VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Nashville, Tennessee

March 28, 2013
12-03629-139

ACRONYMS AND ABBREVIATIONS

HVOC	Homeless Veterans Outreach Coordinator
OIG	Office of Inspector General
QRT	Quality Review Team
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 VA Regional Office, Nashville, Tennessee

Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and 1 Veterans Service Center nationwide that process disability claims and provide a range of services to veterans. We evaluated the Nashville VARO to see how well it accomplishes this mission.

What We Found

Overall, VARO staff did not accurately process 24 (41 percent) of 59 disability claims we reviewed. We sampled claims for certain types of medical disabilities that we considered to be 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 procedures, VBA risks paying inaccurate and unnecessary financial benefits.

Specifically, 47 percent of the 30 temporary 100 percent disability evaluations we reviewed were inaccurate. Generally, these errors occurred because VARO staff did not schedule medical reexaminations or take actions to reduce benefits as appropriate. Further, staff incorrectly processed 34 percent of 29 traumatic brain injury claims. Most errors occurred when peers rather than Quality Review Team staff conducted second-level reviews of TBI claims.

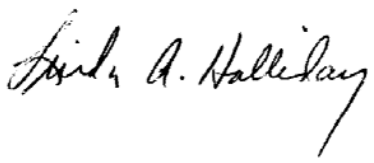
Management generally ensured Systematic Analyses of Operations were complete and timely. However, staff did not always properly address Gulf War veterans' entitlement to mental health care. Staff also did not provide outreach to homeless veterans in their entire area of jurisdiction or consistently identify their claims.

What We Recommend

The VARO Director should develop and implement a plan to ensure suspense diaries are entered in the electronic record, staff follow up to reduce benefits when appropriate, and qualified staff conduct secondary traumatic brain injury claim reviews. Management should provide homeless outreach in its entire area of jurisdiction and accurately track all claims received from homeless veterans.

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
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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 September 2012, we inspected the Nashville 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 (5 percent) of 643 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 without review, according to Veterans Benefits Administration (VBA) policy. We examined 29 (94 percent) of 31 disability claims related to traumatic brain injury (TBI) that VARO staff completed during the period 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

Claims Processing Accuracy

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 Nashville VARO Could Improve Disability Claims Processing Accuracy

Claims Processing Accuracy

The Nashville VARO did not always process temporary 100 percent disabilities and TBI cases accurately. Overall, VARO staff incorrectly processed 24 of the total 59 disability claims we sampled, resulting in 114 improper monthly payments to 6 veterans totaling $27,572.

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 July 2012, the overall accuracy of the VARO's compensation rating-related decisions was 90.9 percent—3.9 percentage points above VBA's FY 2012 target of 87 percent.

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

Table 1

Nashville 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	3	11	14
Traumatic Brain Injury Claims	29	3	7	10
Total	**59**	**6**	**18**	**24**

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

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 14 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 3 of the 14 processing errors we identified affected veterans' benefits and resulted in 83 improper monthly payments totaling $17,909. Details on the processing errors affecting benefits follow.

- A Rating Veterans Service Representative Rating (RVSR) did not establish entitlement to a special monthly compensation benefit as required, based on evaluations of multiple disabilities. As a result, VA underpaid the veteran a total of $10,019 over a period of 2 years and 7 months.
- An RVSR did not establish entitlement to a special monthly compensation benefit as required, based on loss of use of a creative organ. As a result, VA underpaid the veteran a total of $4,802 over a period of 4 years and 2 months.
- An RVSR did not take final action to reduce a veteran's benefits after informing the veteran of the proposed reduction. VA needed to decrease the veteran's monthly benefit payment because medical evidence showed the veteran's prostate cancer was no longer active. As a result, VA overpaid the veteran a total of $3,088 over a period of 2 months.

Of the total 14 claims with errors, 11 had the potential to affect veterans' benefits. In most of these cases, 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. For those cases requiring medical reexaminations, delays ranged from approximately 11 months to 2 years and 3 months. An average of 1 year and 9 months elapsed from the time staff should have scheduled these medical reexaminations through the date of our inspection.

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.

Of the 14 total errors we identified, most errors occurred when VARO staff did not:

- Take final action to reduce benefits after notifying veterans of the proposed adverse actions, or accurately propose to reduce benefits
- Establish suspense diaries in the electronic record, or schedule medical reexaminations after receiving reminder notifications

In November 2009, VBA provided guidance reminding VARO staff about the need to input suspense diaries to the electronic record as reminders to schedule medical reexaminations. However, VARO management had no oversight procedure in place to ensure VSC staff established the suspense diaries and scheduled reexaminations timely, nor did they ensure staff took appropriate actions to reduce benefits. Temporary 100 percent disability evaluations could have continued uninterrupted over the veterans' lifetimes if we had not identified the need for VARO staff to take actions to schedule reexaminations.

National Audit Review Follow Up

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 has since extended the national review deadline to December 31, 2012, and to date is still working to complete this requirement. 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 provided to the Nashville 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 we reviewed. However, in comparing VBA's national review lists with our data on temporary 100 percent disability evaluations, we found 8 cases related to temporary

evaluations involving prostate cancer or non-Hodgkin's lymphoma that VBA had not identified. We will continue monitoring this situation as VBA works to complete its national review.

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 decisions. In May 2011, the Under Secretary for Benefits provided guidance to all 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.

VSC staff incorrectly processed 10 of 29 TBI claims—3 of these errors affected veterans' benefit and resulted in 31 improper payments totaling $9,663. Generally, the errors occurred because the VARO lacked adequate oversight to ensure staff complied with VBA's second signature policies. Further, although 7 of the 10 errors had undergone an additional level of review, most of the reviewers were peers and not Quality Review Team (QRT) members. The types of errors we identified are explained below.

- RVSRs incorrectly used the same symptoms under multiple diagnostic codes to evaluate veterans' disabilities
- RVSRs assigned evaluations or established service connection for TBI-related disabilities that were unsupported by medical evidence

The QRT is responsible for conducting quality reviews at the VARO. The QRT concept is a VBA initiative to ensure standardized quality reviews among VAROs. QRT staff receive specialized training from Systematic Technical Accuracy Review (STAR) Program staff. Had QRT staff performed second level reviews as required, they may have identified and corrected the 10 TBI errors prior to our inspection.

Follow Up To Prior VA OIG Inspection

In our prior report, *Inspection of the VA Regional Office, Nashville,* (Report No. 09-01664-231, September 29, 2009), we identified 3 of 30 instances where VSC staff inaccurately processed TBI claims. Two of the errors occurred when RVSRs used insufficient VA examination reports to evaluate TBI-related claims. In response to our recommendations, the VARO Director provided staff refresher training emphasizing correct procedures for TBI claims processing.

From our current inspection, we found 2 instances out of the 29 claims reviewed where staff used inadequate VA examination reports to evaluate TBI. Based on these results, we concluded VARO staff generally used adequate medical examination reports to evaluate TBI-related disabilities.

Recommendations

1. We recommend the Nashville VA Regional Office Director develop and implement a plan to ensure claims processing staff input suspense diaries in the electronic record to support scheduling of medical reexaminations.
2. We recommend the Nashville VA Regional Office Director develop and implement a plan to ensure claims processing staff take accurate and timely actions to propose or finalize reductions in benefits.
3. We recommend the Nashville VA Regional Office Director develop and implement a plan to ensure accurate second signature reviews of traumatic brain injury claims decisions.

Management Comments

The VARO Director concurred with our recommendations. The Director indicated a software update to VBA's electronic system now forces decision makers to determine whether reexaminations related to temporary 100 percent disability evaluations are required. The software update has been tested and provides the Director assurance that oversight is given to these claims. Further, second-level reviews by the QRT and in-process quality reviews are to provide additional assurance reexaminations are scheduled as required.

In November 2012, as part of its organizational transformation, the VARO implemented workload management plans to ensure staff take accurate and timely actions when proposing and finalizing reductions in benefits. Under the new organizational model, responsibility for TBI claims processing has been realigned under the Special Operations Team, comprised of rating staff with high accuracy rates. Additionally, a QRT member serves as a subject matter expert and second signer for TBI claims. In FY 2013, all RVSRs are required to complete 22 hours of TBI claims processing training.

OIG Response

The Director's comments and actions are responsive to the recommendations. However, without testing more current information, we cannot determine whether VBA's software update adequately ensures staff input suspense diaries in the electronic record to support scheduling medical reexaminations.

II. Management Controls

Systematic Analysis of Operations

We assessed whether VARO management had adequate controls in place to ensure complete and timely submission of 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 mandated SAOs annually.

VARO staff completed all 11 SAOs timely according to the SAO schedule. Ten of the 11 SAOs included thorough analyses using appropriate data, identified weaknesses or concerns, and provided recommendations for improvement. However, the Claims Processing Timeliness SAO did not include analyses in four required areas, including workloads pending greater than 365 days and WMP effectiveness.

Given the VARO was generally compliant in completing SAOs, we make no recommendation for improvement in this area.

Follow Up To VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Nashville,* (Report No. 09-01664-231, September 29, 2009), we determined that the VARO was compliant in completing SAOs as required.

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. 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 2 Gulf War Veterans Did Not Always Receive Entitlement Decisions for Mental Health Treatment

VARO staff did not properly address whether 10 of 30 Gulf War veterans were entitled to receive treatment for mental disorders. These errors generally occurred because the training conducted on mental health treatment for Gulf War veterans did not place emphasis on reviewing prior rating decisions to determine whether RVSRs properly addressed the entitlement. As a result, veterans may be unaware of their possible entitlement to treatment for mental disorders and may not get the care they need. Following are details on the 10 processing errors observed.

- Seven errors occurred when RVSRs did not address treatment for mental disorders on current decisions after previous decisions also did not address the issue.
- Two processing errors occurred when RVSRs did not address veterans' entitlement to mental health treatment in current disability decisions, despite pop-up notifications reminding them to do so.
- One error occurred when an RVSR correctly addressed the entitlement decision, but did not formally annotate the decision on the decision document. When this occurs, VA treating facilities cannot determine whether the veteran is entitled to the mental health care benefit.

Although the RVSRs we interviewed were able to explain correctly the process for addressing Gulf War veterans' mental health care entitlement, they stated it was easy to overlook these entitlement decisions. Staff told us and we confirmed that the training RVSRs received in this area did not emphasize the need for them to determine whether prior rating decisions addressed these entitlement decisions for Gulf War veterans. In

August 2012, RVSRs received additional training on this topic. We could not assess the effectiveness of that training because staff had completed the claims we reviewed prior to receiving the training.

In December 2012, VBA modified its policy that required RVSR staff to address entitlement to health care treatment in all cases that involved Gulf War veterans. Given that the new policy change became effective after we concluded our inspection of the Nashville VARO, we cannot speculate if 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 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 3 Oversight of the Homeless Veterans Outreach Program Needs Improvement

The Nashville VARO has jurisdiction over 95 counties in the State of Tennessee and is 1 of the 20 VAROs designated to have a full-time Homeless Veterans Outreach Coordinator (HVOC). However, the Nashville VARO did not regularly contact or provide information and training to homeless shelters and service providers outside of the Nashville area, nor did it always accurately track homeless veterans' claims in the electronic record. This occurred because VARO management did not provide effective oversight of the VARO's Homeless Veterans Outreach Program.

Prior to notifying VBA on August 23, 2012, of our upcoming inspection, we confirmed that VARO staff did not provide information to all homeless shelters and community service providers. However, the following day, staff mailed their first outreach letters to the 19 facilities on the HVOC contact list—all of the facilities, except for 6, were located in the Nashville area. VARO managers reported they do not conduct outreach events outside of Nashville due to lack of funds. As such, homeless shelters and service providers beyond the city limit may not be aware of available benefits and services. In general, VBA would benefit from instituting a measure to assess the effectiveness of its homeless veterans outreach efforts.

Claims Processing for Homeless Veterans

VARO staff working with homeless veterans' claims told us managers endorse a practice of removing homeless flash indicators from the electronic record and replacing them with hardship flashes in certain situations. In contrast, VBA policy requires that staff associate homeless flash indicators in the electronic record with homeless veterans' claims. This requirement is to

facilitate expedited processing of homeless veterans' claims and support tracking of VARO performance in this area.

We reviewed 10 claims pending completion at the VARO that had hardship flashes associated with them in the electronic record. We determined staff did not correctly identify half of these claims as submitted by homeless veterans. VARO staff told us their practice was to remove homeless flashes and replace them with hardship flashes in the following scenarios.

- After applying financial testing to determine if a veteran has a means of self-support, such as receiving compensation at the 70 percent or higher rate; is receiving pension benefits; or is receiving income from non-VA sources sufficient for self-support.
- When a veteran resides in transitional housing or participates in initiatives such as the Nashville Stand Down or the Department of Housing and Urban Development–VA Supportive Housing Program.
- When VARO staff review VA treatment records and determine the veteran had a change of address, assuming the change of address ended the veterans' homelessness.

For the five claims that VARO staff erroneously identified as financial hardship cases, one or more indicators in the claims files showed the veterans met VBA's definition for being homeless. VARO managers reviewed these five claims folders, but disagreed the veterans were homeless. VARO managers told us they correctly interpreted and applied VBA policy when processing homeless veterans' claims and that staff appropriately processed these claims as financial hardship claims. Indicators of homelessness found in the five folders we reviewed follow.

- Claims from veterans participating in the Nashville Stand Down, which provides consolidated services for homeless veterans.
- Claims where VARO staff used special processing to expedite military service verification for homeless veterans.
- Claims from veterans stating they were homeless, or including VARO staff annotations on the claims forms that the veterans were homeless.

VARO managers denied applying any sort of financial test to determine whether to retain a homeless flash associated with a claim. However, managers stated they considered evidence from all sources when deciding to remove or replace a homeless flash. Managers and staff believed their interpretations regarding use of homeless flashes in the electronic record were correct and in line with VBA policy.

We disagree that VARO staff correctly interpreted VBA policy on processing homeless veterans' claims. Specifically, the policy requires that

staff expedite claims for veterans in transitional housing; there is no provision for staff to assume a veteran is no longer homeless when VA treatment records indicate an address change. Staff misinterpretations of VBA policy on the use of homeless flashes may result in inaccurate performance data on the VARO's processing of homeless veterans' claims and increase the risk of delayed benefits for homeless veterans.

Recommendations

4. We recommend the Nashville VA Regional Office Director develop and implement a plan to ensure staff update the resource directory and regularly contact and provide outreach to homeless shelters and service providers under the VA Regional Office's jurisdiction.
5. We recommend the Nashville VA Regional Office Director develop and implement a plan to ensure staff accurately identify and expedite processing and monitoring of all homeless veterans' claims.

Management Comments

The VARO Director concurred with our recommendations. During our inspection, the VARO updated its resource directory to include over 80 homeless shelters and service providers throughout the State of Tennessee. The HVOC is responsible for updating the directory and making contact with the facilities on a quarterly basis.

The VARO Director also updated its procedures to ensure staff accurately identify claims from homeless veterans. Case management of these claims was reassigned to the Special Operations Team. However, the Director disagreed that staff did not expedite homeless veterans' claims. The Director said the VARO prematurely adopted the Federal definition of homeless and changed flash indicators for these claims in the electronic system from homeless to hardship in some instances. The Director said that regardless of the flash indicators, staff continued to apply the same case management and expedited procedures to process these claims.

OIG Response

The Director's comments and actions are responsive to the recommendations and we will follow up as required. Our review did not examine the effectiveness of the VARO's processing of financial hardship claims. Per VBA policy, the use of homeless flash indicators is to facilitate expedited processing and help track VARO performance in processing homeless veterans' claims. We remain concerned that when these claims are processed as financial hardship claims, the VARO's performance in homeless veterans' claims processing may be inaccurately measured.

Appendix A VARO Profile and Scope of Inspection

Organization

The Nashville VARO administers a variety of services and benefits, including compensation and pension benefits; vocational rehabilitation and employment assistance; benefits counseling; and outreach to homeless, elderly, minority, and women veterans. The Nashville VARO also has a National Call Center.

Resources

As of July 2012, the Nashville VARO had a staffing level of 425.5 full-time employees. Of this total, the VSC had 301.7 employees assigned.

Workload

The Nashville VARO reported 11,637 pending compensation claims in July 2012. The average time to complete claims was 175.6 days—54.4 days less 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 (5 percent) of 643 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 July 26, 2012. We provided VARO management with 613 claims remaining from our universe of 643 for its review. As follow-up to our prior inspection, we sampled an additional 40 temporary 100 percent disability evaluations from the SharePoint list VBA provided to the VARO for its review. We reviewed 29 (94 percent) of 31 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. 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 the VARO completed in FY 2012. We examined 30 completed claims processed for Gulf War veterans from April through June 2012 to determine whether VARO 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 by reviewing its directory of homeless shelters and service providers and examining whether staff regularly attended meetings and provided information on VA benefits and services.

Data Reliability

During our inspection, 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 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 the Nashville VARO 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. Nashville VARO Inspection Summary

Five 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 Code of Federal Regulations (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 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 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			
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 6, 2013

From: Director, VA Regional Office Nashville, Tennessee

Subj: Response to OIG Draft Report, Inspection of the VA Regional Office, Nashville, Tennessee

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

1. Attached are the Nashville VA Regional Office comments on the Office of Inspector General Draft Report: *Inspection of the VA Regional Office, Nashville, Tennessee.*
2. Thank you for the opportunity to provide feedback. Please refer questions to Edna McDonald at (615) 695-6005.

(original signed by:)
Edna MacDonald

Attachment

<u>OIG Recommendation 1.</u> We recommend the Nashville VA Regional Office Director develop and implement a plan to ensure claims processing staff input suspense diaries to the electronic record to support scheduling of medical examinations.

Nashville RO Response: **We concur**.

This OIG report references their national audit on this same topic, "Audit of 100 Percent Disability Evaluations" and the report of those audit findings dated January 24, 2011. The OIG indicated the VBA review of cases identified in error by that audit was extended to December 31, 2012. The primary cause for the national audit finding was a well-documented computer software programming error. The programming error has subsequently been fixed. However, there was a period of time which must be accounted for and corrected through additional reviews. This audit of the Nashville Regional Office was conducted in September 2012, while that VBA clean up review was still underway.

This audit team reviewed progress on VBA's clean up reviews done by the Nashville RO and found that our RO staff took correct and appropriate action on all 40 cases they reviewed. However, in September of 2012, the OIG site visit team concluded that additional reviews were needed at the Nashville RO. Being responsive to the findings, the Nashville Leadership undertook and completed additional reviews based on OIG conclusions. The Nashville Leadership will continue to conduct on-going reviews and will continue to work with the Office of Field Operations and Compensation Service to ensure future review controls for temporary 100 percent evaluations are properly established and timely reviewed.

The software, utilized to ensure oversight is provided to claims needing reevaluation, has been patched and now forces the decision-maker to make a decision on whether or not a routine future examination is warranted. This patch has been tested and there is assurance that oversight is given to these claims. Furthermore, newly implemented in-process reviews and a Quality Review Team (QRT) provide a second level of assurance that decision-makers are making the correct decision when determining whether or not to schedule a routine future examination.

<u>OIG Recommendation 2.</u> We recommend the Nashville VA Regional Office Director develop and implement a plan to ensure claims processing staff take accurate and timely actions to propose or finalize reductions in benefits.

Nashville RO Response: **We concur.**

The Nashville RO agrees that accurate and timely actions must be taken to propose or finalize reductions in benefits. The Nashville RO transformed into a new organizational model on November 26, 2012. As part of this transformation process, the Nashville RO developed and implemented workload management plans to ensure claims processing staff take accurate and timely actions to propose or finalize proposed reductions in benefits.

The two main end products used to control the segment of the workload which requires actions to propose and finalize reductions in benefits are end products 310 and 600, respectively. Since implementation of the plan, reviews by the Systematic Technical Accuracy Review (STAR) staff have not shown errors associated with the end products.

At the end of November 2012, the average days pending for an EP 310 was 135.7 days, at the end of February 2013, this average had been reduced by nearly 150 percent to 54.8 days. At the end of November 2012, the average days pending for an EP 600 was 181.1 days, at the end of February 2013, this average had been reduced by 10 percent to 165.0 days.

The Nashville RO leadership is encouraged by the downward trend in average processing times and the accuracy with which this work is being completed and will continue to effectively implement the workload management plan regarding proposed and final reductions in benefits.

OIG Recommendation 3. We recommend the Nashville VA Regional Office Director develop and implement a plan to ensure accurate second signature reviews of traumatic brain injury claims decisions.

Nashville RO Response: **We concur.**

The Nashville RO transformed into a new organizational model on November 26, 2012. As part of this transformation process, Nashville RO realigned workload. As a result of the realignment, TBI claims (with the exception of Fully Developed Claims) were assigned to the Special Operations Team. Due to the unique and oftentimes complex nature of these types of claims, Nashville staffed the Special Operations Team with rating personnel with a high level of accuracy. In addition, Nashville dedicated a full time resource, a Rating Quality Review Specialist (RQRS) from the Quality Review Team, to the Special Operations Team, to serve as a subject matter expert and second signer of TBI cases. Any Fully Developed Claim involving a TBI claim is also referred to the specially designated RQRS on the Special Operations Team for second signature review. Since transformation, all TBI cases have been reviewed and second signed by a RQRS.

In addition, Nashville's Training Team has developed a plan to ensure all rating personnel successfully complete the TPSS Module on TBI claims during FY 13. The TBI module is approximately 22 hours and will be mandatory for all RVSRs to complete. The RO is on track to complete this training in the third quarter of FY2013.

OIG Recommendation 4. We recommend the Nashville VA Regional Office Director develop and implement a plan to ensure staff update the resource directory and regularly contact and provide outreach to homeless shelters and service providers under the VA Regional Office's jurisdiction.

Nashville RO Response: **We concur.**

During the OIG Site Visit, the resource directory was immediately updated to include over 80 homeless shelters, service providers, state and local coalitions and other community-based organizations throughout the state of Tennessee. The Homeless Veteran Outreach Coordinator (HVOC) is responsible for updating this directory and making contact at least on a quarterly basis.

Due to limited travel funds, outreach to these homeless shelters and service providers will be conducted through letters and telephone contact. The VA Medical Centers (VAMCs) continue to serve as a conduit between our office and the homeless communities in East and West Tennessee. The HVOC maintains weekly contact with the VAMC social workers regarding potential outreach and homeless Veterans needing our assistance.

Lastly, although homeless outreach to East and West Tennessee was limited, homeless Veterans in Middle Tennessee and surrounding counties were provided with numerous outreach opportunities. Based on recent census data from 2011, Nashville/Davidson county ranks number one for total Veterans sheltered and unsheltered in the state of Tennessee. Although our outreach efforts may be minimal in other counties, the data shows we are reaching the majority of the homeless population for the state of Tennessee.

OIG Recommendation 5. We recommend the Nashville VA Regional Office Director develop and implement a plan to ensure staff accurately identify and expedite processing and monitoring of all homeless veterans' claims.

Nashville RO Response: **We concur.**

As this OIG point out on pages 10-11, the requirement for flash indicators in the electronic system is to facilitate expedited processing of homeless Veteran's claims and support tracking of VARO performance in this area. While the Nashville RO prematurely adopted the federal definition of homeless which became effective January 4, 2012 by changing flash designations from homeless to hardship in some instances, the Nashville RO continued to apply the same case management and expedited processing procedures to claims from Veterans with either the homeless or hardship flash. Therefore, the Nashville RO disagrees with the OIG assertion that homeless claims were not expedited.

The Nashville RO has taken the following actions to further ensure homeless Veterans' claims are identified, expedited and monitored. The Nashville RO has updated homeless procedures to include a pre-printed VA Form 21-0820, which will be used by the Homeless Veterans Outreach Coordinator. This Report of Contact will assist the Homeless Claims Case Manager in accurately identifying a homeless claim. The Nashville RO transformed into a new organizational model on November 26, 2012. Homeless claims are now case-managed within the Special Operations lane. The Homeless Veterans Outreach Coordinator assists the case manager with obtaining outstanding evidence and ensuring the Veteran reports for all VHA appointments.

Appendix D Office of Inspector General Contact and Staff Acknowledgments

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