VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office White River Junction, Vermont

January 17, 2012
11-00518-54

ACRONYMS AND ABBREVIATIONS

C&C	Confirmed and Continued
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
VSCM	Veterans Service Center Manager

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Report Highlights: Inspection of the VA Regional Office, White River Junction, Vermont

Why We Did This Review

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

What We Found

White River Junction VARO staff accurately processed traumatic brain injury claims. The VARO was also timely in processing homeless veterans' claims and providing benefits information to local homeless advocacy groups.

The VARO lacked accuracy in processing some disability claims. Inaccuracies in processing temporary 100 percent disability evaluations resulted when staff did not schedule required medical reexaminations. Generally, inaccuracies in processing herbicide exposure claims occurred when staff did not obtain medical examination reports sufficient for evaluating related disabilities. Overall, VARO staff did not accurately process 19 (37 percent) of the total 52 disability claims we sampled as part of our review.

VARO staff did not always correct errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review program. Management did not always complete all elements of Systematic Analyses of Operations or include all mandatory analyses on the annual schedule. Further, management did not always ensure staff daily received all mail from the VA Medical Center mailroom for processing as required. Delays in making final competency determinations occurred when staff did not prioritize these decisions as required.

What We Recommend

We recommend the White River Junction VARO Director develop and implement a plan to improve the quality review process for Rating Veterans Service Representatives with less than 2 years of rating experience. Further, the Director should ensure staff address errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review program, complete all required elements of Systematic Analyses of Operations, process all mail the day the mailroom receives it, and complete final competency determinations timely.

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 White River Junction VARO. The inspection focused on five protocol areas examining eight operational activities. The five protocol areas were disability claims processing, management controls, workload management, eligibility determinations, and public contact.

We reviewed 22 (88 percent) of 25 of available disability claims related to traumatic brain injury (TBI) and herbicide exposure completed from April through June 2011. In addition, we reviewed 30 (60 percent) of 50 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 VARO Staff Could Improve Disability Claims Processing Accuracy

The White River Junction VARO lacked accuracy in processing temporary 100 percent evaluations and claims for herbicide exposure-related disabilities. Due to inadequate controls, VARO staff incorrectly processed 19 (37 percent) of the total 52 disability claims, we reviewed and overpaid approximately $533,930 in benefits payments. Because we sampled claims related to specific conditions, these results may not represent the universe of disability claims processed at this VARO. 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 White River Junction VARO.

Table

VARO White River Junction Disability Claims Processing Results

Type	Reviewed	Claims Incorrectly Processed		
		Total	Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits
Temporary 100 Percent Disability Evaluations	30	15	7	8
Traumatic Brain Injury Claims	1	0	0	0
Herbicide Exposure-Related Disability Claims	21	4	1	3
Total	**52**	**19**	**8**	**11**

Source: VA OIG

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 15 (50 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 (C&C) 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.

Available medical evidence showed that 7 (47 percent) of 15 processing inaccuracies we identified affected veterans' benefits. These inaccuracies involved overpayments totaling approximately $531,825. The remaining eight inaccuracies had the potential to affect veterans' benefits. We could not determine if the evaluations would have continued for these eight cases because the veterans' claims folders did not contain the medical examination reports needed to reevaluate each case.

The most frequent processing inaccuracy noted in 11 (73 percent) of 15 cases 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 the required VA medical reexaminations. For example, the most significant overpayment occurred when a Rating Veterans Service Representative (RVSR) established service connection for prostate cancer and noted the veteran would need a reexamination in November 2001. Because VSC staff did not enter a suspense diary in the electronic record, no reminder notification was generated and the reexamination was never scheduled. VA medical reports showed the veteran's condition improved, and therefore, he was no longer entitled to a 100 percent disability evaluation. As a result, VA overpaid the veteran approximately $185,182 over a period of 7 years and 2 months.

One way to ensure staff enter suspense diaries in the electronic record is to generate award documents when implementing C&C rating decisions, thereby increasing oversight as the award documents undergo the approval process. In November 2009, VBA provided guidance reminding VAROs of this requirement. VSC staff who process rating decisions stated this practice began at the VARO sometime in 2009; however, VARO management contradicted that the generation of award documents had begun many years prior.

By reviewing claims files, we confirmed that VSC staff began generating award documents for C&C rating decisions during 2009. Of the 11 most frequent processing errors involving suspense diaries, 5 were cases related to

C&C rating decisions. Staff processed these five cases prior to 2009 and did not generate awards. Because the practice of generating awards for C&C rating decisions did not appear to be in place prior to 2009, veterans may not have always received correct benefits payments.

For those cases requiring reexaminations, delays ranged from approximately 2 months to 9 years and 10 months. An average of nearly 4 years 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.

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 20 claims remaining from our universe of 50 temporary 100 percent disability evaluations.

Additionally, we observed two temporary 100 percent disability medical reexamination dates that extended 3 years beyond the dates selected by RVSRs. A review of the claims processing award 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 two veterans would have continued inappropriately beyond the reexamination dates. We will continue monitoring reexamination date entries in other offices to determine the frequency of such occurrences.

TBI Claims

VSC staff correctly processed during the third quarter of FY 2011 one TBI claim available for our review. Therefore, we made no recommendation for improvement in this area.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 4 (19 percent) of 21 herbicide exposure-related claims—one of these claims affected a veteran's benefits. In this case, an RVSR used an incorrect effective date to establish service connection for a herbicide exposure-related disability that resulted in an overpayment to the veteran of approximately $2,105 over a 5-month period. Additionally, in this same case, the RVSR did not establish service connection for another disability despite medical treatment records associating it with the veteran's herbicide exposure-related disability.

The three remaining inaccuracies had the potential to affect veterans' benefits. In all three cases, medical examination reports did not contain

information sufficient for evaluating related disabilities. Neither VARO staff nor we can determine the impact of these errors without accurate medical reports.

VSC management and staff thought these processing errors most likely resulted from RVSRs rushing through decisions to meet production standards. VSC management also indicated the RVSRs' experience level might have been a factor. RVSRs with less than 2 years of rating experience made all four errors. Three (75 percent) of the four incorrectly processed claims underwent an additional level of quality review by an experienced RVSR; however, the experienced RVSR also did not identify the errors. As such, management acknowledged a need for more thorough accuracy reviews.

Recommendation

1. We recommend the White River Junction VA Regional Office Director implement a plan to improve the effectiveness of the quality review process for Rating Veterans Service Representatives with less than 2 years of rating experience.

Management Comments

The Acting VARO Director concurred with our recommendation. VARO management amended the Workload Management Plan and implemented a standard operating procedure that requires RVSRs with less than two years experience to have all rating decisions undergo a second review by a Decision Review Officer.

OIG Response

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

2. Management Controls

Systematic Technical Accuracy Review

We assessed management controls to determine 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 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.

Finding 2 Oversight Needed To Ensure Accurate Reporting of Corrective Actions Taken by VARO Staff

VARO staff did not correct 3 (14 percent) of 21 claims files containing errors that STAR program staff identified from April through June 2011. These errors occurred because of a lack of oversight to ensure the accurate reporting of corrections to STAR program staff. As a result, VARO management did not ensure veterans were receiving accurate benefit payments.

The Veterans Service Center Manager (VSCM) served as the single point of contact for managing the process of reporting corrective actions taken on errors identified by VBA's STAR staff. In the absence of the VSCM, she delegated this responsibility to another manager. In two instances, management reported staff took corrective actions; however, a review of the claims files did not disclose a record of those corrective actions. In the remaining case, VSC staff disagreed with the error identified by STAR program staff but did not follow proper procedures to have the case reconsidered. The VSCM was unsure how the inaccurate reporting occurred.

Recommendation

2. We recommend the White River Junction VA Regional Office Director develop and implement a plan to ensure action is taken to correct errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review program.

Management Comments

The Acting VARO Director concurred with our recommendation. Veterans Service Center management amended local Systematic Technical Accuracy Review procedures to provide additional tracking and oversight for cases requiring correction. The VARO management analyst will review a tracking log monthly to provide additional oversight of the process.

OIG Response

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

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 (SAO). We also considered whether VSC staff had adequate data to support the analyses and recommendations identified in the SAOs. 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 an annual SAO schedule designating the staff required to complete the SAOs by specific dates. The VSCM is responsible for ongoing analysis of VSC operations, including completing 12 SAOs annually.

Finding 3 Improved Oversight Needed To Ensure Systematic Analyses of Operations are Timely and Complete

Five (42 percent) of 12 SAOs were untimely or incomplete, missing several required elements and their analyses. This occurred because VARO management lacked adequate controls over the SAO process. As a result, management may not have adequately identified existing and potential problems for corrective action to improve VSC operations.

Of the five inadequate SAOs, four were missing required elements and related analyses. For example, VBA policy requires that the Fiduciary program SAO address and complete analyses in 13 areas; however, VARO staff did not address 9 (69 percent) of the required elements.

VARO management did not have sufficient controls to ensure staff assigned to complete SAOs addressed all required elements and related analyses. The VSCM, responsible for reviewing SAOs, stated she followed VBA policy and used previously completed SAOs as a guide when reviewing new analyses. The VSCM speculated staff might have addressed some required elements of these SAOs under another heading; however, our review confirmed all four SAOs were missing required elements.

VARO staff delayed completing the remaining SAO for 323 days. The VSCM and the VARO Director share responsibility for completing the annual SAO schedule. However, their staff inadvertently omitted the Quality of Control Actions SAO and did not list all 12 mandatory SAOs on the 2010 annual SAO schedule as required. Management did not realize the omission until August 2011 at which time staff took action to complete the SAO.

Recommendation

3. We recommend the White River Junction VA Regional Office Director develop and implement a plan to ensure staff annually schedule all 12 mandatory Systematic Analyses of Operations and address all required elements of each analysis.

Management Comments

The Acting VARO Director concurred with our recommendation and amended the office Workload Management Plan. The amended plan requires the VARO Management Analyst to use a Reports Tracking worksheet to centrally organize and track all mandatory Systematic Analyses of Operations.

OIG Response

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

3. Workload Management

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.

The Triage Team staff did not properly manage 1 (2 percent) of 55 pieces of mail we reviewed. As a result, we determined the White River Junction VARO was generally complying with national and local mail-handling policies. Therefore, we made no recommendation for improvement in this area.

Mailroom Operations

We assessed controls over 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. The White River Junction VARO does not have its own mailroom; however, the VA Medical Center mailroom, co-located with it on the same VA campus, receives all incoming mail for the VARO. VARO staff are responsible for retrieving and processing this mail on a daily basis, including date-stamping the mail.

Finding 4 Improvement Needed for Timely Mail Processing

VARO staff did not always date-stamp mail the same day it arrived at the mailroom as required. This occurred because management was unaware of VBA's policy regarding timely processing of veterans' mail. As a result, beneficiaries may not have received accurate benefits payments.

Mailroom staff indicated they do not typically sort all mail received from the U.S. Post Office by the time VARO staff pick up mail daily. As such, VARO staff collect any mail sorted after the daily pick-up with the next day's mail. For example, during one daily mail delivery, mailroom staff placed seven additional pieces of mail in the VARO's mailbox approximately 30 minutes after VARO staff had picked up their mail. We informed management of their oversight responsibility and they took appropriate action to date-stamp and process that mail.

Claims-related mail that is not properly date-stamped can affect benefits payments. For example, if staff properly date-stamp claims-related mail received on January 31, the benefits would be payable on February 1. However, if staff improperly date-stamp this same mail a day late on February 1, the payment date would be March 1, and VARO staff would unintentionally underpay the beneficiary by 1 month.

Management informed us they were unaware of VBA's policy requiring that mail be date-stamped and routed to the appropriate locations within 4 to 6 hours of receipt. Because of this oversight, some beneficiaries may not have received accurate benefit payments.

Recommendation

4. We recommend the White River Junction VA Regional Office Director develop and implement a plan to ensure staff process all claims-related mail the same day it is received.

Management Comments

The Acting VARO Director concurred with our recommendation. VARO management updated the Workload Management Plan to direct VSC staff pickup mail after 12:30 p.m. daily.

OIG Response

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

4. 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.

VBA policy requires that staff obtain clear and convincing medical evidence that a beneficiary is capable 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. Effective July 2011, VBA defines "immediate" as 21 days.

Finding 5 Inadequate Controls Over Competency Determinations

VARO staff unnecessarily delayed making final decisions in all four competency determinations completed from April through June 2011. Delays for three (75 percent) of the four cases occurred because the VSC workload management plan did not contain procedures emphasizing immediate completion of competency decisions. The risk of incompetent beneficiaries receiving benefits payments without fiduciaries assigned to manage those funds increases when staff do not complete competency determinations timely.

For the four cases we identified, delays in making final competency determinations ranged from 14 to 150 days, with an average completion time of 96 days. In the most egregious case, involving a delay of about 150 days, the veteran received $34,095 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 that VAROs update workload management plans to identify responsibility for managing the determinations. However, VARO management did not take action to update the workload management plan until March 2011.

The VARO's updated plan stated staff must take immediate action on competency determinations; however, it did not assign specific responsibility for managing these determinations. Additionally, the VARO did not update the workload management plan to reflect VBA's newly defined 21-day timeliness standard, which went into effect in July 2011. The delays we identified occurred from September 2010 through February 2011, which was prior to updating the workload management plan. As a result, incompetent beneficiaries received benefit payments for extended periods despite being incapable of managing these funds effectively.

Recommendation: 5. We recommend the White River Junction VA Regional Office Director amend the workload management plan to delineate responsibility for managing competency determinations within the 21-day timeliness standard.

Management Comments The Acting VARO Director concurred with our recommendation and updated the Workload Management Plan. The amended plan provides detailed guidance and assigns specific responsibility for compliance, oversight, and management of competency determinations.

OIG Response The Acting 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

Generally, 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, 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 White River Junction VARO had three homeless veterans' claims pending for an average of 307 days—exceeding VBA's 75-day national target by 232 days. For all three 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.

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 veterans submitted the claims. The actual time pending for the 3 claims we reviewed ranged from 204 to 360 days. To determine the actual number of days the three claims had been pending, we used 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 73 days—2 days better than VBA's national target.

We did identify one case with an actual processing delay. In this case, VSC staff determined a homeless veteran's claim was ready for a rating decision on August 4, 2011; however, by the time of our inspection, VSC staff had not yet rendered that decision—resulting in an 18-day delay. Because the VARO generally processes claims without delay and within the national target, 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 advocacy groups to provide information on VA benefits and services.

The VSC provided a list of 25 homeless shelters and service providers in the local area. Although we did not contact each facility, we did confirm (either by contacting the facility or by reviewing copies of mailings to those facilities) that 11 had received information on VA benefits and services. Additionally, we confirmed the VSC's homeless coordinator worked collaboratively with the White River Junction VA Medical Center homeless coordinators to assist in community service events specific to homeless veterans.

Appendix A VARO Profile and Scope of Inspection

Organization

The White River Junction VARO administers a variety of services and benefits including Compensation and Pension; Vocational Rehabilitation and Employment; benefits counseling; fiduciary services; outreach to homeless, elderly, minority, and women veterans; and public affairs.

Resources

As of July 2011, the White River Junction VARO had a staffing level of 24 full-time employees. Of these employees, 22 (92 percent) were assigned to the VSC.

Workload

As of June 2011, the VARO reported 978 pending compensation claims. The average time to complete claims was 219.7 days—44.7 days beyond the national target of 175 days. As reported by STAR, the accuracy of compensation rating-related decisions was 88.6 percent, exceeding the 90 percent target set by VBA.

Scope

We reviewed selected management, 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 22 (88 percent) of 25 disability claims related to TBI and herbicide exposure completed from April through June 2011. For temporary 100 percent disability evaluations, we selected 30 (60 percent) of 50 existing claims from VBA's Corporate Database. We provided VARO officials with 20 claims remaining from our universe of 50 for their review. The 50 claims represented all instances where VARO staff had granted temporary 100 percent disability evaluations for at least 18 months or longer as of July 19, 2011.

We reviewed all 21 files containing errors identified by VBA's STAR program from April through June 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' disability claims.

Our process differs from that of STAR as we review specific types of disability claims, such as those related to TBI and herbicide exposure that require rating decisions. We also reviewed 12 mandatory SAOs completed in FYs 2010 and 2011.

We reviewed selected mail in various processing stages in the mailroom and the VSC. We did not review a 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 because that claim was processed by another VARO. We reviewed four competency determinations and three 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, White River Junction, VT (405/00)

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

1. Attached are the White River Junction Regional Office's on the OIG Draft Report: Inspection of the VA Regional Office, White River Junction, Vermont.

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

(original signed by:)

Brad Mayes
Acting White River Junction Director

Attachment

Overall Comments: Content (Line 28): "VARO staff incorrectly processed 19 (37 percent) of the total 52 disability claims reviewed."

Eastern Area Comment: The Eastern Area disagrees with the characterization of a 37 percent error rate for White River Junction Regional Office. It should be clearly noted that the sample reviewed was targeted at specific types of cases, chosen because of the difficulty of these cases, and therefore these types of cases are more prone to error. This review does not, however, reflect the overall quality of the work done by the VARO. While Eastern Area and White River Junction Regional Office appreciates the targeted findings of the OIG and will use the feedback to improve operations, it is believed the language used in the draft summary of the report presents an inaccurate and inappropriate view of the service provided by the VARO.

The Eastern Area suggests the OIG, in order to provide the appropriate context for the lay reader, enhance this summary statement to clearly state this sample is not a reflection of the error rate for the overall body of work performed by the RO.

Recommendation 1: We recommend the White River Junction VA Regional Office Director implement a plan to improve the effectiveness of the quality review process for Rating Veterans Service Representatives with less than 2 years of rating experience.

RO Response: Concur.

To improve the effectiveness of the quality rating process, the Regional Office (RO) implemented a standard operating procedure that defines the second signature review policy for Rating Veteran Service Representatives (RVSRs) having less than two years of rating experience. The station standard operating procedure (SOP) directs all reviews to be completed by a Decision Review Officer (DRO) versus an RVSR. The SOP has been provided to all staff and incorporated into the Service Center's Workload Management Plan.

Recommendation 2: We recommend the White River Junction VA Regional Office Director develop and implement a plan to ensure action is taken to correct errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review program.

RO Response: Concur.

The VSC amended the local Systematic Technical Accuracy Review (STAR) process SOP to provide additional tracking and oversight for cases requiring correction. The RO Management Analyst is to review the log monthly to ensure no entries have been missed.

A quality control log serves as an accountability document to ensure action has been taken to correct all errors identified by the Veterans Benefits Administration's STAR program. The Rating Coach updates the completed quality control log and the VSCM provides the second level review and compliance reporting.

Recommendation 3: We recommend the White River Junction VA Regional Office Director develop and implement a plan to ensure staff annually schedule all 12 mandatory Systematic Analyses of Operations and address all required elements of each analysis.

RO Response: Concur.

The White River Junction VA Regional Office Workload Management Plan has been revised to include the requirement for a Reports Tracking worksheet to be maintained by the VARO management analyst. The required Excel workbook format is arranged with individual worksheets for each month of the fiscal year.

Reporting requirements are entered into the Reports Tracking worksheet as they are received. Along with the report name and due date, the frequency of the report, preparer, report format reference, and date submitted are documented as well. Each month, the RO Management Analyst, is tasked with distributing the updated Reports Tracking worksheet for the ensuing month to all potential reports preparers.

While overall reporting responsibility remains with the VSCM, this plan establishes use of a tool to centrally organize and track all mandatory Systematic Analyses of Operations (SAO), and other reports, and provide references for all required reporting elements.

Recommendation 4: We recommend the White River Junction VA Regional Office Director develop and implement a plan to ensure staff process all claims-related mail the same day it is received.

RO Response: Concur.

As a tenant of the VA Medical Center, the RO receives mail from the hospital's central mailroom. The Supervisor of Support Services at the medical center confirms mail is received at the mailroom and all sorting must be completed by 12:00 P.M. There are no mail deliveries to the medical center after that time.

The Workload Management Plan is updated to direct mail pick up by the Claims Assistant daily, no earlier than 12:30 p.m. As stated in the Workload Management Plan, all mail is then received into the Service Center and date stamped by the end of the workday. No mail is left for the next business day.

Recommendation 5: We recommend the White River Junction VA Regional Office Director amend the Workload Management Plan to delineate responsibility for managing competency determinations within the 21-day timeliness standard.

RO Response: Concur.

In September 2011, the Workload Management Plan was updated, providing detailed guidance and specific responsibility for compliance, oversight, and management of the competency determinations. This workload is reported to management every Monday.

Appendix C Inspection Summary

Eight Operational Activities Inspected	Criteria	Reasonable Assurance of	
		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) 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 staff properly processed claims for all disabilities related to in-service TBI.** (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
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. 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			
8. VBA's Homeless Veterans 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: OIG
CFR=Code of Federal Regulations, M=Manual, MR=Manual Rewrite

Appendix D Office of Inspector General Contact and Staff Acknowledgments

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