VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Honolulu, Hawaii

March 26, 2012
12-00151-123

ACRONYMS AND ABBREVIATIONS

HVOC	Homeless Veteran Outreach Coordinator
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, Honolulu, Hawaii

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 Honolulu VARO accomplishes this mission.

What We Found

The Honolulu VARO faces a number of management challenges that contributed to the range of issues we identified in aspects of VSC operations. These challenges include providing regular training to inexperienced supervisors, incorporating oversight mechanisms in the Workload Management Plan, and improving communication with staff.

Honolulu VARO staff accurately processed traumatic brain injury claims. In general, the VARO accurately processed herbicide exposure-related claims and corrected errors identified by VBA's Systematic Technical Accuracy Review program.

However, the VARO lacked accuracy in processing temporary 100 percent disability evaluations. These inaccuracies occurred when staff did not schedule required medical reexaminations. VARO staff did not accurately process 29 (47 percent) of 62 disability claims we sampled as part of our inspection. These results do not represent the accuracy of overall disability claims processing at this VARO.

VARO management did not always provide oversight to ensure staff completed Systematic Analyses of Operations. Further, management did not ensure staff properly processed mail or accurately addressed Gulf War veterans' entitlement to mental health treatment. Management oversight of homeless veterans' claims processing and outreach to homeless shelters and service providers were also ineffective.

What We Recommend

We recommend the Honolulu VARO Director implement a plan that ensures staff complete all required elements of Systematic Analyses of Operations, properly date-stamp mail retrieved from the VA Medical Center, and establish clear guidance for processing and managing mail.

The Director should develop and implement a plan to ensure staff address Gulf War veterans' entitlement to mental health treatment. Further, the Director needs to develop and implement a plan to ensure staff follow VBA's policy for defining homelessness and accomplish all required homeless veteran outreach services, including updating the resource directory and regularly contacting 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.

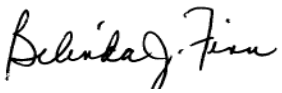

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TABLE OF CONTENTS

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 December 2011, the OIG conducted an inspection of the Honolulu VARO. The inspection focused on five protocol areas examining eight operational activities. The five protocol areas were disability claims processing, management controls, workload management, eligibility determinations, and public contact. We did not examine eligibility determinations related to fiduciary competency determinations because VBA has centralized all Western Area fiduciary activities at the Salt Lake City VARO.

We reviewed 32 (23 percent) of 140 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 (38 percent) of 79 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

HONOLULU VARO MANAGEMENT CHALLENGES

The Honolulu VARO faces a number of management challenges that contributed to the range of issues we identified in aspects of VSC operations. In September 2011, VBA's Western Area office assigned a mentor to the Honolulu VSC management team. The mentor reported to the Western Area Director, that the management team needed to improve communication with the VARO Director and that VSC management needed to provide clearer guidance to its staff. Additionally, the mentor noted that the supervisory staff were new, inexperienced, and needed routine supervisory training.

During several interviews, VSC staff similarly informed us that communication from the VSC manager and supervisors was not always clear or consistent. The acting VSC manager stated some supervisors did not routinely disseminate information to their staff. VSC staff learned of new guidance or practices from other employees rather than from their supervisors. The three supervisors at the Honolulu VARO had an average of 1 year of supervisory experience. Additionally, only one of the three had received formal supervisory training.

Another challenge in VSC operations was incorporating oversight mechanisms in the Workload Management Plan. We confirmed this as we identified several areas where supervisors did not oversee work, such as completing SAOs, processing mail, and expediting claims for homeless veterans. The VARO Director agreed that the Workload Management Plan lacked effective guidance for supervisors to perform reviews of VSC work processes. The acting VSC manager indicated the Workload Management Plan is not an effective tool because it does not align work processes with the office goals.

Moreover, the VARO Director expressed concerns with continuity of VSC leadership. The Honolulu VARO is one of the few offices that require a 3-year contract for the Director and VSC manager position. In most instances, the 3-year contract is the maximum tenure a manager can stay in this position. The VARO Director indicated the 3-year contract does not always allow for consistent leadership. Under the current Director, the VARO has had three temporary VSC managers and one permanent manager. Because of the high turnover in the VSC manager position since 2009, we could not assess the effect of a 3-year contract on VSC operational activities.

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 Needs To Improve Disability Claims Processing Accuracy

The Honolulu VARO lacked controls and accuracy in processing temporary 100 percent disability evaluations and claims for herbicide exposure-related disabilities. VARO staff incorrectly processed 29 (47 percent) of the total 62 disability claims we reviewed, resulting in approximately $200,545 in improper 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 as of October 2011, the overall accuracy of the Honolulu VARO's compensation rating-related decisions was 76.7 percent—15.3 percent below the 92 percent VBA target. The following table reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Honolulu VARO.

Table

Honolulu 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	26	9	17
Traumatic Brain Injury Claims	2	0	0	0
Herbicide Exposure-Related Disability Claims	30	3	3	0
Total	**62**	**29**	**12**	**17**

Source: VA OIG

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 26 (87 percent) of 30 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a service-connected disability following surgery or when a 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 temporary 100 percent disability evaluation.

Available medical evidence showed 9 (35 percent) of 26 processing inaccuracies we identified affected veterans' benefits. These inaccuracies involved overpayments totaling $197,185. The most significant overpayment occurred when VSC staff did not take action to schedule a medical reexamination of a veteran's prostate cancer. VA medical records dated July 2008 revealed the veteran was no longer receiving treatment for prostate cancer. Therefore, the veteran was no longer entitled to receive the temporary 100 percent evaluation. As such, VA overpaid the veteran $81,867 over a period of 2 years and 5 months. The remaining 17 inaccuracies had the potential to affect veterans' benefits—in 16 of the 17, we could not determine whether the evaluations would have continued because the veterans' claims folders did not contain the medical examination reports needed to reevaluate each case. In the remaining case, a Rating Veterans Service Representative (RVSR) did not consider entitlement to additional benefits for Dependents' Educational Assistance, as required.

The most frequent processing inaccuracy noted in 20 (77 percent) of 26 cases occurred because VARO management did not have a mechanism in place to ensure staff timely scheduled reexaminations for temporary 100 percent disabilities. Because effective controls were not in place, temporary 100 percent disability evaluations could have continued uninterrupted over the lifetime of the veterans.

For those cases requiring reexaminations, delays ranged from approximately 2 months to 8 years and 5 months. An average of 1 year and 9 months elapsed from the time staff should have scheduled the reexaminations until the date of our inspection.

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. VBA directed each VARO complete its 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

49 claims remaining from our universe of 79 temporary 100 percent disability evaluations.

TBI Claims

The Department of Defense and VBA commonly define a TBI as a 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 correctly processed the two TBI claims available for our review. As a result, we determined the Honolulu VARO was complying with VBA's policy to process TBI claims. Therefore, we made no recommendation for improvement in this area.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 3 (10 percent) of 30 herbicide exposure-related claims. All of these processing inaccuracies affected veterans' benefits and involved underpayments totaling $3,360. Following are descriptions of these errors.

- In two cases, an RVSR did not grant additional entitlement to special monthly compensation benefits based on loss of use of a creative organ. As a result, VA underpaid one veteran $1,440 over a period of 15 months and one veteran $768 over a period of 8 months.
- In one case, an RVSR established an incorrect effective date for a service-connected disability. As a result, VA underpaid the veteran $1,152 over a period of 12 months.

As one RVSR made two of the three errors, we did not consider this a systemic issue. Therefore, we determined the VARO was generally following VBA policy when processing herbicide exposure-related claims, and we made no recommendation for improvement in this area.

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 that 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.

The Honolulu VARO staff did not correct 2 (7 percent) of 30 errors that STAR program staff identified from April through June 2011. In one case, VARO staff did not seek clarification from the veteran as to the specific disability claimed, as instructed by STAR staff. In the second case, VARO staff did not accurately notify the veteran of the reasons for the final

disability determination. Because VARO management generally followed VBA policy regarding correction of STAR errors, 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 used adequate data to support the analyses and recommendations identified within 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 the SAOs by specific dates. The VSC Manager is responsible for completing the 11 annual SAOs as part of ongoing analysis of VSC operations.

Finding 2 Oversight Needed to Ensure Timely and Complete SAOs

Eight (73 percent) of the 11 SAOs were either untimely, incomplete (missing required elements), or not done at all. 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 (9 percent) of the 11 SAOs was not started, 2 (18 percent) were untimely, 2 (18 percent) were incomplete, and 3 (27 percent) were both untimely and incomplete. According to the VARO Director, management did not start the SAO for Quality of Files Activities because the VSC manager forgot to add this SAO to the annual schedule. December 2010 was the last time VSC staff completed an analysis of the Quality of Files Activities, which includes a review of mail management.

The VARO Director informed us that SAOs were untimely because the VSC manager misunderstood when completed SAOs were due to the Director's office for approval. According to the Director, the VSC manager was to submit completed SAOs to the Director's office by the due date listed on the SAO annual schedule. However, employees responsible for preparing the SAOs informed us the VSC manager provided conflicting guidance and required staff to submit completed SAOs to the VSC manager's office by the due date listed on the annual schedule.

VARO management did not adequately monitor staff responsible for completing SAOs. According to the Director, the VSC manager was responsible for ensuring all SAOs were complete. However, four SAOs approved by the Director's office did not contain analysis of all required

elements. Because controls were lacking, VARO management was unaware staff did not address all required elements and related analyses. In addition, VARO staff never completed the Quality of Files Activities SAO. If they had completed this SAO, they might have determined staff were not complying with search-mail procedures.

Recommendation

1. We recommend the Honolulu VA Regional Office Director develop and implement a plan for staff to address all required elements of Systematic Analyses of Operations and complete them in accordance with the annual schedule.

Management Comments

The VARO Director concurred with our recommendation and implemented an SAO Circular that defines responsibilities for completing SAOs. The Director implemented a control to ensure SAOs are completed and submitted timely to the Director's office for review. Additionally, in March 2012, staff responsible for preparing SAOs will receive training regarding the proper procedures for completing these analyses.

OIG Response

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

3. Workload Management

Mailroom Operations

We assessed controls over 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 any VA facility. The Honolulu VARO does not have its own mailroom. Instead, the VA Medical Center mailroom, located on the same VA campus, receives all incoming mail for the VARO. VSC staff are responsible for retrieving and processing this mail on a daily basis.

Finding 3 Improvement Needed for Timely Mail Processing

VSC staff did not always date-stamp claims-related mail with the date they retrieved it from the VAMC mailroom. This occurred because management did not monitor the Triage Team to ensure they followed VBA policy to date-stamp mail within 4 to 6 hours of receipt at any VA facility. As a result, beneficiaries may not have received accurate benefits payments.

VAMC mailroom staff received mail for the VARO daily. VAMC staff did not open or date-stamp mail intended for the VARO. Based on established procedures, they did not deliver mail to the VARO Triage Team until the next business day. VSC management was aware of the one-day delay associated with the VAMC mail distribution procedure. However, they did not consider the need to apply the correct date stamp to ensure that the one-day delay in mail receipts would not adversely affect veterans' benefits.

Claims-related mail that is not properly date-stamped can affect benefits payments. For example, if staff properly date-stamp claims-related mail received on January 31, the benefits would be payable on February 1. However, if staff improperly date-stamp this same mail a day late on February 1, the payment date would be March 1 and VARO staff would unintentionally underpay the beneficiary by 1 month. We identified six new disability claims received in the VAMC mailroom on November 30, 2011. VSC staff did not date stamp these documents until December 1, 2011. If not for our review, veterans might not have received accurate monthly benefit payments.

Recommendation

2. We recommend the Honolulu VA Regional Office Director develop a plan to ensure staff are notified when mail arrives in the VA Medical Center and that mail is properly date-stamped with the date received at any VA facility.

Management Comments

The VARO Director concurred with our recommendation. The Director planned to coordinate with the Honolulu VA Medical Center to determine the best way to ensure mail is date-stamped on the day of delivery. The Director indicated the VARO would provide an employee to the Medical Center mailroom to date-stamp mail or coordinate with the mailroom to deliver mail to the VARO on the date it arrives at the Medical Center.

OIG Response

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

VSC Mail-Handling Procedures

We assessed mail-processing procedures within the VSC 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 the Control of Veterans Records System, an electronic tracking system, 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 immediate action after staff place the mail in the claims folders.

Finding 4 Controls Over Mail-Management Procedures in the Veterans Service Center Need Strengthening

VSC staff did not correctly process or control 20 (33 percent) of 60 pieces of claims-related mail according to policy. Of the 20 pieces of mail, staff did not accurately and timely process 16 (53 percent) pieces of search mail and 4 (13 percent) pieces of drop mail we reviewed. This occurred because VARO management did not monitor mail processing within the VSC.

Consequently, VSC staff may not always have all available evidence to make decisions and beneficiaries may not receive accurate and timely benefits payments.

Staff did not always use the Control of Veterans Records System to control search mail in 15 of the inaccuracies we identified. For these inaccuracies, staff either incorrectly deleted or disregarded electronic notifications designed to alert them of mail waiting to be associated with claims folders. In addition, staff did not ensure timely and accurate routing of four pieces of drop mail. Following are examples these discrepancies.

- On July 5, 2011, staff received a request to obtain private medical records on behalf of the veteran to support his claim. Staff properly placed this mail on search in the Control of Veterans Records System, as the file was temporarily located at a VAMC to support a medical examination. On September 23, 2011, VAMC staff returned the claims folder to the VARO. Instead of identifying the search mail and processing the request for private medical evidence, VSC staff incorrectly returned the folder to a file storage location within the VARO. By the time of our inspection, staff had delayed requesting the private medical records for 148 days, ultimately delaying completion of the claim.
- On July 5, 2011, VSC staff received mail returned from the U.S. Postal Service. This mail served notification to a veteran of his right to appeal a recent VARO disability decision. Staff routed the mail to the claims folder with no further action instead of attempting to obtain a current address for the veteran. Although appellate rights typically expire 1 year from the date of a benefit decision, 5 months lapsed before staff notified the veteran of his right to appeal.

VSC management did not monitor search or drop mail processes to ensure employees complied with VBA policy. VSC staff also informed us they did not reconcile search mail weekly, nor did they use the Control of Veterans Records System search mail report to monitor mail as required.

Further, in January 2009 the Compensation and Pension Service Site Visit Team requested the VSC create standard operating procedures for the Triage team, including specific guidance for processing drop mail. However, the most recent Workload Management Plan, dated September 2011, did not include specific guidance for staff to follow regarding the search and drop mail processes. The plan also did not include guidance for supervisors to monitor search and drop mail processes within the VSC. If management had completed the Quality of Files Activity SAO, it might have identified weaknesses associated with mail processing.

Recommendations

3. We recommend the Honolulu VA Regional Office Director amend the Workload Management Plan to establish clear guidance for processing search and drop mail.

4. We recommend the Honolulu VA Regional Office Director amend the Workload Management Plan to incorporate guidance for supervisors to monitor processes associated with search and drop mail.

Management Comments

The VARO Director concurred with our recommendations and amended the Workload Management Plan and the Triage Standard Operating Procedures. The amendments included a new process to scan search mail into Virtual VA, a timeliness measure for processing drop mail, and an oversight process that makes supervisors responsible for ensuring staff meet the timeliness goal.

OIG Response

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

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.

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 they deny service connection for a mental disorder. This pop-up notification does not generate if a previous decision did not address entitlement to mental health services and a mental health condition is not part of the current claim.

Finding 5 Gulf War Veterans' Entitlement to Mental Health Treatment Not Always Considered

VARO staff did not properly address whether 10 (38 percent) of 26 Gulf War veterans were entitled to receive treatment for mental disorders. These errors occurred because of inadequate training provided to RVSRs. As a result, veterans may be unaware of potential entitlement to treatment for mental health disorders.

For the 10 cases we identified, Gulf War veterans claimed service connection for mental health conditions due to their military service. VARO staff

properly requested VA medical examinations to determine whether the veterans had mental disabilities. Results of these medical examinations revealed the claimed mental health conditions did not exist. Although RVSRs correctly denied service connection for the conditions, they did not consider entitlement to mental health treatment as required.

In April 2011, the VARO provided refresher training to RVSRs on the requirement to consider Gulf War veterans' entitlement to mental health treatment. However, the training did not provide information on considering entitlement to mental health treatment when denying service connection for mental health conditions that physicians determined did not exist. As such, RVSRs were under the assumption that if a mental disability did not exist, a decision to address mental health treatment was not required. Therefore, not all veterans received notification of their potential entitlement to treatment for mental health conditions.

Recommendation

5. We recommend the Honolulu VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives correctly address and consider Gulf War veterans' entitlement to mental health treatment.

Management Comments

The VARO Director concurred with our recommendation. In December 2011, Rating Veterans Service Representatives received training on the proper procedures for considering Gulf War veterans' entitlement to mental health treatment. Further, the Director will use a newly implemented Quality Review Specialists Team to perform reviews of the entitlement decisions.

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

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 is for claims to remain pending no more than an average of 75 days.

Finding 6 Inadequate Controls for Homeless Veterans' Claims Processing

VARO staff unnecessarily delayed processing homeless veterans' claims. This occurred because VARO staff deviated from VBA's definition of homelessness. As a result, some claims submitted by homeless veterans might not have received expedited processing as required.

According to VBA, the Honolulu VARO had an average of 38 homeless veterans' claims pending a rating decision from April through August 2011. The number of these claims per month during that period ranged from 29 to 46. In September 2011, VBA's data showed 15 homeless veterans claims pending a rating decision.

The sudden decrease in this type of claim occurred because VSC staff instituted a local procedure to simplify their interpretation of VBA's definition of homeless. Specifically, VSC staff removed from veterans' records the electronic control that identified and tracked these claims. Subsequently, the number of pending homeless claims and the average days to process them decreased.

Honolulu's procedure to identify a homeless veteran and provide expedited claims processing did not always comply with VBA policy. VBA policy considers veterans homeless if they stay at shelters subsidized by the Department of Housing and Urban Development and VA's Supportive Housing program. The VARO's local procedure dictated that staff should not consider veterans homeless if they pay for lodging at shelters that provide discounted apartments, regardless of whether the shelters are subsidized.

For example, a veteran filed a claim for disability compensation and reported his homeless status to the VARO. Management made the determination the veteran was not homeless because he resided at a Hoptel. A Hoptel is a facility that provides temporary lodging for homeless individuals recovering from surgery. This veteran's pending claim did not receive expedited processing because management incorrectly determined the veteran was not homeless.

In addition, the local VAMC's Homeless Veterans Outreach Coordinator (HVOC) provided us a list of 26 homeless veterans residing in locations within the VARO's jurisdiction. At the time of our inspection, 15 (58 percent) of the 26 veterans had disability claims pending at the VARO. The VARO did not identify 12 of those 15 as homeless; 10 of the claims revealed the veterans' addresses were a Post Office Box for a local homeless veterans facility. A review of the VARO's electronic record showed that some of the veterans had previously been identified as homeless

by VARO staff. However, VARO staff used their locally created procedure and incorrectly determined the veterans were not homeless. Therefore, their claims did not receive expedited processing, as required.

Recommendation

6. We recommend the Honolulu VA Regional Office Director develop and implement a plan to ensure Veterans Service Center staff follow the Veterans Benefits Administration policy for identifying and expediting claims for homeless veterans.

Management Comments

The VARO Director concurred with our recommendation and developed a Homeless Veterans Standard Operating Procedure for VARO staff to follow. Further, management provided the VARO Homeless Veterans Coordinator with the Benefit Assistance Service and VA Medical Center definition of what constitutes a homeless veteran as it relates to performing outreach activities.

OIG Response

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

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.

Finding 7 Controls Over Outreach to Homeless Veterans Need Improvement

The Honolulu VARO's outreach to homeless shelters and service providers was not always effective. This occurred because VARO management did not provide effective oversight of outreach efforts. Further, the HVOC was not aware of the responsibilities associated with this position. As a result, VARO management had no assurance that all homeless shelters and service providers were aware of available VA benefits and services.

VARO management did not always update its resource directory of homeless shelters and service providers as required by VBA policy. The VSC provided us with a directory that contained contact information for 24 homeless shelters and service providers within the VARO's jurisdiction. We contacted representatives at 13 (54 percent) of the 24 facilities. While four facilities confirmed the VARO provided information on VA benefits and services, nine reported not having any contact with the VARO.

Management informed us that staff last updated the directory in November 2011. However, two of the facilities listed in the directory closed in February 2011.

Management did not check the resource directory to ensure it contained accurate contact information. Neither management nor the HVOC contacted facilities in the resource directory to determine if they were aware of VA benefits and services available to homeless veterans. A supervisor informed us that VARO staff visited some of the homeless shelters and service providers located on several of the Hawaiian Islands. However, VARO staff never considered the option to mail information to these facilities.

VBA published guidance for the HVOC position in September 2002. Although the Honolulu VARO is not required to have a full-time HVOC, in November 2011, the VARO Director assigned this responsibility to one employee who had previously performed these duties on a part-time basis. The Honolulu HVOC informed us, and we confirmed, he was not fully aware of the responsibilities of the position.

The VARO Director held monthly meetings with the HVOC, but was unaware that the resource directory was outdated or that facilities listed in it had not received information to assist homeless veterans. As a result, VARO management lacked assurance that homeless shelters and service providers under its jurisdiction received information regarding VA benefits and services available to homeless veterans.

Recommendation

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

Management Comments

The VARO Director concurred with our recommendation. In addition to updating the homeless shelter resource directory, the Director informed us the Homeless Veterans Coordinator would contact each homeless shelter quarterly via telephone to ensure the directory remains current. The coordinator will conduct additional outreach by mailing letters to each shelter listed on the directory.

OIG Response

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

Appendix A VARO Profile and Scope of Inspection

Organization

The Honolulu VARO administers a variety of services and benefits, including compensation; vocational rehabilitation and employment; home loan guaranty; and outreach to homeless, elderly, minority, and women veterans.

Resources

As of December 2011, the Honolulu VARO had a staffing level of 83.5 full-time equivalent employees. Of these, 64 (77 percent) were assigned to the VSC.

Workload

As of October 2011, the VARO reported 4,769 pending compensation claims. The average time to complete claims was 216.1 days—13.9 days better than the national target of 230 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 32 (23 percent) of 140 TBI and herbicide exposure-related disability claims completed from July through September 2011. For temporary 100 percent disability evaluations, we selected 30 (38 percent) of 79 existing claims from VBA's Corporate Database. We provided VARO officials with 49 claims remaining from our universe of 79 for their review. These 49 claims represented all instances where VARO staff had granted temporary 100 percent disability evaluations for at least 18 months as of September 21, 2011.

We reviewed 30 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 review rating decisions and awards processing involving temporary 100 percent disability evaluations. Additionally, we reviewed the 11 mandatory SAOs completed in FY 2011.

We reviewed selected mail in various processing stages in the mailroom and throughout the VSC. We reviewed 26 Gulf War veterans' claims that VARO staff completed from July through September 2011. We reviewed

10 homeless veterans' claims pending at the time of our inspection. Further, 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: March 8, 2012

From: Director, Honolulu VA Regional Office (459/00)

Subj: Inspection of the VA Regional Office, Honolulu, Hawaii

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

1. The following is submitted in response to the Office of Inspector General (OIG), Benefits Inspection Division (BID) Draft Report.

2. The Honolulu Regional Office (RO) concurs with all the recommendations made by the OIG BID. We appreciate the recommendations and assistance from OIG BID.

3. Questions may be referred to Tracey Betts, Director, Honolulu Regional Office, 808-433-0106.

(original signed by:)

Tracey A. Betts

Director

Attachment

Honolulu Regional Office
Response to Office of Inspector General, Benefits Inspection Division

Recommendation 1: We recommend the Honolulu VA Regional Office Director develop and implement a plan for staff to address all required elements of Systematic Analyses of Operations and complete them in accordance with the annual schedule.

RO Response: Concur

The Director's Office has implemented a SAO Circular detailing the responsibilities of the divisions. Internal controls have been established to ensure that SAO's are completed and submitted to the Director's Office in a timely fashion. In addition, SAO training will be provided on March 22, 2012 to all personnel who prepare or assist in the preparation of SAO's in regards to timeliness and content.

Recommendation 2: We recommend the Honolulu VA Regional Office Director develop a plan to ensure staff is notified when mail arrives in the VA Medical Center and that mail is properly date-stamped with the date received at any VA facility.

RO Response: Concur

As a tenant of the VA Medical Center, the RO receives mail from the hospital's central mailroom. At this time, the VA Medical Center (VAMC) mailroom employees do not date stamp the Honolulu Regional Office's mail. The VAMC's delivery schedule is to deliver the RO mail by 8 a.m. the morning after receipt in their mailroom. The Honolulu RO will work with the VA Medical Center to determine the best practice to ensure that the mail is date stamped on the day of delivery. Possible solutions are to provide an RO employee to date stamp all mail in the mailroom on the date of delivery to the facility or, to have the VAMC mailroom deliver mail to the RO on the date of delivery to the facility.

Recommendation 3: We recommend the Honolulu VA Regional Office Director amend the Workload Management Plan to establish clear guidance for processing search and drop mail.

RO Response: Concur

All search mail will be scanned and uploaded into Virtual VA. The Control of Veterans Records System will be updated to reflect, "search mail" with an annotation that the "search mail" is located in Virtual VA. The Triage Standard Operating Procedures will be updated to reflect this change. In addition, VSC will issue an all employee memo to implement this change by March 19, 2012.

Recommendation 4: We recommend the Honolulu VA Regional Office Director amend the Workload Management Plan to incorporate guidance for supervisors to monitor processes associated with search and drop mail.

RO Response: Concur

The Workload Management Plan is currently being revised and will be completed by April 30, 2012. The revised Workload Management Plan will incorporate the new process of scanning search mail into Virtual VA. The file clerks have been assigned terminal digits to manage the file activity. Therefore, the workload management plan will incorporate a timeliness measure for drop file mail of one business day. The supervisor will be responsible to do a spot check of the drop file mail slots to verify timeliness is being met.

Recommendation 5: We recommend the Honolulu VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives correctly address and consider Gulf War veterans' entitlement to mental health treatment.

RO Response: Concur

The Honolulu Regional Office conducted classroom training on December 15, 2011 to address this issue. The Rating Veterans Service Representatives are required to use a rating checklist, which will prompt the Rating Veterans Service Representatives to address this entitlement to mental health treatment. In addition, the newly implemented Quality Review Specialists Team, during their review, will ensure that Veterans receive a decision regarding their entitlement to mental health treatment.

Recommendation 6: We recommend the Honolulu VA Regional Office Director develop and implement a plan to ensure Veterans Service Center staff follow the Veterans Benefits Administration policy for identifying and expediting claims for homeless veterans.

RO Response: Concur

The Honolulu Regional Office Homeless Veterans Coordinator has been provided with the Benefit Assistance Service and the VA Medical Center definition of a homeless Veteran. A Homeless Veteran Standard Operating Procedure has been developed for the Homeless Veterans Coordinator and Regional Office employees to follow.

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

RO Response: Concur

The Honolulu Regional Office Homeless Veteran Standard Operating Procedure reflects an updated homeless resource directory. In addition, the Homeless Veterans Coordinator will contact each homeless shelter via phone and follow-up with a letter providing his contact information by March 30, 2012. Quarterly contact will be made with each the homeless shelters.

Appendix C Inspection Summary

Eight Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Claims Processing			
1. Temporary 100 Percent Disability Evaluations	**Determine whether VARO staff properly processed 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 VARO 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 connection for herbicide exposure-related disabilities.** (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 addressed Gulf War veterans' 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)		X
Public Contact			
8. Homeless Veterans Outreach 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, 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.
Acknowledgments	Brent Arronte, Director Kristine Abramo Nelvy Viguera Butler Robert Campbell Madeline Cantu Danny Clay Michelle Elliott Lee Giesbrecht Kerri Leggiero-Yglesias Brandi Traylor Lisa Van Haeren

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