



# DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

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

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

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

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

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

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

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

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

## **BACKGROUND INVESTIGATION PROCESS AND GOVERNANCE**

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

### **The Three-Part Background Check and Data Systems**

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

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<sup>2</sup> VA OIG, [VA’s Governance of Its Personnel Suitability Program for Medical Facilities Continues to Need Improvement](#), September 21, 2023.

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

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

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

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

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

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

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

## Governance

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

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<sup>5</sup> 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.

<sup>6</sup> 5 C.F.R. § 736.201 (2019); VA Handbook 0710.

<sup>7</sup> 5 C.F.R. § 736.201 (2019); VA Handbook 0710.

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

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

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

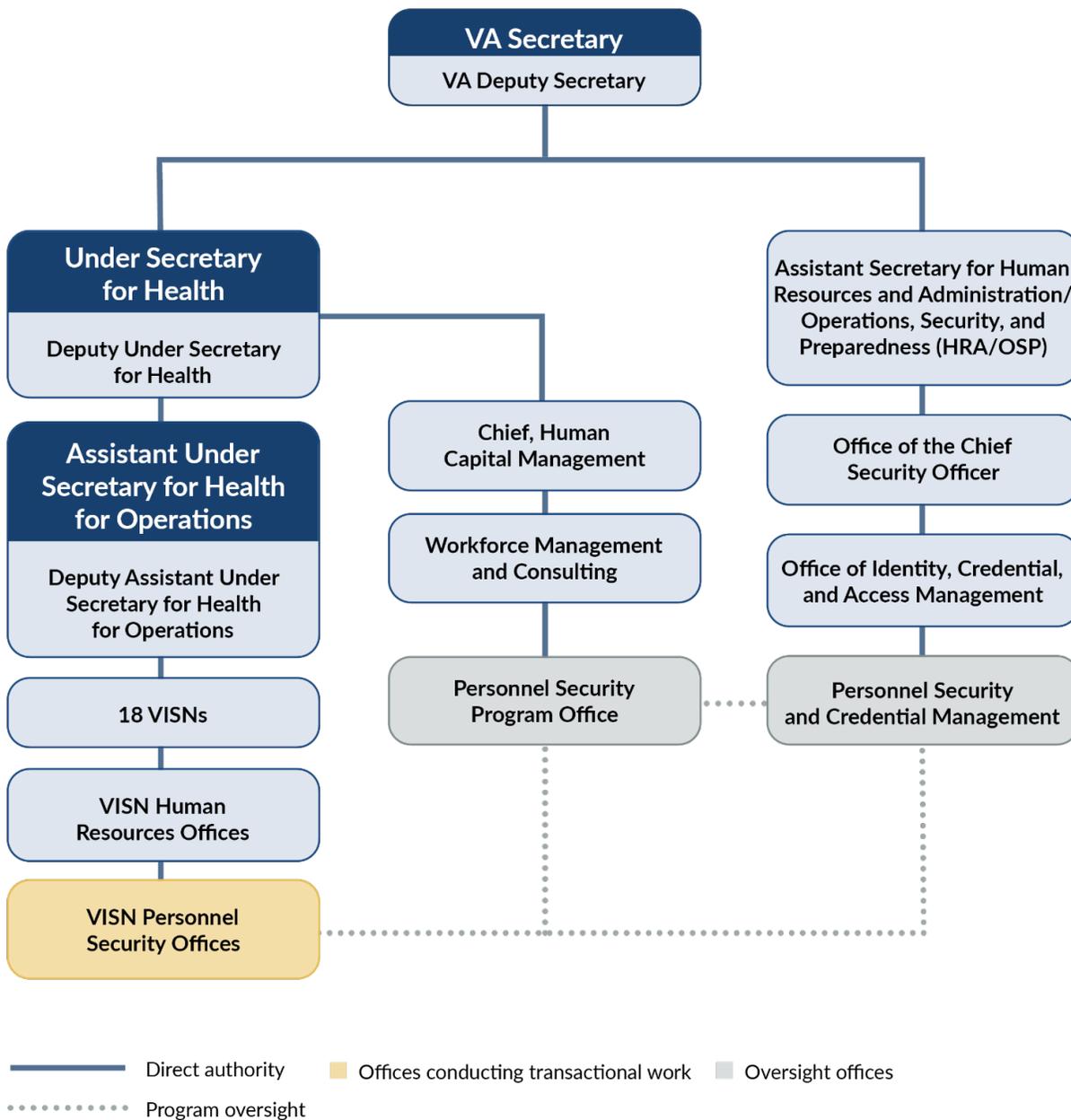
The chart on the next page provides an overview of the VA, HRA/OSP, and VHA organizational structures for governance of the personnel suitability program.

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<sup>9</sup> 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.

<sup>10</sup> VA Handbook 0710.

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



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

## OIG OVERSIGHT HAS FOUND PROGRAM DEFICIENCIES SINCE 2017

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

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

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

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

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<sup>12</sup> VA OIG, [Review of Alleged Human Resources Delays at the Atlanta VA Medical Center](#), January 30, 2017.

<sup>13</sup> VA OIG, [Audit of the Personnel Suitability Program](#), March 26, 2018.

<sup>14</sup> The OIG requests updates on the status of all unimplemented recommendations every 90 days and all recommendations' statuses may be found on the OIG [website](#).

<sup>15</sup> VA OIG, [Potential Risks Associated with Expedited Hiring in Response to COVID-19](#), March 11, 2021.

<sup>16</sup> VA OIG, [Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia](#), May 11, 2021.

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

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

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<sup>17</sup> 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."

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

<sup>19</sup> VA OIG, [Stronger Controls Help Ensure People Barred from Paid Federal Healthcare Jobs Do Not Work for VHA](#), March 1, 2023.

## THE PERSONNEL SECURITY PROGRAM HAS NOT SUSTAINED IMPROVED CONTROLS

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

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

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

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

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

<sup>21</sup> 5 C.F.R. § 736.201; VA Handbook 0710.

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

<sup>23</sup> VA Handbook 0710; VHA Directive 0710, *VHA Personnel Security and Suitability Program*, October 11, 2018.

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

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

### ***HRA/OSP Suspended Required Inspections of the Suitability Program***

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

### ***VHA Did Not Conduct Program Reviews of Its Suitability Functions***

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

### ***VISNs Lacked Sufficient Staff to Consistently Perform Their Suitability Program Responsibilities***

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

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<sup>24</sup> HRA/OSP completed 11 facility inspections by May 2019.

<sup>25</sup> VHA Workforce Management and Consulting, *Personnel Security and Suitability Program Policy*, rev. February 2020.

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

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

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

#### ***What the OIG Recommended Related to Governance***

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

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

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

<sup>27</sup> Government Accountability Office, *Standards for Internal Control in the Federal Government*, September 2014.

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

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

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

#### ***HR Smart Inaccuracies***

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

#### ***VA-CABS Limitations***

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

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

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

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<sup>28</sup> The OIG will request the first update from VA on the progress to implement the recommendations in late December 2023.

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

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

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

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

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

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

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

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

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

### ***What the OIG Recommended Related to Systems***

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

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

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

## **CONCLUSION**

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

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