VA OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDITS & EVALUATIONS

Inspection of VA Regional Office Roanoke, VA

January 14, 2010
09-01995-63

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 VA's Regional Offices (VAROs). The purpose of these independent inspections is to provide recurring oversight of VAROs by focusing on disability compensation claims processing and the performance of Veterans Service Center (VSC) operations. The inspection objectives are to:

- Evaluate how well 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.

To report suspected wrongdoing in VA programs and operations:

Telephone: 1 800 488-8244 between 8:30AM and 4:00PM Eastern Time,

Monday through Friday, excluding Federal holidays

E-mail: vaoighotline@va.gov

Report Highlights: Inspection of VA Regional Office, Roanoke, VA

Why We Did This Review

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

What We Found

The Roanoke VARO management team faces challenges in providing benefits and services to veterans. The VARO did not meet requirements for 6 of 14 operational areas reviewed.

The Roanoke VARO challenges include addressing oversight of operational activities, acquiring space to support adequate storage of large filing cabinets containing veterans' claims folders, associating claimant evidence with the veterans' claims folders, and providing training to staff.

The VARO management team also needs to provide additional oversight and training of personnel responsible for processing claims identified as traumatic brain injury (TBI), herbicide exposure, and Haas cases. Additionally, management needs to improve controls over the safeguarding of veterans' personally identifiable information (PII), handling of claims-related mail, and responding to electronic inquiries.

What We Recommend

We recommend that the VARO coordinate with VA contracted medical staff to ensure medical examiners use the most current examination worksheet when evaluating disabilities associated with TBI. In addition, we recommend the VARO improve oversight to ensure proper safeguards of veterans' PII, improve mail-handling procedures in the Triage team, and improve oversight of electronic responses to veterans. Further, the VARO needs to acquire adequate space to store and safeguard veterans' claims folder.

Agency Comments

The Director of the Roanoke VARO concurred with all recommendations. The management team'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

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Inspection Results

During the period August 25–September 2, 2009, the OIG conducted an inspection of the Roanoke VA Regional Office (VARO). The inspection focused on 5 protocol areas examining 14 operational activities. The VARO did not meet requirements for 6 of 14 operational activities inspected. We also made an observation regarding brokered claims—an issue that VBA policy does not specifically require but one that may affect benefits delivery or VARO performance and provides an opportunity to improve operations.

Roanoke VARO Management Challenges

The Roanoke VARO management team faces challenges in providing quality benefits and services to veterans. These challenges include addressing oversight of operational activities, acquiring space to store veterans' claims folders, improving mail handling procedures in Triage, and providing training to staff.

Disability Claims Processing

We reviewed 118 (13 percent) of 901 completed claims involving disabilities related to herbicide exposure, post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and Haas[1] claims for which the VARO made decisions during the period January–March 2009.

Our analysis revealed errors in 29 (25 percent) of the 118 claims, but the Roanoke VARO processed only 20 of those errors. The nine remaining errors occurred at other VAROs as work associated with VBA's national brokering plan. Of the 29 errors, 8 affected veterans' benefits, with 6 of those processed at other VAROs. Veterans Service Center management concurred with all errors and took measures to correct them. The following table reflects errors by claim type and errors affecting veterans' benefits:

Table 1. Disability Claims Processing Errors

Claim Type	Claims Reviewed	Claims with Processing Errors	Claims with Errors Affecting Veterans' Benefits	Claims with Errors Affecting Veterans' Benefits Processed at Other VAROs
Herbicide Exposure	30	11	7	6
PTSD	30	1	1	0
TBI	28	13	0	0
Haas	30	4	0	0
Total	**118**	**29**	**8**	**6**

[1]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 and whether those veterans are entitled to the presumption of exposure to herbicide agents, including Agent Orange. VA put a stay of adjudication on these claims; however, it lifted the stay in January 2009.

VSC Personnel Need to Improve the Accuracy of Disability Determinations

Disabilities Related to Herbicide Exposure Claims. Seven of 11 processing errors identified for cases of diabetes related to herbicide exposure impacted veterans' benefits. (These claims tend to involve diabetes related to exposure to Agent Orange in Vietnam.)

- VSC staff incorrectly denied service connection for coronary artery disease secondary to the veteran's service-connected diabetes. A physician provided an opinion indicating the coronary artery disease was a complication of his diabetes. VSC staff should have granted service connection. The veteran was underpaid $21,857.
- VSC staff failed to grant a veteran special monthly compensation based on a temporary 100 percent evaluation for treatment of a service-connected right knee amputation secondary to diabetes. VSC staff should have granted special monthly compensation for 1 month. The veteran was underpaid $120.
- VSC staff incorrectly granted service connection to a veteran for diabetes, amputation below the knee, special monthly compensation for loss of use of a creative organ, and automobile benefits based on presumption of exposure to a herbicide agent. Contrary to the veteran's claim, evidence in the claims folder did not show the required service in Vietnam. VSC staff should have denied the claim. The veteran was overpaid $15,640.
- VSC staff incorrectly granted service connection for peripheral neuropathy secondary to the veteran's service-connected diabetes. A VA medical examination specifically noted the veteran did not have neurological complications related to diabetes. The veteran was overpaid $14,103.
- VSC staff did not properly evaluate a veteran's service-connected hypertension secondary to diabetes. Staff incorrectly assigned a 10 percent evaluation; however, based on medical evidence in the claims folder, the correct evaluation should have been 0 percent. The veteran was overpaid $3,018.
- VSC staff established an incorrect effective date for payment of a veteran's service-connected diabetes. The correct date was November 17, 2008, as indicated by the VARO date stamp, and not a handwritten date of October 30, 2008. The veteran was overpaid $230.
- VSC staff did not properly evaluate a veteran's service-connected diabetes. VSC staff incorrectly continued a 40 percent evaluation in spite of medical evidence in the claims folder showing the diabetes warranted a 20 percent evaluation as it did not cause any restriction of activities.

The remaining four errors were procedural in nature. For all four errors, VSC staff improperly documented non-compensable disabilities on the formal rating decision.

PTSD Claims. VSC staff made a processing error by assigning an incorrect effective date for an increase in a veteran's PTSD. As a result, the veteran was underpaid $1,160. VSC staff granted an increased evaluation effective January 30, 2009—the date the veteran submitted a claim for

an increase. The correct effective date should have been October 2, 2008—the date medical evidence showed the veteran's PTSD symptoms worsened. Because we found only one claims processing error for PTSD, we determined the VARO is generally following VBA policy in this area.

TBI Claims. The 13 TBI errors had the potential to impact veterans' benefits. The errors involved decisions based on incorrect and inadequate medical examinations; therefore, VSC staff could not fully assess all residual disabilities associated with a TBI. It could not be determined what evaluations would have been appropriate because the medical examinations were incorrect or inadequate. Following is a summary of those errors:

- Eight occurred because Rating Veterans Service Representatives (RVSRs) made disability determinations without obtaining the correct medical examinations specifically designed to evaluate residuals of TBIs.
- Five occurred because RVSRs made disability determinations based on inadequate TBI examinations received from medical examiners. The TBI examination reports did not follow current guidelines.

We determined that VA contract medical examiners did not use the correct examination worksheets required for completing accurate TBI examinations. In addition, management stated the Rating Veterans Service Representatives should have recognized that the examinations were inadequate and returned them for correction.

Haas Claims. Two of the four processing errors identified for Haas cases had the potential to impact veterans' benefits.

- VSC staff incorrectly denied a veteran service connection for diabetes related to herbicide exposure based on a lack of qualifying Vietnam service. Evidence in the claims folder revealed the veteran had two periods of service. However, the service treatment records from the veteran's first period of service were not in the claims folder. Until VSC staff receives those records, entitlement to service connection cannot be determined.
- VSC staff prematurely denied a veteran service connection for diabetes related to herbicide exposure because they lacked the evidence necessary to make a decision. They should have requested evidence to corroborate whether the veteran served in Vietnam.

The remaining errors were procedural in nature. For example, VSC staff failed to provide proper Haas notification to the veteran.

Recommendation 1. *We recommend the Roanoke VA Regional Office Director coordinate with VA contracted medical staff responsible for completing examinations for traumatic brain injury to ensure examiners use the most current examination worksheets.*

Management Comment

The VARO Director concurred with our recommendation. The Veterans Service Center Manager met with officials from QTC Medical Services, Inc. QTC managers indicated they

would place specific attention during their quality assurance process to ensure medical examiners utilized the new TBI examination worksheets.

OIG Response

Management comments and actions are responsive to the recommendation.

Recommendation 2. *We recommend the Roanoke VA Regional Office Director implement training to ensure Rating Veterans Service Representatives recognize inadequate traumatic brain injury examinations and accurately process diabetes and Haas cases.*

Management Comment

The VARO Director concurred with our recommendation. Training Decision Review Officers will conduct training with all RVSRs no later than January 31, 2010. The training will focus on how to recognize inadequate TBI examinations and how to process diabetes and Haas cases.

OIG Response

Management comments and actions are responsive to the recommendation.

Data Integrity

Generally, VSC staff followed VBA policies on tracking the location of veterans' claims folders in the Control of Veterans Records System and establishing correct claim dates in the electronic record. Of 30 claims reviewed, VSC staff consistently tracked 27 (90 percent) claims folders and established correct dates of claims in the electronic record for 28 (93 percent) claims. VSC management corrected these errors during our inspection.

Management Controls

The Roanoke VARO management team followed VBA policies in all areas reviewed regarding management controls. The VSC was not required to rotate employees under the Claims Processing Improvement model because, according to senior VSC management, the station workload was not under control. VARO staff ensured timely correction for all 13 errors identified by VBA's STAR, which we confirmed. Further, we inventoried all VARO date stamps and determined staff properly maintained accountability of all the assigned stamps.

Generally, VSC staff completed required SAOs, but we determined they did not complete all sections of one SAO in accordance with VBA policy. Management did not address the issue of Control of Veterans Records Systems in the Internal Controls SAOs. This omission did not result in an impact to VSC operations as the VARO generally followed VBA policy regarding the use of this system.

Information Security

The OIG inspection team conducted random inspections of employee workstations to determine if staff properly followed VBA's policy to safeguard veterans' personally identifiable

information (PII). The policy states, "Under no circumstances will claims or guardianship files, loose mail, or material of any kind that has claimant/veteran PII be stored in desk drawers, credenzas, personal two-drawer lockable cabinets, or other personal or provided storage containers." Our inspections focused on these areas and did not include a review of employees' desktops where VBA allows these materials for processing claims. VBA's policy also states material used to develop training courses must be promptly and clearly redacted and stored in a location obviously designated for training course material. In addition, the policy requires supervisors to perform inspections of the workstations to ensure adherence with policy.

We also analyzed mail-handling procedures in the mailroom and the VSC Triage team to ensure the accurate and timely processing of mail. We determined mail-handling procedures within the mailroom were accurate and timely as staff processed mail to each division daily. However, the routing of mail from the Triage team to other sections of the VSC was not always effective.

Veterans' Personally Identifiable Information Not Always Safeguarded

We performed unannounced inspections of 30 (10 percent) of the 304 employees' workstations located in the VSC. We found unredacted PII at 13 (43 percent) of the 30 workstations. We also found PII in unassigned areas within the VSC. The PII primarily consisted of Social Security Administration information requests and unredacted training materials. Following are examples of the PII found:

- Unredacted training material (115 pieces) discovered in unauthorized locations such as cabinets and desk drawers.
- Mail returned as undeliverable by the United States Postal Service (6 boxes containing approximately 4,200 pieces). These boxes were located on top of a bookcase in the VARO file room and consisted of cost of living adjustment notification letters. All of the letters contained veterans' names, social security numbers, and addresses.

VBA policy requires employees to place documents identified for destruction into "red" envelopes or boxes. The Division Records Management Officers then collect, review, and sign the documents. Upon completion of their reviews, they send the documents to the VARO's Records Management Officers for destruction.

We found a claim for dental care located in one employee's shred bin improperly scheduled for destruction. VSC management stated employee carelessness resulted in the original documents being placed in the shred bin. Further, management indicated the Division Records Management Officers and Records Management Officers did not thoroughly inspect the workstations. Although we found no evidence of improper destruction of documents, the VARO Director lacked reasonable assurance that veterans' PII was properly safeguarded because staff did not perform inspections as intended.

Recommendation 3. *We recommend the Roanoke VA Regional Office Director develop and implement a plan to ensure supervisors, Records Management Officers, and Division Records Management Officers perform thorough reviews of workstations and common areas to properly safeguard veterans' personally identifiable information.*

Management Comment

The VARO Director concurred with our recommendation. Effective September 2009, Records Management Officers began performing workplace inspections in addition to the quarterly inspections performed by team supervisors. Additionally, Records Management Officers conducted refresher training on September 23, 2009 and December 8, 2009, focusing on work area responsibilities and proper handling of PII.

OIG Response

Management comments and actions are responsive to the recommendation.

Mail Management Procedures within Triage Team Needs Strengthening

The Claims Process Improvement Model 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 handling procedures in the Roanoke VARO Triage team and concluded the team did not have an effective method to properly control and route mail to support VSC operations. VSC staff did not always record incoming claims-related mail in the electronic record within VBA's national standard of 7 days.

A VSC supervisor informed us the station received multiple boxes of claims-related mail from the Washington, D.C. VARO. The mail contained pieces of correspondence with dates exceeding the VBA 7-day standard, and staff had not recorded this mail in the electronic record upon receipt. Instead, the supervisor incrementally recorded mail into the electronic record to avoid negatively affecting the VARO's ability to meet VBA's 7-day national performance goal. This action resulted in an intentional misrepresentation of the VAROs performance. Once informed of the situation, the VARO Director immediately issued a policy letter directing employees to discontinue this practice.

In addition, staff did not always retrieve claims-related mail (also known as search mail) from the appropriate mail point for inclusion into the veterans' claims folder. Search mail consists of evidence to support veterans' pending claims. Triage staff is responsible for placing this mail at designated mail points for association with veterans' claims folders. We determined 9 (30 percent) of 30 pieces of mail were not processed according to VBA policy.

- Six pieces of mail remained on search for an average of 24 days.
- VSC staff placed three pieces of mail at mail points without recording it in the electronic record; therefore, VSC staff was unaware of this mail.

As of August 2009, the VSC had 504 pieces of search mail waiting to be associated with veterans' claims folders, with 123 pieces (24 percent) remaining on search over 5 days. VBA does not have a national standard describing the amount of time allowed to process search mail.

VSC management stated employees were not always timely in retrieving search mail, ultimately affecting the overall time to process a claim.

As a result, the VARO Director lacked assurance that claims-related mail was timely and accurately recorded into the electronic record. Further, VSC staff may not consistently associate search mail with claims folders to ensure all evidence was of record for making accurate benefits decisions.

Recommendation 4. *We recommend the Roanoke VA Regional Office Director develop and implement a plan to ensure Veterans Service Center staff are timely in recording mail in the electronic record and they retrieve search mail to enable accurate benefits decisions.*

Management Comment

The VARO Director concurred with our recommendation. The Triage coach will conduct weekly meetings with all Triage personnel outlining the need for proper control of incoming mail. In addition, File Clerks will search repositories to ensure all mail is on search by close of business on Fridays.

OIG Response

Management comments and actions are responsive to the recommendation.

Public Contact

The Public Contact team provides benefits 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. Our analysis of 30 IRIS inquiries revealed VARO staff did not follow VBA policy to provide accurate and timely responses within VBA's 5-day standard.

We reviewed 28 congressional inquiries completed by the Roanoke VARO during the period January–March 2009. Our review of those inquiries revealed VARO staff correctly followed VBA policy as the responses provided to veterans were accurate and completed within VBA's 5-day standard.

Inconsistent Accuracy and Timeliness in Responding to Veterans' Electronic Inquiries

We analyzed 30 completed IRIS responses from January–March 2009 to determine if the VSC provided complete, 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 e-mail address (https://iris/va/gov) that enables veterans to send electronic inquiries to VA.

For 6 (20 percent) of the 30 IRIS inquiries, the Public Contact Team did not follow VBA's policy of providing complete, accurate, and timely responses within 5 business days. Of the six

errors, four contained inaccurate responses and two exceeded the 5-day standard by an average of 10 days.

One example of an inaccurate IRIS response involved a veteran who asked if he was entitled to a temporary 100 percent evaluation during a period of convalescence when he informed the VARO of a pending surgery to have a hip replaced. The VARO incorrectly informed the veteran that entitlement to a temporary 100 percent evaluation would last for 6 months. VSC staff should have informed the veteran that entitlement to a temporary 100 percent evaluation would be for a period of 12 months.

On January 3, 2007, VBA issued policy stating VAROs were no longer required to conduct local IRIS quality reviews for national quality purposes but encouraged stations to continue local quality control measures at their discretion. A VSC supervisor told us these errors occurred because management had not performed quality assurance reviews for a "couple of months." As a result, the VARO Director had no assurance veterans' received complete and timely responses.

Recommendation 5. *We recommend the Roanoke VA Regional Office Director develop and implement a plan to improve oversight of the Inquiry Routing and Information System local quality review process to ensure Veterans Service Center staff provide accurate and timely responses to VBA's IRIS Response Center.*

Management Comment

The VARO Director concurred with our recommendation. Effective October 1, 2009, management instituted local quality reviews for the internal responses provided to the IRIS response center.

OIG Response

Management comments and actions are responsive to the recommendation.

Additional Improvement Areas

In addition to the 14 operational activities reviewed during the inspection, we identified additional areas requiring management's attention. These areas involve the safeguarding and storage of veterans' claims folders because of constraints on available space.

VARO Lacks Adequate Space To Store and Safeguard Veterans' Claims Folders

The Roanoke VARO is located in the Poff Federal Building and the General Services Administration provides support for building operations. During our inspection, we identified three floors (10^{th}, 11^{th}, and 12^{th}) within the building designated as file rooms for storage of veterans' claims folders. We observed approximately 10,800 claims folders stored on top of filing cabinets. VBA policy states that staff will not file records beyond the normal capacity of equipment nor place them in a location where a reasonable possibility of losing or discarding the records exists, such as when they are stored on filing equipment.

The picture below shows the magnitude of this condition as veterans' claims folders are stacked on top of filing cabinets within a VSC storage area:

Figure 1. Poff Federal Building Claims Storage for Roanoke VARO

VARO management requested an off-site storage facility through VBA's Southern Area Director in October 2008. The VARO Director sent subsequent requests to the Southern Area Director in December 2008, February 2009, and April 2009.

On September 3, 2009, the General Services Administration received a report from a structural engineer stating that the floor load on the 10th, 11th, and 12th floors of the Poff Federal Building was 160 pounds per square foot, exceeding the recommended floor load of 80 pounds per square foot. The report stated the high floor load was a result of large blocks of filing cabinets distributed throughout the VA space and the placement of additional active files on top of the existing cabinets. These additional files are improperly stored on top of the filing cabinets because of insufficient storage space. The engineering report indicated excessive overloading has the potential to induce structural damage and possible failure to the integrity of the building that can present a threat to the safety of the facility and the occupants.

VSC management informed us that in FY 2007 an overhead sprinkler system leaked water; however, no damage to claims folders occurred because the leak was in an unoccupied area of the file room. In addition, 19 claims folders could not be located during our inspection. A supervisor attributed the missing folders to the overcrowded conditions that interfered with the VARO staff's ability to complete their annual file sequencing process of claims folders.

As a result, the VARO Director lacked assurance that staff could account for all veterans' claims folders within the VARO. Furthermore, the VARO has an increased risk associated with employee safety, safeguarding veterans' claims folders from water damage, and structural failure to the integrity of the building.

Recommendation 6. *We recommend the Roanoke VA Regional Office Director research alternative locations to store and safeguard veterans' claims folders and expeditiously relocate these folders to reduce the risk of structural damage to the building and ensure employee safety.*

Management Comment

The VARO Director concurred with our recommendation. General Services Administration and Roanoke VARO management located and leased an off-site storage facility that is available for use in 60 days. The facility will accommodate 40-60 percent of the VARO's existing file cabinets. This facility will serve as an interim storage location until the General Services Administration and VARO management continue research to locate and procure a facility to safeguard and store all of the VSC's inactive files.

OIG Response

Management comments and actions are responsive to the recommendation and we will follow-up on this action during a future inspection.

Observations

Observations pertain to issues that may affect benefits delivery or diminish VARO performance but are not specifically compliance-related. We observed the following during the inspection:

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. During the period October 2008 through July 2009, the Roanoke VARO brokered 8,701 rating-related claims to other VAROs for processing. We reviewed 25 brokered claims and determined 9 (36 percent) of the 25 claims brokered to other VAROs contained processing errors, with 6 errors affecting veterans' benefits.

In March 2009,[2] we reported that the Systematic Technical Accuracy Review quality assurance process does not provide a complete assessment of the accuracy of compensation claims ratings, partially because it excluded brokered claims from STAR reviews. The accuracy of brokered claims was 18 percent lower than the national accuracy rate 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 the quality of brokered claims in response to the audit recommendations. However, until those procedures are in place, brokered claims will not receive the scrutiny of a quality assurance review. As a result, we will continue to examine and report on the accuracy of brokered claims during VARO inspections.

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

VARO Profile

Organization. The Roanoke VARO is responsible for delivering non-medical VA benefits and services to veterans and their families in Virginia. The office also provides compensation and pension services for the District of Columbia. VARO staff accomplishes this through the administration of Compensation and Pension Benefits, Vocational Rehabilitation and Employment Assistance, Burial Benefits, and Outreach activities. The Roanoke VARO has two out-based offices; the inspection team did not perform any work at those facilities.

Resources. As of March 2009, the Roanoke VARO had a staffing level of 430 Full-Time Employees (FTE). Of the 430 FTE, 304 (71 percent) were assigned to the VSC.

Workload. As of March 2009, the VARO had 12,957 pending compensation and pension (C&P) claims that took an average of 198.8 days to complete, 28.8 days longer than the national target of 170 days. Accuracy for C&P rating-related issues, as reported by VBA's STAR, was 88.8 percent, below the national standard of 90 percent. Accuracy for C&P authorization-related issues, as reported by VBA's STAR was 95 percent, at the national standard of 95 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.

Our inspection covered VARO processing of PTSD, TBI, Haas, and herbicide exposure-related claims; VARO completed IRIS and congressional inquiries; and STAR reported errors for the 3-month period January–March 2009. We conducted this inspection in accordance with the President's Council for Integrity and Efficiency's *Quality Standards for Inspections*.

Appendix B

Department of Veterans Affairs **MEMORANDUM**

Date: **December 30, 2009**

From: **Director, VA Regional Office Roanoke (314/00)**

Subject: **Inspection of VARO Roanoke, VA**

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

1. Attached are the Roanoke VARO's comments on the OIG Draft Report: Inspection of VARO Roanoke.

2. Questions may be referred to Mr. William Nicholas, Director, at 540.597.1120, or Mr. Dave Svirsky, Veterans Service Center Manager, at 540.597.1150.

(original signed by:)
WILLIAM E. NICHOLAS
Director

Attachment

Appendix B

VARO ROANOKE
Benefits Inspection Division Visit

Recommendation 1. *We recommend the Roanoke VA Regional Office Director coordinate with VA contracted medical staff responsible for completing examinations for traumatic brain injury to ensure examiners use the most current examination worksheets.*

VARO Response: Concur.

The Roanoke Regional Office has taken the following steps to address this recommendation:

On October 22, 2009, the Veterans Service Center Manager and his staff met with the Associate Director of Operations for Philadelphia/Atlanta, the QTC Operations Managers responsible for working with this office, and a senior member of QTC's Quality Assurance staff. The Veterans Service Center Manager addressed the findings of the Benefits Inspection Division regarding traumatic brain injury cases and the need to use the most current examination worksheets when evaluating these conditions. The QTC Managers confirmed that QTC has the new TBI examination template and that specific attention will be placed during their quality assurance process to ensure examiners are utilizing the new template. The VSC Exam Coordinator will continue to work closely with QTC personnel to ensure they are aware of all changes to exam worksheets.

Recommendation 2. *We recommend the Roanoke VA Regional Office Director implement training to ensure Rating Veterans Service Representatives recognize inadequate traumatic brain injury examinations and accurately process diabetes and Haas cases.*

VARO Response: Concur.

The Roanoke Regional Office will be taking the following action in an effort to insure Rating Veterans Service Representatives recognize inadequate traumatic brain injury (TBI) examinations and accurately process diabetes and Haas cases:

Our Training Decision Review Officers will be conducting training with all Rating Veteran Service Representatives no later than January 31, 2010. The planned topic of discussion will be how to recognize inadequate traumatic brain injury examinations, and to make sure we are using the most current examination worksheet for TBI claims. Additionally, they will also be discussing how to accurately process diabetes and Haas cases.

Recommendation 3. *We recommend the Roanoke VA Regional Office Director develop and implement a plan to ensure supervisors, Records Management Officers (RMO), and Division Records Management Officers perform thorough reviews of workstations and common areas to properly safeguard veterans' personally identifiable information.*

VARO Response: Concur.

The Roanoke Regional Office has taken the following steps to address this recommendation:

Prior to the OIG visit, the RMOs were actively performing trash receptacle reviews and the supervisors of the individual teams were performing workplace inspections in accordance with VBA Letter 20-08-63. The RMOs monitored the quarterly supervisors' audits and maintained spreadsheets showing the results of these audits. Effective September 2009, the RMOs began performing workplace inspections in addition to the inspections performed quarterly by the team supervisors. RMO inspections include distribution of excerpts from VBA Letter 20-08-63 addressing handling and storage of documents in individual workstations and common areas. RMO inspection findings are maintained electronically, and corrective actions are taken to address any violations found. Additionally, the RMOs conducted refresher training on September 23 and December 8. This training covered employee work area responsibilities and proper handling of PII material per the VBA Letter.

Recommendation 4. *We recommend the Roanoke VA Regional Office Director develop and implement a plan to ensure Veterans Service Center staff are timely in recording mail in the electronic record and they retrieve search mail to enable accurate benefits decisions.*

VARO Response: Concur.

The Roanoke Regional Office has taken the following steps in an effort to improve our mail control process:

1. Effective November 20, 2009, a new Coach was rotated to the Triage Team. Weekly meetings have been instituted with all Triage personnel outlining the need for proper control of the incoming mail to include late flowing mail from other offices. All old mail received is put under control upon receipt. The team is currently up to date on the mail.
2. All Teams have been instructed to have all cubicles and repositories bar-coded by noon each Friday. As of Friday, December 11th, all Teams were informed file deliveries would be stopped at noon on Fridays to give the File Clerks an opportunity to search the Teams and repositories to attach search mail and give the File Clerks ample time to ensure all mail is on search by close of business on Fridays.

Recommendation 5. *We recommend the Roanoke VA Regional Office Director develop and implement a plan to improve oversight of the Inquiry Routing and Information System local quality review process to ensure Veterans Service Center staff provide accurate and timely responses to VBA's IRIS Response Center.*

VARO Response: Concur.

Effective October 1, 2009, local quality reviews were instituted for the internal responses we provide to the IRC when the IRC cannot answer the initial inquiry without additional information from the Regional Office having jurisdiction of the claim.

Recommendation 6. *We recommend the Roanoke VA Regional Office Director research alternative locations to store and safeguard veterans' claims folders and expeditiously relocate these folders to reduce the risk of structural damage to the building and ensure employee safety.*

VARO Response: Concur.

The Roanoke Regional Office has taken the following steps in an effort to resolve our current folder storage issues:

General Services Administration (GSA) and Roanoke Regional Office management have located and leased an off-site storage facility, which will be available for use within 60 days. The facility will accommodate 40-60% of the station's existing file cabinets, greatly reducing the current storage problems in the Poff Federal Building. This off site facility will serve as an interim storage location as GSA and VA Regional Office staff continues research to locate and procure a facility capable of safeguarding and storing all of the Veteran's Service Center inactive files.

Appendix C

Inspection Summary

14 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. Herbicide Exposure	Determine whether service connection for disabilities 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 processed accurately and timely. (M21-1MR, Part II, Chapter 6).		X
14. Congressional Inquiries	Determine if congressional inquiries were processed on time. (OFO Letter 201-02-64) (Fast Letter 01-40) (VA Directive 8100)	X	

Appendix D

OIG Contacts and Staff Acknowledgments

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Acknowledgments	Karen Gooden Joseph Byrd Robert Campbell Maya Ferrandino Kerri Leggiero-Yglesias

Appendix E

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