

**2026
DEFENSE HEALTH INFORMATION
TECHNOLOGY SYMPOSIUM**

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HYATT REGENCY NEW ORLEANS
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Accelerating Workforce Readiness: Eliminating Duplicative EHR Training

Speakers:

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Agenda

1. Introduction and Purpose
2. Background and Origin of the Pilot
3. Why Training Reciprocity Is Important
4. Pilot Design
5. Cohort and Data Breakdown
6. Findings and Results
7. Implications and Wider Applicability
8. Next Steps and Recommendations
9. Q&A / Discussion

Speaker Introduction



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Learning Objectives

- 1 Identify the Readiness Impact:** Recognize how reservists rotating into Department of Veterans (VA) care settings require duplicative Electronic Health Record (EHR) training.
- 2 Elimination of Duplicative EHR Training Pilot:** Describe how a pilot was established to address and resolve the impact-readiness issue.
- 3 Pilot Elements and Output:** Examine the criteria used to analyze and extract gap content to eliminate duplicative training.
- 4 Pilot Performance and Safety:** Evaluate pilot results utilizing objective and subjective data.
- 5 Program Scaling and Opportunities:** Formulate expansion of pilot and discuss requirements for path forward.

Background: Why This Matters

Impeding clinical staff from performing bedside clinical duties decreases their clinical readiness and their patients' readiness for service.

- **Department of War (DOW) and VA Share Clinicians Which Requires Coordinated Total Force Integration:** Coordinated clinician utilization is vital to meeting the growing medical demands of both DOW and VA health networks (38 U.S. Code § 8111).
- **Reservist Integration:** Active-duty and reservist staff regularly rotate into VA care settings for reserve duties and clinical practice.
- **Impact on Recruitment:** Delays the medical processing of active-duty personnel and incoming recruits.

The Readiness Problem This Team Tackled:

DOW and VA Sites with Shared Clinical Services Required End Users to Repeat Training Prior to End User Role Provisioning in the “Sister” Agency



EHR Proficiency Requirement

Many stakeholders were working under the assumption that workflows and user roles were radically different between DOW and VA which would require retraining in the “sister” agency.



The Policy Hurdle

Rules mandated completing EHR training for “new” end users. No exceptions based on experience in another agency.



Duplicative EHR Training

Reservists were required to undergo 20+ hours of duplicative EHR training impacting their professional readiness.



Degraded Medical Readiness

Too many hours were being spent on what was suspected to be mostly redundant training and clinicians were being taken away from essential responsibilities.

Mission Impact

Reduced Staff Availability

Critical clinical personnel are kept away from patient care areas due to duplicative training.

Task Completion Delays

Core clinical tasks and administrative health processing are postponed due to onboarding bottlenecks.

Decreased System Capacity

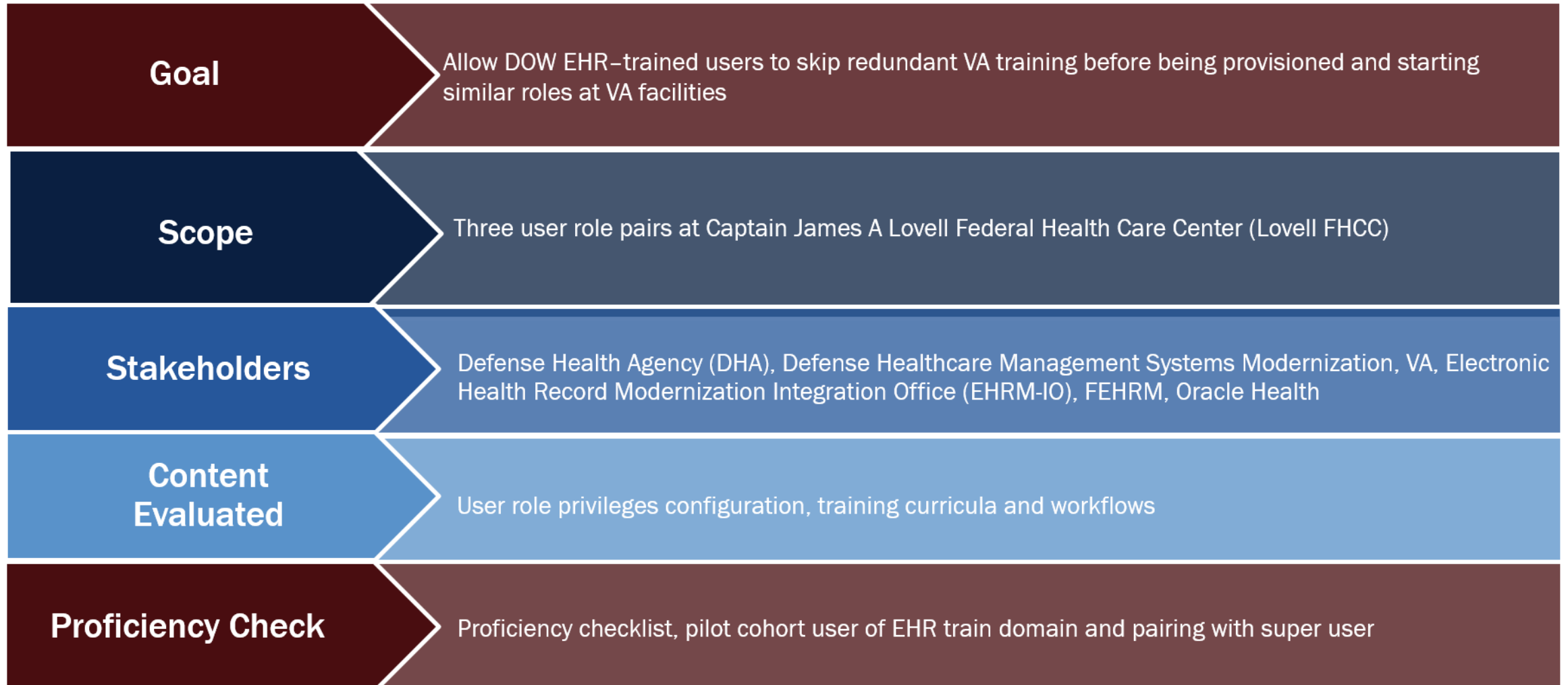
System-wide clinical throughput is reduced.

Inefficient Resource Allocation

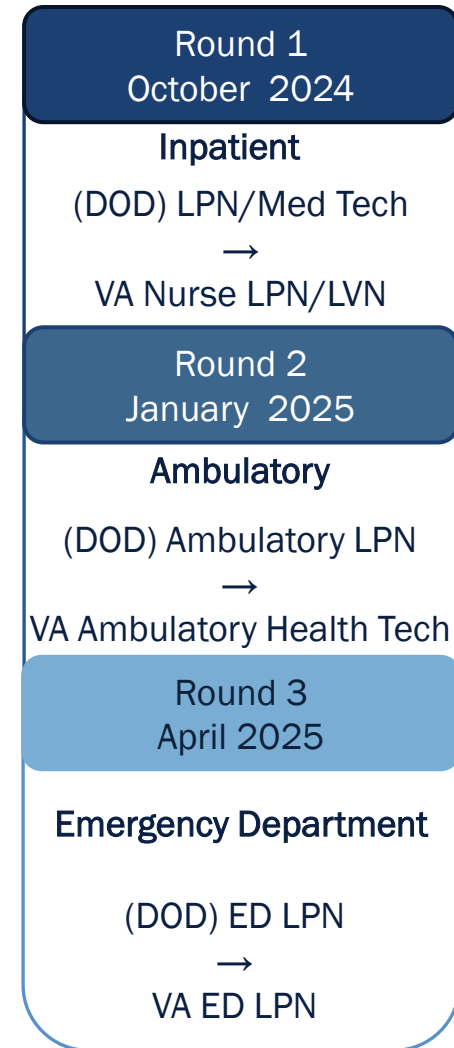
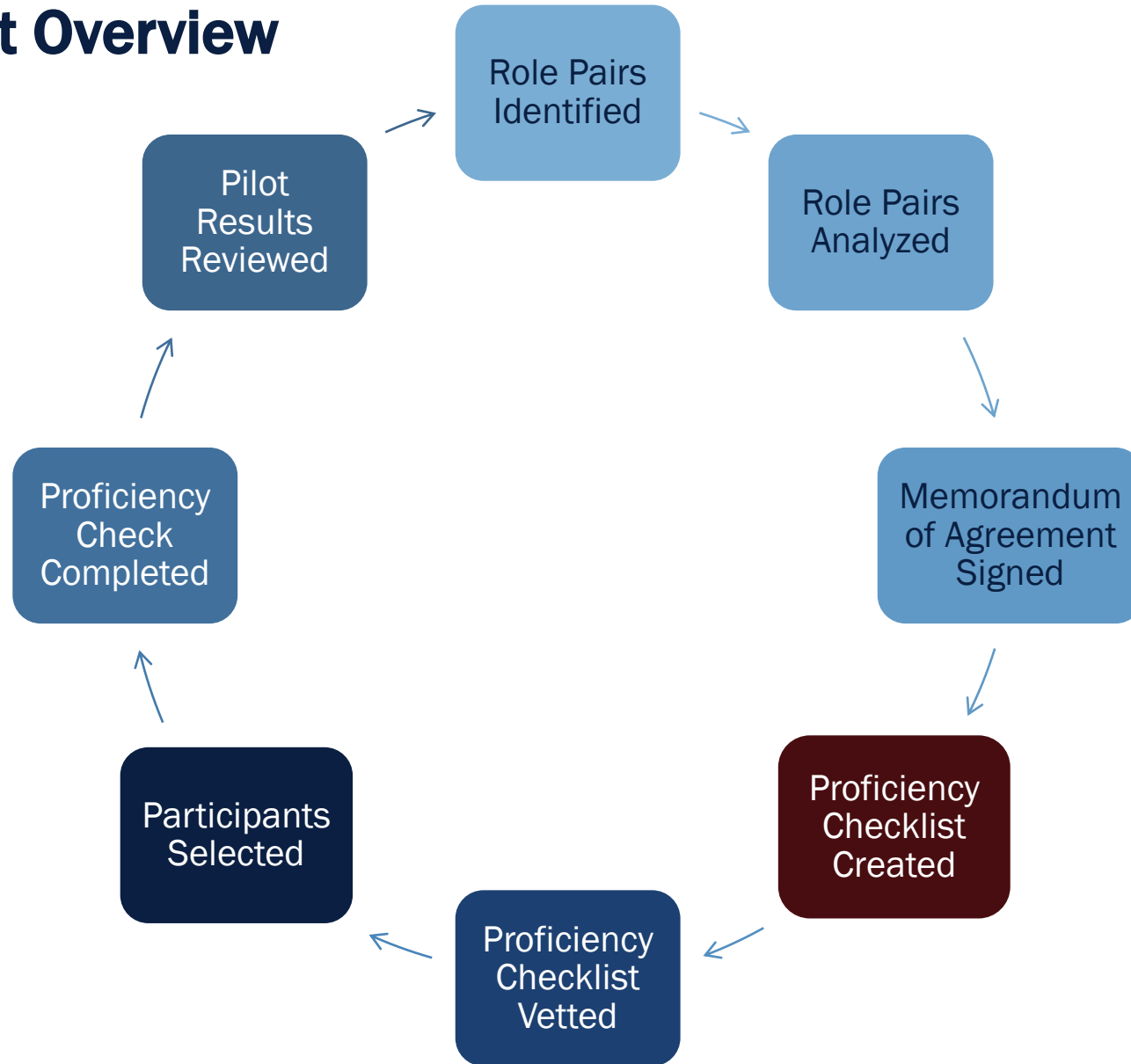
Highly skilled medical personnel are underutilized during high-stress systemic periods. (Stressing the system during summer recruit-processing surge at Lovell FHCC).

Mission Impact

Pilot Design



Pilot Overview



Pilot Breakdown



USER ROLE
PRIVILEGES



TRAINING
CURRICULA



1DOW/1VA
WORKFLOWS

Federal EHR user role privileges comparison. Privileges that did not match were further reviewed for training implications.

Sample

Privilege	DOW Ambulatory: LPN\Med Tech	VA Ambulatory: Health Technologist	Aligned
Add Documentation	Granted	Granted	Yes
Add Image	Granted	Denied	No
Add/Modify Historical Pregnancy	Granted	Granted	Yes
Clinical Trial Pre-Screening	Denied	Denied	Yes
Complete Documented Medication	Granted	Granted	Yes
Aligned Privileges Total			96%

Pilot Breakdown (Slide 2)



USER ROLE
PRIVILEGES



TRAINING
CURRICULA



1DOW/1VA
WORKFLOWS

Computer Based Training (CBT)

- Content extracted from DOW's Joint Knowledge Online (JKO) and VA's Talent Management System (TMS).

DOW Ambulatory LPN\Med Tech	
CBT Hours	200 Level
4.75	DHA-US053, DMIX: Joint Legacy Viewer (JLV) New User Training (FOUO) DHA-US645 Patient Portal - Clinical Staff Video MHSG-US200 Documenting in PowerChart MHSG-US204 Navigating PowerChart MHSG-US205 Concept of Encounters MHSG-US206 Reporting Overview

VA Ambulatory Health Technologist	
CBT Hours	200 Level
5.75	Common Tasks 200a: Message Center Common Tasks 200a: PowerChart Foundations Common Tasks 200a: Medication Administration Common Tasks 200a: Orders and Quick Orders Common Tasks 200a: PowerForms Common Tasks 200a: Ambulatory Organizer Common Tasks 200a: Multi-Patient Task List

Pilot Breakdown (Slide 3)



USER ROLE
PRIVILEGES



TRAINING
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1DOW/1VA
WORKFLOWS

Instructor Led Training (ILT)

- Review of master facilitator guide and user training guide of VA and DOW training curricula

Clinical Scenarios	DOW Ambulatory LPN\Med Tech	VA Ambulatory Health Technologist	Assessed Results
Ambulatory Organizer	- Patient Search - Refresh - Functionality Review - Checkout Status: purple	- Patient Search - Refresh - Functionality Review - Checkout Status: grey	One deviation: check out status color differs between agencies.
Message Center	- Message Center functionality - Patient Portal - functionality explained in DOW CBT DHA-US645 Patient Portal - Clinical Staff Video 200 Level	- Message Center functionality - Patient Portal	Aligned

Pilot Breakdown (Slide 4)



USER ROLE
PRIVILEGES



TRAINING
CURRICULA



1DOW/1VA
WORKFLOWS

DOW and VA workflows comparison.

DOW Ambulatory LPN/Med Tech	VA Ambulatory Health Technologist	Alignment
1DOW - Ambulatory - In Office Orders	1VA - Ambulatory - In Office Orders	Aligned
1DOW - Ambulatory - Phone Calls and Messaging	1VA - Ambulatory - Phone Calls Messaging	Aligned
1DOW - Medication Process - CareAdmin BCMA	1VA - Medication Process - Barcode Medication Administration (Medication Administration Wizard)	One deviation: VA workflow recommends entering a scanning bypass reason if scanning fails.
Unable to obtain an equivalent 1DOW workflow	1VA - Ambulatory - Patient Education	Unable to determine

Pilot Results



USER ROLE
PRIVILEGES



TRAINING
CURRICULA



1DOW/1VA
WORKFLOWS

User Role Privileges Alignment Rates

	DOW User Role	VA User Role	Alignment Rates
Round 1	LPN/Med Tech	VA Nurse: LPN/LVN	89%
Round 2	Ambulatory LPN/Med Tech	VA Ambulatory Health Technologist	96%
Round 3	DOW ED LPN	VA ED LPN	85%

Mitigating Discrepancies: Divergent privileges were analyzed for operational risks and resolved prior to pilot deployment.

Pilot Results (Slide 2)



USER ROLE
PRIVILEGES



TRAINING
CURRICULA



1DOW/1VA
WORKFLOWS

- **Baseline Duplications:** Massive redundancies were identified in core navigation, general clinical charting, and basic EHR functionality.
- **Targeted Gaps Identified:** Curriculum analysis successfully isolated the specific, unique VA elements that required training.
- **Competency Strategy:** Bridged identified gaps by deploying embedded Super Users for at-the-elbow support and directing staff to targeted online training modules.
- **Proficiency Established:** Successfully verified user competency in unique VA workflows without requiring the development of new, role-based curricula.
- **Next Steps:** Scale the Super User support network and continue utilizing targeted online training pathways to sustain competency for broader future deployments.

Pilot Results (Slide 3)



USER ROLE
PRIVILEGES



TRAINING
CURRICULA



1DOW/1VA
WORKFLOWS

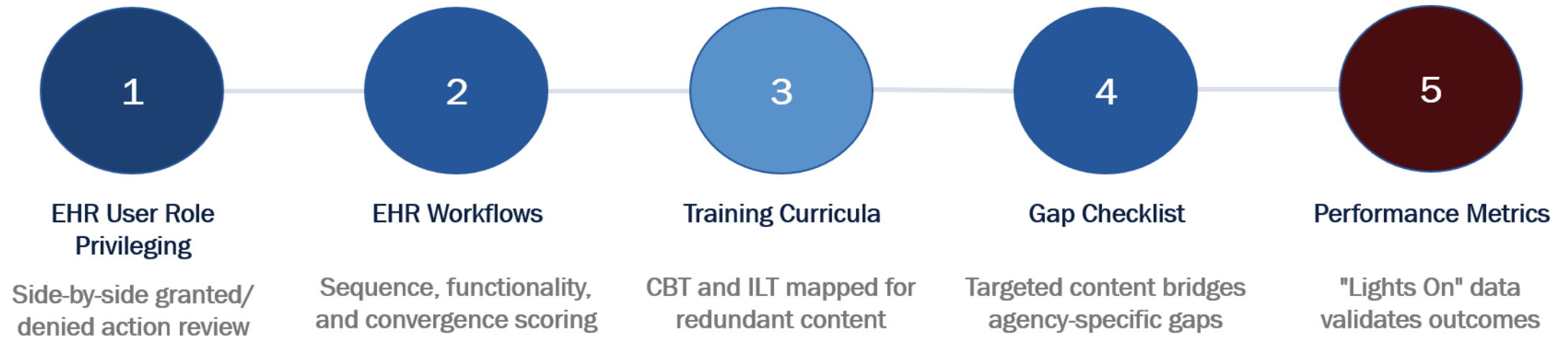
Workflows Alignment Rates

	DOW User Role	VA User Role	Alignment Rates
Round 1	LPN/Med Tech	VA Nurse: LPN/LVN	89%
Round 2	Ambulatory LPN/Med Tech	VA Ambulatory Health Technologist	72%
Round 3	DOW ED LPN	VA ED LPN	77%

No Clinical Barriers: No major clinical workflow barriers were identified that would impede progressing with the pilot.

Analytical Approach

A repeatable FEHRM CHIO methodology evaluates congruency, removes duplicate training, and validates clinical safety.

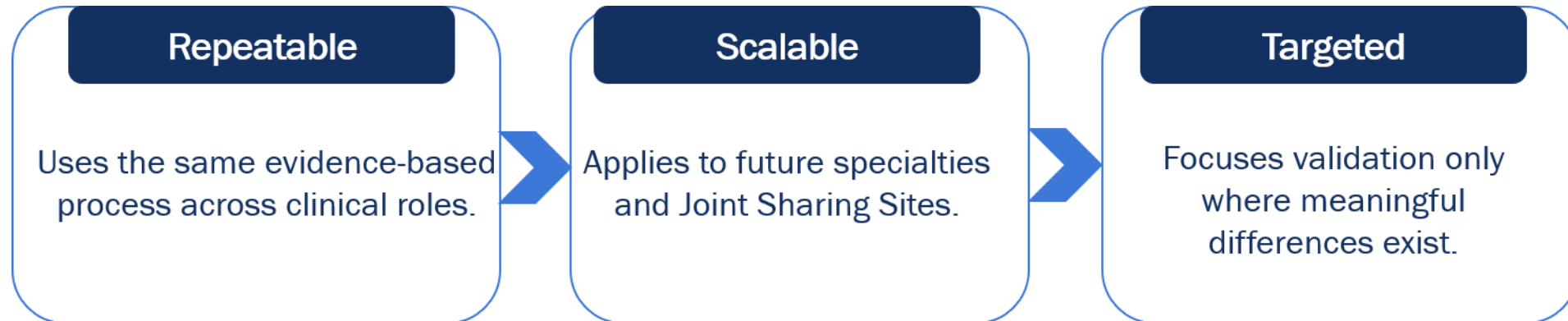


Output: A gap-focused competency checklist that supports reciprocity without building entirely new role-based curricula.

Why the Method Matters

A repeatable framework for training reciprocity

This methodology is more than a one-time analysis.
It creates a sustainable foundation for broader implementation.



A standardized methodology enables training reciprocity while maintaining competency, patient safety, and operational readiness.

Outcomes: Performance and Safety

"Lights On" metrics monitored standard clinical tasks and confirmed participant performance comparable to local staff.



Clicks / Task

Interaction counts
for standard EHR functions



Documentation Time

Time from opening
to digital signature



Equivalent Efficiency

Participants performed
like native VA staff



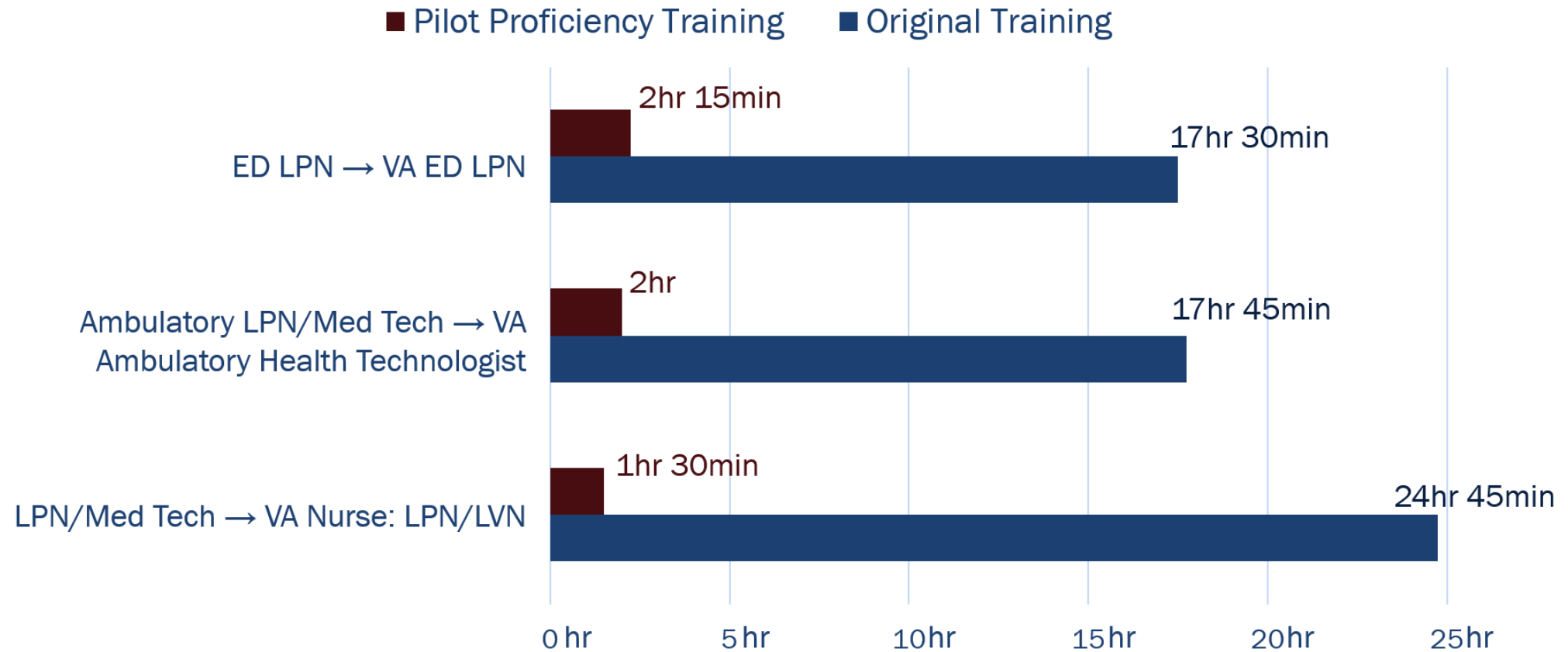
Zero Safety Concerns

No clinical errors,
incidents, or near-misses

Clinical safety validation: No patient safety incidents, clinical errors, or near-misses occurred during the pilots.

Pilot Results

Quantitative results showed substantial VA training reduction while maintaining participant success and safe performance.



Lights On Network & Qualitative Reporting



100% Pilot Participant Success Rate of Charting Time

Defined as being within 10 min of (control) staff.



100% Pilot Participant Medication Scanning

Successful medication barcode and wristband scanning.



“ Pilot participants had no issues using the Federal EHR during their shift at the VA facility ~ FHCC Nurse Supervisor

“ Inpatient pilot participants were proficient in the use of the Federal EHR ~ FHCC Super User

Clinical safety validation: No patient safety incidents, clinical errors, or near-misses involving participants occurred during the 3 rounds of the pilot.

Readiness Gains

Training reciprocity returns clinician time to care delivery, readiness activities, and medical processing.



20-23

HOURS RETURNED

per clinician for patient care and competency maintenance



Weeks →
Minutes

FASTER ONBOARDING

at-the-elbow validation replaces duplicative classroom time



More

FORCE CAPACITY

clinical personnel are available where needed

Readiness impact: Reduced administrative obstacles to support warfighter processing and recruit onboarding.

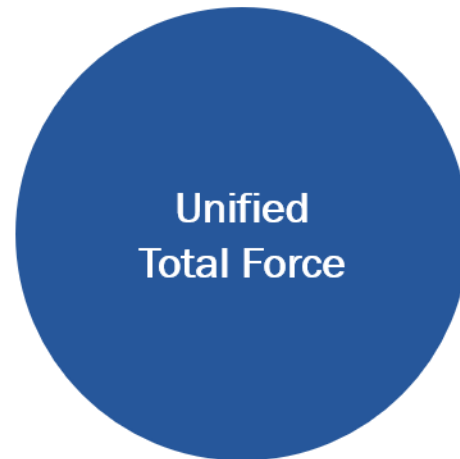
Interagency Alignment

The pilot establishes a joint framework for shared standards, role mapping, and configuration alignment.



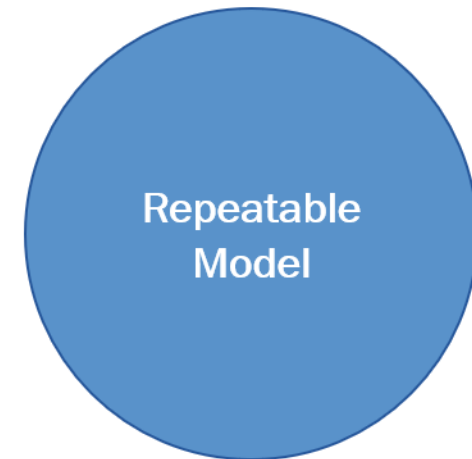
Interoperable Standards

Shared training standards, role mappings, and configuration alignment between DOW and VA.



A Unified Total Force

Integrated cross-agency clinical workforce supports federal health network operations.



Proven Analytical Model

Repeatable framework can rapidly evaluate future modifications and expansion.

Operational Flexibility

By removing redundant EHR training barriers, clinicians can safely shift across DOW and VA environments when mission demand changes.

1

Seamless Clinician Mobility

Shift personnel across agencies during surges, deployments, or workforce shortages.

2

Enhanced Operational Agility

Maximize clinician utility at joint sharing sites and high-stress periods.

3

Bottleneck Elimination

Remove institutional and IT hurdles so clinicians focus on direct patient care.

Summary of the Training Reciprocity Project

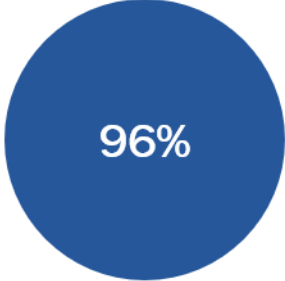
Training reciprocity removes duplicative EHR courses while maintaining safety and strengthening Total Force readiness.



23

HOURS

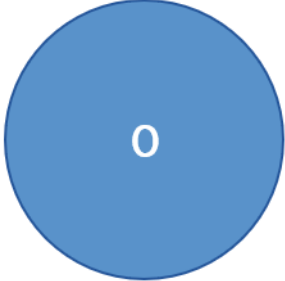
Up to 23 clinical hours returned
per participant



96%

ALIGNMENT

High convergence in role, workflow,
and privilege review



0

SAFETY EVENTS

No clinical errors or safety
incidents during pilots



Total Force

READINESS

Administrative roadblocks reduced
for joint operations

Take-Aways

- What can you take home from the user role analysis and the pilot project which bypassed redundant training?
 - Many DOW and VA end user roles are identical or 75-95% identical when compared for:
 - Privileges
 - Training
 - Workflows
 - End Users that are experienced can be safely provisioned comparable user roles in their “sister” agency without causing any user distress
 - Processes to bypass redundant training and document end user competence (test out) are in-flight and being finalized
 - Some end user roles are highly divergent between agencies due to differing missions
 - Not all comparable user roles will likely be candidates to bypass repeat training



Efficiency & Cost Savings

Cost and efficiency gains come from eliminating redundant courses, reducing training coordination burden, and streamlining provisioning.

Redundant Training Elimination

Removes duplicate EHR courses for personnel proficient on the sister agency baseline.

Cost Reduction Categories

Fewer classroom hours, less instructor time, reduced tracking, and coordination workload.

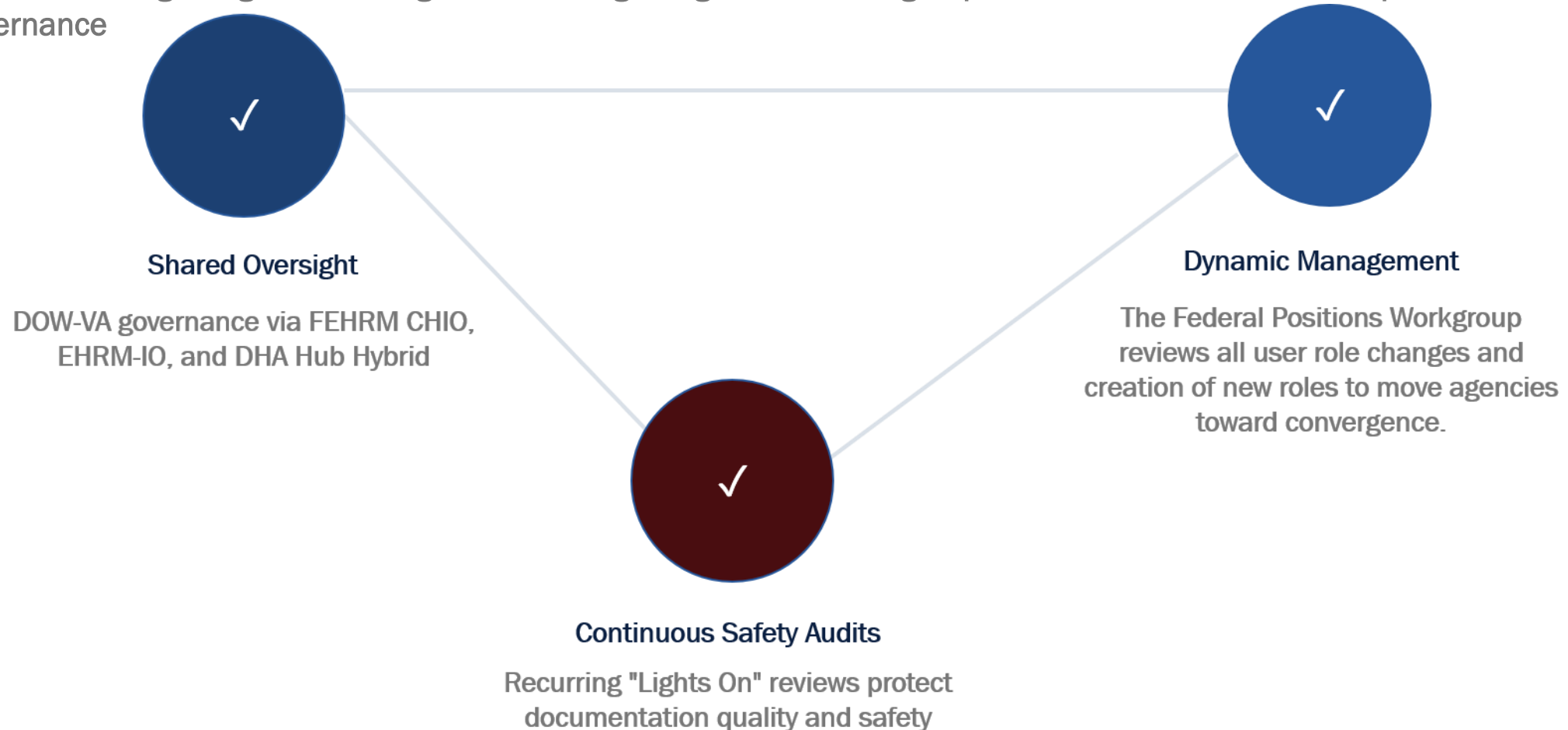
Streamlined User Provisioning

DHA Hub Hybrid validation creates a rapid path for dual-agency credentials. Improves onboarding time and end user satisfaction

Governance Will Sustain the Training Reciprocity Processes

Joint governance monitors role changes, checklist updates, and safety performance

Both DOW recognizing VA's training AND VA recognizing DOWs training requires internal documentation processes AND JOINT governance



The Road Ahead

- 38 U.S. Code § 8111 requires DOW and VA to share health care resources, develop joint strategic plans, and establish joint executive committees to improve care quality and cost-effectiveness.
- The Departments have an opportunity to decrease the costs of duplicative training by:
 - Converging training resources
 - As much as possible, standardizing comparable end user roles' workflows and privileges
- Continue to “field test” at high-demand sites such as Lovell FHCC with anticipated national adoption of training reciprocity using the user role analysis methodology that has already been developed.
- By standardizing user roles and training, the agencies can expand clinical sharing as VA moves forward with deploying the Federal EHR in the next five years (meeting the spirit of USC 8111).



Questions & Answers



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Thank You!



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Reference

38 USC 8111: Sharing of Department of Veterans Affairs and Department of Defense health care resources. [38 USC 811: Sharing of VA and DOD health care resources](#)