

# VA Office of Inspector General

## OFFICE OF AUDITS AND EVALUATIONS



## Inspection of the VA Regional Office Hartford, Connecticut

September 7, 2011  
11-00514-264

## **ACRONYMS AND ABBREVIATIONS**

COVERS	Control of Veterans Records System
FY	Fiscal Year
NOD	Notices of Disagreement
OIG	Office of Inspector General
PTSD	Post-Traumatic Stress Disorder
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
STAR	Systematic Technical Accuracy Review
TBI	Traumatic Brain Injury
VACOLS	Veterans Appeals Control and Locator System
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

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# Report Highlights: Inspection of the VA Regional Office, Hartford, Connecticut

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## Why We Did This Review

The Veterans Benefits Administration (VBA) has a nationwide network of 57 VA Regional Offices (VAROs) that process claims and provide services to veterans. We conducted this inspection to evaluate how well the Hartford VARO accomplishes this mission.

## What We Found

Hartford VARO staff properly established dates of claim in the electronic record and corrected errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review program staff. VARO performance was generally effective in processing claims related to herbicide exposure and post-traumatic stress disorder, and handling claims-related mail.

However, the VARO lacked effective controls and accuracy in processing some disability claims. Inaccuracies in processing temporary 100 percent disability evaluations resulted from human error when staff did not schedule required future medical reexaminations. Errors related to traumatic brain injury claims processing occurred because staff used insufficient medical examination reports to make final disability determinations and incorrectly evaluated the severity of disabilities. Overall, VARO staff did not accurately process 28 (28 percent) of the 100 disability claims we reviewed.

VARO management did not have a mechanism in place to determine if VSC staff processed Notices of Disagreement for

appealed claims within VBA's 7-day standard or produced complete and timely Systematic Analyses of Operations. VSC staff did not always expedite final competency determinations.

## What We Recommended

We recommended VARO management provide additional training to improve the accuracy of evaluating residuals of traumatic brain injuries. Management also needs to strengthen controls over the processing of Notices of Disagreements and improve oversight of Systematic Analyses of Operations. Moreover, management needs to amend the VARO workload management plan to ensure timely completion of competency determinations.

## Agency Comments

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

A handwritten signature in black ink that reads "Belinda J. Finn".

**BELINDA J. FINN**  
Assistant Inspector General  
for Audits and Evaluations

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## INTRODUCTION

### **Objective**

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

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

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

### **Scope of Inspection**

In May 2011, the OIG conducted an inspection of the Hartford VARO. The inspection focused on 5 protocol areas examining 10 operational activities. The five protocol areas were disability claims processing, data integrity, management controls, workload management, and eligibility determinations.

We reviewed 70 (29 percent) of 239 disability claims related to traumatic brain injury (TBI), herbicide exposure, and post-traumatic stress disorder (PTSD) that VARO staff completed from January through March 2011. In addition, we reviewed 30 (23 percent) of 131 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months, generally the longest period a temporary 100 percent disability evaluation may be assigned under VA policy without review.

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

## RESULTS AND RECOMMENDATIONS

### 1. Disability Claims Processing

The OIG inspection team focused on disability claims processing related to temporary 100 percent disability evaluations, TBI, herbicide exposure, and PTSD. We evaluated claims processing accuracy and its impact on veterans' benefits.

#### Finding 1 Disability Claims Processing Lacks Accuracy

Controls and accuracy in processing temporary 100 percent disability evaluations and TBI residual disability claims are lacking at the Hartford VARO. VARO staff incorrectly processed 28 (28 percent) of the total 100 disability claims reviewed. We advised VARO management regarding the inaccuracies noted during our inspection. They agreed with our assessments and initiated corrective measures to address them.

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

**Table**

**Disability Claims Processing Results**

Type	Reviewed	Claims Incorrectly Processed		
		Total	Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits
Temporary 100 Percent Disability Evaluations	30	18	4	14
Traumatic Brain Injury Claims	10	7	1	6
Herbicide Exposure-Related Disability Claims	30	2	2	0
Post-Traumatic Stress Disorder Claims	30	1	1	0
<b>Total</b>	<b>100</b>	<b>28</b>	<b>8</b>	<b>20</b>

Source: VA OIG

#### Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 18 (60 percent) of 30 temporary 100 percent disability evaluations we reviewed. Veterans Benefits Administration (VBA) policy requires a temporary 100 percent disability evaluation for a service-connected disability following surgery or when specific treatment is needed. At the end of a mandated period of

convalescence or upon cessation of treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's temporary 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 the diary matures, the electronic system generates a reminder notification alerting VSC staff to schedule the reexamination.

Based on analysis of available medical evidence, 4 of the 18 processing inaccuracies involved overpayments to veterans totaling \$151,265. The most significant overpayment occurred when a Rating Veterans Service Representative (RVSR) granted service connection for prostate cancer and noted the veteran would need reexamination in July 2008; however, VSC staff did not schedule the required reexamination. Our review of VA medical treatment records showed the veteran's condition had improved and therefore he was no longer entitled to receive temporary 100 percent disability benefits. As a result, VA overpaid the veteran a total of \$79,044 over a period of 2 years and 4 months.

The remaining 14 inaccuracies had the potential to affect veterans' benefits. We could not determine if the evaluations would have continued because the veterans' claims folders did not contain the medical examination reports needed to reevaluate each case.

The processing inaccuracies we identified were the result of human error. The most frequent processing inaccuracy noted in 14 (78 percent) of 18 inaccuracies occurred when VSC staff did not establish suspense diaries in the electronic record. Without suspense diaries, VSC staff did not receive reminder notifications to schedule required VA reexaminations.

The second most frequent processing inaccuracies noted in 4 (22 percent) of 18 inaccuracies occurred when VSC staff did not schedule mandatory reexaminations once they received reminder notifications. For example, in December 2009, an RVSR granted service connection for prostate cancer and appropriately noted staff schedule a future reexamination in March 2010. In March 2010, staff inappropriately cancelled the reminder notification to schedule the reexamination. Medical treatment reports indicated the veteran underwent surgery in September 2009 to remove the prostate. As such, the veteran was no longer entitled to receive a temporary 100 percent disability evaluation. Neither management nor we could determine why staff removed the reminder notification without taking the appropriate action to schedule

the reexamination. As a result, VA overpaid the veteran \$17,056 over a period of 8 months.

Delays in scheduling medical reexaminations ranged from approximately 1 month to 4 years and 8 months. An average of 1 year and 10 months elapsed from the time staff should have scheduled the reexaminations until the date of our inspection—the date staff ultimately took corrective actions to obtain the necessary medical evidence.

VARO management did not provide adequate oversight to ensure VSC staff entered suspense diaries or took appropriate follow-up actions on reminder notifications and proposed benefits reductions. As such, veterans did not always receive correct benefits payments. Because effective controls were not in place, temporary 100 percent disability evaluations could have continued uninterrupted over the course of the veterans' lifetimes.

We provided the VARO with 101 claims remaining from our universe of 131 claims selected for review. In response to a recommendation in our report, *Audit of 100 Percent Disability Evaluations* (Report Number 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 exam date entered in the electronic record. Therefore, we made no additional recommendation for improvement in this area.

### **TBI Claims**

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

VARO staff incorrectly processed 7 (70 percent) of 10 TBI claims—1 of these claims processing inaccuracies affected a veteran's benefits. In this instance, an RVSR incorrectly assigned a 40 percent evaluation for residuals of a TBI. However, the medical evidence revealed the veteran's disability warranted a 10 percent evaluation. As a result, VA overpaid the veteran \$1,358 over a period of 7 months.

The remaining six cases had the potential to affect veterans' benefits. Following are descriptions of these inaccuracies.

- In three cases, RVSRs used insufficient medical examination reports to evaluate TBI-related disabilities. According to VBA policy, when a medical examination report does not address all required elements, VSC staff should return it to the issuing clinic or health care facility as insufficient for rating purposes. Neither VARO staff nor we can



ascertain all of the residual disabilities of a TBI without adequate or complete medical evidence.

- In two cases, RVSRs incorrectly evaluated TBI residual disabilities. In both cases, the inaccuracies did not affect the veterans' current monthly disability payments; however, the incorrect evaluations may affect future payments.
- In one case, a combat veteran requested compensation for residuals of a TBI; however, an RVSR prematurely denied the claim without the benefit of a VA examination report to support the decision.

Generally, errors associated with TBI claims processing occurred because VARO staff found TBI evaluation criteria to be complex and difficult to apply. Additionally, VARO staff indicated the process of returning insufficient medical examination reports led to delays in completing claims. They informed us they used insufficient VA medical examination reports instead of returning them for correction as required. As a result, veterans did not always receive correct benefit payments. VARO management noted it had been over two years since RVSRs had specific training on how to evaluate residuals of TBIs; management only recently became aware RVSRs had difficulty with TBI evaluations.

#### **Herbicide Exposure-Related Claims**

VARO staff incorrectly processed 2 (7 percent) of 30 herbicide exposure-related claims that affected veterans' benefits. In both cases, RVSRs selected earlier effective dates to pay benefits. The veterans' claims folders did not contain any evidence to support the earlier dates to pay these benefits. As a result, VA overpaid one veteran \$34,026 over a period of 13 months and overpaid the other veteran \$2,916 over a period of 12 months.

Because we found only two inaccuracies, we determined the VARO was generally following VBA policy when processing herbicide exposure-related claims. As such, we made no recommendation for improvement in this area.

#### **PTSD Claims**

VARO staff incorrectly processed 1 (3 percent) of 30 PTSD claims. In this case, the RVSR prematurely granted service connection for PTSD using an insufficient medical examination report. The RVSR should have returned the VA examination to the VA facility because the VA examiner did not provide the required link between the current diagnosis and military service as required by VBA policy. Because we found only one inaccuracy, we determined the VARO was generally following VBA policy when processing PTSD claims. As such, we made no recommendation for improvement in this area.

#### **Recommendation**

1. We recommend the Hartford VA Regional Director ensure Rating Veteran Service Representatives receive refresher training on how to evaluate disabilities related to traumatic brain injuries.

**Management  
Comments**

The VARO Director concurred with our recommendation and reported RVSRs had completed TBI refresher training on June 9, 2011. The Director scheduled a second TBI training session for September 8, 2011.

**OIG Response**

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

## **2. Data Integrity**

**Dates of Claim**

We analyzed claims folders to determine if VARO staff were following VBA policy to establish dates of claim in the electronic record. VBA generally uses a date of claim to indicate when a document arrives at a VA facility. VBA relies on accurate dates of claim to establish and track key performance measures, including the average number of days to complete a claim. VARO staff established correct dates of claim in the electronic record for all 30 claims we reviewed; therefore, we made no recommendation for improvement in this area.

**Notices of  
Disagreement**

We reviewed claims folders to determine if VARO staff timely recorded Notices of Disagreement (NOD) in the Veterans Appeals Control and Locator System (VACOLS). An NOD is a written communication from a claimant expressing dissatisfaction or disagreement with a benefits decision and a desire to contest the decision. An NOD is the first step in the appeals process.

VACOLS is a computer application that allows VARO staff to control and track veterans' appeals as well as manage the pending appeals workload. VBA policy states staff must create a VACOLS record within 7 days of receiving an NOD. Accurate and timely recording of NODs is required to ensure appeals move through the appellate process expeditiously.

**Finding 2**

### **Insufficient Controls Over Recording Notices of Disagreement**

The Appeals Team did not always record NODs in VACOLS within VBA's 7-day standard. This occurred because management did not provide sufficient oversight to ensure VARO staff entered NODs in line with the standard. Untimely recording of NODs in VACOLS affects data integrity and misrepresents VARO performance.

VARO staff exceeded VBA's 7-day standard for 17 (57 percent) of 30 NODs we reviewed. It took staff an average of 21 days to record these 17 NODs in VACOLS. Management said they did not monitor local and national reports used to identify the timeliness of entering NODs in VACOLS for their office because of the VAROs current performance in completing NODs. Although staff can improve appeal control time, as of April 2011, the VARO's NODs

had been pending completion an average of 138.4 days, which is 43.6 days better than the national goal of 182 days.

Data integrity issues due to untimely recording of NODs make it difficult for VARO and senior VBA leadership to accurately measure and monitor VARO performance. For example, unnecessary delays in controlling NODs affect national performance for NOD inventory and timely completion of appeals. Further, VBA's National Call Centers rely upon accurate VACOLS information to provide quality service to claimants.

**Recommendation** 2. We recommend the Hartford VA Regional Office Director develop and implement a plan for providing adequate oversight to ensure staff timely record Notices of Disagreement in the Veterans Appeals Control and Locator System.

**Management Comments** The VARO Director concurred with our recommendation and informed us the Veterans Service Center Manager had begun a new process and assigned responsibility for processing all appeals-related mail to Veterans Service Representatives. In July 2011, a random review revealed staff recorded 26 of 30 NODs within VBA's 7-day standard. The Director attributed this improvement to the new process.

Further, the Director stated management provided oversight of the appellate workload and monitored NOD timeliness, including reviews of local and national reports. The VARO now specifically includes all appellate performance, including control time, to monitor the appellate workload better.

**OIG Response** The Director's actions are responsive to the recommendation. The Veterans Service Center Manager informed us they would add NOD timeliness as a measure for tracking appellate work. The Director also informed us the VARO now specifically includes all appellate performance, including control time, to monitor the appellate workload.

### 3. Management Controls

**Systematic  
Technical  
Accuracy  
Review**

We assessed management controls to determine if VARO management adhered to VBA policy regarding correction of errors identified by VBA's Systematic Technical Accuracy Review (STAR) staff. The STAR program is VBA's multifaceted quality assurance program to ensure that veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that VARO staff take corrective action on errors that STAR staff identify. VBA's STAR program staff identified errors in 29 claims files from January through March 2011. VARO staff followed VBA policy by correcting all the errors identified during that period. As such, we made no recommendation for improvement in this area.

**Systematic  
Analysis of  
Operations**

We assessed whether VARO management had controls in place to ensure complete and timely submission of each Systematic Analysis of Operations (SAO). An SAO is a formal analysis of a VSC organizational element or operational function. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. VARO management must publish an annual SAO schedule designating the staff required to complete the SAOs by specific dates. The VSC Manager is responsible for ongoing analyses of VSC operations, including completing 12 SAOs annually.

**Finding 3      Oversight Lacking To Ensure Timely and Complete  
SAOs**

VARO staff did not always ensure SAOs were timely and complete. VARO management did not provide adequate oversight to ensure VSC staff completed SAOs according to the annual schedule and addressed all required elements. As a result, VARO management may not have adequately identified existing and potential problems for corrective action to improve VSC operations.

Our analysis revealed 3 (25 percent) of 12 SAOs were not compliant with VBA policy—1 of the 12 required SAOs was untimely, 1 was incomplete (missing required elements), and 1 was not done at all. The VSC Manager position was vacant for approximately 2 months and during that time, the VARO had insufficient oversight of the SAO process. We could not assess the timeliness of six SAOs because VSC management was unable to locate the Fiscal Year (FY) 2010 SAO schedule providing completion dates for each of the mandated SAOs. According to the current management, the departing VSC Manager maintained responsibility to complete the FY 2010 Fiduciary SAO. However, at the time of our inspection this SAO was not completed.

By not providing adequate oversight of SAOs, VARO management did not identify a problem with VSC operations. VSC staff did not complete the appeals timeliness section of the Appeals SAO. If management had ensured proper completion of this section, they might have determined staff did not timely record NODs in VACOLS and implement measures to monitor control time for entering NOD in VACOLS.

- Recommendation**
3. We recommend the Hartford VA Regional Office Director develop and implement a plan for staff to address all required elements of Systematic Analyses of Operations and complete them in accordance with the VA Regional Office's annual schedule.

**Management  
Comments**

The VARO Director concurred with our recommendation and informed us the VSC manager controlled completion of all required SAOs within that VSC division. The Director advised that the VARO was compliant in addressing all required elements for SAOs completed in FY 2011. Further, the Director indicated the Acting VSC Manager had responsibility for the SAO process during the time that the VSC Manager was vacant.

**OIG Response**

The Director's actions are responsive to the recommendation. We recognize that the Acting VSC Manager had responsibility for the SAO process during the time that the VSC Manager position was vacant. However, we question the sufficiency of this oversight based on the results of our review.

## **4. Workload Management**

**Mailroom  
Operations**

We assessed controls over VARO mailroom operations to ensure staff timely and accurately processed incoming mail. VBA policy states staff will open, date stamp, and route all mail to the appropriate locations within 4 to 6 hours of receipt at the VARO. The Hartford VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Support Services Division. The VARO mailroom staff processed mail according to VBA policy; therefore, we made no recommendation for improvement in this area.

**Triage Mail  
Processing  
Procedures**

We assessed the VSC Triage Team's mail-processing procedures to ensure staff reviewed, controlled, and processed all claims-related mail in accordance with VBA policy. Our assessment included a review of 90 individual pieces of mail. VBA policy indicates that oversight to ensure staff use available plans and systems is the most important part of workload management. It also states that effective mail management is crucial to the control of workflow within the VSC.

**Military File  
Mail**

VBA policy allows the use of a storage area, known as the Military File, for VSC staff to store mail temporarily. Typically, the mail stored in this area pertains to matters over which VA has jurisdiction, does not refer to claims for benefits, and/or does not have return addresses.

Staff incorrectly handled 4 (13 percent) of 30 pieces of Military File mail we reviewed. Each of the four pieces of mail involved claims files physically located at Federal Archive Record Centers. The Triage Team did not request the claims files from the remote locations. Without these files to review, neither VSC staff nor we could determine if staff properly processed this mail. Due to the infrequency of mail handling inaccuracies, we made no recommendation for improvement in this area.

**Search and  
Drop Mail**

VBA policy requires that staff use the Control of Veterans Records System (COVERS), an electronic tracking system, to track claims folders and search mail. VBA defines search mail as active claims-related mail waiting to be associated with a veteran's claims folder. Conversely, drop mail requires no immediate action after staff placed the mail in the claims folder.

VSC staff correctly processed 60 pieces of search and drop mail we reviewed. The Triage Team used VBA's tracking system, Control of Veterans Records System (COVERS), to electronically track veterans' claims folders and control the search mail as required. VARO management implemented additional controls over search mail by restricting full access to the COVERs search mail function to VSC supervisors and Triage Team staff. The Triage Team supervisor also used electronic reports to analyze inventory trends and identify deficiencies in processing and controlling search mail. VSC staff appropriately categorized and processed all drop mail we reviewed. Therefore, we made no recommendations for improvement in this area.

## **5. Eligibility Determinations**

**Competency  
Determinations**

VA must consider beneficiary competency in every case involving a mental health condition that is totally disabling or when evidence raises questions as to a beneficiary's mental capacity to manage his or her affairs. The Fiduciary Unit supports implementation of competency determinations by appointing a fiduciary, a third party who assists in managing funds for an incompetent beneficiary. We reviewed competency determinations completed by the VSC Decision Team to ensure staff completed them accurately and timely. Delays in making these determinations ultimately affect the Fiduciary Unit's ability to appoint fiduciaries timely.

**Finding 4**

### **Inadequate Controls Over Competency Determinations**

VARO staff unnecessarily delayed making final decisions in 5 (28 percent) of 18 competency determinations completed from January through March 2011. The delays ranged from 22 to 60 days, with an average completion time of 44 days. The delays occurred because the VSC workload management plan did not contain procedures emphasizing immediate completion of incompetency decisions. The risk of incompetent beneficiaries receiving benefits payments without fiduciaries assigned to manage those funds increases when staff do not complete competency determinations immediately.

VBA policy requires staff to obtain clear and convincing medical evidence that a beneficiary is incapable of managing his or her affairs prior to making a final competency decision. The policy allows the beneficiary a 65-day due process period to submit the evidence showing an ability to manage funds



and other personal affairs. At the end of the due process period, VARO staff must take immediate action to determine if the beneficiary is competent.

Until recently, VBA did not have a clear, measurable definition of immediate and this time frame varied from office to office. In response to our summary report for FY 2010, *Systemic Issues Reported During Inspections at VA Regional Offices* (Report Number 11-00510-167, May 18, 2011), the Acting Under Secretary for Benefits defined “immediate” as 21 days following the expiration of the due process period.

Using VBA’s newly defined interpretation of immediate, the most significant case of placing funds at risk occurred when VARO staff unnecessarily delayed making a final incompetency decision for a veteran for approximately 53 days. During this period, the veteran received \$5,698 in disability payments. While the veteran was entitled to these payments, fiduciary stewardship was not in place to ensure effective funds management and the welfare of the veteran.

In October 2010, in a Compensation and Pension Service Bulletin, VBA reinforced the importance of immediately completing competency determinations and mandated VAROs update workload management plans to identify responsibility for managing the determinations. However, VARO management informed us they were unaware of this guidance. The VARO workload management plan lacked corresponding procedures for immediate completion of incompetency determinations and oversight of the process. As a result, incompetent beneficiaries received benefit payments for extended periods despite being incapable of managing these funds effectively.

In addition to processing delays, we identified one instance where VSC staff did not follow VBA policy when determining if a beneficiary was competent to handle VA funds. Staff determined the veteran was incompetent without affording the veteran the mandatory due process period to provide evidence to contest the determination. Because staff did not follow VBA policy, the prematurely appointed fiduciary received \$6,336. Due to the infrequency of this processing inaccuracy, we make no recommendation for improvement in this area.

- Recommendation** 4. We recommend the Hartford VA Regional Office Director amend the workload management plan to provide procedures for Veteran Service Center staff to complete final competency determinations timely.

**Management Comments** The VARO Director concurred with our recommendation. In June 2011, management updated the workload management plan to require that final competency determinations be reviewed each Monday and cases with past due suspense dates be worked the same week. Additionally, management

created a “flash” process to help staff readily identify claims needing competency determinations.

***OIG Response***

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

***Additional  
Management  
Comments***

The VARO Director provided an additional comment regarding information in Appendix A. The Director stated the Hartford VARO does not administer Home Loan Guaranty or Education Benefits.

***OIG Response***

VBA’s intranet provides information packets with specific operational and demographic information related to each VARO. General information on page 6 of the Hartford VARO packet indicates, “The Hartford Regional Office administers a variety of services and benefits including Compensation and Pension, Home Loan Guaranty, Education, Vocational Rehabilitation and Employment.” The VARO last updated this information in April 2011. Based on the Director’s comments, we removed Home Loan Guaranty and Education Benefits from the appendix describing services provided by the Hartford VARO.



## **Appendix A   VARO Profile and Scope of Inspection**

**Organization**       The Hartford VARO administers a variety of services and benefits including Compensation and Pension, and Vocational Rehabilitation and Employment. Other services include specially adapted housing grants, benefits counseling, fiduciary services, and outreach to homeless, elderly, minority, and women veterans.

**Resources**         As of March 2011, the Hartford VARO had a staffing level of 108 full-time employees. Of these, the VSC had 84 employees (78 percent) assigned.

**Workload**          As of April 2011, the VARO reported 2,352 pending compensation claims. The average time to complete these claims was 116.6 days, which is 58 days better than the national target of 175 days. As reported by STAR staff, the accuracy of compensation rating-related issues was 84.1 percent, which is below the 90 percent target set by VBA.

**Scope**             We reviewed selected management control, claims processing, and administrative activities to evaluate compliance with VBA policies regarding delivery of benefits and nonmedical services to veterans and other beneficiaries. We interviewed managers and employees and reviewed veterans' claims folders.

Our review included 70 (29 percent) of 239 disability claims related to TBI, herbicide exposure, and PTSD that the VARO completed from January through March 2011. For temporary 100 percent disability evaluations, we selected 30 (23 percent) of 131 existing claims from VBA's Corporate Database. We provided the VARO staff with 101 claims remaining from our universe of 131 for their review. These 101 claims represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months or longer as of April 2011.

We reviewed the 12 mandatory SAOs completed in FYs 2010 and 2011. Additionally, we reviewed 18 available competency determinations and 29 claims files containing errors identified by VBA's STAR program staff from January through March 2011. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR assessments include a review of work associated with claims requiring rating decisions. STAR staff review original claims, reopened claims, and claims for increased evaluations. Further, they review appellate issues that involve a myriad of veterans' disabilities claims.

Our process differs from STAR as we review specific types of disability claims related to TBI, herbicide exposure, and PTSD that require rating

decisions. In addition, we review rating decisions and awards processing involving temporary 100 percent disability evaluations.

We reviewed dates of claim for those claims pending at the VARO during our on-site inspection. NODs reviewed had been pending processing at the VARO between 31 and 60 days. Further, we reviewed mail in various processing stages in the VARO mailroom and the VSC.

We completed our review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspections*. We planned and performed the review to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our review objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our review objectives.

## Appendix B VARO Director's Comments

### Department of Veterans Affairs

### Memorandum

**Date:** July 26, 2011

**From:** Director, VA Regional Office Hartford, Connecticut

**Subj:** Inspection of the VA Regional Office, Hartford, Connecticut

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

1. Attached are the Hartford VARO's comments on the OIG Draft Report: Inspection of the VA Regional Office, Hartford, Connecticut.
2. Questions may be referred to Jessica Maki, Assistant Service Center Manager at (860) 666-7306 or Joseph Beaudoin, Veterans Service Center at (860) 666-7355.

*(original signed by)*  
Darryl Brady

Attachment  
Transmittal Letter Addendum

**Recommendation 1:**

**OIG Recommendation:** We recommend the Hartford VA Regional Director ensure Rating Veteran Service Representatives receive refresher training on how to evaluate disabilities related to traumatic brain injuries.

**RO Response:** Concur.

Hartford completed refresher Traumatic Brain Injury (TBI) training on June 9, 2011 for Rating Veterans Service Representatives. TBI training is also scheduled for the 4<sup>th</sup> Quarter on September 8, 2011. In accordance with policy set by VBA Central Office, all Rating Veterans Service Representatives (RVSR) are on second signature for TBI claims until they reach an accuracy rate of 90% for 10 claims. A Decision Review Officer (DRO) on the Quality Team completes the second signature review for all TBI claims.

**Recommendation 2:**

**OIG Recommendation:** We recommend the Hartford VA Regional Office Director develop and implement a plan for providing adequate oversight to ensure staff timely record Notices of Disagreement in the Veterans Appeals Control and Locator System.

**RO Response:** Concur.

In mid-April, Hartford's Veterans Service Center Manager assigned the Appeals Team to work all rating related claims pending with a concurrent appeal in an effort to minimize hand-offs between the Appeals Team and other teams within the office. At that time, Appeals VSRs were also given the responsibilities of processing all appeals related mail in an effort to control all appeals in a timely manner. In a random review on Notices of Disagreement (NOD) entered into the Veterans Appeals Control and Locator System (VACOLS), conducted on July 22, 2011, Hartford bettered the 7-day standard on 26 of the 30 NODs entered into VACOLS. The 30 NODs were entered into VACOLS in an average of 5 days. The four NODs that were not entered into VACOLS timely were entered in an average of 9.5 days. Hartford's NOD control time improved to 23 days for June 2011. Although we still have room for improvement, we anticipate the control time will continue to improve as we now have a process in place to effectively control appeals mail.

**Recommendation 3:**

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

**RO Response:** Concur.

Hartford's Service Center established an FY 2011 Systematic Analyses of Operations (SAO) schedule in September 2010 and all SAOs have either been completed on time, or there is documentation of an approved extension by Hartford's Director or Acting Director. Hartford's

VSCM controls completion of all required SAOs within the VSC division and we are 100% compliant for all required elements of VBA's SAO schedule in FY 2011.

**Recommendation 4:**

**OIG Recommendation:** We recommend the Hartford VA Regional Office Director amend the workload management plan to provide procedures for Veteran Service Center staff to complete final competency determinations timely.

**RO Response:** Concur

Hartford's workload management plan was updated in June 2011 to require that final competency determinations must be reviewed each Monday and cases with past due suspense dates are worked that week. A flash was created for the front of the claims folder to easily identify these claims. All VSC employees were provided the updated workload management plan on June 22, 2011.

The Hartford Regional Office concurs with all finding and recommendations made by the Office of Inspector General in their draft report of the inspection on the Hartford VA Regional Office. However, we note the following inaccuracies in the draft report and request they be corrected:

Finding 2: Insufficient Controls Over Recording Notices of Disagreement (pg. 6). The first paragraph notes, "This occurred because management did not provide any oversight to ensure VARO staff entered NODs in line with the standards." Management oversight of the appellate workload was provided. We recommend the statement quoted above be changed to indicate this.

The second paragraph notes, "Management did not monitor local and national reports used to identify the timeliness of NOD processing for their office. Management informed us they did not monitor NOD timeliness because of the VAROs current performance in completing NODs." Management does monitor NOD timeliness including reviews of local and national reports. To better monitor aspects of the appellate workload, Hartford now specifically includes all appellate performance, to include control time of the appellate workload, on the Monday Morning Workload local tracker. However, we recommend striking the statements quoted above, as factually incorrect.

Finding 3: Oversight Lacking to Ensure Timely and Complete SAOs (pg. 7-8). The second paragraph notes "the VSC Manager position was vacant for approximately 2 months. During that time, the VARO had no oversight of the SAO process." This statement is factually incorrect. The VSC Manager had the responsibility for FY11 until mid-October 2010. The VSC Manager position was vacant in fiscal year 2011 from mid-October 2010 through November 27, 2010. During that time, an Acting VSC Manager had responsibility until the newly appointed VSC Manager arrived on station in November 2010.

Appendix A: Organization (pg. 11). The Hartford VARO does not administer Home Loan Guaranty or Education benefits. The report incorrectly states these benefits are administered by the Harford VARO.

## Appendix C Inspection Summary

10 Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Claims Processing			
1. Temporary 100 Percent Disability Evaluations	Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations. (38 CFR 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (M 21-1 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 claims for service connection for all residual disabilities related to in-service TBI were properly processed. (Fast Letters 08-34 and 08-36, Training Letter 09-01)		X
3. Herbicide Exposure-Related Claims	Determine whether VARO staff properly processed claims for service connection for herbicide exposure (Agent Orange). (38 CFR 3.309) (Fast Letter 02-33) (M21-1MR Part IV, Subpart ii, Chapter 2, Section C.10)	X	
4. Post-Traumatic Stress Disorder Claims	Determine whether VARO staff properly processed claims for PTSD. (38 CFR 3.304(f))	X	
Data Integrity			
5. Dates of Claim	Determine whether VARO staff properly recorded dates of claim in the electronic record. (M21-1MR, Part III, Subpart ii, Chapter 1, Section C)	X	
6. Notices of Disagreement	Determine whether VARO staff properly entered NODs into VACOLS. (M21-1MR Part I, Chapter 5)		X
Management Controls			
7. Systematic Technical Accuracy Review	Determine whether VARO staff properly corrected STAR errors in accordance with VBA policy. (M21-4, Chapter 3, Subchapter II, 3.03)	X	
8. Systematic Analysis of Operations	Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs. (M21-4, Chapter 5)		X
Workload Management			
9. Mail Handling Procedures	Determine whether VARO staff properly followed VBA mail-handling procedures. (M23-1) (M21-4, Chapter 4) (M21-1MR Part III, Subpart ii, Chapters 1 and 4)	X	
Eligibility Determinations			
10. Competency Determinations	Determine whether VAROs properly assessed beneficiaries' mental capacity to handle VA benefit payments. (M21-1MR Part III, Subpart v, Chapter 9, Section A) (M21-1MR Part III, Subpart v, Chapter 9, Section B) (Fast Letter 09-08)		X

Source: OIG

CFR=Code of Federal Regulations, M=Manual, MR=Manual Re-write

## **Appendix D    Office of Inspector General Contact and Staff Acknowledgments**

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