VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Lincoln, Nebraska

July 10, 2012
12-00243-219

ACRONYMS AND ABBREVIATIONS

C&C	Confirmed and Continued
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, Lincoln, Nebraska

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 Lincoln VARO accomplishes this mission.

What We Found

Of the 51 VAROs we have inspected since April 2009, the Lincoln VARO ranked in the top 6 percent for claims processing accuracy.

Generally, VARO staff processed traumatic brain injury and herbicide exposure-related disability claims correctly. However, the VARO did not always accurately process temporary 100 percent disability evaluations. These errors occurred when staff did not schedule required medical reexaminations. Overall, VARO staff did not accurately process 11 (13 percent) of 85 disability claims we sampled as part of our inspection. These results do not represent the overall accuracy of disability claims processing at this VARO because we sampled specific high-risk claims.

VARO staff took appropriate actions when correcting errors identified by VBA's Systematic Technical Accuracy Review program. Management ensured staff completed thorough and timely Systematic Analyses of Operations. Because VARO managers provided effective oversight of mail-processing workspace, they were able to control and route all mail the date it arrived at the VARO. VARO staff also provided adequate outreach to homeless shelters and service providers by working collaboratively with community and advocacy groups. However, VARO staff did not always address Gulf War veterans' entitlement to mental health treatment as required.

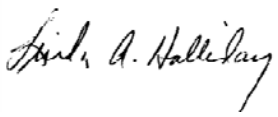
Lincoln VARO leaders attributed their successful operations to robust training efforts resulting in a highly skilled workforce and a unified management team providing exceptional oversight. The VARO provided thorough training at the time it implemented new or amended VBA and local policies. Also, in October 2011, VARO management started recording training sessions and created a training library where staff can check out taped training sessions, thereby ensuring consistency in staff instruction.

What We Recommend

The Lincoln VARO Director should develop and implement a plan to ensure staff address Gulf War veterans' entitlement to mental health treatment.

Agency Comments

The VARO Director concurred with our recommendation. Management's planned action is 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 March 2012, the OIG conducted an inspection of the Lincoln VARO. The inspection focused on five protocol areas addressing eight operational activities. The five protocol areas were disability claims processing, management controls, workload management, eligibility determinations, and public contact.

We reviewed 55 (31 percent) of 178 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 (29 percent) of 104 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 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 Lincoln VARO Could Improve Processing of Temporary 100 Percent Disability Evaluations

Of the 51 VAROs we have inspected since 2009, the Lincoln VARO ranked in the top 6 percent for claims processing accuracy (87 percent), slightly below the Wilmington, DE VARO at 93 percent and the Des Moines, IA VARO at 89 percent. However, we still identified opportunities for additional improvements in claims processing. Lincoln VARO staff incorrectly processed 11 (13 percent) of the total 85 disability claims we sampled. Most errors were related to temporary 100 percent disability evaluations and additional attention is needed to ensure the evaluations are effectively managed.

Based on the errors identified in the three types of claims reviewed, the VARO overpaid a total of $123,121 in benefits. VARO management agreed with our assessment and began to correct the errors identified. Because we sampled claims related to specific conditions, these results did not represent the universe of disability claims processed at this VARO. The following table reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Lincoln VARO.

Table 1

Lincoln 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	7	1	8
Traumatic Brain Injury Claims	25	0	1	1
Herbicide Exposure-Related Disability Claims	30	1	1	2
Total	**85**	**8**	**3**	**11**

Source: VA OIG analysis of veterans' disability claims (Oct-Dec 2011).

As reported by the Veterans Benefits Administration's (VBA) Systematic Technical Accuracy Review (STAR) program as of March 2012, the overall accuracy of the VARO's compensation rating-related decisions was 95.7 percent—8.7 percentage points above the 87 percent target.

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 8 (27 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 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 (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 that one (13 percent) of eight processing errors we identified affected a veteran's benefits. In this case, VARO staff did not schedule a follow-up examination to evaluate a veteran's lymphoma. VA medical treatment reports showed the veteran's disability improved, warranting a reduction in benefits as of April 2011. As a result of the lack of follow-up, VA continued processing monthly benefits and ultimately overpaid the veteran $17,241 over a period of 6 months.

The remaining seven (88 percent) of eight 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 errors, noted in six (75 percent) of eight cases, occurred when VARO staff did not establish suspense diaries in the electronic record; five of the eight errors involved C&C rating decisions. As a result, VARO staff did not receive reminder notifications to schedule the required VA medical reexaminations. The remaining error occurred when a Rating Veterans Service Representative (RVSR) did not establish Dependents Educational Benefits for a veteran despite medical evidence showing his disability was permanent in nature.

VARO management did not provide adequate oversight to ensure VSC staff entered suspense diaries to schedule medical reexaminations for C&C rating decisions. In November 2009, VBA provided guidance reminding VAROs

of this requirement. 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 1 year to 5 years and 10 months. An average of 2 years and 11 months elapsed from the time staff should have scheduled the medical reexaminations until the date of our inspection—the date staff ultimately took corrective actions to obtain the necessary medical evidence.

In response to a recommendation in our report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), the Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each had a future examination date entered in the electronic record. 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 June 2012. We confirmed the Lincoln VARO completed its review of VBA's temporary 100 percent disability evaluations and accurately reported the actions taken on all 14 cases, which involved temporary 100 percent disability evaluations for prostate cancer.

In June 2011, VBA implemented a system modification allowing automatic population of suspense diaries in the electronic record to provide reminder notifications to schedule reexaminations related to C&C rating decisions. Because the errors identified during our inspection occurred prior to VBA's June 2011 system modification, we made no recommendation for improvement in this area. We will continue to monitor VARO performance in this area during future inspections to determine the effectiveness of VBA's system modification.

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 (4 percent) of 25 TBI claims. This one error affected a veteran's benefits. The error occurred when an RVSR incorrectly established compensation at the 100 percent level because the veteran could no longer work because of migraine headaches. In order for veterans to receive additional compensation for being unemployable, VBA policy requires a single disability evaluation to be evaluated as 60 percent or more disabling. Because the RVSR had evaluated the veteran's migraines at 50 percent, he was not entitled to the additional compensation for being unemployable. We determined VA continued processing monthly benefits

and ultimately overpaid the veteran $19,195 over a period of 1 year and 2 months. Due to the frequency of processing these TBI claims correctly, we made no recommendation for improvement in this area.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 2 (7 percent) of 30 herbicide exposure-related claims—one of these claims affected a veteran's benefits. In this case, VARO staff incorrectly conceded exposure to herbicides based on the veteran's service in the Republic of Korea. VBA policy allows decision-makers to concede exposure to herbicides if a veteran served in one of several specific units during certain time periods. In this case, the veteran's military personnel file, a response from VBA's Compensation and Pension Service, and a response from the United States Army and Joint Services Records Research Center did not show the veteran served in one of the specified military units. As a result, VA continued processing monthly benefits and ultimately overpaid the veteran $86,685 over a period of 4 years and 2 months.

The remaining processing error had the potential to affect a veteran's benefits. The error occurred when VARO staff did not schedule a mandatory medical reexamination in December 2011. This error did not affect the veteran's overall disability evaluation but may affect future evaluations for additional benefits.

Because we did not consider the frequency of errors significant, we determined the VARO generally followed VBA policy when 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 VARO staff take corrective action on errors identified by STAR.

STAR staff identified three claims processing errors that Lincoln VARO staff made from October through December 2011. VARO staff followed VBA policy by correcting all of the errors identified during that period; therefore, we made no recommendation for improvement in this area.

Lincoln VARO leaders attributed their successful operations to robust training efforts resulting in a highly skilled workforce and a unified management team providing exceptional oversight. They also told us VARO staff provides thorough training when VBA or the VSC implement new or

amended policy changes. Additionally, in October 2011, VARO management started recording training sessions and created a training library where staff can check out taped training sessions, thereby ensuring consistency in staff instruction.

Systematic Analysis of Operations

We assessed whether VARO management had adequate controls in place to ensure complete and timely submission of each Systematic Analysis of Operations (SAO). We also considered whether VSC staff 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 to propose corrective actions. VARO management must publish annual SAO schedules designating the staff required to complete the SAOs by specific dates. The VSC manager is responsible for ongoing analysis of VSC operations, including completing 11 mandated SAOs annually.

VARO management timely completed all 11 required SAOs. The completed SAOs contained thorough analyses using appropriate data, identified areas for improvement, and made recommendations for improvement of business operations. As a result, we determined the VARO followed VBA policy and we made no recommendation for improvement in this area.

3. Workload Management

Mailroom Operations

We assessed controls over VARO mailroom operations to ensure staff timely and accurately processed incoming mail. VBA policy states staff will open, date-stamp, and route all mail to the appropriate locations within 4 to 6 hours of receipt at the VARO. The Lincoln VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Veterans Service Center Triage Team.

On five different occasions during our inspection, we observed staff processing incoming mail on the date received at the VARO. Best practices we observed included effective visual management of the mail process. Supervisors had physically organized their workspace in a manner that allowed them to provide adequate oversight of all mail-processing activities, including controlling and routing of mail. Managers also ensured mail-processing staff maintained required skill sets by cross-training them in the various VSC Triage Team positions. Additionally, VARO managers established a permanent mailroom team-lead, who was available to timely address the staff's complex mail-related questions, thereby contributing to a highly efficient mailroom operation.

VSC Mail-Processing Procedures

We also assessed mail-management procedures within the VSC to ensure staff reviewed, controlled, and processed all claims-related mail in accordance with VBA policy. The 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 (COVERS), 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 processing action upon receipt.

VSC staff mishandled 4 (7 percent) of 60 pieces of mail. Of the 60 pieces of mail reviewed—30 pieces consisted of search mail and 30 pieces were drop mail. VSC staff did not properly use VBA's COVERS application to process and control four pieces of the search mail. In two of the cases, VSC staff did not establish a mail search in COVERS as required. In the remaining two cases, the search mail was not associated with the veterans' claims folders despite electronic notifications reminding staff that mail was pending for current claims. Due to our overall assessment that mailroom operations were effective and represented a best practice, we made no recommendation for improvement in this area.

4. Eligibility Determinations

Entitlement to Medical Treatment for Mental Disorders

Gulf War veterans are eligible for medical treatment for any mental disorder developed within 2 years of the date of separation from 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 decisions. 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 treatment when denying service connection for a mental disorder.

Finding 2 Gulf War Veterans Did Not Always Receive Entitlement Decisions for Mental Health Treatment

VSC staff did not address whether 8 (27 percent) of 30 Gulf War veterans were entitled to receive treatment for mental disorders. RVSRs told us they found it easy to overlook this entitlement decision despite an understanding of VBA policy. As a result, RVSRs did not always inform veterans of possible mental health treatment benefits.

RVSRs we interviewed were able to explain the correct process for addressing Gulf War veterans' mental health care entitlement and VSC staff received refresher training on this topic in FY 2011. However, the training materials did not cover what to do when a prior decision did not address eligibility for mental health treatment. In such cases, VBA's policy requires RVSRs to correct the errors in the current decision.

VSC management agreed with our assessment and began to correct the errors identified. During our inspection, management conducted additional training that emphasized VBA's policy that RVSRs address a veteran's entitlement to mental health care treatment if it was missed in a prior decision.

Recommendation

We recommend the Lincoln VA Regional Office Director develop and implement a plan to determine whether training was effective in ensuring Rating Veterans Service Representatives address Gulf War veterans' entitlement to mental health treatment as required.

Management Comments

The VARO Director concurred with our recommendation and informed us that staff received training on this topic at the time the OIG team was onsite. Further, management discussed the importance of addressing this entitlement at RVSR team meetings held on March 28 and April 25. Additionally, management created a help tool in March to assist RVSRs in addressing entitlement to mental health treatment for Gulf War veterans.

OIG Response

The 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.

We determined the Lincoln VARO and VHA homeless coordinators worked collaboratively by participating in community service events specific to

homeless veterans in counties under the VARO's jurisdiction. Particularly noteworthy was the VARO's relationship with the local community, including one nonprofit organization that regularly televised outreach messages specific to homeless veterans. Because the VARO provided information on VA benefits and services to homeless shelters and service providers as required, we made no recommendation for improvement in this area.

Appendix A VARO Profile and Scope of Inspection

Organization

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

Resources

As of March 2012, the Lincoln VARO had a staffing level of 248.6 full-time equivalent employees. Of this number, the VSC had 129.6 employees assigned.

Workload

As of February 2012, the VARO reported 3,027 pending compensation claims. The average time to complete claims was 109.9 days—120.1 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 delivery of benefits and nonmedical services to veterans and other beneficiaries. We interviewed managers and employees and reviewed veterans' claims folders.

Our review included 55 (31 percent) of 178 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 (29 percent) of 104 existing claims from VBA's Corporate Database. We provided VARO officials with 74 claims remaining from our universe of 104 for their review. These 74 claims represented all instances where VARO staff had granted temporary 100 percent disability evaluations for at least 18 months or longer as of February 6, 2012.

We reviewed all three files containing 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 assessments include a review of work associated with claims requiring rating decisions. STAR staff review original claims, reopened claims, and claims for increased evaluations. Further, they review appellate issues that involve a myriad of veterans' disability claims.

Our process differs from that of STAR as we review specific types of disability claims related to TBI and herbicide exposure that require rating decisions. We reviewed rating decisions and awards processing involving temporary 100 percent disability evaluations. Additionally, we reviewed the 11 mandatory SAOs for FY 2011.

For our review, we selected mail in various processing stages in the VARO mailroom and VSC. 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.

Reliability of Data

During our inspection, we used computer-processed data from VETSNET Operations Reports and VETSNET Awards. To test the reliability of the data, we reviewed it to determine whether any data were missing from key fields, contained data outside of the period requested, included any calculation errors, contained obvious duplication of records, contained alpha 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 claims, and decision dates in the computer-processed data we received with information contained in the Lincoln VARO's claims folders we reviewed.

Our testing of the data disclosed that it was sufficiently reliable for accomplishing our inspection objectives. Our comparison of the electronic data received with information contained in the veterans' claims folders at Lincoln VARO did not disclose any problems with data reliability.

Compliance with Inspection Standards

We conducted our inspection in accordance with the Council of the Inspectors General on Integrity and Efficiency *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 VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: June 26, 2012

From: Director, Lincoln VA Regional Office (377/00)

Subj: Inspection of the VA Regional Office, Lincoln, Nebraska

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

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

2. Questions may be referred to Margaret Bunde at (402) 420-4239.

(original signed by:)

LOREN MILLER

Director

Attachment

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

OIG Recommendation.

We recommend the Lincoln VA Regional Office Director develop and implement a plan to determine whether training was effective in ensuring Rating Veterans Service Representatives address Gulf War veterans' entitlement to mental health treatment as required. (pg. 8)

Concur with Recommendation

Director's Response: The Lincoln RO conducted training on this topic at the time that the IG team was in the office. Further, we discussed the importance of addressing this entitlement at RVSR team meetings on March 28 and April 25. Additionally, we created a RVSR help tool in March, in response to the IG findings, and updated the tool with additional information in June 2012. The quality reviewers remain diligent in looking for this information on both in-process reviews and formal quality reviews.

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. Lincoln 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 Regulations (CFR) 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 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 errors STAR identified 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) (38 CFR 3.2)		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)	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.
Acknowledgments	Brent Arronte, Director Daphne Brantley Brett Byrd Madeline Cantu Ramon Figueroa Lee Giesbrecht Nora Stokes Lisa Van Haeren Nelvy Viguera Butler

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