VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Inspection of the VA Regional Office Boise, Idaho

April 29, 2013
12-03885-168

ACRONYMS AND ABBREVIATIONS

DRO	Decision Review Officer
OIG	Office of Inspector General
RVSR	Rating Veterans Service Representative
SAO	Systematic Analysis of Operations
TBI	Traumatic Brain Injury
VARO	Veterans Affairs Regional Office
VBA	Veterans Benefits Administration
VSC	Veterans Service Center
WMP	Workload Management Plan

Report Highlights: Inspection of the VA Regional Office Boise, Idaho

Why We Did This Review

The Veterans Benefits Administration (VBA) has 56 VA Regional Offices (VAROs) and 1 Veterans Service Center nationwide that process disability claims and provide a range of services to veterans. We evaluated the Boise VARO to see how well it accomplishes this mission.

What We Found

Overall, VARO staff did not accurately process 16 (46 percent) of 35 disability claims we reviewed. We sampled claims we consider at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Claims processing that lacks compliance with VBA procedures can result in the risk of paying inaccurate and unnecessary financial benefits.

Specifically, 14 of the 30 temporary 100 percent disability evaluations we reviewed were inaccurate, generally because VARO staff did not establish controls to request future medical reexaminations. VARO performance was generally effective in processing traumatic brain injury claims.

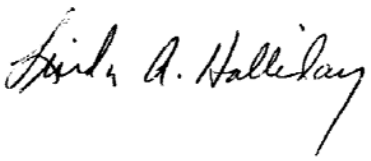
Managers did not ensure staff completed Systematic Analyses of Operations or addressed Gulf War veterans' entitlement to mental health treatment. Boise VARO staff provided adequate outreach to homeless veterans; however, VBA needs a measure to assess its outreach program.

What We Recommend

The VARO Director should ensure all elements of Systematic Analyses of Operations are addressed. Further, management should monitor training to ensure staff follow VBA policy regarding Gulf War veterans' entitlement to mental health treatment.

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 October 2012, we inspected the Boise VARO. The inspection focused on the following four protocol areas: disability claims processing, management controls, eligibility determinations, and public contact. Within these areas, we examined five operational activities: temporary 100 percent disability evaluations, traumatic brain injury (TBI) claims, systematic analysis of operations (SAOs), Gulf War veterans' entitlement to mental health treatment, and homeless veterans outreach program.

We reviewed 30 (30 percent) of 100 disability claims where VARO staff granted temporary 100 percent disability evaluations for at least 18 months. This is generally the longest period a temporary 100 percent disability evaluation may be assigned without review, according to Veterans Benefits Administration (VBA) policy. We examined five of eight disability claims related to TBI that were available for review and VARO staff completed from April through June 2012.

Other Information

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

RESULTS AND RECOMMENDATIONS

I. Disability Claims Processing

Claims Processing Accuracy

The OIG Benefits Inspection team focused on accuracy in processing claims related to temporary 100 percent disability evaluations and TBI. We evaluated these claims processing issues and assessed their impact on veterans' benefits.

Finding 1

The Boise VARO Could Improve Disability Claims Processing Accuracy

The Boise VARO did not consistently process temporary 100 percent disability evaluations and TBI cases accurately. Overall, VARO staff incorrectly processed 16 of the total 35 disability claims we sampled, resulting in 175 improper payments to 7 veterans totaling $236,179 in overpayments and a total of $8,027 in underpayments.

We sampled claims related to specific conditions that we considered at higher risk of processing errors. As a result, the errors identified do not represent the universe of disability claims or the overall accuracy rate at this VARO. As reported by VBA's Systematic Technical Accuracy Review program as of August 2012, the overall accuracy of the VARO's compensation rating-related decisions was 90.3 percent—3.3 percentage points above VBA's target of 87 percent.

The following table reflects the errors affecting, and those with the potential to affect, veterans' benefits processed at the Boise VARO.

Table 1

Boise VARO Disability Claims Processing Accuracy

Type of Claim	Reviewed	Claims Inaccurately Processed		
		Affecting Veterans' Benefits	Potential To Affect Veterans' Benefits	Total
Temporary 100 Percent Disability Evaluations	30	7	7	14
Traumatic Brain Injury Claims	5	0	2	2
Total	**35**	**7**	**9**	**16**

Source: VA OIG analysis of VBA's temporary 100 percent disability evaluations paid at least 18 months or longer and TBI disability claims completed in the third quarter FY 2012

Temporary 100 Percent Disability Evaluations

VARO staff incorrectly processed 14 of 30 temporary 100 percent disability evaluations we reviewed. VBA policy requires a temporary 100 percent disability evaluation for a service-connected disability following a veteran's surgery or when a veteran needs specific treatment. 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 100 percent disability evaluation.

For temporary 100 percent disability evaluations, including confirmed and continued 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 medical reexamination. As a suspense diary matures, the electronic system generates a reminder notification to alert VSC staff to schedule the medical reexamination.

Without effective management of these temporary 100 percent disability ratings, VBA is at increased risk of paying inaccurate financial benefits. Available medical evidence showed that 7 of the 14 processing errors we identified affected veterans' monthly benefits and resulted in 175 improper payments to 7 veterans totaling $244,206. Details on the most significant overpayment and underpayment follow. Four errors involved overpayments totaling $236,179 and three involved underpayments totaling $8,027.

- A Rating Veterans Service Representative (RVSR) correctly continued a temporary 100 percent evaluation for a veteran's prostate cancer in April 1999 and annotated the need for a future medical reexamination. However, VSC staff did not establish a suspense diary to schedule the medical reexamination. VA treatment records showed the veteran had completed medical treatment, warranting a reduction in benefits as of September 1, 2002. As of January 1, 2008, the veteran's benefits were correct. VA ultimately overpaid the veteran $118,115 over a period of 5 years and 4 months.
- An RVSR correctly granted a veteran service connection for metastatic cancer of the lymph nodes and entitlement to an additional special monthly benefit based on evaluations of multiple disabilities. However, the effective date of February 24, 2011, was incorrect because the date used to calculate benefits was not the date of claim. The actual date of claim and entitlement to benefits was October 30, 2009. As a result, VA underpaid the veteran $5,120 over a period of 1 year and 4 months.

The remaining seven errors in processing temporary 100 percent disability evaluations had the potential to affect veterans' benefits. These errors involved VSC staff not taking the following required actions.

- Five involved staff not inputting suspense diaries

- One involved staff not scheduling routine medical reexamination
- One involved staff not taking timely final action following a proposal to reduce a veteran's temporary 100 percent disability evaluation

VARO staff did not schedule medical reexaminations as required for some of the errors we identified. In two cases, we found delays of 1 year and 1 year and 3 months from the time staff should have scheduled these medical reexaminations until the date of our inspection.

Five of the 14 processing errors involved confirmed and continued rating decisions where VSC staff did not input suspense diaries as required. The reasons for the remaining errors varied, and we did not identify a common trend or pattern related to processing temporary 100 percent disability evaluations.

Prior to our inspection, VSC management implemented oversight procedures to ensure that staff accurately process electronic awards for confirmed and continued temporary 100 percent rating decisions. As we did not identify any errors involving confirmed and continued rating decisions after management implemented this procedure, the corrective actions appear effective. Thus, we made no recommendation for improvement in this area.

Follow Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Boise, ID* (Report No. 10-03858-92, February 17, 2011), we identified errors in processing temporary 100 percent evaluations that generally occurred when VARO staff did not properly establish suspense diaries for future VA medical reexaminations. At the time of that inspection, VARO management did not have a local policy or sufficient oversight measures in place to ensure staff entered suspense diaries into the electronic record to generate reminder notifications to schedule the medical reexaminations. The Director of the Boise VARO concurred with our recommendation to review the remaining universe of 47 temporary 100 percent disability evaluations under the Regional Office's jurisdiction to determine if reevaluations are required and to take appropriate action. OIG closed this recommendation on August 2, 2011, after the VARO stated it reviewed the remaining 47 cases and took actions as appropriate.

The Director of the Boise VARO also concurred with our recommendation to implement controls to ensure staff establish suspense diaries for temporary 100 percent disability reevaluations. OIG closed this recommendation on August 2, 2011, after the VARO provided a memorandum in February 2011 requiring review of rating decisions confirming and continuing disabilities at 70 percent or higher. VARO management's new policy appears to be effective, as we did not identify errors involving confirmed and continued rating decisions following its implementation.

Actions Taken in Response to Prior Audit Report

We assessed whether VSC management accurately reported actions taken on temporary 100 percent disability claims identified by VBA. In response to a recommendation in our national report, *Audit of 100 Percent Disability Evaluations* (Report No. 09-03359-71, January 24, 2011), the then-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. Our report stated, "If VBA does not take timely corrective action, they will overpay veterans a projected $1.1 billion over the next 5 years." The then-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. VBA was still working to complete this national review requirement and extended the national review deadline again to December 31, 2012. We are concerned about the lack of urgency in completing this review, which is critical to minimizing the financial risks of making inaccurate benefits payments.

During our 2012 inspection, we followed up on VBA's national review of its temporary 100 percent disability evaluation processing. We sampled 40 cases from the lists of cases needing corrective actions that VBA provided to the Boise VARO for review. We determined VARO staff accurately reported actions, such as inputting suspense diaries or taking actions to schedule reexaminations, on all 40 cases we reviewed. However, in comparing VBA's national review lists with our data on temporary 100 percent disability evaluations, we found 6 cases that VBA had not identified. We will continue monitoring this situation as VBA works to complete its national review.

TBI Claims

The Department of Defense and VBA commonly define a TBI as a traumatically induced structural injury or a 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 staff to evaluate these residual disabilities.

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. The policy indicates second-signature reviewers come from the same pool of staff as those used to conduct local station quality reviews.

VARO staff incorrectly processed two of five TBI claims—both had the potential to affect veteran's benefits. Since the number of TBI claims available for review was small, we did not calculate an error rate specific to TBI. However, we did include these errors in the overall error rate for the VARO. Following are descriptions of the two errors.

- A Decision Review Officer (DRO) assigned a 70 percent evaluation for TBI without supporting medical evidence. Neither VARO staff nor we can ascertain the correct evaluation for TBI without sufficient medical evidence.
- An RVSR incorrectly evaluated TBI as 10 percent disabling, based on symptoms a medical examiner attributed to the veteran's service-connected post-traumatic stress disorder. Because of the veteran's multiple service-connected disabilities, this error did not affect the veteran's monthly benefits, but has the potential to affect future evaluations for additional benefits.

The two TBI claims processing errors were unique and did not constitute a common trend, pattern, or systemic issue. Given our small sample size and the small number of errors that were unique, we made no recommendation for improvement in this area.

Follow Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Boise, ID* (Report No. 10-03858-92, February 17, 2011), we noted that VARO managers and staff indicated TBI training was inconsistent. The Director of the Boise VARO concurred with our recommendation to conduct training on properly evaluating disabilities related to TBI. The OIG closed this recommendation on August 2, 2011, after the VARO provided evidence of completed training for all required staff as requested by OIG. We did not find inconsistent training to be a repeat issue.

The Director of the Boise VARO concurred with our recommendation to establish an additional level of review for all decisions involving TBI. The OIG closed this recommendation on August 2, 2011, after the VARO issued a memorandum in January 2011 requiring that all RVSR ratings involving TBI decisions receive a second signature by either a DRO or the Rating Coach. The VARO issued a second memorandum in December 2011 requiring all RVSR and DRO decisions involving TBI receive a second signature. This new policy appears to be working as the VARO was generally effective in processing TBI claims.

II. Management Controls

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 (SAOs). 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 to 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 SAOs annually.

Finding 2 Oversight Is Needed To Ensure Complete SAOs

Four of 11 SAOs were incomplete (missing required elements). Three of the four did not contain recommendations for identified problems. VARO management did not provide adequate oversight to ensure VSC staff completed the SAOs in accordance with VBA policy and did not have an effective mechanism in place to ensure SAOs were complete. VSC operations may have improved had VARO management included recommended actions in SAOs.

Boise VARO management did not ensure SAOs were complete, as required. Management stated staff used checklists to ensure analyses for all required elements of an SAO were present. Although these checklists included other required elements, they did not include reminders to ensure staff provided recommendations for identified problems. Management stated it did not always provide recommendations because it felt some problems were out of its control, such as mandated brokering of cases from other VAROs that affected the local claims processing timeliness. Additionally, management stated the VARO was a small office, and it could address identified problems without recommendations. However, without recommendations for identified problems, management could miss the opportunity to take the appropriate corrective actions.

An example of an SAO that did not include a recommendation was Claims Processing Timeliness. This SAO noted mandated brokering of cases negatively affected the VARO's inventory and claims processing timeliness. While VARO management may have been unable to stop the incoming brokered cases, a recommendation to mitigate the impact of brokered cases may have improved local claims processing timeliness. The VARO's Director concurred with this analysis and noted management will provide recommendations in the future.

Follow Up to Prior VA OIG Inspection

In our previous report, *Inspection of the VA Regional Office, Boise, ID* (Report No. 10-03858-92, February 17, 2011), we indicated that incomplete and untimely SAOs resulted from a lack of adequate management oversight. The OIG closed this recommendation on September 27, 2011, after the Boise VARO noted it would hold SAO refresher training and the VSC Manager would review SAOs for accuracy/completeness before sending them to the Director for approval. VARO management implemented these recommendations and instituted checklists to ensure completeness of SAOs. During our inspection, we found SAOs to be timely and more complete. However, because the VARO's checklists did not address the requirement that recommendations be included for all SAOs, we continued to find incomplete SAOs.

Recommendation

1. We recommend the Boise VA Regional Office Director develop and implement a plan to ensure staff include recommendations for identified problems in their Systematic Analyses of Operations.

Management Comments

The VARO Director concurred with our recommendation. The VSC Manager issued a memo on March 7, 2013, to all VSC employees responsible for developing SAOs. The memo states that all SAO writers and reviewers will ensure recommendations are made to address all identified problem areas. The VSC's SAO checklists will be updated by March 31, 2013, to reflect this change.

OIG Response

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

III. Eligibility Determinations

Entitlement to Medical Treatment for Mental Disorders

Gulf War veterans are eligible for medical treatment for any mental disorder they develop 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 care treatment when denying service connection for a mental disorder. This pop-up notification does not generate if a previous decision did not address entitlement to mental health services and a mental condition is not part of the current claim.

Finding 3 **Gulf War Veterans Did Not Always Receive Correct Entitlement Decisions for Mental Health Treatment**

VARO staff did not properly address whether 4 of 30 Gulf War veterans were entitled to receive treatment for mental disorders. These errors generally occurred because training and oversight did not emphasize reviewing prior rating decisions to determine whether RVSRs addressed the entitlement decision. As a result, RVSRs did not always inform veterans of possible mental health treatment benefits.

Three of the four errors involved RVSRs failing to consider eligibility for mental health treatment when a previous decision did not address the issue. RVSRs we interviewed were able to explain the correct process for addressing Gulf War veterans' mental health care entitlement. However, training RVSRs received in this area did not emphasize the need for them to ensure prior rating decisions addressed these entitlement decisions for Gulf War veterans. Local quality checklists also did not address this need. In response to our inspection, staff conducted additional training and management updated local checklists to emphasize staff address a veteran's entitlement to mental health treatment when missed in a prior decision.

Recommendation

2. We recommend the Boise VA Regional Office Director develop and implement a plan to monitor the effectiveness of training and the local checklist to ensure staff follow current Veterans Benefits Administration policy regarding Gulf War veterans' entitlement to mental health treatment when previous decisions did not address this issue as required.

Management Comments

The VARO Director concurred with our recommendation. To determine the effectiveness of the checklist and training, Rating Quality Review Specialists and DROs are now required to review Gulf War veterans' claims and ensure that entitlement to mental health treatment is addressed. After each quality or local review, a spreadsheet will be updated with the veteran's claim number, the employee's name, and a check box on whether or not entitlement to mental health treatment was addressed and granted. This information will be used to determine the need for additional training.

OIG Response

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

IV. 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. VBA guidance, last updated in September 2002, directed that coordinators at the remaining 37 VAROs 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, local governments, and advocacy groups to provide information on VA benefits and services.

The Boise VARO has a part-time Homeless Veterans Outreach Coordinator who was familiar with the requirements for improving the effectiveness of VARO outreach to homeless veterans. We interviewed local homeless shelter representatives, homeless veteran outreach staff at the Boise VA Medical Center, and veterans service organization officials.

These interviews confirmed VA staff maintained a liaison with homeless outreach facilities and provided information on VA benefits and services. Our review further confirmed that Boise VARO staff participated in three homeless veterans outreach events a year, during which they explained VA benefits to attendees. Because we determined the VARO coordinator had collaborative partnerships with local homeless outreach facilities, we made no recommendation for improvement in this area. However, VBA needs a measurement to assess the effectiveness of its homeless veterans outreach efforts.

Appendix A VARO Profile and Scope of Inspection

Organization

The Boise VARO administers a variety of services and benefits, including compensation and pension benefits; vocational rehabilitation and employment assistance; specially adapted housing grants; benefits counseling; and outreach to homeless, elderly, minority, and women veterans.

Resources

As of June 2012, the Boise VARO had a staffing level of 67 full-time employees. Of this total, the VSC had 58 employees (87 percent) assigned.

Workload

As of August 2012, the VARO reported 2,387 pending compensation claims. The average time to complete claims was 183.5 days—46.5 days less than the national target of 230.

Scope

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

Our review included 30 (30 percent) of 100 temporary 100 percent disability evaluations selected from VBA's Corporate Database. These claims represented all instances in which VARO staff had granted temporary 100 percent disability evaluations for at least 18 months as of August 7, 2012. We provided VARO management with 70 claims remaining from our universe of 100 for its review. We reviewed five of eight disability claims related to TBI that the VARO completed from April through June 2012. Where we identify potential procedural inaccuracies, this information is provided to help the VARO understand the actions it can take to improve the overall stewardship of financial benefits. This information is not used to require the VAROs to adjust specific veterans' benefits. Processing any adjustments per this review is clearly a VBA program management decision.

We assessed the 11 mandatory SAOs the VARO completed in FY 2012. We sampled 40 temporary 100 percent disability evaluations from the SharePoint list VBA had provided to the VARO for review. We examined 30 completed claims processed for Gulf War veterans from April through June 2012 to determine whether VSC staff addressed entitlement to mental health treatment in the rating decision documents as required. Further, we assessed the effectiveness of the VARO's homeless veterans outreach program.

Data Reliability

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, included any calculation errors, or were outside the time frame requested. We assessed whether the data contained obvious duplication of records, alphabetic or

numeric characters in incorrect fields, or illogical relationships among data elements. Further, we compared veterans' names, file numbers, Social Security numbers, VARO numbers, dates of claim, and decision dates as provided in the data received with information contained in the 65 claims folders we reviewed.

Our testing of the data disclosed they were sufficiently reliable to meet inspection objectives. Our comparison of the data with information contained in the veterans' claims folders at the Boise VARO did not disclose any problems with data reliability.

Inspection Standards

We conducted this 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 inspection objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our inspection objectives.

Appendix B Inspection Summary

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

Table 2. Boise VARO Inspection Summary

Five Operational Activities Inspected	Criteria	Reasonable Assurance of Compliance	
		Yes	No
Disability 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 service connection for all residual disabilities related to in-service TBI. .** (Fast Letter (FL) 08-34 and 08-36) (Training Letter 09-01)	X	
Management Controls			
3. Systematic Analysis of Operations	**Determine whether VARO staff properly performed formal analyses of their operations through completion of SAOs.** (M21-4, Chapter 5)		X
Eligibility Determinations			
4. Gulf War Veterans' Entitlement to Mental Health Treatment	**Determine whether VARO staff properly processed Gulf War veterans' claims, considering entitlement to medical treatment for mental illness.** (38 United States Code 1702) (M21-1MR Part IX, Subpart ii, Chapter2) (M21-1MR Part III, Subpart v, Chapter 7) (FL 08-15) (38 CFR 3.384) (38 CFR 3.2)		X
Public Contact			
5. Homeless Veterans Outreach Program	**Determine whether VARO staff provided effective outreach services.** (Public Law 107-05) (VBA Letter 20-02-34) (VBA Circular 27-91-4) (FL 10-11) (M21-1, Part VII, Chapter 6)	X	

Source: VA OIG

CFR=Code of Federal Regulations, FL= Fast Letter, M=Manual, MR=Manual Rewrite

Appendix C VARO Director's Comments

Department of Veterans Affairs

Memorandum

Date: March 18, 2013

From: Director, VA Regional Office Boise, Idaho

Subj: Inspection of the VA Regional Office, Boise, Idaho

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

1. Attached are Boise VARO's comments on the OIG Draft Report: *Inspection of the VA Regional Office, Boise, Idaho.* We concur in the OIG recommendations contained in their Draft Report

2. Questions may referred to Stephanie Pinque, Human Resources Specialist, at (208) 429-2204.

(original signed by:)

James O. Vance
Director

Attachment

Comments on Draft Report
OIG Office of Audits and Evaluations
Benefits Inspection of the Boise Regional Office

Recommendation 1: *We recommend the Boise VA Regional Office Director develop and implement a plan to ensure staff include recommendations for identified problems in their Systematic Analyses of Operations.*

RO Response: Concur

On March 7, 2013, the VSCM issued a memo to all employees who write VSC SAOs. The memo states that all SAO writers and reviewers will ensure all problem areas are addressed, and recommendations for identified problems are made. The VSC's SAO checklists are being updated to reflect this change. All checklists will be updated by COB March 31, 2013.

Recommendation 2: *We recommend the Boise VA Regional Office Director develop and implement a plan to monitor the effectiveness of training and the local checklist to ensure staff follow current Veterans Benefits Administration policy regarding Gulf War veterans' entitlement to mental health treatment when previous decisions did not address this issue as required.*

RO Response: Concur

The RO Boise checklist has been updated. Section 9 of the checklist has been updated to state: *"1702- If a psychosis was denied for a wartime vet OR any mental illness denied for a GW vet, has healthcare under **1702** been addressed? Do not infer to deny!"*

To ensure the effectiveness of the checklist, and training, RQRS and quality review DROs are now required to review all GWOT claims to ensure that 1702 is addressed with current and previous claims. After each quality or local review the RQRS, and/or DRO will update a spreadsheet with the Veteran's claim number, the employees name, and check a box as to whether 1702 was addressed or not, and whether 1702 was granted or not. The information gathered from these spreadsheets will be used to determine the need for additional training.

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.
Acknowledgments	Brent Arronte, Director Ed Akitomo Brett Byrd Madeline Cantu Lee Giesbrecht Jeff Myers David Pina Diane Wilson

Appendix E Report Distribution

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