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STATEMENT OF
JIM WEAR, ASSISTANT DIRECTOR
NATIONAL VETERANS SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON DISABILITY AND MEMORIAL AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

QUALITY VS. QUANTITY: EXAMINING THE VETERANS BENEFITS ADMINISTRATION'S EMPLOYEE WORK CREDIT AND MANAGEMENT SYSTEMS

WASHINGTON, D.C. **MAY 6, 2010**

MR. CHAIRMAN, RANKING MEMBER LAMBORN, AND MEMBERS OF THE COMMITTEE

On behalf of the 2.1 million men and women of the Veterans of Foreign Wars of the U.S. (VFW) and our Auxiliaries, we appreciate the opportunity to present our views before you today. The Veterans Benefits Administration's (VBA) work credit and management systems deserve careful review by Congress. The VFW applauds this subcommittee for using its oversight authority to examine the incentives within VBA that pit "Quality vs. Quantity."

Further, the VFW compliments Secretary Shinseki's leadership team for VA's Open Government Plan. We fully support all efforts to transform VA into a people-centric, results-driven, forward-looking organization. We welcome every opportunity to work with Secretary Shinseki to encourage a transparent, participatory and collaborative VA that places veterans and their survivors at the center of every decision.

The VFW's chief concern today is the very real perception that VA puts more emphasis on the number of claims that are processed than the accuracy of those claims. This is validated by VA's own measures in the "Monday Morning Report," as well as by many VA Office of Inspector General (IG) reports. Secretary Shinseki's goal of rating all claims with 98% accuracy in under 125 days is extremely laudable, but the VFW would be ecstatic if VA could just reach the 98% goal with the current average wait time of 165 days.

Workload & Management Systems

Claims submitted to VA are tracked by the assignment of a discreet identifier called an 'end product.' VBA's work management and measurement systems have various subsystems to track the age of each pending end product, to track the various development and rating actions taken in end products, and the number of end products completed. VBA's work management system tracks all computer actions taken on pending claims by service center employees.

In our view, the major focus for VA must be on management systems reform and fostering a culture change in VBA. As indicated above, VBA has management and work measurement systems that have been in place with only minimum changes for decades. There is a systematic review of the basis used for these

management and work measurement systems being conducted, but the results have not yet been released.

Quality measurement

The current system employed by the Department of Veterans Affairs, Systematic Technical Accuracy Review (STAR), to analyze and determine accuracy in promulgated claims decisions was created and deployed in 1997. The system determines accuracy by using analytic statistics over the previous 12 months. This is identified as a "rolling 12" since each current month that is added results in dropping the oldest month. When STAR was first used, the accuracy rate was 64% and is currently 83%. Although there has been an increase in overall accuracy, it is far from an acceptable standard.

The system is based on a random selection of promulgated decisions (rating, authorization and fiduciary) under specific rating indicators or "end products." Therefore, not every decision of a claim is subject to the review. Cases are requested from each regional office based on size. It is very difficult to obtain a reliable sample size. A truly representative sample for the larger offices would require many additional reviewers. The current sample size for the "National Average" in rating decisions is 13,199 cases for 57 regional offices for the past 12 months. The current sample size for the "National Average" in authorization decisions is 8,251 cases for 57 regional offices for the past 12 months.

The system is based on the concept that a decision is either entirely correct or entirely wrong. No longer are there classifications of errors from mere procedural to substantial. Once an error is called and the regional office notified, there is a time period (usually 60 days) in which the regional office may request reconsideration of the error. It is their responsibility to "make the case" that the decision was not incorrect. Since an error can be reversed within a period of time, the accuracy rate reflects a period of time that is 3 months delayed. In other words, the report issued in early February covers decisions ending in November 2009. This time delay affects the validation of the numbers.

The group of employees, considered to be staff of the Compensation and Pension Service in VA Central Office, is located in a separate facility in Nashville, Tennessee. Each expert consultant is tasked with a "second look" at cases with identified errors to insure corrective action is completed based on the error. This is assigned on a rotating basis as "other duties as assigned" and not their primary priority.

There are some deficiencies in this analysis of completed claims. Since it is a random selection of certain types of actions, it is only those identified actions that determine the error or accuracy rate. For example, a claim is identified for review based on a completed action in April 2009. That action is completed according to current policies and regulations. However, the consultant discovers an erroneous action taken in January 2006. The consultant has the responsibility to identify that error and direct corrective action under a "comment" rather than a formal error call. That action must be completed, but does not figure into the overall accuracy rate.

There is one big deficiency to this system that constantly presents a major problem to VA. No one learns from their mistakes. The STAR system was designed to enhance training and knowledge. Each regional office is treated as an individual office and not part of a larger quality control system. It is true that the VA "intranet" has links for regional staff to review the number and type of errors being called but there is no mandatory training of personnel. Identification of an error without a clear instruction or resolution is of no value. Each individual rating or authorization decision maker very rarely is counseled on their individual quality. Therefore, they believe that they were not responsible for any mistake. The overall accuracy rate may be part of the performance standards for managers and directors, but an individual employee is graded on a

"pass/fail" standard. VA willingly admits that production is "job one." Training is the first casualty in the war of the pending backlogs. The nature of the work has become extremely complicated and training should be absolutely required for all decision makers. Regular and serious training will not only stop the slide, but will actually enhance individual skills. The training in an open and serious environment will also benefit all VA staff who interacts with veterans. All such training efforts should be thoroughly documented for all interested parties.

Suggestions for Improvement

Quality must be incentivized as the primary component of all VA workload and management systems. The current systems are self-imposed VA models that do not have incentives built into reward accuracy or to correct poor decision-making. The VA must consider the individual training needs of each employee and each regional office in all future work-credit systems. VA leadership must be able to quickly and accurately identify the items that need additional training on the local level.

The current VA nationwide accuracy rate is 83%, which ranges from 92% at the best Regional Office in Des Moines to a 67% worst in Baltimore. All of which still fails to achieve Secretary Shinseki's 98% accuracy goal.

The VFW previously suggested that ratings quality could be improved by instituting a two-signature review on every claim before the rating decision is finalized. The management at the Baltimore Regional Office recently decided to start doing two-signature reviews on all actions, ratings and authorization. We will be watching carefully to see if this practice improves their accuracy rate.

The VFW strongly supports partial rating decisions, thus allowing a veteran immediate financial assistance and access to medical care, while promoting the further development of the complete claim. However, VA must grant work credit for partial decisions to incentivize VA employees to utilize this practice. With the advent of an electronic claim, individual issues will be more easily tracked. Most claims are comprised of multiple conditions/issues. Currently, a claim cannot be counted as completed end product until all claimed conditions have been addressed. Further, veterans cannot be paid until a condition or issue is granted. With the tracking of individual issues, both work-credit and compensation may be awarded as the claim undergoes further development and is finally completed.

VBA leadership needs to reward quality and accuracy. VA must examine each process and decision point and reengineer them to reduce the opportunity for error. Make each decision more difficult to get wrong and errors will be reduced. Regional Offices and individuals with high quality and/or accuracy ratings should be rewarded for their work. The VA management team should focus on changing the culture in VBA so that quality rules, without exception. VBA should emphasize processing an issue correctly the first time.

Finally, VA collects timeliness data to monitor the ability of every office to complete claims within certain pre-established goals. The VFW believes VA should share this information with new claimants via e-mail or letter. Just as many commercial service centers inform telephone callers that "your call will be answered in 3 minutes," it should be just as easy for VA to use real-time information on how long it normally takes to process original compensation claims from, for example, Montgomery, Alabama, which would be 250 days. While that is far too long to process a claim in any world, the veteran would still be knowledgeable of the average length of the wait.

Mr. Chairman, this concludes my testimony. I would be happy to address any questions you or your committee may have. Thank you.