VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Fort Harrison, Montana

November 3, 2011
11-03211-12

ACRONYMS AND ABBREVIATIONS

C&C	Confirmed and Continued
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, Fort Harrison, Montana

Why We Did This Review

The Veterans Benefits Administration has a nationwide network of 57 VA Regional Offices (VAROs) that process claims and provide services to veterans. We conducted this inspection to evaluate how well the Fort Harrison VARO accomplishes this mission.

What We Found

Fort Harrison VARO staff accurately processed herbicide exposure-related claims, corrected errors identified by the Veterans Benefits Administration's Systematic Technical Accuracy Review program, and timely processed homeless veterans' claims. VARO performance was generally effective in processing traumatic brain injury claims and handling claims-related mail.

However, the VARO lacked effective controls and accuracy in processing some disability claims. Inaccuracies in processing temporary 100 percent disability evaluations resulted from human error when staff did not schedule required future medical reexaminations. Overall, VARO staff did not accurately process 13 (16 percent) of 83 disability claims reviewed.

Management did not complete all elements of Systematic Analyses of Operations as required. Management misinterpreted policy and erroneously thought it had the discretion to omit certain elements of VARO operations from its analyses. VARO staff did not always consider whether Gulf War veterans were eligible to receive health care treatment for mental disorders. Further, outreach to homeless shelters and service providers was not always effective.

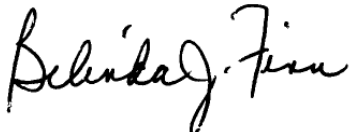
What We Recommend

We recommend the Fort Harrison VARO Director implement a plan to monitor the effectiveness of training for Rating Veterans Service Representatives to ensure they accurately address Gulf War veterans' entitlement to mental health treatment.

We recommend the Director ensure staff receive training to properly address all required elements of Systematic Analyses of Operations. We also recommend the Director implement and monitor a plan to oversee and coordinate programs for homeless veterans that ensures regular contact with 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 on all actions.



BELINDA J. FINN
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 standard coverage, inspections may examine issues or allegations referred by VA employees, members of Congress, or other stakeholders.

Scope of Inspection

In July 2011, the OIG conducted an inspection of the Fort Harrison VARO. The inspection focused on five protocol areas examining eight operational activities. The five protocol areas were disability claims processing, management controls, workload management, eligibility determinations, and public contact. We did not examine eligibility determinations related to fiduciary incompetency determinations because VBA has centralized all Western Area fiduciary activities at the Salt Lake City VARO.

We reviewed 53 (36 percent) of 148 disability claims related to traumatic brain injury (TBI) and herbicide exposure completed from January through March 2011. In addition, we reviewed 30 (36 percent) of 84 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 under VA policy without review.

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 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 Disability Claims Processing Accuracy Could Be Improved

The Fort Harrison VARO lacked controls and accuracy in processing claims for temporary 100 percent and TBI-related disabilities. VARO staff incorrectly processed 13 (16 percent) of the total 83 disability claims we reviewed. VARO management agreed with our assessments and initiated action to correct the inaccuracies identified.

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

Table

Disability Claims Processing Results

Type	Reviewed	Claims Incorrectly Processed		
		Total	Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits
Temporary 100 Percent Disability Evaluations	30	10	1	9
Traumatic Brain Injury Claims	23	3	1	2
Herbicide Exposure-Related Disability Claims	30	0	0	0
Total	**83**	**13**	**2**	**11**

Source: VA OIG

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 10 (33 percent) of 30 temporary 100 percent disability evaluations we reviewed. Veterans Benefits Administration (VBA) policy requires a temporary 100 percent disability evaluation for a service-connected disability following surgery or when specific treatment is needed. At the end of a mandated period of convalescence or upon cessation of 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 the diary matures, the electronic system generates a reminder notification alerting VSC staff to schedule the reexamination.

Our analysis of available medical evidence showed that 1 (10 percent) of 10 processing inaccuracies involved an overpayment to a veteran. The overpayment occurred when a Rating Veterans Service Representative (RVSR) established an incorrect effective date for service-connected prostate cancer. As a result, VA overpaid the veteran $2,823 over 1 month.

The remaining nine inaccuracies had the potential to affect veterans' benefits. We could not determine if the evaluations would have continued for these nine cases because the veterans' claims folders did not contain medical examination reports needed to reevaluate each case.

These processing inaccuracies were the result of human error. The most frequent processing inaccuracy noted in 5 (50 percent) of the total 10 cases occurred when VSC staff did not establish suspense diaries in the electronic record. Without suspense diaries, VSC staff did not receive reminder notifications to schedule required VA medical reexaminations.

For those cases requiring reexaminations, delays ranged from approximately 4 months to 10 years and 7 months. An average of 4 years and 3 months elapsed from the time staff should have scheduled the reexaminations until the date of our inspection—the date staff ultimately took corrective actions to obtain the necessary medical evidence.

VARO management did not provide adequate oversight to ensure VSC staff entered suspense diaries for C&C rating decisions. In November 2009, VBA provided guidance reminding VAROs about the need to input suspense diaries in the electronic record for C&C rating decisions. However, VARO management did not have a local policy in place requiring VSC staff to review the electronic record for C&C rating decisions needing medical reexaminations. As such, veterans may not always receive correct benefits payments. Because effective controls were not in place, temporary 100 percent disability evaluations could have continued uninterrupted over the course of the veterans' lifetimes.

In response to a recommendation in our report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), the Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each evaluation had a future examination date entered in the electronic record. As such, we are making no additional recommendation for improvement in this area. To assist in implementing the agreed upon review, we provided the VARO with 54 claims remaining from our universe of 84 temporary 100 percent disability evaluations. During our inspection of the Fort Harrison VARO, we observed a demonstration where system modifications allowed automatic population of a suspense diary in the electronic record to provide a reminder notification to schedule a reexamination related to a C&C rating decision. We will continue to monitor VBA's progress in addressing this issue nationwide.

Additionally, we observed eight temporary 100 percent disability medical reexamination dates that extended 3 years beyond the dates selected by RVSRs. A review of the claims processing award documents revealed VSC staff had accurately entered the reexamination dates in the electronic record. VSC staff stated they took no action to extend the future examination dates beyond the dates selected by the RVSRs. Neither VARO staff nor we could explain this anomaly. If not for our inspection, the temporary 100 percent evaluations for these eight veterans would have continued 3 years beyond the reexamination dates that RVSRs requested. We will continue monitoring reexamination date entries to determine the frequency of such occurrences.

TBI Claims

The Department of Defense and VBA commonly define a TBI as 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 3 (13 percent) of 23 TBI claims—1 of these processing inaccuracies affected a veteran's benefits. In this instance, an RVSR incorrectly assigned a 70 percent evaluation for a TBI-related disability; however, medical treatment reports in the claim folder revealed the disability warranted a 40 percent evaluation. As a result, VA overpaid the veteran $9,138 over a period of 6 months.

The remaining two cases had the potential to affect veterans' benefits. Following are descriptions of these inaccuracies.

- An RVSR did not provide the medical examiner the veteran's claim file for review as required by VBA policy, thereby rendering the medical examination insufficient. The RVSR used the insufficient examination report to evaluate a TBI-related disability. According to VBA policy,

when a medical examination report does not address all required elements, such as a review of the claim file, VSC staff should return the examination to the issuing clinic or health care facility as insufficient. Neither VARO staff nor we can substantiate all of the TBI-related disabilities without sufficient or complete medical evidence.

- Based on medical treatment records, an RVSR correctly determined a veteran's disability was over-evaluated; however, VSC staff did not take the appropriate action to reduce benefits. Even though the veteran's overall disability evaluation remained unchanged, the reduction was necessary as it may affect future disability evaluations.

The three TBI claims processing errors were unique and did not constitute a common trend, pattern, or systemic issue. As such, we made no recommendation for improvement in this area.

Herbicide Exposure-Related Claims

VARO staff correctly processed all 30 herbicide exposure-related claims we reviewed. Therefore, we made no recommendation for improvement in this area.

2. Management Controls

Systematic Technical Accuracy Review

We assessed management controls to determine whether VARO management adhered to VBA policy regarding correction of errors identified by VBA's Systematic Technical Accuracy Review (STAR) staff. The STAR program is VBA's multifaceted quality assurance program to ensure that veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that VARO staff take corrective action on errors that STAR staff identify. STAR program staff identified errors in six claims files from January through March 2011. VARO staff followed VBA policy by correcting all the errors identified during that period. As such, we made no recommendation for improvement in this area.

Systematic Analysis of Operations

We assessed whether VARO management had controls in place to ensure complete and timely submission of each Systematic Analysis of Operations (SAO). We also considered whether VSC staff had adequate data to support the analyses and recommendations in each SAO. An SAO is a formal analysis of a VSC organizational element or operational function. An SAO provides an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. VARO management must publish an annual SAO schedule designating the staff required to complete the SAOs by specific dates. The VSC Manager is responsible for ongoing analysis of VSC operations, including completing 11 SAOs annually.

Finding 2 Systematic Analyses of Operations Missing Required Elements

Two (18 percent) of 11 SAOs were incomplete, missing several required elements and their analysis. This occurred because VARO management misinterpreted VBA policy and did not realize it was necessary to address all required elements of each SAO. As a result, management may not have adequately identified existing and potential problems for corrective action to improve VSC operations.

VSC management knew the 11 SAOs were mandatory, but did not include all required elements and related analyses for each of those SAOs. For example, the SAO on Claims Processing Timeliness did not include assessments of the VSC's pending inventory or non-rating related claims pending over 6 months. VBA policy outlines the minimum elements staff must cover in each SAO and states management may expand on these; however, it does not allow discretion to omit elements and their analyses.

Recommendation

1. We recommend the Fort Harrison VARO Director ensure all staff responsible for completing Systematic Analyses of Operations receive training on addressing all required elements of those analyses.

Management Comments

The VARO Director concurred with our recommendation. In July 2011, the VSCM trained staff on addressing all required elements of SAOs. Further, the Director informed us that in August 2011, the staff rewrote the two incomplete SAOs we identified during our inspection.

OIG Response

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

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 Fort Harrison VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the VSC. The VARO mailroom staff processed mail according to VBA policy; therefore, we made no recommendation for improvement in this area.

Triage Mail Processing Procedures

We assessed the VSC Triage Team's mail-processing procedures to ensure staff reviewed, controlled, and processed all claims-related mail in accordance with VBA policy. VBA policy indicates that oversight to ensure staff use available plans and systems is the most important part of workload management. It also states that effective mail management is crucial to the control of workflow within the VSC.

Search and Drop Mail

VBA policy requires that VARO staff use the Control of Veterans Records System, an electronic tracking system, to track claims folders and control search mail. VBA defines search mail as active claims-related mail waiting to be associated with veterans' claims folders. Conversely, drop mail requires no immediate action after staff place the mail in the claims folders.

The Triage Team staff did not properly manage 1 (2 percent) of 60 pieces of mail we reviewed. As a result, we determined the Fort Harrison VARO was generally complying with national and local mail-handling policies. Therefore, we make no recommendation for improvement in this area.

4. Eligibility Determinations

Entitlement to Medical Treatment for Mental Disorders

Veterans with Gulf War military service are eligible for medical treatment for any mental disorder they develop within 2 years of the date of separation from 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.

Finding 3 Gulf War Veterans Not Receiving Accurate Entitlement Decisions for Mental Health Treatment

VARO staff did not properly address whether four (57 percent) of seven Gulf War veterans were entitled to receive treatment for mental disorders. RVSRs stated that despite training and their understanding of the policy, they generally found it difficult to remember additional benefits they needed to consider even when not claimed by veterans. As a result, veterans may be unaware of potential entitlement to treatment for mental disorders. Following are descriptions of the four inaccuracies:

- In three cases, RVSRs did not address entitlement to mental health treatment when they denied veterans' service connection for a mental disorder. For two cases, the medical evidence in the claims files indicated the veterans developed mental disorders within the applicable time frame and were entitled to health care. In the remaining case, the veteran claimed service connection for a mental disorder. However, evidence did not show the veteran had a mental disorder diagnosed within the 2-year period following separation, which would have entitled the veteran to treatment.
- In one case, the RVSR indicated the veteran was entitled to treatment for a mental condition; however, the medical records did not show the veteran had a diagnosed mental condition.

VSC management was aware staff were not addressing this entitlement as STAR staff identified related errors on two (25 percent) of eight claims

completed from October through December 2010. RVSRs interviewed were able to explain the correct process for addressing this entitlement issue, but stated it was generally difficult to remember all of the issues to consider when processing claims. Most RVSRs and Decision Review Officers received refresher training on this topic in March 2011. We were unable to assess whether this training was effective because staff finalized the cases we reviewed prior to completing the training.

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 entitlement to health care treatment when they deny service connection for a mental disorder. However, RVSRs stated it was easy to click past the tip master and not address the issue. Our review contained two cases completed after the update, both of which did not contain errors. At this time, we cannot ascertain whether this update will minimize future processing inaccuracies.

Recommendation

2. We recommend the Fort Harrison VA Regional Office Director develop and implement a plan to monitor the effectiveness of Rating Veterans Service Representative training on correctly addressing Gulf War veterans' entitlement to mental health treatment.

Management Comments

The VARO Director concurred with our recommendation. In August 2011, the Director issued policy requiring decision makers to consider entitlement under 38 United States Code 1702 as a separate and distinct issue in rating decisions for every Gulf War veteran denied service connection for a mental disorder. Further, in August 2011, RVSRs and Decision Review Officers received refresher training on the proper procedures for rating claims related to the denial of mental conditions for Gulf War veterans.

OIG Response

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

5. Public Contact

In November 2009, VA developed a 5-year plan to end homelessness among veterans by assisting every eligible homeless veteran willing to accept service. VBA generally defines homeless as lacking a fixed, regular, and adequate nighttime residence. VBA provided guidance to all VAROs that homeless veterans' claims should receive priority processing.

Expedited Claims Processing for Homeless Veterans

We found no excessive delays in processing homeless veterans' claims. VBA's national target for processing homeless veterans' claims is an average of 75 days. At the time of our inspection, the VARO had two homeless veterans' claims pending for an average of 40.5 days—34.5 days better than VBA's national target. VBA calculates the average days a homeless

veteran's claim is pending from the date a VARO receives a claim, divided by the total number of claims pending.

Although VBA does not have a target for the number of days it takes VAROs to complete homeless veterans' claims, the Fort Harrison VARO established a local goal of 100 days. The VARO completed 10 claims for homeless veterans from January through March 2011 in an average of 78 days—22 days better than the local goal. As we did not find any excessive delays, we make no recommendation for improvement in this area.

Outreach to Homeless Shelters and Service Providers

Congress mandated at least one full-time employee oversee and coordinate programs for homeless veterans at each of the 20 VAROs that VA determined to have the largest veteran populations. VBA guidance, last updated in September 2002, directed that the coordinators at the remaining 37 VAROs be familiar with the requirements for improving the effectiveness of VARO outreach to homeless veterans. These requirements for each VARO 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 advocate groups to provide information on VA benefits and services.

Finding 4 No Clear Measures to Assess Effectiveness of Homeless Veterans Outreach Program

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

VSC management did not have a mechanism in place to determine whether homeless shelters and service providers received information from the VARO regarding benefits and services available to homeless veterans. Further, management did not update a resource directory of shelters, homeless day-care facilities, and homeless service providers, as required by VBA policy. The Fort Harrison VARO does not have a full-time coordinator dedicated to address homeless veterans' needs. VARO management assigned one employee to perform this function as a collateral duty.

We attempted to contact Program Directors at 10 (48 percent) of 21 homeless shelters and service providers listed on a directory provided by VSC staff. While three Program Directors confirmed the VARO had made contact with their organizations, five indicated they had not heard from the VARO or received information regarding VA benefits and services. The

remaining two Program Directors did not have updated contact information; therefore, we could not reach out to these organizations.

VSC staff agreed they did not routinely follow up with shelters or homeless service providers to ensure these facilities received outreach information mailed from the VARO. However, staff reported they attempted to contact the facilities when outreach information mailings were returned as undeliverable. VARO management stated VBA policy regarding outreach procedures was unclear on matters such as the frequency of contact the coordinator should have with homeless shelters and service providers.

VARO managers stated they measured the success of their homeless program by whether or not they met VBA's 75-day goal for expedited claims processing. VBA has not established a performance measure or goal to determine whether VARO outreach efforts are effective. Although we determined the Fort Harrison VARO did not maintain contact with the shelters on a regular basis or fully update the resource directory, we found it took initiative in other areas. For example, the VARO attempted to stay in touch with all homeless veterans on a quarterly basis regardless of whether a claim was pending. The purpose of the contact was to inquire about their homeless status and answer questions regarding VA benefits and/or services.

Recommendation

3. We recommend the Fort Harrison VA Regional Office Director develop a mechanism to oversee and coordinate programs for homeless veterans that will ensure VA Regional Office staff regularly contact homeless shelters and service providers.
4. We recommend the Fort Harrison VA Regional Office Director develop and implement a plan to monitor and assess effectiveness in providing outreach information to homeless shelters and service providers.

Management Comments

The VARO Director concurred with our recommendations. The Director created a draft plan that will require VARO staff to contact homeless shelters and service providers semi-annually. Further, in October 2011 the Director issued policy requiring that two weeks after mailing outreach materials on available VA benefits and services, VARO staff contact the homeless shelters by telephone to ensure they received the information.

OIG Response

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

Appendix A VARO Profile and Scope of Inspection

Organization

The Fort Harrison VARO administers a variety of services and benefits, including Compensation, Vocational Rehabilitation and Employment, specially adapted housing grants, benefits counseling, and outreach to homeless, elderly, minority, and women veterans.

Resources

As of July 2011, the Fort Harrison VARO had a staffing level of 57.9 full-time equivalent employees. Of these employees, 49.9 (86 percent) were assigned to the VSC.

Workload

As of May 2011, the VARO reported 1,178 pending compensation claims. The average time to complete these claims was 104 days—approximately 71 days better than the national target of 175 days. As reported by STAR, the accuracy of compensation rating-related issues was 91.5 percent, which was better than the 90 percent target set by VBA.

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 53 (36 percent) of 148 disability claims related to TBI and herbicide exposure completed from January through March 2011. For temporary 100 percent disability evaluations, we selected 30 (36 percent) of 84 existing claims from VBA's Corporate Database. We provided VARO officials with 54 claims remaining from our universe of 84 for their review. These 84 claims represented all instances where VARO staff had granted temporary 100 percent disability evaluations for at least 18 months or longer as of June 9, 2011.

We reviewed all six files containing errors identified by VBA's STAR program from January through March 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' disabilities claims.

Our process differs from that of STAR as we review specific types of disability claims such as those related to TBI and herbicide exposure that require rating decisions. We review rating decisions and awards processing involving temporary 100 percent disability evaluations. Additionally, we reviewed the 11 mandatory SAOs completed in FYs 2010 and 2011.

We reviewed selected mail in various processing stages in the VARO mailroom and the VSC. We reviewed all seven claims completely processed for Gulf War veterans from January through March 2011 to determine whether VSC staff addressed entitlement to mental health treatment in the rating decision documents. We reviewed all 10 homeless veterans claims completed from January through March 2011, as well as two claims that were pending at the time of our inspection. Further, we reviewed the effectiveness of the VARO's homeless veterans outreach program.

We completed our review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.* We planned and performed the review to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our review objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our review objectives.

Appendix B VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: October 13, 2011

From: Acting Director, Fort Harrison VA Regional Office (436/00)

Subj: Inspection of the VA Regional Office, Fort Harrison, Montana

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

1. Enclosed are the Fort Harrison VA Regional Office's (RO) comments and responses to the OIG Draft Report, Inspection of the VA Regional Office, Fort Harrison, Montana, received September 30, 2011. The RO concurs with the findings and recommendations regarding RO activities requiring improvement, which include management controls, eligibility determinations, and public contact. Attached are our comments and responses to the specific recommendations and action items that arose as a result of the review.
2. We appreciate the professionalism and courtesy exhibited by the audit team members during their review of our operations, as well as the analysis they provided. This analysis and the corresponding recommendations for improvement are invaluable in our continued efforts to provide the best possible service to our Veterans.
3. Please feel free to contact me at (801) 326-2400 with any questions or concerns regarding our reply.

(original signed by:)

JOYCE CANGE
Acting Director

Enclosure

Ft. Harrison VA Regional Office
Response to the Office of Inspector General, Benefits Inspection Division, Inspection of the VA Regional Office Draft Report

Comments and Implementation Plan

OIG Recommendations

Recommendation 1. *We recommend the Fort Harrison VA Regional Office Director ensure all staff responsible for completing Systematic Analyses of Operations (SAOs) receive training on addressing all required elements of those analyses.*

Concur with recommendation.

Planned/Completed Action:

The SAO schedule for FY 2012 (attached) has been updated to reflect all required elements of the required SAOs per M21-4, Chapter 5. In order to address prior omissions, the two incomplete SAOs identified during the inspection that did not address all required elements (Appeals and Claims Processing Timeliness) were assigned on July 7, 2011 and rewritten on August 9 and 23, 2011, respectively. The Staff, as well as those Veterans Service Center employees assigned to write the SAOs, received the necessary training from the Veterans Service Center Manager to address all required elements of the SAOs on July 7, 2011. In addition, the FY 2012 SAO Schedule was distributed to the staff and all those assigned to write SAOs, as well as sent to the Director's Office, on September 30, 2011.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 2. *We recommend the Fort Harrison VA Regional Office Director develop and implement a plan to monitor the effectiveness of Rating Veterans Service Representative training on correctly addressing Gulf War veterans' entitlement to mental health treatment.*

Concur with recommendation.

Planned/Completed Action: In March and August 2011 Rating Veteran Service Representatives and Decision Review Officers received refresher training on this topic. On August 16, 2011, local policy was issued to decision makers to consider entitlement under 38 USC 1702 as a separate and distinct issue in the rating decision for every Gulf War veteran claiming service connection for a mental disorder whose claim is denied. This item will continue to be monitored during local and National STAR reviews. Based on results of the quality reviews on decisions rated after August 16, 2011, consideration will be given to instituting second signature review on claims involving denials for mental disorders.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendations 3 and 4. *We recommend the Fort Harrison VA Regional Office Director develop a mechanism to oversee and coordinate programs for homeless veterans that will ensure*

VARO staff regularly contact homeless shelters and service providers. We recommend the Fort Harrison VA Regional Office Director develop and implement a plan to monitor and assess effectiveness in providing outreach information to homeless shelters and service providers.

Concur with recommendation.

Planned/Completed Action: A draft plan exists which will ensure semi-annual contacts with homeless shelters and service providers, either in person or by mail. A mechanism will be put in place to ensure that facilities receive outreach information mailed from the VARO. VARO staff will set a two-week suspense for a telephone contact with the shelter after each mailing to ensure that the information regarding available VA benefits and services was received. The policy was issued to applicable members of the Veterans Service Center on October 11, 2011.

The Veterans Benefits Administration recommends closure of these recommendations.

Appendix C 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 CFR 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) M21-1MR 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 claims for service connection for all residual disabilities related to in-service TBI were properly processed.** (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 (Agent Orange).** (38 CFR 3.309) (Fast Letter 02-33) (M21-1MR Part IV, Subpart ii, Chapter 2, Section C.10)	X	
Management Controls			
4. Systematic Technical Accuracy Review	**Determine whether VARO staff properly corrected STAR errors in accordance with VBA policy.** (M21-4, Chapter 3, Subchapter II, 3.03)	X	
5. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)		X
Workload Management			
6. Mail Handling Procedures	**Determine whether VARO staff properly followed VBA mail-handling procedures.** (M23-1) (M21-4, Chapter 4) (M21-1MR Part III, Subpart ii, Chapters 1 and 4)	X	
Eligibility Determinations			
7. Gulf War Veterans' Entitlement to Mental Health Treatment	**Determine whether VARO staff properly processed Gulf War Veterans' claims for Medical Treatment for Mental Illness.** (38 United States Code 1702) (M21-1MR Part IX, Subpart ii, Chapter 2) (M21-1MR Part III, Subpart v, Chapter 7) (Fast Letter 08-15) (38 CFR 3.384)		X
Public Contact			
8. VBA's Homeless Veterans Program	**Determine whether VARO staff expeditiously processed homeless veterans' claims and provided effective outreach services.** (38 CFR 1.710) (M21-1, Part VII, Chapter 6.06)		X

Source: OIG

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 Brett Byrd Madeline Cantu Kelly Crawford Ramon Figueroa Lee Giesbrecht Nora Stokes Lisa Van Haeren

Appendix E Report Distribution

VA Distribution

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Non-VA Distribution

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U.S. House of Representatives: Dennis Rehberg

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