VA U.S. Department of Veterans Affairs

PRESIDENTIAL TRANSITION

Briefing Book

2016

VA | U.S. Department of Veterans Affairs

A Message from the Secretary of Veterans Affairs

November 1, 2016

To the members of the VA Agency Review Team:

On behalf of the nearly 370,000 employees at the Department of Veterans Affairs, welcome!

We have one of the most noble and inspiring missions in Government – to care for those "who shall have borne the battle," their families, and their survivors. In carrying out this sacred mission, we have had our fair share of challenges, but we have taken ownership of them, and we are making progress in improving all services and outcomes by transforming VA into the high-performing, Veteran-centric organization our Nation's Veterans deserve.

To that end, over the last two years, we have been taking a comprehensive, enterprise-wide approach to this transformation with an initiative called MyVA— a Veteran-centric process that is both top-down and bottom-up driven. We are moving quickly to fulfill our mission and demonstrate our VA Values by putting Veterans in control of how, when, and where they want to be served; by measuring success through Veterans' outcomes; and by optimizing our productivity and efficiency.

As a testament to our progress and current momentum, Veterans are starting to see and experience improvements that demonstrate we are on the right track to become a world-class service provider and the number one customer-service agency in the Federal Government. Nearly 97 percent of appointments are now completed within 30 days of the Veteran's preferred date; 22 percent are same day appointments. Veteran homelessness has been reduced by 47 percent since 2010. We have also reduced the disability compensation and pension claims backlog by more than 87 percent from 2013 levels of more than 611,000. These are just a few of the many accomplishments that are helping us to earn the trust of our Veterans. We know that more needs to be done.

The peaceful transfer of power is a true hallmark of our democracy, but our work must not stop. Our entire VA team, led by Chief of Staff, Bob Snyder, and Principal Deputy Assistant Secretary for Enterprise Integration, Dat Tran, has worked hard to prepare this Presidential Transition Briefing Book. We hope you find useful the information and insights into VA's operations, key management and policy issues, as well as our challenges and opportunities. As we continue the momentum towards transformation, our entire team is ready to work together in a cooperative and supportive manner with the next Administration to serve our Veterans and their families.

Robert A. McDonald

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PART A: ORGANIZATIONAL OVERVIEW

1. VA Mission and Overview

The Department of Veterans Affairs (VA) was established as an independent executive agency on July 21, 1930 (E.O. 5398) and was elevated to Cabinet level on March 15, 1989, (P.L. 100-527). VA is the second-largest Federal department with nearly 370,000 employees dedicated to serving America's Veterans, their families, and survivors with dignity and compassion. As advocates for the Veteran community, VA is committed to providing the very best services with an attitude of caring and courtesy.

On March 3rd, 1865, President Lincoln signed the legislation that would establish for Veterans a network of national facilities – the National Homes for Disabled Volunteer Soldiers. The very next day in his Second Inaugural Address, he gave a vision of healing to a wounded Nation. He counseled, "… let us strive on to finish the work we are in, to bind up the Nation's wounds, to care for him who shall have borne the battle and for his widow and his orphan …." VA derives its mission from President Lincoln's promise – **to care for those "who shall have borne the battle" and for their families** – by serving and honoring the men and women who are America's Veterans.

1.1 Our Core Values

The Core Values, **I**ntegrity, **C**ommitment, **A**dvocacy, **R**espect, and **E**xcellence (ICARE) define "who the VA is," VA's culture, and help guide the actions of staff across the Department to support VA's commitment to care and serve Veterans, their families, and beneficiaries.

Integrity	Act with high moral principle. Adhere to the highest professional standards. Maintain the trust and confidence of all with whom I engage.
Commitment	Work diligently to serve Veterans and other beneficiaries. Be driven by earnest belief in VA's mission. Fulfill my individual responsibilities and organizational responsibilities.
Advocacy	Be truly Veteran-centric by identifying, fully considering, and appropriately advancing the interest of Veterans and other beneficiaries.
Respect	Treat all those I serve and with whom I work with dignity and respect. Show respect to earn it.
Excellence	Strive for the highest quality and continuous improvement. Be thoughtful and decisive in leadership, accountable for my actions, willing to admit mistakes, and rigorous in correcting them.

1.2 Our Vision

VA as the No. 1 customer-service agency in the Federal government – that's our vision. It's guiding all our efforts. It's simple. It's achievable. And we're getting there.

Table 1. Overview of Veteran Population and VA Programs

Veterans Demographics (as of 9/30/16)	
Estimated U.S. Veterans Population	21,368,000
Estimated U.S. Female Veterans Population	2,051,000
Estimated Number of Living WW II Veterans	696,000
Estimated Number of WW II Veterans Pass Away Per Day	416
Percentage of Veteran Population 65 or Older	46%
Veteran Population by Race:	
White	82.0%
Black	12.6%
Hispanic	7.1%
Other	3.3%
Asian/Pacific Islander	1.6%
American Indian/Alaska Natives	0.8%
Veterans Utilization of VA Benefits and Services (as of 9/30/2016 unless otherwise indicated)	
Veterans Receiving VA Disability Compensation	4.36 M
Veterans Rated 100% Disabled	542,147
Veterans Compensated for PTSD	883,631
Veterans in Receipt of Individual Unemployment Benefits	339,339
Spouses Receiving Dependency and Indemnity Compensation	382,145
Veterans Receiving VA Pension	288,715
VA Education Beneficiaries (FY2015)	1.02 M
Life Insurance Policies Supervised and Administered by VA	6.19 M
Face Amount of Insurance Policies Supervised and Administered by VA	$1.23 T
Veterans Receiving Vocational Rehab & Employment Benefits (FY2015)	92,345
Number of Active VA Home Loan Participants	2.62 M
Total Enrollees in VA Health Care System (FY2015)	8.97 M
Total Unique Patients (Veterans & Non-Veterans) Treated (FY2015)	6.74 M
VA Workforce and Facilities	
VA Employees in Pay Status (Full Time/Part Time/Intermittent)	367,480
Number of Full Time VA Employees	339,989
Health Care Professionals Rotating Through VA (FY2015)	123,552
VA Hospitals	144
VA Outpatient Sites	1,221
VA Vet Centers	300
Veterans Benefits Administration Regional Offices	56
VA National Cemeteries	135

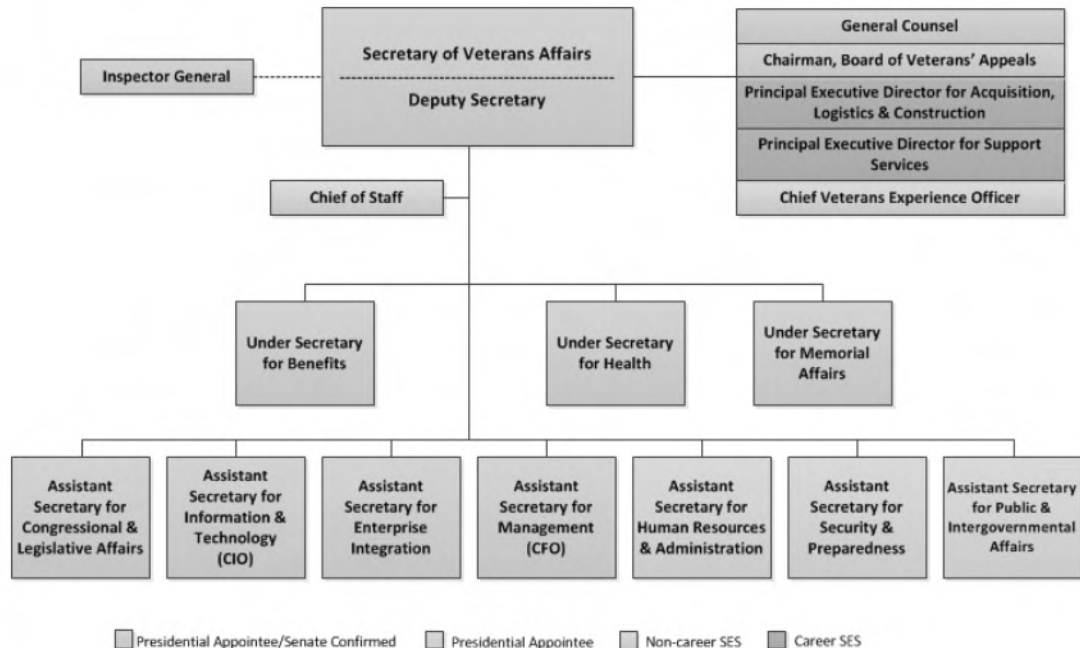
VA Budget (FY2017 Actual Appropriations)	
Department of Veterans Affairs	$176.89 B
Veterans Health Administration	$68.66 B
Veterans Benefits Administration (Discretionary Only)	$2.84 B
National Cemetery Administration	$286.2 M
Information Technology	$4.27 B

1.3 VA Organization: Administrations and Staff Offices

The Department is comprised of three Administrations and Staff Offices responsible for delivering benefits and services to eligible Veterans, their families, and beneficiaries. The three Administrations – Veterans Health Administration, Veterans Benefits Administration, and National Cemetery Administration – provide centralized program direction to field facilities that provide diverse program services to Veterans and their families. Furthermore, each Administration has Central Office components in Washington, D.C., that support the Administration's operations. This organizational structure reflects a basic management approach of centralized policy direction, complemented by consistent decentralized execution.

The Staff Offices provide a variety of enabling and support services to the Department including budgetary and financial management; information and technology management; human resources management; planning and performance management; policy management; operations, preparedness, security, and law enforcement; legal counsel; congressional and public relations; facilities management; and acquisition and logistic support.

Figure 1. VA Basic Structure Organization Chart



Veterans Health Administration (VHA) – VHA is home to the largest integrated health care system in the United States, consisting of medical centers, community-based outpatient clinics, community living centers, Vet Centers and domiciliary facilities. The four statutory missions of VHA are: (1) to develop, maintain, and operate a national health care delivery system for eligible Veterans; (2) to administer a program of education and training for health care personnel; (3) to conduct health care research; and (4) provide contingency support for the Department of Defense (DoD) and Department of Health and Human Services (HHS) during times of war or national emergency.

Veterans Benefits Administration (VBA) – VBA provides a variety of benefits and services to eligible Veterans, their families, and other beneficiaries. These benefits and services include disability compensation; pension; education; vocational rehabilitation and employment; home loan guaranty, and life insurance benefits.

National Cemetery Administration (NCA) – NCA inters eligible Veterans, family members, and Servicemembers in VA national cemeteries; assists state and tribal organizations in providing burial benefits to Veterans through the Veterans Cemetery Grants Program; furnishes headstones and markers for graves in national, federally-administered state, tribal, and private cemeteries; furnishes medallions for privately purchased headstones and markers that signify Veterans' service, and provides Presidential Memorial Certificates to next of kin and other loved ones in recognition of Veterans' honorable service.

Office of Management (OM) – OM provides strategic and operational leadership in budget, financial management, programming, cost analysis, and asset enterprise management. It also promotes public confidence in the Department through stewardship and oversight of business activities that are consistent with national policy, law, and regulation. OM serves as the primary liaison with the Office of Management and Budget (OMB) and Congressional appropriations committees to justify and promote the Department's program plans and budget estimates.

Office of Information and Technology (OI&T) – OI&T delivers available, adaptable, secure, and cost-effective technology services to VA and acts as a steward for all VA's IT assets and resources. It also delivers the necessary technology and expertise that supports Veterans and their families through effective communication and management of people, technology, business requirements, and financial processes.

Office of Enterprise Integration (OEI) – OEI leads and orchestrates the continuous improvement of Veterans and employee experience through effective integration of people, processes, technology across VA; innovations; and maturing organizational management capabilities.

Office of Operations, Security, and Preparedness (OSP) – OSP coordinates VA's emergency management; preparedness; identity management; physical security; personnel

security and suitability; police services; and law enforcement activities. OSP directs and provides oversight for VA's overall operations for planning, response, and security and law enforcement programs in support of the National Response Framework, Homeland Security Presidential Directive (HSPD) 12, and other related executive orders and Federal regulations.

Office of Human Resources and Administration (OHRA) – OHRA leads the development and implementation of human capital management strategies, policies, and practices to cultivate an engaged, proficient, and diverse workforce. OHRA is responsible for VA's human resources management; diversity and inclusion programs; discrimination complaint resolution; labor-management relations; VA's Learning University; senior executive management; and general administrative support for VA Central Office.

Office of Public and Intergovernmental Affairs (OPIA) – OPIA develops and communicates the Department's key messages to engage stakeholders and drives an integrated strategy that includes media relations, digital (online and social media), community relations, public affairs and strategic outreach, intergovernmental affairs, internal communications, as well as Veteran engagement to educate and inform Veterans, their families, their survivors, and other beneficiaries about the benefits and care they have earned and deserve.

***Office of Congressional and Legislative Affairs (OCLA)* –** OCLA coordinates most of VA's activities with Congress. It is the Department's focal point for interactions and engagements with Members of Congress, authorization committees, and personal staff. Additionally, the Office is the Department's liaison with the Government Accountability Office (GAO).

Office of General Counsel (OGC) – OGC provides legal advice and services to the Secretary of VA (SECVA) and all organizational components of the Department. The General Counsel is, by statute, the Department's Chief Legal Officer.

***Office of Acquisition, Logistics, and Construction (OALC)* –** OALC is a multifunctional organization responsible for directing the acquisition, logistics, construction, and leasing functions within VA.

Office of Enterprise Support Services (OESS) – OESS coordinates and oversees the delivery of reliable, consistent, cost-effective support services across the VA enterprise for the following: human resource services; debt management; financial and accounting services; payroll processing; travel and payment processing; electronic commerce/electronic data interchange; background investigations and adjudications for employees and contractors; special training for VA police officers; and records storage, protection, and management services. OESS also oversees the VA Franchise Fund, a revolving fund authorized by Congress to deliver enterprise support services to VA Administrations and staff offices.

The Board of Veterans Appeals (BVA) – BVA's mission is to conduct hearings and decide appeals properly before the Board in a timely manner. The Board has jurisdiction over appeals arising from the Department's regional offices, medical centers, NCA, and OGC. The vast majority of appeals considered involve claims for disability compensation or survivor benefits. Examples of other types of appeals addressed by the Board include fee-basis medical care, waiver of recovery of overpayments, reimbursements for emergency medical treatment expenses, education assistance benefits, vocational rehabilitation training, burial benefits, and insurance benefits.

Veterans Experience Office (VEO) **–** VEO coordinates with Administrations and Staff Offices to make every contact Veterans and their families have with VA predictable, consistent, and easy, regardless of the medium. A key primary role of VEO is to support VA organizations in meeting their goals for improving customer experience.

Office of the Inspector General (OIG) **–** OIG is responsible for conducting oversight of the programs and operations of VA through independent audits, inspections, and investigations.

2. Major Stakeholders

VA recognizes the importance of working with stakeholders from across public and private sectors. No single organization or agency has the expertise and resources to deliver all the benefits, services, and resources necessary to meet the needs and expectations of every Veteran. As a Department, VA continues to improve its ability to partner and work with others through collaborations with Congress; other federal agencies; state and local governments; tribal governments; VA Federal Advisory Committees; Veterans Service Organizations; and nongovernmental organizations.

2.1 Congress

The Office of Congressional and Legislative Affairs (OCLA) is responsible for VA's relations and interactions with Congress, to include the Government Accountability Office (GAO). In this role, OCLA acts as the legislative affairs office for the Department and coordinates closely with individual legislative program offices in the Administrations and Staff Offices.

The House Veterans Affairs Committee (HVAC) and the Senate Veterans Affairs Committee (SVAC) are VA's two major oversight committees, where most legislation related to the Department is introduced and considered. In addition to the HVAC and SVAC, OCLA manages relationships with all Members of Congress, which can occur directly, or through other Congressional committees, such as the Senate Homeland Security and Government Affairs Committee or the House Oversight and Government Reform Committee.

The Office of Management (OM), in collaboration with OCLA, coordinates official business with two additional significant Congressional stakeholders – the Senate Appropriations Subcommittee on Military Construction, Veterans Affairs and Related Agencies; and the House Appropriations Subcommittee on Military Construction, Veterans Affairs and Related agencies.

Additional Resources

- Senate Veteran Affairs Committee: http://www.veterans.senate.gov/
- House Veteran Affairs Committee: https://veterans.house.gov/
- Senate Appropriations Subcommittee on Military Construction and Veterans Affairs, and related Agencies: http://www.appropriations.senate.gov/subcommittees/military-construction-veterans-affairs-and-related-agencies
- House Appropriations Subcommittee on Military Construction, Veterans Affairs, and related Agencies: http://appropriations.house.gov/subcommittees/subcommittee/?IssueID=35986
- Senate Homeland Security and Governmental Affairs Committee: https://www.hsgac.senate.gov/
- House Oversight and Government Reform Committee: https://oversight.house.gov/

2.2 Other Federal Agencies

The challenges facing Veterans are complex and multifaceted, and cannot be resolved by a single agency. Over the past few years, the Department has increased its collaborations with other federal agencies through Cross Agency Priority (CAP) Goals.

Cross Agency Priority (CAP) Goals, required by the Government Performance and Results Act Modernization Act of 2010, are outcome-oriented goals that cover a limited number of crosscutting policy areas and management improvements across the Federal Government in the areas of information technology, financial management, human resources, and real property. VA co-leads two CAP goals:

- **Servicemembers and Veterans Mental Health** – VA, in collaboration with Department of Health and Human Services and DoD, is reducing barriers to seeking mental health treatment by enhancing VA and DoD programs that have proven effective and supporting research that focuses on the improvement of mental health, substance abuse, traumatic brain injury, and post-traumatic stress disorder.
- **Smarter IT Delivery** – VA, in collaboration with the Department of Homeland Security and the Office of Management and Budget, is improving customer satisfaction with its technology services by strengthening Department accountability, implementing new recruitment strategies, streamlining the Federal IT acquisition process, and developing processes to drive outcomes and accountability.

Along with its work through the CAP Goals, VA partners with other federal agencies through legislatively-mandated collaborations and agency-driven initiatives. One of VA's most significant interagency engagements is its work with DoD to improve the access, quality, effectiveness, and efficiency of healthcare, benefits, and services provided to Servicemembers, Veterans, and other beneficiaries. The Office of Policy and Interagency Collaboration (OPIC) within the Office of Enterprise Integration (OEI) serves as the lead on VA/DoD collaboration. It facilitates the development and integration of joint policies and programs between the two Departments, and other agencies, as needed.

VA also collaborates extensively with the Department of Housing and Urban Development, Department of Labor, Department of Education, Social Security Administration, and the Small Business Administration.

Additional Resources

- Cross-Agency Priority Goals: https://www.performance.gov/cap-goals-list?view=public
- VA/DoD Joint Executive Committee Annual Reports and Strategic Plans: http://www1.va.gov/op3/office_of_va_dod_collaboration_and_interagency_integration.asp

2.3 State and Local Government

The Office of Public and Intergovernmental Affairs (OPIA) is responsible for VA's relations and interactions with state and local government partners. Through OPIA, VA maintains communication directly with state and local government partners and through state- and local-level intergovernmental organizations.

All 50 states, the District of Columbia, and the territories of American Samoa, Guam, Northern Marinara Islands, Puerto Rico, and the Virgin Islands each have agencies tasked by their respective governments to serve the Veteran population of their state or territory. The state, district, and territory Directors or Commissioners of Veterans Affairs comprise the National Association of State Directors of Veterans Affairs (NASDVA). Some large municipalities have their own government organizations dedicated to serving Veterans in their communities.

Additional Resources

- Links to each State Department of Veterans Affairs: http://www.va.gov/statedva.htm
- NASDVA: http://www.nasdva.us

2.4 Tribal Government

The Office of Tribal Government Relations (OTGR) within OPIA is responsible for helping VA work more effectively with tribal governments. American Indians and Alaska Natives (AI/AN) serve the U.S. military at higher rates than other groups, but are underrepresented among those accessing benefits and services from VA. To increase the number of AI/AN Veterans accessing services and benefits, VA engages broadly with the governments of federally recognized tribes through formal and informal Tribal Consultations. These engagements emphasize the importance of establishing and sustaining enduring, trusting relationships.

To promote increased access to healthcare, VA has a Memorandum of Understanding with Department of Health and Human Service's Indian Health Service (IHS), Tribal Health Programs (THP), or Urban Indian Health Programs (UIHP). These Tribal Programs and Services are key partners in VA's community care network, and VA reimburses the facilities for care provided to Native Veterans.

VA provides direct home loans to eligible AI/AN Veterans through the Native American Veteran Direct Loan (NADL) to finance the purchase, construction, or improvement of homes on Federal Trust Land, or to refinance a prior NADL to reduce the interest rate. Moreover, VA also provides grants to tribal governments to establish Veterans' cemeteries on tribal lands.

Additional Resources

- VA Tribal Consultations: http://www.va.gov/TRIBALGOVERNMENT/tribal_consultation.asp
- IHS/THP Reimbursement Agreements Program: http://www.va.gov/PURCHASEDCARE/programs/veterans/nonvacare/ihs/index.asp
- NADL Program: http://www.benefits.va.gov/HOMELOANS/nadl.asp

2.5 VA Federal Advisory Committees

The Federal Advisory Committee Act (FACA) and its implementing regulations set forth the processes for establishing, operating and overseeing advisory committees. FACA regulations define Federal advisory committees as any committee, board, commission, council, conference, panel, task force, or other similar group, which is established or utilized by the President or by an agency official, for the purpose of obtaining advice or recommendations for the President on issues or policies within the scope of an agency official's responsibilities.

VA's Committee Management Officer within the Advisory Committee Management Office (ACMO) is responsible for working with the Designated Federal Officer (DFO) of each committee to ensure charters are established and renewed for continuing operations of committees, members are selected in a timely manner, Federal Register Notices are prepared

to announce meetings, conflict of interest documents are reviewed and evaluated, and annual and special reports are compiled and forwarded to appropriate officials.

While most VA advisory committees hold meetings in Washington, D.C., some conduct site visits as appropriate and hold town hall meetings at local VA facilities (benefits offices, hospitals, and cemeteries). Advisory committees meet regularly with VA's senior leadership, and they receive frequent briefings by program managers in subject areas related to the committees' duties.

Additional Resources

- ACMO Website: http://www.va.gov/advisory
- Advisory Committees and VA Committee Managers: http://www.va.gov/ADVISORY/Advisory_Committees.asp

2.6 Veterans Service Organizations

Veterans Service Organizations (VSO) can be Congressionally chartered; recognized by the Secretary of VA (SECVA) for the purpose of assisting claimants for VA benefits in the preparation, presentation, and prosecution of their claims; or recognized by the SECVA because they have been determined to represent the interests of our Nation's Veterans.

VA, through the VSO Liaison in the Office of the SECVA, works with many VSOs but focuses its engagement on a core group: Veterans of Foreign Wars (VFW), The American Legion (TAL), Disabled American Veterans (DAV), Paralyzed Veterans of America (PVA), American Veterans (AMVETS), and Vietnam Veterans of America (VVA). These six organizations collectively represent over five million Veterans and have well organized D.C. offices that advocate for Veterans and lobby Congress. Best known for their posts, halls, and chapters throughout the country, these organizations also employ hundreds of service officers who help Veterans file VA disability claims.

While younger Iraq and Afghanistan Veterans still join the traditional VSOs, a growing number of them are joining newer Veterans organizations that focus less on advocacy and VA policy, and more on community engagement. For example, the following VSO's are geared more towards the Post-9/11 Cohort of Veterans: Student Veterans of America (SVA), Team Red, White & Blue, Mission Continues, Iraq and Afghanistan Veterans of America (IAVA), and Team Rubicon.

The SECVA currently hosts a monthly meeting with the Executive Directors from VFW, TAL, DAV, PVA, AMVETS, VVA, IAVA, and Military Officers Association of America. These candid meetings focus on key issues facing the department and are important in communicating and building relationships with VSOs.

Additional Resources

- VA Online Directory of VSO's: http://www.va.gov/vso/VSO-Directory_2013-2014.pdf

2.7 Nongovernmental Organizations

In addition to its partnerships with VSOs, VA leverages responsible and productive partnership opportunities with other Nongovernmental Organizations (NGOs) that can supplement VA services and help fill urgent or emerging gaps in services. These NGOs help VA assist Veterans with issues such as homelessness, higher education, employment, mental healthcare, caregivers, transition to civilian life, therapeutic recreation, etc. Increased public-private partnerships opportunities provide VA staff with additional tools and resources.

VA engages in a variety of partnerships across its Administrations and Staff Offices with a diverse group of organizations. MyVA's Strategic Partnerships team works at all levels of the Department to not only directly build partnerships, but also provide tools to VA staff needed to engage in partnerships. The Center for Faith-based and Neighborhood Partnerships (CFBNP) develops partnerships between faith-based, nonprofit, and community/neighborhood organizations and VA programs. Additionally, through its Office of Small and Disadvantaged Business Utilization (OSDBU), VA partners with a number of commercial companies to promote Veteran-owned and other small business concerns in capacity building, past performance evaluation, and related small business activities.

Additional Resources

- Faith-based and Neighborhood Partnerships: http://www.va.gov/cfbnpartnerships/
- Corporate Partners: http://www.va.gov/OSDBU/entrepreneur/partnersCorporate.asp

PART B: CURRENT OPERATIONS AND PLANS

3. VA Strategic Plans and Agency Goals

3.1 VA FY2014 – 2020 Strategic Plan

The VA FY2014-2020 Strategic Plan builds on past accomplishments to drive further improvements in quality, customer service, preparedness, and management systems by shifting the focus from improvement within a service or benefit delivery program to coordinating and integrating across programs and organizations. It also includes an emphasis on outcomes for the Veteran, and putting the Veteran in control of how, when, and where they wish to be served.

VA FY2014-2020 Strategic Plan

http://www.va.gov/op3/docs/StrategicPlanning/VA2014-2020strategicPlan.pdf

3.2 VA FY2014 – 2020 Strategic Policy Agenda

The VA Strategic Policy Agenda (VASPA) is an internal document that provides a general road map for coordinated, comprehensive policy analysis and formulation on multidisciplinary issues requiring collaboration across the Department. The VASPA is developed every four years and updated annually with policy priorities organized around the goals and objectives in the VA Strategic Plan.

VA FY2014-FY2020 Strategic Policy Agenda

The full document can be found in the Appendix, section A.2.

3.3 VA FY2016 – 2017 Agency Priority Goals

The VA FY2016-2017 Agency Priority Goals are: (1) Improve Veteran Experience with VA; (2) Improve VA's Employee Experience; (3) Improve Access to Health Care as Experience by the Veterans; and (4) Improve Dependency Claims Processing.

Agency Priority Goals

https://www.performance.gov/agency/department-veterans-affairs?view=public#apg

3.4 Draft VA FY2018 – 2024 Strategic Plan

- The draft VA FY2018-2024 Strategic Plan will incorporate the current MyVA 2017+ Initiatives to accommodate the future realities of the environment in which VA will operate and the evolving expectations of the Department's customers. The timeline for developing the next Strategic Plan is as follows: By December 30, 2016: Present draft Strategic Goals and Objectives to Agency Review Team.
- By February 17, 2017: Present draft Strategic Plan to leadership for review.
- By March 17, 2017: Review feedback and comments received from leadership and amend, as necessary.
- By April 14, 2017: Circulate draft Strategic Plan for Department-wide comments and review for two-week period.
- By May 1, 2017: Submit draft Strategic Plan for concurrence and Secretary of VA approval.
- By June 2, 2017: Send draft Strategic Plan to Office of Management and Budget for review and comments.

Goals and Objectives

The full document can be found in the Appendix, section A.1.

4. VA Strategic Operating Model

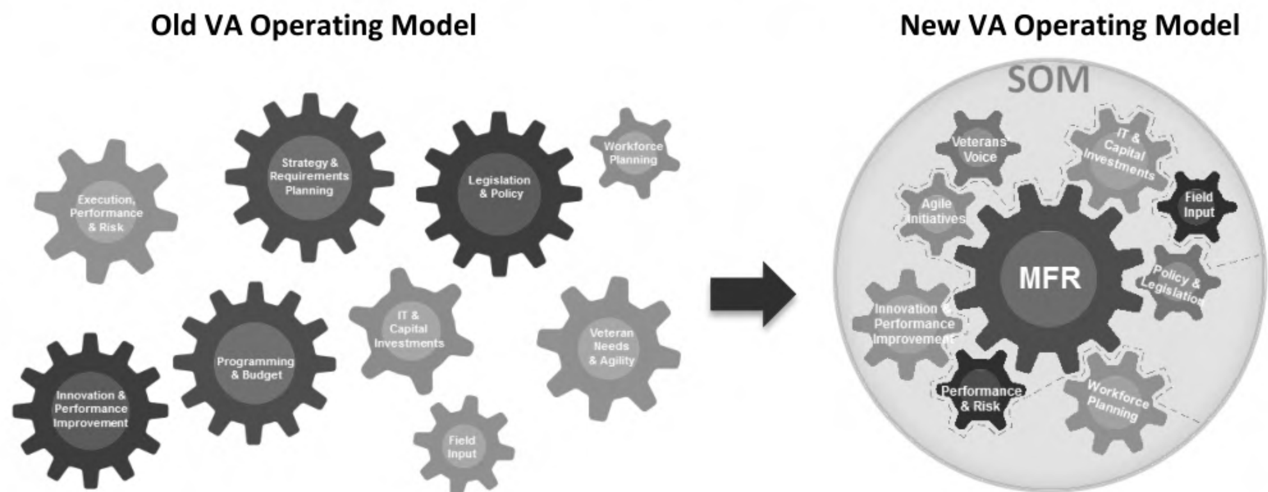
VA does not have a strategic business operating model that synchronizes key processes and functions to efficiently and effectively manage the Department as an integrated enterprise. Previous efforts to connect and integrate VA business processes were not successful due to a number of reasons. First, the processes themselves that VA was trying to connect were not fully established or matured. Most of those processes are now in place and operational but they remain largely disconnected. Further, many of these processes are not sufficiently forward looking to provide solutions that will satisfy future Veteran needs. The lack of an integrated

business operating environment causes the Department to react rather than anticipate problems and proactively implement cost-effective and integrated enterprise solutions.

Second, due to a lack of an integrated business model the Department has become increasingly reliant on "initiatives" to succeed. While these initiatives have proven successful, they are not the optimal solution to fully integrate VA programs in a way that guarantees consistent returns on investment. VA has used these initiatives to solve problems, improve performance, and accelerate success, but have yet to leverage them fully to become a high performing organization.

VA needs a Strategic Operating Model that includes an enterprise-wide "operating rhythm" to effectively and efficiently manage a $170 billion enterprise focused on providing Veterans with health care, benefits, and services. Problems that resulted from not having and integrated enterprise business operating model are obvious across VA. As such, clear momentum exists to integrate the Department's disconnected processes in a manner that aligns resources with the Veteran outcomes VA must deliver.

Figure 2. Strategic Operating Model/Managing for Results

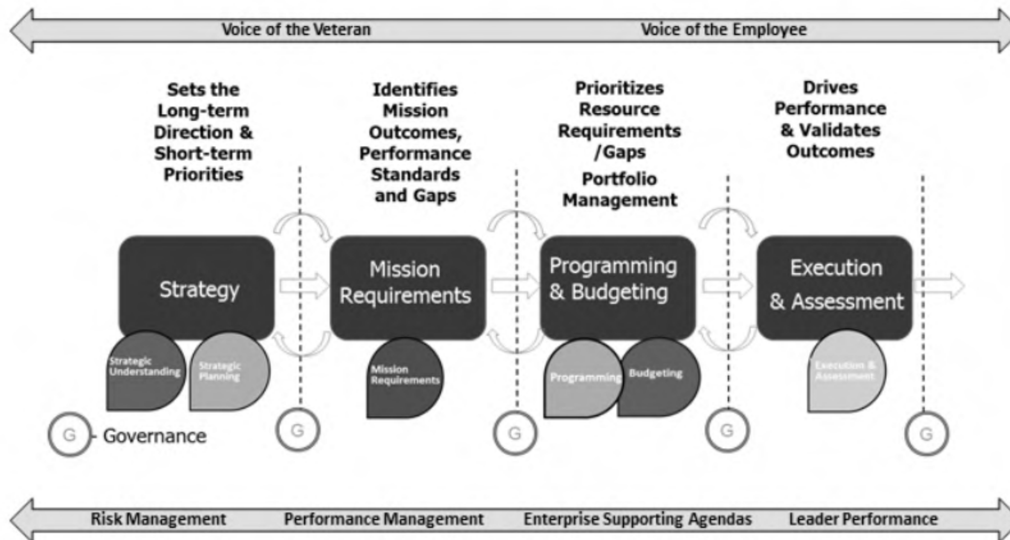


Since 2015, the VA Office of Enterprise Integration (OEI) has been leading and collaborating with key stakeholders across the Department to develop and implement an operating model that connects enterprise business processes (Managing for Results) and integrates them with key business elements (legislation, policy, research, innovations, workforce planning, etc.). This effort to integrate and improve VA management capabilities is known as the Strategic Operating Model/Managing for Results (SOM/MFR).

4.1 Strategic Operating Model/Managing for Results Overview

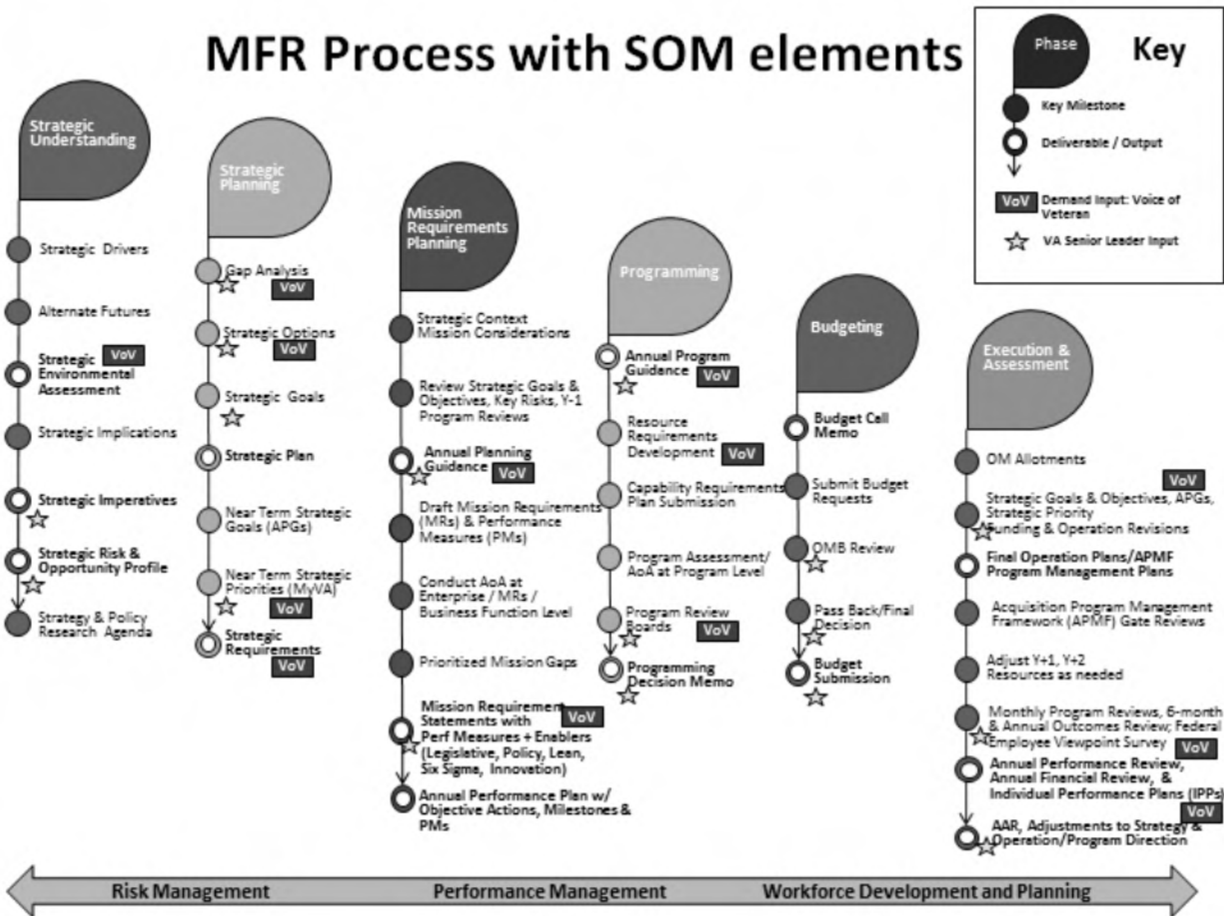
Over the course of several years, implementing and streamlining the VA SOM/MFR will lead to a budget that directly aligns with Veteran requirements and VA strategies to achieve those requirements. VA and its stakeholders will be able to trace dollars spent to outcomes achieved, both at the initiative and program levels, and will be able to see how non-material supporting elements like policy, legislation, innovation, performance improvement, and strategic human capital management contribute to achieving Veteran-focused outcomes, employee satisfaction, and tax payer value. VA and its stakeholders will be able to trace leader performance down to the field level as VA cascades performance and resource alignment, and will be able to understand when a shortfall in resources present a risk to VA being able to achieve required outcomes.

Figure 3. Strategic Operating Model and Managing for Results Alignment



The heart of the Strategic Operating Model (SOM) is the Managing for Results (MFR) process. MFR is a disciplined and agile process to align the Department's strategies, requirements, resources and performance through transparent decision-making and accountability. MFR will integrate the Department's previously disconnected processes. The resources VA spends must clearly lead to the Veteran outcomes VA has to deliver, with leaders held accountable for results. The MFR process integrates performance and risk management processes iteratively and sequentially across the enterprise level, and then the program level, allowing for effective real-time decision-making. The integrated MFR process enables leader assignment, accountability, and succession based on program needs and performance.

Figure 4. Managing for Results Process with Strategic Operating Model Elements



SOM/MFR will accelerate VA progress by leveraging transformational initiatives. The operating model will support the effort to spread corporate learning, best practices, and a performance improvement culture throughout the department. Additionally, the MFR component of the model that integrates strategy, requirements, budget, and execution will effectively support the identification, planning, and execution of future transformational initiatives. MFR will make the transformational initiatives progress sustainable at the strategic level and the transformation strategies will help shape the VA Strategic Plan. Ultimately, the transformational initiatives will evolve into programs that continue forward and maintain a Veteran-focused perspective. MFR will help provide the real time data and input needed for initiative and program course corrections, just as one would expect to see in a high-performing organizations. Actions and decisions for all three elements – MFR alignment of the strategy to requirements to budget processes, transformational initiatives, and programs – will be synchronized through an enterprise-wide “operating rhythm” that implements the right action and provides the information for the right decision by the right leader at the right time.

4.2 Strategic Operating Model/Managing for Results Implementation Approach

The Strategic Operating Model/Managing for Results (SOM/MFR) is designed as a maturity model that will take several years to fully implement. The concept of operation begins with the immediate implementation of management efforts that integrate VA's planning, resourcing, and support processes with existing execution processes, while simultaneously using stakeholder outreach to further improve and mature SOM/MFR. To do so, the Department is executing four lines of effort: *1) establishing a Quarterly Focus for Initiative & Program Reviews; 2) developing the governance process for Monthly Budget, Performance and Risk Reviews; 3) standardizing and aligning governance processes for MFR Discussions, Direction, and Decisions from VA senior leaders; and 4) enhancing the SOM/MFR Implementation Plan through outreach to the stakeholders including those in the field.*

Focus for Initiative & Program Reviews will provide a quarterly theme to shape initiative meetings and program reviews each quarter. The intent is to focus on a logical sequencing of topics each quarter. In Quarter 1, the focus will be on what initiatives and programs have learned from previous year and what revisions they have made to their operations based on that learning. In Quarter 2, the focus will be on feedback from Veterans and employees regarding each program/initiative and how efforts have been refined to better meet outcomes based on that input. In Quarter 3, the focus will be on how to most effectively integrate policy, legislation, performance improvement, and other enabling functions to meet outcomes. In Quarter 4, the focus will be on what each program or initiative outlines as their plan to successfully meet Veteran, employee, and taxpayer outcomes in the next fiscal year. This quarterly focus will begin to tie transformational initiatives and programs together into a more cohesive department operating approach.

FY2017 Monthly Budget, Performance and Risk Program Reviews will combine VA budget and performance reviews so that resources execution and the performance outcomes generated by those resources can be compared to the planned performance glide path. The monthly review will also examine risks at the program level, including those that are emerging from performance gaps. The monthly review will cover programs by enterprise portfolio (Access, Delivery, Enabling/Support Services), rather than by Administration or key Staff Office, and will enable the Department to move closer toward enterprise decision-making. It should be noted that an evolution of the program review to dashboard and virtual components (virtual enables more involvement from VA field leadership) to supplement in-person governance meetings.

MFR Discussions, Direction, and Decisions focus staff, field input, and leader discussions on sequentially aligned strategy, requirements, programming, budget, and key supporting topics at the beginning of each month and reconvene at the end of the month for a decision/direction briefing that links to the next step in the process. Note that the Programming

Decision Memorandum that prioritizes VA resources, and the VA Risk Profile that identifies key emerging threats and opportunities to deliver Veteran outcomes, will serve as two key sources for identifying and selecting future Transformational Initiatives each year. The Department should be able to execute these initiatives much more rapidly with analysis, resource planning, and leadership alignment already completed before launch.

SOM/MFR Detailed Implementation Plan Development based on Input from the Field will allow for an operating model that meets VA needs at the headquarters and in the field. As VA is implementing SOM/MFR, the Office of Enterprise Integration (OEI) continues to collaboratively develop operating model details to ensure it integrates our processes in a manner that provides value to Veterans and all of VA. The key element will be working with stakeholders in the Administrations and Staff Offices – at both the headquarters and field level – to align SOM/MFR so that it provides lasting value to their organizations.

4.3 Strategic Operating Model/Managing for Results Planned Outcomes

- VA will have aligned and integrated Strategy-Requirements-Budget-Execution processes to properly resource the Department's initiatives and programs that effectively deliver benefits and services to Veterans and achieve the planned desirable outcomes.
- VA will improve Veteran and employee outcomes driven by initiatives that are evidence-based and developed to address requirement gaps, risks, and opportunities.
- VA will have a performance and risk management framework that informs the aforementioned processes at the right time and with the right input. That framework will also support programs and initiatives that are measurable; that can articulate their measurable performance path to success; and that can identify and act on risks that are outside of the VA risk appetite.
- VA will have enterprise governance structure that positions VA senior leaders to make data-driven recommendations and decisions.

5. Budget and Performance

5.1 FY2017 / FY2015 Annual Performance Plan and Report

The FY2017 / FY2015 Annual Performance Plan and Report documents VA's performance achievements and commitments, demonstrating the focus on delivering effective and timely care and benefits to Veterans. VA's emphasis is on outcomes; Veteran satisfaction with their VA experiences; and robust, effective programs. These measures are organized by the goals in the VA Strategic Plan.

FY2017 / FY2015 Annual Performance Plan and Report (APP&R)

http://www.va.gov/budget/docs/VAapprFY2017.pdf

5.2 FY2015 Agency Financial Report

The VA FY2015 Agency Financial Report (AFR) provides information enabling Congress, the President, and the public to assess our stewardship over the financial resources entrusted to us and our performance as an organization. The report provides results on VA's progress toward providing America's Veterans with the best in benefits and healthcare; a high-level summary of VA accomplishments during the year; a discussion of the challenges VA faces going forward; and an analysis of our financial position and the Inspector General's Statement on VA's Major Management Challenges. The FY2016 AFR will be provided to the Agency Review Team once it is published.

FY2015 Agency Financial Report

http://www.va.gov/finance/afr/index.asp

5.3 FY2016 VA Budget Execution Summary

Table 2. VA Programs

($ in 000)	2016		Variance - Plan vs Actual		
Program	Plan	Obligation	$	%	Carryover start of 2017
Medical Care					
Medical Services 1/	53,516,204	52,442,183	(1,074,021)	-2.0%	666,865
Medical Support and Compliance	6,114,763	6,060,984	(53,779)	-0.9%	84,501
Medical Facilities	4,680,429	4,688,513	8,084	0.2%	9,934
Total Medical Care	**64,311,396**	**63,191,680**	**(1,119,716)**	**-1.7%**	**761,300**
Veterans Choice Act - SEC 801	2,724,007	2,308,941	(415,066)	-15.2%	1,354,383
Veterans Choice Act - SEC 802 1/	4,240,000	3,232,504	(1,007,496)	-23.8%	4,503,458
Veterans Choice Total	**6,964,007**	**5,541,445**	**(1,422,562)**	**-20.4%**	**5,857,841**
Medical Research	656,520	658,949	2,429	0.4%	61,488
Veterans Benefits Administration GOE	3,258,409	3,127,354	(131,055)	-4.0%	100,000
General Administration	**739,843**	**716,100**	**(23,743)**	**-3.2%**	6,672
Budget Authority	*336,594*	*328,554*	*(8,040)*	*-2.4%*	
Reimbursable Authority	*403,249*	*387,546*	*(15,703)*	*-3.9%*	
Board of Veterans' Appeals	112,936	110,091	(2,845)	-2.5%	2,614
National Cemetery Administration	269,402	264,673	(4,729)	-1.8%	2,000
Information Technology			-		
Development	583,741	460,897	(122,844)	-21.0%	118,770
Sustainment	2,597,317	2,555,514	(41,803)	-1.6%	20,000
Pay & Administration	1,112,568	1,080,870	(31,698)	-2.8%	20,439
EOF/OIF Supplemental (No-year)			-		1,584
Total Information Technology	**4,293,626**	**4,097,281**	**(196,345)**	**-4.6%**	**160,793**
Construction, Major*	1,116,510	1,339,891	223,381	20.0%	2,062,337
Construction, Minor**	925,526	590,073	(335,453)	-36.2%	673,134
Grants for States Extended Care	129,200	128,600	(600)	-0.5%	22,542
Grants for Veterans Cemeteries	54,030	49,252	(4,778)	-8.8%	
Inspector General	142,402	131,992	(10,410)	-7.3%	9,000
Loan Administration Funds *(non-add) included in VBA GOE*	166,090	163,093	(2,997)	-1.8%	
Total VA	**82,973,807**	**79,947,381**	**(3,026,426)**	**-3.6%**	**9,719,720**

1/ Refelects 2016 audit adjustment

* Major construction for VHA and NCA less Denver funding/obligations.

** Minor Construction includes VHA, NCA, VBA, and Staff Office. Staff Office minor obligations are not included in the MBER totals.

Table 3. VA Staff Offices

($ in 000)	2016		Variance - Plan vs Actual	
Program	Plan	Obligation	$	%
Office of the Secretary	16,654	16,622	(32)	-0.2%
Office of the General Counsel	109,187	106,503	(2,684)	-2.5%
Office of Management	102,955	101,807	(1,147)	-1.1%
Office of Human Resources Administration	267,866	258,900	(8,965)	-3.3%
Office of Policy and Planning/OEI	100,931	93,933	(6,998)	-6.9%
Office of Operations, Security & Preparedness	30,837	28,814	(2,024)	-6.6%
Office of Public and Intergovernmental Affairs	25,438	25,089	(349)	-1.4%
Office of Congressional and Legislative Affairs	7,654	7,160	(494)	-6.5%
Office of Acquisitions, Logistics, & Construction/OGR	78,322	77,273	(1,049)	-1.3%
Total Staff Offices	**739,843**	**716,101**	**(23,742)**	**-3.2%**

Note: 2017 start of year carryover is $6.7 million. As a result of under plan levels of FTE in 2016, $9.4 million in BA hire lag was reallocated to the reserve fund for Department priorities. $15.7 million in under plan execution was unrealized reimbursements which were returned to the customers.

Veterans Health Administration (VHA) Programs

- **Care in the Community:** Total obligations (including Choice) were $12.0 billion, $1.3 billion (9.5%) below plan. Spending represented 90.2% of the annual plan of $13.3 billion.
- **Choice Program:** Obligations were $2.7 billion, 70.8% of the plan of $3.8 billion.
  - Choice Program Carryover: $4.5 billion of Section 802 funds carried over into FY2017.
- **Hepatitis C:** Discretionary obligations totaled $875.1 million, $624.9 million (41.7%) below plan, and 58.3% of the FY2016 annual budget of $1.5 billion.
- **Total Carryover:** $761.3 million ($623.3 million in Hepatitis C funds).
  - VHA was authorized to carry over $1.75 billion into FY2017.
  - Audit adjustment has potential impact to lapse $222 million of FY2016 funds. VA is working with the Office of Management and Budget (OMB) on a solution.
- **Veterans Choice Act:** Section 801 obligations totaled $2.3 billion, representing 85% of the annual plan of $2.7 billion; significant under execution was in the IT and Legionella plans. Carryover was $1.35 billion into FY2017.

Other Programs

- **Veterans Benefits Administration (VBA)**: Obligations were $131 million (4%) below plan. Non-pay spending was 10.7% below plan due to delayed procurement actions.
  - **Carryover:** VBA carried over $100 million into FY2017 while turning in $83.6 million in unearned reimbursements.

- **National Cemetery Administration (NCA):** Obligations of $264.6 million were 1.8% below plan. Pay was $1.8 million (1.2%) below and Non-Pay was $3.0 million (2.5%) below plan.
    - **Carryover:** NCA carried over $2 million into FY2017, and expects to carry over an additional $2.7 million, once adjustments are complete.
- **Information and Technology (IT):** Obligations of $4.1 billion were $196.3 million (4.6%) below plan. Spending in all three areas was below plan.
    - **Carryover:** IT carried over $159.2 million into FY2017.
    - **Funding Lapse:** IT lapsed $14.1 million in FY2016.
- **Construction:**
    - VHA Minor Construction execution completed the year significantly below plan for both the Choice Act (76%) and non-Choice (60%).
    - The Non-Recurring Maintenance (NRM) revised operating plan was approved by VA in May; issues continue in the execution of projects not approved in the VA formulation process.
- **General Administration (Gen Ad) for Staff Offices:**
    - Gen Ad obligations were $23.7 million (3.2%) below plan.
    - Gen Ad carryover has now reached the 2016 statutory cap of $10 million.
        - An additional $9 million is expected to be transferred from Gen Ad to VBA in FY2017.
- **Board of Veterans Appeals:**
    - Obligations totaled $110.1 million, $2.8 million (2.5%) below plan.
    - FTE were 660, or 20 FTE below plan.
    - Carryover into 2017 was $2.6 million.

5.4 Budget Process, FY2017 Budget, and FY2018 Budget

VA will provide in-person briefings on the budget process, FY2017 Budget, and proposed FY2018 Budget to the Agency Review Team upon completion of a Record of Disclosure of Non-Public Information.

6. VA Legislative Priorities

In late September 2016, Congress enacted several prominent VA priorities, including VA's full FY2017 appropriation, necessary extensions of authority, some but not all major medical construction authorizations, and enabling legislation for significant homelessness efforts on VA's West LA hospital campus. However, many critical legislative priorities remain for enactment:

- **Appeals Reform** – In close collaboration with Veterans Service Organizations (VSOs), VA developed the appeals modernization proposal that is the foundation of the legislation before both the House of Representatives and Senate. VA's current inventory of appeals is over 464,000. Without significant reform, this inventory is projected to be almost 1.2

million claims by the end of FY2026. While VA continues to utilize resources provided by Congress to improve the timeliness of appeals decisions under current law, the system cannot be reformed without additional Congressional action.

- **Budget Flexibility** – VA has urged Congress to enact measures to allow more flexibility among its appropriations accounts. Barriers created by artificial budget distinctions impede the management of important programs and projects. Without flexibility to respond to dynamic conditions across benefit programs, VA will continue to encounter arbitrary barriers and delays in its programs and operations.
- **Provider Agreements** – Since 2015, VA has urged Congress to retool the Department's authorities for purchased Care in the Community. These authorities would ensure that Veterans receive the necessary care they earned through the fullest complement of non-VA providers. On May 1, 2015, VA transmitted the VA Purchased Health Care Streamlining and Modernization Act to Congress, presenting a way forward on establishing provider agreements. The bill clarified key legal issues regarding VA's purchased care authorities outside of the Veterans Choice Program. Thus far, inaction on this issue has resulted in complications with extended-care providers and other non-Veterans Choice care. Some small long-term care facilities have already withdrawn their support of Veterans due to the overwhelming administrative requirements of the Federal Acquisition Regulations (FAR). In order to offer important care to Veterans, VA needs the authority to enter provider agreements that secure non-VA health care services.
- **Remove "80-hour pay period" Requirement** – VA proposed an end to the arbitrary 80-hour per Federal work period requirement that is not appropriate, efficient, or relevant for most medical professionals, and is behind the current industry standard in the private sector. Enacting legislation on this issue will increase efficiency of hospital operations and it will improve VA's ability to compete effectively with the private sector in recruiting and retaining critical medical professionals.
- **Special Pay Authority for VA Healthcare Senior Managers** – VA continues to urge Congress for special pay authority for VA Medical Center and Veterans Integrated Service Network Directors. As the largest integrated healthcare network in the country dedicated to caring for Veterans and their families, VA should employ the most talented hospital system management professionals. Approval of special pay authority for these positions will allow VA to attract the very professionals needed to lead VA's hospitals and healthcare systems.
- **Construction and Leasing** – In addition to specific work pertaining to the West Los Angeles site, VA has urged action on Congressional authorizations for numerous construction and leasing projects across the country that already have appropriations enacted to fund the projects. These projects will provide a much needed increase in Veterans' access to care closer to home. While Congress did enact some major medical construction projects, two VA proposed major construction projects await action, as well as 24 major medical leases, 18 requested in FY2016 and six in FY2017. A complete list of major leases pending authorization can be found in the Appendix, section A.4.

- **Partnership for Legal Services** – VA currently does not have authority to provide grants or enter into cooperative agreements that would fund partnerships with those who can provide legal services for homeless Veterans. VA believes this assistance would make a significant difference in combating homelessness by leveraging the legal community.
- **VA as Choice Primary Payer** – The Choice Act requirement that VA be the "secondary payer" created new charges for Veterans with other insurance that do not occur when using non-VA care. This has created a frustrating billing process for over one million Veterans that have used the Choice Program.
- **Recording Obligations at Payment** – Current accounting rules require community care expenses to be recorded at the time the care is first authorized. At that time, the ultimate expenditures created by that obligation are very hard to predict, depending on how it is used by the Veteran. Those authorizations can precede the actual expenditures for care by many months. Even with careful management, differences in the amounts recorded at obligation from the actual expenditures can result in "de-obligation" of funds, with the result of VA not being able to use the full amount Congress provides in appropriated funds.
- **Telehealth** – Currently, there is pending legislation that will help ensure that VA can guarantee the fullest use of telehealth capabilities in order to provide easier access to VA healthcare, especially for consultations where the medical professional or the patient are not located in a medical facility.
- **Legislative Changes to Facilitate Sharing of Patient Information** – A special authority, applicable only to VA, restricts the sharing of patient information with other public and private healthcare providers if patient records concern HIV, sickle cell anemia, or drug or alcohol abuse. This authority is obsolete and significantly impedes VA care coordination for some patients. VA supports changing this authority while still applying all provisions of the Health Information Portability and Accountability Act (HIPAA).

PART C: TOP ISSUES FOR LEADERSHIP

7. Key Issues from the Oversight Community

Audits and reviews by our oversight partners, such as VA's Office of Inspector General (OIG) and the U.S. Government Accountability Office (GAO), provide essential accountability and transparency over Department programs and operations. It is VA practice, at all levels of responsibility, to provide reliable, useful, and timely information to our accountability partners during their reviews.

7.1 VA Office of Inspector General

VA OIG is responsible for: (1) conducting and supervising audits and investigations; (2) recommending policies designed to promote economy and efficiency in the administration of, and to prevent and detect criminal activity, waste, abuse, and mismanagement in VA programs and operations; and (3) keeping the Secretary and Congress fully informed about problems and deficiencies in VA programs and operations and the need for corrective action. The OIG has authority to inquire into all VA programs and activities as well as the related activities of persons or parties performing under grants, contracts, or other agreements. In addition, P.L. 100-322, *Veterans Benefits and Services Act of 1988*, charged the OIG with the oversight of the quality of VA health care.

VA OIG is led by the Inspector General (IG), who is appointed by the President with the advice and consent of the Senate. The current Inspector General, the Honorable Michael J. Missal, assumed responsibility as IG on May 2, 2016. While VA OIG employees are employees of the Department, the OIG and its employees remain independent per the Inspector General Act. VA OIG is organized into three line elements: the Offices of Investigations; Audits and Evaluations; and Healthcare Inspections. The OIG also has a contract review office and a support element. The OIG conducts reviews of varying scope and complexity, such as national, enterprise-level audits and local facility-level reviews and inspections.

Additional Resources

- For more information on the types of reports conducted by the OIG, as well as access to all OIG reports and publications, visit: http://www.va.gov/oig/

7.1.1 How VA Interacts with the Office of Inspector General

Each administration and staff office subject to an Office of Inspector General (OIG) audit or review coordinates directly with the OIG. Offices which are subject to many OIG audits and reviews have dedicated staff devoted to audit liaison responsibilities (see Table 4). Offices

which do not have dedicated audit liaison staff generally facilitate the OIG engagement with a front office contact through the Department's regular concurrence process. Because not all OIG reviews are national in scope and require direct coordination with Administrations and Staff Offices, it is the responsibility of each respective office to alert the Office of the Secretary of any OIG matters which require its attention.

Table 4. Audit Liaison Offices and Points of Contact for Office of Inspector General and Government Accountability Office Reviews

Department (for OIG)	Office of the Executive Secretariat
Department (for GAO)	Office of Congressional and Legislative Affairs, Oversight Directorate
Veterans Health Administration	Management Review Service
Veterans Benefits Administration	Program Integrity and Internal Controls
National Cemetery Administration	Business Process Improvement and Compliance Service
Office of Information and Technology	Project Coordination Service
Office of Human Resources and Administration	Office of Quality, Performance, and Oversight
Office of Acquisition, Logistics, and Construction	Office of Resource Management
All Other Staff Offices	Office of the Assistant Secretary or Senior Executive

Source: Office of Enterprise Integration, July 2016.

While each administration and staff office is responsible for its own interactions with the OIG, the processes are largely consistent across the Department. Generally, the OIG audit/review process across VA includes: (1) informing VA of the review [initiation]; (2) entrance conference; (3) OIG audit/review activity; (4) exit conference; (5) OIG provides VA a draft report; (6) VA drafts its agency response and corrective action plan, if necessary; (7) OIG publishes online its final report; and (8) VA implements corrective action/follow-up.

Furthermore, while many OIG reports are focused on facility or programmatic matters, these reports may still be of public importance to VA from a Department perspective. Every two weeks, the OIG provides the Office of the Secretary a list identifying all draft reports, regardless of whether it is a national or facility-level review. The Executive Secretary and Senior Advisor for Strategic Communications will assess this list, in consultation with the appropriate administration/staff office liaison staff, in order to identify reports which may have strategic implications to the Department. Any draft report which has been assessed to have a potential Department-level implications will then be brought to the attention of the Department's strategic communications and public affairs team in order to coordinate a communications plan in response to the pending report.

7.1.2 Office of Inspector General Major Management Challenges

Each year, pursuant to 31 U.S.C. § 3516, the OIG provides VA with an update summarizing what they find to be the most serious management and performance challenges identified by OIG work, as well as an assessment of VA's progress in addressing those challenges. VA publishes the OIG's assessment in its annual Agency Financial Report.

The most current report available is associated with VA's most recent Agency Financial Report (AFR), FY2015. This information will be updated once the FY2016 AFR is released. Table 5 provides a list of the most recent OIG Major Management Challenges.

Table 5. 2015 Office of Inspector General Major Management Priorities and Challenges

Item Number	Description and Responsible Office
OIG 1	**Health Care Delivery (VHA)**
1A	Quality of Care (VHA)
1B	Access to Care (VHA)
1C	Care for Homeless Veterans (VHA)
OIG 2	**Benefits Processing (VBA)**
2A	Improving the Accuracy of Claims and Decisions (VBA)
2B	Improving Data Integrity and Management Within VA Regional Offices (VBA)
2C	Improving Management of the Fiduciary Program (VBA)
OIG 3	**Financial Management (OM, OIT, VHA, VBA)**
3A	Compliance with the Improper Payments Elimination and Recovery Improvement Act (OM, VHA, VBA)
3B	Improving Management of Appropriated Funds (OM, OIT, VHA)
OIG 4	**Procurement Practice (OALC, VHA)**
4A	Improving Contracting Practices (OALC, VHA)
4B	Improving Oversight of Patient Centered Community Care Contracts (OALC, VHA)
OIG 5	**Information Management (OIT)**
5A	Develop an Effective Information Security Program and System Security Controls (OIT)
5B	Improving Compliance with Federal Financial Management Improvement Act (OIT)
5C	Improving Accountability and Oversight of the Project Management Accountability System (OIT)

Source: 2015 OIG Major Management Challenges.

7.1.3 Office of Inspector General Semiannual Report to Congress

Published in November and April of every year, these reports to Congress highlight OIG activity. The most current and previous versions of the OIG Semiannual Report can be found at: http://www.va.gov/oig/publications/semiannual-reports.asp.[1]

7.2 U.S. Government Accountability Office

GAO is an independent, nonpartisan agency that works for Congress. GAO conducts audits, reviews, and investigations on how the federal government spends taxpayer dollars. The head of GAO, the Comptroller General of the United States, is appointed to a 15-year term by the President from a slate of candidates Congress proposes. GAO work is done at the request of Congressional committees or subcommittees or is mandated by public laws or committee reports. GAO supports congressional oversight by: auditing agency operations to determine whether federal funds are being spent efficiently and effectively; investigating allegations of illegal and improper activities; reporting on how well government programs and policies are meeting their objectives; performing policy analyses and outlining options for congressional consideration; and issuing legal decisions and opinions, such as bid protest rulings and reports on agency rules.

Additional Resources

- For more information on GAO reports and publications related to VA, visit: http://www.gao.gov/browse/agency/Executive/Department_of_Veterans_Affairs/

The status of each GAO report with open recommendations is provided by GAO at: http://gao.gov/recommendations and searching target agency "Veterans Affairs."

7.2.1 How VA Works with Government Accountability Office

All VA interactions with Government Accountability Office (GAO) are formally facilitated by the Office of Congressional and Legislative Affairs (OCLA). As VA's audit liaison for all GAO reports, OCLA notifies the Department of all GAO engagements, coordinates and prepares responses to draft and final reports, and ensures responses are provided to GAO in a timely manner. OCLA also keeps VA leadership and strategic communications staff apprised of GAO recommendations. Each administration and staff office liaison also plays a key role in facilitating

[1] The most recent Semiannual reporting period is April 1, 2016 – September 30, 2016. This report becomes available in November. The most recent Semiannual reporting period published covers October 1, 2015 – March 31, 2016.

GAO's fieldwork with each respective office, and coordinates closely with OCLA during this process.

All GAO reports are signed off by the Chief of Staff (COSVA), and therefore routed to the Office of the Secretary for concurrence on VA's response. The process for handling GAO reports is similar to the OIG, except that OCLA formally coordinates the interactions with GAO, and OSVA concurs on and signs on all VA responses.

7.2.2 Government Accountability Office High Risk List

In 1990, GAO began a program to report on government operations that they identified as "high risk" to call attention to agencies and program areas that are high risk due to their vulnerabilities to fraud, waste, abuse, and mismanagement, or are most in need of transformation. Since then, generally coinciding with the start of each new Congress, GAO reports on the status of progress to address high-risk areas and update their High Risk List. GAO's most recent High-Risk update was in February 2015.

The current High Risk report can be found at: http://www.gao.gov/highrisk/overview.[2]

Current risk areas involving VA include:

- **Improving and Modernizing Federal Disability Programs**
- **Managing Risk and Improve VA Health Care**
- **Improving the Management of IT Acquisitions and Operations**

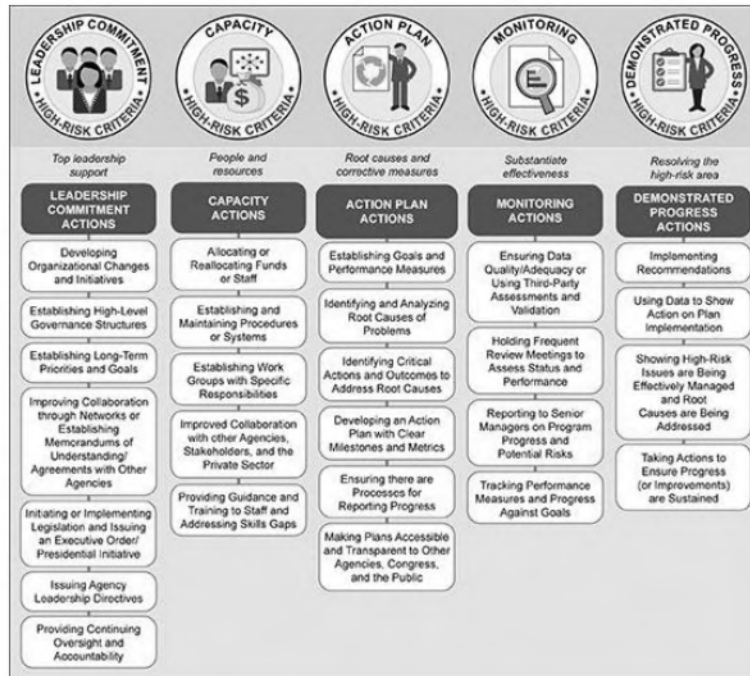
In 2016, GAO published a guide that provided illustrative actions, within each of the five removal criteria, that agencies took that led to progress or removal from the High Risk List. The guide can be found at: http://www.gao.gov/assets/680/676800.pdf.

In order for a high-risk area to be removed from the list, GAO assesses progress using the following criteria: **Leadership Commitment, Capacity, Action Plan, Monitoring, and Demonstrated Progress**. GAO has recently added clarity and specificity to its assessments by rating each high-risk area's progress on each of the five criteria using the following definitions:

- **Met**. Actions have been taken that meet the criterion. There are no significant actions that need to be taken to further address this criterion.
- **Partially Met**. Some, but not all, actions necessary to meet the criterion have been taken.
- **Not Met**. Few, if any, actions toward meeting the criterion have been taken.

[2] Of note, GAO's report to the Congress includes both an assessment of progress as well as recommendations regarding areas where Congressional action is required to facilitate further progress (e.g., legislation; resources).

Figure 5. Government Accountability Office Criteria for Removal from the High Risk List



Source: GAO. | GAO-16-480R

Beginning engagements with a new High Risk area generally begin with a meeting between the Department; the Defense Health Branch, National Security Division, Office of Management and Budget; and the Administration with the High Risk Area; and the Comptroller General of the United States. The purpose of that meeting is present progress and path forward for the High Risk Area and allow for a discussion among the principals to ensure clarity of expectations for each party. Thereafter, the Administration and OMB meet annually to review progress in the High Risk Area.

Close interaction with the GAO's High Risk List Teams is a proven federal best practice. VA interactions with GAO, while still formal, are facilitated by Risk Area leadership. These meetings occur frequently, and focus on actions taken and on additional actions that need to be taken to address the high risk issues.

VA's *Strategy for Health Care High Risk Management*, an annual submission to GAO, is signed off by the Secretary. The GAO Health Care High Risk Task Force leadership coordinates the document with all stakeholders, including OCLA, OGC, COSVA, and the Deputy Secretary.

The following section provides VA's status update at addressing GAO high risk areas relevant to VA:

Improving and Modernizing Federal Disability Programs

GAO identified "Improving and Modernizing Federal Disability Programs" as a VA high risk area in its 2003 High Risk List Update. VBA is working diligently to resolve the issues identified in the latest GAO High Risk Report, dated February 11, 2015. Two of the most important concerns raised by GAO involve updating the VA Schedule for Rating Disabilities (VASRD) and managing VBA disability claims workload.

VASRD. VBA has drafted 14 proposed rulemaking packages that will cover the 15 body systems in the VASRD. VBA has published proposed regulations for notice and comment in the Federal Register for six body systems. The six proposed rules already published include:

- The Hemic and Lymphatic Systems,
- Gynecological Conditions and Disorders of the Breast,
- The Organs of Special Sense (Eye),
- The Endocrine System,
- Dental and Oral Conditions, and
- Skin Conditions.

VBA is addressing all outstanding regulations, which have yet to be published as proposed regulations, by the end of fiscal year FY2017. VBA intends to publish final rulemakings for all VASRD body systems by the end of FY2018. In July 2016, VBA revised the VASRD Project Management Plan. See Attachment A. This new timeline is necessary due to a variety of factors, including frequent changes to medical science, and the applicability of those rapid advancements to VBA disability evaluation process.

VBA will place each VASRD body system into a five-year cycle of staggered reviews. This strategy is based on recommendations from a 2007 Institute of Medicine (IOM) report. In that report, IOM proposed a series of corrections to the existing schedule for rating disabilities and guidance designed to improve Veterans benefits in the 21st century. Additionally, VBA will document work plans and maintain working groups for each of the VASRD body systems to ensure that on a routine basis, findings from discussions on current science and medical advancements are incorporated into the body system reviews as necessary.

Claims Workload. VBA has made and will sustain efficiency gains in processing disability compensation claims through a blend of people, process, and technology enhancements. The continuously improving automation capabilities provided by the Veterans Benefits Management System (VBMS), coupled with the implementation of the National Work Queue (NWQ) and the Centralized Mail (CM) program, are clear examples of enhancements that increase the efficiency of claims processing. Specific functionality was added to VBMS to systematically request DoD Service Treatment Records (STRs) when a Veteran's claim is initiated, and DoD has made significant progress in the timeliness of their responses. In

February 2016, VBA launched NWQ, a national workload distribution tool. With 99.7% of the pending disability compensation claims inventory converted to digital format, VBA is able to efficiently manage the claims workload centrally, set priorities nationally, and distribute claims that are ready to be worked electronically based on individual regional office (RO) capacity levels. As of May 8, 2016, all ROs are receiving disability rating claims through the NWQ. The CM program is a process improvement effort also contributing to claims processing efficiencies.

Managing Risk and Improving Health Care

GAO identified "Managing Risk and Improving VA Health Care" as a VA high risk area in its 2015 High Risk List Update. GAO identified five associated high risk issues:

- Ambiguous policy and processes;
- Inadequate oversight and accountability;
- Information technology challenges;
- Inadequate training; and
- Unclear resources and allocation priorities.

Senior leaders from VA met with senior career officials at the Office of Management and Budget and with the Comptroller General of the United States on April 29, 2016. At that meeting, the Comptroller General rated VA as 'partially met' for leadership commitment, one of the five criteria for removal from the GAO High Risk List. GAO will present formal assessments against all five criteria to Congress in its February 2017 High Risk List Update.

VA submitted its initial *Strategy for Health Care High Risk Management* to GAO on August 18, 2016. The *Strategy*, informed by feedback received from GAO and tightly linked to the MyVA Transformation efforts, outlines VA's plan to address the five health care high risk issues and our progress thus far in mitigating those risks. Further, it serves as a guide for the senior leaders, program offices, and VA employees charged with implementing the *Strategy* and making corrective actions. The *Strategy* is a living document; VA will submit a *Strategy* update to GAO in November 2016 reflecting the information and insights gathered from front line leaders and employees, and to reflect, as applicable, the Commission on Care recommendations the President considers reasonable, feasible, and capable of implementation without further legislation.

The Deputy Under Secretary for Health for Organizational Excellence is designated by the Secretary of VA as the Executive Agent for VA's GAO High Risk List Task Force for Managing Risk and Improving VA Health Care (Task Force), and is responsible for providing leadership and direction to the Task Force. The Task Force is charged with overseeing the implementation of the *Strategy* to identify the root causes of VA's health care high risk issues, developing solutions to manage or mitigate the risks, and overseeing and monitoring implementation of those solutions with the overall goal being to ensure that VA is providing Veterans with timely, cost-effective, safe, and high-quality health care.

Addressing these risks is essential to sustaining breakthrough improvements achieved by the MyVA transformation.

The efforts required to fully manage VA's health care high risk area are an enormous undertaking. No Executive Branch department or agency has satisfied all the criteria for removal from the list in less than four years. Demonstrated strong commitment and top leadership support are essential in making progress to successfully manage high-risk areas. High level governance and continuing oversight at several levels of the organization are necessary to ensure progress is made, obstacles are identified and overcome, and accountability is maintained.

Improving the Management of IT Acquisitions and Operations[3]

In GAO's 2015 High Risk List update, GAO identified "Improving the Management of IT Acquisitions and Operations" as a VA high-risk area. The report stated that federal IT investments too frequently fail or incur cost overruns and schedule slippages while contributing little to mission-related outcomes. VA's Financial and Logistics Integrated Technology Enterprise program and Scheduling Replacement Project were two examples highlighted. GAO noted that these and other failed IT projects often suffered from a lack of disciplined and effective management, such as project planning, requirements definition, and program oversight and governance.

To help address the management of IT investments, VA is working expeditiously to implement the requirements of the December 2014 Federal Information Technology Acquisition Reform Act (FITARA). OI&T's new Strategic Sourcing function will implement industry best practices and end-to-end supplier management strategy, process and metrics to optimize VA IT spend while improving supplier delivered product & service quality. This will transform OI&T to be a customer of choice to suppliers thereby attracting the best talent and the best price, become a pipeline for supplier-led innovation, and identify and deliver savings to VA OI&T. In addition, it supports the ability for OI&T to get products and services delivered quickly, helping VA quickly mitigate health IT risks. OI&T is expected to achieve 100% compliance with goals of the "2015 FITARA Implementation Plan and Self-Assessment" in the first quarter of FY2017.

In the report, GAO highlighted two ongoing VA investments with significant issues:

The DoD and VA electronic health records initiative. VistA Evolution is the joint VHA and OI&T program for improving the efficiency and quality of Veterans' health care by modernizing VA's health information systems, increasing data interoperability with the Department of Defense (DoD) and network care partners, and reducing the time it takes to deploy new health

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[3] This High Risk Area is shared Government-wide.

information management capabilities. VistA Evolution will deliver the next iteration of VistA—VistA 4—in FY2018, in accordance with the VistA Roadmap and VistA Lifecycle Cost Estimate. VistA 4 will bring improvements in efficiency and interoperability, and will continue VistA's award-winning legacy of providing a safe, efficient health care platform for providers and Veterans.

The VistA Evolution program stretches beyond Electronic Health Record (EHR) modernization – through focus on critical investments in systems and infrastructure, supporting interoperability, networking and infrastructure sustainment, continuation of legacy systems, and efforts. These efforts, such as clinical terminology standardization, are critical to the maintenance of the existing and deployment of future EHR functionality. This work is critical to maintaining our operational capability for VistA.

One of VistA Evolution's primary goals is to meaningfully exchange usable healthcare data and information with other systems. This goal is in alignment with the FY2014 National Defense Authorization Act (NDAA) Section 713(b)(1) that mandated the Departments' electronic health record (EHR) systems be interoperable with an integrated display of data by complying with national standards and architectural requirements identified by the DoD/VA Interagency Program Office (IPO) in collaboration with the Office of the National Coordinator for Health Information Technology. On April 8, 2016, DoD and VA, certified to the House and Senate Committees on Appropriations, Armed Services, and Veterans' Affairs that the Departments have met the interoperability requirement of the FY2014 NDAA Section 713(b)(1).

For front-line health care teams, the two most exciting products from VistA Evolution are the Joint Legacy Viewer (JLV) and the Enterprise Health Management Platform (eHMP).

JLV is a clinical application that provides an integrated, chronological display of health data from VA and DoD providers in a common data viewer. VA and DoD clinicians can use JLV to access, on demand, the health records of Veterans and Active Duty and Reserve Servicemembers. JLV provides a patient-centric, rather than facility centric view of health records in near real time. VBA offices have access to JLV and can use it to expedite claims in certain situations.

eHMP is a modern web application and clinical data services platform to support Veteran-centric, team-based, quality driven care. eHMP will natively support interoperability between VA, DoD and community health partners. VA is deploying an initial read only version of eHMP now, and will begin deploying eHMP version 2.0 with write-back capabilities in the second quarter of FY2017. Clinicians will be able to write notes and order laboratory and radiology tests in version 2.0. eHMP 2.0 will also support tasking for team-based management and communication with improved tracking to ensure follow through on tasks.

VA's Outpatient Appointment Scheduling system. VA is developing short- and long-term software solutions to provide innovative tools that help schedulers deliver better access

to care for Veterans. The short-term solutions, referred to as VistA Scheduling Enhancements (VSE) and Veterans Appointment Request (VAR), will enhance the end user experience with a calendar view, and give Veterans the ability to directly request certain types of appointments. The long-term solution will leverage an innovative platform that improves the user experience and satisfaction through comprehensive, intuitive views to manage workload and vacancies.

8. Key Issues from the Veterans Access, Choice, and Accountability Act of 2014

In August 2014, President Obama signed into law the Veterans Access, Choice, and Accountability Act (VACAA) of 2014, also known as the "Choice Act." The intent was to improve access to quality and timely care that Veterans so rightly deserve. The Choice Act provides new authorities, funding, and other tools to facilitate reform at VA.

The Choice Act includes requirements related to health care administrative matters at VA, specifically calling for independent assessments of the health care delivery systems and management processes provided by VA medical facilities (Section 201). These assessments were then examined by the Commission on Care (Section 202), to strategically organize VHA's care delivery for the 20-year period following the Choice Act.

The legislation also includes procurement of VA Major Medical Facilities leases (sections 601 and 602) and authorities to remove senior level employees through an abbreviated process (section 707). With the expansion of new Major Medical Facility leases, VA can continue delivering state-of-the-art facilities to develop and increase access to health care. Lastly, the Act seeks to provide accountability at the highest levels of the Department by giving the Secretary of VA (SECVA) the authority to remove or terminate senior level employees in a more efficient manner for performance or misconduct issues.

Furthermore, the Act established a $10 billion Veterans Choice Fund (section 802) from which VA must pay for non-VA care furnished as part of the Veterans Choice Program. $300 million was authorized for use on administrative requirements. This is a temporary three-year program that will end on August 6, 2017. VA is currently researching options on the way forward after this end date.

8.1 Independent Assessments

Independent Assessments were completed in 12 areas, covering a wide range of Veterans Health Administration (VHA) services, operations, and support. Section 201 of the Choice Act, directed the Department to asses VA's delivery of hospital care and other areas such as staffing, training, medical services, and related health care practices in VA medical facilities.

The Independent Assessment was completed by a number of health care companies and consultants. The primary contractor was the Centers for Medicare & Medicaid Services (CMS), a Federally Funded Research and Development Center (FFRDC) with MITRE. Additional contractors included the Institute of Medicine (IOM), the Rand Corporation, Grant Thornton, and McKinsey and Company. The assessment teams conducted interviews with VA employees and outside observers, visited 87 VA sites, and reviewed over 560 data sets provided by VHA, including information from other sources.

The assessments reviewed current and projected demographics, estimated how demographics may change as a function of other trends, as well as identifying Veteran-unique health care needs compared to the civilian population. The areas of focus for the Independent Assessments included:

- Integrated Report
- Assessment A - Demographics
- Assessment B - Health Care Capabilities
- Assessment B Appendices
- Assessment C - Care Authorities
- Assessment D - Access Standards
- Assessment E - Workflow Scheduling
- Assessment F - Workflow Clinical
- Assessment G - Staffing Productivity
- Assessment G Appendices
- Assessment H - Health Information Technology
- Assessment I - Business Process
- Assessment J - Supplies
- Assessment K - Facilities
- Assessment L - Leadership

8.1.1 Key Findings

The Independent Assessments noted VHA's deep commitment to its mission of serving Veterans and identified four systematic findings that the assessors felt impacted VHA's mission execution:

- A disconnect in the alignment of demand, resources, and authorities;
- Uneven bureaucratic operations and processes;
- Non-integrated variations in clinical and business data and tools; and
- Leaders not fully empowered due to lack of clear authority, priorities, and goals.

The Assessments also note that there are best practices that work effectively within VHA environment that could be leveraged for improvements throughout the health care system.

8.2 Commission on Care

Under Section 202 of the Choice Act, Congress created the Commission on Care, to examine Veterans' access to VA health care and to strategically analyze how to best organize VHA, locate health care resources, and deliver health care to Veterans. The 15-member Commission reviewed findings from the Independent Assessment Report, held public hearings to obtain information from various health care experts to include VA leadership, and delivered testimony to Congress. Based on these findings, the Commission's Final Report outlines 18 recommendations to improve VHA's ability to deliver health care to Veterans.

8.2.1 Key Findings

President Obama and the SECVA responded to the Commission's report, and found 15 out of the 18 recommendations in the Commission's report feasible and advisable. VA has made progress on 12 out of the 18 through the ongoing MyVA transformation initiative. Most of the

recommendations in the Commission's report focus primarily on strengthening VA, from information technology and supply chain practices to support staff and leadership development. The recommendations suggested by the Commission are outlined in Table 6.

Table 6. Commission on Care Recommendations

Recommendations	Status	Suggested Actions
#1 VHA should establish VHA Care System.	In progress	Develop and implement programs in Community Care Report – delivered to Congress in October 2015. (
#2 Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.	In progress	Publish regulation that will standardize full practice authority for advanced practice nurses. Expand Diffusion of Excellence Initiative.
#3 Develop a process for appealing clinical decisions that provides Veterans protections.	Pending	Publish a clinical Appeals Regulation for comment.
#4 Adopt an improvement methodology to support VHA transformation and consolidate best practices under the Veterans Engineering Resource Center (VERC).	Not Feasible	Realign the VERC and the operational improvement arm of Strategic Analytics for Improvement and Learning (SAIL) under the Principal Deputy Under Secretary for Health.
#5 Eliminate health care disparities among Veterans treated in VHA Care System.	Pending	Implement the Health Equity Action Plan by committing adequate personnel and monetary resources to address the causes of the problem and ensuring VHA Health Equity Action Plan is fully implemented.
#6 Develop a strategy for meeting and managing VHA's facility and capital-asset needs.	Pending Legislation	Establish an Independent Facilities Realignment Commission to address capital infrastructure needs.
#7 Modernize VA's IT systems to improve Veterans' health and transform VHA's clinical and business processes.	In Progress	VHA and VA Office of Information and Technology (OI&T) develop a single integrated Digital Health Platform.
#8 Transform the management of the supply chain in VHA.	In progress	VERC to support the two-year supply chain transformation.
#9 Establish a board of directors.	Board of Directors is Not Feasible, but Alternative approach in Progress.	Continue to receive advice from the Special Medical Advisory Group, the MyVA Advisory Committee.
#10 Require leaders of the organization to champion a strategy to transform VHA culture and sustain staff engagement.	In progress	Continue to engage employees via Leaders Developing Leaders and benchmark transformation with use of Prosci Change Management.

Recommendations	Status	Suggested Actions
#11 Rebuild a system for leadership succession.	VHA established the Healthcare Leadership Talent Institute (HLTI) in March 2016 to focus and coordinate VHA's succession planning efforts and build its leadership pipeline. HLTI's talent management strategy, based on benchmarked best practices, includes assessing VHA employees in the succession pipeline against key attributes for successful healthcare leaders. The measures and processes are undergoing pilot testing through 2Q 2017. In addition, VA's Corporate Senior Executive Management Office (CSEMO) initiated development of competency models for VA Senior Executive Service (SES) positions, to include those for healthcare executives in VHA. The models contain both leadership and technical competencies that will ultimately be incorporated into each phase of the human capital lifecycle and form a common reference point for strengthening the healthcare leadership succession pipeline.	Work with VA Corporate Senior Executive Management Office to finalize VHA competency model.
#12 Transform organizational structures and management processes.	Scheduled for January 2017	Initiate a VHACO and VISN organization analysis at the beginning of calendar year 2017.

Recommendations	Status	Suggested Actions
#13 Streamline and focus organizational and personnel performance measurement in VHA.	In Progress	The Performance Accountability Work Group (PAWG) will consolidate healthcare operations metrics to provide a system-wide view of key performance metrics.
#14 Foster cultural and military competence among all VHA Care System leadership, providers, and staff.	In progress	Continue to partner with external stakeholders to implement cultural and military competency training.
#15 Create a new alternative personnel system that applies to all VHA employees.	Pending	Submit a legislative proposal for the FY2018 budget process to modify 38 United States Code to give the Secretary the authority to implement an alternate personnel system unique to VA.
#16 Require VHA to hire a chief talent leader to lead the transformation for the operation's entire HR enterprise.	In progress	Fill VHA's most senior HR executive and implement MyVA initiative to transform VHA Human Capital Management.
#17 Provide a streamlined path to eligibility for health care for Veterans with an other-than-honorable (OTH) discharge who have substantial honorable service.	Not Feasible as written, but Alternative Approach in Progress	Publish a regulation to update and clarify 38 C.F.R. Section 12 regarding Other-than-Honorable discharges.
#18 Establish an expert body to develop recommendations for VA care eligibility and benefit design.	In progress	Establish an expert body to develop recommendations for VA care eligibility and benefit design.

In his letter responding to the Commission on Care, the SECVA stated that VA strongly disagrees with the Commission on its proposed "board of directors" to oversee VHA. Furthermore, he stated that VA believes that such a board is neither feasible nor advisable for both constitutional and practical reasons because it would seem to create VHA as an independent agency. This would disrupt continuing efforts to improve Veterans' experience by combining Veterans health care and services across VA, making it more difficult for Veterans to receive care when they need it. President Obama also voiced his concerns with the Commission's proposed governance structure in his letter responding to the Report, "the proposal would undermine the authority of the Secretary and Under Secretary for Health, weaken the integration of the VA health care system with the other services and programs provided by VA, and make it harder – not easier – for VA to implement transformative change."

8.3 VA Authority to Procure Major Medical Leases

In order to ensure that VA has the capability to deliver high-quality care to Veterans, VA has implemented a leasing program to provide the flexibility to meet the changes in demographics, as well as the ever-changing service needs of Veterans. In Sections 601 and 602 of the Choice

Act, VA is authorized to procure 27 new major facility leases nationwide, to improve and expand access to health care. VA's Office of Construction and Facilities Management (CFM) is leading the procurements and managing the construction of the 27 facility leases.

VA is completing the fourth and final design phase of the last 25 major facility lease projects. VA anticipates the design phase will be completed by the end of the second quarter of FY2017. Each of the 25 leases facilities is expected to begin seeing patients approximately five years from the "project start." The 25 major facility leases will be in 16 states and Puerto Rico. The leases will be located in Arizona, California, Connecticut, Florida, Georgia, Hawaii, Kansas, Louisiana, Massachusetts, Missouri, Nebraska, New Jersey, Oklahoma, South Carolina, Tennessee, Texas, and Puerto Rico.

CFM is responsible for procuring VA leases that have an annual unserviced rent exceeding $1 million per year, known as a "prospectus-level" lease. The procurement process usually takes an average of 26 to 29 months from start to completion.

8.4 Expedited Removal Authority

The Choice Act, in section 707 (codified at 38 U.S.C. § 713) provided the SECVA with the authority to remove or demote a Senior Executive Service (SES) employee or Title 38 SES-equivalent employee, if the individual's performance or conduct warrants removal or demotion. Individuals are entitled to appeal their removal or demotion to a Merit Systems Protection Board (MSPB) administrative judge, but are entitled to no further appeal.

On or around June 1, 2016, the Department of Justice (DOJ) notified Congress that it would not defend a portion of the expedited removal authority that it considered to be unconstitutional. DOJ's decision on the constitutionality of the expedited removal authority was based on a petition for review filed by Sharon Helman, the former Director for the Phoenix VA Medical Center, with the U.S. Court of Appeals for the Federal Circuit. Using the expedited removal authority, VA removed Ms. Helman from the Federal civil service. In her appeal to the Federal Circuit, Ms. Helman argued, among other things, that provisions of the Choice Act's expedited removal authority, which do not allow for further appeals past a MSPB administrative judge, are unconstitutional under the Appointments Clause.

While Ms. Helman's petition is still being considered by the Circuit, DOJ has conceded to her Appointments Clause argument. The matter remains under active litigation and the Circuit recently granted a motion to intervene, which was filed by a number of Veterans Service Organizations (VSOs). Until such time as the litigation is resolved, VA has decided to not use the Choice Act's expedited authority. Rather, VA will use existing Title 5 and Title 38 authorities to discipline its senior executives.

Additional Resources

For more information on Veterans Choice Act, go to:

- http://www.va.gov/opa/choiceact/factsheets_and_details.asp
- http://www.va.gov/opa/choiceact/
- http://www.va.gov/opa/choiceact/documents/choice-act-summary.pdf
- https://www.fas.org/sgp/crs/misc/R43704.pdf

For more information on independent assessments (Section 201), go to:

- http://www.va.gov/opa/choiceact/documents/Fact-Sheet-Independent-Assessments.pdf

9. Key Issues from VA Administrations and Staff Offices

VA has spent the past few years taking vital steps to resolve various challenges and re-position the Department for the years ahead. The following compilation of issues provides a comprehensive view of these efforts. Each section provides background information, planned actions, measures of success, potential risks and mitigation strategies, and ways to include key stakeholders. The first group of papers includes issues that require immediate attention to address critical management, infrastructure, and operational needs of strategic importance. Moreover, some of these issues have garnered significant Congressional, media, and public interest, such as:

- **Current Status of the Phoenix VA Health Care System (PVAHCS)** – VA is making progress to ensure Veterans receive the care they need, when they need it, and where they want to be seen. While more work remains, PVAHCS has expanded access to care and improved waiting times for Veterans in the catchment area of Phoenix, both within VA and in the community.
- **Replacement Denver VA Medical Center Construction Project** – The replacement project at the Denver VA Medical Center has received widespread negative media attention due to a significant increase in cost and schedule. The U.S. Army Corps of Engineers has assumed the role of Construction Agent to complete the project. VA must maintain focus to ensure the project is completed and activated to serve Veterans in the best interest of taxpayers.
- **Developing Credible and Sustainable Leadership Accountability** – VA created the Office of Accountability Review (OAR) in the wake of worldwide media reports that VA facilities were lying about and manipulating data about how long VA patients were waiting for medical appointments. Since OAR's creation, VA has proposed disciplinary action related to patient scheduling, record manipulation, appointment delays, and/or patient deaths against more than 475 employees of which 25 were senior leaders.

- **Ensuring Adequate Funding to Close VA's Key Infrastructure** Gaps – Funding levels received for VA's capital infrastructure continue to be inadequate to meet the Department's continuously growing needs. This is despite a large capital portfolio of over 6,300 owned buildings; 33,000 acres, and 155 million total square feet. The average age of VA's facilities is 57 years old when the design life of a building is 40 years.

The second category of papers include issues that show how VA is continuing to improve delivery of services and benefits to Veterans and their families, such as:

- **Precision Medicine Program** – VA has ongoing collaborations and data sharing with other agencies to enhance its ability in precision medicine that seeks to provide evidence-based, tailored care to specific diseases with a genetic basis. These activities focus on genomic medicine, and mental health research as part of a larger Precision Medicine Initiative.
- **Disability Claims Timeliness and Accuracy** – One of VA's highest priorities has been improving the timeliness and delivery of the disability claims decisions. VA has made great strides toward achieving this goal. In 2011, VA implemented an aggressive and comprehensive plan that has transformed the decades-old, paper claims approach into a state-of-the-art electronic process.
- **Veterans Legacy Program** – VA is developing partnerships with schools and universities around the country to facilitate research and develop educational materials about Veterans enshrined in VA national cemeteries.

While there is still much to be done, VA has before it one of the greatest opportunities in its history to enhance care and services for Veterans, and build a more efficient and effective system. These issues, along with the MyVA 2017+ Initiatives, will provide the new Administration with insights into how they can build upon current successes, manage challenges, and continue on the path of transformation.

9.1 Management, Infrastructure, and Operational Issues

The following topics require immediate attention to address critical management, infrastructure, and operational needs of strategic importance to VA.

9.1.1 Current Status on the Phoenix VA Health Care System

In order to address systemic access problems with scheduling and wait times that came to the public's attention through the 2014 allegations against the Phoenix VA Health Care System (PVAHCS), VA immediately took steps to ensure that Veterans receive the care they need, when they need it, and where they want to be seen. While much work remains, PVAHCS has expanded access to care and improved wait times for Veterans in the Phoenix area, both within VA and in the community.

The problems at PVAHCS arose due to a number of systemic problems, most significantly: (1) growth in outpatient visits outpaced the increase in the number of employees; (2) inconsistent scheduling processes resulted in patients not being put on official lists, masking true demand for care; and (3) a space deficit of 350,000 square feet (sf) due to the landlocked primary location. Since these problems came to the surface in 2014, the PVAHCS has expanded access to care working to effectively treat Veterans in a timely manner.

In June of 2014, VA established an Incident Command System (ICS) at PVAHCS with extensive support from the Veterans Health Administration's (VHA) Office of Emergency Management (OEM). The ICS met face-to-face twice daily to rapidly assess the supply and demand of Primary Care, Mental Health, and Specialty Care appointments. The ICS, which ran until mid-August, implemented the following key actions:

- Provided additional temporary clinic space during the summer of 2014 through Mobile Medical Units (MMUs) brought in from Cheyenne, WY; Big Spring, TX; and Jackson, MS.
- Activated the Disaster Emergency Medical Personnel System (DEMPS) to bring additional temporary help to PVAHCS on two-week deployments.
- Leveraged VHA Interim Staffing Program (ISP) to bring in additional Traveling Nurse Corps (TNC) and Locum Tenens Program (LTP) staff.
- Postponed a major renovation project for the PVAHCS Community Living Center to allow the space to be used for outpatient clinic rooms while developing a more permanent solution to the space challenge.
- Reached out to more than 4,000 Veterans in Phoenix, including all Veterans identified as being on any unofficial list identified by the VA Inspector General or on the facility Electronic Waiting List, from May to July 2014 to coordinate the acceleration of their care.

VA took an enterprise-wide approach to utilize subject matter experts in areas of equal employment opportunity, access, call centers, human resources, quality, and systems redesign. In order to staff critical vacancies during recruitment efforts, VHA supported numerous detail appointments and assignments. As a direct result of the Veterans Access, Choice, and Accountability Act, PVAHCS hired 181 new employees, which provided significant increases in staffing levels in Primary Care and Mental Health for access improvement.

PVAHCS embraced the use of non-traditional encounters, such as telephone visits and secure messaging, to meet Veterans' needs in their homes. The main campus and Southeast Community-Based Outpatient Center (CBOC) also extended hours and weekend clinics in both Primary Care and Mental Health. In 2015, the facility activated the Northeast CBOC in Scottsdale, AZ and an expanded Community Resource and Referral Center in central Phoenix.

During FY2016, PVAHCS completed more than one million outpatient visits, a 7.3% increase from FY2015. Moreover, as of October 20, 2016, VA has filled a significant number of key

leadership vacancies, including the Director and Chief of Staff, and has more than 3,260 FTE on board (a net increase of approximately 800 FTE since October 2014).

While VA has made significant progress, there are remaining challenges. VHA plans to roll out additional facility-wide trainings, open two new CBOCs, and construct a new Health Care Center. PVAHCS continues to take a collaborative approach to evaluating clinic productivity and utilization. Subject matter experts are performing extensive evaluations of clinic practices and workload capture processes. Plans are in place to perform at least three specialty reviews per month, with an initial focus on lowest performing services. Additionally, VHA has provided PVAHCS with a team of performance improvement and data experts from the Office of Quality and Safety to assist them in developing long-term processes aimed at improving quality of care in both inpatient and outpatient care areas.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Roll out facility-wide, focused Medical Support Assistant (MSA) training to train trainers and existing employees.	October 2016 – January 2017	Trainers and employees are trained on scheduling in a standardized manner with the new employee content and training approach.
Open the Southwest CBOC and Midtown CBOC, and relocate 16 Patient Aligned Care Teams (PACT) to the Midtown CBOC.	Schedule to open in January 2017	More permanent solution (additional 20,000 sf at the Southwest CBOC and 30,000 sf at the Midtown CBOC) to address space challenges and offer Mental Health and PTSD services.
Plan, design, and construct new Health Care Center.	• Underway (planning and design) • Q1 of FY2018 (lease awarded) • FY2021 (complete)	More permanent solution (additional 200,000 sf) to address space challenges.

Measures of Success:

- Improved wait times, and reduced Electronic Wait List and New Enrollee Appointment Request List.
- Enhanced Veteran satisfaction scores and improved feedback from Veterans.
- Filled executive leadership positions and reduced staffing vacancies within the organization.

Risk Management:

Risk	Continuum	Mitigation Strategy
Lack of clinical staff could serve as a deterrent to improving access.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
Lack of progress with call center improvements; delay in clinic openings and renovation and construction projects.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
Lack of best qualified candidates for final staffing selections.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Engage
Congress	☒	Involve
Veterans Service Organizations	☒	Engage
Federal Agency Partner	☐	
VA Advisory Board or Committee	☐	
Federal Employee Union	☐	
Tribal Government	☐	
State Veterans Affairs	☐	
Media	☒	Engage
Office of Inspector General	☐	
Government Accountability Office	☐	

9.1.2 Replacement Denver VA Medical Center Construction Project

The replacement Denver VA Medical Center (VAMC) construction project in the Eastern Colorado Health Care System has received widespread negative media attention due to a significant increase in cost and schedule. The U.S. Army Corps of Engineers (USACE) has assumed the role of Construction Agent to complete the project. VA must maintain focus to ensure the project is completed and activated to serve Veterans in the best interest of Taxpayers. Construction is 78% complete as of October 13, 2016 with an estimated construction completion of spring 2018.

The replacement of the existing Denver VAMC began as an idea between the University of Colorado and VA to construct a shared facility. VA requested design funds in FY2004, with an estimated project budget of $328.5 million based on that shared concept. By 2006, VA had developed a plan for a stand-alone facility and subsequently requested appropriations for an $800 million project in 2010 with final funding being requested and received in 2012.

VA retained the services of an architect engineer (AE) firm to complete a design with an Estimated Construction Cost at Award (ECCA) of $582 million. The original acquisition strategy for the project was to complete 100% design and then solicit construction proposals to build

the project. VA contracted Kiewit-Turner (KT) in August 2010 to perform design, constructability, and cost reviews as part of an integrated design construct (IDC) with a joint venture.

VA executed an option with KT on November 11, 2011, to build the replacement hospital, which became known as Supplemental Agreement 07 (SA-07). It stated that VA would ensure that the design produced would meet the ECCA of $582.8 million and that the contractor, KT, would build the project at the firm target price of $604 million, which included pre-construction services and additional items.

KT subsequently filed a complaint with the Civilian Board of Contract Appeals (CBCA). In December 2014, VA was found in breach of contract for failure to provide a design that met the ECCA. In conjunction with granting additional authorization and appropriation, Congress restricted future VA construction projects to a limit of $100 million, requiring VA to use a Federal Construction Agent, such as USACE, for future larger projects.

VA has since entered into a separate agreement with USACE to execute a new construction contract and to act as VA's construction agent to complete the facility. **In an effort to secure authorization and appropriation from Congress, VA proposed to delay completion of the Community Living Center and the PTSD Residential Rehabilitation Facility. Removing this scope from the project necessitates continued operation of the existing Eastern Colorado Health Care System (ECHCS) VA Medical Center Facility. VA must address the need for these functions, so the existing facility may be decommissioned.**

The current program has experienced cost growth from the $800 million original program to the $1.675 billion current program, and delay from April 2015 to January 2018 in construction completion. Over the past five years, VA's Construction program has undergone two internal reviews and three external reviews. In addition to these reviews, VA has taken the necessary steps and made sound construction improvements to ensure the mistakes that occurred on the Denver project will not happen again.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Complete construction of the project with full functionality without requiring additional construction funds.	January 2018	Restore Taxpayer and Veteran confidence.
Outfit, transition, and activate the new VAMC.	2018	Enable provision of contemporary medical care to Veterans through a new, fully functional VAMC.
Initiate solutions for scope not included in the program or removed from the program which keep the current ECHCS complex in operation.	2020	Provide Community Living Center, PTSD Residential Rehabilitation and enable construction of the Fisher House at new complex, which will allow existing ECHCS complex to be decommissioned.

Measures of Success:

- VA is working closely with USACE to complete construction of the Denver VA Replacement Medical Center with full functionality within the revised program of $1.675 billion.
- VA is coordinating initial outfitting and transition activities to enable operation of the complex in a timely manner. Working with USACE, VA anticipates completing the project within the revised program of $1.675 billion.
- VA is planning for the completion of transfer of functions from the existing complex to viable alternative solutions.

Risk Management:

Risk	Continuum	Mitigation Strategy
Insufficient construction funds to complete project.	Known Managed Risk (known, plan, oversight)	Adjust and avoid.
Delays in outfitting and transition to new ECHCS complex.	Known Managed Risk (known, plan, oversight)	Adjust and avoid.
Continued operation of existing ECHCS complex.	Known Managed Risk (known, plan, oversight)	Adjust and avoid.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Involve
Congress	☒	Consult
Veterans Service Organizations (United Veterans Committee of Colorado)	☒	Engage
Federal Agency Partner (USACE)	☒	Engage
VA Advisory Board or Committee	☐	
Federal Employee Union	☒	Engage
Tribal Government	☐	
State Veterans Affairs	☒	Consult
Media	☒	Monitor
Office of Inspector General	☒	Monitor
Government Accountability Office	☒	Monitor

9.1.3 Developing Credible and Sustainable Leadership Accountability

To inform on Leadership Accountability in VA; provide background for formalization of the Office of Accountability Review; and provide a broad update of accountability of senior leaders in VA. ***As of August 2016, VA has proposed disciplinary action related to patient scheduling, record manipulation, appointment delays, and/or patient deaths against more than 475 employees, of which 25 were senior leaders.***

VA created the Office of Accountability Review (OAR) in the wake of worldwide media reports that VA facilities were lying about and manipulating data about how long VA patients were waiting for medical appointments. Congress and the public began to openly question whether the Department, as a whole, was capable of fulfilling its mission. As a result, several top VA executives, including the Under Secretary for Health and the Secretary of VA (SECVA), resigned. Moreover, the reports led to the inaccurate perception, still widespread today, that VA's senior leader ranks were filled with corrupt bureaucrats who could not be trusted to make sound decisions on behalf of Veterans.

During a complete reorganization at the top of the Department, the then acting SECVA established OAR to carry out his vision of completely redefining and resetting senior leader accountability across VA. He directed OAR to develop a program of credible and sustainable senior leader accountability, in which decisions on what actions to take when senior leaders commit misconduct are based on evidence and are not improperly influenced by popular or political will. On February 8, 2015, VA formally established OAR and broadened its charter from addressing senior leader accountability for scheduling and access priorities, to include reviewing and investigating all allegations of serious misconduct and lack of oversight by senior leaders throughout the Department. OAR works closely with the VA Office of Inspector General (OIG), especially on reports where patient scheduling improprieties have been substantiated at a VA facility and with the U.S. Office of Special Counsel (OSC) when whistleblower retaliation has been substantiated against a senior leader.

Based on investigations conducted by OAR and OIG, VA regularly utilized the Veterans Access, Choice and Accountability Act's ("Choice Act") expedited removal authority, 38 U.S.C. § 713, until around June 1, 2016, when the Department of Justice (DOJ) notified Congress that it would not defend a portion of the Act that it considered to be unconstitutional. DOJ's decision on the constitutionality of the Choice Act was based on a petition for review filed by Sharon Helman, the former Director for the Phoenix VA Medical Center, with the U.S. Court of Appeals for the Federal Circuit. Using the Choice Act, VA removed Ms. Helman from the Federal civil service. In her appeal to the Federal Circuit, Ms. Helman argued, among other things, that provisions of the Choice Act's expedited removal authority, which do not allow for further appeals past a Merit Systems Protection Board Administrative Judge, are unconstitutional under the Appointments Clause.

While Ms. Helman's petition is still being considered by the Circuit, DOJ has conceded to her Appointments Clause argument. The matter remains under active litigation and the Circuit recently granted a motion to intervene, which was filed by a number of Veterans Service Organizations (VSOs). Until such time as the litigation is resolved, VA has decided to not use the Choice Act's expedited authority. Rather, VA will use existing Title 5 and Title 38 authorities to discipline its senior executives.

OAR monitors whistleblower disclosure and oversight reports in order to spot trends and address business systems/process deficiencies. Although not resourced to handle

whistleblower cases, OAR, along with the Office of General Counsel (OGC), has begun rolling out training to human resources professionals and Agency Attorneys. Additionally, OGC has worked closely with OSC to successfully resolve whistleblower retaliation complaints, including entering into expedited settlement agreements 28 times as of August 2016. Moreover, OAR centralized a Discipline Data Tracker in September 2014 to ensure a comprehensive and transparent voice from VA to Congress for all discipline-related actions in VA.

On September 29, 2016, HR 5325 was signed into law, enacting the establishment of a Central Whistleblower Office in VA located under OAR, or a successor office designated by the SECVA to investigate whistleblower complaints. VA leaders from OAR, OGC, Office of Human Resources and Administration (OHRA), Office of Resolution Management (ORM), and others met to determine a course of action that would satisfy the requirements and how to best achieve this unfunded mandate. OSC and OIG, in coordination with VA, are currently drafting a proposed legislative repeal or adjustment to the current requirements of the new law. At the same time, OAR and ORM are working together to propose a course of action that would allow VA to implement items during the first 60 days, as required under the law. Due to the labor implications, pre-decisional negotiation is also required.

Using some existing capabilities and funding in ORM and OAR, ORM can increase the capacity of its current toll-free number to add intake of whistleblower disclosures, and create capacity to triage disclosures and track field activity in order to satisfy the law's investigation and reporting requirements. OAR, ORM, and OGC will jointly create operating policies and procedures on how whistleblower disclosures will be made, tracked, and reported, and provide both VA-wide, in-person and distance learning capability for VA.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Improve training resources and aggressively promulgate training across VA.	July 2017 (if funded appropriately)	Training leads to knowledge and knowledge leads to cultural change.
Redefine OAR structure to assume whistleblower mission requirements.	September 2017 (dependent on budget and legislation)	If resourced appropriately OAR can do more than monitor whistleblower trends.
Establish and promulgate senior leader accountability policy.	July/August 2017	Develop a resourced strategic plan and develop policy inclusive of all VA senior leader accountability. Holds all leaders to same standard.

Measures of Success:

- Every VA element nationwide receives consistent training and trends; allegations of retaliation decrease.
- Fully resourced, OAR can develop a program that not only looks at trends, but uses them to identify potential areas of concern and tailor support teams and training to assist in overcoming whistleblower retaliation.
- Fully resourced, OAR can lead the Department in training and policy development to aggressively change the culture of senior leaders.

Risk Management:

Risk	Continuum	Mitigation Strategy
Increase in allegations against senior leaders.	Known Managed Risk (known, plan, oversight)	Acknowledge and accept.
Increase in whistleblower allegations against senior leaders.	Known Un-managed Risk (known, no plan)	Monitor for changes that affect impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Monitor
Congress	☒	Monitor
Veterans Service Organizations	☐	
Federal Agency Partner (OSC)	☒	Involve
VA Advisory Board or Committee	☐	
Federal Employee Union	☐	
Tribal Government	☐	
State Veterans Affairs	☐	
Media	☒	Monitor
Office of Inspector General	☒	Monitor
Government Accountability Office	☒	Monitor

9.1.4 Supreme Court Decision in Kingdomware Case

As a result of a recent Supreme Court ruling, VA is changing the way it implements requirements around contracting and procurement with Veteran-owned small businesses.

The Veterans Benefits, Health Care and Technology Act of 2006 (the “VA Act”) directs VA to prioritize service-disabled Veteran-owned small businesses (SDVOSBs) and Veteran-owned small businesses (VOSBs) in agency contracting. Specifically, the VA Act establishes the “Rule of Two” codified in 38 U.S.C. § 8127(d):

> *Use of Restricted Competition – Except as provided in subsections (b) and (c), for purposes of meeting the goals under subsection (a), and in accordance with this section, a contracting officer of the Department shall award contracts on the*

basis of competition restricted to small business concerns owned and controlled by Veterans if the contracting officer has a reasonable expectation that two or more small business concerns owned and controlled by Veterans will submit offers and that the award can be made at a fair and reasonable price that offers best value to the United States.

VA initially implemented this requirement by utilizing the hierarchy of national contracts and Federal Supply Schedule (FSS) before setting aside to VOSBs. In 2013, Kingdomware, LLC protested VA's use of the FSS, stating that the Government did not use the "Rule of Two" when awarding contracts through the FSS and that VA was unlawful in its award. The Government Accountability Office (GAO) heard the bid protest and determined that VA was unlawful in their award to the FSS contract. VA did not agree and did not abide by the non-binding GAO decision, so Kingdomware filed with the Court of Federal Claims. The Court granted summary judgement to the Government, which the Federal Circuit Court confirmed. Kingdomware sought relief from the Supreme Court (SCOTUS), which issued a decision on June 16, 2016. SCOTUS ruled in favor of Kingdomware's argument that the "Rule of Two" applies to all contracts and not just when VA attempts to meet the Department's annual small business contracting goals.

In effect, the SCOTUS decision treats VA differently from other Departments in a fundamental way. **At VA, the "Rule of Two" is no longer associated with the achievement of a socio-economic goal; rather it is a definitive requirement to contract with SDVOSBs on all competitive requirements when the "Rule of Two" can be met.** This affects VA's use of all full and open competitive requirements, commercial buys, purchases off Federal Supply Schedules, Multiple Award Contracts, etc. It may make it more difficult, for example, to contract with recognized industry leaders in providing specialized services whenever market research reveals SDVOSBs have expertise in these areas.

As a result of the SCOTUS decision, VA expects to see an increase in opportunities for procurement-ready VOSBs and a related increase in the volume of Verification applications, as well as heightened significance of the Vendor Information Pages (VIP). **VA must also update procurement policies and procedures, and train VA staff to execute in accordance with the decision.** The decision emphasizes the necessity for comprehensive and robust Market Research that facilitates identification of procurement-ready SDVOSBs for VA requirements. Implementation could potentially slow down some procurements due to increased workload, and lead to additional protests which would also delay start dates for critical projects.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Provide ongoing training for contracting officers, requirement owners, and private industry.	July - December 2016	Acquisition team and vendor community aware of requirements and regulations associated with SCOTUS decision. Contracts are consistent with decision.
Develop Executive Steering Committee.	August 2016 – TBD	Oversight of implementation, resolve impasses, initiate changes as necessary.

Measures of Success:

- VA issues contracts consistent with the SCOTUS decision.
- Protests against VA are dismissed.

Risk Management:

Risk	Continuum	Mitigation Strategy
Increased procurement cycle time.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
Increased overhead (more contracting actions could potential lead to more costs).	Emerging Risk (unknown, no plan)	Acknowledge and accept.
Increase in protests.	Emerging Risk (unknown, no plan)	Monitor for changes that affect impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Engage
Congress	☒	Engage
Veterans Service Organizations	☒	Engage
Federal Agency Partner (Small Business Administration and General Services Administration)	☒	Engage
VA Advisory Board or Committee	☐	
Federal Employee Union	☐	
Tribal Government	☐	
State Veterans Affairs	☐	
Media	☒	Engage
Office of Inspector General	☐	
Government Accountability Office	☐	
Other (Private industry)	☒	Engage

9.1.5 Alternative Financing to Address VA's Capital Needs

VA is requesting new authority to finance capital needs, including the ability to enter into partnership agreements, as well as expansion of the enhanced use-lease (EUL) authority. These funding mechanisms leverage both monetary resources, such as retained fees, and non-

monetary resources, such as property exchanged in a land swap or space offered in an EUL. Even with increases in appropriations, VA's capital needs are unlikely to be met solely by traditional sources. Alternative financing mechanisms are critical.

Following a 2006 analysis, the Government Accountability Office (GAO) recommended full upfront funding for capital investment as the ideal approach to fulfilling Federal commitments and maintaining fiscal control. Full upfront funding requires that purchases or capital leases be recorded in full in the budget year in which they are made. Federal agencies acquiring or renovating Federal real property regularly face funding challenges and must turn to alternatives, such as public-private partnerships, that allow for disbursement of development costs over multiple years (i.e. rent). Public-private partnerships make it easier to start large projects because they do not require as much funding upfront, and allow federal agencies to use private capital to enhance service delivery and optimize their portfolios. The private sector does not typically obligate or commit all funds upfront.

VA has more than $50 billion in capital needs over the next 10 years to grow, modernize, and maintain its infrastructure. Even with increases in appropriations, capital needs cannot be met solely by traditional sources. Alternative financing mechanisms such as public-private partnerships are critical. The ability to enter into public-private partnership would further VA's mission by enabling it to leverage private resources. Under a public-private partnership agreement, a private entity provides the investment and expertise to develop/renovate and operate a property for government use in exchange for negotiated rent ("lease-back") for a stipulated term. The property could be on public or private land. In public-private ventures, the private entity typically assumes development risk and retains ownership of the underlying property at the end of the partnership. This reduces the need for Federal agencies to maintain government-owned assets, and allows them to find more suitable and updated space over time. Public-private partnerships offer a potential way for VA to align the agency's footprint to changing demographics.

Enhanced-use leasing (EUL) is another alternative financing mechanism that VA can use. VA's EUL program leverages private sector funding, but it is currently limited to supportive housing for Veterans and cannot be used for other VA infrastructure needs, as VA was once able to do. Through the EUL program, VA has raised over $1 billion in private investment/capital to offer expanded services and housing to Veterans and their families. This has resulted in substantial cost savings by facilitating campus realignment projects, and has helped VA meet sustainability goals. Prior to the expiration of VA's EUL authority in December 2011, VA was able to execute a broad range of EUL developments with private sector developers, including such uses as permanent supportive housing, medical office buildings, energy projects, parking structures, and mixed-use projects. With a broader range of reuse options VA was able to repurpose facilities (real estate) that were not necessarily suitable for homeless supportive housing.

In August of 2012, VA received a reauthorization of the EUL authority that limits the program to only developing various types of supportive housing for homeless and at-risk Veterans and their families.

Another tool available to the Department is the historic outleasing program that allows VA to outlease or exchange historic properties with third parties after consultation with the Advisory Council on Historic Preservation, provided the properties are not needed for current or projected agency purposes.

VA submitted legislation the past two years to expand its EUL authority and VA also supports legislation that is being pursued by Congress that would allow the Department to enter into partnership agreements in order to address infrastructure needs identified through the Department's long-range capital planning process. New authorities such as the ability to enter into partnership agreements, as well as expansion of the EUL authority, would allow VA to meet a portion of its capital need, which will likely not be met via traditional appropriations. Senators Fischer and Feinstein recently introduced "Communities Helping Invest through Property and Improvements Needed for Veterans Act of 2016'' or the "CHIP IN for Vets Act of 2016" that would authorize the Secretary of Veterans Affairs to carry out a pilot program to accept the donation of facilities and related improvements for use by VA. A potential site that would be a candidate for donation if legislation is passed is Omaha, Nebraska.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
VA to work with Congress for more flexible legislative authority on various alternative mechanisms (which includes public-private partnerships).	8-12 months	A robust inventory of capital asset projects with various funding options will be readily available with no or minimal upfront cost to VA.
VA to mobilize reliable partners (using a scoring matrix to validate their reliability) for some capital asset projects.	3-6 months after legislative authority	Selected set of opportunities that are ready to move forward for execution.
VA enters into alternative financing arrangements for a selected set of projects.	9-12 months after legislative authority	VA will be able to leverage private financing to invest and re-invest in its capital infrastructure needs.

Measures of Success:

- VA will be able to proceed with needed capital projects.
- Number of alternative mechanisms available to VA to meet its infrastructure needs.
- Number of days to complete a capital project will be reduced due to the flexible alternative mechanism (if approved by Congress) authority.
- Cost avoidance (in dollars) to VA will increase due to leveraging private financings in lieu of traditional appropriations.

- Reduction of operations and maintenance (O&M) costs to VA, as well as potential reduction of Non-Recurring Maintenance (NRM) and Minor funding needs since alternative financing arrangements may negate the need to address deferred maintenance issues.

Risk Management:

Risk	Continuum	Mitigation Strategy
Alternative funding mechanisms are not universally available to all agencies, even within agencies; legal authorities may differ across agency components.	Known Un-managed Risk (known, no plan)	Control and implement actions to minimize impact.
Congressional Budget Office (CBO) Scoring of most alternative financing arrangements will likely be "capital" – meaning VA would have to demonstrate full budget authority up front and the value of the private financing is negated.	Known Un-managed Risk (known, no plan)	Control and implement actions to minimize impact.
Alternative mechanisms rely on partnerships, often public-private partnerships, to leverage resources, hence a significant amount of time is required to identify potential partners and work out beneficial arrangements for both parties.	Emerging Risk (unknown, no plan)	Control and implement actions to minimize impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Engage
Congress	☒	Engage
Veterans Service Organizations	☐	
Federal Agency Partner	☒	Engage
VA Advisory Board or Committee	☐	
Federal Employee Union	☐	
Tribal Government	☐	
State Veterans Affairs	☐	
Media	☐	
Office of Inspector General	☐	
Government Accountability Office	☐	

9.1.6 VA Facility Realignment

VA lacks modern ambulatory health care facilities in many areas, and the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings. Additionally, VA faces environmental, historic preservation, and community support barriers that impact its ability to realign or dispose of assets. Chronic underfunding of

VA's infrastructure has caused degradation of facilities that VA no longer needs and can no longer maintain. It is critical that an objective process be established to enable VA to appropriately manage and maintain its capital infrastructure.

VA is the second largest non-Defense property holder in the Federal Government. The average age of its assets is approximately 60 years. Facility locations are outdated, and do not reflect where Veterans currently reside or where they are expected to reside in the future. VA's current inventory consists of 155 million owned square feet (SF) of operational space at 164 medical centers, 9.7 million SF of disposals planned and authorized, and 28 million SF of authorized construction and leasing projects initiated, but not yet operational. The Department's projected workload for 2024 will require an additional 26 million SF for healthcare. In addition, a portion of VA's vast and outdated existing infrastructure will require significant capital investment to best respond to projected demand, optimize throughput, and patient-centered accommodations, and address safety, security, compliance, and infrastructure issues. Once an appropriate healthcare services model is developed, VA will complete a market-by-market assessment.

The need for increased space is not uniform: several regions nationwide are projecting stagnant or declining Veteran populations, while others are projecting growth in excess of 30% over the next decade (based on VA's Veteran Population Project Model 2014). Facilities that cannot support current technology-intensive modes of healthcare delivery will need to be converted, disposed of, and/or replaced. Although the Veterans Health Administration (VHA) is the largest holder of Department property, all Administrations' requirements must be considered holistically to better meet Veterans' needs.

To streamline, modernize, and realign its real property portfolio, VA must conduct a market by market review of current and expected future services, taking into account both VA and non-VA care. A fully developed, solid realignment plan will necessitate changes to include a combination of additional investments, renovations, partnerships with other Federal, state, and community partners, and divestiture of unneeded assets to establish a portfolio that reflects the services that VA commits to providing for its Veteran population.

As VA stated in its response to the Commission on Care, divestiture of unneeded VA assets is unlikely to generate significant upfront savings because of the costs involved in divestitures, coupled with the minimal market value of the assets. The expected savings will come from consolidating services and reducing expenses for the maintenance of these assets.

Without the proper resources, tools, and authorities, attempts to divest assets or streamline capital project execution will not be effective.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
VA must internally develop its integrated healthcare model of the services which it intends to deliver for Veterans and compare it against the existing inventory on a market-by-market basis.	12 months	A comprehensive list of needs and excesses for all markets nationwide will be developed to be used as a baseline for further planning.
Congress enacts legislation to establish a VHA facility and capital asset realignment process based on the Department of Defense (DoD) Base Realignment and Closure Commission process to be implemented as soon as practicable.	2-5 years to develop a plan and commence initial actions. 3 to 10+ years to fully realign the portfolio.	Veterans' healthcare will be properly aligned in both location and asset mix to meet access, quality, and cost effectiveness goals.
VA begins demolishing, repurposing or selling facilities that have already been designated for closure.	18-24 months for demolition (subject to funding availability), with subsequent divesture in future fiscal years	VA would initially be able to demolish approximately 60 buildings within 18 months, and fully divest as many as 200-300 unused or unwanted assets in total.

Measures of Success:

- VA will save by consolidating assets and reducing maintenance costs.
- VA will significantly reduce or eliminate vacant assets from its inventory.
- VA will acquire state-of-the-art infrastructure, and/or community care capability, aligned with the projected future service needs of Veterans.
- VA will save by reducing or eliminating redundant services and assets and better aligning facilities with the locations where Veterans live.

Risk Management:

Risk	Continuum	Mitigation Strategy
Congressional action is required to provide authorizations for divestiture.	Known Managed Risk (known, plan, oversight)	Acknowledge and accept.
Impact on local community and Veterans as a results of realignment.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
VA needs to ensure proper capital investment to support divestiture, renovation, construction, and infrastructure realignment.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Involve
Congress	☒	Engage
Veterans Service Organizations	☒	Involve
Federal Agency Partner	☒	Monitor
VA Advisory Board or Committee	☒	Consult
Federal Employee Union	☒	Involve
Tribal Government	☒	Involve
State Veterans Affairs	☒	Involve
Media	☒	Engage
Office of Inspector General	☒	Monitor
Government Accountability Office	☒	Monitor

9.1.7 Authority to Procure Major Medical Leases

In its FY2016 budget request, VA requested authority to procure 18 (13 replacement and 5 new) major medical facility leases in 12 states. Additionally, for FY2017, VA requested authority to procure six additional leases (all replacement). Congress has appropriated, but has yet to authorized any of these leases.

Leasing is a major tool for VA to provide services to Veterans when and where they need them. As Veteran demographics and populations change, leasing allows VA to acquire needed services to population centers more quickly than Major construction and provides VA with the flexibility to re-evaluate its space needs as leases expire.

Congressional authorization is required for VA to procure leases of greater than $1 million in average annual unserviced rent (called prospectus-level or Major leases). Traditionally, VA has included its Major leasing request in its annual budget submissions to Congress, and Congress has annually granted that request. However, in the past several years, VA has undergone scrutiny from the Congressional Budget Office (CBO) and the Office of Management and Budget (OMB), regarding the budgetary treatment of its leases with respect to OMB Circular A-11 guidance on whether a lease can be amortized and funded annually or not. **VA temporarily suspended its Major leasing program in late 2013 to evaluate the issues raised by these offices and implement changes to policies and procedures to comply with their guidance. The hold was effectively lifted in July 2014 when the General Services Administration (GSA) rescinded VA's standing delegation of authority and began working with VA on project-specific delegations of authority. Further, in August 2014, the Veterans Access, Choice, and Accountability Act authorized 27 major medical leases, which are currently in various stages of procurement of construction.**

The Office of Construction & Facilities Management (CFM) oversees Major lease procurements

and establishes policies and procedures for VA's leasing program. **CFM has implemented changes such as a new lease scoring model and changes to project requirements that have satisfied OMB and should satisfy CBO, but Congress has not yet authorized the FY2016 and FY2017 Major leases.**

Top Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
VA outreach to Congress and CBO.	FY2017	Obtain stakeholder buy-in to support Congressional authorization of the pending leases.
Congress authorizes VA's FY2016 and FY2017 Major leases.	FY2017	VA can move forward to provide space needed to care for Veterans.

Measures of Success:

- Obtain stakeholder support of VA's changed Major leasing program.
- Congress authorizes FY2016 and FY2017 Major leases.

Risk Management:

Risk	Continuum	Mitigation Strategy
One or more stakeholders is not in support of VA's Major leasing program.	Emerging Risk (unknown, no plan)	Control and implement actions to minimize impact.
Congress is not in support of VA's Major leasing program.	Emerging Risk (unknown, no plan)	Control and implement actions to minimize impact.
Significant delays to project timelines impact Veteran care (undersized or closing facilities).	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Monitor
Congress	☒	Engage
Veterans Service Organizations	☒	Monitor
Federal Agency Partner (CBO, OMB, GSA)	☒	Involve
VA Advisory Board or Committee	☐	
Federal Employee Union	☐	
Tribal Government	☐	
State Veterans Affairs	☐	
Media	☒	Engage
Office of Inspector General	☐	
Government Accountability Office	☒	Monitor

9.1.8 Compliance with the Improper Payments Elimination and Recovery Act and its Amendments

VA is committed to achieving consistent compliance with the Improper Payments Elimination and Recovery Act (IPERA) and reducing improper payments. VA has not achieved consistent compliance with IPERA since reporting began in FY2013 and reported $5.5 billion in improper payments with five programs not achieving compliance in November 2016. The majority of VA's improper payments, over 86%, are in its programs that provide care in the community to Veterans because VA does not currently have the authority to enter into provider agreements with local providers.

To improve the integrity of the Federal Government's payments and the efficiency of its programs and activities, Congress enacted the Improper Payments Elimination and Recovery Act (IPERA) of 2010 (Public Law No. 111-204). It requires VA to review all programs and activities to: identify those that are susceptible to significant improper payments; obtain a statistically valid estimate of the annual amount of improper payments in programs and activities that are identified as susceptible to significant improper payments; and implement corrective action plans and reduction targets for programs and activities found to have significant improper payments. IPERA also requires agencies to conduct payment recapture audits for each program and activity that expends $1 million or more annually, if conducting such audits would be cost-effective and report quarterly on high-dollar overpayments within programs susceptible to significant improper payments. VA reports the results of its annual IPERA activities in the Agency Financial Report (AFR) each November.

In FY2016, VA reported improper payment estimates for 14 programs identified as susceptible to significant improper payments. The 14 programs provide a wide-range of goods and services, including care in the community for our Nation's Veterans; medical supplies to VA hospitals and clinics; benefits including compensation for disabilities, education, and vocational rehabilitation for Veterans; rebuilding after Hurricane Sandy; and payments to Federal employees. Three of these programs have been designated "high priority" by Office of Management and Budget because they each reported over $750 million in improper payments in FY2015. Due to VA's efforts to ensure that technically improper payments are reported in accordance with IPERA, VA reported an increase in overall Department improper payments, even though over half of the 14 programs reported a reduction in improper payments. In May 2017, the Office of Inspector General will report on VA's FY2016 compliance with IPERA based on its review of VA's reported improper payments in the Agency Financial Report and make recommendations for improvement.

In FY2015 and FY2016, VA reported approximately $5 billion and $5.5 billion in improper payments, respectively. This increase over historically lower overall improper payments can largely be attributed to VA's efforts to ensure that it reported fully in accordance with the improper payment definition. Prior to FY2015, VA focused reporting activities on estimating those payments that were made to the wrong person, for the wrong amount, for goods or

services not received, or that were duplicate. These improper payments represent a true loss to the Government and, when those payments are identified, the Government should recover them. Beginning in FY2015, VA began to estimate and report those payments that are technically improper due to noncompliance with a law, policy, or procedure, but are not recovered because they do not represent a true loss to the Government. **The majority of VA's technically improper payments are those associated with providing care in the community to our Veterans because VA does not have authority to purchase care without a contract. VA has requested legislation to grant it the authority to enter into provider agreements.** It is important for VA to continue developing and monitoring corrective actions that correct both technically improper payments as well as those that represent a true loss to the Government.

VA's Agency Accountable Official, the Interim Chief Financial Officer, is responsible for overseeing the Department's efforts to reduce improper payments. In FY2015, VA established the Improper Payments Remediation and Oversight (IPRO) Office, whose sole focus is to implement a robust IPERA compliance program that results in reduced improper payments. In an effort to ensure commitment and accountability at the program level, a Senior Accountable Official for each of the 14 programs is responsible for assessing risk in their program, identifying improper payments, and executing corrective actions for remediation.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Ensure care in the community can be provided in compliance with IPERA.	FY2018	VA obtains legislative authority to enter into provider agreements or works to award contracts that provide broad coverage of services that may be needed by Veterans across the U.S.
Develop and implement effective corrective actions; regularly monitoring results to allow for adjustments or additional actions as needed.	Ongoing	Reduced improper payments and consistent compliance with IPERA in programs without significant legislative barriers. Increased overall Department success in compliance with IPERA.
Increased utilization of tools, to include automation, to include partnership with Department of Treasury for Do Not Pay.	Ongoing	Increased use of automation and other tools to stop improper payments before they occur and decrease VA's estimated improper payments.

Measures of Success:

- Identify areas where contracts with providers for care in the community would reduce improper payments, and monitor progress in awarding contracts that address those areas.
- Set expectations regarding the amount of improper payments that will be remediated by each corrective action, monitor the effectiveness of corrective actions to the expectation, and adjust the corrective action as necessary to obtain expected results.

- Track the number and dollar value of improper payments stopped prior to payment and compare to VA's overall annual estimated improper payment rate.

Risk Management:

Risk	Continuum	Mitigation Strategy
Legislative authority is not provided and VA is unable to contract for all care in the community needed by Veterans.	Known Un-managed Risk (known, no plan)	Control and implement actions to minimize impact.
Corrective actions do not reduce improper payments as expected.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
Payments in VA's programs are too complex to allow for economical reduction of improper payments through Do Not Pay and other tools.	Emerging Risk (unknown, no plan)	Adjust and avoid.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Monitor
Congress	☒	Engage
Veterans Service Organizations	☐	
Federal Agency Partner (Office of Management and Budget, Department of Defense, Department of Treasury, and Social Security Administration)	☒	Involve
VA Advisory Board or Committee	☐	
Federal Employee Union	☐	
Tribal Government	☐	
State Veterans Affairs	☐	
Media	☒	Monitor
Office of Inspector General	☒	Involve
Government Accountability Office	☒	Involve
Other (IPERA Governing Board)	☐	Involve

9.1.9 Enterprise Risk Management

VA is implementing an Enterprise Risk Management (ERM) program that aligns with VA's Strategic Operating Model (SOM) and ties risk based thinking to strategy setting, resourcing, and performance measurement. It also provides a management mechanism for VA leadership to understand and manage the broad spectrum of risks facing VA, including strategic risks. Through early risk identification, assessment, and continuous monitoring of risk indicators, VA is better positioned to develop proactive risk mitigation strategies that leverage resources, supporting functions, and leadership, while implementing timely responses to emerging risks and existing issues. Without effective ERM, VA's delivery of the outcomes Veterans deserve and require is put in jeopardy.

ERM is the application of risk management principles to large, complex organizations facing a broad spectrum of risk. ERM involves thinking of risks with an enterprise portfolio view and considering ways to prioritize actions based on risk analysis and an organization's risk appetite. In July 2016, following two years of study, particularly of private sector and government best practices, the Office of Management and Budget (OMB) released a significantly revised circular A-123 titled "Management's Responsibility for Enterprise Risk Management and Internal Control." VA began to establish an ERM program in 2012 and since May of 2016, has accelerated efforts to implement ERM across VA.

VA's ERM program will meet OMB requirements as outlined in A-123, but will go beyond OMB guidance to tailor ERM to VA's particular needs and to provide maximum benefit to Veterans, employees, and VA leaders. In a September 2016 meeting, OMB described VA's ongoing ERM efforts, to include proposed implementation plan, leadership engagement, and process development and integration, as a leading practice in government. VA has a strong start on ERM, but requires leadership commitment across all levels of the enterprise for the next three years before risk-based thinking becomes a lasting part of VA culture.

ERM looks at risk with an enterprise view. That view allows VA to identify, understand, and act on risks that emerge between the Administrations or Staff Offices, and prevents a narrow, stove-piped approach to mitigating risk. A first key step is identification, analysis, and prioritization of enterprise risks; the top risks to VA achieving our objectives are captured in the VA Risk Profile. The VA Risk Profile is a key tool in getting a holistic view of the strategic and operational risks and opportunities facing VA.

VA's enterprise view of risk also allows its complex organizations to identify relatively small risks that appear in a number of programs and recognize that when bundled, these small risks can become a larger enterprise level risk. ERM then facilitates developing responses that leverage the scale and scope of VA.

VA ERM integrates internal control activities, future strategic risk assessments, and mitigation strategies into formulation of our overarching strategic plan, which helps direct activities at policy, programming, and program execution levels, to manage expected and unanticipated events, and ensure compliance with applicable laws and regulations. **VA's current ERM implementation efforts embed ERM principles and actions throughout the Department's planning and resourcing processes through the VA Strategic Operating Model (SOM) and Managing for Results (MFR) process.** Senior leaders have multiple decision points to shape both the implementation of the VA ERM program and identification, prioritization, and action on Strategic Risks.

VA ERM Implementation Overview
Leader Decision
Key Deliverable
Form A-123 ERM Core & Collaborative Teams
Initial ERM Governance Meeting
Senior Leaders Strategic Risk Discussion
Assess RM Current State
Enhance ERM Capabilities & Communications
Senior Leaders Strategic Risk Discussion
Update Risk Methodology for 2016 A-123
Senior Leaders Strategic Risk Discussion
Deliver VA Risk Profile to OMB
Collaborative ERM Implementation Plan
Deliver VA Risk Profile to OMB
Enhance ERM Analytics & Reporting
Publish Updated ERM policy
Deliver VA ERM Implementation Plan to OMB
Complete integration of ERM and IC processes / data
Oct 16
Mar 17
Oct 17
Oct 18

Top Actions for Way Ahead:

Implementation/Decision Step	Timeframe	Expected Outcome
• Risk Identification including GAO High Risk List and draft Risk Profile developed for Leadership team for guidance (Action and Decision). • Review existing policy and definitions and decide on VA Enterprise and Program Risk Appetite levels (Decision).	Nov 2016 - Jan 2017 Feb 2017	Understand current risks facing VA and state of VA risk management infrastructure and knowledge. Leverage existing capacity to collaboratively develop ERM implementation plan, lexicon, strategic risk register and Risk Profile, and enterprise risk mitigation plans.
• ERM Implementation Plan developed and provided to OMB (Action). • Identify top strategic risks and provide VA Risk Profile to OMB (Decision and Action).	Oct 2016 - Mar 2017 Jun 2017	ERM implementation plan, initial risk identification, and prioritization will be developed and approved by key stakeholders and senior leaders prior to Risk Profile submission; VA will have a clear picture of enterprise risks, and the strategic operating environment.
• Complete integration of ERM and internal controls frameworks (Action).	Sep 2017	Internal controls integration allows for a more holistic look at risks to include material weaknesses and provides a key tool to mitigate risks through effective use of controls.
• Strategic Understanding: integrate findings from strategic environmental assessment and Veteran demand forecast into draft Risk Profile (Action and Decision). • Strategic Planning: integrate draft Risk Profile of top VA risks into VA 2024 Strategic Plan (Action). • Mission Requirements: Use capability gap understanding to begin enterprise level look at mitigating risks (Action). • Programming: use programming solutions to further risk mitigation plans (Decision & Action). • Budgeting: analyze budget pass-back decisions to identify emerging risks from resource shortfalls (Action). • Execution and Assessment: use Monthly Management Review to assess emerging risks from performance & budget shortfalls (Action).	Dec 2016 Feb 2017 Jun 2017 Mar 2017 Aug 2017 Jan 2017	Full ERM integration into SOM/MFR ties together risk based thinking and strategy setting along with resourcing. VA will be able to identify externally and internally driven risks in an anticipatory manner and do thorough work to put in place feasible mitigation plans that reduce risks to an acceptable level. ERM also provides a mechanism for use of real-time program and initiative assessment data to anticipate emerging threats to program success and revise implementation efforts. By using ERM as part of the management system, not only are senior leaders positioned to make better evidence-based decisions, but field leaders and managers see the value in reporting risks as they solutions implemented.

Measures of Success:

- FY2017-Structure: Risk Governance Structures are functioning; Risk reporting deliverables are on time, with concurrence from Leadership.
- FY2017-Tools: VA's Risk Profile provides a prioritized picture of threats and opportunities in VA's strategic operating environment, and is a reliable tool for making informed risk-based decisions.
- FY2018-Diffusion: ERM is relevant and employed vertically and horizontally across the organization; reporting on risk is rewarded with action.
- FY2019-Culture: Risk based thinking – anticipating and reporting problems that Veterans may face or threats to achieving outcomes for Veterans, developing solutions transparently with full enterprise support, and prioritizing resources to mitigate risks – is woven into VA's culture.

Risk Management:

Risk	Continuum	Mitigation Strategy
Failure to communicate value of ERM.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
Change in Executive or Legislative direction impedes ERM program.	Emerging Risk (unknown, no plan)	Acknowledge and accept.
ERM not integrated into SOM/MFR.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Monitor
Congress	☒	Monitor
Veterans Service Organizations	☒	Involve
Federal Agency Partner	☒	Involve
VA Advisory Board or Committee (MyVA; Strategic Planning Teams	☒	Involve
Federal Employee Union	☒	Monitor
Tribal Government	☒	Monitor
State Veterans Affairs	☒	Engage
Media	☒	Monitor
Office of Inspector General	☒	Monitor
Government Accountability Office	☒	Consult

9.2 Service Delivery and Benefits Issues

This section describes issues that show how VA is continuing to improve the delivery of services and benefits to Veterans and their families.

9.2.1 Precision Medicine

VA has ongoing collaborations and data sharing with other agencies to enhance its ability in precision medicine that seeks to provide evidence-based, tailored care to specific diseases with a genetic basis. These activities focus on genomic medicine, cancer, and mental health research as part of a larger Precision Medicine Initiative.

Precision medicine research has great potential for how Veterans can be treated based on their genetic information. These efforts currently focus on three key areas: (1) establishing the largest genomic cohort of Veterans and active duty personnel for precision medicine research, (2) cancer research and precision oncology, and (3) mental health research.

The signature VA genomic medicine activity is the Million Veteran Program (MVP), the largest genomic cohort of its kind in the world, with a database of health, lifestyle, military exposure and genetic data, with over 520,000 Veterans already enrolled at 52 VA Medical Centers and roughly 60 community based out-patient clinics (CBOCs) nationwide. Researchers in MVP are also working closely with the Department of Defense (DoD) and the National Institutes of Health (NIH) to develop collaborations and data sharing through interagency agreements. The agreement with DoD will enable enrollment of active duty members from the Millennium Cohort Study into the MVP. The agreement with NIH will enable enrollment of Veterans into NIH's Precision Medicine Initiative Cohort Program (PMI-CP). Currently eight scientific projects using MVP data are ongoing in the areas of PTSD, serious mental illness, multi-substance abuse, Gulf War Illness, cardiovascular and metabolic diseases, kidney disease and age–related macular degeneration. In 2016, VA established an inter-agency agreement with the Department of Energy to leverage its supercomputing infrastructure and expertise to foster big data science from VA electronic health record data and MVP data. This collaboration will allow MVP to significantly expand MVP data access to researchers within and outside VA.

The VA cancer research portfolio includes nearly 250 active studies aimed at understanding and preventing various cancers found in the Veteran population. VA research focuses on the basic biology, genetic factors and clinical trials to evaluate ways to treat, prevent, or diagnose cancer. In FY2015, approximately $52 million was spent in VA's biomedical, clinical, rehabilitation and health services research services, as well as in its Cooperative Studies Program which specializes in providing definitive evidence to support clinical practice. In MVP, roughly 32% of participants had self-reported cancer diagnoses, which provides an important resource for further genetic exploration of new approaches to cancer management and therapy. Furthermore, VA is partnering with the National Cancer Institute (NCI) and DoD in an effort called the Applied Proteogenomics Organizational Learning and Outcomes (APOLLO) network. The goal of APOLLO is to apply state-of-the-art approaches to include information from proteins and genes to enhance cancer care within the DoD and VA, the two largest federal health care systems.

VA Research's Health Services Research and Development (HSRD) and Genomic Medicine

Implementation programs initiated a new Clinical Precision Medicine in Mental Health initiative that will seek to return genomic results to Veterans with depression in the clinical setting. This groundbreaking study, entitled PRIME Care (Precision Medicine in Mental Health Care), is led by David Oslin, MD at the Corporal Michael J. Crescenz VA Medical Center in Philadelphia, PA, who is also the Director of the VISN 4 Mental Illness Research, Education and Clinical Center and a Core Investigator with the HSRD Center for Health Equity Research and Promotion.

Top Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Million Veteran Program		
Expand Enrollment to all Veterans nationwide through a web-based portal.	*September 2017*	*Veterans will be able to enroll via a web portal in the convenience of their home.*
Collate and compile information from alpha/beta studies, and increase number of researchers accessing data.	July 2017	New scientific discoveries from MVP; researchers within VA and outside VA access MVP data.
Work with DoD to expand enrollment to active duty members.	July 2017	Active duty members will be able to enroll in MVP.
Mental Health		
Establish Study/Scientific Cores/Cores Launched.	Dec 2016	Knowledge translation, value and discovery.
Institutional Review Board (IRB) approval for PRIME Care.	Mar 2017	Approved study protocol.
Finalize Study Sites.	Mar 2017	VA Site enrollment.
Recruit first cohort.	Sep 2017	300 patients recruited.
Recruitment complete.	Sep 2019	2,000 patients enrolled.
Preliminary analysis.	Sep 2020	Results disseminated to leadership.
Final results completed/communicated to leadership.	Sep 2021	Papers/Scientific presentation complete.

Measures of Success (MVP, Cancer/Precision Oncology, Mental Health):

- New MVP sites will be added to replace depleted sites and a contract to develop a web portal for MVP enrollment will be awarded in FY2017.
- At least four new projects using MVP data will be selected for funding in FY2017.
- The memorandum of agreement for data use (MOA/DUA) will be signed by both VA and DoD and recruitment of members from DoD's Millennium Cohort Study (MCS) will be initiated in FY2017. The overall goal is to enroll at least 10% of MCS members, with at least 5000 in FY2017.
- A functional database infrastructure will be established and tested at one of the Department of Energy laboratories in FY2017.
- VA Research for the Precision Oncology Program (RePOP): RePOP is an innovative approach that seeks to integrate research into the clinical setting to enhance VA's learning health care system goals. This activity is done as part of a larger VA Precision Oncology Program conducted by VHA Office of Patient Care Services to enable

capabilities to provide standardized state-of-the-art practices in precision oncology care and research for VA cancer care specialists and Veterans. These activities resulted from an initial two-year old program initiated in VISN1 through the Massachusetts Veterans Epidemiology Research and Information Center (MAVERIC) at the Boston VA Health Care System. It facilitates genomic analysis, tissue repository and molecular oncology support to enhance clinical care, as well as future participation in clinical trials. In FY2017, VA plans to have a research protocol established that will describe specific activities to be jointly conducted with NCI and DoD partners. Success will be measured by the ability to enable a larger number of Veterans access state-of-the-art clinical trials sponsored by NCI and industry. Currently, discussions with potential collaborators are in process and specific measures can be provided when agreements are in place to detail these activities.

- VA Clinical Cancer Research Portfolio: VA Research has additional active clinical oncology studies. Among them, the VA Cooperative Studies Program (CSP) enables an efficient platform for multi-center clinical trials using the shared electronic health records shared among all VAMCs. Among key advances, one study (CSP #380) set the standard for early colorectal cancer screening by showing the efficacy of colonoscopy over sigmoidoscopy. A second CSP study, the Colonoscopy vs. Fecal Immunochemical Testing in Reducing Mortality From Colorectal Cancer (CONFIRM) trial is underway comparing colonoscopy with fecal immunochemical testing in colorectal cancer screening and related mortality. CONFIRM seeks to enroll 50,000 participants into the trial by the end of FY2017. Completion of this trial will provide important insights into guiding patients into effective strategies for colorectal cancer screening. The CSP #2005, "Veterans Affairs Lung cancer surgery or stereotactic Radiotherapy" (VALOR) trial will seek to launch and enroll its first patient in FY2017. Additional studies are ongoing for cancers of prostate, skin, and lungs.
- Last spring, VA Research launched the **Clinical Precision Medicine in Mental Health** initiative based on pioneering work by the MVP and VA's national Precision Medicine clinical platform, and in response to the VA Quality Enhancement Research Initiative (QUERI) Evidence Synthesis Program Scientific Review which strongly suggested the need for more research on genomic testing implementation in the clinical care setting. After a call for proposals this summer, HSRD awarded funding to PRIME Care, which will begin in October 2016, and break new ground by determining optimal approaches to using genomic information to better treat depression in Veterans. PRIME Care focuses on the effectiveness of pharmacogenomics – how genes personally affect a person's response to treatment – and may help shorten time to optimal treatment by predicting how well an individual will tolerate or respond to an antidepressant.

Risk Management:

Risk	Continuum	Mitigation Strategy
Data loss/degradation of systems.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
Limitation of computational requirements.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
Storage of large data sets.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Monitor
Congress	☒	Monitor
Veterans Service Organizations	☒	Engage
Federal Agency Partner (DoD, NIH, NCI, Office of Science and Technology Policy)	☒	Engage
VA Advisory Board or Committee (Genomic Medicine Program Advisory Committee)	☒	Involve
Federal Employee Union	☐	
Tribal Government	☐	
State Veterans Affairs	☐	
Media	☐	
Office of Inspector General	☐	
Government Accountability Office	☐	

9.2.2 Million Veteran Program

VA is currently at the leading edge of the precision medicine revolution and aims at improving healthcare for Veterans and the population at large. As a part of this work and to further its goal of learning more about how genes affect health, VA established the Million Veteran Program (MVP); a large database of genetic, military exposure, lifestyle, and health information.

MVP is an important part of the White House's Precision Medicine Initiative, which aims to enable a new era of medicine through research, technology, and policies that empower patients, researchers, and providers to work together toward development of individualized care. With over 520,000 enrollees as of October 2016, MVP is the largest database of its kind in the world; an integrated health and genomic database tied to a healthcare system. It is the world's largest genomic cohort of Veterans, and has the largest representation of minorities of any genomic cohort in the U.S.

Research findings based on MVP data may lead to new ways of preventing and treating illnesses in Veterans and others. Such findings may help answer questions such as, "Why does a

treatment work well for some people but not for others?" "Why are some people at greater risk for developing certain diseases?" and, "How can we prevent certain illnesses in the first place?" For example, since nearly a third of MVP participants report a history of cancer, discoveries based on MVP are likely to advance the National Cancer Moonshot, a national initiative to accelerate the development of new cancer detection and treatments.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Collate and compile information from alpha/beta studies, and increase number of researchers accessing data.	July 2017	New scientific discoveries from MVP; researchers within VA and outside VA access MVP data.
Work with Department of Defense (DoD) to expand enrollment to active duty members.	July 2017	Active duty members will be able to enroll in MVP.
Expand enrollment to all Veterans nationwide through a web-based portal.	September 2017	Veterans will be able to enroll via a web portal in the convenience of their home.

Measures of Success:

- At least four additional projects using MVP data will be selected for funding in FY2017.
- The memorandum of agreement for data use (MOA/DUA) will be signed by VA and DoD, and recruitment from DoD's Millennium Cohort Study (MCS) will be initiated in FY2017. The overall goal is to enroll at least 10% of MCS members in MVP over a 2-3 year period, with at least 5000 in FY2017. New enrollment sites will be added to replace depleted sites and a contract for developing the web portal will be awarded in FY2017.

Risk Management:

Risk	Continuum	Mitigation Strategy
Data loss/degradation of systems	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
Limitation of computational requirements	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
Storage of large data sets	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Monitor
Congress	☒	Monitor
Veterans Service Organizations	☒	Monitor
Federal Agency Partner (Department of Energy, DoD, Department of Health and Human Services)	☒	Involve
VA Advisory Board or Committee (Genomic Medicine Program Advisory Committee)	☒	Involve
Federal Employee Union	☐	
Tribal Government	☐	
State Veterans Affairs	☐	
Media	☐	
Office of Inspector General	☐	
Government Accountability Office	☐	

9.2.3 Addressing Scheduling-Related Problems

In support of its commitment to provide timely access to healthcare services for Veterans, VA is working on various efforts to address scheduling-related barriers.

The Veterans Health Administration (VHA) is committed to providing timely, high quality care for all enrolled Veterans. **In support of this commitment, VHA published updated scheduling policies and procedures in VHA Directive 1230, "Outpatient Scheduling Processes and Procedures" on July 15, 2016.** The Directive establishes policy for outpatient clinic appointment scheduling processes and procedures in the Veterans Health Information Systems and Technology Architecture (VistA). It specifically requires that Veterans' appointments are scheduled with the goal of scheduling appointments no more than 30 calendar days from the date an appointment is deemed clinically appropriate by a VA healthcare provider or, in the absence of such a date, 30 calendar days from the date the Veteran requests care. Along with updating the policy, VHA is also undertaking the following efforts to address scheduling-related barriers:

- Provide current scheduling training for VHA employees.
- Implement a web-presence and scheduling community of practice.
- Modernize and enhance scheduling tools.
- Ensure all clinical sites of care have a system profile within VHA Site Tracking (VAST) system.

VHA also hired 3,698 Medical Services Assistant (MSA) employees in FY2016. VHA is currently developing MSA training for a train-the-trainer rollout. The instructor guide and the presentations are undergoing vetting by the respective subject matter experts for each topic. Once the vetting is complete, VHA will be ready to begin the training.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Provide education and training on the newly revised and disseminated VHA Directive 1230.	October 2016	VHA employees are trained on VHA Directive 1230 and adopt new procedures when scheduling appointments.
Roll out VistA Scheduling Enhancements (VSE) and training.	February – July 2017	Schedulers are able to make appointments quickly by viewing multiple appointment request types and multiple clinics on one screen; easily view patient requests for service; find next available appointment, and track a patient's appointment process.
Execute Station Numbering Initiative for 226 identified clinical sites of care not operating under a unique station number in VAST.	Summer 2017	All clinical sites of care have a system profile in VHA Site Tracking (VAST) system, which will ensure data accuracy and easier integration among data systems.

Measures of Success:

- If a Veteran needs care right away during regular business hours, the Veteran receives services the same day or, if after hours, by the next day from a VA Medical Center.
- Veterans' appointments are scheduled timely, accurately, and consistently meeting the standards in VHA Directive 1230.
- Veterans are able to conveniently receive medically necessary care, referrals, and information from any VA medical center, in addition to the facility where they typically receive their care.

Risk Management:

Risk	Continuum	Mitigation Strategy
Technology implementation(s) and enhancements are not compatible with existing practices, technologies, and infrastructure.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
New scheduling principles and practices do not lead to sustainable, long-term improvements.	Known Managed Risk (known, plan, oversight)	Monitor for changes that affect impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Engage
Congress	☒	Consult
Veterans Service Organizations (e.g. American Legion)	☒	Consult
Federal Agency Partner (e.g. Department of Defense)	☒	Consult
VA Advisory Board or Committee (e.g. Commission on Care)	☒	Consult
Federal Employee Union	☒	Engage
Tribal Government	☒	Engage
State Veterans Affairs	☒	Engage
Media	☒	Monitor
Office of Inspector General	☒	Monitor
Government Accountability Office	☒	Monitor

9.2.4 Medical Appointment Scheduling System IT Enhancement

VA has a two-pronged plan to improve scheduling that includes (1) national implementation in January 2017 of VistA Scheduling Enhancement (VSE), a relatively inexpensive and partial solution to provide some immediate relief to schedulers; and (2) replacement of VA's approximately 30-year-old, highly manual VistA Scheduling System through a ~$623 million contract to acquire a comprehensive, state-of-the-art commercial off-the-shelf scheduling system.

VA completed an initial Medical Appointment Scheduling System (MASS) task order in November 2015 outlining a plan to implement MASS in every facility, nationally. The Veterans Health Administration (VHA) leadership paused MASS implementation in March 2016 to evaluate VSE, a less expensive and timelier solution. VSE implementation is under remediation and now planned for January 2017 national implementation. Recently, leadership also directed that MASS be re-activated, reduced in size, and piloted at one facility.

VA will consider the following when determining a use for VSE vs. MASS in the future:

- Has VSE been successfully deployed, adequately functioning, and fully adopted in VHA?
- Does VSE meet VHA's scheduling and resource management needs?
- Has MASS been successfully piloted in one facility?
- What degree does VSE vs. MASS achieve the measures of success outlined below?

When determining if MASS has been successfully piloted in one facility, VA will use the following decision criteria:

- Improve provider time management.
    - Reduce no-shows, which increases relative supply of appointments.
    - Combine current grids into one increases the supply of appointments.

- Identify unused appointment slots to increase supply of appointments.
- Improve management of all resources (e.g. provider, room, support staff, equipment utilization, etc.).
- Improve life of the scheduler.
- Simplify and improve scheduling experience for the Veteran.
  - Preferences.
  - Self-Scheduling.
  - Better appointment coordination.
  - Ability to schedule the right provider to the right problem.
  - Short notice call list (to bring patients willing to come on short notice).

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Remediate VSE application and implement nationally.	Start February 2017	Implementation of VSE starting in Primary Care.
Pilot MASS at one facility.	2017	Implement MASS in Boise, ID.
Consider options for future scheduling solution.	2018	Based on experience in 2017, further decisions made.

Measures of Success:

- VHA schedulers make appointments accurately, reliably, and efficiently.
- VHA providers optimize their productivity by managing their resources – time, support staff, rooms, and equipment in order to optimize access to care for both face-to-face and non-face-to-face services.
- Patients are able to make appointments at their convenience according to their preferences and receive accurate and timely reminders according to the route they choose.

Risk Management:

Risk	Continuum	Mitigation Strategy
VSE is unable to be nationally implemented.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
MASS is unable to be implemented in one facility.	Known Un-managed Risk (known, no plan)	Acknowledge and accept.
Both MASS and VSE work, but a decision on standardization is needed.	Known Managed Risk (known, plan, oversight)	Acknowledge and accept.

Stakeholder Overview:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Engage
Congress	☒	Consult
Veterans Service Organizations	☒	Engage
Federal Agency Partner	☐	
VA Advisory Board or Committee	☐	
Federal Employee Union	☒	Engage
Tribal Government	☐	
State Veterans Affairs	☐	
Media	☒	Monitor
Office of Inspector General	☒	Monitor
Government Accountability Office	☒	Monitor
Other (VA Schedulers and clinic staff)	☒	Involve

9.2.5 Long-Term Care Services and Support

While Veterans are aging and the current care models are cost prohibitive, VA is working to provide Veterans with a comprehensive model of care that optimizes access and care coordination, and balances Veterans' preferences.

Long-term care is defined as the range of services and programs required to support Veterans' healthcare needs according to their preferences. These services include, but are not limited to: Adult Day Healthcare, Home Based Primary Care, Homemaker and Home Health Aide, Community Residential and Medical Foster Care, Respite, Skilled home, Palliative Care, and Veteran Directed Care.

Between 2016 and 2026, the number of Veterans enrolled in VA healthcare age 70 and older will increase by 30%, from 3 million to 3.9 million. During this timeframe, the number of enrolled Veterans less than 70 years old is projected to decrease by 8%. The number of "oldest old" (over 85 years) Veterans has increased almost 11-fold between 1999 and 2014, and is projected to surge more than 17-fold by 2034. 50% of enrolled Veterans using VA healthcare services are 65 years or older. The number of enrollees that are priority 1a (70% or greater service connected) is increasing. Between 2013 and 2023, it is estimated that the number of enrolled priority 1a Veterans age 65 and older will double to one million. VA is required by law to provide nursing home care for priority 1a Veterans when it is needed. Other enrolled Veterans also may receive VA-paid nursing home care when it is clinically indicated.

The Veterans Health Administration (VHA) has a comprehensive set of community-based care programs that can meet the needs of this complex population, while honoring Veterans' preferences for care services. Programs include Home Based Primary Care, Adult Day Health Care, Medical Foster Home, Geri-PACT, Geriatric Consultations, as well as 135 VA-owned and

operated Community Living Centers that provide rehabilitation, hospice and extended care to the most vulnerable Veterans. As part of VHA's efforts to transform into a 21st century healthcare organization with a focus on patient centered care, the Office of Geriatrics and Extended Care awarded funding totaling nearly $20 million per year for two years to initiate 59 innovative pilots of patient centered, non-institutional extended care, and to augment the Veteran-Directed Home and Community-Based Care program. These resources enhanced options for Veterans choosing to receive their extended care in the home and community rather than in an institution.

VHA requires a new generation of clinicians with advanced preparation in geriatric and palliative medicine to sustain and staff these efforts. VHA has trained or participated in the training of most U.S. physicians who have specialty status in geriatrics, yet there are still barriers to their employment and retention in VA settings. For example, those with this advanced training are actually in a lower pay band than physicians with less, and more general, training. Educational loan repayment possibilities exist but are configured in a way that discourages use. Due to the undersupply of geriatrics-trained VA clinicians from all disciplines, efforts to enhance the geriatric competencies of the general VHA clinical workforce, as a complementary strategy for addressing the aging VA population, encounter barriers.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Adoption of VA's Community Care Plan.	Pending Legislation	Improved access to nursing home and home care providers and significant reduction in Improper Payments Elimination and Recovery Act (IPERA) error rate.
Shift care to non-institutional settings by rebalancing hospital and nursing home use.	FY2023	Improve Veteran access by expanding options for providing home and community-based services to maintain independence in the community, while minimizing growth in nursing home bed days.
Develop and execute the educational, workforce recruitment and retention, and clinical strategies for ensuring clinical workforce is adequately prepared to treat a population that is predominantly elderly and growing older every year.	FY2022	Reduced hospital, nursing home, and Emergency Department demand as aging and chronically disabled Veterans receive comprehensive geriatric evaluation. Identified healthcare needs managed at lower cost and with better outcomes.

Measures of Success:

- VHA will have authority to pursue and secure quality home and community-based services, including nursing home and hospice care.
- VHA will provide a biennial comprehensive geriatric evaluation to at least 25% of Veterans over age 75 years (literature-based estimate of need is over 30%; present rate is less than 10%).

Risk Management:

Risk	Continuum	Mitigation Strategy
Congress does not authorize VA's Community Care Plan.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
Reluctance to shift from system priority to person priority.	Known Managed Risk (known, plan, oversight)	Monitor for changes that affect impact.
Existence of inadequate and untimely recruitment and retention incentives to clinicians with advanced competency in geriatric and palliative care.	Known Un-managed Risk (known, no plan)	Control and implement actions to minimize impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Involve
Congress	☒	Monitor
Veterans Service Organizations	☐	
Federal Agency Partner (Department of Health and Human Services)	☒	Engage
VA Advisory Board or Committee (VHA Geriatrics and Gerontology Advisory Committee)	☒	Consult
Federal Employee Union	☐	
Tribal Government	☐	
State Veterans Affairs	☒	Involve
Media	☐	
Office of Inspector General	☐	
Government Accountability Office	☒	Monitor

9.2.6 Graduate Medical Education Funding and Expansion

In response to the Veterans Access, Choice, and Accountability Act of 2014, VA is expanding the Graduate Medical Education (GME) program to address physician shortages and areas with a high Veteran population.

38 USC 7302 authorizes VA to contribute to the healthcare workforce of the U.S. by providing health professional training for VA "and the Nation." VA currently provides the largest education and training enterprise for health professionals nationally. VA trains over 40 different types of health professional trainees of all occupations and levels, each year. Over 120,000 individuals receive clinical training at nearly all sites of VHA healthcare delivery system.

Section 301(b) of the Veterans Access, Choice and Accountability Act ("Choice Act") of 2014 authorized VA to increase the number of GME residency positions by up to 1,500 over a five-year period with priorities of primary care and psychiatry. The Choice Act directed VA to place these new positions into particular locations with:

- Physician shortages;
- High Veteran population;
- Health Resources and Services Administration (HRSA)-designated Health Professional Shortage Areas (HPSA); or
- No prior GME programs.

As of July 1, 2016, after two rounds of approvals, 372 positions have been approved, and of those, 320 are already occupied. The third round positions are in the approval process and are expected to be announced after Under Secretary for Health approval. Given the current rate of position requests and approvals, VHA estimates that approximately 880 positions will be authorized after five rounds of approval. This is only half of what Congress intended. As such, VA has requested a legislative extension of the Choice Act's 301(b) authority to continue to add positions to the 1,500 position limit.

VA is celebrating the 70th Anniversary of the GME program and is committed to remaining the Nation's premier GME partner. The expansion opportunities under the Choice Act allow VA to improve Veteran access to care, while growing a key component of its physician recruitment pipeline.

Top Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Request extension of VACAA GME program to 10 years.	FY2018	Facilities ready to host GME programs, and for those programs to be started, accredited, and filled.
Communication and outreach.	Ongoing	Robust communications and outreach to build new VA-academic affiliate strategic partnerships, and to expand existing programs.

Measures of Success:

- Number of GME positions approved and occupied over life of initiative.

Risk Management:

Risk	Continuum	Mitigation Strategy
301 (b) – GME position and Infrastructure funding will run out before GME Expansion goal is reached.	Known Managed Risk (known, plan, oversight)	Adjust and avoid.
301 (b) – VA dependent on academic affiliates to expand and create new GME residency positions.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
301 (b) – Request to extend VACAA GME program to 10-years does not get approved.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☐	
Congress	☒	Engage
Veterans Service Organizations	☐	
Federal Agency Partner (Centers for Medicare and Medicaid Services)	☒	Consult
VA Advisory Board or Committee	☒	Monitor
Federal Employee Union	☐	
Tribal Government	☐	
State Veterans Affairs	☐	
Media	☒	Engage
Office of Inspector General	☒	Monitor
Government Accountability Office	☒	Monitor
Other (Academic Affiliates)	☒	Engage

9.2.7 New Rule for Tiered Medication Copayment Structure

Medication copayments are set by statute and regulations, and are currently capped at 2010 levels. A new rule expected to take effect February 27, 2017 will replace current rates with a 3-tier structure that is expected to result in lower out-of-pocket costs to Veterans, better compliance, and reduced fragmentation of care. The new rates and the list of Tier 1 medications will be published in the final rule. Medication tier assignments will be updated periodically.

Under 38 U.S.C. 1722A(a), VA must require certain Veterans to pay at least a $2 copayment for each 30-day supply of medication furnished on an outpatient basis for the treatment of a non-service-connected disability or condition. This statute provides authority for VA to increase that copayment amount and establish a maximum annual copayment amount (a "cap") through regulation. VA implemented this statute in 38 C.F.R. 17.110.

This final rulemaking replaces the current medication copayment rate with a 3-tier structure. These tiers are defined in the rulemaking and are based in part, on whether the medications are available from multiple sources or a single source, with some exceptions. The effective date of this final rule is February 27, 2017. Under the rule, the following copayment amounts will take effect for a 1-30 day supply: $5 for a Tier 1 medication, $8 for a Tier 2 medication, and $11 for a Tier 3 medication. Medication copayments are capped at $700.

For most Veterans, these copayment amounts will result in lower out-of-pocket costs, encourage greater adherence to prescribed medications, and reduce the risk of fragmented care that results when Veterans use multiple pharmacies to fill their prescriptions.

VA currently charges non-exempt Veterans either $8 or $9 for a 1 to 30 day supply of medication, with a $960 annual cap on copayments. Copayment and cap amounts are currently

frozen at 2010 levels. This rulemaking replaces the current copayment structure and lowers the annual cap.

Medications are currently being assigned to tiers in the VA National Formulary, a listing of products (drugs and supplies) that must be available for prescription at all VA facilities. The assignments will be reviewed on a periodic basis. The Tier 1 medication list will be published in the Federal Register. The changes to be rolled out on February 27, 2017 will ensure that Veterans are charged the correct amount. An overview of VA's regulation/rulemaking process can be found in the Useful References chapter.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Final Rule publication.	December 1, 2016	Final Rule (RIN 2900-AP35) will be published informing public of effective copayment changes.
Internal/Veteran-facing communication.	December 31, 2016	Veterans and internal staff will be notified of medication copayment changes.
Complete IT testing and implementation activities.	February 26, 2017	System will function as designed and be available for VA use.

Measures of Success:

- Final Rule is published notifying the public of impending changes.
- Properly targeted internal and Veteran-facing communications have been deployed informing VA stakeholders, as well as Veterans of impending changes.
- IT Systems supporting tiered medication changes are operational and function as designed within normal operational business parameters.

Risk Management:

Risk	Continuum	Mitigation Strategy
If vendor support ceases shortly after go-live, then there will be a gap to support system if issues are encountered.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
If the Final Rule is not published on-time, then our Veteran-facing communications will be delayed.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Engage
Congress	☒	Consult
Veterans Service Organizations	☒	Engage
Federal Agency Partner (Office of Management and Budget)	☒	Involve
VA Advisory Board or Committee	☐	
Federal Employee Union	☐	
Tribal Government	☐	
State Veterans Affairs	☐	
Media	☒	Engage
Office of Inspector General	☐	
Government Accountability Office	☐	

9.2.8 Dialysis Expansion Moratorium

While many Veterans rely on VA for dialysis, there is significant industry opposition to VA efforts to expand in-house dialysis capacity, and to reimburse community dialysis providers at the Medicare rate.

There are approximately 23,000 Veterans relying on VA for dialysis. Of those Veterans receiving outpatient dialysis, 77% receive dialysis services from non-VA facilities due to lack of in-house capacity. Of all VA spending on non-VA care, dialysis is the highest. In FY2015, VA spending on dialysis care furnished in the community was approximately $543 million. VA has nationwide contracts with 26 dialysis networks that operate approximately 5,692 dialysis facilities throughout the United States. Under the nationwide contracts, VA is paying approximately 30% above the Medicare rate. Failure to achieve parity in Federal payment for dialysis has and will continue to perpetuate an excess cost to taxpayers of approximately $110 million per year.

PL 114-41 Section 4006 (enacted July 31, 2015) prohibits VA from creating new dialysis capability until December 21, 2016. VHA deferred formal notification to the field while leadership sought clarity around the intended scope of the legislation. The Office of General Counsel (OGC) subsequently concluded that VA may not create new dialysis capability or expand existing dialysis capacity. This has resulted in a moratorium on dialysis projects in VA.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Formally notify field of dialysis moratorium.	September 30, 2016	Enterprise-wide awareness of and compliance with PL 114-41.
Pursue legislation requiring Medicare providers of outpatient services to accept VA payment at the Medicare reimbursement rate as requested in VA's annual budget over the past four years (FY2013-FY2016).	September 30, 2017	Annual savings to taxpayers of approximately $110 million.
Create new in-house dialysis capability and expand existing capacity in strategically identified areas.	Begin once prohibition elapses (December 21, 2016)	Improved Veteran access to dialysis.

Measures of Success:

- Legislation enacted that requires Medicare providers of outpatient dialysis to accept VA payment for dialysis at the Medicare rate.
- Creation/expansion of in-house dialysis capability resumes once moratorium expires.

Risk Management:

Risk	Continuum	Mitigation Strategy
Legislation enacted to continue dialysis prohibition.	Known Un-managed Risk (known, no plan)	Control and implement actions to minimize impact.
Industry opposition to VA efforts to achieve federal parity in dialysis payment and to increase in-house dialysis capacity.	Known Un-managed Risk (known, no plan)	Acknowledge and accept.
Formal notification of field results in identification of non-compliance.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Engage
Congress	☒	Engage
Veterans Service Organizations	☒	Engage
Federal Agency Partner (e.g. Centers for Medicare and Medicaid, Department of Health and Human Services)	☒	Consult
VA Advisory Board or Committee (National Leadership Board)	☒	Engage
Federal Employee Union	☐	
Tribal Government	☐	
State Veterans Affairs	☐	
Media	☐	
Office of Inspector General	☐	
Government Accountability Office	☒	Consult

9.2.9 Pilot Program for Veterinary Health Benefits for Mobility Service Dogs

As part of its efforts to promote a VA culture open to healthcare innovation, the Veterans Health Administration (VHA) Office of Community Engagement/Center for Compassionate Innovation recently announced a pilot program authorizing veterinary health benefits for mobility service dogs.

The VHA Office of Community Engagement/Center for Compassionate Innovation promotes a VA culture open to healthcare innovation by exploring emerging and innovative therapies to enhance Veterans' physical and mental well-being when other treatments have not been successful. **In August 2016, the Center announced a pilot program that authorizes veterinary health benefits for mobility service dogs approved for Veterans with a chronic impairment that substantially limits mobility associated with mental health disorders.**

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Communicate clinical protocol with VA clinicians.	ongoing	Conformance with clinical protocol.
Wide external communication.	ongoing	Veterans that meet the criteria are paired with mobility service dogs.
Measure Veteran outcomes.	ongoing	Improved Veteran Mental Health and Veteran Experience.

Measures of Success:

- Number of Veterans paired with mobility service dogs (no pairings have been made to date, as the pilot was just announced in August 2016).
- Veterans report increased functional mobility, improved mental health outcomes, social integration, and quality of life.
- Clinicians report overall improved mental health after Veteran and mobility service dog pairing.

Risk Management:

Risk	Continuum	Mitigation Strategy
External communication.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
Assistance Dogs International cannot meet service dog demand.	Known Un-managed Risk (known, no plan)	Acknowledge and accept.
Clinician failure to follow clinical protocol.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Involve
Congress	☒	Engage
Veterans Service Organizations	☒	Involve
Federal Agency Partner	☐	
VA Advisory Board or Committee	☐	
Federal Employee Union	☐	
Tribal Government	☐	
State Veterans Affairs	☐	
Media	☒	Monitor
Office of Inspector General	☐	
Government Accountability Office	☐	

9.2.10 Expanding Telehealth Capability

As part of its core access strategy/same day access initiative, VA continues to expand telehealth services using a variety of strategies, including deployment of regional telehealth centers to increase clinical resource capacity and recruitment, and mobile solutions to enable Veterans to access VA care from their preferred locations.

In FY2015, VA provided over 2 million telehealth encounters to over 677,000 Veterans for both primary care (Teleprimary) and mental health (Telemental). This represents about 12% of all Veterans accessing care. **To further expand its critical telehealth services, VA must address internal barriers to expansion, including privileging and medical record access, as well as develop processes to address prescribing methods for controlled substances and state licensure requirements.**

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Expand clinical resources and capacity by enabling telehealth center providers in areas of abundance to serve those in areas of need.	Initial work FY2016; Expansion ongoing	4 Telemental health centers in FY2016; 2 Teleprimary care centers in FY2016; 4 more Teleprimary care centers in FY2017-FY2018
Address specific barriers to telehealth service expansion and shared clinical resources.	Initial work FY2016; Expansion ongoing	Streamlined processes for VA privileging, licensure, prescribing, and medical record access.
Offer VA provider- and Veteran-friendly telehealth solutions.	Initial work FY2016; Expansion ongoing	VA Video Connect offering: Virtual Medical Room connectivity for Veterans and VA providers through any mobile platform in FY2016; VA-provided mobile video telehealth device for Veterans without Internet or device in FY2016.

Measures of Success:

- Increases in telehealth activity and Veteran satisfaction with telehealth services.
- Implementation of six telehealth centers.
- Streamlined national VA privileging, licensure, prescribing, and medical record access for VA telehealth services.

Risk Management:

Risk	Continuum	Mitigation Strategy
Funding/staffing for adequate IT and telehealth support ongoing and expansion.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
State licensure requirements.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
Cybersecurity.	Emerging Risk (unknown, no plan)	Monitor for changes that affect impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Engage
Congress	☒	Consult
Veterans Service Organizations (Veterans of Foreign Wars; Paralyzed Veterans of America)	☒	Engage
Federal Agency Partner (Department of Defense, Indian Health Service, Department of Justice)	☒	Involve
VA Advisory Board or Committee	☐	
Federal Employee Union	☒	Consult
Tribal Government	☒	Engage
State Veterans Affairs	☒	Engage
Media	☐	
Office of Inspector General	☐	
Government Accountability Office	☐	

9.2.11 Gender Alteration Rule Change to Allow Transgender Surgeries

VA is committed to ensuring equality for all LGBT Veterans and will work with Congress to request additional funding for medical services in the upcoming budget process to carry out the rule making action in a timely fashion.

Current Veterans Health Administration (VHA) policy mandates care for transgender Veterans, with the exception of surgical interventions. In May 2016, VA began reviewing a 1992 VHA regulation prohibiting “Gender Alterations,” which was previously interpreted in 2011 to prohibit gender transitioning surgeries. **As the fiscal outlook for VHA in FY2017 and FY2018 became more apparent, VA decided to pause the rule making process and ask Congress for**

additional funding to cover projected costs of changing the 1992 regulation. An overview of VA's regulation/rulemaking process can be found in the Useful References section.

VA currently provides many services for transgender Veterans to include hormone therapy, mental healthcare, preoperative evaluation, and long-term care following sex reassignment surgery. Increased understanding of both gender dysphoria and surgical techniques in this area has improved significantly.

Once funding becomes available, VA will need to resolve this issue to ensure that the Department is compliant with Section 1557 of the Affordable Care Act (ACA), which prohibits sex discrimination in services. The Department of Health and Human Services has stated that discrimination based on gender identity is substantively sex discrimination. Resolution will also address the "Petition for Rulemaking to Promulgate Regulations Governing Provision of Sex Reassignment Surgery to Transgender Veterans" filed with VA by Lambda Legal Defense and Education, Inc., and the Transgender Law Center on May 9, 2016.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Seek additional funding from Congress.	Q1 of FY2017	Up to $7 million added to the VA budget annually to cover these clinical services, or request denied.
Identify up to $7 million in the existing annual VA budget.	Q2 of FY2017	Gender transitioning surgeries allowed, when deemed medically necessary.
Acknowledge that Section 1557 of the ACA prohibits banning gender transitioning surgeries as gender identity discrimination.	TBD – dependent on previous actions.	Gender transitioning surgeries allowed, when deemed medically necessary.

Measures of Success:

- VA has obtained sufficient funds in its budget to cover gender-transitioning surgeries when deemed medically necessary.

Risk Management:

Risk	Continuum	Mitigation Strategy
Congress refuses additional funding request.	Known Managed Risk (known, plan, oversight)	Acknowledge and accept.
VA is sued by transgender Veterans for discriminatory practices.	Known Managed Risk (known, plan, oversight)	Adjust and avoid.
Transgender and LGBT advocacy groups depict VA as discriminatory and anti-LGBT.	Known Managed Risk (known, plan, oversight)	Adjust and avoid.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Engage
Congress	☒	Engage
Veterans Service Organizations	☒	Engage
Federal Agency Partner	☐	
VA Advisory Board or Committee	☐	
Federal Employee Union	☐	
Tribal Government	☐	
State Veterans Affairs	☐	
Media	☒	Engage
Office of Inspector General	☐	
Government Accountability Office	☐	

9.2.12 Full Practice Authority for Certain Nurses in VA

Full practice authority would increase Veterans' access to VA healthcare and permit VA to use resources more effectively, while maintaining patient-centered, safe, high-quality care.

VA is amending its medical regulations to permit full practice authority of three roles of VA advanced practice registered nurses (APRN) when they are acting within the scope of their VA employment. Certified Registered Nurse Anesthetists (CRNA) will not be included in VA's full practice authority under this final rule. The final rulemaking establishes the professional qualifications an individual must possess to be appointed as an APRN within VA, establishes the criteria under which VA may grant full practice authority to an APRN, and defines the scope of full practice authority for each of the three roles of APRN. The services provided by an APRN under full practice authority in VA are consistent with the nursing profession's standards of practice for such roles. **This rulemaking increases Veterans' access to VA healthcare by expanding the pool of qualified healthcare professionals who are authorized to provide primary healthcare and other related healthcare services to the full extent of their education, training, and certification, without the clinical supervision of physicians.** It also permits VA to use its healthcare resources more effectively and in a manner that is consistent with the role of APRNs in the non-VA healthcare sector, while maintaining the patient-centered, safe, high-quality care. An overview of VA's regulation/rulemaking process can be found in the Useful References chapter.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
OMB clears Final Regulation.	October – December 2016	OMB approves publication.
Publication in Federal Registers	3-5 days after OMB approval	Regulation is published, will become effectives
Communication about publication.	Concurrent with publication	Stakeholders and VHA employees will understand how they are affected by the changes.

Measures of Success:

- Completion of negotiation with OMB.
- Publication in Federal Register.
- Communications plan is put into effect.

Risk Management:

Risk	Continuum	Mitigation Strategy
Congressional action.	Emerging Risk (unknown, no plan)	Monitor for changes that affect impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Engage
Congress	☒	Monitor
Veterans Service Organizations	☐	
Federal Agency Partner	☐	
VA Advisory Board or Committee	☐	
Federal Employee Union	☒	Engage
Tribal Government	☐	
State Veterans Affairs	☒	Engage
Media	☒	Engage
Office of Inspector General	☐	
Government Accountability Office	☐	
Other (e.g. State and national nursing professional boards and associations)	☒	Engage

9.2.13 Disability Claims Timeliness and Accuracy

VBA is working diligently to deliver timely and accurate benefit decisions to all Veterans, their families, and survivors.

One of VBA's highest priorities has been improving the timeliness and delivery of disability claim decisions. VBA has made great strides toward achieving this goal. In 2011, VBA

implemented an aggressive and comprehensive plan that has transformed the decades-old, paper claims approach into a state-of-the-art electronic process. VBA now processes greater than 99% of disability rating claims electronically. This process leverages digital data transfer and automated calculators to reduce processing time and input errors. **VBA has increased productivity of the claims processing workforce and the quality of decisions through enhanced training, streamlined business processes, new organizational structures, and other initiatives such as prioritizing the oldest claims. In recent years, VA has significantly reduced rating claims pending greater than 125 days and the overall ratings claims inventory as illustrated in the tables below.**

Peak of Rating Claims Pending > 125 days	Rating Claims Inventory	Reduction Date	Rating Claims Inventory	Percent of Reduction
March 2013	611,000	September 2016	71,690	87%

Inventory Peak	Rating Claims Inventory	Reduction Date	Rating Claims	Percent of Reduction
July 2012	884,000	September 2016	377,107	57%

Peak of Rating Claims Pending > 125 days	Average Days Pending	Rating Claims Inventory	Average Days Pending	Percent of Reduction
February 2013	282	September 2016	84.9	68%

In FY2015, VBA's regional offices produced a record-breaking 1.4 million disability claim decisions. In FY2016, VBA completed almost 1.3 million claims. Due to these efforts, Veterans are now waiting less time for their decisions and benefits.

For the remainder of FY2016 and through FY2017, (absent seasonal fluctuations due to holidays and leave usage) VBA expects the volume of rating claims pending more than 125 days to

continue to decrease. This is assuming there are no major changes impacting VBA's claims receipts such as new presumptive entitlements, increased military discharges, etc., or the ability to complete rating claims (such as a court ruling). Additionally, operational overtime continues to serve as an effective tool to help reduce the inventory and the number of rating claims pending greater than 125 days. VBA's original allocation of overtime for compensation rating claims in FY2016 was $47 million and VBA plans to allocate a similar level in FY2017.

VBA Compensation Service conducts national quality assurance reviews on disability compensation claims. Historically, VBA measured and reported accuracy scores at the claim level. In 2013, VBA began reporting accuracy on issue-based accuracy in addition to the historical claim-based accuracy. Issue-based accuracy measures quality of the individual medical issues contained within the rating claim, whereas claim-based accuracy is measured on the rating claim as a whole. Although the accuracy rates for claim-based and issue-based are derived from the claim bundles that include initial and supplemental claims for service-connected disabilities, the rates are calculated differently. The national claim-based accuracy is determined by dividing the total number of cases that are error-free by the total number of cases reviewed, while issue-based accuracy is based on the individual issues contained within the claim. The chart below provides the October 2016 accuracy data.

VBA's October 2016 National Accuracy*		
12 Month Rating Benefit Entitlement Sept15 - Aug16 Disp Dates	3 Month Rating Benefit Entitlement Jun16 - Aug16 Disp Dates	12 Month Authorization Benefit Entitlement Sept15 - Aug16 Disp Dates
Claim-Based Accuracy	Claim-Based Accuracy	Claim-Based Accuracy
87.54%	85.71%	89.46%
Issue-Based Accuracy	Issue-Based Accuracy	Issue-Based Accuracy
95.36%	94.73%	N/A[4]

**Data as of October 26, 2016. Please note that there is a two-month lag time that is necessary to support the case selection, review, and reconsideration processes.*

As part of VBA's ongoing efforts to improve the services provided to Veterans, beginning October 1, 2016, VBA will only report on issue-based accuracy for rating claims. Issue-based reviews provide a deeper, more granular look into the accuracy of rating claims and the medical issues in each claim. For example, as of October 2016, VBA reviewed 9,855 rating claims that contained 52,318 issues individually assessed for accuracy. Issue-based accuracy provides a

[4] VBA currently only tracks 12 Month Authorization Benefit Entitlement as a claim-based measure and will start tracking it as an issue-based measure in the near future.

more detailed analysis and accurate assessment of the work completed by regional offices (ROs). Beginning in October 2016, VBA will begin a similar transition for non-rating (claims that typically do not require a rating decision) by developing a task-based review for this type of work. Task-based accuracy for non-rating claims will provide a deeper, more granular look into the accuracy of non-rating claims, equivalent to what has already been achieved with issue-based reviews on rating claims.

The data collected at the issue level enables VBA to analyze error trends based on distinct medical issues, provides more focused training on the identified issues, and improves the Veteran's experience by delivering accurate rating decisions.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Utilize Overtime (OT).	Continuous	VBA will continue to leverage OT as necessary to drive down the inventory of claims and balance the workload.
Leverage Veterans Benefits Management System (VBMS) and National Work Queue (NWQ).	Continuous	Leverage additional automation and enhancements through VBMS update releases to help efficiency in claims processing. Balanced and prioritized workload, and maximize capacity and optimize employee resource.
Inform ROs and stakeholders of the changes and modify internal systems.	September – October 2016	Updated quality reports and increased awareness of revised reports.

Measures of Success:

- Reduction in the number of claims pending greater than 125 days.
- Average days pending for rating bundle claims.
- Increased issue-based accuracy on rating related claims.

Risk Management:

Risk	Continuum	Mitigation Strategy
Available resources (FTE).	Known Managed Risk (known, plan, oversight)	Monitor for changes that affect impact.
Establishment of new presumptive conditions.	Emerging Risk (unknown, no plan)	Control and implement actions to minimize impact.
Miscommunication of revised quality report.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Engage
Congress	☒	Engage
Veterans Service Organizations	☒	Consult
Federal Agency Partner	☐	
VA Advisory Board or Committee	☐	
Federal Employee Union	☒	Involve
Tribal Government	☒	Engage
State Veterans Affairs	☒	Consult
Media	☒	Engage
Office of Inspector General	☒	Engage
Government Accountability Office	☒	Engage

9.2.14 Update to the VA Schedule for Rating Disabilities

The Veterans Benefits Administration (VBA) has developed a plan to revise its VA Schedule for Rating Disabilities (VASRD) (38 C.F.R. Part 4) by proposing 14 rulemakings that will cover the 15 body systems. This rulemaking review and revision effort is based on recommendations from a 2007 Institute of Medicine (IOM) report. In that report, IOM proposed a series of corrections to the existing schedule for rating disabilities and guidance designed to improve Veterans benefits in the 21st century. Additionally, VBA will maintain a schedule for review and revision for each of the VASRD body systems to ensure that on a routine basis, findings from discussions on current science and medical advancements are incorporated into future rulemakings for the body system as necessary. ***In July 2016, VBA updated the VASRD project management plan to ensure that all rulemakings for all VASRD body systems are finalized and published by the end of FY2018.***

The purpose of disability compensation is to provide a basic entitlement and restore the loss in earning capacity to a Veteran who is disabled as the result of a personal injury or disease (including aggravation of a condition existing prior to service) while in active service if the injury or the disease was incurred or aggravated in line of duty. In 2009, VBA's Under Secretary for Benefits, on behalf of the Secretary, directed the revision and update of the 15 body systems that are contained in VASRD, 38 C.F.R. Part 4, under the authority of 38 U.S.C. §1155.

VBA's Compensation Service is charged with developing and implementing the project management plan (PMP) to revise the VASRD. The PMP includes the implementation of updates to Compensation Service's examination templates and worksheets, as well as the organizational policy, training, manual, and computer systems that are required when final regulations are published in the Federal Register.

The update of these regulations will apply current medical science and econometric earnings loss data to the VASRD. This will provide VA with a more accurate rating system and ensure that Veterans with service-connected diseases or injuries are compensated based on modern standards.

VBA has drafted 14 proposed rulemaking packages that will cover the 15 body systems in the VASRD. **VBA has published proposed regulations for notice and comment in the Federal Register for six of the body systems. The six proposed rules already published include:**

(1) The Hemic and Lymphatic Systems,
(2) Gynecological Conditions and Disorders of the Breast,
(3) The Organs of Special Sense (Eye),
(4) The Endocrine System,
(5) Dental and Oral Conditions, and
(6) Skin Conditions.

After these rulemakings are finalized and published, VBA will implement a five-year cycle of staggered reviews to ensure that the VASRD body systems are timely reviewed and updated based on current medical science developments and modern claims adjudication. This strategy is based on recommendations from a 2007 Institute of Medicine (IOM) report, in which IOM proposed a series of corrections to the existing schedule for rating disabilities and guidance designed to improve Veterans benefits in the 21st century. Additionally, VBA will document work plans and maintain working groups for each of the VASRD body systems to ensure that on a routine basis, findings from discussions on current science and medical advancements are incorporated into the body system reviews as necessary. An overview of VA's regulation/rulemaking process can be found in the Useful References chapter.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
All proposed rules for body systems published.	September 2017	Publication of proposed rulemaking in Federal Register.
All final rules for body systems published.	September 2018	Regulatory authority for changes to 15 body systems finalized and implementation begin.
Five-year staggered reviews of VASR-D body systems.	October 2020	Begin workgroup implementation and research for staggered five-year cycle regulatory reviews of VASRD body systems.

Measures of Success:

- Deliverables and publication of rules based on timelines, as established in the VASRD Project Management Plan.
- Successful implementation of VASRD changes in VBA adjudication claims process.

Risk Management:

Risk	Continuum	Mitigation Strategy
Public comments – volume and ability to draft final rule.	Known Un-managed Risk (known, no plan)	Acknowledge and accept.
Updates to the Veterans Benefits Management System.	Known – IT and systems updates scheduling, funding, and prioritization	Acknowledge and accept.

Stakeholder Overview:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Monitor
Congress	☒	Engage
Veterans Service Organizations	☒	Engage
Federal Agency Partner (OMB)	☒	Consult
VA Advisory Board or Committee (Advisory Committee on Disability Compensation)	☒	Involve
Federal Employee Union	☒	
Tribal Government	☐	
State Veterans Affairs	☐	
Media	☒	Engage
Office of Inspector General	☐	
Government Accountability Office	☒	Engage
Other (IOM, VHA, Workgroup partners)	☒	Consult

9.2.15 Protecting Veterans from Predatory Practices by Bad Actors in Higher Education

For-profit schools approved for the GI Bill have come under increased legal and regulatory scrutiny by Federal and State organizations for predatory recruiting, marketing, and teaching practices. As a result, VA has expanded its role in the enforcement area to protect Veterans from dishonest schools.

On September 6, 2016, ITT Technical Institute (ITT Tech) closed 145 campuses in 38 states. The closure came two weeks after the Department of Education (ED) banned the school from enrolling new students using federal financial aid amid several investigations into its lending practices and the potential loss of its accreditation. The total closure prevented over 6,800 GI Bill students from continuing their education and receiving GI Bill benefits at ITT Tech.

VA advised students they would no longer receive GI Bill benefits, including the monthly housing allowance, for any future classes at ITT Tech, which put many students at risk for homelessness. VA also had no authority to restore GI Bill entitlement used to attend school. Students were faced with the possibility that any credits earned at ITT Tech would not be accepted or transferable to another institution. This left students unsure of their future and

with limited or no benefits to begin a new educational path.

Additional for-profit schools approved for the GI Bill have also come under increased legal and regulatory scrutiny by Federal and State organizations for predatory recruiting, marketing, and teaching practices including promising jobs.

VA has expanded its role from an administrator of benefits to creator of the well-informed consumer, and is now pivoting to enhancing its role in enforcement through more aggressively exercising its authorities to protect Veterans from dishonest schools. VA continues to work with its partners on ways to increase communication between government and service organizations, and to consider how to best protect the interests of GI Bill students.

VA held its first Joint Symposium on August 3, 2016 to review and consider such actions. The discussion centered on VA enforcement mechanics and potential triggers; VA compliance with Title 38, and how to assist student Veterans at Accrediting Council for Independent Colleges and Schools (ACICS) accredited schools.

VA will examine its current enforcement tools and continue encouraging communication among all parties to enable student Veterans to make the best choices possible for their educational pursuits.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
VA General Counsel, Federal Trade Commission (FTC) and other federal agencies examine the range of interim steps VA may be able to take during the process of an FTC (or other federal agency) investigation.	Feb. 2017	Both agencies will agree to what can and cannot be done to a bad actor while under an investigation.
VA to establish a schedule to write new regulations covering GI Bill oversight, or find other non-regulatory methods to codify VA's enforcement triggers and approach.	Feb. 2017	Enforcement and compliance policy will be codified in Title 38 U.S.C.
Review VA/FTC Memorandum of Understanding (MOU) to better clarify information sharing process and standards of evidence.	Feb. 2017	Both agencies will come to agree upon understandings of evidence that can be shared.

Measures of Success:

- More informed students aware of unethical practices by institutions.

Risk Management:

Risk	Continuum	Mitigation Strategy
Timeliness of accomplishment.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
Lack of interagency coordination.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.

Stakeholder Overview:

Stakeholder	Affected	Action Required
Veterans and their Families	☐	
Congress	☐	
Veterans Service Organizations (American Legion, Veterans of Foreign Wars, Student Veterans of America)	☒	Consult
Federal Agency Partner (FTC, ED, Department of Defense, Consumer Financial Protection Board)	☒	Engage
VA Advisory Board or Committee	☐	
Federal Employee Union	☐	
Tribal Government	☐	
State Veterans Affairs	☐	
Media	☐	
Office of Inspector General	☐	
Government Accountability Office	☐	

9.2.16 Medical Disability Contract Examinations

The VA Medical Disability Examination (MDE), also known as Compensation and Pension (C&P) exam, is an essential piece of medical evidence used in considering a Veteran's disability claim. ***VA now has the legal authority to enter into contract for MDEs from non-VA medical sources and plans to centralize management of all such contracts under the Veterans Benefits Administration (VBA).***

On October 9, 1996, Congress enacted Public Law (P.L.) 104-275, Sec. 504, which authorized VA, through the Under Secretary for Benefits, to enter into contracts for MDEs from non-VA medical sources. These contracts, used by the Veterans Health Administration (VHA) and VBA, supplemented VHA's internal capacity to conduct C&P examinations, such as when there was a spike in exam requests or if a VHA provider was not available (e.g. vacancy, extended leave). The authority allowed VBA to cover the cost of MDE contracts from Compensation and Pension Program funding. Considered a pilot program, P.L. 104-275 stipulated that no more than 10 regional offices (ROs) could receive services under MDE contracts.

P.L. 113-235, Sec. 241, passed in December of 2014, provided VA the authority to expand the number of ROs authorized to utilize medical disability exam contracts. This expansion authority allowed for the addition of five ROs over FY2015 and FY2016 for a total of 15 ROs by September

2016. Beginning in FY2017, VA has the discretion to expand the MDE program at as many ROs as the Secretary considers appropriate.

These contracts represent a major step forward in improving the disability examination experience for Veterans. All contracts will be consolidated under a single program management initiative under VBA with representation in the central management group from both VBA and VHA. The new program management process and delivery process will also continue to ensure broad national and international coverage of medical examination requirements to meet Veterans' needs worldwide.

New contracts were awarded on September 16, 2016 to give all 56 ROs authority to order exams. Protests were filed with GAO regarding the awards with an expected resolution in January 2017. While GAO protests are resolved, VA awarded temporary contracts for 90 days (with option for additional period) to provide coverage during the protest period. VBA also extended current MDE contracts and took over four disability examinations management (DEM) contracts from VHA.

Top Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Complete GAO protest period.	January 2017	GAO ruling on protests (see associated risk).
Complete ramp-up period (depends on resolution of protest).	May 2017	Full performance begins (if resolution of protest requires a restart to contract process).

Measures of Success:

- All ROs will be capable of ordering contract examinations under the temporary bridge contracts beginning October 1, 2016.
- All ROs will be capable of ordering contract examinations under the new mandatory contract immediately after the 90-day ramp-up period is complete.
- Exams will be submitted in the amount of time required under the contract at the level of quality required.

Risk Management:

Risk	Continuum	Mitigation Strategy
Delayed vendor IT connectivity	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
Vendor capacity to perform timely exams	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
Resolution of protest requires a restart to contract process (in whole or in part)	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Engage
Congress	☒	Engage
Veterans Service Organizations	☒	Engage
Federal Agency Partner (Department of Defense)	☒	Involve
VA Advisory Board or Committee	☐	
Federal Employee Union	☒	Involve
Tribal Government	☐	
State Veterans Affairs	☒	Engage
Media	☒	Monitor
Office of Inspector General	☒	Monitor
Government Accountability Office	☒	Monitor

9.2.17 Streamlining and Simplifying Character of Discharge Review

The Veterans Benefits Administration (VBA) has begun the process to streamline and simplify the process to review character of service for Veterans, particularly combat Veterans, to seek entitlement to all VA benefits permissible by law and the full context of their active duty military service.

Veteran status requires that an individual be discharged from active military service "under conditions other than dishonorable." See 38 U.S.C. §101(2). A Veteran's Character of Discharge (COD) determines what, if any, benefits he or she can obtain from VA.

Basic eligibility for, and accessibility to, VA healthcare benefits requires the Veteran's COD to be any condition other than dishonorable. The Veterans Health Administration (VHA) routinely requests a COD determination from VBA to assist with healthcare eligibility determinations.

Under Secretarial discretion allowed by 38 U.S.C. §501(a), VA regulation enumerates several scenarios, or bars, in 38 C.F.R. §3.12(d) that clarify when an individual's service fails to qualify as "under conditions other than dishonorable." These regulatory bars disqualify a claimant from receiving Veteran status and VA benefits for a specific period of service.

Under the current regulatory framework, a VA claims processor reviews the facts and circumstances behind a claimant's other than honorable (OTH) discharge to determine if they fit the criteria for a regulatory bar as captured in § 3.12(d). In reviewing the facts and circumstances, VA procedural guidance requires VA to consider the context and any mitigating circumstances of the offense, including whether a service-connected mental or physical condition caused, aggravated, or resulted in the offense. A "mitigating circumstance" is any fact or circumstance that lessens the severity or culpability of a criminal act.

In January 2016, VA received a petition to amend 38 C.F.R. § 3.12 from Swords to Plowshares, the National Veterans Legal Services Program, Legal Services Center of Harvard Law School, and Latham & Watkins LLP. The petition highlighted three concerns with VA's current policy when determining if a claimant's COD was under other than dishonorable conditions:

- VA regulation still contains reference to homosexual acts involving aggravating circumstances. This regulatory bar singles out one class of Servicemembers based on their sexual orientation and excludes them for conduct that might not be used to exclude other Servicemembers with heterosexual orientation.
- Although captured in VA procedures, VA regulation fails to explicitly state that it considers mitigating factors in determining whether a claimant's service is honorable for VA purposes. This omission does not require the Court of Appeals for Veterans Claims to consider these factors under its dishonorable conditions analysis. See Title Redacted by Agency, No. 12-36342 (Bd. Vet. App. Oct. 19, 2012).
- The terms "moral turpitude" and "willful and persistent misconduct" are outdated and vague. As currently written, an employee's understanding of "moral turpitude" and "willful and persistent misconduct" can vary widely, thus resulting in different determinations by different employees.

The June 16, 2016 final report from the Commission on Care recommended VA streamline a path to eligibility for healthcare for those with an other-than-honorable discharge who have substantial honorable service. Specifically, the report recommended VA:

- Amend 38 C.F.R. § 17.34 to provide for tentative eligibility determination applicable to individuals with OTH discharges who have had substantial honorable service, including service in a combat theater.
- Amend 38 C.F.R § 3.12(d) to provide for recognition of extenuating circumstances that show for purposes of healthcare eligibility, that service was not OTH.

VA agreed to make changes to its COD regulations in 38 C.F.R. § 3.12(d). The new procedures direct the Rating Veteran Service Representative to complete a rating decision for all decisions where the Veteran is entitled to healthcare for those conditions determined to be connected to their military service, which will help expedite the Veterans request for healthcare. The guiding principle of these changes is VBA's responsibility in gaining a holistic perspective of the Veteran's COS. Changes to COS procedures included those related to evidence gathering, applying reasonable doubt in favor of the Veteran, and expanding the number of employees who can issue COD determinations. An overview of VA's regulation/rulemaking process can be found in the Useful References chapter.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Amend the COD regulation (38 C.F.R. §3.12).	TBD	To effectively administer the requirements for determining OTH service as required by statute and regulation by retaining and updating the existing framework of regulatory bars and include a provision for consideration of mitigating factors.
Train employees.	TBD	Ensure employees understand the redefined bars and the concept of bars as a minimum threshold for entitlement is also codified in statute at 38 U.S.C. §5303.
Conduct review for regulatory bar to benefits.	TBD	Conduct a review of previous administrative decisions with an eye towards re-adjudicating the issues based on the amended 38 C.F.R. regulations.

Measures of Success:

- At the conclusion of the COD review based on the change in 38 C.F.R. regulations, VA will be able to grant full and partial entitlement to benefits for a quantifiable number of Veterans previously denied.
- A decrease in the number of the homeless and in danger of self-harm Veteran population as benefits and healthcare are granted.

Risk Management:

Risk	Continuum	Mitigation Strategy
Amending C.F.R. regulations.	Known Managed Risk (known, plan, oversight)	Acknowledge and accept.
Conducting a review for bar to benefits.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Engage
Congress	☒	Engage
Veterans Service Organizations	☒	Involve
Federal Agency Partner	☐	
VA Advisory Board or Committee	☐	
Federal Employee Union	☒	Involve
Tribal Government	☐	
State Veterans Affairs	☒	Involve
Media	☐	
Office of Inspector General	☐	
Government Accountability Office	☐	

9.2.18 Traumatic Brain Injury Examination Nationwide Review

The Secretary of VA (SECVA) granted equitable relief to more than 24,000 Veterans following a national review of initial Traumatic Brain Injury (TBI) medical examinations conducted in connection with disability compensation claims processed between 2007 and 2015. VA contacted Veterans identified as part of this national TBI review to offer them an opportunity to be reexamined and have their prior TBI claim reprocessed. If additional benefits are due, VA will award an effective date as early as the date of the prior TBI claim.

TBI is a signature injury of Veterans returning from conflicts in Iraq and Afghanistan. The science of TBI has evolved rapidly since 2007. To improve evaluation of TBI for disability compensation purposes, VA instituted a policy in 2007 requiring that a psychiatrist, physiatrist, neurosurgeon, or neurologist complete all initial compensation TBI examinations, when there is no diagnosis of record, because these specialists have the most experience with TBI. However, as more research became available, VA issued a series of guidance documents that may have affected the implementation of the policy.

In October 2014, the Minneapolis VA Medical Center reviewed initial TBI exams completed between 2010 and 2014 for compliance with the TBI examination policy described above and identified 317 Veterans whose initial TBI examinations did not comply. The local Veterans Health Administration (VHA) and Veterans Benefits Administration (VBA) facilities took the following corrective actions for all affected Veterans:

- Ordered new TBI examinations.
- Requested that these Veterans file new TBI claims, where required, to be reevaluated
- Adjudicated the new TBI claims received based on the reevaluation and any additional evidence obtained.
- Requested equitable relief to pay any retroactive benefits due to affected Veterans based on the date of receipt of their initial TBI claims.

VHA and VBA then conducted a nationwide review of initial TBI examinations completed at VHA medical facilities and at VBA contract examination sites and identified over 24,000 Veterans to be reevaluated. To minimize any burden or financial harm, the Secretary granted equitable relief to all these Veterans on May 3, 2016. Equitable relief authorizes VA to offer these Veterans new TBI exams, in compliance with current policy. Further, equitable relief:

- Enables VA to take action without requiring Veterans to submit new claims.
- Allows VA to award an effective date as early as the date of the original TBI claim.

In July 2016, VA offered affected Veterans an opportunity to be reevaluated and have their prior TBI claim reprocessed. VBA provided briefings to the major Veterans Service Organizations (VSOs) on the reexamination and reprocessing effort. VBA continues to respond to questions from external stakeholders as well as monitor the requests for reprocessing.

Of those awarded equitable relief, VA found that more than 13,000 were already service-connected for TBI at the 10% disability rate or higher. Reexamination of these individuals, may, in some cases, result in a reduction of compensation benefits if there is evidence of material improvement in the service-connected TBI disability. The possibility of this outcome has been thoroughly explained to Veterans, their representatives, and the public.

Top Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Monitor incoming requests for reprocessing.	Ongoing	Gather data on requests, demographics, and outcomes for future stakeholder requests.
Special focus review of reprocessed claims.	TBD	Compliance with reprocessing guidance.

Measures of Success:

- Low rates of error in review of completed claims.
- General satisfaction from Congress, VSOs, and other Veteran stakeholders.

Risk Management:

Risk	Continuum	Mitigation Strategy
Ongoing media and Congressional interest.	Known Managed Risk (known, plan, oversight)	Acknowledge and accept.
Compensation and Pension examination process changes.	Emerging Risk (unknown, no plan)	Monitor for changes that affect impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Monitor
Congress	☒	Monitor
Veterans Service Organizations	☒	Monitor
Federal Agency Partner	☐	
VA Advisory Board or Committee	☐	
Federal Employee Union	☐	
Tribal Government	☐	
State Veterans Affairs	☐	
Media	☒	Monitor
Office of Inspector General	☒	Engage
Government Accountability Office	☐	

9.2.19 Gulf War Presumptive Disabilities

The Veterans Benefits Administration (VBA) is taking steps to ensure Gulf War Veterans entitled to disability compensation under 38 C.F.R. 3.317, which provides presumptive service connection

for certain Gulf War-related illnesses and chronic undiagnosed illness, receive such benefits. These include publishing an interim final rule to extend the current presumptive period end date from December 31, 2016, to December 31, 2021; proposing to add brain cancer to the list of presumptive disabilities; and, clarifying language in the VA Adjudication Procedures Manual, M21-1, to ensure accurate and consistent processing of these claims.

Congress enacted the Persian Gulf War Veterans' Benefits Act, Title I of the Veterans' Benefits Improvement Act of 1994, Public Law 103–446, which is codified in 38 U.S.C. §1117. This law directs the Secretary of VA to prescribe, by regulation, the period of time following service in the Southwest Asia theater of operations in which a disability must manifest to warrant presumptive service connection. Accordingly, VBA published a final rule to add 38 C.F.R. §3.317, which established the framework for VA to pay compensation under the Persian Gulf War Veterans' Benefits Act.

Due to the lack of available scientific or medical evidence about the nature and cause of illnesses suffered by Persian Gulf War Veterans, VBA initially established December 31, 2001, as the date by which an undiagnosed illness must become manifest. Subsequent extensions of this date occurred in 2001 (extending to December 31, 2006), 2006 (extending to December 31, 2011), and 2011 (extending to December 31, 2016).

As current military operations in the Southwest Asia theater of operations continue and scientific uncertainty remains as to the cause of illnesses suffered by Persian Gulf War Veterans, limiting entitlement to benefits payable under 38 U.S.C. §1117 due to the expiration of the presumptive period in 38 C.F.R. §3.317 is premature. Therefore, VBA published an interim final rule, effective October 17, 2016, extending the presumptive period in 38 C.F.R. §3.317 for qualifying chronic disabilities that become manifest to a degree of 10% or more through December 31, 2021 (a period of five years), to ensure those benefits established by Congress are fairly administered to all Persian Gulf War Veterans.

VBA also drafted a regulation to add brain cancer to the list of presumptive disabilities for certain Gulf War Veterans. VBA estimates this policy will provide benefits to approximately 350 Veterans and their survivors per year. The proposed regulation applies the presumption to all Veterans who served in Southwest Asia (Kuwait, Iraq, Saudi Arabia, Bahrain, Qatar, and/or the Persian Gulf) from January 17, 1991, through April 11, 1991, and subsequently develop brain cancer. These dates coincide with the initiation and cessation of Desert Storm hostilities. Scientific studies and the Veterans Health Administration's (VHA's) epidemiology studies have shown a biological mechanism through which exposure to contaminants in Desert Storm result in an increased risk for brain cancer. VHA's studies were conducted using the best available data, which included imperfect models of exposure. The studies indicated that Desert Storm Veterans who served in the Southwest Asia theater of operations during the period beginning on January 17, 1991 and ending on April 11, 1991, have experienced an increased risk of developing brain cancer at an early stage following the war.

While no specific etiological agent for brain cancer was identified, VHA considers exposure to chemical weapons from Iraq, oil, and oil-well fires in Kuwait, the detonation of munitions in Khamisiyah, Iraq, and other possible exposures and combinations thereof as contributing to the increased risk of brain cancer. **Although VA concluded the available scientific studies provide sufficient evidence to indicate that it is at least as likely as not that the identified exposures result in an increased risk of brain cancer, the Office of Management of Budget (OMB) did not agree. In October 2016, VA therefore withdrew the proposed regulation which would have established a presumption of service connections for Gulf War Veterans who develop brain cancer.** VA will continue to carefully study any new scientific evidence, as it becomes available, surrounding this issue in collaboration with the National Academy of Medicine (formerly the Institute of Medicine) and the Gulf War Illness Research Advisory Committee. Should new scientific and medical evidence come to light that strengthens the case for this presumption, VA intends to submit an updated (new) rule in future years.

Finally, VBA has addressed a specific concern of Gulf War Veterans involving the issue of VA medical examiners providing opinions that an identified undiagnosed illness or a diagnosed medically unexplained chronic multi-symptom illness was not related to Gulf War service. Such an opinion is not consistent with 38 C.F.R. §3.317 because these disabilities are presumptively associated with Gulf War service and therefore are automatically service connectable.

Top Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Respond to public comments on interim final rule extending presumptive period under 38 C.F.R. §3.317.	March 2016	Regulatory authority to award presumptive benefits for Gulf War Veterans will continue through 2021.
Monitor and review medical and scientific evidence that supports adding brain cancer to the list of presumptive disabilities under 38 C.F.R. §3.317.	TBD	Regulatory authority to award presumptive service connection for certain Persian Gulf War Veterans.

Measures of Success:

- The addition of brain cancer to the list of Gulf War presumptive disabilities.
- VBA no longer requests medical opinions when examining conditions that qualify for presumptive service connection under §3.317.
- Increase consistency and accuracy in processing of Gulf War disability claims.

Risk Management:

Risk	Continuum	Mitigation Strategy
OMB review of any future Gulf War brain cancer regulation.	Known Managed Risk (known, plan, oversight)	Control and implement actions to minimize impact.
Quality and consistency in application of Gulf War claims processing.	Known Managed Risk (known, plan, oversight)	Monitor for changes that affect impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Monitor
Congress	☐	
Veterans Service Organizations	☒	Monitor
Federal Agency Partner	☐	
VA Advisory Board or Committee	☐	
Federal Employee Union	☐	
Tribal Government	☐	
State Veterans Affairs	☐	
Media	☒	Monitor
Office of Inspector General	☐	
Government Accountability Office	☐	

9.2.20 Camp Lejeune Presumptive Disabilities

The Secretary of VA decided there is sufficient scientific evidence to establish presumptive service-connection for former Servicemembers, to include Reservists and National Guard members, exposed to contaminants in the water supply at Camp Lejeune between August 1, 1953 and December 31, 1987, who later developed one of the following eight diseases: adult leukemia, aplastic anemia and other myelodysplastic syndromes, bladder cancer, kidney cancer, liver cancer, multiple myeloma, non-Hodgkin's lymphoma, and Parkinson's disease.

In the early 1980s, volatile organic compounds (VOCs) including the metal degreaser trichloroethylene (TCE) and dry cleaning agent perchloroethylene (PCE) were discovered in two on-base water supply systems at Camp Lejeune in North Carolina. Benzene and vinyl chloride were also found in the water supply systems. These water systems served housing, administrative, and recreational facilities, as well as the base hospital. The contaminated wells supplying the water systems were shut down in February 1985.

In 2009, the National Research Council (NRC) identified 14 health conditions as having limited or suggestive evidence of an association with TCE, PCE or a mixture of the two. Based on the NRC study, Congress enacted the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Public Law (P.L.) 112-154 ("Camp Lejeune Act"). Section 102 of the Camp Lejeune Act established healthcare entitlement for Veterans who served at least 30 cumulative days of active duty at Camp Lejeune between January 1, 1957 and December 31, 1987, for the 14 conditions the NRC identified as well as non-Hodgkin's lymphoma. Congress later amended this time period to expand healthcare eligibility to those serving at Camp Lejeune from August 1, 1953 through December 31, 1987 (P.L. 113-235).

The Camp Lejeune Act also extended healthcare benefits in the form of reimbursements to certain family members of Veterans who resided at Camp Lejeune during the qualifying period.

However, the law does not establish a presumption of service-connection for purposes of entitlement to VA disability compensation and other benefits.

The 2012 law requires VA to provide healthcare to Veterans and family members for the following illnesses or conditions:

- Bladder cancer
- Breast cancer
- Esophageal cancer
- Female infertility
- Hepatic steatosis
- Kidney cancer
- Leukemia
- Lung Cancer
- Miscarriage
- Multiple myeloma
- Myelodysplastic syndromes
- Neurobehavioral effects
- Non-Hodgkin's lymphoma
- Renal toxicity
- Scleroderma

In August, 2015, the Secretary of VA announced he had met with members of Congress and the director of the Agency for Toxic Substances and Disease Registry (ATSDR), an agency within the Department of Health and Human Services, to discuss the possibility of creating presumptive service-connection for health conditions associated with exposure to contaminated water at Camp Lejeune.

At VA's request, ATSDR collaborated with VA's Camp Lejeune Science Liaison Team (CLSLT) to assist VA policymakers with determining whether there was sufficient scientific evidence to warrant a presumption of service-connection for disabilities associated with the contaminants found in the water at Camp Lejeune during the contamination period. The CLSLT presented its findings to a newly formed VA Technical Workgroup (TWG) composed of subject matter experts in disability compensation, healthcare, environmental medicine, toxicology, epidemiology, Federal rulemaking, communications, and Veterans benefits law. The TWG found sufficient associations for eight diseases.

As for the remaining conditions presented by the CLSLT, the TWG's analysis concluded that the evidence was not strong enough to support the creation of presumptions at this time.

A December 2015 VA news release provided an overview of the preliminary presumptive diseases. Since that time, some changes have been made to the list of proposed presumptive diseases. Additional reviews by VA's TWG concluded that multiple scientific authorities determined there is a positive association between bladder cancer and perchloroethylene (PCE). Conversely, the TWG found that available scientific evidence is currently not sufficient to establish a definitive link between trichloroethylene (TCE) and the development of scleroderma. Therefore, scleroderma has been removed from the final list of presumptive diseases related to service at Camp Lejeune. **Current list of presumptive conditions include: adult leukemia, aplastic anemia and other myelodysplastic syndromes, bladder cancer,**

kidney cancer, liver cancer, multiple myeloma, non-Hodgkin's lymphoma, and Parkinson's disease. The proposed rule also adds a 30-day service requirement (consecutive or cumulative) at Camp Lejeune to match the current Camp Lejeune Act of 2012.

The proposed rule was published in the Federal Register on September 9, 2016. The 30-day period for public review and comment closed on October 11, 2016. VA received nearly 300 comments, including significant ones from Congress and Veterans Service Organizations (VSOs) taking issue with the 30-day service requirement imposed by the proposed rule and its lack of a rational basis in science or law. As a result, VA eliminated the 30-day service requirement for presumptive service connection. The final rule is currently undergoing Department-level review.

Top Action for Way Ahead:

Action Step	Timeframe	Expected Outcome
Publish final rule.	November 2017	Regulatory authority to award presumptive benefits for Camp Lejeune Veterans.

Measures of Success:

- Continued communication with OMB to ensure final rule publication in November 2017.

Risk Management:

Risk	Continuum	Mitigation Strategy
OMB approval of VA's decision to eliminate 30-day service requirement.	Known Managed Risk (known, plan, oversight)	Acknowledge and accept.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Monitor
Congress	☒	Engage
Veterans Service Organizations	☒	Engage
Federal Agency Partner (e.g. OMB)	☒	Engage
VA Advisory Board or Committee	☐	
Federal Employee Union	☐	
Tribal Government	☐	
State Veterans Affairs	☐	
Media	☒	Monitor
Office of Inspector General	☐	
Government Accountability Office	☐	

9.2.21 Agent Orange Exposure Outside Vietnam

Congress established a presumption of Agent Orange exposure for Veterans with service in Vietnam, with automatic service connection for diseases associated with such exposure. VA also

established an equivalent presumption for Korean Demilitarized Zone (DMZ) service during the Vietnam era, as well as for repeated contact with C-123 aircraft previously used for aerial spraying of Agent Orange in Vietnam. Claims of exposure for other locations and circumstances are evaluated on a non-presumptive case-by-case basis.

The Agent Orange Act of 1991 [38 USC §1116] established a presumption of Agent Orange exposure for Veterans with service in Vietnam between January 9, 1962, and May 7, 1975, and also established a method for determining which diseases can be scientifically associated with such exposure. The method involves a VA evaluation of reports from the National Academies of Science based on its biennial reviews of Agent Orange-related scientific research. When the Secretary of VA establishes an associated disease, it can be automatically service-connected for Veterans who are presumed exposed to Agent Orange. A presumption of exposure is also established by VA regulations under 38 C.F.R. §3.307(a) (6) (iv) for service in certain units on the Korean DMZ between April 1, 1968, and August 31, 1971, and by § 3.307(a) (6) (v) for repeated contact with C-123 aircraft previously used for aerial spraying of Agent Orange in Vietnam.

Vietnam service for the presumption of Agent Orange exposure also includes Blue Water Navy Vietnam Veterans who served aboard ships that entered Vietnam's inland waterways or otherwise individually went ashore in Vietnam from their ships. Service solely aboard a ship on Vietnam's offshore waters is not sufficient for a presumption of exposure. VBA's Compensation Service currently maintains a list of over 300 ships that entered Vietnam's inland waterways, or sent crewmembers ashore, for the purpose of assisting VBA regional offices with evaluating Agent Orange exposure-related claims. However, the issue of what constitutes an "inland waterway" is currently under review by the US Court of Appeals for Veterans Claims with the case of *Gray v. McDonald* (2015).

The regulatory presumption of Agent Orange exposure for service in Korea requires that the Veteran served in a military unit operating along the DMZ during the regulatory time frame. The units have been identified for VA by the Department of Defense (DoD). Official documents show that Agent Orange was applied along the DMZ by Korean soldiers, but there is no evidence for use in any other Korean location.

The presumption of exposure also applies to a group of former US Air Force (USAF) Reservists and active duty personnel with flight or maintenance duties associated with C-123 aircraft previously used for aerial spraying of Agent Orange over Vietnam. Following use in Vietnam, these C-123s were sent back to USAF Reserve units in the United States. The presumption of exposure requires evidence of regular and repeated contact with these specific planes.

For claims of Agent Orange exposure in other locations and circumstances, VA evaluates the claims on a non-presumptive case-by-case basis and relies on information and official documents provided by DoD. This information identifies foreign and domestic locations where Agent Orange was tested and stored. Evidence submitted by a Veteran showing participation in

testing or storage activities can result in an acknowledgement of exposure. The most significant testing occurred at Eglin Air Force Base, Florida during the 1960s and early 1970s. Storage of Agent Orange occurred at the US Naval Construction Battalion in Gulfport, Mississippi, prior to its shipment by merchant marine vessels to Vietnam. Storage also occurred at Johnston Island in the Pacific Ocean following termination of use in Vietnam in 1971. Remaining stores of Agent Orange at both locations were incinerated at sea in 1977.

VA receives numerous claims of exposure from Veterans who were stationed in the Pacific Theater of operations during the Vietnam War, primarily from those serving on Okinawa and Guam. However, DoD has stated that there is no evidence for Agent Orange use, testing, or storage at those locations, and there is no credible evidence available to VA refuting this.

Claims of exposure from Veterans who served in Thailand during the Vietnam era are also evaluated on a case-by-case basis. DoD documents show that an unidentified herbicide was periodically used on the fenced-in security perimeters of some USAF bases in Thailand. VA has applied the benefit-of doubt doctrine and thus considered the potential for Agent Orange use on these perimeters. As a result, there is a liberal policy of acknowledging potential exposure for security personnel and guard dog handlers who regularly walked the air base perimeters. This is a limited policy acknowledgement because actual use of Agent Orange has never been documented. VA is currently involved with a legal challenge regarding exposure in Thailand, which will likely result in a new regulation on the issue. An overview of VA's regulation/rulemaking process can be found in the Useful References chapter.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Respond to Court of Appeals for Veterans Claims on *Gray* case dealing with defining Vietnam's inland waterways.	TBD	Determine which Vietnam Navy Veterans qualify for a presumption of Agent Orange exposure.
Generate a VA regulation to specify which Thailand Veterans qualify for a non-presumptive acknowledgement of Agent Orange exposure.	TBD	Clarification on Thailand exposure for Veterans and advocate groups.
Provide evidence for Veterans and advocates on which locations did and did not involve Agent Orange use, testing, or storage.	TBD	Clarification on why Agent Orange exposure-related disability claims are denied for certain locations.

Measures of Success

- Consistent VA regional office adjudication of Agent Orange exposure-related claims.
- Acceptance of official DoD evidence by Veterans and advocates on where Agent Orange was actually used, tested, or stored.
- A fair resolution of the Gray Case by the US Court of Appeals for Veterans Claims

Risk Management:

Risk	Continuum	Mitigation Strategy
Decision by Court of Appeals for Veterans Claims in Gray Case that puts significant burden on VA resources.	Known Un-managed Risk (known, no plan)	Control and implement actions to minimize impact.
Continuing Veterans/advocates dispute with VA on where Agent Orange was/was not used.	Known Un-managed Risk (known, no plan)	Control and implement actions to minimize impact.
Potential legal battle over a VA regulation to address Agent Orange exposure among Thailand Veterans.	Known Un-managed Risk (known, no plan)	Control and implement actions to minimize impact.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Monitor
Congress	☒	Engage
Veterans Service Organizations (e.g. All VSOs)	☒	Engage
Federal Agency Partner (e.g. Department of Defense)	☒	Consult
VA Advisory Board or Committee	☐	
Federal Employee Union	☐	
Tribal Government	☐	
State Veterans Affairs	☒	Engage
Media	☒	Monitor
Office of Inspector General	☐	
Government Accountability Office	☐	

9.2.22 Veterans Legacy Program

The Veterans Legacy Program (VLP) provides opportunities for students, teachers, and the general public to learn and explore how the stories of Veteran service and sacrifice are woven into U.S. history, local history, and contemporary issues.

The VLP was launched on May 30, 2016 as a top priority of the National Cemetery Administration's (NCA) 5-year Long Range Plan. Through the Program, NCA is developing partnerships with schools and universities around the country to facilitate research and develop educational materials about Veterans enshrined in VA national cemeteries. NCA recently established pilots at two national cemeteries, Riverside in California and Beaufort in South Carolina, by developing lesson plans, interactive maps, and video vignettes. Moreover, NCA partnered with the American Battle Monuments Commission (ABMC) to establish a "Teachers Institute" to study VA and ABMC cemeteries. Over the next several years, NCA will develop similar educational resources for additional national cemeteries and develop partnerships with schools and universities.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Develop strategic partnerships.	FY2017	Partnerships with schools and universities are developed and sustained.
Develop educational products.	FY2017	Education products are available for use for national cemeteries.
Develop Legacy Program Advisory Committee.	FY2017	Charter developed and membership secured.

Measures of Success:

- Number of partnerships with schools or universities.
- One national cemetery, per district, has online educational resources.
- First Advisory Committee meeting held in 2017.

Risk Management: No major risks noted.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Engage
Congress	☒	Involve
Veterans Service Organizations	☒	Engage
Federal Agency Partner (American Battle Monuments Comm.)	☒	Involve
VA Advisory Board or Committee	☒	Consult
Federal Employee Union	☐	
Tribal Government	☐	
State Veterans Affairs	☐	
Media	☒	Engage
Office of Inspector General	☐	
Government Accountability Office	☐	

9.2.23 Implementing Pre-Need Burial Eligibility

To increase awareness of VA burial benefits for Veterans, VA is implementing pre-need eligibility as a top priority in its long-range planning.

While the National Cemetery Administration (NCA) typically provides eligibility determinations for burial and memorial benefits at the time of need, pre-need eligibility would provide a determination for benefits in advance of the need. **Along with facilitating burial planning, NCA hopes to increase awareness and utilization of burial benefits for Veterans. Currently, only 13-15% of Veterans use VA burial benefits.** In FY2016, NCA granted over 4,500 pre-need eligibility requests.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Hire employees to process pre-need eligibility applications.	FY2017	Applications are processed in a timely and efficient manner.
Secure office space for new employees.	FY2017	Office space secured.
Deploy external communications plan.	FY2017	Veterans are aware of pre-need eligibility determinations.

Measures of Success:

- Number of employees hired and trained to process pre-need eligibility determinations.
- Processing target of 15,000 applications in FY2017.

Risk Management: No major risks noted.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Engage
Congress	☒	Consult
Veterans Service Organizations	☒	Engage
Federal Agency Partner	☐	
VA Advisory Board or Committee	☒	Consult
Federal Employee Union	☐	
Tribal Government	☒	Engage
State Veterans Affairs	☒	Engage
Media	☒	Engage
Office of Inspector General	☐	
Government Accountability Office	☐	
Other (State Funeral Directors)	☒	Engage

9.2.24 Increasing Access to Burial Benefits

Increasing access to burial benefits has been and will continue to be a top priority for VA through its long-range planning efforts within the National Cemetery Administration (NCA).

NCA currently manages 135 national cemeteries throughout the country, and provides grant funding to 104 state and tribal cemeteries in 47 states, Guam, and Saipan. **Over the next five years, NCA will open 15 new national cemeteries to ensure that 95% of Veterans will have access to a national, state, or tribal cemetery within 75 miles of their homes.** NCA will also increase access by expanding existing cemeteries, and continuing to support state and tribal cemeteries with grant funding.

Top 3 Actions for Way Ahead:

Action Step	Timeframe	Expected Outcome
Open new national cemeteries.	FY2017	Sites are officially dedicated as cemeteries.
Support state and tribal cemeteries.	FY2017	$45 million in grant funding awarded.
Expand existing national cemeteries.	FY2017	$56 million in minor construction funding to support highest priority expansion projects.

Measures of Success:

- Number of new cemeteries dedicated.
- Amount of grant funding awarded to state and local cemeteries.
- Progress made to develop undeveloped acreage at two high priority national cemeteries: Jacksonville and South Florida.

Risk Management: No major risks noted.

Key Stakeholders:

Stakeholder	Affected	Action Required
Veterans and their Families	☒	Engage
Congress	☒	Consult
Veterans Service Organizations	☒	Engage
Federal Agency Partner	☐	
VA Advisory Board or Committee	☒	Consult
Federal Employee Union	☐	
Tribal Government	☒	Involve
State Veterans Affairs	☒	Involve
Media	☒	Engage
Office of Inspector General	☐	
Government Accountability Office	☐	

PART D: MYVA TRANSFORMATION

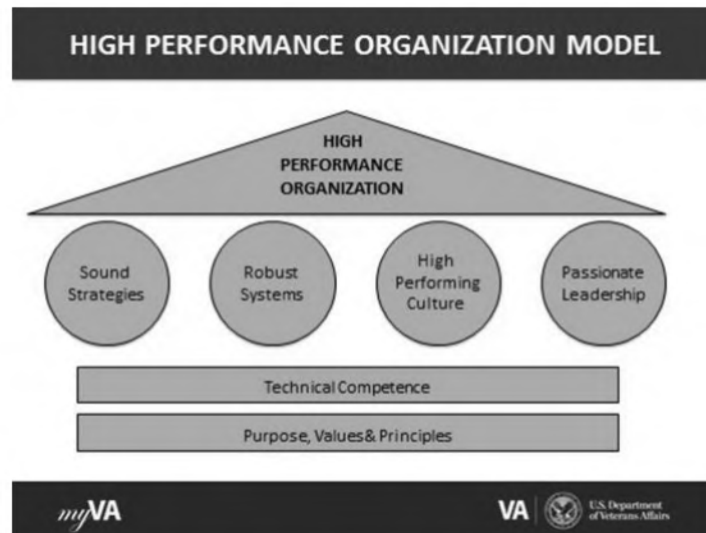
10. MyVA Transformation / MyVA Overview (2014-2016)

MyVA is what we call our transformation from VA's old way of doing business to one that puts the Veterans in control of how, when, and where they wish to be served. It is a catalyst to make VA a world-class service provider. It is modernizing VA's culture, processes, and capabilities to put the needs, expectations and interests of Veterans, their families, and survivors first. MyVA represents an opportunity to affect fundamental changes in VA's systems and structures to align with our mission, values, and our vision, a vision that sees VA as the No. 1 customer-service agency in the Federal government.

10.1 Initial Analysis

The access challenges of 2014 caused the Department Leadership to examine existing programs and operations. As part of that assessment, we looked at the VA FY2014-2020 Strategic Plan. We found that while the plan provided a solid framework for needed transformation, it was not being deployed effectively with adequate resources, performance plans, or metrics. Likewise, when we looked at the organizational structures and processes across VA, we found considerable gaps. Programs worked largely in organizational "silos" with little integration, resulting in inefficient operations. The Department paid inadequate attention to training, leader development, and succession planning. Additionally, leaders were often disconnected from employees. We also found that there were not adequate management systems in place to ensure effective and efficient operations of an organization the size of a Fortune 10 enterprise. We concluded that VA needed a more comprehensive approach, one based on a High Performance Organization Model (see Figure 6).

Figure 6. High Performance Organization Model



In the fall of 2014, Secretary McDonald announced the transformational movement, MyVA, with an emphasis on actually executing and cascading the principles embedded in the FY2014-2020 Strategic Plan throughout the organization. The movement toward MyVA began the process of building the high performing organization required to serve America's Veterans. "As we begin to create an organization that puts the Veteran in control of how, when, and where they want to be served, we will reorganize around Veterans' needs while integrating programs and organizations to optimize productivity and efficiency. Veterans will call it "MyVA," and it will be an organization that employees will be proud of.[5]

This comprehensive transformation is having a wide-ranging impact on Veterans, their families, VA employees, and stakeholders. As a result, we have made improving the Veterans experience and improving the employee experience two of our FY2016/FY2017 Agency Priority Goals (APGs)[6]. Additionally, we know that we owe it to the American people to be good stewards of the resources allocated to us.

For Veterans, Servicemembers, Families, and Survivors. The most important outcome for Veterans is their success after leaving military service. They should be thriving—receiving the health care they need, in meaningful, reliable employment, and secure in their prosperity. For MyVA, the outcome we seek is to make access to the care and services Veterans have earned predictable, consistent, and easy. We will gauge how Veterans view their partnership with VA as a measure of the effectiveness of MyVA's efforts. Indicators of progress around the Veterans Experience APG fall into two mutually reinforcing categories:

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[5] "A MESSAGE FROM THE SECRETARY—MY VA," e-mail from Secretary Bob McDonald to VA employees, October 6, 2014.
[6] For discussion of Agency Priority Goals, see Office of Management and Budget (OMB) Circular A-11.

- **Trust** in VA among America's Veterans.
- **Customer experiences** that are marked by effectiveness, ease, and positive emotion.

For VA Employees. The most important outcome for employees is to feel engaged and empowered to create the highest level of impact every day. Each employee must have meaningful work and a clear view of its benefit to Veterans. Measuring how employees view their experience with VA will reflect the effectiveness of MyVA's efforts. Indicators of progress around the Employee Experience APG include:

- Ranking in the government-wide employee survey
- Employee turnover (retention of 1 year)
- Employee ratings of leadership effectiveness
- Hiring rates

For American Citizens and Tax Payers. Through proper governance and transparent management systems, VA will again deliver effective services and benefits; be a good steward of fiscal resources; reliably protect personal information; and effectively anticipate and efficiently adapt to the future needs of our Nation's Veterans.

10.2 MyVA Integrated Plan and Updates

As MyVA began, we organized around five initial strategies:

- Improving the Veterans experience.
- Improving the employee experience.
- Achieving support services excellence.
- Establishing a culture of continuous performance improvement.
- Enhancing strategic partnerships.

In July of 2015, we laid out the focus, approach, and outcomes for MyVA in the MyVA Integrated Plan and Overview. The MyVA Integrated Plan and Overview outlined these five strategies and their 28 associated outcomes. We established an operating rhythm and began to deliver impact for Veterans. While we were making progress, we knew we could do better. We talked to our stakeholders, evaluated our processes, and researched how high performing organizations create a cadence of execution. As a result, we narrowed our focus to 12 Breakthrough Initiatives to achieve greater organizational impact in 2016. Our initial strategies and outcomes provided the foundation upon which we built our Breakthrough Initiatives.

10.3 Breakthrough Initiatives

During a January 2016 Senate Veteran Affairs Committee hearing, we introduced our 12 Breakthrough Initiatives. These Breakthrough Initiatives allow VA to concentrate our efforts on serving Veterans, their families and survivors, and aligning our resources for success. They reflect the core of our mission and vision – the focus on Veterans. Eight of the Initiatives are oriented toward directly improving service offerings to Veterans. Four Initiatives are critical enablers aimed at improving our employee experience and the infrastructure needed to do both. Without giving employees the tools and resources they need to provide great service, we will never be a high-performing customer service agency that consistently delivers an exceptional Veteran experience.

10.3.1 Becoming a High Performing Organization

We are rigorously managing each of the Breakthrough Priorities by instituting a Department-wide dashboard based on metrics, and a tracking system that includes weekly updates to leadership.

Each Breakthrough Initiative has an accountable and responsible official, as well as a cross-functional, cross-Department team in support. The individual teams meet every other week in person with either the Secretary or Deputy Secretary to discuss progress, identify roadblocks, and reach solutions.

VA leaders throughout the Department are role-modeling behaviors that are evident in successful transformations and high-performing organizations. The Secretary and Deputy Secretary are personally investing roughly 20% of their time directly solving problems and eliminating barriers related to MyVA transformation and the 12 Breakthrough Initiatives.

This is a new VA – more transparent, collaborative, and respectful; less formal and bureaucratic; more execution and outcome-focused; *principles-based, not rules-based*.

10.3.2 Recent Activities

Recent key accomplishments from Breakthrough Initiatives include (as of the end of FY2016):

- Veteran trust improved from a preliminary baseline of 47% to 59%.
- 90 Community Veteran Engagement Boards (CVEBs) formed – on track to establish 100 by the end of calendar year 2016.
- 90% of Veterans surveyed are "satisfied or completely satisfied" with the timeliness of their care.
- Average wait time for primary care is now around 5 days, 6 days for specialty care, and 2 days for mental health care.
- Vets.gov is operational; on track with migration completion in March 2017.

- Healthcare enrollment feature rolled out in vets.gov June 30, 2016, which cut in half the time to enroll and provides instant enrollment. Over 44,000 submissions since then.
- 132 VA Medical Centers (VAMCs) have a “press 7” in place to allow quick transfer to the Veterans Crisis Line (VCL); all sites implemented by October 2016.
- Veterans Benefits Administration (VBA) call center blocked call rate reduced from 59% in January 2016 to less than 1% in September 2016.
- Veteran satisfaction with Compensation and Pension exams has increased from 75% (initial baseline) to 82%.
- Since 2010, over 360,000 Veterans and family members have been housed, rehoused, or prevented from becoming homeless.
- Veteran homelessness nationwide has been cut by 47% since 2010; year-over-year reduction of 17% from 2015 to 2016.
- 29 communities and 2 states have effectively ended Veteran homelessness.
- An Employee Engagement Council has been formed to address enterprise-wide employee engagement matters.
- Federal Employee Viewpoint Survey (FEVS) employee engagement index increased for 2nd year in a row. Scores improved on 66 of 71 questions; one of five agencies cited for a “remarkable turnaround” by the Office of Personnel Management (OPM).
- Over 100,000 employees have participated in Leaders Developing Leaders (LDL). Those who have participated in a post-LDL project drastically more engaged those who have not.
- Approximately 140,000 employees have been cross-trained via “VA101,” an overview course designed to help employees understand how the Department operates to provide the full range of benefits and services to Veterans.
- 84% Medical Center Director positions filled with permanent appointments; selections in pipeline to reach 95% by end of calendar year.
- Office of Information and Technology (OI&T) has moved from 19th to 5th in Office of Management and Budget (OMB) benchmarks for IT Customer Satisfaction.
- Supply Chain initiative has over $100 million in cost avoidance to date; will be $150 million by year end.
- In the last 18 months, several dozen strategic partnerships have brought in more than $155 million in investments and in-kind services to support our nation's Veterans.

10.4 MyVA Task Force

The MyVA Task Force was chartered in December of 2014 to provide management and guidance for the overall transformation effort. It assisted in setting up the Veterans Experience Office (VEO) and helped to institute the single regional framework for the Department. It guided the initial planning and analysis for Shared Services, Continuous Process Improvement, and Strategic Partnerships. The Task Force developed the MyVA Integrated Plan and helped

select the Breakthrough Initiatives that resulted from that plan; it also provided the management construct for execution of the Initiatives. The charter is being renewed with updated duties for the Task Force, including facilitating Senior Leadership Boards and reviews of initiatives, guiding the development of artifacts that document transformational activities, incubating new initiatives, sponsoring transformational studies and analyses, supporting the Departments' analysis of alternatives for reorganizing specified VA structures and processes, and coordinating the Department's work with the MyVA Advisory Committee (MVAC).

10.5 MyVA Advisory Committee

The MyVA Advisory Committee (MVAC) was established in February 2015 under the guidelines of the Federal Advisory Committee Act (FACA). The MVAC serves as a sounding board for the Secretary and provides an external perspective on Department challenges. It reviews our plans and advises us on rebuilding trust with Veterans and other stakeholders, improving service delivery with a focus on Veteran outcomes, and setting the course for longer-term excellence and reform of VA. MVAC membership represents Veterans, medical professionals, educators, customer service experts, experienced transformation leaders, leading technologists, and Veteran advocates. MVAC will also advise on competing short and long-term plans and strategies, and offer information and recommendations on appropriate levels of support and funding for Department plans and strategies, helping the MyVA Executive Director and Secretary to balance competing priorities. The MVAC charter will be renewed in January of 2017 for an additional two years.

11. MyVA 2017 and Beyond

All of our transformation initiatives and management reforms continue to be grounded in the five strategies laid out in the MyVA Integrated Plan. They will enable us to create a high performing organization – one that enables sound strategies based on Veterans' needs, a high performing culture, passionate leadership, and robust management systems. We are in the planning stages of 27 "2017 and Beyond" Initiatives that continue and expand the work we began in 2016 with the Breakthrough Initiatives. Each Initiative has an executive sponsor: either the Secretary or the Deputy Secretary. The Initiatives are grouped into "Breakthrough" Initiatives and "Management" Initiatives. The executive sponsor meets every three weeks with each Breakthrough initiative's team of accountable and responsible leaders to solve problems and identify and remove roadblocks. The Breakthrough Initiatives also have first priority with respect to resource allocation. Progress on Management Initiative is assessed through the Monthly Management Review (MMR), which is an enduring management forum chaired by the Deputy Secretary. They also provide in-person status updates to the executive sponsor on a bi-monthly basis. These Initiatives have second tier priority for resourcing. In addition, the Secretary or the Deputy Secretary chair a weekly MyVA Senior Leader Meeting during which the Department's and Administrations' leaders review progress, discuss accomplishments, share best practices, and gain broader situational awareness.

11.1 Improving the Veterans Experience

Improving the Veteran experience is fundamental to our transformation – and our mission. VA exists to serve and care for Veterans and their families and beneficiaries. We need to see all of our plans and programs through the eyes of the Veterans they are designed to serve. In 2016, we created VEO to generate the insights, connection and awareness of Veterans and their needs and we are using Human Centered Design to ensure that we build capabilities with the Veteran in mind. Our future state vision for Veterans Experience:

- Veterans receive quality care and services when, where, and how they need them. Access to the care and services are predictable, consistent, and easy to navigate.
- Veterans and their families experience consistent, high quality customer service through 21st century technology. Every contact they have with VA is timely, efficient, and user friendly, whether in-person, by phone, online, or by postal mail.
- Veterans from vulnerable and underserved communities (e.g., women, aging) consistently receive appropriate access and services that meet their unique needs.

11.1.1 2017 Initiatives to Improve the Veterans Experience

Same Day Services: Same Day Services is part of the larger MyVA Access priority. MyVA Access was established to review and coordinate all the access efforts happening concurrently in the VA. MyVA Access seeks not only to improve access to care, but to restore Veterans and the public's trust in VA. In January 2016, a group of field Subject Matter Experts (SMEs) participated in a 4 week sequester to analyze current access barriers and develop innovative solutions for enhancing access to primary care and mental health services. The outcome of this sequester is the MyVA Access Implementation Guidebook and it provides 23 highly feasible, high impact, immediately deployable solutions for facilities to consider to improve access to care. These access solutions are components of tailored improvement plans at every facility. The Same Day Services Initiative is focused on improving access to care for Veterans by building on the successes from 2016. This effort involves a systematic transformation in the way healthcare is delivered to Veterans and a strategic communications campaign to ensure Veterans know these service options are available to meet their needs. The objective for 2017 includes the provision of highly reliable open access to Veterans in Primary Care and Mental Health. We will continue improving access to mental health by ensuring the presence of integrated Primary Care Mental Health Integration (PCMHI) providers within primary care clinics (at medical centers and large and very large CBOCs) and via tele-mental health expansion. We will also continue to improve access to specialty care by offering same day services for urgent needs.

Community Care: While VA has worked with private healthcare providers in the past, the Choice Act moved the Department more toward a "provider-payer" model for healthcare. We have greatly expanded our network of private providers and worked to streamline coordination between VA and the private sector, but more must be done. VA Community Care

is taking action as part of an enterprise-wide transformation to include the consolidation of community care programs and business processes that was presented to Congress in the Plan to Consolidate Programs of Department of Veteran Affairs to Improve Access to Care.

Transformation of VA's community care program will address gaps in Veterans' access to health care in a simple, streamlined, and effective manner. This transformation will require a systems approach, taking into account the interdependent nature of external and internal factors involved in VA's health care system. Ultimately, Veterans will have greater choice and ease of use in access to health care services in the community. By streamlining access to the network, we will be able to coordinate care and manage care more efficiently resulting in better access to care. The transformation will clarify eligibility requirements, build on existing infrastructure to develop a high-performing network, streamline clinical and administrative processes, and implement a continuum of care coordination services. Clear guidelines, infrastructure, and processes to meet VA's community care needs will improve Veterans' experience and access to health care.

Consistent and Improved Unified Veteran Experience: Today, Veterans have to navigate over 275 disparately managed organizations with contact center capabilities, approximately 150 medical center call centers, and multiple other facilities to receive the wide variety of services and information that are provided by the VA. These facilities provide services via multiple channels (e.g., walk-in, phone, secure email, secure IM, web self-service, fax, and mail). Veterans must also work through more than 500 public facing VA websites, using multiple logon and passwords, to access VA benefits and services that they have earned. In this environment, Veterans can easily become confused by the complex structure and often receive varied experiences when reaching out for assistance or care. The Unified Veteran Experience Initiative will deliver an improved and unified Veteran experience across the multiple channels of interaction with VA. It will unify the design principles used across these channels and make them consistent, simple, and easy to understand. As a result, Veterans will have a consistent and improved experience interacting with VA no matter what channel (online, by phone, or in-person) they use.

Suicide Prevention: Preventing Veteran suicide is a top priority for VA. In 2014, suicide was the 10th leading cause of death in the United States and rates of suicide in the U.S. general population, and among Veterans, are increasing. In 2014, risk for suicide was 21% higher among Veterans than among U.S. civilian adults. VA is the largest integrated health care system in the country and has a national network of medical centers, Vet Centers, and community-based outpatient clinics, all dedicated to meeting the needs of Veterans and their families. The Department has used these resources to become a leader in the development and implementation of innovative suicide prevention approaches and resources and has invested considerable resources to reach all Veterans who may be at risk for suicide to encourage and facilitate help-seeking. The Office of Suicide Prevention is adopting a public health model strategy to address the issue of Veteran suicide. In 2017, the office will establish a measurement-based management system to monitor suicide prevention workload and inform

staffing resource needs. This system will provide information to track the effectiveness of both prevention and intervention efforts. It will also allow the VA to ensure that the capacity for prevention and intervention can match demand. In addition, VA will fully implement a predictive modeling tool that will identify the top 0.1% of Veterans at increased risk for suicide and provide them an enhanced level of care through their local VA Medical Center. VA will also develop strategic partnerships with several major employers, EAP providers and community-based partners (healthcare networks, VSO's, social service agencies) in an effort to provide better in-reach to Veterans not engaged in VA care.

Non-Clinical Front Line Training: VA is an extremely large organization, and non-clinical, "front line" training (training for professionals who deal directly with Veterans and their families in non-clinical settings) is not yet standard across the Department. This allows variability in the Veteran experience, as well as in operational practices. The Front Line Training initiative will use aspects of the "Own the Moment" training (designed by the Veteran Experience organization to improve customer service) to prepare and support front line employees through the promotion of VA core values and customer service behaviors. Equally important, the Initiative will develop, update and as appropriate standardize training procedures (for example, those for bio-medical technicians, housekeepers and schedulers) to ensure Employees receive high quality, consistent training and ensures that training and follow-up checks are in place.

Streamlined Claims/Appeals Process: The current VA appeals process, which is set in law, is broken and is providing Veterans with a frustrating experience. There are currently 464,000 appeals in our inventory. Appeals have no defined endpoint and require continuous evidence gathering and re-adjudication. The system is complex, inefficient, ineffective, confusing, and splits jurisdiction of appeals processing between the Agency of Original Jurisdiction (AOJ) (generally the Veterans Benefits Administration (VBA)) and the Board of Veterans' Appeals (Board). On average, Veterans are waiting three years for a resolution on their appeal. For cases that reach the Board, Veterans are waiting on average five years. Thousands of Veterans are waiting much longer. VA requested legislative reform in 2016; passage of that law is still pending. This initiative would implement the reforms in the new law, while implementing feasible program enhancements. Additionally, it will simplify the language used to communicate to Veterans about their claims status and their Appeals rights.

Continue to Reduce Veteran Homelessness*:* The goal of ending homelessness among Veterans—and among all Americans without permanent housing—can be achieved through aspirational goal-setting and data-driven approaches; effective coordination of resources and partnerships at the federal, state and community levels; and sufficient numbers of dedicated staff. Despite all of the success to date, there are still homeless and at-risk Veterans who need assistance. VA's continuum of homeless services is designed to address the needs associated with both preventing first time homelessness as well as those who return to homelessness. It focuses not only on assisting Veterans to obtain and maintain permanent housing, but also on the root causes associated with poverty, addiction, mental health, and disability so that

homeless and at-risk Veterans can achieve their optimal level of functioning and quality of life. Our goal for 2017 is to reduce Veteran homelessness by housing or preventing homelessness for 100,000 Veterans and their family members and to accelerate the decline in homelessness through a focus on high-density metropolitan areas. Our 2016 success in significantly 'bending' the rate of decline in the Los Angeles area validates the model we will expand in 2017. We are planning to concentrate on communities with the highest percentage of homeless Veterans, for example, communities in California and Florida.

Equitable Service for Women Veterans: Women are the fastest-growing subpopulation of Veterans. Today, they make up approximately 2 million of over 21 million Veterans, and are expected to grow from 9.6% of the Veteran population to 10.5% in 2020 and continue to increase both numerically and as a share of the Veteran population beyond that. Unfortunately, there are disparities between access to and satisfaction with provision of VA care, benefits, and programs between male and female Veterans. Eliminating those disparities will improve the consistency of the experiences of men and women Veterans and – by enhancing access to high quality, timely care and needed benefits – improve outcomes for women Veterans. In FY2017, we seek to eliminate disparities in clinic wait times for specialty care, while reducing wait times for primary care by 50%. Also in FY2017, the presence and extent of disparities in VBA can be identified and an action plan drafted to eliminate them, if necessary. In the National Cemetery Administration (NCA), a 2% increase in women Veterans' use of burial and memorial benefits is planned for FY2017. This increased equity will provide inherent value for Veterans, as well as ancillary benefits for employees and taxpayers (to the extent that delayed or disparate care results in worse outcomes for women and patients are more costly to treat in the long run).

Measurement: VA Performance According to Veterans: Today's complex, uncoordinated, and inefficient approach to Veteran experience measurement falls short of supporting action and accountability and does not support VA's agency priority goal of increasing Veterans trust in VA (www.performance.gov). In order to hold VA accountable to Veterans, we are executing a clear and consistent national strategy for Veterans experience measurement which centers on amplifying feedback from Veterans throughout their customer journey to decision-makers at all VA levels. In 2017, VA will implement an integrated customer experience management system across VA to establish an actionable view of VA's performance according to Veterans. By connecting Veterans with VA in real-time, VA employees will have the opportunity to resolve customer issues in the moment at the point of service thereby avoiding further escalation. Using real-time analytics, employees will also feel empowered to use actionable customer insights to systematically drive improvements to Veterans experience. By continually improving VA internal processes to meet Veteran needs and expectations, VA will be able to guide the optimal allocation of its resources to minimize inefficiencies and maximize the value of services provided to Veterans. As Veterans see that VA is responding to their feedback, they will feel valued, thereby building their trust in VA.

11.2 Improving the Employee Experience

VA employees are the face of VA. Employees provide the care, the information, and the access to earned benefits for our Veterans and their families. We cannot separate Veteran Experience from Employee Experience. Fulfilled, committed employees make all the difference in how Veterans interact with and perceive VA. We have developed and are now implementing a new leadership model: Innovate, Learn, Engage, Anticipate, Deliver (I-LEAD); centered on the principles of Servant Leadership, grounded in the Department's values, and built on transformational leadership practices. We are committed to continuing our Leaders Developing Leaders training. We are building our internal communications capability so that VA employees have consistent, timely information and ways to provide feedback and insight. Our Employee Engagement Council brings together leaders from across the agency to work on career development and succession planning. Our goal is to have:

- A VA workforce comprised of Veteran-focused individuals with specialized expertise and complementary skills that collaborate innovate and produce consistently superior results.
- VA leaders who foster a culture of trust, inclusion, and accountability.
- VA leaders who engage, inspire, and empower their employees to deliver a seamless, integrated, and responsive Veteran Experience.
- Clear, transparent, two-way communication for VA employees.

11.2.1 2017 Initiatives to Improve the Employee Experience

Internal Communications: VA leadership has identified a significant and continuing lack of knowledge and understanding of MyVA, as well as other important Department efforts down to the employee level. VA is now reconstituting its Internal Communications capability in the Office of Public and Intergovernmental Affairs (OPIA) in order to increase education and understanding of MyVA, and ensure transformative culture change is understood and embraced, in all levels of VA. A robust, efficient Internal Communications capability will facilitate increased knowledge and understanding of MyVA transformation throughout the department, and through regular communication increase trust between leadership and the workforce.

HR Excellence@VA: Effective execution of human capital management is vital to carrying out VA's mission of serving Veterans and their families. Nearly all executive branch agencies, including VA, are challenged by federal human resources (HR) laws and practices that prioritize compliance, risk avoidance, and weak enterprise ownership over business outcomes. For VA, this problem is compounded by the size and complexity of its workforce; decentralized and siloed HR reporting structures; inconsistent resourcing and deployment of employee training and development strategies; fragmented leader development programs; and multiple hiring authorities, each with its own arcane rules. Improved hiring, onboarding, and leadership

development activities will result in a more fully staffed, skilled, and engaged VA workforce serving Veterans better. VA's HR transformation initiative – short-handed as "HR Excellence@VA"-- will deliver immediate value across VA that must be obvious to all employees. Focus areas for 2017 include establishing a shared vision for HR delivery across the enterprise, with specific metrics to track progress: deploying proof-of-concept initiatives to identify effective process and organizational improvements to replicate across VA; institutionalizing optimal hiring capabilities locally and at headquarters for critical leadership and other positions; implementing and integrating the HR Smart and USA Staffing systems across the enterprise; and developing and deploying enterprise-wide training and development strategies to upskill HR specialists from the time they join VA through the end of their careers.

Safety and Security: This initiative will mitigate existing gaps in safety and security (real and perceived) at our facilities to improve both Veterans and employees experience. Our goal for 2017 is to reduce and prevent disruptive or violent behavior using a four part strategy: expanding Veteran Centered Policing; training the workforce on Workplace Violence Prevention; improving enterprise on/off boarding that will empower employees by increasing situational awareness and provide tools to minimize interruptions to healthcare, benefits, and services; and achieving Insider Threat Full Operational Capability (FOC) to provide adequate management of access to sensitive information and foreign access to VA activities across the enterprise which may impact national security.

11.3 Achieving Support Services Excellence

Simply stated, better support to VA employees for services such as Human Resources, Information Technology (IT), and purchasing means better service for Veterans and better value for taxpayers. Better support for our physical environment and assets also creates a better and safer environment and experience both for employees and for Veterans and their families. Full execution of this strategy will mean the following:

- VA has integrated business operations that deliver high-quality, effective, and efficient enabling and support services with an enhanced focus on customer service.
- VA leverages its scope and scale to drive cost reduction and improve efficiencies, making it a good steward of taxpayer dollars.

11.3.1 2017 Initiatives to Achieve Support Services Excellence

IT Transformation: Historically, the Office of Information and Technology (OI&T) relied upon a disconnected governance structure resulting in a proliferation of different governing bodies and ad hoc functions, leading to a lack of accountability and transparency. Many of VA's existing information technology systems are outdated, expensive to maintain, and fail to adequately address the needs of Veterans and employees alike. The OI&T team has worked over the past year to conduct a complete review, analysis, and rework of those functions to provide a more sustainable solution based upon the IT industry standard, the Information

Technology Infrastructure Library (ITIL). This analysis led to the streamlining of over 50 existing governance bodies and functions into a group of 11 boards that cover the full spectrum of all prior activities. VA is continuing its IT transformation by using Service Management concepts to leverage a set of specialized organizational capabilities to provide value to customers by transforming capabilities and resources into efficient, quality services. Service Management provides a cradle-to-grave framework for developing, sustaining, improving, and evolving IT services, and it fosters transparency and consistency to ensure our now, near, and future transformation goals become reality in order to improve the Veteran experience. ITIL offers a practical approach for OI&T – do what works. The framework will integrate with VA's emerging governance structure to increase transparency and facilitate collaboration toward a single aim of delivering value to Veterans, their families and the employees of VA who support them. ITIL enables organizations to deliver benefits, returns on investment, and sustained success. The key characteristics of ITIL are that it is vendor-neutral, non-prescriptive, and an integrated best practice.

Supply Chain Transformation: VA's supply chain is a key operational enabler that starts with the clinician and ends with the Veteran, yet employees have found our current supply chain to be frustratingly inefficient and expensive. VA's supply chain enables clinical care to the Veteran by managing all aspects of the flow of supplies and equipment from identification of the requirement/need through its fulfillment by provision of materiel. The scope of VA's supply chain includes management of equipment inventories valued at approximately $12 billion, and supply inventories of about $161 million. Annual equipment life cycle costs are estimated to be $4 billion, and annual supply costs are also about $4 billion. The Supply Chain Transformation changes VA's supply chain from an antiquated collection of disparate, discrete processes into an advanced integrated system that provides responsive, efficient clinical/non-clinical support. FY2017 will be the second year of the three year first phase designed to stabilize and standardize the system. The following five sub-initiatives comprise the framework needed to accomplish this transformation:

- **Commodity Total Supply Support:** Integrates all major functions/processes into a cohesive, nationally standardized, high-performing supply and demand management support system. This system provides clinical and non-clinical supplies much more efficiently than current processes through strategic sourcing and streamlined procurement, as well as close coordination with suppliers and customers.
- **Equipment Life Cycle Management:** Leverages leading practices to ensure efficient allocation of resources for equipment and related support throughout the asset lifecycle.
- **Data Standardization:** Establishes a National Supply Chain Formulary that standardizes product information and records across the enterprise. This Formulary creates an ability to track actions and realize cost avoidances related to an increased use of national contracts and other changes designed to leverage cost reduction opportunities. In addition, the improved product identification provided via this Formulary improves

clinical safety through recall awareness, standardization, and reutilization / redistribution opportunities.

- **Workforce Management:** Develops a 21st century workforce through education/training to ensure supply chain personnel can properly run a sophisticated healthcare supply chain for VHA. This sub-initiative also develops position management and organizational guidance as well as enabling tools to ensure appropriate staffing.
- **Diffusing Supply Chain Excellence:** Creates Supply Chain Innovation Centers from selected operational sites to test, develop, and integrate transformation initiatives before enterprise wide implementation. These centers will ensure initiatives perform cohesively and meet expectations.

Our goal for 2017 is to realize a 5% decrease in normalized commodity spending. These efforts will lead into the completion of Phase 1 of the transformation in FY2018. The second phase of transforming the organization will be completed in FY2024 with the deployment of an integrated financial, procurement, and logistics system.

Financial Management Transformation*:* As stipulated in OMB M-13-08, VA will migrate to a Federal Shared Service Provider's (FSSP) financial system solution. Recently, VA completed a pre-discovery phase with the Department of the Treasury (Treasury), and United States Department of Agriculture (USDA). The Financial Management Business Transformation (FMBT) program management office (PMO) followed a methodical qualitative and quantitative process leveraging best practices, guidance and lessons learned from Government Accountability Office (GAO), OMB, Unified Shared Services Management (USSM), Department of Homeland Security (DHS), Department of Housing and Urban Development (HUD), Association of Government Accountants (AGA), Project Management Institute (PMI), and International Organization for Standardization (ISO) in evaluating the FSSPs. VA found USDA to be the preferred provider. The Office of Finance and USDA are refining program scope and finalizing the program schedule and timeline.

Shared Services: Shared Services standardizes business processes for how VA performs the work to serve Veterans, which directly reduces variance for VA employees and improves the quality of service and the Veterans experience. In FY2016, VA established the Support Services Governance Board (SSGB) to consolidate transactional services, standardize processes across the enterprise, deliver high levels of customer satisfaction, benchmark and increase the quality of performance, reduce variance between Administrations and Staff Offices, and reduce costs. VA transferred oversight and management of the existing Franchise Fund to the SSGB in order to standardize and align business models for its six existing enterprise centers within the Franchise Fund – Records Center and Vault (under OI&T), Enterprise Operations (under OI&T), Financial Services Center (Under the Office of Management – OM), Debt Management Center (under OM), Law Enforcement Training Center (under Office of Operations, Security, and Preparedness - OSP), and the Security Investigations Center (under OSP). The SSGB transferred the Records Center and Vault from OI&T to Support Services Excellence (SSE) in April 2016. In

FY2017 through FY2020, SSE has a unique opportunity to design, build, implement, operationalize and optimize a Support Services Organization (SSO) with the people, processes, technology and innovation to deliver high levels of customer service, quality, and lower costs for enterprise transactional services. SSO aligns VA capabilities, policies, and processes with the President's Management Council Cross-Agency Priority (CAP) Goal of shared services.

Electronic Health Record Modernization*:* The current VA health care graphical user interface for VA providers called the Computerized Patient Record System, or CPRS, has been in use since 1996. CPRS served VA for many years as an industry leading point of care tool for providers, but it has many limitations for modern care delivery. The electronic health record (EHR) Modernization initiative addresses VA's need to modernize its electronic health record to improve delivery of patient-centered care. In FY2017, this initiative will deliver the Enterprise Health Management Platform (eHMP) across the enterprise. The eHMP is a modern web application and clinical data services platform that supports Veteran-centric, team-based, quality-driven care and also supports interoperability between VA, DoD and community health partners. EHMP is currently in early stages of deployment. This initiative also supports implementation of best practices, and will improve employee experience. The eHMP, with appropriate funding and support, will provide nearly all the CRPS capabilities needed to replace outpatient workflows by the end of 2018.

Enterprise Data Management: Data is widely acknowledged throughout the industry as an organizational resource and strategic asset, yet VA is not taking full advantage of its data to improve the Veteran Experience, the Employee Experience, improve data-based decision-making, increase operational efficiencies, reduce costs, and increase public access to valuable government information. While the Federal government has moved toward more strategic management of data with the issuance of OMB Memorandum 13-13, Open Data Policy-Managing Information as an Asset (and other efforts), VA has participated, but not embraced these efforts. In 2015, VA issued Directive 6518, Enterprise Information Management, but has been slow to implement the policies therein. VA's data remains siloed, with no integrating or governance functions to identify the authoritative source of any particular data element. VA suffers from redundant information across the Department; multiple untapped sources for organizational knowledge; poor central accountability, organization, and protection of data collection and storage; and a lack of subject matter experts and tools to interpret and analyze the data.

Enterprise Data Management will improve organizational effectiveness by:

- Establishing a single source of truth.
- Providing better insight into challenging problems associated with improving processes, productivity, and performance.
- Increasing and streamlining efficiencies to optimize costs and effectively allocate our resource.

As an example, previously, VBA and VHA may have had different addresses or different phone numbers on file for a single Veteran. A single source of data will mean that VA has the most recent contact information — updated across all of VA. Additionally, the proper collection, protection, and analysis of Veteran data leads to analytics-driven innovation that improves the Veteran experience by predicting both needs and outcomes.

OI&T, through its partnership with the Data Governance Council (DGC), will develop an enterprise-wide data management strategy to integrate and align activities and resources. We will provide a framework to support the Veteran seamlessly and proactively… anytime and anywhere.

11.4 Establishing a Culture of Continuous Performance Improvement

We are fostering the creation of a mindset and culture adopted within every level of the organization that centers on the consistent delivery of value, elimination of waste, and the resolution of bottlenecks and constraints that affect the consistent delivery of services and benefits to our Veterans. Our Performance Improvement efforts place the Veteran in the center of everything we do in order to increase the quality of Veteran service delivery. We are using Lean management techniques to review and improve our processes and "RAMMP" (Report Approvals Meetings Measures Policies) techniques to eliminate those that are redundant and no longer useful. We are accelerating a Diffusion of Excellence Initiative to continuously surface best practices in care delivery from the field. The diffusion process spreads promising best practices across the health care system. It helps minimize variability. It empowers employees' innovation sharing. We are now rolling it out to all parts of VA. These improvements empower employees to streamline daily processes and allow managers to escalate challenges to business sponsors to remove barriers. They promote a culture of sharing and openness. As we further mature and deploy this strategy we will see that:

- VA has a culture of continuous performance improvement through enterprise integration of People, Process, and Technology. Teams work across Administrations and Staff Offices to maximize impact - creating a better work environment and increasing the quality of service for Veterans.
- Best practices throughout the organization are diffused and adopted. Innovation becomes a source of new best practices.
- The organization and processes are streamlined to promote agility, reduce unnecessary bureaucracy, and eliminate organizational silos.

11.4.1 2017 Initiatives to Establish a Culture of Continuous Performance Improvement

Strategic Operating Model: The Department lacks a strategic business operating model that connects VA's key processes and functions in a manner that efficiently and effectively delivers Veteran outcomes. VA's disconnected environment results in the need to put out fires and play catch-up on problems, rather than anticipating problems and implementing cost-effective integrated enterprise solutions. Clear momentum exists to connect our processes in a manner that aligns our resources and leadership with the Veteran outcomes we must deliver now and in the future.

This initiative, supported by the existing Managing for Results (MFR) process, will connect our previously disconnected processes. The resources we spend will clearly lead to the Veteran outcomes we have to deliver, with the right leaders accountable for results. Clear links will exist between our budget, requirements, and strategy processes. VA performance and risk processes will allow for effective real-time decision-making. In addition, our leader assignment, accountability and succession processes will be based on program needs and performance. SOM/MFR will assist efforts to improve access and delivery of care, services, and benefits. It will save money for taxpayers by aligning expenditures directly with outcomes and reducing redundant efforts. The strategic operating model, when executed, will allow significant leader attention to be dedicated to initiative success – breakthrough and management Initiatives – and ideally will support the effort to spread corporate learning, best practices, and a performance improvement culture throughout the department. VA will have an aligned and integrated Strategy-Requirements-Budget-Execution processes to properly resource the Department's initiatives and programs that will effectively deliver benefits and services to Veterans, achieving the desirable outcomes.

VA Organizational Design Review: Recommendation #12 from the Commission on Care report, released in June 2016, calls on the Veterans Health Administration (VHA) to, "Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision-making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices." These improvements should improve the Veterans Experience. The report also notes that, "VHA currently lacks effective national policies, a rational organizational structure, and clear role definitions that should support effective leadership of the organization. The responsibilities of VHA Central Office (VHACO) program offices are unclear, and their functions overlap or are duplicative," reducing the effectiveness and ease for both Veterans and Employees.

While the Commission on Care was chartered to focus on health care delivery within VHA, the same issues and the same recommendation apply to the VA enterprise. Therefore, an enterprise-wide organizational design must occur simultaneously and in unison to create the integrated system necessary to enhance the Veterans Experience. The VA Organizational Design

Initiative has two main goals: 1) aligning selected VA support functions to improve the service and experience for their customers (the employees who must deliver care and benefits to Veterans) and 2) complete an organizational redesign (with subsequent phased launch in FY2018 of revised VACO, VHACO, and district operations). The result will be a more agile/integrated VA aligned to high quality experiences for Veterans and employees; enhanced efficiency by reducing redundant layers; and decision-making driven to the lowest level possible.

Diffusion of Excellence*:* This initiative directly supports the diffusion of best practices across the system. To this end, Diffusion of Excellence has created an infrastructure and business rules to achieve not only identification, but consistent re-application of best practices across the nation. Best practice innovation and re-application will be 20% of the performance assessment scores for VHA senior executives beginning in FY2017, as part of sustainment. In addition to being a priority, best practice reapplication was further emphasized by the Choice Act Independent Assessments of 2015. It is an initiative that also supports several other Breakthrough Initiatives. Feedback collected to date from employees across from more than 30 VA Medical Centers (over 20,000 VHA providers and employees using our tools) engaged in the initiative has demonstrated a high level of engagement; and practice implementations are showing measurable improvements leading to improved outcomes for Veterans.

In 2017, the Diffusion of Excellence will improve care delivery to Veterans by streamlining access to care, establishing robust care coordination, improving care quality, and engaging employees in a manner that improves clinical outcomes. By reducing negative variation in practices across the system, Veterans' experience interacting with care providers across the system will be consistent, ultimately increasing Veteran satisfaction and quality of care.

Innovation: The VA Center for Innovation (VACI) was established 2010 to bring fresh thinking to the challenges facing the Department and to create specific responsibility and accountability for increasing the "innovativeness" of the Department. VACI's primary objectives in FY2017 are to:

- Grow and strengthen employee capabilities through the development of the Innovators Network.
- Develop and launch strategic innovation initiatives in Digital Memorialization (NCA), Chronic Kidney Disease (VHA).
- Refresh the department's innovation portfolio through the addition of selected projects from the Innovators Network, VHA Employee Innovation Competition, and through strategic engagement with the private, academic, and non-profit sectors.
- Partner with VA's major lines of business to increase the throughput of mature innovations into operational use – for example with VHA's Diffusion of Excellence initiative.

- Look beyond the near horizon to illuminate, and seize transformational opportunities responsive to future needs of Veterans and employees.
- Develop VA's innovation system through increased integration with OI&T, Acquisitions, OGC, OHRA, and LOB Leadership.

Through these efforts, Veterans, their families, and the public will experience VA as a progressive, innovative organization through the delivery of best of breed services and technologies, through interaction with an empowered staff supported by the Innovators Network, and through VA's thought leadership in emerging opportunity areas of National interest.

Performance Improvement Skills Training: Currently, many organizations within VA are working to drive Performance Improvement (PI), seeking to facilitate a shift in culture and empower VA employees to improve outcomes for Veterans. While these committed practitioners are achieving some important results, several notable gaps exist in the current Performance Improvement structure and culture within VA, including a lack of synergy between and within VA PI organizations, varying methodologies (with some competition among organizations and practitioners of these methodologies), a proliferation of improvement efforts that creates confusion for the field, and disconnects between local and VA-wide solutions that contribute to variability in outcomes. To counter these challenges and capitalize on the opportunity for change, VA will build the architecture and enabling environment to foster a culture of continuous improvement. This "To-Be" state will allow VA to deliver continual value efficiently to Veterans; enable VA employees to lead and contribute to their fullest potential; connect to departmental strategy and goals, and continue to discover better ways of working. Best practices and lessons learned from the MyVA initiatives point to the benefits of Employees properly trained in Lean 6 Sigma, Human Centered Design, and Program Management. These practices will provide the foundation for readiness for improvement across the enterprise.

11.5 Enhancing Strategic Partnerships

Strategic Partnerships enable VA to actively pursue partnerships with external stakeholders to improve the Veteran and employee experience. Our partners are valuable allies in the mission to serve Veterans and their families. They act as a force multiplier for VA, allowing help to be provided to those VA is unable to serve. VA will continue to leverage its convening power to bring together subject matter experts, sponsors and partners to address matters (such as traumatic brain injury, caregiving, etc.) that affect Veterans – and our society as well.

11.5.1 2017 Initiatives to Enhance Strategic Partnerships

MyVA Communities: Based on the success of an existing community collaborative effort in San Diego, Secretary McDonald directed local VA leaders in VHA, VHA, and NCA to become active participants in existing community groups and help spark new community collaborative efforts where none existed to improve Veteran experiences. VEO created the MyVA Community

Model as a customizable tool to assist local communities and VA leaders in building local community Veterans engagement boards (CVEBs) to address local needs of Veterans, Servicemembers, and their families. The value of the MyVA Community is far reaching and will vary by magnitude, timeframe, and maturity of the local community Veterans engagement board. This effort stretches across the nation, benefiting Veterans, Servicemembers (SMs), and their families, as well as local service providers, stakeholders, taxpayers, and finally closing the loop with VA. We will have over 100 MyVA communities in place by the end of 2016. In 2017, we will continue to establish MyVA Communities, improve coordination among the various communities themselves, and provide a mechanism for direct feedback from the Veteran community on what works and what doesn't so service offerings can be customized and tailored to fit individual needs

Strategic Partnerships: We are strategically revising our own policies and practices for Strategic Partnerships to make it easier for Veterans to access community resources. For example, this Fall VA issued a policy guidance clarifying that ride sharing companies like Uber and Lyft are now options for Veterans and Caregivers in our Beneficiary Travel program. We will build on our partnerships with external organizations such as the YMCA, the Elks, the PenFed Foundation, USAA, NASA, GE, IBM, Amazon, LinkedIn, Coursera, Google, Walgreens, academic institutions, other Federal agencies, and many more. By opening our doors and inviting our partners in, we are able to leverage the goodwill, expertise, and resources of countless organizations to better serve Veterans. As we look to the future, we look forward to public-private partnerships to help us solve our infrastructure needs. Issues related to facility construction and maintenance are areas where we can creatively work with partners to meet our needs in a timely manner. We will continue our Pathways to InnoVAtion series, which leverages our convening power to bring together a diverse array of external partners to discuss and understand the needs of Veteran as they relate to health and social service initiatives. Conferences are being planned for Emotional Wellbeing, Brain Trust (traumatic brain injury), Homelessness, and Economic Options. We are completing a Strategic Partnership "toolkit" that will be published to all employees to give them the guidance to evaluate potential partners and propose meaningful and measurable agreements.

Strategic Engagement: Since the access crisis in Phoenix in 2014, VA has been operating in crisis communications mode. Much of our communications and engagement structure has been built to support that posture. Over the past few years, VA has made irrefutable progress and has an incredible success story to tell. However, many of the structures and processes for public engagement and communications remain unchanged, making it difficult to transition into a more proactive posture. This is a disservice to Veterans who deserve to know what benefits and care we have available to them, and it prevents us from being able to tell a compelling, consistent narrative about who we are and why we serve. We must ensure that we are proactively and consistently engaging our strategic partners, Veterans organizations, elected officials, and our employees to ensure that everyone is playing a key role in developing innovative solutions to address the challenges we face. The Strategic Engagement Initiative seeks to ensure effective communications and engagement by ensuring the Public Affairs,

outreach and public engagement positions are adequately staffed and resourced for success; ensuring that VA Central Office communications are coordinated through the Offices of Strategic Engagement and Public Affairs; developing and distributing strategic messaging; updating and standardizing operating procedures; and rationalizing the contract support provided for engagement and messaging.

By developing and executing a 2016-2017 Coordinated Strategic Outreach, Engagement, and Communications plan, VA will successfully change our culture from one of hesitation to one of proactivity. This plan will incorporate priority messaging set by the Secretary, allowing VA to speak with one voice. The VA brand will be clear and consistent.

External Communications: An accurate portrayal of VA in the media - to include traditional, digital and social – will increase the employee experience as they see their good and important work valued in society. More importantly, it will increase the trust and confidence Veterans, their families and survivors have in the department, which is critical to the mission of VA, “caring for those who have borne the battle…” Through an integrated communications approach with an increase in regular media and civic engagements by senior leaders, VA will see a steady rise in the number and rate of neutral to positive news stories that reflect an accurate narrative of the best health care available and the most generous benefits that Veterans have earned. Veterans and other stakeholders will gain increasing balanced coverage through the news media and social media through continued engagement from leaders at all levels.

Table 7. Summary of Breakthrough and Management Initiatives

	Initiative	Improving the Veterans experience	Improving the employee experience	Achieving support services excellence	Establishing a culture of continuous performance improvement	Enhancing strategic partnerships
Breakthrough Initiative	Same Day Services	●				
	Community Care	●				
	Consistent & Improved Unified Veteran Experience	●				
	Suicide Prevention	●				
	Non-Clinical Front Line Training	●				
	Streamlined Claims/Appeals Process	●				
	Continue to Reduce Veterans Homelessness	●				
	Internal Communications		●			
	HR Excellence@VA		●			
	IT Transformation			●		
	Supply Chain Transformation			●		
	Financial Management Transformation			●		
	Shared Services			●		
	Electronic Health Record Modernization			●		
	Enterprise Data Management			●		
	Strategic Operating Model				●	

	Initiative	Improving the Veterans experience	Improving the employee experience	Achieving support services excellence	Establishing a culture of continuous performance improvement	Enhancing strategic partnerships
Management Initiative	Equitable Service for Women Veterans	●				
	Measurement: VA Performance According to Veterans	●				
	Safety & Security		●			
	VA Organizational Design Review				●	
	Diffusion of Excellence				●	
	Innovation				●	
	Performance Improvement Skills Training				●	
	MyVA Communities					●
	Strategic Partnerships					●
	Strategic Engagement					●
	External Communications					●

PART E: CONFIRMATION PROCESS

12. Overview

The confirmation process begins once the President selects a nominee to serve in a politically appointed position that requires Senate confirmation. The Department has 12 leadership positions that require confirmation:

- Secretary of VA
- Deputy Secretary
- Under Secretary for Health
- Under Secretary for Benefits
- Under Secretary for Memorial Affairs
- Assistant Secretary for Congressional and Legislative Affairs
- Assistant Secretary for Information and Technology
- Assistant Secretary for Enterprise Integration (formerly Policy and Planning)
- Chief Financial Officer
- General Counsel
- Inspector General
- Chairman, Board of Veterans' Appeals

The confirmation process and timeline is driven by the Senate Committee on Veterans Affairs (SVAC), but the process and timeline for preparing the nominee is driven internally and begins immediately upon the nomination being made public. This process typically lasts between two and three months.

The Assistant Secretary for Congressional and Legislative Affairs (OCLA) or designee leads the nomination and preparation process. The first step of the confirmation process requires the nominee to respond to the Committee Questionnaire from SVAC. Once the nominee completes the Committee Questionnaire, it would then go through review by the VA Office of General Counsel (OGC), appropriate VA senior leaders, and the White House Office of Presidential Personnel prior to submission to SVAC.

After the Committee Questionnaire is submitted, OCLA would then schedule courtesy meetings between the nominee and all SVAC members starting with the Chairman and the Ranking Member. These courtesy meetings would be scheduled as early as possible in the process preferably before the Committee announces a date for the confirmation hearing. These courtesy meetings give OCLA and the nominee a preview of potential issues of interest to committee members that are important for getting the nominee approved by SVAC and report out to the full Senate for consideration.

OCLA will also schedule courtesy meetings between the nominee and key non-Committee members. These key non-Committee members include Senate leadership and members of VA's secondary Committees, the Senate Appropriations Subcommittee on Military Construction, Veterans Affairs and Related Agencies and the Senate Homeland Security and Governmental Affairs Committee. Another important constituency for the nominee to meet is the Veterans service organizations such as the Disabled American Veterans, Veterans of Foreign Wars, the American Legion, etc.

The Committee will schedule a hearing, at which the witness must appear. Prior to the hearing, usually as a result of the courtesy meetings, the Committee will submit pre-hearing Questions for the Record (QFR). The Committee will not conduct the hearing until the pre-hearing QFR are answered by VA. The nominee's draft testimony needs to be cleared ahead of time by OCLA, OGC, Chief of Staff (COSVA), and the White House Office of Presidential Personnel. Once the hearing has concluded, the nominee, through OCLA, may receive post-hearing QFR. These QFR must be answered, cleared through all channels similar to the testimony, and then returned to the committee.

Once the Committee is satisfied with the post-hearing responses, it will hold a business meeting to vote out the nomination. Once the nomination has been approved by the committee, it then files the nomination with the Senate legislative clerk who notifies the executive clerk to assigns a calendar number to the nomination and placed it on the Senate Executive Calendar and then scheduled for voting.

Sometimes, Senators may place holds on a nominee for policy issues that the Department (rather than the nominee) need to address. OCLA is informed about these holds and works with the appropriate Senate offices to resolve the issue so that the hold may be lifted and the nominee may be confirmed.

Once the Senate has confirmed the nomination, the nominee may not be sworn in and start working until the White House has completed all appropriate paperwork and notify the Department through the VA White House Liaison.

13. Preparation

Internal preparation begins prior to nomination of key positions and includes preparation of briefing books made up of publicly available information about VA for the nominees. These briefing books include an overview of VA operations, high profile issues, an outline of the President's budget priorities for the Department, and biographical and issue-specific information for each member of SVAC. Various VA organizations will compile important data on VA facilities for each SVAC member's state and address any questions that have been posed by the member offices before the courtesy meetings.

Nominees should be scheduled for briefings on high level issues and operations by VA subject matter experts and leaders in the organization in order to provide additional detail and answer questions about the materials in the briefing books.

It is critical to note that throughout the confirmation preparation process, nominees may only be provided information that is available to the public. While this may be frustrating for nominees who are attempting to learn more about the future jobs, having inside knowledge could have detrimental effects on their nomination. Presuming positive action by the Senate and providing nominees with information specific to their ability to do the job they are nominated to will not be received well by Senators who ultimately will vote on these confirmations. It is important to remember that nomination does not ensure confirmation.

Although OCLA is the coordinating office, it is important to note that production of the preparation materials is the responsibility of Administrations and Staff Offices throughout the Department. These briefing books will evolve to include specific issues raised during courtesy meetings.

Preparation sessions or “murder boards” are a vital part of hearing preparations. Senior officials from each of the Department’s Administrations and Staff Offices are invited and participate in the preparation sessions. For example, the Under Secretary for Health (or Acting) serves as the lead resource for Veterans Health Administration issues. Other Administrations and Staff Offices include the Veterans Benefits Administration, the National Cemetery Administration, OGC, Office of Public and Intergovernmental Affairs, Office of Information and Technology, Office of Enterprise Integration, Office of Human Resources and Administration, and Office of Management. The murder boards are also opportunities to raise specific questions from committee members raised during courtesy meetings. In conjunction with the member meetings, this is a part of the confirmation that should start early in the process.

14. Timeline

Timeline provided below is based on three-month time frame that could begin as early as November or December. However, this timeline is subject to change because the nomination for the Secretary of VA will likely be fast tracked.

14.1 January

- President announces nominee
- OCLA to begin work on Committee Questionnaire
- Begin scheduling meetings with SVAC Members
- Begin work on briefing books (only using publicly available information)
- Schedule initial internal briefing for nominee

14.2 February

- Begin scheduling courtesy meetings with key non-Committee Members
- Continue scheduling courtesy meetings with SVAC Members
- Committee schedules hearing
- Begin drafting written and oral testimony
- Update briefing books with information gleaned from courtesy meetings
- Schedule prep sessions to cover all aspects of the Department (this number will range between 10 and 15 sessions, depending on the nominee)

14.3 March

- Continue with prep sessions
- Complete courtesy meetings
- Nominee has Confirmation Hearing
- OCLA leads process for answering Member Questions for the Record
- Nominee is reported out of Committee
- Nomination placed on Senate Calendar for consideration by the full Senate
- OCLA works on any issues that result in a hold on nomination
- Nominee confirmed by full Senate
- White House completes appropriate paperwork
- Nominee can be sworn in and begin service

PART F: CRISIS MANAGEMENT AND EMERGENCY RESPONSE

15. Emergency Management Plan

Under the National Response Framework, managed by the Federal Emergency Management Agency (FEMA), VA supports multiple Emergency Management Support Functions (ESF) employed to manage the consequences associated with crisis. In order to manage this effort, VA created the Comprehensive Emergency Management Plan (CEMP), which consists of several directives that assign emergency management responsibilities across the Department:

1. VA Directive 0320 " VA Comprehensive Emergency Management Program"
2. VA Directive 0321 "Serious Incident Reporting"
3. VA Directive 0322 "VA Integrated Operations Center"
4. VA Directive 0323 "VA Continuity Programs"
5. VA Directive 0324 "VA Exercise, Training, and Evaluation Program"

The CEMP is managed by the Office of Operations, Security, and Preparedness (OSP).

VA Comprehensive Emergency Management Plan Directives

Full set of directives can be found on the VA Publications site.

16. Continuity of Operations Information

The President signed Presidential Policy Directive 40 in August 2016, which outlines management organization, mission, and mission support requirements for all Executive Branch Department and Agency's continuity programs. VA Directive 0323 "VA Continuity Program" serves as the continuity policy for VA and ensures that the Department is compliant with standards and regulations set forth by the White House and the Department of Homeland Security.

VA Directive 0323 "VA Continuity Program"

Directive can be found on the VA Publications site.

17. Intelligence Coordination

On July 22, 2013, the Director of National Intelligence signed Intelligence Community Directive (ICD) 404, which describes how the Office of the Director of National Intelligence will engage with intelligence customers in the Executive Branch of the federal government. VA has implemented elements of ICD 404 that facilitate timely communications and engagements with the Intelligence Community.

Executive Summary

Full document can be found in the Appendix, section A.3.

18. Crisis Management and Emergency Response Points of Contact

Contact	Function
Veterans Affairs Integrated Operation Center (VAIOC)	All hazards notification and situational awareness (24/7 - 365). To reach the VAIOC, call (202) 461-5510.
Assistant Secretary for Operations, Security and Preparedness	Senior Official for Emergency Management, Security, Intelligence, Law Enforcement, and Continuity Coordinator.
Deputy Assistant Secretary for Emergency Management and Resilience	Continuity Manager.
Assistant Secretary for Human Resources and Administration	Delegated Official for Occupancy Emergency Planning and Occupational Safety and Health.
Assistant Secretary for Information Technology	Cyber related incidents and Network Assurance.
Assistant Secretary for Public and Intergovernmental Affairs	Media related incidents and events.
Deputy Assistant Secretary for Administration	VA Central Office Facility Operating Status.
Deputy Assistant Secretary for Administration	VA central Office Evacuation / Occupancy Emergency (OEP) Plan activation.
Insider Threat Program Office	Manage reports of suspicious activity involving VA employees, contractors, and/or affiliates.

PART G: USEFUL REFERENCES

19. Functional Organization Manual

The Functional Organization Manual (FOM) is the authoritative source that documents the current organization structure, missions, functions, and tasks of the Department and its organizations.

Functional Organization Manual (FOM)

http://www.va.gov/landing_organizations.htm

20. 2016 Federal Benefits for Veterans, Dependents and Survivors

Veterans of the U.S. armed forces may be eligible for a broad range of benefits and services provided by VA. Some of these benefits may be utilized while on active duty. These benefits are codified in Title 38 of the U.S. Code.

Federal Benefits for Veterans, Dependents and Survivors

http://www.va.gov/opa/publications/benefits_book.asp

20.1 Veterans Issues not Administered by VA

Table 8. Issue and Responsible Agency

Issue	Responsible Agency
Arlington National Cemetery	Department of the Army
Combat-Related Special Compensation	Department of Defense (DoD) – Branch of Service
Concurrent Receipt	DoD – Defense Finance and Accounting Service (DFAS)
Discharge Upgrade	DoD – Branch of Service
Employment and Training	Department of Labor (DOL) – Veterans' Employment and Training Service (VETS)
Military Medals, Records, or Discharge Documents (DD-214)	National Personnel Records Center (NPRC) Online access: http://vetrecs.archives.gov/
Small Business Loans	Small Business Administration (SBA)
Survivors' Benefits Program	DoD
Tricare	DoD
Veterans Preference	Office of Personnel Management (OPM)
Vietnam Memorial Wall	DoD (compiles the casualty list) National Park Service (maintains the Wall)
Records destroyed in the 1973 fire at the NPRC	NPRC

21. VA Regulation/Rulemaking Process

Within VA's overall mission of serving Veterans and their families, the Office of Regulation Policy and Management (00REG) in the Office of Secretary, provides centralized management and control for the formulation and coordination of all VA regulations.

The process of writing and publishing regulations in the *Federal Register* is commonly known as "Rulemaking". Our mission is to produce "Veteran friendly" regulations that implement changing statutes and policies. VA regulations should be easy to find, read, understand, and apply. They should be drafted carefully, coordinated with VA's major stakeholders, and published in a timely fashion.

- VA's average rulemaking processing time to publish a Final regulation in the Federal Register (FR) takes 20.3 months. VA's average rulemaking processing time to publish simple technical regulations in the FR takes 7.1 months.
- The rulemaking processing time involves a formal legal review and concurrence by the Office of the General Counsel (OGC), which takes an average 4 months. OGC's review/concurrence occurs two times during the rulemaking process, totaling 8 months of OGC review/concurrence time.

- The rulemaking processing time also requires a formal review and concurrence by the Office of Management and Budget (OMB). By law, OMB has up to 90 days/3 months to review and concur on VA regulations/rulemakings. OMB's review/concurrence also occurs two times during the rulemaking process, totaling up to 6 months of OMB review/concurrence time.
- There is also a 60 day/2 month Public Comment period time involved in the rulemaking processing time.

In deciding whether and how Program Offices should start the rulemaking process, the below questions are just a few of the issues and areas that they should assess before initiating a regulation/rulemaking process:

- What are VA's costs and/or savings of the regulation?
- Does VA or can VA obtain the appropriate funding to carry out the provisions of the rulemaking upon implementation?
- Are there any regulatory alternatives, including the alternative of not regulating or drafting a regulation?
- Does VA have the field resources, staff and/or other ancillary resources to carry out the provisions of the regulation/rulemaking?
- Will the regulation be controversial with Veterans or Veterans Service Organizations?
- Does the regulation contain issues worthy of a press/media release?
- What other regulatory alternatives were considered?

21.1 Steps and Details of the Rulemaking Process

***Step 1*: Program Office (PO) Contacts the Office of Regulation Policy and Management, Office of the Secretary (00REG) –** A Program Office (PO) is tasked with writing a VA regulation, usually to implement a new VA policy, legislation and/or amend an existing regulation. They should contact 00REG to initiate the process and/or obtain the necessary guidance/instructions.

***Step 2*: 00REG Issues a Work Plan # to the PO –** The Work Plan # serves as tracking number to identify the PO's regulatory proposal. 00REG's Work Plan # assignment also contains all of the necessary actions, instructions and guidance for the PO to develop a complete rulemaking.

***Step 3*: PO Submits Regulation and Necessary Documents to 00REG** – Once the PO's Under Secretary and/or designated official concurs on the regulation and all other necessary documents/forms, the PO submits all of the them to 00REG to initiate the rulemaking process. The necessary documents and forms must be complete in order for 00REG to initiate the rulemaking process.

***Step 4*: 00REG Reviews Regulation and Documents for RIN Issuance** – 00REG will review the PO's Regulation/rulemaking, Impact Analysis/CFO memo, Concurrence and

Summary Sheet (C&S Sheet), VA Form 0907, PREGA, and RID form. The regulation and documents/forms must meet be completed in accordance with E.O. 12866, the Administrative Procedure Act (APA) and the Federal Register Document Drafting handbook. If all necessary documents and forms are approved by 00REG, they will issue and assign a Regulation Identifier Number (RIN) to the PO's regulation/rulemaking. The RIN is acquired through OMB/OIRA and officially notifies the public of VA's intent to publish the regulation. The issuance of the RIN officially starts the clock for VA's rulemaking processing time.

***Step 5*: 00REG Assigns Regulation to the Appropriate OGC Law Group** – Once a RIN has been assigned to the PO's regulation/rulemaking, 00REG formally assigns the rulemaking to the appropriate OGC Law Group for review and concurrence.

***Step 6*: OGC Law Group Review, GC Concurrence and Assigns Regulation Back to 00REG –** The OGC Law Group may have several rounds of drafts and exchanged edits to the regulation with the PO during this step. The assigned OGC Law Group independently obtains concurrence from the General Counsel and sends the regulation/rulemaking back to 00REG.

***Step 7*: 00REG Assigns Regulation to 001B for VA Deputy Chief of Staff (D-COSVA) Signature –** 00REG prepares the regulation/rulemaking and VA Form 0907 for the D-COSVA's signature/approval and formally assigns the regulation/rulemaking to 001B. 00REG also ensures that public affairs is aware of the regulation and confirms that a press/media release is under development and/or ready for release.

***Step 8*: 00REG Sends Regulation to OMB for a Significance Determination under E.O. 12866 –** 00REG reviews and prepares a Planned Regulatory Action (PREGA) document and sends it to OMB. OMB will determine if the regulation/rulemaking is either "Significant" or "Not Significant", in accordance with E.O. 12866. If OMB determines that the regulation/rulemaking is "Significant", then the D-COSVA's signed/approved version of the regulation/rulemaking is officially sent to OMB via ROCIS. If OMB determines that the regulation/rulemaking is "Not Significant", then the D-COSVA's signed/approved version of the regulation/rulemaking is officially sent to the Federal Register for publication.

***Step 9*: 00REG sends the Regulation to OMB for Formal +/- Day Review –** OMB has up to 90 days/3 months to review and conclude their review on VA's "Significant" regulations/rulemakings under E.O. 12866. OMB may have several conversations, meetings and questions with 00REG, the PO and OGC during this review. 00REG serves as the direct liaison with OMB and coordinates all of these conversations, meetings, edits, and questions recommended by OMB/OIRA/EOP. OMB notifies 00REG when they have concluded their review "approval" of the regulation/rulemaking.

***Step 10*: 00REG Sends Regulation to the Federal Register for Publication** – 00REG prepares and digitally signs the regulation/rulemaking, on behalf of the D-COSVA and formally sends the regulation/rulemaking to the Office of the Federal Register (OFR) for publication.

00REG coordinates all edits with the FR before the regulation/rulemaking publishes in the FR. It typically takes 3 business days for the regulation/rulemaking to publish in the FR.

***Step 11*: PO Repeats Steps 3 through 10 –** If the published regulation/rulemaking is a 2-Stage regulation/rulemaking (i.e., Proposed Rule, Interim Final Rule, or Direct Rule), then the regulation/rulemaking is in a public comment period. During this public comment period (usually 60 days/2 months), 00REG primarily monitors and obtains the public comments through the Federal Document Management System (FDMS). 00REG and the PO may receive public comments via mail, fax and hand delivery. 00REG ensures that the PO receives all comments, so that the public comments can be addressed in the Final regulation/rulemaking. Once the public comment period closes, the PO must complete Steps 3 through 10 again on all 2-stage regulations/rulemakings.

APPENDIX A: ADDITIONAL MATERIALS

A.1. Overview of VA FY2018 – 2024 Goals and Objectives

Goal 1: VA has lifelong and trusted relationships with all our Veterans that anticipate their needs and enhances their lives.

1.1 VA understands, assesses, and improves the Veteran experience at all stages of their life.

- 1.1.1 Build a lifelong relationship with Servicemembers, Veterans, and their support system beginning with their military service to tailor services and benefits as their needs evolve.
- 1.1.2 Transform the Separation experience of the Veteran to support the unique occupational, physical, mental, and emotional needs etc. of Servicemembers transitioning to civilian life.
- 1.1.3 Transform the Retiring and Aging experience of the Veteran to address the changing dynamics of this growing Veteran population segment.

1.2 VA uses analysis to anticipate Veteran needs and improve Departmental performance.
Same Day (myVA)
Homelessness (myVA)
Suicide Prevention (myVA)
Women Veterans (myVA)
Precision Medicine (myVA)

- 1.2.1 Promote a collaborative Ecosystem of partners to provide meaningful economic opportunities and economic security that improves quality of life for Veterans, transitioning Servicemembers, and their families.
- 1.2.2 Ensure positive, productive, long-term relationships with Veterans to improve their health outcomes.
- 1.2.3 Prioritize and customize benefits and support services to meet the unique occupational, physical, mental, and emotional needs etc. of severely wounded, ill, and injured Servicemembers, Veterans, and their families to ensure economic security and promote physical and mental health.
- 1.2.4 Address the specific health care, benefits and services needs of Women Veterans
- 1.2.5 Proactively shape the mental health narrative, to include PTSD, to remove stigma and provide seamless and ongoing access to treatments and support.

Goal 2: VA curates an interoperable network that consistently delivers superlative and seamless benefits, care, and services to our Veterans.

2.1 Leverage scope, capabilities, and expertise among Veteran Ecosystem entities, which includes the Department, to achieve excellent outcomes for Veterans.
Homelessness (myVA)
Strategic Partnership (myVA)
Suicide Prevention (myVA)

- **2.1.1 Communities (myVA)**
- **2.1.2 Community Care (myVA)**
- **2.1.3 Strategic Engagement (myVA)**

2.2 Drive the integration of information and data about the Veteran in support of seamless delivery of care, benefits, and services.
Homelessness (myVA)
Electronic Health Records (myVA)

- 2.2.1 Ensure reliable, accurate, comprehensive and timely information exchanges throughout the Veteran Ecosystem to provide better resources for Veterans.
- 2.2.2 Create a secure data sharing environment that enhances interoperability with Veteran Ecosystem partners to support effective and informed decisions.

The MyVA 2017-2020 Breakthrough and Management Initiatives are embedded in and critical to the achievement of the VA 2024 Strategic Plan

Goal 3: VA is a Veteran-centric, reliable, and high-performing organization that consistently meets the changing needs of Veterans.

3.1 VA relentlessly innovates and strives for quality improvements in everything we do.

- **3.1.1 Claims and Appeals (myVA)**
- **3.1.2 Diffusion of Excellence (myVA)**

3.2 Employees make decisions that contribute to excellent customer experiences.

- 3.2.1 Employee performance standards and goals reflect the VA's core values, and its focus on customer service and mission outcomes.
- **3.2.2 Non-Clinical Frontline Training (myVA)**

3.3 Execute effective internal and external communication to enable positive mission outcomes and excellent customer service.

- **3.3.1 Strategic Engagement (myVA)**
- **3.3.2 Vets.gov and Contact Center (myVA)**

MyVA Initiatives that are foundational to the success of all current and future transformation initiatives of the Department:

- Enterprise Data Management
- External Communications
- Financial System Transformation
- HR Excellence @VA
- Internal Communications
- OIT Transformation
- Org Design
- PI Skills Training
- Safety and Security
- Shared Services
- Strategic Engagement (element 3 & 4)
- Strategic Operating Model
- Supply Chain
- VA Center for Innovation

Legend:

Goal	**Strategy (myVA Initiative)**	Foundational Requirements
Strategic Objective **myVA initiative theme incorporated**	Strategy	

A.2. VA FY2014 – 2020 Strategic Policy Agenda

Department of Veterans Affairs **Memorandum**

Date: FEB 2 2 2016

From: Secretary (00)

Subj: FY 2014 – 2020 VA Strategic Policy Agenda (FY 2016 Update)

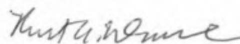
To: Under Secretaries, Assistant Secretaries, and Other Key Officials

1. The Department of Veterans Affairs Strategic Policy Agenda (VASPA) is an internal document that provides a general road map for coordinated, comprehensive policy analysis and formulation on multidisciplinary issues requiring collaboration across the Department.

2. As established in VA Directive 0326, the VASPA is developed every 4 years and updated annually with policy priorities organized around the goals and objectives in the VA Strategic Plan. The Office of Policy and Planning (OPP) develops and coordinates concurrence of the VASPA with input from VA Senior Leadership, subject matter experts (SMEs), the strategic planning process, and environmental scanning efforts.

3. Under Secretaries, Assistant Secretaries, and Other Key Officials ensure that Administrations and Staff Offices work with OPP by designating the appropriate SMEs to participate in Department-wide work groups. These groups analyze each priority and develop recommendations for moving forward with new policies, procedures, and/or programs and services. The Secretary, or a designee, approves the VASPA and provides additional guidance, as needed.

4. The VASPA is a living document subject to available resources and the needs of VA Senior Leadership.



Robert A. McDonald

Attachment:

Updated FY 2014 – 2020 VA Strategic Policy Agenda

VA FORM 2105
MAR 1989

FY 2014 – 2020 VA STRATEGIC POLICY AGENDA (FY 2016 UPDATE)

Goal 1: Empower Veterans to Improve their Well-being.

Objective 1.1: Improve Veteran wellness and economic opportunity.

- Analyze Veteran health and employment policies, programs, and initiatives across key stakeholders as outcomes to VA's core services for maximum utilization, optimization, and synchronization. *(Coordinating Office: VHA and VBA; Key Stakeholders: VA (VHA, NCA, OHRA, OPP, and OSDBU), DOL, DOD, ED, SBA, White House, and Private/Public Industry)*
- Enable the maximum utilization, optimization, and synchronization of internal Department Veteran employment policies, programs, and initiatives in support of VA requirements and Federal partners. *(Coordinating Office: OHRA; Key Stakeholders: VA (VHA, VBA, NCA, OPP, and OSDBU), DOL, DOD, ED, SBA, White House, and Private/Public Industry)*

Objective 1.2: Increase customer satisfaction through improvements in benefits and service delivery policies, procedures, and interfaces.

- Evaluate VA policies to ensure that they reflect the changing demographics of the Veteran population. *(Coordinating Office: VEO; Key Stakeholders: VA Administrations and Staff Offices)*
- Develop or modify policies to facilitate Department-wide, Veteran-centric common customer data management. *(Coordinating Office: OPP; Key Stakeholders: VA Administrations and Staff Offices)*
- Examine the extent to which VA disability policies are keeping pace with changes in society (Veteran demographics, economy, and new demands on VA benefits and health care system). *(Coordinating Office: VBA; Key Stakeholders: VHA and OPP)*

Goal 2: Enhance and Develop Trusted Partnerships.

Objectives 2.1 and 2.2: Enhance VA's partnerships with Department of Defense and with Federal, State, private sector, academic affiliates, and nonprofit organizations.

- Synchronize current VA policies around privacy, security, and patient protection with OMB "open data" policies. *(Coordinating Office(s): OPP, OIT, and OSP; Key Stakeholders: VA Administrations and Staff Offices)*

1

- Work with interagency and State/Local partners to establish integrated data collection and data sharing processes for improved analytics/evidence-based development of Veteran economic and employment policies, programs, and initiatives. *(Coordinating Office: VBA; Key Stakeholders: VA (VHA, NCA, OHRA, OPP, OPIA), DOL, ED, DOD, SBA, White House, VSOs, NGOs, and Private/Public Industry)*
- Review and align VA policies and communication efforts to enable strategic partnership engagements within the Administrations and external stakeholders. *(Coordinating Offices: OSVA Strategic Partnerships and OGC; Key Stakeholders: VA Administrations and Staff Offices)*

Objectives 2.3: Amplify awareness of services and benefits available to Veterans through improved communications and outreach.

- Develop a Department-wide communications policy that coordinates and aligns messaging, processes, and engagements. *(Coordinating Office: OPA; Key Stakeholders: VA Administrations and Staff Offices)*
- Develop a Department-wide public relations policy that guides the coordination of efforts across VA. *(Coordinating Office: OPA; Key Stakeholders: VA Administrations and Staff Offices)*

Goal 3: Manage and Improve VA Operations to Deliver Seamless and Integrated Support.

Objective 3.1: Make VA a place people want to serve.

- Create a comprehensive, enterprise-level training development policy aligned with the workforce needs of the Department. *(Coordinating Office: OHRA; Key Stakeholders: VA Administrations and Staff Offices)*

Objective 3.2: Evolve VA information technology capabilities to meet emerging customer service/empowerment expectations of both VA customers and employees.

Objective 3.3: Build a flexible and scalable infrastructure through improved organizational design and enhanced capital planning.

- Develop Department-level policy and processes for deploying and cascading the VA Strategic Plan in a way that aligns both operational and individual performance to strategic goals and Veteran outcomes. *(Coordinating Office: OPP; Key Stakeholders: VA Administrations and Staff Offices)*
- Evaluate and analyze current policies, processes, and roles and responsibilities for developing, implementing, and evaluating Department-wide policy. *(Coordinating Office: OPP; Key Stakeholders: VA Administrations and Staff Offices)*

- Perform an assessment of VA's audit resolution policies and processes to address gaps and ensure the Department is meeting internal and external reporting requirements, including those contained in OMB A-50 and A-123. *(Coordinating Office: OPP; Key Stakeholders: VA Administrations and Staff Offices)*
- Evaluate VA policies to ensure policies are aligned and synchronized to allow shared services support. *(Coordinating Office: Support Services Governance Board; Key Stakeholders: VA Administrations and Staff Offices)*

Objective 3.4: Enhance productivity and improve efficiency of the provision of Veteran benefits and services.

- Develop end-to-end requirements policy for managing requirements from identification and validation through solution selection and execution. *(Coordinating Office(s): OPP, OALC, OIT, OSP, and OM; Key Stakeholders: VA Administrations and Staff Offices)*

Objective 3.5: Ensure preparedness to provide services and protect people and assets continuously and in times of crisis.

ACRONYMS

DOD	Department of Defense
DOL	Department of Labor
ED	Department of Education
NCA	National Cemetery Administration
OALC	Office of Acquisition, Logistics, and Construction
OGC	Office of General Counsel
OHRA	Office of Human Resources and Administration
OIT	Office of Information and Technology
OM	Office of Management
OPA	Office of Public Affairs
OPP	Office of Policy and Planning
OSDBU	Office of Small and Disadvantaged Business Utilization
OSP	Office of Operations Security and Preparedness
OSVA	Office of the Secretary of Veterans Affairs
SBA	Small Business Administration
VA	Department of Veterans Affairs
VBA	Veterans Benefits Administration
VEO	Veterans Experience Office
VHA	Veterans Health Administration

A.3. Intelligence Coordination

UNCLASSIFIED // FOR OFFICIAL USE ONLY

Executive Summary

Subject: Intelligence Coordination within the Department of Veterans Affairs

Purpose: The purpose of this summary is to illustrate the relationship between the Intelligence Community (IC) and the Department of Veterans Affairs as it pertains to information sharing, collaboration, and information management.

Background: Since the terrorist events of 9/11, the Intelligence Community has increased the level of collaboration with other Executive Branch organizations in order to mitigate the likelihood of future terrorist attacks against the United States. Over the years, this collaboration has matured beyond terrorism and now encompasses the full spectrum of threats to the United States to include espionage, counter intelligence, supply chain risk management, and other threats that challenge national security. On July 22, 2013, The Director of National Intelligence signed Intelligence Community Directive (ICD) 404 which formalized the framework employed across the Intelligence Community. ICD 404 describes how ODNI will engage with intelligence customers in the Executive Branch of the U.S. Government. The Department of Veterans Affairs is one of these customers.

Disposition: The Department of Veterans Affairs has implemented elements of ICD 404 that facilitates timely communications and engagements with the Intelligence Community. As appointed by the Secretary, the Assistant Secretary for Operations, Security, and Preparedness (OSP) serves as the Federal Senior Intelligence Coordinator (FSIC) for the Department. In this capacity, the FSIC serves as the primary liaison between VA and the IC. As delegated by the FSIC, the Deputy Assistant Secretary for Emergency Management and Resilience serves as the Intelligence Point of Contact (IPOC) and is designated the authority to as a liaise with the IC. As delegated by the FSIC, the Office of National Security Services (ONSS) serves as the Federal Intelligence Coordination Office (FICO) for the Department. Under the direction of the IPOC (DAS for Emergency Management and Resilience), the FICO supports intelligence requirements and needs within the Departments through product development and collaboration with the IC at the action officer level.

Together the FSIC, IPOC, and FICO manage the intelligence coordination portfolio on behalf of the Department and are the single gateway between VA and the Intelligence Community. For additional questions regarding Intelligence coordination, please contact the Department's IPOC, Deputy Assistant Secretary Lewis Ratchford at 202.461.5930, lewis.ratchfordjr@va.gov, or lratchford@dva.id.ic.gov (secure email).

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INTELLIGENCE COMMUNITY DIRECTIVE
404

22 July 2013

Executive Branch Intelligence Customers

A. AUTHORITY: The National Security Act of 1947, as amended; Executive Order (EO) 12333, as amended; and other applicable provisions of law.

B. PURPOSE: This Directive establishes a framework for Intelligence Community (IC) engagement with intelligence customers in the executive branch of the U.S. Government.

C. APPLICABILITY

1. This Directive applies to the IC, as defined by the National Security Act of 1947, as amended, and to such elements of any other department or agency as may be designated an element of the IC by the President, or jointly by the Director of National Intelligence (DNI) and the head of the department or agency concerned.

2. For IC elements within departments, this Directive is intended to complement existing departmental policies. This Directive does not supersede any responsibilities such IC elements have to support the missions of their departments.

D. DEFINITIONS

1. Federal Senior Intelligence Coordinator (FSIC). A FSIC is the senior position within an individual executive branch department or agency that has been designated by the head of that organization upon request of the DNI, to serve as the primary liaison between the respective department or agency and the IC.

2. Intelligence Point of Contact (IPOC). IPOCs are personnel within individual executive branch departments and agencies who have been designated by their organization to act as a liaison with the IC.

3. Federal Intelligence Coordination Office (FICO). FICOs are offices within an individual executive branch department or agency that coordinate with the IC to support policy makers and other intelligence customers within their organizations.

E. POLICY

1. The DNI leads a coordinated effort to provide objective, timely, accurate, and insightful intelligence that is responsive to decisionmakers in the executive branch, hereinafter, "executive branch customers."

2. IC elements have established and developed an array of relationships with executive branch customers that have been, and will continue to be, essential to providing effective IC support to decisionmakers.

3. To further foster these productive relationships and to facilitate an understanding of the intelligence needs of customers and the ability of the IC to meet those needs:

a. IC element points of contact shall be made available to executive branch customers to facilitate initial and developing relationships and to support engagement on intelligence needs; and

b. IC elements shall accommodate designations by executive branch customers of liaisons for engagement with the IC on their intelligence needs. Such accommodation includes the provision of information, consistent with classification and control markings applied to the information in accordance with EO 13526 and IC policy.

4. IC elements' efforts to meet the intelligence needs of executive branch customers may, as appropriate, include the provision of capabilities to facilitate the discovery, access, retention or destruction of intelligence and intelligence-related information.

F. IMPLEMENTATION

1. IC elements shall designate points of contact within their organizations to facilitate initial and developing relationships and to support engagements with executive branch customers.

2. As appropriate, IC elements shall work through liaisons designated by the executive branch customers.

a. These liaisons may include FSICs, IPOCs, or FICOs.

b. If no liaison has been designated by a customer's organization, the IC element is encouraged to consult with the Assistant DNI for Partner Engagement (ADNI/PE) to determine an appropriate point of contact regarding the intelligence needs of that organization.

3. In supporting executive branch customers' intelligence needs, an IC element's provision of capabilities to support discovery, access, retention and destruction of intelligence and intelligence-related information shall be consistent with IC policy and DNI guidance.

4. As provided in IC Information Sharing Executive (ISE) 00008, *Use of ICD 501 Dispute Resolution Process for Issues Relating to Attribute-Based Access Control*, executive branch customers whose personnel have a mission need for intelligence and intelligence-related information, and who believe the application of access control restrictions to specific information is inappropriate, may use the dispute resolution process outlined in IC Policy Guidance (ICPG) 501.2, *Sensitive Review Board and Information Sharing Dispute Resolution Process*, using their department or agency FSIC to address their concern with the appropriate IC Sensitive Review Board. FSICs may also, on behalf of specific personnel in their department or agency, seek access to information or systems not yet discoverable, and if denied, may use the dispute resolution process described in ICPG 501.2.

G. RESPONSIBILITIES

1. The DNI will:

a. Through the ADNI/PE,

(1) Establish and lead fora to support this Directive;

(2) As appropriate, assist IC elements in their engagement with executive branch customers, particularly when an organization has not designated a liaison;

(3) Maintain and provide to IC elements a current list of FSICs, IPOCs, and FICOs, with contact information; and

(4) Publish a reference guide to facilitate engagement.

b. Through the IC ISE, address information sharing disputes arising from the implementation of this Directive, in accordance with ICPG 501.2.

c. Through the IC Chief Information Officer (CIO) and in accordance with ICD 502, *Integrated Defense of the Intelligence Community Information Environment*, maintain awareness of technical infrastructure connected to the IC Information Environment, including that which is provided to executive branch customers by IC elements to facilitate discovery, access, retention, or destruction of intelligence and intelligence-related information.

d. Through the National Counterintelligence Executive (NCIX), maintain the IC Sensitive Compartmented Information Facility (SCIF) repository in accordance with ICD 705, *Sensitive Compartmented Information Facilities* and associated IC standards.

2. The heads of IC elements shall:

a. Designate point(s) of contact including at least one at the unclassified level, as a point of entry for engagement with executive branch customers;

b. Make contact information for the point(s) of contact readily available on their element's classified and unclassified web sites for use by executive branch customers;

c. Provide the contact information for the point(s) of contact to the ADNI/PE;

d. Ensure that a customer's liaison is aware of the scope of the IC element's engagement with the liaison's organization;

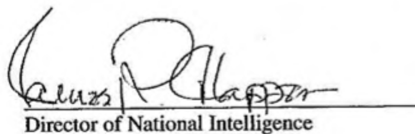
e. Respond in a timely manner to intelligence needs communicated by an executive branch customer through the IC element's points of contact, informing the customer how the need will be met or why it will not be met;

f. Identify to the IC CIO any technical infrastructure connected to the IC Information Environment provided to executive branch customers to facilitate their discovery, access, retention, or destruction of intelligence and intelligence-related information;

g. Ensure the proper handling of classified information by their personnel in engagements with executive branch customers and their liaisons; and

h. Ensure timely input to the IC SCIF repository of required data on SCIFs, including those accredited for executive branch intelligence customers.

H. EFFECTIVE DATE: This Directive becomes effective on the date of signature.



Director of National Intelligence

22 July 2013

Date

A.4. VA Major Leases Pending Authorization

VA Major Leases Pending Authorization

Description	City	State	Budget FY	New or Replacement	Size	Total Annual Un-serviced Rent	Lump Sum Costs
Expand Outpatient Mental Health Lease	Birmingham	AL	2015	New	59,800	$2,007,000	$4,964,000
Expand Outpatient Specialty Services – Clinical Annex II	Birmingham	AL	2015	New	89,900	$3,017,000	$7,462,000
Replace Strom Thurmond Research Building Lease	Charleston	SC	2015	Replacement	48,000	$1,637,000	$4,944,000
Expand Research in Mission Bay and Create Center for Virtual Medicine	San Francisco	CA	2015	New	145,500	$8,467,000	$14,987,000
Replace Denver Chief Business Office Purchased Care (formerly HAC) Lease	Denver	CO	2015	Replacement	168,000	$3,271,000	$13,944,000
Portland Community Based Outpatient Clinic	Togus	ME	2016	Replacement	56,600	$2,148,000	$4,698,000
Missoula CBOC Lease	Missoula	MT	2016	Replacement	60,000	$2,150,000	$4,980,000
Replace Northern Colorado Clinics	Cheyenne	WY	2016	Replacement	74,500	$2,592,000	$6,184,000
Establish a Primary Care Annex	Ann Arbor	MI	2016	New	145,000	$5,058,000	$12,035,000
Establish New Lease for Pike County, GA Community Based Outpatient Clinic	Atlanta	GA	2016	New	49,000	$1,690,000	$4,067,000
Raleigh Health Care Center	Durham	NC	2016	Replacement	185,300	$6,227,000	$15,380,000
Consolidate and Replace the Ocala Community Based Outpatient Clinic and Ocala West Specialty Clinic.	Gainesville	FL	2016	Replacement	45,500	$1,502,000	$3,777,000
Consolidate Mental Health Leases	Gainesville	FL	2016	Replacement	39,500	$1,407,000	$3,279,000
HCC - Hampton Roads Health Care Center - Major Lease	Hampton	VA	2016	New	155,200	$5,242,000	$12,882,000
Expand Specialty Ambulatory Care at Santa Rosa Clinic	San Francisco	CA	2016	Replacement	76,758	$2,348,000	$4,150,000
Replace leases in Daytona Beach	Orlando	FL	2016	Replacement	107,000	$3,783,000	$8,881,000
Oxnard Clinic CBOC	West Los Angeles	CA	2016	New	47,200	$2,379,000	$3,918,000
New Research Lease	Brockton	MA	2016	New	40,600	$2,127,000	$3,370,000
Renew/Replace Lease for Pontiac CBOC to replace existing Pontiac CBOC Lease	Detroit	MI	2017	Replacement	37,619	$1,409,000	$3,123,000
Establish a Jacksonville Outpatient Clinc Expansion Lease	Gainesville	FL	2017	Replacement	164,054	$4,519,000	$13,617,000
Establish New Lease - Terre Haute - Integrative Planning	Indianapolis	IN	2017	Replacement	38,792	$1,255,000	$3,220,000
Consolidate and expand Lakeland leases	Tampa	FL	2017	Replacement	92,681	$2,875,000	$7,693,000
Consolidate Primary Care Outpatient Clinics Corpus Christi	Harlingen	TX	2017	Replacement	66,497	$1,932,000	$5,520,000
Lease Space for ROPC Phase II	Canandaigua	NY	2017	Replacement	55,431	$2,300,000	$4,601,000
					2,048,432	$71,342,000	$171,676,000

A.5. Acronym List

Acronym	Title
ABMC	American Battle Monuments Commission
ACA	Affordable Care Act
ACICS	Accrediting Council for Independent Colleges and Schools
ACMO	Advisory Committee Management Office
AE	Architect Engineer
AFR	Agency Financial Report
AI/AN	American Indian and Alaskan Native
AMVETS	American Veterans
APOLLO	Applied Proteogenomics Organization Learning and Outcomes
APRN	Advanced Practice Registered Nurse
AGA	Association of Government Accounts
ATSDR	Agency for Toxic Substances and Disease Registry
BPR	Business Process Re-engineering
BVA	Board of Veterans Appeals
C&P	Compensation and Pension
CAP	Cross Agency Priority
CBCA	Civilian Board of Contract Appeals
CBO	Congressional Budget Office
CBOC	Community-Based Outpatient Clinic
CFBNP	Center for Faith-based and Neighborhood Partnerships
CFM	Construction and Facilities Management
C.F.R.	Code of Federal Regulations
CLSLT	Camp Lejeune Science Liaison Team
CM	Centralized Mail
CMS	Centers for Medicare & Medicaid Services
COD	Character of Discharge
CONFIRM	Colonoscopy vs. Fecal Immunochemical Testing in Reducing Mortality
COSVA	Chief of Staff of Veterans Affairs
CRNA	Certified Registered Nurse Anesthetists
CSEMO	Corporate Senior Executive Management Office
CSP	Cooperative Studies Program
CVEB	Community Veteran Engagement Board
DAV	Disabled Veterans of America
D-COSVA	VA Deputy Chief of Staff
DEM	Disability Examinations Management
DEMPS	Disaster Emergency Medical Personnel System
DFAS	Defense Finance and Accounting Service
DFO	Designated Federal Officer
DHP	Digital Health Platform

DHS	Department of Homeland Security
DMZ	Demilitarized Zone
DoD	Department of Defense
DOJ	Department of Justice
DOL	Department of Labor
ECCA	Estimated Construction Cost at Award
ECHCS	VA Eastern Colorado Health Care System
ED	Department of Education
eHMP	Enterprise Health Management Platform
EHR	Electronic Health Records
ERM	Enterprise Risk Management
EUL	Enhanced-Use Leasing
FACA	Federal Advisory Committee Act
FAR	Federal Acquisition Regulations
FDMS	Federal Document Management System
FFRDC	Federally Funded Research and Development Center
FITARA	Federal Information Technology Acquisition Reform Act
FMBT	Financial Management Business Transformation
FOM	Functional Organization Manual
FR	Federal Register
FSS	Federal Supply Schedule
FSSP	Federal Shared Service Provider
FTC	Federal Trade Commission
FTE	Full-Time Equivalent
FY	Fiscal Year
GAO	Government Accountability Office
GME	Graduate Medical Education
GSA	General Services Administration
GUI	Graphical User Interface
HHS	Department of Health and Human Services
HIPAA	Health Information Portability and Accountability Act
HLTI	Healthcare Leadership Talent Institute
HPSA	Health Professional Shortage Areas
HRSA	Health Resources and Services Administration
HSPD	Homeland Security Presidential Directive
HSRD	Health Services Research and Development
HUD	Department of Housing and Urban Development
HVAC	House Committee on Veterans Affairs
IAVA	Iraq and Afghanistan Veterans of America
ICARE	Integrity, Commitment, Advocacy, Respect, Excellence
ICS	Incident Command System
IDC	Integrated Design Construction
IG	Inspector General
IHS	Indian Health Service
IOM	Institute of Medicine

IPERA	Improper Payment Elimination and Recovery Act
IPO	Interagency Program Office
IPRO	Improper Payments Remediation and Oversight
IRB	Institutional Review Board
ISO	Internal Organization for Standardization
ISP	Interim Staffing Program
IT	Information Technology
ITIL	Information Technology Infrastructure Library
JLV	Joint Legacy Viewer
KT	Kiewit-Turner
LDL	Leaders Developing Leaders
LGBT	Lesbian, Gay, Bisexual and Transgender
LTP	Locum Tenens Program
MASS	Medical Appointment Scheduling System
MAVERIC	Massachusetts Veterans Epidemiology Research and Information Center
MCS	Millennium Cohort Study
MDE	Medical Disability Examination
MFR	Managing for Results
MMU	Mobile Medical Unit
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MSPB	Merit Systems Protection Board
MVAC	MyVA Advisory Committee
MVP	Million Veteran Program
NADL	Native American Direct Loan
NASDVA	National Association of State Directors of Veterans Affairs
NCA	National Cemetery Administration
NCI	National Cancer Institute
NDAA	National Defense Authorization Act
NGO	Nongovernmental Organizations
NIH	National Institutes of Health
NPRC	National Personnel Records Center
NRC	National Research Institute
NWQ	National Work Queue
NRM	Non-Recurring Maintenance
NWQ	National Work Queue
O&M	Operations and Maintenance
OALC	Office of Acquisition, Logistics, and Construction
OAR	Office of Accountability Review
OCLA	Office of Congressional and Legislative Affairs
OEI	Office of Enterprise Integration
OEM	Office of Emergency Management
OEP	Occupancy Emergency Plan
OFR	Office of Federal Register
OGC	Office of General Council

OHRA	Office of Human Resources and Administration
OI&T	Office of Information and Technology
OIG	Office of Inspector General
OM	Office of Management
OMB	Office of Management and Budget
OOREG	Office of Regulation Policy and Management
OPIA	Office of Public and Intergovernmental Affairs
OPIC	Office of Policy and Interagency Collaboration
OPM	U.S. Office of Personnel Management
OSC	Office of Special Council
OSDBU	Office of Small and Disadvantaged Business Utilization
OSP	Office of Operations, Security, and Preparedness
OTGR	Office of Tribal Government Relations
OTH	Other Than Honorable
PAWG	Performance Accountability Work Group
PCE	Perchloroethylene
PMI	Project Management Institute
PMI-CP	Precision Medicine Initiative Cohort Program
PMO	Program Management Office
PMP	Project Management Plan
PO	Program Office
PREGA	Planned Regulatory Action
PRIME	Precision Medicine in Mental Health Care
PTSD	Post-Traumatic Stress Disorder
PVA	Paralyzed Veterans of America
PVAHCS	Phoenix VA Health Care System
QFR	Questions for the Record
QUERI	Quality Enhancement Research Initiative
RAMMP	Report Approvals Meetings Measures Policies
RePOP	Research for the Precision Oncology Program
RIN	Regulation Identifier Number
RO	Regional Office
SAIL	Strategic Analytics for Improvement and Learning
SBA	Small Business Administration
SCOTUS	Supreme Court of the United States
SDVOSB	Service-Disabled Veteran-Owned Small Business
SECVA	Secretary of Veterans Affairs
SES	Senior Executive Service
SF	Square Feet
SOM	Strategic Operating Model
SSGB	Support Services Governance Board
STR	Service Treatment Record
SVA	Student Veterans of America
SVAC	Senate Committee on Veterans Affairs
TAL	The American Legion

TBI	Traumatic Brain Injury
TCE	Trichloroethylene
THP	Tribal Health Programs
TNC	Traveling Nurse Corps
TWG	Technical Working Group
UIHP	Urban Indian Health Programs
USACE	U.S. Army Corps of Engineers
USAF	United Stated Air Force
USDA	United States Department of Agriculture
USSM	Unified Shared Services Management
VA	Department of Veterans Affairs
VACCA	Veterans Access, Choice, and Accountability Act
VACI	VA Center for Innovation
VAIOC	VA Integrated Operation Center
VALOR	Veterans Affairs Lung cancer surgery Or stereotactic Radiotherapy
VAMC	VA Medical Center
VAR	Veterans Appointment Request
VASPA	VA Strategic Policy Agenda
VASRD	VA Schedule for Rating Disabilities
VAST	VHA Site Tracking
VBA	Veterans Benefits Administration
VBMS	Veterans Benefits Management System
VCL	Veterans Crisis Line
VEO	Veterans Experience Office
VERC	Veterans Engineering Resource Center
VES	VistA Scheduling Enhancements
VETS	Veterans' Employment and Training Service
VFW	Veterans of Foreign Wars
VHA	Veterans Health Administration
VIP	Vendor Information Pages
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture
VLP	Veterans Legacy Program
VOC	Volatile Organic Compounds
VOSB	Veteran-Owned Small Business
VSE	VistA Scheduling Enhancements
VSO	Veterans Service Organization
VVA	Vietnam Veterans of America