Congressional Testimony: Underperforming VA Regional Offices

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STATEMENT OF

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SUBCOMMITTEE ON DISABILITY ASSISTANCE AND MEMORIAL AFFAIRS

WITH REGARDS TO

UNDERPERFORMING VA REGIONAL OFFICES

WASHINGTON, D.C.

Chairman Runyan, Ranking Member McNerney and members of the Committee, thank you for this opportunity to present the views of the 2.1 million veterans and auxiliaries of Veterans of Foreign Wars of the United States on quality problems within VA regional offices.

Secretary Shinseki has committed VA to achieving a 98 percent quality level for disability claims by 2015. While we have grown to appreciate the Secretary's unrelenting focus on improving the Department of Veterans Affairs, especially those elements affecting claims processing, and we accept that VA is undergoing significant and lasting change, I believe we can state without fear of being proven wrong that the VA will not achieve this goal within the next four years.

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One need only examine the data to see why we arrived at this conclusion.

In October 2008, VA's Statistical Technical Accuracy Review (STAR) report for Benefit Entitlement Accuracy showed that the national accuracy rate was 86 percent. This reflects 12 month cumulative data for 56 regional offices. Four (4) of those offices had quality in the 70's; 15 offices had rating quality of 90 or above.

In February 2011 (the most recent data available to us) the national average had fallen to 83 percent and 13 offices had quality results of 79 or below. Only 6 offices had rating quality of 90 or above.

Quality levels in the Baltimore regional office plummeted from 84 percent in 2008 to 65 percent today. That means that one veteran in three is given a decision which contains at least one material error affecting service connection, evaluation or effective date.

Poor quality is a cancer. It is incredibly frustrating to VA employees, nearly all of whom want to do quality work for veterans, their families and survivors. Poor quality has also resulted in an immense well of distrust and suspicion by veterans towards the VA.

Real quality problems and this atmosphere of distrust have driven appeals to record levels. While national rating quality has dropped from 86 percent in October 2008 to 83 percent in February, 2011, appeals backlogs increased from 183,496 to 230,219 (25 percent).[1]

Real problems, practical solutions

There are many reasons to explain VBA's inability to process claims accurately and consistently from office to office. More than poorly trained personnel, the main cause of these problems rests with a culture that has lost its focus. It is our belief, our conviction that most people within VBA want to do a good job. However, conditions beyond their individual control keep them from achieving consistently good work.

We are convinced that VBA's unrelenting efforts to reduce the backlog, poorly trained and inexperienced managers, poor management systems and controls, an inability to devise and bring on-line effective IT tools and systems, and a sea of new employees and a host of other problems, many not of VBA's making, contribute to a breakdown of focus on VA's primary mission: to help veterans and their families to the fullest extent the law allows.

Management

The VA OIG recently released a report summarizing its findings from reviews of 16 regional offices from April 2009 through September 2010.[2] In addition to quality issues, the OIG found widespread management failures, including absent or untimely Statistical Analyses of Operations (SAO's)[3], improper mail handling, untimely establishment of computer

controls, failure to maintain or monitor proper diaries to review or adjust certain awards, and a fascinating comparison of managerial vacancies in the five best and worst offices they visited.[4]

We believe issues such as improper mail handling, failure to maintain proper computer controls and diaries and similar breakdowns to be first and foremost an indication of ineffective or inattentive management. In any large organization, and some VBA offices are quite large enterprises, it is reasonable to assume that systems and processes will break down from time to time. The break down is not the problem; the problem rests with failing to have effective monitoring systems to quickly identify a developing situation and procedures in place to fix the problem before it creates much damage. The creating and maintenance of these systems is strictly a management function. Where they are neglected indicates a problem with management.

SAO's are established to force local management to examine specific areas of their operation on a regular basis. Once per year a manager or a trusted subordinate is expected to conduct a review of the targeted function, identify problems and propose solutions.[5] Regional office directors are charged with ensuring that SAO's are completed on time and any identified problems are corrected. Further, VA Central Office (VACO) routinely conducts staff visits to examine every aspect of regional office operations and is tasked with ensuring that local management is performing required activities such as reviews. That the OIG was able to find so many deficiencies in so many offices points to a serious breakdown in managerial oversight.

At one time some SAO's were required quarterly or semi-annually. We suggest that returning to more frequent formal reviews of operations would help ensure that problems are identified early and corrected. Further, we suggest that these SAO's be included in whatever monthly or quarterly summary of operations to VACO which may currently be required of regional office directors.

We also suggest that an independent study be conducted to determine how managers, from the Assistant Service Center Manager position through regional office Director are developed and selected for their positions. Years of experience in various Veterans Service Center positions should be examined. In addition, this study should examine the extent and nature of training offered to managers at all levels and the relative quality of such training. It would be interesting to see how this training differs with that offered to managers of similar levels of responsibility and pay in both the military and major corporations. Any study of managers should include other areas of interest as thought appropriate. The results of this study may be useful in identifying ways in which VBA can better identify, select and develop individuals to become more effective leaders within VA regional offices.

Rating quality and Single Signature Authority

We believe all VA employees want to make quality decisions. That they fail to do so is a result of poorly constructed systems, sometimes inadequate training, inadequate or absent mentoring, and quality reviews which may be adequate to assess regional office quality but are inadequate to determine individual quality with any assurance.

VA employees should be able to work within a set of systems which ensure that the opportunity to make mistakes is minimized. In an industrial setting, employers devise machines that can only be operated in such a way that the employee cannot put fingers and other body parts at risk of injury. If somehow an employee is injured, the whole process is reexamined to identify what must be changed so that future employees cannot be hurt.

In our view, the rating decision process should be structured in such a way that errors are impossible in those areas where judgment is not a factor. That is why we are pleased to see the Compensation Service adopt new calculators which make purely mechanical computations, such as field of vision, special monthly compensation (SMC) and hearing loss, for the rater.

We have been told that use of the SMC calculator has greatly reduced errors in that area. Development of additional tools to aid rating specialists will go a long way to increase accuracy and consistency between raters.

In the last year VA has reviewed its training program for rating specialists and is introducing changes which promise to better prepare students for their new jobs. However, we remain concerned that new raters receive only limited training once they return to their home offices.

Once formal training is complete, on-the-job training helps solidify learning, ensure proper application of the material to real world claims and fosters continued long term growth and development. We have heard far too many instances of new raters rushed into production with little mentoring or experience.

Even worse, many new raters have been given single signature authority well short of their first anniversary on the job. Single signature authority means that a rater is allowed to write a rating without further review by a seasoned specialist. Mistakes go uncorrected; differences in judgment, which might benefit a veteran, are never explored.

At one time ratings required the review and approval of three rating board members. One of the three was a medical doctor. As a result of court decisions, physicians were removed from the rating boards. Still, two trained raters were required to review and approve each rating.

Single signature authority was first allowed nearly 20 years ago. Originally restricted to the most experienced senior raters, its use slowly expanded to less exceptional raters. In recent

years, single signature authority has been given to more and more new or nearly new raters as the pressure to resolve an ever growing workload mounted.

If VBA did nothing else to improve rating quality, elimination of single signature authority and the reinstitution of a mandatory second review would show immediate and significant improvement in quality. Just last week a VBA director disclosed that a recently trained group of raters in his office produced over 660 rating decisions with 85 percent quality, an error rate better than the national rate of 83 percent.

It is no mystery how this group of new raters was able to achieve what the rest of the nation could not. Each new rater had a mentor who reviewed every rating with them. Not only did the mentor ensure that the veteran receive a more correct rating, every identified problem was an opportunity for the rater to learn something new.

This suggestion is not new. Highly placed VBA leaders have been reminded that second and third reviews were once required before a rating could be promulgated. However, their response has been that the second review was always pro forma; that the second reviewer blindly signed the rating to move the work along. While this was undoubtedly true in some offices and among some employees, the fact remains that where this process is rigorously followed, quality improves. If this process has no value, then perhaps VBA can explain why a large portion of Nehmer cases, those with potential for a significant retroactive award, require two signatures.[6]

Veterans Benefit Management System (VBMS)

VA management has extensively briefed veterans service organizations throughout the early stages of development of the VBMS. We have asked many questions and provided substantive feedback. It appears that many of our concerns are being addressed as this project moves forward. Recently a service officer with extensive field experience from the Disabled American Veterans spent a month working with the VBMS team. From all reports, the collaboration was very successful.

From our perspective, VBMS promises to move VA into the 21 century. A system like this is decades late. The lack of a comprehensive, fully integrated, paperless claims processing system has surely contributed to inefficiencies in claims processing and the backlog.

We believe that VBMS holds great promise for the future. Once fully functional, it promises to allow VBA to move claims, or parts of claims, anywhere in the country with the touch of a button allowing specialists to work on individual elements separately and simultaneously. The system should be able to electronically capture VA and military health care records, import data into rules based decision trees and, in general, allow VA to revolutionize and improve development and rating decision making.

However, none of this will happen tomorrow. VBA is still two years away from rolling out a serviceable first iteration. We have been told not to expect rules based decision capability for several years after that. While VA's ability to move work electronically will surely produce immediate efficiencies, it will be years before the full capability of VBMS can be realized.

It is for this reason that VBMS is not the answer. It provides some answers, the promise of improved processes and enhanced capabilities. However, until rules based decision capability is incorporated into VBMS, it should not have a significant impact on either quality or workload reduction.

Service Organizations

Congress has recognized that properly trained veteran service officers can provide a vital service to veterans and their families in the preparation and presentation of claims within VA. With a veterans permission, we can review their records, help them develop their claims and represent them before VA and the Board of Veterans Appeals.

However, our job is not just that of claims preparer. Our role is that of advocate. To that end we train our service officers in the same laws, regulations and policies that VA teaches to their staff. Our goal is to train our service officers to be as good as or better than the VA employees they deal with on a daily basis.

There are two recurrent problems which frequently arise within VA regional offices which inhibit efforts by service organizations to help VA make the most correct decisions possible in disability ratings.

- VA policy provides that accredited service officers holding a veterans power of attorney must be given two business days to review each completed rating. That means that our service officers provide the very last quality check that those ratings receive before those decisions are promulgated. This service is provided to veterans and the VA for free. Other than office space, this service doesn't cost the government a dime.
- Why is it, then, that we regularly hear from service officers that they were denied the opportunity to review ratings prior to promulgation? The Acting Under Secretary for Benefits has stated, often and loudly, that VSO's must be given those two days to review ratings. To his credit and that of his senior staff, they have intervened when we have alerted them to a problem at a particular office. Somehow, however, that policy, that message, is periodically ignored in the field.
- What happens when a service officer finds a problem with a rating? In the past, he or she would take it back to the rater, discuss the issue and, often, get it fixed before the decision is promulgated. When the rating specialist is right, the service officer learns something new. When the decision is not changed and the service officer remains

convinced a problem exists, they must decide whether to file an appeal. Whatever happens, this simple common sense process allows for informal discussion and correction of problems without having to resort to a lengthy and resource intensive appeal.

- It is unfortunate that management in many offices forbid service officers from conferring with rating specialists. They are forced to go to a rating team coach, or, in some offices, the service center manager, with their concerns. All too often, these managers have less rating experience than the rating specialist who made the decision.
- While the stated objective is to protect the rater from irregular interruptions, hence maximizing the opportunity for doing more work, the reality is that the supervisor acts as a filter, and often not a very good one. If they agree that the rating needs correction, they must still go back to the rater and explain the problem as it was explained to them. This is a totally unnecessary step. What happens all too frequently is that the supervisor fails to take any action, forcing the service officer to appeal the decision.
- We urge VBA to restore the former practice of allowing service officers to meet directly with decision makers. This is an efficient method to resolve problems short of the appeal process.

Both of these examples illustrate a problem with the attitude of management in some VA regional offices. They have come to believe that allowing service officers a review of ratings prior to promulgation, and speaking directly with a rating specialist when a problem is perceived, gets in the way of their production goals. Even if this were true, and it is not, it shows that they care more about production than quality.

They are simply not interested in having ratings reviewed and problems corrected prior to promulgation if it means that a little less work is produced.

An Illustrative History

The Committee has asked us to discuss our ideas for improving VA regional offices with the worst quality. We have already mentioned several things that can be done to improve the quality of decision making. We understand that adoption of some of these suggestions, especially the reinstatement of a second review of every rating, will reduce production. It has to reduce production. Every hour mentoring another person is an hour of lost production.

However, if we are indeed serious about improving quality to ensure that veterans receive the benefits they have earned by their service, without either over or under payment, then changes must be made.

What can be done to help improve those VA offices with the worst quality' The past offers a

possible answer.

In 1999 the Washington, DC regional office (WRO) was floundering. Because of its location near VA Central Office, decades of poaching the best and brightest employees from the WRO ensured a continuous struggle by the remaining workforce to make decisions with acceptable quality and in sufficient numbers. Leadership turned over frequently, with some Directors and senior managers from outside either moving sideways or down a once promising career path. It was not the office of choice for those who sought to show their talents and move up. VA internal reports of the time described the WRO as in "disarray".[7]

Faced with a failing office and negative publicity, VBA decided to make changes. Senior managers were replaced. The new Service Center Manager had a proven track record of managing adjudication divisions in different regional offices. He was given the authority to recruit a half dozen experienced raters from around the country, using bonuses, and in some cases promotions, to encourage them to move to Washington. He established a rating training coordinator position, someone who could set up a training regimen and also mentor rating personnel. He also had authority to replace those who left with other experienced staff.

WRO rating personnel underwent total retraining. Each was assigned a mentor and 100 percent of the work was reviewed and corrected before it was approved. Every case provided an opportunity for learning. Regular classes continued long after the retraining program was completed. The Compensation and Pension Service provided a staff physician to conduct specialized training on anatomy, physiology, different medical conditions and the rating schedule.

In the end, these measures produced results. Independent reviews showed improving quality. Initially, production fell as time was devoted to retraining and mentoring; however, as employee skills and confidence grew, so did production. Under intense scrutiny, some employees left, but those who remained became better raters.[8]

In our view, VBA should undertake similar actions at failing offices. Finding qualified and experienced managers and rating specialists who are willing to move to the affected offices will be the most difficult task. That and accepting that production at those offices will fall off for months, and may never fully recover to previous levels, while quality improves. But that is the vital factor: quality improves.

Once VBA makes a serious commitment to improving poorly performing regional offices, veterans in those states will grow to understand that their government is serious when it tells them that "we are here to help you."

Mr. Chairman and Members of the Committee, this concludes the VFW's testimony. We

again thank you for including us in today's most important discussion and I will be happy to answer any questions you may have.

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[1] From February 28, 2011, to May 23, 2011, the backlog increased an additional 5,301 appeals. Monday Morning Workload Report, May 23, 2011. http:http://www.vba.va.gov/reports/mmwr/

[2] "Systemic Issues Reported During Inspections at VA Regional Offices". VA Office of Inspector General,

11-00510-167, May 18, 2011.

[3] "SAOs provide an organized means of reviewing VSC operations to identify existing or potential problems and propose corrective actions. VBA policy requires VSCs perform SAOs annually, covering all aspects of claims processing, including quality, timeliness, and related factors.", pg 14, ibid.

[4] Ibid, pg 15.

[5] VA Manual M21-4, 5.03, pg 5-1

[6] C&P Fast Letter 10-41, pg 4. September 28, 2010

[7]" VA Report Says Regional Office Is in Chaos", Steve Vogel, Washington Post, April 10, 1999.

[8]I would like to say that there was a happy ending to this story. Unfortunately, I cannot. Several years after this effort began, VBA decided to create the Appeals Management Center (AMC). What's worse, they placed it in Washington in the same building as the WRO. In the end, virtually every employee at the WRO in claims adjudication moved to the AMC. Washington's claims are now processed in Roanoke, VA.