VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Wichita, Kansas

September 5, 2012
12-00249-266

ACRONYMS AND ABBREVIATIONS

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, Wichita, Kansas

Why We Did This Review

The Veterans Benefits Administration (VBA) has 57 VA Regional Offices (VAROs) nationwide that process disability claims and provide a range of services to veterans. We conducted this inspection to evaluate how well the Wichita VARO accomplishes this mission of providing veterans with access to high-quality benefits and services.

What We Found

Wichita VARO staff lacked effective controls and accuracy in processing some disability claims. Specifically, 53 percent of the temporary 100 percent disability evaluations we reviewed were inaccurate, generally because staff not scheduling future medical reexaminations as required. Errors in processing 50 percent of traumatic brain injury claims occurred primarily because inadequate training and ineffective second-level reviews. Staff erroneously processed 50 percent of herbicide exposure-related disability claims, mainly due to inadequate monitoring and ineffective training. Overall, VARO staff did not accurately process 36 (51 percent) of the 70 disability claims. These results do not represent the overall accuracy of disability claims processing at this VARO as we sampled claims we considered at higher risk of processing errors.

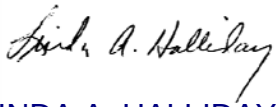
VARO staff followed VBA's policy for correcting errors identified in Systematic Technical Accuracy Reviews, but managers did not ensure timely completion of all elements of Systematic Analyses of Operations. VARO mail processing was generally effective. However, ineffective processing of competency determinations resulted in some incompetent beneficiaries receiving benefits payments without fiduciaries in place to ensure the financial stewardship of their resources. The VARO provided outreach to homeless veterans. However, VBA needs a measure to assess their outreach programs.

What We Recommended

We recommended the VARO Director provide refresher training on processing traumatic brain injury and herbicide exposure-related claims and develop and implement a plan to monitor training effectiveness. The Director should implement a plan to improve the effectiveness of the second-level review process for traumatic brain injury claims. VARO management should ensure staff complete all required elements of Systematic Analyses of Operations. Further, VARO management needs to implement controls to ensure staff follow current VBA policy on processing competency determinations.

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.



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 May 2012, the OIG conducted an onsite inspection of the Wichita 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 were unable to review claims involving Gulf War veterans' entitlement to medical treatment for mental disorders because the one claim completed during the period from October through December 2011 was unavailable for review at the time of our inspection.

We reviewed 40 (25 percent) of 159 disability claims related to traumatic brain injury (TBI) and herbicide exposure that VARO staff completed from October through December 2011. In addition, we reviewed 30 (20 percent) of 152 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 Veterans Benefits Administration (VBA) 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 Benefits Inspection team focused on disability claims processing related to temporary 100 percent disability evaluations, TBI, and herbicide exposure. We evaluated claims processing accuracy and its impact on veterans' benefits.

Finding 1 The Wichita VARO Needs To Improve Disability Claims Processing Accuracy

The Wichita VARO lacked adequate controls and accuracy in processing temporary 100 percent disability evaluations and TBI and herbicide exposure-related claims. VARO staff incorrectly processed 36 of the total 70 disability claims we sampled and overpaid a total of $152,722. VARO management agreed with our findings and began to correct the errors identified.

Because we only sampled claims related to specific conditions, these results do not represent the universe of disability claims processed at this VARO. As reported by VBA's Systematic Technical Accuracy Review (STAR) program as of February 2012, the overall accuracy of the VARO's compensation rating-related decisions was 87.3 percent—0.3 percentage points above VBA's 87 percent target.

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

Table 1

Wichita VARO Disability Claims Processing Results				
Type of Claim	**Reviewed**	**Claims Incorrectly Processed**		
		Affecting Veterans' Benefits	**Potential To Affect Veterans' Benefits**	**Total**
Temporary 100 Percent Disability Evaluations	30	5	11	16
Traumatic Brain Injury Claims	10	1	4	5
Herbicide Exposure-Related Claims	30	4	11	15
Total	**70**	**10**	**26**	**36**

Source: VA OIG Analysis of VBA's disability claims files

Temporary 100 Percent Disability Evaluations

We found excessive errors in VARO processing of temporary 100 percent disability evaluations. VARO staff incorrectly processed 16 of 30 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a veteran's service-connected disability following surgery or when specific treatment is required. 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. A suspense diary is a processing command that establishes a date when VSC staff must schedule a reexamination. As a suspense diary matures, the electronic system generates a reminder notification to alert VSC staff to schedule the reexamination.

Available medical evidence showed 5 of the 16 processing errors affected veterans' benefits—all 5 involved overpayments totaling $134,210. The most significant error occurred because VSC staff did not schedule a medical reexamination after receiving an electronic system-generated reminder notification, as well as notice from the veteran that he had completed treatment for Hodgkin's lymphoma. Medical evidence showed no residuals of the disease warranting a reduction in benefits as of August 1, 2010. As a result, VA continued processing monthly benefits and ultimately overpaid a veteran $53,940 over a period of 1 year and 7 months.

The remaining 11 errors had the potential to affect veterans' benefits. Following are descriptions of these errors.

- In nine cases, VSC staff did not input suspense diaries or establish local controls to remind claims processing staff of the need for medical reexaminations to determine whether the temporary 100 percent disability evaluations should continue.
- A Rating Veterans Service Representative (RVSR) failed to properly notify a veteran of potential entitlement to an additional benefit as required by VBA policy.
- An RVSR correctly granted a 100 percent disability evaluation without requiring a future reexamination. In making this decision, the RVSR also did not consider entitlement to the additional benefit of Dependents' Educational Assistance as required by VBA policy.

For 7 of the 11 errors with the potential to affect veterans' benefits, medical reexaminations were required. An average of 2 years and 10 months elapsed from the time staff should have scheduled medical reexaminations until the

date of our inspection. The delays ranged from approximately 14 months to 5 years and 2 months.

Seven of the 16 errors resulted from staff not establishing suspense diaries when they processed temporary 100 percent disability evaluations requiring medical reexaminations. Five of these errors involved confirmed and continued rating decisions. In November 2009, VBA provided guidance reminding VAROs about the need to add suspense diaries in the electronic record for confirmed and continued rating decisions. However, VARO management lacked an oversight procedure to ensure VSC staff established the suspense diaries and timely scheduled reexaminations as required.

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. The 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 deadline to December 31, 2011, then to June 30, 2012, and then again to September 30, 2012. To assist in implementing the agreed-upon review, we provided the Wichita VARO with 122 claims remaining from our universe of 152 temporary 100 percent disability evaluations. At the time of our inspection, the VARO had completed the review. As such, we made no specific recommendation for this VARO.

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.

VARO staff incorrectly processed 5 of 10 TBI claims—one of the errors affected a veteran's benefits. In this case, an RVSR incorrectly evaluated TBI residuals as 10 percent disabling. However, medical evidence showed TBI residuals warranting no more than a 0 percent disability evaluation, which entitled the veteran to healthcare for the condition but no monetary benefits as compensation. As a result, VA continued processing monthly benefits and ultimately overpaid the veteran $1,332 over a period of 11 months.

The remaining four errors had the potential to affect veterans' benefits. Following are descriptions of these errors.

- In two cases, RVSRs used inadequate VA medical examination reports to evaluate TBI residuals. According to VBA policy, when a medical examination does not address all required elements, VSC staff should return it to the issuing clinic or health care facility as insufficient for rating purposes. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without adequate or complete medical evidence.
- An RVSR did not follow up as required to determine service connection of a medically diagnosed mental condition possibly related to a TBI. Neither VARO staff nor we can ascertain all of the residual disabilities of a TBI without adequate or complete medical evidence.
- An RVSR used an inadequate VA medical examination report to deny service connection for a TBI and did not return the report to the issuing clinic or healthcare facility as insufficient for rating purposes as required. Neither VARO staff nor we can ascertain whether TBI should be service-connected without adequate or complete medical evidence.

Generally, errors occurred because VSC staff received inadequate training on proper processing of TBI claims. VSC staff indicated training and guidance on evaluating TBI claims were not clear. In addition, second-level reviews conducted by VARO staff to ensure accuracy of TBI claims were ineffective. RVSR trainees completed all five errors we found and underwent second-level reviews with no errors identified. VSC staff stated that the additional levels of review were ineffective due to a combination of competing workload priorities and difficulty accomplishing quality reviews for a large number of trainees. Because of these deficiencies, RVSRs did not properly evaluate TBI residuals and veterans may not have always received correct benefits.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 15 of 30 herbicide exposure-related claims we reviewed. Four of the 15 processing errors affected veterans' benefits—all 4 involved overpayments totaling $17,180. The most significant overpayment occurred when an RVSR correctly granted service connection for ischemic heart disease associated with herbicide exposure; however, the effective date of August 31, 2010, for the 60 percent evaluation was incorrect. The actual date of entitlement was May 27, 2011—the date of claim. As a result of this error, VA continued processing monthly benefits and ultimately overpaid the veteran $7,406 over a period of 9 months.

The remaining 11 errors had the potential to affect veterans' benefits. Following are descriptions of these errors.

- In six cases, RVSRs did not consider service connection for all issues associated with the veterans' claims as required by VBA policy.
- In four cases, RVSRs used inadequate VA medical examination reports to evaluate the veterans' disabilities. The RVSRs did not return the exam reports to the issuing clinics or health care facilities as insufficient for rating purposes as required. Neither VARO staff nor we can evaluate the veterans' disabilities without adequate or complete medical evidence.
- An RVSR denied a veteran's claim without obtaining service treatment records to establish service connection as required by VBA policy.

Generally, errors associated with herbicide exposure-related claims processing resulted from the lack of a mechanism to monitor the effectiveness of training. VSC staff received training on several topics associated with herbicide exposure-related claims prior to our inspection. However, some VSC managers and staff stated the training materials were insufficient. Further, several of the errors we identified were consistent with error trends noted in both STAR and local quality control reviews. Adequately monitoring the effectiveness of training might have identified opportunities to improve the VARO's accuracy in processing herbicide exposure-related claims. Because of these deficiencies, RVSRs did not properly evaluate herbicide exposure-related disability claims and veterans may not have always received correct benefits.

Recommendations

1. We recommend the Wichita VA Regional Office Director provide refresher training and implement a plan to improve effectiveness of second-level reviews in processing traumatic brain injury claims.
2. We recommend the Wichita VA Regional Office Director provide refresher training on processing herbicide exposure-related claims and implement a plan to monitor the effectiveness of this training.

Management Comments

The VARO Director concurred with our recommendations. For recommendation 1, the Director stated that refresher training on rating TBI claims was conducted in June 2012. In addition, supervisors will review all TBI ratings until the RVSR achieves a 90 percent accuracy rate, as required.

For recommendation 2, the Director indicated the VARO would conduct refresher training on processing herbicide exposure-related claims by October 31, 2012. The Quality Review Specialists will provide findings on all errors to the Training Manager. VSC will conduct training on these errors monthly.

OIG Response

Management's actions are responsive to the recommendations. We will follow up as required on all actions.

2. Management Controls

Systematic Technical Accuracy Review

We assessed whether VARO management adhered to VBA policy regarding correction of errors identified by VBA's STAR staff. The STAR program is VBA's multifaceted quality assurance program to ensure veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that VARO staff take corrective action on errors identified by STAR.

Wichita VARO staff adhered to VBA policy by taking corrective action on all five cases with errors identified by VBA's STAR program from October through December 2011. Therefore, we made no recommendation for improvement in this area.

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 the analyses and recommendations identified within each SAO. An SAO is a formal analysis of an organizational element or operational function. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. VARO management must publish 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.

Finding 2 Oversight Needed To Ensure Timely and Complete SAOs

Five of the 11 SAOs were not completed timely per the annual schedule or were incomplete. VARO management did not provide adequate oversight to ensure VSC staff completed the SAOs in accordance with VBA policy. As a result, VARO management may not have adequately identified existing and potential problems for corrective actions to improve VSC operations.

At the time of our inspection, 3 of the 11 SAOs were untimely. The VSC manager stated these SAOs were untimely because they were due during a period of management transition, resulting in a lack of oversight. Completion of the remaining eight SAOs was timely. As such, we determined the VARO generally followed VBA policy and we made no recommendation for improvement in this area.

In addition, 2 of the 11 SAOs were incomplete because they did not include analyses of all required elements. VSC management stated these errors occurred due to unclear VBA policy regarding requirements for analyzing VARO operations.

Recommendation

3. We recommend the Wichita VA Regional Office Director develop and implement a plan to ensure staff address all required elements of Systematic Analyses of Operations using relevant data and conducting thorough analysis.

Management Comments

The VARO Director concurred with our recommendation. The Director stated the VSC Manager would provide training to all personnel responsible for completing SAOs by September 30, 2012. The VSC Manager will review submitted SAOs to ensure all required elements are addressed prior to submitting to the Director.

OIG Response

Management's actions are responsive to the recommendation. We will follow up as required on all actions.

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 Wichita VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the Intake Processing Center. Mailroom staff were timely and accurate in processing, date-stamping, and delivering VSC mail to the Intake Processing Center control point daily. As a result, we determined the VARO was following VBA policy and we made no recommendation for improvement in this area.

Intake Processing Center Mail-Management Procedures

VBA has embarked on a multi-year transformation of veterans' claims processing and benefits delivery. As part of this transformation, VBA is pursuing new business concepts with the goal of improving the speed, accuracy, and consistency of claims decisions rendered to veterans and their families. One of the outcomes of this initiative has been the Intake Processing Center, which combines existing VARO mail-processing activities (the mailroom) with Triage sort functions in one location.

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

VSC staff did not properly manage 5 of 60 pieces of mail we reviewed. As a result, we determined the Wichita VARO was generally compliant with national and local mail-handling policies. Therefore, we made no recommendation for improvement in this area.

4. Eligibility Determinations

Competency Determinations

VA must consider beneficiary competency in every case involving a mental health condition that is totally disabling or when evidence raises questions as to a beneficiary's mental capacity to manage his or her affairs. The Fiduciary Unit supports implementation of competency determinations by appointing a fiduciary, a third party who assists in managing funds for an incompetent beneficiary. We reviewed competency determinations made at the VARO to ensure staff completed them accurately and timely. Delays in making these determinations ultimately affect the Fiduciary Unit's ability to appoint fiduciaries timely.

VBA policy requires that staff obtain clear and convincing medical evidence that a beneficiary is capable of managing his or her affairs prior to making a final competency decision. The policy allows the beneficiary a 60-day due process period to submit evidence showing an ability to manage funds and other personal affairs. At the end of the due process period, VARO staff must take immediate action to determine whether the beneficiary is competent. Effective July 2011, VBA defines "immediate" as 21 days.

Finding 3 Inadequate Controls Over Competency Determinations

As measured against VBA's definition of immediate, VARO staff unnecessarily delayed making final decisions in 6 of 11 competency determinations completed from October through December 2011. The delays ranged from 11 to 171 days, with an average delay of 54 days. Delays occurred because the workload management plan did not contain oversight procedures emphasizing immediate completion of competency determinations. The risk of incompetent beneficiaries receiving benefits without fiduciaries assigned to manage those funds increases when staff do not complete competency determinations timely.

The most significant case of placing funds at risk occurred when VARO staff unnecessarily delayed making a final competency decision for a veteran for approximately 6 months. During this period, the veteran received $5,844 in disability payments. While the veteran was entitled to these payments, fiduciary stewardship was not in place to ensure effective funds management and the welfare of the veteran.

Recommendation

4. We recommend the Wichita VA Regional Office Director implement controls to ensure staff follow current Veterans Benefits Administration policy regarding the processing of competency determinations.

Managements Comments

The VARO Director concurred with our recommendation. The Director indicated that Workload Management Plan is being updated to include requirements for a weekly review of competency issues to ensure competency determinations are processed within the required timeframe. Supervisors will assign cases to RVSRs and require notification when the rating determination is completed.

OIG Response

Management's actions are responsive to the recommendation. We will follow up as required on all actions.

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.

Outreach to Homeless Veterans

Congress mandated that 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 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.

The Wichita VARO has a part-time Homeless Veterans Outreach Coordinator. Our review confirmed that the coordinator provided outreach and contacted local homeless service providers as required by VBA policy. Therefore, we made no recommendation for improvement in this area. However, VBA needs a measurement to assess the effectiveness of homeless veterans outreach.

Appendix A VARO Profile and Scope of Inspection

Organization

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

Resources

As of December 2011, the Wichita VARO had a staffing level of 100.5 full-time employees. Of this total, the VSC had 78 employees (78 percent) assigned.

Workload

As of February 2012, the VARO reported 5,300 pending compensation claims. The average time to complete claims was 211 days—19 days less than the national target of 230.

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 40 (25 percent) of 159 disability claims related to TBI and herbicide exposure that the VARO completed from October through December 2011. For temporary 100 percent disability evaluations, we selected 30 (20 percent) of 152 existing claims from VBA's Corporate Database. We provided VARO management with 122 claims remaining from our universe of 152 for its review. These claims represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months as of December 31, 2011.

We reviewed the 11 mandatory SAOs completed in FYs 2011 and 2012. We also reviewed five files with seven errors identified by VBA's STAR program from October through December 2011. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR measurements include a review of work associated with claims that require rating decisions. STAR staff review original claims, reopened claims, and claims for increased evaluation.

Further, they review appellate issues that involve a myriad of veterans' disability claims. Our process differs from STAR as we review specific types of disability claims related to TBI and herbicide exposure that require rating decisions. In addition, we review rating decisions and awards processing involving temporary 100 percent disability evaluations.

For our review, we selected mail in various processing stages in the Intake Processing Center. We also reviewed 11 competency determinations

completed from October through December 2011, and assessed the effectiveness of the VARO's homeless veterans outreach program.

Reliability of Data

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, station numbers, dates of claim, and decision dates as provided in the data received with information contained in the 81 claims folders we reviewed.

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

Compliance With Inspection Standards

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

Appendix B VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: August 20, 2012

From: Director, VA Regional Office Wichita, Kansas

Subj: Inspection of the VA Regional Office, Wichita, Kansas

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

1. The Wichita VARO's comments are attached on the OIG Draft Report: *Inspection of the VA Regional Office, Wichita, Kansas.*

2. Please refer questions to Jason H. Ware, VSCM at 316-688-6838.

(original signed by:)
Mitzi Marsh

Attachment

VA Regional Office Wichita, Kansas Responses

1. We recommend the Wichita VA Regional Office Director provide refresher training and implement a plan to improve effectiveness of second-level reviews in processing traumatic brain injury claims.

   RO Response: The Director concurs with the findings and recommendations. The Regional Office conducted refresher training on rating TBI claims for RVSRs and DROs on June 21, 2012. The RO is following the guidance provided by the OFO email dated May 31, 2011, which stated RVSRs should not be released to single signature on TBI cases until they have reached 90% accuracy on a minimum of 10 cases. We currently have two RVSRs who have been released to single signature authority. Rating Decisions generated by the remaining RVSRs are reviewed by one of two designated supervisors. Rating Decisions generated by RVSRs who do not achieve 90% accuracy after a minimum of 10 cases is reviewed, will remain under the second signature review until they meet the requirement.

2. We recommend the Wichita VA Regional Office Director provide refresher training on processing herbicide exposure-related claims and implement a plan to monitor the effectiveness of this training.

   RO Response: The Director concurs with the findings and recommendations. The Regional Office will conduct refresher training on processing herbicide exposure-related claims by October 31, 2012. The station Quality Review Specialists will track all errors found on herbicide exposure-related ratings and provide their findings to the RO Training Manager through the QRT supervisor. Training will then be conducted monthly during regularly scheduled training sessions on the errors found in the quality reviews

3. We recommend the Wichita VA Regional Office Director develop and implement a plan to ensure staff address all required elements of Systematic Analyses of Operations using relevant data and conducting thorough analysis.

   RO Response: The Director concurs with the findings and recommendations. The VSCM will provide refresher training on the requirements of M21-4 for all personnel responsible for preparing SAOs by September 30, 2012. In addition, the VSCM will review all submitted SAOs to ensure all required elements have been addressed as outlined in M21-4 prior to submittal to the Director's office for review.

4. We recommend the Wichita VA Regional Office Director implement controls to ensure staff follow current Veterans Benefits Administration policy regarding the processing of competency determinations.

   RO Response: The Director concurs with the findings and recommendations. The Workload Management Plan is currently being updated and includes a requirement for the Non-rating Team supervisor to conduct a weekly review of the VOR pending detail listing for

EP 600 competency issues in order to ensure the final competency determination is processed within 21 days of the expiration of the due process period. The cases will be assigned to RVSRs and the supervisor will require the RVSRs to notify him/her upon completion of the Rating Decision.

Appendix C Inspection Summary

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

Table 2. Wichita VARO Inspection Summary

Eight Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Claims Processing			
1. Temporary 100 Percent Disability Evaluations	**Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations.** (38 Code of Federal Regulations (CFR) 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (Manual (M)21-1 Manual Rewrite (MR) Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e)		X
2. Traumatic Brain Injury Claims	**Determine whether VARO staff properly processed claims for service connection for all disabilities related to in-service TBI.** (Fast Letter (FL) 08-34 and 08-36, Training Letter 09-01)		X
3. Herbicide Exposure-Related Claims	**Determine whether VARO staff properly processed claims for service connection for herbicide exposure-related disabilities.** (38 CFR 3.309) (FL 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. Competency Determinations	**Determine whether VARO staff properly assessed beneficiaries' mental capacity to manage VA benefits payments.** (M21-1MR Part III, Subpart v, Chapter 9, Section A) (M21-1MR Part III, Subpart v, Chapter 9, Section B) (FL 09-08)		X
Public Contact			
8. VBA's Homeless Veterans 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 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	Dawn Provost, Director Ed Akitomo Madeline Cantu Lee Giesbrecht Jeff Myers David Pina Rachel Stroup Brandi Traylor Diane Wilson

Appendix E Report Distribution

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