VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Little Rock, Arkansas

July 26, 2012
12-00240-236

ACRONYMS AND ABBREVIATIONS

COVERS	Control of Veterans Records System
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, Little Rock, Arkansas

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 Little Rock VARO accomplishes this mission of providing veterans with access to high-quality benefits and services.

What We Found

The VARO accurately processed 97 percent of the traumatic brain injury and herbicide exposure-related claims we sampled. However, the VARO inaccurately processed a significant number (60 percent) of the temporary 100 percent disability evaluations we reviewed. This occurred because staff did not schedule medical reexaminations as required to determine whether to continue these evaluations. Without effective management of these temporary ratings, VBA risks paying excessive and unnecessary financial benefits. Although our results show VARO staff did not process 20 (22 percent) of the 89 disability claims accurately, these results do not represent the overall accuracy of disability claims processing at this VARO as the claims we sampled were considered at higher risk of processing errors.

Little Rock VARO staff corrected errors identified by the VBA's Systematic Technical Accuracy Review program as required. However, VARO management did not ensure staff completed or used adequate data to support Systematic Analyses of Operations. Further, VARO staff did not properly process mail to ensure raters had all evidence available to make accurate and timely claims decisions. Staff also overlooked reminders to address Gulf War veterans' entitlement to mental health treatment. Therefore, veterans were not always informed of entitlement to treatment for mental disorders. Further, VARO management did not provide oversight to ensure staff provided outreach to homeless shelters and service providers as required and the VSO did not have a mechanism in place to assess outreach effectively.

What We Recommended

We recommended the VARO Director develop and implement a plan to ensure staff complete a thorough analysis of required elements of Systematic Analyses of Operations. Management should ensure staff properly process all mail and address Gulf War veterans' entitlement to mental health treatment. Further, the Director needs to develop and implement a plan to ensure staff fulfill all homeless veteran outreach requirements, including updating the resource directory and regularly contacting homeless shelters and service providers.

Agency Comments

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

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

Scope of Inspection

In April 2012, we conducted an inspection of the Little Rock 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 did not examine eligibility determinations related to fiduciary competency determinations because the Veterans Benefits Administration (VBA) centralized then Central Area fiduciary activities at the Milwaukee VARO.

We reviewed 59 (17 percent) of 353 disability claims related to traumatic brain injury (TBI) and herbicide exposure that VARO staff completed from October through December 2011. In addition, we reviewed 30 (9 percent) of 321 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 our inspection. Appendix B provides the Acting 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 Little Rock VARO Needs To Improve Disability Claims Processing Accuracy

The Little Rock VARO lacked controls and accuracy in processing claims for temporary 100 percent evaluations. However, VARO staff correctly processed 97 percent of the TBI and herbicide exposure-related disability claims reviewed. Overall, VARO staff incorrectly processed 20 (22 percent) of the total 89 disability claims we sampled and processed $78,126 in improper benefits payments. VARO management agreed with our assessment and began to correct the errors identified.

Because we sampled specific types of claims, these results do not represent the universe of disability claims processed at this VARO. As reported by VBA's Systematic Technical Accuracy Review (STAR) program as of March 2012, the overall accuracy of the VARO's rating-related decisions was 82.3 percent—4.7 percentage points below VBA's 87 percent target.

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

Table 1

Little Rock VARO Disability Claims Processing Results				
Type	**Reviewed**	**Claims Incorrectly Processed**		
		Potential To Affect Veterans' Benefits	**Affecting Veterans' Benefits**	**Total**
Temporary 100 Percent Disability Evaluations	30	16	2	18
Traumatic Brain Injury Claims	29	1	0	1
Herbicide Exposure-Related Disability Claims	30	0	1	1
Total	**89**	**17**	**3**	**20**

Source: VA OIG analysis of veteran's disability claims (Oct-Dec 2011)

Temporary 100 Percent Disability Evaluations

VARO staff made a significant number of inaccuracies in processing temporary 100 percent disability evaluations. VARO staff incorrectly processed 18 (60 percent) of 30 temporary evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a service-connected disability following surgery, or when a veteran needs specific treatment. At the end of a mandated period of convalescence or treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's temporary 100 percent disability evaluation.

For temporary 100 percent disability evaluations, including confirmed and continued evaluations where rating decisions do not change veterans' payment amounts, VSC staff must input suspense diaries in VBA's electronic system. A suspense diary is a processing command that establishes a date when VSC staff must schedule a reexamination. As a suspense diary matures, the electronic system generates a reminder notification to alert VSC staff to schedule the reexamination.

Available medical evidence showed 2 of the 18 processing errors affected veterans' benefits. These errors involved overpayments totaling $44,250. The most significant overpayment occurred when VARO staff did not take action to schedule a medical reexamination for a veteran's lung cancer condition as required. VA treatment records show the veteran had no recurrence of or treatment for the cancer since the time of his surgery in January 2010. Nonetheless, VA continued processing monthly benefits and ultimately overpaid the veteran $43,588 over a period of 1 year and 4 months.

The remaining 16 of 18 errors had the potential to affect veterans' benefits. In most cases, we could not determine whether the evaluations would have continued because the veterans' claims folders did not contain the medical examination reports needed to reevaluate each case.

The most frequent processing inaccuracy in 11 of the 18 cases occurred because VARO management did not provide adequate oversight to ensure VSC staff entered suspense diaries to remind of the need to schedule medical reexaminations for confirmed and continued rating decisions. Because effective controls were not in place, the temporary 100 percent disability evaluations could have continued uninterrupted over the lifetime of the veterans if we had not identified the need for reexaminations. We identified no systemic trends as to why the remaining processing inaccuracies occurred.

In November 2009, VBA provided guidance reminding VAROs about the requirement to input suspense diaries in the electronic record. However, VARO management did not have a mechanism in place to ensure VSC staff

complied. As such, veterans may not always receive correct benefits payments.

For those cases requiring medical reexaminations, delays ranged from approximately 8 months to 6 years and 11 months. An average of 3 years and 2 months 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.

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 medical examination date entered in the electronic record. The Acting Under Secretary stated in response to our audit report that the target completion date for the national review would be September 30, 2011. However, VBA did not provide each VARO with a list of temporary 100 percent disability evaluations for review until September 2011. VBA subsequently extended the deadline several times to December 31, 2011, then to March 31, 2012, and then again to June 30, 2012. We confirmed the Little Rock VARO completed its review of VBA's temporary 100 percent disability evaluations and accurately reported the actions taken on all 31 cases that involved evaluations for prostate cancer. However, as of mid-July, VBA was still working to complete this national review requirement.

TBI Claims

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

VARO staff incorrectly processed 1 of 29 TBI claims. This error had the potential to affect a veteran's benefits. In this case, an Rating Veterans Service Representative (RVSR) used an insufficient medical examination to evaluate TBI-related disabilities. Although required, the medical examiners did not indicate whether the veteran's symptoms were associated with residuals of a TBI or a coexisting mental condition.

We did not consider this error rate significant and determined the VARO was generally complying with VBA's policy for processing TBI claims. Therefore, we made no recommendation for improvement in this area.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 1 of 30 herbicide exposure-related claims we reviewed. In this case, an RVSR incorrectly used September 7, 2011, to establish service connection for an herbicide exposure-related disability. This was the date the VARO received the veteran's claim. VARO staff

should have used September 7, 2010—1 year prior, as required by legislative change. As a result of the inaccuracy, VA continued processing monthly benefits and ultimately underpaid the veteran $33,876 over a period of 1 year.

We did not consider this error rate significant and determined the VARO was generally complying with VBA's policy for processing herbicide exposure-related claims. Therefore, we made no recommendation for improvement in this area.

2. Management Controls

Systematic Technical Accuracy Review

We assessed whether VARO management adhered to VBA policy regarding correction of errors identified by VBA's 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.

STAR staff identified 24 errors in 19 claims files processed from October through December 2011. VARO staff followed VBA policy by correcting all 24 errors identified during that period. As such, we made no recommendation for improvement in this area.

Systematic Analysis of Operations

We assessed whether VSC 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 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 an annual SAO schedule designating the staff required to complete the SAOs by specific dates. The VSC Manager is responsible for ongoing analysis of VSC operations, including completing 11 mandated SAOs annually.

Finding 2 Improved Oversight Needed To Ensure Complete Systematic Analyses of Operations

VARO management completed its SAOs timely. However, 2 of 11 SAOs were incomplete, missing data, and the supporting analyses. These errors occurred because VARO management did not provide adequate oversight to ensure VSC staff completed all annual SAOs with sufficient data to support their analyses and conclusions. As a result, VARO management may not have adequately identified existing and potential problems for corrective action to improve VSC operations.

SAOs were incomplete because VSC management did not provide effective oversight during the reviews. VARO managers said they utilized VBA's manual outline to guide their review of the SAOs. However, VBA's current policy does not delineate the specific data that staff should use to assist in completing these analyses. As such, this process was ineffective in ensuring proper justification and applicable data in the minimum areas to substantiate SAO conclusions and recommendations.

For example, the SAO on Quality of Files Activities did not include sampling of mail processing or a review of local reports on use of the Control of Veterans Records System (COVERS), an electronic system for tracking claims folders and ensuring search mail compliance. Nonetheless, VSC management reviewed and approved this SAO. In lieu of sampling mail in search mail areas, management's analysis consisted of an email sent to all team coaches requesting the total volume of pending search mail in their areas, which was a repeat of the prior year's SAO. Without conducting a hands-on review of search mail, management may not be able to identify staff non-compliance with mail tracking requirements by using COVERS. Additionally, staff confirmed that they did not have a written local policy governing the SAO process and they typically used the previous year's SAO as a template.

Despite the lack of completeness, management ensured all annual SAOs were timely completed and, in most cases, before the deadlines on the annual schedule. Management achieved this timeliness by establishing two due dates for each SAO—one for VSC managers and another for the Director's office, which provided ample time for management to review and correct the SAOs within established timeframes.

VBA policy suggests that management discuss previous as well as proposed reviews and actions to correct deficiencies or improve operations by using SAOs. However, in completing the Internal Controls SAO, staff did not make a recommendation to address all of the weaknesses identified during their review of data matching programs, nor did they discuss recurring weaknesses. VSC management acknowledged the weaknesses identified during our review of its SAOs and agreed that, had it been more thorough on its reviews, it may have identified areas where staff could have enhanced their analysis to promote improvements in VSC operations.

Recommendation

1. We recommend the Little Rock VA Regional Office Director develop and implement a plan for staff to use sufficient data to support analysis and recommendations when completing Systematic Analyses of Operations.

Management Comments

The Acting VARO Director concurred with our recommendation and stated all management staff will receive training on the preparation and content of SAOs. Further, the Veterans Service Center Manager, the Assistant Service

Center Manager, and a Coach will review all completed SAOs prior to submission to the Director's office to ensure management uses sufficient data to support analysis and recommendations.

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

3. Workload Management

VBA has embarked on a multi-year transformation of veterans' claims processing and benefits delivery. As part of this transformation, VBA is pursuing new business concepts with the goal of improving the speed, accuracy, and consistency of decisions rendered to veterans and their families. One outcome of the initiative has been implementation of the Intake Processing Center (IPC) at the Little Rock VARO, which began in March 2010. The IPC combines incoming mail processing activities (the mailroom) and VSC claims-related mail processing into a single, centrally located area. VBA policy suggests the combined activities of these two entities provide for rapid and accurate identification and distribution of claims-related mail into the VSC workload, normally on the same day.

Another outcome of this initiative has been the VSC's transition into the integrated team model. In March 2010, the VSC reorganized from the Claims Processing Improvement business model to a fully integrated team model, or "POD," where teams are composed of employees with various skill sets from across the VARO. For example, an integrated team might consist of supervisory staff, claims assistants, RVSRs, and Veterans Service Representatives collectively assigned to process compensation claims.

Intake Processing Center We assessed controls over VSC IPC 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 Little Rock VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the IPC. IPC staff processed and delivered VSC mail to the mail control points as required. Therefore, we made no recommendation for improvement in this area.

POD Mail-Processing Procedures We assessed mail-processing procedures within the PODs 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.

VBA policy requires that VSC staff use COVERS 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 upon receipt.

Finding 3 Controls Needed for Proper Processing of Veterans Service Center Mail

VSC staff did not correctly process or control 9 of 60 pieces of claims-related mail according to policy. This occurred because VARO management did not adequately monitor mail processing within the VSC's PODs. Consequently, VSC staff may not always have all available evidence to make claims decisions and beneficiaries may not receive accurate and timely benefits payments.

Search and Drop Mail

Staff improperly used electronic applications when processing search and drop mail. For example, they did not accurately control search mail in COVERS and they did not update the electronic systems designed to track and manage mail received in support of claims. Overall, staff did not accurately process 5 of 30 pieces of search mail and 4 of 30 pieces of drop mail we reviewed.

Staff ignored electronic notifications designed to alert them of mail needing to be associated with claims folders because supervisors did not always check COVERS compliance. In addition, staff did not ensure they updated the electronic record prior to sending drop mail for association with related files in the storage area. Following are examples of these discrepancies.

- On December 13, 2011, POD staff received forms from a veteran to request private medical evidence on his behalf to support his claim. For 3 months, staff did not place this mail on search in COVERS after they received it, finally doing so on March 12, 2012. Additionally, staff did not timely associate this mail with the claims folder for processing on March 15, 2012, the day COVERS notified them of the pending search mail. At the time of our inspection, staff had not processed this request for medical records for 106 days, ultimately delaying completion of the claim and delivery of benefits.
- On May 17, 2011, POD staff received from a veteran a form to request medical evidence to support his claim. Staff properly updated the electronic record to indicate the VARO had received the mail; however, they did not associate this evidence with the related claims folder as required. An RVSR subsequently completed a disability decision on the veteran's claim without having this evidence available to support the determination. Although this evidence would not have changed the

outcome of the decision, the potential exists that decision-makers may not have all available evidence when making a disability determination.

VSC management did not consistently monitor search or drop mail processes to ensure employees and management conducted weekly reviews, as required. In March 2012, prior to our inspection, the VSC initiated a review of its search mail activities, using available COVERS reports combined with physical inspection of all mail points. Findings from the review revealed approximately 3,000 electronic mail and folder search notifications had gone unaddressed in COVERS, dating back to 2006. Management discovered mail in search folders without corresponding active mail search notifications in COVERS. Further, staff did not associate claims-related mail with the related files despite electronic notifications in COVERS showing the need to do so. To address these findings, the reviewing official recommended training all staff on the proper use of the COVERS application. We were unable to assess the effectiveness of corrective action in response to this recommendation given the scope of our inspection; however, we will follow up on this processing activity during future Benefit Inspections.

VSC management confirmed weaknesses associated with mail-processing controls. VSC management did not review local COVERS reports, which would have shown that some POD supervisors were not performing compliance checks as required. In November 2011, management requested that POD supervisors complete quality reviews of their mail-processing activities. However, supervisors did not always perform these reviews, stating the VARO's production goals took precedence. In addition, POD staff informed us they did not always reconcile search mail weekly as they did not have the available resources, nor did they use COVERS search mail reports to monitor mail, as supervisors did not find the reports useful.

Management did not require teams to report the amount of search mail pending or the oldest search mail date, relying instead upon visual management of mail operations. Additionally, the workload management plan did not include guidance for supervisors to monitor drop mail. The local policy was to control in COVERS all mail that could not be immediately associated with claims folders; however, not all POD mail staff were following this policy, depending upon their workloads. If management had required staff to sample search mail when completing the Quality of Files Activities SAO, it might have identified these weaknesses in mail processing.

VBA policy on IPC implementation states the intake analyst position should have a strong knowledge of claims processing applications; however, the intake analyst was not required and did not use these applications when sorting mail. Some staff and supervisors stated that not using the

applications sometimes resulted in misrouting mail by social security numbers, despite corresponding veterans' claim numbers.

VSC managers and some supervisors stated that the new initiatives were working, and felt they had better control over the mail through visual management. However, one supervisor who thought the initiative was working also had approximately 125 pieces of mail returned by the United States Postal Service as undeliverable, some more than a year old. Another POD supervisor who was part of the IPC pilot believed it had not yet achieved the desired results. Furthermore, we were not able to obtain any objective evidence that the IPC and POD model had improved search or drop mail-handling operations, as management did not track pending volume or age of these types of mail.

Recommendation

2. We recommend the Little Rock VA Regional Office Director develop a plan for oversight of mail control areas and ensuring compliance with requirements for using the Control of Veterans Records System.

Management Comments

The Acting VARO Director concurred with our recommendation. In May 2012, all Service Center personnel received training on mail procedures and the use of COVERS. Supervisors are required to spot check and certify COVERS compliance to the Assistant Veterans Service Center Manager. Further, management is revising the Workload Management Plan to include supervisory spot checks of mail control areas.

OIG Response

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

4. Eligibility Determinations

Entitlement to Medical 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 mental health care when denying service connection for a mental disorder.

Finding 4 Gulf War Veterans Do Not Always Receive Entitlement Decisions for Mental Health Treatment

VSC staff did not address whether 13 of 30 Gulf War veterans were entitled to receive treatment for mental disorders. RVSRs found it easy to overlook this entitlement decision despite an understanding of VBA policy. As a result, staff did not accurately inform veterans of entitlement to treatment for mental disorders.

Although the RVSRs interviewed were able to explain the correct process for addressing Gulf War veterans' mental health care entitlement, they stated it was easy to overlook the entitlement, even with tip master notifications reminding them to do so. Additionally, since at least October 2010, RVSRs had not received any refresher training emphasizing the need to consider Gulf War veterans' entitlement to mental health treatment.

In 8 of 13 errors we found, RVSRs might have considered Gulf War veterans' entitlement to mental health treatment if they had heeded the pop-up notifications. In the remaining five cases, current rating decisions did not address veterans' mental health conditions that were required for the tip master to generate reminder notifications to consider the mental healthcare entitlement. The majority of staff and management we interviewed felt the tip master notification was not effective because it was easy to ignore.

Recommendation

3. We recommend the Little Rock VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives correctly address Gulf War veterans' entitlement to mental health treatment.

Management Comments

The Acting VARO Director concurred with our recommendation. In April 2012, RVSRs received refresher training on Gulf War veterans' entitlement to mental health treatment. Further, quality reviewers look for these issues on both formal quality reviews and in-process reviews.

OIG Response

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

5. Public Contact

Outreach to Homeless Veterans

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.

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 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.

Finding 5 No Clear Measures To Assess Effectiveness of the Homeless Veterans Outreach Program

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

The Little Rock VARO is not one of the 20 VAROs mandated to have a full-time Homeless Veterans Outreach Coordinator. Management had temporarily assigned one employee to perform the Homeless Veterans Outreach Coordinator functions as a collateral duty until a new outreach coordinator could be selected.

VARO management did not update its resource directory of homeless shelters, day-care facilities, and service providers, as required by VBA policy. We contacted representatives at 7 of 30 shelters and service providers listed in the VARO directory. The representatives indicated VARO staff had not contacted them, nor had they received information regarding VA benefits and services. VSC staff confirmed they had not routinely followed up or provided information to homeless shelters and service providers as required. We nonetheless verified that the VARO's Homeless Veterans Outreach Coordinator provided weekly assistance and education to staff and homeless veterans at one facility, the Little Rock VA Hospital's Help Center.

VSC management did not have a mechanism in place to assess the effectiveness of its outreach program. For example, supervisors did not contact homeless shelters or service providers to verify the Homeless Veterans Outreach Coordinator's reported outreach activities. As a result, VARO management had no assurance homeless shelters and service providers received information from the VARO regarding benefits and services available to homeless veterans.

Recommendations

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

5. We recommend the Little Rock Regional Office Director develop and implement a plan outlining how VA Regional Office staff will accomplish all required homeless veteran outreach services, including updating the resource directory and regularly contacting homeless shelters and service providers.

Management Comments

The Acting Director concurred with our recommendations and issued a Standard Operating Procedure for Homeless Outreach and Claims Processing in June 2012. In May 2012, staff updated the resource directory and the newly assigned Outreach coordinator mailed contact information to each homeless shelter. In addition, the coordinator called each facility to ensure they received the mailed information.

OIG Response

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

Appendix A VARO Profile and Scope of Inspection

Organization

The Little Rock VARO administers a variety of services and benefits, including compensation benefits; vocational rehabilitation and employment assistance; specially adapted housing grants; benefits counseling; and outreach to homeless, elderly, minority, and women veterans.

Resources

As of March 2012, the Little Rock VARO had a staffing level of 181 full-time equivalent employees. Of this number, the VSC had 155 employees assigned.

Workload

As of March 2012, the VARO reported 8,272 pending compensation claims. The average time to complete claims was 189 days—41 days better than the national target of 230 days.

Scope

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

Our review included 59 (17 percent) of 353 disability claims related to TBI and herbicide exposure that the VARO completed from October through December 2011. For temporary 100 percent disability evaluations, we selected 30 (9 percent) of 321 existing claims from VBA's Corporate Database. We provided VARO officials with 291 claims remaining from our universe of 321 for further review. These 321 claims represented all instances where VARO staff had granted temporary 100 percent disability evaluations for at least 18 months or longer, as of February 3, 2012.

We reviewed all 19 files containing 24 errors identified by VBA's STAR program from October through December 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 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. In addition, we review rating decisions and awards processing involving temporary 100 percent disability evaluations. We reviewed the 11 mandatory SAOs for FY 2012.

We reviewed selected mail in various processing stages in the IPC and VSC PODs. We reviewed 30 completed claims processed for Gulf War veterans from October through December 2011 to determine whether VSC staff

addressed entitlement to mental health treatment in the rating decision documents as required. We also reviewed the effectiveness of the VARO's homeless veterans outreach program.

Data Reliability

During our inspection, we used computer-processed data from Veterans Service Network Operations Reports and Awards. To test reliability, we reviewed the data to determine whether they were missing key fields, contained data outside of the timeframe requested, included calculation errors, contained obvious duplication of records, contained alphabetic or numeric characters in incorrect fields, or contained illogical relationships among data elements. Further, we compared veterans' names, file numbers, social security numbers, station numbers, dates of claim, and decision dates provided in the data received with information contained in the 119 claims folders we reviewed.

Our testing of the data disclosed they were sufficiently reliable for our inspection objectives. Our comparison of the data provided with information contained in the veterans' claims folders at VARO Little Rock also did not disclose any problems with data reliability.

Inspection Standards

We completed our inspection 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 inspection to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our review objectives.

Appendix B Acting VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: July 17, 2012

From: Acting Director, Little Rock VA Regional Office (350/00)

Subj: Inspection of the VA Regional Office, Little Rock, Arkansas

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

1. Attached are the Little Rock VARO's comments on the OIG Draft Report: *Inspection of the VA Regional Office, Little Rock, Arkansas*

2. Please refer questions may be referred to Richmond H. Laisure, Acting Director at 501-370-3700.

(Original Signed)

Richmond H. Laisure
Acting Director

Attachment

Little Rock VA Regional Office
Response to the OIG
Benefits Inspection Division
Draft Report of the Little Rock Regional Office

Recommendation 1 – *We recommend the VARO Director develop and implement a plan for staff to use sufficient data to support analysis and recommendations when completing Systematic Analyses of Operations.*

Concur with recommendation

Response: Training on the preparation and content of Systematic Analyses of Operations (SAOs) is scheduled for all Little Rock management staff on August 14, 2012. A Coach, the Assistant Veterans Service Center and the Veterans Service Center Manager review all completed SAOs prior to submission to the Office of the Director to ensure sufficient data is used to support analysis and recommendations.

Recommendation 2 – *We recommend the Little Rock VA Regional Office Director develop a plan for oversight of mail control areas and ensuring compliance with requirements for using the Control of Veterans Records System.*

Concur with recommendation

Response: Training was conducted on mail procedures and Control of Veterans Records System (COVERS) for all Service Center personnel on May 1 and May 2, 2012.

The Little Rock RO has an all station COVERS day each week with follow-up spot checks completed by each first line supervisor. The Workload Management Plan requires spot checks of COVERS compliance by supervisors with certification to the Assistant Veteran Service Center Manager (AVSCM) or designee. The AVSCM or designee conducts a spot check of the random checklist to ensure compliance and maintains electronic documentation that COVERS compliance checks were conducted.

The Workload Management Plan is currently being revised to include supervisory spot checks of mail control areas.

Recommendation 3 – *We recommend the Little Rock VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives correctly address Gulf War veterans' entitlement to mental health treatment.*

Concur with recommendation

Response: Refresher training on this topic was conducted with Rating Veterans Service Representatives on April 19, 2012. The importance of addressing this entitlement continues to be stressed at training sessions. Quality reviewers continue to look for this information on both formal quality reviews and reviews of work in process.

Recommendation 4 – *We recommend the Little Rock VA Regional Office Director develop and implement a plan to assess and monitor effectiveness in providing outreach information to homeless shelters and service providers.*

Concur with recommendation

Response: A Standard Operating Procedures (SOP) for Homeless Outreach/Claims Processing was issued on June 5, 2012. After action reports are provided following each outreach event to include the point of contact, facility visited, the hours expended, number of Veterans present and claims taken.

Recommendation 5 – *We recommend the Little Rock Regional Office Director develop and implement a plan outlining how VA Regional Office staff will accomplish all required homeless veteran outreach services, including updating the resource directory and regularly contacting homeless shelters and service providers.*

Concur with recommendation

Response: A Standard Operating Procedures (SOP) for Homeless Outreach/Claims Processing was issued on June 5, 2012.

The resource directory was updated in May 2012. The newly assigned Outreach Coordinator made initial contact with each homeless shelter in May 2012, by sending a letter that provided his contact information. Follow-up telephone calls were made to ensure the mailing was received and to ascertain if any further information and/or visit are needed. Contact will be made quarterly as outlined in the SOP.

The Outreach Coordinator will contact the HVOC at the Central Arkansas Veterans Healthcare System and Veterans Healthcare System of the Ozarks monthly in accordance with the SOP to share information and outreach initiatives.

Appendix C Inspection Summary

Table 2. Little Rock 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 processed temporary 100 percent disability evaluations.** (38 Code of Federal Regulations (CFR) 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) Manual (M)21-1Manual 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 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-related disabilities**. (38 CFR 3.309) (Fast Letter 02-33) (M21-1MR Part IV, Subpart ii, Chapter 2, Section C.10)	X	
Management Controls			
4. Systematic Technical Accuracy Review	**Determine whether VARO staff properly corrected STAR errors in accordance with VBA policy.** (M21-4, Chapter 3, Subchapter II, 3.03)	X	
5. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)		X
Workload Management			
6. Mail-Handling Procedures	**Determine whether VARO staff properly followed VBA mail-handling procedures.** (M23-1) (M21-4, Chapter 4) (M21-1MR Part III, Subpart ii, Chapters 1 and 4)		X
Eligibility Determinations			
7. Gulf War Veterans' Entitlement to Mental Health Treatment	**Determine whether VARO staff properly processed Gulf War veterans' 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)		X
Public Contact			
8. Homeless Veterans Outreach Program	**Determine whether VARO staff 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 Letter 20-02-34) (C&P Service Bulletins, January 2010 and April 2010) (M21-1MR, Part VII, Chapter 6.06)		X

Source: VA OIG
C&P=Compensation and Pension, CFR=Code of Federal Regulations, M=Manual, MR=Manual Rewrite

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.
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