

VA Office of Inspector General



# Veterans Health Administration

*Audit of  
the Personnel Suitability  
Program*

March 26, 2018  
17-00753-78

# ACRONYMS

COI	Certificate of Investigation
eOPF	Electronic Official Personnel Folder
FY	Fiscal Year
OIG	Office of Inspector General
OPM	Office of Personnel Management
OSP	Office of Operations, Security, and Preparedness
PAID	Personnel and Accounting Integrated Data
PSCM	Personnel Security & Credential Management
PIPS	Personnel Investigations Processing System
PSS	Personnel Security and Suitability
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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# Executive Summary

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## Why the OIG Did This Audit

The OIG conducted this audit to evaluate controls over the adjudication of background investigations at VA medical facilities for the five-year period ending September 30, 2016. The objective also included determining if adjudication actions for Veterans Health Administration (VHA) employees were completed timely and recorded reliably.

During the course of this audit, the OIG received congressional inquiries from five U.S. Senators and Representatives related to human resources and suitability actions at VA medical facilities. The OIG added two sites to review components of those requests.

## What the OIG Found

VA did not provide effective governance of the personnel suitability program necessary to ensure that background investigation requirements were met at medical facilities nationwide. Background investigations were required for most medical facility staff, including physicians, nurses, pharmacists, and laboratory technicians. The OIG projected that about 6,200 employees who were working at the facilities did not have a background investigation initiated. The OIG also found that adjudicators had not been reviewing background investigations timely and suitability staff were not maintaining official personnel records as required.

VA could also not independently attest to the status of personnel suitability determinations. HR Smart investigation data were not reliable for reporting on the status of suitability adjudications at VA medical facilities. Fields necessary to track background investigations to conclusion did not exist and other critical data points were incomplete. VA had to rely on data from the Office of Personnel Management's Personnel Investigations Processing System to monitor the program. The OIG also had to rely on that dataset to analyze personnel suitability actions and determine the status of employee background investigations.

These irregularities were not detected and corrected timely because the Office of Operations, Security, and Preparedness (OSP) did not monitor or ensure compliance with program requirements at VA medical facilities. In addition, OSP's Personnel Security and Suitability (PSS) Program Management Office, responsible for evaluating compliance with the suitability program requirements, lacked sufficient staff to conduct regular oversight.

Without sufficient staff, the Director of PSS also did not delegate oversight responsibilities to VHA for nearly six years. As such, the personnel suitability program was allowed to operate unmonitored and without assurance that background investigations were properly initiated and adjudicated. VHA's local implementation of the program was also inadequate to achieve key

project objectives. Key internal control requirements, such as quarterly reviews of facility background investigations, were largely absent at VA medical facilities reviewed.

Finally, OSP and VHA did not effectively manage their business processes to ensure that sufficient investigation data were created and maintained in support of program objectives. As a result, VA cannot reliably attest to the suitability of its largest workforce, exposing veterans and employees to individuals who have not been properly vetted. Unless internal controls and data are improved, VA and the public lack assurance that VHA has a workforce suitable for serving our nation's veterans.

## What the OIG Recommended

The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness establish robust management oversight of the personnel suitability program, implement and report on the monitoring program, ensure that reliable investigation data are collected and maintained, establish quality and performance metrics, evaluate human capital needs and facilitate workload management, and obtain corrective action plans from VHA.

The OIG also recommended the Executive in Charge, Office of the Under Secretary for Health, ensure background investigations are properly initiated and adjudicated nationwide, implement VA requirements to improve governance, evaluate human capital needs, and coordinate resources to manage workload.

Finally, the OIG recommended the Assistant Secretary for Operations, Security, and Preparedness coordinate with the Executive in Charge, Office of the Under Secretary for Health, to correct current data integrity issues and improve the accuracy of the data, and to implement a plan to review the suitability status of all VHA personnel and correct delinquencies.

## Agency Comments

The Assistant Secretary for Operation, Security, and Preparedness and the Executive Director, Office of the Under Secretary for Health, concurred with all recommendations and submitted acceptable corrective action plans. The OIG will monitor implementation of planned actions and will close the recommendations when VA provides sufficient evidence demonstrating progress in addressing the issues identified.



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## INTRODUCTION

**Objective**

The purpose of the audit was to evaluate controls over the adjudication of background investigations at VA medical facilities and determine if adjudication actions were completed timely and recorded reliably.

**Personnel Suitability Program**

All VA employees are evaluated and determined suitable for work through a background investigation process. VA determines the level of investigation by the sensitivity of the incumbent's position, which is then rated as low, moderate, or high risk. At a minimum, VA employees receive a Tier 1 investigation to verify that the individual is suitable for employment. Most medical facility staff, including physicians, nurses, pharmacists, and laboratory technicians, are required to receive this type of investigation. Table 1 describes the position risk categories and the investigation types associated with each occupation.

**Table 1. Investigation Type and Position Risk Categories<sup>1</sup>**

Investigation Type	Risk Category	Occupations
Tier 1	Low	Most Employees
Tier 2	Moderate	Human Resources, Information Technology, Police, Program Managers
Tier 4	High	Management, Adjudicators, Security Officers, Fiscal and Finance

Source: VA Handbook 0710 and VHA Handbook 0710.01

Adjudication includes reviewing the impact of any derogatory information from the investigation on the individual's suitability for employment. Designated human resources personnel review the results, consider any negative information, and validate suitability for employment. At VA medical facilities, adjudicative decisions are recorded in VA's HR Smart system and in the Office of Personnel Management (OPM) Personnel Investigations Processing System (PIPS). Supporting documentation, such as a Certificate of Investigation (COI), is uploaded into an employee's electronic Official Personnel Folder (eOPF).

<sup>1</sup> Tier 3 and 5 are investigations for sensitive national security positions with access to classified information.

VA Directive 0710 designates the Assistant Secretary for Operations, Security, and Preparedness (OSP) as responsible for developing, coordinating, and overseeing the implementation of policy, programs, and guidance for the suitability program.<sup>2</sup> This responsibility included performing periodic site evaluations to ensure compliance with security and program standards. The Veterans Health Administration (VHA) Workforce Management and Consulting Office is responsible for coordinating departmental regulations and policies involved with the overall personnel security and suitability program. VA medical facilities are responsible for the day-to-day implementation of the program.

**FY 2017  
OIG Review of the  
Atlanta VAMC**

In January 2017, the OIG issued a report titled, *Review of Alleged Human Resources Delays at the Atlanta VA Medical Center* (Report No. 15-03401-76), which substantiated the existence of a backlog of unadjudicated background investigations dating back to 2012. The delinquencies occurred because Atlanta VA Medical Center (VAMC) management did not maintain adequate internal controls, including sufficient records, within its personnel security program. In addition, mandatory OPM and VA policies were not implemented, as required, and human resources staff were not appropriately trained.

**Congressional  
Interest**

During the course of this audit, the OIG received congressional inquiries from five U.S. Senators and Representatives related to human resources and suitability actions at VA medical facilities. As a result of these concerns, the OIG expanded our methodology and added two sites to review components of those requests.

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<sup>2</sup> VA Directive 0710, Section 3(b)

## RESULTS AND RECOMMENDATIONS

### **Finding 1**      **VA's Management of the Personnel Suitability Program for VHA Employees Needs Improvement**

VA did not provide effective governance of the personnel suitability program necessary to ensure that required background investigations were completed for staff at medical facilities nationwide. The OIG found that employees, who were working at the facilities, did not have a background investigation initiated or adjudicated. The OIG projected that about 6,200 background investigations were not initiated as required. Moreover, the OIG found that adjudicators had not been reviewing background investigations in a timely manner and suitability staff were not maintaining official personnel records as required.

These irregularities were not detected and corrected timely because OSP did not monitor or ensure compliance with program requirements at VA medical facilities. In addition, OSP and VHA did not effectively manage human capital resources or ensure that sufficient and appropriate staff were assigned suitability functions. Due to the lack of governance and oversight of the personnel suitability program, VA cannot reliably attest to the suitability of its largest workforce, exposing veterans and employees to individuals who have not been properly vetted. Unless controls are implemented and data are improved, VA and the public lack assurance that VHA has a properly investigated workforce appropriate for providing health care to our nation's veterans.

***Personnel Suitability Program Not Effectively Governed***

VA did not ensure that background investigations were consistently completed or recorded at medical facilities nationwide. According to Executive Order 13764 and OPM regulation, each civilian officer or employee appointed in any Federal department or agency is required to undergo a background investigation to determine his or her suitability for employment.<sup>3</sup>

The OIG reviewed personnel records for VHA employees as of September 30, 2016 who had been initially hired at VA medical facilities within the previous five years. The OIG estimated this population to be about 129,000 VHA employees.<sup>4</sup> The OIG evaluated adjudication actions for those employees through June 2017 and identified numerous employees who worked at VA medical facilities without timely actions to initiate investigations or complete suitability determinations. Investigations also

<sup>3</sup> Executive Order 13764 – Amending the Civil Service Rules and Title 5 Code of Federal Regulations § 731.104

<sup>4</sup> Appendix B discusses data reliability issues encountered during our audit. Appendix C summarizes our statistical sampling methodology.



lingered unadjudicated for extended periods without appropriate action. For cases that were properly processed, VA medical facilities did not consistently update official personnel records.

*Background  
Investigations  
Not Initiated*

VA medical facilities are required to initiate the background investigation process within 14 calendar days of an employee's appointment. The appointee completes an electronic questionnaire and the facility submits it to OPM, who conducts the investigation.<sup>5</sup> However, the OIG projected that about 6,200 VHA employees (6 percent) did not have background investigations initiated.<sup>6</sup> The examples below identify instances where employees, who were working at the facility, did not have background investigations initiated by facility staff.

- At the Dayton VAMC, a registered nurse worked for 1,452 days before a background investigation was initiated. The delinquency was identified as a result of the OIG's site visit and case review, and the facility took immediate corrective action to initiate the background investigation.
- At the Charlie Norwood VAMC in Augusta, GA, a registered nurse had been working for 774 days before a background investigation was initiated. The facility became aware of the delinquency and took corrective action as a result of the OIG's site visit and case review.

In both of these cases, the individuals were employed to provide direct patient care to veterans, even though VHA had not initiated background investigations to determine their suitability for employment. In the absence of a completed suitability determination, VA lacks assurance that the VHA workforce is properly vetted and appropriate for providing health care to the nation's veterans. In addition, initiating background investigations in a timely manner is critical to mitigate the risk to VHA and ensure that unsuitable staff may be removed during the probationary employment period.

*Completed  
Investigations  
Not Adjudicated  
Timely*

Once an investigation has been completed and returned from OPM, a suitability adjudicator reviews the report of investigation using OPM's Suitability Processing Handbook, and makes an adjudicative determination. A determination is based on an objective analysis of both favorable and unfavorable information about a person's character and conduct. OPM

<sup>5</sup> VA Handbook 0710, Section 9(b)(1)

<sup>6</sup> The OIG only evaluated investigations that should have been adjudicated by a VA medical facility, which was estimated to be about 100,800 employees hired during the 5-year period ending September 30, 2016. The OIG did not evaluate investigations reciprocally accepted by VA that were adjudicated by other government entities or Tiers 2 through 5 which are adjudicated by the VA's Security and Investigations Center.

regulation requires agencies to report adjudicative decisions to OPM within 90 days of the receipt of the final investigative report.<sup>7</sup>

The OIG identified instances at 5 of 18 medical facilities reviewed where some investigations had not yet been adjudicated. For example, at the VA Eastern Colorado Health Care System, workload management practices resulted in four Tier 1 investigations not being adjudicated. As of September 2016, these employees had worked for a range of 138 to 600 days—an average of 390 days—with a completed background investigation that was not adjudicated by VA. According to the facility adjudicator, as of June 2017, these investigations remained unadjudicated.

In addition, the OIG determined that suitability staff had not been consistently adjudicating background investigations within the 90-day requirement. Overall, the OIG projected that about 10,400 cases (13 percent) were not adjudicated in a timely manner. Specific examples include:

- At the VA Long Beach Healthcare System, the OIG identified 47 cases that exceeded the 90-day timeliness requirement. Processing times ranged from 124 to 2,312 days to complete and averaged 1,153 days.
- At the VA Eastern Colorado Health Care System, eight of the cases reviewed exceeded the 90-day timeliness requirement ranging from 97 to 870 days to adjudicate and averaged 477 days to complete.
- At the VA North Texas Health Care System, three of the cases reviewed exceeded the 90-day timeliness requirement ranging from 113 to 490 days to adjudicate and averaged 255 days.

Timely adjudication of background investigations is necessary to ensure that VHA may take appropriate action to remove unsuitable staff.

*Investigations  
Not Consistently  
Retained*

VA medical facilities did not consistently ensure that official personnel records accurately reflected the status of background investigations. VA Handbook 0710 required that, upon a favorable determination, the COI is signed and a copy is placed in the employee's personnel folder.<sup>8</sup> However, at all the VA medical facilities visited, suitability staff did not regularly upload copies of the COI in an employee's eOPF. The OIG projected that about 35,200 of the cases that required adjudications (42 percent) did not have a COI uploaded into eOPF. Specific examples include:

<sup>7</sup> Title 5 Code of Federal Regulations § 731.203(g)

<sup>8</sup> VA Handbook 0710, Section 9(b)(4)

- At the VA Greater Los Angeles Health Care System, eOPF did not contain a COI for 24 of the 26 sample cases that required an investigation.
- The VA Boston Healthcare System did not enter COIs into eOPF for seven of the 15 sample cases that required an investigation.

VA Handbook 0710 also required that COIs be stored in locked cabinets, if not maintained electronically, for a minimum of two years.<sup>9</sup> The OIG noted that 15 of 18 facilities did maintain records onsite and documentation could be retrieved for analysis. However, because this is a time-limited requirement, it did not allow us to review or reconcile cases that were not uploaded into an eOPF. Without properly updated personnel records, VA lacked the transparency necessary to account for and attest to the suitability of its VHA workforce.

**VA Lacked Effective Internal Controls**

Systematic lapses in completing and recording suitability activities were not detected and corrected timely because the internal controls over the personnel suitability program were not effective. Specifically:

- OSP did not monitor or ensure compliance with program standards, as required.
- OSP did not delegate certain oversight responsibilities to VHA for many years, leading to inadequate program implementation at VA medical facilities.
- OSP and VHA officials did not effectively manage human capital resources or ensure that sufficient and appropriate staff were assigned suitability functions.

The Office of Management and Budget Circular (OMB) A-123 and Government Accountability Office (GAO) guidance require management to establish and maintain internal controls necessary to achieve the objectives of effective and efficient program operations. Management is responsible for establishing control activities such as policies and procedures; monitoring of the program operations; and a control environment that includes appropriate staffing and training.<sup>10</sup>

<sup>9</sup> VA Handbook 0710, Section 14(b)

<sup>10</sup> OMB Circular A-123, Section II and GAO Standards for Internal Control in the Federal Government, Sections 2.04 and 10.03

*OSP Did Not  
Provide Adequate  
Oversight*

Delinquent or untimely adjudications were not detected because OSP did not provide adequate oversight of the personnel suitability program. VA Directive and Handbook 0710 stated that the Office of Personnel Security and Identity Management, within OSP, is responsible for developing, coordinating, and overseeing the implementation of policy, programs, and guidance for VA's personnel suitability program.<sup>11</sup> The handbook also required the Personnel Security and Suitability (PSS) Program Management Office to conduct oversight and functional program reviews to evaluate compliance and implementation of the handbook's requirements.<sup>12</sup> However, the OIG did not identify any form of regular oversight by PSS from 2011 until the initiation of our audit in 2017. PSS staff acknowledged that the program office lacked sufficient staff to conduct regular oversight. The Director of PSS also stated that requests for more staff were previously made, but as of FY 2017, only two additional employees were hired into the office.

Beginning in February 2017, PSS conducted a nationwide review of VHA suitability determinations. The review used the PIPS Overdue Adjudication Listing Report to identify delinquent adjudications by facility.<sup>13</sup> PSS developed a list of delinquent facilities and identified the most egregious location—the Long Beach Healthcare System—as having more than 2,900 delinquent suitability adjudications. The OIG confirmed PSS's findings for that facility and determined that many of the overdue adjudications dated back to 2011. Regular oversight and monitoring could have identified and addressed these delinquencies in a more timely manner. PSS needs to continue providing this type of oversight of the personnel suitability program.

*VHA Suitability  
Program Lacked  
Oversight*

VHA was not responsible for providing oversight of the personnel suitability program for many years. VA Directive 0710, issued June 2010, stated that OSP was solely responsible for providing broad departmental-wide policy direction, coordination, and performance assessment for organizational components within VA.<sup>14</sup> However, according to the Director of PSS, only three staff were dedicated to administering the program nationally.

In the absence of sufficient resources, OSP did not delegate oversight responsibilities to VHA for nearly six years. The May 2016 update to VA Handbook 0710 added a requirement that each VA administration and staff office appoint a Personnel Security Program Manager to coordinate departmental regulations and policies related to the overall personnel security and suitability program, and to coordinate with the PSS.<sup>15</sup> According to the Workforce Management and Consulting Office, the required position was

<sup>11</sup> VA Directive 0710, Section 3(b) and VA Handbook 0710, Section 4(c)

<sup>12</sup> VA Handbook 0710, Section 1(b)(13)

<sup>13</sup> For this review, delinquent adjudications were defined as those suitability determinations that were not reported to OPM following the facility's adjudication process.

<sup>14</sup> VA Directive 0710, Section 3(b)(1)

<sup>15</sup> VA Handbook 0710, Section 3(c)

established and filled within VHA in June 2016. However, the OIG did not identify evidence of any other form of supplemental VHA oversight to support OSP's mandate to assess program operations and ensure compliance with policy.

The lack of formal oversight also permitted inconsistent implementation of internal VHA policy. For example, VHA Handbook 0710.01 required medical facilities to implement a local policy for the suitability program.<sup>16</sup> Sixteen of the 18 facilities associated with the OIG's sample had a local suitability policy. Conversely, key internal control requirements outlined by policy were largely absent at VA medical facilities reviewed. VHA Handbook 0710.01 also required medical facilities to conduct quarterly reviews of 10 percent of all new employee background investigations.<sup>17</sup> The quarterly reviews were designed to ensure adjudication actions were completed accurately and timely. However, only three of 18 VA medical facilities reviewed were aware of the requirement and had conducted the quarterly reviews.

In the absence of robust management oversight, OSP allowed the personnel suitability program to operate unmonitored and without assurance that background investigations were properly initiated and adjudicated. Internal controls designed to prevent and detect issues within the program also were largely unimplemented.

*Insufficient  
Human Capital  
Management*

Suitability determinations were not consistently initiated, adjudicated, and documented due to inconsistent staffing and human capital management within the personnel suitability program. Relevant VA policy did not identify any guidance stipulating staffing requirements for the suitability program. The Director of PSS indicated that each facility should have at least one qualified adjudicator on staff. However, many facilities reported challenges managing workload and identified it as a contributing factor in their ability to initiate and adjudicate background investigations timely. Management assigned only one person adjudication responsibilities at 11 of 18 facilities reviewed and these facilities did not have a designated back-up or contingency.

VA also permitted human resources staff who lacked the appropriate investigation level to make suitability determinations. An adjudicator must have been subject to a favorable determination based on the results of a Tier 4 background investigation.<sup>18</sup> However, neither VHA nor PSS verified compliance with this requirement. Staff who did not meet qualification requirements were assigned to adjudicate background investigations at 8 of the 18 facilities reviewed.

<sup>16</sup> VHA Handbook 0710.01, Section 6(f)

<sup>17</sup> VHA Handbook 0710.01, Section 6(g)

<sup>18</sup> OPM INV 15, Section 2

**VHA Risks  
Unsuitable  
Workforce**

Ineffective governance over the personnel suitability program resulted in lapses in the background investigation process. In the absence of robust internal controls, VA management cannot reliably attest to the suitability of its VHA staff and risks exposing veterans and employees to individuals who have not been properly vetted. Furthermore, delays in adjudication actions could limit VHA's ability to easily remove unsuitable staff prior to the end of probationary employment periods. Unless improved controls are implemented, VA and the public lack assurance that VHA has a properly investigated workforce appropriate for providing health care to our nation's veterans.

**Conclusion**

VA needs to implement effective governance to ensure that background investigations are properly processed at VA medical facilities nationwide. VA has allowed employees to work for extended periods without a properly initiated, adjudicated, or documented suitability determination. The absence of adequate oversight controls by OSP and VHA permitted these delinquencies to remain undetected for many years. Unless corrective action is taken and robust internal controls are established, VA risks exposing veterans and employees to individuals who have not been properly vetted.

**Recommendations**

1. The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness implement the monitoring program required by policy and establish robust management oversight of the personnel suitability program.
2. The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness report the results of program monitoring activities and obtain corrective action plans from the Veterans Health Administration.
3. The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness establish and enforce quality and performance metrics for the personnel suitability program.
4. The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness evaluate human capital needs for program oversight and facilitate the delegation or brokering of duties necessary to manage the background investigation workload.
5. The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness coordinate with the Executive in Charge, Office of the Under Secretary for Health, to implement a plan to review the suitability status of all Veterans Health Administration personnel and correct delinquencies to ensure a properly vetted workforce.

6. The OIG recommended the Executive in Charge, Office of the Under Secretary for Health, 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.
7. The OIG recommended the Executive in Charge, Office of the Under Secretary for Health, execute VA requirements to improve the governance of the personnel suitability program.
8. The OIG recommended the Executive in Charge, Office of the Under Secretary for Health, evaluate human capital needs and coordinate appropriate resources to manage personnel suitability workload at VA medical facilities.

**OSP  
Management  
Comments**

The Assistant Secretary for Operations, Security, and Preparedness agreed with the findings and Recommendations 1 through 5. To address Recommendation 1, the Assistant Secretary designated the Personnel Security & Credential Management (PSCM) office as responsible for conducting program reviews of personnel security and suitability. These program reviews will assess the overall background investigation and suitability adjudication processes across the VA enterprise. To address Recommendation 3, PSCM's program reviews will also include an assessment of quality and performance metrics for the facility's personnel suitability program. OSP anticipates finalizing a program review standard operating procedure related to these recommendations by March 1, 2018.

For Recommendation 2, the Assistant Secretary stated that completed program reviews at VHA facilities will include an After Action Report that identified deficiencies in the process and areas where improvements are needed. These reports will provide recommendations related to the facilities' quality and performance metrics and will request VHA to respond with corrective actions. OSP expects to perform program reviews of 24 VA facilities and deliver the accompanying After Action Reports by October 1, 2018.

For Recommendation 4, the Assistant Secretary stated that PSCM awarded a contract for the VA Centralized Adjudication and Background Investigation System in September 2017. This system is meant to serve as VA's case management system for investigation and adjudication data and should allow management to evaluate and adjust adjudicator caseload. OSP anticipates that the system will be operation in early FY 2019. Until that time, PSCM recommends that VHA facilities that do not have a trained adjudicator use the VA Security and Investigations Center's adjudication-only service.

Finally, for Recommendation 5, the Assistant Secretary stated that, on a quarterly basis, PSCM receives and reviews OPM's Delinquent Adjudication

Case Report,<sup>19</sup> and contacts facilities with delinquencies for corrective action. The Assistant Secretary acknowledged that when this process was implemented in January 2017 there were 20,638 delinquent cases. However, by December 2017, this number was reduced by approximately 65 percent to 7,275 delinquent cases. OSP expects to further reduce delinquent cases below 2,500 by October 1, 2018. Appendix D provides the full text of the Assistant Secretary's comments.

**VHA  
Management  
Comments**

The Executive Director, Office of the Under Secretary for Health, agreed with the findings and Recommendations 6 through 8. For Recommendation 6, the Executive Director stated that, to improve management oversight of VHA's personnel security programs, immediate publication of a revised VHA Personnel Security Directive is necessary. The directive would establish a VHA Personnel Security Director, a VHA Personnel Security Program Office, and appoint VISN human resources officers as "suitability coordinators" for their networks. Under this configuration, the VHA Personnel Security Program Office will:

- Review HR Smart ad-hoc reports and OPM quarterly adjudication reports,
- Notify the VISN suitability coordinator of case initiation deficiencies or delinquent adjudications, and
- Receive responses from the VISNs that provide the reason for any discrepancies or delinquencies.

VISNs will also be required to maintain updated rosters on personnel with access to restricted VA and OPM personnel systems. VHA expects to implement these new requirements by September 2018.

For Recommendation 7, the Executive Director stated that VHA policy will be updated to organizationally realign suitability roles and responsibilities. VA medical facilities will be required to notify their VISNs when confronted with serious or controversial suitability issues prior to making a favorable hiring decision. VHA's Personnel Security Program Office will also create a submission pipeline for VA medical facilities and VISNs to propose debarments for applicants deemed unsuitable for employment. Through coordination with OSP, that debarment system will be made accessible to appropriate VA medical facility staff to ensure that individuals deemed ineligible will be excluded from consideration. VHA expects to make these organizational changes by July 2018.

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<sup>19</sup> OPM's Delinquent Adjudication Case Report identifies background investigations that have been closed but not adjudicated within 90 days.



Finally, for Recommendation 8, the Executive Director stated that VHA's Workforce Management and Consulting Office will query VA medical facilities to determine the current staffing levels for employees performing security administration tasks. Based on the results, VHA will determine if resource shortages are systemic, propose updated metrics as appropriate, and issue those metrics to facilities for implementation. VHA expects to complete these actions by December 2018. Appendix E provides the full text of the Executive Director's comments.

**OIG Response**

The Assistant Secretary's and Executive Director's comments and corrective action plans are responsive to the intent of the recommendations. However, OSP's response to Recommendation 3 did not identify specific quality and performance targets for relevant personnel suitability metrics.<sup>20</sup> Because that corrective action is reliant on OSP's establishment of the PSCM Program Review Standard Operation Procedures, the OIG will expect those procedures to include the necessary quality and performance metrics.

The OIG will monitor implementation of planned actions and will close recommendations when VA provides sufficient evidence demonstrating progress in addressing the issues identified.

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<sup>20</sup> Personnel suitability performance metrics are discussed in Finding 1 of this report and may be found on pages 4 and 5.

## **Finding 2      VA Needs To Improve the Reliability of Human Resources Data**

VA could not independently attest to the status of personnel suitability determinations. HR Smart investigation data were not reliable for reporting on the status of suitability determinations at VA medical facilities. Fields necessary to track background investigations to conclusion did not exist and other critical data points were incomplete. The OIG had to rely on data from OPM's PIPS to analyze VHA's personnel suitability actions and to determine the status of employee background investigations.

Data weaknesses occurred because OSP and VHA did not effectively manage their business processes to ensure that sufficient investigation data were created and maintained in support of the objectives of the personnel suitability program. Unless internal controls and program data are strengthened, VA cannot properly account for or track suitability determinations for each VA medical facility nationwide.

***Investigation  
Data  
Not Reliable  
or Available***

VA lacked sufficient and appropriate data to manage or monitor the VHA personnel suitability program. HR Smart only collected minimal information pertaining to background investigations and was not reliable for determining the status of suitability determinations at VA medical facilities.

For example, VA Handbook 0710 required appropriate designated officials ensure that adjudicative determinations are reflected in HR Smart or subsequent data systems.<sup>21</sup> However, based on available data definitions, HR Smart does not have a data field for the date an adjudicative determination is made. HR Smart only has a field to indicate when an investigation has been closed by OPM, which actually represents the starting point of VA's responsibility to adjudicate the investigation in 90 days. Without appropriate data fields representing both ends of the process, suitability personnel cannot track the status or timeliness at the case level. Furthermore, VA officials cannot track suitability determinations in aggregate by facility or nationally using these data.

The Director of PSS acknowledged that data from the HR Smart system alone were not sufficient for program oversight since the systems inception in 2014. Beginning February 2017, after the start of our audit, PSS conducted a nationwide review of VHA suitability determinations. To perform this review, however, PSS had to use the PIPS Overdue Adjudication Listing Report generated by OPM.

<sup>21</sup> VA Handbook 0710, Section 5(b)(2)

In addition, many VA medical facilities developed and used alternative tracking mechanisms instead of HR Smart. Overall, the OIG identified that nine out of 10 facilities visited during the audit used alternative tracking methods. For example, the San Francisco VA Health Care System used a Microsoft Access database to track investigations for all facility employees. Similarly, the Dwight D. Eisenhower VA Medical Center in Leavenworth, KS, used a Microsoft Excel spreadsheet as an internal tracking tool. While these methods allowed each facility to track background investigations at the case level, they did not facilitate management or oversight activities at the national level.

*HR Smart Fields  
Not Accurately  
Maintained*

HR Smart fields that were available to be populated were either not current or useful for program management. At 16 of 18 facilities reviewed, suitability staff did not consistently record information into HR Smart. Key investigation data fields were either incorrectly populated or left blank when compared with source documentation. The OIG projected that 40,200 of the background investigations reviewed (54 percent) were not up to date in HR Smart when compared to corresponding COIs.

*VA Lacked  
System  
Functionality  
and  
Internal Controls*

The lack of transparency in personnel suitability data occurred because OSP and VHA did not effectively manage their business processes to ensure that quality data were available to support the management and oversight objectives of the program. OMB and GAO guidance stipulate that relevant and reliable information should be communicated to personnel at all levels within an organization.<sup>22</sup> Additionally, agencies must assess the effectiveness of internal controls in the normal course of business, in addition to periodic review, reconciliations, or comparisons of data.<sup>23</sup>

The HR Smart system is a commercial off-the-shelf solution not specifically designed for VA. While it has fields dedicated to collecting personnel suitability information, those fields do not cover the whole background investigation process. According to PSS staff, despite input from key stakeholders, the Human Resources Information Service declined requests for revisions to HR Smart during procurement because this would have increased costs.

OSP and VHA did not have or develop any other case management system that collected and maintained all data necessary to conduct oversight and monitoring of the personnel suitability program. According to the Director of PSS, efforts dating back to 2008 were taken to procure a VA Centralized Adjudication & Background Investigation System. However, a contract was

<sup>22</sup> OMB Circular A-123, Section III and GAO Standards for Internal Control in the Federal Government, Section 13.04 and 14.02

<sup>23</sup> OMB Circular A-123, Section III and GAO Standards for Internal Control in the Federal Government, Section 16.05

not expected to be awarded until June 2017. In addition, the system would not be operational until July 2018.

Finally, controls were also not in place to ensure that VHA suitability staff consistently maintained investigation data that were available in HR Smart. Neither VHA nor PSS reviewed HR Smart data on a regular basis to evaluate the accuracy or completeness of existing data fields. Iterative reviews may have identified problems in HR Smart data that could have been mitigated through more stringent controls.

**VA Cannot  
Monitor  
Suitability  
Actions**

The limitations in the HR Smart system significantly impacted VA's ability to collect and maintain accurate data for the personnel suitability program. Moreover, incomplete investigation data prevented VA from managing and monitoring the personnel suitability program using its own system. VA instead relied on data from a system administered by OPM to monitor suitability actions. Without improving internal controls and program data for HR Smart, VHA lacks assurance that suitability adjudications are completed timely and recorded at each facility nationwide.

**Conclusion**

The reliability of VA's human resources data needs improvement. VA could not independently attest to the status of personnel suitability adjudications. This occurred because VA lacked effective internal controls over human resources data. Unless program oversight and HR Smart data are improved, VA leadership cannot make reliable program-level decisions using the data.

**Recommendations**

9. The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness develop and execute a project management plan to ensure sufficient and appropriate data are collected in support of suitability program objectives.
10. The OIG recommended the Assistant Secretary for Operations, Security, and Preparedness ensure that personnel suitability investigation data are fully evaluated and reliable for program tracking and oversight.
11. The OIG recommended the Executive in Charge, Office of the Under Secretary for Health, coordinate with the Assistant Secretary for Operations, Security, and Preparedness to implement a plan to correct current data integrity issues and improve the accuracy of personnel suitability program data.

**OSP  
Management  
Comments**

The Assistant Secretary for Operations, Security, and Preparedness agreed with the findings and Recommendations 9 through 11. For Recommendation 9, the Assistant Secretary stated that PSCM has a solution roadmap for the VA Centralized Adjudication and Background Investigation System that will be enhanced and updated to a project management plan once the system is deployed. OSP anticipates that the system will be operation in early FY 2019. Until that time, PSCM will review employee background investigation data from OPM.

For Recommendation 10, the Assistant Secretary stated that PSCM generates HR Smart Compliance Reports to review if an employee's personnel suitability investigation data is accurate. These reports are distributed to VA medical facilities on a bi-monthly basis for remediation. Once the VA Centralized Adjudication and Background Investigation System has been implemented, PSCM will transition to using that system's data, instead of HR Smart data, for program tracking and oversight. The system will also interconnect with OPM and HR Smart to reduce incidences of incomplete or unreliable data and provide accurate and secure investigation and adjudication information across the enterprise. OSP expects the VA Centralized Adjudication and Background Investigation System to be operational in early FY 2019.

Finally, for Recommendation 11, the Assistant Secretary affirmed that PSCM will continue to coordinate with VHA and provide security and suitability compliance reports. These reports identify personnel without background investigation information in HR Smart for action by the local facility. Appendix D provides the full text of the Assistant Secretary's comments.

**VHA  
Management  
Comments**

The Executive Director, Office of the Under Secretary for Health, agreed with the findings and Recommendations 11. The Executive Director stated that VHA will engage with OSP to generate two pools of data: (1) current HR Smart investigation data, and (2) investigative records from OPM's Clearance Verification System. Using this data, VHA and OSP will scrub HR Smart records and update them as appropriate. Each VISN will also be responsible for coordinating a record review and certifying that records were appropriately reviewed and updated as needed. VHA expects to complete this review by September 2018. Appendix E provides the full text of the Executive Director's comments.

**OIG Response**

The Assistant Secretary's and Executive Director'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 recommendations when VA provides sufficient evidence demonstrating progress in addressing the issues identified.

## Appendix A Background

### Suitability Determinations

OPM requires applicants to covered positions to undergo a background investigation to determine their suitability for Federal employment.<sup>24</sup> Depending on the responsibilities of the position, the level of investigation varies. All individuals selected for employment are required to receive a pre-screening Special Agreement Check, which is a limited investigation including law enforcement checks. Once appointed, the facility begins a background investigation appropriate to the risk level of the position. Table 2 identifies the position risk categories and the investigation types associated with each category.

**Table 2. Investigation Type and Position Risk Categories**

Investigation Type	Risk Category	Occupations
Special Agreement Check	N/A	All
Tier 1	Low	Most Employees
Tier 2	Moderate	Human Resources, Information Technology, Police, Program Managers
Tier 4	High	Management, Adjudicators, Security Officers, Fiscal and Finance

*Source: VA Directive 0710, VA Handbook 0710, and VHA Handbook 0710.01*

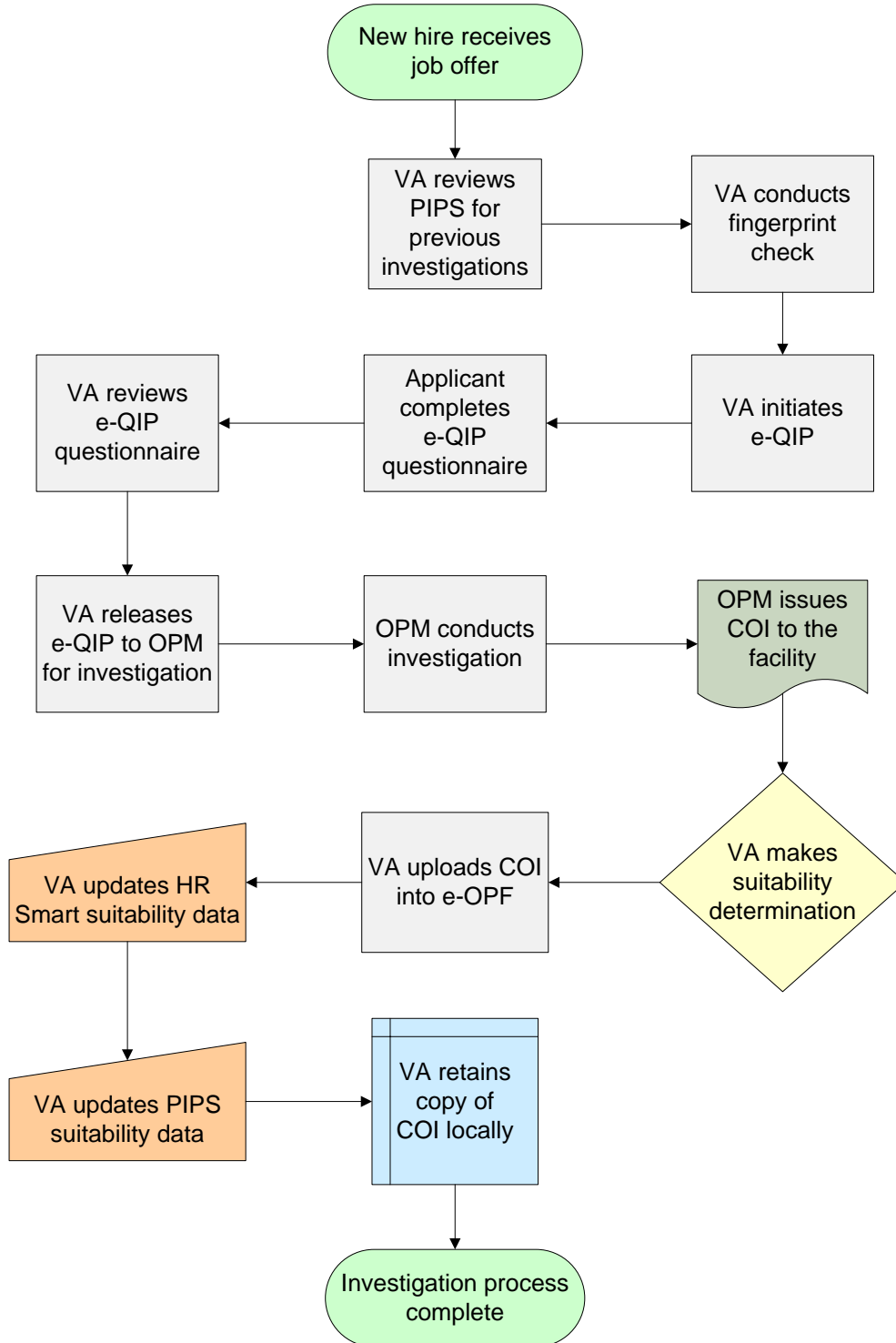
Local VA facilities adjudicate Special Agreement Check and Tier 1 investigations. VA's Security and Investigations Center in North Little Rock, AR, adjudicates Tier 2 and Tier 4 investigations.

### Adjudicative Process

After the facility receives the results of the background investigation from OPM, the adjudicative process begins. Designated human resources personnel review Tier 1 investigation results to validate suitability for employment. If the result of the investigation yields derogatory information, adjudicators consider the sensitivity level of the position, length of time since the offense, as well as the effect on the agency decision. Suitability decisions should be recorded in VA's HR Smart system and OPM's PIPS. The figure on the following page outlines the general process flow for background investigations.

**Figure. VA's Background Investigation Process**

<sup>24</sup> Title 5 Code of Federal Regulations § 731.104



Source: OIG Analysis of VA's Background Investigation Process

## Appendix B Scope and Methodology

### Scope

The OIG conducted audit work from January 2017 through December 2017. The OIG reviewed personnel records for VHA employees as of September 30, 2016 who had been initially hired at VA medical facilities within the previous five years. The OIG evaluated adjudication actions for those employees through June 2017.

### Methodology

To achieve the objective, the OIG identified and reviewed applicable laws, regulations, VA policies, and operating procedures. The OIG interviewed and obtained relevant testimonial information from 82 employees in VA's Personnel Security and Suitability Program Management Office, VHA's Workforce Management and Consulting Office, and various VA medical facilities. The OIG performed site visits at the following VA medical facilities from January through July 2017:

- Anchorage, AK
- San Francisco, CA
- Denver, CO
- Wilmington, DE
- Augusta, GA
- Chicago, IL
- Hines, IL
- Leavenworth, KS
- Dayton, OH
- Dallas, TX

During site visits, the OIG interviewed management and staff regarding topics related to the audit objective and reviewed sample cases with facility adjudicators. The OIG also conducted audit work remotely for the following VA medical facilities.

- Loma Linda, CA
- Los Angeles, CA
- Gainesville, FL
- North Chicago, IL
- Lexington, KY
- Brockton, MA
- Bronx, NY
- Pittsburgh, PA

The OIG also reviewed a statistical sample of 540 records of VHA employees as of September 30, 2016, who had been initially hired within the previous five years. Appendix C contains details of the statistical sampling methodology. The OIG independently extracted COIs from eOPF prior to beginning fieldwork. The OIG solicited each VA medical facility associated with the sample to obtain copies of COIs and local standard operating procedures. The OIG performed data matching of the sample data. The tests identified some inconsistencies in the background investigation fields between the Personnel Accounting and Integrated Data (PAID) system and HR Smart. The OIG analyzed personnel data in OPM's PIPS for each of the 540 randomly selected employee records.



**Fraud  
Assessment**

The audit team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this audit. The audit team exercised due diligence in staying alert to any fraud indicators. The OIG did not identify any instances of fraud during this audit.

**Data  
Reliability**

The OIG relied on personnel information from PIPS, which was received from OPM's National Background Investigations Bureau. To test for reliability, the OIG compared data elements, such as investigation completion dates, level of investigation, and adjudication dates with COI documents extracted from the eOPF. The OIG concluded that the data were reliable and appropriate to support the findings and recommendations.

PAID is an automated payroll system that processes VA's biweekly salary payments. The OIG used PAID data to establish our universe of employees by selecting those individuals who received their first paycheck during a five-year period ending September 30, 2016. To test for reliability, the OIG compared information extracted from personnel action documentation from eOPF to the data to determine when individual employees were initially hired. The OIG found that 443 of 540 sampled records represented VHA employees as of September 30, 2016 who had been initially hired within the previous five years. The remaining 97 records were associated with positions not subject to investigation, such as student interns, without compensation appointments, or fee basis providers. The OIG used the confirmed set of 443 records to estimate the universe of VHA employees and to achieve audit objectives. However, the OIG did not use PAID data to develop findings, conclusions or recommendations. As such, the OIG concluded that the data were sufficiently reliable and appropriate for sample selection.

Finally, the OIG planned to use data from HR Smart to assess the timeliness and reliability of personnel suitability information. To test for reliability, the OIG compared COI documents, previously corroborated by PIPS, to corresponding fields in HR Smart and found that HR Smart was not reliable for determining the adjudicative status of VHA personnel. Based on available data definitions, HR Smart did not have a data field to enter the date an adjudicative determination is made. As a result, the OIG could not evaluate the timeliness of personnel suitability actions using HR Smart data.

In addition, HR Smart investigation fields did not provide sufficient information necessary to ascertain the status of suitability determinations. Conditions such as reciprocity from another Government agency, transfers between VA medical facilities, and determinations by the Security and Investigations Center could only be identified using source documents. As a result, the OIG could not evaluate the reliability of personnel suitability data using HR Smart alone. Overall, the OIG concluded that HR Smart data were not sufficiently reliable and, therefore, were not used to support findings or recommendations in this report.

**Government  
Standards**

The OIG's assessment of internal controls focused on those controls relating to the audit objective. The OIG conducted this performance audit in accordance with generally accepted government auditing standards. These standards require that the team plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for findings and conclusions based on the audit objective. The evidence obtained provides a reasonable basis for the findings and conclusions regarding internal controls over the personnel suitability program at VA medical facilities.

## Appendix C Statistical Sampling Methodology

To evaluate if adjudication actions were completed timely and recorded reliably, the OIG conducted a two-stage random sample. For each sample case, the OIG requested supporting documentation from VA medical facilities and traced investigation data to assess the accuracy of records in HR Smart.

### **Population**

HR Smart is VA's human resource information system that manages personnel records for VA employees. HR Smart's investigation data consist of elements such as investigation type, investigation status, and investigation closed date. PAID system data were migrated into HR Smart when the new system was deployed.

For audit purposes, the OIG planned to focus on the population of HR Smart records associated with VHA employees, as of September 30, 2016, who had been initially hired within the previous five years. This population, based on available data descriptions, consisted of 152,995 records. However, the OIG identified that the population included records for positions not subject to investigation, such as student interns, without compensation appointments, or fee basis providers. The OIG estimated a population of 128,764 VHA employees as of September 30, 2016, who had been initially hired within the previous five years.

### **Sampling Design**

The OIG selected a two-stage sample. The first stage selected 16 VAMCs using systematic sampling, sorted into four strata based on geographic location, with probability proportional to total employee counts at the facilities. The 17<sup>th</sup> and 18<sup>th</sup> sites were selected based on congressional interest.<sup>25</sup> For the second stage of sampling, the OIG randomly selected 30 current VHA employees initially hired at each facility during the five-year period ending September 30, 2016.

Based on the sampling approach, the OIG reviewed 540 randomly selected records. However, the OIG identified that only 343 records (66 percent) in the sample met the parameters of the objective, which targeted personnel actions that should have been adjudicated by VA medical facilities. As a result, the analysis and conclusion were based on that subset of sample data.

### **Weights**

The OIG calculated estimates in this report using weighted sample data. Sampling weights are computed by taking the product of the inverse of the probabilities of selection at each stage of sampling. The OIG used WesVar software to calculate population estimates and associated sampling errors. WesVar employs replication methodology to calculate margins of error and

<sup>25</sup> The Leavenworth, KS, and Anchorage, AK, VA medical facilities were added as a result of congressional interest.

confidence intervals that correctly account for the complexity of the sample design.

**Projections and Margins of Error**

The margins of error and confidence intervals are indicators of the precision of the estimates. If the OIG repeated this audit with multiple samples, the confidence intervals would differ for each sample, but would include the true population value 90 percent of the time. Table 3 summarizes our projections.

**Table 3. Summary of Background Investigation Projections**

<b>Category</b>	<b>Sample Size in Error</b>	<b>Estimate (Percent)</b>	<b>Margin of Error (Percent)</b>	<b>90 Percent Confidence Interval Lower Limit (Percent)</b>	<b>90 Percent Confidence Interval Upper Limit (Percent)</b>
Investigations Not Initiated	21	6,200 (6.2)	2,097 (2.0)	4,103 (4.1)	8,296 (8.2)
VHA Employees	443	128,764 (84.2)	4,185 (2.7)	124,580 (81.4)	132,949 (86.9)
Investigations Requiring VAMC Adjudication	343	100,800 (65.9)	4,821 (3.2)	95,979 (62.7)	105,621 (69.0)
COI Not in eOPF	123	35,215 (42.4)	4,193 (4.3)	31,021 (38.1)	39,408 (46.7)
Investigations Not Adjudicated Timely	35	10,400 (12.5)	2,769 (3.1)	7,600 (9.4)	13,139 (15.6)
HR Smart Errors	132	40,190 (54.4)	4,056 (4.5)	36,134 (50.0)	44,245 (58.9)

*Source: OIG statistical analysis performed by the Office of Audits and Evaluations statistician*

## **Appendix D Management Comments – Assistant Secretary for Operations Security and Preparedness**

### **Department of Veterans Affairs Memorandum**

Date: January 24, 2018

From: Assistant Secretary for Operations, Security, and Preparedness (007)

Subj: Response to OIG Audit of the Personnel Suitability Program (OIG Project No. 2017-00753-D2-0036)

To: Office of Inspector General (50)

1. The VA Office of Inspector General (OIG) conducted an audit to evaluate controls over the adjudication of background investigations at VA medical facilities for the five year period ending September 30, 2016. Their objective also included determining if adjudicative actions for Veterans Health Administration (VHA) employees were completed timely and recorded reliability.
2. The Office of Operations, Security, and Preparedness (OSP) concurs with recommendations 1, 2, 3, 4, 5, 9, 10, and 11, but refer recommendations 6, 7, 8, and 11 to the Executive in Charge of VHA.
3. Attached is our response with corrective actions included.
4. If additional information is needed, please contact Mr. Rodney Emery, Executive Director, Office Identity, Credential, and Access Management at [Rodney.emery@va.gov](mailto:Rodney.emery@va.gov).

*(Original signed by)*

Donald P. Loren

Attachment

**Office of Operations, Security and Preparedness (OSP)  
Action Plan**

**OIG Draft Report, Department of Veterans Affairs: Audit of the Personnel Suitability Program-  
Project No. 2017-00753-D2-0036**

**Date of Draft Report: December 13, 2017**

Recommendations/ Actions	Status	Target Completion Date
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**Recommendation 1. We recommended the Assistant Secretary for Operations, Security, and Preparedness implement the monitoring program required by policy and establish robust management oversight of the personnel suitability program.**

Concur. The Personnel Security & Credential Management (PSCM) is responsible for conducting program reviews of personnel security and suitability. PSCM will rely heavily on cooperative efforts with the Executive in Charge, VHA.

These program reviews include data captured in HR Smart correlated with Office of Personnel Management (OPM) background investigation information. These reviews will include a holistic assessment of the overall background investigation and suitability adjudication processes across the VA enterprise, and will provide recommendations for enhancing the maturity of the VHA facilities' capabilities.

- 1) Finalize Program Review Standard Operation Procedures (SOP)

<b>Status:</b> In Process	<b>Target Completion Date:</b> 3/1/2018
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**Recommendation 2. We recommended the Assistant Secretary for Operations, Security, and Preparedness report the results of program monitoring activities and obtain corrective action plans from the Veterans Health Administration.**

Concur. Completed program reviews at VHA facilities will include an After Action Report to identify deficiencies in processes and if improvements are needed in the adjudicated processes. The report will request the VHA respond with corrective actions. PSCM will be able to perform program reviews of 24 VA facilities in FY18 and provide After Action Reports for each of these facilities.

- 1) Deliver After Action Reports (24) after completing virtual PSOC Program Reviews

<b>Status:</b> In Process	<b>Target Completion Date:</b> 10/1/2018
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**Recommendation 3. We recommended the Assistant Secretary for Operations, Security, and Preparedness establish and enforce quality and performance metrics for the personnel suitability program.**

Concur. The PSCM program review includes an assessment of the quality and performance metrics of the facility's personnel suitability program. After Action Reports will also include recommendations on how to improve the facility's quality and performance metrics.

- 1) Finalize PSOC Program Review SOP

<b>Status:</b>	<b>Target Completion Date:</b>
In Process	3/1/2018

- 2) Deliver After Action Reports (24) after completing virtual PSOC Program Reviews

<b>Status:</b>	<b>Target Completion Date:</b>
In Process	10/1/2018

**Recommendation 4. We recommended the Assistant Secretary for Operations, Security, and Preparedness evaluate human capital needs for program oversight and facilitate the delegation or brokering of duties necessary to manage background investigation workload.**

Concur. PSCM awarded a contract for the VA Centralized Adjudication and Background Investigation System (VA-CABS) in September 2017 to serve as the VA's case management system for investigation and adjudication data. VA CABS is projected to be operational in early FY2019. Among the features of VA-CABS is the ability to evaluate if individual caseload should, if needed, be adjusted to other adjudicators. This capability will permit both the local Human Resources staff, as well as PSCM to properly manage the background investigation workload. Prior to the implementation of VA CABS, PSCM recommends that VHA facilities that do not have a trained adjudicator use the Security and Investigations Center's (SIC) adjudication-only service

- 1) VA-CABS go-live

<b>Status:</b>	<b>Target Completion Date:</b>
In Process	Early FY 2019

- 2) Evaluate human capital needs for program oversight and facilitate delegation using VA-CABS

<b>Status:</b>	<b>Target Completion Date:</b>
In Process	09/30/2018

**Recommendation 5. We recommended the Assistant Secretary for Operations, Security, and Preparedness coordinate with the Executive in Charge, Veterans Health Administration to implement a plan to review the suitability status of all Veterans Health Administration personnel and correct delinquencies to ensure a properly vetted workforce.**

Concur. On a quarterly basis, PSCM receives a Delinquent Adjudication Case Report from the OPM. This report identifies background investigations that have closed, but have not been adjudicated within the 90 day timeframe. PSCM monitors these reports on a monthly basis and contacts the facilities to correct these delinquencies to ensure a properly vetted workforce. When this process was implemented in January 2017, there were 20,638 delinquent cases. As of December 2017, this number was reduced by approximately 65 percent to 7,275 delinquent cases. PSCM will continue this process to further reduce the number of delinquent cases.

- 1) Reduce delinquent cases below 2,500

**Status:**  
In Process

**Target Completion Date:**  
10/1/2018

**Recommendation 6. We recommended the Executive in Charge, Veterans Health Administration 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.**

Concur. PSCM will coordinate with the Executive in Charge, VHA to provide guidance on how to improve management oversight of the personnel suitability program at VA medical facilities.

**Recommendation 7. We recommended the Executive in Charge, Veterans Health Administration execute VA requirements to improve the governance of the personnel suitability program.**

Concur. PSCM will coordinate with the Executive in Charge, VHA to provide guidance on how to improve management oversight of the personnel suitability program at VA medical facilities.

**Recommendation 8. We recommended the Executive in Charge, Veterans Health Administration evaluate human capital needs and coordinate appropriate resources to manage personnel suitability workload at VA medical facilities.**

Concur. PSCM will coordinate with the Executive in Charge, VHA to provide guidance on how to improve management oversight of the personnel suitability program at VA medical facilities.



**Recommendation 9. We recommended the Assistant Secretary for Operations, Security, and Preparedness develop and execute a project management plan to ensure sufficient and appropriate data are collected in support of suitability program objectives.**

Concur. PSCM currently has a Solution Roadmap for VA-CABS which will be enhanced and updated to a Project Management Plan once the system is deployed. Until that time, PSCM reviews employee background investigation data utilizing OPM's Central Verification System (CVS).

- 1) Enhance Solution Roadmap for rollout of VA-CABS to VA facilities and training of VHA personnel on data collection

<b>Status:</b>	<b>Target Completion Date:</b>
In Process	8/1/2018

- 2) VA-CABS go-live

<b>Status:</b>	<b>Target Completion Date:</b>
In Process	Early FY 2019

**Recommendation 10. We recommended the Assistant Secretary for Operations, Security, and Preparedness ensure that personnel suitability investigation data are fully evaluated and reliable for program tracking and oversight.**

Concur. PSCM is currently leveraging a data analysis tool to generate HR Smart Compliance Reports which reviews if an employee's personnel suitability investigation data is accurate. HR Smart Compliance Reports are distributed to VHA facilities on a bi-monthly basis and the local facility personnel security specialists remediate non-compliant records and update HR Smart. Once VA-CABS has been implemented as the VA system of record for investigation and adjudication data, PSCM will transition to using VA-CABS data instead of HR Smart data for program tracking and oversight. VA-CABS will integrate directly with OPM to receive investigation data electronically and security personnel will securely record and store adjudicative determinations. This eDelivery of investigation data will reduce incidences of incomplete and unreliable data. The data in VA-CABS will be correlated with HR Smart data through the VA Onboarding Solution, providing accurate and secure investigation and adjudication data across the enterprise.

- 1) Continue distributing HR Smart Compliance Reports to VHA facilities

<b>Status:</b>	<b>Target Completion Date:</b>
In Process	On-going

- 2) VA-CABS go-live

<b>Status:</b>	<b>Target Completion Date:</b>
In Process	Early FY 2019

**Recommendation 11.** We recommended the Executive in Charge, Veterans Health Administration coordinate with the Assistant Secretary for Operations, Security, and Preparedness to implement a plan to correct current data integrity issues and improve the accuracy of personnel suitability program data.

Concur. PSCM, under the Assistant Secretary for Operations, Security, and Preparedness, will continue to coordinate with the Executive in Charge, VHA, and provide security and suitability compliance reports. These reports identify the personnel without background investigation information in HR Smart for action by the local facility.

**Status:**  
In Process

**Target Completion Date:**  
10/1/2018

*For accessibility, the format of the original documents in this appendix has been modified to fit in this document, to comply with Section 508 of the Americans with Disabilities Act.*

## **Appendix E Management Comments – Executive in Charge, Office of the Under Secretary for Health**

### **Department of Veterans Affairs Memorandum**

Date: January 31, 2018

From: Executive in Charge, Office of the Under Secretary for Health (10)

Subj: OIG Draft Report, Department of Veterans Affairs: Audit of the Personnel Suitability Program (VAIQ 7870096)

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

1. Thank you for the opportunity to review and comment on VA Office of Inspector General (OIG) draft report Department of Veterans Affairs: Audit of the Personnel Suitability Program. I concur with the recommendations to my office and provide corrective actions to address the concerns raised in this report.
2. If you have any questions, please email Karen Rasmussen, M.D., Director, Management Review Service at [VHA10E1DMRSAction@va.gov](mailto:VHA10E1DMRSAction@va.gov).

*(Original signed by)*

Carolyn M. Clancy, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)  
Action Plan

OIG Draft Report, Department of Veterans Affairs: Audit of the Personnel Suitability Program

Date of Draft Report: December 13, 2017

Recommendations/ Actions	Status	Target Completion Date
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**Recommendation 1.** We recommended the Assistant Secretary for Operations, Security, and Preparedness implement the monitoring program required by policy and establish robust management oversight of the personnel suitability program.

**OSP Responsibility**

**Recommendation 2.** We recommended the Assistant Secretary for Operations, Security, and Preparedness report the results of program monitoring activities and obtain corrective action plans from the Veterans Health Administration.

**OSP Responsibility**

**Recommendation 3.** We recommended the Assistant Secretary for Operations, Security, and Preparedness establish and enforce quality and performance metrics for the personnel suitability program.

**OSP Responsibility**

**Recommendation 4.** We recommended the Assistant Secretary for Operations, Security, and Preparedness evaluate human capital needs for program oversight and facilitate the delegation or brokering of duties necessary to manage background investigation workload.

**OSP Responsibility**

**Recommendation 5.** We recommended the Assistant Secretary for Operations, Security, and Preparedness coordinate with the Executive in Charge, Veterans Health Administration to implement a plan to review the suitability status of all Veterans Health Administration personnel and correct delinquencies to ensure a properly vetted workforce.

**OSP Responsibility**

**Recommendation 6.** We recommended the Executive in Charge, Veterans Health Administration 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.

**VHA Comment:** Concur.

Veterans Affairs (VA) Handbook 0710, May 2, 2016, requires each administration to maintain responsibility for field operation of suitability programs within their respective organizations. To meet this requirement, and improve management oversight of the administration's personnel security programs, the Veterans Health Administration (VHA) proposes the immediate publication of a revised VHA Personnel Security Directive to:

- 1) Establish a VHA Personnel Security Director;
- 2) Establish a VHA Personnel Security Program Office; and
- 3) Appoint Veterans Integrated Service Network (VISN) Human Resources (HR) Officers as "Suitability Coordinators" for their networks.

VISNs will be required to maintain updated rosters of personnel with access regarding administrative access to restricted VA and Office of Personnel Management (OPM) systems such as: VA's Case Adjudication and Background Investigation System (VA-CABS), Personal Identity Verification (PIV), the Electronic Questionnaire for Investigations Processing (e-QIP), and OPM's Clearance Verification System (CVS). VISNs will be instructed to immediately terminate access when employees leave security administration support positions.

To remediate case initiation deficiencies, VHA's Personnel Security Program Office will work with VA's Office of Operations, Security, and Preparedness (OSP) and HR Smart personnel to generate an ad-hoc report that shows new employees without investigative information entered into HR Smart within 14 days of entry on duty. New employees with missing investigation information after 14 days will be reported to the VISN Suitability Coordinator for further dissemination to field facilities for correction. Facilities will be required to provide the VISN with the reason for the discrepancy to include PIV credential issuance dates as PIV credentials should not be issued without proof of investigation initiation.

To address delinquent adjudications, VHA's Personnel Security Program Office will coordinate with OSP's Personnel Security and Credential Management (PSCM) office to obtain quarterly adjudication reports that OPM sends to PSCM. Delinquent adjudication reports will be sent to each VISN Suitability Coordinator who will be required to provide the reason for the delinquency to include any ongoing case actions (such as appeals) preventing timely adjudication.

**Status:**  
In progress

**Target Completion Date:**  
September 2018

**Recommendation 7.** We recommended the Executive in Charge, Veterans Health Administration execute VA requirements to improve the governance of the personnel suitability program.

**VHA Comment:** Concur.

VA Handbook 0710, May 2, 2016, requires each administration to maintain responsibility for field operation of suitability programs within their respective organizations. Improving governance of the VHA's personnel security program involves updating VHA policy to organizationally realign suitability roles and responsibilities to:

- 1) Require medical centers to notify their VISNs when confronted with serious or controversial suitability issues, prior to making a favorable hiring decision.

- 2) Maintain up-to-date rosters of VA employees with access to sensitive OPM systems, at the VISN level.
- 3) Ensure that suitability adjudicators at VA medical centers are properly trained and certified to adjudicate investigations in accordance with OPM standards.
- 4) Create a submission pipeline for medical centers and VISNs to propose debarments for applicants deemed unsuitable for employment.
- 5) Coordinate with OSP to ensure that VA's debarment system is accessible to appropriate medical center staff too so that individuals deemed ineligible for future appointment are appropriately excluded from consideration.

**Status:**  
In progress

**Target Completion Date:**  
July 2018

**Recommendation 8. We recommended the Executive in Charge, Veterans Health Administration evaluate human capital needs and coordinate appropriate resources to manage personnel suitability workload at VA medical facilities.**

**VHA Comment:** Concur.

Workforce Management and Consulting will create an action item to query medical centers to determine current staffing levels for employees performing security administration tasks. Work will be separated into two categories:

- 1) Security administration work directly supporting background investigations (i.e., fingerprinting, case review, adjudication).
- 2) PIV roles directly supporting the badge issuance/credentialing process.

For facilities where security administration and PIV support work are shared, the medical centers will be asked to identify the percentage of coverage dedicated to completion of each task.

Once this data is collected, the HR Delivery Model will be used as a baseline to determine if resource shortages are systemic.

If resource shortages are systemic, updated metrics will be proposed to the VHA Executive In Charge and issued to facilities for implementation.

**Status:**  
In progress

**Target Completion Date:**  
December 2018

**Recommendation 9. We recommended the Assistant Secretary for Operations, Security, and Preparedness develop and execute a project management plan to ensure sufficient and appropriate data are collected in support of suitability program objectives.**

**OSP Responsibility**

**Recommendation 10. We recommended the Assistant Secretary for Operations, Security, and Preparedness ensure that personnel suitability investigation data are fully evaluated and reliable for program tracking and oversight.**

**OSP Responsibility**

**Recommendation 11.** We recommended the Executive in Charge, Veterans Health Administration coordinate with the Assistant Secretary for Operations, Security, and Preparedness to implement a plan to correct current data integrity issues and improve the accuracy of personnel suitability program data.

**VHA Comment:** Concur.

An administration-wide data integrity review is already being discussed internally within OSP due to the pending release of their new Case Adjudication and Background Investigation System (VA-CABS). VHA will engage with OSP to generate two pools of data:

- 1) Current HR Smart investigative data
- 2) Investigative records as memorialized in OPM's Clearance Verification System (CVS)

Once the data is generated, VHA will engage with OSP to scrub HR Smart records using OPM CVS as the originating system of record. This will require both broad updates and individual record manipulation as each employee will possess a unique investigative history. In order to execute this update, each VISN will be responsible for coordinating a record review based on the consolidated HR Smart/OPM CVS data provided through the VA Intranet Quorum (VAIQ). Each VISN will then certify that records were appropriately reviewed and updated as needed.

**Status:**  
In Progress

**Target Completion Date :**  
September 2018

*For accessibility, the format of the original documents in this appendix has been modified to fit in this document, to comply with Section 508 of the Americans with Disabilities Act.*

## Appendix F **OIG Contact and Staff Acknowledgments**

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Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Acknowledgments	Steven Wise, Director Candice Brown Dustin Clark Michael Derick Susanna Fischer Justin Kerly Shawn Steele
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