VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Baltimore, Maryland

April 11, 2013
12-04179-167

ACRONYMS AND ABBREVIATIONS

HVOC	Homeless Veterans Outreach Coordinator
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
TBI	Traumatic Brain Injury
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of VA Regional Office Baltimore, MD

Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and one Veterans Service Center nationwide that process disability claims and provide a range of services to veterans. We evaluated the Baltimore VARO to see how well it accomplishes this mission.

What We Found

Overall, VARO staff did not accurately process 28 (68 percent) of 41 disability claims we reviewed. We sampled claims that we consider to be at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Claims processing that lacks compliance with VBA procedures can result in the risk of paying inaccurate and unnecessary financial benefits.

Specifically, 83 percent of the 30 temporary 100 percent disability evaluations we reviewed were inaccurate. The primary reason was a lack of management oversight to ensure staff took timely actions to schedule future medical reexaminations when alerted to do so. VARO staff inaccurately processed 3 of 11 traumatic brain injury claims when they did not follow VBA's policy for second signature reviews.

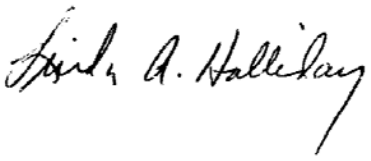
VARO staff did not always timely complete Systematic Analyses of Operations or address Gulf War veterans' entitlement to mental health treatment. Further, VARO staff did not conduct homeless veterans outreach activities as required.

What We Recommend

We recommended the VARO Director implement a plan to ensure scheduling of medical examinations to support temporary 100 percent disability reevaluations. Further, management should ensure staff follow VBA's second signature review requirements for traumatic brain injury claims. The Director needs to implement plans to ensure managers timely complete Systematic Analyses of Operations and accomplish all required homeless veterans outreach activities.

Agency Comments

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



LINDA A. HALLIDAY
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objective

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

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

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

Scope of Inspection

In October 2012, we inspected the Baltimore VARO. The inspection focused on four protocol areas examining five operational activities. The four protocol areas were disability claims processing, management controls, eligibility determinations, and public contact.

We reviewed 30 (6 percent) of 508 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months. This is generally the longest period a temporary 100 percent disability evaluation may be assigned without review, according to Veterans Benefits Administration (VBA) policy. We examined all 11 disability claims related to traumatic brain injury (TBI) that were available, and that VARO staff had completed, from April through June 2012.

Other Information

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

RESULTS AND RECOMMENDATIONS

I. Disability Claims Processing

The OIG Benefits Inspection team focused on accuracy in processing claims related to temporary 100 percent disability evaluations and TBI. We evaluated these claims processing issues and assessed their impact on veterans' benefits.

Finding 1 Baltimore VARO Could Improve Disability Claims Processing Accuracy

Claims Processing Accuracy

The Baltimore VARO did not consistently process temporary 100 percent disability evaluations and TBI cases accurately. Overall, VARO staff incorrectly processed 28 of the total 41 disability claims we sampled resulting in 65 improper monthly payments to 5 veterans totaling $79,911.

We sampled claims related only to specific conditions that we considered at higher risk of processing errors. As a result, the errors identified do not represent the universe of disability claims processed at this VARO. As reported by VBA's Systematic Technical Accuracy Review program as of September 2012, the overall accuracy of the VARO's compensation rating-related decisions was 74.4 percent—12.6 percentage points below VBA's target of 87 percent.

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

Table 1

Baltimore VARO Disability Claims Processing Accuracy				
Type of Claim	**Reviewed**	**Claims Inaccurately Processed**		
		Affecting Veterans' Benefits	**Potential To Affect Veterans' Benefits**	**Total**
Temporary 100 Percent Disability Evaluations	30	5	20	25
Traumatic Brain Injury Claims	11	0	3	3
Total	**41**	**5**	**23**	**28**

Source: VA OIG analysis of VBA's temporary 100 percent disability evaluations paid at least 18 months or longer and TBI disability claims completed during third quarter FY 2012

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 25 of 30 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a service-connected disability following a veteran's 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.

Without effective management of these temporary ratings, VBA is at risk of paying inaccurate financial benefits. Available medical evidence showed 5 of the 25 processing errors we identified affected veterans' benefits and resulted in 65 improper payments to the 5 veterans totaling $79,911 from April 2010 until the time of our inspection. Details on the improper payments follow.

- In two cases, VARO staff failed to act upon reminder notifications and did not schedule medical reexaminations of the veterans' cancer conditions. As a result, VA continued processing monthly benefits and ultimately overpaid these veterans a total of $39,992.
- For two veterans, VARO staff did not take final action to reduce benefits after informing them of proposed reductions based on medical evidence showing their disabilities no longer warranted the previously assigned 100 percent disability evaluations. As a result, VA continued processing monthly benefits at incorrect amounts and ultimately overpaid these veterans a total of $30,209.
- A Rating Veterans Service Representative (RVSR) did not grant a veteran entitlement to an additional special monthly benefit as required, based on evaluations of multiple disabilities. As a result, VA continued processing monthly benefits and ultimately underpaid the veteran $9,710 over a period of 30 months. This is the only underpayment identified within the sample of claims we reviewed.

The remaining 20 of the total 25 errors had the potential to affect veterans' benefits. We could not determine whether the evaluations would have continued because the veterans' claims folders did not contain the medical examination reports needed to evaluate each case. Where examination reports were available, we determined errors involved VSC staff not scheduling routine future medical reexaminations as required. In cases where routine future medical reexaminations were not scheduled as required, claims processing delays ranged from 7 months to 10 years and 7 months. An average of 2 years and 3 months elapsed from the time staff should have scheduled these medical examinations until the date of our inspection.

The most frequent processing inaccuracies in 9 of the 25 errors were due to a lack of management oversight to ensure staff took timely action to schedule medical reexaminations upon receipt of the system-generated reminder

notifications. We discovered the Baltimore VARO had 1,587 of these reminder notifications pending at the time of our inspection. On average, the reminder notifications had been pending 1 year and 2 months, and ranged from just over a month to 3 years and 10 months.

According to VBA policy, VARO staff have 30 days to process reminder notifications. Further, the Baltimore VARO had a local policy that required staff to review these reminder notifications on a weekly basis. However, there were no procedural requirements in place for managers to monitor and ensure staff took appropriate follow-up actions to schedule the medical reexaminations as required. Both VARO staff and managers stated they were not reviewing these reminder notifications.

VARO management cited an emphasis on processing rating-related compensation claims over all other types of claims at the VARO as the reason these reminder notifications did not receive timely action. Where the required reexaminations were not ordered, veterans may be at increased risk of receiving inaccurate benefits payments.

Actions Taken in Response to Prior Audit Report

In response to a recommendation in our national report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), the then 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. Our report stated, "If VBA does not take timely corrective action, they will overpay veterans a projected $1.1 billion over the next 5 years." The then Acting Under Secretary for Benefits stated in response to our audit report that the target completion date for the national review would be September 30, 2011.

VBA did not provide each VARO with a list of temporary 100 percent disability evaluations for review until September 2011. VBA subsequently extended the national review deadline to December 31, 2011, and then again to June 30, 2012. At the time of our inspection, VBA was working to complete this national review requirement, but extended the deadline again to December 31, 2012. We are concerned about the lack of urgency in completing this review, which is critical to minimize the financial risks of making inaccurate benefits payments.

During our 2012 inspection, we followed up on VBA's national review of its temporary 100 percent disability evaluation processing. We sampled 40 cases from the lists of cases needing corrective actions that VBA had provided to the Baltimore VARO for review. We determined VARO staff accurately reported actions, such as inputting suspense diaries or taking actions to schedule reexaminations, on all 40 cases reviewed.

However, in comparing VBA's national review lists with our data on temporary 100 percent disability evaluations, we found five cases involving

prostate cancer that VBA had not identified. We could not determine why VBA did not identify these cases; however, we will continue monitoring this situation as VBA works to complete its national review. In the interim, we provided VARO management with 478 claims remaining from our universe of 508 claims for its review. Management planned to determine if those claims folders contained errors similar to the ones we identified during our inspection.

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.

In response to a recommendation in our annual report, *Systemic Issues Reported During Inspections at VA Regional Offices* (Report No. 11-00510-167, May 18, 2011), VBA agreed to develop and implement a strategy for ensuring the accuracy of TBI claims decisions. In May 2011, the Under Secretary for Benefits provided guidance to VARO Directors to implement a policy requiring a second signature on each TBI case an RVSR evaluates until the RVSR demonstrates 90 percent accuracy in TBI claims processing. The policy indicates second signature reviewers come from the same pool of staff as those used to conduct local station quality reviews.

We determined VARO staff incorrectly processed 3 of the 11 TBI claims we reviewed—none of these processing errors affected veterans' benefits. Generally, the errors occurred because the VARO lacked adequate oversight and supervisory review to ensure VSC staff complied with VBA's policy to have an additional level of review for TBI claims.

The reviewers might have identified the errors and corrected them before issuing final decisions, had these cases undergone the second level review. VARO managers agreed the policy of staff self-identifying that they had TBI claims for second signature review was not effective. Managers also stated that none of the RVSRs in the VSC had met the criteria to evaluate TBI claims independently. Because of these deficiencies, veterans may be at increased risk of not receiving correct disability evaluations.

Follow Up to VA OIG Inspection

Our prior report, *Inspection of the VA Regional Office, Baltimore,* (Report No. 09-01993-29, November 19, 2009), stated TBI processing errors occurred because of a lack of internal quality assurance reviews and inexperienced RVSR staff. We recommended the Baltimore VARO Director develop and implement a mechanism to improve oversight of the quality assurance process and ensure the correct procedures for processing TBI claims are followed. The OIG closed this recommendation in December 2009.

Although a Quality Review Team is now in place and RVSRs have received refresher training in this area since our last inspection, VARO managers have not provided oversight to ensure claims with TBI-related issues undergo the required secondary review and veterans receive accurate disability evaluations.

Recommendations

1. We recommended the Baltimore VA Regional Office Director develop and implement a plan to ensure staff review all existing reminder notifications and schedule medical reexaminations as required.
2. We recommended the Baltimore VA Regional Office Director develop and implement a plan to ensure that for the future, staff routinely review reminder notifications and timely schedule medical reexaminations as required.
3. We recommended the Baltimore VA Regional Office Director conduct a review of the 478 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.
4. We recommended the Baltimore VA Regional Office Director develop and implement a plan to ensure compliance with the Veterans Benefits Administration's second signature requirements for traumatic brain injury claims.

Management Comments

The VARO Director concurred with our recommendations. In November 2012, VARO staff received additional training on processing reminder notifications and scheduling medical reexaminations. Staff processed pending actions on 1,448 temporary 100 percent disability evaluations in January 2013. Rating decisions were completed to establish disabilities as permanently disabling or review examinations were requested. The 478 temporary 100 percent disability evaluations identified in the OIG's universe were included in the 1,448 cases reviewed; 215 cases are pending review.

As part of its organizational transformation, management created a non-rating team to ensure oversight of 800 series work items, including establishing reminder notifications to schedule medical reexaminations for claims pending review. VSC managers will provide monthly reports to the Director indicating the number and timeliness of these pending reviews.

VARO staff received training on workload management in March 2013. Work is underway to develop more in-depth training on VBA's second signature review process for traumatic brain injury claims. Management plans to revise the VARO's second signature policy to include timely feedback for staff processing TBI claims. Managers will also begin monthly reporting to the Director on the results of TBI disability claim reviews. Further, in April 2013, VARO staff will undergo Station Enrichment

Training, which includes additional TBI training for RVSRs assigned to the Special Operations Lane.

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

II. Management Controls

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 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. The VSC Manager is responsible for ongoing analysis of VSC operations, including completing 11 SAOs annually.

Finding 2 Oversight Needed To Ensure Timely and Complete Systematic Analyses of Operations

All SAOs used sufficient data for analysis; however, 7 of the 11 SAOs were untimely or incomplete (missing required elements). VARO management did not provide adequate oversight to ensure VSC staff completed the SAOs in accordance with VBA policy. As a result, management may not have adequately identified existing and potential problems for corrective action to improve VSC operations.

The Quality of Files SAO dated April 6, 2012, identified the lack of a file sequence schedule, but did not recommend one be created. The SAO noted staff last completed a file sequence check in August 2010. VBA policy states VARO management will establish a schedule to ensure the checking of all file banks at least once a year and that staff are to conduct some sequence checking on a daily basis. It further states proper and continual sequence checking improves the control of veteran's records.

Follow Up to VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Baltimore, MD* (Report No. 09-01993-29, November 19, 2009), we identified a lack of management oversight that resulted in all SAOs being either incomplete, and/or untimely. We recommended the Baltimore VARO Director develop and implement a mechanism to ensure VSC managers perform complete accurate and timely SAOs, and take appropriate corrective action to fix the problems identified. The VARO Director concurred with the recommendation and stated the VSC manager developed an SAO completion schedule for the management team, and all SAOs identified as incomplete had been completed. The OIG closed this recommendation in December 2009.

During our October 2012 inspection, we found the VARO was using an SAO completion schedule that listed each SAO, applicable criteria, the personnel assigned to complete the SAO, and the due date. However, there was

insufficient oversight to ensure staff submitted SAOs timely and completed them in accordance with VBA policy. VSC staff sent follow-up reminders to those assigned to SAOs with maturing or past due dates. However, there was no consistent method to monitor SAO completion as these reminders were sent whenever there was time, rather than according to the SAO due dates. Additionally, VSC managers did not record the dates they received SAOs and therefore were not measuring SAO timeliness. The VSC manager agreed the current method of monitoring SAO timeliness was insufficient and cited frequent changes in management positions as a contributing factor to untimely SAOs. VSC staff and management assigned to review SAOs for completeness felt their lack of oversight resulted in staff not always addressing required sub-topics.

Recommendation

5. We recommended the Baltimore VA Regional Office Director develop and implement a plan to ensure staff timely address all required elements of Systematic Analyses of Operations.

Management Comments

The VARO Director concurred with our recommendation. Managers are developing operating procedures to ensure staff submit timely and complete SAOs. The operating procedures will include a specific timeline and identification of staff responsible for completing each SAO. Division level managers also provide monthly updates to the Director on the status of recommendations made in prior SAOs.

OIG Response

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

III. Eligibility Determinations

Entitlement to Medical 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 mental health treatment when denying 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 condition is not part of the current claim.

Finding 3 Gulf War Veterans Did Not Always Receive Entitlement Decisions for Mental Health Treatment

VARO staff did not properly address whether 13 of 22 Gulf War veterans were entitled to receive treatment for mental disorders. These inaccuracies generally occurred because VSC staff overlooked reminder notifications to consider entitlement to mental health treatment. As a result, these 13 veterans may be unaware of their possible entitlement to treatment for mental disorders and may not get the care they need. Following are summaries of the 13 errors observed:

- Eight errors occurred when RVSRs did not address veterans' entitlement to mental health treatment in current disability decisions, in spite of pop-up notifications reminding them to do so.
- In five cases, errors occurred when RVSRs did not address veterans' treatment for mental disorders on current decisions after previous decisions also did not address the issue. Most of these errors occurred prior to February 2011—the date VBA modified its system to generate reminders for RVSRs to consider this entitlement.

The VSC provided training sessions on this topic in January, February, and April 2012. RVSRs we interviewed were able to explain the correct process for addressing Gulf War veterans' entitlement to mental health care.

The majority of RVSRs and managers we interviewed thought the pop-up notification was not effective because it was easy to ignore. RVSRs cited production pressures as the reason staff overlooked the generated reminder, but management disagreed and felt any production pressure was self-imposed.

In December 2012, VBA modified its policy requiring that RVSR staff address entitlement to health care treatment in all cases involving Gulf War veterans. Because the policy change became effective after we concluded our inspection of the Baltimore VARO, we cannot speculate whether the change would have affected the number of errors we identified. Therefore, we make no recommendation for improvement.

IV. Public Contact

Outreach to Homeless Veterans

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.

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, directs that coordinators at the remaining 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 4 Oversight of the Homeless Veterans Outreach Program Needs Improvement

The VARO's Homeless Veterans Outreach Coordinator (HVOC) had not conducted the required outreach activities. This occurred because VARO management did not place emphasis on homeless veterans outreach activities. As a result, VARO management had no assurance that homeless shelters and service providers were aware of available VA benefits and services when assisting homeless veterans.

The VARO has a part-time HVOC in place to conduct homeless veteran outreach. However, the assigned staff had not performed the required outreach duties. Staff had not created a resource directory of shelters, homeless day-care facilities, or homeless service providers; contacted local shelters or providers; or provided community homeless facilities with information or training on VA benefits and services. Additionally, the staff did not maintain liaisons with the VA Medical Center HVOCs within their jurisdiction as required.

The VSC manager informed us that he placed emphasis on processing homeless veterans' pending claims and not on ensuring staff conducted the required homeless veterans outreach activities. Had VARO managers established oversight measures to assess the effectiveness of outreach, they may have determined that homeless shelters and service providers under their jurisdiction had not been contacted or received information regarding VA benefits and services available for homeless veterans. Additionally, VBA needs a performance measurement to assess the effectiveness of its homeless veterans outreach efforts.

Recommendation

6. We recommended the Baltimore VA Regional Office Director develop and implement a plan outlining how Veterans Service Center staff will accomplish all required homeless veterans outreach services, including creating a resource directory and regularly contacting homeless shelters and service providers.

Management Comments

The VARO Director concurred with our recommendation. VARO staff are creating a comprehensive listing of homeless services available throughout the State of Maryland, as well as a schedule to ensure regular visits to homeless shelters. VARO staff are also working to increase collaboration with VA medical center staff involved in homeless veterans outreach. In June 2013, the Director will receive the first monthly report describing staff outreach activities during the prior month.

OIG Response

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

Appendix A VARO Profile and Scope of Inspection

Organization

The Baltimore VARO administers a variety of services and benefits, including compensation and pension benefits; vocational rehabilitation and employment assistance; specially adapted housing grants; benefits counseling; and outreach to homeless, elderly, minority, and women veterans.

Resources

As of September 2012, the Baltimore VARO had a staffing level of 169.1 full-time employees. Of this total, the VSC had 143.4 employees assigned.

Workload

As of September 2012, the VARO reported 19,200 pending compensation claims. The average time to complete claims was 342.8 days—112.8 days more than the national target of 230.

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 30 (6 percent) of 508 temporary 100 percent disability evaluations selected from VBA's Corporate Database. These claims represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months as of August 22, 2012. We provided VARO management with 478 claims remaining from our universe of 508 for its review. As follow-up to our prior inspection, we sampled 40 temporary 100 percent disability evaluations from the SharePoint list VBA provided to the VARO as part of its national review.

We reviewed all 11 TBI-related disability claims that the VARO completed from April through June 2012. Where we identify potential procedural inaccuracies, this information is provided to help the VARO understand the procedural improvements it can make for enhanced stewardship of financial benefits. This information is not provided to require the VAROs to adjust specific veterans' benefits. Processing any adjustments per this review is clearly a VBA program management decision.

We assessed the 11 mandatory SAOs completed in Fiscal Year 2012. We examined 22 completed claims processed for Gulf War veterans from April through June 2012 to determine whether VSC staff addressed entitlement to mental health treatment in the rating decision documents as required. Further, we assessed the effectiveness of the VARO's homeless veterans outreach program.

Data Reliability

We used computer-processed data from the Veterans Service Network's Operations Reports and Awards. To test for reliability, we reviewed the data to determine whether any data were missing from key fields, contained data outside of the timeframe requested, included any calculation errors, contained obvious duplication of records, contained alphabetic or numeric characters in incorrect fields, or contained illogical relationships among data elements. Further, we compared veterans' names, file numbers, Social Security numbers, VARO numbers, dates of claim, and decision dates as provided in the data received with information contained in the claims folders we reviewed.

Our testing of the data disclosed that they were sufficiently reliable to meet our inspection objectives. Our comparison of the data with information contained in the veterans' claims folders at VARO Baltimore did not disclose any problems with data reliability.

Inspection Standards

We conducted this inspection 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 inspection to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our inspection objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our inspection objectives.

Appendix B Inspection Summary

Table 2 reflects the operational activities inspected, applicable criteria, and whether or not we had reasonable assurance of VARO compliance.

Table 2. Baltimore VARO Inspection Summary

Five Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Disability 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) (M21-1 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 of in-service TBI.** (FL 08-34 and FL 08-36) (Training Letter 09-01)		X
Management Controls			
3. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)		X
Eligibility Determinations			
4. Gulf War Veterans' Entitlement to Mental Health	**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) (FL 08-15) (38 CFR 3.384) (38 CFR 3.2)		X
Public Contact			
5. Homeless Veterans Outreach Program	**Determine whether VARO staff provided effective outreach services.** (Public Law 107-05) (VBA Letter 20-02-34) (VBA Circular 27-91-4) (FL 10-11) (M21-1, Part VII, Chapter 6)		X

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

Appendix C VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: March 22, 2013

From: Director, VA Regional Office Baltimore, Maryland

Subj: Inspection of the VA Regional Office, Baltimore, Maryland

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

1. The Baltimore VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office, Baltimore, Maryland.*

2. Please refer questions to me at 410-230-4510.

(original signed by:)
Michael A. Scheibel

Attachment

Attachment

1. Disability Claims Processing

Recommendation 1: We recommend the Baltimore VA Regional Office Director develop and implement a plan to ensure staff review all existing reminder notifications and schedule medical reexaminations as required.

Director Response: Concur

In November 2012, training was provided to the Veterans Service Representatives (VSR) and Rating Veterans Service Representatives (RVSR) on how to process the notifications and scheduling of medical examinations related to permanent and total ratings. As part of this training, there was increased focus on identifying, reviewing, and implementing future medical reexaminations.

During January 2013, 1,448 temporary 100% claims pending action were reviewed and processed. As needed, rating decisions were completed to implement permanent and total status for a disability or requested the necessary review examination. There are 215 cases remaining to be completed.

In April 2013, the entire Baltimore Veterans Service Center (VSC) will undergo Station Enrichment Training (SET). Following this training, the management staff of VSC will develop a Standard Operating Procedure (SOP) and will be required to provide monthly reports, due by the 5th workday of each month, as to the number and timeliness of these pending reviews. The first report will be due June 5, 2013.

Recommendation 2: We recommend the Baltimore VA Regional Office Director develop and implement a plan to ensure that for the future, staff routinely review reminder notifications and timely schedule medical reexaminations as required.

Director Response: Concur

The Baltimore RO moved into the Transformation Organizational Model in December 2012. At that time, a team was created to focus on Non-Rating claims. This team also has oversight of the 800 Series Work Items, including 810 work items pertaining to reminder notifications for future medical examinations. The Coach of this team has oversight of these work Items, and responsibility to ensure that future reminder notifications and timely scheduling of medical reexaminations is completed as required.

In April 2013, the entire Baltimore Veterans Service Center (VSC) will undergo Station Enrichment Training (SET). Following this training, the management staff of VSC will develop a Standard Operating Procedure (SOP) and will be required to provide monthly reports, due by the 5th workday of each month, as to the number and timeliness of these pending reviews. The first report will be due June 5, 2013.

Recommendation 3: We recommend the Baltimore VA Regional Office Director conduct a review of the 478 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.

Director Response: Concur

The VSC incorporated this list of 478 cases into the remaining cases reviewed for the temporary 100 percent project. In January 2013, 1,448 of these cases were reviewed and processed. As needed, rating decisions were completed to implement permanent and total status for a disability or requested the necessary review examination. There are 215 cases remaining to be completed. We continue to track these cases as we work through VA examinations that were ordered in January and February of 2013.

Recommendation 4: We recommend the Baltimore VA Regional Office Director develop and implement a plan to ensure compliance with the Veterans Benefits Administration's second signature requirements for traumatic brain injury claims.

Director Response: Concur

In March 2013, a seasoned Veterans Service Center Manager (VSCM) from another station was detailed to the Baltimore RO to assist with workload management and training. As part of this detail, the VSCM is working with the VSC management staff to develop a more in-depth second signature review and training plan for traumatic brain injury (TBI) claims. This process will increase our employee knowledge base and ensure they are fully trained prior to release from second signature on TBI claims.

During SET in April 2013, the members of the Special Operations lane will receive targeted training on the handling of TBI claims. This will include a significant portion of time spent working with instructors and mentors to ensure that the training provided is being applied correctly. During SET, RVSRs will receive daily feedback on completed claims to reinforce training concepts.

Prior to completion of SET, a revised second signature review SOP will be developed by VSC management and will be implemented immediately following the completion of SET in May 2013. This will provide timely feedback on TBI claims to help reinforce training and ensure that VSC personnel are correctly processing these complex claims.

VSC management will be required to provide the Director monthly reports, due by the 5th workday of each month, as to the results of the previous month's TBI reviews. The first report will be due June 5, 2013.

2. Management Controls

Recommendation 5: We recommend the Baltimore VA Regional Office Director develop and implement a plan to ensure staff timely address all required elements of Systematic Analyses of Operations.

Director Response: Concur

The VSC is currently developing an SOP for the timely and thorough completion of all Systematic Analyses of Operations (SAO), with a completion date of April 8, 2013. The SOP will include specific timeline matrix and identification of personnel who will complete each SOP for the VSC.

VSC Division Level Management will conduct monthly reviews to ensure that SOPs are completed timely. These monthly reviews will include status updates on the recommendations cited in the previous SAO of the same subject.

The monthly reviews will begin in April 2013. The monthly review results will be provided to the Directors Office to ensure compliance no later than the first working day of the following month. The first report is due to the Director on May 1, 2013.

3. Eligibility Determinations

Recommendation: No recommendation for improvement noted

4. Public Contact

Recommendation 6: We recommend the Baltimore VA Regional Office Director develop and implement a plan outlining how Veterans Service Center staff will accomplish all required homeless veterans outreach services, including creating a resource directory and regularly contacting homeless shelters and service providers.

Director Response: Concur

In January 2013, the Regional Office Homeless Veteran Outreach Coordinator (RO HVOC) began coordination with VHA's VISN 5 Homeless Veterans Outreach Coordinator (HVOC). The RO HVOC represents the Baltimore RO by participating in regular calls with the VISN 5 HVOCs. This will ensure there is increased communication between the RO and VISN 5 HVOCs concerning Homeless Veterans issues. In addition, the ROHC has reached out to the Maryland Center for Veterans Education and Training (MCVETS). MCVETS is a non-profit organization established to provide homeless Veterans and other Veterans in need with comprehensive services that will enable them to rejoin their communities as productive citizens.

The RO HVOC is currently creating a comprehensive list of services available throughout the state of Maryland. The RO HOVC is creating a schedule to ensure regular visits to local homeless shelters and increasing our collaboration with VISN HVOCs.

In addition, the RO HVOC is working with Maryland Department of Veterans Affairs (MDVA) to establish regular visit to local prisons. These visits will help identify potential at-risk Veterans to determine what pre-emptive action can be taken to reduce homelessness when they are released and provide general information on the claims process or follow-up on claims in process. The VSC is also expanding our partnership with MDVA to become increasingly more involved in community outreach activities.

The VSCM will be required to provide to the Director monthly reports, due by the 5th workday of each month, describing the homeless outreach conducted by the RO HVOC. The report will include the location of the outreach, the number of homeless Veterans encountered, and the number of claims taken or reviewed during each outreach event. The first report will be due June 5, 2013.

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	Nora Stokes, Director Kristine Abramo Madeline Cantu Danny Clay Kelly Crawford Lee Giesbrecht Kerri Leggiero-Yglesias Suzanne Murray Nelvy Viguera Butler Mark Ward

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