VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Winston-Salem, North Carolina

September 13, 2012
12-00244-276

ACRONYMS AND ABBREVIATIONS

C&C	Confirmed and Continued
COVERS	Control of Veterans Records System
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
STAR	Systematic Technical Accuracy Review
TBI	Traumatic Brain Injury
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center

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Report Highlights: Inspection of the VA Regional Office, Winston-Salem, NC

Why We Did This Review

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

What We Found

The Winston-Salem VARO lacked accuracy in processing some disability claims. VARO staff inaccurately processed one-half of the temporary 100 percent disability evaluations we reviewed, primarily because staff did not schedule medical reexaminations as required. Without effective management of these temporary ratings, VBA risks paying inaccurate and often unnecessary financial benefits. VARO staff accurately processed most herbicide exposure-related claims, but needed to improve accuracy in processing traumatic brain injury claims as staff did not always follow VBA's policy for second signature reviews. Overall, VARO staff did not accurately process 20 (22 percent) of 90 disability claims. These results do not represent the overall accuracy of disability claims processing at this VARO as we sampled claims we considered at higher risk of processing errors. VARO staff took appropriate actions in correcting errors identified by VBA's Systematic Technical Accuracy Review program. Further, managers ensured staff thoroughly completed Systematic Analyses of Operations. Although VARO staff correctly processed incoming mail on the date received, errors subsequently occurred when Triage Team staff did not properly control search and drop mail due to a lack of management guidance and oversight.

VARO staff did not always advise Gulf War veterans they were entitled to mental health treatment at VA facilities. The VARO provided outreach to homeless veterans. However, VBA needs a measure to assess their outreach programs. Additionally, we observed the VARO lacked adequate storage space for approximately 37,000 claims folders.

What We Recommend

The Winston-Salem VARO Director should develop and implement plans to ensure staff comply with VBA's second signature requirements for processing traumatic brain injury claims, provide oversight for managing mail, and ensure Gulf War veterans are advised of their entitlement to mental health treatment. We issued a Management Advisory to VBA leadership to address the issue of inadequate storage space for veterans' claims folders.

Agency Comments

The VARO Director concurred with our recommendations. Management's planned actions are responsive and we will follow up as required.

LINDA A. HALLIDAY
Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Objective

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

- Evaluate how well VAROs are accomplishing their mission of providing veterans with access to high-quality benefits and services.
- Determine whether management controls ensure compliance with VA regulations and policies; assist management in achieving program goals; and minimize the risk of fraud, waste, and other abuses.
- Identify and report systemic trends in VARO operations.

In addition to this oversight, inspections may examine issues or allegations referred by VA employees, members of Congress, or other stakeholders.

Scope of Inspection

In May 2012, the OIG conducted an inspection of the Winston-Salem VARO. The inspection focused on five protocol areas addressing eight operational activities. The five protocol areas were disability claims processing, management controls, workload management, eligibility determinations, and public contact. We did not examine eligibility determinations related to fiduciary competency determinations because the Veterans Benefits Administration (VBA) has centralized this work at the Columbia, South Carolina office.

We reviewed 60 (6 percent) of 926 disability claims related to traumatic brain injury (TBI) and herbicide exposure that VARO staff completed from January through March 2012. In addition, we reviewed 30 (3 percent) of 1,079 rating decisions where VARO staff granted temporary 100 percent disability evaluations for at least 18 months, generally the longest period a temporary 100 percent disability evaluation may be assigned without review, according to VBA's policy. All disability claims and temporary 100 percent disability evaluations reviewed were statistically selected.

Appendix A provides details on the VARO and the scope of our inspection. Appendix B provides the VARO Director's comments on a draft of this report. Appendix C provides criteria we used to evaluate each operational activity and a summary of our inspection results.

RESULTS AND RECOMMENDATIONS

1. Disability Claims Processing

The OIG Benefits Inspection team focused on disability claims processing related to temporary 100 percent disability evaluations, TBI, and herbicide exposure. We evaluated claims processing accuracy and its impact on veterans' benefits.

Finding 1 The Winston-Salem VARO Could Improve Processing of Temporary 100 Percent Disability Evaluations

The Winston-Salem VARO lacked controls and accuracy in processing temporary 100 percent disability evaluations and TBI claims, but correctly processed most of the herbicide exposure-related claims we reviewed. Overall, VARO staff incorrectly processed 20 of the total 90 disability claims in our sample. Overpayments in compensation benefits totaled $114,893 and underpayments were $35,612 for the 6 claims identified as affecting veterans' benefits. We were unable to identify whether overpayments or underpayments were made on the 14 claims lacking medical evidence. VARO management agreed with our findings and began to correct the errors identified.

Because we sampled claims we considered to be at higher risk of processing errors, these results do not represent the universe of disability claims processed at this VARO. The following table reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Winston-Salem VARO.

Table 1

Winston-Salem VARO Disability Claims Processing Results

Type	Reviewed	Claims Incorrectly Processed		
		Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits	Total
Temporary 100 Percent Disability Evaluations	30	2	13	15
Traumatic Brain Injury Claims	30	3	1	4
Herbicide Exposure-Related Disability Claims	30	1	0	1
Total	**90**	**6**	**14**	**20**

Source: VA OIG analysis of VBA's disability claims files.

As reported by the VBA's Systematic Technical Accuracy Review (STAR) program as of March 2012, the overall accuracy of the Winston-Salem VARO's rating-related decisions was 81.1 percent—5.9 percentage points below VBA's 87 percent target.

Temporary 100 Percent Disability Evaluations

Inaccuracies in processing temporary 100 percent disability evaluations were significant. VARO staff incorrectly processed 15 of 30 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a veteran's service-connected disability following surgery or when specific treatment is needed. At the end of a mandated period of convalescence or treatment, VARO staff must request a follow-up medical examination to help determine whether to continue the veteran's temporary 100 percent disability evaluation.

For temporary 100 percent disability evaluations, including confirmed and continued (C&C) evaluations where rating decisions do not change veterans' payment amounts, VSC staff must input suspense diaries in VBA's electronic system. A suspense diary is a processing command that establishes a date when VSC staff must schedule a reexamination. As a suspense diary matures, the electronic system generates a reminder notification to alert VSC staff to schedule the reexamination.

Available medical evidence showed that 2 of the 15 processing errors affected veterans' benefits. VSC staff continued processing monthly benefits and ultimately overpaid and underpaid the veterans. Details on the overpayment and underpayment follow.

- An overpayment occurred when a Rating Veterans Service Representative (RVSR) established a temporary 100 percent disability evaluation for multiple myeloma; however, the medical evidence showed the veteran did not have multiple myeloma. VA continued processing monthly benefit payments and ultimately overpaid the veteran $87,513 over a period of 2 years and 7 months.
- An underpayment occurred when an RVSR did not establish a veteran's entitlement to special monthly compensation for erectile dysfunction despite medical evidence relating this condition to service-connected prostate cancer. Consequently, VA continued processing monthly benefit payments and ultimately underpaid the veteran $1,152 over a period of 1 year. We discussed the underpayment with VARO officials who agreed to take corrective action.

The remaining 13 of 15 errors had the potential to affect veterans' benefits. In most cases, we could not determine whether the evaluations would have continued because the veterans' claims folders did not contain the medical examination reports needed to reevaluate each case.

The most frequent processing errors in 10 of the 15 cases occurred because VARO staff did not establish suspense diaries in the electronic record so they would receive reminder notifications to schedule required VA medical reexaminations. Eight of the 10 errors involved C&C rating decisions. In November 2009, VBA provided guidance reminding VAROs about the requirement to input suspense diaries in the electronic record for C&C rating decisions. However, VARO management did not have a mechanism in place to ensure VSC staff complied. Because effective controls were not in place, the temporary 100 percent disability evaluations might have continued over the veterans' lifetimes if we had not identified the need for the reexaminations.

For those cases requiring medical reexaminations, delays ranged from approximately 2 years and 1 month to 8 years and 4 months. An average of 4 years and 4 months elapsed from the time staff should have scheduled the medical reexaminations until the date of our inspection—the date staff ultimately took corrective actions to obtain the necessary medical evidence.

In response to a recommendation in our national report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), the Acting Under Secretary for Benefits agreed to review all temporary 100 percent disability evaluations and ensure each evaluation had a future examination date entered in the electronic record. VBA provided each VARO with a list of temporary 100 percent disability evaluations for review in September 2011. The Acting Under Secretary for Benefits stated in response to our audit report that the target completion date for the national review would be September 30, 2011. However, VBA did not provide each VARO with a list of temporary 100 percent disability evaluations for review until September 2011. VBA subsequently extended the national review deadline to December 31, 2011, and then again to June 30, 2012. To assist in implementing the agreed-upon review, we also provided the Winston-Salem VARO with 1,049 claims remaining from our universe of 1,079 temporary 100 percent disability evaluations. VBA is still working to complete this national review requirement and has since extended the national review deadline to September 30, 2012.

TBI Claims

The Department of Defense and VBA commonly define a TBI as a traumatically induced structural injury or physiological disruption of brain function caused by an external force. The major residual disabilities of TBI fall into three main categories—physical, cognitive, and behavioral. VBA policy requires that staff evaluate these residual disabilities.

VARO staff incorrectly processed 4 of 30 TBI claims. Three of the four processing errors affected veterans' benefits and resulted in overpayments totaling $27,380. In two of the three cases affecting benefits, RVSRs used the same symptoms to evaluate TBI-related disabilities and coexisting mental

disorders. However, VBA policy prohibits using the same manifestations or symptoms related to different diagnoses to evaluate disabilities.

In the most significant case, an RVSR incorrectly evaluated TBI residuals as 70 percent disabling. Medical evidence showed TBI residuals warranting no more than a 10 percent disability evaluation. As a result, VA continued processing monthly benefits and ultimately overpaid the veteran $14,755 over a period of 1 year and 3 months.

The remaining error had the potential to affect a veteran's benefits. In this case, an RVSR determined that TBI-related disabilities causing a veteran to be housebound met the criteria for additional special monthly compensation. However, the RVSR did not also consider whether the TBI-related disabilities entitled the veteran to a higher rate of special monthly compensation, specifically established for veterans with brain injuries.

In response to a recommendation in our annual report, *Systemic Issues Reported During Inspections at VA Regional Offices* (Report No. 11-00510-167, May 18, 2011), VBA agreed to develop and implement a strategy for ensuring the accuracy of TBI decisions. In May 2011, the Under Secretary for Benefits provided guidance to all VARO Directors to implement a policy requiring a second signature on each TBI case an RVSR evaluates until the RVSR demonstrates 90 percent accuracy in TBI claims processing. Upon demonstrating proficiency, the RVSR receives single signature authority for future TBI claims. Further, the policy directs VAROs to use data obtained during the second signature requirement period to identify and address training needs. The target completion date for VAROs to implement the new second signature policy was September 30, 2011.

Generally, errors associated with TBI claims were due to inadequate oversight to ensure VSC staff complied with local and VBA second signature policies. These cases lacked second signature reviews as required. The second reviewers might have identified the errors and corrected them before issuing final decisions. VARO managers agreed the policy of self-identifying TBI claims for second signature was not effective. They also stated that only 5 of 42 RVSRs had met the criteria to independently evaluate TBI claims. As a result, veterans did not always receive accurate benefits payments.

Herbicide Exposure-Related Claims

VARO staff incorrectly processed 1 of 30 herbicide exposure-related claims we reviewed. An RVSR reduced a veteran's compensation benefit because his prostate cancer was no longer active. However, medical evidence showed ongoing prostate cancer treatment using hormone therapy, which supported a continued 100 percent disability evaluation. In this case, VA prematurely reduced the veteran's benefits and ultimately underpaid the veteran $34,460 over a period of 1 year and 2 months. We discussed the

underpayment with VARO officials who agreed to take corrective action. Because VARO staff generally processed herbicide exposure-related disability claims correctly, we made no recommendation for improvement in this area.

Recommendation

1. We recommend the Winston-Salem VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives comply with the Veterans Benefits Administration's second signature requirements for traumatic brain injury claims.

Management Comments

The VARO Director concurred with our recommendation and effective May 21, 2012, RVSRs began routing all TBI claims through each Rating Board Coach prior to going to the Quality Review Team. The Rating Board Coaches meet with the RVSR individually and provide additional refresher training on the proper procedures. The VARO is in the process of completing a standard operating procedure (SOP) for TBI second signature cases in order to centralize all of the current procedures into one document for all employees. The anticipated completion date for this SOP is August 31, 2012.

OIG Response

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

2. Management Controls

Systematic Technical Accuracy Review

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

STAR staff identified errors in 12 veterans' claims folders that the Winston-Salem VARO processed from October through December 2011. VARO staff followed VBA policy by correcting all of the errors identified during that period; therefore, we made no recommendation for improvement in this area.

Systematic Analysis of Operations

We assessed whether VARO management had adequate controls in place to ensure complete and timely submission of Systematic Analyses of Operations (SAO). We also considered whether VSC staff used adequate data to support the analyses and recommendations identified within each SAO. An SAO is a formal analysis of an organizational element or operational function. SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. VARO management must publish annual SAO schedules designating the staff required to complete the SAOs by specific dates. The

VSC manager is responsible for ongoing analysis of VSC operations, including completing 11 mandated SAOs annually.

VARO management timely completed all required SAOs. The completed SAOs included thorough analyses using appropriate data, identified areas for improvement, and made recommendations for improvement of business operations. As a result, we determined the VARO followed VBA policy and we made no recommendation for improvement in this area.

3. Workload Management

Mailroom Operations

We assessed controls over VARO mailroom operations to ensure staff timely and accurately processed incoming mail. VBA policy states staff will open, date-stamp, and route all mail to the appropriate locations within 4 to 6 hours of receipt at the VARO. The Winston-Salem VARO assigns responsibility for mailroom activities, including processing of incoming mail, to the VSC's Triage Team.

On several occasions, we observed staff processing incoming mail on the dates received in the VSC. We determined the VARO followed VBA policy and we made no recommendation for improvement in this area.

VSC Mail-Processing Procedures

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

Search and Drop Mail

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

Finding 2 Control and Guidance for Mail Management Procedures Need Strengthening

VSC Mail-Processing Procedures

VSC staff did not correctly manage 28 of 60 pieces of mail we reviewed. Of this total, 30 pieces were search mail and 30 pieces were drop mail. The processing inaccuracies occurred because VSC management did not provide adequate guidance or oversight to ensure staff processed mail according to VBA policy. Consequently, beneficiaries may not receive accurate and timely benefits payments.

VSC staff told us they did not have local written procedures in place on how they should process mail. Additionally, staff told us and we confirmed that mail control points were not reviewed weekly as required. VSC managers acknowledged local directives did not contain guidance for processing search and drop mail, and supervisory review mechanisms were not in place to ensure staff processed mail according to VBA policy. During our inspection, management provided staff updated written guidance related to search and drop mail; however, we were unable to assess the effectiveness of the new guidance.

Claims Folder Storage

VBA policy requires that claims folders will not be filed 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.

We observed approximately 37,000 claims folders being stored on tops of file cabinets. VSC managers and staff told us inadequate claims folder storage impeded their ability to timely associate mail with folders and resulted in lost or misfiled folders. For tracking purposes, a VSC manager created a local spreadsheet for staff to log missing mail. Based on our concerns regarding inadequate storage space and timely mail processing, we issued a Management Advisory memorandum, *VBA's Claims Folder Storage at the VA Regional Office Winston-Salem, North Carolina* (Report No. 12-00244-241, August 9, 2012) to VBA leadership to address these issues.

Search Mail

VSC staff did not properly use COVERS to process and control 21 of the 30 pieces of search mail pending at the time of our inspection. Of these 21 pieces of mail, 14 errors occurred when staff did not input electronic notices of pending search mail in COVERS—thereby making it difficult for VSC staff to know the mail existed. The remaining seven pieces of mail included electronic notices of pending search mail requests in COVERS; however, staff did not retrieve the mail and associate it with related claims folders as required. Following are descriptions of the search mail discrepancies observed.

- On December 22, 2011, VSC staff received a request from a veteran to remove his deceased spouse from his compensation award. Staff established a claim in the electronic record to modify the award and forwarded the mail to the mail control point; however, they did not put the mail on search in COVERS. Overpayments to the veteran increased with each month the VARO delayed acting on his request to remove his deceased spouse from his compensation award. At the time of our inspection, staff had delayed taking action on this claim for almost 5 months.

- On January 30, 2012, in support of a claim for post-traumatic stress disorder, VSC staff received a veteran's statement describing stressful events experienced during military service. Staff forwarded the mail to a mail control point, but did not place it on search in COVERS as required. Because VSC staff did not know the veteran's statement of stressful events existed, they initiated a follow-up request to the veteran. At the time of our inspection, staff had unnecessarily delayed the veteran's claim by 102 days.

Drop Mail

Staff mishandled 7 of the 30 pieces of drop mail. In general, staff did not correctly categorize the drop mail and take action as required. Following are descriptions of two of the drop mail discrepancies observed.

- On August 24, 2011, VSC staff received a veteran's service treatment records and updated the electronic record indicating receipt of the records. However, VSC staff mistakenly associated these records with another veteran's claims folder. Because VSC staff were unaware of this mistake, they sent a letter to the veteran asking him to provide copies of the records needed to support his claim. At the time of our inspection, staff had inappropriately delayed the veteran's claim by 260 days.
- On October 27, 2011, staff received evidence from a veteran to support his pending claim. Because VSC staff incorrectly categorized the correspondence as drop mail, it was not immediately associated with the veterans' claims folder. Consequently, an RVSR rendered a rating decision on March 30, 2012, without considering the medical evidence the veteran identified. After we identified the error, VSC staff took appropriate action to ensure an RVSR would once again review the veterans' claim and consider the missing medical evidence.

Recommendation

2. We recommend the Winston-Salem VA Regional Office Director develop and implement a plan for providing guidance and oversight to ensure mail-processing staff accurately and timely process search and drop mail.

Management Comments

The VARO Director concurred with our recommendation. On May 18, 2012, VSC management issued a new memorandum to all employees that provided guidance for pull and drop mail procedures. In addition, the Pre-Determination Teams developed a lost mail checklist. The checklist ensures that all review points have been checked prior to implementing lost claims/evidence procedures.

In June 2012, the VSC ordered mail bins to replace search mail carts in order to improve the search mail process. VARO staff will sequence all search mail and place the mail in these centrally located bins by August 31, 2012. The Triage supervisor and lead file clerk will audit search mail monthly.

Further, two File Clerks were hired on August 13, 2012 and one additional File Clerk will report on August 27, 2012. The additional staffing will improve the timeliness of mail, drop or search, being associated with claim folders.

OIG Response

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

4. Eligibility Determinations

Entitlement to Medical Treatment for Mental Disorders

Gulf War veterans are eligible for medical treatment for any mental disorder developed within 2 years of the date of separation from military service. According to VBA, whenever an RVSR denies a Gulf War veteran service connection for any mental disorder, the RVSR must consider whether the veteran is entitled to receive mental health treatment.

In February 2011, VBA updated its Rating Board Automation 2000, a computer application designed to assist RVSRs in preparing disability ratings. The application provides a pop-up notification, known as a tip master, to remind staff to consider Gulf War veterans' entitlement to mental health treatment when denying service connection for a mental disorder.

Finding 4 Gulf War Veterans Did Not Always Receive Entitlement Decisions for Mental Health Treatment

VSC staff did not address 11 of 30 Gulf War veterans' entitlement to receive treatment for mental disorders. Generally, errors occurred because the tip master was inadequate in ensuring RVSRs considered this entitlement decision when denying compensation claims for mental disorders. As a result, the veterans may not be aware of possible mental health treatment benefits. VSC management agreed with our assessment and began to correct the errors identified. Following are summaries of the 11 errors observed.

- Four errors occurred when RVSRs did not consider the mental health entitlement despite pop-up notifications reminding them to do so.
- Four errors occurred when RVSRs correctly addressed the entitlement, but did not document the denial of mental health treatment in the decision. VBA policy authorizes an RVSR to address the denial of both health care and compensation for a mental disorder as a single decision. If the RVSR does not take additional steps to annotate the denial of mental health treatment on the formal rating document, VA treating facilities cannot determine whether the veteran is entitled to the benefit.
- Three errors occurred when RVSRs did not address veterans' entitlement to mental health treatment in current disability claims decisions. RVSRs also did not inform the veterans of this entitlement when they denied their previous claims for mental health disabilities.

RVSRs we interviewed were able to explain the correct process for addressing the mental health care entitlement for Gulf War veterans. However, they told us it was easy to overlook the tip master because the pop-up notification closes quickly and does not require any action. We confirmed VSC staff received training on this topic in FY 2012; however, RVSRs stated the training materials did not address the importance of annotating the denial of mental health treatment as part of claims decision. This information is needed so that VA medical facilities can confirm that a veteran is eligible to receive treatment.

Recommendation

3. We recommend the Winston-Salem VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives address Gulf War veterans' entitlement to mental health treatment as required.

Management Comments

The VARO Director concurred with our recommendation. VSC management held a team meeting with RVSRs and Decision Review Officers during the week of May 21, 2012 to discuss the proper way to address Gulf War Veterans' entitlement to mental health treatment. After discussions with the RVSRs, it was determined that most of them were addressing the issue in the narrative of the rating, but not in the rating decision code-sheet.

The Quality Review Team began calling local quality errors if Gulf War Veterans' entitlement to mental health treatment was not addressed properly on the rating decision code-sheet. The Quality Review Team will be conducting a formal refresher class on properly addressing Gulf War Veterans' entitlement to mental health treatment with a target completion date of September 15, 2012

OIG Response

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

5. Public Contact

Outreach to Homeless Veterans

In November 2009, VA developed a 5-year plan to end homelessness among veterans by assisting every eligible homeless veteran willing to accept service. VBA generally defines "homeless" as lacking a fixed, regular, and adequate nighttime residence.

Congress mandated that at least one full-time employee oversee and coordinate homeless veterans programs at each of the 20 VAROs that VA determined to have the largest veteran populations. The Winston-Salem VARO is one of the 20 VAROs with a full-time homeless coordinator. VBA guidance, last updated in September 2002, directed that coordinators be familiar with requirements for improving the effectiveness of VARO outreach to homeless veterans. These requirements include developing and

updating a directory of local homeless shelters and service providers. Additionally, the coordinators should attend regular meetings with local homeless service providers, community governments, and advocacy groups to provide information on VA benefits and services.

The VSC provided a list of 13 homeless shelters and service providers in the local area. Although we made multiple attempts to contact each facility, we were only able to contact eight—of these, all but one told us they had received information on VA benefits and services. We also determined the Winston-Salem VARO and Veterans Health Administration homeless coordinators worked collaboratively by participating in community service events specific to homeless veterans in counties under the VARO's jurisdiction. Because the VARO provided information on VA benefits and services to homeless shelters and service providers as required, we made no recommendation for improvement in this area.

Appendix A VARO Profile and Scope of Inspection

Organization The Winston-Salem VARO administers a variety of services and benefits, including compensation benefits; vocational rehabilitation and employment assistance; specially adapted housing grants; benefits counseling; outreach to homeless, elderly, minority, and women veterans; and public affairs.

Resources As of May 2012, the Winston-Salem VARO had a staffing level of 659 full-time equivalent employees. Of this number, the VSC had 368 employees assigned.

Workload As of March 2012, the VARO reported 33,153 pending compensation claims. The average time to complete claims was 296.1 days—66.1 days more than the national target of 230 days.

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

Our review included 60 (6 percent) of 926 disability claims related to TBI and herbicide exposure that the VARO completed from January through March 2012. For temporary 100 percent disability evaluations, we selected 30 (3 percent) of 1,079 existing claims from VBA's Corporate Database. We provided VARO officials with 1,049 claims remaining from our universe of 1,079 for their review. The 1,049 claims represented all instances where VARO staff had granted temporary 100 percent disability evaluations for at least 18 months or longer as of March 23, 2012.

We reviewed 12 claims folders containing errors identified by VBA's STAR program from October through December 2011. VBA measures the accuracy of compensation and pension claims processing through its STAR program. STAR assessments include a review of work associated with claims requiring rating decisions. STAR staff review original claims, reopened claims, and claims for increased evaluation. Further, they review appellate issues that involve a myriad of veterans' disability claims.

Our process differs from that of STAR as we review specific types of disability claims such as those related to TBI and herbicide exposure that require rating decisions. We reviewed rating decisions and awards processing involving temporary 100 percent disability evaluations. Additionally, we reviewed the 11 mandatory SAOs for FY 2011 and 2012.

For our review, we selected mail in various processing stages in the VARO mailroom and VSC. We reviewed 30 completed claims processed for Gulf War veterans from January through March 2012 to determine whether VSC

staff addressed entitlement to mental health treatment in the rating decision documents as required. We also reviewed the effectiveness of the VARO's homeless veterans outreach program.

Management Advisory

Prior to the issuance of this report, we issued a Management Advisory letter to the Under Secretary for Benefits to take immediate action regarding our concerns associated with inadequate claims storage space at the Winston-Salem VARO. The Under Secretary for Benefits comments and our Management Advisory letter can be found on the OIG's website, *VBA's Claims Folder Storage at the VA Regional Office Winston-Salem, North Carolina* (Report No. 12-00244-241, issued August 9, 2012).

Reliability of Data

During our inspection, we used computer-processed data from the Veterans Service Network's Operations Reports and Awards. To test for reliability, we reviewed the data to determine whether any data were missing from key fields, contained data outside of the period requested, included any calculation errors, contained obvious duplication of records, contained alpha or numeric characters in incorrect fields, or contained illogical relationships among data elements. Further, we compared veterans' names, file numbers, Social Security numbers, station numbers, dates of claims, and decision dates in the computer-processed data we received with information included in the claims folders we reviewed.

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

Compliance with Inspection Standards

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

Appendix B VARO Director's Comments

Department of Veterans Affairs **Memorandum**

Date: August 22, 2012

From: Director, Winston-Salem VA Regional Office (318/00)

Subj: Inspection of the VA Regional Office, Winston-Salem, North Carolina

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

1. Pursuant to the Office of Inspector General (OIG) Draft Report dated August 8, 2012, the Winston-Salem VA Regional Office concurs with the findings and recommendations. Responses to findings and recommendations are attached.

2. Questions may be referred to Julie Patton, AVSCM, at 336-251-0707.

(original signed by:)

C. J. Rawls

Attachment

Winston-Salem VA Regional Office
Response to the OIG
Benefits Inspection Division
Draft Report of the Winston-Salem Regional Office

OIG Recommendation #1.

We recommend the Winston-Salem VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives comply with the Veterans Benefits Administration's second signature requirements for traumatic brain injury claims.

Concur with Recommendation

Director's Response: A team meeting was held with Rating Veterans Service Representatives (RVSR) on May 16, 2012 to discuss the second signature requirements on traumatic brain injury (TBI) claims. An email reminder was also sent to all RVSRs on May 16, 2012. Effective May 21, 2012, RVSRs began routing all TBI claims through each Rating Board Coach prior to going to the Quality Review Team. Each VSR places a TBI rating decision requiring second signature on a designated table and the Coach logs the case onto the spreadsheet and takes it to the Quality Review Team Coach.

At the end of each month, the Quality Review Team Coach conducts an audit of all TBI rating decisions completed during the month compared to the TBI log. The Coach searches the local database using the key word "traumatic brain injury" to locate rating decisions involving a TBI claim. Any TBI rating decisions completed that were not on the TBI log are sent to the Rating Board Coaches. The Rating Board Coaches meet with the RVSR individually and provide additional refresher training on the procedures. The station is in the process of completing a standard operating procedure (SOP) for TBI second signature cases in order to centralize all of the current procedures into one document for all employees. The anticipated completion date for this SOP is August 31, 2012.

OIG Recommendation #2.

We recommend the Winston-Salem VA Regional Office Director develop and implement a plan for providing guidance and oversight to ensure mail-processing staff accurately and timely process search and drop mail.

Concur with Recommendation

Director's Response: The Veterans Service Center (VSC) has implemented the following actions to ensure compliance with the OIG recommendations. Veterans Service Center Memorandum 21-12-03, "Procedure for VSC Pull & Drop Mail for New Claims and Supplemental Mail" was issued May 18, 2012 to all employees. The Memorandum provided clear guidance for pull and drop procedures. In coordination with this memorandum, the Pre-

Determination Teams developed a lost mail checklist. The checklist ensures that all review points have been checked prior to implementing lost claims/evidence procedures.

In June 2012, the VSC ordered mail bins to replace search mail carts in order to improve the search mail process. The mail bins were delivered on August 1, 2012. All search mail will be sequenced and placed in these centrally located bins by August 31, 2012. Employees will be notified of the location changes and procedures at that time.

Two File Clerks were hired on August 13, 2012 and one additional File Clerk will report on August 27, 2012. The VSC continues to work with Vocational Rehabilitation and Education (VR&E) to gain additional staffing in the file clerk ranks. The additional staffing will improve the timeliness of mail, drop or search, being associated with claim folders.

All search mail will be audited monthly by the lead file clerk and Triage supervisor. On July 16, 2012, one additional Assistant Coach was added to the Triage Team with the primary assignment of improving Search Mail accuracy and timeliness. The Mail Routing Guide from the St. Petersburg Regional Office has been reviewed and will be incorporated into the Winston-Salem Mail Routing Guide by September 7, 2012. The Winston-Salem Regional Office (WSRO) is scheduled to execute VBA's Transformation Initiative in the first half of FY 2013. This will require the WSRO to implement an Intake Processing Center (IPC), which will require modification to local mail routing procedures.

OIG Recommendation #3.

We recommend the Winston-Salem VA Regional Office Director develop and implement a plan to ensure Rating Veterans Service Representatives address Gulf War veterans' entitlement to mental health treatment as required.

Concur with Recommendation

Director's Response: The Veterans Service Center (VSC) has implemented the following actions to ensure compliance with the OIG recommendations. A team meeting was held with Rating Veterans Service Representatives (RVSR) and Decision Review Officers (DRO) during the week of May 21, 2012 to discuss the proper way to address Gulf War Veterans' entitlement to mental health treatment. After discussions with the RVSRs, it was determined that most of them were addressing the issue in the narrative of the rating, but not in the rating decision code-sheet.

The Quality Review Team began calling local quality errors if Gulf War Veterans' entitlement to mental health treatment was not addressed properly on the rating decision code-sheet. The Quality Review Team will be conducting a formal refresher class on properly addressing Gulf War Veterans' entitlement to mental health treatment with a target completion date of September 15, 2012

Appendix C Inspection Summary

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

Table 2. Winston-Salem VARO Inspection Summary

Eight Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Claims Processing			
1. Temporary 100 Percent Disability Evaluations	**Determine whether VARO staff properly reviewed temporary 100 percent disability evaluations.** (38 Code of Federal Regulations (CFR) 3.103(b)) (38 CFR 3.105(e)) (38 CFR 3.327) (Manual (M)21-1 Manual Rewrite (MR) Part IV, Subpart ii, Chapter 2, Section J) (M21-1MR Part III, Subpart iv, Chapter 3, Section C.17.e)		X
2. Traumatic Brain Injury Claims	**Determine whether VARO staff properly processed claims for disabilities related to in-service TBI.** (Fast Letters 08-34 and 08-36, Training Letter 09-01)		X
3. Herbicide Exposure-Related Claims	**Determine whether VARO staff properly processed claims for service connection for herbicide exposure-related disabilities.** (38 CFR 3.309) (Fast Letter 02-33) (M21-1MR Part IV, Subpart ii, Chapter 2, Section C.10)	X	
Management Controls			
4. Systematic Technical Accuracy Review	**Determine whether VARO staff properly corrected errors STAR staff identified in accordance with VBA policy.** (M21-4, Chapter 3, Subchapter II, 3.03)	X	
5. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)	X	
Workload Management			
6. Mail-Handling Procedures	**Determine whether VARO staff properly followed VBA mail-handling procedures.** (M23-1) (M21-4, Chapter 4) (M21-1MR Part III, Subpart ii, Chapters 1 and 4)		X
Eligibility Determinations			
7. Gulf War Veterans' Entitlement to Mental Health Treatment	**Determine whether VARO staff properly processed Gulf War veterans' entitlement to medical treatment for mental illness.** (38 United States Code 1702) (M21-1MR Part IX, Subpart ii, Chapter 2) (M21-1MR Part III, Subpart v, Chapter 7) (Fast Letter 08-15) (38 CFR 3.384) (38 CFR 3.2)		X
Public Contact			
8. Homeless Veterans Outreach Program	**Determine whether VARO staff provided effective outreach services.** (Public Law 107-05) (M21-1MR Part III Subpart ii, Chapter 1, Section B) (M21-1MR Part III, Subpart iii, Chapter 2, Section I) (VBA Letter 20-02-34) (C&P Service Bulletins, January 2010 and April 2010)	X	

Source: VA OIG

C&P=Compensation and Pension, CFR=Code of Federal Regulations, M=Manual, MR=Manual Rewrite

Appendix D Office of Inspector General Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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