VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Providence, Rhode Island

January 3, 2012
11-03465-58

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

Report Highlights: Inspection of the VA Regional Office, Providence, Rhode Island

Why We Did This Review

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

What We Found

Providence VARO staff provided adequate outreach to homeless shelters and service providers. VARO performance was generally effective in processing herbicide exposure-related and homeless veterans' claims and in correcting errors identified by VBA's Systematic Technical Accuracy Review program.

The VARO lacked effective controls and accuracy in processing some disability claims. Inaccuracies in processing temporary 100 percent disability evaluations resulted when staff did not schedule medical reexaminations as required. Also, VARO staff used inadequate exam reports to process traumatic brain injury claims. VARO staff did not correctly process 25 (37 percent) of the 68 disability claims we sampled as part of our inspection. These results may not represent the overall accuracy of disability claims processing at this VARO.

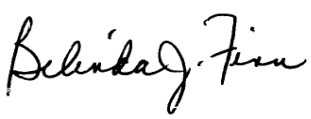
VARO management did not ensure staff timely completed Systematic Analyses of Operations, properly processed mail, and accurately addressed Gulf War veterans' entitlement to mental health treatment. Further, processing of competency determinations was not fully effective, resulting in unnecessary delays in making final decisions.

What We Recommended

We recommended the VARO Director develop and implement a plan to ensure staff return insufficient medical examination reports to hospitals for correction to support proper processing of traumatic brain injury claims. VARO management needs to develop and implement a plan to ensure oversight and control of mail handling, as well as timely completion of Systematic Analyses of Operations. Management also needs to implement training and controls to ensure staff follow VBA policy regarding processing competency determinations and Gulf War veterans' entitlement to mental health treatment.

Agency Comments

The VARO Director concurred with our recommendations. The Director also provided technical comments, which we addressed as appropriate throughout this report. Management's planned actions are responsive and we will follow up as required on all actions.



BELINDA J. FINN
Assistant Inspector General
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INTRODUCTION

Objective

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

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

In addition to this 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 Providence 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 (31 percent) of 123 disability claims related to traumatic brain injury (TBI) and herbicide exposure completed from April through June 2011. In addition, we reviewed 30 (37 percent) of 82 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 the 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, and herbicide exposure. We evaluated claims processing accuracy and its impact on veterans' benefits.

Finding 1 Providence VARO Could Improve Disability Claims Processing Accuracy

The Providence VARO lacked controls and accuracy in processing claims for temporary 100 percent disabilities, TBI, and herbicide exposure. VARO staff incorrectly processed 25 (37 percent) of the total 68 disability claims we sampled during our inspection. VARO management agreed with our findings and initiated action to correct the inaccuracies identified.

Because we sampled claims related to specific conditions, these results may not represent the universe of disability claims processed at this VARO. As reported by VBA's Systematic Technical Accuracy Review (STAR) program as of July 2011, the overall accuracy of the Providence VARO's compensation rating-related decisions was 84.6 percent—5.4 percent below the 90 percent VBA target.

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

Table

Providence VARO Disability Claims Processing Results

Type	Reviewed	Claims Incorrectly Processed		
		Total	Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits
Temporary 100 Percent Disability Evaluations	30	20	5	15
Traumatic Brain Injury Claims	8	2	0	2
Herbicide Exposure-Related Claims	30	3	1	2
Total	**68**	**25**	**6**	**19**

Source: VA OIG

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 20 (67 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 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 a suspense diary matures, the electronic system generates a reminder notification to alert VSC staff to schedule the reexamination.

Available medical evidence showed 5 of the 20 processing inaccuracies affected veterans' benefits—3 involved overpayments totaling $43,350 and 2 involved underpayments totaling $30,626. Details on the most significant overpayment and underpayment follow.

- VARO staff did not schedule a follow-up medical examination to evaluate a veteran's prostate cancer. VA medical treatment records showed the veteran had completed treatment, warranting a reduction in benefits as of June 1, 2010. As a result, VA overpaid the veteran $39,522 over a period of 14 months.
- A Rating Veterans Service Representative (RVSR) established an incorrect effective date for service connection for prostate cancer. As a result, VA underpaid the veteran $28,224 over a period of 12 months.

The remaining 15 inaccuracies had the potential to affect veterans' benefits. Following are descriptions of these inaccuracies.

- In 10 cases, VSC staff did not schedule follow-up medical reexaminations needed to determine whether the temporary 100 percent evaluations should continue. An average of 2 years elapsed from the time staff should have scheduled the medical reexaminations until the date of our inspection—the date staff ultimately ordered the reexaminations or obtained the necessary medical evidence. The delays ranged from 3 months to 4 years and 4 months.
- In three cases, RVSRs incorrectly requested future reexaminations for veterans diagnosed with incurable multiple myeloma or chronic lymphocytic leukemia. In making these decisions, the RVSRs also did

not consider entitlement to additional benefits for Dependents' Educational Assistance as required by VBA policy.

- In two cases, RVSRs correctly proposed reducing veterans' temporary 100 percent disability evaluations. VARO staff received the veterans' requests for personal hearings to protest the proposed reductions in April 2009 and July 2010; however, VARO staff had not taken action on these requests at the time of our inspection in August 2011. Until they conduct the requested hearings, neither VARO staff nor we can ascertain the current level of the veterans' disabilities.

Eleven of the 20 errors resulted from staff not establishing suspense diaries when they processed rating decisions requiring temporary 100 percent disability reexaminations. Nine of these errors involved C&C rating decisions. In November 2009, VBA provided guidance reminding VAROs about the need to enter suspense diaries in the electronic record for C&C rating decisions. VARO management had no oversight procedure in place for C&C rating decisions to ensure staff established suspense diaries as reminders of the need for reexaminations.

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 evaluation had a future examination date entered in the electronic record. As such, we made no specific recommendation for this VARO. To assist in implementing the agreed upon review, we provided the VARO with 52 claims remaining from our universe of 82 temporary 100 percent disability evaluations.

TBI Claims

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

VARO staff incorrectly processed two (25 percent) of eight TBI claims—both of these claims processing inaccuracies had the potential to affect veterans' benefits. In both cases, RVSRs and a Decision Review Officer prematurely evaluated TBI residuals using insufficient medical examination reports. According to VBA policy, when a medical examination report does not address all required elements, VSC staff should return it to the clinic or healthcare facility as insufficient for rating purposes. Neither VARO staff nor we can ascertain all residuals of a TBI without an adequate or complete medical examination.

Generally, errors associated with TBI claims processing occurred because VARO officials did not return insufficient medical examination reports to the issuing clinics or healthcare facilities as needed to ensure all required elements were addressed. Interviews with VSC management and staff revealed RVSRs and Decision Review Officers were using their own interpretations of medical examination results to decide TBI claims when medical professionals failed to provide opinions. VSC staff told us they tried to extract enough information from insufficient medical examinations in order to meet individual production goals and provide timely rating decisions. VSC staff stated they were reluctant to return insufficient examination reports to VA medical facilities, as the process was time-consuming and would further delay claims processing. As a result of using insufficient medical examination reports, veterans may not have always received correct benefits.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 3 (10 percent) of 30 herbicide exposure-related claims—1 of these claims processing inaccuracies affected a veteran's benefits. In this case, an RVSR incorrectly established an effective date of September 9, 2010—the date VA received the claim. However, the correct effective date should have been August 31, 2010—the date of a related legislative change. According to VA regulations, when a claimant submits a claim within 1 year from the date of a legislative change, VA may authorize benefits effective the date of that legislative change, if the veteran is eligible. In this instance, eligibility existed to pay the veteran from the date of the law change because medical evidence showed a diagnosis at that time. As a result of using an incorrect effective date, VA underpaid the veteran $123 over a period of 1 month.

The remaining two inaccuracies had the potential to affect veterans' benefits. Following are summaries of these inaccuracies.

- An RVSR prematurely evaluated an herbicide exposure-related condition using an insufficient medical examination report. VSC staff did not return the report to the clinic or healthcare facility as insufficient for rating purposes as required. Neither VARO staff nor we can ascertain all of the disabilities related to diabetes without an adequate or complete medical examination.
- An RVSR correctly requested an immediate medical examination to ascertain the current level of a veteran's disability following prostate cancer surgery. VSC staff failed to schedule the medical examination. Until the examination is completed, neither VARO staff nor we can ascertain the current level of the veteran's disability.

The three herbicide exposure-related processing errors were unique and did not constitute a common trend, pattern, or systemic issue. As such, we made no recommendation for improvement in this area.

Recommendations

1. We recommend the Providence VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives and Decision Review Officers return insufficient medical examination reports to health care facilities to obtain the evidence needed to support traumatic brain injury claims rating decisions.

Management Comments

The VARO Director concurred with our recommendation. The Director indicated the VARO hosted a joint training session between VA medical center and VARO staff in September 2011. VSC staff also received training in October and November 2011. Finally, the Director stated, the VARO implemented recent VBA policy requiring two signatures on TBI decision documents.

OIG Response

Management's actions are responsive to the recommendation. We will follow up as required on all actions.

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 VAROs take corrective action on errors identified by STAR.

VARO staff did not correct 1 (9 percent) of 11 errors identified by VBA's STAR program from January through March 2011. 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 Systematic Analyses of Operations (SAOs). We also considered whether VSC staff used adequate data to support the analyses and recommendations identified within each SAO. An SAO is a formal analysis of an organizational element or operational function. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. VARO management must publish annual SAO schedules designating the staff required to complete the SAOs by specific dates.

Finding 2 Oversight Needed To Ensure Complete and Timely SAOs

For the 12 required SAOs, management used adequate data to support their analyses. For example, management obtained data from a VETSNET Operations Report that revealed the percentage of claims pending greater than 125 days was rising. Management recommended that VSC staff renew efforts to target completion of the oldest pending claims.

However, five (42 percent) of the 12 SAOs were not completed timely per the annual schedule, were incomplete (missing required elements), or were both untimely and incomplete. The VSC Manager is responsible for completing the 12 annual SAOs as part of ongoing analysis of VSC operations. VARO management did not provide adequate oversight to ensure VSC staff completed the SAOs in accordance with VBA policy. As a result of incomplete and untimely SAOs, VARO management may not have adequately identified existing and potential problems for corrective actions to improve VSC operations.

At the time of our inspection, 2 (17 percent) of the 12 SAOs were not timely, 2 (17 percent) were partially completed, and 1 (8 percent) was both partially completed and not timely. One of the SAOs the VARO did not accurately complete involved mail handling. Although the SAO identified a significant number of pieces of drop mail that had not been associated with veterans' files, the SAO included no recommendation to address the problem. During our inspection, we also found claims-related mail incorrectly processed as drop mail.

VARO management did not have sufficient controls to ensure staff assigned to complete SAOs addressed all required elements and related analyses. VSC staff involved in writing SAOs stated they had not had any formal training on the requirements for SAOs. In an interview with us, the VSC Manager responsible for reviewing SAOs could not state why SAOs were missing required elements. This official further said area staff had complimented the station on its SAO addressing fiduciary activities. Nonetheless, the VSC Manager accepted responsibility for the untimely SAOs, stating the primary focus was ensuring quality of the SAOs.

Recommendation

2. We recommend the Providence VA Regional Office Director develop and implement a plan to ensure staff complete Systematic Analyses of Operations timely and address all required elements.

Management Comments

The VARO Director concurred with our recommendation. The Director stated he released the FY 2012 SAO schedule with additional controls in place for timely and sufficient completion. A VSC Management Analyst will review and provide feedback prior to VSC Manager finalizing and

submission to the Director. Further, the Director indicated training will be provided to all staff that prepare or assist with SAOs.

OIG Response Management's actions are responsive to the recommendation. We will follow up as required on all actions.

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 Providence VARO assigns responsibility for mailroom activities, including processing incoming mail, to the Support Services Division. Mailroom staff were timely and accurate in processing, date-stamping, and delivering VSC mail to the Intake Processing Center control point daily. Because the mailroom staff were following VBA policy, we made no recommendation for improvement in this area.

Mail Management Procedures We assessed the VSC's mail management 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 the claims processing 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 processing action before placing it in the related claims folders.

VSC staff did not control 1 (3 percent) of 30 pieces of search mail reviewed. The delay occurred when the VARO received evidence from the medical center dated August 8, 2011, and correctly placed the evidence in the search mail holding area, but did not control the mail as required. Due to the infrequency of search mail handling inaccuracies, we made no recommendation for improvement in this area.

Finding 3 Oversight Needed To Ensure Proper Control and Processing of Mail

Intake Processing Center staff did not properly control 5 (17 percent) of 30 pieces of drop mail reviewed. At the time of our inspection, approximately 721 pieces of drop mail were awaiting association with the appropriate claims folders. The most significant error occurred when the VARO received a veteran's claim for benefits on August 9, 2011. VARO

staff should have controlled this piece of mail through the Control of Veterans Records System and placed it in the search mail holding area. However, staff did not properly control the piece of mail and incorrectly placed it in the drop mail holding area.

The above errors resulted from inadequate oversight of the drop mail holding areas. VSC supervisory staff stated they do not consistently review drop mail, and the station's Workload Management Plan does not address oversight of drop mail. The Quality of Files Activities SAO was incomplete and therefore did not adequately assess drop mail management. If VARO staff had completed the SAO and provided recommendations to reduce the amount of pending drop mail, staff may have identified search mail inappropriately placed in the drop mail holding area. Untimely association of mail with veterans' claims folders can cause delays in processing benefits claims. As a result, VSC staff may not have all available evidence to make decisions and beneficiaries may not receive accurate and timely benefits payments.

Recommendation

3. We recommend the Providence VA Regional Office Director develop and implement a plan to ensure management oversight and control of mail-handling and amend the Workload Management Plan to incorporate procedures for oversight and control of drop mail.

Management Comments

The VARO Director concurred with our recommendation. The Director stated all Triage staff received training and updated procedures for drop mail in August 2011. VSC updated the Workload Management Plan to include procedures and a monthly audit for drop mail.

OIG Response

Management's actions are responsive to the recommendation. We will follow up as required on all actions.

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 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.

VBA policy requires staff to 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 4 Inadequate Controls Over Competency Determinations

As measured against VBA's new definition of immediate, VARO staff unnecessarily delayed making final decisions in 3 (23 percent) of 13 competency determinations completed from April through June 2011. The delays ranged from 24 to 100 days, with an average completion time of 61 days. Delays occurred because VARO staff responsible for overseeing and processing final competency determinations stated they were unaware of VBA policy requiring immediate action and therefore did not prioritize these cases. The risk of incompetent beneficiaries receiving benefits without fiduciaries assigned to manage those funds increases when staff do not complete competency determinations timely.

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 3 months. During this period, the veteran received $8,019 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.

Recommendation

4. We recommend the Providence VA Regional Office Director provide refresher training and implement controls to ensure staff follow current Veterans Benefits Administration policy regarding the processing of competency determinations.

Management Comments

The VARO Director concurred with our recommendation and planned to provide training for VSC management and staff in December 2011. In addition, the Director stated VSC management updated the Workload Management Plan requiring monitoring reports on a bi-monthly basis.

OIG Response

Management's actions are responsive to the recommendation. We will follow up as required on all actions.

Entitlement to Medical Care and Treatment for Mental Disorders

Gulf War veterans are eligible for medical treatment for any mental disorder they develop within 2 years of the date of separation from military service. According to VBA, whenever an RVSR denies a Gulf War veteran service connection for any mental disorder, the RVSR must consider whether the veteran is entitled to receive mental health treatment.

In February 2011, VBA updated its Rating Board Automation 2000, a computer application designed to assist RVSRs in preparing disability

ratings. The application provides a pop-up notification, known as a tip master, to remind staff to consider entitlement to health care treatment when staff deny service connection for a mental disorder.

Finding 5 Gulf War Veterans Not Receiving Accurate Entitlement Decisions for Mental Health Treatment

VARO staff did not properly address whether four (67 percent) of six Gulf War veterans were entitled to receive treatment for mental disorders. RVSRs stated that despite training and their understanding of the policy, they generally found it difficult to remember additional benefits they needed to consider when not claimed by veterans. VSC management and supervisors stated they were not aware of the pop-up notification in the electronic system to remind staff to consider entitlement to health care treatment when they deny service connection for a mental disorder. RVSRs who were aware of this prompt stated it was easy to ignore the reminder notification. As a result, veterans may be unaware of potential entitlement to treatment for mental disorders and may not get the care needed. Following are descriptions of these inaccuracies.

- In three cases, RVSRs did not consider entitlement to mental health treatment when they denied service connection for mental disorders, as required by VBA policy.
- In one case, an RVSR granted entitlement to mental health treatment in one section of the decision document, but denied it in another section.

VSC management and training staff were aware RVSRs were not consistently addressing this entitlement because STAR staff identified such errors on 5 (8 percent) of 62 claims completed from July 2010 through June 2011. The VARO also noted errors in local quality reviews. VSC staff provided refresher training on this topic in June and July of 2011. However, VSC staff completed the rating determinations on all four inaccuracies we identified before July 2011; therefore, we were unable to assess whether this training was effective.

Recommendations

5. We recommend the Providence VA Regional Office Director develop and implement a plan to monitor the effectiveness and adequacy of training on Veterans Benefits Administration policy regarding Gulf War veterans' entitlement to mental health treatment.

Management Comments

The VARO Director concurred with our recommendation. The Director stated all RVSRs and Decision Review Officers received training on Gulf War Veterans' entitlement to mental health treatment in August 2011. The VARO will monitor national STAR findings to ensure compliance. Further, the Director indicated local quality reviewers will enhance focus on

entitlement to mental health treatment for Gulf War Veterans during local quality reviews in FY 2012.

OIG Response

Management's actions are responsive to the recommendation. We will follow up as required on all actions.

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' disability claims. At the time of our inspection, VBA determined its national performance measure for processing the homeless veterans' claims based on the average days the claims were pending. VBA's national target was for the claims to be pending no more than an average of 75 days. This measure did not reflect how long it took VARO staff to make determinations on the claims and inform the veterans; it only reflected the average time elapsed from claims receipt at the VARO until the current date.

At the time of our inspection, the Providence VARO had 71 homeless veterans' disability claims pending. The 23 (32 percent) of 71 claims available for our review had been pending 5 to 208 days. The average pending time for these claims was 85 days, which exceeded VBA's national target by 10 days. For 3 of the 23 claims, VARO staff were not aware the veterans were homeless because the veterans did not indicate this status upon initial claims submission. The veterans informed the VARO of their homelessness in subsequent correspondence related to their claims. In addition, 4 of the 23 claims had been pending at other VAROs before receipt at the Providence VARO. We adjusted the average time pending for the 23 claims based on this information. We found that the claims had actually been pending at the Providence VARO an average of 75 days—VBA's national target. As such, we made no recommendation for improvement in this area.

Outreach Efforts to Homeless Shelters and Service Providers

Congress mandated at least one full-time employee oversee and coordinate programs for homeless veterans programs at each of the 20 VAROs that VA determined to have the largest veteran populations. VBA's 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.

Our review of the VARO's homeless veterans outreach processes and contact with local homeless service providers confirmed the Providence Homeless Veterans Outreach Coordinator provided effective outreach as required by VBA policy. Therefore, we made no recommendation for improvement in this area.

Appendix A VARO Profile and Scope of Inspection

Organization

The Providence Regional Office 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 June 2011, the Providence VARO had a staffing level of 173 full-time employees. Of these, the VSC had 97 employees (56 percent) assigned.

Workload

As of July 2011, the VARO reported 2,826 pending compensation claims. The average time to complete claims was 172.7 days—2.3 days less than the national target of 175 days.

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 (31 percent) of 123 claims related to TBI and herbicide exposure-related disabilities that the VARO completed from April through June 2011. For temporary 100 percent disability evaluations, we selected 30 (37 percent) of 82 existing claims from VBA's Corporate Database. We provided the VARO management with 52 claims remaining from our universe of 82 for further review. These claims represented all instances in which VARO staff granted temporary 100 percent disability determinations for at least 18 months or longer as of July 5, 2011.

We reviewed the 12 mandatory SAOs completed in FYs 2010 and 2011. We reviewed 11 errors identified by VBA's STAR program during 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 evaluation. 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 related to TBI and herbicide exposure that require rating decisions. In addition, we review rating decisions and awards processing involving temporary 100 percent disability evaluations.

For our review, we selected mail in various processing stages in the VARO mailroom and VSC. We also reviewed six completed claims processed for

Gulf War veterans from April through June 2011 to determine whether VSC staff addressed entitlement to mental health treatment in the rating decision documents as required. We reviewed 13 competency determinations and 19 homeless veterans' claims completed for the same 3-month period. Further, we reviewed 23 homeless veterans' claims pending at the time of our inspection, and assessed 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: November 30, 2011

From: Director, VA Regional Office Providence, Rhode Island

Subj: Inspection of the VA Regional Office, Providence, Rhode Island

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

1. Attached are two documents from the Providence VARO in response to the OIG Draft Report: Inspection of VARO Providence, Rhode Island. Attachment A contains the RO's response to the recommended action items from the inspection team. Attachment B contains a response from the RO Director in relation to several statements and/or quotations made within the narrative of the report.[1]

2. Questions may be referred Mr. Earl Hutchinson, Director, at (401) 223-3600.

(original signed by:)

Earl J. Hutchinson, Director

Attachment

[1] Because of the technical nature of the Director's additional comments, we did not include his Attachment B in this report. Nonetheless, we addressed the Director's technical comments as appropriate throughout the report.

Attachment A: Providence VA Regional Office Recommendations Response

OIG Recommendation 1: We recommend the Providence VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives and Decision Review Officers return insufficient medical examination reports to health care facilities to obtain the evidence needed to support traumatic brain injury claims rating decisions.

RO Response: Concur

Training on requesting examinations and medical opinions and reviewing sufficiency of examination reports was provided to VSRs, RVSRs and DROs in several sessions between October 31 and November 16. Additionally, the Providence RO hosted a joint training session between the Director of Quality Management at the Providence VAMC, two neurologists who specialize in traumatic brain injury and RVSRs and DROs on September 23, 2011. Finally, VBA recently implemented policy requiring two signatures on rating decisions involving TBI until sufficient accuracy is proven on the part of the RVSR. The Providence RO has implemented this policy.

OIG Recommendation 2: We recommend the Providence VA Regional Office Director develop and implement a plan to ensure staff complete Systematic Analyses of Operations timely and address all required elements.

RO Response: Concur

For FY12, the RO released the SAO schedule, with additional controls in place to ensure timely and sufficient completion of these analyses. SAOs will be submitted to the VSC Management Analyst, who will have sufficient time to review and provide feedback. SAOs will then be finalized by the Veterans Service Center Manager and submitted to the Director prior to the due date. Additionally, during FY12, training will be provided to all personnel who prepare or assist in the preparation of SAOs in regards to timeliness and content compliance.

OIG Recommendation 3: We recommend the Providence VA Regional Office Director develop and implement a plan to ensure management oversight and control of mail-handling and amend the Workload Management Plan to incorporate procedures for oversight and control of drop mail.

RO Response: Concur

On August 26, 2011, training was provided to all Triage personnel on non-actionable mail eligible for immediate association with the claims file. Updated procedures for drop mail were released to the Veterans Service Center on August 26, 2011, and were added to the Workload Management Plan on September 27, 2011. Additionally, the Workload Management Plan has been amended to include a monthly audit of 30 pieces of drop mail, to ensure the appropriateness of mail identified as “drop”.

OIG Recommendation 4: We recommend the Providence VA Regional Office Director provide refresher training and implement controls to ensure staff follow current Veterans Benefits Administration policy regarding the processing of competency determinations.

RO Response: Concur

The Providence RO will provide refresher training to all VSC employees between December 5 and 9, 2011. Additionally, training will be provided to supervisors on December 6, 2011 regarding appropriate workload management, to include the monitoring of workload reports on a bi-monthly basis. This was added to the Workload Management Plan Reports Generation Schedule on November 30, 2011.

OIG Recommendation 5: We recommend the Providence VA Regional Office Director develop and implement a plan to monitor the effectiveness and adequacy of training on Veterans Benefits Administration policy regarding Gulf War veterans' entitlement to mental health treatment.

RO Response: Concur

Training on entitlement to mental health treatment for Gulf War Veterans was provided to all decision-makers (RVSRs and DROs) on August 26, 2011. A review of Providence rating errors identified by VBA's Systematic Technical Accuracy Review (STAR) reveals that the last error identified for this issue was in April 2011. National STAR findings will also be monitored to ensure compliance. Finally, local quality reviewers will ensure that this topic has an enhanced focus within the local quality review process during FY12.

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 reviewed temporary 100 percent disability evaluations.** (38 CFR 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (M21-1 Manual Rewrite (MR) Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e)		X
2. Traumatic Brain Injury Claims	**Determine whether VARO staff properly processed claims for service connection for all disabilities related to in-service TBI.** (FL 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) (FL 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)		X
8. Gulf War Veterans' Entitlement to Mental Health Treatment	**Determine whether VARO staff properly processed Gulf War Veterans' claims, considering entitlement to Medical Treatment for Mental Illness.** (38 United States Code 1702) (M21-1MR Part IX Subpart ii, Chapter 2) (M21-1MR Part III, subpart v, Chapter 7) (Fast Letter 08-15) (38 CFR 3.384) (38 CFR 3.2)		X
Public Contact			
9. 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) (Compensation & Pension 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 OIG Contact and Staff Acknowledgments

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