Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 1217
Transmittal Sheet
August 14, 2024

VHA OPERATING UNITS

1. SUMMARY OF MAJOR CHANGES: Major changes include:

a. Adding responsibilities for the Deputy Under Secretary for Health, Chief of Staff, Chief Operating Officer (COO), Veterans Integrated Service Network (VISN) Director, and Department of Veterans Affairs (VA) medical facility Director (paragraph 2).

b. Adding definitions (paragraph 7) and defining Levels of Authority (Appendix A) for VISNs and VA medical facilities.

2. RELATED ISSUES: VHA Directive 1217.01(2), VHA Central Office Governance Board, dated September 10, 2021; VHA Directive 1023, Waivers to VHA National Policy, dated March 5, 2024.

3. POLICY OWNER: The Office of Governance, Regulations, Appeals and Policy (10B-GRAP) is responsible for the contents of this Veterans Health Administration (VHA) directive. Questions may be referred to 10B-GRAP at: VHA10BRAPPolicy@va.gov.

4. LOCAL DOCUMENT REQUIREMENT: There are no local document requirements in this directive.

5. RESCISSIONS: VHA Directive 1217, VHA Central Office Operating Units, dated September 10, 2021, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of August 2029. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

7. IMPLEMENTATION SCHEDULE: This directive is effective upon publication. ***NOTE:*** *The COO's responsibilities will not become effective until the COO enters on duty.*

BY DIRECTION OF THE OFFICE OF THE UNDER SECRETARY FOR HEALTH:

/s/ Shereef Elnahal, M.D., MBA
Under Secretary for Health

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter***.**

DISTRIBUTION: Emailed to the VHA Publications Distribution List on August 15, 2024.

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VHA OPERATING UNITS

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1. POLICY

It is Veterans Health Administration (VHA) policy that decision rights of VHA operating units be followed in accordance with the responsibilities (paragraph 2) and Level of Authority Matrix (Appendix A) of this directive. **AUTHORITY:** 38 U.S.C. § 7301(b). ***NOTE:*** *This policy must not be used to grade positions, establish staffing requirements, or differentiate pay bands. VHA positions must be graded in accordance with Title 5 U.S.C., Title 5 C.F.R., and guidance provided by the Office of Personnel Management (OPM)*.

2. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for:

(1) Providing leadership and direction for VHA.

(2) Ensuring overall VHA compliance with this directive.

b. **Deputy Under Secretary for Health, Chief of Staff, Chief Operating Officer.** Collectively, the Deputy Under Secretary for Health, Chief of Staff, and Chief Operating Officer are responsible for:

(1) Collaborating with the Under Secretary for Health and other senior executives to develop and implement VHA's strategic plans by translating the Department of Veterans Affairs' (VA's) priorities into operational plans, initiatives, and performance metrics.

(2) Providing oversight and guidance for VHA Principal Offices, Program Offices, Veterans Integrated Service Network (VISN) Directors, and program officials in VHA Central Office (VHACO) and VA medical facilities.

(3) Developing policy, program initiatives, and management requirements that align with VA's strategic plan and enterprise-wide solutions.

c. **Deputy Under Secretary for Health.** The Deputy Under Secretary for Health is additionally responsible for:

(1) Providing innovative and forward-looking fiscal investment planning, programming, and budget execution oversight throughout VHA.

(2) Overseeing the monitoring of integrity, quality, and value of clinical services at VA medical facilities.

d. **Chief of Staff.** The Chief of Staff is additionally responsible for:

(1) Ensuring VHA's message is clear, concise, and consistent with VA's current position and strategic direction.

(2) Collaborating with partners throughout VA, including but not limited to, the Secretary of VA, Office of Management (OM), Office of Public Affairs and Intergovernmental Affairs (OPIA), Office of General Counsel (OGC), and Office of the Inspector General (OIG).

e. **Chief Operating Officer.** The Chief Operating Officer is additionally responsible for:

(1) Managing and coordinating the collective efforts of a multi-disciplined, geographically dispersed staff in the organization, planning, direction, integration, and execution of all aspects of VHA health care management and clinical operations.

(2) Formulating and providing strategies, policy, and guidance governing development and execution for operational, clinical, and support functions critical to VHA's operational capabilities.

f. **VHA Principal Office.** VHA Principal Offices are responsible for:

(1) **Governance.** Setting strategy for national programs and operations. Examples include but are not limited to:

(a) Serving as voting members on boards and councils established by the Under Secretary for Health.

(b) Approving changes to organizational structure.

(c) Launching major initiatives within delegated authority and consistent with resource prioritization and programming process.

(d) Ensuring oversight and distribution of Specific Purpose funding for core office operations and field support.

(e) Delegating appropriate authority to Program Offices.

(f) Ensuring management of information technology (IT) requirements and priorities.

(2) **Expertise.** Although Principal Office leaders need not be subject matter experts in their subordinate programs, they must have expertise in leadership and organizational stewardship to meet the following responsibilities:

(a) Providing recommendations to the Under Secretary for Health.

(b) Serving as a public-facing representative of VHA or VHA Program Offices at the national level.

(c) Using situational awareness and technical knowledge to resolve conflicts between Program Offices that reflects an understanding of their own Level of Authority (LOA), other components of VHA, VA and other affected entities.

(3) **Leadership.**

(a) Issuing national policies and providing guidance and oversight necessary to ensure the timely and successful implementation of strategy and other policy to meet VHA organizational needs.

(b) Establishing Integrated Project Teams.

(c) Developing integrated and coordinated Principal Office-level strategic or operating plans in alignment with agency-level plans.

(d) Supervising and developing Program Office leaders to support succession planning and retention.

(e) At minimum every 5 years, assessing policy for continued need, feasibility, and effectiveness.

(4) **Oversight.** Ensuring oversight of national programs and operations for operating units within their span of control. Examples include but are not limited to:

(a) Ensuring execution of responsibilities by operating units within their span of control and taking appropriate corrective action when noncompliance is identified.

(b) Ensuring operating units within their span of control operate within resource programming processes.

(c) Ensuring national goals are implementable by those responsible for execution in the field and elsewhere.

(d) Sunsetting programs or initiatives (or recommending same to the VHACO Governance Board or Under Secretary for Health, as appropriate) that are no longer needed or that do not meet organizational goals. For more information about VHACO Governance Board, see VHA Directive 1217.01(2), VHA Central Office Governance Board, dated September 10, 2021.

(e) Ongoing review of subordinate operating unit leaders within their span of control and making necessary changes to programs to ensure continued alignment with organizational goals, appropriate resourcing, responsiveness to field-based operating units, etc.

(f) Appropriate reporting of significant enterprise risks and issues.

g. **VHA Program Office.** VHA Program Offices are responsible for the following related to their national program and any Sub Offices organized within the Program Office:

(1) **Governance.** Systemic oversight and resource allocation. Examples include but are not limited to:

(a) Allocating resources (e.g., personnel, materials, equipment) within their span of control, and oversight of the Specific Purpose funds provided to VISNs and VA medical facilities.

(b) Developing training and setting standards for education. ***NOTE:*** *All mandatory or required training must be developed in accordance with VHA Directive 1052, Appropriate and Effective Use of VHA Employee Mandatory and Required Training, dated June 29, 2018*.

(c) Managing IT requirements and priorities.

(d) Managing professional standards within their span of control.

(2) **Expertise.** Serving as subject matter and technical experts for their national program(s). Examples include but are not limited to:

(a) Identifying emerging national issues.

(b) Adopting evidence-based strategies based on population needs.

(c) Ensuring development, publication, implementation, and operationalization of legislative requirements through regulations, national policies, guidance, and best practices.

(d) Establishing and managing Sub Offices as necessary.

(3) **Leadership.** Communicating with internal and external stakeholders. This communication is on a national level with the purpose of facilitating:

(a) Responsiveness to local needs, addressing issues identified by local offices.

(b) Communication with Veterans.

(c) Communication with Veterans Service Organizations.

(d) Communication with professional or advocacy organizations and auditing bodies.

(e) Communication with other VHA and VA entities.

(f) Communication with Congress.

(4) **Oversight.** Managing quality, compliance, and risk. Examples include but are not limited to:

(a) Ensuring performance within their span of control.

(b) Promoting a culture of integrity within a high reliability organization.

(c) Setting quality measures, performance measures and key indicators for performance and risk.

(d) Evaluating the effectiveness of outcomes and efficiency of outputs, including assessing the accuracy of data used for such evaluation. For example, where data is used to evaluate a program and is gathered and provided by a field-based operating unit, Program Offices must note any potential weakness in the data or the systems used to obtain the data.

(e) In coordination with VISNs, overseeing consistent implementation of VHA national policies, guidance, and best practices and systematically identifying risks and unintended variances, including to ensure uniformly high-quality care at all points of care. ***NOTE:*** *VHA Program Offices must review waiver requests from VISNs and VA medical facilities for any instances of non-compliance with policy. See VHA Directive 1023, Waivers to VHA National Policy, dated March 5, 2024.*

(f) Appropriately reporting significant enterprise risks and issues to the VHA Principal Office.

(g) Documenting all identified deficiencies and ensuring corrective actions are taken.

h. **Veterans Integrated Service Network Directors.** VISN Directors are responsible for the following related to the VA medical facilities within their VISN:

(1) **Governance.** Developing VISN-specific priorities governing all VA medical facilities within their jurisdiction in order to achieve VISN goals (i.e., goals not covered by VA and VHA strategic plans), including construction, expansion of services or purchase of equipment.

(2) **Management.** VISN management and resource allocation. Examples include but are not limited to:

(a) Allocating resources (e.g., personnel, materials, equipment, general purpose funding) within their span of control, and managing the Specific Purpose funds provided to VA medical facilities.

(b) Ensuring training is implemented in accordance with VHA standards for education. ***NOTE:*** *All mandatory or required training must be developed in accordance with VHA Directive 1052.*

(c) Managing professional standards within their span of control.

(3) **Expertise.** Serving as subject-matter and technical experts for their VISN program and VA medical facilities within the VISN. Examples include but are not limited to:

(a) Identifying emerging issues.

(b) Adopting evidence-based strategies based on population and market needs.

(c) Developing and ensuring implementation of VISN-level policy and VISN standard operating procedures as appropriate. ***NOTE:*** *Local policy (that is, VISN policy and Medical Center Policy (MCP)) may be established only by exception. For more information, see VHA Directive 0999(1), VHA Policy Management, dated March 29, 2022, and VHA Local Policy Support: https://dvagov.sharepoint.com/sites/VHARAP/SitePages/VHA-Local-Policy-Support.aspx. This is an internal VA website that is not available to the public.*

(4) **Leadership.** Communicating with internal and external stakeholders. This communication is on a national, regional, and local level as needed with the purpose of facilitating:

(a) Responsiveness to regional needs and, upon request, helping to address issues identified by VA medical facilities within their respective VISNs.

(b) Communication with Veterans.

(c) Communication with Veterans Service Organizations.

(d) Communication with professional or advocacy organizations and auditing and accrediting bodies.

(e) Communication with State and Local government entities.

(f) Communication with other VHA and VA entities.

(g) Communication with Congressional offices.

(5) **Oversight.** Managing quality, compliance, and risk. Examples include but are not limited to:

(a) Promoting integrity and a just culture within a high reliability organization.

(b) Implementing quality measures, performance measures, and key indicators for performance and risk as set forth by VHA, and evaluating performance within their span of control.

(c) Evaluating the effectiveness of outcomes and efficiency of outputs, including assessing the accuracy of data used for such evaluation, at the VISN and respective VA medical facilities within the VISN.

(d) In coordination with Program Offices, overseeing consistent implementation and operationalization of VHA national policies, guidance, and best practices and systematically identifying risks and unintended variances at VA medical facilities within the VISN. ***NOTE:*** *VISNs must submit a waiver request for any identified instances of non-compliance with policy. For further information, see VHA Directive 1023.*

(e) Appropriately documenting and reporting significant enterprise risks, issues, and deficiencies to the appropriate VHA Principal Offices and Program Offices.

(f) When appropriate, establishing necessary Corrective Action Plans in concert with VA medical facility and Program Office representatives and ensuring immediate corrective actions are taken to address identified risks and issues.

i. **VA Medical Facility Directors.** VA medical facility Directors are responsible for:

(1) **Management.** VA medical facility management and resource allocation. Examples include but are not limited to:

(a) Managing resources (e.g., personnel, materials, equipment, funding) within their span of control.

(b) Implementing training in accordance with VHA standards for education. ***NOTE:*** *All mandatory or required training must be developed in accordance with VHA Directive 1052.*

(c) Managing professional standards within their span of control.

(2) **Expertise.** Serving as subject-matter and technical experts for all points of service within the VA medical facility. Examples include but are not limited to:

(a) Identifying and elevating emerging issues.

(b) Adopting evidence-based strategies based on population needs.

(c) Developing and ensuring implementation of VA medical facility policy and standard operating procedures as appropriate. ***NOTE:*** *Local policy (that is, VISN policy and MCP) may be established only by exception. For more information, see VHA Directive 0999(1) and VHA Local Policy Support: https://dvagov.sharepoint.com/sites/VHARAP/SitePages/VHA-Local-Policy-Support.aspx. This is an internal VA website that is not available to the public.*

(3) **Leadership.** Communicating with internal and external stakeholders. This communication is on a local level with the purpose of facilitating:

(a) Responsiveness to local needs, addressing issues identified in each VA medical facility.

(b) Communication with Veterans.

(c) Communication with Veterans Service Organizations, as it pertains to each VA medical facility.

(d) Communication with professional or advocacy organizations, accrediting bodies, and auditing bodies, as it pertains to each VA medical facility.

(e) Communicating with State and Local government entities.

(f) Communication with other VHA and VA entities.

(4) **Oversight.** Managing quality, compliance, and risk. Examples include but are not limited to:

(a) Promoting integrity and a just culture within a high reliability organization.

(b) Implementing quality measures, performance measures, patient safety requirements, and key indicators for performance and risk as set forth by VHA, and evaluating performance within their span of control.

(c) Evaluating the effectiveness of outcomes and efficiency of outputs, including assessing the accuracy of data used for such evaluation, at the VA medical facility.

(d) Overseeing consistent implementation and operationalization of VHA national and VISN policies, guidance, and best practices, systematically identifying risks and unintended variances within the VA medical facility, and submitting a waiver request for any identified instances of non-compliance with policy. ***NOTE:*** *For further information on waivers, see VHA Directive 1023.*

(e) Appropriately reporting significant risks and issues.

(f) When appropriate, establishing necessary Corrective Action Plans in concert with VISN and Program Office representatives, and ensuring that corrective actions are taken to address risks and issues identified in the Plans.

3. DETERMINING PROGRAM OFFICE LEVEL OF AUTHORITY

a. A Program Office's LOA is based on span of control, complexity, and responsibilities – not reporting hierarchy (e.g., positions required by statute to report to the Under Secretary for Health are not automatically designated as LOA 3). Similarly, effort must be taken to categorize positions within LOA based on their span of control and not simply upon the assigned LOA. ***NOTE:*** *For more information, see Appendix B, Differences Between VHA Central Office Levels of Authority 4 and 5.*

b. A specific Program Office's LOA is recommended by Principal Office leadership and approved by the Under Secretary for Health.

4. TRAINING

There are no training requirements associated with this directive.

5. RECORDS MANAGEMENT

All records regardless of format (for example, paper, electronic, electronic systems) created by this directive must be managed as required by the National Archives and

Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management can be addressed to the appropriate Records Officer.

6. BACKGROUND

a. Section 201 of the Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146) required an independent assessment of the hospital care, medical services and other health care furnished in VA medical facilities. The Act specifically directed that assessments be conducted in 12 areas, covering a broad spectrum of VHA including leadership, operations and services. The leadership assessment found that leaders are not fully empowered due to a lack of clear authority, priorities, and roles. In response to this finding, the assessment made several recommendations including a redesign of VHA's operating model to create clarity for decision-making authority, prioritization, and long-term support. Specifically, the assessment recommended that VHA should immediately lead an effort to clearly define roles and decision rights at each level (i.e., VA medical facility, VISN and VHACO) and increase coordination throughout VHA, refocusing the role of VHACO to managing outcomes and providing "corporate center"-like support to the field.

b. The Government Accountability Office (GAO) High-Risk Report of 2015, Managing Risks and Improving VA Health Care, cited VHA's inadequate oversight and accountability in the High-Risk area. A formally accepted, clear articulation of VHA operating units helps clarify their decisional, oversight and accountability responsibilities.

c. Office of Management and Budget (OMB) Memorandum M-17-22, Comprehensive Plan for Reforming the Federal Government and Reducing the Federal Civilian Workforce, directs Federal agencies to optimize spans of control and delegations of authority to accomplish the work with the fewest amount of management layers needed to provide for appropriate risk management, oversight, and accountability. In addition, the memorandum directs agencies to assess options that improve organizational decision making.

d. OMB Circular A-123, Management's Responsibility for Enterprise Risk Management and Internal Control, advises that effective enterprise risk management (ERM) should include an understanding of the combined impact of risks as an interrelated portfolio, rather than addressing risks only within silos. ERM should provide an enterprise-wide, strategically-aligned portfolio view of organizational challenges to provide better insight about how to most effectively prioritize resource allocations to ensure successful mission delivery.

e. VA Directive 5010, Manpower Management Policy, dated October 28, 2019, requires that organizational structure have a standardized hierarchy that identifies levels of authority and maintains an effective span of control. LOAs designate decisional authority and accountability for VHA operating units by defining their span of control and

areas of responsibility. In addition, LOAs clarify the different governance versus management roles within VHA.

f. Research has demonstrated that successful organizations quickly and reliably make high-quality decisions. Assigning decision authority to operating units assists employees in identifying the scope of decisions and the level of the organization those decisions should be made. Routine decisions may have a significant impact over time. Identifying decision authority is necessary to create prompt and effective program management, ensure an appropriate level of oversight and control, eliminate, or shorten procedural steps and improve services to Veterans.

g. By defining and explicitly setting forth decision authorities within VHA's operating units, this directive enables the articulation of a clear, sustainable, and repeatable governance process that, in turn, empowers action at all LOAs, is less leadership dependent and supports robust oversight and management of VHA activities.

7. DEFINITIONS

a. **Decision Rights.** Decision rights are a declaration of the authority of an individual or group to choose a path to an outcome, align activities to strategy, bind others (including outside of their chain of command) to a course of action, or otherwise resolve an issue. An individual's decision rights supplement their responsibilities by clarifying the specific choices that they are responsible for making, actions they can take to bind others, etc.

b. **Governance.** Governance is defined in VA Directive 0214, Department of Veterans Affairs Enterprise Governance Structure and Process, dated May 14, 2019, as the process by which VA Senior Leadership makes decisions, provides strategic direction, and maintains accountability in a transparent and collaborative manner. It enables informed decision-making based on current strategic objectives, VA's risk appetite, and responsible resources allocation.

c. **Levels of Authority.** LOAs are the framework used to organize VHA's operating units. LOAs establish spans of control, decisional authority, and systems of accountability for all operating units in VHA. Specific descriptions of LOAs for operating units are provided in the LOA Matrix (see Appendix A). VHA's LOAs align with VA organizational requirements.

d. **National Programs.** National Programs are systems of policies, strategies and tools that are designed to produce specific, measurable, enterprise-wide outcomes. Although National Programs may, as part of their strategy, seek to produce outcomes at the local level, such local outcomes are part of a national strategy. VHA National Programs are managed by Program Offices that report to a larger Program Office or LOA 3 office.

e. **Operating Unit.** Operating units are organizational structures (i.e., offices) with clearly defined spans of control. In VHA, the operating units are Principal Offices,

Program Offices, Sub Offices, VISNs, VA medical facilities, and service lines/departments.

f. **Principal Offices.** VHA Principal Offices are organized at LOA 3. Principal Offices oversee, resource, and manage multiple Program Offices. Principal Offices have broad spans of control and ensure that program outcomes are organized and aligned within a comprehensive strategy. Principal Offices are led by a single, accountable Senior Executive who is responsible for signing all subordinate Program Office policies and overseeing, facilitating, and aligning the work of subordinate Program Offices, as well as assisting other Principal Office leaders where programs overlap. Principal Office leaders report to the Under Secretary for Health, Deputy Under Secretary for Health, or Chief Operating Officer, and are typically Associate Deputy Under Secretaries for Health or Assistant Under Secretaries for Health. Note, however, that not all offices that report to the Under Secretary for Health, Deputy Under Secretary for Health, or Chief Operating Officer are Principal Offices. A Principal Office is resourced appropriate to the complexity of its programs. Specific Principal Office responsibilities are set forth in paragraph 2.

g. **Program Offices.** Program Offices are operating units organized at LOA 4 and 5. They are the main operating units at VHACO, responsible for overseeing and developing policies and strategies and providing tools to the field in support of national goals. The specific responsibilities of Program Offices are set forth in paragraph 2. The differences between LOA 4 and LOA 5 Program Offices are described in Appendix B. Program Offices works with VISN Directors to oversee the performance of VA medical facilities within each VISN.

h. **Span of Control.** Span of control refers to a position or operating unit's specific roles, responsibilities, and decision authority. Unless clearly established by statute, spans of control are delegated to VHA leaders by the Under Secretary for Health in accordance with 38 U.S.C.§ 7301. A supervisory position's span of control (i.e., program scope and effect) and decision authority (i.e., managerial authority exercised) are described in the position description. An operating unit's span of control (i.e., mission, function, tasks) and authorities are described in the VA Functional Organizational Manual (FOM).

i. **Sub Offices.** Sub Offices are subordinate offices within a Program Office. Sub Offices have specific expertise and are not independently responsible for the development and implementation of policy. Sub Offices must coordinate with their parent program office to direct funds and personnel. ***NOTE:*** *Sub Offices may also be referred to as business lines.*

j. **VA Medical Facilities.** VA medical facilities are organized at LOA 5. VA medical facilities provide health care services to Veterans through a variety of settings, including inpatient and outpatient facilities, community clinics and community care. Each VA medical facility is led by a VA medical facility Director who reports to the VISN Director.

k. **Veterans Integrated Service Networks.** VISNs are organized at LOA 3 (as Governance Board members) and LOA 4 (as VISN Directors). VHA is divided into 18 VISNs, which are regional networks comprised of various types of VA medical facilities that work together to serve Veterans in the region and provide greater access to care. Each VISN is led by a VISN Director who provides operational oversight of VA medical facilities within the VISN. VISNs are the regional operating unit of VHA and are responsible for in-person and virtual coordination of Veteran care through various service delivery locations, including care that is purchased in the community. These include, but are not limited to, acute and chronic care inpatient facilities of various size and complexity, to ambulatory care facilities and telehealth hubs of various size and complexity in urban and rural communities. VISNs also provide direct care to Veterans through various means, including Clinical Resource Hubs and Clinical Contact Centers, and assist employees through consolidated services such as Human Resources. Through these means, VISNs have the authority to enable and execute patient care. The sites of care mirror the needs of the Veterans residing within the VISN. ***NOTE:*** *For additional information about which VA medical facilities belong to each VISN, see https://www.va.gov/directory/guide/map.asp.*

8. REFERENCES

a. P.L. 113-146.

b. 38 U.S.C. § 7301(b).

c. VA Directive 0000, Delegations of Authority, dated November 14, 2018.

d. VA Directive 0214, Department of Veterans Affairs Enterprise Governance Structure and Process, dated May 14, 2019.

e. VA Directive 5010, Manpower Management Policy, dated October 28, 2019.

f. VHA Directive 0000, Delegations of Authority, dated October 11, 2023.

g. VHA Directive 0999(1), VHA Policy Management, dated March 29, 2022.

h. VHA Directive 1023, Waivers to VHA National Policy, dated March 5, 2024.

i. VHA Directive 1052, Appropriate and Effective Use of VHA Employee Mandatory and Required Training, dated June 29, 2018.

j. VHA Directive 1217.01(2), VHA Central Office Governance Board, dated September 10, 2021.

k. Interactive VISN Map: https://www.va.gov/directory/guide/map.asp.

l. VA Functional Organization Manual: https://department.va.gov/wp-content/uploads/2024/06/va-functional-organizational-manual-volume-1.pdf.

m. VHA Local Policy Support: https://dvagov.sharepoint.com/sites/VHARAP/SitePages/VHA-Local-Policy-Support.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

n. VHA Pre-Decisional Deliberative Documents: http://vhagovboard.vssc.med.va.gov/Pages/default.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

o. U.S. Government Accountability Office. Report to Congressional Committees. High-Risk Series: An Update. GAO-15-290. Managing Risks and Improving Veterans Affairs (VA) Health Care. February 2015: https://www.gao.gov/assets/gao-15-290.pdf.

p. U.S. Office of Management and Budget (OMB) Circular No. A-123, Management's Responsibility for Enterprise Risk Management and Internal Control, dated July 15, 2016: https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/memoranda/2016/m-16-17.pdf.

q. U.S. OMB Memorandum M-17-22, Comprehensive Plan for Reforming the Federal Government and Reducing the Federal Civilian Workforce, dated April 12, 2017: https://www.whitehouse.gov/wp-content/uploads/legacy_drupal_files/omb/memoranda/2017/M-17-22.pdf.

r. U.S. Office of Personnel Management (OPM). General Schedule Supervisory Guide. HRCD-5 (1998): https://www.opm.gov/policy-data-oversight/classification-qualifications/classifying-general-schedule-positions/functional-guides/gssg.pdf.

LEVEL OF AUTHORITY MATRIX

1. "Span of control" uses applicable terms from the Office of Personnel Management's General Schedule Supervisory Guide HRCD-5, which does not define operating units below Major Organization. The Veterans Health Administration (VHA) Central Office (VHACO) has used "Program Office" historically to describe any office responsible for a program with a national scope. VHACO continues that use here noting that the scope and effect will determine a Program Office Level of Authority (LOA).

2. ACRONYM KEY

a. **USH.** Under Secretary for Health.

b. **DUSH.** Deputy Under Secretary for Health.

c. **COO.** Chief Operating Officer.

d. **ADUSH.** Associate Deputy Under Secretary for Health.

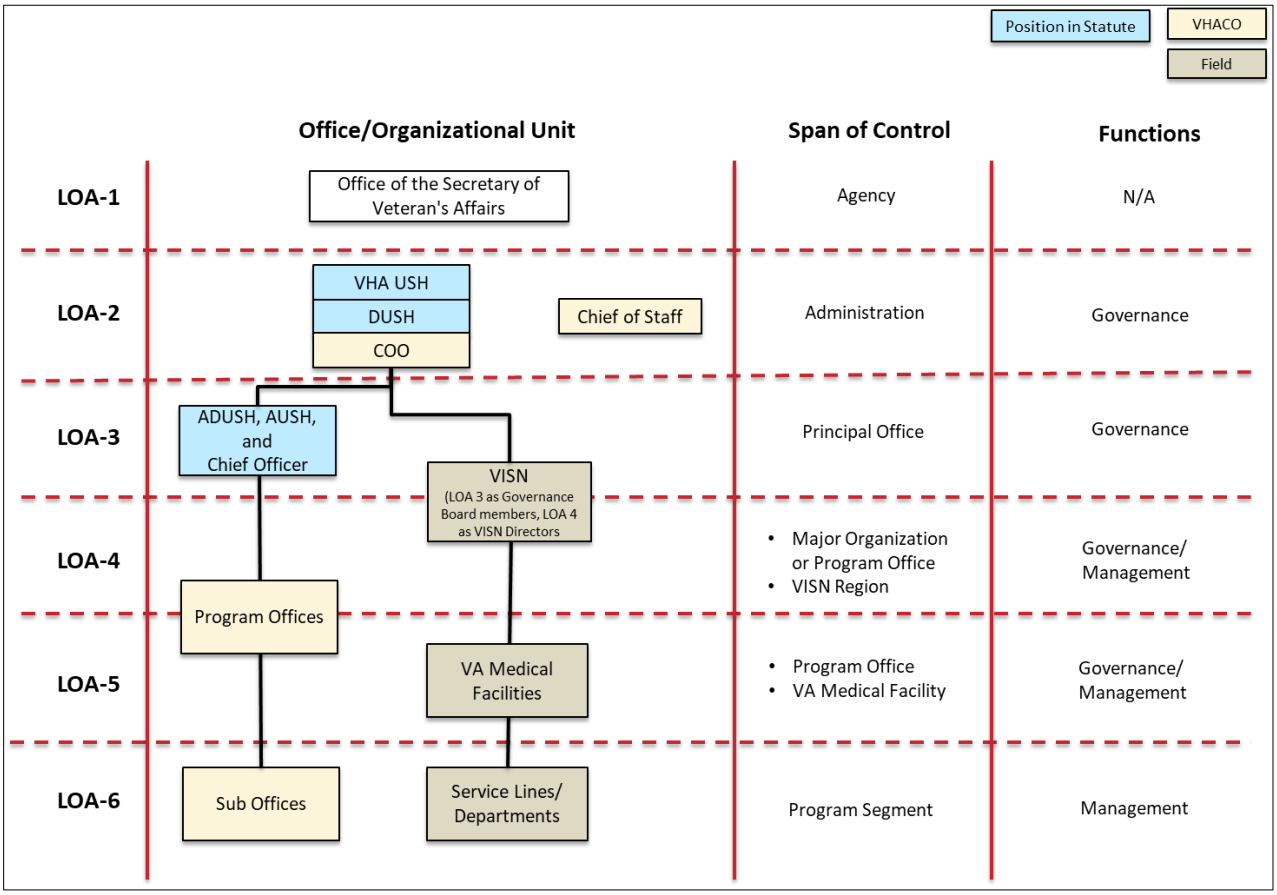
e. **AUSH.** Assistant Under Secretary for Health.

f. **VISN.** Veterans Integrated Service Network.

g. **VA.** Department of Veterans Affairs.

3. LEVELS OF AUTHORITY

NOTE: *This is for informational purposes only. A Program Office's LOA is based on span of control, complexity, and responsibilities – not reporting hierarchy (e.g., positions required by statute to report to the Under Secretary for Health are not automatically designated as LOA 3). See the graphic below and paragraph 3 of the directive for more information.*


Position in Statute
VHACO
Field
Office/Organizational Unit
Span of Control
Functions
LOA-1
Office of the Secretary of Veteran's Affairs
Agency
N/A
LOA-2
VHA USH
DUSH
COO
Chief of Staff
Administration
Governance
LOA-3
ADUSH, AUSH, and Chief Officer
VISN
(LOA 3 as Governance Board members, LOA 4 as VISN Directors
Principal Office
Governance
LOA-4
Program Offices
• Major Organization or Program Office
• VISN Region
Governance/ Management
LOA-5
VA Medical Facilities
• Program Office
• VA Medical Facility
Governance/ Management
LOA-6
Sub Offices
Service Lines/ Departments
Program Segment
Management

DIFFERENCES BETWEEN VHA CENTRAL OFFICE LEVELS OF AUTHORITY 4 AND 5

1. Level of Authority (LOA) 4 programs have significant resources, broad patient impact, and are associated with a higher level of risk. LOA 4 Program Offices are often responsible for one or more subordinate LOA 5 Program Offices. LOA 4 Program Office accountable leaders must report directly to the Veterans Health Administration Principal Office leader (Assistant Under Secretary for Health or Chief). A LOA 4 Program Office cannot be organized under another Program Office.

2. LOA 5 programs are more focused, with targeted impact and less risk; however, they are still responsible for the Program Office duties described in this directive (i.e., they are not Sub Offices). Leadership positions may be Senior Executive Service (SES) or General Schedule. LOA 5 programs generally report through an LOA 4 SES.

3. LOA is one factor considered in categorizing and determining resources for a Program Office but is neither definitive nor the single most important factor. Program Offices that are responsible for highly complex national programs may need to have leadership and individuals that are experienced medical professionals or individuals with specific educational qualifications. Such positions within operating units must be categorized and include individuals with careful attention to the operating unit's span of control, impact on the health and welfare of Veterans and programmatic or systemic impact and complexity.

4. FACTORS TO CONSIDER WHEN DETERMINING WHETHER A VHA CENTRAL OFFICE PROGRAM OFFICE IS LEVEL OF AUTHORITY 4 OR LEVEL OF AUTHORITY 5

a. Span of control (national).

b. Organizational impact (i.e., how many Operating Units or employees must follow the directive, and the span of control of those impacted offices or employees).

c. Veteran impact (i.e., total number of Veterans the program affects and how they are affected).

d. Level of administrative function (e.g., total number of Sub Offices, employees, contracting and budget functions, and role in communication or concurrence processes).

e. Amount of external stakeholder involvement.

f. Range of products and services for which the program is responsible.

g. Issues of high sensitivity and high political visibility.

h. Total number of medical research projects and whether any include external organizations.

i. The program’s annual budget for:

(1) Staffing.

(2) Information technology.

(3) Contracted services.

(4) Benefits or services to Veterans.

(5) Benefits or services to employees.