Written by By Carolie Watkins Guest Columnist
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I have been telling Albuquerque VA Regional Office that suicide rates are partially due to inaccurate compensation claims raters not reviewing all medical conditions that are available to them via electron Health records.

Albuquerque VARO continues to ask Veterans over and over for their medical records when they have them available at the touch of a hand. I further believe this is used as a stall technique. Veterans unable to work and support themselves or and a family finally give up and feel his or her family would be better off without carrying the load of caring for the Veteran

Office of Inspector General, recently conducted an inspection to evaluate the circumstances surrounding the death of a patient at the VA San Diego Healthcare System. The Office of Healthcare Inspections evaluated the quality of care provided for the patient prior to his suicide.

The Office of Audits and Evaluations assessed whether the San Diego VA Regional Office (VARO) Rating Decision accurately decided the patient's compensation claim. It was determined that the quality of care provided for the patient's chronic pain did not adhere to the VA/DoD clinical practice guidelines.

We determined that the patient was newly diagnosed with traumatic brain injury and post-traumatic headaches during a Compensation and Pension examination in January 2014, but there was no follow-up plan to address these issues.

Although the San Diego VA Regional Office decided the patient's claim prematurely without obtaining all relevant service treatment records.

It was recommended that the Under Secretary for Health ensure that Compensation & Pension examiners document patients with new diagnoses are counseled on the need for follow-up care and provided assistance in obtaining VA care, and that all **clinically relevant communications are documented in the electronic health record** ; the System Director implement processes to ensure that providers adhere to the VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, including follow-up assessment at appropriate intervals, when treating patients with chronic opioid

therapy, and confer with Regional Counsel for possible disclosure(s) to the surviving family member(s) of the patient; and the San Diego VA Regional Office Director
review a sample of the specific rater's work
and determine whether failure to obtain relevant service treatment records is a
systemic issue with
this rater
when making compensation claim decisions.

Carolie Watkins, of Vanderwagen, husband is a Vietnam era Veteran. She has a passion for helping veterans with disability claims and has been volunteering her services for 17 years. She says that she is currently helping 57 veterans in five states, "doing what Attorneys do, but for free."

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