VA | U.S. Department of Veterans Affairs | Fact Sheet
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Accountability
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The Department of Veterans Affairs (VA) has one of the most important missions in Federal government: caring for Veterans and their families, and the Department has strong institutional values to guide employees in those mission–critical ideals that influence day-to-day behavior and performance: Integrity, Commitment, Advocacy, Respect, and Excellence (I CARE).

To better fulfill our mission and to improve service to those who have 'borne the battle,' their families, and Survivors, VA has taken a series of actions to create an environment of sustainable accountability and rebuild trust with Veterans and the American people.

VA has taken the following steps to strengthen accountability:

Creating a Culture of Accountability

- Each employee across the enterprise has reaffirmed their commitment to the mission and core values of the Department. This now happens annually.
- The Department has revised all Senior Executives' performance plans to include required critical elements relating to Veteran service and employee engagement. VA's executives are evaluated on their ability to provide exceptional service to America's Veterans and on their engagement with employees around VA's mission and values.
- Beginning in October 2014, the annual performance objectives of every medical center director included core requirements of care quality, patient safety, patient satisfaction, and other key Veteran outcome measures.
- For the Fiscal Year 2014 performance period, VA re-evaluated Senior Executive performance ratings to ensure a distribution of ratings equal to top-rated companies in the private sector.
- VA has initiated establishment of a Department-wide program office to implement our Anti-Harassment Policy. This new program will ensure that allegations of harassment are promptly investigated and that VA management is alerted to conduct that is not consistent with our ICARE Values.

- VA's goal continues to be strengthening its culture of accountability and putting renewed focus on employee-led, Veteran-centric change. Improvements in workforce culture, with a focus on ICARE values, will allow VA to address issues as they arise, rather than necessitating employee termination following repeated and/or pervasive poor behavior.
- The Secretary and Deputy Secretary have held over 60 employee town halls and more than 30 meetings with union leaders.
- Over 6,540 Network Director/Medical Center Director site inspections have been completed.
- Over 8,309 staff have completed the VA-developed training "Access and Scheduling Core Concepts and Business Practices".
- VA leadership sent a message to all employees regarding the importance of whistleblower protection, emphasizing that managers and supervisors bear a special responsibility for enforcing whistleblower protection laws. All VA supervisors are required to take annual "Whistleblower Rights and Protection & Prohibited Personnel Practices" training.

Strong Independent Oversight

- The Office of Special Counsel, the Office of the Inspector General, the Office of the Medical Inspector, and the newly established Office of Accountability Review provide strong oversight independent of field organizations within VA.
- VA was the first cabinet-level agency to secure certification from the U.S. Office of Special Counsel (OSC) under OSC's 2302(c) Whistleblower Protection Certification Program, which ensures that Federal agencies meet the statutory obligation to inform their workforce about the rights and remedies available to them under the Whistleblower Protection Enhancement Act and related civil service laws.
- As of April 2015, VA has worked closely with OSC to provide relief for over 45 VA employees who have filed whistleblower retaliation complaints, including three individuals at the VA Phoenix Health Care System.
- The Office of the Inspector General publishes more than 300 reports of investigations and reviews each year either in response to their regular program of organizational review, a specific request from senior VA leaders, or a member of Congress, or in response to a Hotline call alleging improper activity.
- Secretary McDonald and Deputy Secretary Gibson have repeatedly said that where wrongdoing is confirmed by our partner agencies such as DEA, FBI and DOJ, as well as local law enforcement, disciplinary actions will be pursued.
    - As a result of the indictment announced July 17, 2015 by the Department of Justice, VA immediately terminated a Georgia VA employee's access to all of VA's systems and placed the employee on administrative leave. VA appreciates the work done by VA's Office of Inspector General and the

U.S. Department of Justice to investigate this case and present the evidence needed to take appropriate action.

- The Office of the Medical Inspector, under new leadership, has completed a substantial overhaul of standards and processes to create a strong independent oversight of medical care delivered in VHA.
- VA has established the Office of Accountability Review (OAR) to ensure leadership accountability for improprieties related to patient scheduling and access to care, whistleblower retaliation, and related matters that impact public trust in VA.
- When the IG develops sufficient evidence that a VA employee committed a potential violation of criminal law, the IG initiates a criminal investigation and promptly notifies the Federal Bureau of Investigations of the investigation in accordance with the Attorney General's Guidelines for Offices of Inspector General. In criminal investigations, Federal prosecutors are consulted early to ensure that the allegations, if proven, would be prosecuted. In fiscal year 2014, 62 cases investigated by the IG resulted in criminal conviction of a VA employee.

Openness and Transparency

- Recognizing openness and transparency are central to sustainable accountability, VA publishes detailed wait time data twice each month and detailed care quality data each quarter.
- The results of the comprehensive field audit completed in fiscal year 2014 were published and briefings completed for congressional staff and members.
- The Secretary and Deputy Secretary have held more than 80 media engagements over the last year.

Accountability Actions

- As a result of issues surrounding the integrity of health-care-access-related performance data, no VHA Senior Executive received a performance award for FY 2014.
- By VA policy, Senior Executives who are the subject of a pending investigation have their performance ratings deferred until the investigation is complete. Any adverse finding is then addressed in the rating itself. VA implemented the expedited Senior Executive removal authority provided by Section 707 of the Veterans Access, Choice, and Accountability Act of 2014, and has thus far used that authority to propose removal of six Senior Executives. Four of those Senior Executives have been removed from Federal service and two have retired.
- Federal employees may be terminated for a variety of reasons ranging from absence without leave and inability to maintain performance standards to serious offenses such as falsification of records, misuse of government property, or

sexual harassment. The vast majority of VA's more than 300,000 employees are committed to serving Veterans effectively and well. Where performance or conduct issues warrant removal, however, VA takes appropriate action to terminate employment.

  - In calendar year 2014, VA terminated more than 1100 employees.
  - VA has terminated more than 1755 employees since Secretary McDonald was confirmed on July 29, 2014. (Note: this includes removals and probationary terminations.)
  - VA has proposed disciplinary action related to data manipulation or patient care against more than 187 employees nationwide. Once disciplinary action has been proposed, the employee has the opportunity to respond to the charges before a final decision is made. If the decision is to remove, demote, or suspend the employee for more than 14 days, he or she generally has the right to appeal the action.

- The 113 medical facilities identified in the 2014 field audit where questions were raised about appropriate scheduling practices were all referred to the Office of the Inspector General. OIG accepted 99 of those referrals for formal investigation. After the OIG completes their review, as it has done in approximately 50 facilities, a follow-on field inspection may be necessary to collect all of the necessary evidence related to individual employee culpability. Where both the IG and any follow-on inspection confirm no wrongdoing, those results are announced to inform Veterans and the public. This has either been completed or public notifications are in process for 28 medical facilities at which no wrongdoing was found. Where wrongdoing is confirmed, disciplinary actions are pursued. These are in process for 2 locations and completed in 4 other locations. In 16 locations, follow-on field inspections are in process to determine whether, and what, accountability actions may be warranted. OIG findings are still pending at 49 locations.