VA Office of Inspector General

OFFICE OF AUDITS & EVALUATIONS

Inspection of the VA Regional Office Portland, OR

February 22, 2011
11-00070-93

ACRONYMS AND ABBREVIATIONS

COVERS	Control of Veterans Records System
NOD	Notices of Disagreement
OIG	Office of Inspector General
PTSD	Post-Traumatic Stress Disorder
RVSR	Rating Veterans Service Representative
SAO	Systematic Analyses of Operations
STAR	Systematic Technical Accuracy Review
TBI	Traumatic Brain Injury
VACOLS	Veterans Appeals Control and Locator System
VARO	VA Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

Report Highlights: Inspection of the VA Regional Office, Portland, OR

Why We Did This Review

The Benefits Inspection Division conducts onsite inspections at VA Regional Offices (VAROs) to review disability compensation claims processing and Veterans Service Center operations.

What We Found

The Portland VARO correctly processed disability claims for post-traumatic stress disorder. Additionally, VARO staff corrected errors identified by the Veterans Benefits Administration's (VBA) Systematic Technical Accuracy Review program and established correct dates of claim in the electronic record. Generally, VARO staff correctly processed herbicide exposure-related disability claims and ensured timely controlling of Notices of Disagreements for appealed decisions.

VARO staff should emphasize the need to improve the control of processing temporary 100 percent disability evaluations and ensure the accuracy of processing traumatic brain injury claims. Further, we found the staff made rating decisions based on inadequate medical examinations. Overall, VARO staff did not accurately process 24 (20 percent) of the 120 disability claims reviewed. Further, the controls over mail handling and completion of Systematic Analyses of Operations need strengthening.

What We Recommended

We recommended that Portland VARO management review all temporary 100 percent evaluations to determine if reevaluations are required and take appropriate actions. Management needs to implement controls to ensure reminder notifications for temporary 100 percent disability reevaluations are established.

Further, we recommended management provide refresher training on the proper procedures for processing traumatic brain injury claims and develop a plan to ensure the staff returns inadequate medical examinations to the appropriate hospitals for correction. We also recommended VARO management strengthen controls to ensure timely and complete preparation of Systematic Analyses of Operations and implement a plan to ensure accurate control and processing of incoming mail.

Agency Comments

The Director of the Portland VARO concurred with all recommendations. Management's planned actions are responsive and we will follow up as required on all actions.

(original signed by:)

BELINDA J. FINN
Assistant Inspector General
for Audits and Evaluations

TABLE OF CONTENTS

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 convenient access to high quality benefits and services.
- Determine if 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 November 2010, the OIG conducted an inspection of the Portland VARO. The inspection focused on four protocol areas examining nine operational activities. The four protocol areas were disability claims processing, data integrity, management controls, and workload management. We did not examine eligibility determinations because VBA has centralized all Western Area fiduciary activities at the Salt Lake City VARO.

We reviewed 90 (10 percent) of 899 disability claims related to post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and herbicide exposure that the VARO completed from July through September 2010. In addition, we reviewed 30 (14 percent) of 213 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 Portland 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 evaluations, PTSD, TBI, and herbicide exposure. We evaluated claims processing accuracy and its impact on veterans' benefits.

Finding 1 VARO Staff Need To Improve Disability Claims Processing Accuracy

The Portland VARO needs to improve the accuracy of disability claims processing for temporary 100 percent disability evaluations and TBI. VARO staff incorrectly processed 24 (20 percent) of the total 120 disability claims reviewed. We advised VARO management of the inaccuracies noted during our inspection and they initiated corrective measures to address them. The table below reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Portland 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	16	3	13
PTSD	30	0	0	0
TBI	30	7	2	5
Herbicide Exposure-Related Claims	30	1	1	0
Total	**120**	**24**	**6**	**18**

Temporary 100 Percent Evaluations

VARO staff incorrectly processed 16 (53 percent) of 30 temporary 100 percent disability evaluations we reviewed. Veterans Benefits Administration (VBA) policy requires a temporary 100 percent evaluation for a service-connected disability needing surgery or specific treatment. At the end of a mandated period of convalescence or cessation of treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's 100 percent disability benefits.

Based on analysis of available medical evidence, 3 of the 16 processing inaccuracies identified involved overpayments totaling $137,262, which

affected veterans' benefits. The most significant overpayment occurred when a Rating Veterans Service Representative (RVSR) correctly proposed reducing a veteran's prostate cancer evaluation from 100 percent to 20 percent disabling. However, at the time of our inspection, VSC staff had not taken the final action to reduce the veteran's benefits. As a result, VA overpaid the veteran $76,413 over a period of 2 years and 6 months.

The remaining 13 inaccuracies had the potential to affect veterans' benefits. In 12 cases, VSC staff did not establish the reminder notifications needed to alert VARO staff that VA reexaminations needed to be scheduled. For the remaining case, a rating decision required a reexamination in November 2011. At the time of our inspection, no reminder notification was in place to ensure the reexamination would actually occur.

We could not determine if these 13 temporary 100 percent disability evaluations would have continued because the veterans' claims folders did not contain evidence of the medical examinations needed to reevaluate each case. An average of 1 year and 9 months elapsed from the time staff should have scheduled these medical examinations until the date of our inspection (the date staff ultimately took corrective actions to obtain the necessary medical evidence). The delays ranged from 61 days to 5 years and 7 months.

For temporary 100 percent disability evaluations, including confirmed and continued evaluations where rating decisions do not change a veteran's payment amount, VSC staff must input a suspense diary (or reminder notification) in VBA's electronic system. A 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.

The most frequent processing inaccuracies noted in 6 (38 percent) of the 16 cases reviewed occurred when VARO staff did not properly establish suspense diaries for future VA examinations. VSC management stated, and we verified, the VARO did not have a procedure in place requiring VSC staff to review implementation of confirmed and continued rating decisions calling for routine future examinations.

PTSD Claims

VARO staff correctly processed all 30 PTSD claims reviewed. Therefore, we made no recommendations for improvement in this area.

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: (1) physical, (2) cognitive, and (3) behavioral. VBA policy requires staff to evaluate these residual disabilities.

VARO staff incorrectly processed 7 (23 percent) of 30 TBI claims. Following is a summary of the two inaccuracies affecting veterans' benefits.

- An RVSR granted service-connection for headaches related to TBI; however, no medical evidence provided a distinct diagnosis of headaches. Additionally, the RVSR failed to grant special monthly compensation for loss of use of a creative organ. As a net result, VA overpaid the veteran $2,753 over a period of 8 months.
- An RVSR failed to assign a separate 30 percent evaluation for migraine headaches related to a TBI despite medical evidence showing a link between the two. As a result, VA underpaid the veteran $1,864 over a period of 8 months.

Following are details on the remaining five TBI inaccuracies that had the potential to affect veterans' benefits.

- In two cases, RVSRs incorrectly evaluated residual TBI-related disabilities using inadequate medical examinations. Neither VARO staff nor we can ascertain all of the residual disabilities related to TBI without an adequate or complete medical examination.
- In one case, an RVSR failed to assign a separate evaluation for migraine headaches diagnosed in a VA examination. This change did not affect the veteran's current 80 percent evaluation, but may affect future evaluations for additional benefits.
- In one case, an RVSR granted service connection for headaches related to TBI. However, there was no medical evidence providing a distinct diagnosis of headaches. This change did not affect the veteran's current 90 percent disability evaluation, but may affect future evaluations for additional benefits.
- In one case, an RVSR improperly proposed reducing a veteran's evaluation of TBI residuals from 40 percent to 20 percent disabling despite a VA examination clearly showing symptoms to support the disability evaluation of 40 percent. If not for our review, VSC staff would have incorrectly reduced the veteran's benefits.

Generally, errors associated with TBI claims processing occurred because VARO staff interpreted VBA policy incorrectly and used VA medical examinations that were inadequate for decision-making purposes. VARO management stated these errors were due to inexperienced RVSRs, a lack of understanding of TBI evaluation procedures, and pressure to process claims more quickly. VARO staff indicated the process of returning inadequate medical examinations was time consuming; therefore, RVSRs made decisions based on the information initially provided instead of returning

inadequate medical examination reports for clarification. As a result, veterans did not always receive correct benefits payments.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 1 (3 percent) of 30 herbicide exposure-related claims. We did not consider the frequency of errors significant; however, this error affected a veteran's benefits. An RVSR failed to grant entitlement to special monthly compensation benefits, which resulted in an underpayment of $960 over a period of 10 months.

Recommendations

1. *We recommend the Portland VA Regional Office Director review the remaining universe of 183 temporary 100 percent determinations under the regional office's jurisdiction to determine if reevaluations are required and take appropriate action.*
2. *We recommend the Portland VA Regional Office Director implement controls to ensure staff establish suspense diaries for temporary 100 percent disability reevaluations.*
3. *We recommend the Portland VA Regional Office Director ensure Rating Veterans Service Representatives receive training on how to properly evaluate disabilities related to traumatic brain injuries and identify inadequate medical examinations.*
4. *We recommend the Portland VA Regional Office Director develop and implement a plan to ensure medical examinations determined to be inadequate for rating purposes are returned to the appropriate VA medical facility for correction.*

Management Comments

The VARO Director concurred with our recommendations for improving disability claims processing accuracy. The Director indicated VSC staff will complete and review 183 additional temporary 100 percent evaluations by February 28, 2011, and will request medical examinations when appropriate. On November 8, 2010, the Director implemented a Standard Operating Procedure that requires VARO staff to review all confirmed and continued temporary 100 percent evaluations to ensure staff properly record future medical examination dates in the electronic record.

Further, VARO staff received training during January 2011 on all facets of rating traumatic brain injury claims, to include the procedures to return an inadequate medical examination to the VA Medical Center for correction. In addition, management will cite unreturned inadequate examinations as a substantial error and included as part of the review of the individual's end-of-year performance appraisal.

OIG Response

Management's actions are responsive to the recommendations.

2. Data Integrity

We analyzed claims folders to determine if the VARO is following VBA policy to establish effective dates and dates of claim in the electronic record and timely record Notices of Disagreement (NOD) in the Veterans Appeals Control and Locator System (VACOLS). Because the VARO correctly followed VBA policy when establishing effective dates and dates of claim and generally followed VBA policy for NODs, we made no recommendations for improvement.

Effective Dates

Generally, an effective date indicates when entitlement to a specific benefit arose. VARO staff followed VBA policy and correctly established effective dates for all 120-disability claims we reviewed.

Dates of Claim

VBA commonly uses the date of claim to indicate when a document arrives at a VA facility. VBA relies on accurate dates of claim to establish and track key performance measures, including the average days to complete a claim. VARO staff established the correct dates of claim in the electronic record for all 30 claims reviewed.

Notices of Disagreement

An NOD is a written communication from a claimant expressing dissatisfaction or disagreement with a benefits decision and a desire to contest the decision. An NOD is the first step in the appeals process. VACOLS is a computer application that allows VARO staff to control and track veterans' appeals and assist with managing the pending appeals workload. VBA policy states staff must create a VACOLS record within 7 days of receiving an NOD. Accurate and timely recording of NODs is required to ensure appeals move through the appellate process expeditiously. The VARO exceeded VBA's 7-day standard for 2 (7 percent) of 30 NODs we reviewed.

3. Management Controls

Systematic Technical Accuracy Review

We assessed management controls to determine if 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 multi-faceted quality assurance program to ensure that veterans and other beneficiaries receive accurate and consistent compensation and pension benefits. VBA policy requires that the VARO take corrective action on errors that STAR identifies. VARO staff adhered to the policy by taking corrective actions to address all 12 errors VBA's STAR program identified. In addition, VARO management appropriately used information regarding these errors to develop a plan to train staff. As such, we made no recommendations for improvement in this area.

Systematic Analyses of Operations

We assessed operations to determine if VARO management had controls in place to ensure complete and timely submission of Systematic Analyses of Operations (SAOs). We determined management should improve oversight of SAO completion. An SAO is a formal analysis of a VSC 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 an annual SAO schedule designating the staff required to complete the SAOs by specific dates.

Finding 2 Improved Oversight Is Needed To Ensure SAOs Are Timely and Complete

The Veterans Service Center Manager is responsible for ongoing analysis of VSC operations, including completing 11 annual SAOs. Our analysis revealed 4 (36 percent) of the 11 SAOs were either incomplete or not completed within the designated time frame as listed on the annual SAO schedule. This occurred because VARO management did not provide adequate oversight to ensure VSC staff completed SAOs in accordance with VBA policy. As a result, the VARO may not have adequately identified existing or potential problems in need of correction to improve VSC operations.

At the time of our inspection, 3 of the 11 SAOs were not completed and 1 did not assess all of the required areas. For the three not completed, the dates ranged from 73 to 101 days late. For one SAO, Quality of Control Actions, staff did not complete a portion related to the analysis of mail processing.

The Veterans Service Center Manager attributed the inadequate oversight of the SAO process to his decision to place higher priority on new VSC performance measures implemented by VBA in July 2010. Consequently, staff did not complete the three remaining FY 2010 SAOs. The Veterans Service Center Manager identified other factors contributing to delays in completing SAOs. For example, VBA and VARO leadership temporarily reassigned several managers normally responsible for SAOs to other duties within the VARO and at other offices. Further, VSC supervisors received the additional task of overseeing the hiring of 50 additional employees during the last quarter of FY 2010.

In one instance, VARO staff did not complete the SAO for Appeals processing. A VBA report revealed that the Portland VSC did not achieve the VBA's FY 2010 Appeals goal of timely processing and reducing the inventory of pending NODs. If VARO managers had ensured proper

completion of the required SAO on Appeals, they may have identified potential weaknesses affecting performance.

Recommendation

5. *We recommend the Portland VA Regional Office Director develop and implement a plan to ensure staff complete Systematic Analyses of Operations timely and address all required elements.*

Management Comments

The VARO Director concurred with our recommendation and informed us the Veterans Service Center Manager implemented a stringent deadline for completing SAOs timely. Further, timely and complete SAOs are now part of an individual's performance standards.

OIG Response

Management's actions are responsive to the recommendations.

4. Workload Management

We assessed controls over mailroom operations to ensure VARO staff timely and accurately processed incoming mail. VBA uses various plans and applications to control workload. VBA policy indicates the most important part of workload management is oversight to ensure the staff efficiently uses the plans and systems available. It also states that effective mail management is crucial to the success and control of workflow within the VSC.

Mail Room Operations

VBA policy states staff will open, date stamp, and route all mail to the appropriate locations within four to six hours of receipt at the VARO. The Portland VARO has assigned responsibility for mailroom activities, including processing of incoming mail, to the VSC. We made no recommendations in this area because VSC mailroom staff timely and accurately processed, date stamped, and delivered VSC mail to the Triage Team daily as required.

Triage Mail Processing Procedures

Further, we assessed the VSC's Triage Team mail processing procedures to ensure staff reviewed, controlled, and processed all claims-related mail in accordance with VBA policy. We determined that the VARO's search mail procedures need strengthening.

VBA defines search mail as active claims-related mail waiting to be associated with a veteran's claims folder. The VARO staff is required to use the Control of Veterans Records System (COVERS) to electronically track veterans' claims folders and control search mail. COVERS provides notification of search mail awaiting pick-up when staff access an electronic record for a specific claims folder.

Finding 3 Triage Team Search Mail Procedures Need Strengthening

The Triage Team did not always control and process search mail according to VBA policy. For 4 (13 percent) of 30 pieces of search mail reviewed, staff did not properly use COVERS to ensure accurate processing and control of search mail. This occurred because the VSC's local guidance was unclear and conflicted with current VBA policy. As a result, claimants may not have received prompt and accurate decisions on benefits.

Staff delayed processing by not properly controlling two of the four pieces of search mail in COVERS. The most significant delay occurred when VARO staff did not immediately associate search mail with a claims folder. Further, on September 10, 2010, the VARO received mail regarding a pending claim. Staff did not put the evidence on search in COVERS and were not aware of the mail until we identified it during our inspection. As a result, staff unnecessarily delayed processing this claim by 54 days. For the remaining two errors, staff did not retrieve search mail even though COVERS generated electronic reminders of pending search mail available for pickup.

The VSC had two local written policies that provided conflicting guidance to staff. For example, a local VSC Circular governing the use of COVERS directed employees to make every effort to associate search mail with the claim folder upon initial electronic notification in COVERS. In contrast, the local Standard Operating Procedures allowed staff to delay association of search mail until processing or transferring the file, regardless of when COVERS generated an electronic notification.

Recommendations

6. *We recommend the Portland VA Regional Office Director amend the Workload Management Plan and local mail policies to ensure consistent procedures for processing search mail.*

Management Comments

The VARO Director concurred with our recommendation and amended the local circular on the use of COVERs to ensure consistency with the VSC's Standard Operating Procedures regarding search mail.

OIG Response

Management's actions are responsive to the recommendations.

Appendix A VARO Profile and Scope of Inspection

Organization

The Portland VARO is responsible for delivering non-medical VA benefits and services to veterans and their families in Oregon. The VARO fulfills these responsibilities by administering compensation and pension benefits, vocational rehabilitation and employment assistance, and outreach activities.

Resources

As of October 2010, the Portland VARO had a staffing level of 231 full-time employees. Of these, the VSC had 184 employees (80 percent) assigned.

Workload

As of October 2010, the VARO reported 7,540 pending compensation claims. The average time to complete these claims during FY 2010 was 159.5 days—9.5 days longer than the national target of 150 days. As reported by STAR, accuracy of compensation rating-related issues was 86.2 percent, or 3.8 percent below the 90 percent target set by VBA.

Scope

We reviewed selected management controls, claims processing, and administrative activities to evaluate compliance with VBA policies regarding delivery of benefits and non-medical services to veterans and other beneficiaries. We interviewed managers and employees and reviewed veterans' claims folders.

Our review included 90 (10 percent) of 899 disability claims related to PTSD, TBI, and herbicide exposure that the VARO completed during July to September 2010. For temporary 100 percent disability evaluations, we selected 30 (14 percent) of 213 existing claims from VBA's Corporate Database. We provided the VARO with the 183 claims remaining from the universe of 213 to assist in implementing our first report recommendation. These claims represented instances in which staff granted temporary 100 percent disability determinations for at least 18 months.

We reviewed 12 errors identified by VBA's STAR program during the period of April to June 2010. VBA measures the accuracy of compensation and pension claims processing through its STAR Program. STAR's measurements include a review of work associated with claims requiring rating decisions. The STAR staff reviews 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 STAR as we review specific types of disability claims such as PTSD, TBI, and herbicide exposure that require rating decisions. In addition, we review rating decisions and awards processing involving temporary 100 percent disability claims.

We selected for review dates of claim and NODs pending at the VARO during the time of our inspection. We completed our review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspections.*

Appendix B VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: February 2, 2011

From: Director, Portland VA Regional Office (348/00)

Subj: Inspection of the VA Regional Office Portland, OR

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

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

2. Please feel free to contact me at (503) 412-4530 with any questions or concerns regarding our reply.

(original signed by:)

Chris Marshall
Director

Attachment

OIG Recommendations:

Recommendation 1: *We recommend the Portland VA Regional Office Director review the remaining universe of 183 temporary 100 percent determinations under the regional office's jurisdiction to determine if reevaluations are required and take appropriate action.*

Regional Office Response: We concur with the recommendation. We began the review in mid-January and expect to have all available cases reviewed by February 28, 2011. If cases require re-examinations, we will submit those requests by February 28, 2011.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 2: *We recommend the Portland VA Regional Office Director implement controls to ensure staff establish suspense diaries for temporary 100 percent disability reevaluations.*

Regional Office Response: We concur with the recommendation. On November 8, 2010, the Regional Office implemented Standard Operating Procedures (SOP) to ensure Veterans Service Representatives assigned to the Post-Determination Team review all confirmed and continued rating decisions for a future examination date. A copy of the SOP was provided to the OIG team during their inspection.

The Regional Office previously discovered, and communicated to the OIG team during their inspection, that if the Regional Office were to confirm and continue a temporary 100% evaluation using the PCLR command, all routine future examination dates in the system prior to the command would disappear, resulting in no mechanism to conduct a follow-up review. The new SOP requires a review of the system following the PCLR command, and if the future examination date has indeed disappeared, the SOP identifies instructions for correcting the system and appropriate future follow-up.

On January 8, 2011, all Veterans Service Representatives responsible for completing Post-Determination functions were instructed to establish future examination dates in accordance with M21-MR III.iv.3.C.17. Authorizers were instructed that mandatory reviews at the time awards are authorized are required to ensure future examination dates are correctly coded.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 3: *We recommend the Portland VA Regional Office Director ensure Rating Veterans Service Representatives receive training on how to properly evaluate disabilities related to traumatic brain injuries and identify inadequate medical examinations.*

Regional Office Response: We concur with the recommendation. On January 6 and January 11, 2011, the Regional Office conducted training for its Rating Veterans Service Representatives and Decision Review Officers. All facets of rating claims for traumatic brain injuries and its residuals were covered during this training.

On January 13 and 18, 2011, training was conducted to the same audience on the proper review of examinations, including those for traumatic brain injuries and its residuals. One of the emphasized topics of this training was when to return an examination to the VA Medical Center as inadequate.

On January 20, 2011, training was conducted to the same audience on writing examination requests for traumatic brain injury claims. This reinforced the training provided earlier and should serve to elevate the quality of completed examinations returned to the Regional Office by the VA Medical Center.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 4: *We recommend the Portland VA Regional Office Director develop and implement a plan to ensure medical examinations determined to be inadequate for rating purposes are returned to the appropriate VA medical facility for correction.*

Regional Office Response: We concur with the recommendation. The above training provided to the Regional Office's Rating Veterans Service Representatives and Decision Review Officers is intended to improve their ability to identify and return inadequate VA examinations. On January 1, 2011, the Regional Office tasked its Service Center's Quality Team to conduct thorough reviews of examination reports as part of the quality review process. If an individual fails to return an inadequate examination to the VA Medical Center, it will be cited as a substantial error and included as part of the review of the individual's end-of-year performance appraisal.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 5: *We recommend the Portland VA Regional Office Director develop and implement a plan to ensure staff complete Systematic Analyses of Operations (SAO) timely and address all required elements.*

Regional Office Response: We concur with the recommendation. On December 1, 2010, the Veterans Service Center Manager implemented a more stringent deadline schedule for completing the FY 2011 SAOs. The schedule requires SAOs to be completed with sufficient lead-time for review prior to submission to the Director. A follow-up schedule was additionally established to remind individuals about SAOs coming due. Moreover, a mechanism for recording late reports against an individual's performance standards has been established.

The Veterans Benefits Administration recommends closure of this recommendation.

Recommendation 6: *We recommend the Portland VA Regional Office Director amend the Workload Management Plan and local mail policies to ensure consistent procedures for processing search mail.*

Regional Office Response: We concur with the recommendation. The Regional Office is amending its station-wide circular regarding COVERS. These new changes will make the

COVERS circular consistent with the Veterans Service Center's SOP for search mail. The new circular will be completed by February 28, 2011.

The Veterans Benefits Administration recommends closure of this recommendation.

Appendix C Inspection Summary

9 Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Claims Processing			
1. 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. Post-Traumatic Stress Disorder	**Determine whether VARO staff properly processed claims for PTSD.** (38 CFR 3.304(f))	X	
3. Traumatic Brain Injury	**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
4. Herbicide Exposure-Related Claims	**Determine whether VARO staff properly processed claims for service connection for disabilities related to herbicide exposure (Agent Orange).** (38 CFR 3.309) (Fast Letter 02-33) (M21-1MR Part IV, Subpart ii, Chapter 2, Section C.10)	X	
Data Integrity			
5. Date of Claim	**Determine if VARO staff properly recorded dates of claim in the electronic records.** (M21-1MR, Part III, Subpart ii, Chapter 1, Section C)	X	
6. Notice of Disagreement	**Determine if VARO staff properly entered NODs into VACOLS.** (M21-1MR Part I, Chapter 5)	X	
Management Controls			
7. Systematic Analysis of Operations	**Determine if VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)		X
8. Systematic Technical Accuracy Review	**Determine if VARO staff properly corrected STAR errors in accordance with VBA policy**. (M21-4, Chapter 3, Subchapter II, 3.03)	X	
Workload Management			
9. Mail Handling Procedures	**Determine if 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

Appendix D OIG Contact and Staff Acknowledgments

OIG Contact	Brent Arronte
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Appendix E Report Distribution

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