BACKGROUND CHECKS: ARE VA'S HR FAILURES RISKING DRUG ABUSE AND VETERAN HARM?

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS

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C O N T E N T S

WEDNESDAY, DECEMBER 6, 2023

BACKGROUND CHECKS: ARE VA'S HR FAILURES RISKING DRUG ABUSE AND VETERAN HARM?

WEDNESDAY, DECEMBER 6, 2023

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:03 a.m., in room 360, Cannon House Office Building, Hon. Jen Kiggans [chairwoman of the subcommittee] presiding.

Present: Representatives Kiggans, Radewagen, Bergman, Rosendale, Mrvan, Pappas, and Cherfilus-McCormick.

OPENING STATEMENT OF JENNIFER A. KIGGANS, CHAIRWOMAN

Ms. KIGGANS. Good morning. The subcommittee will come to order. Thank you all for being here today as the subcommittee conducts important oversight on VA's background check process. To obtain VA employment, applicants must go through a three-part background check. First, applicants must self report information, including violations of law. Second, applicant fingerprints are submitted to the Federal Bureau of Investigation (FBI) for a criminal history check. Finally, the Defense Counterintelligence and Security Agency investigates the applicant. During each step of this process, VA staff reviews relevant information to determine if the applicant is qualified, competent, and suitable for the position they are applying to. If the background check reveals an applicant has a felony-controlled substance related conviction, and the applicant will have access to controlled substances in their VA position, the VA must submit a waiver for Drug Enforcement Agency or DEA approval.

Though these background checks take time, they are a crucial part of the hiring process. Even though there has been a lot of pressure to hire as many VA employees as possible, it is also crucial that the right people care for our veterans so veterans and their family members know they are in safe hands. Individuals with a controlled substance criminal history should not, absent a DEA employment waiver, be hired for positions where they have access to controlled substances.

When the wrong people are hired for the job, veteran safety is put at risk. Just a few years ago, one of VA's nursing assistants in Clarksburg, West Virginia, murdered seven patients after delib-

erately administering lethal insulin dosages. Since then, there have been numerous instances where medical professionals have been caught stealing medication that is procured for veterans. These instances contributed to the more than 1,400 incidents of controlled substance theft or loss at VA, about 7 percent of the 20,000 total incidents reported to the DEA in 2021.

Given the VA's consistent failure to get rid of its few bad employees, including in situations I have heard about, like employee drug theft, it is crucial that the VA does not hire dangerous employees in the first place. Despite the importance of effectively carrying out the employee background check process, evidence suggests the VA is failing to follow the law and commonsense policy, resulting in background check deficiencies.

Inspector General (IG) reports in both 2019 and 2023 highlight major issues with the VA's management of the background check process. The 2023 report outlines how the VA background investigations are often initiated late, not timely, or not properly documented, in violation of the VA's own policies. Disturbingly, the report also highlights in some cases for unknown reasons, applicants have never had background investigations done in the first place. This includes hundreds of employees with indications of a controlled substance related criminal history that Government Accountability Office (GAO) estimates have not completed background investigations.

The absence of these background investigations is alarming, as DEA regulations require employers, including the VA, to apply for and receive employment waivers for those with access to controlled substances who were convicted of a controlled substance related felony. Simply put, this is not optional. These DEA regulations are in place to prevent drug theft and loss, which is common at the VA, unfortunately.

Evidence suggests the VA is not properly executing DEA employment waivers as well. GAO in both 2019 and 2023, found Veterans Health Administration (VHA) has a zero DEA employment waiver policy in place, including guidance for determining whether employees have access to controlled substances. I am very concerned that over 4 years have passed since the VA was first made aware of these deficiencies, and there has still been little to no progress made to improve the background check process. I look forward to all of you testifying before us today explaining why the VA has failed to fix the deficiencies in its background check and DEA employment waiver process. With that, I now recognize Ranking Member Mrvan for his opening comments.

OPENING STATEMENT OF FRANK J. MRVAN, RANKING MEMBER

Mr. MRVAN. Thank you, Chair Kiggans. I appreciate you holding this hearing. Ensuring VA has an effective and robust workforce is a priority for me. As the Department implements the Honoring Our PACT Act and its monumental expansion of veterans benefits, it is critical VA has the staff it needs to support existing and new veterans entering the VA healthcare system. It is equally critical that those new VA workers have the required skills and background as we entrust them to care for our veterans. I share Chair Kiggans's

concerns about the deficiencies in VA personnel suitability program that have been identified by the VA Office of Inspector General (OIG) and the Government Accountability Office.

I hope this hearing can help us identify ways to improve VA's process for screening employees so that we can strike the right balance of swiftly onboarding the staff we need while promptly and accurately vetting them to ensure patient safety. The length of VA's onboarding process has long been cited as a recruitment and retention issue. Historically, VA has struggled to attract and keep talent due in part to the lengthy timeline to get prospective staff to work after an offer of employment is made. Throughout the COVID–19 pandemic, the Office of Personnel Management (OPM) authorized VA to use hiring flexibilities in an expedited process to get staff into positions more quickly. However, there are risks associated with instituting a quicker process, and there need to be safeguards in place to ensure that the hired staff have the background and skills needed to care for and deliver benefits to our veterans.

After reviewing the testimony prepared by our witnesses today, it seems to me that a common thread and core cause of weaknesses in vetting is staffing. This is a bit circular, but it appears that VA does not have the requisite staffing levels needed to onboard additional staff. The areas of improvement identified by both the IG and the GAO all seem to center around the fact that VA does not have enough qualified personnel to run its personnel suitability program. This has created an unattainable cycle of staff shortages, causing new staff to enter the VA workforce without the completion of appropriate and required vetting.

I am particularly concerned by the IG's findings related to the VA Information Technology (IT) system that are used to track and manage background check processes. In my role last Congress as the Technology Modernization Subcommittee Chairman, I frequently did deep dives into VA software capabilities. VA currently has two information systems to manage the sustainability determination process, HR Smart and the VA Centralized Adjudication Background Investigation System, or VA-CABS. In its review of the VA's personnel suitability program, the VA IG identified issues with these data management systems and determined the use of the multiple data systems can lead to missing or inaccurate information.

I hope to hear an update today from the VA on its implementation of the VA-CABS 2.0 and its plan to ensure that future systems offer the functionality needed to effectively oversee and manage the background investigation process. I am disappointed that VA did not make sustained improvements of the execution or oversight of its personnel suitability program between the 2018 and 2023 IG audits. This hearing serves as an opportunity for VA to commit to plans to improve staffing levels and data management throughout the functions of its personnel suitability and credentialing programs. I look forward to the VA following up on the coming months as to its progress.

Finally, I was disturbed by the GAO's findings related to the VA's lack of control procedures for determining whether employees who have access to controlled substances have been adequately vetted. Again, this process seems to be stifled by VA not having

enough staff to operate and oversee an effective background check and credentialing process in compliance with the policy and regulation related to the Controlled Substance Act. Ensuring all practitioners who care for veterans are in compliance with the Controlled Substance Act and the DEA policies is important, and I hope to hear today from our witnesses how this vetting process translates for care veterans receive from community providers.

Thank you to our witnesses for being here today, and I look forward to a productive conversation. With that, I yield back.

Ms. KIGGANS. Thank you, Ranking Member Mrvan. We will now turn to witness testimony. Testifying before us today on our panel we have Mr. Daniel Galik, the Executive Director for Identity Credential and Access Management in the Office of Human Resources and Administration, Operations, Security and Preparedness (HRA/OSP) at the Department of Veteran Affairs. We have Ms. Jessica Bonjorni, the Chief of Human Capital Management at the Veteran Health Administration. We have Mr. Shawn Steele, Director of the Healthcare Infrastructure Division at the Office of Inspector General. We have Mr. Seto Bagdoyan, Director for Audit Services in the U.S. Government Accountability Office for Forensic Audits and Investigative Service. Will the witnesses please stand and raise your right hand and be sworn in.

[Witnesses sworn.]

Ms. KIGGANS. Thank you very much. Let the record reflect that the witnesses answered in the affirmative. Mr. Galik, you are now recognized for 5 minutes to provide your testimony.

STATEMENT OF DANIEL GALIK

Mr. GALIK. Thank you. Good morning, Chairwoman Higgins, Ranking Member Mrvan, and members of the subcommittee. Thank you for the opportunity to discuss the Department of Veterans Affairs Human Resources background investigation and suitability programs and processes. I am accompanied today by Jessica Bonjorni, Chief Human Capital Management, Veterans Health Administration.

VA recognizes that rigorous suitability protocols for its workforce are vital to maintaining the trust of veterans, caregivers, and veterans' families. VA's suitability program aligns with the guidelines established by the Office of Personnel Management. Preemployment screening and suitability determinations are mandatory for Federal employees to determine their suitability for employment.

Once a tentative offer of employment has been made to the applicant, VA begins preemployment screening. At this stage, self-declared information and available criminal history are reviewed. In line with Federal regulations, any issues identified during the preemployment screening process are forwarded to a trained adjudicator for review and appropriate action. If the adjudicator cannot mitigate the issues found during the preemployment screening process, VA may withdraw the offer.

An applicant's qualifications and credentialing requirements are also reviewed by VA's credentialing and privileging staff. If issues are identified with professional licensing or credentialing, these are communicated to HR to determine the appropriate follow-up action. If an applicant has a favorable initial screening, a background in-

vestigations is initiated at the appropriate level for the position with the Defense, Counterintelligence and Security Agency (DCSA).

After the background investigation is completed by DCSA, a final suitability determination is made by a VA suitability adjudicator. This determination involves a review of a person's character or conduct that may have impact on the integrity or efficiency of the service. When issues are discovered after a person is hired, such as when a report or an alert is received by the VA from DCSA or other sources, these reports and alerts are reviewed by a VA adjudicator and HR staff. If necessary, VA or HR may initiate the appropriate action on employees that are past their probationary period.

In late 2020, VA established working groups to conduct governance, oversight, and compliance and to review the processes used within VA to initiate background investigations and the subsequent adjudication by VA staff. Process enhancements were identified and implemented for instances where there were weaknesses in how background investigations were adjudicated by VA's adjudicators. VA has made progress, but more work is needed to strengthen governance, oversight, compliance, and policies.

VA is also addressing weaknesses in the governance of the suitability program, as identified in September 2023 VA OIG audit. HRA/OSP is developing an updated plan with each administration to establish this more robust governance and oversight of VA's personnel suitability program, including conducting program reviews at VA facilities, updating policies and oversight processes, verifying that background investigations are initiated and adjudicated within prescribed timelines, and that documentation is filed as required.

The administration, and in particular VHA, has taken action to create a more structured approach to oversight and compliance. The VA, HR and suitability programs are working with the VA CIO's information technology team to also address and resolve the data quality and other issues identified with our IT systems that support the HR and suitability programs.

We appreciate this opportunity to share more information on VA's background investigation and HR processes and how VA helps protect our veterans. Our objective is to give the Nation's veterans the top-quality care they have earned and deserve by carefully and thoroughly vetting all personnel who will interact with veterans, their families, and others at VA. We appreciate this subcommittee's continued support and encouragement. This concludes my testimony.

[THE PREPARED STATEMENT OF DANIEL GALIK APPEARS IN THE APPENDIX]

Ms. KIGGANS. Thank you so much, Mr. Galik. Mr. Steele, you are now recognized for 5 minutes to provide your testimony.

STATEMENT OF SHAWN STEELE

Mr. STEELE. Good morning. Chairwoman Kiggans, Ranking Member Mrvan, and members of the subcommittee, thank you for the opportunity to testify on the OIG's oversight of VA's personnel suitability program. A high performing screening program is critical for VHA to ensure the integrity of its workforce, to support the

delivery of safe, high-quality patient care, and to protect sensitive information from misuse.

As the OIG has documented, VA faces significant staffing shortages across many of its programs, including critical positions within VHA. These staffing shortages extend to human resources and personnel suitability staff essential to the hiring and vetting process. We have published reports on deficiencies in the personnel suitability program for several years. Our 2018 report recommended that VA and VHA establish robust oversight, ensure reliable investigation data are collected and maintained, correct data integrity issues, and implement a plan to review the suitability status of all VHA personnel. While we closed those recommendations between 2019 and 2022, the OIG became concerned that the program was not sustaining the improved controls.

Our September 2023 follow-up audit had two main findings. First, neither VA nor VHA provided effective governance of the program, and second, they lacked adequate IT systems to ensure that required background investigations were completed timely. In our first finding, we identified that VA did not consistently initiate or adjudicate background investigations timely or at all. In multiple instances, staff were in position to provide direct patient care without being vetted.

These issues occurred because neither VA nor VHA dedicated sufficient resources to carry out key internal controls or accomplish program tasks. HRA/OSP suspended required inspections of the suitability program due to insufficient staffing. VHA's Workforce Management Consulting office also did not conduct program reviews of its suitability functions, largely delegating oversight to the Veterans Integrated Services Networks (VISNs). The VISNs, however, lacked sufficient staff to consistently perform their responsibilities. VISN personnel security chiefs reported they did not consistently review their suitability programs because they were covering for VISN staffing shortages. Many VISN suitability specialists also reported difficulty handling their workload.

Our report highlighted examples of facilities that were supported by only one adjudicator despite employee counts ranging from 1,200 to 4,700 Full-Time Equivalency (FTE). We issued four recommendations for this first finding calling on VA to refocus its oversight of VHA's personnel suitability program and implement updated staffing metrics to ensure requirements were met.

Next, we found that VA's background investigation data and information systems were insufficient to track the status of investigations or conduct program oversight. For example, HR Smart data were not consistently up to date. Similarly, critical VA-CABS data fields were either empty or inaccurate.

While we recognize VA has now replaced VA-CABS, they did not provide us with evidence during our audit that VA-CABS 2.0 will address known program and data weaknesses. As such, VA may have allocated resources toward developing a system that has functionality issues or duplicates other efforts given that a governmentwide suitability IT system is in development.

Unless data reliability and system design and functionality are improved, VA lacks assurance that investigations have been fully processed and data integrity concerns have been mitigated. For this

finding, we issued three recommendations for VA to collect and maintain sufficient and appropriate data to track investigations, as well as ensure that future systems can support the management and oversight of the background investigation process.

The issues found in this report persisted from 2018, and a single responsible party was needed to coordinate corrective actions taken by HRA/OSP and VHA, all seven of the report's recommendations were issued to the Deputy Secretary. VA concurred with all the recommendations which remain open. In conclusion, the OIG remains committed to continued oversight of VA's personnel suitability program because of its importance to onboarding a highly qualified workforce and because of the risk to veterans, their family members, and staff if employees are not fully vetted. Presently, OIG audit teams are evaluating the personnel suitability programs in Veterans Benefits Administration (VBA) and National Cemetery Administration (NCA) to gain an enterprise-wide perspective. Additionally, the OIG is assessing VA's compliance with requirements for vetting contractor employees.

Madam Chairwoman, this concludes my statement. I would be happy to answer any questions you or members of the subcommittee may have.

[THE PREPARED STATEMENT OF SHAWN STEELE APPEARS IN THE APPENDIX]

Ms. KIGGANS. Thank you, Mr. Steele. Mr. Bagdoyan, you are now recognized for 5 minutes to provide your testimony.

STATEMENT OF SETO BAGDOYAN

Mr. BAGDOYAN. Thank you. Chairwoman Kiggans, Ranking Member Mrvan, members of the Subcommittee, I am pleased to appear before you today to discuss GAO's February 2023 report on VHA's employee screening process. As context, VHA operates one of the largest healthcare systems in the Nation, with over 9 million veterans enrolled in the VHA healthcare program. VHA is responsible for ensuring that its 400,000-plus healthcare providers and support staff are qualified, competent, and suitable to provide safe care to veterans.

Of this number, we identified 12,569 employees with indications of criminal history related to controlled substances, of whom we estimate 1,800 had felony convictions. A projectable sample of 305 from this universe constituted the basis of our analyses. We referred over 12,500 out of the original number to VHA for review and appropriate action.

My remarks today will address our report's two principal findings, the extent to which VHA has responded to adverse information regarding its employees' criminal history or DEA registrations. Second, whether vulnerabilities exist in VHA's processes for completing and documenting employee background investigations or BIs. Our bottom line, our findings pose a double risk. As you mentioned, first, harm to veterans' care and also diversion of controlled substances for illegal purposes.

Regarding our first finding, VHA received adverse information about some employees, but lacked policies and controls to ensure it responded as required. For example, VHA received information about some employees' control substance related felony convictions

and actions taken against certain employees by DEA. VHA was required to obtain waivers from DEA for any of these employees whose job involved access to controlled substances. Specifically, from our projectable sample, we identified 50 employees who had one or more felony convictions related to controlled substances. VHA did not request DEA waivers for 48 of these individuals and could not confirm it requested waivers for the other two.

At the time of our review, VHA did not have a waiver policy to guide its actions, but nevertheless determined that no waivers were required. Without such a policy, including guidance for determining whether an employee has access to controlled substances, VHA cannot assess whether its employees require waivers. Further, VHA risks that its facilities are not consistently complying with DEA regulations designed to control against theft and diversion of controlled substances.

Regarding our second finding, we identified vulnerabilities in VHA's processes for completing employee background investigations. Specifically, we found that 13 employees in our projectable sample did not have a background investigation completed as required by both OPM guidance and VA policy. VHA was not aware of this until we brought the matter to its attention.

Without adequate controls to ensure that it completes background investigations as required, VHA lacks reasonable assurance that its employees are properly vetted and suitable to provide care to veterans. In our February 2023 report, we made 14 recommendations to VHA, including five involving finalizing and implementing a DEA waiver policy and others for establishing controls to ensure that BIs are completed and documented. VHA agreed with the recommendations and outlined some actions in response, including reviewing a draft policy on waivers with a March 2024 target for implementation. As of today, all recommendations remain open.

In closing, I would note first that our findings are consistent with those that resulted in veterans healthcare being added to GAO's high-risk list in 2015 involving ambiguous policies, inconsistent processes, and inadequate oversight. They are also generally consistent with the Veterans Administration-Office of Inspector Genera's (VA-OIG's) findings that Mr. Steele just enumerated. Second, the control deficiencies we identified could have broader implications for the vetting of all VHA employees beyond those with just criminal histories. Accordingly, VHA should act decisively and implement our recommendations in a timely fashion to enhance its oversight of and controls over employee vetting and help minimize the risks I identified.

Chairwoman Kiggans, Ranking Member Mrvan, and members of the subcommittee, this concludes my opening remarks. I would be pleased to answer your questions. Thank you.

[THE PREPARED STATEMENT OF SETO BAGDOYAN APPEARS IN THE APPENDIX]

Ms. KIGGANS. Thank you very much for all of your testimonies. We will now move to questions, and I yield myself 5 minutes first. Mr. Galik how does the DEA define access to a controlled substance?

Mr. GALIK. Chairwoman, I am going to defer to my colleague here as the VHA team is working the details of the DEA waiver policy.

Ms. KIGGANS. Okay.

Ms. BONJORNI. Yes, thank you. The DEA definition of access to controlled substances includes anyone who dispenses or administers a controlled substance and anyone who has access or influence to how those controlled substances are administered or stored.

Ms. KIGGANS. Mr. Bagdoyan, do you agree with that definition?

Mr. BAGDOYAN. That is my general understanding that it is correct to access, dispensation, influence, proximity. It does not have to be direct access based on my understanding, but that is generally accurate, yes.

Ms. KIGGANS. Thank you. Mr. Galik, are there VA employees who do not prescribe or dispense controlled substances but still have access to them according to the DEA's definition?

Mr. GALIK. Again, I am sorry, but I will have to defer to my colleague to respond to that.

Ms. BONJORNI. Yes, there are employees who do not dispense or administer, and those would be reviewed on an individual basis at each facility based on their procedures. This new review, based on the feedback that we got from the GAO, is in our draft policy that we are working to roll out in January of this year to do the review that they recommended.

Ms. KIGGANS. Thank you. Mr. Bagdoyan, under what circumstances would a VA employee who has access to controlled substances need a DEA employment waiver?

Mr. BAGDOYAN. Yes, if they have a criminal history with a felony conviction for a controlled substance, and also, they do not have DEA registration, which would provide upfront sort of a dispensation that that was considered. Those would be the two principal triggers. Of course, access is——

Ms. KIGGANS. Right.

Mr. BAGDOYAN [continuing]. another issue as well, yes——

Ms. KIGGANS. Right.

Mr. BAGDOYAN [continuing]. or consideration, rather.

Ms. KIGGANS. Gotcha. Ms. Bonjorni, when was the last time the VA requested a DEA employment waiver?

Ms. BONJORNI. We do not track that centrally under not having the policy in place yet that has been recommended. Under the new policy, any request for a waiver would have to come all the way up to central office, and so we would be able to track those centrally, and they would be reviewed at a national level.

Ms. KIGGANS. Okay. Just out of curiosity, what is the biggest problem with doing these background checks? We hear from other jobs that require background checks, and the length of time it takes to get them is one problem. What do you think the hindrance is? I think maybe, in my personal opinion, everyone should have a background check who is directly related to care for our veterans. What is the biggest problem with asking for and implementing background checks?

Mr. GALIK. I would say staffing is definitely a consideration, but all of our adjudicators who perform the adjudication of the background investigation results that come from DCSA are trained in

accordance with the standards and criteria for how to conduct a background or how to assess the results of a background investigation. I think the VA, we are committed to performing those background investigations consistently and properly so that we have good workforce.

These particular instances that have been noted in the reports do not really have a good explanation for how some of these occurred. We are trying to improve our oversight and compliance to track those and catch those instances where background investigations maybe were deficient or were not performed for whatever reason. I do not really have a good explanation as to why they occurred, but we are committed to ensuring that those types of events do not continue to occur in the future.

Ms. KIGGANS. Several of you mentioned just staffing challenges with tracking. What does the tracking process look like during that hiring process? People that require background checks, is there an electronic system? Is it a paper, or how are we actually charting who needs a background check, who has had one? Where they are in that process, is that adequate?

Mr. GALIK. Right. As highlighted, we have two primary systems right now, HR Smart, and also a new system, relatively new system, VA-CABS. We are moving toward VA-CABS being the one centralized system that captures all the data that is collected in the hiring process, the fingerprint results, the documentation that the application fills out related to the background investigation, also the results of the DCSA investigation. Right now, we do have some of that information in HR Smart, which is our HR primary system for employee tracking, but we are moving all of that here in early 2024 to one system, VA-CABS.

Ms. KIGGANS. Okay. Then, just out of curiosity, before I yield to Ranking Member Mrvan, what is the security like in your pharmacies? Are there cameras on all medications? Is there especially security cameras on things like the opioid distribution machines? I know different hospital systems are set up differently. Sometimes the staff has to scan a card before they can have access to the machines. For the medication to get in the machine, there are a lot of places where the medication has to get from where it is manufactured into the building, into the pharmacy, into the distribution machine. Is there adequate security? Are there cameras? Is there scanning of badges to know who comes in and out of the room and who has access to the machines? Or what does that security look like?

Mr. GALIK. I will ask my colleague to address that.

Ms. BONJORNI. The detailed specifics are outside of my realm of expertise. My understanding is that, yes, there are requirements for scanning in and out whenever we are dispensing or administering any controlled substances. We have adequate control procedures in place with our pharmacy teams.

Ms. KIGGANS. Are there cameras installed?

Ms. BONJORNI. I would have to get back to you on that.

Ms. KIGGANS. Just curious if that is a requirement or not. Great. Thank you so much. I yield to Ranking Member Mrvan.

Mr. MRVAN. Thank you, Chairwoman. Mr. Bagdoyan, did the GAO's review of the VA's compliance with DEA policies and proce-

dures include a review of the community care providers' compliance with the DEA policies? How can the VA ensure providers in the community who are reimbursed for caring for veterans are in compliance with DEA policies?

Mr. BAGDOYAN. Thank you for your question, Mr. Mrvan. That was not something that we focused on in our audit work leading to the report. The responsibility for seeking waivers, for example, for those providers, if appropriate, rests with their employers. With that in mind, VHA really does not have any influence on that process, at least that is my understanding. Our VHA colleagues may have a different take on it, but that is not something that we looked at.

Mr. MRVAN. Okay. Mr. Galik, Chairman Kiggins asked a quick question, and you had answered that staffing is a consideration to one of the reasons why the process is not up to speed. Can you take a little deeper dive of what you mean as staffing as a consideration?

Mr. GALIK. Yes. Thank you for the question. Both department wide and also specifically VHA have put a good amount of time into assessing the workload and determining what are the appropriate grade levels and staffing levels that are necessary to support as we ramped up to support The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act and the hiring surge there over the more recent past. All this occurred around the COVID timeframe and we lost some momentum there in the 2020 timeframe.

Basically, it is a staffing analysis. We did bring on some contractor support to do some work on assessing the workload, and what would be the appropriate grade levels and numbers of individuals required to support the workload. We just have not followed up yet and actually done the hiring to support the requirements that were identified.

Mr. MRVAN. Thank you. Ms. Bonjorni, what policies and procedures are in place to ensure that community care providers are in compliance with the requirements of the Controlled Substance Act?

Ms. BONJORNI. I would echo the comments of my GAO colleague that those would be the requirements of their employer. It is not something that we would administer in the human capital space in VHA.

Mr. MRVAN. Right. The next level would that, does the VA verify from their employers that they are in compliance prior to allowing the veterans to go to a third party? Can you identify the loophole that we are trying to hone-in on?

Ms. BONJORNI. Yes, I understand what you are asking. It is——

Mr. MRVAN. Okay.

Ms. BONJORNI [continuing]. that would be something that is required in the contracts that we have with our community care providers and the overall network, but outside of my portfolio.

Mr. MRVAN. Okay. Can someone get us that answer?

Ms. BONJORNI. Absolutely.

Mr. MRVAN. Okay, thank you. My next question is, Mr. Galik, per VHA policy, the adjudicators have discretion in reviewing an onboarding employee's record and making a final suitability determination. In instances when a prospective employee has a criminal

record, what information regarding that record do adjudicators take into account when making that sustainability determination, for example?

Mr. GALIK. Yes. All our adjudicators are formally trained in the criteria and standards that are established by the Office of Personnel Management. Includes factors such as criminal record, the debt commitment.

Mr. MRVAN. Can I ask, does the length of time from the violation that it occurred, is that taken into account?

Mr. GALIK. Yes, that is taken into account. In terms of was it something that occurred perhaps a long time ago? If it was an employee, maybe something occurred with that individual where they were in the college environment and committed some type of activity or a crime like marijuana use or something along those——

Mr. MRVAN. Is that policy on paper?

Mr. GALIK. In terms of the timeline? It is discussed——

Mr. MRVAN. For the crime timeline consideration and the types of crime?

Mr. GALIK. Right. It is in the OPM guidelines——

Mr. MRVAN. Okay.

Mr. GALIK [continuing]. and standards where that assists the adjudicator in making that call.

Mr. MRVAN. How does this process take into account when state laws reclassify felony drug offenses as misdemeanors?

Mr. GALIK. I would have to get back to you on that one particular question, sir. I do know that dealing—we have to comply with the state laws in terms of those type of issues or they are taken into consideration. It becomes an area where the staff will need assistance from OGC, General Counsel and others, in making their ruling.

Mr. MRVAN. Thank you. With that, I yield back.

Ms. KIGGANS. Thank you, Mr. Mrvan. Mrs. Radewagen, you are now recognized for 5 minutes for questioning.

Ms. RADEWAGEN. Thank you, Chairwoman Kiggans and Ranking Member Mrvan for holding this hearing today. Thank you to the witnesses for your testimony. Mr. Steele, your testimony highlighted steps VA should take to improve its background check program. Could you explain these steps?

Mr. STEELE. Yes, thank you. Our work identified gaps related to people, processes, and technology that support the personnel suitability program. We made numerous recommendations to establish robust oversight, commit staff to both oversight and operations at the headquarters level and in the field, and commit resources to ensuring that future systems support case management for the program.

Ms. RADEWAGEN. Mr. Steele, in your testimony, you also note how VA's information systems do not adequately support the background check program. Can you discuss this further? I mean, what is inadequate about VA's information systems?

Mr. STEELE. The IT systems were critical to the issues that we identified. As Mr. Galik noted in his testimony, VA relies on two systems, HR Smart and VA-CABS, to support the personnel suitability program and track the five key milestones that are associ-

ated with that process. While that is not prohibited, it is not ideal for case management and complicates the issue.

We also identified some functionality issues with VA-CABS. For example, a field that was meant to collect the date when an investigation was scheduled with DCSA was meant to be auto populated. However, we found that in about one third of the cases that did not occur, and the process was able to move forward without that particular field being populated. We made recommendations for VA to consider closing those gaps, which we will monitor through our process.

Ms. RADEWAGEN. What can VA do to ensure its information systems adequately support VA's background check program moving forward?

Mr. STEELE. I can speak to the gaps that we identified during our audit, which were lack of functionality and the duality of the systems that impaired case management. In terms of the resources that VA needs to carry those out, I would have to defer those questions to VA.

Ms. RADEWAGEN. Mr. Galik, has VA made any improvements to its background check related information systems?

Mr. GALIK. Yes, that is very important to us. We are putting quite a bit of attention and effort into the new system, VA-CABS. We do have two systems at this time, HR Smart, to track the employee background investigation, and that data is moving, including making automated connections to move the data from HR Smart to VA-CABS. Working with our Chief Information Officer (CIO) information technology partners to address the requirements, whether it is provide the appropriate reports that can enable staff to perform their oversight role and also to improve the data quality so the data is accurate for each of the key milestones that enable us to track performance of those systems so the employees would feel that they are getting an effective tool to enable them to perform their job.

Ms. RADEWAGEN. Thank you, Madam Chairwoman. I yield back.

Ms. KIGGANS. Thank you, Mrs. Radewagen. Mr. Pappas, you are now recognized for 5 minutes for questions.

Mr. PAPPAS. Well, thank you very much, Madam Chair. I find the reports that we heard about from OIG and GAO deeply concerning. We are talking about a breakdown of basic governance, oversight, compliance that is potentially putting veterans at risk. Maybe I could start with you, Mr. Galik, and just ask if VA was surprised by these recommendations at all and if you can tell us any more about a timetable for when these recommendations will be satisfied and closed?

Mr. GALIK. Yes, thank you for the question. This is obviously the report findings and recommendations highlight a number of key issues. We kicked off a number of working groups and are putting together an overall oversight compliance plan that involved reinstituting the program reviews and onsite inspections or virtual inspections of each of the programs at each of the VA facilities. The timeline, it appears that most of the recommendations have moved a little bit to the right beyond the initial commitments, and we are working to complete most all of them in 2024, early calendar 2024.

Mr. PAPPAS. Well, maybe if I can ask you about a comment I heard from Mr. Steele, I believe just talking about insufficient staff, which you have explored with some of the other members here through their questioning. He said that some of this work has been delegated down to the VISN level, but we also lack oversight in terms of what is happening at the VISN level. According to the OIG team, all five VISN personnel security chiefs that they interviewed did not consistently conduct reviews of the programs in their network.

Oversight is basic. It is so essential, and we need to see more of it at VA at the VISN level. What are the plans to provide VISN security chiefs with the adequate support, staffing or otherwise, that they need to be able to conduct these reviews of the programs in their networks?

Mr. GALIK. I will ask my colleague to address that one for VHA.

Ms. BONJORNI. Sure. Thank you for the question, Congressman. We were not surprised by the reports, as you asked about earlier, but it did put things into clear guidelines and pathways that we need to follow. Based on the recommendations that we received from OIG and GAO, we have developed a staffing model for personnel security functions in the field in VHA that we rolled out last month. That tool is now available for facilities to evaluate how well their staffing is doing.

We did increase the total number of personnel security staff we have on board by about 35 percent over last year. We are making an improvement there. Then within our own office, we are adding additional personnel to perform those compliance and oversight duties and reinstitute the onsite personnel security reviews starting in 2024 once we fill our positions. We are taking all of their advice very, very seriously.

Mr. PAPPAS. Well, thank you for that. Another question. As part of the Cleland-Dole Act that was signed into law last year, we enacted provisions that require VA to improve its credentialing processes to include ensuring covered healthcare professionals hold active DEA registrations. It also required VA to audit Veterans Administration Medical Centers (VAMCs) annually to check compliance. The first reports are due to Congress at the end of this year, and I am wondering if you can tell us when we expect to receive those reports and if you have any sort of a preview on that.

Mr. GALIK. I will ask my colleague to address that.

Ms. BONJORNI. Credentialing is another area that is not in my portfolio, but we will be happy to get back for you on the timeline for that.

Mr. PAPPAS. Okay. Well, thank you for that. With that, I will yield back. Thank you, Madam Chair.

Ms. KIGGANS. Thank you, Mr. Pappas. Mr. Bergman, you are now recognized for 5 minutes for questions.

Mr. BERGMAN. Thank you, Madam Chairwoman. Let us get right to it. Mr. Steele, when did OIG first find deficiencies in VA's background check process?

Mr. STEELE. The OIG became alert to potential issues in the background process when a whistleblower identified a backlog of cases at the Atlanta VA Medical Center. We substantiated those issues in a January 2017 report, but it was clear that we needed

to conduct a nationwide review of the program. Our March 2018 audit identified gaps related to insufficient staffing, inadequate processes, and inadequate IT systems. We made numerous recommendations to VA at that time for corrective action.

Mr. BERGMAN. Okay. 2017 identified through a whistleblower. You did your due diligence, issued a report. Are these deficiencies similar to those the OIG described in its September 2023 report?

Mr. STEELE. Yes. VA has, in between our two reports, implemented new advisories and policies. They introduced VA-CABS between our 2018 report and 2023, but the underlying issues remain the same. There are still gaps related to people, processes, and technology that need to be closed.

Mr. BERGMAN. If we are identifying the same things over and again, why or what has not allowed—what has been inhibiting VA from making significant progress in fixing the deficiencies?

Mr. STEELE. The personnel suitability program is a people-driven process, and I think the theme as we have——

Mr. BERGMAN. Define people driven process in this case.

Mr. STEELE. There is workload that needs to be completed and a need for people to be dedicated to carrying——

Mr. BERGMAN. Okay.

Mr. STEELE [continuing]. out those tasks.

Mr. BERGMAN. You have got a workload that is not matched with the humans, the number of humans' ability to really get into that workload. Are you saying you need more people?

Mr. STEELE. That is correct.

Mr. BERGMAN. Okay. Do you need them full-time or do we just work off the backlog? Are there any folks that VA could contract with to bring in qualified, for lack of a better term, investigators, adjudicators, whatever you want to call it, to bring down the backlog? I see you shaking your head. The answer is no. Why not? Whether it be the governmental sector or the private sector, there are expertises that exist that if your goal is to knock down a backlog or decrease the time without adding unnecessarily full-time equivalents, because if you add full-time equivalents now, you have got someone on the payroll. If you knock it down, do they have work to do? Okay. Tell me, you were shaking your head. Why is it the way it is?

Ms. BONJORNI. Adjudicators are one of those inherently governmental functions that cannot be contracted out to a contractor.

Mr. BERGMAN. By law, by policy, or by capability?

Ms. BONJORNI. I believe by law and OPM requirements.

Mr. BERGMAN. It is not as though it cannot be done by changing the requirements and the law, it is just that it is being used as a reason to not do it because it is the law, it is the policy. Am I hearing you correctly?

Ms. BONJORNI. Yes. I would add that it is because we are asking them to make a decision about whether someone is suitable for Federal employment. That is not typically something we would want to outsource outside the government.

Mr. BERGMAN. Want to or need to? What do we sacrifice by delaying? Do we sacrifice the ability of our good people who are trying to do the job and do it right and get others in? Who fails in the end? Where does the burden of lack of performance, lack of the

ability to get it down? Who does that lie with? Does that lie with the bureaucracy? Does that lie with who? The policymakers like us? Who should we pin the rose on?

Ms. BONJORNI. Right now, you can continue to pin it on the VA because we need to be making more improvements swiftly to staff, which is what we are doing right now. We are staffing up those positions to make sure that we can address backlogs and issues.

Mr. BERGMAN. Some of us who have been to the war fight, when you are in the fight, you are really not worried about policy. You are worried about what have you got for ammunition and what have you got for support? I would suggest we could all improve. We want to work with you, but how do we take, do the right thing long term, but do something in the short term that actually benefits the veterans through good adjudication, then hiring, and all of that? With that, Madam Chair, I yield back.

Ms. KIGGANS. Thank you very much. Mrs. Cherfilus-McCormick, you are now recognized for 5 minutes for questions.

Ms. CHERFILUS-MCCORMICK. Thank you, Madam Chair. I wanted to kind of circle back to one of the initial conversations you were having with Ranking Member Mrvan. I wanted to know what is your oversight mechanisms to ensure that the community care providers are living up to their contractual obligations? Now, Mr. Steele mentioned real quick the audit process, I just want to dive a little deeper into that.

Mr. GALIK. I will ask my colleague if she could address that.

Ms. BONJORNI. I will continue to need to get back to you. Community care is outside of my area of expertise.

Ms. CHERFILUS-MCCORMICK. What is the audit process or oversight process you have? One of my concerns is, before I came to Congress, I worked 15 years as a Chief Executive Officer (CEO) of a healthcare company. One of our preliminary things that we did, we had an audit process to make sure we were living up to our contractual obligations. Compliance was always the first lever. Those who gave us the contract, they actually had a mechanism in place even before you can get paid. That has been the priority that I have seen, the standard. I wanted to know what was yours, because I think that is really going to be one of the linchpins in figuring out how to solve this long term and short term. I would love to get that information back, because I think that is where we are really finding the problem.

I heard a lot about the policies, procedures. Policies and procedures and reports are wonderful, but we are really looking at the implementation plan so we can protect our veterans. Is there any implementation plans that you could talk about today that will assist us in protecting our veterans?

Ms. BONJORNI. As it relates to community care providers or our employees?

Ms. CHERFILUS-MCCORMICK. Employees, community care providers. I am really looking into the background checks, the lapse of those people who were able to work without those background checks.

Ms. BONJORNI. Oh, as it relates to background investigations for our employees, I could speak to what we are doing internally to VHA. As mentioned, we are increasing our staffing to try to tackle

those issues to make sure we do not end up with situations as Mr. Steele referenced before, where we had just one person onsite to adjudicate background investigations. We have to make sure that we have multiple people there for checks and balances. We have instituted that already across the system.

We are also instituting a compliance checklist that we are piloting in two networks right now based on some of the recommendations we got from our partners here on the dais that we are going to roll out throughout the system in March 2024.

Ms. CHERFILUS-MCCORMICK. The proficiency of the things that you are implementing right now, are you confident that they are actually going to solve this problem, that we will not be going into 2024 finding the lapse of background checks?

Ms. BONJORNI. Yes. I think that we are finally identifying the things that we really need to tackle with the help of the technology improvements that we are seeing.

Ms. CHERFILUS-MCCORMICK. My next question, it is really about the hiring. We looked, and we see that throughout the entire spectrum of healthcare, there is a shortage of getting qualified nurses, nurse practitioners into the system. When I visited VAs from in my State of Florida and also in Texas, they all complained about the lag time. They are extremely long. We heard from our stakeholders during the hearing also that we had that employee hiring process times at the VA often can run as long as 6 months. By contrast, effectively run private hospitals typically turned around the same level of paperwork no longer than 4 weeks.

In addition to that, when we spoke to healthcare providers, they said they would love to work for the VA. However, the long time of waiting made it unacceptable for them because they had to take another job. What steps are you taking to actually cut it down? I am aware of the problems that we are having with our technology modernization as the ranking member, so I wanted to know what we can do on that front also to cut down those times?

Ms. BONJORNI. Sure, I could speak to the hiring process improvements. Our team is charged with tackling that. It remains a priority for our leadership. Right now, we are doing a lot of different things in 2024, looking at sharing best practices across the system. We look at each of our locations that have done one step in the process really, really well. We are trying to take what they have learned at that site and share it across the system to improve time to hire.

Ms. CHERFILUS-MCCORMICK. In that process—I do not mean interrupt you—it looks like you are looking at best practices. When you are looking at best practices in hiring, what has been the average rate, timeframe? You are going from not 6 months now, the ones that who have the best practices, what is that timeline like?

Ms. BONJORNI. It is still longer than the community. In the places where we are doing the best, we have locations where they have time to fill in the range of 90 days. That is still much better than our average, which is 168 days for time to fill in VHA.

Ms. CHERFILUS-MCCORMICK. What do you think is an acceptable timeframe in this area that we are in where it is so hard to get healthcare professionals, what is the goal timeframe that you would like to see the VA in hiring?

Ms. BONJORNI. Our goal, in conjunction with OPM, is 80 days for hires. I still think that is too long. We would love to get closer to 60 days or less.

Ms. CHERFILUS-MCCORMICK. Thank you. I yield back.

Ms. KIGGANS. Thank you so much. Mr. Rosendale, you are now recognized for 5 minutes for questions.

Mr. ROSENDALE. Thank you very much, Madam Chair, and thank you very much, Madam Chair, for holding this hearing. The U.S. Department of Veteran Affairs is required to have individuals to go through an extensive background check before being hired to protect veterans, veterans' family members, and fellow VA employees. Any employee of the VA must properly be vetted to ensure that our veterans receive the best possible care.

VA's personnel suitability program governs the background check process and is designed to ensure individuals hired to care for veterans or handle veterans' sensitive information are suited for those responsibilities. The Office of the Inspector General and the Government Accountability Office have both released reports that found the VA violates its own policies by allowing individuals to obtain employment without completed background checks. This is unacceptable, and I appreciate the committee's effort to search for those answers.

More closer to home, we had these problems arising at the Fort Harrison medical facility in Montana. It was so, so terrible and egregious that after an investigation was conducted, we most recently had been able to have the director removed from that facility. That is what we call accountability in Montana.

I am tired of representatives from the Veterans Administration sitting here and telling us, I take fully responsibility for these actions and the things that are going on, but they continue in their same positions with their same compensation, and that is not taking responsibility.

More recently, I want to ask about human resources failure by the VA. This is to Ms. Bonjorni. I cosigned a letter by Congressman Luttrell regarding Shekeba Morrad, an attorney at the VA who shared a video where she was antisemitic and mocked hostages. The VA was supposed to have provided a response by last night and has not done so. What is the VA's response to this disturbing video?

Ms. BONJORNI. Thank you for raising that issue. It has absolutely been brought to the attention of leaders throughout the organization. We have had extensive conversations about the importance of educating employees on appropriate social media use.

Mr. ROSENDALE. Brought to the attention, and we have had conversations about educating them. Okay.

Ms. BONJORNI. Yes, but——

Mr. ROSENDALE. If anyone in this dais had conducted themselves in the way that Ms. Morrad did, they would be calling for an expulsion on the House floor right now. The action took place on November 12. The letter was sent out on November 30, so this was not like 72 hours. The letter for request of information was sent out on November 30. We have had 3–1/2 weeks since the act. What action has been taken place except to identify that, yes, we do have a problem?

Ms. BONJORNI. To my knowledge, it is an ongoing investigation without final decision.

Mr. ROSENDALE. Is Ms. Morrad still receiving compensation and sitting in her regular duties?

Ms. BONJORNI. I would have to get back to you on that.

Mr. ROSENDALE. I would like to know that, because that is very problematic for someone who released an antisemitic video that was posted on November 12. Ms. Morrad actively mocked the Israeli hostages being held captive by Hamas.

As you were well aware, on October 7 of this year, Hamas committed one of the vilest terrorist attacks in recent history. I am taking this directly from the letter. During the attack, men, women, and children, and children that Hamas did not kill, were taken back to Gaza to be held as hostages. Ms. Morrad's mocking of these people and their families is unacceptable and quite frankly, dangerous to the other staff and dangerous to the actions that are taking place in the facility. I find it troubling that you would sit there and say that we have identified that issue, but yet you have no understanding of where Ms. Morrad is, if she is being compensated, and what has taken place.

This letter went out on November 30, and so I would say by close of business today, I would like to have some kind of information about her status as it exists right now and what actions are being taken as we move forward. I yield back. Thank you very much, Madam Chair.

Ms. KIGGANS. Thank you, Mr. Rosendale. I want to proceed to just a second round of questions and getting back to some of the issues with background checks and whatnot. Mr. Steele, is it possible that some of the VA employees with felony drug convictions have never received a background check?

Mr. STEELE. Well, I cannot speak to that element of the background check process. Our report did identify gaps related to people, processes, and technology that suggests that VA does not consistently complete suitability actions timely or at all. In terms of the specific DEA waiver process, I would have to defer that to VA.

Ms. KIGGANS. It is possible that there are people with felony drug convictions that have not received a background check working at the VA?

Mr. STEELE. There are gaps in the background check process that do not ensure that they are completed.

Ms. KIGGANS. Thank you. Mr. Bagdoyan, does the VA have a policy in place to determine whether an employee has access to controlled substances?

Mr. BAGDOYAN. Policy for access, I am not sure, I know they do not have one for waivers. I would redirect to the VA if they do. Apologies for not knowing that off the top of my head.

Ms. KIGGANS. Would it be possible, do you think, for and maybe, Ms. Bonjorni, you would be better suited to answer the question, but for someone like a maintenance staff or cleaning staff that might have access to controlled substances?

Ms. BONJORNI. Maintenance staff or cleaning staff would not have access to controlled substances. However, in the draft policy that we are planning to move forward with in January, we are going to be issuing guidance to facilities as well to evaluate each

position so they are able to understand how to make that designation of which positions have access or do not. A maintenance worker would not have access.

Ms. KIGGANS. In this report that will come out then in January, this policy, will security be addressed in that as well so there will be ways to track? I feel like that is another just step of good deterrence for when people know that they are being watched and on camera.

Ms. BONJORNI. That would be covered under other policies about how we administer and manage controlled substances. The one that we are putting forward is an HR policy.

Ms. KIGGANS. Okay. Great. We will follow up on that. Mr. Bagdoyan, in your testimony, you note the risk that the VA is taking by not having this policy. Could you talk about the risks of not having just a policy in place to determine whether an employee has access or not?

Mr. BAGDOYAN. Sure, yes. As I highlighted in my opening remarks, it is the care or the attention that a veteran needs when in facility and also, of course, the diversion risk. As reported to DEA in 2021 there were 50 instances within VHA where there was employee theft involved. I am not certain whether that involved also diversion for illegal purposes.

You know, if you go by a standard of one is one too many, it is close to an absolute standard. Given that veterans are involved, that may be something to really take a close look at in terms of how certain do you have to be through processes and procedures to make sure that these potentially unsuitable employees do not have access and then harm veterans or engage in other illegal activities.

Ms. KIGGANS. Can any of you answer just this question? When you do find in a VA facility that there has been people that there are controlled substances that are missing, there are people there that are involved in maybe some nefarious activities, what is the process done then? Is there a procedure in place that they come in and they take a closer look at each employee that has access to those controlled substances? What are we doing to actually rectify that problem once it is highlighted?

Ms. BONJORNI. Yes, so, our facilities do have standard procedures to do investigations. When there is an issue identified of potential loss or diversion of controlled substances, those procedures are standard and in place.

Ms. KIGGANS. They happen every time?

Ms. BONJORNI. Yes.

Ms. KIGGANS. Okay. Mr. Bagdoyan, when did the GAO first recommend that the VA develop a policy?

Mr. BAGDOYAN. For waivers, yes. That goes back to our 2019 report that we issued. The audit work for that actually went back as far as 2015. That is something that we flagged quite a while ago. Of course, our 2023 report found similar challenges with the absence of a waiver policy, which is the anchor in terms of, or the roadmap, if you will, of what needs to be done. Further to Mr. Steele's point of people, processes, and technology, you will not know what you need unless you have a policy to anchor all those activities on.

Ms. KIGGANS. It has been a while, several years——
Mr. BAGDOYAN. Yes, ma'am.
Ms. KIGGANS [continuing]. and multiple occasions——
Mr. BAGDOYAN. Yes.
Ms. KIGGANS [continuing]. that you have asked for that.
Mr. BAGDOYAN. Eight years and counting, yes.
Ms. KIGGANS. Okay. Ms. Bonjorni, why has it taken so long for the VA to create this policy?
Ms. BONJORNI. My understanding is that our group who was looking at developing the policy had extensive discussions with the DEA to make sure that we understood what their requirements were until we got to a point where we feel we understand exactly what they are looking for and we can publish a policy. It has been drafted now for a few months, and we are getting ready to issue it.
Ms. KIGGANS. January we will receive a policy or we can find it——
Ms. BONJORNI. An interim policy will come out in January, yes.
Ms. KIGGANS. Okay, great.
Ms. BONJORNI. That facilities can start making sure they are doing the appropriate reviews.
Ms. KIGGANS. I am looking forward to reviewing that. Will the policy include the DEA's definition of access to controlled substances?
Ms. BONJORNI. Yes, it will.
Ms. KIGGANS. Great. Last question, Mr. Bagdoyan, will you be reviewing the VA's policy when they publish it?
Mr. BAGDOYAN. Yes, that is part of our recommendation monitoring process. We engage regularly with VA and other agency personnel as they implement our recommendations, of course, within the boundaries of independence on both sides. Yes, we look forward to seeing that as evidence so that we consider closing the recommendation and giving the department credit for taking action. I would point out that it has to be action in fact, in addition to action on paper. Those are two different things.
Ms. KIGGANS. Right.
Mr. BAGDOYAN. I just want to make a note of that.
Ms. KIGGANS. We too in this committee will be anxiously looking forward to reviewing the policy and following up on its implementation. Thank you very much for that, and I yield to Ranking Member Mrvan.
Mr. MRVAN. Mr. Steele, in your audit of the VA's personnel suitability program, you determine that staffing is a core deficiency leading to the issues with how the personnel suitability program operates or fails to operate effectively. In your audit, you identified examples of human capital concerns throughout the personnel suitability process. For instance, there is a single VISN adjudicator to address thousands of employee onboarding files at a number of facilities. In your view, how many employees are needed to fill the need to onboard on time to get to the goals that Mrs. Bonjorni talked about?
Mr. STEELE. Our audit identified clearly that personnel suitability actions were not being completed timely or at all, and that could be attributed to a lack of staffing. We did not evaluate staff-

ing metrics or other benchmarks that would guide that. VA did provide us a draft staffing model that we highlighted in our report. However, we made a recommendation that we will follow up on to see where they eventually end up with that metric. In terms of specific questions related to staffing levels, I would have to defer to VA.

Mr. MRVAN. Okay. Ms. Bonjorni, as far as that staffing model, can you elaborate on what that looked like?

Ms. BONJORNI. Sure. The staffing model that we recently rolled out for facility use includes recommendations around total staffing for both personnel security specialists and personnel security assistants who participate in this entire process in the HR realm. Right now, we have about 800 total on board between those two occupational groups, and we estimate that we still have a gap of about 145 total that still need to be hired to get to full capacity.

Mr. MRVAN. Okay. Mr. Steele, we heard from the VA that they have made progress in implementing the new case management IT system for personnel suitability deemed the VA-CABS 2.0. Has the IG had a chance to review this updated system? What features would an updated case management IT system ideally have to help the VA effectively manage its personnel suitability program?

Mr. STEELE. We made recommendations related to the new VA-CABS 2.0 system. However, our first follow up to those recommendations will not occur until later this month. We have not reviewed anything related to how VA has defined their requirements for that new system.

Mr. MRVAN. Okay. With that, I yield back, chairwoman.

Ms. KIGGANS. Thank you, Mr. Mrvan. The chair now recognizes Mr. Rosendale for 5 minutes for questions.

Mr. ROSENDALE. Thank you very much, Madam Chair. You did a really good job of outlining the process that is deficient and trying to establish a new one going forward. I appreciate that. That wiped out a bunch of my questions. It sounds to me just what I am hearing here is that the focus needs to be on the actual onboarding of the employees, that joining the VA is not the origins of these people having different drug problems, Okay? They had these problems with substance abuse and/or the felonies prior to joining the VA. We really need to be drilling down on the onboarding process, the hiring process, to make sure that we are not bringing these people that already have problems into a system that might provide them with the means to access the substances that are giving them problems in their lives to begin with. Mr. Bagdoyan, am I pronouncing that correctly?

Mr. BAGDOYAN. Yes, sir, thank you.

Mr. ROSENDALE. Bagdoyan, yes, sir. VA testified that it has been years since the last submitted a DEA employment waiver. Do you think the department was properly following Federal laws and regulations by doing so?

Mr. BAGDOYAN. Well, Mr. Rosendale, if they do not have a policy which I identified as the anchor of what VA should be doing, I do not want to speculate on whether they violated something or not, but it clearly is a gap that should be closed. As Ms. Bonjorni indicated——

Mr. ROSENDALE. If they were not violating something, they certainly were not following the intent of what DEA was trying to do, then can we say that?

Mr. BAGDOYAN. I would say that in the case of the 50 people we identified in our projectable sample, the determinations that these individuals, at least for 48 of them, that VA confirmed that they did not need a waiver for one reason or another. That was kind of an ad hoc decision, if you will, that was not——

Mr. ROSENDALE. Yes. So, again——

Mr. BAGDOYAN [continuing]. grounded in policy——

Mr. ROSENDALE [continuing]. the waiver was not necessary. However, they had previous problems that had not been detected. Again, this is where we go to the onboarding. If somebody has a problem, I mean, are we going to take a kleptomaniac and leave them in charge of security of the store? I do not think so, okay. Do not expose them.

Ms. Bonjorni, I hope that you are now clear on DEA's guidance. How many current VA employees require employment waivers but do not have them?

Ms. BONJORNI. That is one of the things that we will be reviewing when we roll this policy out.

Mr. ROSENDALE. Do we have any kind of estimate whatsoever? Is this some numbers that you can provide to us within the next week?

Ms. BONJORNI. When we do the review, so when we roll out the draft policy as well as the guidance for facilities about how to do the review, we will be able to provide you additional information on that.

Mr. ROSENDALE. Okay. Ms. Bonjorni, in 2021, VA accounted for 7 percent of DEA's total reports of theft or loss of controlled substances. Have any of these incidents involved employees with a criminal record?

Ms. BONJORNI. I would need to get back to you on that.

Mr. ROSENDALE. Okay. Again, I am drilling down, trying to get to the point that what we need to be focusing on is the preemployment. We have to be focused on the onboarding of these employees so that we are not putting people in a position where they can be a danger to themselves and others. Do you think that having a controlled substance policy that complies with DEA regulations could help reduce those numbers?

Ms. BONJORNI. I do think it could help, but I would offer that right now, we are following the personnel suitability requirements that are in place already from OPM. We also are reviewing to make sure that people have appropriate unrestricted licenses. Any type of felony conviction would tend to have some kind of impact on licensure already. That is reviewed in the credentialing process as well.

Mr. ROSENDALE. Okay. Thank you, Madam Chair. I would yield back the balance of my time.

Ms. KIGGANS. Thank you, Mr. Rosendale. I just want to thank our committee members and especially those of you who came to testify before us today. Thank you very much. I know there is work to be done. It was very educational for me and I am sure the other members to hear of the good work that you all are doing.

I feel like the opioid crisis is a crisis, right? We are working to just make positive changes in all facets of it. I feel like we have done a good job. The DEA works hard with providers. As a nurse practitioner, I know that we have a drug data base. We are careful about our prescribing habits. I think that the VA does a good job of ensuring patient safety through things like drug contracts and drug screenings and just really watching how we are prescribing opioids.

This is kind of the back end of that loop. Just curtailing that, again, nefarious activity. We have made it harder to get opioids, which is a good thing.

We need to close the loop on the back end to make sure that we are—the employees that we are hiring, not just for patient safety, but cost too. I mean, there are costs associated with that type of theft. Making sure we are doing all of the right things to provide the best care for our veterans. Thank you for all the good work you are doing. Thank you to our members. I ask unanimous consent that all members have 5 legislative days in which to revise and extend their remarks and include any extraneous material. Hearing no objection, so ordered. This hearing is now adjourned.

[Whereupon, at 11:17 a.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Daniel Galik

Good afternoon, Chairwoman Kiggans, Ranking Member Mrvan and Members of the Subcommittee. Thank you for the opportunity to discuss the Department of Veterans Affairs (VA) Human Resources (HR) and Background Investigation processes. I am accompanied today by Jessica Bonjorni, Chief, Human Capital Management, Veterans Health Administration (VHA).

VA recognizes that rigorous personnel security and suitability protocols for its health care workforce are vital to maintaining the trust of Veterans, Veteran families, and VA employees in its health care delivery system. VA's background investigation processes for all employees aligns with 5 C.F.R. Part 731 and guidelines established by the Office of Personnel Management (OPM).

Suitability Processes

Pre-employment screening for Federal employees to determine suitability for employment generally begins once a tentative job offer is made. At this stage, self-declared information and available criminal history are reviewed. Once an applicant has a favorable screening, a background investigation is initiated at the appropriate level for the position.

Suitability determinations involve a review of the person's character or conduct that may have an impact on the integrity or efficiency of the service. Once a completed background investigation is sent from Defense Counterintelligence and Security Agency (DCSA) to VA and a trained suitability adjudicator makes a final determination. This determination considers whether the individual has the appropriate character and conduct for Federal employment in the position sought.

The Office of Human Resources and Administration/Operations, Security and Preparedness (HRA/OSP) sets VA enterprise policy and has oversight over background investigations processed for VA employees. VA Administrations (VHA, Veterans Benefits Administration and National Cemetery Administration) are responsible for following VA policy when processing background investigations to ensure the safety of Veterans, employees and visitors. Achievement of the investigative requirements is verified during VA information technology account provisioning and Personal Identity Verification badge issuance.

Background investigations for Federal employees should be initiated before appointment but no later than 14 calendar days after placement in the position. VA uses the same standard for contractors. A final suitability decision is made after the conclusion of the background investigation by the Defense Counterintelligence and Security Agency (DCSA) and in accordance with 5 C.F.R. part 731, must be reported to the governmentwide reciprocity system no later than 90 days after the investigation is completed.

Issues discovered during the pre-employment screening process are forwarded to a trained adjudicator for review and appropriate action. If the adjudicator cannot mitigate the issues found during the pre-employment screening process, the VA HR Onboarding Point-of-Contact (POC) may decide to withdraw the offer.

Qualification issues, to include U.S. Drug Enforcement Administration (DEA) registration, are also identified by VA's credentialing POC and communicated to the HR POC to determine the appropriate follow-up action.

Similarly, issues discovered during the background investigation process are forwarded to a trained adjudicator for review and appropriate action [1]. If the adjudicator cannot mitigate the identified issues, a decision of unsuitable may be rendered. The adjudicator will determine if a suitability action or action under another applicable authority may be appropriate. The decision on which authority may be

[1] 5 C.F.R. Part 731, Office of Personnel Management, https://www.ecfr.gov/current/title–5/part–731

applied may take into account the length of time on the job and the seriousness of the issues.

When issues are discovered after a person is hired, such as when an alert is received by VA from DCSA Continuous Vetting products updated criminal history information), these alerts are reviewed by a trained adjudicator[2]. As appropriate, Employee Relations and Labor Relations may initiate appropriate adverse action on employees. In response to GAO Audit (#23–104296) VA, under HRA/OSP guidance, developed a RAP BACK action plan that includes development of control procedures and any other action that must be completed to ensure RAP BACK notifications are routed and resolved appropriately.

Efforts to improve VA's Personnel Security and Suitability Program

In late 2020, VA established working groups and Integrated Project Teams (IPT) to review the processes used within VA to initiate background investigations and the subsequent adjudication by VA staff of those investigations. The IPTs identified process enhancements that were implemented to mitigate weaknesses and inconsistencies in how background investigations were adjudicated by VA's adjudicators. The findings from the Fiscal Year 2022 Federal Information Security Management Act (FISMA) audit determined that VA has made and continues to make progress, and continued focus is needed to processing address the improvements identified in the audit. VA is continuing to update our corrective action plans to resolve issues identified in the FISMA audit reports.

VA is also addressing how to improve governance of the personnel suitability program as identified in VA Office of Inspector General (OIG) Audit Report 21–03718–189, dated September 21, 2023. HRA/OSP is leading the development of a VA-wide plan with actions and milestones to increase oversight of VA's personnel security and suitability program, identify roles and responsibilities, review and update oversight processes as well as verify that background investigations are initiated and adjudicated within prescribed timelines and that documentation is filed as required. VHA completed a personnel security oversight and compliance pilot on October 31, 2023, to test guidelines and job aids to enhance VHA Personnel Security programs. Those guidelines and job aids are being refined for deployment across VHA through March 2024. This more structured approach to oversight and compliance will be supported through a new Personnel Security staffing model recently published for Veterans Integrated Service Networks and other VHA offices to implement.

In partnership with HRA/OSP, the Administrations will also develop plans to establish robust oversight of their personnel suitability programs. HRA/OSP will integrate these plans into the VA-wide plan. The plan will include the actions and resources required by HRA/OSP and the Administrations to reimplement the monitoring program required by VA Handbook 0710 on the personnel vetting program. It will also identify, prevent, and mitigate any systemic areas of improvement in the personnel suitability program. The plan will be submitted to OIG by December 31, 2023.

VA's Rehabilitation Program

VA emphasizes the importance of finding a balance in our mission to provide world-class health care to Veterans and our mission to support the rehabilitation of Veterans who have had complex histories including substance abuse. For example, VA's Compensated Work Therapy (CWT) program is a clinical vocational rehabilitation program offered at every VA medical center. CWT provides Veterans with evidence-based vocational rehabilitation services. These services include partnerships with business, industry and Government agencies to provide Veteran candidates with employment.

To be considered for participation in the CWT program, a Veteran must be eligible to receive VA health care services, have a goal of returning to competitive employment and have experienced barriers to obtaining and/or retaining employment, which requires the intensive supports provided by one of the CWT service components. There are numerous success stories of the CWT program, including Veterans who graduated from VA's CWT program to become full-time employees at VA medical centers or as cemetery caretakers, and employers have realized the benefits of hiring Veterans from the program.

VA seeks to hire Veterans who have rehabilitated on their own or through structured VA programs, including the 52,000 Veterans VA serves annually through the CWT program. Enhancing Veteran readiness for re-employment and successful reintegration back into the workforce balances VHA care delivery with our mission to

[2] 5 C.F.R. Part 731, Office of Personnel Management, https://www.ecfr.gov/current/title–5/part–731

rehabilitate Veterans, including those with histories of substance use, or prior criminal history. In the event a CWT program participant is offered employment at VA at the conclusion of their therapy, these Veterans are subject to the same suitability requirements as other VA employees.

Conclusion

Madam Chair and Members of the Subcommittee, thank you for the opportunity to share more information on VA's background investigation and HR processes and how VA helps protect Veterans. Our objective is to give the Nation's Veterans the top-quality care they have earned and deserve by carefully and thoroughly vetting all personnel who will interact with Veterans, their families, and others at VA. We appreciate this Subcommittee's continued support and encouragement.

This concludes my testimony. Ms. Bonjorni and I are prepared to respond to any questions you may have.

Prepared Statement of Shawn Steele

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

STATEMENT OF SHAWN STEELE
DIRECTOR, HEALTHCARE INFRASTRUCTURE DIVISION,
OFFICE OF AUDITS AND EVALUATIONS
OFFICE OF INSPECTOR GENERAL, US DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
US HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS' AFFAIRS
HEARING ON
BACKGROUND CHECKS: ARE VA'S HR FAILURES RISKING DRUG ABUSE AND VETERAN HARM?
DECEMBER 6, 2023

Chairwoman Kiggans, Ranking Member Mrvan, and members of the Subcommittee, thank you for the opportunity to testify on the Office of Inspector General's (OIG) oversight of the Department of Veterans Affairs' (VA) personnel suitability program. A high-performing screening program with properly administered background investigations is vital for VA. This is particularly critical for the Veterans Health Administration (VHA) to ensure its medical facility workforce has the integrity and qualifications to support safe and quality patient care. This program also helps protect sensitive health and personally identifiable information from misuse or unauthorized disclosure and fosters a secure environment for VHA personnel, veterans, and visitors.

As the OIG has reported, VA faces high vacancy rates and significant staffing shortages across many of its programs and operations, including critical positions within VHA.[1] VHA's human resources and personnel suitability programs across the country have themselves suffered from inadequate staffing that can impede its ability to hire. While new demands and challenges increase the urgency for VA to address long-standing staffing shortages, it must balance the need to conduct proper background investigations with the quick onboarding of staff. Having the right people in the right positions committed to doing the right thing is essential to building and maintaining a culture of accountability.

The OIG has published reports on deficiencies in the personnel suitability program since 2017, with its most recent September 2023 report confirming that problems continue. In particular, that audit found

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[1] VA OIG, *OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2023*, August 22, 2023. The OIG annually determines a minimum of five clinical and five nonclinical VHA occupations with the largest staffing shortages within each VA medical center. VHA reported 3,118 severe occupational staffing shortages across 282 occupations in fiscal year (FY) 2023. This was an increase from 2,622 severe occupational staffing shortages across 285 occupations in FY 2022, following annual decreases during FY 2018–FY 2021.

VA did not provide effective governance of the program or have effective data and information technology systems to ensure that required background investigations were initiated, completed, or adjudicated within required timelines for staff at medical facilities nationwide.[2]

Although many of the VA employees with delayed checks were later found to be suitable, these program weaknesses increase opportunities for bad actors to make their way into the workforce. In a horrific criminal case, nursing assistant Reta Mays pled guilty to murdering seven patients at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia. The OIG report on this matter, discussed later in this statement, found that she had not undergone a timely background check that might have prevented her from remaining in her position.[3]

To provide context for the OIG's oversight findings, this statement will first discuss the background investigation process and governance, before highlighting areas of concern, including inadequate program governance and data systems, and associated recommendations for VA improvements.

BACKGROUND INVESTIGATION PROCESS AND GOVERNANCE

Applicants or appointees for VA positions undergo background investigations as a condition of their employment to help protect veterans, their family members, employees, and visitors to VA facilities, as well as to secure sensitive information and resources.[4] VA determines the level of investigation by assessing the risk of the position. Most VA employees, including many medical facility staff, do require an investigation to verify suitability for employment. These positions include physicians, nurses, pharmacists, and laboratory technicians.

The Three-Part Background Check and Data Systems

Applicants for VA employment undergo a three-part background check. First, when applicants accept a tentative offer for employment, they submit a form (an OF 306), Declaration for Federal Employment, which allows applicants to self-report information related to past or ongoing legal violations, prior terminations of employment, and delinquent federal debt. VA staff then compare the applicants' responses and the relevant position descriptions to determine if the reported information could disqualify them from being employed. For example, an applicant with a recent conviction for prescription drug theft might be disqualified from a position in a pharmacy, but not a groundskeeper position.

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[2] VA OIG, *VA's Governance of Its Personnel Suitability Program for Medical Facilities Continues to Need Improvement*, September 21, 2023.

[3] VA OIG, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, May 11, 2021; VA OIG, *Personnel Suitability Process Concerns at the Beckley VA Medical Center in West Virginia*, February 23, 2023.

[4] An applicant refers to "a person who is being considered or has been considered for employment." An appointee refers to "a person who has entered on duty and is in the first year of a subject-to-investigation appointment" as defined in 5 C.F.R. § 731.101 (2019). For readability, "applicant" in this statement refers to both.

Then, the applicant is subject to a fingerprint criminal history check. Fingerprinting should generally be completed before employment but may be conducted up to five days after the entrance on duty date (after taking the sworn oath on their first day of work).[5]

Finally, the Defense Counterintelligence and Security Agency (DCSA) conducts the required background investigation, providing VA with comprehensive information needed to verify suitability for employment.[6] This investigation includes (1) a name check with the FBI and other federal databases and (2) written inquiries to employers, candidate-supplied references, and places of education and residence. This process must be scheduled within 14 days of the entrance on duty date.[7]

Once DCSA completes the investigation, the resulting information is submitted to VA for review and adjudication. Suitability staff review the results of the background investigation, consider any negative information, and validate the applicant's suitability for employment.[8] Finally, the certificate of investigation is uploaded into the employee's electronic personnel folder.

Information from the completed investigation is recorded in two VA information technology systems:

- **HR Smart**: This human resources system supports personnel suitability, payroll, and position management. HR Smart captures data about the type of investigation required for a position, the type of investigation the incumbent is undergoing, and the status of that investigation.
- **VA Centralized Adjudication Background Investigation System (VA-CABS)**: This centralized case management system is used for processing background investigations and tracking suitability-related data. An off-the-shelf version of VA-CABS was launched in April 2019 and captured data about fingerprint checks, background investigations, and reinvestigations. In July 2022, VA-CABS became the system of record for all VA personnel suitability data. VA subsequently completed implementation of a customizable replacement system in September 2023, referred to as VA-CABS 2.0.

Governance

Several VA leaders have responsibility for the department's suitability program, starting with the assistant secretary for Human Resources and Administration/Operations, Security, and Preparedness (HRA/OSP), who has the authority to establish and maintain personnel suitability programs throughout the department consistent with applicable laws, rules, regulations, and executive orders.

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[5] VA Handbook 0710, *Personnel Security and Suitability Program*, May 2, 2016. The entrance on duty date is when the employee takes their oath of office, which is their first day of work.

[6] 5 C.F.R. § 736.201 (2019); VA Handbook 0710.

[7] 5 C.F.R. § 736.201 (2019); VA Handbook 0710.

[8] A suitability determination must be rendered within 90 days after the background investigation is closed. A negative determination may result in dismissal. 5 C.F.R. § 731.203 (2019); VA Handbook 0710.

HRA/OSP's Office of Identity, Credential, and Access Management is responsible for developing, coordinating, and overseeing the implementation of policy, programs, and guidance for the department's suitability program. A suboffice, Personnel Security and Credential Management, conducts oversight and program reviews to evaluate compliance with and implementation of the handbook's requirements.[9]

The three VA administrations—VHA, the Veterans Benefits Administration, and the National Cemetery Administration—must appoint a personnel security program manager to coordinate departmental regulations and policies involved with the overall personnel security and suitability program.[10] VHA's personnel suitability oversight is conducted by the Personnel Security Program Office within Workforce Management and Consulting (WMC). Regionally, VHA's Personnel Security and Suitability Program Policy requires Veterans Integrated Service Network (VISN) personnel security chiefs to ensure that investigations and adjudications are completed within required time frames.[11]

The chart on the next page provides an overview of the VA, HRA/OSP, and VHA organizational structures for governance of the personnel suitability program.

[9] VA Handbook 0710. The handbook specifies requirements for (1) checking fingerprints within timelines, (2) initiating and adjudicating background investigations, (3) uploading investigation documentation into an employee's personnel file, and (4) updating data systems with relevant information.

[10] VA Handbook 0710.

[11] VHA Workforce Management and Consulting, *Personnel Security and Suitability Program Policy*, rev. February 2020. In October 2018, VHA began implementing a shared services model for human resources that consolidated all 140 facility human resources offices under the 18 VISNs that manage and oversee medical facilities in their specific geographic areas. Personnel suitability functions, such as initiating background investigations and adjudicating closed investigations, resided with the VISNs at the time the September 2023 report was written.

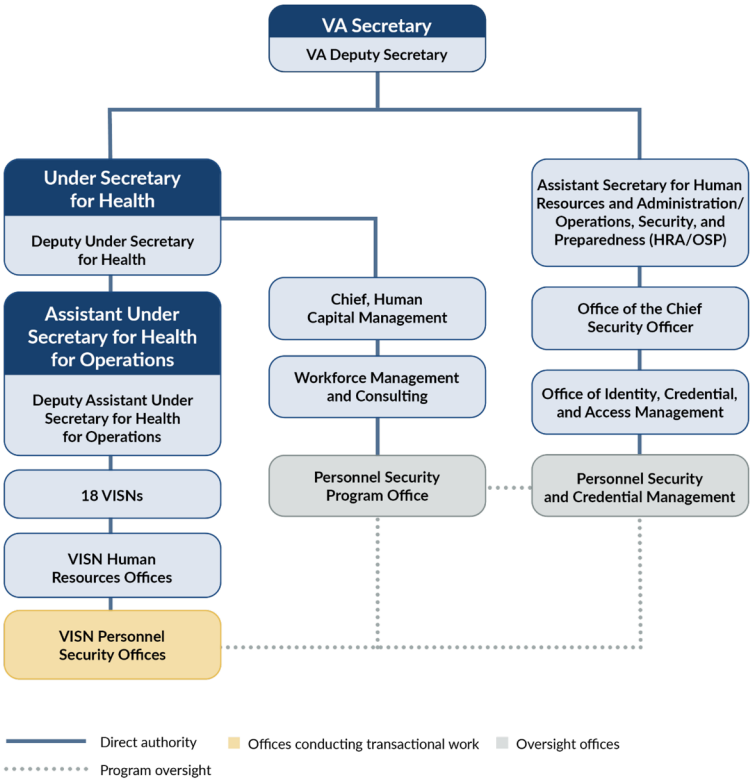

Figure 1. *Overview of the organizational structures for governance of the personnel suitability program. Source: OIG analysis of organizational charts, VA and VHA policy, and VHA websites and position descriptions. Note: As shown in this chart, VA guidance assigns responsibility to offices and, at other times, specific positions.*

OIG OVERSIGHT HAS FOUND PROGRAM DEFICIENCIES SINCE 2017

In 2017, the OIG determined the Atlanta VA Medical Center had a backlog of more than 300 unadjudicated background investigations and that mandatory post-employment drug testing of new hires did not occur during a six-month period.[12] These deficiencies prompted the OIG to initiate a national audit. The resulting March 2018 report on the personnel suitability program concluded that neither VA nor VHA effectively governed the program to ensure background investigation requirements were met at medical facilities nationwide.[13] The OIG estimated that VHA had not initiated a background investigation for 6,200 employees from October 1, 2011, through September 30, 2016. Additionally, human resources staff did not adjudicate background investigations within required time frames. Finally, VA could not independently attest to the status of personnel suitability adjudications because HR Smart lacked the data fields necessary to track background investigations to conclusion, and key investigation fields that were available were either populated incorrectly or left blank. As a result, VA could not account for the investigation status of VHA personnel, which risked exposing veterans and employees to individuals who may not have been properly vetted.

The OIG's 2018 report made 11 recommendations to VA and VHA for establishing robust oversight of the personnel suitability program, ensuring reliable investigation data were collected and maintained, correcting existing data integrity issues, and implementing a plan to review the suitability status of all VHA personnel.[14] These recommendations were closed between January 2019 and March 2022, based on documentation VA provided to the OIG.

In a management advisory memorandum published in March 2021, the OIG identified risks associated with VHA's efforts to expedite hiring and onboarding during the COVID-19 pandemic.[15] These risks included delays in fingerprint-based criminal history checks that may also have affected the timely adjudication and reporting of background investigations. The risk was amplified by the large number of new employees appointed from VHA's expedited hiring efforts. The OIG determined that, in the absence of completed background investigations, more safeguards may be warranted for new employees until vetting is completed. The OIG conveyed this important information for VHA to consider but did not make any specific recommendations for corrective action in this memorandum.

As previously mentioned, the OIG issued a report in May 2021 on care and oversight deficiencies related to multiple homicides at the Louis A. Johnson VA Medical Center.[16] On July 14, 2020, Reta

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[12] VA OIG, *Review of Alleged Human Resources Delays at the Atlanta VA Medical Center*, January 30, 2017.

[13] VA OIG, *Audit of the Personnel Suitability Program*, March 26, 2018.

[14] The OIG requests updates on the status of all unimplemented recommendations every 90 days and all recommendations' statuses may be found on the OIG website.

[15] VA OIG, *Potential Risks Associated with Expedited Hiring in Response to COVID-19*, March 11, 2021.

[16] VA OIG, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, May 11, 2021.

Mays, a former nursing assistant, pled guilty to seven counts of second-degree murder and one count of assault with the intent to commit murder, all by deliberately administering lethal doses of insulin to patients. The medical center had not adjudicated Mays' background investigation within 90 days; specifically, the Office of Personnel Management, the federal agency then responsible for conducting investigations, closed her investigation in September 2015, and the medical center did not adjudicate the investigation results before her employment was terminated in March 2019. Had the medical center reviewed them in a timely manner, responsible personnel could have identified and followed up on outstanding inquiries to previous employers.[17] Inquiries may have revealed the prior allegations of Ms. Mays' using excessive force as a corrections officer. Review and adjudication of her background investigation within prescribed timelines could have disqualified her from VA employment or assuming a position that provided direct patient care.

Under federal law and VA policy, VHA cannot employ individuals who have been formally excluded from having a paid position in a federal healthcare program.[18] This check should be completed before the personnel suitability process begins. Exclusions can result from an individual committing healthcare fraud, patient abuse, controlled substance violations, acts resulting in license revocation, and other misconduct as specified by federal law. The List of Excluded Individuals and Entities (LEIE), maintained by the US Department of Health and Human Services Office of Inspector General, is meant to prevent individuals who have been found unsuited for working in a federally funded healthcare program from having access to medical facilities given the need to protect their assets, patients, and information systems. In March 2023, the OIG issued an administrative investigation report that compared January 2022 VHA personnel pay information against LEIE data and found VHA was generally in compliance, though improperly employing four former nursing professionals. None, however, were engaged in patients' health care.[19] Three of them were on the list because of nursing license revocation or suspension, while the fourth was convicted of healthcare fraud. VA took prompt action to terminate the employees. VHA also concurred with the report's three recommendations for completing policy and process improvements, taking additional actions to prevent violations from recurring, and conducting, by January 2024, a one-time audit to confirm compliance with the federal law. The latter two recommendations remain unimplemented.

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[17] VHACOPERSEC Advisory 16-12, VHA Adjudicator Consistency, September 29, 2016. This advisory states, "With employer vouchers, if OPM inquiries to prior employers are undeliverable, returned, discrepant, or present issues, follow-up with the employer should occur to obtain any relevant employment records."

[18] 42 U.S.C. § 1320a-7; VA Handbook 5005, Staffing, part II, chap. 1, sec. B(2)(b), April 15, 2002; VA Handbook 5021/2, Employee/Management Relations, part I, chap. 3, para. 5(g), part VI, para. 10(f), June 26, 2003.

[19] VA OIG, *Stronger Controls Help Ensure People Barred from Paid Federal Healthcare Jobs Do Not Work for VHA*, March 1, 2023.

THE PERSONNEL SECURITY PROGRAM HAS NOT SUSTAINED IMPROVED CONTROLS

The September 2023 follow-up audit evaluated VA controls over the background investigation process for medical facilities nationwide to determine if adjudication actions were completed within expected timelines and reliably recorded. The audit team estimated about 54,800 VHA employees were hired for VA medical facilities from October 1, 2019, through September 30, 2021, (the most current fiscal year data completed at the time of the audit) and required an investigation. The OIG evaluated investigation actions through December 2022 for a sample of those employees.

VA's Governance of the Personnel Suitability Program for Medical Facility Employees Continues to Need Improvement

In response to multiple OIG reports, including the 2018 audit of the personnel suitability program, HRA/OSP and VHA implemented new policies and conducted reviews of its program data between May 2018 and March 2021. However, those new program controls were not sustained or did not adequately mitigate weaknesses. As such, the OIG found that VA's processing of background investigations did not consistently meet requirements, and many of the issues revealed in the 2018 audit were identified again in this follow-up audit. The team found noncompliance at several points in the suitability process:

- **Failure to initiate.** The team found that five of the 313 employees in the OIG audit sample did not have investigations initiated.[20] However small, any number of uninitiated background investigations poses a risk that warrants further attention by VA senior leaders. This is especially important for employees who provide patient care.
- **Delays in investigation.** Even when background investigations were initiated, the team estimated that 7 percent were not actually started within 14 calendar days of an employee's start date as required.[21] In particular, the 18 delinquent investigations in the team's sample were initiated between 17 and 419 days after the employees' start date and averaged 100 days.
- **Adjudications exceeded the required deadline.** The team also estimated that 23 percent of investigations closed by DCSA were not adjudicated within the required 90 days of the date of the final investigative report.[22]
- **Documentation not maintained in personnel folders.** About 48 percent of employees did not have a certificate of investigation uploaded into their electronic personnel folder at the end of the suitability process.[23]

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[20] The team reviewed a sample of 313 personnel records from the estimated total of 54,800 VHA employees initially hired to work in medical facilities from October 1, 2019, through September 30, 2021.

[21] 5 C.F.R. § 736.201; VA Handbook 0710.

[22] 5 C.F.R. § 731.203; VA Handbook 0710; Exec. Order No. 13,869, 84 Fed. Reg. 18,125 (Apr. 29, 2019).

[23] VA Handbook 0710; VHA Directive 0710, *VHA Personnel Security and Suitability Program*, October 11, 2018.

VA's Lack of Oversight Led to Personnel Suitability Program Deficiencies

VA did not identify or mitigate continued deficiencies in completing and recording personnel suitability actions because officials did not effectively execute internal program controls. Each governing entity had a requirement established by VA policy to conduct program reviews evaluating the efficiency and effectiveness of the personnel suitability function. However, HRA/OSP suspended required inspections of the program in May 2019. WMC also did not conduct required VHA program reviews. Additionally, responsible VA officials cited insufficient staffing as a barrier to conducting effective oversight.

HRA/OSP Suspended Required Inspections of the Suitability Program

The OIG reported in 2018 that HRA/OSP did not conduct routine oversight until after the initiation of that audit. Accordingly, the OIG recommended that HRA/OSP implement the monitoring program required by policy and establish management oversight of the personnel suitability program. HRA/OSP subsequently implemented an inspection program that consisted of site visits to VA facilities with high rates of noncompliance on critical background investigation metrics. These inspections made findings and provided recommendations to improve these facilities' suitability functions.[24] However, HRA/OSP reported that due to insufficient staffing, the inspections were suspended in May 2019—four months after the OIG closed the 2018 report recommendation as implemented. The responsible HRA/OSP director had reported that a replacement for the inspection program would be implemented by the end of fiscal year 2023, but the OIG is not aware if this occurred.

VHA Did Not Conduct Program Reviews of Its Suitability Functions

Officials reported a desire to implement an audit program but stated that staffing constraints prevented WMC from conducting program reviews of the personnel suitability function at the 18 VISNs. Instead, WMC largely delegated remediation efforts to human resources staff at the VISNs that also faced staffing limitations. Delegating oversight responsibilities essentially requires the VISNs to execute their suitability workload and then conduct oversight of their own work. As of October 2022, the former VHA personnel security director in WMC proposed expanding the program office from five to 20 full-time-equivalent employees and dedicating nine staff to ensure VHA complies with these requirements. To date, the OIG is not aware of any increase in staff levels.

VISNs Lacked Sufficient Staff to Consistently Perform Their Suitability Program Responsibilities

VHA policy requires VISN personnel security chiefs to ensure that investigations are processed within established timelines and are appropriately documented.[25] The five VISN personnel security chiefs interviewed by the OIG had not consistently conducted reviews of their network's suitability program.

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[24] HRA/OSP completed 11 facility inspections by May 2019.

[25] VHA Workforce Management and Consulting, *Personnel Security and Suitability Program Policy*, rev. February 2020.

Further, four told the team that they routinely processed investigation actions to help facilities that either lacked an adjudicator or had an adjudicator on leave.

VISN adjudicators also cited staffing shortages as a cause for delinquent adjudications and reported difficulty maintaining regular operations. They stated that in addition to their responsibilities processing background investigations, they had to fill in for personnel security assistants who issued identification cards in the badging office. VISN staff also reported dedicating time and resources to completing all-personnel data reviews delegated to them by WMC.[26]

In the OIG's 2018 report, several VA facilities were identified as having only one employee assigned to adjudication responsibilities. Despite a previous OIG recommendation to evaluate human capital needs and coordinate resources for the program, this issue, which conflicts with federal standards, was detected again in the September 2023 audit.[27] The audit team identified numerous examples where VISNs in the OIG sample did not have an adjudicator, or only had one, assigned to a subordinate facility. In response to a recommendation from the 2018 audit, VHA stated that it would evaluate staffing levels, determine if resource shortages are systemic, and update the staffing metrics accordingly. An updated staffing metric was under review by WMC leaders as of January 2023.

What the OIG Recommended Related to Governance

Because of the long-standing issues with the personnel suitability program and the need for a single responsible party to coordinate corrective actions taken by HRA/OSP and VHA, the OIG issued recommendations in its 2023 audit to the VA deputy secretary to take the following steps:

1. Establish robust oversight of the personnel suitability program within responsible office(s) that includes verifying background investigations are initiated and adjudicated within prescribed timelines and that documentation is filed as required.
2. Reimplement the monitoring program specifically required by VA Handbook 0710 as part of VA's oversight efforts, or an appropriate equivalent, to identify and prevent systemic weaknesses in the personnel suitability program.
3. Assess program resources and allocate staff as needed to prioritize oversight of the personnel suitability program within responsible office(s).
4. Establish a plan to implement the updated staffing metrics for VHA's suitability function and consider using available hiring flexibilities.

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[26] In January 2020, HRA/OSP directed each administration to review all personnel with access to facilities and information systems to ensure they were properly vetted. In March 2021, HRA/OSP initiated a targeted review of employees hired from October 2019 through January 2021 that examined data for discrepancies such as whether the employee had no fingerprint check but a closed investigation. VHA also conducted an all-employee review and reported its results in September 2020.

[27] Government Accountability Office, *Standards for Internal Control in the Federal Government*, September 2014.

The OIG will monitor implementation of all planned actions and will close the recommendations, which are all open, when VA provides enough evidence to demonstrate sufficient progress in addressing the intent of the recommendations and the issues identified.[28]

VA's Systems and Data Do Not Adequately Support the Personnel Suitability Program

The audit's second finding was that VA's background investigation data and information systems were insufficient to track the status of investigative actions and key metrics, or to conduct program oversight. VA relied on HR Smart and VA-CABS to capture significant background investigation milestones, but missing or inaccurate data impeded program oversight. VA-CABS—the system of record for suitability information—did not track the entire investigation process. This means VA lacks one authoritative source for the personnel suitability program. While relying on two systems does not violate requirements, it can complicate staff's work. Unless data reliability and the functionality and design of its systems are improved, VA lacks assurance that investigations have been fully processed and long-standing data integrity concerns have been mitigated.

HR Smart Inaccuracies

In 2018, the OIG reported that data in 54 percent of background investigation fields used for managing the suitability program were inaccurate. While differences in scope do not permit direct comparisons between the 2018 and 2023 OIG audits, the latter found that these inaccuracies were still of concern—with an estimated 36 percent of HR Smart data fields not consistently up to date when compared to corresponding certificates of investigation.

VA-CABS Limitations

In response to HR Smart data quality concerns identified in the 2018 report, HRA/OSP implemented VA-CABS to ensure that personnel suitability data would be reliable for program tracking and oversight. However, VA-CABS did not achieve this goal, as data fields critical for tracking background investigations were either empty or inaccurate. Specifically, the OIG estimated

- 98 percent of electronic questionnaire initiation dates were not completed,
- 27 percent of the investigation-scheduled dates were not populated by the system, and
- 22 percent of the adjudication dates did not match the corresponding certificate of investigation.

For example, as noted above, VHA did not consistently initiate its employees' background investigations. This data field—the date the investigation is initiated—can help ensure a critical step of the onboarding process is complete. The director of Personnel Security and Credential Management

[28] The OIG will request the first update from VA on the progress to implement the recommendations in late December 2023.

stated that suitability staff were not required to update this field and that, in the future, it would no longer be included in the system. However, retaining this field, ensuring it is populated accurately, and conducting regular analyses to identify gaps could serve as an improved internal control. The program would also benefit from establishing similar requirements and internal controls for recording the dates that investigations were both scheduled and adjudicated.

VA-CABS had functional limitations as well. It did not reliably transmit adjudication information to DCSA, which caused investigations to appear on delinquent adjudication reports as being outstanding for more than 90 days. A VA official told the team that VA-CABS has different formatting for names than DCSA's system, which may cause this issue. However, that does not explain how DCSA can successfully transmit the investigation results to VA, but VA-CABS cannot return the adjudication decision. Thus, suitability staff workload includes manually reconciling VA-CABS and DCSA's delinquent adjudication report to see if an adjudication has not been made or if it did not transmit.

When background investigations with no issues were automatically adjudicated by DCSA, VA-CABS did not notify suitability staff.[29] However, suitability staff were still required to upload the signed certificate of investigation into the employee's personnel folder and update HR Smart, so they had to manually pull a report, adding to their workload. Failure to complete that check may have resulted in suitability staff not realizing further action on these investigations was necessary for compliance.

These issues occurred because VA did not ensure that sufficient tools were available to support the objectives of the suitability program, to include correcting known data quality issues with HR Smart and considering information needs when implementing VA-CABS. As a result, VA has lacked one reliable system for program oversight. Unless VA improves data reliability and its systems' functionality and design, it lacks assurance that background investigations have been fully processed and long-standing data integrity concerns have been mitigated.

Concerns with VA-CABS Persist with the Development of Its Next Iteration

As stated earlier, the off-the-shelf VA-CABS was replaced with a custom-built case management system (VA-CABS 2.0) in September 2023. The OIG identified concerns with this effort because HRA/OSP has not provided evidence that the new system would address known program and data integrity isses. Simply put, VA had not demonstrated that VA-CABS 2.0 would effectively support the personnel suitability program, particularly given that VA did not provide the OIG with documentation of critical business requirements. Specifically, VA awarded a contractor over $7.5 million as of January 2023 without finalizing and documenting its stakeholders' needs. At the same time, DCSA is developing a government-wide system, the National Background Investigation Services (NBIS), that may duplicate VA-CABS functions. VA staff will be required to use some functions of NBIS, such as

[29] VA implemented automatic adjudication in July 2021, also referred to as eAdjudication, which allows DCSA to automatically render decisions on background investigations when no issues were found.

determining what investigation level is required for a given position, submitting questionnaires to initiate background investigations, and determining if a new employee's previous investigation satisfies the requirements of their position. As such, VA may be allocating resources toward developing a new system that has functionality problems and duplicates other federal efforts.

If VA does not mitigate the identified issues, it risks carrying over known deficiencies into a new system. Furthermore, unless the integrity of its suitability data improves, VA will not have the necessary assurances that investigation actions have been completed within required timelines and properly recorded for tracking or follow-up actions.

What the OIG Recommended Related to Systems

The OIG issued the following additional recommendations to the VA deputy secretary regarding its finding on information systems:

5. Incorporate formal data-testing procedures (and data-matching as appropriate) of HR Smart and VA-CABS (or any replacement systems) into the monitoring program discussed in recommendation 2.
6. Develop and execute a plan to collect, maintain, and access sufficient and appropriate data through a single system to support the tracking of background investigations from initiation to adjudication.
7. Establish a plan to ensure that future systems support the functionality needed to effectively oversee and manage the background investigation process, including addressing limitations identified in the current systems and incorporating the fields necessary to track timeliness metrics.

These three recommendations remain open, and as with the prior recommendations, the OIG will close them when VA provides enough evidence to demonstrate sufficient progress in addressing their intent and the issues identified.

CONCLUSION

The OIG is committed to continued oversight of the department's personnel suitability program because of its centrality to onboarding a highly qualified and suitable workforce and because of the grave risk to veterans, their family members, and staff when newly hired employees have not been fully vetted. OIG reports have repeatedly identified issues of inadequate program governance, insufficient staffing, and weak program controls. When combined with poorly structured information technology systems, VA officials lack accurate and complete data to manage the program. Dedicating appropriate resources and leadership attention to this program is essential to ensuring the safe operation of VA medical facilities and providing patients with the high quality of care they should expect from VA.

Madam Chairwoman, this concludes my statement. I would be happy to answer any questions you or members of the Subcommittee may have.

Prepared Statement of Seto Bagdoyan

United States Government Accountability Office

Testimony

Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

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VETERANS HEALTH ADMINISTRATION

Actions Needed to Address Persistent Control Weaknesses and Related Risks in Employee Screening Processes

Statement of Seto J. Bagdoyan, Director, Forensic Audits and Investigative Service

GAO-24-107188

GAO Highlights

Highlights of GAO-24-107188, a testimony before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

The Department of Veterans Affairs (VA) operates one of the largest health care systems in the nation, with over 9 million veterans enrolled in the VHA health care program. VHA is responsible for ensuring that its more than 400,000 health care providers and support staff are qualified, competent, and suitable to provide safe care.

This testimony discusses (1) VHA's policies and procedures for dealing with employees with controlled substance-related felony convictions and the need to obtain waivers from DEA before employing these people in certain positions; and (2) VHA's suitability process, including control weaknesses associated with the conduct of background investigations.

This testimony is based primarily on GAO's February 2023 report on VHA's employee screening processes. For that report, GAO analyzed a generalizable sample of 305 VHA employees employed as of January and June 2020 with indications of controlled substance-related criminal history. GAO examined court records and other documentation, reviewed regulations and policies, and interviewed officials from VHA, DEA, and other agencies. For this statement, GAO also obtained updates on actions VA has taken to address related GAO recommendations.

What GAO Recommends

In February 2023, GAO made 14 recommendations to VA. As of November 2023, the recommendations are not yet implemented.

View GAO-24-107188. For more information, contact Seto J. Bagdoyan at (202) 512-6722 or bagdoyans@gao.gov.

December 6, 2023

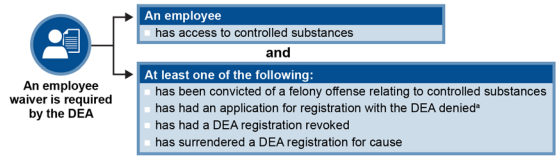
VETERANS HEALTH ADMINISTRATION

Actions Needed to Address Persistent Control Weaknesses and Related Risks in Employee Screening Processes

What GAO Found

The Veterans Health Administration (VHA) received information regarding some employees but did not have control procedures to ensure it responded as required. For example, VHA received information about some employees' controlled substance-related felony convictions and actions taken against certain employees by the Drug Enforcement Administration (DEA). VHA was required to obtain waivers from DEA for any of these employees whose job gave them access to controlled substances.

Drug Enforcement Administration (DEA) Employment Waiver Requirements



Source: GAO analysis of DEA information and sdecoret/stock.adobe.com (icon). | GAO-24-107188

[a]DEA registrations are required for certain health care practitioners licensed to dispense, administer, or prescribe controlled substances.

GAO identified 12,569 VHA employees with indications of controlled substance-related criminal history. Of these, GAO obtained further information about a generalizable sample of 305 employees and found 50 of them had one or more controlled substance-related felony convictions. However, VHA has no policy regarding DEA employment waivers, including guidance for determining whether an employee has access to controlled substances. VHA confirmed that it did not request waivers for 48 of the 50 employees GAO identified. VHA did not confirm whether it requested waivers for the remaining two. GAO previously recommended the development of a waiver policy and, while VA agreed, it had not yet developed the policy. Therefore, in February 2023, GAO recommended that VHA establish a timeline for finalizing and implementing a waiver policy. In November 2023, VA informed GAO that it is developing a DEA waiver policy and expects to implement it in March 2024. Until VHA implements such a policy with guidance for determining whether an employee has access to controlled substances, it cannot assess whether its employees need waivers. VHA also lacks assurance that its facilities are complying with DEA regulations and controlling against theft and diversion of controlled substances.

GAO also identified vulnerabilities in VHA's process for completing employee background investigations. For example, GAO found that 13 of the 305 employees in the generalizable sample did not have background investigations as required by regulation and policy. From the universe of the approximately 12,569 VHA employees, GAO estimated that about 400 (3 percent) did not have completed background investigations. As a result, in February 2023, GAO recommended that VHA establish control procedures to ensure background investigations are completed as required. In November 2023, VA informed GAO this recommendation would be implemented by March 2024.

Chairwoman Kiggans, Ranking Member Mrvan, and Members of the Subcommittee:

I appreciate the opportunity to discuss our work on persistent control weaknesses and related risks in the Veterans Health Administration's (VHA) employee screening processes.

The Department of Veterans Affairs' (VA) Veterans Health Administration operates one of the largest health care systems in the nation. Currently, there are over 9 million veterans enrolled in the VA health care program. VHA employs more than 400,000 health care professionals and support staff.

VA is responsible for ensuring that employees who work in its medical facilities are qualified, competent, and suitable to provide safe care to veterans. As part of the federal hiring process, applicants to federal agencies, including VA, must undergo a broad screening process, which includes determining their suitability for employment.[1] As part of this process, individuals must disclose their criminal and drug-use histories and certify that the information provided is true, correct, complete, and made in good faith.[2] VA must perform a suitability review for its applicants based on character and conduct to determine whether employing an applicant may adversely affect the integrity or efficiency of the federal service.[3]

[1]Depending on the type of position, VA personnel security staff or contracting officers determine whether the individual needs a background investigation. For example, a new investigation may not be needed if a prior investigation is still considered current.

[2]The Declaration for Federal Employment (OF-306) is required for all applicants, including those who do not require background investigations. It requires that applicants disclose, among other criminal history information, felony and misdemeanor convictions that occurred during the preceding seven or ten years, depending on the version of the form. VA officials review the applicant's applications, the position description, Declaration for Federal Employment, electronic Questionnaires for Investigations Processing form (if applicable), and the results of a fingerprint Special Agreement Check. Based on this information, the adjudicator makes an interim suitability determination, pending a full investigation. If the determination is favorable, the person is hired and may begin working for VHA.

[3]The Defense Counterintelligence Security Agency (DCSA) completes the background investigation. This includes compiling criminal history information from local law enforcement agencies as well as the Federal Bureau of Investigation (FBI). DCSA provides the completed investigation to the VA office that requested the information. The VA adjudicator uses the information in the file to make a final suitability determination.

In addition, the Controlled Substances Act requires persons and businesses that handle controlled substances to register with the Drug Enforcement Administration (DEA).[4] These "registrants" with the DEA include certain health care practitioners licensed to dispense, administer, or prescribe controlled substances and pharmacies authorized to fill prescriptions.[5] Further, registrant employers, such as VHA, are required to apply for and receive an employment waiver for certain individuals. Specifically, such waivers are required before employing any person in a position with access to controlled substances who, at any time

- has been convicted of a felony related to controlled substances, or
- has had an application for a DEA registration denied or had a DEA registration revoked or surrendered for cause.[6]

VHA is not required to obtain a DEA employment waiver if an applicant holds an active DEA registration, because DEA has already determined that the person is suitable to handle controlled substances.[7]

Both GAO and the VA Office of Inspector General (OIG) have previously reported on VA's systemic oversight deficiencies in hiring personnel. For example, in 2018, the VA OIG reported on deficiencies in VA's management of the personnel suitability program.[8] The OIG found that VA did not manage its personnel suitability program effectively and lacked the oversight necessary to ensure that employee background investigations were completed and documented as required. In 2019, we found that VHA did not have policies regarding DEA employment waivers,

[4]DEA enforces the controlled substances laws and regulations of the United States. The Controlled Substances Act defines substances as controlled based on the substance's medical use, potential for abuse, and safety or dependence liability.

[5]21 U.S.C. § 822.

[6]21 C.F.R. § 1301.76(a) prohibits registrants from employing persons with such a history. 21 C.F.R. § 1307.03 allows any person to "apply for an exception to the application of any provision of this chapter by filing a written request with the Office of Diversion Control, Drug Enforcement Administration, stating the reasons for such exception." For purposes of this statement, we refer to applications for exception from application of 21 C.F.R. § 1301.76(a) as "DEA employment waivers."

[7]A DEA registrant may possess more than one registration. According to DEA officials, if DEA took action against only one of an individual's multiple registrations, the individual would not require an employment waiver if he possessed another active registration.

[8]Department of Veterans Affairs Office of Inspector General, *Veterans Health Administration: Audit of the Personnel Suitability Program*, 17-00753-78 (Washington, D.C.: Mar. 26, 2018).

and that this may affect its ability to prevent the diversion of controlled substances in its medical facilities.[9] That work also identified two providers for whom VHA should have had waivers to employ in positions with access to controlled substances. We recommended, among other things, that VHA develop a policy for DEA employment waivers. In 2021, VHA officials told us they had established an interdisciplinary project team to identify an approach for VHA to take for managing and overseeing DEA employment waivers.[10]

My comments today present the findings from our February 2023 report pertaining to how VA manages DEA employment waivers and employee background investigations.[11] Specifically, my comments address

1. VHA's policies and procedures for dealing with employees with controlled substance-related felony convictions or actions taken against their DEA registrations and the need to obtain waivers from DEA before employing these people in certain positions, and
2. VHA's suitability process, including control weaknesses associated with the conduct of background investigations.

My comments pertaining to VHA's policies and procedures regarding employees with felony convictions or actions taken against their DEA

[9]See GAO, *Veterans Health Administration: Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care*, GAO-19-6 (Washington, D.C.: Feb. 28, 2019). Drug diversion is the illegal acquisition of legally produced controlled pharmaceuticals for non-medical use. In 2015, we added VA health care to GAO's High-Risk List because of (1) ambiguous policies and inconsistent processes and (2) inadequate oversight and accountability, among other things. See GAO, *High-Risk Series: An Update*, GAO-15-290 (Washington, D.C.: Feb. 11, 2015). GAO's High Risk List identifies government operations with vulnerabilities to fraud, waste, abuse, and mismanagement, or in need of transformation. In addition, in March 2021, we added drug misuse to GAO's High Risk List because national rates of drug misuse have increased, and drug use represents a serious risk to public health. See GAO, *High-Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas*, GAO-21-119SP (Washington, D.C.: Mar. 2, 2021). We previously identified preventing drug diversion as an opportunity to strengthen the federal government's efforts to address this persistent and increasing problem. See GAO, *Drug Misuse: Sustained National Efforts Are Necessary for Prevention, Response, and Recovery*, GAO-20-474 (Washington, D.C.: Mar. 26, 2020).

[10]The Interdisciplinary Project Team is responsible for preparing a proposal for VHA leadership that identifies an approach to management and oversight of DEA waivers in response to our recommendation.

[11]See GAO, *Veterans Health Administration: Action Needed to Address Persistent Control Weaknesses in Employee Screening Processes*, GAO-23-104296 (Washington, D.C.: Feb. 23, 2023).

registrations and waivers are based on data we examined for our February 2023 report. This statement also provides updated information on recommendations specifically related to DEA waivers and background investigations.[12]

To identify VHA employees who may have needed DEA waivers for our February 2023 report, we matched a list of 400,339 individuals employed at VHA as of January and June 2020 to the FBI's Next Generation Identification (NGI) system and the Department of Health and Human Services National Practitioner Data Bank (NPDB) data.[13] This matching identified a population of 12,569 employees who had indications of criminal history related to controlled substances.[14] From this population, we selected a generalizable, stratified random sample of 305 employees for further review and verification.[15] In addition to our sample of 305 employees, we reviewed information for 11 employees we identified with actions taken against their DEA registrations as reported in NPDB and for

[12]In the February 2023 report we made 14 recommendations to VA. As of November 2023, the recommendations are not yet implemented.

[13]The NGI System provides an electronic repository of biometric and criminal history record information voluntarily submitted by all states and territories, as well as federal and some foreign criminal justice agencies. NGI provides the criminal history record information on file for an individual identified via a fingerprint check, plus any record indexed in the national system that is maintained by a state that supports the purpose of the request. NGI is one of the systems used by DCSA to identify criminal history as part of the federal background investigation process. Because law enforcement entities send criminal history information to the FBI on a voluntary basis, criminal history records may not contain a given individual's full criminal history. NPDB is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health-care practitioners, providers, and suppliers. Created by Congress, the NPDB is a workforce tool that prevents practitioners from moving state to state without disclosure or discovery of previous damaging performance.

[14]We described our matches as employees who had indications of criminal history because (1) law enforcement entities send criminal history information on a voluntary basis and NGI records may not contain a given individual's full criminal history; (2) biographic information reported to NGI may not always be complete or accurate; and (3) NGI data do not readily distinguish controlled substance-related criminal offenses, so we relied on keyword searches to identify possible offenses related to controlled substances. As described below, we took additional steps to verify the identities and criminal histories of employees in our generalizable sample.

[15]We weighted the employees in the generalizable sample to reflect differences between strata in their proportions of the population of 12,569 employees. Thus, the estimated percentages of the population we project throughout the statement differ from the actual percentages we found in the sample of 305 employees. All estimates derived from this sample have a margin of error, at the 95 percent confidence level, of plus or minus 7 percentage points or fewer.

13 employees with indications of drug-related warrants, thus totaling 329 employees for review.[16]

For these 329 employees, we verified the accuracy of the information we obtained using law enforcement and courthouse records, DEA information, and other sources.[17] We also asked VHA to identify which of the 329 employees had access to controlled substances, its method for determining access, and whether it requested DEA employment waivers for the employees with certain adverse information.

To examine the extent to which vulnerabilities exist in VHA's processes for completing and documenting employee background investigations, we analyzed documents maintained in the Office of Personnel Management's (OPM) electronic Official Personnel Folder (eOPF) system, DCSA's Personnel Investigations Processing System (PIPS), and VA's Centralized Adjudication and Background Investigation System (VA-CABS) for the 329 employees in our review and reviewed relevant regulations and policies from VA, VHA, and OPM.[18] More detailed information on our objectives, scope, and methodology can be found in the February 2023 report.[19]

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[16]Only the results from the generalizable sample of 305 employees are projectable to the population of 12,569 with indications of controlled substance-related criminal history.

[17]We also interviewed relevant officials from VHA, DEA, and other agencies.

[18]OPM is responsible for developing regulations and providing guidance to federal agencies about investigative requirements and oversees suitability adjudications and the federal government's suitability program. OPM also oversees agency compliance with suitability program requirements. eOPF contains documentation of the employment history of individuals employed by the federal government. PIPS is the system DCSA uses to process and complete background investigations and contains a repository of background investigation records. VA-CABS was launched in 2018 as VA's case management system for background investigations and suitability adjudications. According to VA officials, it became VA's system of record for background investigations in August 2022.

[19]GAO-23-104296.

VHA Did Not Have Control Procedures for Determining Whether Employees Had Access to Controlled Substances or Required DEA Waivers

As discussed in our February 2023 report, we found that VHA received information about some employees' controlled substance-related felony convictions and actions taken against employees' DEA registrations. We also found, however, that VHA did not have control procedures for determining whether the employees had access to controlled substances or required DEA employment waivers.

Specifically, of the 305 VHA employees in our generalizable sample, 50 employees had one or more controlled substance-related felony convictions, indicating they may need DEA waivers if they held positions with access to controlled substances and did not possess active DEA registrations.[20] These employees held a range of positions at VHA, including physician, pharmacy technician, and food service worker, among others.

Of these 50 employees, VHA received information about at least one controlled substance-related felony conviction for 49 of them. VHA received this information via criminal history records or employee attestations on screening forms.[21] For example, one employee we identified was convicted of both felony possession and sale of hydrocodone, an opioid used to treat pain, in February 1988. VHA received information about these convictions via a criminal history record in July 2006 and hired the employee as a pharmacy technician in October 2007. As of September 2022, the employee continued to work at VHA as a pharmacy technician.

Based on our analysis of our generalizable sample, we estimated that

- about 1,800 (14 percent) of the 12,569 employees we initially identified as having indications of controlled substance-related

[20]We were unable to obtain court records for 42 employees in the sample. Thus, it is possible that additional employees had controlled substance-related felony convictions.

[21]We obtained copies of the criminal history records provided to VHA by DCSA and its predecessor agencies as part of the employees' suitability screening to determine whether they contained information about the convictions. Because DCSA removes investigative materials, including criminal history records, from its system of records after a specified retention period, the criminal history records we obtained were not inclusive of all reports VHA received for the employees under review. Thus, it is possible that VHA received criminal history records about these convictions before the date listed in the case below. Further, because law enforcement entities send criminal history information to the FBI on a voluntary basis, criminal history records may not contain a given individual's full criminal history. This may explain why we did not find evidence that VHA received information about one individual's controlled substance-related felony conviction.

criminal history had at least one controlled substance-related felony conviction, and

- VHA received information about at least one controlled substance-related felony conviction for nearly all—about 1,700—of the approximately 1,800 employees with controlled substance-related felony convictions.

We asked VHA whether the 50 employees we identified in our sample with controlled substance-related felony convictions had access to controlled substances and if VHA had sought DEA employment waivers for these employees. VHA said that it had not requested employment waivers for 48 of these employees. VHA further stated that these employees did not require waivers because their job duties did not involve dispensing controlled substances and did not require DEA registrations.[22]

Further, in our February 2023 report we found that VHA received information about actions taken against providers' DEA registrations. Specifically, we identified five providers who were not in the generalizable sample and who required DEA employment waivers if they held positions with access to controlled substances because they surrendered their DEA registrations for cause and did not hold other active registrations. VHA received information regarding all five providers' DEA registration actions via NPDB reports and employee attestations in the VetPro credentialing system.[23] VHA officials confirmed that VHA did not request DEA employment waivers for these five providers. Although all five providers have since left VHA employment or obtained active DEA registrations, they worked for VHA without DEA registrations or employment waivers for periods of time ranging from less than a month to over three and a half years.

VHA's responses—stating that employees did not require DEA employment waivers because their job duties did not involve prescribing,

[22]VHA did not confirm whether it sought or obtained employment waivers for the remaining two employees, a physician and a pharmacy technician. Rather, in its responses regarding these two employees, VHA stated that it reviewed providers with revoked or surrendered DEA registrations in response to our February 2019 report. It found no providers writing controlled substance prescriptions with a revoked or surrendered DEA registration. In March 2020 VA officials told us that their review identified one provider with a revoked or surrendered DEA registration. Because VHA did not disclose the identity of the provider, we were unable to determine whether this employee was among those we found with controlled substance-related felony convictions.

[23]VetPro is VHA's credentialing system, which contains data on VHA employees, contractors, and other types of non-federally appointed employees.

dispensing, or having physical access to controlled substances and did not require DEA registrations—do not align with DEA's definition of what constitutes "access." DEA guidance states that access to controlled substances is not limited to physical access but includes any influence over the handling of controlled substances and is not limited to prescribers of controlled substances. VHA could not assess whether the employees we identified with controlled substance-related felony convictions or actions taken against their DEA registrations required DEA employment waivers. This is because VHA has not issued policies or guidance regarding the process for determining which employees have access to controlled substances and the circumstances in which employment waivers are required.

Standards for Internal Control in the Federal Government state that management should implement control activities through policies.[24] They further state that agencies are to ensure that the findings of audits and other reviews are promptly resolved. To that end, agencies are to complete and document corrective actions to remediate internal control deficiencies on a timely basis.

Without policies regarding DEA employment waivers, which include guidance for determining whether an employee has access to controlled substances and which specify the circumstances for which employment waivers are required, VHA cannot assess whether its applicants and employees need waivers. Further, without establishing a timeline for finalizing and implementing such policies and reviewing current employees we identified with indications of controlled substance-related criminal history to determine whether they need waivers, VHA does not have assurance that its facilities comply with DEA regulations that help control against theft and diversion of controlled substances.

In our 2019 report, we recommended that VHA develop policies and guidance regarding DEA registrations, including the circumstances in which DEA waivers may be required, the process for requesting them, and a mechanism to ensure that facilities follow these policies.[25] VA agreed with our recommendation. Four years later, no policy or guidance was in place. Consequently, in our February 2023 report we

[24]GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: Sept. 2014).

[25]GAO-19-6.

recommended that VHA establish a timeline for finalizing and implementing a policy regarding DEA employment waivers.

In that report we also made recommendations pertaining to what the policy should include and steps to take after the policy is implemented to determine if individuals we identified with indications of controlled substance-related felony convictions need DEA employment waivers.

Further, as part of the Consolidated Appropriations Act, 2023, Congress directed VA to institute policies and procedures pertaining to DEA employment waivers.[26]

As of November 2023, VA informed us that it is developing a DEA waiver policy and expects to implement it in March 2024.

Persistent Vulnerabilities Exist in VHA's Processes for Completing and Documenting Employee Background Investigations

In our February 2023 report, we also found vulnerabilities in VHA's processes for completing and documenting employee background investigations. These investigations are critical for ensuring that VHA can identify and remove unsuitable individuals from the VHA workforce and mitigate the risk to veterans. Specifically, we found that some VHA employees did not have completed background investigations as required by OPM regulation and VA policy. As a result, VHA does not have assurance that its personnel are properly vetted and suitable to provide care to veterans.

VHA Did Not Always Ensure Employees Had Completed Background Investigations When Required

OPM regulation and VA policy require that most VHA employees undergo background investigations.[27] Specifically, per regulation and policy, VHA should initiate an individual's background investigation before appointing the individual. If that is not possible, VHA must initiate the investigation within 14 days of the individual's appointment. When we requested certifications of investigation or equivalent documentation of completed and adjudicated background investigations for the 305 employees in our

[26]Pub.L. No. 117-328, Div. U, Title I, subtitle B, § 112(a), 136 Stat. 4459, 5411 (as codified at 38 U.S.C. § 7414).

[27]5 C.F.R. §§ 731.101, 731.104; VA Handbook 0710.

generalizable sample, VHA confirmed that 13 of these employees did not have background investigations completed as required.[28]

For example, in one case we reviewed, VHA hired the employee as a medical technician in October 2017. VA later removed the individual from employment in August 2020 for reasons unrelated to the lack of a background investigation. According to VHA, the department initiated a background investigation for the employee. However, VA-CABS data indicated the employee's investigation was unacceptable as of October 2017. VHA officials told us the investigation was never completed. The director of the VHA Central Office Personnel Security Program Office told us that DCSA designates investigations as unacceptable if there are too many mistakes or fields left blank on investigative questionnaires such that DCSA cannot initiate an investigation. He further said DCSA contacts the agency requesting the investigation before designating it as unacceptable. DCSA cancels the investigation if the agency does not respond to its outreach or the employee being investigated does not fix the forms. Thus, this employee worked at VHA without a required background investigation between October 2017 and August 2020.

Based on our analysis of our generalizable sample, we estimated that about 400 (3 percent) of the approximately 12,569 employees with indications of controlled substance-related criminal history did not have completed background investigations.

Consistent with our findings, in March 2018, VA OIG reported that VA did not ensure that background investigations were completed when required. In response to the OIG findings, VA conducted "100 percent audits" of suitability data for all VA personnel. According to the director of the VHA Central Office Personnel Security Program Office, these 100 percent audits consisted of verifying that employees' background investigation closure dates were correctly recorded in HR Smart.[29]

[28]Certifications of investigation contain information showing that the case was investigated, the level of the investigation, confirmation the case was adjudicated, and the date a suitability determination was made.

[29]According to VA officials, HR Smart was VA's system of record for background investigations until August 2022, at which time VA-CABS became VA's system of record for background investigations. VHA officials told us that VHA conducted two "100 percent audits" of suitability data. The officials said that limited resources amid VHA's efforts to respond to the coronavirus pandemic prevented VHA from taking corrective action based on the information obtained during the first audit, so VHA completed a second audit.

In light of VA's efforts in response to the OIG's recommendations, we asked why some employees did not have background investigations when required. VHA officials stated that VHA does not have an automated means for monitoring whether background investigations are completed. Instead, VHA relies on manual processes. The officials told us that they would have expected the audits of suitability data to identify employees who did not have required background investigations. They noted, however, that such manual monitoring is prone to human error and that the extent and frequency of such monitoring is limited due to resource constraints. Thus, according to the officials, VHA's current control procedures are insufficient for identifying employees without required background investigations and for ensuring such instances are addressed.

VA launched VA-CABS in 2018 as its case management system for background investigations and suitability adjudications. VA officials told us, however, that VA-CABS may not contain complete information for some employees, so VA cannot currently use it for automated monitoring of whether employees have completed background investigations. The VHA officials stated that they expect future efforts to integrate background investigation data from various government-wide databases into VA-CABS. They believe this will enable automated monitoring, such as reports identifying employees who do not have investigations when required. The officials stated that these efforts would be part of VA's response to material weaknesses in its enterprise-level background investigation data identified in prior VA OIG audits assessing VA's compliance with the Federal Information Security Modernization Act.[30] However, the officials did not provide a timeline for when efforts at integrating background investigation data into VA-CABS would be complete or when VHA would be able to automate the monitoring of employee background investigations.

Standards for Internal Control in the Federal Government state that management should establish and operate activities to monitor the internal control system and evaluate the results.[31] They also state that management should evaluate and document internal control deficiencies,

[30]See Department of Veterans Affairs Office of Inspector General, *Federal Information Security Modernization Act Audit for Fiscal Year 2020*, 20-01927-04 (Washington, D.C.: Apr. 29, 2021).

[31]GAO-14-704G.

determine appropriate corrective actions, and complete and document such corrective actions on a timely basis.

Without adequate control procedures to ensure employee background investigations are completed as required by OPM regulation and VA policy, VHA lacks assurance that its personnel, including those with indications of controlled substance-related criminal history, are properly vetted and suitable to provide care to veterans. Moreover, by not ensuring that background investigations are completed, as required, for the employees who we found did not have completed investigations, VHA cannot reliably attest to the suitability of these employees and will continue to expose veterans to individuals who have not been properly vetted.

In our February 2023 report, we recommended that VHA establish control procedures to ensure that employee background investigations are completed as required by OPM regulation and VA policy. VA agreed with our recommendation. In November 2023, VA informed us this recommendation would be implemented by March 2024.

VHA Did Not Always Document Employee Background Investigations as Required

In our February 2023 report, we found VHA did not document background investigations for some employees as required by OPM guidance and VA policy. Specifically, our review of the eOPF system found that VHA did not always file its employees' certifications of investigation or Declarations for Federal Employment in eOPF.

OPM guidance states that a certification of investigation or similar agency form should be filed permanently in an employee's official personnel folder. OPM guidance also states that a Declaration for Federal Employment should be filed permanently in the employee's official personnel folder. VA policy states that a signed copy of the certification of investigation should be filed in the employee's eOPF upon a favorable suitability determination. However, VA policy does not address the filing of Declarations for Federal Employment, as discussed below.

Of the 305 employees in our generalizable sample, we found that eOPF did not contain certifications of investigation or equivalent forms for 54 employees when required. Upon our request, VHA subsequently provided certifications of investigation or equivalent forms for 51 employees. However, the documents for 32 of these employees were signed and dated after our document request. VHA was unable to provide

certifications of investigation or equivalent documents for three employees.[32]

Similarly, of the 305 employees in our generalizable sample, we found that eOPF did not contain Declarations for Federal Employment for 26 employees. Upon our request, VHA provided Declarations for Federal Employment for 24 of these employees. Six of these were signed after our request. VHA was unable to provide Declarations for Federal Employment for two employees. Based on additional analysis of our generalizable sample, we estimated that

- about 1,700 employees (14 percent) of the 12,569 employees we initially identified as having indications of controlled substance-related criminal history do not have certifications of investigation in eOPF as required, and
- about 1,100 (8 percent) of the 12,569 employees we initially identified as having indications of controlled substance-related criminal history do not have Declarations for Federal Employment in eOPF as required.[33]

Consistent with our findings, in March 2018 VA OIG reported that VA did not ensure that certifications of investigation were filed in eOPF when required. Accordingly, VA OIG recommended that VA, among other things, improve oversight of the personnel suitability program at VA medical facilities and ensure that investigation data are fully evaluated and reliable for program tracking and oversight. VA OIG told us that VA implemented these recommendations by establishing a VHA personnel security program office, appointing regional suitability coordinators,

[32]These numbers do not include employees who were not present in the eOPF system, such as contractors, or those whose eOPF folders appeared to have been transferred to another agency or to the National Archives and Records Administration and no longer under VA's control. Further, the number of employees without the certification of investigation or equivalent documentation in eOPF does not include individuals who VA confirmed did not have completed background investigations. DCSA PIPS data for the three employees for whom VHA was unable to provide certifications of investigation or equivalent documentation upon request showed indications of completed background investigations, suggesting that certifications of investigation or equivalent documentation for these employees should have been in eOPF.

[33]In addition to the employees in the generalizable sample described above, we also examined whether background investigations were documented as required for the 24 employees we identified with actions taken against their DEA registrations and with active warrants. Among these groups, we found another five employees who did not have certifications of investigation or equivalent documents in eOPF as required and another five employees who did not have Declarations for Federal Employment in eOPF as required.

implementing a quarterly review process for delinquent adjudications, and conducting "100 percent audits" of suitability data for all VA personnel.

Although VA took these actions, VA policy does not assign responsibility for filing certifications of investigation and Declarations for Federal Employment in eOPF. Specifically, although VA policy states that a copy of the signed certification of investigation should be filed in an employee's eOPF after a favorable suitability determination, it does not establish who is responsible for doing so. Additionally, VHA's staffing policy does not contain procedures for filing the Declaration for Federal Employment in eOPF. Also, VHA officials told us that VHA does not have control procedures to ensure that certifications of investigation and Declarations for Federal Employment are filed in eOPF as required.[34]

Standards for Internal Control in the Federal Government state that management should document responsibilities for internal control through policies and design control activities to achieve objectives and respond to risks.[35] Further, management should establish and operate monitoring activities to monitor the internal control system and evaluate the results. Management should also evaluate and document internal control deficiencies, determine appropriate corrective actions, and complete and document such corrective actions on a timely basis.

Without policies that establish who is responsible for documenting employee background investigations in eOPF in accordance with OPM guidance and VA policy and control procedures to ensure that these policies are followed, VHA lacks assurance that its personnel are properly vetted and suitable to provide care to veterans. Further, by not ensuring that background investigations are documented in eOPF as required for the employees who we found lacked such documentation and those with indications of controlled substance-related criminal history, VHA cannot reliably attest to the suitability of these employees.

In February 2023, we recommended that VA develop and implement policies that establish who is responsible for documenting employee

[34]This insufficient oversight of VHA's documentation of background investigations is not unique to the 12,569 employees we identified with indications of controlled substance related criminal history but characterizes the onboarding and background investigation processes for all VHA employees who require investigations. Therefore, it is possible that VHA also did not appropriately document background investigations for some employees outside our study population.

[35]GAO-14-704G.

background investigations in eOPF in accordance with OPM guidance and VA policy and control procedures to ensure that these policies are followed. VA agreed with our recommendation.

In August 2023, VA told us that it has initiated efforts to review and update policies that establish or clarify who is responsible for documenting employee background investigations in eOPF in accordance with OPM guidance. This effort includes the development and implementation of control procedures to ensure that these policies are followed. The target date for implementing this recommendation was September 2023. That date was not met and VA did not provide us with a new date.

Chairwoman Kiggans, Ranking Member Mrvan, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions.

GAO Contact and Staff Acknowledgments

For further information about this testimony, please contact Seto J. Bagdoyan, Director, Forensic Audits and Investigative Service, at (202) 512-6722 or bagdoyans@gao.gov. Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions to this testimony include David M. Bruno (Assistant Director), Gloria Proa (Analyst in Charge), Garrick Donnelly, Colin Fallon, Barbara Lewis, Maria McMullen, Lisa Rogers, and Sabrina Streagle.

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