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VAOIG: VA'S SAN JUAN REGIONAL OFFICE DYSFUNCTIONAL

Office had lowest accuracy in ratings decisions and failed to meet standards in 10 of 15 operational areas.

by Larry Scott, VA Watchdog dot Org

Veterans, veterans' service officers and attorney who practice veterans' law have often told me that the worst Regional Office in the Veterans Benefits Administration system is in San Juan, Puerto Rico.

Now, the VA's Office of Inspector General (VAOIG) pretty much confirms that assessment with this report:

> **Inspection of VA Regional Office San Juan, PR -- Report Number 09-01996-41, 12/4/2009 | Summary | Report (PDF)**

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While the highlights posted below paint a bleak picture, the really scary stuff is in the full report ... like:

- ***A veteran was over evaluated for vision loss associated with diabetes ...***
- ***A veteran was under evaluated for diabetes ...***
- ***A veteran was under evaluated for diabetes and over evaluated for diabetic nephropathy with hypertension ...***
- ***A veteran was incorrectly granted entitlement to special monthly compensation for erectile dysfunction ...***
- ***A veteran's effective date for entitlement to special monthly compensation was incorrect ...***

And, there's plenty more. Maybe "dysfunctional" was too kind a word.

Report Highlights: Inspection of VA Regional Office, San Juan, PR

Why We Did This Review

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

What We Found

The San Juan Regional Office management team faces challenges in providing quality benefits and services to veterans, to include improving the quality of formal benefits decisions. At the end of March 2009, the VARO had the lowest accuracy associated with these decisions in the nation at 60 percent. Also, the Regional Office did not meet all requirements in 10 of the 15 operational areas reviewed.

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

• Correcting errors identified by the Veterans Benefits Administration's (VBA) Systematic Technical Accuracy Reviews (STAR).

• Completing Systematic Analysis of Operations (SAO) accurately and timely.

• Safeguarding veterans' personally identifiable information (PII).

• Safeguarding VARO date stamps.

• Handling claims-related mail.

• Responding to electronic inquiries.

• Processing fiduciary activities.

What We Recommend

We recommend that the VARO improve oversight of the quality assurance process for the operational areas found lacking. We also recommend the VARO ensure mandatory PTSD training modules are completed.

Agency Comments

The Director of the San Juan Regional Office concurred with all recommendations but offered qualifications and commentary on some issues. We have responded to each of management's assertions in the report. Management's planned actions are responsive and we will follow-up as required on all actions.

TOPICS: veterans, veterans' benefits, VA, Department of Veterans' Affairs, VAOIG

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