VA OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDITS & EVALUATIONS

# *Inspection of VA Regional Office Baltimore, MD*

**November 19, 2009**
**09-01993-29**

# Office of Inspector General

# Benefits Inspection Program

The Benefits Inspection Program is part of the Office of Inspector General's (OIG's) efforts to ensure our Nation's veterans receive timely and accurate benefits and services. The Benefits Inspection Division contributes to the improvement and management of benefits processing activities and veteran services by conducting onsite inspections at 57 VA Regional Offices. The purpose of these independent inspections is to provide recurring oversight of VA Regional Offices by focusing on disability compensation claims processing and performance of Veteran Service Center operations. The objectives of the inspections are to:

- Evaluate how well VA Regional Offices (VAROs) and Veterans Service Centers (VSCs) are accomplishing their missions of providing veterans with convenient access to high quality benefits services.
- Determine if management controls ensure compliance with VA regulations and policies; assist management in achieving program goals; and minimize risk of fraud, waste, and other abuses.
- Identify and report systemic trends in VSC operations.

In addition to this standard coverage, inspections may examine issues or allegations referred by VA employees, members of Congress, or others.

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# Report Highlights: Inspection of VA Regional Office, Baltimore, MD

## Why We Did This Review

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

## What We Found

The Baltimore VARO Management team faces multiple challenges in providing benefits and services to veterans, including numerous personnel issues and a loss of experienced staff needed to support the Disability Evaluation System joint project with the Department of Defense. The VARO did not meet the requirements for 14 of the 15 operational areas reviewed and senior management acknowledged its workload was not under adequate control.

The VARO Management team needs to provide additional oversight and training for personnel responsible for processing claims identified as diabetes, post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and Haas cases. The team also needs to improve controls over:

- Tracking veterans' claims in Control of Veterans Records System (COVERS) and establishing the correct dates of claims.
- Correcting errors identified by VBA's Systematic Technical Accuracy Reviews (STAR).
- Completing Systematic Analysis of Operations (SAO) accurately and timely, and safeguarding veterans' personally identifiable information (PII), and VARO date stamps.
- Handling claims-related mail and responding to congressional and other electronic inquiries.
- Processing fiduciary activities.

## What We Recommend

We recommended that the Under Secretary for Benefits assign a remedial action team to train and help support VSC operations, the VARO improve oversight of the quality assurance process for the operational areas found lacking, and the VARO provide refresher training on the proper procedures for establishing a correct date of claim and processing fiduciary claims.

## Agency Comments

The Under Secretary for Benefits concurred with our recommendation and assigned VBA's Eastern Area Director to conduct bi-monthly performance briefings with VSC management. Also, the Compensation and Pension Service will conduct a follow-up site visit in June 2010.

The Director of the Baltimore VA Regional Office concurred with all of the recommendations. The management team's planned actions are responsive, and we will follow-up as required on all actions.

*(original signed by:)*

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# Results of Inspection

During the week of June 15–June 19, 2009, the OIG conducted an inspection of the Baltimore VA Regional Office (VARO). The inspection focused on 5 protocol areas examining 15 operational activities. The VARO did not meet the requirements for 14 of the 15 operational activities inspected. (See Appendix A for a description of the protocol areas and operational activities reviewed.) We also made observations pertaining to issues that are not specifically required by VBA policy or procedure but still affect benefits delivery or VARO performance and provide opportunity to improve operations.

# Management Challenges at the Baltimore VARO

The Baltimore VARO management team faces multiple challenges within the Veterans Service Center (VSC). These challenges include improving oversight of operational activities, gaining control over its workload, and providing training to staff as identified within this report. In fact, we found mail processing throughout the VSC was unorganized and lacked consistent workflow. Also, senior VSC management revealed the most experienced Rating Veterans Service Representatives (RVSRs) were recently transferred to the Disability Evaluation System[1] (DES) project leaving RVSRs with minimal experience available to process claims.

During our inspection, the responsibilities of the senior VSC manager were temporarily performed by a manager from another VARO. The Baltimore VARO Director informed us that the previous senior VSC manager was reassigned in March of 2009 as a result of several issues, including not providing the Director with reliable information regarding performance of that division. In addition to this management vacancy, two other supervisors were reassigned within the VSC to perform other duties while the inspection team was onsite.

Based on the results of an internal review, VARO management and VBA's Compensation & Pension Service had identified 102 items requiring additional management attention. VARO management were developing corrective action plans to address these items. The Eastern Area Director is requiring the VARO Director to provide status reports twice a month regarding the progress of corrective actions taken to improve VSC performance.

# VARO Activities Needing Management Attention

## *Disability Claims Processing*

We reviewed 76 (20 percent) of 374 completed diabetes (to include disabilities related to herbicide exposure), post-traumatic stress disorder (PTSD), traumatic brain injury (TBI) and

[1]DES is a joint VA-Department of Defense program designed to conduct one examination, make one disability evaluation, and reduce the overall time it takes a service member to progress from referral to a Medical Evaluation Board to receipt of VA benefits.

Haas[2] claims for which the VARO made a decision regarding these issues. The claims decisions were made during the time period of January 1, 2009, through March 31, 2009. Management agreed to take appropriate action to correct all errors identified during the inspection.

Our analysis revealed errors in 29 (38 percent) of the 76 claims, but the Baltimore VARO actually processed only 21 (28 percent) of those errors. The eight remaining errors were attributable to processes completed at other VAROs. Regardless of where claims decisions are processed, these errors can negatively impact the delivery of benefits to veterans, and two of the claims processed at other VARO's contained errors that affected veterans' benefits. The following table reflects the errors by claim type and errors impacting veterans' benefits:

**Table 1. Disability Claims Processing Errors**

| Claim Type | Claims Reviewed | Claims with Errors | Errors with Impact on Veteran Benefits | Claims Processed at Another VARO Containing Impact Errors |
|---|---|---|---|---|
| **Diabetes** | 29 | 16 | 9 | 1 |
| **PTSD** | 27 | 9 | 6 | 1 |
| **TBI** | 12 | 2 | 1 | 0 |
| **Haas** | 8 | 2 | 1 | 0 |
| **Total** | **76** | **29** | **17** | **2** |

### VSC Personnel Need to Improve the Accuracy of Disability Determinations

Diabetes and Disabilities Related to Herbicide Exposure. Nine of the 16 processing errors identified for diabetes cases impacted veterans' benefits. For example:

- A veteran was entitled to an earlier effective date for service connection of diabetes related to herbicide exposure. The veteran was underpaid $2,735 and management initiated actions to correct this issue.
- A veteran was not accurately evaluated for prostate cancer related to herbicide exposure. The veteran underwent a surgical procedure to remove the prostate. VBA policy allows for a temporary 100 percent evaluation for this procedure; however the veterans benefits were not adjusted. The veteran was underpaid $1,663.
- A veteran was over evaluated for diabetes related to herbicide exposure. The VARO incorrectly assigned a 40 percent evaluation; however, the medical evidence of record in the claim file revealed the correct evaluation should have been 20 percent because the veteran was not prescribed insulin. The veteran was overpaid $1,220.
- A veteran was not properly granted entitlement to special monthly compensation for a secondary condition supported by available medical evidence that showed the secondary condition was related to the veteran's service-connected diabetes. The veteran was underpaid $576.

[2]A Haas claim is a claim affected by a U.S. Court of Appeals for Veterans Claims decision in *Haas v. Nicholson*. Haas claims involve veterans who served in waters off Vietnam and did not set foot in Vietnam, potentially precluding those veterans from entitlement to presumption of exposure to herbicide agents, including Agent Orange. VA had put a stay of adjudication on these claims; however, VA lifted the stay in January 2009.

- A veteran was incorrectly granted service connection for a secondary disability related to diabetes. The VA claims examiner stated the secondary disability was related to vascular disease and not diabetes. Therefore, service connection was not warranted. The veteran was overpaid $1,127.
- Three veterans were incorrectly granted an earlier effective date for payment of their benefits because the claims examiners did not use the date of the examination as the effective date for payment. The veterans did not specifically claim certain disabilities, but the VA medical examination supported a diagnosis of new disabilities associated with diabetes. VSC staff should have paid the veteran from the date the VA medical examination identified these new disabilities. The three veterans were overpaid $1,684, $338, and $182.
- A veteran's benefits were delayed for 2 months because VARO staff incorrectly requested a VA medical examination when the medical evidence already available in the claims folder contained adequate information for a proper disability evaluation. The examination request delayed the veteran's receipt of benefits for 2 months.

The remaining seven errors were procedural in nature. For example, errors were related to VSC staff improperly separating out a non-compensable complication of diabetes.

PTSD Claims. Six of the nine processing errors identified for PTSD cases impacted veterans' benefits. For example:

- Three veterans were incorrectly granted service connection for PTSD by VARO staff. The available VA medical examinations did not support the required nexus between the veterans' in-service stressful event and the current diagnosis of PTSD.
- A veteran was denied service connection for PTSD by VARO staff because the RVSR determined the veteran's claimed in-service stressful event could not be verified. However, the veteran did provide the location, date, and a description of the claimed stressful event—adequate information for the VARO to search military records for evidence of the event.
- A veteran was over evaluated for PTSD. VARO staff incorrectly evaluated PTSD as 70 percent disabling. The VA medical examination revealed the veteran's symptoms equated to an evaluation of a 30 percent disability. The veteran was overpaid $7,892.
- A veteran was assigned an incorrect effective date by VARO staff when granting service connection for PTSD and entitlement to special monthly compensation related to PTSD. Service connection for PTSD was granted effective November 27, 2007, the date the veteran submitted a claim for benefits other than PTSD. The correct effective date should have been September 25, 2008—the date the veteran amended the claim to include PTSD. The veteran was overpaid $3,020.

The remaining three errors were related to VARO staff assigning the incorrect effective date for the grant of benefits. However, these errors did not affect the monthly payments.

TBI Claims. One of the two processing errors identified for TBI cases impacted the veterans' benefits. The non-impact error occurred because the claims examiner failed to provide the veteran with the reason service connection for TBI was granted. The error impacting the veteran's benefits occurred when the veteran claimed service connection for chronic headaches

and a brain injury. VA medical treatment reports revealed the veteran was treated for these conditions, yet the VARO staff incorrectly denied service connection indicating the conditions did not exist and no medical examination was requested. VBA policy requires a medical examination in this instance.

Haas Claims. One of the two processing errors identified for Haas cases impacted a veteran's benefits. The non-impact error occurred because VSC staff unnecessarily requested evidence that was not needed to process the claim, thus causing an unnecessary delay. The error impacting a veteran's benefits occurred when the veteran's service-connected prostate cancer was under evaluated. VARO staff incorrectly assigned a 20 percent evaluation for prostate seed implants. The veteran should have been assigned a 100 percent evaluation for 18 months. The veteran was underpaid $25,377. This claim was processed after VA lifted the stay on Haas claims.

During the time when the processing errors for diabetes, PTSD, TBI, and Haas claims occurred, internal monthly quality assurance reviews were not being performed. In fact, we were told by a senior VSC official that internal quality reviews were not conducted from October 1, 2008, through April 1, 2009, because supervisors were not held accountable to perform such reviews. In addition, the current staff of RVSRs lacked sufficient experience to accurately process these complicated claims because the more experienced RVSRs were assigned to the DES project. A senior VSC official indicated the majority of the remaining RVSR staff had less than 1 year of claims-related processing experience. Ultimately, the lack of internal quality assurance reviews coupled with inexperienced RVSRs led to a high occurrence of inaccurate disability decisions.

***Recommendation 1.*** *We recommend the Baltimore VA Regional Office Director develop and implement a mechanism to improve oversight of the quality assurance process to ensure the correct procedures for processing diabetes, post-traumatic stress disorder, traumatic brain injury, and Haas decisions are followed.*

**Management Comment**

The VARO Director concurred with the recommendation and selected a Quality Decision Review Officer to conduct local quality reviews to ensure that the procedures for following these claims are followed. The Baltimore VARO also provided training for PTSD on July 8, 2009, and TBI on July 11, 2009.

**OIG Response**

Management comments and actions are responsive to the recommendation.

## *Data Integrity*

We assessed the data in VBA's Control of Veterans Records System (COVERS) to determine if the VARO was accurately tracking the location of veterans' claims folders. The primary function of COVERS is tracking the location of claims folders within and between VAROs. COVERS also supports VARO claims folder activities such as requesting folders and identifying mail to associate with folders.

In addition, we reviewed claims folders to determine if the VARO is following VBA policy regarding the correct establishment of the date of claim in the electronic record. The date of claim is generally used to indicate when a document arrives at a specific VA facility. VBA relies on an accurate date of claim to establish and track a key performance measure that determines the average days to complete a claim.

**Controls Over Tracking Claims Folders in the VSC Need Strengthening**

Our review of 30 disability claims to determine if VSC staff consistently tracked veterans' claims folders revealed 7 (23 percent) of the 30 claims did not have a correct current location in COVERS. Current VARO policy states that all files will be updated in COVERS every Tuesday and Thursday. Specifically:

- The elapsed time to update the 7 claims in COVERS averaged 16 days.
- One folder had not been tracked in COVERS for 70 days.

A senior official informed the inspection team that first-line supervisors were supposed to conduct "spot checks" to ensure employees properly used COVERS. However, VSC management did not provide adequate oversight of these supervisors. Ultimately, the VARO management team lacks reasonable assurance regarding the location of its claims folders within the VSC.

***Recommendation 2.*** *We recommend the Baltimore VA Regional Office Director develop and implement a mechanism to ensure Veterans Service Center staff follow established policies regarding the use of Control of Veterans Records Systems.*

**Management Comment**

The VARO Director concurred with the recommendation. On July 13, 2009, the Director revised the Workload Management Plan to specifically address the use of COVERS and assigned responsibility to VSC supervisors for performing regular compliance checks.

**OIG Response**

Management comments and actions are responsive to the recommendation based upon the revisions to the Workload Management Plan. (*Note: We have not included the Workload Management Plan that was attached to management's comments in this report due to the voluminous nature of the document.*)

**Correct Date of Claim Inconsistently Established**

Our analysis of 30 disability claims to determine if VSC staff established the correct date of claim in the electronic record revealed 9 (30 percent) of the 30 claims contained the incorrect date of claim. Seven of the incorrect dates of claim erroneously improved VARO performance. For example, evidence in the veteran's claims folder revealed a date stamp showing the document was received on December 23, 2008. However, a review of the electronic system

showed an employee incorrectly input the date of claim as April 15, 2009, a difference of 113 days.

A senior VSC official stated these errors occurred because employees assigned to the Triage team were not properly trained and several of the tenured employees were not correctly following VBA policy to properly establish the correct date of claim.

Given the significance of this error rate detected during this spot check, the VARO lacks reasonable assurance that beneficiaries are being paid on the correct effective date. In addition, incorrect dates recorded in the electronic record affect data integrity and misrepresent VARO performance. Data integrity issues make it difficult for senior leadership to accurately determine station performance.

***Recommendation 3.*** *We recommend the Baltimore VA Regional Office Director develop and implement a training plan to ensure Veterans Service Center staff follow policies regarding the proper procedures to establish the correct date of claim.*

**Management Comment**

The VARO Director concurred with the recommendation. Training on the proper procedures to establish the correct date of claim was conducted on July 7, 2009, for all Veterans Service Representatives. Training will also be provided on a semi-annual basis.

**OIG Response**

Management comments and actions are responsive to the recommendation.

## *Management Controls*

We assessed management controls to determine if VARO management adhered to VBA policy regarding employee rotations within the Claims Process Improvement (CPI) business model, corrected errors identified by the STAR staff, completed Systematic Analysis of Operations (SAOs), and ensured VARO date stamp accountability. The Baltimore VARO was not required to rotate employees under the CPI model because, according to senior VSC management, the station workload was not under control.

**Strengthening Oversight Will Help Ensure VSC Staff Correct Errors Identified by STAR**

Our review of 22 files that contained errors identified by VBA's STAR program between October 1, 2008, and December 31, 2008, showed that 20 (91 percent) of the 22 STAR errors were not corrected in accordance with VBA policy.[3] The policy requires VARO staff to take and report on corrective actions and retain error documentation for training. Further, we noted that VSC staff erroneously informed the STAR program staff that 8 (40 percent) of the 20 errors had been corrected. Three of those eight errors impacted the veterans' benefits. For example:

[3]VBA Manual M21-4, *Manpower Control and Utilization in Adjudication, Quality Assurance,* updated June 29, 2007.

- STAR instructed the VARO to schedule a VA medical examination and prepare a new decision based on the examination results. Although the examination was completed, no formal decision was processed.
- STAR instructed the VARO to reopen a claim for PTSD as the veteran claimed service connection for PTSD secondary to sexual trauma. Although the RVSR indicated a need for additional evidence, 6 months passed without any action taken.
- STAR instructed the VARO to consider the veteran as being unemployable based on the severity of disabilities. VARO staff should have requested information from the veteran to determine if his service-connected disabilities would prevent gainful employment. The VARO granted the additional benefit without requesting the evidence to justify actual entitlement to the benefit.

The remaining errors were procedural in nature. For example, VSC staff failed to remove the STAR error notification documents from the veterans' claims folders as required by VBA policy.

Interviews with VARO management revealed these errors occurred due to a lack of oversight to ensure all corrective actions had been completed. As a result, the VARO Director lacked assurance employees were adhering to VBA's quality assurance program.

***Recommendation 4.*** *We recommend the Baltimore VA Regional Office Director develop and implement a plan to ensure timely corrective action is taken to address errors identified by the Veterans Benefits Administration Systematic Technical Accuracy Review staff.*

**Management Comment**

The VARO Director concurred with the recommendation. The Director has revised the Workload Management Plan and assigned a Quality Decision Review Officer to provide oversight of all cases returned from STAR. Rating Veterans Service Representatives will have two workdays to complete the action needed for compliance with STAR errors. Once the errors have been corrected, the case will be routed back to the Quality Decision Review Officer.

**OIG Response**

Management comments and actions are responsive to the recommendation.

**Inadequate Oversight for Timely and Accurate Completion of SAOs**

An SAO is a formal analysis of an organizational element or operational function of the VSC. SAOs provide an organized means for reviewing operations to identify existing or potential problems and propose corrective actions. VBA policy requires SAOs to be performed annually and must cover all aspects of claims processing, including quality, timeliness, and related factors.

We reviewed all 12 mandatory SAOs for FY 2009. Our analysis revealed the 12 SAOs were not properly completed or timely in accordance with the VARO's annual SAO schedule. In

addition, the annual schedule was not completed prior to September 1, 2008, as required by VBA policy.[4]

The following table reflects the required 12 SAOs and highlights the minimum requirements not addressed by the Baltimore VARO:

**Table 2. Required SAOs**

| SAO | Incomplete | Untimely | Minimum Requirement Not Addressed |
|---|---|---|---|
| **1. Claims Processing Timeliness** | X | | Average cycle time/pending inventory. |
| **2. Quality of Compensation, Pension, and Ancillary Actions** | X | | Monthly internal quality reviews. Clear and unmistakable error. |
| **3. Quality of Development Activity** | X | | Burial claims. |
| **4. Quality of Files Activity** | X | | COVERS compliance. |
| **5. Examination, Hospital Summaries, and Hospital Adjustments** | X | | Timeliness of hospital summaries. |
| **6. Appeals** | X | | Decision Review Officer activities. |
| **7. Fiduciary** | X | | FBS management. |
| **8. Quality of Control Actions** | | X | All areas addressed. |
| **9. Division Management** | | X | All areas addressed. |
| **10. Direct Services and Outreach** | | X | All areas addressed. |
| **11. Quality of Correspondence** | X | X | IRIS responses and rating decisions. |
| **12. Internal Controls** | X | X | Control of veterans' records |

During this inspection we identified several operational activities where the VSC did not follow VBA policy. If VSC management had properly completed the required SAOs, some of the existing or potential problems might have been identified. For example, monthly quality assurance reviews should have been addressed in the *Quality of Compensation, Pension, and Ancillary Actions* SAO. We determined management did not complete this requirement. Our inspection revealed quality assurance reviews had not been completed for a 7-month period. Thus, the VARO management team did not detect the high error rate for those specific claims.

Senior VSC management stated a plan to complete the required SAOs was not communicated to any member of the VSC, nor was authority to review this work assigned to any member of the VSC. The VARO Assistant Director indicated the SAOs had been assigned to first-line supervisors who did not adequately understand the correct process needed to thoroughly complete this type of work. The VARO Assistant Director also indicated training and guidance had been provided to all of the first-line supervisors regarding the proper method to complete SAOs. The effectiveness of this training and guidance could not be assessed during this inspection as the work we reviewed was complete prior to these events.

As a result of the lack of oversight to ensure the SAOs were completed in an accurate and timely manner, the VARO Director lacked assurance that existing or potential problems within the VSC were being identified and corrective actions were being developed.

[4]VBA Manual M21-4, *Manpower Control and Utilization in Adjudication, Systematic Analyses of Operations,* updated April 1, 2009.

***Recommendation 5.*** *We recommend the Baltimore VA Regional Office Director develop and implement a mechanism to ensure Veterans Service Center managers perform complete, accurate and timely Systematic Analysis of Operations and take appropriate corrective action to fix problems identified.*

**Management Comment**

The VARO Director concurred with the recommendation. The Veterans Service Center Manager developed an SAO completion schedule for the management team on June 30, 2009. In addition, those SAOs identified as incomplete by the OIG site visit team were completed on September 11, 2009.

**OIG Response**

Management comments and actions are responsive to the recommendation.

**VBA Policy for Accounting and Safeguarding VARO Date Stamps Not Followed**

VBA uses date stamps to indicate when information is received in any VA facility. The date a document is received at a VA facility is important because it may be relied upon to determine disability payment effective dates. On March 19, 2009, VBA issued policy providing guidance for the accountability and safeguarding of date stamps.[5] The policy states "manual (hand-held) date stamps will be replaced with electronic date stamps in all VBA regional offices." In addition, "an Electronic Date Stamp Inventory Control Log will be created listing the date stamp manufacturer, model, serial number, and assigned location."

A VARO management official indicated the office uses nine electronic date stamps, which we confirmed during our review. The manager indicated all manual stamps were collected and secured once the VARO transitioned to electronic date stamps. However, while conducting desk audits in the VARO, the inspection team found two unaccounted for manual date stamps in one employee's desk. The inspection team could not determine if the employee had been using those stamps. VSC management collected and secured the date stamps found. As a result of this oversight, the VARO Director did not have assurance that all date stamps were properly accounted for and safeguarded.

***Recommendation 6.*** *We recommend the Baltimore VA Regional Office Director perform a one-time inspection of all employee work stations to ensure accountability of all manual date stamps.*

**Management Comment**

The VARO Director concurred with the recommendation. In June 2009, an inspection was conducted and all date stamps have been accounted for and are secured when not in use.

[5]VBA Letter 20-09-10, *VBA Policy to Maintain Accountability of Official Date Stamps*, dated March 19, 2009.

**OIG Response**

Management comments and actions are responsive to the recommendation.

## *Information Security*

The OIG inspection team conducted random inspections of employee work stations to determine if staff properly followed VBA policies to safeguard veterans' PII. We also analyzed mail handling procedures in the VARO mailroom and the VSC Triage team to ensure the accurate and timely processing of mail.

Our review of the Baltimore VARO revealed PII at 15 employees' desks, and VARO staff were not always following policy regarding the destruction of documents. Our analysis additionally revealed mail handling procedures within the mailroom were accurate and timely as mail was processed to each division daily. However, the routing of mail from the Triage team to other sections of the VSC was not effective.

**Veterans' Personally Identifiable Information Not Always Safeguarded**

During our review, we performed 28 (20 percent) unannounced desk audits of the 137 employees' workstations located in the VSC. We found PII in unauthorized locations at 15 (54 percent) of the 28 employee's work stations. The PII was primarily related to formal decision documentation and unredacted training materials. VBA policy requires all claims-related documents be stored in specified areas of the employee's workstation. Also, the policy requires supervisors to perform inspections of the workstations to ensure adherence with policy. Following are examples of the PII found:

- 158 Casualty Assistance Reports containing the names of deceased veterans and their Social Security Numbers (SSNs) were found in one employee's desk drawer. This documentation included information spanning the period FY 2007 through FY 2008 and should have been maintained in veterans' claims files.
- 66 Debt Waiver Decisions containing the beneficiary's name, SSN, and personal debt information were located in one employee's desk. The oldest waiver decision was dated June 3, 1996, and along with the others, it should have been in the veterans' claims folders.
- One employee had an unmarked cardboard box under the desk containing notification letters to veterans and computer-generated printouts containing veterans' names and SSNs. VBA policy requires documents containing PII be placed on the desk, on the top of a work site credenza, or on other surfaces clearly visible to supervisory inspection.

VBA policy also requires employees to place documents identified for destruction into "red" envelopes or boxes. This information is to be collected, reviewed, and signed by the Division Records Management Officers (DRMOs) weekly to ensure proper safeguarding of documents scheduled for destruction. Once the review is completed, the DRMOs send the documents to the VARO's Records Management Officer (RMO) for destruction.

We reviewed the contents of five employees' "red" boxes to ensure all documents were properly annotated for destruction as required by VBA policy. Documents scheduled for destruction by three of the five employees did not have the required DRMO signatures. In addition, one employee had documents waiting for destruction since March 24, 2009. The RMO took corrective action to ensure all documents were properly annotated for destruction when notified of this issue. One senior VSC manager indicated the DRMOs did not clearly understand their responsibilities.

VSC staff did not follow VBA policy to protect information containing PII. Some DRMOs did not clearly understand their responsibilities, and we found documents scheduled for destruction that did not contain the appropriate review. Although we found no evidence of improper destruction of documents, the VARO Director lacked assurance that veterans' PII were properly safeguarded.

***Recommendation 7.*** *We recommend the Baltimore VA Regional Office Director provide training to Division Records Management Officers to ensure proper safeguarding of veterans' personally identifiable information.*

**Management Comment**

The VARO Director concurred with the recommendation and the Records Management Officer provided additional training to the Division Records Management Officers and VSC coaches on July 23, 2009.

**OIG Response**

Management comments and actions are responsive to the recommendation.

**Mail Management Procedures Within Triage Team Needs Strengthening**

The Claims Process Improvement Model (CPI) Implementation Plan indicates the Triage team is responsible for reviewing, controlling, processing, or routing of all incoming mail. It is the critical "first step" for the effective coordination of other specialized teams within the VSC. VBA policy states "effective mail management is crucial to the success and control of workflow within the division."

We observed mail procedures at the Baltimore VARO and concluded mail processing was unorganized with no consistent workflow procedures to ensure all incoming mail was processed accurately or timely. Mail involving new claims was not placed under control within seven days, other mail was not controlled in designated areas, and a large volume of mail was waiting to be associated with claims folders. Following are examples of the processing errors found:

- Nine (30 percent) of 30 pieces of incoming mail were not recorded in the electronic system within VBA's standard of 7 days. One piece of mail was a new claim for benefits received on April 22, 2009, but was not recorded until June 11, 2009, a difference of 50 days.

- Approximately 400 pieces of mail related to active claims were waiting to be associated with the beneficiaries' claims folders (also known as search mail). The oldest piece of mail was dated November 28, 2008.
- The United States Post Office returned 2,140 pieces of mail as undeliverable. All were VA's notification of a one-time payment to veterans under the American Recovery and Re-investment Act. The VARO as waiting for guidance from VBA Central Office on how to proceed with the returned mail.
- Approximately 3,000 pieces of mail not related to pending claims (also known as drop file mail) were waiting to be associated with the beneficiaries' claims folders.

The Triage team also has a "mail processing room" where additional mail sorting occurs. Our observation of this process revealed a box containing several pieces of mail. We identified one original claim for benefits located at this distribution point. This claim was received March 13, 2009, at the Washington VARO and was subsequently transferred to VARO Baltimore on March 23, 2009. The claim was submitted by a Global War on Terrorism (GWOT) veteran and no action had been taken as of the date of our inspection to process this claim (approximately 84 days) in spite of VBA's goal to complete GWOT claims in 100 days.

As a result of the aforementioned mail handling concerns, we expanded our review to include an analysis of 30 claims requiring initial development for evidence. We determined 15 (50 percent) of the claims reviewed contained no initial actions to develop for evidence. As of June 15, 2009, those 15 claims had been waiting an average of 62 days with 1 claim pending 76 days. VBA policy requires initial development to occur within 7 days.

Senior VSC management stated the reason for not properly controlling and processing mail in Triage is a result of too many mail distribution points. Regardless, not having an effective method to properly control and route mail causes a delay in processing claims expeditiously. Furthermore, our results support that the VARO Director lacks assurance that claims-related mail processed within the VSC is properly recorded into electronic systems and that initial development for evidence is occurring as required by VBA policy.

***Recommendation 8.*** *We recommend the Baltimore VA Regional Office Director develop and implement a mechanism to ensure all mail is properly controlled and processed within the Triage team.*

**Management Comment**

The VARO Director concurred with the recommendation. On July 13, 2009, the Director revised the Workload Management Plan to include standard operating procedures for mail processing within the Triage team.

**OIG Response**

Management comments and actions are responsive to the recommendation. We also recommended the Baltimore VA Regional Office Director research the status of the associated one-time payments for the mail received as undeliverable to ensure payments under the

American Recovery and Reinvestment Act are made as intended. VBA's Compensation and Pension Service issued instructions on September 10, 2009, stating those returned Economic Recovery payment informational letters may be shredded if no additional address was provided by the U.S. Postal Service. As a result of that guidance we withdrew our recommendation.

## *Public Contact*

The Public Contact team provides benefit information to veterans, beneficiaries, and congressional staff through several methods including e-mail and written correspondence. We reviewed VA's Inquiry Routing and Information System (IRIS) and congressional inquiries for accuracy and timeliness of the responses. In addition, we inspected Fiduciary Program activities to determine if VA designated fiduciaries are properly managing VA and personal funds of veterans who are unable to do so.

**Inconsistent Accuracy and Timeliness in Responding to Veterans' Electronic Inquiries**

We selected 29 completed IRIS messages to determine if the VSC provided accurate and timely responses to veteran inquires. IRIS is VA's internet-based public message management system and is one method used by VSCs to communicate with veterans. Each written correspondence provided to the veteran contains an email address (https://iris.va.gov) that provides a method for veterans to send electronic inquiries to VA.

Our analysis revealed 11 (38 percent) of the 29 inquiries did not adhere to VBA policy that requires accurate and complete responses be provided within 5 business days. Of the 11 errors, 10 exceeded the 5 day standard and 1 contained the following incomplete response.

The incomplete response involved a veteran who informed the VARO of the intention to submit an application for benefits. The veteran asked if medical/dental records could be submitted with the application. VARO staff informed the veteran to submit the application along with the medical records.

The response should have informed the veteran that this inquiry would be considered an informal claim and a formal claim must be received within one year in order for VA to pay benefits based on the date of this inquiry.

The supervisor for IRIS informed the inspection team that additional assistance was required in providing a response to some of the complex inquiries. Senior VSC management attributed these errors to lack of experience on the part of the first-line supervisor to effectively oversee these processes.

***Recommendation 9.*** *We recommend the Baltimore VA Regional Office Director develop and implement a plan to improve oversight of the Inquiry Routing and Information System to ensure accurate and timely responses are provided to veterans.*

**Management Comment**

The VARO Director concurred with the recommendation and assigned an additional two staffing resources. Responses are reviewed bi-weekly by the Public Contact Team Coach to ensure accurate responses.

**OIG Response**

Management comments and actions are responsive to the recommendation.

**Controls Over Processing Congressional Inquiries Need Strengthening**

Review of all second quarter FY 2009 congressional inquiries revealed 11 (61 percent) of the 18 exceeded VBA's policy for completing these inquires within 5 days. On average, it took 14 days to complete these inquiries although 1 response took 54 days to complete.

For eight of the inquiries, we could not verify the accuracy of the response as the original inquiries could not be located. The remaining responses were both accurate and timely. We found that VARO staff did not place completed congressional inquiries into the veterans' claims folder. VBA policy states that any correspondence requiring a reply must be filed in the veterans' record. Failure to place the congressional inquiry in the folder precludes the veteran from obtaining a complete copy of documents in the folder under the Freedom of Information Act. Also, VSC staff would be unaware if members of Congress had requested they be advised of subsequent developments in a specific case.

The supervisor in charge of processing this type of work stated no one was assigned primary responsibility for completing congressional inquiries, and a shortage of staff contributed to the untimely responses.

***Recommendation 10.*** *We recommend the Baltimore VA Regional Office Director develop and implement a mechanism to improve oversight to ensure the accurate and timely processing of congressional inquiries.*

**Management Comment**

The VARO Director concurred with the recommendation and assigned two additional resources on September 17, 2009. These responses are reviewed by the Assistant Veterans Service Center manager and the Director's Management Analyst to ensure that they are accurate and timely.

**OIG Response**

Management comments and actions are responsive to the recommendation.

**Controls Over Fiduciary Activities Need Strengthening**

Analysis of 29 Principal Guardianship Folders (PGF) that were completed during April 1, 2009, through May 31, 2009, found processing errors in the following type of fiduciary activities:

- Initial Appointments (IA)—IA field examinations involve the qualification and appointment of a fiduciary to receive VA benefits on behalf of an incompetent beneficiary.
- Fiduciary Beneficiary (FB)—Follow-up field examinations involve the reassessment of incompetent veterans' needs and determine whether funds have been properly used and protected. The first FB must be completed within one year of the initial appointment. Subsequent FB's are determined by the field examiner's assessment of the current status of the beneficiary and the fiduciary
- Accountings—Fiduciary's written report of the management of a beneficiary's income and estate.

Table 3 below reflects the number of errors by claim type and errors that impacted veterans' benefits:

**Table 3. Fiduciary Processing Errors**

| Claim Type | Number of Cases Reviewed | Number of Cases In Error | Number of Cases With Errors Impacting Veterans' Benefits |
|---|---|---|---|
| **Initial Appointment (IA)** | 11 | 11 | 9 |
| **Fiduciary Beneficiary (FB)** | 17 | 17 | 9 |
| **Accountings** | 1 | 1 | 1 |
| **Total** | **29** | **29** | **19** |

Following is a description of errors that may impact the safeguarding of incompetent veterans' benefits:

**Initial Appointments (IA):**

- 6 IAs—Fiduciary's credit history was not thoroughly assessed. There was no evidence of the credit report in the PGF or discussion in the field exam. In five of these IA's, the agreement with the fiduciary regarding how the veteran's funds were to be spent was also incomplete.
- 2 IAs—Fiduciary staff did not take appropriate action to ensure the beneficiaries were afforded the maximum benefit under Medicaid provisions.
- 1 IA—Agreement with the fiduciary regarding how the veteran's funds were to be spent was incomplete. For example, there was no guidance to the fiduciary describing how monthly income was to be handled after all monthly expenses were paid at the time of the initial appointment.

**Fiduciary Beneficiary (FB):**

- 5 FBs—Agreement with the fiduciary regarding how the veterans' funds were to be spent was incomplete or missing. For example, there was no guidance to the fiduciary describing how monthly income was to be handled after all monthly expenses were paid during the follow up field examinations.
- 2 FBs—Field examiner did not personally visit the veteran during the follow-up field exam. VBA policy requires the field examiner to visit adult beneficiaries in person to determine their well-being. Also, in one of the FB's, the agreement with the fiduciary regarding how the veteran's funds were to be spent was incomplete. After paying approved monthly expenses, the veteran had excess income available and the fiduciary was not provided instructions regarding the disposition of this income.
- 1 FB—Fiduciary unit prematurely removed the work product in the Fiduciary Beneficiary System (FBS) that is designed to track completed work. Thus, the fiduciary unit was unable to provide assurance all claim-related actions were completed.
- 1 FB—Fiduciary submitted the required accounting of the beneficiaries funds, however, the fiduciary unit failed to verify whether the accounting was accurate.

**Accountings:**

- 1 Accounting—Fiduciary staff correctly disapproved a fiduciary accounting; however as of June 19, 2009, 59 days had lapsed, and no follow-up was taken to ensure an accurate accounting was resubmitted.

A senior VSC official reviewed and concurred with all fiduciary errors. This official informed the inspection team that the identified errors occurred because of a lack of adequate training.

***Recommendation 11.*** *We recommend the Baltimore VA Regional Office Director provide training to Legal Instrument Examiners and Field Examiners emphasizing the correct procedures for processing Initial Appointments, Fiduciary Beneficiaries, and Accountings.*

**Management Comment**

The VARO Director concurred with the recommendation. VBA's Compensation and Pension Service provided two subject matter experts who provided onsite training to the newly assigned Coach, Assistant Coach, and team members during the period July 13–July 21, 2009.

**OIG Response**

Management comments and actions are responsive to the recommendation.

## *VBA Action Needed*

Correcting the conditions noted in this report will be very difficult given the current resource limitations that challenge the Baltimore VARO to process claims for benefits and effectively manage operations. These challenges stem largely from a lack of experienced personnel to

process claims and provide the needed management oversight. Managers at the Baltimore VARO told us that several experienced RVSR's were recently reassigned to the DES pilot project, leaving the office with less experienced personnel to process the normal workload of claims. We believe the conditions reported here warrant additional management assistance between VBA and the Baltimore VARO in order to improve the stations ability to process and manage its workload.

***Recommendation 12.*** *We recommend the Under Secretary for Benefits assign a remedial action team to the Baltimore VA Regional Office to train and help support managers and inexperienced staff to manage operations and process claims in accordance with VBA policies, procedures, and expectations.*

***VBA Response****:* Concur in part. VBA concurs with OIG's assessment that the Baltimore RO needs to train and support managers and inexperienced staff to better manage operations and claims processing. To meet this challenge, the VBA recently selected an experienced manager to oversee operations in the Veterans Service Center (VSC). The VSC Manager made changes in the management team and implemented a workload management plan to ensure the proper operational controls are followed and appropriate oversight is conducted. Baltimore RO managers received technical and managerial training to develop their leadership skills and will receive additional training as needed.

Currently, the Eastern Area Director is conducting bi-monthly performance briefings with the VSC managers to assess station progress. In lieu of a remedial action team, the Compensation and Pension Service will conduct a follow-up site visit the week of June 21, 2010. This visit will evaluate the RO's compliance with VBA policy and procedures as well as their progress on correcting the action items identified during the May 2009 site visit.

**OIG Response**

Management comments and actions are responsive to address the intent of the recommendation even though VBA proposed a different method to train and support inexperienced staff. We will follow-up to determine the effectiveness of the planned actions.

## *Observations*

Observations pertain to issues that may affect benefits delivery or diminish VARO performance but are not specifically compliance-related. Several observations were noted during the inspection:

- Workload Credit for Unfinished Claims. VARO Baltimore took credit for completing fiduciary claims for 25 (93 percent) of the 29 files reviewed prior to completing all work associated with those claims. VBA policy states work should be completed as soon as practical. This policy does not clearly outline a specific standard as to when the work credit should be taken or if all work associated with a fiduciary claim must be completed prior to taking credit for completing the claim. For example, VARO Baltimore took work credit for one claim, however, work continued on that claim for an additional 72 days.

The work on the claims we reviewed was ultimately completed. We are providing this observation as a practice to be aware of because once the work credit has been taken, there is no control to ensure the completion of additional internal actions associated with fiduciary estate administration. Furthermore, senior VBA leaders do not receive accurate information relating to the actual time required to complete fiduciary claims.

- Brokered Claims. VBA has established a brokering plan that allows VAROs to send (broker) claims designated as ready-to-rate to other VAROs for processing. VAROs that broker claims typically do not have the rating capacity to complete such work in a specific time. VARO Baltimore brokered 1,883 rating-related claims to other VAROs for processing from October 2008 through June 2009. During our review of claims processing, 12 of the claims were brokered to other VAROs and 8 contained processing errors, with 2 errors impacting veterans' benefits.

  In March 2009,[6] we reported that the Systematic Technical Accuracy Review (STAR) quality assurance process does not provide a complete assessment of compensation claim rating accuracy, partially because it excluded brokered claims from STAR reviews. The accuracy of brokered claims was 18 percent lower than the national accuracy VBA reported for the 12-month period ending February 2008 in *VA's FY 2008 Performance and Accountability* report. VBA agreed to establish procedures for reviewing quality of brokered claims in response to the audit recommendations. However, until those procedures are in place, brokered claims do not receive the scrutiny of a quality assurance review.

[6] *Audit of Veterans Benefits Administration Compensation Rating Accuracy and Consistency Reviews* (Report No. 08-02073-96, March 12, 2009.)

## VARO Profile

**Organization.** The Baltimore VARO is responsible for delivering non-medical VA benefits and services to veterans and their families in Maryland. This is accomplished through the administration of Compensation and Pension Benefits (C&P), Vocational Rehabilitation and Employment (VR&E) Assistance, Burial Benefits, and Outreach activities. The Baltimore VARO has four out-based offices; however, the inspection team did not perform any work at those facilities.

**Resources.** As of April 2009, the Baltimore VARO had a staffing level of 167 Full-Time Employees (FTE). Of the 167 FTE, 134 (80 percent) were assigned to the VSC.

**Workload.** As of April 2009, the VARO had 7,029 pending C&P claims that took an average of 210.6 days to complete, which is 40.6 days longer than the national target of 170 days. Accuracy for C&P rating–related issues, as reported by VBA's STAR, was 76.8 percent, below the national standard of 90 percent. Accuracy for C&P authorization-related issues, as reported by VBA's STAR was 97.2 percent, above the national standard of 95 percent. As reported by VBA's STAR, accuracy for fiduciary-related activities was 77.3 percent, below the national standard of 90 percent.

## Scope of the Inspection

**Scope.** We reviewed selected management controls, benefits claims processing, and administrative activities to evaluate compliance with VBA policies as they related to benefits delivery and non-medical services provided to veterans. As part of our inspection, we interviewed managers and employees, reviewed veterans' claims folders, and inspected work areas.

The disability claims processing review covered VARO operations from January 1, 2009, through March 31, 2009. STAR reviews covered cases reported as errors by STAR staff from October 1, 2008, through December 31, 2008. IRIS and congressional inquiries reviews covered inquiries completed at the VARO from October 1, 2008, through March 31, 2009. Fiduciary activities review covered cases completed from April 1, 2009, through May 31, 2009. The reviews were done in accordance with the President's Council for Integrity and Efficiency's *Quality Standards for Inspections.*

The inspection covered 15 operational activities in the 5 protocol areas of claims processing, data integrity, management controls, information security, and public contact, as detailed in Table 4 that follows:

**Table 4. Protocols with Activities Reviewed**

| **Inspection Protocols** | | | | |
|---|---|---|---|---|
| **Claims Processing** | **Data Integrity** | **Management Controls** | **Information Security** | **Public Contact** |
| **15 Activities Reviewed** | | | | |
| Haas Claims | Date of Claim | Systematic Analysis of Operations (SAO) | Mail Handling Procedures | Inquiry Routing and Information System (IRIS) |
| Post-traumatic Stress Disorder (PTSD) Claims | Control of Veterans Record System (COVERS) | Systematic Technical Accuracy Review (STAR) Compliance | Destruction of Documents | Congressional Inquiries |
| Traumatic Brain Injury (TBI) Claims | | Employee Rotation in Claims Process Improvement (CPI) Model | | Fiduciary |
| Diabetes Claims | | Date Stamp Accountability | | |

**Appendix B**

**Department of Veterans Affairs** **MEMORANDUM**

**Date:** **September 18, 2009**

**From:** **Director, VA Regional Office Baltimore**

**Subject:** **Inspection of VARO Baltimore, MD**

**To:** **Assistant Inspector General for Audit (52)**

1. Attached are the VARO Baltimore's comments on the OIG Draft Report: Inspection of VARO Baltimore. The VARO appreciates the in-depth review conducted by the OIG team that followed the April 2009 Compensation and Pension Service site visit. VARO management met with both teams during their visits, noted all items requiring corrective measures, and then began taking immediate, aggressive action to address these issues. These actions included hiring an experienced Veterans Service Center Manager (VSCM), promoting several employees to the positions of Assistant Coach and Coach to ensure an adequate management team, and realigning the Veterans Service Center to adequately distribute the resources to address workload needs. In addition, a new Coach and Assistant Coach were selected to manage the Fiduciary activity. The Compensation and Pension Service provided the Fiduciary activity with 56 hours of formal on-site training to improve service to our incompetent claimants and to safeguard these cases from misuse.

2. To ensure that workload management, monitoring and internal controls were addressed, the VARO developed a comprehensive Workload Management Plan (WMP) that was approved by VBA's Eastern Area Office and disseminated to all employees on July 13, 2009 (copy attached).

3. Questions may be referred to [VARO point of contact with telephone Questions may be referred to me or Ms. Bonnie Miranda, Assistant Director, at 410-230-4510. Thank you.

*(original signed by:)*
Dr. George Wolohojian

Attachment

**Appendix B**

**RESPONSES TO OIG RECOMMENDATIONS**
**DRAFT REPORT**
**INSPECTION OF VARO BALTIMORE**
**SEPTEMBER 2009**

The VARO Baltimore's responses are provided below to the OIG's draft report recommendations.

***Recommendation 1.*** *We recommend the Baltimore VA Regional Office Director develop and implement a mechanism to improve oversight of the quality assurance process to ensure the correct procedures for processing diabetes, post-traumatic stress disorder, traumatic brain injury, and Haas decisions are followed.*

***VARO Response****:* The VARO Baltimore concurs with this recommendation. Following the OIG site visit, the station selected a Quality Review Decision Review Officer (DRO) to conduct local quality reviews to ensure that the procedures for processing these claims are followed. If errors are found, the Quality DRO returns the claim to the Rating Veterans Service Representative (RVSR) and per the Workload Management Plan (WMP), the RVSR has two business days to correct the error. Please see Attachment 11 of the WMP. Regarding correct procedures for processing diabetes, post-traumatic stress disorder, traumatic brain injury, and Haas decision, the VARO has reviewed the cases and provided refresher training on the following dates: PTSD on July 8, 2009 and TBI on July 11, 2009. Haas training was originally provided on March 11, 2009, as well as Diabetes (Haas vs. Peake) on March 20, 2009. Coaches continued to emphasize and reinforce the training materials for these two topics in subsequent team meetings.

***Recommendation 2.*** *We recommend the Baltimore VA Regional Office Director develop and implement a mechanism to ensure Veterans Service Center staff follow established policies regarding the use of Control of Veterans Records Systems.*

***VARO Response***: The Baltimore VARO concurs with this recommendation. The WMP addresses this issue and the Service Center coaches are responsible for regular compliance checks on the use of COVERS. The Director's office has confirmed that coaches are conducting these reviews. Please see Attachment 4 of the WMP.

***Recommendation 3.*** *We recommend the Baltimore VA Regional Office Director develop and implement a training plan to ensure Veterans Service Center staff follow policies regarding the proper procedures to establish the correct date of claim.*

***VARO Response****:* The VARO concurs with this recommendation. Training on the proper procedures to establish the correct date of claim was conducted on July 7, 2009 for all VSRs on station. Training is being provided to all new personnel who came on board in August and September 2009. Training will continue to be provided to incumbent personnel on a semi-annual basis. This training is coordinated by the Training Manager and input into the Learning Management System (LMS). Please see Attachment 9 of the WMP.

***Recommendation 4.*** *We recommend the Baltimore VA Regional Office Director develop and implement a plan to ensure timely corrective action is taken to address errors identified by the Veterans Benefits Administration Systematic Technical Accuracy Review staff.*

***VARO Response****:* The VARO concurs with this recommendation. A Quality DRO was assigned this task in June 2009. The Quality Review DRO reviews all cases returned from STAR to determine if there was an error called. If STAR has called a rating error, the Quality Review DRO will review the error sheet and the file for concurrence. If the Quality Review DRO agrees with the error, the spreadsheet will be annotated. The DRO will complete a transmittal sheet to the RVSR's Coach and to the RVSR for correction. Then the case will be routed back to the Quality Review DRO, who will update the spreadsheet that the error has been corrected. The RVSR will have two workdays to complete the action needed for compliance with the STAR error. Please see Attachment 10 of the WMP.

***Recommendation 5.*** *We recommend the Baltimore VA Regional Office Director develop and implement a mechanism to ensure Veterans Service Center managers perform complete, accurate and timely Systematic Analysis of Operations and take appropriate corrective action to fix problems identified.*

***VARO Response***: The VARO concurs with this recommendation. The Acting VSCM developed a SAO completion schedule for the management team and disseminated it on June 30, 2009. In addition, those SAOs identified as incomplete by the OIG site visit team were completed on September 11, 2009. Please see attached SAO calendar spreadsheet.

***Recommendation 6.*** *We recommend the Baltimore VA Regional Office Director perform a one-time inspection of all employee work stations to ensure accountability of all manual date stamps.*

***VARO Response:*** The VARO concurs with this recommendation. In June 2009, an inspection was conducted and all date stamps have been accounted for and are secured when not in use.

***Recommendation 7.*** *We recommend the Baltimore VA Regional Office Director provide training to Division Records Management Officers to ensure proper safeguarding of veterans' Personally Identifiable Information.*

***VARO Response***: The VARO concurs with this recommendation. The Records Management Officer provided additional training to the Division Records Management Officers and VSC coaches on July 23, 2009.

***Recommendation 8.*** *We recommend the Baltimore VA Regional Office Director develop and implement a mechanism to ensure all mail is properly controlled and processed within the Triage team.*

***VARO Response****:* The VARO concurs with this recommendation. VARO Standard Operating Procedures for mail management are contained in Attachment 3 of the WMP and are being followed.

***Recommendation 9.*** *We recommend the Baltimore VA Regional Office Director develop and implement a plan to improve oversight of the Inquiry Routing and Information System to ensure accurate and timely responses are provided to veterans.*

***VARO Response***: The VARO concurs with this recommendation. An additional two staffing resources have been added to this activity and responses are being reviewed bi-weekly by the Public Contact Team Coach to ensure accurate responses.

***Recommendation 10.*** *We recommend the Baltimore VA Regional Office Director develop and implement a mechanism to improve oversight to ensure the accurate and timely processing of congressional inquiries.*

***VARO Response:*** The VARO concurs with this recommendation. The VARO assigned two additional resources on September 17, 2009. The responses are reviewed by the Assistant Veterans Service Center Manager and the Director's Management Analyst to insure that they are accurate and timely.

***Recommendation 11.*** *We recommend the Baltimore VA Regional Office Director provide training to Legal Instrument Examiners and Field Examiners emphasizing the correct procedures for processing Initial Appointments, Fiduciary Beneficiaries, and Accountings.*

***VARO Response:*** The VARO concurs with this recommendation. The Compensation and Pension Service provided two subject matter experts who provided on-site training to the newly assigned Coach, Assistant Coach, and team members during July 13-21, 2009.

**Department of Veterans Affairs**

# Memorandum

**Date:** Nov – 4 2009

**From:** Under Secretary for Benefits (20)

**Subj:** OIG Status Update – Inspection of the VA Regional Office, Baltimore, Maryland

**To:** Assistant Inspector General for Audit (52)

1. Attached are VBA's comments to OIG's status update request on OIG Report: Inspection of Baltimore VA Regional Office.

2. Questions may be referred to Mr. Steve Furrer, Executive Management Officer, at (202) 461-9340.

*(original signed by:)*

P.W. Dunne

Attachment

**Appendix B**

Attachment

## Inspection of the Baltimore VA Regional Office

**Recommendation 12.** We recommend the Under Secretary for Benefits assign a Remedial action team to the Baltimore VA Regional Office (RO) to train and help support managers and inexperienced staff to manage operations and process claims in accordance with VBA policies, procedures, and expectations.

**VBA Response:** Concur in part. VBA concurs with OIG's assessment that the Baltimore RO needs to train and support managers and inexperienced staff to better manage operations and claims processing. To meet this challenge, the VBA recently selected an experienced manager to oversee operations in the Veterans Service Center (VSC). The VSC Manager made changes in the management team and implemented a workload management plan to ensure that proper operational controls are followed and appropriate oversight is conducted. Baltimore RO managers received technical and managerial training to develop their leadership skills and will receive additional training as needed.

Currently, the Eastern Area Director is conducting bi-monthly performance briefings with the VSC managers to assess station progress. In lieu of a remedial action team, the Compensation and Pension Service will conduct a follow-up site visit the week of June 21, 2010. This visit will evaluate the RO's compliance with VBA policy and procedures as well as their progress on correcting the action items identified during the May 2009 site visit.

**Appendix C**

# Inspection Summary

| 15 Activities Inspected | Criteria | Reasonable Assurance of Compliance | |
|---|---|---|---|
| | | Yes | No |
| **Claims Processing** | | | |
| 1. Haas | Determine if Haas claims were properly identified and if service connection was correctly granted or denied. (38 CFR 3.313) (M21-1MR Part IV, subpart ii, Chapter 1, Section H) ( Fast Letter 09-07 and 06-26) | | X |
| 2. Post-traumatic Stress Disorder (PTSD) | Determine whether service connection for PTSD was correctly granted or denied. (M21-1MR Part III, Subpart iv, Chapter 4, Section H.28.B) | | X |
| 3. Traumatic Brain Injury (TBI) | Determine whether service connection for TBI and all residual disabilities was correctly granted or denied. (Fast Letters 08-34 and 36, Training Letter 09-01) | | X |
| 4. Diabetes | Determine whether service connection for diabetes related to herbicide exposure (Agent Orange) and all related disabilities were correctly granted or denied. (38 CFR 4.119) (Fast letter 02-33) (M21-1MR Part III, Subpart iv, Chapter 4, Section F) | | X |
| **Data Integrity** | | | |
| 5. Date of Claim | Determine if VAROS accurately recorded the correct date of claim in electronic records. (M21-1MR, Part III, Subpart ii, Chapter 1, Section C) | | X |
| 6. Control Of Veterans Records System (COVERS) | Determine if VAROs complied with the use of COVERS to track claims folders. | | X |
| **Management Controls** | | | |
| 7. Systematic Analysis of Operations (SAO) | Determine if VAROs performed a formal analysis of their operations through completion of SAOs. (M21-4, Chapter 5) | | X |
| 8. Systematic Technical Accuracy Review (STAR) | Determine if VAROs timely and accurately corrected STAR errors. (M21-4, 3.03) | | X |
| 9. Date Stamp Accountability | Determine if VAROs accounted for and safeguarded date stamps. (M23-1 1.12, b. (1), (2), (3), (4)) (VBA Letter 20-09-10 Revised dated March 19, 2009) | | X |
| 10. Claims Process Improvement (CPI) | Determine if VAROs complied with VBA's CPI Implementation Plan 08-05. | X | |
| **Information Security** | | | |
| 11. Mail Handling Procedures | Determine if VAROs complied with mail handling procedures. (M23-1) (M21-4, Chapter 4) (M21-1MR Part III, Subpart ii, Chapter 1 & 4) | | X |
| 12. Destruction of Documents | Determine if VAROs complied with VBA policy regarding proper destruction of documents. (VBA Letter 20-08-63 revised March 13, 2009 and attachments) | | X |
| **Public Contact** | | | |
| 13. Inquiry Routing and Information System (IRIS) | Determine if IRIS responses were accurately and timely processed. (M21-1MR, Part II, Chapter 6). | | X |
| 14. Congressional Inquiries | Determine if congressional inquiries were timely in processing. (OFO Letter 201-02-64) (Fast Letter 01-40) (VA Directive 8100) | | X |
| 15. Fiduciary | Determine if the Fiduciary unit was properly overseeing the welfare of beneficiaries to include protecting their assets, assuring their benefit entitlement rights, and selecting and monitoring the best suited fiduciary. (38 CFR 13.100-13.111) ( M21-1MR, Part XI) (FBS Users Guide) (LIE Program Guide) | | X |

**Appendix D**

# OIG Contacts and Staff Acknowledgments

| | |
|---|---|
| OIG Contact | Brent Arronte (727) 395-2436 |
| Acknowledgments | Karen Gooden<br>Kristine Abramo<br>Joseph Byrd<br>Robert Campbell<br>Kerri Leggiero-Yglesias |

**Appendix E**

# Report Distribution

## VA Distribution

Office of the Secretary
Veterans Benefits Administration
Assistant Secretaries
Office of General Counsel
VBA Eastern Area Director
VARO Baltimore Director

## Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Benjamin L. Cardin, Barbara A. Mikulski
U.S. House of Representatives: Roscoe Bartlett, Elijah Cummings, Donna F. Edwards, Steny H. Hoyer, Frank M. Kratovil, Jr., Dutch Ruppersberger, John P. Sarbanes, Chris Van Hollen

This report will be available in the near future on the OIG's website at http://www.va.gov/oig/publications/reports-list.asp. This report will remain on the OIG website for at least 2 fiscal years after it is issued.