VA OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDITS & EVALUATIONS

Inspection of VA Regional Office Anchorage, AK

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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 (VSCs) operations. The objectives of the inspections are to:

- Evaluate how well VAROs and 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, Anchorage, AK

Why We Did This Review

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

What We Found

The Anchorage VARO management team faces challenges in providing benefits and services to veterans. VARO senior management acknowledged its workload was not under adequate control. Challenges include addressing oversight of operational activities, improving insufficient network capacity to support business processes, and providing training to staff. In addition, we found that an internal claims brokering process was in use. However, the process lacks criteria for what type of claim can be brokered. Management indicated it was difficult to manage and monitor the timely completion of brokered work to other VAROs. Further, we found the VARO did not meet the requirements for 13 of 14 operational areas reviewed.

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

- Tracking veterans' claims in Control of Veterans Records System (COVERS).
- Establishing correct dates of claims.
- Correcting errors identified by VBA's Systematic Technical Accuracy Review (STAR).
- Completing Systematic Analysis of Operations (SAOs) accurately and timely.
- Safeguarding VARO date stamps and veterans' personally identifiable information (PII).
- Handling veterans' claims-related mail and responding to congressional and other electronic inquiries.

What We Recommended

We recommended that the VARO improve oversight of the quality assurance process for the operational areas where we identified weaknesses. We also recommended the VARO develop and implement a mail routing guide to ensure mail is properly controlled and processed, research the causes and solutions for network capacity issues, and report internal brokering to VBA leadership.

Agency Comments

The Director of the Anchorage 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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Results of Inspection

During the period July 28–August 6, 2009, the OIG conducted an inspection of the Anchorage VA Regional Office (VARO). The inspection focused on 5 protocol areas examining 14 operational activities. The VARO did not meet the requirements for 13 of the 14 operational activities inspected. We also made observations pertaining to issues that VBA policy or procedures do not specifically require but may affect benefits delivery or VARO performance and provide an opportunity to improve operations.

Anchorage VARO Management Challenges

The Anchorage VARO management team faces challenges in the Veterans Service Center (VSC). These challenges include improving oversight of operational activities, improving insufficient network capacity to support business processes, and providing training to staff. In addition, we found that an internal claims brokering process was in use and the VARO lacked control over its workload. VSC management indicated it was difficult to manage and monitor the timely completion of work brokered to other VAROs. Further, due to the lack of quality control regarding the brokered claims-related decisions, we will continue to examine this issue in future inspections at other VAROs.

The current Veterans Service Center Manager (VSCM) accepted assignment to this position in May 2009. Prior to this appointment, the VSCM position was vacant for approximately 8 months, and a coach performed VSCM duties during that period. The new manager concurred with our assessment of the VSC and agreed with all errors identified by the inspection team. The manager also stated that since his arrival, he observed that standards within the VSC were not always enforced and he attributed this to the delay in filling his position. The absence of the VSCM played a role in the VARO not having control of its workload. In addition, the VARO does not have a Director physically located in Anchorage. The Director of the Salt Lake City VARO remotely manages the regional office.

VARO Activities Requiring Management Attention

Disability Claims Processing

We reviewed 78 (88 percent) of 89 completed diabetes (to include disabilities related to herbicide exposure), post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and Haas[1] claims for which the VARO made a decision regarding these specified issues. The VARO made these decisions during the period of April–June 2009.

Our analysis revealed errors in 23 (29 percent) of the 78 claims, but the Anchorage VARO actually processed only 17 of those errors. The six remaining errors were attributable to

[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.

brokered work completed at other VAROs. One of the claims processed at another VARO contained an error that affected the veteran's benefits. VSC management concurred with the errors and took measures to correct them. The following table reflects the errors by claim type and those errors affecting veterans' benefits:

Table 1. Disability Claims Processing Errors

Claim Type	Claims Reviewed	Claims with Errors	Claims with Errors Affecting Veteran's Benefits	Claims with Errors Affecting Veterans' Benefits Processed by Other VAROs
Haas	28	11	1	0
PTSD	27	7	1	0
Diabetes	16	3	1	1
TBI	7	2	0	0
Total	**78**	**23**	**3**	**1**

VSC Personnel Need to Improve the Accuracy of Disability Determinations

Haas Claims. One of the 11 processing errors identified for Haas cases affected the veteran's benefits. The error occurred when a Rating Veterans Service Representative (RVSR) did not grant entitlement to special monthly compensation for a condition related to the veteran's service-connected diabetes. The veteran was underpaid $288. The processing of this claim occurred after VA lifted the stay on Haas claims.

Of the remaining 10 errors, 5 had the potential to affect veterans' benefits because VSC staff prematurely denied the claim before obtaining all necessary evidence. For example, in one case, a veteran alleged exposure to herbicide agents while serving in Thailand. The claim folder documentation confirmed he had served in Thailand. VSC staff should have requested information to determine exposure to herbicide agents in Thailand. The final five errors did not affect veterans' benefits, as they were procedural in nature. VSC staff improperly identified these cases as Haas claims and placed them on stay causing the veteran an unnecessary delay in receiving a decision.

PTSD Claims. One of the seven processing errors identified for PTSD cases affected a veteran's benefits when an RVSR assigned an incorrect effective date for payment of PTSD benefits. Staff should have paid benefits to the veteran from the day after discharge from active duty and not the date on which the VARO received the claim. As a result, the veteran was underpaid $4,758.

Another error had the potential to affect the veteran's benefits, as VSC staff did not obtain military personnel records from the National Personnel Records Center to support the claim. The final five errors were procedural in nature and did not affect the veterans' benefits. For example, VSC staff requested the veteran provide evidence of a stressful event to support a claim for PTSD even though the required evidence verifying the stressful event was already in the veteran's record.

Diabetes and Disabilities Related to Herbicide Exposure Claims. One of the three processing errors identified for diabetes cases affected a veteran's benefits. An RVSR incorrectly denied a

veteran service connection for hypertension and did not properly consider retinopathy secondary to service-connected diabetes. Medical evidence associated with the veteran's claims folder revealed a physician provided a medical opinion linking the hypertension and retinopathy to the diabetes. VSC staff should have granted service connection for each disability. This claim had no monetary affect as both the hypertension and retinopathy disabilities were not severe enough to warrant a compensable evaluation. However, the veteran will not receive VA health care for these conditions until the VARO grants service connection.

One error had the potential to affect benefits. VSC staff prematurely denied a veteran service connection for a neurological condition related to diabetes without requesting a medical examination to determine if the condition was related to diabetes. Senior VSC management requested an examination to correct this error. The final error was procedural in nature as VSC staff incorrectly used the wrong date to document the entitlement of a dependent's educational benefit.

TBI Claims. Two processing errors identified for TBI cases had the potential to affect veterans' benefits. One error occurred because VSC staff incorrectly used old criteria to evaluate the residual disabilities of TBI. VSC staff should have requested a new medical examination and evaluated the residual disability of TBI under the new criteria. We could not determine to what extent the VSC error has affected the veteran's benefits without the results of the medical examinations.

The other error was a result of VSC staff incorrectly denying service connection for residual disability of a traumatic brain injury. The RVSR denied the claim because the in-service event could not be verified. The veteran was a combat veteran who was involved in two Improvised Explosive Device (IED) explosions. VBA policy states, "Satisfactory lay or other evidence that an injury or disease was incurred or aggravated in combat will be accepted as sufficient proof of service connection if the evidence is consistent with the circumstances." VSC staff should have requested a medical opinion to determine if the current residual disability of the TBI claim were a result of the veteran's involvement in IED explosions.

The claims processing errors occurred due to a lack of training. A Decision Review Officer located at the Ft. Harrison, Montana VARO was responsible for performing the monthly RVSR training supporting VARO Anchorage training monthly. Management told us the VSC struggles with RVSR training because the VARO did not have a Decision Review Officer assigned, and the current monthly training was not sufficient to maintain proficiency. Since concluding our inspection, a Decision Review Officer was assigned to the VARO.

VSC management attempted to provide RVSR training via video with the Salt Lake City VARO several times. Management cancelled training because of insufficient network capacity to support normal business processes. Ultimately, senior VSC management discontinued this type of training.

Recommendation 1. *We recommend the Anchorage VA Regional Office Director develop and implement a training plan to ensure Rating Veterans Service Representatives consistently receive training to maintain required skills.*

Management Comment

The VARO Director concurred with our recommendation and implemented a new training plan for RVSRs. Weekly training included increased emphasis regarding the correct procedures for processing Haas, post-traumatic stress disorder, diabetes and disabilities related to herbicide exposure and traumatic brain injury claims.

OIG Response

Management comments and actions are responsive to the recommendation. The new training plan provides for weekly RVSR training through March 2010.

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 to track 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 indicates 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 found 10 (33 percent) of the 30 claims folders were not updated in COVERS at the correct location. Current VARO policy states that all files at employee desks will be updated in COVERS every Monday. Specifically:

- The elapsed time to update the 10 claims in COVERS averaged 19 days.
- One folder was not tracked in COVERS for 36 days.

A VSC official stated that supervisors should perform random checks once a week to ensure employees followed COVERS policy, but recently the checks had not been completed. A senior VSC manager informed us there had been little enforcement of standards while the VSCM position was vacant. Ultimately, the VARO management team lacked reasonable assurance regarding the location of its claims folders within the VSC.

Recommendation 2. *We recommend the Anchorage 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 our recommendation and implemented a new policy on November 4, 2009. This policy requires staff to track claims folders in COVERs weekly and provides for a quality review program to ensure employees adhere to the policy.

OIG Response

Management comments and actions are responsive to the recommendation.

Correct Date of Claim Inconsistently Established

Our analysis of 30 disability claims to determine if VSC staff established the correct date of claim revealed 5 (17 percent) of the claims were either incorrectly established in the electronic record, the wrong date was stamped on the incoming document, or the document did not contain a VARO date stamp. Following is a description of the errors:

- Three errors occurred because the incorrect year (2010) was programmed into the electronic date stamp. The correct year should have been 2009. VSC staff entered the correct month and day into the electronic record; however, they did not amend the year on the paper documents. Our concern was that once the incorrectly stamped 2010 date on the document passes, decision-makers have an increased risk of using that incorrect date to pay benefits, rather than paying benefits back to the correct 2009 date.
- One error occurred because VSC staff entered the incorrect date of claim in VBA's electronic record. The veteran submitted a claim on February 17, 2009. The electronic record revealed the incorrect date of May 27, 2009, erroneously improving VARO performance by 99 days.
- On June 17, 2009, the VARO received a claim via fax. Although the VSC staff recorded the correct date of claim in the electronic record, they did not affix the proper date stamp to the paper document in accordance with VBA policy.

In addition to the 30 claims reviewed, the VARO received a claim on October 2, 2007 via the Inquiry Routing and Information System (IRIS). On March 5, 2009, the claimant submitted an inquiry as to the status of this claim. VSC staff erroneously recorded March 5, 2009 into the electronic record instead of the correct date of October 2, 2007. The potential existed for the claimant to lose over one year of benefit payments due to the incorrect date of claim. VSC management corrected the error.

A senior VSC manager stated these errors occurred because supervisors were not completing quality assurance reviews for Veterans Service Representatives responsible for establishing the correct dates of claim. The manager also indicated oversight of the first-line supervisors was lacking because the VSCM position had been vacant. VSC management concurred with the errors and responded appropriately to correct them.

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. Further, not ensuring the correct date of claim on paper documents increases the risk for inaccurate benefits payments.

Recommendation 3. *We recommend the Anchorage VA Regional Office Director develop and implement a plan to complete timely quality assurance reviews to ensure Veterans Service Representatives follow policy regarding proper procedures to establish the correct date of claim.*

Management Comment

The VARO Director concurred with our recommendation. The VARO completed an analysis of date of claim integrity that resulted in VSC staff reviewing 100 cases a month with a report due to the Director in February 2010. In addition, Claims Assistants and Veterans Service Representatives completed refresher training on October 22, 2009. Senior VSC management implemented a new Division Quality Review Plan to ensure supervisors are performing local quality reviews in accordance with national performance standards.

OIG Response

Management comments and actions are responsive to the recommendation. The OIG inspection team will assess the effectiveness of these new policies in a future site inspection.

Management Controls

We assessed management controls to determine if VARO management adheres to VBA policy regarding employee rotations within the Claims Process Improvement business model, correction of errors identified by the Systematic Technical Accuracy Review (STAR) staff, completion of Systematic Analysis of Operations (SAOs), and VARO date stamp accountability. According to senior VSC management, the Anchorage VARO was not required to rotate employees under the CPI model because the station's workload was not under control.

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

VBA administers a multi-faceted quality assurance program to ensure veterans and beneficiaries receive accurate and consistent compensation and pension benefits. STAR is a key mechanism for evaluating VARO performance in processing accurate benefits claims.

Our review of 19 files that contained errors identified by VBA's STAR program between January–March 2009 showed that 8 (42 percent) of the STAR errors were not corrected in accordance with VBA policy.[2] The policy requires the VARO to take and report on corrective actions and retain error documentation for training. We noted that VSC staff erroneously informed STAR that all eight errors had been corrected. Two of those eight errors affected the veterans' benefits as described below:

- STAR instructed the VARO to grant service connection for a sleeping disorder that VSC staff improperly denied. Our analysis of the claims folder revealed staff did not prepare a new decision to grant service connection. As of August 2009, the veteran was underpaid $5,397.

[2]VBA Policy M21-4, "Manpower Control and Utilization in Adjudication," *Quality Assurance*, dated June 29, 2007.

- STAR instructed the VARO to send a letter notifying a widow of a $59 overpayment and the denial of entitlement to pension benefits. The VARO did not correct the error as reported to STAR.

The remaining six errors were procedural in nature. For example, VSC staff failed to correct information in a letter to the veteran regarding an explanation of benefits. VSC management concurred with the errors and responded appropriately to correct them.

VSC senior management told us these errors occurred due to a lack of oversight to ensure completion of all corrective actions. A VSC supervisor told us the VARO did not have a formal process to review the errors and stated, "We trusted employees to take the corrective action and keep management informed." As a result, the VARO Director lacked assurance employees were maintaining the integrity of VBA's quality assurance program.

Recommendation 4. *We recommend the Anchorage 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's Systematic Technical Accuracy Review staff.*

Management Comment

The VARO Director concurred with our recommendation and implemented a new policy on November 4, 2009. This policy requires the senior VSC manager to report the results of corrective action taken on STAR errors to the VARO Director.

OIG Response

Management comments and actions are responsive to the recommendation. The OIG inspection team will assess the effectiveness of this new policy in a future site inspection.

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 VAROs to perform SAOs annually and to cover all aspects of claims processing, including quality, timeliness, and related factors. In addition, the VARO is required to publish an annual schedule indicating when each SAO is to be completed.[3]

We analyzed the VAROs annual SAO schedule for FY 2009 and determined that 8 of the 11 SAOs should have been completed at the time of our inspection. Our analysis revealed five were completed late; two had not been completed even though they were due, and one was only partially completed.

During our inspection, we identified several operational activities where the VSC did not follow VBA policy. If VSC management had properly completed the required SAOs, they might have

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

identified some of the existing or potential problems. For example, supervisors addressed STAR errors in the *Quality of Compensation, Pension, and Ancillary Actions* SAO. However, management did not discuss the effectiveness of their process to ensure the correction of STAR errors. If staff completed a more thorough analysis, management might have known STAR errors remained uncorrected.

VSC management informed us that SAOs were untimely because the VSCM position was vacant for almost 8 months, and the remaining managers could not provide adequate oversight of this activity. In addition, the VSC sends SAOs to the Director of the Salt Lake City VARO for approval and a supervisor stated this practice causes delays in the timely completion of these analyses.

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

Recommendation 5. *We recommend the Anchorage VA Regional Office Director develop and implement a mechanism to ensure the Veterans Service Center management team performs complete, accurate, and timely Systematic Analysis of Operations and takes appropriate corrective action to fix identified problems.*

Management Comment

The VARO Director concurred with our recommendation. Staff created a tracking spreadsheet to more efficiently monitor and receive SAOs. In addition, the Director's office will monitor all follow-up actions related to SAOs and senior VSC management will ensure existing or potential problems are identified and corrective action taken.

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 arrives in any VA facility. The date a VA facility receives a document is important because VBA may rely on it to determine disability payment effective dates. On March 19, 2009, VBA issued policy providing guidance for the accountability and safeguarding of date stamps.[4] 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 two electronic date stamps, which we inventoried during our review. We observed that the electronic date stamp assigned to the Triage team was in a common area for use by all VSC personnel and was unattended on several

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

occasions. This date stamp did not have a locking mechanism to restrict its use when unattended. Senior VSC management told us some non-VA personnel had the code to access secure doors to the VSC, thus allowing uncontrolled access to the Triage date stamp.

The OIG completed work in June 2008 that revealed VBA lacked sufficient guidance directing VAROs to maintain adequate control over their official date stamps. As a result of this work, the OIG determined VAROs will continue to be vulnerable to fraud from backdated claims documentation.[5]

VSC management informed us they were drafting a local policy to help strengthen controls over date stamp accountability and safeguarding them from unauthorized use. Management did not complete the policy at the time of our inspection. Although the VSCM is creating a new policy, VARO management did not properly secure all electronic date stamps. As a result, the VARO Director did not have assurance that all date stamps were properly accounted for and safeguarded.

Recommendation 6. *We recommend the Anchorage VA Regional Office Director develop and implement a plan to safeguard date stamps against unauthorized use.*

Management Comment

The VARO Director concurred with our recommendation and implemented a new policy on October 15, 2009. The policy includes a signed delegation of authority to limit date stamp use to authorized personnel. In addition, the VARO now uses an electronic date stamp containing two locking devices.

OIG Response

The OIG inspection team will assess the effectiveness of the new policy in a future site inspection. Management comments and actions are responsive to the recommendation.

Information Security

The OIG inspection team conducted random inspections of employee workstations to determine if staff properly followed VBA's new 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 storage containers. Our inspections focused on these areas and did not include a review of employees' desktops where these materials are allowed 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. Also, the policy requires supervisors to perform inspections of the workstations to ensure adherence with policy.

[5]OIG report *Review of Veterans Benefits Administration Large Retroactive Payments* (Report No. 08-01136-156), issued June 30, 2009.

We also analyzed mail-handling procedures in the mailroom and the VSC Triage team to ensure the accurate and timely processing of mail. The VARO is co-located with a VA Medical Center (VAMC) and VAMC mailroom staff performed initial mail processing. VAMC staff delivered mail daily to the VARO and we observed no deficiencies with this process.

Veterans' Personally Identifiable Information Not Always Safeguarded

During our review, we performed unannounced inspections of 5 (20 percent) of the 25 employees' workstations located in the VSC. We found unredacted PII at 4 (80 percent) of the 5 employees' workstations. The PII primarily consisted of unredacted training materials.

VSC supervisors performed internal inspections of employee workstations in June–July 2009 and found no PII violations. However, in July 2009, our review of three of the same workstations identified PII violations. A VSC supervisor stated, "There is not enough time to review all the documents at every employee's work stations."

We concluded VSC management did not perform adequate inspections of employees' workstations. Although we found no evidence of improper destruction of documents, the VARO Director lacked assurance that staff properly safeguarded veterans' PII.

Recommendation 7. *We recommend the Anchorage VA Regional Office Director develop a mechanism to ensure supervisors are consistently performing inspections of the Veterans Service Center to more effectively safeguard veterans' Personally Identifiable Information.*

Management Comment

The VARO Director concurred with our recommendation and implemented a new Records Management circular. Monthly desk audits are performed and the results are forwarded to the VARO Director for review. Further, VSC staff received training, to include proper safeguarding of veterans' PII and proper destruction of materials.

OIG Response

The OIG inspection team will assess the effectiveness of the training and new circular in a future site inspection. Management comments and actions are responsive to the recommendation.

Mail Management Procedures Within Triage Team Need Strengthening

The Claims Process Improvement Model (CPI) Implementation Plan indicates the Triage team is responsible for reviewing, controlling, processing, or routing 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 within the Triage team of the Anchorage VARO and concluded employees did not always process incoming mail according to VBA policy. Further, VSC supervisors did not ensure the timely and accurate processing of mail in accordance with the VARO's workload management plan.

Following are examples of control weaknesses found regarding mail management in the Triage team:

- Eight (27 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 claim for benefits received on July 3, 2009, but was not recorded until July 21, 2009, a difference of 18 days.
- Seven (23 percent) of 30 pieces of mail related to active claims were at mail points waiting to be associated with the veterans' claims folders (also known as search mail). A review of COVERS revealed all seven claims folders were physically located at the Anchorage VARO. VSC staff should have retrieved those folders to attach the mail. One piece of claims-related mail had been sitting at a mail point for 58 days.
- On April 10, 2009, VSC staff routed an original claim to the wrong mail point. Although properly recorded in the electronic record, VSC staff had taken no action to process the claim as of July 29, 2009, a difference of 110 days.

The *Quality of Files Activity* SAO completed by VSC management on July 10, 2009, identified 45 pieces of mail at one mail point with the oldest document dated February 25, 2009. VSC management concluded the file clerk had not reviewed this mail point for "some time" and provided the recommendation in the SAO to perform weekly reviews of mail points. However, the same supervisor that made the SAO recommendation told us management is still not performing reviews.

VBA policy[6] requires VAROs to have a mail routing guide that establishes explicit delivery procedures for all categories of mail and the VSCM should review the guide at least once a year to ensure that it is current. VSC management told us the Anchorage VARO had never completed a mail routing guide. Further, the VARO mail-user plan does not contain provisions to ensure VSC managers perform workload management reviews of mail handling procedures as directed by VBA policy.[7]

As a result, the VARO Director lacked assurance that claims-related mail processed within the VSC was properly recorded into electronic systems and that mail was timely and accurately processed. Because VSC supervisors did not ensure staff followed the VARO workload management plan, the Director could not determine its effectiveness.

Recommendation 8. *We recommend the Anchorage VA Regional Office Director develop and implement a mail routing guide and improve the oversight of mail handling procedures to ensure Veterans Service Center staff follow policy to provide assurance mail is properly controlled and processed within the Triage team.*

[6]VBA policy M21-1MR, Part III, subpart ii, Chapter 1, Section A.4.b, *Individual and Group Responsibilities for Division Mail Management*, dated September 26, 2008.

[7]VBA policy M21-4, Chapter 2, subchapter II, 2.05.i, *Workflow Management*, dated August 31, 2009.

Management Comment

The VARO Director concurred with our recommendation and issued a new Triage Workflow Plan, to include a Mail Routing Guide, on September 2, 2009. The Triage coach is responsible for providing senior VSC management with a monthly summary of all mail actions, as well as any follow-up action, as required.

OIG Response

The OIG inspection team will assess the effectiveness of the new Triage Workflow Plan and Mail Routing Guide in a future site inspection. 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.

Inconsistent Accuracy and Timeliness in Responding to Veterans' Electronic Inquiries

We analyzed all 23 completed IRIS messages from January–March 2009 to determine if the VSC provided complete, accurate, and timely responses to veteran inquiries. IRIS is VA's internet-based public message management system and is one method used by VSCs to communicate with veterans. Each written correspondence to the veteran contains an email address (https://iris.va.gov) that provides a method for veterans to send electronic inquiries to VA.

For 22 (96 percent) of the 23 inquiries, the Public Contact team did not follow VBA's policy of providing accurate and complete responses within 5 business days. Of the 22 errors, 19 exceeded the 5-day standard, 2 contained incomplete responses, and 1 was both untimely and incomplete. Following is an example of the VARO's incomplete response to a veteran who stated:

> *I was exposed to what may have been asbestos while in service and have asthma. My asthma and additional disabilities are related to asbestos exposure.*

The VARO properly instructed the veteran on how to file this claim. However, the response should have informed the veteran that this inquiry is 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.

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. Senior VSC officials told us these errors occurred because management had not performed quality assurance reviews since April 2009. As a result, the VARO Director had no assurance that veterans receive accurate, complete, and timely responses.

Recommendation 9. *We recommend the Anchorage VA Regional Office Director develop and implement a plan to improve quality assurance reviews for Inquiry Routing and Information System inquiries to ensure responses to veterans are timely and accurately completed.*

Management Comment

The VARO Director concurred with our recommendation and implemented the IRIS Quality Review Policy on November 5, 2009. This policy requires the Public Contact Team Coach to review five IRIS queries and responses each month. If individual quality drops below 90 percent for accuracy and timeliness, quality reviews will be expanded to improve performance.

OIG Response

Management comments and actions are responsive to the recommendation. The OIG inspection team will assess the effectiveness of the policy in a future site inspection.

Controls Over Processing Congressional Inquiries Need Strengthening

During the 3-month period January–March 2009, the VARO received 14 congressional inquiries. However, only nine were available for review as the remaining claims folders were temporarily unavailable. For all 9 inquiries, VSC response times exceeded 5 days and averaged 76 days. The longest response time was 122 days or more than 4 months. VBA's policy requires VSC staff to respond to congressional inquiries within 5 business days.

One of the responses was both untimely and inaccurate. In this instance, VSC staff informed Senator Murkowski's office that the VARO would reopen a veteran's claim for Hepatitis C and schedule a medical examination. However, the claims folder revealed this claim was already on appeal. Once on appeal, a claim may not be reopened and a medical examination may not be scheduled. The VSC staff did not provide this update to the Senator.

The supervisor in charge of processing this type of work stated he was not aware of VBA's policy to complete congressional inquiries within 5 days. In addition, supervisors did not perform quality assurance reviews over this work because management did not have a procedure in place to ensure the required actions were completed. Senior VSC management attributed these errors to a lack of thorough reviews.

Recommendation 10. *We recommend the Anchorage VA Regional Office Director develop and implement a mechanism to ensure congressional inquiries are processed timely and accurately.*

Management Comment

The VARO Director concurred with our recommendation and implemented the Handling of Congressional/Controlled Correspondence Policy on November 6, 2009. Congressional inquiries are now controlled, assigned, and approved by the senior VSC manager. The Public Contact Team now ensures inquires are recorded in a control log within one day of receipt and processed within two days of being assigned.

OIG Response

Management comments and actions are responsive to the recommendation. The OIG inspection team will assess the effectiveness of the policy in a future site inspection.

Additional Areas Identified

Network Capacity to Support Business Processes Needs Improvement

According to VSC management, the Anchorage VARO has serious information technology concerns. As a result, VSC staff is not always able to access applications required to process claims, such as Rating Board Automation 2000 (RBA 2000), Modern Awards Processing-Development (MAP-D), SHARE, and video-teleconference equipment.

RBA 2000 is a Veterans Network (VETSNET) application designed to assist VBA RVSRs in the preparation of formal disability decisions and transfers captured data into a VA corporate database. MAP-D is a VETSNET application designed to facilitate the development of evidence in claims processing. SHARE is a computer application the VARO employees use to establish and manage claims data.

Three RVSRs provided us with information regarding the lack of accessibility of these programs during a normal workday. One RVSR stated these information technology issues have been ongoing for over a year. We observed one RVSR restart the computer four times in one day because RBA 2000 was unresponsive. RVSRs informed us that they had to restart their computers on average of three times a day, each time taking approximately 5 minutes. Based on this approximation, 7.5 production hours per RVSR is lost over a 30-day period. The Anchorage VARO has six RVSRs assigned to the VSC.

VSC management informed us they cancelled several training sessions because the video-teleconference connection with the host site in Salt Lake City was interrupted or of poor quality. Also, the OIG inspection team experienced degraded video-teleconference signals during our entrance and exit briefings with the Director in Salt Lake City. Because of the insufficient network capacity to support business processes, the Anchorage VARO lost valuable production and training time that ultimately affected the delivery of benefits to veterans.

Recommendation 11. *We recommend the Anchorage VA Regional Office Director conduct research to determine the cause of insufficient network capacity and implement a plan to improve network capacity to support business processes.*

Management Comment

The VARO Director concurred with our recommendation and informed us four T-1 lines are to be installed in November 2009. The Director believes this action will improve access issues related to business applications such as the Rating Board Application 2000.

OIG Response

Management comments and actions are responsive to the recommendation. The OIG inspection team will assess the effectiveness of the new T-1 lines during a future site inspection.

Internal Claims Brokering Plan Does Not Always Enhance VARO Performance

According to VBA's Performance Analysis and Integrity (PA&I) staff, the Anchorage VARO brokered 927 rating-related claims to other VAROs for processing from October 2008 through June 2009. During our site visit, however, Anchorage VSC management provided us documents showing 1,936 claims had been brokered to other VAROs for processing. The VARO Director stated the discrepancy in the number of brokered claims reported by the VARO versus the number of brokered claims reported by PA&I occurred because claims brokered internal by the VARO were not reported to PA&I.

The Director explained that internal brokering is a plan created by the Director to move rating-related claims only between the Anchorage, AK, Ft. Harrison, MT, and Salt Lake City, UT VAROs, as he is the Director for all three stations. The Director told us the advantage of an internal brokering plan is that no criteria are required for what type of claim can be brokered to other stations to complete. In comparison, VBA's brokering plans have established requirements regarding which cases VAROs can broker.

Additional issues we noted regarding brokering at the Anchorage VARO involved mail handling, workload management, and staffing. One supervisor told us that brokering impacts mail handling operations in Triage because mail often "chases" the claims folders throughout the claims process. It is difficult to associate mail to an appropriate claims folder if the claims folder is located at another station due to its being brokered. For instance, the Anchorage VARO could receive a claims folder with a completed decision from the brokered station. However, they might then have to rework the claim if the brokered decision did not contain all the evidence because the mail had not caught up with the associated claims file.

The internal brokering plan is not consistent or manageable. The VSCM informed us the VSC is notified via e-mail how many claims will be sent to other stations to work. Recently, the VARO Director changed the brokering request three times in one week. According to the VSCM, approximately 30 percent of the station's workload is brokered to other VAROs. The manager stated he does not have control of his workload, and that it makes it difficult to create a workload management plan that can monitor brokered work.

The VSCM also informed us that the Anchorage VARO does not have the staffing level comparable to other VAROs with a similar workload. VSC management estimated a staffing level comparable to that of the Boise VARO would be sufficient to sustain their workload without assistance from other VSCs and make brokering unnecessary. We compared the Anchorage VARO workload and Full-Time Employees (FTE) to that of the Boise, ID VARO. The following table reflects that comparison:

Table 2. Comparison of the Anchorage and Boise VAROs

VARO	VSC Staffing Level	FY09 Brokered Claims to Other VAROs (Oct–Jun 2009)	FY 09 Brokered Claims from Other VAROs (Oct–Jun 2009)	Total Claims Inventory of Rating and Non-Rating Claims (as of Jun 2009)
Boise	47	0	786	1,816
Anchorage	25	927	0	1,906

Our analysis revealed the Boise VARO has 22 additional FTE and this enabled them to sustain their own inventory without relying upon other VAROs for assistance. Over the same period, Boise was able to broker in more than two-thirds of the workload that Anchorage brokered out. Based on our analysis and interviews with VSC staff, we believe the Anchorage VARO internal brokering process obscures the effects of internal claims brokering on VARO staff and operations for senior VBA leadership.

Recommendation 12. *We recommend the Anchorage VA Regional Office Director report results of internal brokering to VBA Leadership monthly to ensure VBA Leadership is aware of the effect of this process.*

Management Comment

The VARO Director concurred with our recommendation. The Director indicated there is no requirement to report file movement between stations, although he coordinates all brokering issues, to include number of brokered cases, through the Western Area Office, as the next level in his supervisory chain of command. The VARO keeps the Western Area Office informed of any significant short-term movements of work in order to achieve the greatest efficiencies in servicing veterans as timely as possible.

OIG Response

Management comments and actions are responsive to the recommendation. Despite the lack of a requirement to report the file movement between stations, senior VBA leadership needs visibility over internal brokering programs. The OIG is conducting a VBA-wide audit to evaluate how VARO brokering of claims affects the processing timeliness of disability rating claims.

Observations

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

Brokered Claims. VBA has established a brokering plan that allows VAROs to send (or 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. During our review of claims processing at the Anchorage VARO, 18 claims had been brokered to other VAROs and 6 contained processing errors, with 1 error affecting a veteran's benefits.

In March 2009, an OIG audit[8] reported that VBA's STAR quality assurance process does not provide a complete assessment of compensation claims 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 in *VA's FY 2008 Performance and Accountability* report for the 12-month period ending February 2008. 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. As a result, we will continue to examine and report on the accuracy of brokered claims during VARO inspections.

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

Appendix A

VARO Profile

Organization. The Anchorage VARO is responsible for delivering non-medical VA benefits and services to veterans and their families in Alaska. 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 Anchorage VARO has one out-based office; however, the inspection team did not perform any work at that facility.

Resources. As of December 2008, the Anchorage VARO had a staffing level of 32 FTE. Of the 32 FTE, 25 (78 percent) were assigned to the VSC.

Workload. As of June 2009, the VARO had 1,378 pending C&P claims that took an average of 190.3 days to complete, which is 21 days longer than the national target of 169.3 days. Accuracy for C&P rating-related issues, as reported by VBA's Performance Analysis and Integrity, was 81.5 percent, below the national standard of 90 percent. Accuracy for C&P authorization-related issues, as reported by VBA's Performance Analysis and Integrity, was 93.2 percent, below 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.

The disability claims processing review covered VARO operations during the 3-month period April–June 2009. Reviews of STAR, IRIS, and congressional inquiries covered the 3-month period January–March 2009. The reviews were done in accordance with the President's Council for Integrity and Efficiency's *Quality Standards for Inspections.*

Appendix B

Department of Veterans Affairs

Memorandum

Date: November 9, 2009

From: Director, VA Regional Office Anchorage (463/00)

Subj: Inspection of VA Regional Office, Anchorage, Alaska

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

Enclosed is the Anchorage VA Regional Office comments and response to the OIG Draft Report, Inspection of the VA Regional Office, Anchorage, Alaska, from July 28 to August 6, 2009. The Anchorage Regional Office concurs with the findings and recommendations regarding the VARO Activities Needing Additional Management Attention, which include Disability Claims Processing, Data Integrity, Management Controls, Information Security, Public Contact, and Additional Areas Identified and concurs with the suggested improvement items for our station. Attached are our comments and responses to the specific recommendations and improvement actions resulting from the review. Recommendations that have Actions that are completed have been annotated after each "Planned/Completed Action."

We appreciate the professionalism and courtesy exhibited by the audit team members during their review, as well as the analysis provided by the team. This analysis and suggested improvement actions are invaluable in our continued efforts to provide the best possible benefits and services to our veterans.

Please feel free to contact me at (801) 326-2400 with any questions or concerns regarding our reply.

(original signed by:)
MARK M. BILOSZ
Director

Enclosure

Anchorage VA Regional Office
Response to the Office of Inspector General, Benefits Inspection Division, Inspection of the VA Regional Office Draft Report

Comments and Implementation Plan

OIG Recommendations

Recommendation 1. *We recommend the Anchorage VA Regional Office Director develop and implement a training plan to ensure Rating Veterans Service Representatives consistently receive training to maintain required skills.*

Concur with recommendation.

Planned/Completed Action: A new training plan for Rating Veterans Service Representatives (RVSR) has been developed and implemented by the Veteran Service Center Manager, beginning with training conducted on September 28, 2009, and continuing weekly on the every Monday. Current plan has training topics planned until March 29, 2010. Emphasis items included increased emphasis on the correct procedures for processing Haas, Post Traumatic Stress Disorder, Diabetes and Disabilities Related to Herbicide Exposure, and Traumatic Brain Injury (TBI) claims. (Action Completed.)

Recommendation 2. *We recommend the Anchorage 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.*

Concur with recommendation.

Planned/Completed Action: The Veterans Service Center Manager implemented a consistent policy in controlling and tracking claims folders in a November 4, 2009 VSC Directive (09-05). This policy requires Claim folders to be COVER'd weekly. The policy provides a quality review program tracking compliance and ensures employees are responsible for COVERing all claims folders at their work area each Monday morning. Coaches are responsible for follow-up and any other required actions necessary, such as reports and identifying any trends or deficiencies. (Action Completed.)

Recommendation 3. *We recommend the Anchorage VA Regional Office Director develop and implement a plan to complete timely quality assurance reviews to ensure Veterans Service Representatives follow policy regarding proper procedures to establish the correct date of claim.*

Concur with recommendation.

Planned/Completed Action: On October 21, 2009, a Systematic Analysis of Operations (SAO) on Date of Claim Integrity was completed on this issue. As a result, 100 cases a month are now being reviewed with a report due February 2010. Findings included an overall error rate of 5 percent (6.5 percent on rating related claims and 3.5 percent on non rating related claims).

Immediate refresher training to Claims Assistants and VSRs was completed on October 22, 2009. Coaches are responsible to provide timely and corrective feedback when errors are found. February 2010 Report will be sent to the VARO Director for his review. In addition, VSC Division Directive 09-03, Division Quality Review Plan, was implemented on August 13, 2009. This policy implemented a consistent policy in conducting local quality reviews. Coaches are responsible for ensuring local quality reviews are done in accordance with national performance standards and can be increased if necessary, based on trends, training needs, and any deficiencies. Weekly training will be held on scheduled topics and exceptions noted during the month. (Action Completed.)

Recommendation 4. *We recommend the Anchorage 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's Systematic Technical Accuracy Review staff.*

Concur with recommendation.

Planned/Completed Action: A Division policy, Directive 09-06, Handling of STAR Errors, dated November 4, 2009, is now place for the proper handling of STAR errors and response. Reports to the Director showing corrective action are the sole responsibility of the VSCM. (Action Completed.)

Recommendation 5. *We recommend the Anchorage VA Regional Office Director develop and implement a mechanism to ensure the Veterans Service Center management team performs complete, accurate, and timely Systematic Analysis of Operations and takes appropriate corrective action to fix identified problems.*

Concur with recommendation.

Planned/Completed Action: All required SAOs have been identified, and the appropriate actions are being taken to bring any delinquent ones current, as well as ensure future SAOs are completed in a timely manner. In addition, the Director, through the VSCM, will ensure existing or potential problems identified in the SAOs are identified and corrective actions taken. The Director's Secretary and Program Assistant, working with the VARO Management Analysts, will monitor the SAO Fiscal Year Schedule for compliance with SAO completion dates, as well as completion dates for any required follow-up actions to correct any identified problems or deficiencies. A tracking spreadsheet for FY 2010 has been implemented to more efficiently monitor and receive SAOs that are due, and any follow-up actions are now being monitored to completion at the Director's office level. (Action Completed.)

Recommendation 6. *We recommend the Anchorage VA Regional Office Director develop and implement a plan to safeguard date stamps against unauthorized use.*

Concur with recommendation.

Planned/Completed Action: A station policy, Date Stamp Control Delegation of Authority 03-09, dated October 15, 2009, is now in place, along with an electronic date stamp with two

locking devices. A signed delegation of authority is in place, limiting date stamp use. (Action Completed.)

Recommendation 7. *We recommend the Anchorage VA Regional Office Director develop a mechanism to ensure supervisors are consistently performing inspections of the Veterans Service Center to more effectively safeguard veterans' Personally Identifiable Information.*

Concur with recommendation.

Planned/Completed Action: In response to these findings, as well as the need to conduct Records Management Training, the Salt Lake City Records Management Officer (RMO) was sent to the Anchorage Office for a site visit. Audit checks were performed at all workstations. PII training, to include proper safeguarding of veterans' PII and proper destruction of materials, was given to all station employees. In addition, a new Records Management station circular was published. Monthly desk audit checks are now performed with results forwarded to the Director's office for review. (Action Completed.)

Recommendation 8. *We recommend the Anchorage VA Regional Office Director develop and implement a mail routing guide and improve the oversight of mail handling procedures to ensure Veterans Service Center staff follow policy to provide assurance mail is properly controlled and processed within the Triage team.*

Concur with recommendation.

Planned/Completed Action: Division Directive 09-04, Triage Workflow Plan, dated September 2, 2009, to include a Mail Routing Guide, has been developed and implemented. All mail actions are completed at the earliest possible stage of the process and at the lowest level to eliminate duplication of effort and maximize effectiveness. Products of work actions are delivered to the operational element responsible for the next action no later than 3:00 PM daily. Incoming mail for the VSC is sorted and delivered to the Triage Team based on current work assignments no later than close of business on the date of receipt at the Regional Office. The Triage Team screens incoming mail daily. Priority Mail received same day processing. Action Mail is controlled, attached to the claims folder, and delivered to the team/activity responsible for processing the mail with five calendar days of receipt at the Regional Office. Mail Controls are established/updated in accordance with the Workload Management Plan, VETSNET Business Rules, and COVERS User Plan. The Mail Routing Guide contains specific guidance and required actions for each type of mail, as well as defines the various mail categories - Priority Mail, Unidentified Mail, Action Mail, and File Mail. The Triage Coach will provide the VSCM with a monthly summary of all mail actions, as well as any follow-up actions, as required. (Action Completed.)

Recommendation 9. *We recommend the Anchorage VA Regional Office Director develop and implement a plan to improve quality assurance reviews for Inquiry Routing and Information System inquiries to ensure responses to veterans are timely and accurately completed.*

Concur with recommendation.

Planned/Completed Action: Division Directive 09-07, IRIS Quality Review Policy, dated November 5, 2009, has been developed and implemented. This Directive implements a consistent policy for controlling quality reviews of IRIS queries and responses. The Public Contact Team Coach will review five IRIS queries and responses each month for each employee answering IRIS inquiries. Results of the reviews will be discussed with the employee as necessary for any corrections and performance improvement. If individual quality goes below 90% for accuracy or timeliness, the quality reviews will be expanded to identity any corrective measures and to improve performance. (Action Completed.)

Recommendation 10. *We recommend the Anchorage VA Regional Office Director develop and implement a mechanism to ensure congressional inquiries are processed timely and accurately.*

Concur with recommendation.

Planned/Completed Action: Division Directive 09-08, Handling of Congressional/Controlled Correspondence Policy, dated November 6, 2009, is now in place for the proper handling of congressional inquiries and responses. Congressional inquiries are now controlled, assigned, and approved by the Veteran Service Center Manager (VSCM). The Public Contact Team receives all controlled correspondence, to include congressional inquiries, and maintains a log of all controlled correspondence. Inquiries will be logged in within one day and assigned to a Senior Veterans Service Representative for their action. The individual receiving the assignment has two days to prepare a response and return to the VSCM for approval. Once approved, the document will be returned to the Public Contact Team for release to meet VBA's policy to respond to congressionals within five business days. The Public Contact Team Log will then be updated. (Action Completed.)

Recommendation 11. *We recommend the Anchorage VA Regional Office Director conduct research to determine the cause of insufficient network capacity and implement a plan to improve network capacity to support business processes.*

Concur with recommendation.

Planned/Completed Action: Four T-1 lines will be installed in November 2009, which should improve access issues with RBA 2000. Video training is no longer used for VSRs and RVSRs and limited to supervisory training only. We are currently having difficulty identifying and printing completed VA exams using CAPRI. VHA inputs the exams using VISTA. IRM reports this problem has been elevated to C&P service. We are waiting for a resolution to this problem.

Recommendation 12. *We recommend the Anchorage VA Regional Office Director report results of internal brokering to VBA Leadership monthly to ensure VBA Leadership is aware of the effect of this process.*

Concur with recommendation.

Planned/Completed Action: Presently, there is no requirement to report file movement between functions or stations under the VARO Director's jurisdiction. A multitude of functions

are performed at the Director's discretion for our staff throughout Western Area, i.e. Fiduciary, Support Services, Vocational Rehabilitation and Employment, Management Analyst support, HR support etc. All brokering issues, to include number of brokered cases, are coordinated through our Western Area Office, which is our next level of VBA Leadership. The VARO keeps the Western Area Office informed of any significant short-term movements of work in order to achieve the greatest efficiencies in servicing veterans as timely as possible.

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	Determine whether service connection for PTSD was correctly granted or denied. 38 CFR 3.304 and (M21-1MR Part III, Subpart iv, Chapter 4, Section H.28.B).		X
3. Traumatic Brain Injury	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	Determine if VAROs complied with the use of COVERS to track claims folders.		X
Management Controls			
7. Systematic Analysis of Operations	Determine if VAROs performed a formal analysis of their operations through completion of SAOs. (M21-4, Chapter 5, "Manpower Control and Utilization in Adjudication," *Systematic Analyses of Operations*, updated April 1, 2009).		X
8. Systematic Technical Accuracy Review	Determine if VAROs timely and accurately corrected STAR errors. (M21-4, "Manpower Control and Utilization in Adjudication," *Quality Assurance*, dated June 29, 2007).		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	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 and Safeguarding of Documents	Determine if VAROs complied with VBA policy regarding proper destruction and safeguarding of documents. (VBA Letter 20-08-63 revised dated March 13, 2009, and attachments.		X
Public Contact			
13. Inquiry Routing and Information System	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

Appendix D

OIG Contacts and Staff Acknowledgments

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Acknowledgments	Karen Gooden Joseph Brett Byrd Robert Campbell Kelly Crawford Kerri Leggiero-Yglesias Lisa Van Haeren

Appendix E

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