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DEPUTY ASSISTANT INSPECTOR GENERAL
FOR AUDITS AND EVALUATIONS
OFFICE OF AUDITS AND EVALUATIONS
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON
"ASSESSING VA'S RISKS FOR DRUG DIVERSION"
FEBRUARY 27, 2017

Mr. Chairman, Ranking Member Kuster, and Members of the Subcommittee, thank you for the opportunity to testify today on the Office of Inspector General's (OIG) work related to oversight of controlled substances and drug free workplace programs at VA facilities. I am accompanied by Emorfia Valkanos, a member of the OIG's Office of Healthcare Inspections staff in Manchester, New Hampshire, who is also a pharmacist.

BACKGROUND

The Federal Drug-Free Workplace Program was initiated by Executive Order 12564 in 1986. The Executive Order established the goal of a drug-free Federal workplace and made it a condition of employment for all Federal employees to refrain from using illegal drugs on or off duty. The following year, Congress passed legislation (P.L. 100-71, Supplemental Appropriations 1987) designed to establish uniformity among Federal agencies' drug testing, confidentiality of drug test results, and centralized oversight of the drug testing program.

Within VA, the Deputy Assistant Secretary for Human Resources Management is responsible for the implementation of the Department's Drug-Free Workplace Program. Drug Program Coordinators at each Veterans Health Administration (VHA) facility are responsible for scheduling drug tests each month for randomly selected employees. Department-wide, VA randomly selects 285 employees each month across its facilities for drug testing—for an annual total of 3,420 employees.

VA Directive and Handbook 5383, *VA Drug-Free Workplace Program,* establishes policies and procedures for VA's Drug-Free Workplace Program. The Handbook designates safety-sensitive occupational series as Testing Designated Positions (TDPs), such as physicians, nurses, police officers, motor vehicle operators, and Senior Executive Service employees.

There are several components to VA's Drug-Free Workplace Program, including:

- Pre-employment applicant testing of final selectees for TDPs.
- Random monthly drug testing of employees in TDPs. (Human Resources officials are responsible for properly coding employees in TDPs with the drug test code in VA's personnel information system.)
- Drug testing of employees when there is reasonable suspicion of on-the-job drug use or where drug use is suspected following a workplace accident or injury.

VA also requires that managers at VHA facilities ensure that a controlled substance inspection program is implemented and maintained. VHA Handbook 1108.02, *Inspection of Controlled Substances*, details requirements for facility controlled substances inspections.

OIG WORK

In recent years, the OIG has conducted an audit and a review where we assessed aspects of the Drug-Free Workplace Program. The audit included a comprehensive assessment of the effectiveness of VA's Drug-Free Workplace Program. We identified program weaknesses and made recommendations to improve the effectiveness of the program. The review revealed one medical center did not conduct drug testing for a 6 month period. The review also revealed a lack of oversight of the Drug-Free Workplace Program, both at a local and national level, in that the 6 month lapse in testing was not timely identified.

Drug-Free Workplace Program

In March 2015, we reported VA needed to improve the management of its Drug-Free Workplace Program to ensure the program was effective in maintaining a workplace that is free from illegal drug use.[1] We identified program weaknesses and determined VA's Program was not accomplishing its primary goal of ensuring illegal drug use was eliminated and VA's workplace was safe.

<u>Pre-Employment Applicant Drug Test</u>

We reported that VA's Office of Human Resources Management (OHRM) did not ensure facility Human Resource Management Officers complied with VA's policy to drug test all applicants selected for a TDP prior to appointment. Instead, VA selected about 3 of every 10 applicants selected for a TDP for pre-employment drug testing. If a tested applicant has a verified positive test result, VA should decline extending a final offer of employment. While VA's Drug-Free Workplace Program Handbook states every individual tentatively selected for employment in a TDP is subject to a drug test before appointment, OHRM officials interpreted this language as meaning only some finalists for TDPs needed to be drug tested before being appointed. Because of this interpretation, we estimated approximately 15,800 (70 percent) of the nearly 22,600 individuals VA reported appointing into TDPs during fiscal year (FY) 2013 were not drug tested before being hired.

[1] *Audit of VA's Drug-Free Workplace Program*, March 30, 2015.

Employee Random Drug Testing

We estimated VA achieved a national employee random drug testing rate of 68 percent of the 3,420 employees selected for random drug testing in FY 2013. Of 22 randomly selected facilities, we found 4 did not test any randomly selected employees, 10 had compliance rates ranging from 31 to 89 percent, and 8 tested at least 90 percent of their randomly selected employees. Facility Coordinators could not explain why the majority of the 32 percent of employees were not tested.

We also estimated at least 19,100 (9 percent) of about 206,000 employees in TDPs were not subject to the possibility of random drug testing because they were not coded with a Drug Test code, as required, in VA's personnel information system. Those not subjected to random drug testing included physicians, nurses, and addiction therapists. In addition, VA may have incorrectly identified as many as 13,200 employees with the Drug Test code—meaning, employees in positions that do not usually require random drug testing were subject to testing. We found VA did test non-DTP employees, which reduced the probability that employees in high-risk, safety sensitive TDPs were selected for drug testing.

Reasonable Suspicion Drug Testing

OHRM lacked sufficient oversight practices to monitor whether facilities referred all employees with a positive drug test result to the Employee Assistance Program (EAP). VA's Drug-Free Workplace Program Handbook requires facilities to refer all employees with a positive drug test result to its EAP for assessment, counseling, and referral for treatment or rehabilitation. However, facility Coordinators reported that only 17 of 51 employees who tested positive for drugs as a result of reasonable suspicion or after a workplace accident or injury were referred to their facility's EAP.

We made five recommendations to the Deputy Assistant Secretary for Human Resources Management. These recommendations included:

- Ensuring all final selectees for TDPs complete pre-employment drug testing prior to appointment
- Increasing accountability to ensure all employees selected for random drug testing are tested
- Improving the accuracy of Drug Test coding in VA's personnel information system
- Implementing procedures to ensure Custody and Control forms are accurately completed
- Ensuring compliance with Program requirements, such as referring employees who test positive to the EAP.

The then Acting Deputy Assistant Secretary concurred with our recommendations and provided action plans that were responsive to our recommendations. This included a plan to require mandatory pre-employment drug testing of all candidates selected for a TDP. Action in response to four of the five recommendations has been completed. VA

continues to work on actions to ensure the accuracy of Drug Test coding in its personnel information system. Recently, VA notified us that they continue to work with their personnel information system business partner to implement this recommendation. We will continue to track their progress until we receive documentation that action is complete.

Human Resources Delays

In January 2017, we reported on delays in the processing of certain human resources functions at the Atlanta VA Medical Center (VAMC).[2] We conducted our work to assess allegations that there was a backlog of unadjudicated background investigations[3] and mandatory drug testing for new hires in TDPs [4] did not occur for a period of at least 6 months between 2014 and 2015. We substantiated both allegations. Regarding the allegation that the Atlanta VAMC did not administer the Drug-Free Workplace Program for 6 months, we found no drug testing was completed at the VAMC from November 2014 through May 2015. This lapse occurred because the facility Coordinator left the position in September 2014 and the alternate Coordinator did not assume the collateral duties required of this position. Further, other VAMC Human Resources personnel were unaware of the Drug-Free Workplace Program responsibilities. Despite the lack of drug testing for 6 months, we found no indications VA management was aware of the lapse. Because no drug testing occurred, the Atlanta VAMC lacked assurance that employees who should have been subject to drug testing remained suitable for employment. We made five recommendations in the report:

- Develop an action plan to ensure staff have appropriate background investigations and determinations are accurately recorded
- Ensure all suitability adjudicators receive the mandatory training and background investigation required for the position
- Provide training to all human resources staff on the requirements of the personnel suitability program
- Ensure human resources staff are trained on the requirements of the Drug-Free Workplace Program and the responsibilities of their positions
- Review the Drug-Free Workplace Program on a regular basis to ensure compliance with regulations and that employees hired during gaps are subject to corrective testing.

The Atlanta VAMC Director concurred with our recommendations and reported that action has been taken with regards to the Drug-Free Workplace Program. When we receive documentation of action related to those recommendations, we anticipate closing them.

Evaluation of the Controlled Substances Inspection Program

During our past inspections of VHA medical centers through our Combined Assessment Program reviews (CAP Reviews), we analyzed pharmacy operations including

[2] *Review of Alleged Human Resources Delays at the Atlanta VAMC,* January 30, 2017.
[3] An adjudication is considered backlogged after 90 days without a determination.
[4] There was also no monthly random drug tests for current employees in TDPs.

environment of care, management of controlled substances, and pharmacy security. In 2008, we reported facility managers needed to reinforce compliance with VHA policy regarding controlled substances inspections. We conducted another review during our fiscal year 2013 CAP Reviews to include 58 facilities and issued a summary of the results in June 2014.[5] The summary report contained 10 recommendations focused on opportunities for improvements:

- Conducting annual physical security surveys and correcting identified deficiencies
- Completing controlled substances quarterly trend reports and providing them to facility Directors
- Conducting monthly controlled substances inspections of non-pharmacy areas
- Completing non-pharmacy controlled substances inspection activities
- Performing emergency drug cache quarterly controlled substances physical counts and monthly verification of seals
- Validating completion of required drug destruction activities
- Verifying 10 percent of outpatient pharmacy written prescriptions for Schedule II drugs
- Validating accountability of prescription pads stored in the pharmacy
- Defining policy for acceptable reasons for missed controlled substances area inspections
- Providing annual controlled substances inspectors training.

VA concurred with the recommendations and reported in December 2014 that action had been taken to address these recommendations.

Investigative Work

The OIG conducts criminal investigations regarding drug diversion classified in three categories.

Diversion of Controlled and Non-controlled Substances by VHA Employees

Diversion by healthcare providers is a serious issue that OIG diligently pursues. Not only is it an issue of theft, it is potentially an issue of patient safety if the provider is ingesting controlled substances while on duty, if false entries are placed in patient files to cover up the diversion, or if patients are given another substance in place of the diverted drug. OIG recently concluded an investigation of drug diversion that resulted in a former Albany, New York, VAMC hospice nurse being sentenced to 82 months' incarceration and 3 years' supervised release after pleading guilty to tampering with a consumer product and obtaining controlled substances by deception and subterfuge. The investigation by the OIG and the Food and Drug Administration, Office of Criminal Investigation, revealed the defendant stole oxycodone hydrochloride from syringes and replaced the contents with Haldol, an anti-psychotic medication. The investigation further revealed the defendant may have inflicted pain and suffering on

[5] *Combined Assessment Program Summary Report – Evaluation of the Controlled Substances Inspection Program at Veterans Health Administration Facilities*, June 10, 2014.

dying hospice patients by diverting their pain medications for his own use and replacing it with a drug that was subsequently administered by other nurses.

Diversion of Controlled and Non-controlled Substances for Illegal Distribution

VA pharmaceuticals are also diverted or stolen for the purpose of illegal sale. An ongoing investigation at the Little Rock, Arkansas, VAMC has led to two pharmacy technicians and a pharmacy technician student trainee being indicted for charges to include conspiracy, theft, and possession with intent to distribute. The OIG investigation resulted in the defendants being charged with diverting and distributing 4,000 oxycodone tablets, 3,300 hydrocodone tablets, 308 oz. of promethazine with codeine syrup, and over 14,000 Viagra and Cialis tablets. Three additional VA employees were identified as part of the drug diversion, resulting in a resignation and reassignments. The monetary loss to VA is over $77,000.

Diversion of Controlled Substances via Theft of Mailed Pharmaceuticals

Mailed pharmaceuticals are vulnerable to theft at any point in the process. The most common occurrence is theft by employees of the mail carrier, either Government or private. This type of diversion results in veterans experiencing delays in receiving their medication. A recent VA OIG and UPS Security investigation revealed a defendant stole several VA packages containing oxycodone and morphine that were intended for veterans residing in Memphis, Tennessee. During the investigation, the defendant was caught attempting to steal an additional package and confessed to the thefts. The (now) former UPS driver was sentenced to time served and 3 years' probation after pleading guilty to theft.

CONCLUSION

The OIG has provided cross cutting oversight of the Drug-Free Workplace Program through our audits, inspections, and investigations. This oversight is necessary to ensure that VA takes the necessary steps to reduce risks to the safety and well-being of veterans and VA employees by having and following the proper program controls. We also have an active program investigating and having those engaged in drug diversion prosecuted. Without appropriate actions, we concluded VA lacked reasonable assurance that it is achieving a drug-free workplace and adequately securing controlled substances.

Mr. Chairman, this concludes our statement. We would be happy to answer any questions that you or other Subcommittee Members may have.