VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of VA Regional Office Wilmington, Delaware

June 11, 2013
12-04328-211

ACRONYMS AND ABBREVIATIONS

OIG	Office of Inspector General
QRT	Quality Review Team
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
TBI	Traumatic Brain Injury
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of VA Regional Office Wilmington, DE

Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and 1 Veterans Service Center nationwide that process disability claims and provide a range of services to veterans. We evaluated the Wilmington VARO to see how well it accomplishes this mission.

What We Found

Overall, VARO staff did not accurately process 17 (50 percent) of 34 disability claims we reviewed. We sampled claims that we considered to be at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Claims processing that lacks compliance with VBA procedures can result in the risk of paying inaccurate and unnecessary financial benefits.

Specifically, 17 of 30 temporary 100 percent disability evaluations we reviewed were inaccurate. Generally, errors in processing the temporary evaluations occurred because VARO staff did not input suspense diaries or take timely actions to schedule medical reexaminations or reduce benefits as appropriate. All four traumatic brain injury claims that VARO staff completed from April through June 2012 were correctly processed.

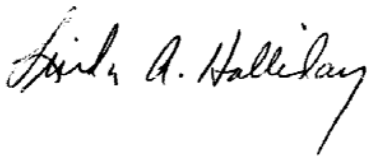
Management ensured Systematic Analyses of Operations were complete and timely. However, staff did not always annotate Gulf War veterans' entitlement to mental health care on decision documents. Staff also did not provide adequate outreach to homeless veterans in their area of jurisdiction.

What We Recommend

The VARO Director should develop and implement a plan to ensure staff input suspense diaries, schedule medical reexaminations, and follow up to reduce benefits for temporary 100 percent disability evaluations when appropriate. The Director should ensure staff review the temporary 100 percent disability evaluations to determine if reexaminations are required for those claims not reviewed as part of the OIG statistical sample. Management should also implement a plan to provide outreach to homeless shelters and service providers.

Agency Comments

The 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 November 2012, we inspected the Wilmington VARO. The inspection focused on the following four protocol areas: disability claims processing, management controls, eligibility determinations, and public contact. Within these areas, we examined five operational activities: temporary 100 percent disability evaluations, traumatic brain injury (TBI) claims, Systematic Analysis of Operations (SAOs), Gulf War veterans' entitlement to mental health treatment, and the homeless veterans outreach program.

We reviewed 30 (34 percent) of 87 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months, This is generally the longest period a temporary 100 percent disability evaluation may be assigned without review, according to Veterans Benefits Administration (VBA) policy. We examined all four disability claims related to traumatic brain injury (TBI) that VARO staff completed during the period April through June 2012.

Other Information

- Appendix A includes details on the VARO and the scope of our inspection.
- Appendix B outlines criteria we used to evaluate each operational activity and a summary of our inspection results.
- Appendix C provides the VARO Director's comments on a draft of this report.

RESULTS AND RECOMMENDATIONS

I. Disability Claims Processing

The OIG Benefits Inspection team focused on accuracy in processing claims related to temporary 100 percent disability evaluations and TBI. We evaluated these claims processing issues and assessed their impact on veterans' benefits.

Finding 1 Wilmington VARO Could Improve Disability Claims Processing Accuracy

Claims Processing Accuracy

The Wilmington VARO did not consistently process temporary 100 percent disability cases accurately. The four TBI claims completed and available for our inspectors to review were processed accurately. Overall, VARO staff incorrectly processed 17 of the total 34 disability claims we sampled. The inaccurate processing of the temporary 100 percent disability cases resulted in 179 improper monthly payments to 10 veterans totaling $297,289 from February 2009 until the time of our inspection.

We sampled claims related only to specific conditions that we considered at higher risk of processing errors. As a result, the errors identified do not represent the universe of disability claims processed at this VARO. As reported by VBA's Systematic Technical Accuracy Review program as of July 2012, the overall accuracy of the VARO's compensation rating-related decisions was 75.2 percent—11.8 percentage points below VBA's FY 2012 target of 87 percent. This program information was not reviewed during the scope of this inspection.

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

Table 1

Wilmington VARO Disability Claims Processing Accuracy

Type of Claim	Reviewed	Claims Inaccurately Processed		
		Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits	Total
Temporary 100 Percent Disability Evaluations	30	10	7	17
Traumatic Brain Injury Claims	4	0	0	0
Total	**34**	**10**	**7**	**17**

Source: VA OIG analysis of VBA's temporary 100 percent disability evaluations paid at least 18 months or longer and TBI disability claims completed in the third quarter FY 2012

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 17 of 30 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a service-connected disability following a veteran's 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 in VBA's electronic system. Wilmington had five errors where suspense diaries were not established. 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 to alert VSC staff to schedule the reexamination.

Without effective management of these temporary ratings, VBA is at risk of paying inaccurate financial benefits. Available medical evidence showed 10 of the 17 processing errors we identified affected veterans' benefits. The processing inaccuracies resulted in 179 improper monthly payments totaling $297,289 from as early as February 2009 until the time of our inspection. Details on the most significant overpayment and underpayment follow.

- A Rating Veterans Service Representative (RVSR) correctly assigned an evaluation of 100 percent for a veteran's laryngeal cancer and annotated the need for a routine future examination in July 2008; however, VSC staff did not input a suspense diary in the electronic system as required; therefore, a reminder notification to schedule the reexamination did not generate. VA treatment reports showed the veteran's cancer was no longer active so a reduction in benefits should have occurred in April 2009. As a result, VA overpaid the veteran $110,662 over a period of 3 years and 7 months.
- An RVSR did not establish entitlement to a special monthly compensation based on loss of use of a creative organ due to prostate cancer, as required. As a result, VA underpaid the veteran $3,777 over a period of 3 years and 3 months.

The remaining 7 of the total 17 errors had the potential to affect veterans' benefits. We could not determine whether the evaluations would have continued because the veterans' claims folders did not contain the medical examination reports needed to evaluate each case. In cases where routine future medical reexaminations were not scheduled as required, claims processing delays ranged from approximately 9 months to 8 years and 2 months. An average of approximately 3 years elapsed from the time staff

should have scheduled these medical reexaminations until the date of our inspection.

Summaries of the 17 total errors we identified follow.

- Five errors occurred when staff did not establish suspense diaries in the electronic record; thereby, removing the possibility that staff would receive reminder notifications to schedule medical reexaminations.
- Five errors occurred when staff did not timely reduce benefits after notifying veterans of the intent to do so. On average approximately 1 year and 3 months elapsed from the time staff should have reduced benefits until the date of our inspection and ranged from 1 month to 3 years and 9 months. As a result, veterans' claims were not effectively managed.
- Two errors occurred when RVSRs did not establish entitlement to special monthly compensation for a medical condition secondary to service connected prostate cancer.
- Two errors occurred when RVSRs entered incorrect routine future examination dates on the rating decision code sheet. The dates entered by RVSRs extended temporary 100 percent disability evaluations beyond the required reexaminations dates by 1 and 10 years, respectively. The temporary 100 percent disability evaluations may have continued uninterrupted until the erroneous reexamination dates and resulted in inaccurate benefits payments, had we not identified these cases for review during our inspection.
- One error occurred when staff did not schedule a medical reexamination in November 2004 as requested by an RVSR. A review of the claims folder showed the veterans' reexamination date was entered correctly in the electronic system; however, the paper reminder notification to schedule the reexamination was not in the claims folder nor did staff schedule the reexamination.
- One error occurred when an RVSR entered an incorrect code related to a special monthly compensation benefit for a veteran. In this case, staff entered an incorrect code which resulted in incorrect payments to the veteran.
- One error occurred when an RVSR did not grant entitlement to Dependents' Educational Assistance in March 2011 despite medical evidence of a disability considered by VBA to be permanently and totally disabling.

In November 2009, VBA provided guidance reminding VARO staff about the need to input suspense diaries to the electronic record as reminders to schedule medical reexaminations. However, VARO managers had no oversight procedure in place to ensure VSC staff established suspense diaries

and scheduled reexaminations timely, nor did they ensure staff complied with established procedures to reduce benefits when appropriate. Temporary 100 percent disability evaluations could have continued uninterrupted over the veterans' lifetimes if we had not identified the need for VARO staff to take actions to schedule reexaminations.

Actions Taken in Response to Prior Audit Report

In response to a recommendation in our national 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. Our report stated, "If VBA does not take timely corrective action, they will overpay veterans a projected $1.1 billion over the next 5 years." The then Acting Under Secretary for Benefits stated in response to our audit report that the target completion date for the national review would be September 30, 2011.

VBA did not provide each VARO with a list of temporary 100 percent disability evaluations for review until September 2011. VBA subsequently extended the national review deadline to December 31, 2011, and then again to June 30, 2012. At the time of our inspection, VBA was working to complete this national review requirement, but extended the deadline again to December 31, 2012. We are concerned about the lack of urgency in completing this review, which is critical to minimize the financial risks of making inaccurate benefits payments.

During our 2012 inspection, we followed up on VBA's national review of its temporary 100 percent disability evaluation processing. We sampled 40 cases from the lists of cases needing corrective actions that VBA had provided to the Wilmington VARO for review. We determined VARO staff accurately reported actions, such as inputting suspense diaries or taking actions to schedule reexaminations, on all 40 cases we reviewed. However, in comparing VBA's national review lists with our data on temporary 100 percent disability evaluations, we found five cases involving prostate cancer or non-Hodgkin's lymphoma that VBA had not identified. We could not determine why these cases were not identified by VBA; however, we will continue monitoring this situation as VBA works to complete its national review.

TBI Claims

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

In response to a recommendation in our annual report, *Systemic Issues Reported During Inspections at VA Regional Offices* (Report No. 11-00510-167, May 18, 2011), VBA agreed to develop and implement a

strategy for ensuring the accuracy of TBI claims decisions. In May 2011, VBA provided guidance to all VARO Directors to implement a policy requiring a second signature on each TBI case an RVSR evaluates until the RVSR demonstrates 90 percent accuracy in TBI claims processing. The policy indicates second signature reviewers come from the same pool of staff as those used to conduct local station quality reviews.

VSC staff correctly processed all four TBI claims completed from April through June 2012 and complied with VBA's second signature policies that require these types of claims undergo an additional level of review. The Quality Review Team (QRT) is responsible for conducting local quality reviews at the Wilmington VARO. The QRT concept is an initiative implemented by VBA to ensure standardized quality reviews among VAROs. Staff assigned to QRT teams in VAROs receive specialized training by Systematic Technical Accuracy Review (STAR) Program staff.

Follow Up to Prior VA OIG Inspection

Our prior report, *Inspection of the VA Regional Office, Wilmington, Delaware* (Report No. 09-01994-230, September 29, 2009), stated staff followed VBA policy when processing TBI-related disability claims. Results of our current inspection indicate staff continue to process TBI claims accurately.

Recommendations

1. We recommend the Wilmington VA Regional Office Director develop and implement a plan to ensure claims processing staff input suspense diaries in the electronic record and timely schedule medical reexaminations when the reminder notifications generate.

2. We recommend the Wilmington VA Regional Office Director develop and implement a plan to ensure claims processing staff take timely actions to finalize reductions in benefits when appropriate.

3. We recommend the Wilmington VA Regional Office Director conduct a review of the 57 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.

Management Comments

The VARO Director concurred with our recommendations. In December 2012 and again in February 2013, VARO staff received additional training on processing reminder notifications and scheduling medical reexaminations. The Director also plans to address these issues in future Systematic Analysis of Operations. Additionally, the Director updated the VARO's workload management plan to include supervisory oversight procedures to ensure staff take timely actions to reduce benefits when appropriate. VARO staff reviewed the 57 temporary 100 percent disability evaluations remaining from the OIG's inspection universe and took appropriate actions.

OIG Response

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

II. Management Controls

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 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. The VSC Manager is responsible for ongoing analysis of VSC operations, including completing 11 SAOs annually.

VARO staff completed all 11 mandated SAOs timely according to the SAO schedule. All 11 SAOs included thorough analyses using appropriate data, identified weaknesses or concerns, and provided recommendations for improvement.

Follow Up To Prior VA OIG Inspection

Our prior report, *Inspection of the VA Regional Office, Wilmington, Delaware* (Report No. 09-01994-230, September 29, 2009), stated staff timely completed all analyses related to mandatory SAOs as required. Results of our current inspection indicate staff continue to complete thorough and timely SAOs.

III. Eligibility Determinations

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 a Gulf War veteran's entitlement to mental health 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 2 Gulf War Veterans Did Not Always Receive Entitlement Decisions for Mental Health Treatment

VARO staff did not properly address whether 5 of 14 Gulf War veterans were entitled to receive treatment for mental disorders. In all five cases, VSC staff correctly addressed the entitlement decisions, but did not formally annotate the decisions on the decision documents. These errors generally occurred because RVSRs and QRT staff were unaware of the requirement to annotate entitlement decisions on the decision documents.

We reviewed FY 2012 training records and confirmed VARO staff had not received training emphasizing the need to document these entitlement decisions on the rating documents. When VARO staff do not annotate entitlement decisions on decision documents, VA treating facilities cannot determine whether veterans are entitled to mental health care benefits.

In December 2012, VBA modified its policy to state that RVSRs no longer have to address Gulf War veterans' entitlement to mental health care in all cases. RVSRs only have to consider this entitlement when the veteran's mental health benefit can be granted based on diagnosis of a mental disorder within 2 years of separation from military service. Because this policy modification became effective after we concluded our inspection of the Wilmington VARO, we cannot determine whether the change might have affected the number of errors we identified. Therefore, we make no recommendation for improvement.

IV. 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, directs that coordinators at the remaining 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 3 Oversight of the Homeless Veterans Outreach Program Needs Improvement

The Wilmington VARO did not regularly contact or provide information and training to homeless shelters and service providers in areas under its jurisdiction. VARO management did not provide oversight or guidance to ensure effective homeless veterans outreach. As a result, homeless shelters and service providers may not be aware of benefits and services available to homeless veterans.

Although VARO staff attended some local outreach events targeting homelessness, they did not maintain a directory of homeless shelters and service providers within their area of jurisdiction as required. Consequently, staff did not regularly contact or provide these shelters and service providers with information on benefits and services available to veterans. Management told us they did not provide guidance or oversight of the homeless veterans program prior to our inspection because they were unaware of the requirement to do so. They instead focused on processing claims received from homeless veterans.

In October 2012, VARO staff created a Homeless Veterans Standard Operating Procedure that included the required directory of shelters and service providers; however, we were unable to determine the impact of the operating procedure on the homeless veterans outreach program because it was implemented after we notified the VARO of our inspection. We also noted that VBA needs a performance measurement to assess the effectiveness of its homeless veterans outreach efforts.

Recommendation

4. We recommend the Wilmington VA Regional Office Director develop and implement a plan to ensure staff update the resource directory and regularly contact and provide outreach to homeless shelters and service providers under the VA Regional Office's jurisdiction.

Management Comments

The VARO Director concurred with our recommendation. In February 2013, staff updated the directory of homeless shelters and service providers within the VARO's jurisdiction. Staff then mailed information about homeless veterans benefits and services to the shelters and service providers listed in the directory. Management designated staff responsible for updating the directory annually. Additionally, the outreach coordinator will now conduct outreach to homeless shelters under the VARO's jurisdiction on a quarterly basis.

OIG Response

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

Appendix A VARO Profile and Scope of Inspection

Organization

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

Resources

As of October 2012, the Wilmington VARO had a staffing level of 28 full-time employees. Of this total, the VSC had 25 employees assigned.

Workload

The Wilmington VARO reported 1,076 pending compensation claims in October 2012. The average time to complete claims was 210.5 days; 39.5 days less than the national target of 250.

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 30 (34 percent) of 87 temporary 100 percent disability evaluations selected from VBA's Corporate Database. These claims represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months as of September 5, 2012. We provided VARO management with 57 claims remaining from our universe of 87 for its review. As follow-up to the National audit, we sampled 40 temporary 100 percent disability evaluations from the SharePoint list VBA provided to the VARO as part of its national review. We also reviewed all four TBI-related disability claims that the VARO completed from April through June 2012.

Where we identify potential procedural inaccuracies, this information is provided to help the VARO understand the procedural improvements it can make for enhanced stewardship of financial benefits. This information is not provided to require the VAROs to adjust specific veterans' benefits. Processing any adjustments per this review is clearly a VBA program management decision.

We assessed the 11 mandatory SAOs completed in FY 2012. We examined 14 completed claims processed for Gulf War veterans from April through June 2012 to determine whether VARO staff addressed entitlement to mental health treatment in the rating decision documents as required. Further, we assessed the effectiveness of the VARO's homeless veterans outreach program.

Data Reliability

We used computer-processed data from the Veterans Service Network's Operations Reports and Awards. To test for reliability, we reviewed the data to determine whether any data were missing from key fields, contained data outside of the time frame requested, included any 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, VARO numbers, dates of claim, and decision dates as provided in the data received with information contained in the claims folders we reviewed.

Our testing of the data disclosed that they were sufficiently reliable to meet our inspection objectives. Our comparison of the data with information contained in the veterans' claims folders at the Wilmington VARO did not disclose any problems with data reliability.

While this report references VBA's Systematic Technical Accuracy Review (STAR) data, the overall accuracy of the VARO's compensation rating-related decisions was 75.2 percent—11.8 percentage points below VBA's FY 2012 target of 87 percent. This data was not reviewed as part of this inspection.

Inspection Standards

We conducted this 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 inspection objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our inspection objectives.

Appendix B Inspection Summary

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

Table 2. Wilmington VARO Inspection Summary

Five 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) (M21-1 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 an in-service TBI.** (FL 08-34 and 08-36) (Training Letter 09-01)	X	
Management Controls			
3. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)	X	
Eligibility Determinations			
4. 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 USC 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			
5. Homeless Veterans Outreach Program	**Determine whether VARO staff provided effective outreach services.** (Public Law 107-05) (VBA Letter 20-02-34) (VBA Circular 27-91-4) (FL 10-11) (M21-1, Part VII, Chapter 6)		X

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

Appendix C VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: May 1, 2013

From: Director, VA Regional Office Philadelphia, Pennsylvania

Subj: Inspection of the VA Regional Office, Wilmington, Delaware

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

1. The Philadelphia Regional Office remotely manages the Wilmington Regional Office. The Wilmington VA Regional Office (RO) comments are attached on the OIG Draft Report, *Inspection of the VA Regional Office, Wilmington, DE.*

2. Please refer questions to me at (215) 381-3001.

(original signed by:)

Robert McKenrick

Attachment

Recommendation 1: We recommend the Wilmington Regional Office Director develop and implement a plan to ensure claims processing staff input suspense diaries in the electronic record and timely schedule medical reexaminations when the reminder notifications generate.

Concur: The Wilmington RO will include this in our future SAOs. Since this finding, the RO had RVSR training on December 18, 2012 and again on February 5, 2013, to address this issue.

Recommendation 2: We recommend the Wilmington Regional Office Director develop and implement a plan to ensure claims processing staff take timely actions to finalize reductions in benefits when appropriate.

Concur: The Workload Management Plan of December 12, 2012, includes oversight for monitoring and processing claims involving proposed disability evaluation reduction ensuring that prompt action is taken to minimize potential overpayments.

Recommendation 3: We recommend the Wilmington VA Regional Office Director conduct a review of the 57 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.

Concur: The Wilmington staff reviewed and took appropriate action on all 57 remaining temporary 100 percent disability evaluations.

Recommendation 4: We recommend the Wilmington VA Regional Office Director develop and implement a plan to ensure staff update the resource directory and regularly contact and provide outreach to homeless shelters and service providers under the VA Regional Office's jurisdiction.

Concur. In February 2013, the Wilmington RO staff updated the directory of homeless shelters and service providers within the RO's jurisdiction. At that time, RO staff contacted these shelters and service providers by mail to communicate information of homeless Veterans' benefits and service. The outreach coordinator will make quarterly outreach to the Homeless Shelters in the Wilmington Jurisdiction. Management also designated staff responsible for ensuring that update of homeless resource directory and outreach to shelters and service providers occur annually.

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	Nora Stokes, Director Daphne Brantley Robert Campbell Madeline Cantu Ramon Figueroa Kyle Flannery Lee Giesbrecht Lisa Van Haeren Nelvy Viguera Butler

Appendix E Report Distribution

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U.S. House of Representatives: John C. Carney, Jr.

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