NATIONAL EXECUTIVE COMMITTEE
OF
THE AMERICAN LEGION
INDIANAPOLIS, INDIANA
MAY 6 - 7, 2015

Resolution No. 30: Department of Veterans Affairs Accountability
Origin: Register Resolution No. 2725 (AK) Department Convention
Submitted By: Veterans Affairs & Rehabilitation Commission

WHEREAS, The Department of Veterans Affairs (VA) has come under scrutiny by Congress, veteran service organizations, media and in the veterans community for its failures in leadership performance and accountability which has resulted in numerous quality of care issues, patient safety issues and veteran deaths; and

WHEREAS, In Pittsburgh, PA, the Veteran Integrated Service Network Director received a Presidential Distinguished Rank award in the amount of $66,000 despite an outbreak of Legionella at the facility where five veterans died; and

WHEREAS, In Atlanta, GA, two VA Office of the Inspector General (VAOIG) reports identified serious instances of mismanagement at the facility that led to the drug-overdose death of two patients and the suicide of another veteran related to mismanagement and lengthy waiting times for mental health care; and

WHEREAS, In Jackson, MS, Congress held a field hearing and investigation with multiple concerns regarding missed diagnoses of fatal illnesses; understaffing; overbooked patients; lack of oversight for the medical center's nurse practitioners; lack of patient access to physicians; radiology reports being misread and unread within 30 days; improper sterilization of medical instruments; and

WHEREAS, In Fayetteville, NC, according to a VAOIG, facility employees did not complete required suicide prevention follow-ups 90 percent of the time for patients at a high risk of suicide and the facility was noncompliant with cleanliness of patient care areas, environmental safety, dental clinic safety and training and testing procedures; and

WHEREAS, In Columbia, SC, the facility had 11 director acting/interim directors within a three-year period during which time, there were six deaths and a total of 20 institutional disclosures sent to veterans for the facility's delayed in providing gastrointestinal screenings for colorectal cancer; and

WHEREAS, In Phoenix, AZ, according to news reports, the director authorized and promoted the illegal use of paper wait lists among the facility staff which led to increased wait times for primary care and 40 deaths of veterans who died while waiting for their care; and

WHEREAS, Each of the facility directors that presided over these delays, lack of quality care and preventable veteran deaths received bonuses; and

WHEREAS, If there is a lack of performance and accountability among a senior executive service employee, the only disciplinary actions the Secretary of Veterans Affairs can take are to issue reprimands or transfer VA senior executive service employees to other VA facilities; now, therefore, be it

RESOLVED, By the National Executive Committee of The American Legion in regular meeting assembled in Indianapolis, Indiana, on May 6-7, 2015, That The American Legion urges Congress to enact legislation that provides the Secretary of Veterans Affairs the authority to:

Remove any individual from the senior executive service if the Secretary determines the performance of the individual warrants such removal; or

Transfer the individual to a General Schedule position without any increased monetary benefit.