

VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS



Inspection of VA Regional Office Jackson, Mississippi

July 29, 2013
13-00709-257

ACRONYMS AND ABBREVIATIONS

HVOC	Homeless Veterans Outreach Coordinator
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

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Report Highlights: Inspection of the VA Regional Office, Jackson, MS

Why We Did This Review

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

What We Found

Overall, VARO staff did not accurately process 13 (25 percent) of 52 disability claims reviewed. We sampled claims we consider 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 lacked consistent compliance with VBA procedures and resulted in paying inaccurate and unnecessary financial benefits.

Specifically, 10 of 30 temporary 100 percent disability evaluations we reviewed were inaccurate. Errors in processing temporary 100 percent disability evaluations generally occurred because VARO staff did not establish suspense diaries in the electronic record to schedule medical reexaminations as required.

Management also did not ensure second signature reviews and therefore staff incorrectly processed 3 of 22 traumatic brain injury claims completed from July through September 2012.

VARO managers ensured Systematic Analyses of Operations were complete and timely. Generally, VARO staff completed

rating decisions that correctly addressed Gulf War veterans' entitlement to mental health treatment. However, staff did not provide adequate outreach to homeless veterans in the VARO's area of jurisdiction. We could not fully assess the effectiveness of these outreach activities because VBA needs performance metrics for its homeless veterans outreach program.

What We Recommend

The VARO Director should implement a plan to ensure staff enter suspense diaries in the electronic record and review for accuracy the 195 temporary 100 percent disability evaluations remaining from the OIG's inspection universe of related claims. Management also should implement a plan to ensure effective second signature reviews of traumatic brain injury claims and adequate outreach to homeless veterans within the VARO's area of jurisdiction.

Agency Comments

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

A handwritten signature in black ink that reads "Linda A. Halliday".

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 January 2013, we inspected the Jackson 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 two high-risk claims processing areas of temporary 100 percent disability evaluations and traumatic brain injury claims. We also examined three operational activities—Systematic Analyses of Operations (SAOs), Gulf War veterans' entitlement to mental health treatment, and the homeless veterans outreach program.

We reviewed 30 (13 percent) of 225 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 also examined 22 disability claims related to traumatic brain injury (TBI) that VARO staff completed from July through September 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

Claims Processing Accuracy

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

Finding 1

The Jackson VARO Could Improve Disability Claims Processing Accuracy

The Jackson VARO did not consistently process temporary 100 percent disability evaluations and TBI cases accurately. Overall, VARO staff incorrectly processed 13 of the total 52 disability claims we sampled. We identified 77 improper monthly payments to 4 veterans totaling \$100,189 from March 2010 until January 2013.

We sampled claims related to specific conditions we considered to be 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 (STAR) program as of December 2012, the overall accuracy of the VARO's compensation rating-related decisions was 86 percent—4 percentage points below VBA's FY 2013 target of 90 percent. The STAR 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 Jackson VARO.

Table 1

Jackson VARO Disability Claims Processing Accuracy				
Type of Claim	Number of Claims Reviewed	Claims Inaccurately Processed		
		Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits	Total Errors
Temporary 100 Percent Disability Evaluations	30	4	6	10
Traumatic Brain Injury Claims	22	0	3	3
Total	52	4	9	13

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 fourth quarter FY 2012

**Temporary
100 Percent
Disability
Evaluations**

VARO staff incorrectly processed 10 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. We identified five instances where suspense diaries were not established as required. A suspense diary is a processing command that establishes a date when VARO staff must schedule a reexamination. As a suspense diary matures, the electronic system generates a reminder to alert VARO staff to schedule the reexamination.

Without effective management of these temporary 100 percent disability ratings, VBA is at risk of paying inaccurate financial benefits. Available medical evidence showed 4 of the 10 processing errors we identified affected veterans' benefits and resulted in 77 improper monthly payments to 4 veterans totaling \$100,189 from as early as March 2010 until January 2013. The remaining 6 of the 10 errors had the potential to affect veterans' benefits. Details on the most significant overpayment and underpayment follow.

- A Rating Veterans Service Representative (RVSR) established the need for a follow-up medical examination in October 2009 for a veteran's heart condition. In this case, two VARO staff members processed the veteran's rating decision; but neither of these claims processing staff entered the suspense diary in the electronic record as required. Therefore, the system could not generate a reminder notification to schedule a reexamination. VA treatment reports showed the veteran's medical condition had improved and the temporary 100 percent disability evaluation was no longer supportable per VBA's policies. As a result, VA overpaid the veteran \$52,775 over a period of 2 years and 10 months.
- An RVSR did not establish a veteran's entitlement to special monthly compensation based on loss of use of a creative organ related to prostate cancer. As a result, VA underpaid the veteran \$1,768 over a period of 1 year and 6 months.

VARO staff did not schedule medical reexaminations as required for some of the errors identified. In six cases, we found scheduling delays of approximately 1 year and 8 months to 3 years and 5 months. An average of approximately 2 years and 4 months elapsed from the time staff should have scheduled these medical reexaminations until January 2013.

Summaries of the total 10 errors we identified follow.

- Five errors occurred when staff did not establish suspense diaries in the electronic record as required; thus, the system did not generate automated alert notifications to schedule medical reexaminations.
- Two errors occurred when staff did not timely take final actions to reduce veterans' benefits after notifying veterans of the intent to do so. On average, approximately 1 year elapsed from the time staff should have reduced benefits until January 2013. The delays ranged from 2 months to 1 year and 11 months.
- One error occurred when an RVSR did not establish a future reexamination date for a temporary 100 percent disability evaluation related to prostate cancer as required. Reexaminations are required for temporary 100 percent disability evaluations except in cases where the evidence shows a veteran's medical condition is permanently and totally disabling—at which time the RVSR is required to establish entitlement to Dependents' Educational Assistance. In this case, the RVSR did neither, thereby increasing the risk that the veteran would receive inaccurate payments or be unaware of the education benefits for which his dependents are entitled.
- One error occurred when staff inappropriately cancelled the suspense diary but did not schedule the medical reexamination as required, thereby removing the reminder for VARO staff to review the temporary evaluation again at a later date.
- One error occurred when an RVSR did not establish entitlement to special monthly compensation for a medical condition related to prostate cancer.

In November 2009, VBA provided refresher guidance to VARO staff about the need to input suspense diaries to the electronic record to provide reminders to schedule medical reexaminations. However, VARO managers had no oversight procedure in place to ensure staff established suspense diaries, scheduled reexaminations, or followed up timely to reduce benefits. Temporary 100 percent disability evaluations and related monthly benefits could have continued uninterrupted over veterans' lifetimes if we had not identified the need for VARO staff to take required 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, dated January 24, 2011), the then-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.

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 national review deadline to December 31, 2011, and then June 30, 2012, and then again to December 31, 2012. Based on the numerous delays and our continued findings, we are concerned about the lack of urgency in completing this review, which is critical to minimize the financial risk of making inaccurate benefits payments. To date, our national audit recommendation for VBA to review all temporary 100 percent disability evaluations remains open. We do not intend to close this recommendation with VBA until our inspection results show a significant decrease in the types of errors identified during our national audit.

During our 2013 inspection, we followed up on VBA's national review of its temporary 100 percent disability evaluation processing. We sampled 40 cases from the list of cases needing corrective actions that VBA provided to the Jackson VARO for review. We determined VARO staff accurately reported taking actions, such as inputting suspense diaries or scheduling reexaminations, in all 40 cases we reviewed. However, in comparing VBA's national review lists with our data on temporary 100 percent disability evaluations, we found seven cases involving prostate cancer or non-Hodgkin's lymphoma that VBA had not identified. We could not determine why VBA did not identify these cases; however, we will continue monitoring this situation as VBA works to complete its national review.

**Follow-Up to
Prior VA OIG
Inspection**

Our prior report, *Inspection of the VA Regional Office, Jackson, MS* (Report No. 10-02460-240, dated September 3, 2010), stated 24 of the 30 total temporary 100 percent disability evaluations reviewed had processing errors. The majority of the errors occurred because staff cancelled reminder notifications alerting them to schedule medical reexaminations; thus, they did not schedule the examinations. In response to our recommendations, the VARO Director reported staff received refresher training on processing reminder notifications and scheduling VA examinations. The Director amended the workload management plan to require staff to review a work items cancellation report on a monthly basis. The OIG closed this recommendation in February 2011.

During our January 2013 inspection, 1 of the 30 cases we reviewed involved VARO staff not taking the required action to schedule a required medical reexamination after receiving a reminder notification to do so. However, since staff properly processed most reminder notifications we reviewed during our inspection, we determined the corrective actions put in place to address our 2010 inspection results were effective.

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, dated May 18, 2011), VBA agreed to develop and implement a strategy for ensuring accurate TBI claims rating decisions. In May 2011, VBA provided guidance to 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. Further, the policy directs VAROs to use data obtained during the second-signature requirement period to identify and address training needs.

VARO staff incorrectly processed 3 of 22 TBI claims we reviewed—none of these processing errors affected veterans' benefits. Summaries of the errors follow.

- In two cases, RVSRs used incomplete medical examinations to evaluate TBI residual disabilities. One case resulted in an incorrect evaluation because the examiner did not assess the severity of a veteran's headaches due to TBI. In the other case, the examiner did not assess or diagnose a residual disability despite medical evidence in the report noting the veteran suffered daily headaches after exposure to blasts. VBA policy requires that VSC staff return examination reports that are insufficient for rating purposes to the examining facilities for correction. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without adequate or complete medical evidence.
- In the remaining case, an RVSR granted a veteran permanent total disability, although medical evidence showed the veteran's condition had improved and did not support such an evaluation. The RVSR also did not consider a seizure disorder associated with the veteran's TBI in making the rating decision.

A local VARO policy required staff from the Quality Review Team (QRT) to conduct second-signature reviews for all TBI claims; however, management had no mechanism in place to ensure staff complied with VBA or local second signature policies. Of the total 22 TBI disability claims we reviewed, only 7 had the required second signatures by QRT staff. In the 15 remaining cases, including the 3 cases we found with errors, 12 did not have additional reviews for the required second signatures. The remaining 3 cases had second-signature review, but QRT staff did not complete those

reviews as required by local policy. Had VARO staff followed VBA or their own local second-signature policy, the second reviewer may have recognized the errors we identified and taken corrective actions.

**Follow-Up to
Prior VA OIG
Inspection**

Our prior report, *Inspection of the VA Regional Office Jackson, MS* (Report No. 10-02460-240, dated September 3, 2010), stated VARO staff correctly processed all 17 TBI claims staff completed from January through March 2010. Comparatively, results of the 2013 inspection show staff incorrectly processed 3 of the 22 claims completed from July through September 2012 despite a stringent local policy requiring all TBI claims undergo a secondary review for accuracy. However, VARO management did not have procedures in place to ensure staff complied with the local policy to forward TBI claims to QRT staff for the required secondary review.

Recommendations

1. We recommend the Jackson VA Regional Office Director develop and implement a plan to ensure claims processing staff input suspense diaries in the electronic record and schedule medical reexaminations as required.
2. We recommend the Jackson VA Regional Office Director develop and implement a plan to review the 195 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.
3. We recommend the Jackson VA Regional Office Director develop and implement a plan to ensure compliance with Veterans Benefits Administration and local second-signature requirements for traumatic brain injury claims.

**Management
Comments**

The VARO Director concurred with our recommendations. Subsequent to our inspection, VARO staff created a standardized operating procedure that provides staff guidance on entering future examination diaries in the electronic record. The newly implemented procedure also establishes validation procedures to ensure staff enter diaries during monthly quality reviews.

As recommended, VARO staff created a plan to review the 195 cases remaining from the OIG's inspection universe. Management expects to complete reviews and necessary actions for the remaining cases by September 30, 2013. Additionally, to ensure effective second signature reviews of TBI claims, management issued a formal directive to staff on VBA's second signature policy and directed staff from the Quality Review Team to monitor compliance during local quality reviews.

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 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 management ensured SAOs contained sufficient analyses using appropriate data, identified deficiencies, and made recommendations for improvements where appropriate. SAOs were also submitted by the required due date. As such, we made no recommendation for improvement in this area.

Follow-Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office Jackson, MS* (Report No. 10-02460-240, dated September 3, 2010), we determined VARO staff followed VBA policy when completing SAOs. Results of our current inspection show staff continue to follow VBA policy when processing SAOs.

III. 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. However, RVSRs should address entitlement to mental health care in their decisions when the entitlement can be granted.

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 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.

VARO staff did not properly address whether 2 of 30 Gulf War veterans were entitled to receive treatment for mental disorders despite medical evidence in the claims folder showing the disorders were diagnosed within 2 years from the veterans release from active military service. As a result, veterans may be unaware of their entitlement to treatment for mental disorders and may not get the care they need.

Because most of the decisions we reviewed were accurately processed, we determined VARO staff generally follow VBA's policy when making mental health care treatment decisions for Gulf War veterans; therefore, we made no recommendation for improvement in this area.

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, directed 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 government, and advocacy groups to provide information on VA benefits and services.

Finding 2

Oversight of the Homeless Veterans Outreach Program Needs Improvement

The Jackson VARO has jurisdiction over veterans residing in the State of Mississippi and has a part-time Homeless Veterans Outreach Coordinator (HVOC). The HVOC did not regularly contact or provide information to homeless shelters and service providers to all areas under VARO jurisdiction as required by VBA policy. This occurred because VARO management did not have mechanisms in place to provide effective oversight or assess outreach efforts. As a result, homeless shelters and service providers may not be aware of available VA benefits and services.

Our review confirmed the HVOC maintained a collaborative partnership with homeless coordinators at VA Medical Centers; however, contact with shelters and service providers was limited to Jackson and Hattiesburg, MS. Further, VARO managers were unaware that staff had not contacted the majority of the homeless shelters and service providers within the VARO’s jurisdiction or updated their homeless veterans resource directory as required.

Had management provided adequate oversight of the VARO’s outreach efforts, it may have determined that staff were not contacting homeless shelters and service providers within the VARO’s jurisdiction as required. Management may have also realized shelters and service providers were not receiving information on VA benefits and services available to homeless veterans. VBA also needs performance measures for its homeless veterans outreach program. Without such measures, we cannot fully assess the effectiveness of its outreach activities.

Recommendation

4. We recommend the Jackson 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 within the VA Regional Office's jurisdiction.

Management Comments

The VARO Director concurred with our recommendations. Management requires staff to provide weekly updates to ensure staff regularly updates its resource directory and provides outreach to homeless shelters and service providers. VARO staff also began using social media to assist in their outreach efforts to homeless veterans in Mississippi.

OIG Response

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

Appendix A VARO Profile, Scope, and Methodology of Inspection

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

Resources As of January 2013, the Jackson VARO had a staffing level of 197 full-time employees. Of this total, the VSC had 170 employees assigned.

Workload As of December 2012, the VARO reported 9,324 pending compensation claims. The average time to complete claims was 316.8 days—66.8 days more than the national target of 250.

Scope VBA has 56 VAROs, and 1 VSC in Cheyenne, Wyoming, that process disability claims and provide a range of services to veterans. We evaluated the Jackson VARO to see how well it accomplishes this mission.

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 (13 percent) of 225 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 November 30, 2012. We reviewed 30 claims and provided VARO management with 195 claims remaining from our universe of 225 for its review. As follow-up to our national audit, we also 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 the 22 total TBI-related disability claims VARO staff completed from July through September 2012.

Where we identify potential procedural inaccuracies, we provide this information to help the VARO understand the procedural improvements it can make for enhanced stewardship of financial benefits. We do not provide this information to require 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 the VARO completed in FY 2012 and FY 2013. We examined 30 completed claims processed for Gulf War veterans from July through September 2012 to determine whether VSC staff had 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 by reviewing its directory of homeless shelters and service providers and determining whether staff regularly attended meetings and provided information on VA benefits and services.

**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, included any calculation errors, or were outside the time frame requested. We also assessed whether the data contained obvious duplication of records, alphabetic or numeric characters in incorrect fields, or 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 for our inspection objectives. Our comparison of the data with information contained in the veterans' claims folders at the Jackson VARO did not disclose any problems with data reliability.

While this report references VBA's STAR data, the overall accuracy of the VARO's compensation rating-related decisions was 86 percent; 4 percentage points below VBA's FY 2012 target of 90 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. Jackson VARO Inspection Summary			
Five Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Disability Claims Processing			
1. Temporary 100 Percent Disability Evaluations	Determine whether VARO staff properly processed temporary 100 percent disability evaluations. (38 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 all disabilities related to in-service TBI. (FL 08-34 and FL 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 United States Code 1702) (M21-1MR Part IX, Subpart ii, Chapter 2) (M21-1MR Part III, Subpart v, Chapter 7) (FL 08-15) (38 CFR 3.384) (38 CFR 3.2)	X	
Public Contact			
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) (M27-1, Part II, Chapter 2)		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: July 11, 2013
From: Director, VA Regional Office Jackson, Mississippi
Subj: Inspection of the VA Regional Office, Jackson, Mississippi
To: Assistant Inspector General for Audits and Evaluations (52)

1. The Jackson VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office, Jackson, Mississippi.*
2. Please refer questions to Mr. Thomas Sanders, Acting Director, at 601-364-7010.

(Original signed)

Thomas O. Sanders

Attachment

Attachment

Inspection of the VA Regional Office, Jackson, Mississippi Draft Report Dated 06-20-2013	
Recommendation 1:	We recommend the Jackson VA Regional Office Director develop and implement a plan to ensure claims processing staff input suspense diaries in the electronic record and schedule medical reexaminations as required.
RO Comments	Concur
VA Response:	<p>The Jackson RO has implemented a new (SOP) for future exam diaries which clearly outlines our new directives. These directives advise employees concerning current VA guidelines in reference to determining when there is a need to verify either the continued existence or the current severity of a disability. Generally, it defines the need for reexaminations and when they will be required if it is likely that a disability has improved, or if evidence indicates there has been a material change in a disability or that the current rating may be incorrect. Individuals for whom reexaminations have been authorized and scheduled are required to report for such reexaminations.</p> <p>We have attached a copy of the SOP and the work validation procedures that have been implemented in the Jackson Veterans Service Center. By implementing this new SOP and procedure, we believe that we have taken action to correct the deficiency identified by the OIG auditors during the site visit. VSC employees have received training on these new procedures in team meetings on 06-26-2013 and 07-10-2013. We project that all VSC employees will have completed training on these SOPS during team meetings NLT 07-12-2013.</p>
Supporting Documentation:	<ul style="list-style-type: none"> • SOP Future VA Exam Diaries 06-26-13 • FLASH - ROUTINE
Status:	We request closure of this recommendation based on the evidence provided above.
Recommendation 2:	We recommend the Jackson VA Regional Office Director develop and implement a plan to review the 195 temporary 100 percent disability evaluations remaining from our inspection universe and take appropriate action.

RO Comments	Concur
VA Response:	<p>The Jackson VSC Manager has developed a plan to review the pending one hundred ninety five (195) temporary 100 percent cases within a fixed period of time.</p> <p>The plan is attached to this document for your review. This plan clearly outlines the work validation procedures to ensure that the plan is followed within the Jackson VSC. As the recommended plan has been developed and is being implemented and compliance tracked, we submit that the requirements of the recommendation have been fully met.</p> <p>VSC employees have received training on these new procedures in team meetings on 06-26-2013 and 07-10-2013. We project that all VSC employees will have completed training on this SOP during team meetings NLT 07-12-2013.</p>
Supporting Documentation:	Plan for Temporary 100 Evaluations
Status:	It is expected that the reviews outlined in the plan will be completed by the end of FY 2013. Once we are complete with our reviews, we will provide notice. Notification is requested if closure of this action item is dependent on certification of completion of the reviews.
Recommendation 3:	We recommend the Jackson VA Regional Office Director develop and implement a plan to ensure compliance with Veterans Benefits Administration and local second signature requirements for traumatic brain injury claims.
RO Comments	Concur

<p>VA Response</p>	<p>The Jackson VSC Manager has issued a formal directive in the form of a memorandum, which outlines the Office of Field Operations guidance with respect to second signatures being required on TBI cases until a RVSR achieves a 90% accuracy after a review of 10 cases. A copy of this memorandum is attached for your review.</p> <p>A log is kept by the QRT team which records all cases that receive second signatures on SME review. Additionally, the Jackson VSC Workload Management Plan has been amended for tighter control of TBI cases in the Special Ops Lane. Additionally, the Jackson VSC Workload Management Plan has been amended to require the VSC MA to review a sampling of completed TBI cases in conjunction with each quarterly MAPD Compliance SAO to monitor for VSC compliance with OFO and VACO directives.</p> <p>Finally, Jackson VSC RVSRs and DROS are in the process of completing the TPSS-TBI modules. This training will assist with improving accuracy on TBI cases within the Jackson VSC. These actions by the VSC Manager has corrected the deficiency identified by the OIG found during the site visit.</p>
<p>Supporting Documentation:</p>	<ul style="list-style-type: none"> • Review Rating Memo OIG 06-27-2013 • VSC WMP 07-11-2013
<p>Status:</p>	<p>We request closure of this recommendation based on the evidence provided above.</p>
<p>Recommendation 4:</p>	<p>We recommend the Jackson 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 within the VA Regional Office’s jurisdiction.</p>
<p>RO Comments</p>	<p>Concur</p>

<p>VA Response</p>	<p>The Jackson VSC Public Contact Coach has developed a homeless outreach contact spreadsheet that will be maintained by the Homeless Coordinator on a weekly basis. The spreadsheet shows the date the spreadsheet is updated along with new information and updated contact information. The Homeless Outreach Coordinator will be providing weekly updates to the Public Contact Supervisor to ensure that the Jackson VSC regularly conducts/contacts Homeless Outreach to all Homeless Shelters and service providers with Jackson ROs area of jurisdiction.</p> <p>The Homeless Coordinator is working with the Director of the State Veterans Affairs Board at the Jackson Regional Office to compile a list of homeless shelters and providers throughout the State of Mississippi that he plans to visit in future months. The SVAB Director has contacted each of the County Service Officers throughout the State of Mississippi who are attempting to gather homeless shelter information. Once all of the information is received, we will add this information to our spreadsheet/resource directory for homeless outreach.</p> <p>The Jackson VSC has also created a Facebook page to assist in conducting regular Homeless contact and outreach throughout the state. This Facebook page will be instrumental in sharing information with homeless providers, doing daily or weekly information “pushes” to places that we routinely cannot quickly reach on a daily or weekly basis. The address for the Facebook page is www.facebook.com/VARegionalOfficeHomelessOutreach.</p> <p>As the recommended plan has been developed and is being implemented and compliance tracked, we submit that the requirements of the recommendation have been fully met.</p>
<p>Supporting Documentation:</p>	<p>Homeless Resource Guide</p>
<p>Status:</p>	<p>As the many contacts that are needed to complete and update of the resource guide and homeless shelter spreadsheet are ongoing, we recognize that the recommendation may need to remain open. Once those actions are complete, we will provide notice. Notification is requested if closure of this action item is dependent on certification of completion the updated guide and spreadsheet.</p>

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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Acknowledgments	Nora Stokes, Director Danny Clay Kelly Crawford Lee Giesbrecht Ambreen Husain Kerri Leggiero-Yglesias Suzanne Murray Lisa Van Haeren Nelvy Viguera Butler Mark Ward
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