VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Manchester, New Hampshire

November 22, 2011

11-03384-31

ACRONYMS AND ABBREVIATIONS

OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
STAR	Systematic Technical Accuracy Review
TBI	Traumatic Brain Injury
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of the VA Regional Office, Manchester, New Hampshire

Why We Did This Review

The Veterans Benefits Administration 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 Manchester VARO accomplishes this mission.

What We Found

Manchester VARO staff accurately addressed entitlement to mental health treatment for Gulf War veterans. VARO performance was generally effective in processing traumatic brain injury and herbicide-related claims, correcting errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review program, ensuring Systematic Analyses of Operations were timely and complete, and handling claims-related mail.

However, the VARO lacked accuracy in processing some disability claims. Inaccuracies in processing temporary 100 percent disability evaluations occurred when staff did not schedule required medical reexaminations. Overall, VARO staff did not accurately process 18 (26 percent) of 68 disability claims we reviewed.

Management did not have mechanisms in place to timely process competency determinations. Further, outreach to homeless shelters and service providers was not always effective.

What We Recommend

We recommend the Manchester VARO Director amend the Veterans Service Center workload management plan to ensure timely completion of competency determinations.

We also recommend the Director develop and implement a plan to monitor and assess effectiveness in providing outreach information to homeless shelters and service providers.

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.

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

Scope of Inspection

In August 2011, the OIG conducted an inspection of the Manchester VARO. The inspection focused on five protocol areas examining nine operational activities. The five protocol areas were disability claims processing, management controls, workload management, eligibility determinations, and public contact.

We reviewed 38 (33 percent) of 115 disability claims related to traumatic brain injury (TBI) and herbicide exposure completed from April through June 2011. In addition, we reviewed 30 (50 percent) of 60 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 evaluations, TBI, and herbicide exposure. We evaluated claims processing accuracy and its impact on veterans' benefits.

Finding 1 Disability Claims Processing Accuracy Could Be Improved

The Manchester VARO lacked accuracy in processing claims for temporary 100 percent disabilities. Due to inadequate controls, VARO staff incorrectly processed 18 (26 percent) of the total 68 disability claims we reviewed. VARO management agreed with our assessments and initiated action to correct the inaccuracies identified.

The table below reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Manchester 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	14	2	12
Traumatic Brain Injury Claims	8	3	0	3
Herbicide Exposure-Related Disability Claims	30	1	1	0
Total	**68**	**18**	**3**	**15**

Source: VA OIG

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 14 (47 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 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.

Our analysis of available medical evidence showed that 2 (14 percent) of 14 processing inaccuracies involved overpayments to veterans totaling $66,550. The most significant overpayment occurred when a Rating Veterans Service Representative (RVSR) continued a 100 percent evaluation for cancer and noted the veteran would need reexamination in February 2009; 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 $52,478 over a period of 2 years and 8 months.

Further, 12 of the 14 inaccuracies had the potential to affect veterans' benefits. We could not determine if the evaluations would have continued for 11 cases because the veterans' claims folders did not contain medical examination reports needed to reevaluate each case. The remaining case involved an incorrect proposal to reduce a disability evaluation.

All 14 processing inaccuracies were the result of human error. The most frequent processing inaccuracy noted in 10 (71 percent) of the 14 cases occurred when VSC staff did not establish or incorrectly established suspense diaries in the electronic record. Without suspense diaries, VSC staff did not receive reminder notifications to schedule required VA medical reexaminations.

For those cases requiring reexaminations, delays ranged from approximately 5 months to 6 years and 9 months. An average of 2 years and 8 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 for confirmed and continued rating decisions. In November 2009, VBA provided guidance reminding VAROs about the need to input suspense diaries in the electronic record for confirmed and continued rating decisions needing medical reexaminations. However, VARO

management did not have a local policy in place requiring VSC staff to review the electronic record for such cases. As a result, 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.

In response to a recommendation in our 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 had a future examination date entered in the electronic record. As such, we are making no specific recommendation for this VARO. To assist in implementing the agreed-upon review, we provided the VARO with 30 claims remaining from our universe of 60 temporary 100 percent disability evaluations. We will continue to monitor VBA's progress in correcting this issue nationwide.

Additionally, we observed 5 temporary 100 percent disability medical reexamination dates that extended 3 years beyond the dates selected by RVSRs. A review of the claims processing awards documents revealed VSC staff had accurately entered the reexamination dates in the electronic record. VSC staff stated they took no action to extend the future examination dates beyond the dates selected by the RVSRs. Neither VARO staff nor we could explain these anomalies. If not for our inspection, the temporary 100 percent evaluations for these five veterans would have continued inappropriately beyond the requested reexamination dates. We will continue monitoring reexamination date entries in other offices to determine the frequency of such occurrences.

TBI Claims

The Department of Defense and VBA commonly define a TBI as a 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 three (38 percent) of eight TBI claims. All of these processing inaccuracies had the potential to affect veterans' benefits. Following are descriptions of these inaccuracies.

- In two cases, RVSRs used insufficient medical examinations 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 TBI-related disabilities without sufficient or complete medical evidence.

- In the remaining case, an RVSR incorrectly granted service-connection for a TBI-related disability. However, the evidence did not show the veteran sustained a TBI while on active duty. The inaccuracy did not affect the veteran's current monthly disability payments.

We did not identify a systemic issue with TBI claims processing as one RVSR was responsible for all three TBI errors, indicating a lack of understanding on the part of this individual. We advised VARO officials of this potential training deficiency. Because of the limited nature of this matter, we made no recommendation for improvement in this area.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 1 (3 percent) of 30 herbicide exposure-related claims we reviewed. In this case, an RVSR established an incorrect effective date for a service-connected disability. As a result, VA underpaid the veteran $2,673 over a period of 1 month.

Because we found only one inaccuracy, 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.

2. Management Controls

Systematic Technical Accuracy Review

We assessed whether 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 veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that VARO staff take corrective action on errors identified by STAR.

VARO staff did not correct 1 (6 percent) of 18 claims files containing errors that STAR program staff identified from January through March 2011. In this instance, VARO management erroneously reported to STAR staff that they had completed all corrective actions. Because VARO management generally followed VBA policy regarding correction of STAR errors, we made no recommendation for improvement in this area.

Systematic Analysis of Operations

We assessed whether VARO management had adequate controls in place to ensure complete and timely submission of each Systematic Analysis of Operations (SAOs). We also considered whether VSC staff had adequate data to support the analyses and recommendations identified in each SAO. An SAO is a formal analysis of a VSC organizational element or operational function. An SAO provides 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 12 SAOs annually.

VARO management did not complete 1 (8 percent) of 12 required SAOs. Management did not complete the SAO for Quality of Correspondence because of a lack of oversight. The VSC Manager assigned the SAO to the VARO Director's office; however, management did not follow up to ensure completion of the SAO.

For the 11 completed SAOs, management used adequate data to support their analyses. For example, management obtained data from the Fiduciary Beneficiary System that revealed fiduciaries did not always provide complete accounting of income and expenses for incompetent beneficiaries. Management recommended staff receive refresher training on how to track income and expenses. Because management generally followed VBA policy by ensuring SAOs were timely and complete, we made no recommendation for improvement in this area.

3. 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 Manchester VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Support Services Division. 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. 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.

Search and Drop Mail

VBA policy requires that VARO staff use the Control of Veterans Records System, an electronic tracking system, to track claims folders and control search mail. VBA defines search mail as active claims-related mail waiting to be associated with veterans' claims folders. Conversely, drop mail requires no immediate action after staff place the mail in the related claims folders.

VSC staff did not properly manage 2 (3 percent) of 60 pieces of mail we reviewed. As a result, we determined the Manchester VARO was generally complying with national and local mail-handling policies. Therefore, we made no recommendation for improvement in this area.

4. Eligibility Determinations

Entitlement to Medical Treatment for Mental Disorders

Gulf War veterans are eligible for medical treatment for any mental disorder developed within 2 years of the date of separation from 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.

For the one case available for our review, VARO staff followed VBA policy by properly considering entitlement to mental health treatment. As such, we made no recommendation for improvement in this area.

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 made at the VARO 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 2 Inadequate Controls Over Competency Determinations

VARO staff unnecessarily delayed making final decisions in 5 (36 percent) of 14 competency determinations completed from April through June 2011. The delays occurred because the VSC workload management plan did not contain procedures emphasizing completion of incompetency decisions within VBA's 21-day standard. 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 60-day due process period to submit 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 whether the beneficiary is competent. In July 2011, VBA defined "immediate" as 21 days.

For the 5 cases we identified, delays in making final competency determinations ranged from 17 to 115 days, with an average completion time of 49 days. In the most egregious case, involving a delay of about 115 days, the beneficiary received $4,224 in disability payments. While the beneficiary was entitled to these payments, fiduciary stewardship was not in

place to ensure effective funds management and the welfare of the beneficiary.

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 competency 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.

Recommendation

1. We recommend the Manchester VA Regional Office Director amend the workload management plan to include procedures for Veterans Service Center staff to complete final competency determinations timely.

Management Comments

The VARO Director concurred with our recommendation and amended the Workload Management Plan to incorporate revised procedures to control competency determinations. The Director ensured employees received training on the revised Workload Management Plan. In addition, the Service Center now tracks the average days these claims are pending as another control for the claims inventory.

OIG Response

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

5. Public Contact

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. VBA provided guidance to all VAROs that claims submitted by homeless veterans should receive priority processing.

Expedited Claims Processing for Homeless Veterans

We found no excessive delays in processing homeless veterans' claims. VBA's national performance measure for processing homeless veterans' claims is determined by the average days claims are pending completion. VBA calculates this average using the total lapsed days since VA received all of the claims collectively, divided by the total number of claims pending. VBA's national target is for homeless veterans' claims to be pending no more than an average of 75 days.

At the time of our inspection, according to VBA, the Manchester VARO had 10 homeless veterans' claims pending an average of 137 days—exceeding VBA's 75-day national target by 62 days. For 4 of the 10 claims, VARO staff were not aware the veterans were homeless because the veterans did not

notify the VARO of their homeless status upon initially submitting the claims. The veterans informed the VARO of their homeless state in subsequent correspondence related to their claims. These four claims had been pending an average of 62 days; lapsed time since individual claims were submitted ranged from 27 to 104 days.

VBA's performance measure of average days pending does not reflect how long it takes VARO staff to process and complete these claims; it only reflects the average time elapsed since the pending claims were submitted. To determine the actual time the 10 claims were pending, we recalculated the average days pending, using the time elapsed from the date VARO staff became aware of the veterans' homeless status to the time of our inspection. As a result, the adjusted average pending time for these claims was 41 days—34 days better than VBA's national target. As such, we made no recommendation for improvement in this area.

Outreach to Homeless Shelters and Service Providers

Congress mandated at least one full-time employee oversee and coordinate programs for homeless veterans at each of the 20 VAROs that VA determined to have the largest veteran populations. VBA guidance, last updated in September 2002, directed that the 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 advocate groups to provide information on VA benefits and services.

Finding 3 No Clear Measures to Assess Effectiveness of the Homeless Veterans Outreach Program

The Manchester VARO's outreach to homeless shelters and service providers was not always effective. This occurred because VARO management did not have a local process or procedure in place to assess outreach efforts. As a result, VARO management had no assurance that homeless shelters and service providers were aware of available VA benefits and services.

VARO management did not update a resource directory of homeless shelters, day-care facilities, and service providers, as required by VBA policy. We contacted representatives at 12 (50 percent) of 24 homeless shelters and service providers listed on a version of the directory VSC staff provided. The representatives indicated VARO staff did not contact them, nor did they receive information regarding VA benefits and services. VSC staff confirmed they did not routinely follow up with homeless shelters or service providers or provide these facilities with outreach information.

The Manchester VARO did not have a full-time coordinator dedicated to address homeless veterans' needs. VARO management had assigned one employee to perform this function as a collateral duty. VSC management also did not have a mechanism in place to determine whether its homeless veteran outreach efforts were effective. As a result, VARO management had no assurance homeless shelters and service providers received information from the VARO regarding benefits and services available to homeless veterans.

Recommendations

2. We recommend the Manchester VA Regional Office Director develop and implement a plan to monitor and assess effectiveness in providing outreach information to homeless shelters and service providers.

Management Comments

The VARO Director concurred with our recommendation. In August 2011, the Director implemented a plan to monitor and assess outreach to homeless shelters and service providers. The Director amended the Workload Management Plan to incorporate a Standard Operating Procedure for Homeless Veterans claims processing, outreach, and instructions for internal reporting. Further, in August 2011, the Homeless Veterans Coordinator and Service Center staff completed training on these program changes.

OIG Response

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

Appendix A VARO Profile and Scope of Inspection

Organization

The Manchester VARO administers a variety of services and benefits including Compensation and Pension, Vocational Rehabilitation and Employment, and Home Loan Guaranty. Other services include specially adapted housing grants, fiduciary/guardianship services, benefits counseling, and outreach to homeless, elderly, minority, and women veterans.

Resources

As of July 2011, the Manchester VARO had a staffing level of 48 full-time employees. Of these employees, 33 (69 percent) were assigned to the VSC.

Workload

As of July 2011, the VARO reported 1,886 pending compensation claims. The average time to complete claims was 202.7 days, which exceeded the national target of 175 days by 27.7 days. As reported by STAR staff, accuracy of compensation rating-related decisions was 79.3 percent, which was below the 90 percent target set by VBA.

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 38 (33 percent) of 115 disability claims related to TBI and herbicide exposure completed from April through June 2011. For temporary 100 percent disability evaluations, we selected 30 (50 percent) of 60 existing claims from VBA's Corporate Database. We provided VARO management with the 30 claims remaining from our universe of 60 for their review. These claims represented all instances in which VARO staff granted temporary 100 percent disability determinations for at least 18 months.

We reviewed all 18 files containing errors identified by VBA's STAR program from January through March 2011. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR measurements include a review of work associated with claims that require 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' disability claims.

Our process differs from STAR as we review specific types of disability claims such as those related to TBI and herbicide exposure that require rating decisions. We review rating decisions and awards processing involving temporary 100 percent disability evaluations. Additionally, we reviewed the 12 mandatory SAOs completed in FYs 2010 and 2011.

We selected mail in various processing stages in the VARO mailroom and the VSC. We reviewed one claim completed for a Gulf War veteran from April to June 2011 to determine whether VSC staff addressed entitlement to mental health treatment in the rating decision document as required. We reviewed 14 competency determinations and 10 homeless veterans' claims pending at the time of our inspection. Further, we reviewed the effectiveness of the VARO's homeless veterans outreach program.

We completed our review 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 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: October 31, 2011

From: Acting Director, VA Regional Office Manchester, NH (373/00)

Subj: Inspection of the VA Regional Office, Manchester, NH

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

1. Attached are the Manchester VARO's comments on the OIG Draft Report: Inspection of the VA Regional Office, Manchester, NH.

2. Questions may be referred to Pam Tebo-Piccione, Acting Veterans Service Center Manager at (603) 222-5711.

(original signed by:)

J. McGonagle

Attachment

Manchester VA Regional Office Response

OIG Recommendation 1: We recommend the Manchester VA Regional Office Director amend the Workload Management Plan to include procedures for Veterans Service Center staff to complete final competency determinations timely.

RO Response: Concur.

The Workload Management Plan (WMP) update was completed in September 2011, incorporating revised procedures to control competency determinations and include processes established by Fast Letter 11-20, Timeliness Standard for Final Competency Determinations.

Training on FL 11-20 was completed in July 2011 and employees received training on the content and use of the revised WMP on October 20, 2011.

To further control this portion of the workload, on May 23, 2011, the Service Center added a count for these claims on the internal Monday Morning Workload Report (MMWR). The average days pending for these cases will be added to the MMWR as another control for this inventory.

OIG Recommendation 2: We recommend the Manchester VA Regional Office Director develop and implement a plan to monitor and assess effectiveness in providing outreach information to homeless shelters and service providers.

RO Response: Concur.

During August 2011, the Manchester VA Regional Office fully implemented a plan to monitor and assess outreach to homeless shelters and service providers. The program changes are documented in the revised Workload Management Plan, incorporating a Standard Operating Procedure for Homeless Veterans claims processing, outreach guidance, instructions for internal reporting, outreach frequency, and required Homeless Veterans Outreach Coordinator (HVOC) training.

The HVOC and Service Center staff completed training on the program changes in August 2011, with an additional overview provided on October 13, 2011, when training was provided on the revised WMP.

Appendix C Inspection Summary

Nine 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 CFR 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) M21-1MR 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 all disabilities related to in-service TBI.** (FLs 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-related disabilities.** (38 CFR 3.309) (Fast Letter 02-33) (M21-1MR Part IV, Subpart ii, Chapter 2, Section C.10)	X	
Management Controls			
4. 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	
5. 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			
6. 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			
7. Gulf War Veterans' Entitlement to Mental Health Treatment	**Determine whether VARO staff properly processed Gulf War Veterans' claims for Medical Treatment for Mental Illness.** (38 United States Code USC 1702) (M21-1MR Part IX, Subpart ii, Chapter 2) (M21-1MR Part III, Subpart v, Chapter 7) (Fast Letter 08-15) (38 CFR 3.384)	X	
8. 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) (FL 09-08)		X
Public Contact			
9. Homeless Veterans Outreach Program	**Determine whether VARO staff expeditiously processed homeless veterans' claims and provided effective outreach services.** (Public Law 107-05) (M21-1MR Part III Subpart ii, Chapter 1, Section B) (M21-1MR Part III Subpart iii, Chapter 2, Section I) (VBA Circular 20-91-9) (VBA Letter 20-02-34) (C&P Service Bulletins August 2009, January 2010, April 2010, May 2010)		X

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

Appendix D Office of Inspector General Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Brent Arronte, Director Kristine Abramo Daphne Brantley Robert Campbell Madeline Cantu Danny Clay Lee Giesbrecht Kerri Leggiero-Yglesias Nelvy Viguera Butler Mark Ward

Appendix E Report Distribution

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