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DEPARTMENT OF VETERANS AFFAIRS

VA's Governance of its Personnel Suitability Program for Medical Facilities Continues to Need Improvement

Audit | **21-03718-189** | **September 21, 2023**

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Executive Summary

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—as well as sensitive information and resources.[1] VA determines the level of investigation needed by assessing the risk of the position. The majority of VA employees, such as most medical facility staff, receive a Tier 1 investigation to verify suitability for employment. These positions include physicians, nurses, pharmacists, and laboratory technicians.

Applicants for VA employment must undergo a three-part background check. First, VA screens the applicant by reviewing self-reported information including past or ongoing legal violations, terminations of employment, or delinquent federal debt. Then, the applicant is subject to a fingerprint criminal history check. Finally, the Defense Counterintelligence and Security Agency (DCSA) conducts the required background investigation, which provides VA with comprehensive information needed to verify suitability for employment.[2]

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 suitability for employment.[3] After the investigation is completed, information from the investigation is recorded in HR Smart (VA's human resources information system) and the VA Centralized Adjudication Background Investigation System (VA-CABS). This information is also transmitted to DCSA's Personnel Investigations Processing System. Finally, the certificate of investigation is uploaded into the employee's electronic personnel folder.

In a 2018 audit of the Veterans Health Administration's (VHA) personnel suitability program, the VA Office of Inspector General (OIG) found that neither VA nor VHA effectively governed the program to ensure that background investigation requirements were met at medical facilities nationwide.[4] Also, after a former nursing assistant pled guilty in 2020 to second-degree murder of seven patients at a VA medical center in Clarksburg, West Virginia, an OIG inspection

[1] 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 report refers to both.

[2] 5 C.F.R. § 736.201 (2019); VA Handbook 0710, *Personnel Security and Suitability Program*, May 2, 2016. The background investigation must be scheduled within 14 days of the entrance on duty date. The Office of Personnel Management defines this as the date a person completes the required paperwork and is sworn in as an employee. Office of Personnel Management, "General Instructions for Processing Personnel Actions," chap. 3, section 4-3 in *The Guide to Processing Personnel Actions*, March 2017.

[3] 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.

[4] VA OIG, *Audit of the Personnel Suitability Program*, Report No. 17-00753-78, March 26, 2018. Appendix A lists the corrective actions taken after the 2018 report was issued.

included a finding that the medical center did not adjudicate her background investigation within the required 90 days. Additionally, the inspection found that VA did not follow up on delinquent inquiries to previous employers. The OIG later learned that the former nursing assistant had concerning conduct identified in a prior non-VA position. While VA's vetting process has multiple steps, had the investigation been reviewed and timely adjudicated, she could have been disqualified from VA employment or prevented from filling a position providing direct patient care.[5] Deficiencies were found to have occurred in Beckley, West Virginia, as well, in the course of conducting this follow-up audit in 2022 to evaluate controls over the background investigation process for VA medical facilities across the nation and to determine if adjudication actions were completed in a timely manner and reliably recorded.[6]

What the Audit Found

VA did not provide effective governance of the personnel suitability program to ensure that required background investigations were completed for staff at medical facilities nationwide. In addition, VA's systems and data do not adequately support the personnel suitability program. Although VA implemented new program controls between May 2018 and March 2021 in response to multiple OIG reports, those controls were not sustained or did not adequately mitigate weaknesses. Specifically, the OIG determined in this follow-up audit that VHA personnel suitability staff did not always initiate or adjudicate background investigations in a timely manner and did not maintain personnel records as required. These deficiencies occurred in part because neither VA nor VHA provided effective oversight by executing internal controls over the program, including not conducting program inspections and reviews, respectively. Additionally, Veterans Integrated Service Networks (VISNs) lacked sufficient staff to manage and maintain regular operations.[7]

VA also did not effectively ensure that sufficient tools such as information systems were available to support the objectives of the suitability program. The OIG further determined that VA's background investigation data and information systems were incomplete and unreliable to track the status of investigative actions and key metrics or to conduct effective program oversight. Each of these issues was identified in the 2018 audit. The deficiencies identified in

[5] VA OIG, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, Report No. 20-03593-140, May 11, 2021.

[6] VA OIG, *Personnel Suitability Process Concerns at the Beckley VA Medical Center in West Virginia*, Report No. 21-03718-47, February 23, 2023. Of 48 employees examined, the review team found multiple issues with the background investigations and fingerprinting for 29 of them.

[7] In October 2018, VHA began implementing a shared services model for human resources that consolidated all 140 medical facility human resources offices under the 18 regional networks called VISNs that manage and oversee medical facilities in their specific geographic areas. Personnel suitability functions, such as initiating background investigations and adjudicating closed investigations, reside with the VISNs at the time this report was written.

this report undercut VA's efforts to ensure that the VHA workforce is suited to care for and serve the nation's veterans.

VHA Did Not Ensure Background Investigation Actions Were Completed in a Timely Manner

The team reviewed investigative actions taken for employees initially hired for positions in VA medical facilities from October 1, 2019, through September 30, 2021, and who required an investigation that should have been processed by VHA human resources offices.[8] The OIG estimated this population to be about 54,800 VHA employees.[9] The team found multiple weaknesses with the required background investigation process for the employees examined:

- **Failure to initiate.** The team found that five of the 313 employees in the OIG sample did not have investigations initiated. Because most VA employees must have an investigation, this gap indicates the need for further scrutiny by VA.
- **Delays in investigation.** Even when background investigations were initiated, the team estimated that 7 percent were not started within 14 calendar days of an employee's start date as required.[10]
- **Adjudications that exceeded the required deadline.** The team also estimated that 23 percent of investigations closed by DCSA were not adjudicated within 90 days of the date of the final investigative report as mandated.[11]
- **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 in accordance with VA guidance.[12]

The OIG identified instances when staff were in positions to provide direct patient care despite not being fully vetted, which underscores the importance of the background investigation process. Completing background investigation actions on time ensures that VHA obtains information necessary to determine whether individuals are suitable for holding positions that often involve providing medical care for veterans.

[8] The team reviewed a sample of 313 personnel records from five VISNs and evaluated investigative actions for those employees through December 2022. See appendix B for more details on the audit's scope and methodology.

[9] For more on the population and sampling methodology, see appendix C.

[10] 5 C.F.R. § 736.201 (2019); VA Handbook 0710.

[11] 5 C.F.R. § 731.203 (2019); VA Handbook 0710; Exec. Order No. 13,869, 84 Fed. Reg. 18,125 (Apr. 29, 2019).

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

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

VA did not identify or mitigate continued systemic deficiencies in completing and recording personnel suitability actions because responsible officials did not effectively execute internal controls over the program. 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, the Office of Human Resources and Administration/Operations, Security, and Preparedness (HRA/OSP) suspended required inspections of the program. The Workforce Management and Consulting (WMC) office also did not conduct program reviews of VHA as required. Additionally, responsible VA officials cited insufficient staffing as a barrier to oversight.

Per VA policy, HRA/OSP's Personnel Security and Credential Management office is responsible for oversight and functional program reviews that evaluate compliance with and implementation of handbook requirements.[13] The OIG reported in 2018 that HRA/OSP did not conduct regular 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 facilities' suitability functions.[14] However, HRA/OSP reported that these reviews were suspended in May 2019 due to insufficient staffing—four months after the OIG closed the 2018 report recommendation. The responsible HRA/OSP director recently reported that a replacement for the inspection program would be implemented again by the end of fiscal year 2023.

VHA is required to establish and maintain an effective suitability program and address and correct conditions that are noncompliant with regulatory guidance.[15] VHA's oversight is conducted by WMC. However, WMC did not conduct program reviews of the personnel suitability function at the 18 VISNs. Instead, WMC largely delegated remediation efforts to human resources staff at the VISNs.

[13] VA Handbook 0710. The handbook specifies requirements for the (1) timeliness of fingerprint checks, (2) initiation and adjudication of background investigations, (3) uploading investigation documentation into an employee's personnel file, and (4) updating data systems with relevant information.

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

[15] VA Handbook 0710.

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.[16] VISN personnel security chiefs reported not consistently conducting reviews of the suitability program at their networks, and the chiefs routinely processed investigative actions because they were covering the workload for short-staffed facilities.

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.[17]

In its 2018 report, the OIG identified VA facilities where only one person was assigned adjudication responsibilities. Despite a previous OIG recommendation to evaluate human capital needs and coordinate resources for the program, this issue has been detected again and conflicts with federal standards.[18] In the current audit, the team identified numerous examples where sampled VISNs did not have an adjudicator, or only had one, assigned to a subordinate facility. In response to a recommendation from the 2018 suitability audit, VHA had 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.

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

VA's background investigation data and information systems were not sufficient 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 background investigation milestones, but those data were not always accurate.

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

[17] In January 2020, HRA/OSP directed each administration to review all personnel to ensure they were properly vetted. Additionally, in March 2021, HRA/OSP initiated a targeted review of employees hired from October 2019 through January 2021 that examined suitability data to identify discrepancies such as whether the employee had a fingerprint check and a closed investigation. VHA elected to conduct an all-employee review beyond those targeted by HRA/OSP.

[18] Government Accountability Office (GAO), *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

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. Although differences in scope between the 2018 OIG report and this audit do not permit direct comparisons, the current audit team found these issues are 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

VA-CABS, intended to be VA's investigation case management system, also had critical data fields essential for tracking background investigations that were either empty or inaccurate. Specifically, the OIG estimated

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

VA-CABS had functional limitations as well. It did not transmit data consistently, notify staff about automatic adjudications for further processing, or contain key information needed to manage the background investigation process. These issues occurred because VA did not ensure that sufficient tools were available to support the objectives of the suitability program. This included correcting known data quality issues with HR Smart and considering information needs when implementing VA-CABS.

As a result, VA does not have 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 longstanding data integrity concerns have been mitigated.

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

VA is replacing VA-CABS with a custom-built case management system, called VA-CABS 2.0. The OIG identified concerns with the implementation of this effort because VA has not provided evidence that the new system will address known program and data integrity weaknesses. Specifically, VA has 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 that may duplicate VA-CABS, and some functionality of this system will be required for VA. As such, VA may be allocating resources toward developing a new system that has functionality issues and duplicates other federal efforts.

If VA does not mitigate the identified issues, it risks implementing a new system that contains the same deficiencies as VA-CABS. Furthermore, unless VA improves suitability data, it does not have the necessary assurances that investigation actions have been completed in a timely manner and are reliably recorded.

What the OIG Recommended

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 to the VA deputy secretary.[19] Specifically, the OIG recommended the VA deputy secretary establish robust oversight of the personnel suitability program to ensure timelines and documentation requirements are met; reimplement the required monitoring program; assess resources and allocate staff as needed (using updated staffing metrics) to prioritize program oversight; and ensure that sufficient and appropriate data are collected, tested, and accessible through a single system to support investigation tracking. The OIG further recommended the deputy secretary ensure that future case management systems have the needed functionality and address identified limitations.

VA Comments and the OIG Response

The acting VA deputy secretary concurred with all recommendations and submitted acceptable corrective action plans. The VA response includes that HRA/OSP will lead the development of a VA-wide plan to establish more robust oversight of the personnel suitability program, which will confirm the roles and responsibilities of VA organizational components, update oversight processes, reimplement the required monitoring program, assess program resources, and begin allocating required staff to prioritize oversight. Further, each administration will develop a plan establishing robust oversight of their suitability programs. VHA is planning to continue using hiring flexibilities and will develop a workload-based staffing model for their personnel security occupations by December 31, 2023.

[19] The recommendations addressed to the VA deputy secretary are directed to anyone in an acting status or performing the delegable duties of the position.

HRA/OSP will also collaborate with the Office of Information and Technology to incorporate formal data-testing procedures in relevant data systems by the end of 2023 as well. HRA/OSP will work with VA offices and relevant outside agencies to provide requirements for enhancing VA-CABS and to develop a plan to ensure future systems improve oversight and management of the background investigation process. Appendix D provides the full text of the acting VA deputy secretary's comments. The OIG will monitor implementation of planned actions and will close the recommendations when VA provides sufficient documentation demonstrating progress addressing the issues identified.

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Contents

Abbreviations

DCSA	Defense Counterintelligence and Security Agency
GAO	Government Accountability Office
HRA/OSP	Human Resources and Administration/Operations, Security, and Preparedness
NBIS	National Background Investigation Services
OIG	Office of Inspector General
VA-CABS	VA Centralized Adjudication Background Investigation System
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
WMC	Workforce Management and Consulting

Introduction

VA has designated staff to coordinate background investigations to determine the suitability of individuals for positions they are seeking with the department and whether they can be given access to its facilities and information systems. These investigations are conducted to protect veterans, family members, other employees, and visitors, in addition to securing sensitive information and resources. This process is particularly important for screening staff who will potentially have access to patients, their records, drugs stored in the facility, and other assets.

VA determines the level of investigation needed for a position by assessing its level of risk—rated as low, moderate, or high. At a minimum, most VA employees receive a Tier 1 investigation to verify that each individual is suitable for a job. Most medical facility staff, including physicians, nurses, pharmacists, and laboratory technicians, are required to receive a Tier 1 investigation. Table 1 describes the position risk categories and the investigation types associated with each occupation.

Table 1. Investigation Type and Position Risk Categories

Investigation type	Risk category	Examples of occupations
Tier 1	Low	Most employee positions
Tier 2	Moderate	Human resources staff, information technology staff, police officers, service line managers
Tier 4	High	Facility directors, adjudicators, privacy officers, fiscal officers, and finance officers

Source: VA Handbook 0710 and VHA Directive 0710.

Note: The examples of occupations listed in Tiers 2 and 4 are not exhaustive. Tiers 3 and 5 are investigations for sensitive national security positions with potential access to classified information; these investigations are processed through VA's Personnel Security Adjudication Center.

In March 2018, the VA Office of Inspector General (OIG) reported on deficiencies within the Veterans Health Administration's (VHA) personnel suitability program. Those deficiencies led to delinquent initiation and adjudication of employee background investigations.[20] The report concluded that neither VA nor VHA effectively governed the background investigation process to ensure requirements were met at medical facilities nationwide. As discussed later in this report, a former nursing assistant pled guilty in 2020 to second-degree murder of seven patients at a VA medical center in Clarksburg, West Virginia—prompting an OIG inspection that included a finding that the medical center did not adjudicate her background investigation within

[20] VA OIG, *Audit of the Personnel Suitability Program*, Report No. 17-00753-78, March 26, 2018.

the required 90 days. Had that been completed, she could have been disqualified from VA employment or prevented from filling a position providing direct patient care due to concerning conduct identified in prior non-VA positions.[21] Weaknesses were also found in Beckley, West Virginia, during the follow-up audit that is the focus of this report.[22] This follow-up audit was conducted to evaluate controls over the background investigation process for VA medical facilities nationwide and to determine if adjudication actions were completed in a timely manner and reliably recorded.

Background Checks for New VA Employees

VA's hiring process requires applicants or appointees to agree to a three-part background check to determine if they are suitable for employment.[23] Figure 1 on the following page details the background check process.

[21] VA OIG, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, Report No. 20-03593-140, May 11, 2021.

[22] VA OIG, *Personnel Suitability Process Concerns at the Beckley VA Medical Center in West Virginia*, Report No. 21-03718-47, February 23, 2023. The review team found multiple issues with the background investigations and fingerprinting for 29 of the 48 employees examined.

[23] 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 report refers to both.

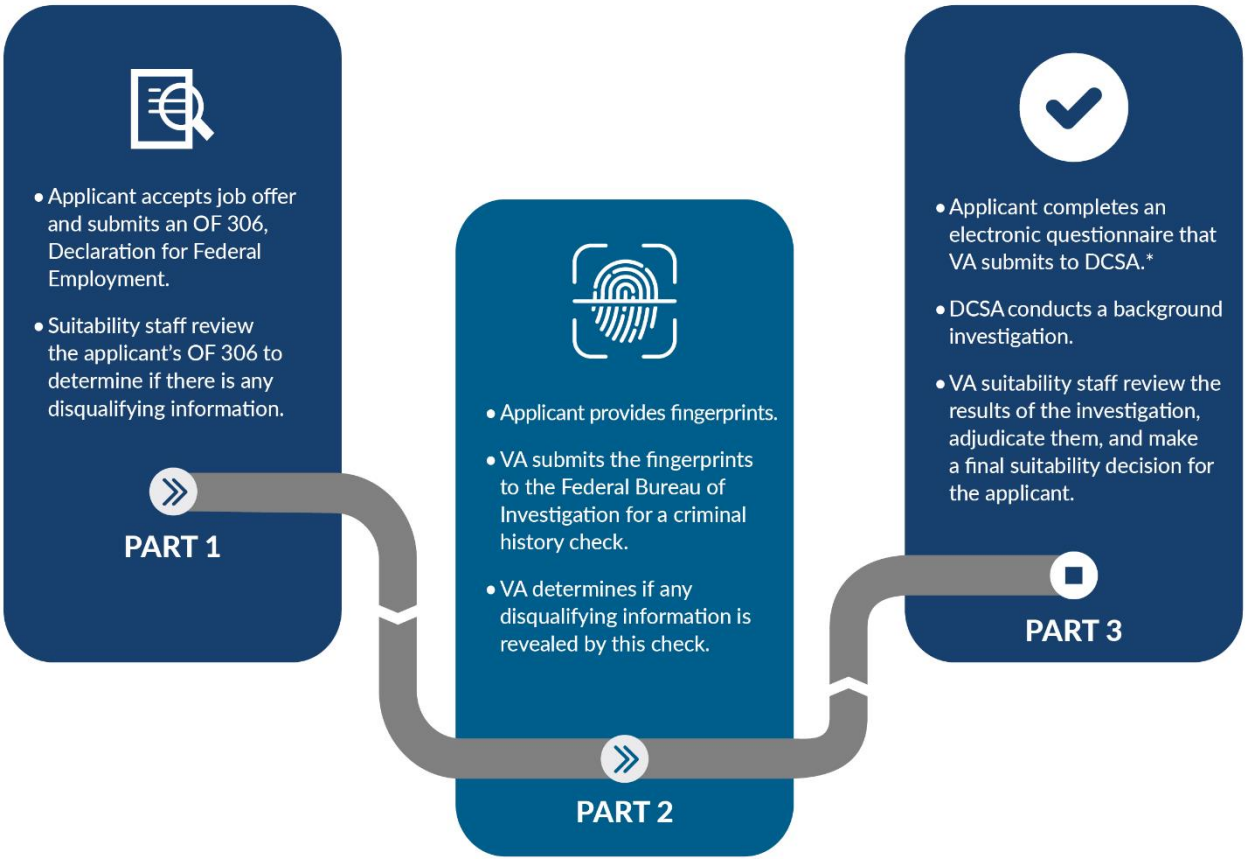

Figure 1. *VA's background check process.*
Source: OIG analysis of VA and VHA policy and forms used for the investigation process.
**DCSA stands for Defense Counterintelligence and Security Agency.*

First, when applicants accept a tentative offer for employment, they submit 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. Suitability 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, if an applicant reported a recent conviction for prescription drug theft, that information may disqualify them from a position as a pharmacist. However, this type of issue might not affect their candidacy for a groundskeeper position.

The second screening is referred to as a special agreement check. VA obtains the applicants' fingerprints and submits them for a Federal Bureau of Investigation criminal history check. This check provides a degree of assurance that the individual is not subject to an ongoing inquiry and does not have a prior criminal conviction that could affect suitability for the position. Fingerprinting should generally be completed before employment but may be conducted up to

five days after the entrance on duty date.[24] Similar to the OF 306 screening, if this check revealed information that would disqualify an individual from the position, then VA could decide to rescind the tentative offer or not retain the employee.

Finally, the applicant completes an electronic questionnaire that VA submits to the Defense Counterintelligence and Security Agency (DCSA) to conduct the required background investigation.[25] At a minimum, this investigation includes (1) a name check with the Federal Bureau of Investigation and other federal databases and (2) written inquiries to employers, candidate-supplied references, and places of education and residence. This process is intended to provide VA with the comprehensive background information needed to verify suitability for employment and must be scheduled within 14 days of the entrance on duty date.[26]

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 suitability for employment. A suitability determination must be rendered within 90 days after the background investigation was closed.[27] If suitability staff make an unfavorable determination, VA can take action, including removal, under the appropriate authority.[28]

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

- **HR Smart**: This is VA's human resources information system that supports personnel suitability, payroll, and position management. HR Smart organizes data by position, rather than by employee, and allows for real-time human resources transaction-processing for all of VA.
- **VA Centralized Adjudication Background Investigation System (VA-CABS)**: The centralized case management system is used for processing background investigations and tracking suitability-related data. VA-CABS was launched in April 2019 and captures data about fingerprint checks, background investigations, and reinvestigations. In July 2022, VA-CABS became the system of record for all VA personnel suitability data.

[24] 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.

[25] For sampled records from the Veterans Integrated Service Networks (VISNs), the background investigation process generally took about two months to complete, on average, from the date it was scheduled to the date it was closed.

[26] 5 C.F.R. § 736.201 (2019); VA Handbook 0710. The Office of Personnel Management defines the entrance on duty date as the date a person completes the required paperwork and is sworn in as an employee. Office of Personnel Management, "General Instructions for Processing Personnel Actions," chap. 3, section 4-3 in *The Guide to Processing Personnel Actions*, March 2017.

[27] 5 C.F.R. § 731.203 (2019); VA Handbook 0710.

[28] 5 C.F.R. § 731.203 (2019). Title 5 and Hybrid Title 38 employees are subject to a one-year probationary period pursuant to 5 C.F.R. § 315.802 (2019). Title 38 employees are subject to a two-year probationary period pursuant to 38 U.S.C. § 7403.

VA plans to replace the current commercial off-the-shelf VA-CABS with a customizable system, named VA-CABS 2.0. As of September 2023, VA was implementing VA-CABS 2.0.

Investigation information is also transmitted to the Personnel Investigations Processing System, which is owned by DCSA. Supporting documentation, such as a certificate of investigation, is uploaded into an employee's electronic personnel folder.

This background investigation process helps ensure that VA employees are suitable to work with patients at medical facilities or handle veterans' sensitive information. If these checks are circumvented or not completed on time, then VA runs the risk that patients and their records may be exposed to individuals who have not been fully vetted.

Responsible Offices

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).[29] According to VA guidance, this position has the authority to establish and maintain personnel suitability programs throughout the department consistent with applicable laws, rules, regulations, and executive orders.[30]

The **Office of Identity, Credential, and Access Management**, under HRA/OSP, 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**, is required to conduct oversight and functional program reviews to evaluate compliance and implementation of the handbook's requirements.[31]

Each of the three VA administrations—VHA, the Veterans Benefits Administration, and the National Cemetery Administration—is required to appoint a personnel security program manager to coordinate departmental regulations and policies involved with the overall personnel security and suitability program.[32] According to VA guidance, the **under secretary for health** must ensure that VHA complies with personnel suitability policies and procedures.[33] The under secretary is also required to establish and maintain an effective suitability and fitness

[29] Effective September 12, 2018, the position of assistant secretary for Operations, Security, and Preparedness was eliminated. The Office of Operations, Security, and Preparedness and its associated functions were reassigned to the assistant secretary for Human Resources and Administration. For consistency, this office is referred to as HRA/OSP throughout this report.

[30] VA Directive 0710, *Personnel Security and Suitability Program*, June 4, 2010.

[31] 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.

[32] VA Handbook 0710.

[33] VA Directive 0710.

determination program using automated processes while taking actions to address and correct conditions that are noncompliant with regulatory guidance.[34] VHA's personnel suitability oversight is conducted by the **Personnel Security Program Office** within **Workforce Management and Consulting (WMC)**.

Finally, VHA's Personnel Security and Suitability Program Policy requires **Veterans Integrated Service Network (VISN) personnel security chiefs** to ensure that investigations are conducted in a timely manner and adjudications are made within the required time frames.[35]

Figure 2 on the following page provides an overview of VA's organizational structure for governance of the personnel suitability program.

[34] VA Handbook 0710.

[35] 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, reside with the VISNs at the time this report was written.

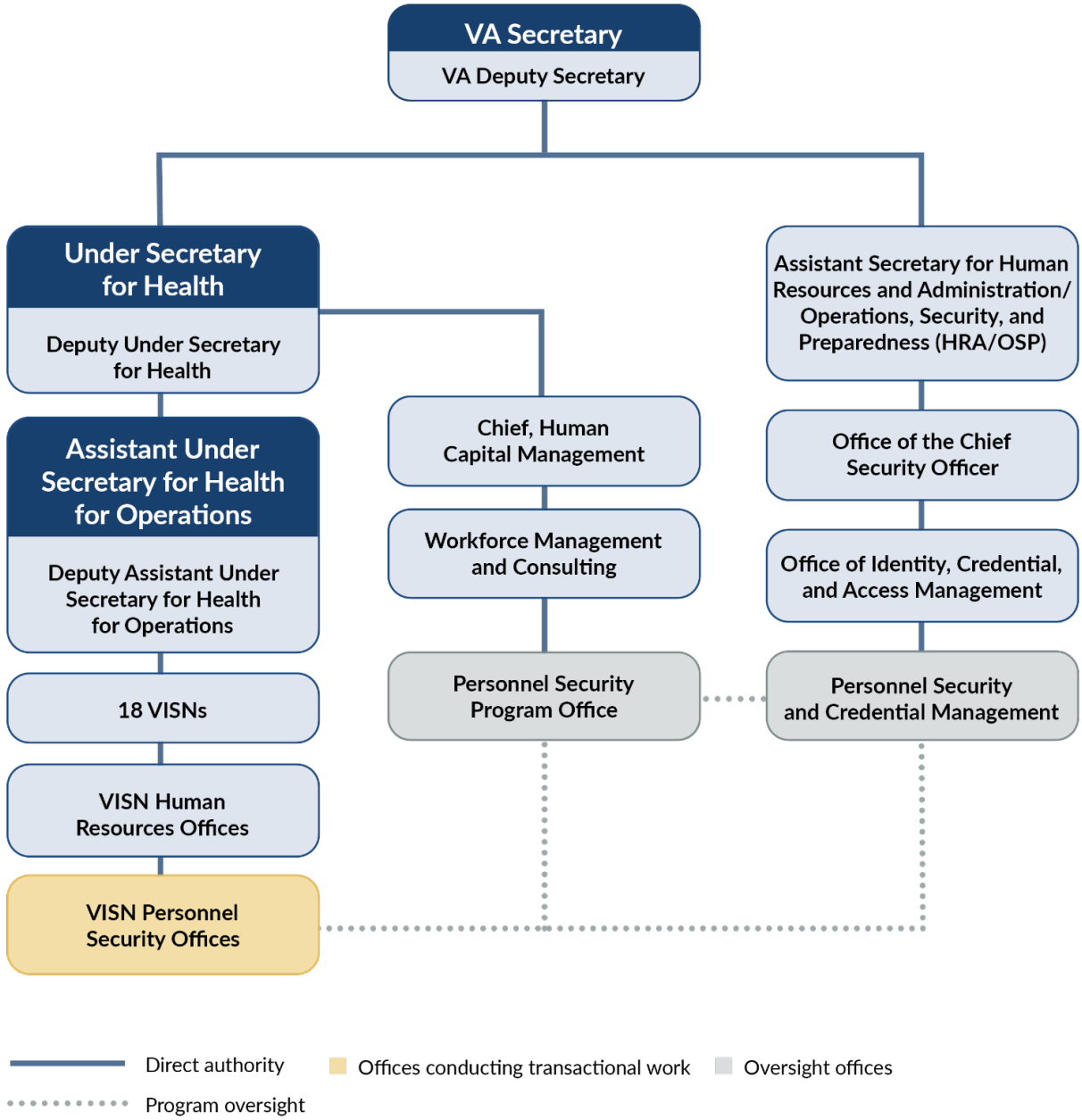

Figure 2. *Overview of VA's organizational structure for governance of the personnel suitability program. Source: OIG analysis of organizational charts, VA and VHA policy, and VHA websites and position descriptions.*
Note: As shown in this chart, VA guidance assigns responsibility to offices and, at other times, specific positions.

Each of these officials and offices have responsibilities for ensuring that background investigations of new employees are completed in a timely manner and are reliably recorded in

VA's systems. Per VA policy, these offices must collaborate with one another to ensure that the personnel suitability program is effective and efficient.[36]

Prior Oversight Reports on the Personnel Suitability Program

As noted previously, a March 2018 OIG report on the personnel suitability program found that neither VA nor VHA effectively governed the program necessary to ensure that background investigation requirements were met at medical facilities nationwide.[37] 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 fields necessary to track background investigations to conclusion did not exist or were incomplete. 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. These recommendations were closed starting in January 2019, with the last recommendation closed in March 2022. More information about these 11 recommendations can be found in appendix A.

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.[38] 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 important information for VHA to consider but did not make any specific recommendations for corrective action in this memorandum.

In May 2021, the OIG issued a report regarding care and oversight deficiencies related to multiple homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia.[39] On July 14, 2020, Ms. Reta Mays, a former nursing assistant, pled guilty to seven counts of

[36] VA Directive 0710.

[37] VA OIG, *Audit of the Personnel Suitability Program*.

[38] VA OIG, Management Advisory Memorandum 20-00541-34, "Potential Risks Associated with Expedited Hiring in Response to COVID-19," March 11, 2021.

[39] VA OIG, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, Report No. 20-03593-140, May 11, 2021.

second-degree murder and one count of assault with the intent to commit murder, all by deliberately administering lethal doses of insulin to patients. As stated earlier, the medical center had not adjudicated Ms. Mays' background investigation within 90 days as required. Specifically, the Office of Personnel Management 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 delinquent inquiries to previous employers.[40] The OIG later learned that Ms. Mays' employment history contained allegations that she used excessive force while she was previously employed as a corrections officer. While VA's vetting process has multiple steps, timely review and adjudication of Ms. Mays' background investigation could have disqualified her from VA employment or prevented her from filling a position that provided direct patient care.

Finally, a February 2023 Government Accountability Office (GAO) report highlighted lapses in VHA's screening processes for employees with controlled substance–related criminal histories.[41] In addition to issues with VHA's process for obtaining waivers from the Drug Enforcement Administration for these employees, the GAO found that certain background investigation requirements were not completed. Specifically, some employees did not have background investigations completed, and others did not have documented investigations in their personnel files.

Future State of the Suitability Program

The federal government intends to overhaul its personnel security function by fiscal year 2025. Beginning in March 2018, the Office of Personnel Management and the Office of the Director of National Intelligence launched the Trusted Workforce 2.0 effort with partner agencies across the federal government. Trusted Workforce 2.0 will change the personnel vetting process by replacing periodic reinvestigations with a continuous vetting program. Continuous vetting involves regularly reviewing an individual's background to ensure they continue to meet position requirements. This vetting uses information from databases on criminal, terrorist, and financial activity, as well as public records. In addition, low-risk positions, which currently are not subject to reinvestigations, will undergo continuous vetting. Lastly, this effort will replace the current five investigation tiers with three tiers.

Moreover, DCSA is developing a National Background Investigation Services (NBIS) information system to initiate, conduct, and adjudicate background investigations for all federal

[40] 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."

[41] GAO, *Action Needed to Address Persistent Control Weaknesses and Related Risks in Employee Screening Processes*, GAO-23-104296, February 23, 2023.

employees, military members, and government contractors. This service will act as a case management system with automated workflows. The system will build on and replace DCSA's legacy background investigation information technology systems, which will be decommissioned in stages throughout 2023.

Results and Recommendations

Finding 1: VA's Governance of the Personnel Suitability Program for Medical Facility Employees Continues to Need Improvement

VA did not provide effective governance of the personnel suitability program to fully and continuously remediate previously identified deficiencies or ensure VHA staff at medical facilities were effectively vetted nationwide. VA implemented new program controls between May 2018 and March 2021 in response to multiple OIG reports; however, those controls were not sustained or did not sufficiently 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. Specifically, the team found noncompliance with requirements at several points in the suitability process:

- **Failure to initiate.** The team found that five of the 313 employees examined for the audit did not have investigations initiated.[42] Because most VA employees must have an investigation, this gap indicates the need for further scrutiny by VA.
- **Delays in investigation.** Even when background investigations were initiated, the team estimated that 7 percent were not started within 14 calendar days of an employee's start date.[43]
- **Adjudications exceeded the required deadline.** The team also estimated that 23 percent of investigations closed by DCSA were not adjudicated within 90 days of the date of the final investigative report.[44]
- **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.[45]

These issues occurred in part because neither HRA/OSP nor VHA conducted required oversight that focused on the efficiency and effectiveness of processes within the personnel suitability program. VISNs also lacked sufficient staff to supervise program operations and complete workload requirements. Additionally, VA's background investigation data and information

[42] The team reviewed a sample of 313 personnel records from an estimated total of 54,800 VHA employees initially hired to work in medical facilities from October 1, 2019, through September 30, 2021, and evaluated investigation actions for those employees through December 2022.

[43] 5 C.F.R. § 736.201; VA Handbook 0710.

[44] 5 C.F.R. § 731.203; VA Handbook 0710; Exec. Order No. 13,869, 84 Fed. Reg. 18,125 (Apr. 29, 2019).

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

systems were not sufficient to conduct program oversight.[46] Without appropriate governance and resources, VA cannot ensure that background investigation requirements are met. As a result, VA's assurance that the VHA workforce is suitable for caring for and serving the nation's veterans could be improved.

The following determinations formed the basis for this finding and led to the OIG's recommendations:

- VA has implemented corrective actions and conducted reviews of its personnel suitability records, but those measures did not ensure VHA background investigation actions were completed in a timely manner.
    - VHA suitability staff did not always initiate or adjudicate background investigations within required timelines and did not maintain personnel records.
- VA's lack of oversight led to deficiencies within its personnel suitability program.
    - Required inspections were suspended, and program monitoring could be improved.
- VISNs lacked sufficient staff to consistently perform suitability program responsibilities.

What the OIG Did

The team estimated about 54,800 VHA employees were hired for VA medical facilities from October 1, 2019, through September 30, 2021, and required an investigation that should have been processed by VHA human resources offices.[47] The team reviewed a sample of 313 personnel records and evaluated investigation actions for those employees through December 2022. The team also conducted five virtual site visits to VISN human resources offices and reviewed sample records with personnel suitability staff. The team interviewed personnel suitability officials and staff in the VA central office, VHA central office, and from the five VISNs that processed the 313 investigation actions. Finally, the team considered potential program improvements reported by suitability officials through February 2023.

VA Implemented Corrective Actions and Conducted Reviews of Its Personnel Suitability Records

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. These actions included the following:

[46] Finding 2 details issues concerning VA's background investigation data and information systems.

[47] Appendix B discusses data reliability issues encountered during the audit. Appendix C summarizes the audit team's statistical sampling methodology.

- **May 2018.** HRA/OSP began on-site inspections of VA facilities to evaluate whether their personnel suitability functions adhered to regulations, policies, and procedures and were operating effectively and efficiently. However, HRA/OSP reported that these inspections were suspended in May 2019.
- **October 2018.** VHA published an updated personnel suitability directive that established the Personnel Security Program Office and appointed suitability coordinators for the VISNs.
- **December 2019.** VHA began distributing quarterly reports to the VISNs detailing investigations that had not been adjudicated within 90 days.[48] VISNs were then required to reduce delinquencies by 10 percent each month and report the status to the WMC.
- **January 2020.** HRA/OSP directed each administration to review all personnel with current access to facilities and information systems to ensure they were properly vetted. VHA completed its review in July 2020 and reported the results to HRA/OSP in September 2020.
- **January 2020.** HRA/OSP also established an integrated project team that included representatives from each administration, as well as seven VA staff offices. The project team was tasked with reviewing personnel suitability policies and processes, assessing VA's progress in resolving the issues identified by OIG reports, and reviewing the vetting process for health professions trainees.[49] From this effort, HRA/OSP developed an action plan to improve the program; however, many of the recommendations were placed on hold due to the pandemic.[50]
- **March 2021.** HRA/OSP again initiated a targeted review of about 56,000 employees who were hired from October 2019 through January 2021. The review compared multiple systems, including HR Smart and VA-CABS, to identify whether the employee had a fingerprint check and a closed investigation. HRA/OSP instructed each administration to review the discrepancies, correct them, and report the results by May 2021.[51]

The OIG acknowledges VA's efforts to review and correct its personnel suitability records and the additional stresses experienced during the pandemic. However, these efforts only corrected

[48] VHA deputy under secretary for health for operations and management, "Notification of Delinquent Background Investigation Adjudications," memorandum to the VISN directors, December 2, 2019.

[49] Health professions trainees are individuals performing clinical or research training to satisfy program or degree requirements and are appointed to temporary positions at VA medical facilities. These trainees include students, interns, residents, and fellows.

[50] The integrated project team was subsequently suspended from March to December 2020.

[51] VHA elected to conduct an all-employee review beyond those targeted by HRA/OSP. As of November 2022, VHA had reviewed 97 percent of VHA employees.

discrepancies after they occurred, rather than identifying or remediating programmatic weaknesses affecting investigative actions in VA's human resources offices. As a result, many of the previously identified program deficiencies were not fully resolved.

VHA Employee Background Investigative Actions Were Not Completed within Required Timelines

The team for the current audit found that VHA personnel suitability staff did not consistently complete required actions on time throughout the background investigation process. These actions included initiating the background investigation, adjudicating the investigation's results, and uploading required documentation in the employee's electronic personnel folder.

Although this audit was a follow-up of the OIG's 2018 report, it is important to note that the results between the two publications are not directly comparable. The 2018 report assessed the suitability program over a five-year period and focused on investigative actions processed at VA medical facilities. The current audit assessed a two-year period to ensure the analysis considered program-wide changes, such as shifting personnel suitability functions to the VISNs and expanding hiring flexibilities. As a result of the differences in scope, the OIG cannot state in each section that follows whether the conditions have improved or worsened. The audit team simply notes the respective results for transparency.

Suitability Staff Did Not Always Initiate Background Investigations for New Employees

VA is required to initiate the background investigation process within 14 calendar days of an employee's appointment.[52] In 2018, the OIG reported that 6 percent of employees working at VA medical facilities did not have background investigations initiated at all by responsible staff.[53] During the current audit, the team found that five employees in its sample of 313 did not have background investigations initiated. 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. For example, a nurse at the VA Washington DC Healthcare System in VISN 5 worked for about 19 months without having a background investigation initiated. The nurse's time-limited appointment ended before the OIG's audit, and she left VA employment; therefore, the VISN was unable to take corrective action to initiate the investigation.

In another significant example, a medical supply technician at the VA Northern Indiana Healthcare System in VISN 10 worked for over two years before a background investigation was initiated. Medical supply technicians can be involved in critical roles, such as sterile processing,

[52] 5 C.F.R. § 736.201; VA Handbook 0710.

[53] VA OIG, *Audit of the Personnel Suitability Program*.

which is necessary for safe medical procedures. The VISN took corrective action as a result of the OIG's inquiry and, as of October 2022, the investigation had been closed and favorably adjudicated.

The team also found two instances in which staff employed at the Beckley VA Medical Center in West Virginia did not have a background investigation initiated. This discovery led the OIG to conduct a more extensive analysis of staff hired at that facility. The results of that review were published in a separate report highlighted earlier, which found investigations were not initiated for an additional seven employees.[54]

Initiating background investigations in a timely manner is critical to mitigating risk to VHA by ensuring relevant information—both favorable and unfavorable—is aggregated and shared with appropriate human resources officials for review and adjudication.

Suitability Staff Also Delayed Initiating Background Investigations for New Employees

Even in instances when background investigations were initiated, VHA suitability staff started some after the required 14 calendar days following an employee's start date.[55] The OIG estimated based on its sample that 3,700 investigations (7 percent) were not initiated within this period.[56] 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.

Table 2 summarizes the days it took VA to initiate the 18 delinquent investigations in the team's sample.

[54] VA OIG, *Personnel Suitability Process Concerns at the Beckley VA Medical Center in West Virginia*.

[55] 5 C.F.R. § 736.201; VA Handbook 0710. Federal regulations and VA Handbook 0710 do not, however, define when an investigation is considered initiated. Additionally, VA and VHA suitability officials could not provide a consistent definition for the initiation date. An Office of Personnel Management memorandum from December 15, 2020, states that an investigation is considered initiated when the department or agency has submitted the request for investigation to the federal background investigation provider and the provider has scheduled the investigation. Office of Personnel Management Acting Director Memorandum, "Credentialing Standards Procedures for Issuing Personnel Identity Verification Cards under HSPD-12 and New Requirement for Suspension or Revocation of Eligibility for Personnel Identity Verification Credentials," December 15, 2020. For the purposes of this audit, the OIG used the date the investigation was scheduled with DCSA.

[56] See Table C.2. in appendix C for the calculation of estimates. The OIG did not test or report on this element in the 2018 personnel suitability audit. However, the team provided these results to demonstrate an unmitigated risk to VHA identified in the follow-up audit.

Table 2. Age of Delinquent Initiations

Days to initiate	Cases
15–30	8
31–90	4
91–180	2
181–360	3
Over 360	1
Total	**18**

Source: Certificates of investigation received from sampled VISNs and employee electronic personnel folders and personnel action documents retrieved from employee electronic personnel folders.

Of the 18 delinquent cases, 11 were for staff who provided veterans with medical care. For example, a physician at the VA Saginaw Healthcare System in Michigan in VISN 10 was employed for over three months before a background investigation was scheduled. Six of the cases were for staff members who supported medical care. For example, an advanced medical support assistant at the VA Connecticut Healthcare System in VISN 1 was employed for over nine months before a background investigation was initiated. The remaining employee was a worker with the environmental management service at a VISN 8 facility.

As of August 2022, all 18 investigations had been closed and favorably adjudicated. However, VHA still needs to ensure that similar delays in initiating background investigations do not occur for its employees. Initiating investigations promptly is necessary to obtain information that allows VHA to determine whether an employee is suitable for holding a position.

Suitability Staff Adjudicated Employees' Background Investigations Late

Once an investigation has been completed and returned from DCSA, a VHA adjudicator reviews the investigation report and makes a suitability determination. A determination is based on an analysis of both favorable and unfavorable information about a person's character and conduct. VHA's human resources offices must report adjudicative decisions to DCSA within 90 days of the closure date of the final investigative report.[57]

In 2018, the OIG reported that 13 percent of investigations were not adjudicated within the required time frame.[58] In response, VA implemented automatic adjudication, also referred to as eAdjudication, which allows DCSA to automatically render decisions on background

[57] 5 C.F.R. § 731.203; VA Handbook 0710; Exec. Order No. 13,869.

[58] VA OIG, *Audit of the Personnel Suitability Program*.

investigations when no issues were found. During the current audit, the team estimated 13,400 background investigations (27 percent) were automatically adjudicated by DCSA, which should have reduced the adjudication workload for suitability staff.[59]

However, despite these changes, VHA suitability staff continued to have difficulty in consistently manually adjudicating background investigations within the required 90 days. The team estimated that 11,700 investigation adjudications (23 percent) were late. Delinquent adjudications in the team's sample ranged from 91 to 702 days and averaged 208 days.

Employees at multiple VISNs who directly interacted with patients experienced significant delays before their background investigations were adjudicated. For example, suitability staff took more than one year to adjudicate the background investigations for a dental assistant at the Martinsburg VA Medical Center in West Virginia in VISN 5, 17 months for a nurse at the Orlando VA Medical Center in Florida in VISN 8, and over one year for a social worker with the VA Portland Health Care System in Oregon in VISN 20. Although these background investigations were eventually adjudicated favorably, timely completion is necessary for suitability staff to consider any negative information uncovered during the vetting process.

Suitability Staff Did Not Consistently Upload Required Documentation into Employee Personnel Folders

Per VA and VHA policy, the certificate of investigation must be signed, and a copy must be placed in the employee's electronic personnel folder upon a favorable determination.[60] This requirement applies to all certificates of investigation, regardless of the entity that made the suitability determination.

In 2018, the OIG reported that 42 percent of investigations did not have corresponding documentation in the personnel folder.[61] In this follow-up audit, suitability staff did not regularly upload copies of the certificate of investigation in the personnel folder within all five VISNs reviewed. Based on its sample, the team estimated 24,300 investigations (48 percent) lacked a corresponding certificate in the personnel folder.[62] If no information is available in other data systems, the certificate can serve as proof the investigation was completed and favorably adjudicated. Without the certificate, VA and other agencies may not be able to validate an employee's investigation.

[59] The team did not identify any delinquent eAdjudications in its analysis.

[60] VA Handbook 0710; VHA Directive 0710.

[61] VA OIG, *Audit of the Personnel Suitability Program*.

[62] For more information on these estimates, see table C.2. in appendix C.

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

VA did not identify or mitigate continued systemic deficiencies in completing and recording personnel suitability actions because responsible HRA/OSP and VHA officials did not effectively execute internal controls for the program. The Office of Management and Budget Circular A-123 and the *Standards for Internal Control in the Federal Government* require that managers establish and maintain internal controls necessary for effective and efficient program operations.[63] Managers are responsible for establishing policies and procedures, monitoring program operations, and ensuring appropriate staffing levels.[64] Each governing entity is also required by VA policy to conduct program reviews evaluating the efficiency and effectiveness of the personnel suitability function. Despite these requirements,

- HRA/OSP suspended inspections of the personnel suitability program, and
- WMC did not conduct program reviews of VHA's suitability functions.

Responsible VA officials cited insufficient staffing as a barrier to conducting this program oversight.

HRA/OSP Suspended Required Inspections of the Personnel Suitability Program

Per VA policy, HRA/OSP's Personnel Security and Credential Management office is responsible for conducting oversight and functional program reviews to evaluate compliance and implementation of the handbook's requirements.[65] The OIG reported in 2018 that HRA/OSP did not conduct regular oversight until February 2017 after the first audit team initiated its work and, even then, that review focused on correcting delinquencies reported to VA by the Office of Personnel Management.[66] As a result, the OIG recommended that HRA/OSP implement the monitoring program required by policy and establish robust management oversight of the personnel suitability program.

[63] Office of Management and Budget Circular A-123, *Management's Responsibility for Enterprise Risk Management and Internal Control*, July 15, 2016; GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

[64] GAO, *Standards for Internal Control in the Federal Government*.

[65] 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.

[66] During the 2018 personnel suitability audit, the Office of Personnel Management's National Background Investigation Bureau had responsibility for conducting background investigations. These functions transferred to DCSA on October 1, 2019. Exec. Order No. 13,869.

HRA/OSP subsequently implemented an inspection program that involved site visits to VA facilities that had high rates of noncompliance with critical requirements, such as not meeting prescribed timelines for background investigation submissions to DCSA and overdue adjudications. The inspection reports provided findings and recommendations to improve the suitability functions at the locations. For example, a report identified insufficient training for one facility's adjudicator, weaknesses in the background investigation process, delinquent adjudications, and issues with HR Smart data quality. HRA/OSP completed 11 facility inspections by May 2019.

However, HRA/OSP reported that these reviews were suspended in May 2019 due to insufficient staffing—four months after the OIG closed the related 2018 report recommendation as implemented. HRA/OSP further reported that it would be developing a "virtual audit" in its place. However, this new process had not been launched at the time this report was written. In February 2023, the responsible HRA/OSP director expected that this effort would be implemented by the end of fiscal year 2023.

WMC's Efforts to Monitor the Program Could Be Improved with Comprehensive Reviews

VA policy also required that the under secretary for health ensure that VHA complies with personnel suitability policies and procedures.[67] The under secretary must establish and maintain an effective suitability and fitness determination program by using automated processes and by addressing and correcting conditions that are noncompliant with regulatory guidance.[68] Further, VA guidance directs each of the three VA administrations to appoint a personnel security program manager to coordinate departmental regulations and policies involved with the overall personnel security and suitability program.[69]

VHA's personnel suitability oversight is conducted by the WMC Personnel Security Program Office. However, WMC did not conduct program reviews or inspections of the personnel suitability program at the 18 VISNs. Officials reported a desire to implement an audit program but stated that staffing constraints have hindered this effort. As of October 2022, the former VHA personnel security director proposed expanding the program office from five to 20 full-time–equivalent employees and dedicating nine staff to ensure VHA complies with requirements.

In the absence of additional staff, WMC has largely delegated remediation efforts to human resources staff at the VISNs. However, as discussed in the next section of this report, VISN human resources offices also face staffing limitations. Delegating oversight responsibilities

[67] VA Directive 0710.

[68] VA Handbook 0710.

[69] VA Handbook 0710.

essentially requires the VISNs to execute their suitability workload and then conduct oversight of their own work. For example, WMC leveraged VISN resources to conduct the March 2021 data compliance review noted previously. Although this effort was to be completed by December 31, 2021, the earliest VISN reviews were not completed until May 2022.

Despite WMC having made some progress in identifying and correcting delinquencies within VHA's personnel suitability program, VHA should determine how to review the efficiency and effectiveness of the suitability process going forward. A consistent and comprehensive oversight approach can identify issues that might contribute to missing investigations or employees working for years without being fully vetted.

VISNs Lacked Sufficient Staff to Consistently Perform Their Suitability Program Responsibilities

VHA's Personnel Security and Suitability Program Policy requires VISN personnel security chiefs to ensure that investigations are conducted in a timely manner, adjudications are made within the required time frames, and the required documentation is completed and filed in the employee's electronic personnel folder.[70] All five VISN personnel security chiefs interviewed by the OIG team have not consistently conducted reviews of the suitability program in their networks. Further, four of the five VISN personnel security chiefs told the team that they routinely processed investigation actions to help facilities that either lacked an adjudicator or had an adjudicator on leave. The switch in focus from oversight to transaction processing may have inhibited the chiefs' ability to conduct the required reviews.

Adjudicators at all five VISNs also consistently cited staffing shortages as a cause for delinquent adjudications and reported difficulty maintaining routine operations. Adjudicators stated that in addition to their responsibilities with the background investigation process, they had to fill in for the personnel security assistants who issued identification cards in badging offices. VISNs also reported dedicating time and resources to completing the all-personnel data reviews delegated by WMC. The shift away from processing background investigations may have contributed to the delinquencies. In 2018, the OIG identified VA facilities where only one person was assigned adjudication responsibilities. This issue with understaffing has not been resolved despite a previous OIG recommendation.[71] The *Standards for Internal Control in the Federal Government* also stipulate that managers are responsible for establishing a control environment that includes appropriate staffing and training.[72]

[70] VHA Workforce Management and Consulting, *Personnel Security and Suitability Program Policy*.

[71] The OIG closed the related recommendation after VHA shared a plan demonstrating that staffing concerns would be addressed as part of their human resources modernization initiative.

[72] GAO, *Standards for Internal Control in the Federal Government*.

Table 3 provides examples of medical facilities in the sampled VISNs that either had only one adjudicator or did not have any adjudicators specifically assigned to that facility.

Table 3. Examples of VISN Adjudicator Staffing Concerns

Number of adjudicators	VISN	Facilities	State	Total employee count
1	1	Providence VA Medical Center	Rhode Island	1,599
1	1	White River Junction VA Medical Center	Vermont	1,177
0*	1	VA Central Western Massachusetts Healthcare System; Manchester VA Medical Center	Massachusetts; New Hampshire	1,976
1	10	Chillicothe VA Medical Center; Chalmers P. Wylie Ambulatory Care Center	Ohio	2,834
1	10	VA Northern Indiana Health Care System; Aleda E. Lutz VA Medical Center	Indiana; Michigan	3,186
1	20	Puget Sound Health Care System	Washington	4,712

Source: VA OIG analysis of interviews with VISN personnel suitability staff and VA Staffing and Vacancy Reporting as of March 31, 2022.

Note: Some healthcare systems in the table have two medical centers.

**The VISN personnel security chief told the OIG that she and the supervisor assumed responsibility over adjudications at these facilities. She further stated that the VISN would be hiring two adjudicators for these facilities.*

In 2010, the under secretary for health established staffing ratios for human resources functions. In particular, the staffing metric for suitability required one full-time employee per 800 employees served. During this time, the personal identity verification badging function was aligned under the police service at VA medical facilities and was not included in this metric.[73] In its 2018 suitability audit, the OIG recommended that VHA evaluate human capital needs and coordinate appropriate resources to manage personnel suitability workload. In response, VHA stated that it would determine the current staffing levels for employees performing these tasks, determine if resource shortages are systemic, and if so, update the staffing metrics.

[73] In May 2020, during the human resources modernization effort, this function was realigned from police services to human resources.

The updated staffing metric was being reviewed by WMC leaders as of January 2023. According to documentation provided by VHA, there were 769 full-time VISN suitability staff as of January 2023. After implementing the updated staffing metric, the VISNs would need 952 additional staff, a 124-percent increase.

WMC acknowledged difficulties in hiring and retaining staff in the personnel suitability program. Multiple VISN officials also communicated concerns about hiring staff and attributed difficulties to the grading of the positions. VHA should leverage available hiring flexibilities to ensure the personnel suitability function is staffed appropriately to conduct regular oversight and handle the background investigation workload.

Finding 1 Conclusion

Continued ineffective governance over the personnel suitability program led to background investigations not being initiated, investigations not being adjudicated within required time frames, and documentation not being retained in employees' personnel folders. These conditions were previously identified in the OIG's 2018 personnel suitability audit, but VA's corrective actions that followed were not sustained or did not fully remediate the weaknesses. This occurred in part because HRA/OSP and VHA did not conduct adequate oversight to detect process deficiencies in the efficiency and effectiveness of program operations. VISNs also lacked sufficient staff to complete all their responsibilities. Without improved oversight and adequate resources, VA cannot be sure of the suitability of its workforce at VHA medical facilities and risks exposing veterans, their family members, and staff to newly hired employees who have not been fully vetted.

Recommendations 1–4

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 to the VA deputy secretary to take the following steps:[74]

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.

[74] The recommendations addressed to the VA deputy secretary are directed to anyone in an acting status or performing the delegable duties of the position.

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 the Veterans Health Administration's suitability function and consider using available hiring flexibilities.

VA Management Comments

The acting VA deputy secretary concurred with the four recommendations and provided corrective action plans. HRA/OSP will lead the development of a department-wide plan to establish more robust oversight of VA's personnel suitability program. This effort will include confirming the roles and responsibilities of the administrations and staff offices, reviewing and updating oversight processes, reimplementing the required monitoring program, assessing program resources, and beginning the allocation of required staff to prioritize oversight. Additionally, the administrations will develop plans to establish robust oversight of their personnel suitability programs. Lastly, WMC is developing a workload-based staffing model for personnel security occupations in VHA human resources operating offices, to include potentially leveraging incentives and hiring flexibilities. Although VHA's analysis and use of hiring flexibilities is ongoing, all of the other proposed corrective actions have a targeted completion date of December 31, 2023. Appendix D provides the full text of the acting VA deputy secretary's comments.

OIG Response

The acting VA deputy secretary's comments and corrective action plans are responsive to the intent of the recommendations. The OIG will monitor implementation of planned actions and will close the recommendations when VA provides evidence demonstrating sufficient progress in addressing the issues identified.

Finding 2: VA's Systems and Data Do Not Adequately Support the Personnel Suitability Program

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 multiple systems to capture background investigation milestones, but those data were not always accurate. Issues with inaccurate or missing background investigation data used for managing the suitability program were again found after the OIG's initial report in 2018. The team for the current audit found HR Smart data were not consistently up to date when compared to corresponding certificates of investigation. Additionally, critical VA-CABS data fields essential for tracking background investigations were either empty or inaccurate.

The team also found the investigation case management system, VA-CABS, had functional limitations that meant it did not transmit data consistently, notify staff about automatic adjudications, or contain key information needed to manage the background investigation process. These issues occurred because VA did not ensure that effective tools were available to support the objectives of the suitability program. This included correcting previously identified issues with HR Smart and considering information needs when implementing VA-CABS.

As a result, VA does not have a single, reliable system to conduct program oversight. Unless VA improves the reliability of its data and the functionality and design of its systems, it lacks assurance that background investigations have been fully processed and long-standing data integrity concerns have been mitigated. VA also risks implementing a new solution (VA-CABS 2.0) with the same flaws that will not ensure background investigation data are captured within prescribed timelines and reliably recorded.

The following determinations formed the basis for this finding and led to the OIG's recommendations:

- VA must rely on multiple data systems to capture significant background investigation milestones, but missing or inaccurate data impede program oversight.
- VA-CABS does not have the functionality needed for a case management system.
- Lack of functionality was due to VA not appropriately planning and managing VA-CABS implementation.
- Concerns with VA-CABS persist with the development of the next iteration of the system.

What the OIG Did

The team estimated about 54,800 VHA employees were hired for VA medical facilities from October 1, 2019, through September 30, 2021, and required an investigation that should have

been processed by VHA human resources offices.[75] The team reviewed 313 personnel records and evaluated investigative actions for those employees through December 2022. The team compared data from VA-CABS and HR Smart to certificates of investigation from the employees' electronic personnel folders and from the VISNs. The team also interviewed suitability staff at five VISNs, the VHA central office, and the VA central office. Finally, the team considered potential program improvements reported by suitability officials through February 2023.

VA Must Rely on Multiple Data Systems to Capture Significant Background Investigation Milestones, but Missing or Inaccurate Data Impede Program Oversight

The background investigation process has five key milestones that can be used to track the timeliness of critical processes, such as initiation and adjudication. VA must rely on both HR Smart and VA-CABS for this information, as neither system captures all relevant data.

Table 4 illustrates the five milestones and where the related data are captured.

Table 4. Background Investigation Process Milestones

Milestone	Definition	HR Smart	VA-CABS
Entrance on duty	Date the employee completes paperwork and oath (entrance on duty date)	Yes	No
Initiation of electronic questionnaire	Date electronic questionnaire was sent to the employee for completion	No	Yes
Scheduling of background investigation	Date DCSA begins the background investigation	No	Yes
Closure of background investigation	Date DCSA completed the investigation and returned the investigative file to VA	Yes	Yes
Adjudication of background investigation	Date VA adjudicator reviewed investigative file and rendered a suitability determination	No	Yes

Source: OIG analysis of federal regulations; Office of Personnel Management, VA, and VHA guidance; and HR Smart and VA-CABS system functionality.

Although leveraging two systems to track the steps of the suitability process does not violate requirements, it does complicate case management. For example, to calculate the 14-day initiation timeliness metric, VA must use the entrance on duty date from HR Smart and the date

[75] Appendix B discusses data reliability issues encountered during the audit. Appendix C summarizes the OIG's statistical sampling methodology.

the background investigation is scheduled from VA-CABS. This configuration means that VA lacks one authoritative source for the personnel suitability program. VA-CABS—the system of record for suitability information—does not track the entire investigation process.

Beyond the dual-system configuration, HR Smart and VA-CABS data were not consistently accurate or useful for program administration or oversight. VA must also rely on DCSA's Personnel Investigations Processing System for some oversight. The audit team found

- previously reported HR Smart data quality issues have not significantly improved and
- VA-CABS data were not reliable for administering the suitability program.

Previously Reported HR Smart Data Quality Issues Have Not Significantly Improved

As noted earlier in the report, VA-CABS became the system of record for all personnel suitability data in July 2022. However, VA and VHA policy—updated as recently as August 2021—still require human resources staff to complete certain data fields related to background investigations in HR Smart, such as the investigation level, status of the investigation, and the date it was closed.[76] Personnel suitability data do not automatically flow from VA-CABS to HR Smart when background investigations are processed; as a result, manual updates to HR Smart are required.

The team found that VHA staff did not enter accurate information in HR Smart that could be used for managing the suitability program. The concern about inaccurate information was identified in the 2018 audit with 54 percent of investigations reported as not up to date in HR Smart. In this follow-up audit, the team estimated that 36 percent of the background investigations reviewed were not kept current in HR Smart when compared to corresponding certificates of investigation.

For example, an employee at the Manchester VA Medical Center in New Hampshire in VISN 1 had a certificate of investigation with a closure date of December 3, 2020. However, the corresponding record in HR Smart had a closure date of March 19, 2021. An employee at the VA Tampa Healthcare System in Florida in VISN 8 had a certificate of investigation with a closure date of November 18, 2020. However, the employee's record in HR Smart indicated the investigation was in progress instead of closed.

[76] VA PERSEC Advisory 16-03, *Entering Personnel Security Data into HR Smart*, July 2016; VHA COPERSEC Advisory 16-11, *Entering Personnel Security Data into HR Smart*, November 21, 2016, revised August 9, 2021, and August 13, 2021.

VA-CABS Data Also Were Not Reliable for Administering the Suitability Program

In response to HR Smart data quality concerns identified by the OIG's 2018 report, HRA/OSP implemented VA-CABS to ensure that personnel suitability data are reliable for program tracking and oversight. However, VA-CABS did not achieve this goal. Data fields essential for tracking critical steps of the background investigation process included empty or inaccurate information.

In particular, suitability staff did not consistently input data in the field necessary for tracking the initiation of the electronic questionnaire. This date field represents a control that can help ensure a critical step of the onboarding process is complete. The team estimated from its sample that the initiation date was not completed for 45,900 records (98 percent) where a signed certificate of investigation was found.[77] These data would need to be tracked through a separate system. The director of Personnel Security and Credential Management stated that suitability staff were not required to update this field and that, in the future, this date would no longer be included in the system. However, as reported in finding 1, VHA did not consistently initiate background investigations for its employees. Mandating use of this field, ensuring it is populated, and conducting regular analyses to identify gaps could serve as an improved internal control to help remediate that issue.

Similarly, the VA-CABS field designated to capture the date an investigation is scheduled was not consistently populated. This field should be automatically filled when VA-CABS imports the status of investigations from DCSA. However, the team estimated the scheduled date was not completed for 12,700 records (27 percent) when compared to the corresponding certificate of investigation.[78] This field also cannot be edited by suitability staff. As a result, VA cannot use this field to accurately calculate the timeliness of background investigation initiation without relying on supplementary sources such as the certificate of investigation or DCSA's data.

Lastly, suitability staff did not consistently record the date an investigation was adjudicated. The team estimated that 10,100 records (22 percent) had dates in VA-CABS that did not match the signed certificate of investigation. For example, an employee at the Roseburg VA Health Care System in Oregon in VISN 20 had a certificate of investigation signed on August 10, 2020. However, the corresponding record in VA-CABS showed an adjudication date of January 27, 2020. Discrepancies with these dates prevent VA from capturing an accurate picture of adjudication timeliness.

Overall, the limitations with VA-CABS data hinder VA from using its own system to oversee the suitability program and accurately determine whether investigations are being processed in a

[77] See table C.2 for details on the team's statistical estimates.

[78] Also see table C.2. in appendix C of this report.

timely manner. In turn, VA's ability to identify delinquencies—such as those identified in finding 1—is significantly impaired, as well as its assessment of enterprise-wide weaknesses. Until VA corrects these data limitations, it will be difficult to implement remedial action or ensure that program requirements are met.

VA-CABS Does Not Have the Functionality Needed for a Case Management System

Beyond data integrity concerns, the team found system functionality issues with VA-CABS that impeded its use as a case management system. These deficiencies are important to note as a VA-CABS 2.0 is in development.

In particular, VA-CABS did not

- reliably transmit adjudication information to DCSA,
- routinely notify suitability staff when adjudications were automatically completed, and
- consistently task staff with reviewing additional investigative information received after the initial adjudicative decision was made.

These issues can hinder suitability staff's ability to process investigations and ensure proper suitability determinations.

VA-CABS Does Not Always Transmit Adjudication Information to DCSA

VHA's suitability staff are required to enter the suitability determination for the employee into VA-CABS.[79] This decision is subsequently transmitted to DCSA, which maintains the federal database of background investigations for employees, military personnel, and contractors. However, VA-CABS did not consistently transmit adjudication information to DCSA, which subsequently caused investigations to appear on delinquent adjudication reports as being outstanding 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.

Because of this transmission issue, suitability staff must manually reconcile VA-CABS and DCSA's delinquent adjudication report to determine whether an adjudication has not been made

[79] VA PSCM Advisory 19-04, *Compliance with VA-CABS – Policy update to VA Handbook 0710*, *Personnel Security and Suitability Program,* February 14, 2019.

or whether it simply did not transmit. This step adds to the workload of an already short-staffed suitability program.

VA-CABS Does Not Notify Staff of Automatic Adjudications for Further Processing

When background investigations with no issues are automatically adjudicated by DCSA, VA-CABS does not notify suitability staff. In these situations, suitability staff are still required to upload the signed certificate of investigation into the employee's personnel folder and update HR Smart. Suitability staff must manually pull a separate report to identify these cases, which adds to their workload. Conversely, if that manual check is not completed, suitability staff may not be aware that further action is needed on these investigations necessary to comply with requirements.

VA-CABS Did Not Consistently Create Tasks for Suitability Staff to Review Additional Information Received after Adjudication

As part of DCSA's investigation, the agency solicits employers and educational institutions for information related to the individual. However, these inquiries might not be returned to DCSA by the time the investigation has been closed and returned to VA for adjudication. When documentation is received after an investigation has been adjudicated by VA suitability staff, VA-CABS should create an entry called a "straggler review" that should signal that an adjudicator has new information to consider. However, VA-CABS does not consistently create this entry.

The VA-CABS straggler review was configured to be tied to the date an investigation was created in the system. As of July 2022, a straggler review was only created if the new information was received within 365 days after the investigation was created in VA-CABS.[80] If VA received additional investigative information after that time, a straggler review might never be created. Considering that several sampled investigations took over 200 days to be completed by DCSA and VA's adjudications have taken more than 165 days, the OIG contends that the time frame implemented in VA-CABS may prevent suitability staff from reviewing information that could change the outcome of the original suitability decision.

Lack of Functionality Was Due to VA Not Appropriately Planning and Managing VA-CABS Implementation

Data weaknesses and case management deficiencies occurred because VA did not effectively manage its business processes to ensure that sufficient data systems were available to support the

[80] Initially, the straggler review was limited to 120 days after the investigation was created. This limit was changed due to feedback from system users.

objectives of the suitability program. In response to the OIG's 2018 report that found similar data quality issues in HR Smart, VA stated that VA-CABS (in development at that time) would "reduce incidences of incomplete or unreliable data" and "provide accurate and secure investigation and adjudication information across the enterprise."[81] However, because previously identified deficiencies were again detected in the follow-up audit, VA-CABS did not achieve those goals. It is also not clear that VA considered the information needed for staff to calculate timeliness and track process steps when implementing VA-CABS.

For example, the 2016 VA-CABS business requirements document that outlined VA's goals for the system did not incorporate the date the employee was placed in their position—a necessary field to calculate VA performance against the investigation initiation timeliness metric required by regulation.[82] Additionally, VA-CABS was designed to rely on other systems, but that interconnectivity did not occur.

Furthermore, VA itself found that the system was inadequate to meet its needs and moved forward with the implementation of the custom-built VA-CABS 2.0.

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

The team found HRA/OSP had not provided requested evidence demonstrating that VA-CABS 2.0 will address known program and data integrity weaknesses. As of February 2023, and based on evidence provided to the team, VA had not finalized a business requirements document (or appropriate equivalent), a crucial step in the development process that can help demonstrate whether VA-CABS 2.0 would effectively support the personnel suitability program. Despite lacking this document, VA has already contracted with a vendor and committed funds to developing the system:

- In February 2022, VA awarded $4.4 million to a vendor to develop the new system.
- In March 2022, VA modified the contract for about $400,000 to migrate data from a system used by VA's Personnel Security Adjudication Center.
- In September 2022, VA modified the contract for over $1 million to implement additional requirements related to OIG audit compliance, onboarding processes, and the Trusted Workforce effort.

[81] VA OIG, *Audit of the Personnel Suitability Program*.

[82] 5 C.F.R. § 736.201. A business requirements document identifies what capabilities the stakeholders and users need and why these needs exist.

- In January 2023, VA modified the contract for about $1.7 million to "ensure that VA-CABS maintains compliance with Federal policy."[83]

In total, VA has awarded over $7.5 million as of January 2023 without finalizing and documenting its stakeholders' needs. As of May 2023, VA did not have a definitive date to begin system implementation. Because VA has not addressed potential user needs during the initial planning process, it risks spending even more taxpayer money to address these needs once the new system launches.

In what may result in a duplication of efforts, DCSA is developing a government-wide system called NBIS, which will replace existing systems and include the case management functionality that is being developed for VA-CABS 2.0. VA staff will be required to use some functions of NBIS, such as determining what investigation level is required for a given position, submitting questionnaires to initiate background investigations, and determining whether a new employee has a previous investigation that satisfies the requirements of their position. NBIS will also be integrated with the Trusted Workforce effort. Therefore, VA may be allocating resources toward developing a new system that continues to have transmission issues with DCSA and overlaps with other federal efforts.

Unless VA mitigates the issues identified during this audit and fully engages stakeholders, it risks implementing a new system with the same flaws as VA-CABS. Additionally, without improving suitability data, VA lacks assurance that background investigation actions comply with timeline requirements and are reliably recorded.

Finding 2 Conclusion

The data reliability and functionality of VA's systems used for the personnel suitability program need improvement. Limitations in HR Smart and VA-CABS prevented VA from collecting and maintaining accurate background investigation data to oversee its personnel suitability program. The data in these systems did not reflect the actual status of background investigations because some fields were inaccurate, empty, or not required. VA-CABS also had issues with its functionality that impeded its use as a case management system and hindered investigation processing.

These issues occurred because VA did not take sufficient steps to fully address and sustain responses to previously identified data integrity concerns or ensure that there were adequate systems to support the objectives of the suitability program. VA itself found that these systems were not suitable for its needs and had initiated implementing VA-CABS 2.0. However, VA has

[83] VA Contract No. VA118-16-D-1015, Task Order No. 36C10B21N10150056, Modification No. P00040, January 9, 2023.

not demonstrated that VA-CABS 2.0 would effectively support the personnel suitability program, particularly lacking documentation of critical business requirements.

As a result of these deficiencies, VA could not—and may continue to lack the means to—adequately monitor the status of the personnel suitability program for its medical facility employees. Unless data reliability and system functionality are improved, VA cannot rely on its data to govern the program or ensure that background investigations have been fully processed to promptly and properly vet staff.

Recommendations 5–7

The OIG recommended the VA deputy secretary take the following steps:[84]

5. Incorporate formal data-testing procedures (and data-matching as appropriate) of HR Smart and the VA Centralized Adjudication Background Investigation System (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.

VA Management Comments

The acting VA deputy secretary concurred with the three recommendations and provided corrective action plans. These actions include HRA/OSP working with the Office of Information and Technology to incorporate formal data-testing procedures in HR Smart and VA-CABS (or any replacement system). In response to the recommendation to execute a plan for a single system to support background investigation tracking from start to finish, HRA/OSP will also work with VA offices and relevant outside agencies to provide requirements for the development and implementation of enhancements to VA-CABS that will enable it to interface with other systems. To implement the final recommendation, HRA/OSP will collaborate with internal and external offices and agencies to develop a plan with actions and milestones to ensure future systems support the functionality needed to effectively oversee and manage the background investigation process. The plan will also address limitations identified in current systems and incorporate the fields necessary to track timeliness metrics. All recommended plans are targeted

[84] The recommendations addressed to the VA deputy secretary are directed to anyone in an acting status or performing the delegable duties of the position.

for completion by December 31, 2023, with VA-CABS enhancements initiated before March 31, 2024. Appendix D provides the full text of the acting VA deputy secretary's comments.

OIG Response

The acting VA deputy secretary's comments and corrective action plans are responsive to the intent of the recommendations. The OIG will monitor implementation of planned actions and will close the recommendations when VA provides evidence demonstrating sufficient progress in addressing the issues identified.

Appendix A: Corrective Actions Taken Since the Audit of VHA's Personnel Suitability Program in 2018

Table A.1. VA Corrective Actions Taken Since Previous OIG Audit

Office	OIG recommendation	Action taken	Date closed
HRA/OSP	1. Implement the monitoring program required by policy and establish robust management oversight of the personnel suitability program.	Established an oversight and compliance team charged with performing inspections of facilities' overall suitability process to ensure adherence to program standards.	January 3, 2019
HRA/OSP	2. Report the results of program monitoring activities and obtain corrective action plans from VHA.	Obtained a corrective action plan from VHA to resolve the issues with the program and considered the plan to be suitable.	March 28, 2022
HRA/OSP	3. Establish and enforce quality and performance metrics for the personnel suitability program.	Produced performance reports on quality and timeliness and inspected facility personnel suitability programs, which included reviewing quality and timeliness metrics.	January 3, 2019
HRA/OSP	4. Evaluate human capital needs for program oversight and facilitate the delegation or brokering of duties necessary to manage background investigation workload.	Implemented automatic adjudication of investigations where no issues were found and deployed VA-CABS, which allowed for workload reassignment. The integrated project team directed a review of the suitability staffing model.	July 27, 2021
HRA/OSP and VHA	5. Coordinate to implement a plan to review the suitability status of all VHA personnel and correct delinquencies to ensure a properly vetted workforce.	HRA/OSP implemented a plan to review the suitability status of all VHA personnel and correct delinquencies. VHA finalized their 100-percent audit and provided results to HRA/OSP.	January 19, 2021
VHA	6. Improve management oversight of the personnel suitability program at VA medical facilities and ensure background investigations are properly initiated and adjudicated nationwide, and internal control mechanisms required by policy are properly implemented.	Revised its Personnel Security Directive to establish a personnel security director and program office, appoint VISN human resources officers as suitability coordinators for their networks, and detail roles and responsibilities for suitability officials to include tracking adjudicator qualifications, conducting data reviews, tracking access to systems, and maintaining documentation. Additionally, VHA implemented a requirement that VISNs reduce delinquent adjudications monthly and report their statuses quarterly.	February 16, 2021

Office	OIG recommendation	Action taken	Date closed
VHA	7. Execute VA requirements to improve the governance of the personnel suitability program.	(As stated in recommendation 6, the revised Personnel Security Directive established a personnel security director and program office, appointed VISN human resources officers as suitability coordinators for their networks, and detailed roles and responsibilities for suitability officials.)	March 26, 2019
VHA	8. Evaluate human capital needs and coordinate appropriate resources to manage personnel suitability workload at VA medical facilities.	Completed the first phase of its human resources modernization effort, transitioning its human resources function from the medical centers to the VISNs.	May 10, 2021
HRA/OSP	9. Develop and execute a project management plan to ensure sufficient and appropriate data are collected in support of suitability program objectives.	Implemented VA-CABS and formed an integrated project team to identify areas for program improvement, including data collection.	May 10, 2021
HRA/OSP	10. Ensure that personnel suitability investigation data are fully evaluated and reliable for program tracking and oversight.	Implemented VA-CABS and required a 100-percent audit of all personnel records, as stated in recommendation 5.	May 10, 2021
VHA and HRA/OSP	11. Coordinate to implement a plan to correct current data integrity issues and improve the accuracy of personnel suitability program data.	Completed a plan for the VHA data scrub of HR Smart records with a report to HRA/OSP to ensure that employees and affiliates are properly onboarded and offboarded.	October 29, 2020

Source: VA OIG, Audit of the Personnel Suitability Program*; VA and VHA comments provided through routine status updates to the OIG follow-up team; and supporting documentation for recommendation closure.*
Note: Rows 1–4 and 9–10 are shaded to indicate that the offices listed are only HRA/OSP.

Appendix B: Scope and Methodology

Scope

The team conducted its work from January 2022 through July 2023. The scope of the audit focused on VA medical facility staff initially hired between October 1, 2019, and September 30, 2021 (two fiscal years) and who were still onboard as of September 30, 2021. The team examined investigative actions for those employees through December 2022 to assess controls over the background investigation process for medical facilities across the nation and to determine if adjudication actions were completed within required timelines and consistently recorded.

Methodology

To accomplish the objectives, the team identified and reviewed applicable executive orders, regulations, and VA and Veterans Health Administration (VHA) policies and procedures. The team interviewed 85 officials and staff in the Personnel Security and Credential Management office, Workforce Management and Consulting (WMC) office, and five Veterans Integrated Service Networks (VISNs). The team conducted virtual site visits to the following VISN offices:

- VISN 1 (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont)
- VISN 5 (Maryland; Washington, DC; and West Virginia)
- VISN 8 (Florida and Puerto Rico)
- VISN 10 (Indiana, Michigan, and Ohio)
- VISN 20 (Alaska, Idaho, Oregon, and Washington)

During these site visits, the team interviewed human resources managers and personnel suitability staff and reviewed sample cases with the VISN adjudicators.

The team reviewed a statistical sample of 375 records obtained from HR Smart and validated whether the records were associated with VA medical facility employees within the audit review period (as stated above, initially hired between October 1, 2019, and September 30, 2021), and required a background investigation to be processed through one of the five VISNs examined. The team found that 313 of the 375 records met these conditions and used this subset of records to (1) estimate the actual universe of employees and (2) analyze investigation actions. Appendix C contains details of the statistical sampling methodology. In addition, the team independently extracted certificates of investigation and personnel action documentation from employee personnel files and solicited the VISN human resources offices for related evidence. To determine the status of investigations, the team reviewed data from the VA Centralized

Adjudication Background Investigation System (VA-CABS), the Personnel Investigations Processing System, and the Electronic Questionnaires for Investigations Processing. The team also considered potential program improvements reported by suitability officials through February 2023.

Internal Controls

The team assessed the internal controls of VA and VHA's personnel suitability program significant to the audit objective. This included an assessment of the five internal control components: control environment, risk assessment, control activities, information and communication, and monitoring.[85] In addition, the team reviewed the principles of internal controls as associated with the objective. The team identified five components and 11 principles as significant to the objective.[86] The team identified internal control weaknesses during this audit and proposed recommendations to address the following control deficiencies:

- Component 1: Control Environment
    - Principle 2: Exercises oversight responsibility
    - Principle 4: Demonstrates commitment to competence
- Component 5: Monitoring Activities
    - Principle 16: Conducts ongoing and/or separate evaluations
    - Principle 17: Evaluates issues and remediates deficiencies

Fraud Assessment

The team assessed the risk that fraud and noncompliance with provisions of laws, regulations, and contracts, significant within the context of the audit objectives, could occur during this audit. The team assessed fraud indicators and their likelihood of occurrence and exercised due diligence in staying alert to any indicators. The OIG did not identify any instances of fraud or potential fraud during this audit.

Data Reliability

HR Smart is VA's human resources information system that supports position management, payroll, and personnel suitability. The team used HR Smart data to establish the universe of employees at VA medical facilities who were initially hired during a two-year period ending September 30, 2021. To test for reliability, the team compared personnel action documentation

[85] GAO, *Standards for Internal Control in the Federal Government*.

[86] Because the audit was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit.

extracted from employees' electronic personnel folders to confirm when individual employees were initially hired, when they were initially assigned to facilities within the VISNs examined, and if they were still on board as of September 30, 2021. The team found that the data were sufficiently reliable and appropriate for sample selection only.

Instead of relying on HR Smart data, the team used documentation, such as personnel action files and certificates of investigation, to assess the timeliness of investigative actions for VA medical facility employees. The team found that this documentation was sufficiently reliable to develop the findings, conclusions, and recommendations for this report.

Finally, the team assessed the reliability of personnel suitability information in VA-CABS. To test for reliability, the team compared certificates of investigation to corresponding fields in VA-CABS. The team found that in many instances the data did not match. Additionally, the team found other fields in the system did not contain data. The team concluded that the system was not sufficiently reliable for determining the investigative status of VHA personnel and did not rely on this system alone to support the findings, conclusions, or recommendations for this report.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on the audit objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

Appendix C: Statistical Sampling Methodology

Approach

To accomplish the audit objectives, the team reviewed a statistical sample of records as of September 30, 2021, for VA medical facility employees who were initially hired during the previous two fiscal years (the review period). The team used statistical sampling to quantify compliance with the timeliness of investigative actions against requirements and to determine whether they were reliably recorded.

Population

The review population at the outset included 65,674 records for VA medical facility employees who appeared to have been initially hired during the review period. This population was used to select the sample. However, the team's early analysis of that sample found records that did not meet the audit parameters. This included employees who (1) were no longer employed by VA on September 30, 2021; (2) had their background investigation processed by the VA's Personnel Security Adjudication Center; (3) did not require a background investigation because a previous background investigation had been completed; or (4) were not initially hired in the selected Veterans Integrated Service Network (VISN).[87] As a result, the team excluded 10,856 records from the review population. The team estimated the actual population size eligible for this audit to be about 54,800.

Sampling Design

The team initially selected a statistical sample of 375 records from the review population of 65,674. The review population was clustered by region, and five of the 18 VISNs were selected for review. The team selected a simple random sample of records from those VISNs as shown in table C.1.

[87] The team did not include individuals appointed to student positions because they are nonfederal employees.

Table C.1. Selected VISNs with Samples of Records

VISN	Total number of records	Sample size
1	3,029	75
5	2,298	75
8	5,623	75
10	4,641	75
20	3,445	75
Total	**19,036**	**375**

Source: VA OIG statistician's selected population. Data were obtained from HR Smart.

As noted previously, the team's analysis of the sample found that 62 records did not meet the parameters outlined by the project's scope. The team used the remaining 313 records that met audit parameters to estimate the actual population size of 54,800. The team's analyses and conclusions were based on that data sample.

Weights

Samples were weighted to represent the population from which they were drawn, and the weights were used in the estimate calculations. For example, the team calculated the error rate estimates by first summing the sampling weights for all sample records that contained the given error, then dividing that value by the sum of the weights for all sample records.

Projections and Margins of Error

The projection is an estimate of the population value based on the sample. The associated margin of error and confidence interval show the precision of the estimate. If the OIG repeated this audit with multiple sets of samples, the confidence intervals would differ for each sample but would include the true population value 90 percent of the time.

The OIG statistician used statistical analysis software to calculate estimates, margins of error, and confidence intervals that account for the complexity of the sample design.

The sample size was determined after reviewing the expected precision of the projections based on the sample size, potential error rate, and logistical concerns of the sample review. While precision improves with larger samples, the rate of improvement decreases significantly as more records are added to the sample review.

Figure C.1 shows the effect of progressively larger sample sizes on the margin of error.

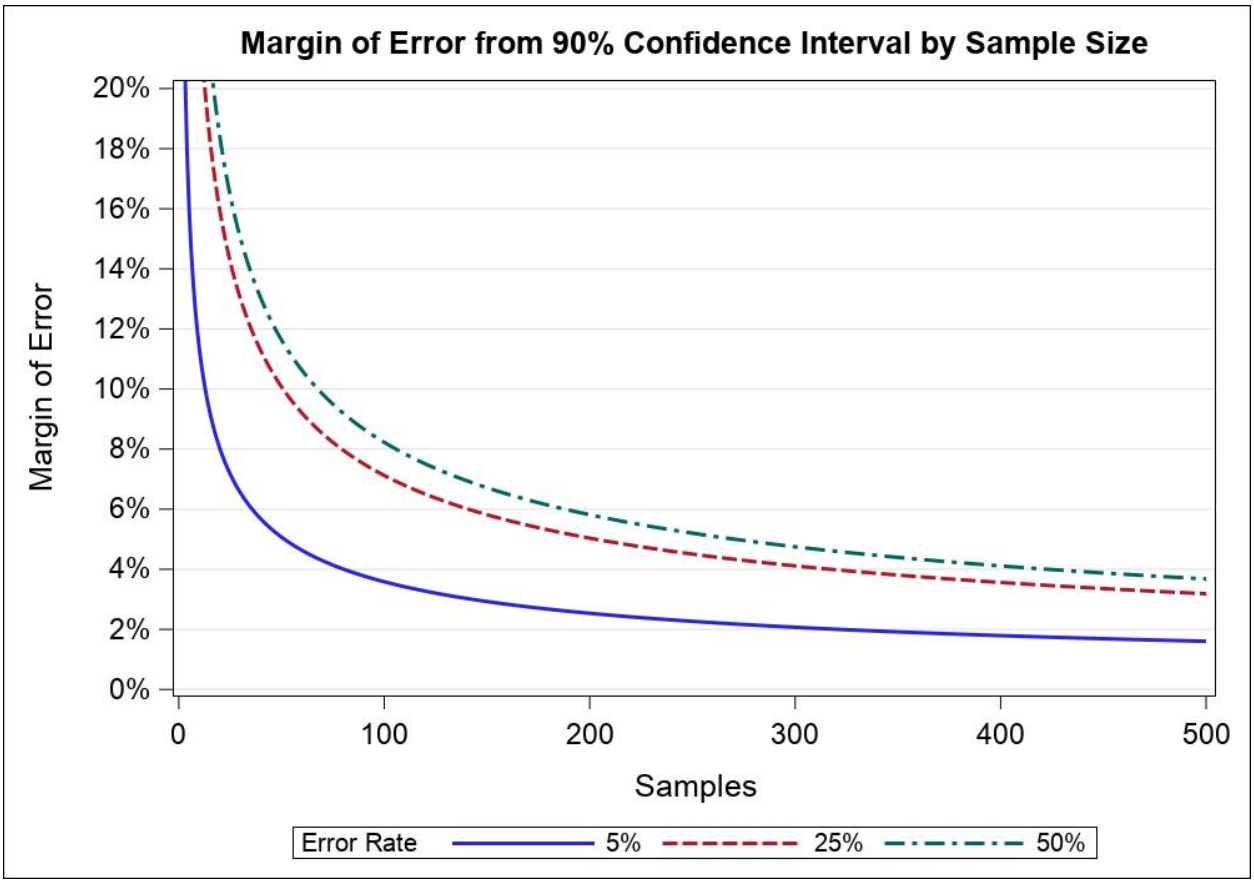

Figure C.1. *Effect of sample size on margin of error.*
Source: VA OIG statistician's analysis

Projections

Table C.2 details the team's statistical estimates.

Table C.2. Summary of Estimates for Investigative Actions

Estimate name	Estimate number	90 percent confidence interval			Sample count
		Margin of error	Lower limit	Upper limit	
Total in-scope records	54,818 (83%)	3,314 (5%)	51,504 (78%)	58,132 (89%)	313
Investigations not initiated on time	3,728 (7%)	1,381 (3%)	2,526 (5%)	5,289 (11%)	18

Estimate name	Estimate number	90 percent confidence interval			Sample count
		Margin of error	Lower limit	Upper limit	
Investigations automatically adjudicated by DCSA	13,409 (27%)	2,332 (5%)	11,193 (23%)	15,857 (31%)	78
Investigations adjudicated late	11,654 (23%)	6,706 (16%)	6,048 (11%)	19,460 (39%)	77
Certificate not in personnel folder	24,330 (48%)	7,222 (11%)	17,440 (37%)	31,883 (59%)	135
HR Smart errors	17,036 (36%)	13,595 (29%)	5,987 (14%)	33,177 (65%)	110
Questionnaire initiation date blank in VA-CABS	45,926 (98%)	2,639 (2%)	43,209 (91%)	48,487 (100%)	265
Scheduled date blank in VA-CABS	12,668 (27%)	5,899 (15%)	7,540 (15%)	19,338 (42%)	79
Adjudication date in VA-CABS does not match certificate	10,145 (22%)	2,101 (5%)	8,180 (18%)	12,381 (26%)	62

Source: VA OIG analysis of statistically sampled VHA employee records in HR Smart from October 1, 2019, through September 30, 2021.

Abbreviations: DCSA for Defense Counterintelligence and Security Agency; VA-CABS for VA Centralized Adjudication Background Investigation System.

Note: The above percentages only include records that could be evaluated for a given category. Projections in table C.2 denote the number and percentage of estimates for investigative actions. Clopper Pearson confidence intervals are reported to conservatively bound these values. Unlike standard intervals where the lower and upper bounds are the same distance from the estimate, Clopper Pearson intervals are asymmetric around the estimated value. The margin of error is therefore calculated as half the difference between the two-sided 90 percent confidence interval's upper and lower bounds. That means that the margin of error cannot simply be added or subtracted to get the upper and lower limit of the estimate, and the percentages will not sum to 100 percent.

Appendix D: VA Management Comments

Department of Veterans Affairs Memorandum

Date: August 21, 2023

From: Acting Deputy Secretary (001)

Subj: Draft Report, Department of Veterans Affairs' (VA) Governance of its Personnel Suitability Program for Medical Facilities Continues to Need Improvement (Project Number 2021-03718-AE-0183)

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review and comment on the Office of Inspector General, Healthcare Infrastructure Division, Draft Report, VA's Governance of Its Personnel Suitability Program for Medical Facilities Continues to Need Improvement. VA concurs on the report and provides the attached response and comments for completing the open recommendations. As Acting Deputy Secretary, I will oversee and coordinate the corrective actions to the responsible offices as reflected in the attached responses.

The OIG removed point of contact information prior to publication.

(Original signed by)

Guy T. Kiyokawa

Attachment

Attachment

Department of Veterans Affairs (VA)

Response to Recommendations in Office of the Inspector General (OIG) Project Number 2021-03718-AE-0183: VA's Governance of its Personnel Suitability Program for Medical Facilities Continues to Need Improvement

1. **OIG Recommendation: 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.**

   VA Response: Concur. The Office of Human Resources and Administration/ Operations, Security and Preparedness (HRA/OSP) will lead the development of a Department-wide plan with actions and milestones to establish more robust oversight of VA's personnel suitability program. The plan will confirm the roles and responsibilities of the Administrations and Staff Offices, and review and update oversight processes. It will also include actions and milestones to verify that background investigations are initiated and adjudicated within prescribed timelines and that documentation is filed as required.

   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 Department-wide plan.

   Target Completion Date: Initial actions to establish more robust oversight will be initiated by October 31, 2023. VA will develop and complete the Department-wide plan by December 31, 2023.

2. **OIG Recommendation: 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.**

   VA Response: **Concur**. HRA/OSP will lead the development of a Department-wide plan with actions and milestones as described in the response to OIG Recommendation 1. 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. It will also identify and prevent systemic weaknesses in the personnel suitability program.

   Target Completion Date: VA will reimplement the monitoring program by December 31, 2023.

3. **OIG Recommendation: Assess program resources and allocate staff as needed to prioritize oversight of the personnel suitability program within responsible office(s).**

   VA Response: Concur. HRA/OSP will lead the development of a Department-wide plan with actions and milestones as described in the response to OIG Recommendation 1. The plan will include assessments of program resources and include steps to begin allocating required staff to prioritize oversight of personnel suitability programs.

   Target Completion Date: The assessments will be completed prior to, and incorporated in, the Department-wide plan developed by December 31, 2023.

4. **OIG Recommendation: Establish a plan to implement the updated staffing metrics for the Veterans Health Administration's suitability function and consider using available hiring flexibilities.**

VA Response: Concur. The Veterans Health Administration's (VHA) Workforce Management & Consulting (WMC) organization is currently developing a workload-based staffing model for Personnel Security occupations in the VHA human resources (HR) operating offices. The project team is refining the data set and incorporating feedback from the initial briefing to VHA Human Capital Management (HCM) leadership. Upon HCM approval, the model will be briefed to Veterans Integrated Service Network (VISN) and WMC leadership as a tool to support future staffing decisions. During fiscal year (FY) 2024, the tool will be validated by the VA Manpower Management Service and vetted with VHA HR leadership.

Personnel Security occupations are eligible for recruitment, retention and relocation incentives (3R). VHA is already using the direct hire authority for Personnel Security Specialists granted by the Office of Personnel Management to support the Promise to Address Comprehensive Toxics (PACT) Act (P.L. 117-168) obligations. Other authorities available to VA through the PACT Act may also apply to the Personnel Security occupations. More specifically, through WMC's analysis of occupations, which included looking at 3R utilization, a recommendation has been made to include the 0080 Personnel Security occupation as part of a package of occupations potentially eligible for national Critical Skills Incentives (CSI). While the 0086 occupation was not previously identified for consideration as part of the national CSI Strategy, it was identified to be part of the package for title 5 Special Salary Rates (SSRs). Both packages (i.e., the national strategy recommendations for CSIs and title 5 SSRs) are in review with a VISN leadership group, prior to presentation to the full group of Network Directors for decision. That presentation is expected to occur by end of FY 2023.

Target Completion Date: The VHA plan to implement an updated staffing model for VHA's suitability function is expected by December 31, 2023. VHA's analysis and utilization of hiring flexibilities is ongoing. VHA leadership decisions on additional authorities available through PACT Act are also expected by December 31, 2023.

5. **OIG Recommendation: Incorporate formal data-testing procedures (and data-matching as appropriate) of HR Smart and the VA Centralized Adjudication Background Investigation System (or any replacement systems) into the monitoring program discussed in recommendation 2.**

   VA Response: Concur. HRA/OSP will work with the Office of Information and Technology (OIT) to incorporate formal data-testing procedures (and data-matching as appropriate) in HR Smart and the VA Centralized Adjudication Background Investigation System (VA-CABS), or any replacement systems, in FY 2024, into the monitoring program discussed in recommendation 2.

   Target Completion Date: VA will incorporate formal data-testing procedures (and data-matching, as appropriate) by December 31, 2023.

6. **OIG Recommendation: 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.**

   VA Response: Concur. HRA/OSP will work with OIT, other VA offices, the General Services Administration (GSA), Office of Personnel Management (OPM) and Defense Counterintelligence Security Agency (DCSA) to develop a plan and provide requirements for the development and implementation of required additional enhancements to VA-CABS. These enhancements will enable VA-CABS to interface with other systems as required to collect, maintain and access

sufficient and appropriate data supporting the tracking of background investigations from initiation to adjudication.

Target Completion Date: The plan will be completed by December 31, 2023. The actions and steps to begin development and implementation of VA-CABS enhancements will be initiated prior to March 31, 2024.

7. **OIG Recommendation:** **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.**

   VA Response: **Concur.** HRA/OSP will work with OIT, other VA offices, GSA, OPM and DCSA to develop a plan that includes actions and milestones ensuring future systems support the functionality needed to effectively oversee and manage the background investigation process. The plan will also address limitations identified in current systems and incorporate the fields necessary to track timeliness metrics.

   Target Completion Date: VA will establish a plan by December 31, 2023.

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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