STATEMENT OF
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ON
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INTRODUCTION

Senator Akaka, thank you for the opportunity to testify today on the results of the Office of Inspector General's (OIG) inspection of Honolulu VA Regional Office (VARO) operations *(Inspection of the VA Regional Office, Honolulu, Hawaii,* March 26, 2012). Accompanying me today is Mr. Brent Arronte, Director of the OIG's Benefits Inspection Division in Bay Pines, Florida, whose office conducted the review.

BACKGROUND

The Veterans Benefits Administration (VBA), specifically the Office of Field Operations, is responsible for oversight of the nationwide network of 57 regional offices. The regional offices administer a range of veterans benefits programs, including compensation, pension, education, home loan guaranty, vocational rehabilitation and employment, and life insurance. Delivering benefits and services to the millions of veterans who provided military service to our Nation is central to this VBA responsibility and the larger VA mission. As of October 2011, the Honolulu VARO reported providing benefits and services to approximately 129,000 veterans.

The OIG's Benefits Inspection Program was created with your support in 2009 to review individual VARO operations. We currently are on schedule to complete a review of each VARO every 3 years. Our inspections include five protocols focused on high-risk functional areas within each VARO's Veterans Service Center (VSC). These areas include disability claims processing, management controls, workload management, eligibility determinations, and public contact. Upon completion of each inspection, we issue a report to the VARO Director on the results and publish a report with the Director's comments.

Since September 2009, we have consistently reported the need for enhanced policy guidance, oversight, workload management, training, and supervisory review to improve the timeliness and accuracy of disability claims processing and VARO operations.

RESULTS

We conducted our inspection in Honolulu in December 2011. Of the eight operational areas we reviewed, the Honolulu VARO performed well in three: processing traumatic brain injury (TBI) claims, processing herbicide exposure-related claims, and correcting errors reported through VBA's Systematic Technical Accuracy Review (STAR) program. We examined 2 TBI claims and sampled 30 of the herbicide exposure-related claims

completed and available for review at the VARO. VARO staff correctly processed both TBI claims and 27 (90 percent) of the 30 herbicide-related claims, including making accurate benefit payments for each.

Additionally, the Honolulu VARO staff reviewed and properly corrected 28 errors that STAR program staff identified from April through June 2011. The program is VBA's multifaceted quality assurance program to ensure that veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that VAROs take corrective action on errors identified through the STAR program.

Areas for Improvement

The VARO did not meet VBA's standards for five of the eight operational areas we inspected:

Disability Claims Processing – VARO staff did not accurately process 29 (47 percent) of the 62 disability claims we sampled. However, these results do not represent the accuracy of overall disability claims processing at this VARO as we review high-risk claims areas, and not all types of claims processed by the VARO.

Most of the errors identified in disability claims processing were in the area of temporary 100 percent disability evaluations, typically resulting from VBA staff not scheduling medical reexaminations needed to provide evidence to support continued entitlements. High error rates in processing temporary 100 percent evaluations are not unique to the Honolulu VARO—none of the 47 VAROs for which we have issued reports to date have been compliant in this area. In our January 2011 report, *Audit of 100 Percent Disability Evaluations*, we stated that from January 1993 through January 2011, VBA paid veterans a net $943 million without adequate medical evidence. In response to our report, VBA has initiated reviews of temporary 100 percent disability evaluations to ensure that medical reexaminations are scheduled as needed to support entitlements decisions. However, the frequency with which we continue to identify these errors remains a significant concern.

In addition to issues with claims processing accuracy, VBA continues to struggle with timeliness in completing disability claims. VBA's national target for completing disability claims is 230 days. As of February 2012, the average for all VAROs nationwide was 236 days—6 days over the target. In comparison, for the same time period, the Honolulu VARO averaged 264 days to complete disability claims, which was 34 days more than the national target.

Systematic Analysis of Operations (SAO) – SAOs provide management an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. Because of inadequate management oversight, there was no assurance that 8 (73 percent) of the 11 mandatory SAOs were timely or thoroughly completed. For example, managers did not complete an analysis of the VARO's mail-

handling operations, which are critical to timely and accurate processing of veterans claims.

Mail-Management – In the area of mail processing, we found that due to a lack of management oversight, staff incorrectly processed 20 (33 percent) of 60 pieces of claims-related mail. As such, claims processing staff responsible for making disability determinations may not always have all available evidence and beneficiaries may not receive accurate and timely benefits payments. Had managers completed their own analysis of mail processing, they may have identified and addressed this mail management weakness prior to our inspection.

Homeless Veterans Outreach – Outreach to assist homeless veterans was not always effective. VBA policy requires each VARO to maintain and update a resource directory of homeless shelters and service providers within its jurisdiction. Management informed us that staff last updated the resource directory in November 2011. However, two of the facilities listed in the directory closed in February 2011. We contacted representatives at 13 (54 percent) of the 24 facilities listed on the VARO's directory. While four facilities confirmed the VARO provided information on VA benefits and services, nine reported not receiving any VA contact. Because VARO managers did not provide effective oversight of outreach efforts, they were unaware the directory was not kept up-to-date.

Additionally, in September 2002, VBA published guidance mandating that 20 VAROs each have a full-time Homeless Veterans Outreach Coordinator to contact and provide homeless shelters and service providers with information related to VA benefits and services. The Honolulu VARO is not required to have a full-time coordinator. However, in November 2011, the VARO Director took proactive measures by assigning homeless outreach responsibilities to a full-time employee who previously performed this role on a part-time basis.

Another objective of the Homeless Veterans program is providing expedited disability claims processing for veterans identified as homeless. However, the Honolulu VARO's procedure for identifying homeless veterans and expediting their claims did not always comply with VBA policy. VBA policy considers veterans homeless if they stay at shelters subsidized by the Department of Housing and Urban Development or VA's Supportive Housing program. The VARO's local procedure did not consider veterans homeless if they paid for lodging at shelters that provided discounted apartments, regardless of whether the shelters were subsidized.

Because management was unaware VARO staff deviated from VBA's definition of homeless, some claims submitted by homeless veterans did not receive expedited processing. For example, the Honolulu VA Medical Center's Homeless Veterans Outreach Coordinator provided us a list of 26 homeless veterans residing within the VARO's jurisdiction. At the time of our inspection, 15 (58 percent) of the 26 veterans had disability claims pending at the VARO. The VARO did not identify 12 of those 15 as

homeless; the address for 10 of the veterans' claims was a Post Office box for a local homeless veterans facility.

Gulf War Veterans' Mental Health Treatment – Even though these veterans may be denied service-connection for mental disabilities, by law they are still entitled to medical treatment for any mental disability developed within 2 years of the date of separation from military service. We found that VARO staff did not properly address whether 10 (38 percent) of 26 Gulf War veterans were entitled to receive treatment for mental disorders. Due to inadequate training, Rating Veterans Service Representatives did not receive the information they needed to consider the veterans' entitlement to this treatment, particularly in instances where physicians determined mental conditions did not exist. In such instances, claims raters were under the assumption that decisions to address mental health treatment were not required. As a result, Gulf War veterans may be unaware of their potential entitlement to mental health care.

Leadership Challenges

The issues we identified at the Honolulu VARO were fundamentally due to a lack of management oversight or unclear guidance. Our interviews with the VARO director, acting VSC manager, supervisors, and employees responsible for processing claims and providing services for veterans and their dependents disclosed a need for improved communication between VARO and VSC leadership on the status of daily operations. VSC staff similarly informed us that communication from the VSC manager and supervisors was not always clear or consistent. The acting VSC manager stated some supervisors did not routinely disseminate information to their staff. VSC staff learned of new guidance or practices from other employees rather than from their supervisors. The three supervisors at the Honolulu VARO had an average of 1 year of supervisory experience. Additionally, only one of the three had received formal supervisory training even though Office of Personnel Management regulations require agencies to provide such training within 1 year of an employee's initial appointment to a supervisory position. This lack of experience contributed to the overall performance of the Honolulu office.

Another challenge in VSC operations was incorporating oversight mechanisms in the Workload Management Plan. VBA's workload management system is comprised of various user plans, such as a mail plan, and computer applications to control all work inherent to the disability claims process. VBA policy indicates the most important part of the workload management system is oversight to ensure staff efficiently utilize the plans and systems available to ensure accomplishment of their mission responsibilities.

We identified several areas where supervisors did not oversee activities, such as completing SAOs, processing mail, and expediting claims for homeless veterans. The VARO Director agreed that the Workload Management Plan lacked effective guidance for supervisors to oversee VSC work processes. The acting VSC manager indicated the Workload Management Plan was not an effective tool because it did not align work processes with office goals.

Moreover, the VARO Director expressed concerns with the continuity of VSC leadership. The Honolulu VARO is one of the few offices that require a 3-year contract for the director and VSC manager positions. In most instances, the 3-year contract is the maximum tenure a manager can stay in this position. The VARO director indicated the 3-year contract does not always allow for consistent leadership. Under the current director, the VARO has had three temporary VSC managers and one permanent manager. Despite the high turnover in the VSC manager position since 2009, we did not identify a direct correlation between the 3-year contract and VSC operations. However, the changes in leadership did appear to affect the continuity of operations.

Recommendations
We made seven recommendations in our report:

- Implement a plan to ensure all required elements of SAOs are addressed.
- Date-stamp all incoming mail the date it is received at the VA Medical Center.
- Establish clear guidance for processing claims-related mail.
- Incorporate guidance for supervisors to monitor the mail-handling process.
- Implement a plan to ensure staff properly address Gulf War veterans' entitlement to mental health treatment.
- Implement a plan to ensure staff follow VBA's policy for defining homelessness.
- Implement a plan to ensure staff accomplish all required homeless veterans outreach services.

The Director agreed with our recommendations and initiated corrective actions. Our Benefits Inspections Divisions will follow up on implementation of these corrective actions.

COMPARISON TO OTHER REGIONAL OFFICES

The Honolulu VARO faces challenges achieving the performance exhibited by some of the VAROs we inspected. From April 2009 through March 2012, we published 47 VARO inspection reports. None of the VAROs totally complied with all of the operational areas we reviewed. Of the 47 VAROs on which we reported, the Jackson, Mississippi, and St. Paul, Minnesota, VAROs had the highest level of overall compliance (70 percent) with VBA policy in the areas inspected. Conversely, the Baltimore, Maryland, and Anchorage, Alaska, offices had the lowest rate of compliance (7 percent) with VBA standards. The Honolulu VARO fell in the middle range with an overall compliance rate of 38 percent.

Further, few VAROs achieved VBA's national target of 87 percent accuracy in claims processing alone. The highest claims processing accuracy rates based on our inspections were at the Wilmington, Delaware, VARO (93 percent), followed by Des Moines, Iowa (89 percent), and Nashville, Tennessee (86 percent). In contrast, other VAROs fell far short—namely, Houston, Texas (43 percent), St. Petersburg, Florida (53 percent), and Honolulu, Hawaii (53 percent). Although similar in size to the Honolulu

office, the Reno, Nevada, and Boise, Idaho, VAROs had better claims processing accuracy rates of 76 and 70 percent, respectively.

CONCLUSION

The challenges Honolulu faces to improving are not insurmountable. A VARO management focus on improving communication with staff and continuing training of inexperienced, first-line supervisors should go a long way in addressing the range of issues we identified. We are encouraged by the director's comments and proposed actions in response to our report recommendations. However, we will not be certain of any improvements until we conduct another inspection. We do not anticipate another visit until FY 2014 or later, which will allow management time to train staff and thoroughly implement improvement plans.

Senator Akaka, thank you for the opportunity to testify here today. Mr. Arronte and I would be pleased to answer any questions that you may have.