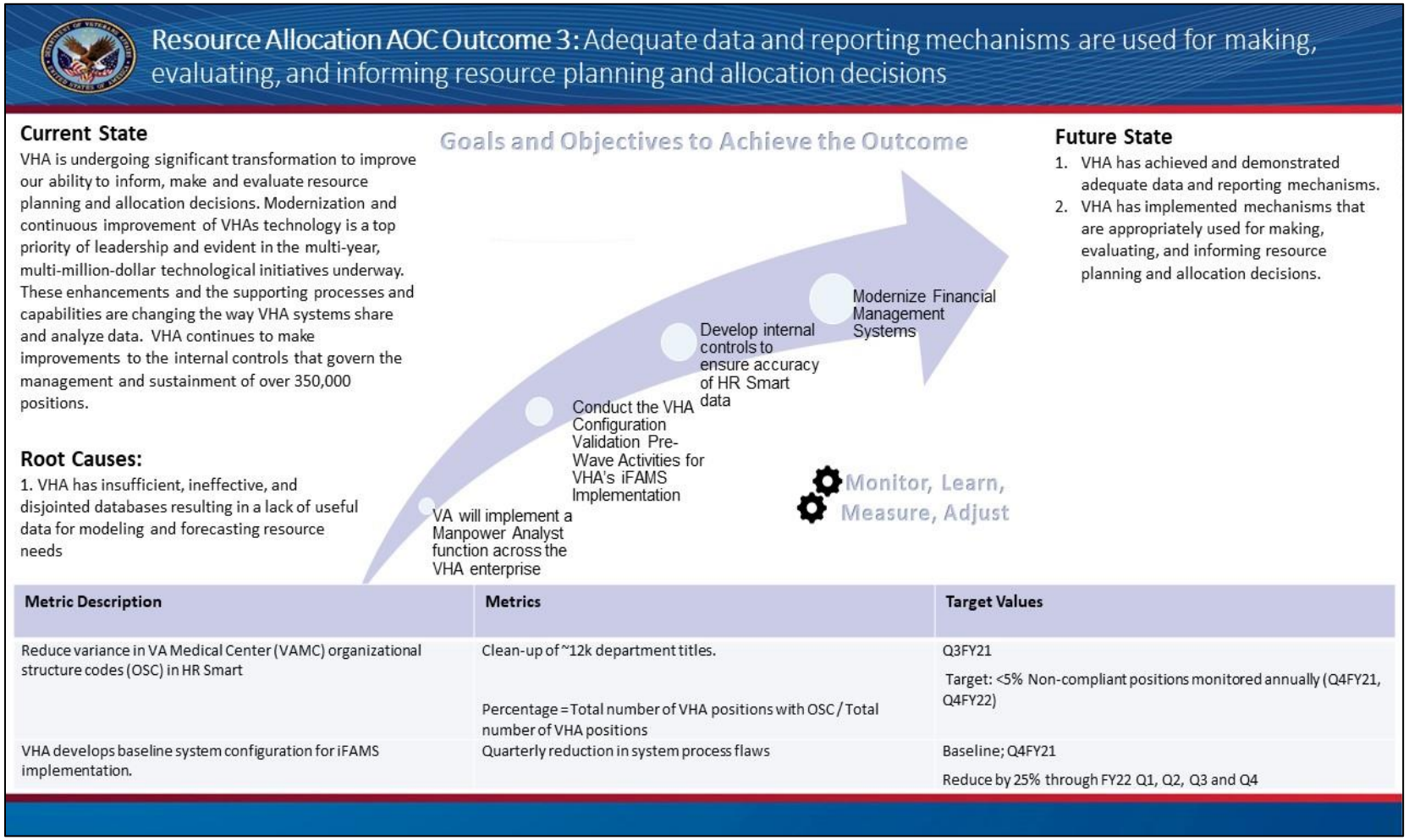


Figure 5-4. RA-3 Roadmap

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

Table 5-11. RA-3 Measures/Metrics

Success Measure Description	Metric & Calculation	Milestone & Target	Reporting Period
Reduce variance in VA Medical Center department codes in HR Smart	Clean-up of approximately 12,000 department titles. Percent = Total number of VHA Medical Center departments with a standard department code / Total number of VHA Medical Center departments	Q3FY 2021 Target: <5% Non-compliant department codes (Q4 FY 2021, Q4 FY2022)	Q1/Annual
VHA develops baseline system configuration for iFAMS implementation	Quarterly reduction in system process flaws	Baseline; Q4 FY 2021 Reduce by 25% through FY 2022 Q1, Q2, Q3 and Q4	Q1/Annual

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

Table 5-12. RA-3 Action Plan

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

Actions	Projected Date	Actual/ Adjusted Date	Status
These Actions were developed prior to Goals and Objectives, these actions are still aligned to the outcome			
(3.1) Identify and pull FTE reports from the VHA Office of Finance and Manpower and identify variances.	Q3 FY 2020		**Complete.** VHA manpower and Finance collaborated to identify and put into place, policies and protocols for addressing FTE variances.
(3.2) VHA Manpower reviews and maintains approved structure at VHA headquarters and regional offices.	Q1 FY 2020		**Sustaining.** VHA Manpower continues to review and maintain approved structures to ensure accurate representation of resources across VHACO and VISNs.
(3.3) Position Transparency Initiative: Monthly monitoring of variance.	Q1 FY 2019		**Sustaining.** VHA Manpower continues to conduct monthly monitoring of variances.
(3.4) Position Transparency Initiative: Increase communications to Position Management population.	Q1 FY 2020		**Complete.** VHA Manpower has strengthened and sustained lines of communication with the Position Management population.
(3.5) Position Transparency Initiative: Increase consultations as needed.	Q2 FY 2020		**Complete.** As per the Initiative, VHA Manpower is working with stakeholders to conduct more frequent consultations as needed.

Actions	Projected Date	Actual/ Adjusted Date	Status
(3.6) Implement LEAF system technology to track/report on Manpower requirements.	Q2 FY 2020		**Complete.** The LEAF system technology has been implemented and provides data utilized to track and report on Manpower requirements.
(3.7) Implement HR Smart Manpower Module to track/report Manpower requirements.	Q1 FY 2022		**In Progress**
RA Goal 6: Develop internal controls to ensure accuracy of HR Smart data	**Objective 6.1:** VA will make systemic enhancements to improve the accuracy of HR Smart data.		
(3.8) Recommend policy requirements around role access in HR Smart.	Q2 FY 2022		**In Planning**
(3.9) Implementation of the Manpower module in HR Smart will enhance data standardization and provide additional internal controls to drive compliance and data accuracy.	Q4 FY 2021		**In Planning**
(3.10) VA will implement standard department codes in HR Smart.	Q4 FY 2021		**In Progress**

Actions	Projected Date	Actual/ Adjusted Date	Status
	Objective 6.2: VA will implement a Manpower Analyst function across the VHA enterprise.		
(3.11) VHA Manpower will stand up a formal Manpower Analysis Program to govern the VISN and medical center manpower function.	Q3 FY 2021		**In Progress**
(3.12) VHA Manpower will conduct monthly CoP calls to build awareness and desire while reinforcing knowledge of the manpower analyst function.	Q1 FY 2020		**Sustaining.** CoP Calls are continuing to occur on a monthly basis to address stakeholder concerns and spread best practices.
(3.13) VHA will conduct an annual Manpower Analyst supervisor summit to build awareness and increase supervisory competency of the newly implemented function.	Q4 FY 2022		**In Planning**
	Objective 6.3: VHA will establish a training platform for enhanced proficiency and proper data entry		

Actions	Projected Date	Actual/ Adjusted Date	Status
(3.14) On-demand technology training will be available for Manpower Analysts on an as-needed basis.	Q4 FY 2022		**In Planning**
RA Goal 7: Modernize Financial Management Systems.	**Objective 7.1:** Annual funding allocations will be scheduled and distributed on-time to VHACO and VISN Offices.		
(3.15) Determine VHA Funding Allocation between Specific Purpose and General Purpose Funding.	Q4 FY 2021		**In Progress**
(3.16) Allocate funding in financial system by October 1.	Q1 FY 2022		**In Planning**
	Objective 7.2: Conduct the VHA Configuration Validation Pre-Wave Activities for VHA's iFAMS implementation		

Actions	Projected Date	Actual/ Adjusted Date	Status
(3.17) In conjunction with the VA FMBTS team, VHA will align critical program efficiencies and products that create value and efficiency by the end of Q2 FY 2023 to meet its common end goal of VHA's iFAMS implementation.	Q2 FY 2023		**In Planning**
(3.18) In conjunction with the VA FMBTS team, VHA will develop baseline system configuration and system process flaws by the end of Q4 FY 2022 to meet its common end goal of VHA's iFAMS implementation.	Q4 FY 2022		**In Planning**
(3.19) In conjunction with the VA FMBTS team, VHA will define its operating model, standardize business processes, and prioritize capabilities across VISNs by end of Q2 FY 2023 to meet it common goal of VHA's iFAMS implementation.	Q2 FY 2023		**In Planning**

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

Table 5-13. RA-3 Description of Actions Toward Removal Criteria

RA-3 Description of Actions Toward Removal Criteria
Leadership Commitment • The VA has committed to improving the databases used in planning and forecasting allocation decisions through the implementation of HR Smart. VA leadership highlights improved manpower management in the VA draft Strategic Plan 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 MMO 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 • Through the commitment to implement the new systems, VA is continuing to advance the capacity of the Department to provide more detailed and structured reports. With the establishment of the VHA MMO as the authority for VHA's organizational structure, VHA is recruiting for manpower analysts at the regional level to support the initiative and provide position structure reporting at the field level, enhancing the capacity for data reporting. • One example of this is VHA is working to identify and pull FTE reports from the VHA Office of Finance and Manpower and identify variances. This structure will provide more detailed information in the creation of staffing forecasts for budgetary reports. In FY 2020-2021 VHA will implement the Manpower Module functionality within HR Smart improving internal controls towards a more accurate and real-time accessible position inventory.

RA-3 Description of Actions Toward Removal Criteria
Monitoring • The VHA is monitoring actions taken to ensure efforts achieve the intended progress. The implementation of the LEAF and HR Smart systems has provided VHA to improve tracking and reporting on Manpower requirements. Additionally, VHA has instituted a Position Transparency Initiative, which increases communications to position manager population and provides monthly monitoring reports on variances. The VHA MMO now reviews proposed changes to organizational structure and makes recommendations for approval by the Chief of Staff for all structure changes in VHA headquarters and the regional offices. • This plan's metrics and measures 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 • In FY 2020 – FY 2021, VHA MMO continued to refine VHA position management policy and internal controls to improve workforce position and vacancy data. VHA MMO actively manages the VHA headquarters manpower validation process by overseeing changes to organizational charts, position management, approval of change requests, and responding to stakeholder inquiries on organizational and position structure. In FY 2020, VHA introduced position transparency initiatives, including monthly monitoring of variances and increase in consultations.

GAO-OIG Accountability Liaison (GOAL)

The GOAL Office was established in October 2018 to oversee VA's response and actions to GAO's high-risk listing on VA health care. GOAL reports on GAO high-risk portfolio management activities to the Deputy Under Secretary for Health. VHA increased GOAL's portfolio management capacity by leveraging existent staff who had experience working with GAO, adding support staff to the office, and allocating funds for contract support. GOAL's responsibilities include:

- Serving as VHA's primary liaison to GAO and VA's Office of the Inspector General
- Setting Department strategic and operational direction for addressing the areas of concern
- 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 legislation S. 1550, the Program Management Improvement and Accountability Act of 2015 (PMIAA), the GOAL office has contracted 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, 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 behavioral change over time. Incorporating effective organizational change management (OCM) strategies into each AOC 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.

The GOAL Office is also leveraging communications to assist with addressing the areas of concern. GOAL developed a communications plan that was shared with the areas of concern to highlight the focal points for FY 2021 as well as themes, key messages, etc. Additionally, GOAL hosts monthly communications meetings; develops and disseminates a monthly GOAL Post with updates from leadership, GAO updates, and other important information; and develops communications products for the areas of concern to use in communicating with their stakeholders. Meeting and briefing

communication materials are most frequently designed to create awareness, further understanding or secure or enhance leadership commitment through decision-making.

Leadership Commitment			
Actions	**Projected Date**	**Actual/Adjusted Date(s)**	**Status/Comments**
Conduct Sponsor Assessment. GOAL Office facilitated Prosci Sponsor Assessments with Executive Sponsors and AOC Outcome Leads. Additionally, GOAL provided an analysis to the sponsors with recommended focus areas to strengthen their sponsorship.	**Q2 FY 2021**	**Q2 FY 2021**	**Complete:** The first round of sponsor assessments was completed in FY 2021.
Reestablish Steering Committee. GOAL Office restructured the Steering Committee to become agile and more decision oriented, established charters for how it would operate, along with identifying key executives to fulfill the roles of the Chair and Co-Chair.	**Q3 FY 2021**	**Q3 FY 2021**	**In Progress:** New Steering Committee has been established since December 2020. Meetings have been held monthly since December.
Establish Oversight Board. The VHA and OIT Senior accountable officials met with executive sponsors and set expectations and goals for oversight of GAO HRL.	**Q3 FY 2021**	**Q4 FY 2021**	**Complete:** First meeting was held in February 2021.
Conduct Strategic Planning Conference. Plan and execute strategy sessions with AOC leadership to coordinate planning efforts and share best practices for HRL removal strategies.	**Q4 FY 2020**	**Q4 FY 2020**	**Complete:** Conducted a two-day strategy session with all Areas of concern on August 2020.
	Q2 FY 2021	**Q2 FY 2021**	**Complete:** Conducted a two-day strategy session with all Areas of concern on March 2021.

	Q4 FY 2021	**Q4 FY 2021**	**In Progress:** Work is underway for the planning efforts for the next conference that will be held in August 2021.
Actions	**Projected Date**	**Actual/Adjusted Date(s)**	**Status/Comments**
Engaged in Inter Agency Coalition. GOAL is an active participant with OEI, OMB and the Executive Advisory Board (EAB) that fosters inter agency HRL work. Emerging opportunity with the new Drug Misuse listing as that will require a inter agency response.	**Q3 FY 2020**	**Q3 FY 2020**	**Complete:** GOAL is an active participant in the board.
Engaged in Intra agency MOU. Established an MOU with the Office of Acquisitions, Logistics and Construction (OALC) to share strong practices for HRL removal efforts.	**Q4 FY 2020**	**Q4 FY 2020**	**Complete:** MOU between VHA and OALC was signed on July 2020 and collaborative efforts are ongoing.
Actively collaborate with OALC counterparts. Share best practices, provide input and guidance on strategic direction, etc. To facilitate this collaboration, GOAL and OALC leadership attend monthly meetings specific to the High Risk List to share best practices, provide input and guidance on strategic direction.	**Q4 FY 2022**	**Q4 FY 2022**	**Sustaining:** This meeting has provided an important forum to build trusted relationships, for leadership and staff to come to a common understanding of what is required to address the areas of concern, and form an agency wide integrated approach to address our high risk concerns/issues.
Develop meeting and briefing communication materials. Meeting and briefing communication materials are most	**Q4 FY 2022**	**Q4 FY 2022**	**Sustaining:** These activities are ongoing and will mature as needs for the areas

frequently designed to create awareness, further understanding or secure or enhance leadership commitment through decision-making.			of concern and GOAL mature.

Action Plan			
Actions	**Projected Date**	**Actual/Adjusted Date(s)**	**Status/Comments**
Implement a Change Control Process. Process ensures the integrity of the AP is maintained 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.)	**Q2 FY 2020**	**Q2 FY 2020**	**Sustaining:** Reviewed the process with GAO and AOC Steering Committee on May 2020. Process is actively being utilized.
Posting the Action Plan to the Federal Register. GOAL cleared the AP through the requisite organizations within the VA to gain concurrence prior to publishing the AP on the Federal Register.	**Q2 FY 2020**	**Q1 FY 2021**	**Complete:** Action Plan was posted on the Federal Register on December 18, 2020.
Posting the Action Plan and Executive Summary to VA Plans, Budget & Performance external site. GOAL cleared the AP and AP Executive Summary through the requisite organizations within the VA to gain concurrence prior to publishing both documents to the VA Plans, Budget & Performance on the Federal Register.	**Q2 FY 2020**	**Q1 FY 2021**	**Complete:** Action Plan and Executive Summary was posted in December 2020.
Development of Goals and Objectives. Provided guidance to areas of concern on establishing goals and objectives that serve as milestones towards the eventual outcomes.	**Q1 FY 2021**	**Q1 FY 2021**	**Complete:** Through guidance by GOAL, areas of concern have established goals and objectives that are now reflected in the Action Plan.

Demonstrated Progress			
Actions	**Projected Date**	**Actual/Adjusted Date(s)**	**Status/Comments**
Implement Artifact Management Process. Drives a level of standardization for how artifacts are named and stored. Implemented for collecting, cataloging, and storing artifacts that demonstrate completion or sustainment of all AOC actions identified in the VA HRL Action Plan.	**Q2 FY 2020**	**Q3 FY 2020**	**Complete:** Reviewed the process with GAO and AOC steering committee on May 2020. Process is actively being utilized.
Leverage Artifact Management Process to Deliver Artifacts to GAO. Collect and verify artifacts collected to date for completed and sustaining actions. Then deliver the artifacts to GAO.	**Q2 FY 2021**	**Q3 FY 2021**	**In Progress:** Developed a standard operating procedure for the delivery of the artifacts. Need to verify the process of submission of artifacts to GAO.
Drive Improvement on GAO Removal Criteria. Based off feedback from GAO, GOAL developed guidance to assist areas of concern in gaining improvement in the Action Plan. GOAL staff also worked directly with areas of concern to continually review content for overall improvement.	**Q1 FY 2020**	**Q1 FY 2020**	**Complete:** Areas of concern updated the Action Plan with the guidance provided and were able to achieve an increase in capacity from not met to met.

Monitoring			
Actions	**Projected Date**	**Actual/Adjusted Date(s)**	**Status/Comments**
Checkpoint. Monitoring function that drives consistency of how each AOC progresses through the lifecycle. Ensures all phases of the action items lifecycle and GAO Criteria for Removal are monitored accordingly for quality.	**Q4 FY 2021**	**Q4 FY 2020**	**In Progress:** Process has been developed. Need to gain approval from the Steering Committee prior to utilizing the process
Metrics Dashboard. As a part of monitoring demonstrating Action Plan progress, each AOC developed metrics to measure the benefits of the efforts underway. These metrics were then incorporated into a dashboard that graphically depicts the metrics data, the desired targets, and trends in a uniform format. The unified view from the dashboard allows users to quickly interpret the performance of the efforts and make appropriate course corrections.	**Q1 FY 2020**	**Q1 FY 2020**	**Sustaining:** Dashboard has been developed. Results have been captured within the dashboard and has been shared with GAO for three quarters since 2020.
Risk Management. Framework to proactively identify risks and issues threatening HRL removal success and develop timely actions to mitigate those risks.	**Q4 FY 2020**	**Q4 FY 2020**	**Sustaining:** Reviewed the process with GAO and AOC steering committee on July 2020. Process is actively being utilized.
Integrated Master Schedule. Consolidates schedules across the portfolio. This includes AOC and GOAL activities along with dates,	**Q4 FY 2020**	**Q4 FY 2020**	**Sustaining:** Schedules from areas of concern are consolidated within the IMS. Next step is to consistently review the schedule risks with the

resources, dependencies and relationships.			areas of concern during the Steering Committee.

Capacity			
Actions	**Projected Date**	**Actual/Adjusted Date(s)**	**Status/Comments**
Resource Assessment. To demonstrate the capacity and adequacy of FY 2020 AOC resources to GAO and to identify any resource gaps.	**Q3 FY 2020**	**Q3 FY 2020**	**Complete:** Results were included in the submitted Action Plan in October 2020. Work was recognized as the removal criteria for capacity increased from not met to met.
Resource Assessment. To demonstrate the capacity and adequacy of FY 2020 AOC resources to GAO and to identify any resource gaps.	**Q2 FY 2021**	**Q2 FY 2021**	**Complete:** Results are included in this iteration of the Action Plan update.
Self-Assessment. Cross-cutting effort with an overall goal of improving GOAL's ability to support the areas of concern by identifying and prioritizing improvement areas	**Q3 FY 2021**	**Q3 FY 2021**	**Sustaining:** Baseline was conducted in July 2020. Improvement areas were identified and are being actively addressed.