VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Oakland, California

May 10, 2012
12-00247-175

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, Oakland, California

Why We Did This Review

The Veterans Benefits Administration 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 Oakland VARO accomplishes this mission.

What We Found

Oakland VARO staff followed the Veterans Benefits Administration's policy for correcting errors identified through the Systematic Technical Accuracy Review program and provided outreach to homeless shelters and service providers. VARO performance was generally effective in processing herbicide exposure-related disability claims.

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 or establish controls for future medical reexaminations. Staff incorrectly interpreted policy and used inadequate medical examinations to process traumatic brain injury claims. Overall, VARO staff did not correctly process 35 (39 percent) of the 90 disability claims we sampled. These results do not represent the overall accuracy of disability claims processing at this VARO.

VARO management did not ensure staff timely completed all elements of Systematic Analyses of Operations, properly processed mail, accurately addressed Gulf War veterans' entitlement to mental health treatment, and properly reviewed claims pending for more than a year.

What We Recommended

We recommended the VARO management conduct refresher training and implement plans to ensure staff follow current Veterans Benefits Administration policy on processing traumatic brain injury claims, and Gulf War veterans' entitlement to mental health treatment. The VARO Director needs to develop and implement plans to ensure staff complete all required elements of Systematic Analyses of Operations timely and ensure management oversight and control of search mail. Further, the VARO Director should develop and implement a plan for management oversight of all claims pending for more than 1 year.

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.

Linda A. Halliday
Assistant Inspector General for
Audits and Evaluations

TABLE OF CONTENTS

Introduction 1
Results and Recommendations 2
1. Disability Claims Processing 2
2. Management Controls 5
3. Workload Management 7
4. Eligibility Determinations 9
5. Public Contact 10
6. Special Review of Claims Processing Timeliness 11
Appendix A VARO Profile and Scope of Inspection 13
Appendix B VARO Director's Comments 15
Appendix C Inspection Summary 19
Appendix D Office of Inspector General Contact and Staff Acknowledgments 20
Appendix E Report Distribution 21

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

Scope of Inspection

In January 2012, the OIG conducted an inspection of the Oakland 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. Additionally, we conducted a special review of the VARO's ten oldest disability claims pending at the time of our inspection. We did not review competency determinations because the Veterans Benefits Administration (VBA) has centralized all Western Area activities at the Salt Lake City VARO.

We reviewed 60 (11 percent) of 550 disability claims related to traumatic brain injury (TBI) and herbicide exposure that VARO staff completed from July through September 2011. In addition, we reviewed 30 (4 percent) of 721 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 without review according to VBA's policy.

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 benefits 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 The Oakland VARO Could Improve Disability Claims Processing Accuracy

The Oakland VARO lacked controls and accuracy in processing temporary 100 percent disability evaluations and TBI-related claims. VARO staff incorrectly processed 35 (39 percent) of the total 90 disability claims we sampled during our inspection. VARO management agreed with our findings and began to correct the inaccuracies identified.

Because we sampled claims related to specific conditions, these results do not represent the universe of disability claims processed at the Oakland VARO. At the time of our inspection, VBA's accuracy target was 92 percent. As reported by VBA's Systematic Technical Accuracy Review (STAR) program as of December 2011, the overall accuracy of the VARO's compensation rating-related decisions was 80.2 percent—11.8 percentage points below VBA's 92 percent target.

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

Table 1

Oakland 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	16	3	13
Traumatic Brain Injury Claims	30	17	0	17
Herbicide Exposure-Related Claims	30	2	2	0
Total	**90**	**35**	**5**	**30**

Source: VA OIG Analysis of VBA's disability claims files

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 16 (53 percent) of 30 temporary 100 percent disability evaluations we reviewed. 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 evaluations where rating decisions do not change veterans' payment amounts, VSC staff must input suspense diaries to 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 evidence showed 3 (19 percent) of the 16 processing inaccuracies affected veterans' benefits—2 involved overpayments totaling $284,256 and 1 involved an underpayment totaling $1,223. Details on the most significant overpayment and the underpayment follow.

- VARO staff failed to take appropriate action after receiving a veteran's form for entitlement to VA's Civilian Health and Medical Program in August 2002. On the form, staff indicated a future examination was needed. VSC staff should have reviewed the VA medical treatment records and scheduled a reexamination. By not doing so, VA continued processing monthly benefits and ultimately overpaid the veteran $272,901 over a period of 8 years and 10 months.
- VARO staff assigned a temporary 100 percent disability evaluation with an incorrect effective date of September 5, 2003. Medical treatment records showed active cancer warranting an increased evaluation effective August 18, 2003. As a result, VA underpaid the veteran $1,223 over a period of 1 month. We discussed this underpayment with VARO staff who agreed to take corrective action.

The remaining 13 inaccuracies had the potential to affect veterans' benefits. The reasons for these inaccuracies varied, including staff not establishing reminders for future medical reexaminations as required. We did not identify a common trend or pattern.

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. Then in September 2011,

VBA provided each VARO with a list of temporary 100 percent disability evaluations for review. VBA directed each VARO to complete this review by the end of March 2012. As such, we made no specific recommendation for this VARO.

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 staff to evaluate these residual disabilities.

VARO staff incorrectly processed 17 (57 percent) of 30 TBI claims. All of these processing inaccuracies had the potential to affect veterans' benefits. Following are summaries of these inaccuracies.

- In 15 cases, Rating Veterans Service Representatives (RVSRs) incorrectly evaluated TBI residuals using inadequate VA medical examinations. According to VBA policy, when a medical examination does not address all required elements, VSC staff should return it to the issuing health care facility as insufficient for rating purposes. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without an adequate or complete medical examination.
- In one case, a Decision Review Officer did not follow up to determine service connection when a VA medical examination showed a diagnosed mental condition possibly related to a TBI.
- In another case, an RVSR incorrectly discontinued service connection for TBI residuals evaluated at 10 percent disabling.

Generally, inaccuracies associated with TBI claims processing occurred because VARO staff incorrectly interpreted VBA policy and used inadequate medical examinations to make decisions. Prior to our inspection, VSC staff conducted a local quality review of 11 of these 17 inaccurate rating decisions without identifying any errors. Interviews with VSC staff indicated prior training and guidance for evaluating TBI was not clear. As a result, RVSRs did not properly evaluate TBI residuals. VSC training schedules showed staff would receive TBI training after completion of our inspection.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 2 (7 percent) of 30 herbicide exposure-related claims we reviewed. Both processing inaccuracies affected veterans' benefits—involving underpayments totaling $9,851. According to VA regulations, when a claimant submits a claim within 1 year of a legislative change, VA may authorize benefits from the date of the legislative change, if the veteran is eligible. The most significant underpayment occurred because medical evidence showed a diagnosis at the time of the law change, making the veteran eligible for benefits. An RVSR correctly granted

service connection for ischemic heart disease associated with herbicide exposure; however, the effective date of March 30, 2011, was incorrect. The actual date of entitlement was August 31, 2010—the date of the related legislative change. As a result, VA underpaid the veteran $8,120 over a period of 7 months. We discussed this underpayment with VARO staff who agreed to take corrective action.

Because the frequency of inaccuracies was insignificant, we determined the VARO generally followed VBA policy for processing herbicide exposure-related claims. Therefore, we made no recommendation for improvement in this area.

Recommendations

1. We recommend the Oakland VA Regional Office Director conduct refresher training on the proper processing of traumatic brain injury claims.
2. We recommend the Oakland VA Regional Office Director implement a plan to ensure staff return insufficient medical examination reports to health care facilities to obtain the evidence needed to support traumatic brain injury rating decisions.

Management Comments

The VARO Director concurred with our recommendations. In response to recommendation 1, the Director stated the VSC provided training in January 2012 to all decision makers and Decision Review Officers on the proper processing of TBI. Additionally, the newly formed Quality Review Team monitors the effectiveness of the training through both in-process and local quality reviews. In response to recommendation 2, the Director indicated that during a meeting in January 2012, the VSC Manager shared our findings with VA medical staff regarding insufficient medical examinations and the need to ensure they request mental health examinations as required.

OIG Response

Management's actions are responsive to the recommendations. 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 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.

Oakland VARO staff adhered to VBA policy by taking corrective action on all 18 cases with 23 errors identified by VBA's STAR program from

July through September 2011. Therefore, 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 Timely and Complete SAOs

Eight (73 percent) of the 11 SAOs were either incomplete (missing required elements) or both incomplete and not timely. The remaining three (27 percent) contained adequate data to support the analyses. The VSC Manager is responsible for ongoing analysis of VSC operations, including completing 11 SAOs annually. VARO management did not have sufficient controls to ensure staff submitted SAOs timely and addressed all required elements. As a result, VARO management may not have adequately identified existing and potential problems for corrective actions to improve VSC operations.

At the time of our inspection, 5 (45 percent) of the 11 SAOs were incomplete (missing required elements) and 3 (27 percent) were both incomplete and not timely. VSC staff responsible for review of SAO completion and timeliness stated they may have been too lenient in providing feedback to the preparers. The VSC manager stated she did not ensure all of the elements of the SAOs were present; her primary concern was the significance of the SAO findings. In one of the SAOs involving mail handling, the results indicated an ongoing problem with lack of control of search mail; however, VSC staff did not implement the recommendation made for this issue. If they had implemented this recommendation, we may not have identified search mail inaccuracies as we did during our inspection.

Recommendation

3. We recommend the Oakland 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 VSC officials provided feedback to employees responsible for completing SAOs. The Director also assigned a member of his staff to

provide additional oversight of SAOs. The VARO is working with the VSC divisions on completing past due SAOs by April 2012.

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 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 Oakland VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Support Services Division. Mailroom staff were timely and accurate in processing and date-stamping VSC mail, and the Triage Team retrieved mail from the control point daily. Because we determined the VARO was following VBA policy, we made no recommendation for improvement in this area.

Triage Mail Management Procedures We assessed the VSC's Triage Team 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 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 manage 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 control 1 (3 percent) of 30 pieces of drop mail we reviewed. The inaccuracy occurred when the VARO received a claim from a former spouse for an apportioned share of a veteran's benefit and placed it in the drop mail location. VSC staff should have controlled the claim in the electronic system and associated it with the veteran's claims folder. Due to the infrequency of drop mail handling inaccuracies, we made no recommendation for improvement in this area.

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

VARO Triage Team staff did not properly control 8 (27 percent) of 30 pieces of search mail we reviewed. Inaccuracies related to search mail occurred because supervisors did not follow oversight requirements in the station's

workload management plan. As a result, VSC staff may not have all available evidence to make decisions and beneficiaries may not receive accurate and timely benefits payments.

The most significant error occurred when the VARO received medical evidence to support a veteran's claim and VSC staff did not properly control this piece of mail through the Control of Veterans Records System as required. Without ensuring this medical evidence is placed into the veteran's claims folder, VSC staff could make an incorrect rating decision. If we had not identified this piece of mail, the veteran may have received inaccurate benefits.

The workload management plan indicated the VARO Triage Team staff were responsible for reviewing search mail on a quarterly basis and reporting results to the supervisor for discussion with appropriate staff. However, the Triage Team had no schedule to conduct these reviews. Staff completed the last review in September 2011, nearly 4 months prior to our inspection. VSC management thought staff were screening the mail weekly and was unaware these reviews had ceased.

In March 2011, Compensation and Pension Service officials previously found Triage Team staff were not routinely screening mail and also determined VSC management needed to ensure proper control of search mail. Additionally, VSC staff completed a required SAO in June 2011, Quality of Files Activity, which provided an analysis of mail-handling procedures. In the SAO, staff acknowledged search mail continued to be the greatest issue facing the Triage Team and recommended management publish a plan on search mail management. We determined the frequency of reviews continued to be insufficient for proper control of mail.

If management had implemented the instructions given by the Compensation and Pension Service officials, or the SAO recommendation, we may not have found inaccuracies in search mail handling. Untimely association of mail with veterans' claims folders can cause delays in processing benefits claims and potentially result in an inaccurate rating decision.

Recommendation

4. We recommend the Oakland VA Regional Office Director develop and implement a plan to ensure management oversight and control of search mail.

Management Comments

The VARO Director concurred with our recommendation. The Director indicated VSC staff provided training to Triage Team members in January 2012 on proper search mail procedures. In February 2012, VSC managers assigned a staff member to ensure the Triage Team properly establishes electronic searches in COVERS for all mail located in the search mail holding areas. The staff member provides findings to a senior VSC official

who now gives individual feedback and identifies training needs. The Director stated a member of his staff would closely monitor VSC staff compliance with the workload management plan, which addresses oversight of search mail.

OIG Response

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

4. Eligibility Determinations

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 Gulf War veterans' entitlement to health care treatment when denying service connection for a mental disorder. This pop-up notification does not generate if a previous decision did not address entitlement to mental health services and a mental condition is not part of the current claim.

Finding 4 Gulf War Veterans Not Receiving Accurate Entitlement Decisions for Mental Health Treatment

VARO staff did not properly consider whether five (83 percent) of six Gulf War veterans were entitled to receive treatment for mental disorders. These inaccuracies occurred because RVSRs did not receive refresher training on this topic. As a result, veterans may be unaware of potential entitlement to treatment for mental disorders.

VARO staff did not address whether Gulf War veterans were entitled to mental health treatment as required when denying service connection for mental disorders. In interviews, RVSRs did not recall receiving refresher training on this topic and some lacked sufficient understanding of the VBA policy. In September 2011, VARO management implemented a mandatory checklist to remind RVSRs to consider the entitlement. We were unable to determine whether this checklist was successful in ensuring follow through because staff completed the cases we reviewed prior to its implementation.

In four (67 percent) of the six cases we reviewed, pop-up notifications reminded RVSRs to consider entitlement to mental health treatment. For the remaining two cases, electronic pop-up notifications did not generate

because mental conditions were not part of the claims. The majority of staff and management we interviewed felt the pop-up notification was not effective because it was easy to ignore.

Recommendation

5. We recommend the Oakland VA Regional Office Director implement a plan, including refresher training, to ensure staff follow current policy regarding Gulf War veterans' entitlement to mental health treatment.

Management Comments

The VARO Director concurred with our recommendation. The Director stated the VSC provided refresher training in January 2012 on the proper processing of Gulf War veterans' entitlement to mental health treatment. The Director indicated local quality reviewers and in-process reviewers ensure that there is an enhanced focus on this area during their quality assurance process. In addition, VSC staff monitor national STAR findings to ensure compliance in this area.

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.

Outreach to Homeless Veterans

Congress mandated that at least one full-time employee oversee and coordinate homeless veterans programs 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 Oakland VARO has a full-time Homeless Veterans Outreach Coordinator. Our review confirmed the Oakland Homeless Veterans Outreach Coordinator provided outreach and contacted local homeless service providers as required by VBA policy. Therefore, we made no recommendation for improvement in this area.

6. Special Review of Claims Processing Timeliness

According to congressional delegations, veterans in California were experiencing lengthy processing delays related to their requests for VA benefits. VBA policy requires that division managers conduct a monthly review of all claims pending more than one year. If it is not feasible for division managers to personally review the claims, as an alternative, the managers must review a monthly report prepared by staff designated the review responsibility.

We assessed controls over the VARO's management procedures to determine whether staff timely and accurately processed the oldest pending claims. As of December 2011, the Oakland VARO had just under 32,500 claims pending an average of 269.1 days—89.1 days more than the national target of 180. Three of the 10 oldest claims folders were at medical facilities awaiting veterans' medical examinations. The seven remaining claims had been pending from 1,040 to 3,187 days. We provided our observations on these seven claims to VSC management.

Finding 5 Oversight Needed To Ensure Timely Claims Processing

VSC staff did not monthly review claims older than 1 year as required. Processing delays occurred because of unclear guidance. As a result, veterans did not receive timely benefit payments.

Generally, delays occurred when VSC staff requested evidence to support veterans' additional disability claims, or when staff did not resolve all issues before finalization of the claims. For example, in September 2010, VARO staff discovered unresolved issues regarding a claim received on April 18, 2003. Staff established control for this claim in the electronic system using the original date of claim as required. VARO staff completed the claim on February 29, 2012—533 days from the date the unresolved issues were discovered. Additionally, two (29 percent) of the seven oldest claims had appeals pending and the claims folders were located at the Board of Veterans Appeals. In order to ensure timely processing, VSC staff should have requested that the Board of Veterans Appeals temporarily return the claims folders to the VARO, as required by VBA policy.

The VSC Workload Management Plan indicates a VSC management analyst should provide oversight for all claims pending greater than 2 years. In contrast, VBA policy requires that division management review all claims pending more than 1 year. All seven claims were pending over 2 years. Regardless of the unclear guidance, management should have reviewed all seven claims. If division managers could not personally review the claims, as an alternative, they were to review a monthly report prepared by staff designated this review responsibility.

Recommendation

6. We recommend the Oakland VA Regional Office Director develop and implement a plan to update the Workload Management Plan to ensure division management oversight of all claims pending for more than 1 year in accordance with Veterans Benefits Administration policy.

Management Comments

The VARO Director concurred with our recommendation. The Director indicated VSC managers are updating the workload management plan to ensure oversight of all claims pending more than 1 year in accordance with VBA policy. VSC staff frequently review detailed reports that focus on claims pending more than 1 year. Further, VARO staff have prepared a Wellness Plan to ensure that 95 percent of the claims completed during the remainder of FY 2012 will be claims pending more than 1 year.

OIG Response

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

Appendix A VARO Profile and Scope of Inspection

Organization

The Oakland VARO administers a variety of services and benefits including compensation benefits; vocational rehabilitation and employment assistance; benefits counseling; and outreach services for homeless, elderly, minority, and women veterans.

Resources

As of December 2011, the Oakland VARO had a staffing level of 269 full-time employees. Of this total, the VSC had 215.1 employees (80 percent) assigned.

Workload

As of December 2011, the VARO reported just under 32,500 pending compensation claims. The average time to complete claims was 275.6 days—45.6 days more than the national target of 230.

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 60 (11 percent) of 550 disability claims related to TBI and herbicide exposure that the VARO completed from July through September 2011. For temporary 100 percent disability evaluations, we selected 30 (4 percent) of 721 existing claims from VBA's Corporate Database. We provided VARO management with 691 claims remaining from our universe of 721 for further review. These claims represented all instances in which VARO staff granted temporary 100 percent disability evaluations for at least 18 months or longer as of November 1, 2011.

We reviewed the 11 SAOs required in FY 2011. We reviewed 18 files with 23 errors identified by VBA's STAR program during July through September 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 VSC. We also reviewed six completed claims processed for Gulf War veterans from July through September 2011 to determine whether VSC staff

addressed entitlement to mental health treatment in the rating decision documents as required. We assessed the effectiveness of the VARO's homeless veterans outreach program and reviewed seven of the oldest disability claims pending at the time of our inspection.

Compliance With Inspection Standards

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: April 25, 2012

From: Director, VA Regional Office Oakland, California

Subj: Inspection of the VARO Oakland, California

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

1. Attached are the Oakland VARO's comments on the OIG Draft Report: Inspection of VARO Oakland, California.

2. Questions may be referred to Jessica Arifianto at (510) 637-6005.

(original signed by:)
Douglas L. Bragg

Attachment

Oakland VA Regional Office
Response to the Office of Inspector General, Benefits Inspection

Recommendation 1: We recommend the Oakland VA Regional Office Director conduct refresher training on the proper processing of traumatic brain injury claims.

RO response: Concur

The VARO Director concurs with this recommendation. The VSC provided training on traumatic brain injury (TBI) for all decision makers on January 26, 2012.

All TBI cases that are rated now require second signature by designated Decision Review Officers (DROs). Refresher training was provided to these DROs the week of January 23, 2012.

The newly constituted Quality Review Team (QRT) with its Quality Review Specialists (QRSs) completed training during the week of February 6, 2012. The team of three GS-12 QRSs and five GS-13 QRSs specifically address improving the consistency and accuracy of exam requests and reports through completion of both local quality reviews and "in-process reviews" (IPRs). These reviews monitor the effectiveness of all training provided to Veteran Service Representatives (VSRs) and Rating VSRs (RVSRs). Because these reviews also include TBI claims, the QRSs are able to determine if the information provided during training was retained and implemented by employees.

The Oakland Regional Office (RO) would like to request closure of this item.

Recommendation 2:

We recommend the Oakland VA Regional Office Director implement a plan to ensure staff returns insufficient medical examination reports to health care facilities to obtain the evidence needed to support traumatic brain injury rating decisions.

RO response: Concur

The VARO Director concurs with this recommendation. During the January 2012 VARO/VISN 21 monthly meeting, the Veterans Service Center Manager (VSCM) summarized TBI findings from the Inspector General's (IG's) visit, especially highlighting the need for neurological examiners to order mental health exams if they cannot provide a proper opinion on neurological/mental symptomatology. The VSCM also indicated that cases identified with errors would be returned to VA medical centers (VAMCs) for clarification. The Oakland RO would like to request closure of this item.

Prepared by Oakland Regional Office
April 24, 2012

Recommendation 3: We recommend the Oakland 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

The VARO Director concurs with this recommendation. The RO acknowledges timeliness issues in completing SAOs. The VSC Management Analyst (MA) has provided feedback to personnel tasked with completion of Systematic Analyses

of Operations (SAOs). The Director has also tasked a new Management Analyst (MA), assigned to his office as of January 2012, to provide additional oversight over SAOs. The RO is working with the divisions on completing any past due SAOs by EOM April 2012.

Recommendation 4: We recommend the Oakland VA Regional Office Director develop and implement a plan to ensure management oversight and control of search mail.

RO Response: Concur

The VARO Director concurs with this recommendation. The VSC provided training for the entire Triage Team on January 27, 2012, on proper search mail procedures. Additionally, effective February 15, 2012, one Claims Assistant (CA) was assigned to perform consistent physical management of the search mail cart. This CA reviews search mail to ensure mail is properly placed on electronic search in the COVERS program. Findings are provided to the Triage Super Senior VSR who provides individual feedback and identifies any necessary training needs. Lastly, the Director's office, with the new MA, will more closely monitor compliance with the workload management plan, which does address oversight of search mail.

The Oakland RO would like to request closure of this item.

Recommendation 5: We recommend the Oakland VA Regional Office Director implement a plan, including refresher training, to ensure staff follow current policy regarding Gulf War Veterans' entitlement to mental health treatment.

RO Response: Concur

The VARO Director concurs with this recommendation. VSCM Memo 11-03 was released on September 27, 2011, requiring all DROs and RVSRs to complete a checklist when assigning a 100 percent evaluation or denying service connection for a mental disorder.

Prepared by Oakland Regional Office
April 24, 2012

As part of training provided on January 17, 2012, and January 26, 2012, all decision makers received refresher training regarding entitlement to mental health treatment for Gulf War veterans. National STAR findings are continually monitored to ensure compliance. Finally, local quality reviewers and in-process reviewers continue to ensure that this topic has an enhanced focus within the local quality review process during FY12.

The Oakland RO would like to request closure of this item.

Recommendation 6: We recommend the Oakland VA Regional Office Director develop and implement a plan to update the Workload Management Plan to ensure division management oversight of all claims pending for more than one year in accordance with Veterans Benefits Administration policy.

RO Response: Concur

The VARO Director concurs with this recommendation. The VSC is in the process of updating the Workload Management Plan to assign oversight of all claims pending for more than one year in accordance with Veterans Benefits Administration policy with a target date for revisions of the WMP by April 30, 2012. In the interim, the team is frequently reviewing pending issue detail reports with a focus on claims pending more than one year. The station has also prepared a Wellness Plan that is focused on inventory reduction and resolution of old inventory. Under the plan, the station will ensure that 95 percent of the work completed by the station during the remainder of FY12 will be one year old or older.

Prepared by Oakland Regional Office
April 24, 2012

Appendix C Inspection Summary

Table 2 reflects the operational activities inspected, applicable criteria, and whether or not we had reasonable assurance of VARO compliance.

Table 2. Oakland VARO Inspection Summary

Eight 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 Code of Federal Regulation 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (Manual (M) 21-1 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.** (Fast Letter (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. 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) (FL 08-15) (38 CFR 3.384) (38 CFR 3.2)		X
Public Contact			
8. Homeless Veterans Outreach Program	**Determine whether VARO staff provided effective outreach services.** (Public Law 107-95) (VBA Letter 20-02-34) (FL 10-11) (VBA Circular 27-91-4) (M21-1, Part VII, Chapter 6)	X	

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

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	Dawn Provost, Director Ed Akitomo Nelvy Viguera Butler Madeline Cantu Kelly Crawford Lee Giesbrecht David Pina Brandi Traylor Diane Wilson

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