United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

WASHINGTON, DC 20510–6250

April 30, 2018

The Honorable Robert Wilkie
Acting Secretary
U.S. Department of Veterans Affairs
810 Vermont Ave., NW
Washington, DC 20420

Dear Mr. Wilkie:

I am writing regarding a recent report from the Department of Veterans Affairs (VA) Office of the Inspector General (OIG) that found significant gaps in the adjudication of background investigations for VA employees.[1]

As you may know, the Veterans Health Administration (VHA) is the largest integrated health care system in the United States, providing care at 170 VA medical centers and more than 1,000 outpatient sites across the country.[2] Missouri is home to four VA medical centers and thousands of VA employees at Harry S. Truman Memorial in Columbia, John J. Pershing in Poplar Bluff, the VA St. Louis Health Care System, and the Kansas City VA Medical Center, as well as 30 community-based outpatient clinics.

According to the VA handbook on the Personnel Security and Suitability Program, at a minimum, all VA staff must undergo a background investigation to verify suitability for employment.[3] Most medical facility staff, including physicians, nurses, pharmacists, and laboratory technicians must receive a Tier 1 investigation, as employees in this category are deemed "low risk."[4] VA medical facilities are required to initiate background checks for employees within 14 calendar days of their employment. OIG found that an estimated 6,200 active employees at VA medical facilities did not yet have background checks initiated.[5] For those employees whose background checks have been initiated, there can be significant delays. The OIG found that, on average, medical staff at certain facilities could be working for 390 days

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[1] Veterans Administration, Office of the Inspector General, Veterans Health Administration, *Audit of the Personnel Suitability Program* (17-00753-78) (Mar. 2018).

[2] Department of Veterans Affairs, Veterans Health Administration, About VHA (www.va.gov/health/aboutVHA.asp) (accessed Apr. 4, 2018).

[3] Department of Veterans Affairs, *VA Handbook 0710* (May 2016).

[4] Veterans Administration, Office of the Inspector General, Veterans Health Administration, *Audit of the Personnel Suitability Program* (17-00753-78) (Mar. 2018).

[5] *Id.*

before a proper background check is initiated.[6] In many of these delayed instances, the background check was only triggered by a site visit from OIG.

The OIG made 11 recommendations in its report. The recommendations included establishing required monitoring programs, improving management oversight, reporting corrective action plans, developing quality and performance metrics, evaluating human capital needs, and correcting data integrity issues. Notably, OIG recommended the Office of the Undersecretary of Health improve management oversight of the personnel suitability program at VA medical facilities, ensure background investigations are properly initiated and adjudicated nationwide, and implement internal control mechanisms. Finally, OIG recommended the Office of the Undersecretary for Health coordinate with the Assistant Secretary for Operation, Security, and Preparedness (ASOP) to implement a plan to correct data integrity issues and improve the accuracy of personnel suitability program data.[7]

To better understand the current processes in place, any new initiatives, and the steps you are taking in order to address the backlog of background investigations, I request that you provide a response to the following questions on or before May 21, 2018:

1. How does VA plan to manage this backlog of pending background checks?

2. What specific steps have been taken, if any, to implement OIG's recommendations?

3. In VA's response to OIG's report, the agency stated that Office of Operations, Security, and Preparedness (OSP) would finalize a program review standard operating procedure by March 1, 2018. Please provide a copy of this review.

4. OIG projected that about 6,200 VHA employees are employed and have not had background checks initiated.

    a. How many of these employees have worked for VHA for more than one year?

    b. Please provide a breakdown by occupation for staff without background checks initiated.

    c. Please provide a breakdown by VA medical center location or outpatient site for staff without background checks initiated.

    d. Please provide a breakdown of by VA medical center location or outpatient site in Missouri for staff without background checks initiated.

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[6] *Id.*

[7] *Id.*

5. What impact have vacancies within VA leadership, such as the Secretary and Undersecretary for Health, had on the ability of the agency to perform timely background investigations?

6. What policies have been put in place to ensure adjudicators are reviewing background investigations in a timely manner?

7. What actions have been taken to ensure that suitability staff properly maintain official personnel records?

If you have any questions, please contact Hannah Berner with my Committee staff at (202) 224-5065 or Hannah_Berner@hsgac.senate.gov. Please send any official correspondence related to this request to Rina Patel at Rina_Patel@hsgac.senate.gov. Thank you in advance for your attention to this matter.

Sincerely,

Claire McCaskill
Ranking Member

cc: Ron Johnson
Chairman