AMENDED
January 19, 2025

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 1217(1)
Transmittal Sheet
August 14, 2024

VHA OPERATING UNITS

1. SUMMARY OF MAJOR CHANGES:

a. **Amendment dated January 19, 2025:**

(1) Adds a collective responsibility for the Deputy Under Secretary for Health, Chief of Staff, and Chief Operating Officer to provide oversight and make resource allocation decisions related to Principal Office fiscal reviews, contract portfolio reviews, Unfunded Requests (UFRs), staffing requests, and other resource requests for the Veterans Health Administration (VHA) Central Office (VHACO) budgets and spend plans, via the VHACO Executive Resource Board (ERB) (paragraph 2.b.).

(2) Adds Level of Authority (LOA) assignments for VHACO operating units in Appendix A.

(3) Adds the VHACO ERB charter as Appendix C.

b. **As published August 14, 2024,** major changes included:

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

(2) Added definitions (paragraph 7) and defined 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 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 RESCISSIONS: VHA Directive 1217, VHA Central Office Operating Units, dated September 10, 2021, is rescinded.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 This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.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.

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

VHA OPERATING UNITS

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.

(4) Providing oversight and making resource allocation decisions related to Principal Office fiscal reviews, contract portfolio reviews, Unfunded Requests (UFRs), staffing requests, and other resource requests for VHACO budgets and spend plans, via the VHACO Executive Resource Board (ERB) (see Appendix C, VHACO ERB Charter). This includes authority to require allocation of new or additional resources on behalf of the Under Secretary for Health.

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. ***NOTE:*** *For a list of approved LOA assignments for VHACO operating units, see Appendix A.*

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.

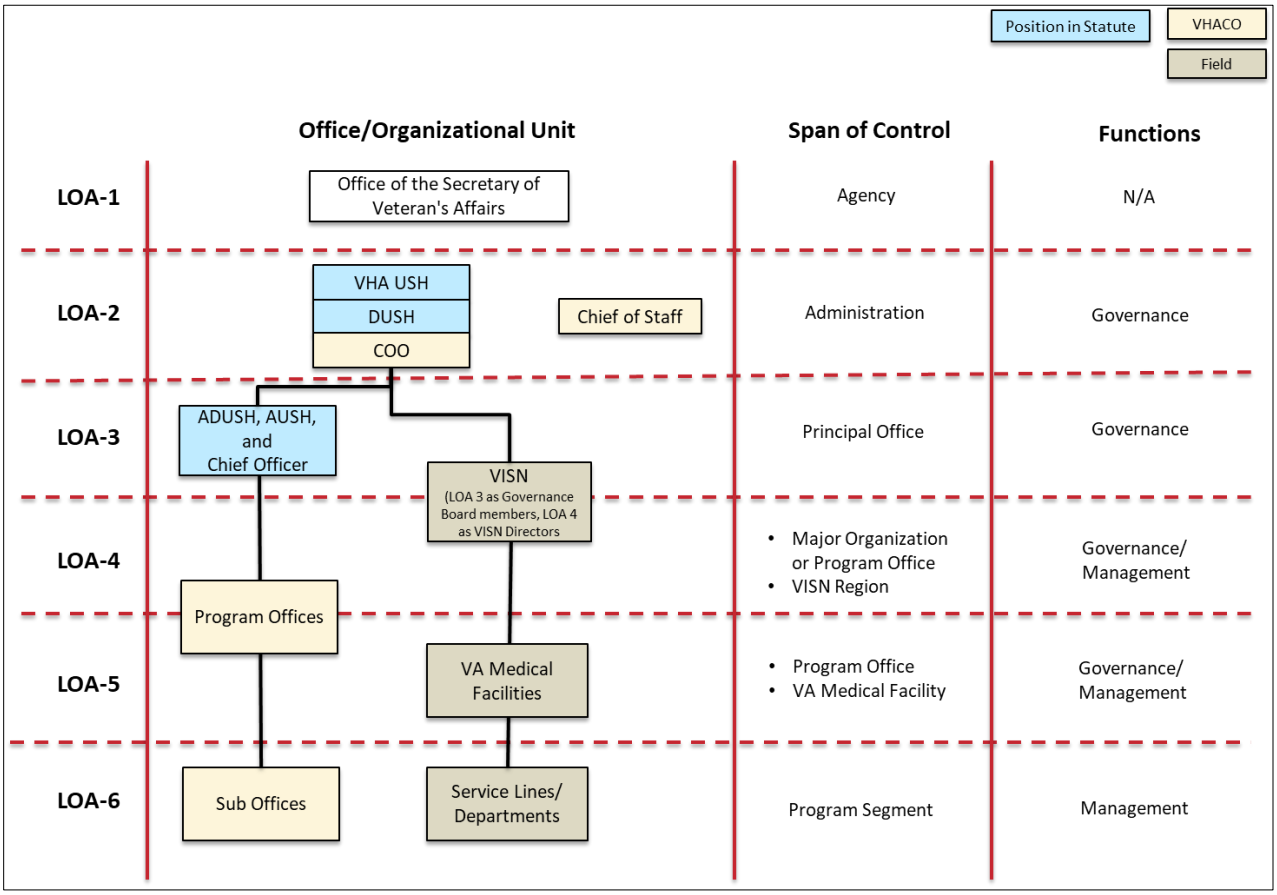
e. **AUSH.** Assistant Under Secretary for Health.

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.*



4. LEVEL OF AUTHORITY ASSIGNMENTS FOR VHA CENTRAL OFFICE OPERATING UNITS

The following table provides a list of VHACO Principal and Program Offices and their approved LOAs. LOAs may change as program scope, responsibilities, and authorities evolve. Assignment of an LOA in no way signifies greater or lesser importance of a particular program and is not used to determine pay grades or classifications of positions. The LOA structure is designed to consider all aspects of VHA operating unit responsibility. ***NOTE*****:** *VHA operating units below LOA 5 are not listed. Any changes to LOA designation must be approved by the Under Secretary for Health.*

Mail Code	Operating Unit Name	LOA
10	**Under Secretary for Health**	**LOA 2**
10A	**Deputy Under Secretary for Health**	**LOA 2**
10ADEI2	Assault and Harassment Prevention Office	LOA 5
10B	**Chief of Staff**	**LOA 2**
10BCOM	Communications	LOA 4
10BCOM2	Media Relations	LOA 5
10BCOM3	Digital Media	LOA 5
10BCOM4	Internal Communications	LOA 5
10BCOM5	Broadcast and Video	LOA 5

Mail Code	Operating Unit Name	LOA
10BEXC	Executive Correspondence	LOA 5
10BVA-DoD	VA/Department of Defense (DoD) Health Affairs	LOA 4
10B-GRAP	Office of Governance, Regulations, Appeals, and Policy	LOA 4
10BSIM	Strategic Investment Management	LOA 4
10BSIM BA	Business Architecture	LOA 5
10BSIM IGS	Investment Governance Service	LOA 5
10BSIM RDM	Requirements Development & Management	LOA 5
10PADV	**Patient Advocacy**	**LOA 4**
10OIC	**Office of Integrity and Compliance**	**LOA 3**
10MI	Medical Inspector	LOA 4
10IA	Internal Audit	LOA 5
10GOAL	Government Accountability Office (GAO)/Office of Inspector General (OIG) Accountability Liaison (GOAL)	LOA 5
10ERM	Enterprise Risk Management	LOA 5
10RCS	**Readjustment Counseling**	**LOA 3**
10T	**Healthcare Transformation**	**LOA 3**
10W	**Women's Health**	**LOA 3**
10CHAP	**Chaplain Services**	**LOA 5**
10ORO	**Office of Research Oversight**	**LOA 4**
10DH	**Digital Health Office**	**LOA 3**
10DH01	Digital Health Experience & Product Delivery	LOA 4
10DH02	Artificial Intelligence (AI) & Emerging Technology	LOA 4
10DH03	Health Informatics	LOA 4
CIDM	Clinical Informatics and Data Management	LOA 4
CIDM HFE	Human Factors Engineering	LOA 5
CIDM VHIE	Veteran Health Informatics Exchange	LOA 5
CIDM IHI	Interagency Health Informatics	LOA 5
CIDM E&O	Engagement & Operations	LOA 5
CIDM FIS	Field Informatics Stewardship	LOA 5
CIDM HSM	Health Solutions Management	LOA 5
CIDM DMA	Data Management & Analytics	LOA 5
CIDM KBS	Knowledge Based Systems	LOA 5
CIDM IPS	Information Patient Safety	LOA 5
ONI	Office of Nursing Informatics	LOA 4
CNI NI Mgr	Nursing Informatics Managers	LOA 5
CNI NI Spt	Nursing Informatics Support	LOA 5
HIG	Health Information Governance	LOA 4
HIG HIM	Health Informatics Management	LOA 5
HIG IAP	Information Access & Privacy	LOA 5
HIG NDS	National Data Systems	LOA 5
HIG HCS	Health Care Security	LOA 5
HIG DQP	Data Quality Program	LOA 5

Mail Code	Operating Unit Name	LOA
HIG VALN	VA Library Network	LOA 5
10DH04	Connected Care	LOA 4
	Chief Operating Officer	**LOA 2**
HOC	Healthcare Operations Center	LOA 5
CDCE	VA Center for Development & Civic Engagement	LOA 4
EM	Emergency Management	LOA 4
MEM	Member Services	LOA 4
HEF	Healthcare Environment and Facilities Program	LOA 4
HEFB	Occupational Safety and Health	LOA 5
HEFC	Environment Programs Service	LOA 5
HEFD	Enterprise Support Service	LOA 5
HEFE	Healthcare Engineering	LOA 5
HEFF	Capital Asset Management	LOA 5
HEFG	Special Engineering Projects	LOA 5
HTM	Healthcare Technology Management	LOA 4
PLO	Procurement and Logistics	LOA 4
PLO Log	Logistics	LOA 5
19PLO Pro	Procurement	LOA 5
VALOR	VA Logistics Office of Redesign (VALOR)	LOA 4
VCS	Veterans Canteen Service	LOA 4
11	**Clinical Services**	**LOA 3**
11DEN	Dentistry	LOA 4
11DEN	Dental Laboratory Operations	LOA 5
11DEN	Homeless Veteran Dental Program	LOA 5
11DIAG	Diagnostics	LOA 4
11DIAG1	Imaging	LOA 5
11DIAG2	Pathology and Laboratory Medicine Service	LOA 5
11DIAG3	Nuclear Medicine	LOA 5
11DIAG4	Teleradiology	LOA 5
11HPO	Homeless	LOA 4
11HPO	Housing and Urban Development VA-Supportive Housing	LOA 5
11HPO	Supportive Services for Veteran Families Program	LOA 5
11HPO	Health Care for Homeless Veterans Program	LOA 5
11HPO	Grant and Per Diem	LOA 5
11HPO	Veterans Justice Programs	LOA 5
11HPO	Homeless Patient Aligned Care Team	LOA 5
11MH	Mental Health	LOA 4
11SP	Suicide Prevention	LOA 4
11PC	Primary Care	LOA 4
11PC1	Disability and Medical Assessment	LOA 5
11SCID	Spinal Cord Injuries and Disorders	LOA 4
11SPEC	Specialty Care	LOA 4

Mail Code	Operating Unit Name	LOA
11SPEC1	Allergy and Immunology	LOA 5
11SPEC2	Anesthesiology	LOA 5
11SPEC3	Cardiology	LOA 5
11SPEC4	Critical Care and Pulmonary	LOA 5
11SPEC5	Dermatology	LOA 5
11SPEC6	Diabetes and Endocrinology	LOA 5
11SPEC7	Emergency Medicine	LOA 5
11SPEC8	Gastroenterology and Hepatology	LOA 5
11SPEC9	Genomic Medicine Service	LOA 5
11SPEC10	HIV, Hepatitis, and Related Conditions (HHRC)	LOA 5
11SPEC11	Hospital Medicine	LOA 5
11SPEC12	National Health Physics Program (NHPP)	LOA 5
11SPEC13	National Infectious Diseases Service (NIDS)	LOA 5
11SPEC14	Nephrology	LOA 5
11SPEC15	Neurology	LOA 5
11SPEC16	Nutrition and Food Services	LOA 5
11SPEC17	Oncology	LOA 4
11SPEC18	Ophthalmology	LOA 5
11SPEC19	Optometry	LOA 5
11SPEC20	Pain Management, Opioid Safety and Prescription Drug Monitoring Program	LOA 4
11SPEC21	Podiatry	LOA 5
11SPEC22	Radiation Oncology	LOA 5
11SPEC23	Rheumatology	LOA 5
11SPEC24	Tele-Critical Care	LOA 5
11SPEC25	Sleep Medicine	LOA 5
11SURG	Surgery	LOA 4
12	**Patient Care Services**	**LOA 3**
12CMSW	Care Management and Social Work Services	LOA 4
12CSP	Caregiver Support Program	LOA 4
12GEC	Geriatrics and Extended Care	LOA 4
12NUR	Nursing	LOA 4
12PAS	Physician Assistant Services	LOA 4
12PBM	Pharmacy Benefits Management Services	LOA 4
12PCCCT	Patient Centered Care and Cultural Transformation	LOA 4
12POP1	Health Equity	LOA 4
12POP2	Health Solutions	LOA 4
12POP3	Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ+) Health Program	LOA 4
12POP4	National Center for Health Promotion and Disease Prevention	LOA 4
12POP5	Health Outcomes Military Exposures (HOME)	LOA 4
12POP6	Public Health Surveillance and Research	LOA 4

Mail Code	Operating Unit Name	LOA
12POP7	Rural Health	LOA 4
12RPS	Rehabilitation and Prosthetic Services	LOA 4
12RPS1	Audiology and Speech	LOA 5
12RPS2	Blind Rehabilitation	LOA 5
12RPS3	Chiropractic	LOA 5
12RPS4	Clinical Orthotic and Prosthetic	LOA 5
12RPS5	National Veteran Sports	LOA 5
12RPS6	Physical Medicine and Rehabilitation	LOA 5
12RPS7	Prosthetic and Sensory Aids	LOA 5
12RPS8	Recreation and Creative Arts Therapy	LOA 5
12OSP	Office of Sterile Processing	LOA 4
12ETH	National Center for Ethics in Health Care	LOA 5
14	**Discovery, Education, and Affiliate Networks (DEAN)**	**LOA 3**
14AA	Academic Affiliations	LOA 4
14RD	Research and Development	LOA 4
14HAP	VHA National Center for Healthcare Advancement & Partnerships	LOA 5
14HIL	Healthcare Innovation and Learning	LOA 5
16	**Integrated Veteran Care**	**LOA 3**
16IA	Integrated Access	LOA 4
16IA1	Integrated Access Optimization	LOA 5
16IA2	Integrated Access Integrated Care Management	LOA 5
16IA3	Integrated Access Alternative Care Modalities	LOA 5
16IEN	Integrated External Networks	LOA 4
16IFO	Integrated Field Operations	LOA 4
16IFO1	Integrated Field Support Teams	LOA 5
16IFO2	Integrated Field Support Technology	LOA 5
16IFO3	Integrated Field Support Technology	LOA 5
16IIA	Integrated Informatics & Analytics	LOA 4
16AC	Compliance	LOA 5
16CMO	Chief Medical Officer	LOA 4
16CNO	Chief Nursing Office	LOA 4
16EO	Executive Officer	LOA 4
16EO1	Business Operations	LOA 4
16EO2	Communications	LOA 4
16EO3	Policy	LOA 4
16EO4	Project Management	LOA 4
17	**Quality and Patient Safety**	**LOA 3**
17API	Office of Analytics and Performance Integration	LOA 4
17API1	Inpatient Evaluation Center	LOA 5
17API2	Performance Measurement	LOA 5
17API3	Center for Strategic and Analytic Reporting	LOA 5

Mail Code	Operating Unit Name	LOA
17API4	Productivity, Efficiency, and Staffing	LOA 5
17API5	VHA Support Service Center	LOA 5
17API6	Clinical Systems Development and Evaluation	LOA 5
17API7	Health Systems Innovation and Planning	LOA 5
17PS	National Center for Patient Safety	LOA 4
17PS1	Product Effectiveness	LOA 5
17PS2	Utilization Management	LOA 5
17QM	Office of Quality Management	LOA 4
17QM1	External Accreditation Services and Programs	LOA 5
17QM2	Systems Redesign and Improvement	LOA 5
17QM5	Evidence-Based Practice	LOA 5
17QM6	Medical Staff Affairs	LOA 5
17QM7	Medical-Legal Risk Management	LOA 5
17HiRES	High Reliability Enterprise Support	LOA 5
104	**Finance**	**LOA 3**
106	**Human Capital Management**	**LOA 3**
106A	Workforce Management and Consulting	LOA 4
106B	Institute for Learning, Education, and Development (ILEAD)	LOA 4
106C	National Center for Organization Development	LOA 5
108	**Strategy**	**LOA 3**
108EF	Enrollment & Forecasting	LOA 4
108SAS	Strategic Analysis Service	LOA 4
108SPS	Strategic Planning Service	LOA 4
108	Policy Analysis	LOA 4
108	Healthcare Analytics & Informatics	LOA 4
108	Operations	LOA 5

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.

VHA CENTRAL OFFICE EXECUTIVE RESOURCE BOARD CHARTER

1. BACKGROUND

a. The Under Secretary for Health directed the Veterans Health Administration (VHA) Central Office (VHACO) Executive Resource Board (ERB) to provide a centralized, standardized, transparent, and efficient process across three key areas:

(1) Principal Office fiscal reviews that increase real-time visibility into financial performance, ensure resources are allocated appropriately across strategic priorities, and enable more proactive planning.

(2) Contract portfolio reviews that provide greater leadership visibility into current use of contracts and identify opportunities for improved efficiencies and more effective management of contracts.

(3) Review and approval of Unfunded Requests (UFR), Full Time Equivalent (FTE) staffing requests, and other resource requests that align with strategic priorities and impact VHACO budgets and spend plans.

b. The Government Accountability Office High-Risk Report of 2023, Efforts Made to Achieve Progress Need to Be Maintained and Expanded to Fully Address All Areas, identified the need to establish linkages between resource alignment and organizational priorities. The VHACO ERB makes decisions on the most appropriate alignment and funding to support VHACO in fulfilling its mission, workforce, and execution of VHACO-level contracts after designations of funds have been approved by VHA Finance. ***NOTE:*** *This is with the exception of Executive Decision Memorandums (EDMs) generated by VHACO when requesting field funding. These EDMs are reviewed by the VHA Governance Board.*

2. PURPOSE

The purpose of the VHACO ERB is to increase visibility into Principal Office financial performance, to enable more proactive planning, and to ensure that VHACO is effectively and efficiently resourced to support organizational priorities. This is accomplished through reviews of staffing requests, financial performance, and contract portfolios. The reviews utilize the expertise and diversity of Assistant Under Secretaries for Health, Chief Officers, and VHA's fiscal and workforce management subject matter experts (SMEs), in coordination with VHA field resources.

3. SCOPE

a. **In Scope.** The VHACO ERB makes resource allocation decisions and provides senior leadership oversight to ensure alignment with VHA organizational structure principles and priorities. This includes:

(1) Principal Office fiscal reviews that provide visibility into financial performance, ensure resources are allocated appropriately across strategic priorities, and enable proactive planning.

(2) Contract portfolio reviews that provide leadership visibility into current use of contracts and identify opportunities for improved efficiencies and more effective management of contracts.

(3) Review of UFRs, staffing requests, and other resource requests that align with strategic priorities and impact VHACO budgets and spend plans.

(4) Identification and assignment of appropriate VHACO-level initiatives to special workgroups with appropriate SMEs for action. ***NOTE:*** *Chairpersons of workgroups may be appointed by the VHACO ERB Chair and approved by VHACO ERB voting members.*

b. **Out of Scope.** The following are out of the scope for the VHACO ERB:

(1) Veterans Integrated Service Network (VISN)-level budget reviews.

(2) Requests for VHA-funded technologies.

(3) VISN and Department of Veterans Affairs (VA) medical facility budget requests (these are addressed through VHA Finance or the VHA Governance Board).

(4) EDM funding and approval. The VHACO ERB and VHA Governance Board will coordinate to ensure appropriate routing and review of EDMs that cross responsibilities.

4. MEMBERSHIP AND RESPONSIBILITIES

a. **Voting Members.** The VHACO ERB has four voting members, with delegated authority from the Under Secretary for Health, and all decisions are based on simple majority voting (the Under Secretary for Health will break any ties).

(1) **Chief of Staff.** The VHACO ERB is chaired by the VHA Chief of Staff. Responsibilities include:

(a) Keeping the VHACO ERB aligned with the purpose, objectives, and responsibilities outlined in this charter.

(b) Approving meeting agendas and meeting minutes.

(c) Establishing and applying criteria for resource allocation.

(d) Overseeing the development, implementation, and evaluation of established outcome measures.

(e) Communicating resource opportunities, outcomes, and challenges to senior leaders across VHA.

(f) Assigning staff to serve as administrative members of the VHACO ERB (see paragraph 4.d. in this appendix).

(g) Assigning appropriate VHACO-level initiatives to special workgroups and appointing workgroup chairpersons (as needed).

(2) **Under Secretary for Health.** The Under Secretary for Health serves as a voting member, provides delegation of authority to the other voting members, and serves as the final decision-maker when a simple majority vote is not attained.

(3) **Deputy Under Secretary for Health.** The Deputy Under Secretary for Health serves as a voting member and is responsible for collaborating with all offices in preparation for review and disposition of action items following VHACO ERB meetings.

(4) **Chief Operating Officer.** The Chief Operating Officer serves as a voting member and is responsible for collaborating with all offices in preparation for review and disposition of action items following VHACO ERB meetings.

b. **Advisory Members.** VHACO ERB advisory members do not vote, but do provide insight and guidance to support the voting members in making well-informed decisions.

(1) Advisory members include:

(a) Associate Deputy Under Secretary for Health for Quality and Patient Safety.

(b) Assistant Under Secretaries for Health.

(c) Chief Officers.

(d) Representative(s) from VHA Finance.

(e) Representative(s) from VHA Workforce Management and Consulting (WMC).

(f) Representative(s) from Office of General Counsel.

(2) Advisory member responsibilities include:

(a) Actively participating in meetings; members must participate in and be present for all meetings or assign a proxy.

(b) Disclosing if a resource request is within a member’s own area of responsibility.

(c) Ensuring that formal recommendations submitted to the VHACO ERB for review and approval address deployment, expected outcomes, and time frames, for implementation.

(d) Following up to ensure completion of assigned action items or projects.

(e) Reviewing materials sent prior to meetings to promote efficiency and identifying any additional data or information necessary to frame the discussion.

(f) Routinely reviewing and responding to e-approval requests outside of designated meeting times within the requested timeframe.

(g) Approving appointment of chairpersons to special workgroups by the VHACO ERB Chair.

c. **Ad Hoc Members.** Ad-hoc members are SMEs invited to participate in the VHACO ERB meetings on a temporary or as-needed basis, utilizing their expertise to contribute to topics under discussion. Ad-hoc members do not vote, but do support voting members in making well-informed decisions. Ad-hoc members include:

(1) SMEs from VHA Finance.

(2) SMEs from WMC.

(3) SMEs from VHA Contracting.

(4) Representatives from other specialized fields as requested by VHACO ERB.

d. **Administrative Support.** The Office of the VHA Chief of Staff provides administrative support to VHACO ERB meetings. The administrative support members are responsible for providing meeting support and coordination, including agenda preparation, distribution of materials, meeting minutes, and follow-up.

5. MEETING CADENCE

a. VHACO ERB meetings generally occur on a monthly basis and include reviews of VHACO financial performance, fiscal reviews and deep dives on selected financial and resource allocation issues, contract portfolio reviews for selected VHACO offices or across the enterprise, and UFR/FTE review sessions.

b. The VHACO ERB conducts Principal Office resource allocation reviews across a subset of Principal Offices and rotates which Principal Office is reviewed according to a monthly rotation cadence.

6. QUORUM

a. Voting members may vote if a quorum of the voting members are present during a meeting for which there was reasonable notice and opportunity for discussion of

agenda items.

b. A quorum is considered 50% of voting members in attendance. Voting members directly impacted by a decision should abstain from voting if there is a conflict of interest.

c. Electronic voting may be utilized when members are unable to be present in-person during the meeting to provide a quorum; however, the VHACO ERB Chair must ensure votes are clearly documented and recorded.

7. DOCUMENTATION

a. The VHACO ERB uses a Microsoft Teams/SharePoint Document Repository to store and maintain documents related to VHACO ERB meetings. At a minimum, this includes charters, briefings, agendas, meeting minutes, and decisional memoranda of record and for the record. ***NOTE:*** *This is an internal VA website that is not available to the public.*

b. Required materials for resource requests must be submitted and maintained in the VHACO ERB LEAF site and the VHACO ERB Microsoft Teams/SharePoint Document Repository for intake forms (until request portals are consolidated at a later date). ***NOTE:*** *These are internal VA websites that are not available to the public.*