VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office St. Petersburg, Florida

February 8, 2012
11-04243-86

ACRONYMS AND ABBREVIATIONS

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

Report Highlights: Inspection of the VA Regional Office, St. Petersburg, Florida

Why We Did This Review

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

What We Found

St. Petersburg VARO staff timely processed homeless veterans' claims, provided adequate outreach to homeless shelters and service providers, and followed VBA's policy for correcting errors identified by Systematic Technical Accuracy Review program staff. VARO performance was generally effective in processing herbicide exposure-related claims.

The VARO lacked effective controls and accuracy in processing some disability claims. Inaccuracies in processing temporary 100 percent disability evaluations resulted when staff did not schedule medical reexaminations. In addition, VARO staff used insufficient medical examination reports to process traumatic brain injury claims. VARO staff did not correctly process 42 (47 percent) of the 90 disability claims we sampled during our inspection. These results do not represent the overall accuracy of disability claims processing at this VARO.

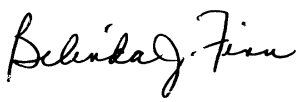
VARO management did not ensure staff completed Systematic Analyses of Operations, properly processed mail, and accurately addressed Gulf War veterans' entitlement to mental health treatment. Further, processing of competency determinations was not effective, resulting in unnecessary delays in making final decisions and improper benefits payments.

What We Recommended

We recommended the VARO Director develop and implement a plan to monitor the effectiveness of training and ensure staff return insufficient medical examination reports for traumatic brain injury claims. VARO management needs to timely complete Systematic Analyses of Operation, and ensure oversight of search mail and proper processing of competency determinations. Further, management needs to conduct training and implement a plan to ensure staff follow current VBA policy on addressing Gulf War veterans' entitlement to mental health treatment.

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
for Audits and Evaluations

TABLE OF CONTENTS

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 St. Petersburg 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 60 (3 percent) of 1,994 disability claims related to traumatic brain injury (TBI) and herbicide exposure that VARO staff completed from July through September 2011. In addition, we reviewed 30 (2 percent) of 1,678 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 the 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 St. Petersburg VARO Could Improve Disability Claims Processing Accuracy

The St. Petersburg VARO lacked controls and accuracy in processing claims for temporary 100 percent disabilities and TBI. VARO staff incorrectly processed 42 (47 percent) of the total 90 disability claims we sampled and overpaid a total of $400,323 in benefits payments. VARO management agreed with our findings 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 as of September 2011, the overall accuracy of the St. Petersburg VARO's compensation rating-related decisions was 81.8 percent—8.2 percent below the 90 percent VBA target.

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

Table

St. Petersburg VARO Disability Claims Processing Results

Type	Reviewed	Claims Incorrectly Processed		
		Total	Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits
Temporary 100 Percent Disability Evaluations	30	25	10	15
Traumatic Brain Injury Claims	30	13	2	11
Herbicide Exposure-Related Claims	30	4	1	3
Total	**90**	**42**	**13**	**29**

Source: VA OIG

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 25 (83 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 treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability evaluation.

For temporary 100 percent disability evaluations, including confirmed and continued evaluations where rating decisions do not change veterans' payment amounts, 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 a suspense diary matures, the electronic system generates a reminder notification to alert VSC staff to schedule the reexamination.

Available medical evidence showed that 10 of the 25 processing inaccuracies affected veterans' benefits—all 10 involved overpayments totaling $387,252. In the most significant case, VARO staff did not schedule a follow-up medical examination to evaluate a veteran's prostate cancer. VA medical treatment records showed the veteran had completed treatment, warranting a reduction in benefits as of August 2007. As a result, VA overpaid the veteran $122,635 over a period of 3 years and 9 months.

The remaining 15 inaccuracies had the potential to affect veterans' benefits. Following are descriptions of these inaccuracies.

- In 14 cases, VSC staff did not schedule follow-up medical reexaminations needed to determine whether the temporary 100 percent evaluations should continue. An average of 1 year and 4 months elapsed from the time staff should have scheduled the medical reexaminations until the date of our inspection. The delays ranged from 5 months to 4 years and 4 months.
- In one case, an RVSR incorrectly annotated the need for future reexamination of a veteran diagnosed with incurable chronic lymphocytic leukemia. In making this decision, the RVSR also did not consider entitlement to the additional benefit of Dependents' Educational Assistance as required by VBA policy.

Twenty-three of the 25 errors occurred because VARO management did not have a mechanism in place to ensure staff timely scheduled reexaminations for temporary 100 percent disabilities. Twelve of these errors involved confirmed and continued rating decisions. In November 2009, VBA provided guidance to the VAROs about the need to enter suspense diaries in the electronic record as reminders to schedule reexaminations for confirmed

and continued rating decisions. However, VARO management had no oversight procedure in place to ensure VSC staff established the suspense diaries as required.

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 evaluation 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. VBA directed each VARO to complete the review by the end of March 2012. As such, we made no specific recommendation for this VARO. To assist in implementing the agreed upon review, we provided the VARO with 1,645 claims remaining from our universe of 1,675 temporary 100 percent disability evaluations.

TBI Claims

The Department of Defense and VBA commonly define a TBI as a traumatically induced structural injury or a 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 staff to evaluate these residual disabilities.

VARO staff incorrectly processed 13 (43 percent) of 30 TBI claims we reviewed. Two of the 13 processing inaccuracies affected veterans' benefits—both involved overpayments totaling $13,071. Details on these overpayments follow.

- An RVSR incorrectly evaluated TBI residuals as 40 percent disabling. Medical evidence showed TBI residuals warranting no more than a 10 percent disability evaluation. Also, the RVSR assigned separate evaluations for headaches and fatigue as residuals of TBI; however, the evidence did not show distinct diagnoses to support additional entitlement to separate evaluations. As a result, VA overpaid the veteran $9,855 over a period of 9 months.
- An RVSR incorrectly evaluated TBI residuals as 40 percent disabling. Medical evidence showed residuals warranting no more than a 10 percent disability evaluation. As a result, VA overpaid the veteran $3,216 over a period of 1 year and 4 months.

The remaining 11 inaccuracies had the potential to affect veterans' benefits. Following are summaries of these inaccuracies.

- In ten cases, RVSRs and Decision Review Officers (DROs) prematurely evaluated TBI residuals using insufficient medical examination reports. According to VBA policy, when a medical examination does not address

all required elements, VSC staff should return it to the 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 an adequate or complete medical examination.

- An RVSR incorrectly evaluated TBI residuals as 10 percent disabling. Medical evidence showed residuals warranting no more than a 0 percent disability evaluation, entitling the veteran to health care for the condition but not monetary compensation. Because of the veteran's multiple service-connected disabilities, this error did not affect the veteran's monthly benefits but could affect future evaluations for additional benefits.

Generally, errors associated with TBI claims processing resulted from the use of insufficient medical examination reports and inadequate quality oversight. Prior to our inspection, Quality Review DROs conducted an additional review on 10 of the 13 decisions without identifying any errors. VSC management indicated increased workload for the Quality Review DROs could have affected the accuracy of their additional reviews. Interviews with RVSRs and DROs revealed that despite recent training, VSC staff were using their own interpretation of incomplete or inconclusive medical examination results to decide TBI claims. Further, VSC staff indicated that pressure to produce rating decisions negatively affected quality and resulted in improper decisions. As a result, veterans did not always receive correct benefit payments.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 4 (13 percent) of 30 herbicide exposure-related claims reviewed—1 of these inaccuracies affected a veteran's benefits. In this case, an RVSR established an incorrect effective date for a service-connected disability. As a result, VA underpaid the veteran $369 over a period of 3 months.

The remaining three inaccuracies had the potential to affect the veterans' benefits. Following are summaries of these errors.

- An RVSR prematurely denied an herbicide exposure-related condition based on an insufficient medical examination report. VSC staff did not return the report to the clinic or healthcare facility as insufficient for rating purposes as required. Neither VARO staff nor we can ascertain all of the disabilities related to herbicide exposure without an adequate or complete medical examination.
- An RVSR prematurely denied service connection for prostate cancer associated with herbicide exposure without verifying if the veteran had been exposed to a herbicide agent. VSC staff must attempt to obtain substantiating evidence prior to making a determination as required by VBA policy.

- An RVSR incorrectly granted a veteran service connection for a disability of his lower right extremity due to Parkinson's disease. The veteran had already been granted service-connection for this same disability as it related to diabetes. VBA policy prohibits service connection for the same symptoms under different diagnoses. This rating did not affect the veteran's monthly benefits but could affect future evaluations for additional benefits.

The four herbicide exposure-related processing errors were unique and did not constitute a common trend, pattern, or systemic issue. As such, we made no recommendation for improvement in this area.

Recommendations

1. We recommend the St. Petersburg VA Regional Office Director develop and implement a plan to monitor the effectiveness of training on the proper processing of traumatic brain injury claims.
2. We recommend the St. Petersburg VA Regional Office Director develop and implement a plan to ensure Rating Veteran Service Representatives and Decision Review Officers return insufficient medical examination reports to health care facilities to obtain the evidence needed to support traumatic brain injury rating decisions.

Management Comments

The VARO Director concurred with our recommendations. In response to recommendation 1, the Director indicated the newly constituted Quality Review Teams completed training in January 2012, which focused on improving the consistency and accuracy of examination requests through quality reviews. During these reviews, the Quality Review Specialists will determine whether staff retained and implemented the information provided during training.

In response to recommendation 2, the Director stated the VARO conducted training on medical examinations in several sessions between February 2011 and January 2012. During their reviews, the Quality Review Team will ensure staff are returning insufficient medical examinations. In addition, the VARO will host a joint training session with Compensation and Pension Clinic staff on insufficient medical examinations during the second quarter of FY 2012.

OIG Response

Management's actions are responsive to the recommendations. We will follow up as required on all actions.

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 VAROs take corrective action on errors identified by STAR.

St. Petersburg VARO staff adhered to VBA policy by taking corrective action on all 11 cases with errors identified by VBA's STAR program from April through June 2011. Therefore, 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 Systematic Analyses of Operations (SAOs). We also considered whether VSC staff used adequate data to support the analyses and recommendations identified within each SAO. An SAO is a formal analysis of an 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 annual SAO schedules designating the staff required to complete the SAOs by specific dates.

Finding 2 Oversight Needed To Ensure Timely and Complete SAOs

Three (25 percent) of the 12 SAOs were incomplete (missing required elements), were not done at all, or did not include adequate data. The VSC Manager is responsible for completing the 12 annual SAOs as part of the ongoing analysis of VSC operations. VARO management did not provide adequate oversight to ensure VSC staff completed the SAOs in accordance with VBA policy. As a result, VARO management may not have adequately identified existing and potential problems for corrective actions to improve VSC operations.

At the time of our inspection, 1 (8 percent) of the 12 SAOs was incomplete (missing required elements), 1 (8 percent) had not started, and 1 (8 percent) did not include adequate data. The SAO on fiduciary activities was incomplete because it did not include assessments of timeliness or accuracy. Management did not start the Direct Services SAO because they did not know it was required. Further, VSC management did not obtain and use adequate data from the Control of Veterans Records System, an electronic file tracking system, or conduct physical reviews as required to complete the SAO on mail handling.

VARO management did not have sufficient controls to ensure assigned staff timely completed all SAOs, addressing all of the required elements and conducting related analyses. The VSC manager stated that staff involved in writing SAOs had not received any recent training on requirements for SAOs. Staff did not always reference VBA policy and primarily checked for completeness of the SAOs by comparing them to previous years' submissions.

Recommendation

3. We recommend the St. Petersburg VA Regional Office Director develop and implement a plan to ensure staff complete Systematic Analyses of Operations timely and address all required elements.

Management Comments

The VARO Director concurred with our recommendation. The Director stated the VARO's SAO schedule for FY 2012 includes additional controls to ensure analyses are sufficient and timely. Further, the Director indicated the VARO will provide training on the preparation of SAOs to ensure they are complete and timely.

OIG Response

Management's actions are responsive to the recommendation. We will follow up as required on all actions.

3. Workload Management

Mailroom Operations

We assessed controls over VARO mailroom operations to ensure staff timely and accurately processed incoming mail. 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. The St. Petersburg VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Support Services Division. Mailroom staff were timely and accurate in processing, date-stamping, and delivering VSC mail to the Triage Team control point daily. As a result, we determined mailroom staff were following VBA policy and made no recommendation for improvement in this area.

Triage Mail Management Procedures

We assessed the VSC's Triage Team mail-management procedures 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 control of workflow within the VSC.

Search and Drop Mail

VBA policy requires that VARO staff use Control of Veterans Records System (COVERS) to track claims folders and control search mail. VBA defines search mail as active claims-related mail waiting to be associated with veterans' claims folders. Conversely, drop mail requires no processing action upon receipt. We reviewed 30 pieces of drop mail and found no inaccuracies.

Finding 3 Oversight Needed To Ensure Proper Control and Processing of Search Mail

Triage Team staff did not properly control 9 (21 percent) of 42 pieces of search mail reviewed. Errors related to search mail occurred because VARO guidance did not include provisions for supervisory oversight of the search mail holding areas. As a result, VSC staff may not have all available evidence to make decisions, and beneficiaries may not receive accurate and timely benefits payments.

At the time of our inspection, VSC staff did not have electronic notices of pending search mail in COVERS for 7 (78 percent) of the 9 mail processing inaccuracies we identified—making it difficult for staff to know the mail existed. For the remaining 2 (22 percent), VSC staff improperly used COVERS to control the mail. In both these instances, staff should have associated the mail with the claims folders located in the VARO's storage area.

VSC management stated they did not consistently review the search mail holding areas to ensure compliance with search mail management procedures. Additionally, the Quality of Files Activities SAO was incomplete and did not adequately assess search mail management. If VARO staff had provided a complete analysis of search mail in this SAO, staff may have identified search mail not properly controlled in COVERS. Untimely association of mail with veterans' claims folders can cause delays in processing benefits claims.

Recommendation

4. We recommend the St. Petersburg VA Regional Office Director develop and implement a plan to ensure management oversight and control of search mail.

Management Comments

The VARO Director concurred with our recommendation. The Director indicated the VSC issued a memorandum on December 9, 2011, to all employees regarding mail management. In January 2012, the VARO provided refresher training to employees. Further, the Director stated the workload management plan addresses management oversight of search mail.

OIG Response

Management's actions are responsive to the recommendation. We will follow up as required on all actions.

4. Eligibility Determinations

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 made at the VARO 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 4 Controls Over Competency Determinations Inadequate

As measured against VBA's definition of immediate, VARO staff unnecessarily delayed making final decisions in 13 (43 percent) of 30 competency determinations completed from July through September 2011. The delays ranged from 4 to 126 days, with an average completion time of 42 days. Delays occurred because the workload management plan did not contain oversight procedures emphasizing immediate completion of competency determinations. The risk of incompetent beneficiaries receiving benefits without fiduciaries assigned to manage those funds increases when staff do not complete competency determinations timely.

The most significant case of placing funds at risk occurred when VARO staff unnecessarily delayed making a final incompetency decision for a widow for approximately 4 months. During this period, the widow received $4,224 in disability payments. While the widow was entitled to these payments, fiduciary stewardship was not in place to ensure effective funds management and the welfare of the widow.

Further, VSC staff incorrectly processed 2 (7 percent) of 30 competency determinations we reviewed. According to VBA policy, VARO staff should pay all current monthly benefits for existing disabilities, but should not release any retroactive benefits for these disabilities until making final competency determinations. In the most egregious case, on January 14, 2011, an RVSR granted entitlement to an additional monthly benefit based on the veteran having multiple service-connected disabilities. In the same rating decision, the RVSR proposed incompetency. VSC staff correctly paid the veteran's monthly benefit of $6,819 beginning January 1, 2011. However, staff incorrectly released a retroactive payment of $35,976 due to the veteran for the period December 9, 2009, through December 31, 2010, before determining whether the veteran was competent to manage the funds.

Recommendation

5. We recommend the St. Petersburg VA Regional Office Director implement controls to ensure staff follow Veterans Benefits Administration policy regarding processing of competency determinations.

Management Comments

The VARO Director concurred with our recommendation. The Director stated the VARO provided refresher training in November and December 2011 to all VSC employees.

OIG Response

Management's actions are responsive to the recommendation. We will follow up as required on all actions.

Entitlement to Medical Care and Treatment for Mental Disorders

Gulf War veterans are eligible for medical treatment for any mental disorder they develop 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.

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 Gulf War veterans' entitlement to health care treatment when denying service connection for a mental disorder.

Finding 5 Gulf War Veterans Not Receiving Accurate Entitlement Decisions for Mental Health Treatment

VARO staff did not properly address whether 22 (59 percent) of 37 Gulf War veterans were entitled to receive treatment for mental disorders. These errors occurred because VSC staff lacked understanding of VBA policy and overlooked reminder notifications to consider entitlement to mental health treatment. As a result, veterans may be unaware of their possible entitlement to treatment for mental disorders and may not get the care they need.

Interviews with VSC management and staff confirmed RVSRs did not always follow VBA policy to consider entitlement to mental health treatment when they denied the Gulf War veterans service connection for mental disorders. RVSRs stated the criteria regarding entitlement to mental health treatment for Gulf War veterans was confusing and that it was easy to ignore the reminder notification. VSC management stated they last had training on this topic in December 2010.

Recommendation

6. We recommend the St. Petersburg VA Regional Office Director conduct refresher training and implement a plan to ensure staff follow Veterans Benefits Administration policy regarding Gulf War Veterans' entitlement to mental health treatment.

Management Comments

The VARO Director concurred with our recommendation. The Director stated the VARO provided training to all VSC decision makers on Gulf War Veterans' entitlement to mental health treatment in October 2011. The Director indicated VSC staff would monitor STAR findings and local reviews to ensure compliance with VBA policy on the entitlement.

OIG Response

Management's actions are responsive to the recommendation. We will follow up as required on all actions.

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

At the time of our inspection, VBA determined its national performance measure for processing homeless veterans' claims based on the average days the claims were pending. VBA's national target was for the claims to be pending no more than an average of 75 days.

Seven (23 percent) of 30 homeless veterans' claims pending at the time of our inspection had processing delays. The seven delayed claims had been pending from 29 to 124 days. However, as of September 30, 2011, homeless veterans' claims at the St. Petersburg VARO were pending an average of 66 days, 9 days less than the national target. Therefore, we made no recommendation for improvement in this area.

Outreach to Homeless Shelters and Service Providers

Congress mandated that at least one full-time employee oversee and coordinate homeless veterans programs 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 be familiar with requirements for improving the effectiveness of VARO outreach to homeless veterans. These requirements include developing and updating a directory of local 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.

The St. Petersburg VARO has a full-time Homeless Veterans Outreach Coordinator. Our review confirmed that the coordinator provided effective homeless veterans outreach and contact with local homeless service providers as required by VBA policy. Therefore, we made no recommendation for improvement in this area.

Appendix A VARO Profile and Scope of Inspection

Organization

The St. Petersburg Regional Office administers a variety of services and benefits, including compensation benefits; vocational rehabilitation and employment assistance; specially adapted housing grants; benefits counseling; fiduciary services; and outreach services for homeless, elderly, minority, and women veterans.

Resources

As of September 2011, the St. Petersburg VARO had a staffing level of 971.7 full-time employees. Of these, the VSC had 766 employees (79 percent) assigned.

Workload

As of September 2011, the VARO reported 44,113 pending compensation claims. The average time to complete these claims was 217.7 days—43 days more than the national target of 175.

Scope

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

Our review included 60 (3 percent) of 1,994 disability claims related to TBI and herbicide exposure that the VARO completed from July through September 2011. For temporary 100 percent disability evaluations, we selected 30 (2 percent) of 1,678 existing claims from VBA's Corporate Database. We provided VARO management with 1,645 claims remaining from our universe of 1,678 for further review. These claims represented all instances in which VARO staff granted temporary 100 percent disability determinations for at least 18 months as of September 16, 2011.

We reviewed the 12 mandatory SAOs completed in FYs 2010 and 2011. We reviewed 13 errors identified by VBA's STAR program during April through June 2011. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR measurements include a review of work associated with claims that require rating decisions. STAR staff review original claims, reopened claims, and claims for increased evaluation. Further, they review appellate issues that involve a myriad of veterans' disability claims. Our process differs from STAR as we review specific types of disability claims related to TBI and herbicide exposure that require rating decisions. In addition, we review rating decisions and awards processing involving temporary 100 percent disability evaluations.

For our review, we selected mail in various processing stages in the VARO mailroom and VSC Triage Team. We also reviewed 37 completed claims processed for Gulf War veterans from July through September 2011 to determine whether VSC staff addressed entitlement to mental health treatment in the rating decision document as required. We reviewed 30 competency determinations completed for the same 3-month period. Further, we reviewed 30 homeless veterans' claims pending at the time of our inspection and assessed 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 Inspections 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: January 27, 2012

From: Director, VA Regional Office St. Petersburg, FL

Subj: Inspection of the VA Regional Office, St. Petersburg, FL

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

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

2. Questions may be referred to Kerrie Witty, Director, at (727) 319-5900.

(original signed by:)

Kerrie Witty

Attachment

Attachment A: St. Petersburg VA Regional Office Recommendations Response

OIG Recommendation 1: We recommend the St. Petersburg VA Regional Office Director develop and implement a plan to monitor the effectiveness of training on the proper processing of traumatic brain injury claims.

RO Response: Concur

The newly constituted Quality Review Team (QRT) with its Quality Review Specialists (QRS's) completed training during the week of January 17, 2012. The team of 19 GS-12 QRS's and 17 GS-13 QRS's will specifically be addressing improving the consistency and accuracy of exam requests and reports through providing both local quality reviews and "in process reviews (IPR's)." By performing these reviews, they will also be monitoring the effectiveness of all training provided to VSRs and RVSRs, to include those processing traumatic brain injury claims, as they will be able to determine through results of their reviews if the information provided during training was retained and implemented by employees.

OIG Recommendation 2: We recommend the St. Petersburg VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives and Decision Review Officers return insufficient medical examination reports to health care facilities to obtain the evidence needed to support traumatic brain injury claims rating decisions.

RO Response: Concur

Training on requesting examinations and medical opinions and reviewing sufficiency of examination reports was provided to VSRs, RVSRs, and DROs in several sessions between February 2011and January 2012. Additionally, the St. Petersburg RO is planning to host a joint training session between the RO staff and the VISN 8 C&P Clinic staffs in Quarter 2 of FY12 during which the topic of returning insufficient medical examination reports will be addressed. The Quality Review Team (QRT), through their reviews, will also ensure that RVSRs and DROs are returning insufficient medical examination reports to obtain evidence needed to support decisions.

OIG Recommendation 3: We recommend the St. Petersburg VA Regional Office Director develop and implement a plan to ensure staff complete Systematic Analyses of Operations timely and address all required elements.

RO Response: Concur

For FY 12, the RO released the SAO schedule, with additional controls in place to ensure timely and sufficient completion of these analyses. SAOs will be assigned and prepared by either the VSC Management Analysts or specific Assistant VSCM, who will have sufficient time to review and provide feedback. SAOs will then be finalized by the Veterans Service Center Manager and submitted to the Director prior to the due date. Additionally, during

FY12, training will be provided to all personnel who prepare or assist in the preparation of SAOs in regards to timeliness and content compliance.

OIG Recommendation 4: We recommend the St. Petersburg VA Regional Office Director develop and implement a plan to ensure management oversight and control of search mail.

RO Response: Concur

VSCM memo on Mail Management, dated December 9, 2011, was issued to all employees and addressed the issue of search mail. Mail Management refresher training was provided to employees during the week of January 17, 2012. The RO workload management plan includes management oversight of search mail.

OIG Recommendation 5: We recommend the St. Petersburg VA Regional Office Director implement controls to ensure staff follow Veterans Benefits Administration policy regarding processing of competency determinations.

RO Response: Concur

The St. Petersburg RO provided refresher training to all VSC employees between November 22, 2011 and December 8, 2011.

OIG Recommendation 6: We recommend the St. Petersburg VA Regional Office Director conduct refresher training and implement a plan to ensure staff follow Veterans Benefits Administration policy regarding Gulf War Veterans' entitlement to mental health treatment.

RO Response: Concur

Training on entitlement to mental health treatment for Gulf War Veterans was provided to all decision-makers (RVSRs and DROs) on October 27, 2011. National STAR findings will be monitored to ensure compliance. Finally, local quality reviewers and in-process reviewers will ensure that this topic has an enhanced focus within the local quality review process during FY12.

Appendix C Inspection Summary

Nine Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
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) (M21-1 Manual Rewrite (MR) 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 VARO staff properly processed claims for service connection for all residual disabilities related to in-service TBI.** (FL 08-34 and 08-36, Training Letter 09-01)		X
3. Herbicide Exposure-Related Claims	**Determine whether VARO staff properly processed claims for service connection for herbicide exposure-related disabilities.** (38 CFR 3.309) (FL 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. 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
8. Gulf War Veterans' Entitlement to Mental Health Treatment	**Determine whether VARO staff properly processed Gulf War Veterans' claims, considering entitlement to medical treatment for mental illness.** (38 United States Code 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) (38 CFR 3.2)		X
Public Contact			
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) (Compensation & Pension Service Bulletins August 2009, January 2010, April 2010, May 2010)	X	

Source: VA OIG

CFR=Code of Federal Regulations, FL=Fast Letter, M=Manual, MR=Manual Re-write

Appendix D OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Dawn Provost, Director Bridget Bertino Orlan Braman Madeline Cantu Michelle Elliott Lee Giesbrecht Rachel Stroup Dana Sullivan

Appendix E Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Assistant Secretaries
Office of General Counsel
Veterans Benefits Administration Southern Area Director
VA Regional Office St. Petersburg Director

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Bill Nelson, Marco Rubio
U.S. House of Representatives: Sandy Adams, Gus M. Bilirakis, Corrine Brown, Vern Buchanan, Kathy Castor, Ander Crenshaw, Theodore E. Deutch, Mario Diaz-Balart, Alcee L. Hastings, Connie Mack, John L. Mica, Jeff Miller, Richard B. Nugent, Bill Posey, David Rivera, Thomas J. Rooney, Ileana Ros-Lehtinen, Dennis A. Ross, Steve Southerland, II, Cliff Stearns, Debbie Wasserman Schultz, Daniel Webster, Allen B. West, Frederica S. Wilson, C. W. Bill Young

This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/publications/reports-list.tasp. This report will remain on the OIG Web site for at least 2 fiscal years.