VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Pittsburgh, Pennsylvania

February 27, 2012
11-04216-103

ACRONYMS AND ABBREVIATIONS

COVERS	Control of Veterans Records System
IPC	Intake Processing Center
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
STAR	Systematic Technical Accuracy Review
TBI	Traumatic Brain Injury
VAMC	Veterans Affairs Medical Center
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of the VA Regional Office, Pittsburgh, Pennsylvania

Why We Did This Review

The Veterans Benefits Administration has a nationwide network of 57 VA Regional Offices (VAROs) that process claims and provide services to veterans. We conducted this inspection to evaluate how well the Pittsburgh VARO accomplishes this mission.

What We Found

Pittsburgh VARO staff corrected errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review program. VARO performance was generally effective in processing herbicide exposure-related claims.

The VARO lacked accuracy in processing some disability claims. Inaccuracies in processing temporary 100 percent disability evaluations resulted when staff did not schedule required medical reexaminations. Generally, errors related to traumatic brain injury claims occurred because staff used insufficient medical examination reports to make disability determinations. VARO staff did not accurately process 36 (41 percent) of 88 disability claims we sampled as part of our inspection. These results do not represent the overall accuracy of disability claims processing at this VARO.

VARO management did not always provide oversight to ensure staff addressed all elements of Systematic Analyses of Operations, considered Gulf War veterans' entitlement to mental health treatment, and provided outreach to homeless shelters and service providers. Oversight and policy guidance needed for proper mail-handling were lacking as well. Delays in making final competency determinations occurred when staff did not prioritize these decisions.

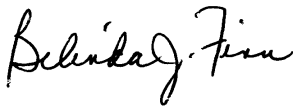
What We Recommend

We recommend the VARO Director implement plans for ensuring follow-up action on temporary 100 percent disabilities. Management also needs to ensure staff return inadequate medical examination reports for traumatic brain injury claims.

The Director should develop plans to ensure staff address all elements of Systematic Analyses of Operations, amend local mail handling directives, monitor training on Gulf War veterans' entitlement to mental health care treatment, and complete final competency determinations timely. We also recommend the Director implement and monitor a plan to oversee and coordinate homeless veterans outreach programs to ensure regular contact with homeless shelters and service providers.

Agency Comments

The VARO Director concurred with our recommendations. Management's planned actions are responsive and we will follow up as required on all actions.



BELINDA J. FINN
Assistant Inspector General
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INTRODUCTION

Objective

The Benefits Inspection Program is part of the Office of Inspector General's (OIG) efforts to ensure our Nation's veterans receive timely and accurate benefits and services. The Benefits Inspection Division contributes to improved management of benefits processing activities and veterans' services by conducting onsite inspections at VA Regional Offices (VAROs). These independent inspections provide recurring oversight focused on disability compensation claims processing and performance of Veterans Service Center (VSC) operations. The objectives of the inspections are to:

- Evaluate how well VAROs are accomplishing their mission of providing veterans with access to high quality benefits and services.
- Determine whether management controls ensure compliance with VA regulations and policies; assist management in achieving program goals; and minimize the risk of fraud, waste, and other abuses.
- Identify and report systemic trends in VARO operations.

In addition to this standard coverage, inspections may examine issues or allegations referred by VA employees, members of Congress, or other stakeholders.

Scope of Inspection

In October 2011, the OIG conducted an inspection of the Pittsburgh VARO. The inspection focused on five protocol areas examining nine operational activities. The five protocol areas were disability claims processing, management controls, workload management, eligibility determinations, and public contact.

We reviewed 58 (12 percent) of 467 available disability claims related to traumatic brain injury (TBI) and herbicide exposure completed from April through June 2011. In addition, we reviewed 30 (8 percent) of 379 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months, generally the longest period a temporary 100 percent disability evaluation may be assigned under VA policy without review.

Appendix A provides details on the VARO and the scope of our inspection. Appendix B provides the VARO Director's comments on a draft of this report. Appendix C provides criteria we used to evaluate each operational activity and a summary of our inspection results.

RESULTS AND RECOMMENDATIONS

1. Disability Claims Processing

The OIG inspection team focused on disability claims processing related to temporary 100 percent disability evaluations, TBI, and herbicide exposure. We evaluated claims processing accuracy and its impact on veterans' benefits.

Finding 1 VARO Staff Could Improve Disability Claims Processing Accuracy

The Pittsburgh VARO lacked accuracy in processing temporary 100 percent disability evaluations and claims for TBI. Due to inadequate controls, VARO staff incorrectly processed 36 (41 percent) of the total 88 disability claims we reviewed. They overpaid $228,712 and underpaid $3,080 in benefits payments. VARO management agreed with our assessments and initiated action to correct the inaccuracies identified.

Because we sampled claims related to specific conditions, these results do not represent the universe of disability claims processed at this VARO. As reported by VBA's Systematic Technical Accuracy Review (STAR) program, the overall accuracy of the Pittsburgh VARO's compensation rating-related decisions was 83.6 percent—8.4 percent below the 92 percent VBA target.

The table below reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Pittsburgh VARO.

Table

VARO Pittsburgh Disability Claims Processing Results

Type	Reviewed	Claims Incorrectly Processed		
		Total	Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits
Temporary 100 Percent Disability Evaluations	30	27	3	24
Traumatic Brain Injury Claims	28	7	0	7
Herbicide Exposure-Related Disability Claims	30	2	1	1
Total	**88**	**36**	**4**	**32**

Source: VA OIG

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 27 (90 percent) of 30 temporary 100 percent disability evaluations we reviewed. Veterans Benefits Administration (VBA) policy requires a temporary 100 percent disability evaluation for a service-connected disability following surgery or when specific treatment is needed. At the end of a mandated period of convalescence or upon cessation of treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's temporary 100 percent disability evaluation.

For temporary 100 percent disability evaluations, VSC staff must input suspense diaries in VBA's electronic system. A suspense diary is a processing command that establishes a date when VSC staff must schedule a reexamination. As the diary matures, the electronic system generates a reminder notification alerting VSC staff to schedule the reexamination.

Available medical evidence showed that 3 (11 percent) of 27 processing inaccuracies we identified involved overpayments to veterans totaling $228,712. The most significant overpayment occurred when a Rating Veterans Service Representative (RVSR) granted service connection for prostate cancer and noted the veteran would need reexamination in December 1999; however, VSC staff did not schedule the required examination. Medical treatment records showed the veteran's condition had improved as of June 2005, and therefore he was no longer entitled to receive temporary 100 percent disability payments. As a result, VA overpaid the veteran a total of $159,656 over a period of 6 years.

The remaining 24 inaccuracies had the potential to affect veterans' benefits. Of these errors, 23 involved rating decisions for which VSC staff did not input or take action on reminder notifications to reexamine veterans for temporary 100 percent disabilities. We could not determine if the compensable evaluations should have continued for these cases, as the veterans' claims folders did not contain the medical examination reports needed to reevaluate each case. The remaining error involved an RVSR granting service connection for prostate cancer based on a veteran's claimed in-country Vietnam service. VSC staff did not obtain all the necessary evidence to verify that the veteran served in Vietnam.

For those cases requiring reexaminations, delays ranged from approximately 2 months to 11 years and 10 months. An average of 2 years and 3 months elapsed from the time staff should have scheduled the reexaminations until the date of our inspection—the date staff ultimately took corrective actions to obtain the necessary medical evidence.

The most frequent processing inaccuracy noted in 17 (63 percent) of 27 cases occurred when VSC staff did not take action on reminder notifications. Of

those 17 inaccuracies, 12 involved 810[1] work items. During our inspection, we discovered the Pittsburgh VARO had 496 of these work items pending longer than 30 days for future medical examinations. The work items ranged from 35 to 855 days, with an average of 271 days pending.

In response to a recommendation in our report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), the Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each had a future examination date entered in the electronic record. In September 2011, VBA provided each VARO with a list of temporary 100 percent disability evaluations for review by the end of March 2012. To assist in implementing the agreed upon review, we provided the VARO with 349 claims remaining from our universe of 379 temporary 100 percent disability evaluations.

TBI Claims

The Department of Defense and VBA commonly define a TBI as traumatically induced structural injury or physiological disruption of brain function caused by an external force. The major residual disabilities of TBI fall into three main categories—physical, cognitive, and behavioral. VBA policy requires that staff evaluate these residual disabilities.

VARO staff incorrectly processed 7 (25 percent) of 28 TBI claims. All inaccuracies had the potential to affect veterans' benefits. Following are descriptions of these inaccuracies.

- In six cases, RVSRs used insufficient medical examination reports to evaluate TBI-related disabilities. According to VBA policy, when a medical examination report does not address all required elements, VSC staff should return it to the issuing clinic or healthcare facility as insufficient for rating purposes. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without adequate or complete medical evidence.
- In the remaining case, an RVSR incorrectly evaluated a TBI-related disability. This inaccuracy did not affect the veteran's current monthly disability payment; however, the incorrect evaluation may affect future payments.

Generally, errors associated with TBI claims processing occurred because RVSRs used insufficient medical examination reports when making disability decisions. VARO staff stated that returning insufficient medical examination reports to VA Medical Centers for correction created processing delays. In addition, quality review of TBI claims processing was ineffective.

[1]An 810 work item is a system generated reminder notification to take future action on a claim.

VARO quality review staff performed reviews of three TBI cases that we identified as having processing errors, but failed to identify the same errors. As a result of the processing errors, veterans did not always receive accurate benefits payments.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 2 (7 percent) of 30 herbicide exposure-related claims—one of these claims affected a veteran's benefits. In this case, an RVSR used an incorrect effective date to establish service connection for a herbicide exposure-related disability, resulting in an underpayment to the veteran of $3,080 over an 8-month period.

The remaining inaccuracy had the potential to affect a veteran's benefits. An RVSR assigned an incorrect evaluation for a residual disability of the veteran's service-connected diabetes mellitus. This inaccuracy did not affect the veteran's overall disability evaluation but may affect future evaluations for additional benefits.

Because we did not consider the frequency of errors significant, we determined the VARO generally followed VBA policy when processing herbicide exposure-related claims. Therefore, we made no recommendation for improvement in this area.

Recommendations

1. We recommend the Pittsburgh VARO Director develop and implement a plan to ensure staff process 810 work items on a recurring basis.
2. We recommend the Pittsburgh VARO Director develop and implement a plan to ensure staff return inadequate traumatic brain injury examination reports to the appropriate healthcare facilities for correction.

Management Comments

The VARO Director concurred with our recommendations for improving disability claims processing. The Director implemented a team to process all pending 810 work items. Additionally, a supervisor is required to provide VARO management weekly reports to ensure continued progress in this area.

On November 9, 2011, VARO staff received TBI training that focused on the adequacy of medical examinations. VARO management created a mechanism to track inadequate TBI medical examinations and coordinated with Veterans Health Administration staff to address inadequate TBI medical examinations.

OIG Response

The Director's comments and actions are responsive to the recommendations.

2. Management Controls

Systematic Technical Accuracy Review

We assessed whether VARO management adhered to VBA policy regarding correction of errors identified by VBA's STAR staff. The STAR program is VBA's multifaceted quality assurance program to ensure veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that the VARO take corrective action on errors that STAR staff identify. STAR staff identified errors in 14 claims processed from April through June 2011. VARO staff followed VBA policy by correcting all of the errors identified during that period. As such, we made no recommendation for improvement in this area.

Systematic Analysis of Operations

We assessed whether VARO management had adequate controls in place to ensure complete and timely submission of each Systematic Analysis of Operations (SAO). We also considered whether VSC staff obtained adequate data to support the analyses and recommendations identified in each SAO. An SAO is a formal analysis of a VSC organizational element or operational function. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. VARO management must publish an annual SAO schedule designating the staff required to complete each SAO by specific dates. The VSC Manager is responsible for ongoing analysis of VSC operations, including completing 12 SAOs annually.

Finding 2 Improved Oversight Needed to Ensure SAOs are Effective

Seven (58 percent) of the 12 SAOs were inadequate and some were missing data to support their analyses. Specifically, four of the 12 required SAOs were incomplete, 2 were untimely per their schedule, and 1 was both incomplete and untimely. Although VSC management completed all of the SAOs during FY 2011, VARO management did not always ensure they were timely per the annual schedule. This occurred because VARO management did not provide adequate oversight throughout the SAO process. As a result, VARO management may not have adequately identified existing and potential problems for corrective action to improve VSC operations.

SAOs were untimely because VSC management did not have a formal process for requesting and documenting extension requests for these internal reviews. While managers stated they granted extensions to VSC staff, documentation of the extensions varied. For example, VARO management granted an extension for completion of the Quality of Correspondence SAO through email; however, it did not update the annual schedule to reflect this change. Further, the only supporting documentation for the extension of the Division Management SAO was a handwritten note on the schedule. VSC

management confirmed that the station did not have a local policy directing the SAO process.

VARO management created a template known as the SAO Review and Validation Sheet to ensure staff completed sufficient analysis for all required SAO elements. This worksheet allowed staff to document the criteria used for each analysis and let managers provide input as needed. The Internal Controls SAO disclosed that management performed periodic reviews to ensure staff complied with local Control of Veterans Records System (COVERS) policies. Management documented its review of this SAO on the worksheet; however, they did not recognize that staff did not use any data to support the analysis. If VSC staff had obtained the data needed to support the SAO, they may have determined that the periodic reviews were not occurring.

Recommendation

3. We recommend the Pittsburgh VA Regional Office Director develop and implement a plan for staff to adequately assess all required elements of Systematic Analyses of Operations and complete them in accordance with the VA Regional Office's annual schedule.

Management Comments

The VARO Director concurred with our recommendation. The Director indicated VARO management created a mechanism to track the completion and concurrence process associated with all SAOs. Further, VSC staff received training on the proper preparation and timeliness requirements associated with completing SAOs. VBA's Eastern Area headquarters now requires the Pittsburgh VARO to provide regular updates regarding the timely processing of SAOs throughout the year.

OIG Response

The Director's comments and actions are responsive to the recommendation.

3. Workload Management

Intake Processing Center

VBA has embarked on a multi-year transformation of veterans' claims processing and benefits delivery. This initiative included creation of the Intake Processing Center (IPC) at the Pittsburgh VARO in June 2011. The IPC combines existing VARO incoming mail-processing activities (mailroom) and VSC claims-related mail processing in a single centrally located area.

Since the inception of the IPC, the VSC has reported a reduction in the total amount of search mail from 994 pieces in June 2011 to 363 in October 2011. In addition, IPC management has established a local program to train staff responsible for processing mail.

Incoming Mail Operations

We assessed controls over VARO incoming mail operations to ensure staff timely and accurately processed this mail as required. VBA policy states staff will open, date-stamp, and route all mail to the appropriate locations within 4 to 6 hours of receipt at the VARO. Because IPC staff processed mail according to VBA policy, we made no recommendation for improvement in this area.

Drop Mail

IPC staff correctly processed all 30 pieces of drop mail we reviewed. Drop mail requires no processing action before being placed in the related claims folders. Because we did not identify any deficiencies, we determined the VARO was compliant in processing drop mail. Therefore, we made no recommendation for improvement in this area.

VSC Mail Processing

We assessed VSC mail-handling to ensure staff reviewed, controlled, and processed all claims-related mail in accordance with VBA policy. VBA policy indicates that oversight to ensure staff use available plans and systems is the most important part of workload management. It also states that effective mail management is crucial to the success and control of workflow within the VSC. Further, VBA policy requires that staff use COVERS to track claims folders and search mail. VBA defines search mail as active claims-related mail waiting to be associated with veterans' claims folders.

Finding 3 Controls Need Strengthening for Processing Search Mail

VSC staff did not correctly process or control 9 (30 percent) of 30 pieces of search mail according to policy. Management did not verify staff complied with local policies regarding the use of COVERS. In addition, management did not have procedures for staff to follow in case a file was lost. Consequently, RVSRs may not have had all available evidence to make decisions and beneficiaries potentially did not receive accurate and timely benefits.

VSC staff did not properly use COVERS to ensure accurate and timely processing of search mail. Staff did not retrieve 4 (13 percent) of 30 pieces of search mail and associate it with related claims folders even though COVERS contained electronic notices of the pending search mail requests. For an additional four pieces of search mail, staff did not attempt to locate related claims folders that had potentially been misplaced. For the remaining piece of mail, staff did not place it on search in COVERS. Following are descriptions of discrepancies we found during our review of search mail.

- On August 9, 2010, a veteran filed an original claim for disability compensation and pension benefits. Staff did not establish a claims folder for the veteran's claim for approximately 14 months until we disclosed the error during our review.

- A veteran submitted a claim on May 20, 2011. VSC staff placed this mail on search on May 24, 2011, without attempting to locate the claims folder or initiating lost file procedures. Local directives did not address follow-up procedures on search mail for files that could not be located within the VARO. Instead, this mail typically remained on search, unprocessed and unassociated with the related claims folder. As a result, the claim remained unprocessed for over 4 months until we prompted action at the time of our inspection.

VSC management confirmed control weaknesses associated with mail processing. For example, the Workload Management Plan required spot checks for COVERS compliance throughout the VSC; however, staff had not completed these checks from May 11, 2011, to the time of our inspection. VSC managers acknowledged they did not always ensure compliance with station COVERS procedures or check for deleted mail searches with IPC staff. IPC management implemented some controls over search mail by restricting access to COVERS search mail functions to VSC management and IPC staff. Although the initiative has resulted in enhanced mail processing, management needs to implement additional controls to ensure continued improvement in some aspects of mail management.

Recommendation

4. We recommend the Pittsburgh VA Regional Office Director amend the Workload Management Plan and Intake Processing Center procedures to ensure management oversight and control of claims-related mail.

Management Comments

The VARO Director concurred with our recommendation. The Director amended the Workload Management Plan to include procedures for an aggressive COVERS compliance policy. Further, VARO management created a Standard Operating Procedure for search mail and a mechanism to track all permanent mail transferred to the VARO.

OIG Response

The Director's comments and actions are responsive to the recommendation.

4. Eligibility Determinations

Entitlement to Medical Treatment for Mental Disorders

Gulf War veterans are eligible for medical treatment for any mental disorder developed within 2 years of the date of separation from military service. According to VBA, whenever an RVSR denies a Gulf War veteran service connection for any mental disorder, the RVSR must consider whether the veteran is entitled to receive mental health treatment.

Finding 4 Gulf War Veterans Not Receiving Accurate Entitlement Decisions for Mental Health Treatment

VARO staff did not properly address whether 21 (70 percent) of 30 Gulf War veterans were entitled to receive treatment for mental disorders. These errors

occurred because VSC staff found the VBA policy difficult to remember, despite training and understanding of the policy requirements. As a result, veterans may be unaware of their potential entitlement to treatment for mental disorders.

Although RVSRs and Quality Review Team personnel were able to explain the correct process for addressing this entitlement, they stated it was difficult to remember to consider Gulf War veterans' entitlement to mental health treatment when processing their claims. This occurred despite staff receiving four separate training sessions where trainers reminded VARO staff about these types of errors.

In February 2011, VBA updated its Rating Board Automation 2000, a computer application designed to assist RVSRs in preparing disability ratings. The application provides a pop-up notification, known as a tip master, to remind staff to consider entitlement to health care treatment when they deny service connection for a mental disorder. Our review included cases completed after the update.

One RVSR who was responsible for three of the errors found during our review was also unaware of the tip master's existence. RVSRs who were aware of this prompt stated it was easy to overlook the reminder notification--a view corroborated by management who knew of the tip master.

Recommendation

5. We recommend the Pittsburgh VA Regional Office Director develop and implement a plan to monitor the effectiveness of training Rating Veterans Service Representatives on correctly addressing Gulf War veterans' entitlement to mental health treatment.

Management Comments

The VARO Director concurred with our recommendation. In October 2011, VARO management ensured staff received training on the proper procedures for addressing Gulf War veterans' entitlement to mental health treatment. Additionally, VARO management implemented a peer-to-peer review policy to ensure VARO staff properly address this entitlement

OIG Response

The Director's comments and actions are responsive to the recommendation.

Competency Determinations

VA must consider beneficiary competency in every case involving a mental health condition that is totally disabling or when evidence raises questions as to a beneficiary's mental capacity to manage his or her affairs. The Fiduciary Unit supports implementation of competency determinations by appointing a fiduciary, a third party who assists in managing funds for an incompetent beneficiary. We reviewed competency determinations completed by the VSC Decision Team to ensure staff completed them accurately and timely. Delays in making these determinations ultimately affect the Fiduciary Unit's ability to appoint fiduciaries timely.

VBA policy requires that staff obtain clear and convincing medical evidence that a beneficiary is capable of managing his or her affairs prior to making a final competency decision. The policy allows the beneficiary a 60-day due process period to submit evidence showing an ability to manage funds and other personal affairs. At the end of the due process period, VARO staff must take immediate action to determine whether the beneficiary is competent. Effective July 2011, VBA defines "immediate" as 21 days.

Finding 5 Inadequate Controls Over Competency Determinations

VARO staff unnecessarily delayed making final decisions in 6 (55 percent) of 11 competency determinations completed from April through June 2011. Delays occurred because management emphasized processing other pending claims instead. The risk of incompetent beneficiaries receiving benefits payments without fiduciaries assigned to manage those funds increases when staff do not complete competency determinations timely.

For the six cases we identified, delays in making final competency determinations ranged from 9 to 60 days, with an average completion time of 37 days. In the most egregious case involving a delay of 60 days, the veteran received $5,346 in disability payments to which he was entitled. However, fiduciary stewardship was not in place to ensure effective funds management and the welfare of the veteran.

In July 2011, the VARO created a specialized team with responsibility for processing final competency determinations. The delays we identified occurred prior to the creation of this team. Managers and staff we interviewed stated that before the creation of the team, the VSC's focus was on processing compensation claims rather than final competency determinations. As a result, incompetent beneficiaries received benefit payments for extended periods despite being incapable of managing these funds effectively.

Recommendation

6. We recommend the Pittsburgh VA Regional Office Director implement a plan to ensure Veterans Service Center staff timely complete competency determinations.

Management Comments

The VARO Director concurred with our recommendation. The Director informed us VARO management created a mechanism that requires staff to process competency determinations when the suspense date expires or when the VARO receives information from the claimant that allows staff to proceed with processing these determinations.

OIG Response

The Director's comments and actions are responsive to the recommendation.

5. Public Contact

In November 2009, VA developed a 5-year plan to end homelessness among veterans by assisting every eligible homeless veteran willing to accept service. VBA generally defines "homeless" as lacking a fixed, regular, and adequate nighttime residence. VBA provided guidance to all VAROs that claims submitted by homeless veterans should receive priority processing.

Expedited Claims Processing for Homeless Veterans

Generally, we found no excessive delays in processing homeless veterans' claims at this VARO. VBA's national performance measure for processing homeless veterans' claims is determined by the average days claims are pending completion. VBA calculates this average using the total lapsed days since VA received all of the claims, divided by the total number of claims pending. VBA's national target is for homeless veterans' claims to be pending no more than an average of 75 days.

At the time of our inspection, the Pittsburgh VARO had four pending homeless veterans' claims available for review. The lapsed time these claims were pending ranged from 49 to 83 days. These cases had been pending an average of 58 days—17 days better then VBA's national target. A review of the claims folders did not reveal any excessive delays in processing the claims. As such, we made no recommendation for improvement in this area.

Outreach to Homeless Shelters and Service Providers

Congress mandated at least one full-time employee oversee and coordinate programs for homeless veterans at each of the 20 VAROs that VA determined to have the largest veteran populations. VBA guidance, last updated in September 2002, directed that the coordinators at the remaining 37 VAROs, which included Pittsburgh, be familiar with requirements for improving the effectiveness of VARO outreach to homeless veterans. These requirements include developing and updating a directory of homeless shelters and service providers. Additionally, the coordinators should attend regular meetings with local homeless service providers, community governments, and advocacy groups to provide information on VA benefits and services.

Finding 6 No Clear Measures To Assess the Effectiveness of the Homeless Veterans Outreach Program

The Pittsburgh VARO's outreach to homeless shelters and service providers was not effective. This occurred because VARO management did not provide oversight or have any mechanism in place to assess outreach efforts. As a result, VARO management had no assurance that homeless shelters and service providers were aware of VA benefits and services available to homeless veterans.

VSC staff provided a directory containing the names and contact information for five homeless facilities and service providers in Allegheny County where the Pittsburgh VARO is located. We contacted representatives at three (75 percent) of the four homeless shelters and service providers listed. Representatives from those facilities indicated VARO staff had not contacted them, nor had they received information regarding VA benefits and services. Further, the directory did not contain any contact information for facilities located in the remaining 30 counties under the Pittsburgh VARO's jurisdiction.

A VSC manager confirmed they had not contacted or provided necessary information to homeless shelters or service providers under the VARO's jurisdiction. Further, they had not updated the directory as required. A supervisor informed us he was unaware of the requirement to reach out to other facilities under the Pittsburgh VARO's jurisdiction. Further, one manager stated he did not provide any oversight because he was unfamiliar with VBA's homeless veterans outreach policy.

Because the outreach program was not effective, we expanded our review and interviewed Homeless Veteran Outreach Coordinators (HVOCs) at three VA Medical Centers (VAMCs) under the VARO's jurisdiction. We determined VARO management had not contacted or provided training for two of the three HVOCs. The coordinators said they were unaware of the procedures for expediting homeless veterans' claims through the VARO.

The Director at one VAMC provided us with a list of 18 homeless veterans living in the area under the VARO's jurisdiction. Six (33 percent) of the 18 veterans had active disability claims pending; however, these veterans had not been identified as homeless and their claims had not received priority processing. The claims had been pending from 20 to 573 days. The most significant delay involved an unprocessed payment for $75,641 owed to a homeless veteran. If not for our review, further delays in processing the payment would have occurred.

As a result of these deficiencies, VARO management lacked assurance that homeless shelters and service providers under their jurisdiction received information regarding VA benefits and services available to homeless veterans.

Recommendations

7. We recommend the Pittsburgh VA Regional Office Director develop and implement a plan outlining how VA Regional Office staff will accomplish all required homeless veteran outreach services, including updating the resource directory and regularly contacting homeless shelters and service providers.

8. We recommend the Pittsburgh VA Regional Office Director develop and implement a plan to monitor and assess the effectiveness of outreach to VA Medical Centers, shelters, and service providers regarding VA benefits and services available to homeless veterans.

Management Comments

The VARO Director concurred with our recommendations. VARO management assigned a new Homeless Veterans Outreach Coordinator that made contact and provided outreach to the VA Medical Centers in Erie and Pittsburgh. To strengthen the homeless program, in December 2011, the Pittsburgh RO sent a letter to all VISN 4 medical centers as well as homeless facilities within the Pittsburgh jurisdiction. Additionally, VARO management established a tracking system to ensure completion of outreach to homeless veterans.

OIG Response

The Director's comments and actions are responsive to the recommendation.

Appendix A VARO Profile and Scope of Inspection

Organization

The Pittsburgh VARO administers a variety of services and benefits including compensation; vocational rehabilitation and employment; benefits counseling; fiduciary services; public affairs; and outreach to homeless, elderly, minority, and women veterans.

Resources

As of October 2011, the Pittsburgh VARO had a staffing level of 158 full-time employees. Of these employees, 133 (84 percent) were assigned to the VSC.

Workload

As of October 2011, the VARO reported 7,033 pending compensation claims. The average time to complete claims was 230.2 days—5.2 days beyond the national target of 235 days.

Scope

We reviewed selected management, claims processing, and administrative activities to evaluate compliance with VBA policies regarding delivery of benefits and nonmedical services to veterans and other beneficiaries. We interviewed managers and employees and reviewed veterans' claims folders.

Our review included 58 (12 percent) of 467 disability claims related to TBI and herbicide exposure completed from April through June 2011. For temporary 100 percent disability evaluations, we selected 30 (8 percent) of 379 existing claims from VBA's Corporate Database. We provided VARO officials with 349 claims remaining from our universe of 379 for their review. The 349 claims represented all instances where VARO staff had granted temporary 100 percent disability evaluations for at least 18 months or longer as of September 7, 2011.

We reviewed all 14 files containing errors identified by VBA's STAR program from April through June 2011. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR assessments include a review of work associated with claims requiring rating decisions. STAR staff review original claims, reopened claims, and claims for increased evaluations. Further, they review appellate issues that involve a myriad of veterans' disability claims.

Our process differs from that of STAR as we review specific types of disability claims, such as those related to TBI and herbicide exposure that require rating decisions. We also reviewed 12 mandatory SAOs completed in FY 2011.

We reviewed selected mail in various processing stages in the mailroom and the VSC. We reviewed 30 claims completely processed for Gulf War veterans from April to June 2011 to determine whether VSC staff addressed entitlement to mental health treatment in the rating decision documents.

Further, we reviewed 11 competency determinations to determine whether staff processed them within VBA's 21-day standard. We reviewed all four homeless veterans' claims pending at the time of our inspection. In addition, we reviewed the effectiveness of the VARO's homeless veterans outreach program.

We completed our review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.* We planned and performed the review to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our review objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our review objectives.

Appendix B VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: February 10, 2012

From: Jennifer Stone-Barash, Director, VA Regional Office

Subj: Inspection of the VA Regional Office, Pittsburgh, Pennsylvania

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

1. Attached are the Pittsburgh VARO's comments on the OIG Draft Report: Inspection of the VA Regional Office, Pittsburgh, Pennsylvania.

2. Questions may be referred to Mr. Shannon Kelly, Assistant Director, VA Regional Office, Pittsburgh, Pennsylvania.

(original signed by:)

J. STONE-BARASH

Director

Attachment

Recommendation 1:

We recommend the Pittsburgh VARO Director develop and implement a plan to ensure staff process 810 work items on a recurring basis.

Concur: In January 2012, the Pittsburgh RO implemented a team to address all pending message work items. This team consists of four journey level Veterans Service Representatives (VSR), one Rating Veterans Service Representative (RVSR), and one Assistant Coach. Their mission is to ensure that all message work items are processed in a timely manner.

The Pittsburgh RO has strengthened their controls and now requires weekly reports from the Assistant Coach of this newly formed team. The RO will make adjustments, when needed, to ensure continued progress.

Recommendation 2:

We recommend the Pittsburgh VARO Director develop and implement a plan to ensure staff return inadequate traumatic brain injury examination reports to the appropriate healthcare facilities for correction.

Concur: The Pittsburgh RO has continued to provide training through their Quality Review Team (QRT) to ensure that traumatic brain injury issues are properly evaluated. In June 2011, the Regional Office put in place a policy of peer-to-peer review of all TBI claims, in compliance with VBA policy.

The Pittsburgh RO has contacted their Veterans Health Administration (VHA) partners regarding TBI examinations. VHA staff is committed to working with the Pittsburgh Regional Office to address any issues related to inadequate examinations.

On November 9, 2011, TBI training was again conducted for all RVSRs and DROs, with a focus on examination adequacy. A local tracking spreadsheet has been developed to track any TBI examinations found to be inadequate. As of January 2012, there have been no insufficient exams regarding TBI. Additionally, as of January 2012, there have been no local errors found regarding the evaluation of TBI.

Recommendation 3:

We recommend the Pittsburgh VA Regional Office Director develop and implement a plan for staff to adequately assess all required elements of Systematic Analyses of Operations and complete them in accordance with the VA Regional Office's annual schedule.

Concur: In October 2011, the Pittsburgh RO began tracking all Systematic Analyses of Operations on one spreadsheet. This spreadsheet is used to annotate when extensions are requested as well as the date received, sent back to division, and when approved by the Office of the Director. All extensions are now required via email, and all emails are kept in a separate folder.

Training was conducted within the Veterans Service Center on the preparation of SAOs and timeliness requirements. The Assistant Veterans Service Center Manager (AVSCM), Management Analyst in the Veterans Service Center, and Veterans Service Center Manager (VSCM), review all completed SAOs prior to submission to the Office of the Director, to ensure all required elements are addressed.

The Pittsburgh Regional Office is responsible for providing regular updates to the Eastern Area Office on their timeliness of SAOs throughout the fiscal year, as well as providing a random sample of SAOs for review. The Eastern Area Office will continue to monitor the compliance of the Pittsburgh Regional Office and provide feedback as appropriate.

Recommendation 4:

We recommend the Pittsburgh VA Regional Office Director amend the Workload Management Plan and Intake Processing Center procedures to ensure management oversight and control of claims-related mail.

Concur: While the OIG was on station, the Intake Processing Center (IPC) Coach established a permanent transfer in (PTI) action plan to include the creation of a PTI excel database to track all PTI mail currently on station. Based upon further recommendation, a Standard Operating Procedure for search mail was created. In addition, the IPC separated search mail and PTI mail based upon guidance from the OIG while on station.

The Pittsburgh RO Workload Management Plan was amended to include a more aggressive COVERS compliance policy. This policy includes an all COVERS day with follow-up completed by the VSCM or his/her designee. All RO Workload Management Plans are due to the Eastern Area Office at the end of January 2012.

Recommendation 5:

We recommend the Pittsburgh VA Regional Office Director develop and implement a plan to monitor the effectiveness of training Rating Veterans Service Representatives on correctly addressing Gulf War veterans' entitlement to mental health treatment.

Concur: The Pittsburgh RO continues to provide training on this issue with emphasis on ensuring the all tools available to the Rating Veterans Service Representatives are utilized.

Additional training on correctly addressing Gulf War Veterans' entitlement to mental health treatment occurred in October 2011. Local quality reviews completed by the Quality Review Team include a review of the issue of entitlement to mental health treatment to ensure this is properly considered.

To validate the effectiveness of the training, Pittsburgh VARO implemented a peer-to-peer review policy similar to that currently utilized for TBI cases. This will ensure RVSRs and DROs properly address Gulf War Veterans' entitlement to mental health treatment.

Recommendation 6:

We recommend the Pittsburgh VA Regional Office Director implement a plan to ensure Veterans Service Center staff timely complete competency determinations.

Concur: In July 2011, VBA implemented a policy defining "immediate" as 21 days. The claims reviewed for this portion of the audit were completed prior to the implementation of this policy. However, to ensure compliance with the current standard, the Pittsburgh RO developed a Daily Tracker for claims where competency is at issue to ensure timely processing. The Pittsburgh RO is focusing to ensure that cases are worked when the suspense date has expired or when information has been received from the Veteran/claimant regarding their concurrence or non-concurrence of the competency determination. This revised process was put in place in October 2011 to assist the specialized team implemented in July 2011, which is now responsible for these types of cases.

Since the development of the daily tracker, the Pittsburgh RO has seen a decrease in the number and processing time of claims awaiting a competency determination. All competency determinations are completed as outlined in FL 09-08.

Recommendation 7:

We recommend the Pittsburgh VA Regional Office Director develop and implement a plan outlining how VA Regional Office staff will accomplish all required homeless veteran outreach services, including updating the resource directory and regularly contacting homeless shelters and service providers.

Concur: The newly assigned Homeless Veterans Outreach Coordinator has made contact and provided outreach to the VA Medical Centers in Erie and Pittsburgh. To strengthen the homeless program, in December 2011, the Pittsburgh RO sent a letter to all VISN 4 medical centers as well as homeless facilities within the Pittsburgh jurisdiction with contact information.

The Homeless Veterans Outreach Coordinator will follow up with local resources to identify any unmet needs and determine the appropriate frequency of visits to these facilities. Additional training on homeless Veterans for members of the Public Contact Team occurred in January 2012.

Recommendation 8:

We recommend the Pittsburgh VA Regional Office Director develop and implement a plan to monitor and assess the effectiveness of outreach to VA Medical Centers, shelters, and service providers regarding VA benefits and services available to homeless veterans.

Concur: The Pittsburgh VA Regional Office has established a tracking system to ensure completion of outreach to homeless Veterans and to assess the effectiveness. The log contains the facility visited, hours expended, and claims taken.

Appendix C Inspection Summary

Nine Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Disability Claims Processing			
1. Temporary 100 Percent Disability Evaluations	**Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations.** (38 CFR 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) M21-1MR Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e)		X
2. Traumatic Brain Injury Claims	**Determine whether staff properly processed claims for all disabilities related to in-service TBI.** (Fast Letters 08-34 and 08-36, Training Letter 09-01)		X
3. Herbicide Exposure-Related Claims	**Determine whether VARO staff properly processed claims for service-connected herbicide exposure-related disabilities (Agent Orange).** (38 CFR 3.309) (Fast Letter 02-33) (M21-1MR Part IV, Subpart ii, Chapter 2, Section C.10)	X	
Management Controls			
4. Systematic Technical Accuracy Review	**Determine whether VARO staff properly corrected STAR errors in accordance with VBA policy.** (M21-4, Chapter 3, Subchapter II, 3.03)	X	
5. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)		X
Workload Management			
6. Mail-Handling Procedures	**Determine whether VARO staff properly followed VBA mail-handling procedures.** (M23-1) (M21-4, Chapter 4) (M21-1MR Part III, Subpart ii, Chapters 1 and 4)		X
Eligibility Determinations			
7. Gulf War Veterans' Entitlement to Mental Health Treatment	**Determine whether VARO staff properly processed Gulf War Veterans' entitlement to Medical Treatment for Mental Illness.** (38 United States Code USC 1702) (M21-1MR Part IX, Subpart ii, Chapter 2) (M21-1MR Part III, Subpart v, Chapter 7) (Fast Letter 08-15) (38 CFR 3.384)		X
8. Competency Determinations	**Determine whether VAROs properly assessed beneficiaries' mental capacity to handle VA benefits payments.** (M21-1MR Part III, Subpart v, Chapter 9, Section A) (M21-1MR Part III, Subpart v, Chapter 9, Section B) (FL 09-08)		X
Public Contact1			
9. VBA's Homeless Veterans Program	**Determine whether VARO staff expeditiously processed homeless veterans' claims and provided effective outreach services.** Public Law 107-05) (M21-1MR Part III Subpart ii, Chapter 1, Section B) (M21-1MR Part III Subpart iii, Chapter 2, Section I) (VBA Circular 20-91-9) (VBA Letter 20-02-34) (C&P Service Bulletins August 2009, January 2010, April 2010, May 2010)		X

Source: VA OIG
CFR=Code of Federal Regulations, M=Manual, MR=Manual Rewrite

Appendix D Office of Inspector General Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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