VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Detroit, Michigan

January 11, 2013
12-03355-88

ACRONYMS AND ABBREVIATIONS

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
WMP	Workload Management Plan

Report Highlights: Inspection of the VA Regional Office, Detroit, Michigan

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 Detroit VARO accomplishes this mission.

What We Found

Overall, VARO staff did not accurately process 31 (52 percent) of 60 disability claims we reviewed. We sampled and reviewed claims we considered at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Where claims processing lacks compliance with VBA's procedures, VBA risks paying inaccurate and unnecessary financial benefits.

Specifically, 60 percent of the 30 temporary 100 percent disability evaluations we reviewed were inaccurate, generally because of a lack of training related to the process to control future medical reexaminations. Errors in processing 43 percent of 30 traumatic brain injury claims occurred primarily because staff used insufficient medical examination reports.

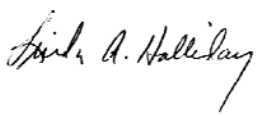
A lack of management oversight also caused delays in gathering related evidence and processing some of the oldest disability claims completed from January through March 2012. However, claims processing untimeliness was overstated because staff used incorrect claim dates, making some of the claims appear older. Even with the inaccurate dates, we still identified some significant claims processing delays. Managers did not ensure staff fully completed Systematic Analyses of Operations or addressed Gulf War veterans' entitlement to mental health treatment. Staff provided adequate outreach to homeless veterans; however, VBA needs a measure to assess its homeless outreach program.

What We Recommend

We recommend the VARO Director institute training and controls to ensure staff schedule future medical reexaminations for temporary 100 percent evaluations, return insufficient examination reports related to traumatic brain injury claims, and follow VBA policy on establishing dates of claim. The Director should also implement plans for managers to review claims pending over 6 months, ensure all elements of Systematic Analyses of Operations are addressed, and monitor effectiveness of training to ensure staff address Gulf War veterans' entitlement to mental health treatment.

Agency Comments

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



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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 August 2012, the OIG conducted an inspection of the Detroit VARO. The inspection focused on four protocol areas examining six operational activities. The four protocol areas were disability claims processing, management controls, eligibility determinations, and public contact.

We reviewed 30 (6 percent) of 541 disability claims 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 without review, according to Veterans Benefits Administration's (VBA) policy. We examined 30 (63 percent) of 48 disability claims related to traumatic brain injury (TBI) that VARO staff completed from January through March 2012. Also, we analyzed the 10 oldest completed claims available at the time of our inspection.

Appendix A provides details on the VARO and the scope of our inspection. Appendix B provides 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

Claims Processing Accuracy and Timeliness

The OIG Benefits Inspection team focused on accuracy in processing temporary 100 percent disability evaluations and TBI disability claims. We also assessed timeliness in processing the oldest completed disability claims at the VARO. We evaluated these claims processing issues and assessed their impact on veterans' benefits.

Finding 1 Detroit VARO Needs To Improve Disability Claims Processing Accuracy

Claims Processing Accuracy

The Detroit VARO did not always process temporary 100 percent disability evaluations and TBI cases accurately. VARO staff incorrectly processed 31 of the total 60 disability claims we sampled—staff overpaid a total of $231,436 and underpaid a total of $18,426. In total, we identified 6 improper payments.

We sampled claims related 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 June 2012, the overall accuracy of the VARO's compensation rating-related decisions was 77 percent—10 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 Detroit VARO.

Table 1

Detroit 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	13	18
Traumatic Brain Injury Claims	30	1	12	13
Total	**60**	**6**	**25**	**31**

Source: VA OIG analysis of VBA's temporary 100 percent disability evaluations paid 18 months or longer and TBI disability claims completed in the second quarter FY 2012.

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 18 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 required. At the end of a mandated period of convalescence or treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability evaluation.

For temporary 100 percent disability evaluations, including confirmed and continued evaluations where rating decisions do not change veterans' payment amounts, VSC staff must input suspense diaries in VBA's electronic system. A suspense diary is a processing command that establishes a date when VSC staff must schedule a reexamination. As a suspense diary matures, the electronic system generates a reminder notification to alert VSC staff to schedule the reexamination.

In 7 of the total 18 processing errors, VSC staff did not input suspense diaries or take appropriate action on reminder notifications to reexamine veterans for temporary 100 percent evaluations. These errors resulted from a lack of training on entering diaries in the electronic record and controlling future examinations. VSC officials reported they had not conducted training on entering diaries and controlling future examinations. The reasons for the remaining 11 errors varied, and we did not identify a common trend or pattern related to processing temporary 100 percent disability evaluations.

Without effective management of temporary 100 percent disability ratings, VBA is at increased risk of paying excessive and unnecessary financial benefits. Available medical evidence showed that 5 of the 18 processing errors affected veterans' benefits. These errors involved monthly payments for five veterans. Details on the processing procedure errors follow.

- A Rating Veterans Service Representative (RVSR) correctly assigned an evaluation of 100 percent for a veteran's kidney condition based on the need for hemodialysis; however, the RVSR did not annotate the need for a future examination as required. VA medical treatment records showed improvement in the veteran's condition following a kidney transplant, warranting a reduction in benefits as of October 1, 2001. As a result, VBA did not pay accurate monthly benefits to this veteran.
- In separate decisions, RVSRs did not grant a veteran entitlement to additional special monthly benefits based on evaluations of multiple disabilities and loss of use of a creative organ as required by VBA policy. As a result, VBA did not pay accurate monthly benefits to this veteran.

The remaining 13 errors in processing temporary 100 percent disability evaluations had the potential to affect veterans' benefits. Generally, these errors involved VSC staff not:

- Inputting suspense diaries as required
- Scheduling routine medical examinations as required, and,
- Considering entitlements to the additional benefit of Dependents' Education Assistance as required

In 4 of the 13 cases with the potential to affect veteran's benefits, medical reexaminations were required. An average of 2 years and 6 months elapsed from the time staff should have scheduled these medical examinations until the date of our inspection. The delays ranged from 5 months to 3 years and 9 months.

Follow Up To Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Detroit, Michigan* (Report No. 10-02079-226, August 19, 2010), we indicated errors in processing temporary 100 percent evaluations generally occurred because VSC staff did not properly record dates for future medical reexaminations in the electronic system as required. The Director of the Detroit VARO concurred with our recommendation to conduct a review of all temporary 100 percent evaluations under the regional office's jurisdiction to determine if reevaluations were required and take appropriate action. OIG closed this recommendation in January 2011 after VARO officials stated that a review had been conducted, and rating decisions or final actions were completed on all temporary 100 percent claims.

The Director of the Detroit VARO also concurred with our recommendation to develop and implement a plan to monitor compliance with the VARO's new policy on confirmed and continued decisions to ensure accurate processing of temporary 100 percent evaluations. OIG closed this recommendation in January 2011 after VARO officials stated VSC employees received training on inputting future diaries, system updates, and processing confirmed and continued decisions. In addition, VARO officials stated VSC management and staff would conduct additional levels of review of pending diaries beginning January 2011. However, there was turnover of VARO management following the prior OIG inspection, and current VSC managers stated they were not aware of this response to the OIG. Therefore, they did not implement this local policy for performing additional levels of review of pending diaries.

Actions Taken In Response To Prior Audit Report

We assessed whether VARO management accurately reported actions taken on temporary 100 percent disability claims identified by VBA. In response to a recommendation in our national report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), the Acting Under

Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each evaluation had a future examination date entered in the electronic record. 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.

However, 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. VBA was working to complete this national review requirement and extended the national review 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.

We determined VARO staff accurately reported actions taken on all 43 cases on its list of temporary 100 percent disability evaluations for review. Therefore, we made no recommendation for improvement in this area.

TBI Claims

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

VARO staff incorrectly processed 13 of 30 TBI claims—one of these processing errors affected a veteran's benefits. In this case, an RVSR did not establish a separate evaluation for TBI-related migraine headaches as required. As a result, VA underpaid the veteran $1,911 over a period of 7 months. Management agreed with our finding and began to correct the errors identified.

The remaining 12 processing errors had the potential to affect veterans' benefits. Generally, these errors involved VSC staff not:

- Returning inadequate VA medical examinations as required. Neither VARO staff nor we can ascertain all of the residual disabilities of TBI without an adequate or complete medical examination
- Properly granting or denying service connection for TBI

Interviews with management and staff revealed RVSRs and Decision Review Officers inappropriately used their own interpretations to decide TBI claims because they felt they had the authority to resolve ambiguities in VA

examination reports. As a result, veterans may not always receive correct benefit decisions.

Follow Up To VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Detroit, Michigan* (Report No. 10-02079-226, August 19, 2010), we identified 5 of 30 TBI processing errors attributed to lack of training. Two of the five errors were due to staff using inadequate VA medical examinations. Staff received training subsequent to our inspection and we could not assess the effectiveness of that training. Our current review shows staff continue to use inadequate VA medical examinations when making their decisions.

Recommendations

1. We recommend the Detroit VA Regional Office Director provide training and implement controls to ensure staff follow current Veterans Benefits Administration policy on scheduling medical reexaminations for temporary 100 percent evaluations.
2. We recommend the Detroit VA Regional Office Director develop and implement a plan to ensure staff return insufficient medical examination reports to health care facilities to obtain the required evidence needed to support traumatic brain injury claims rating decisions.

Management Comments

The VARO Director concurred with our recommendations. The Veterans Service Center provided updated training to both Veterans Service Representatives and RVSRs on scheduling medical examinations for temporary 100 percent disability evaluations. The training for VSRs was completed on September 19, 2012, and the training for RVSRs was completed on August 29, 2012. To ensure timely and consistent action, the VSC consolidated the responsibility for reviewing actions on system-generated work items under one Assistant Coach. The VSC also consolidated processing of TBI claims to a Special Operations Processing Lane within the VSC. TBI training was conducted for VSRs on August 22, 2012, and for RVSRs on December 5, 2012.

OIG Response

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

Claims Processing Timeliness

The OIG Benefits Inspection team focused on delays in processing the oldest completed disability claims at the VARO. We evaluated these claims processing delays and their impact on veterans' benefits.

Finding 2 Detroit VARO Needs To Improve Oversight To Ensure Timely Claims Processing

VBA policy requires VAROs to develop local processing timeliness goals within the Workload Management Plan (WMP) to meet VA's strategic target

of completing all claims within 125 days. Workload management is a coordinated system used to control how claims and other work move through VBA's adjudicative process.

The WMP should provide for timely review throughout claims processing, and prevent inefficient processing practices and delays. VBA has identified national average cycle times to measure performance at each phase of the claims process. Table 2 outlines the claims processing phases and associated performance measures.

Table 2

VBA's Claims Processing Phases and National Performance Measures		
Phases	**Definitions**	**Cycle Times**
Control Time	Time from date of claim receipt at the VARO until establishment in the electronic record	7 days
Waiting To Develop for Evidence	Time from the date a claim is established until staff initiate requests for evidence	20 days
Waiting for Receipt of Evidence	Time from initial requests for evidence until the claim is ready for a decision	83 days
Waiting for Claims Decision	Time from when a claim is ready for a decision until a decision is complete	15 days
Waiting for Award	Time from when a decision is complete until the award for payment is generated	5 days
Waiting for Award Authorization	Time from when an award for payment is generated until the award payment is authorized	2 days

Source: VBA's Office of Performance Analysis and Integrity as of August 2012.

VBA policy states higher-level management is responsible for reviewing cases pending longer than 6 months. In addition, VBA policy requires that VSC management conduct monthly reviews of all claims pending more than 1 year. If it is not feasible to personally review the claims, as an alternative, managers must review monthly reports prepared by designated staff.

We reviewed the 10 oldest disability claims completed from January through March 2012, available at the time of our inspection. According to the electronic record, VBA staff took 830 to 2,080 days to complete these claims, with an average of 1,097 days. We reviewed these cases to identify opportunities for the Detroit VARO to improve its local claims processing timeliness.

Three of the 10 oldest completed claims showed VSC staff used incorrect claim dates, causing the claims to appear older than their actual processing times. In one case, staff processed a claim in 486 days. However, because staff incorrectly entered an earlier claim date in the electronic record, the VARO mistakenly recorded the claim as taking 886 days to complete. As a

result, the VARO inaccurately measured actual claims processing timeliness. Even with the inaccurate dates, we still identified some significant claims processing delays. VSC management indicated staff lacked understanding of the proper procedures to establish dates of claim and would therefore receive training to address this issue.

VARO management lacked adequate controls to minimize avoidable delays in claims processing timeliness. As of June 2012, 11,068 (61 percent) of Detroit's 18,023 pending claims were over 125 days old. Our review of the VARO's 10 oldest completed cases showed significant delays in four phases of claims processing: control time, waiting to develop for evidence, waiting for receipt of evidence, and waiting for claims decision. These 10 claims took an average of 381 days to establish control, an average of 30 days to initiate development to obtain evidence, an average of 282 days to receive evidence, and an average of 39 days for a decision.

Generally, Detroit VARO delays in claims processing were due to inadequate management oversight and non-compliance with VBA policy. The following are examples of some of the more egregious delays caused by the Detroit VARO.

- On October 25, 2007, the VARO received a veteran's disability claim. However, the VSC staff did not take immediate action to address two new disabilities claimed on the VA form. In May 2008, the VARO temporarily transferred the veteran's claims folder to Washington, DC, where the claim remained undetected for approximately 3 years and 3 months until VA staff discovered and returned it to the VARO in September 2011. Nonetheless, VSC staff did not take action to establish control of the claim until December 1, 2011, or 1,498 days later. The national target for average control time is 7 days. This claim took 1,546 days to complete.
- On November 16, 2010, VA received a disability claim while another related claim for the veteran was pending. On December 15, 2010, VSC staff sent a letter to the veteran that failed to include two claimed disabilities as required. In May 2011, the Detroit VARO transferred the veteran's claims folder to another VARO, where it remained for approximately 3 months until it was returned in July 2011. VSC staff did not initiate development for this additional claim until August 10, 2011, 267 days later. The national target for average days waiting to develop evidence is 20 days. The veteran filed five separate claims that took a total of 837 days to complete.
- In December 2010, a veteran missed attending a scheduled VA medical examination, which was required to establish service connection for a claimed mental condition. On June 13, 2011, VSC staff received

evidence prompting a VA examination. However, staff did not order the examination until November 26, 2011, or 166 days later. The national target for average days awaiting receipt of evidence is 83 days. This claim took 486 days to complete.

- On March 10, 2011, VSC staff updated a claim as ready for decision in the electronic record. However, review of the Control of Veterans Records System (COVERS) indicated that VSC staff had misplaced the claims folder, causing a significant delay in claims processing. Staff did not complete a decision on this claim until January 31, 2012, or 327 days later. The national target for average days awaiting a claims decision is 15 days. This claim took 908 days to complete.

We also identified significant delays in claims processing that were outside Detroit VARO's control. VA OIG *Audit of Compensation Program Claims Brokering* (Report No. 09-03154-271, September 27, 2011), reported that a major challenge to VBA has been the processing of an increased number of veterans' compensation benefit claims. To address this challenge, VBA began forwarding claims from certain VAROs to 1 of 13 Day One Brokering Centers, or other VAROs, to better align workloads with staffing resources and help the staff meet their processing timeliness targets. Three of the 10 cases we reviewed were brokered during the claims processing period for various reasons. The following are examples of delays.

- In December 2010, VSC staff brokered a claim to another VARO in order to obtain a decision document. That VARO returned the claims folder to Detroit in January 2011 for additional development. Detroit staff brokered the claim a second time to the same VARO in March 2011. That VARO returned the claims folder to Detroit in June 2011 for additional development and the Detroit VARO took action to complete the claim. The total brokering time was approximately 136 days. Overall, this claim took 549 days to complete.

The following are examples of significant delays in claims processing that were outside of the Detroit VARO's control.

- On August 31, 2009, another VARO received a veteran's disability claim, but did not place the claim under control until January 23, 2012, 875 days later. The VARO transferred the claim to Detroit on January 24, 2012. Upon receipt of the claims folder, the Detroit VARO completed the claim in 19 days. Overall, this claim took 905 days to complete.
- On September 14, 2011, VSC staff requested a medical opinion from a VA Medical Center. The VA Medical Center mistakenly cancelled the request on October 7, 2011, and the VARO submitted a second request on November 29, 2011. The VA Medical Center's improper cancellation

of the VARO's initial request for a medical opinion added 68 days to the claim. Overall, this claim took 587 days to complete.

Although VBA policy stipulates that supervisors and managers review claims pending longer than 6 months and a member of division management personally review cases pending for more than a year, the Detroit VARO WMP does not require these reviews. Contrary to this policy, VARO management reported that old claims processing should not be part of the WMP because supervisors are closest to the work and know best how to direct workloads within their teams. Effective and timely review of these claims could have prevented unnecessary processing delays.

Recommendations

3. We recommend the Detroit VA Regional Office Director develop and implement a plan to ensure Veterans Service Center staff follow Veterans Benefits Administration policy on proper establishment of dates of claim.
4. We recommend the Detroit VA Regional Office Director amend the local Workload Management Plan to include specific requirements for management oversight and review to improve claims processing timeliness.

Management Comments

The VARO Director concurred with our recommendations. The VSC will continue to review date of claim accuracy during monthly local quality reviews, as well as during monthly Quality Review Team progress reviews for the Regional Office. The Intake Processing Team Supervisor also conducts random quality reviews of claims established by Claims Assistants throughout the month. Any deficiencies found will continue to be addressed in local training sessions. Intake Processing Center Team Supervisors will continue to conduct random quality reviews of established claims.

The Detroit VSC transitioned to the new VBA Organizational Model in November 2012. The VSC Leadership team is developing a new Workload Management Plan based on the model and recommendations from the OIG. Further, the VSC Management Team reviews the oldest claims in the workload on a regular basis. The VSC Management team regularly reviews the Veterans Operation Report lists of claims over 125 and 365 days old to ensure they receive proper attention from first line supervisors.

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 the analyses and recommendations identified within each SAO. An SAO is a formal analysis of an organizational element or operational function. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and to 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 3 Oversight Needed To Ensure Complete SAOs

Ten of 11 SAOs were incomplete (missing required elements). Seven of the 10 did not contain adequate data analysis. VARO management did not provide adequate oversight to ensure VSC staff completed the SAOs in accordance with VBA policy and did not have an effective mechanism in place to ensure SAOs were complete. As a result, VARO management may not have adequately identified existing and potential problems for corrective action to improve VSC operations.

Management did not ensure SAOs were complete, as required. Managers responsible for completing SAOs stated they were not provided instructions on what to include in their analyses. Current management staff stated prior management vacancies resulted in lack of guidance and expectations regarding SAOs.

To illustrate, one SAO regarding Quality of Compensation, Pension, and Ancillary Actions did not address all required areas for review. This SAO identified errors involving effective dates of claims, but did not provide a recommendation. We identified instances of incorrect effective dates during our review of temporary 100 percent disability evaluations and TBI claims. If VARO managers had provided a recommendation in the SAO, they may have implemented measures to ensure correct effective dates.

Recommendation

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

Management Comments

The VARO Director concurred with our recommendation. The VSC Manager conducted SAO training on December 4, 2012, for VSC management staff. The VSC will also provide a quarterly update to the Director's Office showing recommendations and status toward completing 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 care treatment when denying service connection for a mental disorder.

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

VARO staff did not properly address whether 8 of 11 Gulf War veterans were entitled to receive treatment for mental disorders. These inaccuracies occurred because VSC staff lacked understanding of VBA policy and overlooked reminder notifications to consider entitlement to mental health treatment. As a result, these eight veterans may be unaware of their possible entitlement to treatment for mental disorders and may not get the care they need.

VSC staff confirmed they did not always follow VBA policy to consider entitlement to mental health treatment when denying Gulf War veterans service connection for mental disorders. In July 2012, staff conducted training on mental health treatment for Gulf War veterans. VSC staff stated that despite this recent training, they still did not have a clear understanding of VBA policy and it was easy to bypass the reminder notifications.

Recommendation

6. We recommend the Detroit VA Regional Office Director develop and implement a plan to monitor the effectiveness of training to ensure staff follow current Veterans Benefits Administration policy regarding Gulf

War veterans' entitlement to mental health treatment when denying service connection for mental disorders.

Management Comments

The VARO Director concurred with our recommendation. In July 2012, RVSRs received training on the proper procedures related to processing entitlement decisions for Gulf War veterans. In addition, an email was sent to employees reinforcing this policy. Decisions regarding entitlement to mental health treatment for Gulf War veterans' are routinely reviewed for accuracy at both the local and National levels as part of a random review process. Errors found are shared with supervisors and individual employees on a monthly basis.

OIG Response

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

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, directed that coordinators at the remaining 37 VAROs be familiar with requirements for improving the effectiveness of VARO outreach to homeless veterans. These requirements include developing and updating a directory of local homeless shelters and service providers. Additionally, the coordinators should attend regular meetings with local homeless service providers, community governments, and advocacy groups to provide information on VA benefits and services.

The Detroit VARO has a full-time Homeless Veterans Outreach Coordinator. Our review confirmed that the coordinator was familiar with requirements for improving the effectiveness of VARO outreach to homeless veterans. The coordinator had collaborative partnerships with local homeless outreach facilities to provide information on VA benefits and services. We made no recommendation for improvement in this area. However, VBA needs a measurement to assess the effectiveness of its homeless veterans outreach efforts.

Appendix A VARO Profile and Scope of Inspection

Organization

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

Resources

As of June 2012, the Detroit VARO had a staffing level of 227 full-time employees. Of this total, the VSC had 173 employees (76 percent) assigned.

Workload

As of June 2012, the VARO reported 18,023 pending compensation claims. The average time to complete claims was 319 days—89 days longer than the national target of 230. However, the number of claims pending greater than 125 days was 11,068, comprising 61 percent of the Detroit VARO's pending workload.

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 541 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 May 18, 2012. We provided VARO management with 511 claims remaining from our universe of 541 for its review. We also reviewed 43 cases from the list of temporary 100 percent disability evaluations VBA provided to the VARO for review. We reviewed 30 of 48 disability claims related to TBI that the VARO completed from January through March 2012. In addition, we analyzed the 10 oldest completed claims available for review from that same time period. Where we identify potential procedural inaccuracies, this information is provided to help the VARO understand the procedural improvements it can make and to improve the overall 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 reviewed the 11 mandatory SAOs completed in FYs 2011 and 2012. We also reviewed 11 completed claims available for our review that were processed for Gulf War veterans from January through March 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 time frame 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 81 claims folders we reviewed.

Our testing of the data disclosed that they were sufficiently reliable for our inspection objectives. Our comparison of the data with information contained in the veterans' claims folders at VARO Detroit 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 3 reflects the operational activities inspected, applicable criteria, and whether or not we had reasonable assurance of VARO compliance.

Table 3. Detroit VARO Inspection Summary

Six Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Disability Claims Processing			
1. Temporary 100 Percent Disability Evaluations	**Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations.** (38 Code of Federal Regulations (CFR) 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (M21-1Manual Re-write(MR)) Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e). (VBA response to OIG Audit Report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011)		X
2. Traumatic Brain Injury Claims	**Determine whether VARO staff properly processed claims for service connection for all residual disabilities related to in-service TBI.** (Fast Letter (FL) 08-34 and 08-36) (Training Letter 09-01)		X
3. Claims Processing Timeliness	**Determine whether VARO staff unnecessarily delayed processing disability claims.** (Manual (M) 21-4, Chapter 2) (FL) 12-04 and 10-23)		X
Management Controls			
4. 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			
5. Gulf War Veterans' Entitlement to Mental Health Treatment	**Determine whether VARO staff properly processed Gulf War veterans' claims, considering entitlement to medical treatment for mental illness.** (38 United States Code 1702) (M21-1MR Part IX, Subpart ii, Chapter 2)(M21-1MR Part III, Subpart v, Chapter 7) (FL 08-15) (38 CFR 3.384) (38 CFR 3.2)		X
Public Contact			
6. Homeless Veterans 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: December 6, 2012

From: Director, VA Regional Office Detroit, Michigan

Subj: Inspection of the VA Regional Office, Detroit, Michigan

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

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

2. Please refer questions to Dave Leonard, Director, Detroit Regional Office (313) 471-3600.

(original signed by:)

Dave Leonard
Director, Detroit RO

Attachment

Detroit VARO's comments

Recommendation 1. We recommend the Detroit VA Regional Office Director provide training and implement controls to ensure staff follow current Veterans Benefits Administration policy on scheduling medical reexaminations for temporary 100 percent evaluations.

Concur: The Veterans Service Center (VSC) provided updated training to both Veterans Service Representatives (VSR) and Rating VSR (RVSR) on scheduling medical examinations for temporary 100 percent evaluations. The VSR training was completed September 19, 2012 and the training for RVSRs was completed August 29, 2012. To ensure timely and consistent actions on system-generated work items the VSC consolidated the responsibility for this review to one Assistant Coach.

Recommendation 2. We recommend the Detroit VA Regional Office Director develop and implement a plan to ensure staff return insufficient medical examination reports to health care facilities to obtain the required evidence needed to support traumatic brain injury claims rating decisions.

Concur: The VSC has consolidated the processing of TBI claims to a Special Operations Lane within the VSC. The VSR TBI training was conducted on August 22, 2012. RVSR TBI training was conducted on December 5, 2012.

Recommendation 3. We recommend the Detroit VA Regional Office Director develop and implement a plan to ensure Veterans Service Center staff follow Veterans Benefits Administration policy on proper establishment of dates of claim.

Concur: The Veterans Service Center reviews and will continue to review date of claim accuracy during monthly local quality reviews, as well as when the Quality Review Team does the monthly in progress reviews for the regional office. Additionally, the Intake Processing Team Supervisor also conducts random quality reviews of claims established by Claims Assistants throughout the month. Any deficiencies found will continue to be addressed in local training sessions and one on one mentoring sessions. Also, during FY12, the Detroit Regional Office's performance was at 98.9% accuracy on the national date of claim reviews. In FY13, the Detroit Regional Office's performance was at 99% at end of month October 2012. The Intake Processing Center Team Supervisors will continue to conduct random quality reviews of claims established.

Recommendation 4. We recommend the Detroit VA Regional Office Director amend the local Workload Management Plan to include specific requirements for management oversight and review to improve claims processing timeliness.

Concur: The Detroit VSC transitioned to the new VBA Organizational Model in November 2012. The VSC Leadership team is developing a new workload management plan based on the model and recommendations from the IG. Also, the VSC Management Team review's the oldest claims in the workload on a regular basis. The VSC Management team reviews the VOR list of claims over 125 days and 365 days old regularly to ensure the proper attention is being paid to

those cases by first line supervisors. In fact, in calendar year 2012, claims pending greater than 125 days was reduced from more than 13,000 in January to less than 10,500 at the end of September 2012. Moreover, claims pending greater than one year old was reduced from over 4,000 in January 2012 to 2,788 by the of September 2012.

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

Concur: The VSC Manager conducted Systematic Analyses of Operations (SAO) training on December 4, 2012 for VSC management staff. The VSC will also provide a quarterly update to the Director's Office showing recommendations and status towards completion of same.

Recommendation 6. We recommend the Detroit VA Regional Office Director develop and implement a plan to monitor the effectiveness of training to ensure staff follow current Veterans Benefits Administration policy regarding Gulf War veterans' entitlement to mental health treatment when denying service connection for mental disorders.

Concur: On July 24, 2012, 38 U.S.C. 1702 training was provided to RVSRs. In addition, an email was sent to employees reinforcing the 1702 policy on July 24, 2012. Decisions regarding 1702 are routinely reviewed for accuracy at both the local and National levels as part of the random review process. Errors found are shared with supervisors and with the individual employees on a monthly basis.

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 Ed Akitomo Nelvy Viguera Butler Madeline Cantu Lee Giesbrecht Jeff Myers David Pina Diane Wilson

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