

Evaluation of SSA's Disability Quality Assurance (QA) Processes and Development of QA Options That Will Support the Long-Term Management of the Disability Program

Contract Number 0600-96-27331

Final Report

Submitted to:

The Social Security Administration

Prepared by:

The Lewin Group, Inc.

Pugh Ettinger McCarthy Associates, L.L.C.

Cornell University

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ACKNOWLEDGEMENTS

We take this opportunity to thank and acknowledge the contributions of the many SSA employees and management that assisted us with our research and gave us guidance and support during the development of our report and the formulation of possible options for SSA. Throughout the course of the project, we encountered enthusiasm, openness, and support at every level and from everyone we interviewed or from whom we requested information. Without this assistance, we could not have completed the task.

Special recognition is due to Deputy Commissioner of Finance, Assessment and Management Yvette Jackson, Associate Commissioner for Quality Assurance and Performance Assessment Thomas Evans, his Deputy Terris King, Director of the Office of Disability Program Quality Marlene Thomas, and their staff who opened doors and championed this effort on behalf of SSA. The project could not have been accomplished without the able assistance of Frank Boback, Task Manager, and his predecessor Thomas Fohl. In addition to the many other ways in which they contributed to the project, Frank Boback, Thomas Evans, Peter Wheeler and Terris King also participated in one or more of the site visits for the benchmarking effort.

We would also like to thank the other Deputy Commissioners and their many staff members who participated in interviews for this project and supported this project in many other ways. The members of the Intercomponent Advisory Workgroup established for this project provided extensive feedback and many constructive suggestions on earlier reports. They include: Peter M. Wheeler, Office of Policy; Alan Shafer, Office of Disability; Judge Nellie Hutt, Office of Hearings and Appeals; Katherine Thornton, Office of Operations; Art Spencer, National Council of Disability Determination Directors; Shaun O'Connell, American Federation of Government Employees; Jim Hill, National Treasury Employees Union; and Judge Ronald Bernoski, Association of Administrative Law Judges/International Federation of Professional and Technical Engineers.

Early in the project, we participated in site visits to SSA regional offices in Atlanta, Chicago, Denver and Philadelphia, including visits to Field Offices and Offices of Hearings and Appeals in their cities, and to Disability Determination Services in Alabama, Wisconsin, Colorado and Pennsylvania, and. We would like to thank all of those we interviewed, and especially the Directors of the respective Regional Offices of Quality Assurance, who arranged the interviews: Wayne Harmon, James Scagnelli, Ronald Miller, and Robert Horan. Special thanks are also due to the respective Directors of the Disability Determination Services, who not only facilitated our visits to their offices, but also provided support for our analysis of variation in disability examiner allowance rates: Thomas Warren, Judith Fryback, William Starks, and Howard Thorkelson.

We would also like to thank the four benchmarking organizations for their cooperation, and especially thank the individuals who hosted our site visits. They are: Timothy Arnold and Donald Boutin, UNUM/Provident; Retha Oliver and Robert Dalrymple, Food Stamps Program (FSP) Central Office, Alexandria, Virginia; Esther Phillips, FSP Regional Office in Dallas, Texas; Erma Bernea and Carl Spicawitz, FSP Office for the State of Texas, in Austin; Steven Jencks, Health Care Financing Administration (HCFA) Office of Clinical Standards and Quality, Baltimore, Maryland; Arja Adair, Colorado Foundation for Medical Care (a HCFA Peer Review

Organization), Denver, Colorado; William Bauer and Robert Epley, Veterans' Benefits Administration (VBA) Central Office, Washington, DC; and William Fillman, VBA office in Muskogee, Oklahoma.

We would also like to express our appreciation to the staff of The Lewin Group, led by Gina Livermore, and her predecessor, Taylor Dennen, and including Rachel Duguay and Julia Graffam, for their significant contributions to the content of the report and assistance with technical and administrative support. Contributions by Peter McCarthy and Joel Ettinger of PEM were also critical to the success of the effort.

Finally, we would like to thank former Commissioner Kenneth Apfel for his interest and leadership, which was the impetus for this effort.

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EXECUTIVE SUMMARY

A. Background

Since 1994, the Social Security Administration (SSA) has been committed to reform of the disability claims process. A parallel effort to redesign the Quality Assurance (QA) process has met with considerable disagreement among internal and external stakeholders. In response, SSA contracted with The Lewin Group (Lewin) and Pugh Ettinger McCarthy Associates, LLC (PEM Associates), to conduct an independent and objective assessment of the QA practices used in the disability determination process, and to make recommendations that will enhance the responsiveness of the disability program to its primary stakeholders.

This document is our final report. In preparing this report, we have conducted a broad study of SSA practices, a review of the literature, and a series of site visits and interviews with people from throughout the SSA and state Disability Determination Service (DDS) structure. We have also visited four organizations whose quality management systems might, to some degree, serve as benchmarks for SSA's system. This document brings together material from two earlier reports (Lewin and PEM Associates, 2000a and 2000b), and also includes a set of options for SSA to consider as it continues with its reform efforts.

In the course of the project, and based on our research and review, we came to the following general conclusions:

1. **Given the challenges faced by SSA, the design of the Prototype Process, and the current performance of the existing QA system, no amount of retooling, refocusing, redesign, tinkering or the simple addition of resources to the existing QA processes will achieve SSA's quality improvement goals.** (See Chapter IIIB Challenges to Quality and Quality Management, Chapter IV The Current Quality Assurance Process, Appendix D: The Current Quality Assurance System for Disability Determinations, Appendix E: Performance of the Current Quality Management System).
2. **The only way that SSA will achieve its quality objectives for the disability programs is to adopt a broad, modern view of quality management that includes efforts outside of OQA and the current quality assurance process.** (See Chapter II Best Practices of Quality Management Systems and Appendix A Quality Management Systems).

The options presented are designed to help SSA move away from a dependence on the QA system and toward a more advanced system that, we believe, can help SSA meet current challenges and long-term quality objectives. The options should not, however, be interpreted as a blueprint of how to get from today's system to an advanced system. Instead, they represent our attempt at pointing SSA in the right direction. While some of the options could be adopted quickly, many need further consideration and development. Some are likely to be significantly improved, others might be discarded, and new options are likely to emerge. We think SSA needs to follow the overall thrust of the options to significantly improve quality, not the specific details. This transformation cannot be accomplished overnight. It will require many years, and sustained leadership through a period that will encounter some failures along with what we believe will be many successes.

B. Quality Management Best Practices

SSA's QA activities must be understood and assessed in the context of the broader concept of quality management, which encompasses all of the efforts of an organization to produce quality products. In the quality literature, QA is the term that is generally used for end-of-line inspection. Systems that rely heavily on QA for quality management are considered dated and relatively ineffective compared to more advanced approaches. In hospitals, for example, QA systems similar to those employed by SSA were the dominant model for some thirty years, but now have evolved into process-focused activities that employ many techniques and tools used throughout the manufacturing and service industries. Hospitals now take advantage of quality activities focused on work processes—not on individual workers. Older QA models spotlighted error, and the individual committing the error, while newer approaches place importance on work processes and organization-wide acceptance of quality management tools.

Quality management is an evolving discipline. Most organizations deploy quality management systems that do not purely reflect just one school of thought. New tools are added to existing organizational practices when they are useful and allow for incremental improvement. There is not one single quality management system that can be used, off-the-shelf, for any organization—especially a multi-layer, multi-location, and multi-disciplinary one like SSA. There are, however, certain characteristics present in all quality management systems that may be used to promote quality within any organization.

In the most advanced quality management systems, the focus shifts from the tools and methods of quality management to the integration of quality into the strategy and overall performance of the organization. In these advanced systems, quality management is not a separate function; it is integral to the vision, strategy, performance measurement and culture of the organization.

Current best practices for quality management include:

- Leadership practices that support organizational culture change;
- Adoption of the Malcolm Baldrige National Quality Award criteria as a framework for strategy and improvement of organizational performance;
- Process-based quality management systems that are integrated with the daily work of the organization;
- Use of performance indicators that are linked to strategy and operations;
- Benchmarking to gauge performance against alternatives;
- Rapid cycle process improvement teams and methods to facilitate rapid improvement; and
- Data routinely graphed and displayed in the context of time so that all workers can understand both quality indicators and progress toward meeting quality objectives.

C. Challenges to Quality Disability Determinations and Quality Management

There are many challenges to performing high quality disability determinations and to quality management of the process. The most significant is that disability determinations are highly complex, and place extraordinary demands on individual adjudicators. Other systems that deal with such complex issues often use a team approach, with specialization among team members. Perhaps the second most significant challenge is the subjective nature of many determinations. Some decisions, and perhaps many, could legitimately go either way (“close-call” cases). Subjectivity contributes to disagreement at the initial and appellate levels and to inconsistency across jurisdictions. Subjectivity also makes detection of errors difficult. A third challenge that seems particularly important is the federal/state split of responsibilities for conducting disability determinations. There are other significant challenges as well.

D. Requirements for the Quality Management of the Disability Programs

Based on our findings and our understanding of current best practices, we have developed seven recommended requirements for quality management of SSA’s disability programs, in general, and disability determinations, in particular. A best-practice quality management system would:

1. Develop and pursue a clear operational definition of quality that supports the disability programs’ mission, with multiple components. Definitions for specific processes (e.g., disability determinations) should flow from the higher-level program definition, and also have multiple dimensions (e.g., accuracy, timeliness, efficiency, customer service, due process, etc.). The objective of each component of the determination process should be to help achieve this common objective;
2. Develop and support organizational and process performance measures that are closely tied to the definition of quality;
3. Support a quality-focused culture. This means that employees and management must be responsible for quality, not just the designated quality department. Managers in every component unit must champion the common quality objective;
4. Provide information that can be used to improve the process of disability determination and disability policy. Such a system would provide information from the process that can be used to improve work processes, promote process unification, help redesign the process, and support policy improvement efforts;
5. Provide employees with the resources to produce quality outcomes and service. The system should focus on the work processes and the outcomes, not the individuals. Employees should be provided with the resources they need to produce high quality, and be valued for their contribution to success;
6. Ensure that the disability programs are national programs. This should include a measurement system that can identify variation, and a systematic effort to address variation when it is identified; and

7. Support statutory and regulatory requirements. This goes beyond measuring performance as required by statute to providing information that can address Congressional concerns, assist in the analysis of proposed legislation, and support the monitoring and evaluation of its implementation. This requirement should be integrated with SSA's effort to meet Government Performance and Results Act (GPRA) goals.

E. Assessment of the Current System

The current quality management system at SSA relies heavily on QA. While QA plays a role in a best-practice system, QA alone falls far short of other best practices. Hence, while we find some merit in the current QA system, we also find it substantially deficient with respect to our seven recommended requirements.

1. SSA's definition of quality is narrow. A broader definition is needed, encompassing timeliness, customer service, and efficiency, as well as accuracy. Customer service needs to include due process. This is especially important for "close-call" cases, where either decision could be considered accurate.
2. SSA measures many dimensions of performance already. A careful review of some measures might be warranted. SSA currently has no way to measure the number of close-call cases. In addition, these measures need to be integrated into the quality management system, including integration into GPRA and into performance measures for various components of the determination process.
3. While most staff we met seemed highly committed to job performance, we found little evidence that the current quality management system supports a quality-focused culture. Instead of taking responsibility for quality, there is a heavy reliance on the Office of Quality Assurance (OQA) to ensure quality via inspection. This is inherent in QA systems.
4. Although explanations varied, managers we interviewed all agreed that the current QA system is not consistently used to improve the disability determination process or disability policy. There are important exceptions, however.
5. We encountered significant frustration from those involved in the daily work of the disability process, stemming from resource issues. These include: DDSs with high-turnover and non-competitive compensation; FO staffing in urban centers that appears out of alignment with work requirements; budget and hiring/allocation restrictions that leave some offices critically short of qualified personnel; insufficient time for special analysis or special quality studies; dated information technology; and poor documentation of policy changes. Given the difficulty of obtaining additional resources to support quality improvement, it is critical that options to improve the quality management system do so by reallocating resources in a more efficient manner.
6. Concerns about national consistency were the immediate impetus for this project. We find compelling evidence of inconsistency. This evidence seems to contradict the findings of consistency reviews, which show agreement between national reviewers and DQB reviewers of 98 percent or higher. There are, however, plausible ways to reconcile these observations.

7. A very high share of SSA's quality management effort is devoted to satisfying statutory and regulatory requirements. While the requirements are met, from a technical perspective, there is considerable skepticism and criticism about the value of this activity.

F. Findings from the Benchmark Studies

We visited four "benchmark" organizations. Benchmarking is an approach to finding better or best practices and strategies that have potential application to the benchmarking organization. The four entities chosen for this exercise were:

1. UNUM/Provident Insurance Company;
2. Food Stamp Program;
3. Health Care Financing Administration Professional Review Organization (PRO) Program (HCFA-PRO); and
4. Veterans Benefits Administration, Disability Program (VBA).

Visiting high performing organizations and/or organizations facing similar challenges to learn and observe practices and strategies that might be adaptable, or pitfalls to avoid, can offer important insights. The value of benchmarking is the observation of elements of practices that, with proper adaptation, can modestly or significantly improve performance. The following are important lessons for SSA from these four visits:

- Re-examination of mission drives change in focus toward the bottom line for consumers at the three federal agencies. Their refocused mission has become central to quality management.
- All of the entities surveyed during the benchmarking process defined quality more broadly than accuracy.
- All three federal agencies we visited have adopted "servant leadership" approaches. The Food Stamp Program and the VBA have adopted this approach as the basis of the relationship between their respective central, regional, and state offices.
- Incentives play a critical role in the quality management programs of all three federal agencies we visited.
- Reduced reliance on end-of-line inspection is evident, especially at UNUM and HCFA PRO; both have significantly reduced resources spent on end-of-line inspection. Two of the federal agencies conduct their quality management activities in ways that clearly support national consistency. The HCFA PRO assigns national responsibility for each disease process to one of four regional offices.
- Operations and quality management are integrated in each of the benchmarked organizations.

- The focus on quality can be lost when systems are changed from old to new—illustrated by experiences at HCFA and VBA. UNUM/Provident and VBA, which make disability determinations similar in complexity to those made by SSA, both use team approaches and substantial investments in training to promote quality.
- Appeal and appellate allowance rates for disability determinations can be much lower than they are for SSA’s programs.

The quality management experiences of UNUM and VBA are consistent with the notion that committing more resources to helping claimants and beneficiaries return to good health and to work can both increase their economic security and reduce program expenditures.

G. Overview of an Advanced Quality Management System for the Disability Programs

In our interactions with SSA leadership and disability program management, we have consistently been encouraged to frame our options in the context of moving SSA to a highly advanced quality management system for the disability programs, with features like those described in Section B, above. This will require changes in leadership philosophy, organizational structure, and the strategic planning process. Further, to accommodate an advanced quality system that is integrated into program processes, the processes themselves must change.

The options we present build on work already begun within the Agency. They are designed to accelerate the pace of change toward creating both a highly advanced quality management system at SSA and a highly performing operational culture. Conversion to a highly advanced quality management system will take many years, require the buy-in of many stakeholders and encounter some failures along with greater successes. The conversion will need to be managed in a way that minimizes transition costs, limits the risk of failure and guards against temporary declines in program quality.

Because the gap between current QA and an advanced quality management system is so wide, it is important for SSA to have a clear picture of the characteristics and structure of a highly advanced quality management system as it considers options for improvement. For this reason, we have developed a set of key principles to which SSA should adhere if it is to develop a highly advanced system:

- Quality is a leadership responsibility. Leadership is responsible for fostering an organizational culture that is quality focused. Cultural values, formal and informal, are reinforced by leadership actions. What you do is more important than what you say.
- Quality is the responsibility of all SSA disability program employees and affiliates (most notably DDS employees); it must be this way if quality is to be the foundation of the organizational culture.
- SSA adopts a broader definition of quality that is linked to the mission of the disability programs. Quality is more than decisional accuracy.

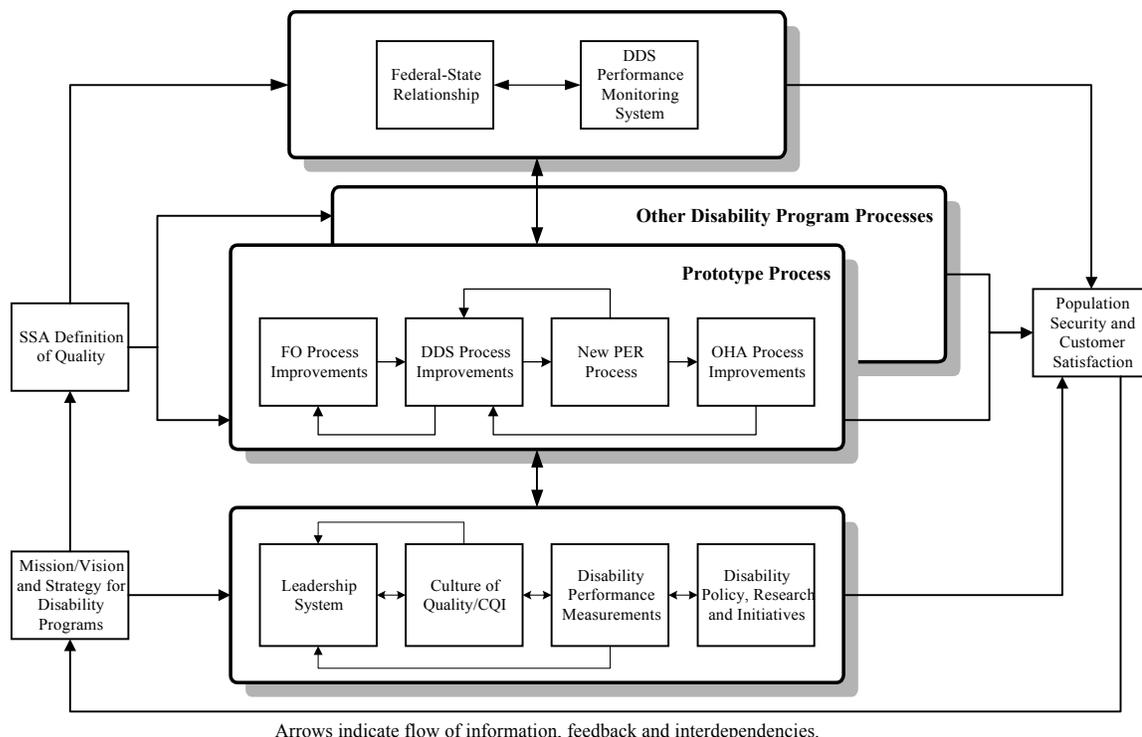
- Quality management is a process of ensuring that the right things are done well the first time at every level of the organization. The quality management system is designed to support the entire scope of the disability programs.
- The quality management system is integrated with the strategy, planning, operations, and training functions of the organization.
- Quality management is deployed in the daily work of the organization.
- Process management theory and methods must be learned. Training and education is deployed organization wide to support understanding and use of theory and methods.
- The measurement of decision accuracy and performance monitoring are functions of the quality management system.
- Measurement drives performance. You get what you measure.
- Organizational, structural, and process changes are required to implement an advanced quality management system for the disability program.
- Expert teams are more effective than individuals in complex decision-making processes.
- A new quality management system will require an investment in training, measurement systems, and transition costs that should result in lower administrative costs by reducing rework, duplication of effort, and redundant inspection-based QA.
- The quality management system should increase the confidence of SSA leadership that program costs are being appropriately managed.
- Management is held accountable for achieving results.

To provide a clearer picture of a future advanced quality management system at SSA, we have developed a high-level, conceptual description of what that system might look like (*Exhibit ES.1*). The arrows indicate the flow of information, feedback, and interdependencies among the components of the system. The lower tier components (Leadership Systems, Culture of Quality/CQI, Disability Performance Measurements and Other Disability Program Initiatives, Research and Projects) form the foundation of the quality management system. The middle tiers represent all disability program processes that serve the program's customers. These include the disability determination processes (the Prototype and continuing disability reviews), and include other processes that serve the program's customers – benefit payment, return-to-work services, outreach efforts, etc.¹ Quality management for disability determinations is part of a comprehensive advanced quality management system for the entirety of disability programs. The top tier (Federal-State Relationships and DDS Performance Monitoring System) represents the

¹ In order to graphically display the quality management system, it is not possible to depict all disability processes. The key point, though, is that an advanced quality management system would address quality in all program processes, not just disability determinations.

components that drive the relationship with the states, critical for achieving the required levels of performance in each DDS.

**Exhibit ES.1
An Advanced Quality Management System for Disability Determinations:
Relationship of Key Components**



The Mission/Vision and Strategy of the Disability Program drives all of the components of the system and is informed by the component on the far right, Population Security and Customer Satisfaction. The latter, as gauged by the Disability Performance Measurement component, feeds information back to the SSA leadership who evaluate the success of the strategy and progress toward meeting the mission and vision of the Disability Program. The Mission and Vision also drive SSA’s definition of quality, which in turn sets the expectations for the determination process, the other disability processes, and the relationship with the states and the DDSs. Each component is summarized below, highlighting features that are notably different than the current system.

Mission/Vision and Strategy for the Disability Programs. The system begins with the mission and vision of the organization. There is clear alignment between the mission and vision of the organization, the quality definition, strategy, and operations. Quality management, strategic planning, performance measurement, and operations become integrated activities. SSA senior leadership recognizes and acts on its responsibility to create a clear vision of how the mission is to be achieved and then puts in place performance measures that drive operations aligned with the mission and goals of the organization.

Definition of Quality. SSA adopts a broad definition of quality that reflects the mission and vision of the disability program. The definition of quality puts forward the concept of the fundamental aim of the disability programs and also emphasizes that a commitment to the mission drives the strategy, management actions, and culture of the organization.

Leadership Systems. Traditionally, leadership is depicted at the top of diagrams and organizational charts. Instead, we view leadership as an element of the foundation of quality management upon which all other systems and process to support quality are built. Leadership can be viewed as a process of focusing talented individuals on a common goal.

Key leadership requirements include:

- Organizational performance and quality management are core responsibilities of SSA senior leadership.
- Resources are allocated based on process and customer needs to support the definition of quality, mission and strategy of the disability program.
- Performance objectives are created for all levels of SSA management and are linked with the goals and strategies. Management at all levels is held accountable for performance.
- Progress toward strategic objectives is the core of all operational reviews, discussions, and decision-making.
- Appropriate organizational structures are developed that align responsibility for the programmatic and operational aspects of the disability programs.
- Leaders continuously communicate the vision and performance goal, celebrating successes and telling stories about SSA achievements that emphasize the culture and commitment to the level of quality and performance that is desired.

Culture of Continuous Improvement. SSA pursues efforts to develop a culture that values customer service, teamwork, accuracy, employee involvement, and stewardship of resources. Organizational culture has a direct impact on the speed of organizational change. A quality culture will, by definition, promote and support continuous improvement, leading to better quality in all respects, including administrative savings. Quality is an integrated process in the daily work of the disability program and has become the responsibility of all employees and management.

Performance Measurement System. You get what you measure. Measurement, analysis, and the use of data in decision-making are value-added activities and routine in the daily work of both management and employees. The future quality management system collects more data and measures more processes than the current system. However, the purposes of measurement are to monitor and control processes and to support improvement efforts rather than to simply measure error rates. Measurement is also the key to driving performance and to measuring success in achieving strategic objectives.

- SSA leadership defines clear, unambiguous organizational performance goals linked to the mission and strategy.
- Disability program operating performance targets are based on external and internal benchmarks rather than arbitrary or historical performance.
- Performance metrics are developed and deployed for the disability program as a whole and for each major process/unit involved in the determination process.
- Leaders utilize balanced scorecards of these performance metrics in the management and leadership of the organization.
- Performance metrics are deployed, visible, and understood at all levels of the organization.

Disability Policy, Research and Initiatives. The final elements of the foundation tier of the quality management system are the functions of policy, research, and initiatives. These functions support the Prototype Process and other initiatives of the disability program.

The Prototype Process. The focus of the quality management system is on disability program processes. The quality management system is designed to support continuous improvement of the Prototype Process. One cultural shift supported by an advanced quality management philosophy is that experimentation, rapid redesign of processes to better meet objectives and innovation are important values of a quality culture. Hence, in the advanced quality management culture, the Prototype Process will be continuously improved and changed.

- SSA's advanced quality management system supports advanced quality management systems at each of the DDSs.
- Pre-effectuation review is integrated into the process. It continues to be used to catch and correct errors as long as accuracy is low enough to make quality control necessary and required by statute. At the same time, its purpose is broadened to collect that can be used for policy analysis.
- The PER sample is driven by policy analysis needs and interests, and meets the stewardship responsibilities of the disability program.
- National consistency is enhanced by single-unit responsibility for specific PER review samples and studies (i.e. all psychiatric cases reviewed by one unit, all cardiology cases by another, etc.), and routine analysis of test cases.

Appellate Process. The advanced quality management system is designed to support basic process management and improvement in the appellate process, just as it does at the initial determination level.

- OHA accepts responsibility for the quality of appellate decision-making and the leadership of OHA is accountable for performance.

- Resources are devoted to supporting quality management functions, which includes peer review, process improvement, measurement and feedback. The ALJs are responsible for conducting and managing a peer review function that: promotes positive change in behaviors among peers; examines variation in decision outcomes that identifies policy issues and opportunities for process improvement; promotes national consistency; and protects the rights of claimants.
- Methods and systems are implemented to provide consistent feedback and communication with DDSs and OD on types of cases reversed and an analysis of the reasons for decision reversals.
- The Appeals Council becomes the primary source of information on appellate, due process, and judicial issues for the disability programs which is then used for policy improvement and process improvement.

Federal-State Relationships. The advanced quality management system supports:

- A redefinition of the Federal-State relationship as a partnership based on frequent and clear communication between the highest levels of state administrations and the disability program.
- Relationships with the states established by renewable agreements, or contracts, that provide incentives for the states to perform, potential sanctions for non-performance, and delineate SSA's obligations to the states.
- SSA funding of DDS operations through a risk-sharing mechanism that provides incentives for DDSs to produce high quality determinations.
- Financial incentives that reward States that perform at superior levels.

DDS Performance Monitoring System. The method of monitoring performance of the DDSs is closely aligned with the management of the relationships between the states and the federal program. States must meet SSA established standards for accuracy, timeliness, customer satisfaction, cost, and achievement of strategic objectives. DDS performance is evaluated against all component measures and a balanced scorecard of performance is utilized as the basis of communicating with the senior leaders of state administrations.

- DDSs are required by contract to implement quality management systems that meet SSA disability program specifications.
- Case review and accuracy sampling is conducted by the DDS quality management unit. Redundant federal and DDS end-of-line reviews are eliminated.
- SSA conducts validation audits on self-reported DDS accuracy and other performance metrics, and uses the findings to adjust state measures.
- SSA utilizes test cases to support national consistency.

- The results of the New PER process are included in assessing the accuracy of DDS determinations.
- DDS performance is monitored through use of a balanced scorecard of key performance indicators.
- The performance indicators serve as the foundation of the new federal state relationship.

H. Options

We have developed numerous options. Each is intended to help SSA accelerate its effort to move away from a quality management system that relies heavily on end-of-line review toward an advanced quality management system, like that described above. While the options are primarily focused on supporting the Prototype disability determination process, they also consider the larger context of the disability programs.

We divide the options into eight areas:

| | |
|----------------|--|
| Option Area A. | Leadership and Organization |
| Option Area B. | Performance Management System |
| Option Area C. | Promoting a Quality Culture |
| Option Area D. | Quality Control |
| Option Area E. | Performance Monitoring Systems |
| Option Area F. | Federal-State Relationships |
| Option Area G. | Initial Disability Determination Process |
| Option Area H. | Appellate Process |

Within each area, we present both short-term and long-term options. In general, short-term options could be pursued relatively quickly, and at little cost. Most are focused on disability determinations, but some would lay the groundwork for a broader effort to develop an advanced quality management system that serves all disability program processes. In comparison to the short-term options, the long-term options require more development, require a higher degree of organizational readiness, involve larger changes and transition costs, and are more oriented toward the entirety of the disability programs, not just disability determinations. Such long-term options will need to be pursued eventually if SSA is to achieve an advanced quality management system for the disability programs and develop a sustainable quality culture. Each option in an area could be implemented on its own, but in many instances individual options reinforce one another. In some instances options are alternatives to one another.

SSA does not need to implement all the options to achieve significant progress toward improving quality management of disability determinations, but will need to pursue many, in principle if not in detail, if it is to develop an advanced quality management system.

1. Option Area A: Leadership Options

a. Short-term Options

- Endorse the development of an advanced quality management system for the future.
- Develop disability program senior leadership skills and knowledge.
- Revisit the mission of the disability programs and create a clear vision that can be translated into the daily work of the organization.
- Create a strong link between the mission and goals of the disability programs and clearly define how the goals are to be measured.
- Adopt a broad definition of quality that reflects the mission and vision of the disability program.
- Develop and implement a communication plan that supports the understanding of the mission, vision, and quality definition for the disability programs at all levels of the organization.
- Create performance objectives for all levels of SSA management that are linked with the goals and strategies.
- Define a new context for operational reviews and decision-making based on mission and strategy.
- Allocate resources based on process and customer needs to support the definition of quality, mission, and strategy of the disability program.
- Develop a Disability Quality Council to guide development of the new quality management system.
- Establish an Office of Quality Management (OQM) to provide centralized support for the quality management system.

b. Long-term Options

- Utilize external benchmarking methods to set strategic targets and performance goals.
- Integrate the budget process with strategic and quality planning.
- Develop data systems to support the quality management system.

- Develop a new organizational structure that clearly establishes programmatic responsibility for the disability programs across all SSA functions.

2. Option Area B: Performance Measurement Systems

a. Short-term Options

- Define clear, unambiguous organizational performance goals for the disability program linked to the mission and strategy.
- Develop and deploy an initial set of performance metrics for the disability determination as a whole and for each major process/unit involved in the determination process.
- Create initial disability determination operating performance targets based on internal benchmarks rather than arbitrary or historical performance.
- Develop an initial balanced scorecard for the disability determination process utilizing existing or easily obtained performance data.
- Deploy performance metrics in a format that is visible and understood at levels of the organization.

b. Long-term Options

- Develop and deploy a set of performance metrics for the disability program as a whole.
- Develop and deploy a balanced scorecard to track disability program performance beyond the dimensions of the determination process.
- Benchmark external operational processes and organization and identify best-in-class processes and methods that can be translated into performance targets for the disability programs.
- Collect data at each point in the disability process to be used to inform the previous process step and improve the overall process.

3. Option Area C: Promoting a Culture of Quality

a. Short-term Options

- Develop a new set of organizational values that are aligned with mission and vision.
- Train managers and employees in the theories and methods of process improvement.
- Review training content and processes at all levels and make changes that support continuous improvement.

- Involve employees in a process to identify opportunities to improve the determination work processes.
- Identify and initiate a set of process improvement projects that have organizational learning value.
- Implement management training on coaching and team skills for front-line and mid-level management.

b. Long-term Options

- Implement a process that periodically assesses gaps between current and desired culture.
- Develop and deploy a 360 Degree review process for all levels of management.
- Implement an employee satisfaction survey process that delivers information to leadership on a monthly basis.
- Develop a Quality Management University.

4. Option Area D: Quality Control and Pre-effectuation Review

a. Short-term Options

- Integrate PER into the disability determination process as a joint responsibility of the Office of Quality Assurance and the Office of Disability;
- Improve the profile system for selecting PER cases;
- Improve the measurement and reporting of the net savings from PER;
- Streamline the review of selected cases;
- Develop and deploy a new process to identify and review difficult cases;
- Develop and deploy a system of Test Reviews to measure consistency and identify reasons for inconsistency;
- Begin the development of a review process that cuts across regions; and
- Expand the purpose of PER to address policy and process issues.

b. Long-term Options

- Transform PER to focus on process and policy improvement, or
- Expand PER as an error-correction mechanism, to include all disability determinations.

The second of these scenarios is an undesirable outcome, only to be considered as a last resort if denial accuracy continues to be low.

5. Option Area E: DDS Performance Monitoring System

a. Short-term Options

- Develop and test DDS performance measurement requirements.
- Develop and implement a DDS scorecard and benchmarks.
- Develop and test DDS quality management models.

b. Long-term Options

- Implement the new DDS quality measurement system;
- Revise and expand the DDS scorecard to take advantage of new data collection efforts; and
- Implement DDS quality management requirements.

6. Option Area F: Federal-State Relationships

a. Short-term Options

- Take initial steps to redefine the federal-state relationship as a partnership, based on frequent and clear communication between the highest levels of state administrations and SSA.
- Establish a federal-state leadership group to develop terms of the federal-state relationship that will support objectives of advanced quality management system.
- Introduce financial incentives to both improve DDS performance and reduce administrative costs.

b. Long-term Options

Once a process for establishing agreements between SSA and the DDSs is developed, including the framework for the agreements, SSA and the DDSs would negotiate individual agreements with many common features. The features might include:

- Capitation payments.
- Other financial incentives for superior performance, tied to the (expanded) scorecard.
- Technical assistance provided by SSA.
- Conditions for modification and renewal of the agreement.

7. Option Area G: Initial Disability Determination Process

a. Short-term Options

SSA is in the process of completing a major overhaul of its initial determination process, through nationwide implementation of the Prototype. Implementation follows an extensive testing phase. While these tests have been important, they have also been costly to the Agency, and a significant burden on the disability determination process.

An organization that implements an advanced quality management system will seek to continuously improve its production processes. For SSA, this means continuation of efforts to improve the determination process, indefinitely. A key difference between such efforts and those that culminated in the Prototype, is that they are more incremental. Because they are more incremental, testing should be less burdensome. Over time, improvement in management's understanding of the tools of continuous quality improvement (*Option Area C*), and in performance measurement (*Option Area B*) will also reduce the burden of testing.

Short-term options in this area are incremental changes to the Prototype process that SSA might want to develop and test:

- Use teams to manage workload and production in FOs. The role of FO supervisor could become coach and technical expert.
- Restrict FO responsibility for intake to non-medical information, and task the DDS with the initial medical interview.
- Share DDS electronic provider lists with FOs.
- Establish in-line quality processes at FOs and active process improvement teams that work on improving processes at every FO.
- Use sampling techniques to review the completeness and accuracy of FO claim submissions to the DDSs.
- Routinely rotate FO and DDS staff through each other's offices to provide on-site expertise on process and eligibility issues.
- Identify and test DDS ideas for improving the collection of MER and the use of CEs.
- Triage initial determinations to move clearly eligible cases into a fast approval cycle and potentially difficult cases into more intensive reviews.
- Test team approaches aimed at improving the Prototype process.
- Develop and test innovations that reduce reliance on POMS.
- Test written rationales versus check-list rationales versus intermediate formats.

b. Long-term Options

In the long-term, continuous process improvement efforts for disability determinations would become routine, and innovations that prove successful would be adopted. Continuous improvement efforts would also be undertaken for other disability program processes.

8. Option Area H: Appellate Process**a. Short-term Options**

Developing an advanced quality management system that incorporates the appeals process seems more problematic than developing a system for other processes because of significant organizational, management, and process issues that are beyond the scope of this project. Hence, our short-term options in this area are limited, but include a significant effort to examine fundamental issues of the appeals process:

- Include OHA leaders in all efforts to develop quality management leadership.
- Develop in-line HPI data collection, analysis and dissemination.
- Task the Appeals Council with the responsibility for being the primary source of information on appellate, due process, and judicial issues for the disability programs.
- Develop an OHA scorecard.
- Establish a Task Force to examine potential reforms to the appeals process and its management.

b. Long-term Options

In the long term, it seems to us that SSA needs to go in one of two directions if it is to successfully establish an advanced quality management system in the appeals process. These alternatives are:

- Assign the responsibility for appellate quality management to OHA, measure performance, and hold the leadership of OHA accountable; or
- Redesign the appeals process to include an SSA representative, and transform the ALJ's role to insurer of due process and judge of evidence presented by both sides.

I. Moving the Process Forward

We conclude the report with some suggestions for how SSA can move the reform process forward. A complete transformation to an advanced quality management system will take many years, as evidenced by HCFA's efforts, which are 10 years old and yet to be completed. Moving forward will require buy-in from the many stakeholder groups involved. All need to be convinced that the transformation will improve SSA's performance, empower them to contribute to improvement, and make SSA a better place to work -- which it will. Ultimately, success will

depend on the ability and willingness of Senior Executives to pursue the process in a sustained manner. We are also convinced that significant improvement of the relationship between the DDSs and SSA is necessary to improve performance.

As SSA moves forward, it should do so cautiously, to avoid high costs and major missteps that could undermine the process. The Agency should look for low-cost changes that can demonstrate early success and more than pay for themselves. Cost will be a significant issue as the Agency moves forward. We believe that implementation of an advanced quality management system will yield process improvements that reduce costs in the long run. In the short run, however, it is clear that investments will need to be made to achieve that objective. It is also possible that quality improvement efforts will not be enough to attain the Agency's quality goals. Additional resources might be necessary, and failure to either scale back quality objectives or provide the resources need to obtain them will defeat the Agency's effort to develop an organizational culture that is focused on quality improvement. Use of evidence-based quality improvement methods should help the Agency obtain the resources needed to achieve its goals, because it should be better able to demonstrate the benefits from additional resources.

We suggest several first steps the Agency could take to move the process along:

1. Have the Commissioner endorse the objective of moving SSA toward a highly advanced quality management system, and provide support for such a system's key features.
2. Establish the Disability Programs Quality Council, to plan and oversee the transformation of the quality management system (see *Option Area A*).
3. Develop disability program senior leadership knowledge of advanced quality management theory and methods (see *Option Area A*).
4. Initiate review of the appeals process, to address a number of issues that seem critical for improving the quality of the appeals process (see *Option Area H*).

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I. INTRODUCTION

A. Project Background

Since 1994, the Social Security Administration (SSA) has been committed to reform of the disability determination process. As a result, the Prototype process for claims adjudication has been developed. Currently piloted in ten states, it will eventually be implemented nationwide.

Along with the redesigned disability determination process, efforts to assess and improve the quality assurance (QA) process for disability determinations have also been underway. A recent assessment of the system conducted by the Office of the Deputy Commissioner for Finance, Assessment and Management came to the following conclusions:

- The current system has many strong attributes;
- There is an established framework on which to build;
- QA cannot be done only “end-of-line”, but also needs to be built in at the front end and throughout the process with validation at the back end; and
- The QA process needs to better service process and policy unification across all levels of disability decision-making.

Redesign of the QA process has, however, met with considerable disagreement among both internal and external stakeholders. In response to this, SSA has contracted with The Lewin Group (Lewin) and Pugh Ettinger McCarthy Associates, LLC, (PEM Associates) to conduct an independent and objective assessment of the quality assurance practices undertaken in the disability determination process, and to develop and assess options for improvements.

Prior to drafting this report, we conducted the following activities:

- interviewed key Central Office staff and senior executives;
- visited four SSA regions and collected information from staff of the following organizations: SSA regional offices, including Regional Commissioners, Disability Quality Branches (DQB), Regional Offices of Quality Assurance (ROQA), Regional Medical Consultant Staff (RMCS), Centers for Disability Programs/Operations, Area Directors’ offices; state Disability Determination Services (DDS); Offices of Hearings and Appeals (OHA); and SSA Field Offices (FO);
- collected, reviewed and analyzed published and unpublished reports, data, and other materials relevant to SSA’s disability determination process, QA activities, and related issues; and
- conducted site visits to four organizations to learn about processes that might serve as benchmarks for improvements to SSA’s quality assurance.

This report reflects information obtained from all of these activities. It also reflects the considerable experience that PEM associates have gained from supporting quality improvement in the healthcare industry and the considerable experience that Lewin has gained from providing SSA with evaluation assistance in its disability process redesign effort. More generally, it reflects experience gained from conducting policy research on the employment and program participation of people with disabilities.

B. Quality Management versus Quality Assurance

In the quality literature, QA is the term that is commonly used for end-of-line inspection. While our nominal charge was to assess and develop options for improvement in the QA system for the medical aspects of disability determinations, SSA's recent discussions about QA reform and the scope of work for this project clearly go beyond the literature's definition of QA to the larger issue of Quality Management (QM), which encompasses all of the efforts of an organization to produce quality products.

As many at SSA recognize, a QM approach that relies solely on QA, as defined in the literature, is considered dated and relatively ineffective compared to more advanced approaches. In hospitals, for example, QA systems similar to those employed by SSA were the dominant model for some thirty years, but have now evolved into process-focused activities that employ many techniques and tools used throughout the manufacturing and service industries. Hospitals now take advantage of quality activities focused on work processes—not on individual workers. Older QA models spotlighted error, and the individual committing the error, while newer approaches place importance on work processes and organization-wide acceptance of quality management tools. To a large extent, the Health Care Financing Administration (HCFA) has adopted a process-focused QM approach to improving the quality of health care services provided to Medicare beneficiaries (see *Chapter VI*).

For the remainder of this report, we use the term Quality Management to reflect the entire scope of quality promoting activities, and follow the literature in the use of the term Quality Assurance. QA surely will have a place in SSA's future QM program, but if SSA were to follow the most far-reaching options we present, it would be only one part of a much larger set of activities.

In the course of the project, and based on our research and review, we came to the following general conclusions:

- 1. Given the challenges faced by SSA, the design of the Prototype Process, and the current performance of the existing QA system, no amount of retooling, refocusing, redesign, tinkering or the simple addition of resources to the existing QA processes will achieve SSA's quality improvement goals.** (See Chapter IIIB Challenges to Quality and Quality Management, Chapter IV The Current Quality Assurance Process, Appendix D: The Current Quality Assurance System for Disability Determinations, Appendix E: Performance of the Current Quality Management System).
- 2. The only way that SSA will achieve its quality objectives for the disability programs is to adopt a broad, modern view of quality management that includes efforts outside of**

OQA and the current quality assurance process. (See Chapter II Best Practices of Quality Management Systems and Appendix A Quality Management Systems).

The options presented are designed to help SSA move away from a dependence on the QA system and toward a more advanced system that, we believe, can help SSA meet current challenges and long-term quality objectives. The options should not, however, be interpreted as a blueprint of how to get from today's system to an advanced system. Instead, they represent our attempt at pointing SSA in the right direction. While some of the options could be adopted quickly, many need further consideration and development. Some are likely to be significantly improved, others might be discarded, and new options are likely to emerge. We think SSA needs to follow the overall thrust of the options to significantly improve quality, not the specific details. This transformation cannot be accomplished overnight. It will require many years, and sustained leadership through a period that will encounter some failures along with what we believe will be many successes.

C. Quality versus Accuracy

At SSA, QA has focused on decision accuracy, or more correctly, whether the adjudicator's decision is adequately supported. In the quality literature, quality usually refers to a broad range of product attributes. In fact, SSA's goals for disability determinations include good customer service (including short processing times) and efficiency, as well as accuracy. In this report, we use the word quality to reflect the broader interpretation, and use the term decision accuracy when referring to the attribute of disability determinations that has always been the focus of SSA's QA system.

D. Overview of the Report

In *Chapter II*, we discuss current best practices in quality management. A history of the evolution of QM best practices can be found in *Appendix A*. In *Chapter III* we briefly describe the Prototype process and discuss the challenges SSA faces in producing high quality disability determinations. More details on these topics are provided in *Appendices B* and *C*. We present a brief overview of the current QA system in *Chapter IV*, with supporting material in *Appendix D*.² In *Chapter V* we discuss seven requirements for SSA's quality management system that were developed in an earlier report, and then assess the current system against these requirements. Supporting material for this assessment is provided in *Appendix E*. In *Chapter VI* we summarize the findings from our benchmark studies, with supporting information provided in *Appendix F*. In *Chapter VII* we provide an overview of what an advance quality management system might look like for the disability programs. The options are presented and discuss in *Chapter VIII*. Backup material on costs appears in *Appendix G*. Each of the options is designed to help SSA move toward an advanced quality management system, like that described in *Chapter VII*. Each option has considerable individual merit, but greater gains will be achieved if

² These documents include: site visit memoranda for our visits to the Atlanta, Denver, Chicago, and Philadelphia regions; a memorandum summarizing findings from interviews of Central Office staff; a memorandum summarizing findings from our interviews of Senior Executives; a *Basic Requirements and Preliminary Assessment* report (Lewin and PEM Associates, 2000a); and *Report On Benchmarking Studies* (Lewin and PEM Associates, 2000b).

the option is implemented as part of a larger effort to build a highly advanced quality management system. We provide a summary and concluding remarks in **Chapter IX**. In **Appendix H**, we summarize the comments received on previous drafts of this report from SSA components, and provide our response to those comments.

II. BEST PRACTICES IN QUALITY MANAGEMENT

A. Introduction

The Options presented later in this report have been developed and based on the premise that, in order for SSA to achieve its quality goals, it must move beyond the current QA processes, toward adopting the philosophies, structures, tools, and methods characteristic of advanced quality management systems. In this chapter of the report, we provide an overview of the philosophical differences in quality management approaches, a discussion of QA and the use of inspection, general requirements and characteristics of quality management systems, and a description of a set of quality management best practices. *Appendix A: Quality Management* provides important support for this chapter, and should be viewed as a foundation to understanding this and successive chapters. It contains a description of the history of quality and quality management, the Malcolm Baldrige Program and the President's Quality Award, and a discussion of the definition of quality.

B. Quality Management Philosophies

QM is an evolving discipline. Most organizations deploy QM systems that do not purely reflect just one school of thought. New tools are added to existing organizational practices when they are useful and allow for incremental improvement. There is not one single QM system that can be used, off-the-shelf, for any organization—especially a multi-layer, multi-location, and multi-discipline one like SSA. There are, however, certain characteristics present in all QM systems that may be used to promote quality within any organization.

A main feature of current best practice systems is their focus on the system, and changes to the system that improve quality. Quality Improvement (QI) and Continuous Quality Improvement (CQI) are terms sometimes used to describe such systems. These stand in contrast to the inspection-based philosophy of QA, which focuses on the detection, and correction, of error in the product against pre-established criteria. QA is sometimes referred to as “eliminating the bad apples” (*Exhibit II.1*).

Instead of focusing on detecting and correcting errors in the final product, CQI/QI focuses on reducing variation and improving the processes that yield products or services, thereby improving the quality of the end product (*Exhibit II.2*).

Exhibit II.1
The Quality Assurance Model

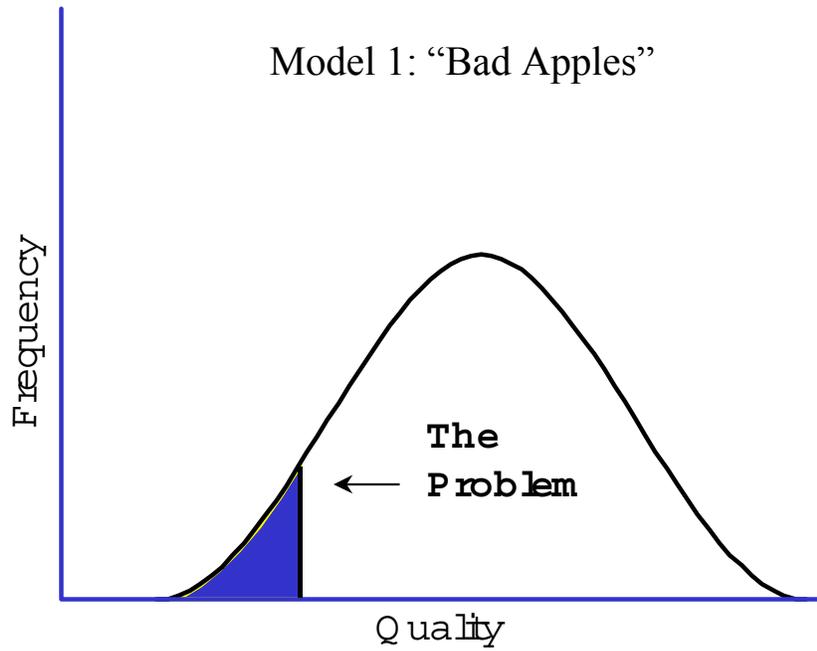
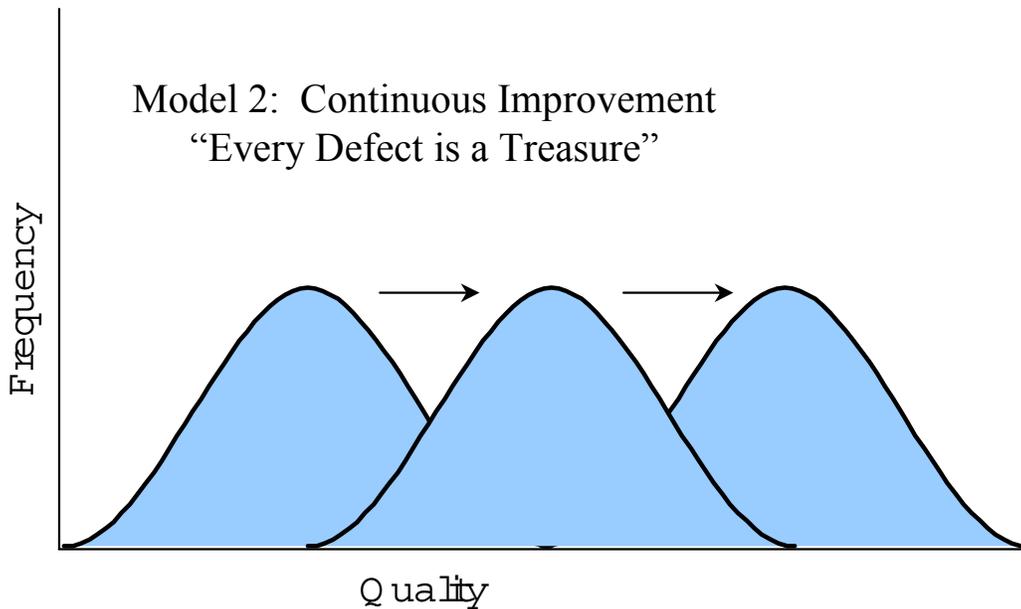


Exhibit II.2
Continuous Improvement Model



Because the focus of CQI is on the work processes, then deployment of theory, tools and methods generally must be organization-wide. Successful integration of process management and improvement into the daily work of an organization often results in dramatic changes in the organizational culture and work environment, and improvements in production processes that can generate substantial savings. Because of the amount of leadership attention required to develop an organizational culture that is focused on customers and processes (rather than people and problems), QI/CQI is often described as a leadership or management philosophy rather than a quality management program or method.

C. Quality Assurance

In current quality management literature, Quality Assurance is rarely discussed except in reference to historical approaches to quality management. Generally speaking, QA and end-of-line inspection are considered dated and relatively ineffective compared to more advanced quality management methods. In hospitals, where QA models similar to the model SSA currently deploys were the dominant models for thirty years, quality management has evolved toward process-focused models that employ many of the techniques and tools found in other industries. Current efforts to improve health care quality focus on decreasing variation in care processes, outcome measurement, service process improvement, improving patient/customer satisfaction and benchmarking of care practices. The accreditation standards for hospitals require the adoption of continuous improvement tools and methodology as well as the establishment of targets for improvement based on benchmark data. The trend in health care is to re-deploy the resources traditionally dedicated to QA activities to support improvement activities previously described.

There is substantial variation across manufacturing and service industries in the application of quality management tools and methods. However, the clear trend is away from end-of-line product inspection methodologies. In almost all manufacturing environments, advanced quality management systems are routinely deployed to improve processes as a core operating strategy to remain cost competitive. In competitive service industries, including hotels, transportation/delivery and financial services, there is a clear understanding of the importance of the customer focus. Manufacturing and service industries are moving beyond basic, inspection-based, quality management systems due to:

- The high cost of inspection with little or no value added during the inspection process;
- The competitive need to continue to lower the cost of production and service through the reduction of waste and rework and process improvement;
- A focus on customer requirements and satisfaction, rather than internally-generated standards;
- The lack of reliability in end-of-line inspection sampling, methods, and processes; and

- Inspection shifts responsibility for quality from the producer to the reviewer.³

It is also important to distinguish between how inspection is used in QA systems and advanced quality management systems. Like QA systems, advanced quality management systems routinely use inspection as a tool, but in a different manner and for a different purpose. As a result, many advanced quality management systems collect more data, perform more process inspections and more reviews than many traditional QA systems. The fundamental differences are in who does the inspection, how it is performed, and for what purpose.

In advanced quality management systems, the individuals performing the work are responsible for much of the data collection and inspection/correction of their own processes and this activity is seen as a routine part of the work process. End-of-line sampling for statistical process control⁴ and the identification of data useful for improvement is a common feature, but this is done by those working or directly responsible for the process. Inspection methods may also be used in advanced quality management systems to meet external regulatory or accreditation requirements.

Clearly the use of inspection for these purposes, with the exception of regulatory compliance, is very different than the focus of the current disability program QA system that inspects in order to:

1. achieve a level of quality control by correcting error at the end of the process (PER), and
2. score the performance of DDSs without systematically using the system to support process improvement.

D. General Requirements and Characteristics of Quality Management Systems

In the most advanced quality management systems, the focus shifts from the tools and methods of quality management to the integration of quality into the strategy and overall performance of the organization. In these advanced organizations, quality management is not a function. However, it is integral to the vision, strategy, performance measurement and culture of the organization. The Baldrige and President's Quality Award⁵ programs are designed to provide a framework for organizational performance excellence based on the core concepts and philosophy of continuous improvement. Baldrige winners are companies and Federal agencies that have successfully made the transition from quality as a function or program to the integration of quality management into the leadership systems of the organization.

³Deming, W.E. (1986). *Out of the Crisis*. Cambridge, MA: Massachusetts Institute of Technology, Center for Advanced Engineering Study.

⁴Statistical process control is an advanced quality concept based on the theory that the outputs of a stable process will all fall within an expected range of values due to random factors that are present in the process. If an output value falls outside the expected range, then a special cause is present that has changed the process (created instability) or a one-time event has occurred, reducing the ability to predict with reasonable certainty the expected or desired outcome of the process. Control charts are the primary tools used to track process stability and to search for special causes that drive unacceptable variation in a process.

⁵ See *Appendix A* for a more detailed description of the Baldrige and President's Quality Award programs.

Exhibit II.3 depicts the characteristics of quality management systems from basic to highly advanced, identifying the underlying philosophies, quality definitions, focus of efforts, and tools and methods routinely deployed.

Exhibit II.3
Characteristics of Quality Management Systems

| Quality Management System Level | Core Philosophy | Quality Definition Theme | Primary Focus | Common Tools and Methods Deployed |
|---------------------------------|---|---|--|---|
| Basic | Inspection as the means to control/achieve quality | Conformance to Standards | <ul style="list-style-type: none"> • Detection and correction of error • Standardization of policy and requirements | <ul style="list-style-type: none"> • Quality/QA departments perform inspections • End of line and/or end of major process step inspection • Error reports • Variance from standard analysis • Performance Scoring and target setting |
| Intermediate | Process control and improvement as the means to control/achieve quality | Conformance to customer requirements | <ul style="list-style-type: none"> • Variation • Process management and improvement • Reducing inspection • Skill training • Team development • Customer satisfaction | <ul style="list-style-type: none"> • Quality departments that collect and analyze data to be used for process improvement • 7 basic quality tools applied to projects • Data Displayed graphically over time • Statistical Process Control (SPC) methods • Project teams • ISO 9002 international standards |
| Advanced | Continuous improvement of all process and systems | Exceed Customer Expectations | <ul style="list-style-type: none"> • Redesign processes and products • Eliminate inspection • Develop leadership • Develop knowledge for improvement • Employees • Culture • Customer knowledge | <ul style="list-style-type: none"> • Quality departments that support training and deployment of tools and methods • Quality Planning • Benchmarking • 7 Basic tools and SPC deployed as basic skills of management • Self directed work and improvement teams • Organization-wide quality measures |
| Highly Advanced | Continuous improvement as driver of organizational vision and culture | Quality expressed in all aspects of the business and work of the organization | <ul style="list-style-type: none"> • Deepening of primary focus areas found in advanced level • Integration of strategy • Organizational performance measures • Building and maintaining culture | <ul style="list-style-type: none"> • Deepening of all methods used in advanced culture • Baldrige Framework • Integrated quality and strategic planning • Balanced Scorecards |

E. Best Practices in Quality Management

The current Quality Management methods and approaches PEM Associates consider best practices include:

Leadership practices that support organizational culture change. In order to implement Advanced and Highly Advanced quality management systems, the senior leadership of the organization must take accountability for the organizational quality performance and adopt leadership practices and structures that support cultural change. These practices include, but are not limited to: alignment of strategy, prioritization of improvement efforts, approval of resources, consistent communication, individual deepening of improvement knowledge and theory, organizational structural changes, adoption of organization-wide quality measures, removal of barriers, policy changes, and decision-making processes.

Adoption of the Baldrige criteria as a framework for strategy and improvement of organizational performance. The Baldrige Program criteria (see *Appendix A*) provide a framework for achieving organizational performance excellence by providing methods and direction in the organization wide deployment of strategy and measurement.

Process-based quality management systems that are integrated with the daily work of the organization. Advanced and highly advanced quality management systems make process management, improvement and redesign part of the daily work of the organization. Supervisors and employees utilize basic quality management tools to reduce variation and re-aim processes to meet customer needs. External inspection is eliminated. Continuous reduction in complexity, rework, waste and cost is expected.

Development of performance indicators that are linked to strategy and operations and utilized by the senior leaders in the management of the organization (Balanced Scorecards/Dashboards).⁶ Balanced Scorecards/Dashboards are used to quantify organizational performance measures used by the senior leaders of the organization to monitor progress on key strategic, financial and quality performance efforts. Leaders must be able to answer three questions:

1. What do we want to achieve or accomplish? (Aim)
2. How will we know that we accomplished our aim? (Measure)
3. What will we do? (Action)

The balanced scorecard/dashboard is used by leaders to measure progress against strategic and quality objectives and assists in the integration of quality management systems and organizational strategy.

⁶ Kaplan, R.S. & Norton, D.P. (1996). *The Balanced Scorecard: Translating Strategy into Action*. Boston, MA: Harvard Business School Press.

Benchmarking. Many organizations benchmark to gauge their performance against competitors or establish stretch performance targets. Although these efforts are useful, the real power of benchmarking comes not from comparison, but from the knowledge gained by learning how the benchmark performance was achieved. Benchmarking processes outside a company's competitive set can lead to breakthrough thinking and introduction of innovations not previously deployed within an industry.

Rapid-cycle process improvement teams and methods. Early process improvement teams and methods often fail due to the complexity of the project undertaken, the time available and a strict adherence to a prescribed improvement methodology that sometimes becomes the project, rather than the method. Advanced and Highly Advanced quality management systems deploy process improvement methodologies that are streamlined and allow for rapid improvement. Improvement of complex systems can be broken into smaller steps that allow for immediate return on the efforts.

Data routinely graphed and displayed in the context of time. One of the most powerful quality management methods is to graphically display important data in simple run charts that display the data points over time. Graphic display leads to quick analysis of trends and deepens an organization's understanding of variation.

A brief history of quality management practices and the evolution to current best practices appears in *Appendix A*.

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III. DISABILITY DETERMINATIONS

A. The Disability Determination Process

1. Eligibility Criteria

The Social Security Disability Insurance (DI) program and Supplemental Security Income (SSI) program for those under 65 rely on the same definition of disability, but have different non-medical requirements for eligibility.⁷ The DI program is an entitlement program for which non-medical eligibility and benefit levels are based on a worker's past contributions in the form of wage taxes paid while engaged in Social Security covered employment. The SSI program is a means-tested program for which eligibility is based on the individual's monthly income, resources, and living arrangements.

To be medically eligible, a claimant must "have a medically determinable physical or mental impairment that has lasted or is expected to last at least twelve months or result in death and that prevents him/her from performing any substantial gainful activity." Substantial gainful activity (SGA) is currently defined as work resulting in earnings of at least \$700 per month. This definition is qualified for SSI applicants under age eighteen, who must have an impairment that results in "marked or severe functional limitations" (Social Security Advisory Board, 1998).

There is a five-step process for adjudicators to follow in making medical determinations, known as the "sequential evaluation" process:

1. If the adjudicator determines that the applicant is engaging in SGA, the claim is denied, and the process ends.
2. If the adjudicator determines that the claimant has an impairment that has no more than a minimal effect on the applicant's ability to perform work tasks, the claim is denied, and the process ends.
3. If the adjudicator determines that the claimant has an impairment that meets or equals (i.e., is equivalent to) one the impairments in SSA's Listing of Impairments ("medical listings"), the claim is allowed, and the process ends.
4. If the adjudicator determines that the claimant's residual functional capacity (RFC) is sufficient for the claimant to perform past work (either as described by the claimant, or as normally performed in the national economy), the claim is denied, and the process ends.
5. If the adjudicator determines that the claimant's RFC allows the claimant to do other work that would be equivalent to SGA, taking into account the claimant's age, education and skill level, the claim is denied. If not, the claim is allowed.

⁷ See *Appendix B*, for a more detailed description of the disability determination process.

2. The Prototype Process

Claimants initiate the disability determination process by filing a claim in one of SSA's approximately 1,100 **Field Offices** (FOs). A Claimant Representative (CR) at the FO establishes the application folder, interviews the claimant (usually by phone), and coordinates the movement of the folder throughout the disability determination process. The CR focuses on non-medical eligibility factors. Unless it is immediately apparent that the claimant is ineligible for DI for non-medical reasons, the CR obtains the claimant's vocational history, information about treating physicians, and some medical information.

The FO forwards the application to a state **Disability Determination Service** (DDS), where the medical evidence is further developed and a medical determination is made by a state disability examiner (DE). The DE:

- Gathers medical evidence from medical records (MER), consultative examinations (CE), and interviews with the claimants themselves.
- Assesses the medical evidence and vocational information to determine if the case meets the criteria for a medical allowance. In making this determination, DEs are guided by the Program Operations Manual System (POMS). POMS is a voluminous document containing detailed interpretations of laws, regulations, and rulings, as well as procedural instructions on deciding cases. In making the determination, DEs may consult with medical and/or vocational consultants (MCs/VCs), supervisors, or QA staff at the DDS. Under the Prototype, DEs are required to consult with an MC on childhood and mental disability cases before they can deny the application. If the evidence supports an allowance, an allowance is made.
- Offers to conduct a claimant conference (CC) prior to denying the claim. The DE discusses the reasons why the application will be denied and offers the claimant the opportunity to provide further information that might support an allowance.

After a medical determination is made at the DDS, the disability folder is returned to the FO for further processing and effectuation of the decision. For SSI allowances, the CR must verify the claimant's income and resources before effectuation.

In recent years, DDSs have processed approximately two million disability determinations annually. The average processing time for an initial decision is 90 to 100 days, with denials generally taking longer to process than allowances. The allowance rate for claims at the initial level is about 37 percent. Claims allowed at the initial level represent about 70 percent of all final disability awards.⁸

Claimants who are denied at the initial (DDS) level can appeal within 60 days to the **Office of Hearings and Appeals** (OHA) and request review by an Administrative Law Judge (ALJ). There are 140 hearings offices nationwide, staffed by about 1,100 ALJs and 5,700 support staff.

⁸ These statistics reflect the experience under the pre-Prototype process. Representative data on processing times, allowance rates, and appeals are not yet available for the Prototype process.

In the recent past, about 65 percent of claims denied at the DDS level are appealed to the ALJ level.

ALJs conduct a *de novo* review of the claim. Under the Hearing Process Improvement (HPI) initiative, the OHA component of the Prototype, the appeals process proceeds as follows:

- Cases are assigned to a “group” unit made up of a group supervisor, several ALJs, a legal advisor, attorney and paralegal analysts, case technicians, and other support staff. The processing group is self-contained and responsible for all aspects of ALJ case adjudication. Cases are initially screened and reviewed by an attorney/legal advisor, dismissed, developed where needed and allowed on the record (with ALJ approval), or referred to case technicians for more in-depth development. Cases not allowed on the record, after adequate development and collection of evidence, are assigned to and reviewed by a specific ALJ in the group unit. The ALJ may then refer the case for further development or deem it ready to schedule for a hearing.
- An ALJ hearing is scheduled and convened. Testimony is taken and evidence is added to the record as needed. The claimant may be represented by private counsel at the ALJ hearing, and has the opportunity to plead his/her case in-person.
- Following the hearing, the case may require further development or receipt of evidence. When no further development is warranted, a decision is prepared by the ALJ, or drafted by an attorney analyst/advisor under the instructions of the ALJ. In making the decision, ALJs are guided by the law, regulations, and federal court findings. The Hearings, Appeals, and Law Litigation Manual (HALLEX) provides ALJs and other OHA attorneys guidelines for interpreting the law and rendering decisions. The ALJs do not use the POMS, but are guided by the laws and regulations that are the basis of the POMS. The final decision is signed by the ALJ and the claimant is notified of the decision.

In 1998, ALJs processed about 600,000 disability cases. The average processing time for an ALJ decision is about one year. About 55 to 60 percent of claims appealed to the ALJ level are allowed. ALJ allowances represent about 27 percent of all final disability awards.⁹

Claimants denied at the ALJ level may request a review by the Appeals Council (AC) within 60 days of receiving the ALJ decision. All unfavorable ALJ decisions are sent to the AC and are held pending further claimant action (request for AC review or court action). About 40 percent of claimants denied at the ALJ level request AC review. About 70 percent of these requests are denied a review by the AC, another 25 percent are remanded to the ALJ, about 4 percent are allowed, and about one percent are denied. The AC may also conduct own-motion reviews of ALJ allowances and denials where the claimant has not requested AC review.

The AC does not generally seek new evidence or hold hearings, but only reviews ALJ decisions to determine whether they are supported by substantial evidence and whether proper procedures

⁹ These statistics do not reflect the specific experience under the Prototype or HPI.

were followed in making the decision. Currently, it takes about 18 months for the AC to issue an action on a case accepted for review.

If a claimant wants to appeal the AC decision, the claimant must file a civil action in Federal District Court within 60 days of the AC decision or denial of the request for AC review. The court may enter a judgment affirming, modifying, or reversing SSA's decision, with or without remanding the case to SSA. The court may also return the case to SSA to obtain additional evidence before a decision is rendered.

About 13,000 disability cases are appealed to federal court annually. The courts can take up to two years to reach a decision. In 1997, the federal courts affirmed 52 percent, reversed six percent, and remanded 42 percent to SSA (Advisory Board, 1998).

B. Challenges to Quality and Quality Management

There are a number of features of the disability determination process that present substantial challenges to achieving high quality and to the improvement of the QM system. We discuss these below.

1. Highly Complex Eligibility Criteria Are Assessed by Individuals

Clearly the biggest challenge to producing quality decisions is the complexity of the eligibility criteria. The amount of material that an adjudicator is required to master is truly impressive. Any adjudicator, no matter how well trained, is likely to make errors, some of which will result in incorrect decisions. While the adjudicator might consult with others, and is even required to consult in some cases, ultimately it is the adjudicator's responsibility to make the decision.

Individual adjudication seems to be a part of the disability determination culture at SSA. While we have not traced the origins of this approach, it seems likely that it is rooted in how decisions were made in medicine during the developmental years of the disability programs – by individual physicians. Since that time, the practice of medicine has evolved considerably, reflecting the growing complexity of medical knowledge and the recognition that individual physicians often make errors.

Team approaches to medical decision-making in complex cases have become common in medical institutions with strong quality management systems. Typically, individual team members are responsible for making assessments in their area of expertise. The team then meets, discusses these assessments, and makes a collective decision. Such a process is less likely to result in an error because team members gain greater expertise in their area of specialization and because conflicting opinions will be challenged, discussed, and reconciled. Notably, HCFA's quality management program is trying to encourage the team approach in medical practice, and discourage continuation of the "physician as superhero" model. We also encountered an impressive example of team decision-making for private disability insurance (UNUM/Provident) adjudications in our benchmark study (see *Chapter IV*).

2. Heavy Workloads and the Pressure to Produce

For many years, adjudicators at all levels have been working under the pressure of large backlogs of pending cases, reflecting both high growth in the number of applications and staff cutbacks. During our interviews, we heard many anecdotes about how pressure to clear cases resulted in diminished accuracy. There is a widespread belief in a trade-off between accuracy and productivity, and that SSA's emphasis on improving productivity has resulted in reduced accuracy.

Workloads are not likely to diminish substantially in the coming years relative to resources, in part because of the aging of the baby boom generation, and in part because there is little political will to increase the resources available for the administration of the disability programs. Hence, improvements in quality must come from better use of existing resources. This requires finding ways to improve both accuracy and productivity.

3. Subjective Factors

Individual determinations require the exercise of judgment on subjective factors. The listings for some physical impairments (such as those involving Human Immunodeficiency Virus and certain musculoskeletal conditions) and virtually all mental impairments require the adjudicator to make subjective evaluations regarding the degree to which the health condition leads to: (1) restrictions of daily activities; (2) difficulties maintaining social functioning; (3) deficiencies in concentration, persistence, or pace that result in failure to complete tasks in a timely manner; (4) episodes of deterioration in work settings that cause the individual to have exacerbated signs and symptoms; (5) functional deterioration, especially as related to relevant abnormal signs and laboratory findings; and (6) pain (GAO, 1997).

For mental RFC determinations, functional abilities such as understanding, remembering, and carrying out instructions are considered. RFCs for physical impairments assess whether the impairment limits the claimant's ability to perform the physical strength demands of work (exertion). There are five categories of physical exertion—sedentary, light, medium, heavy, very heavy. The decision is based on the findings of the assessment and the claimant's age, education, and skill levels or prior work. The older, less educated, and less skilled a claimant is, the more likely is an allowance.

Subjectivity also enters into the decision process because the adjudicator needs to assess the credibility of evidence. This can include considering the potentially conflicting medical evidence from the claimant's provider(s), the consultative examiner(s), and the medical consultant(s).

Many people we interviewed believe that expert adjudicators could reasonably disagree on medical eligibility for an unknown number of cases because of subjective factors. Some say the share of such "close call" cases is almost zero, but others say it could be as high as 20 percent; most suggested 5 to 10 percent. While there is no direct evidence on the extent to which adjudicators would reach the same conclusion (inter-rater reliability), there is significant indirect evidence of substantial disagreement (see *Appendix C*).

The subjective nature of many cases, and the possibility that a substantial share of cases could go either way, has a number of significant implications for quality and quality assurance:

- For cases that could go either way, there is no wrong decision, *per se*. Dimensions of quality other than “correct decision” become paramount – due process, efficiency, service to the claimant.
- Even if all initial decisions are of very high quality, there will be some initial denials that are allowed by OHA on the DDS record, because OHA considers each appealed case *de novo*.
- The share and characteristics of close call cases is of interest to the Agency and policymakers, and the QA system could routinely generate statistics on these cases.
- The subjective nature of the process lends itself to substantial, systematic inconsistencies in decisional outcomes across individual adjudicators of the same type, and across groups of adjudicators of different types, or who are working in different organizations. The reason is that individuals, or the groups they belong to, form different habits in their treatment of subjective issues. Thus, for instance, a lead psychiatric consultant in a Regional Office might influence how DQB reviewers in a region and, by extension, DEs in the regional DDSs, treat certain issues related to psychiatric impairments. In an analysis of variation in initial allowance rate across high-workload, experienced DEs within each of four DDSs, we found allowance rates spreads across examiners who adjudicated randomly assigned applications of 22 to 29 percentage points. These spreads are more than twice as large as we would anticipate from random variation in the claims they reviewed (see *Appendix C*).
- Incentives can play a substantial role in determining the outcome of close call cases. An incentive could easily influence the decision if an adjudicator finds it easier—for any substantial reason—to deny rather than allow, or vice versa. We return to a discussion of incentives below.
- Detecting incorrect decisions in the review process is problematic. Reviewers at all levels assess whether a decision is supported—not simply whether it is correct. When subjective issues are involved, it is essential for reviewers to understand the adjudicator’s rationale. This requires that the adjudicator adequately convey that rationale to the reviewer, which is a time-consuming and challenging task.
- When substantial subjective issues are involved, the outcome of quality reviews will depend on the review standard – substantial evidence, preponderance of the evidence, or some other standard. Similarly, the temptation to substitute judgment only exists if there are subjective issues. In the absence of subjective issues, we would expect nearly identical outcomes under the substantial and preponderance standards.

The importance of subjectivity appears to have increased substantially over the last two decades. This is due to policy changes, mostly mandated by legislation or court decisions, that have introduced substantially more subjectivity into the process, and might help explain increases in the variability of initial allowance rates across states (see *Appendix C*). The importance of recognizing the implications of subjectivity for quality and quality assurance has also increased. To our knowledge, SSA has not systematically examined this dimension of disability determinations, or routinely considered the impact of policy changes on subjectivity and, consequently, the quality of the disability determination process.

While this discussion focuses on the subjectivity of adjudicator interpretation of evidence, the nature of medical evidence itself increases the challenges described in ways that are likely substantial, if not well appreciated. While medical evidence is often described as “objective,” it is well known that for any given condition there may be substantial variation in how physicians collect, interpret, and report it. Research on the practice of medicine has revealed large variations in practice patterns--how physicians diagnose and treat specific conditions. These variations reflect differences in training, experience, and judgment. No doubt such variations are also reflected in the medical evidence obtained for disability determinations, including medical consultant interpretation of that evidence.

4. Federal-State Division of Responsibility

The fact that state DDSs are responsible for initial determinations has substantial implications for quality and quality management. The most significant of these is its impact on SSA’s ability to manage the initial determination process. While in some respects the states resemble contractors to SSA, in one overriding respect they do not. They are political entities, and can individually or collectively influence SSA’s management of the disability determination process through the political process. The reverse is also true. Currently, the DDSs have wide latitude with respect to the management of their processes (see *Appendix B*). SSA monitors quality and productivity at the end of the line and intervenes only when a problem is identified. Federal efforts to improve quality assurance processes within the DDSs will be constrained by SSA’s ability to influence DDS management via regulation or funding incentives.

Second, the management of each DDS is subject to state civil service rules and other state requirements that can sometimes impede quality improvement efforts. The most obvious example is when DDSs are unable to provide sufficient compensation to retain qualified employees because of state civil service rules. The DDS must also operate within the state’s labor/management relationship. A DDS manager must be able to adapt any quality assurance system to the DDS’s unique environment. SSA might need to intervene forcefully when some aspect of the environment is incompatible with quality requirements.

Third, the division of responsibilities means that each claim passes through multiple offices that are physically separated. Office-to-office handoffs are a potentially significant source of quality problems because of lack of ownership—one office’s poor quality might be another office’s problem. This becomes emphasized when personnel in the various offices have limited opportunities to interact and therefore have little appreciation for each other’s needs or contribution. This also limits advancement of personnel from one job to another within the process.

Fourth, states might have objectives that are in conflict with SSA’s. Most pertinently, states have incentives to shift individuals from welfare programs that are financially supported by states and their counties to SSI and DI, which is primarily funded federally. While nobody has indicated to us that such conflicts affect DDS performance today, some have indicated that this has been an issue with some states in the past.

5. Incentives to Produce Quality

The incentives faced by program administrators and other personnel are often key to the production of quality and the management of the quality assurance system. Poor quality can be costly, but the effect of the costs of poor quality and quality assurance depend on the extent to which program administrators and others are held accountable for those costs.

There are three types of costs to poor quality in disability determinations: program costs, administrative costs and claimant costs. Discussions within SSA of the cost of errors usually focus on the programmatic costs, which are very high for allowance errors, and zero or negative for denial errors. The programmatic cost of an allowance error is the value of any benefits paid to the ineligible person. This can be very high because once an allowance is effectuated, it cannot be reversed unless SSA can demonstrate medical improvement. Benefit payments cannot be terminated until SSA can demonstrate improvement or the beneficiary leaves the rolls for other reasons. Benefits paid to someone who should have been found ineligible cannot be recovered. The programmatic cost of denial errors is zero if the denied claim is allowed on appeal, and is negative if not.

The asymmetry of programmatic costs for allowance and denial errors is the rationale behind pre-effectuation review of allowances (PER), described further in *Chapter IV*. As a result, about 50 percent of all initial allowances are reviewed by SSA's Regional Disability Quality Branches (DQBs), compared to just a small fraction of denials. The effect is to increase the DDS administrative cost of allowing a marginal case. If an error is found, it will appear in the DDS's statistics, require further effort, and be an annoyance to one or more DDS employees. Denial errors are also represented in DDS statistics, but the DDS administrative cost of a denial error is small because a very small share of these errors (those identified in the QA review) generate additional work. The incentive effects of PER on DDS decisions is likely an important explanation for the reduction in allowance error rates and increase in denial error rates that occurred in the first few years after PER was introduced; it appears that DEs became more likely to deny cases that were difficult to adjudicate (see *Appendix E*).

In contrast, OHA has a much larger incentive to avoid denial errors than allowance errors, because of the high cost to OHA of an appeal to the court system. We believe that the differences in incentives between DDSs and OHA help explain why so many DDS denials are appealed and reversed, although the evidence is not entirely definitive (see *Appendix E*).

Errors can also have administrative costs, but these costs are often not fully internal to the office that makes them. Most importantly, the substantial administrative burden of a DDS denial error falls on OHA. Similarly, but perhaps of a lesser magnitude, much of the administrative burden of poor quality intake by a FO is likely to fall on a DDS.

The costs of poor quality to claimants can be very high—erroneous denials or long delays in receiving much needed benefits; attorney fees; and miscellaneous financial, time, and psychological costs associated with completing the process. While SSA administrators are genuinely concerned about costs to claimants, these costs do not appear in the Trustees' Report on the soundness of the Trust Fund, or in their administrative budgets. In fact, they are not measured in any systematic way. As long as these costs stay below a level that draws the

attention of the media or elected officials, then SSA administrators have little incentive to reduce them.

The limited accountability of SSA administrators for claimant costs is particularly important because there are tradeoffs between claimant costs and both programmatic and administrative costs. Denial errors can reduce programmatic costs, at the expense of claimants, and DDS denials reduce DDS administrative costs at the expense of claimants. Similarly, holding quality constant, faster processing times would reduce costs to claimants, but would increase administrative expenditures.

Lurking behind the programmatic, administrative, and claimant costs are “political costs,” associated with public outcry over program and administrative costs that are considered too high, beneficiaries that are considered undeserving, applicants who are considered unjustly denied, customer service that is considered poor, or treatment of the DDSs that is considered heavy-handed.

6. Differences in the Objectives of Initial and Appellate Determinations

While both the initial determination and appellate processes have the objective of adjudicating claims, from an administrative perspective their objectives differ, and this difference has consequences for the conduct of determinations, quality, and quality assurance at the two levels.

The objective of the initial process is to adjudicate an enormous volume of claims in an efficient manner. This should result in well supported decisions, fair treatment and provision of good service to clients. It should not place an excessive burden on the appeals process. The objective of the appeals process is to ensure due process for a much smaller number of claimants who believe their claims were unjustly denied at the DDS level.

A key implication of this difference is that the initial process must be staffed by large numbers of adjudicators (DEs) who are not required to obtain very expensive, advanced degrees, but who can be trained to follow a set of detailed rules in a systematic manner, while the appeals process must be staffed by adjudicators (ALJs) who have advanced training and experience in ensuring due process. SSA should expect these two types of workers to disagree and to process cases in a different manner—even when both are following the same rules and regulations. This is a challenge to quality management because it is difficult to assess the extent to which differences in outcomes at the two levels are due to actual problems with one or both of the processes, or are due to the normal result of inherent differences in the process. For instance, while high rates of appeals and high allowance rates for appealed cases are interpreted as evidence that the processes need to be “unified,” we do not know what appeal and allowance rates would be consistent with a process that is satisfactorily unified.

Another key implication of this difference is the importance of adjudicative independence for the appeals process: judges cannot protect the rights of individual claimants if the Agency can influence decisions through administrative oversight. Any quality assurance system must be consistent with the Administrative Procedures Act (APA), which exempts ALJs from certain management controls to help ensure that their judgments are independent.

7. The Non-Adversarial Appeal Process

The appeals process is not adversarial. The claimant is usually represented by a lawyer, but SSA is only represented by the ALJ, who is supposed to be an impartial adjudicator. Non-adversarial appeals processes are unusual. We are aware of only one other program that has an appeals process that is non-adversarial at some stage – for veterans’ benefits. Federal administrative appeals processes that are adversarial include the National Labor Relations Board; the Equal Employment Opportunity Commission, the Black Lung program; the Longshore program, and the Immigration and Naturalization Service. We also understand that state workers’ compensation administrative appeals process are also adversarial, although we have not been able to confirm that this is always true in every state.

Adversarial appeals processes have features that help ensure quality that are absent from SSA’s process. To help understand the need for improved quality management in the non-adversarial process, it is useful to consider how the adversarial nature of other appeals processes helps to ensure quality.

First, in an adversarial process, either side could appeal an initial decision. In the context of the disability programs, this would mean that SSA could appeal an initial allowance. The appeals process would then be a balanced quality assurance mechanism, protecting against both allowance and denial errors.

The pre-effectuation review of initial allowances can be viewed as a substitute for SSA’s ability to appeal an initial allowance. Under an adversarial system, the possibility that SSA would appeal an allowance would create an incentive for the DDS to avoid allowance errors equivalent to the incentive they have for avoiding denial errors. The incentive to avoid allowance errors created by PER is stronger than the incentive that would be associated with the right of SSA to appeal an allowance, because appealed allowances would not create more work for the DDSs.

Second, in an adversarial process, both sides can agree to a settlement prior to a decision by the adjudicator. In such cases, the two parties agree that the matter has been settled to their satisfaction and there is no further appeal. This is usually considered a high quality outcome. The pre-hearing process under HPI can be viewed as a substitute for the pre-hearing settlement process.

Third, the adjudicator hears arguments from both sides, which allows the adjudicator to focus on the core of the parties’ differences. The adjudicator’s role is limited to conducting a fair process and judging the relative merits of the arguments. The adjudicator is not distracted by irrelevant information, and need not have extensive programmatic expertise; the adjudicator specializes in judging. The HPI might also serve to narrow areas of disagreement and allow the ALJ to focus on areas of disagreement.

Fourth, in an adversarial process, advocates for the program would learn about which cases are likely to be allowed on appeal and why. Advocates for the program would learn how to discriminate between appeals which should be settled before a hearing, and those which should not. Further, the advocates would become a source of feedback to the program. They would be able to identify systemic problems with the initial determination process that lead to

inappropriate denials, or systemic problems with policy. This same type of information will be generated in the early stages of the HPI process, but no comparable feedback mechanism is in place.

Finally, in an adversarial process, either side can appeal the adjudicator's decision to a higher appellate body. In the context of SSA's process, this would mean that the program could appeal an allowance to the Appeals Council.¹⁰ In an adversarial process, the appeal board has a very strong interest in the quality of the adjudicator's work, no matter what the decision is, because the poorer the quality, the more appeals they will receive. Those adjudicators who write inadequate opinions are not appreciated by those who must carefully review their opinions. The proportion of adjudicator decisions appealed is an important indicator of quality in the adversarial system. This is not true in SSA's system because of the one-sided incentive to avoid denials. This last statement also applies to appeals to the courts. The pre-effectuation review of a sample of ALJ decisions can be viewed as a substitute for SSA's ability to appeal an allowance, but the current effort is small relative to the number of denials that are appealed.

8. Open Record

New information can be added to a claimant's record at any point during the initial or appellate process. In some cases, this is new information about the claimant's condition at the time the claim is filed, and in other cases it describes changes in the claimant's impairment. Clearly, a situation where the known facts of a case can change at any time create a challenge to those charged with making quality decisions. It is a challenge in quality assessment because the right decision at a point in time must depend on information available at that point in time. For example, many ALJ allowances are based on information that was not available to the DDS and as such, might or might not be indicative of a poor initial decision but may result from failure of the DDS to pursue appropriate information. It should be said, as well, that this also can occur when the DDS vigorously pursues all appropriate information.

Another reason that the open record is a challenge to quality is that the claimant or the claimant's attorney may be slow in providing evidence. Under a closed record system, the claimant and attorney would have a strong incentive to aid in the collection of evidence and ensure that all information is provided by a deadline. That incentive is not present in an open record system. As a result, a greater onus is put on SSA and the DDSs to collect the evidence. Further, we have heard allegations from judges and others that attorneys withhold evidence early in the process to ensure a basis for appeal. Some further allege that attorneys have a less than ethical reason for such activity-- delaying the decision up to a point increases the attorney's fee, which is usually 25 percent of past due benefits up to a limit. Either way, the effect is a reduction in the availability of evidence early in the process. Given the open record, better knowledge about delays in evidence, and reasons for the delay, might help SSA to develop rules and procedures that improve the timely collection of evidence.

¹⁰ The AC can reverse or remand allowances on its own initiative, but its focus is on appeals of ALJ denials, and the AAJs, like the ALJs, are supposed to be impartial arbiters, not advocates for either side. No allowances are appealed to the courts.

9. Labor/Management Relations

The labor/management environment at SSA and the DDSs is complex. Federal workers are largely unionized, the ALJs have their own union, and some DDS employees are unionized while others are not. We have visited some federal OHA offices that appear to have poor labor/management relations and seem dysfunctional. We have visited many other offices, including OHA offices, where labor and management appear to have strong, functional relationships.

SSA has scrupulously avoided infringing on judicial independence since the repeal of the Bellmon Amendment in 1984. Many have suggested to us that the Agency's management of the appeals process has suffered as a result, and that management of the process can be tightened without violating judicial independence. This point of view has considerable appeal. It is also apparent, however, that the line between management of the appeals process and infringement on judicial independence is very difficult to define, and that this has been a source of friction between ALJs and SSA management.

Quality assurance efforts can easily become a source of contention between labor and management. Labor's perception of such efforts, rightly or wrongly, is often that workers are being held to higher levels of accountability and are asked to do more, without reasonable compensation or appropriate appreciation for the difficulty of their task. Systematically poor quality, however, is the result of system limitations and individual workers cannot be held responsible. While individual workers will always make mistakes, and some will perform at a higher level than others, the focus of quality management has to be on system improvements that make it possible to produce quality work. It is critical to engage labor in the effort to improve quality.

In many large organizations, union leadership has a fundamental distrust of management. Based on our observations, SSA is no exception. One important reason for this is that leaders act in ways that do not support the organization's mission, contradicting their expectations for employees, and leading employees to conclude that leadership actions are for nefarious purposes.

SSA has attempted to address this issue through a union/management partnership approach. One effort of that approach is the 1996 *Report of the Management Information Partnership Team*, candidly addresses misuse of management information within the Agency by managers who have incentives that are not in line with Agency objectives. Many of the recommendations of that report are echoed in the options we present in *Chapter VIII*.

IV. THE CURRENT QUALITY ASSURANCE PROCESS

A. Overview

SSA's primary QA system for the disability program is administered at the regional/central office level, is heavily weighted towards review of support for DDS initial disability decisions and can be characterized as having an end-of-line focus. Even before DDS decisions are formally reviewed by the regional DQBs, they undergo some manner of QA sampling and end-of-line review at the DDS. This review varies by state. Other, more informal QA activities related to the documentation of the disability decision might also occur at both the FO and DDS. Additional smaller scale QA activities are applied to the DQB reviews themselves, and ALJ decisions. We briefly describe each of the review processes below. A brief history of QA activities and a more complete description of the current system appear in *Appendix D*.

B. DDS Decisions

1. Field Office QA

The primary issue relevant to the FO associated with the quality of disability determinations is the quality of the medical information collected on the intake form (Form 3368). There is no formal or systematic QA at the FO level. In general, CRs have their work reviewed by management occasionally, more frequently if there have been problems identified or if the CR is a new employee. Periodically, there are efforts in the regions to improve the quality of the 3368 information collected at the FO. These might include sampling and review of products by FO management, feedback on FO products from the DDS, and the training of CRs on specific issues.

2. Internal DDS QA

DDSs are not required to have internal QA departments or formal QA processes in place. All DDSs, however, have some manner of internal QA procedures. They are generally characterized by an end-of-line review of cases conducted similarly to those conducted by the DQB (described below). Samples sizes tend to be large, and error rates are, in some instances, used as a measure of examiner performance.

More informal QA practices might also be undertaken by DDS unit supervisors. This might include a random review of cases in the process of being developed and a review of all decisions of new DEs prior to internal QA sampling.

In addition to assessments of decision accuracy, DDSs also use other information to assess the quality and performance of DEs, including statistics on: processing time, workloads pending, age of the workloads, use of consultative examinations, and medical evidence of record (MER) requests. These statistics are commonly produced by examiner and examiner unit and are shared with DDS supervisors and DEs to manage the claims process and address performance issues.

DDS QA activities often change in response to specific quality or workload issues. When workloads increase, QA staff are sometimes reassigned to processing claims and QA reviews are cut back. Similarly, when concerns about the DDS's accuracy rate arise, QA staff may increase or target their review activity.

3. DQB Quality Assurance Review of DDS Decisions

For Quality Assurance Review (QAR), the regional DQB draws a random sample of DDS decisions designed to capture 70 initial allowances and 70 initial denials per quarter for each DDS (reconsideration and CDR decisions are also sampled separately). Cases selected are reviewed before they are effectuated. The DQB review of the sampled decisions utilizes examiners, medical consultants, and, less frequently, vocational consultants. The DQB examiner conducts the review with the goal of identifying factors that have the potential to affect the decision, as well as the correctness of the decision. In almost all cases, a medical consultant also reviews the case. Errors found are classified into three groups: the decision is either wrong or not sufficiently supported (Group I); the period of disability is incorrect (Group II); or there are technical deficiencies which are unlikely to affect the decision or period of disability (Group III). Only Group I deficiencies are used in the calculation of performance accuracy.

Errors found are documented and returned to the DDS for corrective action and subsequent return to the DQB. DDSs may rebut errors, and there is a mechanism for resolving disagreements.

If a DDS has an accuracy rate of less than 90.6 percent on initial decisions for two consecutive quarters, SSA must provide management and performance support to the DDS.

4. DQB Pre-effectuation Review of DDS Title II Allowances

Pre-effectuation Review (PER) of DDS Title II decisions is mandated by law: 50 percent of all Title II initial allowances must be reviewed prior to effectuation of payment. SSA uses a profiling system to select error-prone cases. The reviews are similar to QA reviews, except that only PER cases judged to have an error by the DQB examiner are required to have medical consultant review. Errors are returned to the DDS for corrective action.

5. Consistency Reviews of DQB Reviews

OQA's central office samples from, and re-reviews cases that have been reviewed by the ten regional DQBs, after effectuation. The CO reviewer reviews the case and assesses the review of the DQB reviewer, rather than conducting an independent review of the case.

C. ALJ Decisions

1. Hearing Office Review of ALJ Decisions

Hearing Offices have no formal internal quality assurance processes in place for ALJ decisions. Regional Chief ALJs cannot change decisions, but they can educate ALJs for the purpose of future cases.

2. Quality Assurance Review of ALJ Decisions

A national random sample of ALJ allowances and denials is selected for review prior to effectuation review by the Appeals Council. This activity, however, has recently been discontinued to accommodate heavier PER sampling of ALJ allowances.

3. Pre-effectuation Review of ALJ Allowances

A sample of ALJ allowances with error-prone profiles is selected for screening and review before effectuation. Currently, about 7,000 cases are reviewed each year. The Appeals Council has the authority to conduct the review, with assistance from OQA. OQA staff conduct the initial review. The Appeals Council reviews cases where OQA disagrees with the ALJ decision, and returns those it agrees with to the ALJ. It is then up to the ALJ to take any further action. A recent OQA probe of cases returned to ALJs found that many of the allowances returned remained unsupported (see *Appendix D*).

D. Longitudinal Peer Reviews

A random sample of ALJ decisions is selected for review at all levels of the adjudicative process, post effectuation. The review is conducted by an examiner and medical consultants, as well as ALJs (ALJ Peer Review). This is also known as the Disability Hearings Quality Review Process (DHQRP). The purpose of the review is to provide information to address broad program issues and to provide ALJs with feedback on their decisions.

E. Other QA Activities and Special Studies

SSA periodically undertakes a variety of additional reviews and studies intended to assess the quality of decisions made in the disability determination process. Recent examples include support of pilot tests for changes to the determination process and special reviews of childhood disability re-determinations, stemming from the SSI child eligibility reforms of 1996.

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V. REQUIREMENTS FOR THE SSA QUALITY MANAGEMENT SYSTEM AND ASSESSMENT OF THE CURRENT SYSTEM

A. Introduction

In this section we present and discuss our recommended requirements for an SSA Quality Management system. The use of the term “quality management” rather than “quality assurance” in this section is intentional, to be consistent in our use of terminology and not assume a specific methodology or philosophy to achieve the system’s aims. SSA should not confuse the current role of OQA in performing some of the required functions that may support an aim with the required aims of the quality management system. What follows is not a list of tasks for OQA or any other division within SSA, but a set of overarching aims for the quality management system. Options for the design of a quality management system that supports each aim are discussed in *Chapter VIII*.

In what follows, we refer to organizational performance measures. We wish to make it very clear that we are referring to measures of performance for the organization as a whole, or measures of process performance, and are not referring to performance of individuals or individual performance-rating systems.

We begin with a brief overview of the recommended requirements for a quality management system governing SSA’s disability determination process. We then discuss the individual requirements in more depth. This is followed by the presentation of proposed criteria for evaluating the options for change presented in *Chapter VIII*. The criteria build on the proposed requirements. Finally, we assess the extent to which SSA’s current system meets the recommended requirements.

B. SSA Quality Management System Requirements

We have identified seven aims that the SSA quality management system for the disability determination process should strive to achieve. Listed in order of priority, they are:

1. Develop and pursue a clear operational definition of quality;
2. Develop and support organizational and process performance measures;
3. Support a quality-focused culture;
4. Provide information that can be used to improve the disability determination process and disability policy;
5. Provide employees with the resources to produce quality outcomes and service;
6. Ensure that the disability programs are national programs; and
7. Support statutory and regulatory requirements.

For the most part, these aims reflect what we have heard from Central Office personnel, Senior Executives, and a variety of individuals interviewed during our regional site visits. As expected, there was considerable variation in opinion as to the relative importance and priority of the aims. For the most part, interviewees expressed aims in the context of the existing SSA quality assurance program -- aims that are worthy, given the challenges faced by SSA. Clearly, improvements can be made in the existing quality assurance process that would help SSA make incremental progress toward achieving the aims.

We believe, however, that simply adjusting quality assurance, as defined in the quality management literature, will not adequately address all of the concerns that we have heard. In order to achieve the desired aims, SSA must move beyond the current inspection-based approach (i.e., quality assurance) and adopt a quality management system that utilizes philosophies and methods found in best-practice systems

C. Discussion of Specific Requirements

1. Develop and Pursue a Clear Operational Definition of Quality

Currently, the operational definition of quality varies widely within SSA. The QA system is focused narrowly on accuracy, but clearly SSA considers timeliness, efficiency, and customer service to be important goals. Best-practice QM systems use more comprehensive definitions of quality, and make it the mission of all system components to achieve high quality. That is, the FOs, the DDSs, OHA, OQA, the Office of Disability, etc., should all be striving toward a common goal with a clear operational definition. The performance of each component should be assessed in terms of its contribution to the common quality objective.

SSA's definition of quality needs to have many dimensions – accuracy, timeliness, efficiency, customer service, etc. SSA executives and central office administrators must set priorities, and all components of the process must work towards the prioritized objectives; otherwise, outcomes will be determined by a haphazard process, with different components pushing in different directions. SSA has already adopted the objective of producing accurate decisions early, efficiently, and with a high level of customer service. This, or a similar objective, needs to become the objective of the quality management system.

We found strong support for broadening the definition of quality beyond decision accuracy. There is widespread agreement that quality should incorporate the dimensions of customer service, timeliness, and efficiency.

The power of customer service in the quality management system affects the leadership process and the culture of the organization. While those involved in the disability determination process primarily think of claimants as their customers (“external” customers), they also need to recognize their internal customers – those who use or are otherwise affected by their work products.

Service to external customers should go beyond the treatment of the customer and customer satisfaction, to include some notion of due process, or fairness. This is especially critical if some disability decisions are too close to call. In such cases either decision could be accurate. A

related goal could be the reduction of close-call cases through improvements to the disability determination process. We return to this, below.

Behind the goals of (external) customer service and timeliness is another objective that was articulated by a few interviewees – minimizing the burden of the process on claimants. They recognized that long delays, denial errors, and the complexity of the process place a significant burden on many individuals who are having a difficult time anyway.

The goal of efficiency is also extremely important. A more efficient process can produce savings that free up resources to address other quality goals.

2. Develop and Support Organizational and Process Performance Measures

A best practice of quality management is to support the development of organizational performance measures that reflect the operational priorities of the organization. These measures should be utilized by the leaders of the organization to monitor organizational performance, and should be tied to the overall strategy of the organization. Because quality management systems are designed to improve organizational performance, the development and use by leadership of an appropriate set of measures is an important aim of the system.

We found strong support for developing a quality management system that will help SSA management measure system performance and set priorities. Performance measures should be consistent with the definition of quality adopted and supported by SSA. Possible measures include:

- timeliness of decisions (including indicators of whether the claim was unnecessarily delayed for some reason, such as collection of unneeded evidence);
- accuracy (including designation of cases that are too close to call);¹¹
- due process;
- administrative costs/productivity;
- service quality (treatment of customers during their interactions with the system); and
- customer satisfaction.

Substantial effort will be required to operationalize these concepts. Timeliness measures could go beyond overall processing time. The quality management system should support the development and implementation of outcome measures that transcend the current allowance/denial rates and measure whether or not the right people are receiving their due benefits in a timely manner. More specific performance measures and goals for individual components of the process must be consistent with the overall measures and goals.

¹¹ The QA program for the Canada Pension Plan disability program uses such a measure.

3. Support a Quality-Focused Culture

In order for SSA to achieve its quality goal, the quality management system must support leadership practices that positively affect the culture of the organization. In advanced quality management systems, the responsibility for quality and service rests on the shoulders of all employees and management, not just the designated quality department. The rate of improvement and change in an organization is driven by leadership practices that positively affect the culture of the organization. We found strong support at all levels for the development of an organizational culture within SSA that values quality and service, and in which management actions are consistent with those values. This requires appointing managers in every component of the process who support SSA's quality goal, and rewarding them for efforts that contribute to meeting the goal.

4. Provide Information Useful to Improving the Disability Determination Process and Policy

As evidenced by the documents we have reviewed and our interview findings, within SSA there is understanding of the theories and methods of advanced quality management systems. At all levels, we found very strong support for a quality management system that supports process management and improvement. The quality management system should provide information that can be systematically used by operational leaders to improve the component steps and work processes of the disability determination process, as well as to assess and improve disability policy itself.

More specifically, the quality management system should provide support for these four functions:

1. Incremental process improvement – supporting incremental changes to the disability determination process that improve quality (broadly defined);
2. Policy improvement – supporting the evaluation of current policy, the development of policy changes, and the implementation of those changes;
3. Process unification – helping ensure that the initial and appellate processes are implementing the same policies while continuing to serve very different functions; and
4. Disability process redesign – supporting efforts to design and implement substantial changes to the determination process.

We found strong support at operational and policy levels for the use of a process-based quality management system. Such a system should provide information that is used by line managers to improve their work processes and align their management priorities with the organizational priorities of SSA. In advanced quality management systems, the process measurement and improvement function is integrated with the work processes and not performed by an external quality review group.

We also found significant support for a quality management system that supports the policy development and implementation functions. The quality management system should identify

areas of confusion relative to policies and regulation that drive poor quality in both the initial determination process and the appellate process. This aim is closely linked to the aim of a National Program (see below). The quality management system should provide information on policy implementation at both the process and outcome levels. Using both levels of information and feedback, SSA management can simplify, clarify, modify, and/or implement new policy. The quality management system should also support the monitoring of new or revised policies to ensure that the impact of a policy is as intended.

Process unification has been undertaken to bridge the perceived gap between the initial (DDS) and the appellate (OHA) decision-making processes. There is an expectation that the quality management system should provide information that can be used to identify differences in decision criteria that are the drivers of inconsistency. Once identified, SSA management can address them through modification of policy, regulation, or process changes.

Support for this aim varied by level and responsibility within SSA. At the operational levels of both initial appellate determinations, there was a remarkable lack of understanding of the other half of the disability process. For the most part, both halves think the other half is doing it wrong and the solution is “Have them do it like we do.” At senior levels within SSA, we found a more global understanding of the differences and support for a quality management system that could provide information to help bridge the gap between the DDS and OHA processes.

The disability determination process is a uniquely complex process. Previously, we cited strong support for a quality management system that provides information to help improve work processes. However, in order to achieve desired levels of performance for the disability program, it might be necessary to redesign and simplify the determination process. Incremental process improvement and process redesign require different methods and different interventions by leadership. While it is the responsibility of line management to improve the work processes for which they are responsible, it becomes the responsibility of senior management to set the direction and expectations, and to design/redesign the overall disability process to meet the objectives of the program. The quality management system must support both functions.

One specific objective for process and policy improvement was mentioned by some interviewees and that was to reduce the number of close call cases. The QM system could play a significant role in identifying process and policy factors that contribute to the number of such cases, and support incremental changes that reduce their number.

5. Provide Employees with the Resources to Produce Quality Outcomes and Service

The quality management system should support employees in their efforts to achieve high quality performance, broadly defined. This means assigning workers to jobs that match their capabilities, providing them with compensation that is attractive relative to other opportunities, providing appropriate initial and on-going training, providing appropriate technical support, and rewarding them for their contributions to the quality objective.

The quality management system should support a focus on the work processes and the outcomes, not the individuals. In advanced quality management systems, employees are viewed as an

important source of process knowledge, and management and employees value participation in improvement efforts. We believe that a quality management system that supports all of the aims previously cited will result in improved job satisfaction for employees and management, and better relations between them.

6. Ensure that the Disability Programs Are National Programs

We found very strong support for a quality management system that helps ensure that the disability determination process produces consistent outcomes, regardless of where a claim is filed. While this aim could be expressed as a component of quality, and therefore subsumed under the requirement of a clear, operational definition of quality, it is such an important goal to SSA, as well as Congress and the Administration, that it should be a requirement in itself.

Variation in process outcomes (e.g., allowance rates) will always exist across geographic regions due to variation in local factors that affect outcomes (applicant demographics, and the local economic, political, and cultural environment). Hence, such outcome measures alone are inadequate as indicators of uniformity.

Ensuring that the disability programs are national programs is closely linked to the requirement to develop and support an organizational performance measurement system that incorporates dimensions of performance consistent with SSA's definition of quality. Ideally, such measures should not be sensitive to local factors.

The quality measurement system does not control variation, but can only identify where variation exists. It becomes management's responsibility to identify root causes of inappropriate variation and implement actions that remove those causes, or make changes to the disability process that will lead to preferred outcomes.

7. Meet Statutory and Regulatory Requirements

The federal/state split in responsibility for the disability determination process creates a need for a check-and-balance system to ensure compliance by the states with federal statute and regulation. We found strong support for the concept of compliance monitoring, but equally strong disagreement as to the methods, and substantial criticism of the current statutory requirements for decision accuracy. We believe there continues to be support for the monitoring of DDS performance as an aim of the quality management system.

The aim of meeting statutory and regulatory requirements is broader than simply monitoring DDS performance. We found support for a quality management system that can provide information about program performance to address congressional concerns and assist in the analysis of proposed legislation, and the monitoring and evaluation of its implementation. This aim is also closely linked to the aim of supporting measures that are used by SSA leadership to gauge organizational performance, and should be integrated with SSA's efforts to meet Government Performance and Results Act (GPRA) goals.

D. Evaluation of Current SSA Quality Management System in Achieving Required Aims

1. Develop and Pursue a Clear Operational Definition of Quality

SSA's operational definition of quality is narrow and reflects an approach to quality management that is not considered best practice. Quality is defined as accuracy of eligibility and payment against policy. In practice, accuracy appears to take second place to productivity, especially when workloads are high. While customer service and timeliness are stated objectives, in practice they appear to be a distant third in a trilogy of operational priorities.

The current definition of quality also has no room for close call cases; if accepted at face value, every decision is right or wrong. While due process is obviously an objective, and perhaps THE objective for the ALJs, we did not find explicit mention of due process in statements of system objectives.

2. Develop and Support Organizational and Process Performance Measures

Various components of SSA measure various aspects of performance – accuracy, processing time, productivity, workloads, service to claimants, and others. A careful review of some of these measures and how they are produced is warranted. There are no measures of close call cases or due process.

Of equal importance to the measures themselves is their integration into the quality management system. OQA is charged with monitoring “quality,” but is essentially limited to monitoring accuracy and customer service. The GPRA report should be considered an important part of SSA's quality management system, but instead, appears to be simply an external reporting requirement that has little impact on how priorities are set within SSA. Outcome measures that gauge the entire performance of the disability process are not widely distributed, and management priorities of individual components don't appear to be in line with overall Agency objectives. The relationship between measures of performance for system components and overall system performance needs to be carefully considered.

3. Support a Quality-Focused Culture

We encountered a high level of personal commitment to job performance at all levels of SSA, and within the DDSs. Staff believe that disability determinations are important, and need to be done well. What we did not see was the organization of the quality management system to support employees and management in their efforts. We found little evidence that the current quality management system supports a quality-focused culture.

A shift of responsibility for quality from operations to the quality departments is inherent in quality management systems that rely heavily on quality assurance (i.e., inspection) to achieve standards. Although there has been much discussion about “in-line” quality, which reflects an awareness of higher-order quality management systems, we saw little evidence of actual implementation. Thus, while employees and managers care about quality, broadly defined, the quality management system does not foster their caring. We encountered individual offices in

which managers clearly were promoting a quality-focused culture with some degree of success, but their efforts were limited by inadequate support from and constraints imposed by the larger system.

4. Provide Information Useful to Improving the Disability Determination Process and Policy

Although explanations varied, managers we interviewed all agreed that the current quality assurance system is not consistently used by management to improve the disability determination process or disability policy. The two review efforts that use most of OQA's resources seem to contribute little to this objective. QAR is focused on scoring DDS performance, not systematically identifying trends and areas of potential improvement. No meaningful information is collected and analyzed through using PER findings.

Some information for improvement does flow from the QAR and PER process, but may not be used by DDSs or FOs to improve the process. It was reported to us during each of the regional site visits that similar errors are repeated period after period. We saw an intensive data collection process at one FO we visited, but the management of the FO did not know how to use the information to improve their operational processes. From time to time, regional offices do identify problem areas from the QA process, and respond by deploying teams to visit DDS offices to train or troubleshoot.

The effort allocated to OQA analysis of quality data has been reduced significantly in recent years due to staff reductions and the necessity of using remaining staff to perform required activities. The QA data are not readily accessible to other offices.

There are instances when analysis of the QA data has contributed to policy change. An example is the use of Longitudinal Reviews to support development of the process unification initiative. The existing quality management system does not, however, provide timely measures that can be used to assess the success of process unification. The only measures mentioned to us were the DDS and ALJ allowance rates, but these are affected by so many other factors that they are of little use in assessing the impact of process unification. There is no systematic effort to obtain feedback from the appeals process about why appealed cases are allowed. Similarly, there is no systematic process to analyze Circuit Court remands and incorporate the lessons learned into policy or process changes. Overall, the longitudinal review appears to us to be the most useful of OQA's activities for the purpose of supporting process and policy improvements, although regrettably slow.

5. Provide Employees with the Resources to Produce Quality Outcomes and Service

At all levels of our review, we encountered frustration in the daily work of the disability process. High variation exists within the DDSs in the skill levels, longevity, compensation and turnover rates of DEs, creating production, service, and accuracy problems for the disability process. FO staffing in urban centers appears to be out of alignment with work requirements. Budget and hiring restrictions and staff allocations leave some offices critically short of qualified personnel, creating problems downstream in the process. Resource shortages at the CO and regional offices

do not allow the QA staff time to do analysis or special studies that could support improvements. Improvements in information technology, which could reduce other costs and improve quality, are long overdue. Staffing and labor/management issues in some OHA offices appear to severely hinder their ability to function. We heard many complaints that documentation and communication of policy and process changes is often slow and very disorganized.

Given the difficulty of obtaining additional resources to support quality improvement, it is critical that options to improve the quality management system do so by reallocating resources in a more efficient manner.

6. Ensure that the Disability Programs Are National Programs

Although the consistency reviews seem to indicate a fairly uniform initial process nationwide, substantial evidence (e.g., a special study of child re-determinations, and DQB out-of-region reviews) exists that policy is not applied consistently across regions and states. Concerns about consistency were the immediate impetus for this project.

Significant variation in DDS allowance rates might also reflect inconsistent application of policy. While much variation might be explained by other factors, the magnitude of the variation makes many skeptical about the consistent application of policy.

The fact that the process is clearly implemented differently in different states (as evidenced by differences in DDS staffing, QA processes, and error rates) also creates considerable skepticism about consistency. The consistency reviews are widely viewed as ineffectual because of such evidence, even though they typically show 98 percent or so agreement with DQB reviews in both clean and deficient cases.

While it is not clear how to reconcile the evidence on inconsistency with the findings from the consistency reviews, we have heard two plausible suggestions. The first is that the 98 percent figure for clean cases does not support the conclusion that reviews are being conducted consistently. If a DQB is finding deficiencies in five percent of all cases, and the consistency reviewer finds errors in two percent of remaining cases (i.e., 98 percent agreement), then the DQB missed 29 percent of the errors. A second explanation is that the consistency review is not independent; the reviewer reads the DQB review before making a decision about whether the review is supported. If the consistency reviewer instead repeated the review process, independently, and findings were then compared to findings from the DQB review, a higher level of disagreement might be found.

7. Meet Statutory and Regulatory Requirements

The focus of the quality management system is on rating DDS performance, required by law and regulation. A very high share of quality management effort and resources is devoted to QAR and PER review. OQA does provide some support for special studies and analysis in support of congressional inquiry or proposed legislation, but several interviewees expressed a desire for more support than was available.

At face value, the current QA system is very responsive to statutory and regulatory requirements. Many are skeptical about the validity of QA measures, however. For instance, a number of

interviewees in a variety of offices have indicated that reviewers adjust their standards downward for DDSs that are struggling with poor quality and/or high workloads.

Others have questioned the value of the statutory and regulatory requirements. The PER requirements are the foremost example. While interviewees believe that PER has reduced allowance error rates at the DDS level, they point out that a large share of claims reversed by PER, subsequently end up as allowances. Many are skeptical about the Trust Fund savings from PER. This partly reflects ignorance about how the actuaries calculate the savings. While we have some cause for concern about how well the savings estimates reflect the numbers of claimants who eventually receive benefits after being denied initially in the PER (*Appendix C*), a more important criticism is that the resources used for PER could potentially be used in a way that produces even more program savings. Perhaps more importantly, many point out the large, but unmeasured cost of PER to claimants arising from: delays in allowances to those whose initial allowance was reversed by PER, but reversed again on appeal; denials by PER that do not get appealed but might have been allowed on appeal; and possibly an increase in denial errors because PER creates an incentive to deny.

VI. FINDINGS FROM THE BENCHMARK STUDY

A. Introduction

One of the activities we performed for this project was to visit four “benchmark” entities. Benchmarking is an approach to finding better or best practices that have potential application to the benchmarking organization. The four entities chosen for this exercise were:

1. UNUM/Provident Insurance Company;
2. Food Stamp Program;
3. Health Care Financing Administration Professional Review Organization (PRO) Program (HCFA-PRO); and
4. Veterans Benefits Administration, Disability Program (VBA).

These four organizations were selected out of twenty-three organizations and companies that we identified and researched. Fourteen entities were considered stronger candidates and were subject to further evaluation. In addition to consideration of the similarity or dissimilarity of the actual services provided, each potential benchmark location was evaluated based on six attributes:

- Systematic Application of Eligibility Requirements;
- Multiple Approval/Appeal Levels;
- Common Culture;
- Produces Complex Products with In-Line Quality;
- Federal-State Partnership; and
- Strong Union Presence.

SSA made the final site selection. Details of the conduct and findings from the individual site visits are provided in *Appendix F*.

It is important to understand the value of benchmarking to improve performance. Benchmarking is often a powerful learning and motivating experience. The opportunity to visit high performing organizations and/or organizations facing similar challenges to learn and observe practices to adapt or avoid can offer important insights. It is important, however, to place in proper context key differences that may exist between the benchmarking organization and the organizations to be benchmarked that make it difficult for any organization to adopt in wholesale form the practices observed in another organization. Often, the value of benchmarking is the observation of elements of practices that, with proper adaptation, can modestly or significantly improve performance.

Hence, not all observations made during the four site visits are either appropriately or easily transferable to SSA. SSA functions in a complex operating and political context similar in some ways to the Food Stamp Program, HCFA, and VBA yet different in others ways including, for example, budget appropriation methods. Compared to UNUM/Provident, SSA differs in several important operational and political characteristics including, SSA's large Title XVI constituency and the budget firewall between administrative and program costs. We believe that many of the processes observed at UNUM are consistent with high performing organizational practice that should be considered by SSA but with an understanding that the direct application of these practices by SSA can be difficult or may require at least modest revision to function effectively within the SSA environment. Despite these differences in organization structure and operations, a great deal was learned during the four site visits. We believe that many of the practices or elements of practices observed have performance improvement value to SSA.

In the following section, we present a summary of the significant learning points from the visits

B. Learning Points

Re-examination of mission drives change in focus toward the bottom line for consumers at the three federal agencies. Their refocused mission has become central to quality management. In recent years, the Central Office leadership at the Food Stamp Program, HCFA PRO, and VBA have re-examined their agencies principal missions and operational programs. In each case the re-examination has led to significant re-direction of purpose, priorities and programs. For example, the Food Stamp Program is implementing changes to re-direct its principal focus from a food voucher program to one devoted to reducing hunger and improving nutrition. HCFA PRO concluded that its principal purpose should transition from review of millions of medical records focused on Medicare payment errors to a program devoted to improving health and the continued stewardship of Medicare resources. VBA leadership introduced team processes to the culture of the Central Office and the VBA Regional Offices to improve VBA performance based on a range of measures set forth in a balanced scorecard. In general, these changes reflect a shift toward the bottom line for consumers: better health care, less hunger and better nutrition, and economic security for disabled veterans. We've seen evidence of a similar change in focus at SSA – specifically, increased interest in helping those with disabilities stay in the workforce or return to work. At this point, however, it appears that quality management remains very focused on the accuracy of disability determinations and payment. The agencies we visited, especially HCFA, have reached a point where their refocused mission has become central to quality management.

All of the entities surveyed during the benchmarking process defined quality more broadly than accuracy.

All three federal agencies we visited have adopted "servant leadership" approaches. The Food Stamp Program and the VBA have adopted this approach as the basis of the relationship between their respective central, regional, and state offices. Each agency has also taken steps to push decision-making down to the regional and state level. This philosophy was deployed by the Food Stamp Program to the state offices through the regional offices (ROs). The RO mission now focuses on how it can assist the state offices to achieve performance targets. Both the Food Stamp Program and the VBA have moved away from a belief that the regional offices exist to

serve the interests of the Central Office, toward one where the Central Office exists to enable the regional and state offices to achieve performance expectations. In an analogous fashion, the HCFA PRO philosophy is to be servant leaders to health care providers.

Incentives play a critical role in the quality management programs of all three federal agencies we visited. Both the Food Stamp Program and VBA have performance-based incentive programs. VBA incentives are based on a wide range of performance measures included in its Balanced Scorecard. The Food Stamp Program provides incentives and penalties based on accuracy rates. However, the incentive/penalty approach may be reconsidered to include a broader set of measures relative to its new focus to reduce hunger and improve nutrition. The HCFA PRO uses private contractors, rather than state agencies or regional offices, to conduct quality management activities in the states. The HCFA approach relies heavily on performance incentives, via competitive contracting. PRO organizations compete for contracts in certain states based on explicit performance criteria set forth in the cost-plus contracts. HCFA staff believes that the competitive nature of the contracting process is critical to the progress it has achieved.

Reduced reliance on end-of-line inspection is evident, especially at UNUM and HCFA PRO; both have significantly reduced resources spent on end-of-line inspection. The eight UNUM FTEs assigned to case review use the results of their audits to identify training opportunities and do not generate reports of decisional accuracy. The HCFA PRO workforce composition has been significantly altered since their mission has changed from comprehensive inspection of medical records to health care quality improvement and case review sampling. This process consumes 40 percent of the PRO budget while 60 percent of the budget is now allocated to quality improvement through a national approach to special projects analysis.

Two of the federal agencies conduct their quality management activities in ways that clearly support national consistency. The HCFA PRO assigns national responsibility for each disease process to one of four regional offices. The VBA conducts its reviews of state-office reviews at its central office. Like SSA, the Food Stamp Program conducts reviews in regional offices, and also has central office reviews of regional office reviews.

Operations and quality management are integrated in each of the benchmarked organizations. Except for the eight FTE audit staff at UNUM, operations and quality management report up to a single executive. At UNUM, operations and quality management are further integrated by “Impairment Teams” that function both in an operational capacity to make disability determinations and as a continuous quality management system -- it is not possible to separate critical quality activities from the decision process. They are fully integrated within the UNUM team process.

The focus on quality can be lost when systems are changed from old to new—illustrated by experiences at HCFA and VBA. A new inspection-intensive program in the VBA disability process is scheduled for implementation within the next six months, a result of the Agency’s expanded definition of accuracy. The VBA admits that, although the actual error rates remain unchanged, the new definition resulted in the reporting of increased accuracy error rates and was not adequately explained to Congress and other decision-makers. The HCFA PRO transition to quality improvement from an inspection/resource management focus was not easily achieved. The first transition effort to repair HCFA PROs ineffective inspection system was to do more

intensive inspection. This strategy failed and led to the current emphasis in quality improvement. HCFA recommends demonstration projects when new quality approaches are considered, to ensure that performance will not suffer when quality definitions are expanded.

UNUM/Provident and VBA, which make disability determinations that are similar in complexity to those made by SSA, both use team approaches and substantial investments in training to promote quality. UNUM and VBA have adopted an approach, and committed the resources, to make the disability determination decision right the first time through a vigorous commitment to team process and workforce training and mentoring. Training is ongoing—not just a snapshot on a subject without reinforcement. Although they frontload additional expense to support team processes in the initial decision, the amount of resources spent on inspection is dramatically reduced. In addition, these organizations create teams with individuals who are expert in certain disease conditions, or other factors important to disability determination, to reduce the error rate and to improve decision-making on all cases. A computer-based case triage system is used by UNUM to better align staff with disability case types and workload.

Appeal and reversal rates for disability determinations can be much lower than they are for SSA's programs. The experiences of UNUM and the VBA are consistent with the notion that improved initial decisions can greatly reduce appeals and reversals, although there might be other explanations for their low rates. Ten to 15 percent of cases denied by UNUM are appealed, with reversal rates between seven and 12 percent. A total of 18.5 FTEs are allocated for the appeals process. The VBA appeal rate is eight percent, of which:

- 22 to 26 percent of denials are reversed (or disability ratings are increased);
- 29 to 36 percent are remanded back for reconsideration; and
- 40 to 42 percent of the initial decisions are upheld.

The quality management experiences of UNUM and VBA are consistent with the notion that committing more resources to helping claimants and beneficiaries return to good health and to work can both increase their economic security and reduce program expenditures. UNUM has acquired a subsidiary with 1,100 employees for this purpose and reports significant success in achieving return to work targets critical to their financial performance and shareholder expectations. The VBA has created a vocational rehabilitation function that, although not yet achieving UNUM level results, is reported to effectively assist certain disabled veterans to return to the workforce.

VII. OVERVIEW OF AN ADVANCED QUALITY MANAGEMENT SYSTEM FOR THE DISABILITY PROGRAMS

A. Introduction

As discussed in the *Introduction* and *Chapter IV*, SSA's current quality management system is highly dependent on a narrow definition of quality (accuracy) and inspection-based quality assurance (QA) to find error. In our interactions with SSA leadership and disability program management, we have consistently been encouraged to frame our options in the context of moving SSA to a highly advanced quality management system. As evident from the description of such systems in the *Introduction*, *Chapter II*, and *Appendix A*, this requires more than a simple retooling of the existing Quality Assurance activity, which alone would not result in significant performance improvement or meet the goals of SSA leadership. Development of a highly advanced quality management system for the disability programs requires changes in leadership philosophy, organizational structure and the strategic planning process. Further, in order to accommodate an advanced quality system that is integrated into program processes, the processes themselves must change.

The leadership of the Social Security Administration has publicly committed to improve the overall performance of the disability program and has set out a series of goals and targets that it intends to achieve by 2005. The mission of SSA is:

“To promote the economic security of the nation’s people through compassionate and vigilant leadership in shaping and managing America’s Social Security programs.”¹²

The aim of the quality management system must be to support this mission as deployed through strategic planning and the organization's operational processes. The RFP states that the goal of this project must be to design a quality management system that will serve SSA well for many years to come. The options we have developed provide steps that SSA could take to move away from the marginally effective QA system toward an advanced quality management system for disability determinations and, more broadly, the disability programs.

In high-performing organizations, the quality management system is closely aligned with the organization's mission and vision and integral to the organization's strategic planning process. Organizational performance and success is judged against the achievement of the mission and expressed in terms of customer satisfaction, achievement of strategy, and financial success. The quality management system must be designed to support organizational and operational decision-making in the context of mission and strategy, rather than to simply produce a set of measures that are independent of day-to-day operations.

The options we present in the next chapter build on work already begun within the Agency. They are designed to accelerate the pace of change toward creating both a highly advanced quality management system at SSA and a high performing operational culture. Conversion to a highly

¹² Keeping the Promise” SSA Strategic Plan 1997-2002

advanced quality management system will take many years, require the buy-in of many stakeholders, and encounter some failures along with greater successes. The conversion will need to be managed in a way that minimizes transition costs, limits the risk of failure, and guards against temporary declines in program quality.

B. Quality Management as a System

In *Chapter II* and *Appendix A*, we discuss in detail the difference between QA and quality management. Rather than focusing on a set of isolated activities, high performing organizations approach the improvement of quality and performance in a systematic manner, organization-wide. The integration of leadership actions, strategic deployment, measurement, training and education, customer knowledge, and process improvements forms a system that supports the mission and vision of the organization. The options described in the next chapter are designed to support the concept of quality management as a system and to move SSA forward toward the establishment of a highly advanced quality management system.

Quality management is an evolving discipline. Most organizations deploy quality management systems that are neither pure QA (inspection-based) nor pure CQI (process-based), reflecting the evolution of philosophy, tools, and practices. New tools and methods are added to existing organizational quality management practices because they are useful and bring incremental improvement. However, the effectiveness of the tools is not optimized when the underlying philosophy (inspection vs. process) is at odds with the methods and structure. Congruence between philosophy and methods leads to higher returns from the quality management system. If SSA moves toward an advanced quality management system, it will move away from dependence on inspection to achieve accuracy and toward a system where the philosophy of continuous improvement is a driver of process improvements, leadership actions, and culture.

In the most advanced quality management systems, the focus shifts from the tools and methods of quality management to the integration of quality into the strategy and overall performance of the organization. If SSA adopts such a system, then quality management will not be a separate function, but integral to the vision, strategy, performance measurement and culture of the organization.

The seven requirements that we have developed for SSA's quality management system, presented in *Chapter V*, were developed to be consistent with the requirements of an advanced quality management system. For ease of reference, they are to:

1. Develop and pursue a clear operational definition of quality;
2. Develop and support organizational and process performance measures;
3. Support a quality-focused culture;
4. Provide information that can be used to improve the disability determination process and disability policy;
5. Provide employees with the resources to produce quality outcomes and service;

6. Ensure that the disability programs are national programs; and
7. Support statutory and regulatory requirements.

1. Principles of a Highly Advanced Quality Management System for the Disability Programs

A large gap currently exists between SSA's quality assurance activities and a highly advanced quality management system. Closing this gap will take considerable time and effort. It is important for SSA to have a clear picture of the characteristics and structure of a highly advanced quality management system as it considers options for improvement. To help understand the changes required, we have developed a set of key principles to which SSA should adhere if it is to develop a highly advanced system:

- Quality is a leadership responsibility. Leadership must be responsible for developing and maintaining an organizational culture that is quality focused. Cultural values, formal and informal, are reinforced by leadership actions. What you do is more important than what you say.
- Quality is the responsibility of all SSA disability program employees and affiliates (most notably DDS employees); it must be this way if quality is to be the foundation of the organizational culture.
- SSA adopts a broader definition of quality that is linked to the mission of the disability programs. Quality is more than decisional accuracy.
- Quality management is a process of ensuring that the right things are done well the first time at every level of the organization. The quality management system is designed to support the entire scope of the disability programs.
- The quality management system is integrated with the strategy, planning, operations, and training functions of the organization.
- Quality management is deployed in the daily work of the organization.
- Process management theory and methods must be learned. Training and education is deployed throughout the organization to support understanding and use of theory and methods.
- The measurement of decision accuracy and performance monitoring are functions of the quality management system.
- Measurement drives performance. You get what you measure.
- Organizational, structural, and process changes are required to implement an advanced quality management system for the disability program.
- Teams of experts are more effective than individuals in complex decision-making processes.

- A new quality management system will require an investment in training, measurement systems, and transition costs that should result in lower administrative costs by reducing rework, duplication of effort, and redundant inspection-based QA.
- The quality management system should increase the confidence of SSA leadership that program costs are being appropriately managed.
- Management is held accountable for achieving results.

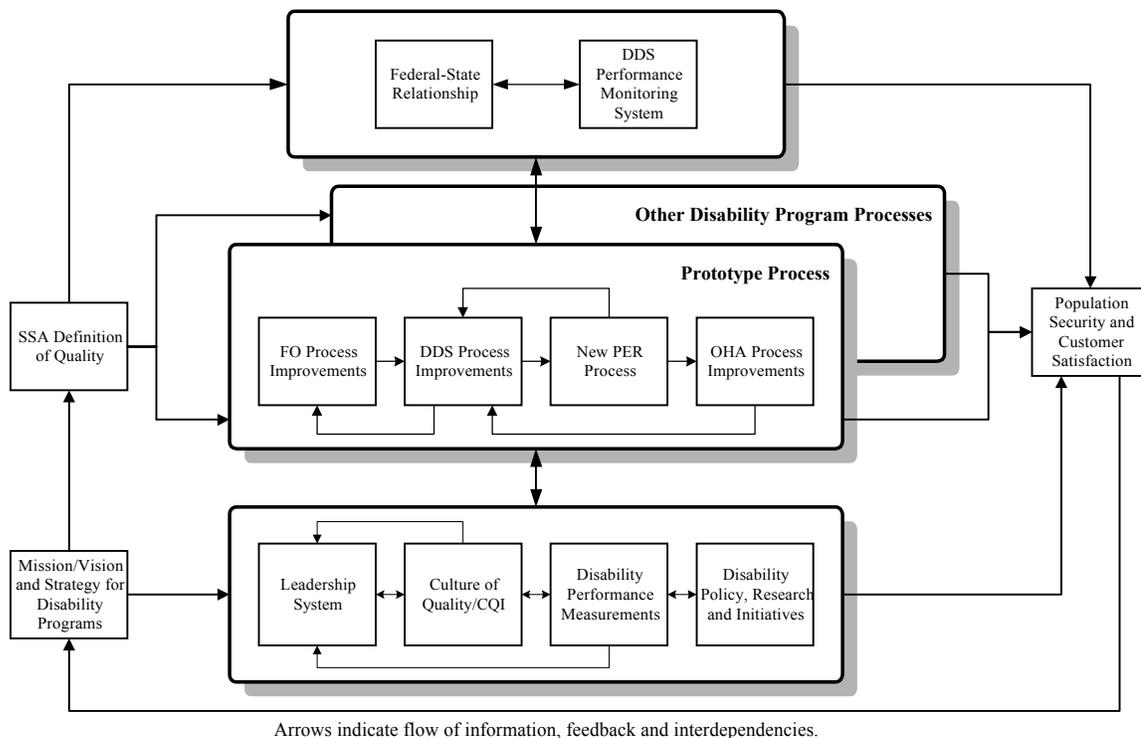
2. Overview of a Highly Advanced Quality Management System for the Disability Programs

In the next chapter, we present “short-term” and “long-term” options for SSA’s consideration. These options have been designed to help SSA move from its current QA system for disability determinations toward an advanced quality management system for the disability programs. Short-term options focus on what can be done in the near term to support disability determinations under the Prototype, while long-term options will require more study, time, and resources to deploy. In order to understand and evaluate the options, the leadership of SSA’s disability programs must have a clear picture of how the principles and practices found in other highly advanced quality management systems could be applied to the SSA disability programs. This overview provides such a picture.

Exhibit VII.1 is a high-level system diagram of a future quality management system for disability programs. The arrows indicate the flow of information, feedback, and interdependencies among the components of the system. The lower tier of components (Leadership Systems, Culture of Quality/CQI, Disability Performance Measurements and Other Disability Program Initiatives, Research and Projects) forms the foundation of the quality management system. The middle tiers represent all disability program processes that serve the program’s customers. These include the disability determination processes (the Prototype and continuing disability reviews), and include other processes that serve the program’s customers – benefit payment, return-to-work services, outreach efforts, etc.¹³ Quality management for disability determinations is part of a comprehensive advanced quality management system for the entirety of disability programs. The top tier (Federal-State Relationships and DDS Performance Monitoring System) represents the components that drive the relationship with the states, critical for achieving the required levels of performance in each DDS.

¹³ In order to graphically display the quality management system, it is not possible to depict all disability processes. The key point, though, is that an advanced quality management system would address quality in all program processes, not just disability determinations.

Exhibit VII.1
An Advanced Quality Management System for Disability Determinations:
Relationship of Key Components



The Mission/Vision and Strategy of the Disability Program drives all of the components of the system and is informed by the component on the far right, Population Security and Satisfaction. Population security and customer satisfaction, as gauged by the Disability Performance Measurement component, feeds information back to the SSA leadership who evaluate the success of deployed strategy and progress toward meeting the mission and vision of the Disability Program. The Mission and Vision also drives the definition of quality component, which in turn sets the expectations for the determination process and the other disability process and the relationship with the states and the DDSs.

The tiers are interdependent. The leadership/culture/performance measurement tier, as the foundation of the quality management system, directly supports the determination process components and the other disability program processes. These components then interact and are interdependent with the top tier of components and together drive population satisfaction and security.

C. Overview of the Components of an Advanced Quality Management System for SSA

Following are discussions of the components of the future quality management system for the disability programs. The purpose of these is to describe the management actions, theories, and processes that are inherent in an advanced quality management system for the disability

programs. Comments in italics on the existing system amplify various points. As the quality management system evolves, details of the system components will likely vary from our description of the future, but the underlying theories that drive the components should remain constant.

1. Mission/Vision and Strategy for the Disability Programs

The advanced quality management system for the disability programs begins with the mission and vision of the organization. There is clear alignment between the mission and vision of the organization, the quality definition, strategy and operations. Quality management, strategic planning, performance measurement and operations become integrated activities. SSA senior leadership recognizes and acts on its responsibility to create a clear vision of how the mission is to be achieved and then puts in place performance measures that drive operations aligned with the mission and goals of the organization.

The clear and consistent communication of a vision that is understood and incorporated into daily operations at all levels of the organization is just as important as creation of the vision. SSA senior leadership will have revisited the mission of the disability program and developed a clear, communicable vision for the organization that is understood by every SSA employee and is translated into the daily work of every SSA and DDS employee.

In SSA's advanced quality management system, senior leadership will have:

- Revisited the mission of the disability programs and articulated a vision that is understood by all employees and incorporated into the daily work of the organization.
- Created a strong link between the mission and goals of SSA and clearly defined how the goals are measured.
- Revisited the current strategic plan and developed new strategies and objectives that:
 - Have a clearly articulated aim that supports the goal and mission;
 - Are measured over time for monitoring progress toward achieving the aim;
 - Are directly translated into operational priority settings and resource allocation decision-making; and
 - Form the foundation of the GPRA reporting requirements.
- Developed external benchmarks that can be used to set strategic targets, rather than arbitrary performance targets based on historical performance.
- Communicated the mission and vision continuously at all levels of the organization, with examples of how they are being translated into the daily work of the disability program.

- Routinely tested decision-making against the published values of the organization. Management actions that are seen by employees and customers as inconsistent with stated values are viewed as highly destructive to a culture that supports quality in daily work.

2. Definition of Quality

SSA adopts a broad definition of quality that reflects the mission and vision of the disability program.

Clearly, it is up to the leadership of SSA to determine the high-level definition of quality, as viewed by customers and consistent with what the mission of SSA might be. For purposes of discussion and to make our point, we suggest a definition, below, but do not intend to presume what the high-level quality definition should ultimately be. Developing the definition of quality is the responsibility of SSA senior leadership.

Quality is one of the five themes of the Strategic Plan 1997-2002. In line with the principles of a highly advanced quality management system, SSA of the future has adopted a broad and inclusive definition of quality that conveys the purpose and mission of the disability program. The definition of quality establishes the fundamental aim of the program and emphasizes that a commitment to the mission drives the strategy, management actions, and culture of the organization.

In the advanced quality management system, the definition of quality for the disability programs directly reflects SSA's overall mission that appears at the beginning of this chapter. In line with this mission, the high-level definition of quality for the disability programs might be:

Economic security for people with significant impairments who are below the normal retirement age.

This definition is broad enough to accommodate major changes in the approach taken by the disability programs to promote the economic security of those with significant impairments who are below the normal retirement age (the "target population"). In the past, the approach of the program has been primarily to identify individuals with impairments so significant that they are unable to work and to provide them with replacement income. Consistent with the goals of the Americans with Disabilities Act (ADA), the programs are beginning to place more emphasis on support that promotes employment and economic independence. This definition of quality is broad enough to encompass both approaches.

Adopting a definition that focuses quality on economic security of the target population has significant ramifications for the disability programs. It forces SSA to revisit strategy and consider the best approaches to promote this population's economic security. This process is already underway at SSA. An important benefit of this quality definition is that it reinforces the fact that the Agency's leadership values efforts that include and exceed the notion of simply identifying people who cannot work and sending them a check for the correct sum. This

definition seems consistent with the Agency's strategic plan and the direction of the Agency's GPRA effort.¹⁴

This high-level quality definition intentionally focuses on SSA's ultimate objective: to promote economic security for the target population—an objective that all components of the disability programs need to understand if they are to collectively work to promote it. There are, however, many specific components of quality that are implicit in this definition. For instance, while the definition says nothing explicitly about using taxpayer dollars efficiently and responsibly, doing so is necessary to achieve the highest level of economic security for the target population that can be achieved with those dollars.¹⁵

The components of quality that are implicit in the high-level definition are stated explicitly and are the basis for operational performance measures of quality. These include the traditional elements of accuracy, timeliness, satisfaction, and efficiency. The components of quality are also broad enough to encompass major changes in SSA's approach to achieve its mission, although operational measures for each component, which we return to later, will likely be narrower in scope.

3. Leadership Systems

Traditionally, leadership is depicted at the top of diagrams and organizational charts. Instead, we view leadership as an element of the foundation of quality management upon which all other systems and process to support quality are built. Leadership can be viewed as a system or process of focusing talented individuals on a common goal.

“Leadership system refers to how leadership is exercised throughout the organization—the way that key decisions are made, communicated, and carried out at all levels. An effective leadership system creates clear values respecting the requirements of all stakeholders of the organization and sets high expectations for performance and performance improvement. It builds loyalties and teamwork based upon organizational values and the pursuit of shared purposed. It encourages and supports initiative and risk taking. An effective leadership system includes mechanisms for the leaders’ self-examination and improvement.”¹⁶

During our interactions with the leadership and management of SSA, their depth of knowledge, commitment, and skills consistently impressed us. Nothing in this discussion should be construed as an indictment of current leadership or program management. Instead, we hope to provide a set of tools, methods, and ideas that will help SSA leadership focus energy and effort on issues critical to the disability program's future success. Some of the points below reflect current activities within SSA. Our intent is to bring additional focus to such activities and efforts and to

¹⁴ See SSA, Keeping the Promise, Strategic Plan 1997 – 2002, 1997.

¹⁵ An analogy from the private sector might be helpful to understand this point. To maximize corporate earnings, a corporation needs to use its resources efficiently to build products that have high value to its customers.

¹⁶ Malcolm Baldrige Quality Award definition of leadership system

raise the level of attention to their importance in support of the quality management system that builds on work already begun in the strategic planning process and in the development of the Government Performance and Results Act (GPRA) measures and reports.

Key requirements for leadership in the future quality management system include:

Organizational performance and quality management are core responsibilities of SSA senior leadership.

Performance for the disability program is defined by achievement of the mission and vision, levels of customer satisfaction and the successful stewardship of resources. The organizational commitment to quality and performance starts with leadership. Leaders have set the tone and expectations for the organization and have allocated resources to support attainment of performance objectives. Leaders are responsible for ensuring that communication and management actions support development of an organizational culture that is committed to customer service and continuous improvement at all levels.

- Disability program senior leaders accept responsibility for the performance of the disability programs, clearly define expectations, and support the achievement of these expectations by their leadership actions. The leaders do not delegate responsibility for quality to a single office that is separate from other program functions.
- Leadership actions include assignment of resources, management of organizational structures, methods of monitoring performance, and holding management accountable. Leadership actions are consistent with communications.

Resources are allocated based on process and customer needs to support the definition of quality, mission and strategy of the disability program.

A critical responsibility of senior leadership is the allocation of resources to support the mission and strategy of the disability program.

- The definition of resources goes beyond budgets to include time, attention by senior leadership and management talent.
- Resource allocation decisions are prioritized based on mission and strategy.
- The budgeting process is integrated with the strategic process. Historical resource allocations do not bind SSA leadership.
- Leaders understand that there is no trade-off between quality, however broadly defined, and cost. The high-performing disability program achieves both high quality and low cost through allocation of resources and improvement of processes that reduce waste and rework. Leaders understand that traditional thinking about the quality/cost trade-off only applies when more money and effort is put into inefficient processes misaligned with the mission and producing waste, rework, and excess complexity.

- Data systems to support the quality management system are developed and continuously improved.
- In order to reduce the time necessary for disability determinations decision, key elements of the determination decision process such as eligibility information, listing grids and rationale statements, and key elements of support documentation are available on-line in the future quality management system.

SSA currently has several major initiatives to develop information systems and data support for the disability program. Review of these initiatives was outside the scope of this project. However, given that the new quality management system is data driven, SSA might consider re-examining its current information technology strategy. SSA should ensure that the plans underway support any of its decisions with respect to implementation of the quality management system options.

Performance objectives are created for all levels of SSA management and are linked with the goals and strategies. Management at all levels is held accountable for performance.

Clear accountability is critical for success. The disability program goals and strategies have been redefined and overall performance measures have been established. Performance objectives and measures have been developed for each level of management within the disability program.

- A new performance review system for management has been deployed that aligns individual management performance with the goals of the disability program.
- Every manager has performance objectives that relate directly to the achievement of disability program strategy and performance metrics.
- Individual managers are held accountable for their individual objectives, performance metrics of the disability program, and performance metrics for their individual unit/department.

Progress toward strategic objectives is the core of all operational reviews, discussions and decision-making.

Leadership focuses attention and effort on key strategies and measures that reflect the mission of the organization.

- Review of progress against strategic objectives is on the agenda of every senior leadership meeting and every operational management meeting.
- More than a token report, this activity is the core of operational discussions and decision-making with in-depth review of metrics and deployment of strategy.
- Leaders demonstrate their focus and commitment by what they spend time discussing and reviewing.
- Every management issue is evaluated in the context of strategy, mission and the definition of quality.

- Balanced scorecards of performance measures help create leadership focus.

Appropriate organizational structures are developed that align responsibility for the programmatic and operational aspects of the disability programs.

SSA's current organizational structure is along functional, rather than programmatic, lines. Many have told us that the objectives of these offices are not aligned, and have said they often perform as semi-independent "silos," each with its own objectives. This is a common complaint in large organizations, and would also likely be heard even if SSA were organized along programmatic lines. Mechanisms are needed to align the objectives of the components with larger Agency objectives, and to facilitate the collaboration of components in working toward Agency objectives.

- Effective matrix relationships and responsibilities for resources and functions that support broader SSA programs beyond the disability programs are required.
- The quality management system is designed to support all processes of the disability programs and therefore should be integrated with the operational responsibility for those programs.
- Resources are allocated to develop a central unit that supports the quality management infrastructure and initiatives.

Leaders continuously communicate the vision and performance goal, celebrating successes and telling stories about SSA achievements that emphasize the culture and commitment to quality and performance that is desired.

Top leadership understands their critical role in advocating the mission, vision and strategy of the organization. Leadership actions drive the culture of the organization.

- SSA senior leadership is an active advocate for quality and mission. The strategy, mission, and progress toward objectives are highlighted in every speech, research paper, and general communication to employees.
- Leaders routinely utilize the leadership best practice of storytelling. Leaders take examples of routine daily work and translate them into stories about SSA employees and actions that typify the mission and values of the organization. Leaders celebrate small successes and employee efforts that are aligned with the mission and strategy of the disability programs. Recognition is a powerful driver of individual performance.
- A goal of SSA leadership is to have every SSA and DDS employee understand the mission and strategy of the disability programs. This message is communicated in a myriad of innovative ways and SSA leadership devotes the time and resources to deliver the message to each SSA employee.

4. Culture of Continuous Improvement

The second element of the foundation of the future quality management system is organizational culture. Critical to the success of any quality management system is the culture in which it operates. In the advanced quality management system, SSA pursues efforts to develop a culture that values customer service, teamwork, accuracy, employee involvement and stewardship of resources. Organizational culture has a direct impact on the speed of organizational change. A quality culture will, by definition, promote and support continuous improvement, leading to better quality in all respects, including administrative savings. Quality is an integrated process in the daily work of the disability program and has become the responsibility of all employees and management.

Currently, there is recognition within SSA that quality is more than an outcome or set of independent measures of accuracy or customer service. In “Keeping the Promise,” Strategic Plan 1997-2002, SSA states,

“Our strategic deliberations have made us realize that quality is more than the sum of our strategic objectives: it is also an attitude and a methodology for approaching our mission work that are interwoven throughout our plans and our operations.”¹⁷

The key concept is that achieving quality is an organization-wide process that is integrated into the daily work of the organization at all levels.

In the quality management system diagram, the component of culture is closely linked to the leadership system and there is continuous interplay between the two. Leadership is responsible for promoting an organizational culture of accountability, performance, customer service and continuous improvement. In the advanced quality management system, SSA pursues five related actions to help build the quality culture.

- Leaders periodically assess the current culture, communicate the desired culture and address gaps between the desired and existing culture.
- Leaders and employees are trained in the theories and tools that support the highly advanced quality management system.
- Training content and training processes across all disciplines are aligned with improvement efforts.
- Improvement knowledge and process management tools are routinely deployed and utilized in the daily work of the organization.

¹⁷ “Keeping the Promise” Strategic Plan 1997-2002 pg. 3

- Employees are empowered to participate in the quality management system and are routinely recognized for their contributions to improvement efforts. Performance Measurement Systems.

5. Performance Measurement Systems

The third element of the foundation of the future quality management system is the performance measurement system. You get what you measure. Measurement, analysis and the use of data in decision-making are value-added activities and routine in daily work of both management and employees. The future quality management system collects more data and measures more processes than the current system. However, the purposes of measurement are to monitor and control processes and to support improvement efforts rather than to simply measure error rates. Measurement is also the key to driving performance and to measuring success in achieving strategic objectives.

SSA leadership defines clear, unambiguous organizational performance goals linked to the mission and strategy.

It is a critical leadership function to set performance targets that are clearly linked to the mission, goals of SSA and the strategic objectives for the disability program. The performance measures are displayed graphically and plotted over time. In addition to actual performance, the target performance levels are displayed on the same graphic. These measures form the core of a balanced scorecard that senior leaders of SSA and the disability program utilize to track progress, make operational decisions, report to external customers, and convey priorities to employees and management.

In setting expectations, senior SSA leadership carefully defines how to the measure link to the strategy and objective. Goals and objectives avoid lofty terms like “World Class Service” or “Best-in-Business” since these terms can be misinterpreted and may generate cynicism among employees when individual interpretations or definitions are not met. Instead, objectives and performance measures are concrete and germane to the disability programs.

Disability program operating performance targets are based on external and internal benchmarks rather than arbitrary or historical performance.

Benchmarking is an important tool for improving quality, and is applied wherever feasible. When the objective is to significantly improve quality, historical performance is a poor benchmark.

- Benchmarks are based on performance levels achieved for similar systems and processes considered “best” either within or outside of SSA.
- The power of benchmarking is to understand how that target is being achieved elsewhere, often requiring management to make fundamental changes in process or operating assumptions in order to produce equal results.

- Both attribute and measurement data is utilized. Attribute data (subjective values) are used to measure customer satisfaction. Measurement data (time, number, etc.) from key processes are often used as a proxy for customer attribute data. The underlying assumption in many benchmark systems is that improvement in speed will result in improvement in customer satisfaction and improvements in cost structure.
- Performance goals include financial indicators and targets. These are both programmatic and administrative cost measures.
- In the analysis of performance data, it is important to understand that averages may be misleading. Averages may be tracked at high levels if the distribution of data approaches a normal distribution and the average is equal to or close to the median value of the data set. However, many complex processes do not produce normal distributions and therefore require stratification and analysis of stratified data. It is a better practice to track and target percentiles rather than averages in measurement data such as wait time, processing time, etc.

Performance metrics are developed and deployed for the disability program as a whole and for each major process/unit involved in the determination process.

The performance measurement system starts with the goals of SSA and then cascades down through the disability program to the lowest level of work production. At each level, metrics are in place reflecting the operational responsibility and key processes for that level. At the highest level, the measures are indicators for the components of quality that are associated with the Agency's high-level definition of quality for the disability programs. In the advanced quality management system, performance metrics for each component of the disability program cascade from the high-level measures of performance. This includes metrics for the disability determination process, and each component of that process.

The metrics are closely tied to the individual management performance review system. Metrics become more specific and specific-process-based as they move closer to the actual work processes. For example, the FO may measure time to appointment and time from appointment to completion of application. The DDS may measure time from receipt to decision, stratified by types of applications. The Regional Office may measure time from initial contact to complete effectuation. The key principle involved is that each component measures and seeks to improve the part of the process it controls. Each layer of management monitors a larger process comprised of the individual component processes.

Leaders utilize balanced scorecards of these performance metrics in the management and leadership of the organization.

The key management tool for tracking performance is the balanced scorecard where "balanced" refers to the inclusion of key customer satisfaction data, process times, strategic indicators, and financial indicators on a single report. This allows leaders and managers to have a complete picture of organizational performance thereby stimulating better decision-making. While balanced scorecard data can be displayed in a variety of formats, one key attribute in highly advanced quality management systems is the display of data in the context of time. For displaying key performance data, simple run charts will generally suffice.

Performance metrics are deployed, visible and understood at all levels of the organization

All SSA disability program employees know the key performance metrics for their operating units in particular, and for the overall disability program in general. Performance metrics are displayed visually in the work areas of the program. Senior leadership and operational management share information with employees and solicit help from employees in meeting the targets. Sharing and displaying performance metrics helps leaders reinforce the mission, vision and values of the disability program.

6. Disability Policy, Research, and Initiatives

The final elements of the foundation tier of the quality management system are the functions of policy, research, and initiatives. These functions support the Prototype Process and other initiatives of the disability program.

- Information collected at various stages of the determination process, in the New PER process, and through the Disability Performance Measurement system is used to set priorities for research and policy development.
- Process improvement tools and methods are applied in the daily work of the functions.
- The aims of policy, research and disability initiatives are aligned with the mission and vision of the organization.
- The functions support and are interdependent with the other components of the disability program. Data collected at any point in the process is available to support policy and research. Data collected by the functions is widely available to the organization and is used to improve processes.
- Disability program initiatives that are aimed at improving economic security for beneficiaries are data driven. Effectiveness of programs is measured by the performance measurement system.

7. The Prototype Process

The focuses of the quality management system are on the processes that drive determinations and on investing resources at the front end of the determination process. The Prototype Process and Process Unification both are aimed at reducing the number and costs of appeals. The quality management system is designed to support continuous improvement of the Prototype Processes. One cultural shift supported by an advanced quality management philosophy is that experimentation, rapid redesign of processes to better meet objectives and innovation are important values of a quality culture. In the advanced quality management culture, the Prototype Process will be continuously improved and changed.

The middle tier of the system diagram represents the Prototype Process. A new PER process is included in this tier because we believe that PER in the future quality management system should be the last step in the initial determination process, not a separate activity. The components of the second tier work together to jointly achieve the quality and performance goals

of the disability program. In the quality management system diagram depicted earlier in this Chapter, the arrows indicate the flow of information between the components of the determination process that is used to inform and improve the disability determination process. The internal supplier/customer concept is critical to the deployment of the quality management system.

- Each process step has both a supplier and a customer. In a complex process like disability, there are multiple handoffs of information.
- Each handoff denotes a process step and in each successive step, the role of customer and supplier is switched.

For example, the DDS is an internal customer of the FO because the FO provides the basic application information necessary to begin processing the disability application. Once the DDS determination is made, the roles are switched and the FO becomes the customer of the DDS because it receives the information it needs from the DDS to either effectuate the claim or send a denial notice to the claimant. In both steps, one unit depends on the completeness, accuracy, and timeliness of the other's work. In a similar fashion, the OHA provides the DDSs with detailed information on the types of cases that are appealed, final disposition, and the reasons for the appellate decision. This information is then used by DDS management and employees to improve the initial determination process and to identify potential areas in which the interpretation of regulations at the OHA level is inconsistent with the application of the POMS during the initial determination process. Information collected at the process level is also utilized to evaluate policy and improve the consistency of the determination process. The feedback of information for improvement helps SSA meet the goals of process unification.

The initial determination process is supported by the quality management system:

- Metrics are in place that can inform the supplying process of key quality characteristics like accuracy, completeness, legibility, timeliness, etc. This feedback loop provides quality control information that can be used by the supplying unit to identify points of process breakdown.
- Data collected is used for both process improvement and to support policy and research functions.
- At each point in the disability process, data is collected and is used to inform the previous process step and improve the overall process.
- Data is collected and tracked as part of daily work by the employees who work in the process and the managers that own the work processes.
- Statistical Process Control charts and other data tracking methodologies are routinely deployed.
- Teams are routinely used at all levels of the process.

- The role of supervision becomes one of coach and technical expert.
- Best practices are identified and shared across the program.
- Rapid cycle process improvement methodologies are utilized for both internal process improvements and cross-functional process improvements.

A New PER process is implemented

Highly advanced quality management systems focus on building quality into work processes to achieve desired outcomes rather than inspection at the end of the process to detect and remove error. However, even in advanced quality management systems some processes may require quality control functions that rely on inspection based methodologies. One theoretical approach to quality control of complex processes is to inspect all outputs of the process since sampling techniques will likely miss a high percentage of errors. To implement PER on all determinations would be cost prohibitive. PER can be implemented to target cases with a high probability of error, as it already is. It can also be used to target cases for other reasons, related to policy.

Because PER is a quality control function, it is the final step in the initial determination process. Data is collected for policy and research requirements in addition to the quality control function. For many cases, a limited review is conducted that maximizes efficiency and reduces the current allocation of resources to the process. PER methodology varies, with more intense review conducted on difficult policy and gray-area cases, as well as increased sampling of DDS production in problem DDSs.

The main features of a new PER process, applicable only to DDS determinations, are:

- Inspection-based methods to catch and correct decision errors (quality control) continue to be utilized to meet regulatory and statutory requirements, and support the performance measurement system.
- The method of PER is changed and the purpose broadened. PER is performed as a final step in the initial determination process and data is collected that can be used for policy analysis.
- The PER sample is driven by policy analysis needs and interests and meets the stewardship responsibilities of the disability program.
- National consistency is enhanced by single unit responsibility for specific PER samples and studies (i.e. all psychiatric cases reviewed by one unit, all cardiology cases by another, etc.).

Improvements in the quality of DDS determinations (both initial determinations and CDRs) will diminish the value of PER for DDS determinations over time. The PER process could be reformulated in a way that enhances its value considerably. The new PER process serves the error-correction function, but goes beyond error correction to support: national consistency, process unification, and policy and process improvement. In addition, the error-correction function is expanded to address denial errors that impose significant administrative expense and costs to claimants.

Appellate Process

The advanced quality management system is designed to support basic process management and improvement in the appellate process, just as it does at the initial determination level. In addition to the basic points discussed above:

- OHA accepts responsibility for the quality of appellate decision-making and the leadership of OHA is accountable for performance.
- Resources are devoted to supporting quality management functions which includes peer review, process improvement, measurement and feedback.
- Methods and systems are implemented to provide consistent feedback and communication with DDSs and OD on types of cases reversed and an analysis of the reasons for decision reversals.
- The Appeals Council becomes the primary source of information on appellate, due process and judicial issues for the disability programs which is then used for policy improvement and process improvement.
- The ALJs are responsible for conducting and managing a peer review function that:
 - Promotes positive change in behaviors among peers;
 - Examines variation in decision outcomes that identifies policy issues and opportunities for process improvement;
 - Promotes national consistency; and
 - Protects the rights of claimants.

Significant organizational, management, and process issues exist within SSA's appellate process. SSA leadership has recognized that these issues exist and has taken steps to address them (e.g., Process Unification and the Hearing Process Improvements). These efforts show promise and are in their early stages, so it is too soon to determine whether they will meet their intended goals. We think, however, that considerably more effort will be required to obtain a level of performance with which SSA and others will be satisfied. In the future, we believe that the same principles that apply to quality management in the initial determination process should apply and be integrated into the appellate process.

8. Federal-State Relationships

The top tier of the advanced quality management system diagram includes the elements of the Federal-State Relationship and the DDS Performance Monitoring System. Both components are significantly changed from their current configuration and are integral to the success of the future quality management system.

Our benchmarking visits to the Texas Regional Office of the Food Stamp Program, the HCFA Central Office, and the Colorado PRO reinforced the importance of relationships between parties in meeting goals and mission. The success of the deployment of the quality management system and improvements in all dimensions of the quality of disability determinations may, in large part, depend on SSA's ability to change existing relationships with the DDSs and the state administrations. In the future, the quality management system supports the goal of establishing a new and positive relationship that is aligned with the goals and mission of the disability program.

The quality management system supports:

- A redefinition of the Federal-State relationship as a partnership based on frequent and clear communication between the highest levels of state administrations and the disability program.
- Relationships with the states established by renewable agreements, or contracts, that provide incentives for the states to perform as well as potential sanctions for non-performance, and delineate SSA's obligations to the states, as well.
- SSA funding of DDS operations through a risk-sharing mechanism that provides incentives for DDSs produce high quality determinations.
- Financial incentives that reward States that perform at superior levels.

9. DDS Performance Monitoring System

The method of monitoring performance of the DDSs is closely aligned with the management of the relationships between the states and the federal program. The future quality management system requires states to meet SSA-established standards for accuracy, timeliness, customer satisfaction, cost, and achievement of strategic objectives. DDS performance is evaluated against all component measures and a balanced scorecard of performance is utilized as the basis of communicating with the senior leaders of state administrations. DDS performance is measured by the DDSs themselves, following SSA requirements and subject to systematic SSA audit.

One dimension of the DDS quality management system could include a new model for monitoring the accuracy of DDS decision-making. This could be patterned after the model utilized by the Food Stamp program to judge the accuracy of Food Stamp allowances. Each DDS would be required, by contract, to have a performance measurement function that measures quality, not limited to accuracy, on the basis of reviews of a random sample of individual cases. SSA then conducts a validation audit of the self-reported DDS accuracy. Claim adjudication accuracy is included in the overall measures of state performance.

- DDSs are required by contract to implement quality management systems that meet SSA disability program specifications.
- Case review and accuracy sampling is conducted by the DDS quality management unit. Redundant federal and DDS end-of-line reviews are eliminated.

- SSA conducts validation audits on self-reported DDS accuracy and other performance metrics, and uses the findings to adjust state measures.
- SSA utilizes sample cases to identify variation in audit validation processes to support national consistency.
- The results of the New PER process are included in assessing the accuracy of DDS determinations.

DDS performance is judged by a balance of accuracy, due process, production, financial and customer service metrics.

- DDS performance is monitored through use of a balanced scorecard of key performance indicators.
- The performance indicators serve as the foundation of a new federal state relationship. Point scores for each category are developed from the sub-measures to produce category measures. These two are then weighted and summed to obtain a total point score, which is used to compare DDS performance against national standards for overall point scores and category point scores.
- The scorecard becomes the basis for management discussions with the DDS and senior state administration officials and is utilized in contract negotiations with the states and for the awarding of performance bonuses and sanctions.

D. Linking the SSA Requirements to the Advanced Quality Management System for the Disability Programs

It is important to evaluate the future advanced quality management system against the seven basic requirements for the SSA Quality Management System described in ***Chapter V***.

**Exhibit VII.2
Contribution of Features of the Advanced Quality Management System to SSA
Requirements**

| | 1) Develop and pursue a clear definition of quality | 2) Develop/ support organizational and process performance measures | 3) Support a quality- focused culture | 4) Provide information to improve the disability determination process and disability policy | 5) Provide employees with the resources to produce quality outcomes and service | 6) Ensure that the disability programs are national programs | 7) Support statutory and regulatory requirements |
|--|---|---|---------------------------------------|--|---|--|--|
| Mission/Vision and Strategy | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Supports</i> | <i>Supports</i> | <i>Supports</i> | <i>Strongly Supports</i> |
| Leadership System | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Supports</i> | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Supports</i> |
| Culture of Quality | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Supports</i> | <i>Strongly Supports</i> | <i>Supports</i> | <i>Neutral</i> |
| Disability Performance Measurements | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Supports</i> | <i>Strongly Supports</i> | <i>Strongly Supports</i> |
| SSA Definition of Quality | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Supports</i> | <i>Strongly Supports</i> |
| Prototype Process Improvements | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Supports</i> | <i>Supports</i> | <i>Supports</i> | <i>Strongly Supports</i> |
| New PER Process | <i>Supports</i> | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Supports</i> | <i>Strongly Supports</i> | <i>Strongly Supports</i> |
| Federal State Relationship | <i>Supports</i> | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Supports</i> | <i>Strongly Supports</i> | <i>Supports</i> | <i>Strongly Supports</i> |
| DDS Performance Monitoring System | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Strongly Supports</i> | <i>Supports</i> | <i>Strongly Supports</i> | <i>Strongly Supports</i> |

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VIII. OPTIONS

A. Introduction

In this chapter we present numerous options for SSA's consideration. These options are intended to help SSA accelerate its effort to move away from a quality management system that relies heavily on end-of-line review toward an advanced quality management system, like that described in the previous chapter. While the options are primarily focused on supporting the Prototype disability determination process they also consider the larger context of the disability programs. An advanced quality management system for disability determinations can best be implemented in the context of an advanced quality management system for the disability programs in their entirety.

We divide the options into eight areas:

- Option Area A: Leadership and Organization
- Option Area B: Performance Management System
- Option Area C: Promoting a Quality Culture
- Option Area D: Quality Control
- Option Area E: Performance Monitoring Systems
- Option Area F: Federal State Relationships
- Option Area G: Initial Disability Determination Process
- Option Area H: Appellate Process

Within each area, we present both short-term and long-term options. In general, short-term options are those that the Agency could pursue very quickly and at little cost. Most are focused on disability determinations, but some would lay the groundwork for a broader effort to develop an advanced quality management system that serves all disability program processes. In comparison to the short-term options, the long-term options require more development, require a higher degree of organizational readiness, involve larger changes and transition costs, and are more oriented toward the entirety of the disability programs, not just disability determinations. Such long-term options will need to be pursued if SSA is to achieve an advanced quality management system for the disability programs and develop a sustainable quality culture.

Each option in an area could be implemented on its own, but in many instances individual options reinforce one another. In some instances options are alternatives to one another. SSA does not need to implement all the options to achieve significant progress toward improving quality management of disability determinations, but will need to pursue many, in principle if not in detail, if it is to develop an advanced quality management system.

At the end of each option presented, we include a brief discussion of costs. Supporting material for these discussions appears in *Appendix G*, especially for *Option Areas D* and *E*.

In general, we have defined cost as the additional (or incremental) dollars that SSA might have to spend above and beyond what is being spent currently by SSA. One can argue that there is cost in the form of leadership time and attention that is redirected to the new efforts to improve quality and performance. Clearly, there are trade-offs in leadership and management time, but we do not believe that these trade-offs result in increased or decreased expenditures by SSA on management salaries and budgets. Leadership is a continuous process of defining priorities and allocating time and attention between implementing new strategies and managing existing processes. We view development and implementation of a new quality management as a critical strategy for improving the performance of the disability programs. Hence, if SSA adopts some of the options, it would support its implementation in part by prioritizing the effort and redirecting the energy of its disability program leaders and managers.

In some instances we have provided an indication of the amount of SSA staff time required, but not applied a cost estimate as we do not know the extent to which this time can be taken from other activities that promote quality improvement. When a permanent position to implement an option may be required and it is an incremental expense to SSA, we note accordingly and estimate the future annual cost. However, it is our view that in many cases, no incremental employee cost is necessary if existing resources are redeployed.

On some of the options, we simply state “no significant incremental cost” when we believe that the incidental costs (meetings, documents, postage, communications, travel, outside consultation, staff time, etc.) are minor and no new permanent positions are created to support the option.

We do not have information on the resources that states currently devote to quality assurance activities, and we do not know the extent to which these could be redeployed to support new quality management activities. We understand, however, that these resources are very substantial. Redeploying them will be a challenge, however, because of the state-federal relationship.

The cost analysis of determinations focuses on applications. There would also be costs and savings associated with changes in the reviews of CDRs, but we expect these to be small by comparison.

Finally, as stated at multiple points in this report, the potential savings from the adoption of advanced quality management practices will be far greater than the investments required for training and deployment. Increased productivity and decreased costs are a real and reasonable expectation, consistent with the experiences of other organizations that have made the transformation. Depending on the rate and scope of initial deployment, SSA could experience short-term ramp up expenses during initial budget cycles of deployment, but should also expect significant improvements in the intermediate and long term that far exceed investments.

We think the potential for such savings at SSA is enormous. In manufacturing and service industries, the costs of poor quality have been demonstrated to be 20 to 40 percent of total

operating costs.¹⁸ Our expectation is that administrative cost savings from quality improvements would dwarf increases in administrative costs that would be needed to support some of the options. As discussed above, SSA spent \$2.8 billion on disability determinations in FY 1999. It is reasonable (perhaps very conservative) to believe that an advanced quality management system could help SSA reduce the cost of operations by five percent of this amount, \$140 million annually, while improving the other dimensions of disability program performance. As will become evident in the discussion of the options, the costs of implementing all of the options are small by comparison, especially if existing resources can be successfully focused on this effort.¹⁹

In addition to discussing the likely cost of each option, at the end of each option area we provide an overall evaluation of the options in the area. This evaluation considers the relevance of the options to the seven requirements developed in *Chapter V*, how success in implementation of the options can be assessed, the likely support of various stakeholders for the options, human resource requirements to support the options, training needs, investment in equipment and facilities, and the possible need for regulatory or statutory change.

B. Quality Management Options

1. Option Area A: Leadership Options

As described in the previous chapter, leadership systems are integral to the foundation of an advanced quality management system. In many respects, the short- and long-term options presented may appear appealing because they generally do not require extensive research or the significant expenditure of economic resources. However, they do represent fundamental changes in management and leadership practices and will require significant effort to successfully deploy. The ultimate success of the quality management system rests squarely on the shoulders of the disability program leadership.

During our interactions with the leadership, management, and other SSA employees, their depth of knowledge, commitment, and skills consistently impressed us. Nothing in this option should be construed as an indictment of current leadership, management, or other employees. Instead, the leadership options provide a set of tools and methods that will help SSA leadership focus

¹⁸ “Understanding and focusing on internal poor-quality costs can result in substantial cost savings and improved quality and organizational profitability. Study after study in both manufacturing and service organizations -- and particularly in health care -- shows that costs associated with wasted effort and rework are between 20 percent and 40 percent of total operating expenses.” Anthony J. Romagnole “Chapter 12: Cost-of-Poor Quality Analysis: The Prescription for Profitable Change Management,” pg, 287 in *The Handbook for Managing Change in Health Care*, Chip Caldwell, editor. ASQ Quality Press, 1998

¹⁹ We anticipate skepticism by SSA management, a common and normal response by any management team at the beginning of a quality management transformation, as to the magnitude of cost improvements that might be available from improved processes and quality. If such skepticism is a barrier to change, SSA could consider seeking outside assistance to perform a Cost of Poor Quality Analysis (COQA) that would validate the size of the improvement opportunity. COQA looks at the amount of rework, work-around processes, excess inspection, inadequate facility or staff utilization, waste, sub-optimal processes and excess process variation to determine the magnitude of cost improvement opportunities. Depending on the scope and design of the study, we estimate that a COQA study could be performed for under \$350,000 and could provide valuable information to guide the implementation of the quality management system options presented.

energy and effort on issues critical to the disability program's future success. Some of the options reflect current activities within SSA. Our intent is to bring additional focus to those activities and efforts and to raise the level of attention to their importance in support of the quality management system. The options build on work already begun in the strategic planning process and development of the Government Performance and Results Act (GPRA) measures and reports.

a. Short-term Options

We have identified eleven short-term options in the area of Leadership Responsibilities for consideration by SSA leadership. Each of the options stands alone and can be implemented independent of the others. However, because leadership is a system, as defined in the previous chapter, there are synergies among the options that, when deployed together, will yield higher returns for the disability program. These short-term options include to:

- Endorse the development of an advanced quality management system for the future.
- Develop disability program senior leadership skills and knowledge.
- Revisit the mission of the disability programs and create a clear vision that can be translated into the daily work of the organization.
- Create a strong link between the mission and goals of the disability programs and clearly define how the goals are to be measured.
- Adopt a broad definition of quality that reflects the mission and vision of the disability program.
- Develop and implement a communication plan that supports the understanding of the mission, vision, and quality definition for the disability programs at all levels of the organization.
- Create performance objectives for all levels of SSA management that are linked with the goals and strategies.
- Define a new context for operational reviews and decision-making based on mission and strategy.
- Allocate resources based on process and customer needs to support the definition of quality, mission and strategy of the disability program.
- Develop a Disability Quality Council to guide development of the new quality management system.
- Establish an Office of Quality Management (OQM) to provide centralized support for the quality management system.

Endorse the development of an advanced quality management system for the future.

Performance for the disability program is defined by achievement of the mission and vision, levels of customer satisfaction and the successful stewardship of resources. The organizational commitment to quality and performance starts with the disability program senior leadership whose endorsement will signal to the employees and management of the disability programs that mission and quality have a new level of importance in the organization. SSA leadership can set the stage for change and define expectations for the organization. A verbal commitment is not enough. SSA leadership must re-deploy resources, including their own time, to support development of the new quality management system. Leaders are also responsible for ensuring that communication and management actions support development of an organizational culture committed to customer service and continuous improvement at all levels.

- Disability program senior leaders accept responsibility for the performance of the disability programs, clearly define expectations and support the achievement of these expectations by their leadership actions. The leaders do not delegate responsibility for quality to a single office separate from other program functions, but recognize that the improvement of quality is the function of all employees and management.
- Leadership actions include assignment of resources, management of organizational structures, methods of monitoring performance, and holding management accountable. Leadership actions should be consistent with communications.

Estimated Cost: No significant incremental cost to SSA.

Develop disability program senior leadership skills and knowledge.

One of the key reasons that quality management systems fail to deliver promised returns is the failure of the organization's senior leadership to understand and embrace the underlying theories that support the system. As stated in earlier chapters, responsibility for quality and performance cannot be delegated. This option creates a foundation of leadership knowledge upon which all other options are built.

The initial thrust of quality management knowledge development within the disability programs should be at the senior leadership level. While the language of quality management may be familiar and commonly used, leaders in many organizations do not understand the underlying theories and applications. In advanced quality management systems, the theories of improvement drive the leadership philosophies of the organization. In this option, SSA would invest resources to develop greater knowledge among senior leadership of the disability program as one of the initial steps of the quality management system deployment.

In most organizations, senior leadership avoids classes and programs that are developed and deployed internally. Attending an internally developed course is an option, but other approaches might be more effective. These include:

- Retreats/off-campus sessions focused on building quality management knowledge.

- Site visits by groups of senior leaders to other agencies (HCFA, Food Stamps, VBA) that provide opportunities for interaction between peers along with presentations on how these organizations manage and improve quality.
- Site visits by groups of senior leaders to Malcolm Baldrige and President's Quality Award winners and other organizations that have advanced quality management systems. During these visits, it is important for the disability program leadership to have an opportunity to interact with the host organization's senior leadership.
- Public courses and national meetings.
- On-campus presentations/seminars by external experts and industry leaders.
- Appointment of a Senior Leadership Quality Coach that works exclusively with the senior leadership as an internal leadership and quality management consultant.
- Individual knowledge development through books, articles, discussions, videotapes and other educational tools

Initial knowledge development might be focused on the top 30 to 50 senior leaders of the disability programs and then expanded to other leaders over time. A senior leadership knowledge development plan should be committed to and deployed over a six- to 18-month period. The implementation of this option will likely have a very important secondary benefit by increasing communication between leaders and the development of a common vision for the disability programs.

Estimated Cost:

- \$100,000-\$150,000 for off-site meetings/retreats, travel, outside speakers, consultants, coordination, seminar fees, etc.
- \$90,000-\$125,000 annual salary for Senior Leadership Quality Coach (may be funded through redeployment of existing resources). This position will require someone with skills to effectively function in a coaching/facilitating capacity with senior leaders and be grounded in the theories and methods of quality management systems. Several approaches or combinations of approaches might include:
 - the reassignment on a full- or part-time basis of an interested senior leader with the required skill sets (or one willing to learn the required skills);
 - use of an external consultant; or
 - the recall of a respected former disability program leader as an independent contractor to the program.
- Significant commitment of senior leadership time and effort.

Revisit the mission of the disability programs and create a clear vision that can be translated into the daily work of the organization.

To develop an advanced quality management system, SSA leadership must revisit the mission of the disability program and develop a vision that can be clearly articulated and understood by all SSA employees. Beyond simply an exercise or a display of the mission and vision on the office wall (a common practice in many organizations), the vision should drive the strategy and the daily work of the disability program. There should be clear and obvious alignment between the mission and vision of the organization, the quality definition, strategy and operations. Over the longer term, quality management, strategic planning, performance measurement and operations will become integrated activities.

The clear and consistent communication of a vision that is understood and incorporated into daily operations at all levels of the organization is just as important as creation of the vision. The goal of SSA leadership should be to create a clear communicable vision for the organization that is understood by every SSA employee and is translated into the daily work of every SSA and DDS employee.

SSA has clearly made steps toward defining the mission and vision, and translating the mission into goals and strategy, as evidenced in “Keeping the Promise,” Strategic Plan 1997-2002. However, this effort needs to be extended. The current SSA strategic plan sets forth five goals:

1. To promote valued, strong and responsive social security programs and conduct effective policy development, research, and program evaluations.
2. To deliver customer responsive, world-class service.
3. To make SSA program management the best-in-business with zero tolerance for fraud and abuse.
4. To be an employer that values and invests in each employee.
5. To strengthen public understanding of the social security program.

These are laudable goals. However, in our review of the existing disability program and quality management system, we saw a gap between the strategic goals and implementation at the operational level. There was little evidence that the current goals of the strategic plan are clearly communicated and incorporated into the operations of the disability program. That is not to say that the goals are ignored, instead they appear to be separate from the day-to-day management and decision-making of the disability programs. One of the primary functions of the quality management system is to close the gap between goals and operations.

We recognize that SSA currently devotes significant time and energy in developing its five-year strategic plan. We believe that SSA could consider investing more time annually reaffirming the goals of the plans and making mid-course corrections. Initially, this may appear to be overly burdensome. However, revising goals will require less time and effort as the deployment of strategy becomes more effective and performance measures are deployed causing operations to become aligned with mission.

Estimated cost:

- Significant leadership time and commitment
- We are not familiar with the process that SSA currently utilizes to support the strategic planning function. However, we assume that the internal and external resources normally devoted to this function could be redirected to support the option without additional significant incremental cost to SSA.

Create a strong link between the mission and goals of the disability programs and clearly define how the goals are to be measured.

Each organizational goal should have a performance measure, or set of three to five measures that are tracked and clearly visible to the whole organization. These measures form the core of the balanced scorecard that drives leadership decision-making, assessment of organizational performance and the achievement of mission. SSA leadership then translates the goals into strategy for the disability program. An effective way to approach the development of appropriate measures might be to apply the following sequence of questions to possible goals.

1. What are you trying to achieve? (Clear articulation of the aim)
2. How will you know when we have accomplished our aim? (Defines the measure)
3. What are you going to do? (Strategy/Operational implementation)

These questions can be used successively through the organization as the goal and supporting strategy is deployed at each level of the disability program, ensuring the translation of goals into the daily work of the program. In reviewing goals and developing measures, SSA leadership should ensure that the goals and measures are aligned with GPRA reporting requirements.

Estimated Cost:

- Significant discussion time by senior leadership.
- Internal task force (or Quality Council, see Option below) could be charged with developing and formatting initial performance measures for approval by senior leadership.
- Task force support, travel, limited outside consultation, distribution and communication: \$15,000-\$25,000.

Adopt a broad definition of quality that reflects the mission and vision of the disability program.

Developing a broad definition of quality for the disability programs is the number one priority identified as a requirement for the new quality management system. In order to deploy an advanced quality management system, SSA must adopt a broad and inclusive definition of quality that conveys the purpose and mission of the disability program. The definition of quality should put forward the concept of the fundamental aim of the program and emphasize that a

commitment to the mission drives the strategy, management actions, and culture of the organization.

The definition of quality for the disability programs should directly reflect SSA's overall mission:

“To promote the economic security of the nation’s people through compassionate and vigilant leadership in shaping and managing America’s social security programs.”²⁰

In line with this mission, the high-level definition of quality for the disability programs might be:

Economic security for people with significant impairments who are below the normal retirement age.

This definition is intended to be broad enough to accommodate major changes in the approach taken by the disability programs to promote the economic security of those with significant impairments who are below the normal retirement age (the “target population”). In the past, the approach of the program has been primarily to identify individuals with impairments so significant that they are unable to work and to provide them with replacement income. In line with the goals of the Americans with Disabilities Act, the programs are beginning to place more emphasis on support that promotes employment and economic independence. This definition of quality is broad enough to encompass both approaches.

Adopting a definition that focuses quality on economic security of the target population has significant ramifications for the disability programs. It forces SSA to revisit strategy and consider the best approaches to promote this population’s economic security. This process is already underway at SSA. An important benefit of this quality definition is that it reinforces the fact that the Agency’s leadership values efforts that include and exceed the notion of simply identifying people who cannot work and sending them an accurate check for the correct sum. This definition seems consistent with the Agency’s strategic plan and the direction of the Agency’s GPRA effort.²¹

In our benchmarking visits to UNUM/Provident Insurance and the VBA disability program--organizations that also aim to provide economic security to groups of people with disabilities--we saw significant resources devoted to removing individuals from the disability rolls (or, in the case of VBA, moving to lower disability ratings) and back in to the workforce. In both cases, successful achievement resulted in higher quality outcomes for both the company/agency and the beneficiary. The high-level definition of quality in both organizations goes well beyond identifying people who cannot work and sending them a check for the right amount.

We also visited HCFA and the Food Stamp Program. Both programs have undergone significant change in mission, vision and quality definition. Over the past eight years, HCFA has changed its focus from payment accuracy inspection to health care quality improvement. Although HCFA is

²⁰ Source: SSA, *Accountability Report for FY 1999*, 1999, p. 1.

²¹ See SSA, *Keeping the Promise*, Strategic Plan 1997 – 2002, 1997.

still concerned with payment accuracy and stewardship of public funds, its focus is to improve the care that Medicare recipients receive from hospitals and physicians. HCFA has made the connection that when a Medicare recipient receives the right care, at the right time, in the right location, then not only is the well-being of the Medicare patient improved, but long-term cost to the Medicare Program will be reduced, thereby meeting HCFA's public stewardship responsibility. In pursuing its new mission, HCFA has moved from an adversarial relationship with health care providers to a partnership with them to assist in doing a better job for patients, even though it still has responsibility for payment accuracy and preventing payment error.

The Food Stamp Program has made a similar shift. Instead of focusing primarily on administration, the program has now made the end of hunger its primary goal. Its definition of quality is the courteous, accurate and timely delivery of benefits in support of that mission. As with HCFA, a key strategy of the Food Stamp Program is to develop partnership relationships with the states to meet the mission, while maintaining its Federal responsibility for stewardship.

This high-level quality definition intentionally focuses on SSA's ultimate objective: to promote economic security for the target population--an objective that all components of the disability programs need to understand if they are to collectively work to promote it. There are, however, many specific components of quality that are implicit in this definition. For instance, while the definition says nothing explicitly about using taxpayer dollars efficiently and responsibly, doing so is necessary to achieve the highest level of economic security for the target population that can be achieved with those dollars.²²

The components of quality that are implicit in the high-level definition should be stated explicitly and become the basis for operational performance measures of quality. These include the traditional elements of accuracy, timeliness, satisfaction and efficiency. The components of quality should also be broad enough to encompass major changes in SSA's approach to achieve its mission, although operational measures for each component will likely be narrower in scope.

Specific components of quality might include:

- The adequacy of family incomes of individuals in the target population;
- The earnings of working-age individuals in the target population relative to the earnings of their peers;
- The adequacy of educational and other human capital investments being made in the target population to promote economic security, especially among minors and young adults;
- The accurate and timely identification of individuals in the target population;
- The delivery of services to beneficiaries and those who seek support from the programs in a fashion that is not excessively burdensome but provides due process and is consistent, equitable, timely and courteous;

²² An analogy from the private sector might be helpful to understand this point. To maximize corporate earnings, a corporation needs to use its resources efficiently to build products that have high value to its customers.

- The coordination of the disability programs with other programs (including retirement and other programs) in a manner that promotes the well-being of the target population;
- The efficient use of resources in the promotion of the economic security of the target population;
- Program security to assure that the target population can rely on the program in the present and the future;
- Compliance with the law and its intent; and
- Accurate and timely communication of information about the program to the target population, other Executive agencies, Congress, the Judiciary, and the general public.

It is important to distinguish between the goals of quality and the measurement of their achievement. In the short-term, SSA could specify the goals, as indicated above, but development of operational measures of success in achieving those goals will take longer (see *Option Area B*).

Estimated Cost:

- Significant thought and discussion time by senior leadership.
- Internal task force (or Quality Council, see below) could be charged with developing new definition for adoption by senior leadership. Redeployment of existing resources.
- Task force support, travel and possible outside consultation, distribution and communication: \$25,000-\$50,000.

Develop and implement a communication plan that supports the understanding of the mission, vision and quality definition for the disability programs at all levels of the organization.

SSA leadership could develop and deploy a communication plan that assists leaders in conveying the importance of the mission and how it drives the strategy and quality.

- SSA could review the various existing channels of communication with employees and devise methods to utilize these channels to communicate the importance of mission and quality.
- SSA leadership could develop an “elevator speech”²³ that is inserted in all formal speeches, meeting addresses and informal opportunities to communicate with SSA employees.

²³ An “elevator speech” is a two to four minute speech/talk that leaders utilize to reinforce important concepts during interactions with employees. The idea is to be able to convey key concepts in the space of time one experiences waiting for and riding an elevator.

- All publications, newsletters, advertisements and telecommunications could be used to consistently convey the importance of quality and progress on strategy.²⁴
- SSA leadership could demonstrate their commitment to quality by framing all operational discussions in the context of mission/vision and quality. Leaders could utilize questions like:
 - How will this help us meet the mission of the disability program?
 - How will this improve the economic security of the population we serve?
 - How will this help us improve the quality of our services?
 - How will this help us improve the accuracy of our determinations?
 - If we did _____, how will we know that we have achieved our objective?
- Storytelling is a leadership best practice. SSA leaders might consider developing stories about real SSA employees and efforts that demonstrate the values of the organization and help the broader employee population understand how mission and quality are demonstrated in daily work life.
- A goal of SSA leadership would be to have every SSA and DDS employee understand the mission and strategy of the disability programs. There are myriad creative ways to communicate this message, and SSA leadership would devote resources to delivering the message to each SSA employee.

Estimated Cost: No significant incremental cost to SSA.

Create performance objectives for all levels of SSA management that are linked with the goals and strategies.

Clear accountability is critical for success. Once the disability program goals and strategies are redefined and overall performance measures are established, then performance objectives and measures should be developed for each level of management within the disability program.

- A new performance review system for management would need to be developed to align individual management performance with the goals of the disability program.
- Every manager would have performance objectives that relate directly to the achievement of disability program strategy and performance metrics.

²⁴ During the 1980s, Ford Motor Company developed the slogan “Quality is Job One.” Their advertising campaign was aimed as much internally as externally. Although SSA does not routinely advertise in the same manner as Ford or other companies, any public service announcements that are made could utilize a similar strategy for communicating to employees while communicating to the public.

- Individual managers would be accountable for their individual objectives, performance metrics of the disability program and for performance metrics for their individual unit/department.

SSA leaders will be faced with hard decisions with respect to operational leadership when performance objectives are not met. We recognize that there is a commitment to long-term employees of SSA and we are not suggesting that this commitment be violated. Instead, it is the responsibility of leadership to move non-performing individuals with operational responsibility for the program toward other support roles where they can continue to contribute. During a transition period, SSA leadership will need to be creative and compassionate to find opportunities for these individuals but must remain focused on finding and rewarding management that performs and is aligned with the strategy of the organization.

Estimated Cost:

- Significant leadership discussion time and review of proposed systems.
- Internal reallocation of Human Resource and disability program leadership to develop process and supporting materials that could be guided by either Quality Council (see Option below) or Task Force of senior and mid-level disability leaders. May be desirable to test process and supporting materials on small scale prior to deployment.
- Incremental cost of staff support, travel and meetings, outside consultation if necessary, supporting document development, communications, training and deployment: \$250,000-\$350,000.
- No significant recurring incremental expense since it replaces existing management review systems.

Define a new context for operational reviews and decision making based on mission and strategy.

Leadership should focus attention and effort on key strategies and measures that reflect the mission of the organization.

- Review of progress against strategic objectives would be on the agenda of every senior leadership and operational management meeting.
- More than a token report, this activity would be the core of operational discussions and decision-making with in-depth review of metrics and deployment of strategy.
- Leaders would demonstrate their focus and commitment by what they spend time discussing and reviewing.
- Every management issue would be evaluated in the context of strategy, mission and the definition of quality.
- Balanced scorecards of performance measures will help create leadership focus.

Estimated Cost: No significant incremental cost to SSA.

Allocate resources based on process and customer needs to support the definition of quality, mission, and strategy of the disability program.

A critical responsibility of senior leadership is the allocation of resources to support the mission and strategy of the disability program.

- The definition of resources should be broader than budgets to include time, attention by senior leadership, and management talent.
- Resource allocation decisions need to be prioritized based on mission and strategy.
- Leaders must understand that there is not necessarily a trade-off between quality and cost. High-performing organizations achieve both high quality and low cost through allocation of resources and improvement of processes that reduce waste and rework. Traditional thinking about the quality/cost trade-off only applies when more money and effort is put into inefficient processes misaligned with the mission and producing waste, rework and excess complexity.
- As a starting point, SSA leadership could initiate an internal review of the existing resource allocation process and assess current effectiveness in meeting program objectives, identify gaps/process problems and identify improvement opportunities. Many organizations struggle with the issue of resource allocation because the budgeting process often is aimed at controlling costs at current levels, rather than allocating resources based on strategy or changing priorities. Changes in resource allocation methodologies and budgeting processes will require successive cycles of improvement over multiple budget years as SSA strikes a balance between cost control and strategic allocation.

Estimated Cost:

- Requires leadership commitment and discussion time.
- No significant incremental cost to perform review. Should be conducted internally with existing resources and part of budgeting process.

Develop a Disability Quality Council to guide development of the new quality management system.

Because the new quality management system touches all dimensions of the disability program, a new leadership structure is required to guide efforts during the development and transition. One option that SSA might consider is to implement a senior level Quality Council that would:

- Consist of senior leaders with operational and policy responsibility for the disability program and policy, including DDS and union leadership (10 to 15 members). Initially, the membership might be weighted toward leaders responsible for the disability determination process, consistent with the initial focus of the quality management system. However, other

disability leadership should also be represented because the quality management system ultimately supports all dimensions of the disability programs.

- Be chaired by one of the most senior disability program leaders.
- Be administratively supported by the new OQM (see next option).
- Meet on a weekly/biweekly basis over a two to three year transition period.

The functions of the Quality Council would include:

- Developing an implementation plan for the quality management system.
- Developing a new definition of quality aligned with the mission and vision of the program.
- Developing priorities for the quality management system and overseeing the deployment of the components.
- Removing and/or overcoming organizational barriers to deployment of the quality management system.
- Advising the Commissioner and senior SSA leadership on progress.

Estimated Cost:

- Very significant commitment of time by members of Quality Council. May require a redistribution of some responsibilities and a reprioritization of individual time and efforts. However, this should be able to be accomplished without the addition of leadership positions. Quality Council participation is not a full time assignment, since the power of the council is to be able to deploy the programs and decisions within the functions they represent.
- No significant incremental cost to operate other than meeting expense and travel.
- Administrative support provided as a function of OQM (see next option). Alternative is to have Senior Leadership Quality Coach provide support. If this alternative chosen, SSA might need to redeploy a clerical FTE for additional support: \$25,000-\$35,000 per year.

Establish an Office of Quality Management (OQM) to provide centralized support for the quality management system.

Under this option, SSA would centralize the various skills and resources required to support development and deployment of the new quality management system. One option might be to establish a new Office of Quality Management (OQM). Although some of the current functions of OQA/DQB are part of the mission of the new OQM, there is a significant modification and redeployment of resources and the office's mission is closely aligned with the operations of the disability programs. In addition to current OQA/DQB efforts, the OQM also provides some functions that are currently deployed through policy, OD and training and education.

The primary intent of this option is to bring together the resources required to support the deployment of the quality management system across all disability programs and functions, but not to create a new organizational silo that is “responsible for quality.” Simply adding responsibilities to OQA or some other existing office without changing the organizational dynamics will likely lead to sub-optimization. This should not be viewed as an extension of OQA’s responsibilities, but rather as creation of a new entity that serves the highest level of disability program leadership. SSA leadership will have to carefully consider the functional and reporting relationships for this new office to ensure that it has broad access to all disability functions and is not captive to any one branch or division. Ideally, the new OQM would report to the Commissioner of SSA through a principal deputy to enhance the importance and commitment by senior leadership and to give it access to all dimensions of the disability programs. However, there are other structures that might work equally well.

If SSA creates a Disability Quality Council (see previous option), the new OQM could be governed by that Council, although functionally assigned to one of the Deputy Commissioners. Another possibility is to have the OQM organizationally assigned to the new Disability Quality Council. OQM could report organizationally to the chair of the council for administrative purposes and the Quality Council could act as the governing body. A fourth variation would be to have the new OQM report to the Commissioner or a principal deputy, with the Quality Council serving as the governing body for the office, possibly relieving the Commissioners Office of any day-to-day management issues.

Primary responsibilities of a new OQM could include:

- Conduct the PER process as the last step in initial determinations;
- Collect and analyze data on policy issues;
- Develop and administer the performance metrics for the disability program;
- Conduct DDS validation audits on self-reported accuracy;
- Organize and support SSA/DDS Determination Expert Teams (see Options D and E);
- Provide quality management technical support to DDSs and FOs;
- Provide quality management expertise in the areas of process management, improvement tools, and methods;
- Provide facilitation and support to program-wide process improvements; and
- Provide training and education on quality management methods.

Estimated Cost:

- \$750,000-\$1,000,000 to organize, transition, and develop skills and knowledge. SSA should set a fixed budget for transition and organizational cost during initial deployment and expect that the new OQM work within that budget. As with many new endeavors, the cost of transition can easily get out of control as managers and leaders try to maintain what they have always done while adding new responsibilities. A fixed transition budget will force leaders to consider the priorities they want to achieve against those priorities they need to achieve. The cost estimate range presented here is based on an expectation that significant effort is devoted to planning the transition and training the leaders and key staff prior to implementation, then allowing for some duplication of effort during a transition period. After further exploration and review, SSA could set a transition budget either higher (based on a desire to accomplish more in a shorter time period) or lower (based on a desire to minimize transition cost and go slower).
- Staffing should come from the reallocation of existing OQA, OD, DP, and training and be budget neutral after the transition period.
- Some staffing (both consultation and permanent staff) from outside the agency may be required to obtain specific skills and knowledge.
- Some possible incremental ongoing cost depending on other options chosen, specifically PER and expansion of quality management at OHA (See Quality Control and Appellate Options).

b. Long-term Options

In the previous chapter, we described some attributes of an advanced quality management system for the disability programs that likely cannot be deployed in the immediate term, primarily due to a lack of required organizational readiness for the changes or because the current level of organizational sophistication is insufficient to yield a significant return on the effort. However, this should not preclude SSA from planning for eventual adoption and deployment. The five long-term options include:

- Utilize external benchmarking methods to set strategic targets and performance goals.
- Integrate the budget process with strategic and quality planning.
- Develop data systems to support the quality management system.
- Develop a new organizational structure that clearly establishes programmatic responsibility for the disability programs across all SSA functions.
- Establish a new Office of Disability Programs with responsibility for the disability programs across all SSA functions.

Utilize external benchmarking methods to set strategic targets and performance goals.

Although it is possible to begin the benchmarking process in the short-term, it is more feasible to do so during subsequent phases of strategic plan development and performance measurement.

The primary purpose of benchmarking is to gain an understanding of how other organizations achieve levels of performance beyond simply noting their performance statistics. Many individuals view benchmarking as a quantitative method to find a process or outcome measure and then adopt the external measure as an organizational target. This approach is generally insufficient since benchmarking is as much a qualitative methodology as it is a quantitative method. For example, it would do little good to adopt the return-to-work percentage experienced by a commercial disability carrier such as UNUM/Provident without understanding how that level of performance is achieved.

Benchmarking enables leaders to learn and think outside the dimensions of their own experiences. Before applying benchmarking methods to set strategic targets, SSA should first build greater internal knowledge and experience in quality management that will enable leaders to apply the knowledge gained from benchmarking.

Estimated Cost:

- \$25,000-\$50,000 per year for external travel and site visits. After two years, this cost should decrease as the need to externally benchmark becomes more focused. However, SSA may find that this is a valuable experience for leaders and choose to devote more resources in future periods. SSA should expect that the resources devoted to benchmarking will create significant returns from the implementation of improved processes and systems.

Integrate the budget process with strategic and quality planning.

In the long-term, the budgeting process is aligned with the strategic planning and quality improvement processes. Although we offer among the short-term options a suggestion to begin an evaluation of the current resource allocation process, we note that the integration of budgeting and strategic planning is a long-term effort that will require repetitive improvements in multiple budget cycles. In many organizations, there is a gap between the budgeting process and organizational strategy because budgets are traditionally built on the known cost of current operations, not on what might be achieved in the future. In advanced quality management systems, leadership is not bound by historical allocation of resources. All resource allocation decisions should be made in the context of support of the mission and strategies to achieve the mission. The quality management system supports bringing these activities together.

Estimated cost: No significant incremental expense.

Develop data systems to support the quality management system.

In order to reduce the time necessary for disability determinations decision, key elements of the determination decision process such as eligibility information, listing grids and rationale statements, and key elements of support documentation need to be available on-line in the future

quality management system. SSA currently has several major initiatives to develop information systems and data support for the disability program. We did not review these initiatives for this project. However, given that the new quality management system is data driven, SSA might consider reexamining its current information technology strategy. SSA should ensure that the plans underway support any of its decisions with respect to implementation of the quality management system options.

Estimated Cost: Unknown.

Develop a new organizational structure that establishes programmatic responsibility for the disability programs across all SSA functions.

A modification in the organizational structure and a redeployment of resources could help support SSA's efforts to move toward an advanced quality management system. Quality management should be an integrated function with operations. It follows then that the resources to support performance monitoring (PER review, policy analysis, performance measurement and disability program operations) should be closely aligned and in a common organizational reporting relationship. To the extent possible, organizational structures need to be aligned by key processes. This does not necessarily mean, however, that functional offices need to be disbanded in favor of program offices. Functional offices generate efficiencies because of the common functions of the retirement and disability programs. Yet the disability programs have unique features -- most notably the sensitivity of disability determinations to program administration and the reliance on state government to perform a critical determination step. These features require the undivided attention of a single program leader, with authority that cuts across functional offices. Hence, whether main offices are organized along program or functional lines, reorganization is likely to require effective matrix relationships and responsibilities for resources and functions that support all SSA programs.

Estimated Cost:

- Transition cost to be determined based on degree of reorganization.
- No net increase in staffing anticipated. An opportunity exists to reduce overall cost by reducing redundancy and duplication of functions that currently exists that would more than offset any transition costs.

Establish a new Office of Disability Programs with responsibility for the disability programs across all SSA functions.

This option is offered as a specific approach to implementing the intent of the previous option. Our purpose here is to illustrate what the reorganized offices might look like, and discuss why, rather than to be prescriptive about the details of the reorganization. Much more groundwork would need to be done to develop a reorganization plan that would meet the objectives of this option.

Just as the disability determination process is complex, so is the existing organizational structure that manages and supports the process within SSA. Multiple departments, offices, sections, divisions and branches have responsibility for parts of the disability program.²⁵ However, until one reaches the level of Commissioner of SSA, no single individual has responsibility for the entire scope and function of the disability programs. This fragmentation leads to competing interests and agendas, and makes managing change a challenge.

As an agency, SSA has responsibility well beyond the disability programs and it is a reasonable approach to leverage scarce resources across multiple programs. Without giving up the advantages of the current organizational structure, SSA should consider establishing an Office of Disability Programs at the Deputy Commissioner level, responsible for the disability programs across all of SSA functional areas. The only objective of the new office is to meet the mission of the disability program and improve the processes and programs that support that mission. The intent is not to create operational independence and duplication of efforts that serve more than the disability program, like Field Office operations, but to create a single point of accountability for program responsibility.

Matrix relationships are common in large multi-mission organizations like SSA. These relationships work when individuals with functional responsibility for an operation and people with programmatic responsibility recognize they are each other's customers. Possible duties of the new senior level office include:

- Leadership of the program and implementation of SSA strategic objectives for the program;
- Supporting functional management of the disability programs;
- Deployment of quality management system support resources;
- Deployment, monitoring, and accountability for performance metrics and balanced scorecards;
- Policy analysis and deployment;
- Conduct of PER and collection of data to be used for policy analysis;
- Conduct of DDS performance monitoring system;
- Establishing and maintaining relationships with individual state Governor's offices and senior state administrative leadership;
- Negotiating and monitoring performance agreements/contracts with the states for DDS functions;

²⁵ The responsibilities that 14 different offices have for the disability programs are described in Social Security Advisory Board (1998), p. 55.

- Providing technical/expert support to DDSs and FOs on process management, policy and operations;
- Identifying and advocating resource needs for the program aligned with strategy and mission;
- Developing management and leadership skills within the disability programs;
- Deployment of training and employee skill development; and
- Maintaining an organizational culture focused on mission, vision, customer service, and performance.

Many functions currently conducted under the leadership of other Deputy Commissioners would be moved to this office, including much of the work that is currently the responsibility of the Office of Disability and the Office of Quality Assurance. A variant of the option would establish offices for the Principal Deputy for Disability Programs and the Principal Deputy for Retirement Programs. This would give the respective deputies higher status than the other deputies, in recognition of the fact that the other offices are there to serve the programs' missions.

Significant progress toward an advanced quality management system is required before OQA responsibilities can be merged with some of the responsibilities of OD and other offices in the new office we envision. Under the current QA system, OQA's principal job is to assure quality as an independent guardian of program integrity—consistent with the inspect-and-fix philosophy of older quality management systems. Under an advanced quality management system, responsibility for quality is built in to every process, eliminating the need for inefficient, often ineffective, independent reviews. The Quality Council and Office of Quality Management options we have described for the short term are intended to be interim entities that would facilitate the integration process while maintaining the integrity of the program through independent inspections during a transition period that might take many years or until the Agency is confident that it has successfully implemented an advanced quality management system. Even then, there is likely to be some need for independent audits, but not of the nature and magnitude of those currently undertaken by OQA (see *Option Area E* for further discussion).

Estimated Cost:

- Transition cost to be determined based on degree of reorganization.
- No net increase in staffing anticipated. An opportunity exists to reduce overall cost by reducing redundancy and duplication of functions that currently exists that would more than offset any transition costs.

**Exhibit VIII.1
Option Area A Evaluation**

| Evaluation Criteria | Option Area A: Leadership Responsibilities |
|--|--|
| 1. To what degree are the primary aims of the quality management system supported by this option? | |
| <ul style="list-style-type: none"> Develop and pursue a clear operational definition of quality | <p align="center">High Major objective of this option.</p> |
| <ul style="list-style-type: none"> Develop and support organizational and process performance measures | <p align="center">High This option would support the creation of clear goals and performance measures aligned with the mission of the disability program. Supports other options.</p> |
| <ul style="list-style-type: none"> Support a quality focused culture | <p align="center">High Major leadership responsibility. New quality definition and aligned strategy creates foundation for communicating the priorities of the program. Supports other options.</p> |
| <ul style="list-style-type: none"> Provide information that can be used to improve disability determinations | <p align="center">Moderate Creates the foundation of leadership support for developing performance measurement and process improvement efforts. Supports other options.</p> |
| <ul style="list-style-type: none"> Provide employees with the resources to produce quality outcomes and service | <p align="center">High Leadership responsibility to allocate resources based on strategy and program priorities. Supports other options.</p> |
| <ul style="list-style-type: none"> Ensure that the disability programs are national programs | <p align="center">Moderate Supports other options.</p> |
| <ul style="list-style-type: none"> Support statutory and regulatory requirements | <p align="center">Neutral Not the direct focus of this option.</p> |
| 2. By what measure(s) or method(s) of assessment will you know that the option is successfully deployed? | |
| <ul style="list-style-type: none"> Develop and pursue a clear operational definition of quality | <p align="center">New definition developed that is aligned with mission? (Yes/No)</p> |
| <ul style="list-style-type: none"> Develop and support organizational and process performance measures | <p align="center">New performance measures deployed and aligned with strategy? (Yes/No) Performance measures show improvement over time.</p> |
| <ul style="list-style-type: none"> Support a quality focused culture | <p align="center">Implement employee survey process to measure degree of alignment between management actions and communications. Measure results over time.</p> |
| <ul style="list-style-type: none"> Provide information that can be used to improve disability determination | <p align="center">Strategic performance measures and disability program performance metrics deployed? (Yes/No). Performance measures for the disability program improve over time.</p> |
| <ul style="list-style-type: none"> Provide employees with the resources to produce quality outcomes and service | <p align="center">Is the budget process driven by the strategic objectives and are resources allocated accordingly? (Yes/No) Employee survey of adequacy of resources to produce quality outcomes.</p> |
| <ul style="list-style-type: none"> Ensure that the disability programs are national programs | <p align="center">Does the definition of quality and strategy support national consistency? (Yes/No) Disability program performance metrics improve over time.</p> |
| <ul style="list-style-type: none"> Support statutory and regulatory requirements | <p align="center">GRPA reports and results.</p> |

**Exhibit VIII.1 (continued)
Option Area A Evaluation**

| Evaluation Criteria | Option Area A: Leadership Responsibilities |
|--|---|
| 3. To what degree will the option be supported within SSA? | |
| • Senior Executives | High |
| • Central Office Leadership | High |
| • OD Leadership | High |
| • Regional Office Leadership | High |
| • DDS Directors | High |
| • Union Leadership | High |
| • OHA Leadership | High |
| • Administrative Law Judges | Unknown |
| 4. What human resources/staffing will be required by this Option? | |
| • Requires additional human resources within SSA | During the transition period, leadership will need support to develop and implement plans, and investment in leadership training will be required. |
| • Requires the reallocation of human resources within SSA | Would likely lead to managerial reassignments for some and reallocation of other employees aligned with strategic objectives and to support performance measurement systems. |
| • Will result in a reduction of human resources within SSA | Anticipated in the long run. In the short run, will depend on success in the reallocation of resources driven by mission and strategy. |
| • Requires additional human resources at the DDSs | Will require the attention of DDS leadership, who made need support for other activities. Will require investment in leadership training and deployment of measurement systems. |
| • Requires a reallocation of resources within the DDSs | Might lead to managerial reassignments for some and reallocation of resources aligned with strategic objectives and to support performance measurement systems. |
| • Will result in a reduction of human resources at the DDSs | Not from this activity alone. |
| 5. To what degree will the option/method impact operating and program costs for the disability program? | |
| • SSA operating cost | High reductions in excess of training and performance measurement investment. |
| • DDS operating cost | High reductions in excess of training and performance measurement investment. |
| • SSA Program costs | Unknown. Dependent on mission and goals. |

**Exhibit VIII.1 (continued)
Option Area A Evaluation**

| Evaluation Criteria | Option Area A: Leadership Responsibilities |
|--|---|
| 6. To what degree is an investment in training and education required to implement the option/method? | |
| • Field Offices | Moderate Leadership training. |
| • Disability Determination Services | Moderate Leadership training. |
| • Office of Hearings and Appeals | Moderate Leadership training. |
| • Office of Quality Assurance | Moderate Quality management training to support performance measurement development. |
| • Office of Disability | High Quality management training and leadership training. |
| • Regional Offices | High Leadership training. |
| • Central Offices | High Leadership training. |
| 7. To what degree is an investment in new equipment, facilities and or information systems required? | |
| • Field Offices | None |
| • Disability Determination Services | None |
| • Office of Hearings and Appeals | None |
| • Office of Quality Assurance | None |
| • Office of Disability | None |
| • Regional Offices | None |
| • Central Offices | None |
| 8. What regulatory or statutory change is required to implement the option/method? | |
| | None |

2. Option Area B: Performance Measurement Systems

You get what you measure. Measurement, analysis, and the use of data in decision-making are value-added activities and routine in daily work of both management and employees. Under this option, the disability program quality management system would collect more data and measure more processes than the current system. However, the purposes of measurement are to monitor and control processes and to support improvement efforts, rather than simply to measure error rates. Measurement is also the key to driving performance and to measuring success in achieving strategic objectives. Along with leadership systems and organizational culture, performance measurement systems form the foundation of the future quality management system for the disability program.

a. Short-term Options

Each of the options can be deployed individually. However, like the previous Leadership Options, some of the options offered here are synergistic. The disability program currently collects many performance measures that can be utilized in initial efforts to implement the options suggested, allowing SSA to continue to develop higher levels of sophistication over time.

Performance measurement development and deployment is always “work-in-progress” as organizations refine strategy and leaders learn which measures drive improvement in their organizations. Five short-term options for consideration include:

- Define clear, unambiguous organizational performance goals for the disability program linked to the mission and strategy.
- Develop and deploy an initial set of performance metrics for the disability determination as a whole and for each major process/unit involved in the determination process.
- Create initial disability determination operating performance targets based on internal benchmarks rather than arbitrary or historical performance.
- Develop an initial balanced scorecard for the disability determination process utilizing existing or easily obtained performance data.
- Deploy performance metrics in a format that is visible and understood at levels of the organization.

Define clear, unambiguous organizational performance goals for the disability program linked to the mission and strategy.

It is a critical leadership function to set performance targets that are clearly linked to the mission, goals of SSA and the strategic objectives for the disability program.

- Based on the five current goals of SSA, fifteen to twenty-five key performance metrics for the disability program should be developed that directly support attainment of the goals.
- The measures should be displayed graphically and plotted over time. In addition to actual performance, the target performance level should be displayed on the same graphic.
- These measures would form the core of a balanced scorecard that senior leaders of SSA and the disability program would utilize to track progress, make operational decisions, report to external customers and convey priorities to employees and management.

In setting expectations, senior SSA leadership must carefully define how the measure links to the strategy and objective. Goals and objectives should avoid lofty terms like “World Class Service” or “Best-in-Business” because these terms can be misinterpreted and may generate cynicism among employees when individual interpretations or definitions are not met. Instead, objectives and performance measures should be concrete and germane to the disability programs.

Estimated Cost:

- Significant discussion time by senior leadership to review goals and adopt measures.
- Internal task force (or Quality Council, see *Option Area A*) could be charged with developing and formatting initial performance measures for approval by senior leadership.

Also could be an additional task for the internal resources assigned to support the strategic planning process.

- Task force support, travel, outside consultation, testing, distribution and communication: \$25,000-\$50,000.
- No significant incremental ongoing cost once metrics are deployed.

Develop and deploy an initial set of performance metrics for the disability determination as a whole and for each major process/unit involved in the determination process.

Developing performance indicators for each major process/component of the disability determination process is a critical first step in developing the new quality management system. The performance measurement system should start with the goals of SSA and then cascade down through the determination process to the lowest level of work production. At each level, metrics would be put in place reflecting the operational responsibility and key processes for that level. At the highest level, the measures would be indicators for the components of quality that are consistent with the Agency's high-level definition of quality for the disability programs.

As a starting point, leadership should utilize what is available and identify the gap between what exists and what is desired in the future. Lack of existing data and indicators in key areas should not preclude to moving forward. In choosing the initial set of performance indicators, leadership should pay particular attention to indicators that support improvement in the determination process. Beyond the current definition of accuracy, SSA could begin with indicators that include the dimensions of timeliness, customer and employee satisfaction, productivity, cost, allowance and denial rates, appellate rates, and other possible measures that currently exist.

- Both attribute and measurement data may be utilized in developing performance indicators. Attribute data (subjective values), are used to measure customer satisfaction. Measurement data (time, number, etc.) from key processes are often used as a proxy for customer attribute data. The underlying assumption in many systems is that improvement in speed will result in improvement in customer satisfaction and improvements in cost structure. However, given the nature of the disability program, this assumption should be carefully examined.
- In the analysis of performance data, it is important to understand that averages may be misleading. Averages may be tracked at high levels if the distribution of data approaches a normal distribution and the average is equal to or close to the median value of the data set. However, many complex processes do not produce normal distributions and therefore require stratification and analysis of stratified data. It is a better practice to track and target percentiles rather than averages in measurement data such as wait time, processing time, etc.

Metrics for the whole of the disability determination process might include, but not be limited to:

- Accuracy expressed in percentage, stratified by types of claims and level of decision;
- Timeliness expressed in terms of percentiles of performance against targets;

- Customer satisfaction expressed in percent against target levels;
- Customer wait times and processing times expressed in percentiles against targets;
- Cost per unit;
- Allowance rates stratified by type of claims and claimants;
- Percent of initial determinations appealed;
- Percent of all allowances made at each level (DDS, ALJ, AC); and
- Due process indicators, based on claim audits.

These metrics are closely tied to the individual management performance review system. Metrics become more specific and specific-process-based as they move closer to the actual work processes. For example, the FO may measure time to appointment and time from appointment to completion of application. The DDS may measure time from receipt to decision, stratified by types of applications. The Regional Office may measure time from initial contact to complete effectuation. The key principle involved is that each component measures and seeks to improve the part of the process it controls. Each layer of management monitors a larger process comprised of the individual component processes.

Many of the data elements required to support performance measurement may already be collected and analyzed within the disability program. SSA could decide on the set of metrics that defines performance for the program and investigate if and where required data is or could be. In some cases, it may be efficient to require each unit to collect some data elements based on a disability program data collection plan and then roll-up the data by organizational level to develop the overall program measure. This “reverse cascade” is similar to routine collection of financial information that is used to develop financial statements and ensures that performance metrics are being reviewed at each operational level.

Our understanding is that SSA’s current strategic plan includes an effort to build a “barometer” to measure the well being of the Agency’s target populations, in general, and at the national level. For the population with disabilities, these measures could be an important component of the top-level program scorecard.

Estimated Cost:

- Significant discussion time by senior leadership to review performance measures and sponsor deployment.
- Internal task force (or Quality Council, see *Option Area A*) could be charged with developing and formatting initial performance measures for approval by senior leadership.
- Task force support, travel, possible limited outside consultation, testing of metrics, distribution and communication \$175,000-\$250,000.

- No significant incremental ongoing once deployed.

Create disability determination operating performance targets based on internal best-in-class performance rather than arbitrary or historical performance.

Initial efforts to create operating performance targets for the determination process should focus on identifying current levels of “best” performance within the components of the disability determination processes. The investigation and review of operating performance across the various regions will likely reveal variation in current performance for key indicators. If little variation is evident, then SSA should consider if the performance indicator is being correctly measured or if it sensitive enough to reflect true performance of the underlying process. Once best-in-class performance is identified, SSA should utilize methodology similar to external benchmarking methods and learn how the performance is being achieved. Once this knowledge is shared with all similar operating units, then SSA can set target levels of performance for the components of the determination process without the appearance of arbitrariness.

Estimated Cost: No significant incremental cost.

Develop an initial balanced scorecard for the disability determination process utilizing existing or easily obtained performance data.

The key management tool for tracking performance is the balanced scorecard where “balanced” refers to the inclusion of key customer satisfaction data, process times, strategic indicators and financial indicators on a single report. This allows leaders and managers to have a complete picture of organizational performance thereby stimulating better decision-making. While balanced scorecard data can be displayed in a variety of formats, one key attribute in highly advanced quality management systems is the display of data in the context of time and against performance targets. For displaying key performance data, simple run charts will generally suffice.

It is important to understand that the routine review of the scorecard as a core leadership function and decision-making that aligns operations to achieve performance targets is far more important than the format of the scorecard. Scorecard development often takes longer than necessary due to uncertainty about what to measure and how to display the information. To paraphrase Voltaire, “perfect is the enemy of good.” SSA should start with the data and measurements that are available and continue to improve the scorecard as new measurements are developed and as strategy is redefined and focused. Balanced scorecards should display both the actual and the target performance and include both programmatic and administrative cost measures.

An additional key point is that the measures reviewed by senior leadership may be different than the scorecards developed and utilized by lower levels of leadership in the organization. However, the measures should be linked so that the measures reviewed at one level are a component or drive the measures at the next level.

Estimated Cost:

- Significant discussion time by senior leadership to review proposed scorecards and sponsor deployment.

- Internal task force (or Quality Council, see *Option Area A*) could be charged with developing and formatting initial performance measures for approval by senior leadership.
- This option could be combined with previous option at marginal incremental expense to that effort. If done independently utilizing existing data, then task force support, travel, possible limited outside consultation, testing of metrics, distribution and communication should be accomplished in the range of \$75,000-\$150,000.
- No significant incremental ongoing cost once deployed.

Deploy performance metrics in a format that is visible and understood at levels of the organization.

All SSA disability program employees must know the key performance metrics for their operating units in particular, and for the overall disability program in general. Performance metrics should be displayed visually in the work areas of the program. Senior leadership and operational management should share information with employees and solicit help from employees in meeting the targets. Sharing and displaying performance metrics helps leaders reinforce the mission, vision and values of the disability program.

Estimated Cost: No significant incremental cost to SSA.

b. Long-term Options

As discussed above, performance measurement is both a short-term and long-term effort. Should SSA adopt any of the short-term options, efforts to improve the initial measurement systems will be ongoing. In this option area, we have identified four long-term options that are classified as long-term based on current organizational readiness. Both options can be argued to be short-term and SSA may choose to pursue sooner, rather than later on a limited basis. The four long-term options for consideration include:

- Develop and deploy a set of performance metrics for the disability program as a whole.
- Develop and deploy a balanced scorecard to track disability program performance beyond the dimensions of the determination process.
- Benchmark external operational processes and organization and identify best-in-class processes and methods that can be translated into performance targets for the disability programs.
- Collect data at each point in the disability process to be used to inform the previous process step and improve the overall process.

Develop and deploy a set of performance metrics for the disability program as a whole.

In *Option Area A*, we offered a possible high-level definition of quality and listed ten components. If these were adopted, performance metrics for each would need to be developed.

Many of these would be built up from performance metrics for the various disability program processes, including disability determination. Others might require data from other sources.

One formidable challenge for the Agency is the difficulty of obtaining information about the disability programs' target population, defined here as those people under normal retirement with severe impairments. As indicated in the discussion of the short-term scorecard, the Agency has already launched an effort in this area. It seems to us that the ultimate measure of the Agency's performance for adults in this population is their economic security—both the adequacy of their income, relative to need, and their economic independence. For children, adequate family income and progress in the development of skills that will lead to economic security as an adult are relevant. The Agency would also want to know whether its programs are reaching the people they are supposed to serve in a timely way. The Agency also has an interest in knowing whether the target population is receiving services that are outside its domain, but that might be critical to economic security (e.g., health care).

Ideally, the Agency would have this information relative to the target population in each state and track it year to year. State-level data are critical because initial disability determinations are performed by states, and because state agencies provide or regulate many services and supports that people with disabilities use, often with support from the federal government (e.g., Medicaid, Vocational Rehabilitation, Employment Services, Workers Compensation, Special Education, Food Stamps, Transitional Assistance for Needy Families, general assistance), and state economies vary widely.²⁶

Significant challenges to the development of ideal metrics for these components of quality include the difficulty of finding and communicating with many who are in this population, and the extreme cost of identifying those in the target population. SSA is currently conducting a national survey to obtain information about this population (the National Survey of Health and Activity [NSHA]). This is a multi-year effort at a cost of tens of millions of dollars. While the survey is taking extraordinary measures to address the challenges of collecting these data, we will not be able to gauge its success for some time. It seems unlikely that it is feasible to use a survey methodology that is both accurate at the state level and replicated every year.

As part of this option, however, SSA could launch a program aimed at developing practical state-level, annual metrics for its target population. Approaches that might be considered are:

- Surveys of program beneficiaries and applicants;
- Surveys that complement the American Community Survey;
- Use of measures derived from the Current Population Survey based on findings from NSHA; and
- Collaboration with other federal agencies serving the same population.

²⁶ One could argue that county-level data are needed in larger states, especially those in which many services and supports are county-specific.

Surveys of applicants are practical because they are relatively easy to contact during the application process, but care must be taken to avoid interference with the application process itself. Such surveys could also be used to obtain information about the performance of the disability determination process itself.²⁷

Currently, a high level of federal effort is being devoted to improving employment of people with disabilities, including the interagency effort led by the President's Task Force on Employment of People with Disabilities. This effort, and the importance of interagency cooperation necessary to achieve its objective, seem to make this an especially propitious time to explore an interagency effort with the Departments of Health and Human Services, Education, and Labor, and perhaps others. SSA might also find that it can enlist state support for this effort.

Ideally, performance metrics for each component of the disability programs would cascade from the high-level measures of performance. This includes metrics for the disability determination process, and each component of that process.

Estimated Cost:

- Significant discussion time by senior leadership to review and approve performance measures and sponsor deployment.
- Internal task force (or Quality Council, see *Option Area A*) could be charged with developing and formatting performance measures for approval by senior leadership.
- Task force support, travel, outside consultation, testing of metrics, outside surveys, research, distribution, and communication: \$400,000-\$600,000.
- No significant incremental ongoing cost to SSA once deployed.

Develop and deploy a balanced scorecard to track disability program performance beyond the dimensions of the determination process.

Building on the balanced scorecard developed for the determination process described in the short-term options, SSA should expand that effort with measures of performance that encompass all of the programs and initiatives of the disability programs. This option is closely linked to the overall development of performance measures that are closely aligned with a broad definition of quality and the evolving strategy of the program.

Estimated Cost: No significant incremental cost to SSA if a continuation of short-term option. Otherwise, see short-term option cost.

Benchmark external operational processes and organizations, and identify best-in-class processes and methods that can be translated into performance targets for the disability programs.

²⁷ SSA conducted an applicant survey in 1992.

The power of benchmarking is to understand how a target is being achieved elsewhere, often requiring management to make fundamental changes in process or operating assumptions in order to produce equal results (an expanded discussion on Benchmarking may be found in **Option Area A Long-term Options**). Although disability program management may learn valuable lessons from specific process benchmarking, application of the knowledge for improvement and translation into performance targets for the disability programs requires experience and knowledge for improvement. However, there may be exceptions worth pursuing at an early stage in the development of the quality management system.

One exception may be the development of performance goals related to financial performance indicators and targets. These may be both programmatic and administrative cost measures. UNUM/Provident and the VBA Disability program could be used to benchmark both processing time and administrative cost per determination at an early stage.

Estimated Cost:

- \$25,000-\$50,000 per year for external travel and site visits.
- After two years, this cost could decrease as the need to externally benchmark becomes more focused. However, SSA may find this to be a valuable experience for leaders and choose to devote more resources in future periods. SSA should expect that the resources devoted to benchmarking will create significant returns from the implementation of improved processes and systems.

At each point in the disability process, data is collected that is used to inform the previous process step and improve the overall process.

Process specific data and the sharing of information between components of a complex process are fundamental tenets of quality management systems. However, the collection of data absent the tools and knowledge to use the information for improvement will not yield returns commensurate with the effort. Therefore, we have listed this option under long-term. Again, SSA may find that application of this option in the short term makes sense in a limited fashion as a method of experimenting and building knowledge and commitment to improvement, or to support a specific process improvement project/initiative. Under the short-term options described in both **Option Areas G and H**, we present possible options that include developing process data for several specific improvements to the determination process. However, we believe that the systematic deployment of this option across all disability processes is a long-term option.

A process can be defined as a series of handoffs of information or work product from one step to the next and between both the internal and external customers recognized by SSA.

- Each process step has both a supplier and a customer. In a complex process like disability, there are multiple handoffs of information.
- Each handoff denotes a process step and in each successive step, the role of customer and supplier is switched. For example, the DDS is an internal customer of the FO because the FO provides the basic application information necessary to begin processing the disability

application. Once the DDS determination is made, the roles are switched and the FO becomes the customer of the DDS because it receives the information it needs from the DDS to either effectuate the claim or send a denial notice to the claimant. In both steps, one unit depends on the completeness, accuracy, and timeliness of the other's work.

- In advanced quality management systems, metrics are in place that can inform the supplying process of key quality characteristics such as accuracy, completeness, legibility, timeliness, etc. This feedback loop provides quality control information that can be used by the supplying unit to identify points of process breakdown. Statistical Process Control charts and methodology are commonly used for this purpose.
- Data is collected and tracked as part of daily work by the employees who work in the process and the managers that own the work processes.

Estimated Cost:

- As a long-term option, it is assumed that a base of knowledge has been developed from the deployment of other options and therefore, there should be no significant incremental cost to SSA as these efforts are deployed as part of the daily work of the programs. In addition, SSA should expect significant improvement in productivity and decreased operating expense as measures are utilized to reduce rework and improve decision-making at all levels of the program.
- Should SSA decide to implement as a short-term option, then resources will need to be devoted to the training and development of management knowledge and methods at the work process level and SSA can expect to make an initial investment to deploy. However, SSA should expect short-term improvements in cost as a result. A strategy for SSA might be to deploy in a limited fashion those components that are known to be high rework/high cost processes as a method of developing immediate savings that could be used to fund other deployments. Simple cost/benefit analysis could be performed to determine potential applications (See *Option Area C: Developing a Culture of Quality*).

**Exhibit VIII.2
Option Area B Evaluation**

| Evaluation Criteria | Option Area B: Performance Measurement Systems |
|--|--|
| 1. To what degree are the primary aims of the quality management system supported by this option? | |
| <ul style="list-style-type: none"> Develop and pursue a clear operational definition of quality | <p align="center">High</p> <p>Performance measurement system designed to support quality definition.</p> |
| <ul style="list-style-type: none"> Develop and support organizational and process performance measures | <p align="center">High</p> <p>Major objective of this option.</p> |
| <ul style="list-style-type: none"> Support a quality focused culture | <p align="center">High</p> <p>Deployment of measures identifies what is important to all employees and progress toward objectives. Supports other options.</p> |
| <ul style="list-style-type: none"> Provide information that can be used to improve disability determinations | <p align="center">High</p> <p>Measurement drives improvement. Supports other options.</p> |
| <ul style="list-style-type: none"> Provide employees with the resources to produce quality outcomes and service | <p align="center">High</p> <p>Performance metrics support resource allocations. Supports other options.</p> |
| <ul style="list-style-type: none"> Ensure that the disability programs are national programs | <p align="center">High</p> <p>Performance measurement system can be used to compare program across regions to identify variation and initiate root cause analysis. Supports other options.</p> |
| <ul style="list-style-type: none"> Support statutory and regulatory requirements | <p align="center">High</p> <p>Performance measures linked to GPRA. Supports other options.</p> |
| 2. By what measure(s) or method(s) of assessment will you know that the option is successfully deployed? | |
| <ul style="list-style-type: none"> Develop and pursue a clear operational definition of quality | <p>Performance measures directly linked to new definition? (Yes/No)</p> |
| <ul style="list-style-type: none"> Develop and support organizational and process performance measures | <p>New performance measures deployed and aligned with strategy? (Yes/No)</p> <p>Balanced scorecards used to track progress? (Yes/No)</p> <p>Performance measures show improvement over time.</p> |
| <ul style="list-style-type: none"> Support a quality focused culture | <p>Performance measures widely deployed and understood at all levels of the organization? (Yes/No)</p> |
| <ul style="list-style-type: none"> Provide information that can be used to improve disability determination | <p>Strategic performance measures and disability program performance metrics deployed? (Yes/No)</p> <p>Performance measures for the disability program improve over time.</p> |
| <ul style="list-style-type: none"> Provide employees with the resources to produce quality outcomes and service | <p>Are the performance measures used in the budget process in allocation decisions? (Yes/No)</p> <p>Productivity and service measures improve over time.</p> |
| <ul style="list-style-type: none"> Ensure that the disability programs are national programs | <p>Are the performance measures used to investigate variation across regions? (Yes/No)</p> <p>Disability program performance metrics improve over time.</p> |
| <ul style="list-style-type: none"> Support statutory and regulatory requirements | <p>Are the performance measures aligned with GRPA? (Yes/No)</p> <p>GRPA reports and results.</p> |

**Exhibit VIII.2 (continued)
Option Area B Evaluation**

| Evaluation Criteria | Option Area B: Performance Measurement Systems |
|--|--|
| 3. To what degree will the option be supported within SSA? | |
| • Senior Executives | High |
| • Central Office Leadership | High |
| • DDS Directors | High |
| • Office of Disability Leadership | High |
| • Regional Office Leadership | High |
| • Union Leadership | Variable |
| • OHA Leadership | High |
| • Administrative Law Judges | Unknown |
| 4. What human resources/staffing will be required by this Option? | |
| • Requires additional human resources within SSA | Some initial investment in deployment of measurement systems. |
| • Requires the reallocation of human resources within SSA | Yes Develop, deploy and maintain. |
| • Will result in a reduction of human resources within SSA | Possible over time. |
| • Requires additional human resources at the DDSs | Some initial investment in deployment of measurement systems. |
| • Requires a reallocation of human resources within the DDSs | Yes Develop, deploy and maintain. |
| • Will result in a reduction of human resources at the DDSs | Possible over time. |
| 5. To what degree will the option/method impact operating and program costs for the disability program? | |
| • SSA operating cost | High reductions in excess of training and performance measurement investment if used to improve the program. |
| • DDS operating cost | High reductions in excess of training and performance measurement investment if used to improve. |
| • SSA Program costs | Unknown. Dependent on mission and goals. |
| 6. To what degree is an investment in training and education required to implement the option/method? | |
| • Field Offices | Moderate Use of data, deployment of system, setting expectations. |
| • Disability Determination Services | Moderate Use of data, deployment of system, setting expectations. |
| • Office of Hearings and Appeals | Moderate Use of data, deployment of system, setting expectations. |
| • Office of Quality Assurance | High Development and maintenance of system. |
| • Office of Disability | High Setting expectations and use of system to align operations and achieve strategy. |
| • Regional Offices | High Setting expectations and use of data to drive decisions. |
| • Central Office | High Setting expectation and use of system to align operations and achieve strategy. |

**Exhibit VII.2 (continued)
Option Area B Evaluation**

| Evaluation Criteria | Option Area B: Performance Measurement Systems |
|---|---|
| 7. To what degree is an investment in new equipment, facilities and or information systems required? | |
| <ul style="list-style-type: none"> Field Offices | <p style="text-align: center;">Low</p> <p>May need some IT investment to support performance measurement.</p> |
| <ul style="list-style-type: none"> Disability Determination Services | <p style="text-align: center;">Low</p> <p>May need some IT investment to support performance measurement.</p> |
| <ul style="list-style-type: none"> Office of Hearings and Appeals | <p style="text-align: center;">Low</p> <p>May need some IT investment to support performance measurement.</p> |
| <ul style="list-style-type: none"> Office of Quality Assurance | <p style="text-align: center;">Low</p> <p>May need some IT investment to support performance measurement.</p> |
| <ul style="list-style-type: none"> Office of Disability | <p style="text-align: center;">Low</p> <p>May need some IT investment to support performance measurement.</p> |
| <ul style="list-style-type: none"> Regional Offices | <p style="text-align: center;">Low</p> <p>May need some IT investment to support performance measurement.</p> |
| <ul style="list-style-type: none"> Central Office | <p style="text-align: center;">Low</p> <p>May need some IT investment to support performance measurement.</p> |
| 8. What regulatory or statutory change is required to implement the option/method? | |
| None | |

3. Option Area C: Promoting a Culture of Quality

Critical to the success of any quality management system is the culture in which it operates. In order to support an advanced quality management system, SSA would need to pursue efforts to develop a culture that values customer service, teamwork, accuracy, employee involvement and stewardship of resources. Organizational culture has a direct impact on the speed of organizational change. A quality culture will, by definition, promote and support continuous improvement, leading to better quality in all respects, including administrative savings.

As discussed in the previous chapter, organizational culture is one of the foundation elements of an advanced quality management system. In *Option Area A: Leadership Responsibilities*, we discussed the importance of leaders communicating the mission and vision and a new definition of quality. Clearly, this will have a positive impact on organizational culture. The visible display of both strategic goals and performance indicators, as described in *Option Area B: Performance Measurement*, also support development of a quality-focused culture. It is critically important for employees to know what is important and the organizational “score.”²⁸

²⁸A sports analogy that is commonly used to describe the level of importance attached to knowing the organizational score is as follows:

Imagine playing baseball and not being allowed to know the score, the number of outs, or the pitch count. An individual hitter might swing for the fences when all that is needed is a sacrifice bunt or a

Leadership is responsible for promoting an organizational culture of accountability, performance, customer service and continuous improvement. The short and long-term options presented in this section are aimed at supporting four primary strategies for developing a quality-focused culture and promoting continuous improvement:

- Build organizational knowledge for improvement.
- Assess the current culture, communicate the desired culture, and address gaps between the desired and existing culture.
- Create organizational learning through process improvement projects and initiatives, leading to the deployment of improvement theory and methods in the daily work of the organization.
- Encourage and empower employees to experiment and innovate.

a. Short-term Options

Six short-term options that would foster development of a quality focused culture and support the strategies enumerated above include:

- Develop a new set of organizational values that are aligned with mission and vision.
- Train managers and employees in the theories and methods of process improvement.
- Review training content and processes at all levels and make changes that support continuous improvement.
- Involve employees in a process to identify opportunities to improve the determination work processes.
- Identify and initiate a set of process improvement projects that have organizational learning value.
- Implement management training on coaching and team skills for front line and mid-level management.

As with the other option areas presented, each of the options presented can be implemented independently, but combinations of options will accelerate change. Under several of the options, we offer specific tactics that may also be pursued independently. As SSA leadership considers

fielder may simply throw to first when a double play is required. Individual play may be great, but to what end?

Many organizations are like the analogy above. There may be great individual effort, but because employees do not know the priorities and the “score”, their efforts may be for naught. In many surveys of employee attitudes about work, pay and benefits rank below issues such as recognition, knowing what one does is important, having the tools and knowledge to do their jobs, clear understanding of responsibilities, and understanding how an individual job contributes to the overall process.

these options, there will likely be other tactics and methods suggested internally that meet the intent of the options, a process we encourage.

Develop a new set of organizational values that are aligned with mission and vision.

Formal organizational values are used to communicate cultural and behavioral expectations. In many organizations, the informal values reflect “what is really important around here” and are much stronger than the formal stated values of the organization. This misalignment often occurs because either the values are not current/relevant to daily work or management actions are consistently at odds with stated values. Employees pay more attention to what is done than what is said. The goal of leadership should be to close the gap between the formal values of the organization and the informal or perceived values.

Efforts to align, modify, or create a renewed emphasis on values will require significant leadership thought and effort. Values form the rules of engagement for interactions and organizational behavior, signaling what is important to the organization. Values also build expectations. From an employee perspective, values are used to judge management behavior. Does management do what they say? Are resources allocated based on what the values say is important? Gaps between management behavior and the stated values can create employee and management cynicism, especially if a renewed emphasis on values does not translate to changes in priorities and management behavior.

There are several themes that SSA might consider including in a new set of organizational values that would support the development of a quality-focused culture. These include:

- Teamwork as a way of emphasizing the power of working together;
- Customers as the final arbiter of what is done or produced;
- Continuous improvement as a philosophy that suggests that every work process or effort can and should be improved;
- Change and speed of change that results in improved performance and outcomes;
- Empowerment of employees that leads to innovation and experimentation; and
- Everyone is responsible for quality.

There are other themes that might also be considered. Sometimes, it is important to choose a value theme that is in contrast to current behaviors as a way of signaling change.

SSA leadership could begin a process to modify the existing values for the disability program that includes employee participation and broad organizational representation. Possible values and value statements/definitions could be tested with different groups of employees and management before being broadly disseminated. A communication plan could be developed that includes direct senior leadership participation. One effective way of communicating values is to utilize examples/stories of values being practiced in the daily work of the organization.

Once the new values have been established, disability program leadership should periodically review decisions in the context of the values, just as decisions should be evaluated against mission and strategy. Consistent reference to organizational values and conscious attention to management actions and policy in the context of values can be a powerful leadership tool to drive cultural change.

Estimated Cost:

- Significant senior leadership time to discuss and review possible values/value statements.
- Task force (or Quality Council, see *Option Area A*) could be charged with overseeing developing and overseeing process.
- Support of task force, conduct of small group employee meetings (25-30), travel, communication and deployment: \$75,000-\$100,000.

Train managers and employees in the theories and methods of process improvement.

Process improvement methods and theories are specific bodies of management knowledge and expertise. The deployment of the quality management system is dependent on a broad understanding by the leaders, managers and employees of the basic concepts and methods. Specific areas of training should include:

- Basic theories and methods of improvement;
- The leadership responsibility for the quality management system;
- Theories and methods of obtaining customer feedback;
- Basic data collection methods used in process improvement;
- How to analyze and display simple process data;
- Steps to analyze a process and the seven basic tools utilized in process improvement;
- Deployment of rapid cycle improvement methods;
- Teamwork and formal improvement teams;
- System theory;
- Variation and the appropriate type of management actions for dealing with special cause and common cause variation; and
- When to utilize tools and methods of process design/redesign versus tools to improve existing processes.

One strategy for effective deployment of training is to train employees and line management on a Just-In-Time basis in the context of actual improvement efforts (see following options). It is generally not effective to widely deploy improvement training and then wait for something to happen, so we do not suggest that SSA launch an effort to train every employee as a short-term option. It is more efficient to integrate core concepts of improvement into other existing training activities to ensure alignment and minimize the cost of training. As the quality management system develops, employees will be exposed to the concepts, tools and methods in all training and communications. However, it is important that some specific training resources be devoted to building management and leadership knowledge across the disability program and supporting employee skill training on a Just-in-Time basis.

To deploy this option, SSA could develop an internal quality management training team that would support expansion of knowledge and methods. Should SSA decide to implement the OQM option discussed in the Leadership options, quality management training would initially be located within this office, perhaps with support from the Office of Training (OT), to ensure coordination with all other aspects of the quality management system. Expansion of the current OT effort is another possible method. In either case, it is likely that SSA will look outside the agency to employ experienced quality management trainers and facilitators who will form the initial core of internal experts.

Estimated Cost:

- The staffing costs could be part of a new OQM and within that budget (See *Option Area A*). However for purposes of evaluation and the possibility that SSA might choose to do this as an expansion of the current training resources.
- A small core training/facilitation/methods unit of five to seven FTEs would cost \$500,000-\$550,000 per year to staff and support. Such a unit could not be deployed to train all leaders and managers in the short-term, but could be utilized to train-the-trainer and to support selected improvement projects and targeted leadership/management groups. SSA could consider redirecting current training resources to develop the core unit.
- Content development, outside consultation, IVR production, printed manuals, travel, meetings, seminars etc.: \$250,000 per year.
- SSA should expect high economic returns in both the short and immediate-term from deployment of this option.

Review training content and processes at all levels and make changes that support continuous improvement.

Ongoing training of employees is critical to long-term success. SSA already devotes considerable resources to training, in part because of the highly technical nature of the disability programs. SSA could review its training program to ensure that employees receive periodic training that goes beyond technical issues to include:

- Team skills;

- Customer service training;
- Process improvement theory and methods; and
- Data collection and process management.

Each training interaction provides an opportunity to reinforce the mission, vision, and performance expectations for the disability program.

Estimated Cost:

- We did not review the current training structure and budgets for the disability programs. However, an internal review should not create any incremental expense. Based on the result of the review, SSA could make decisions to redirect training budgets to develop needed content or make a decision to add incremental development dollars to budgets.

Involve employees in a process to identify opportunities to improve the determination work processes.

Based on our interviews across the agency, we heard many suggestions from leaders, management and employees on what needs to be done to improve quality. At an early stage in the deployment of the new quality management system, SSA might consider initiating a process to solicit employee and management input on which work processes might be candidates for initial efforts. Over the past ten years, SSA has devoted enormous resources to a series of major projects. This option is not a suggestion to launch another round of those types of efforts and projects.

Instead, cultural support for process improvement can be fostered through a series of small, rapid-cycle improvements that make a difference in the daily work lives of employees. These “small wins” become a laboratory for learning which tools and methods have the most promise for moving the disability programs forward and lead the way to larger, more complex process improvements.

It follows that the choice of initial projects should include input from the employees and the management directly responsible. An investment in time and effort to gain this input sends important, positive messages to the organization.

This option can be deployed in a manner that is not overly elaborate and does not incur significant organizational expense. Disability program leadership, supported by trained facilitators, could conduct a series (10 to 20) of small work sessions (including seven to 15 employees/management) across the determination component organizations that combine very brief quality management training (what is process, internal customers, basic measurement) with active solicitation of process-centered ideas. Utilizing simple brainstorming and nominal group techniques²⁹, questions might be asked like:

²⁹ Brainstorming and Nominal Group Process are simple group process tools to solicit ideas. Nominal Group is a form of brainstorming where ideas are individually written down in response to a question and then presented by

- What processes do not work well?
- What processes cause significant amounts of rework and waste?
- What do our customers (both external and internal) complain about?
- What do employees complain about?
- What could we do a better job of here?

The responses then could be collated and reviewed for themes and opportunities and be used to select an initial set of sponsored process improvements (see next option). It is important that disability leadership actually conduct the sessions themselves, with support from training/facilitation/OQM. First, this attaches a level of importance to the activity that signals change. Second, it gives disability program leaders an opportunity to directly interact with employees at different levels of the organization. And third, the presentation/teaching of basic concepts by senior leaders is a powerful incentive for individual learning.

Estimated Cost: No significant incremental cost.

- Significant senior leadership time to discuss and review results of employee input and possible improvements.
- Task force (or Quality Council, see *Option Area A*) could be charged with developing and overseeing process.
- Support of task force, conduct of small group employee meetings (10 to 20), travel, communication and deployment: \$25,000-\$50,000.

Identify and initiate a set of process improvement projects that have organizational learning value.

In order for improvement to become part of the daily work of the disability program, the tools and methods must be deployed at all levels of the organization. This cannot be done overnight. Instead, SSA would need to pursue a program that gradually builds experience. This might proceed as follows.

- To begin the effort, management could involve employees in identifying work processes that routinely require rework and duplication, create customer dissatisfaction, waste limited resources and/or make it difficult for employees to do their jobs well (see previous option). DDSs should be included in these efforts. As one DDS manager pointed out to us, the autonomy of the DDS makes them a natural breeding ground for new ideas and improvements, and SSA would do well to encourage appropriate efforts in a way that maximizes the benefit to the Agency as a whole.

the individuals in a round-robin fashion until all ideas have been expressed, ensuring that all group members have an opportunity to participate.

- Based on management knowledge of process and employee feedback, SSA might choose two to four key processes for improvement and organize a program-wide effort to initially focus efforts on these processes.
- Potential savings from potential process improvement projects should be a major determinant of initial projects. We anticipate considerable skepticism from sectors of the disability program with respect to the options presented. It is important that initial projects are successful and create a financial return to SSA as a method of blunting this skepticism. Savings developed from initial projects could be “reinvested” in further deployment of the quality management system options.
- Choice of the initial processes is an important decision. Large and intractable problems that have plagued the Agency for years and/or highly political issues are poor candidates for initial efforts. Many people we have encountered seem burned out, or fed up, with the many tests that were conducted for Disability Process Redesign. New efforts should be smaller, with a clear beginning and end, and important to both employees and management. Improvement should increase internal and external customer satisfaction and have the potential for quick, measurable gains.
- Leadership should require initial efforts to have, at worst, a neutral financial impact on administrative cost and minor capital expenditures. This approach prevents process improvement efforts from being diverted into political activity to secure more resources for existing work processes or pet projects never previously approved. At some point, there may be improvements that require the shifting of resources within the Agency or a major capital investment (like an information system, for example) that will have positive cost impacts in a future period. Leadership should avoid choosing processes for initial improvement that are likely to require such approaches in the initial deployment of process improvement efforts.
- To reduce risk and ease the process of change, projects should be initially implemented, tested and refined on a small scale (e.g., in a few offices only), then expanded.
- Success in initial projects can be used as a learning point for the organization and should be widely publicized within the agency.
- Once success has been demonstrated, a second wave of program-wide process improvements could be deployed.
- After the second wave of projects, SSA leadership might consider including process improvement efforts in the performance requirements for management. Each manager could lead or sponsor an improvement effort within his or her area of responsibility with the results of those efforts included in annual management reviews.
- Training for individuals involved in the first and second wave of process improvement projects can be performed on a just-in-time basis as part of the improvement team process.

Estimated Cost:

- Significant senior leadership time to discuss and choose initial set of projects.
- Task force (or Quality Council, see *Option Area A*) could be charged with developing and overseeing the process.
- Support of initial efforts would come from either OQM (see *Option Area A*) or training/facilitation/methods group (see earlier option). A third alternative might be to contract with outside process improvement consultants to support selected projects. This cost depends on the scope of the project. SSA should be cautious that if outside consultants are utilized, which may be appropriate for initial projects even if supported internally, their role be limited to advisors rather than doers. The primary objective of the initial projects should be to create replicable, organizational knowledge that can be deployed to other processes without dependence on outside consultation.
- Clearly, this option has the potential of creating savings that can be utilized to fund other quality management efforts. Selection of initial projects should consider the possible savings that might accrue as a result of improvements.

Implement management training on coaching and team skills for front-line and mid-level management.

One of the key assets of SSA is the skilled and intelligent work force of the agency. Consistent with the strategy of empowering employees discussed in the introduction to these options, SSA could consider investing in developing management and leadership practices that support employees and recognize the value of employee participation.

Often, the success of quality management efforts depends on the ability of front-line supervision and mid-level management to lead change at the work level of the organizations. Beyond the tools and methods of process improvement, front-line leaders require management skills that are aligned with the values and culture that SSA seeks to promote.

In the basic principles of advanced quality management systems discussed previously, teams and teamwork are identified as core principles. Several options presented in later sections contemplate the increased use of teams to accomplish complex tasks and changes in the role of supervision. For these options/strategies to be successful, management practices need to evolve from traditional command and control, to coaching and facilitating. These skills and concepts should form the foundation of a leadership development program for this group of SSA leaders.

To deploy this option, SSA could utilize existing internal training resources to develop IVR training modules that introduce basic concepts. To supplement these programs, on-site or regional courses could be deployed that give participants opportunities to practice basic skills and techniques.

Estimated Cost:

- As stated in a previous cost estimate, we did not review the SSA training structure and budgets. Our assumption is that basic management training is (or should be) a priority of the

training programs and that existing resources be redirected to accomplish this option. Should this assumption be invalid, then SSA should develop a detailed estimate of the development and deployment cost for this option.

b. Long-term Options

Four long-term options are presented for consideration. Consistent with the introductory discussions in other sections, these options require a greater degree of organizational readiness or may be dependent on the successful deployment of short-term options. The four long-term options for consideration include:

- Implement a process that periodically assesses gaps between current and desired culture.
- Develop and deploy a 360 Degree review process for all levels of management.
- Implement an employee satisfaction survey process that delivers information to leadership on a monthly basis.
- Develop a Quality Management University.

Implement a process that periodically assesses gaps between current and desired culture.

SSA could implement a process to periodically assess the organizational culture and identify gaps between values stated by the Agency and informal values perceived by employees. Employees and management look more closely at what is done than what is said. If, for example, senior leadership talks about the importance of customer service but 90 percent of management discussion and review focus on cost savings, then the informal message is that financial issues are more important than service. Employees and management will then center their efforts on short-term cost reduction, often at the expense of service, because management, by their actions, has signaled that cost is more important than service. During our review we often heard that accuracy was not really important to SSA because the majority of effort and management discussion focused on increasing the production of disability determinations, not on their accuracy. In addition:

- Management actions should be routinely reviewed and evaluated against the stated values of the organization.
- Similarly, formal and informal communications should be reviewed and evaluated for consistency with management actions and the values of the organization.

Estimated Cost: No significant incremental cost.

Develop and deploy a 360 Degree review process for all levels of management.

SSA might consider implementing a 360 degree management performance appraisal process that asks both those that supervise management and those that directly work for the manager being reviewed for input on the manager's performance relative to the mission, vision, strategy, and

values of the organization. This process can serve as a tool to ensure alignment of management approach to the desired values and culture of the organization.

Estimated Cost: No significant incremental cost.

- There are numerous articles and publications concerning 360 Degree reviews as well as commercial/proprietary systems available to SSA. It is likely that the SSA Human Resource function has detailed information on different approaches and methods. Given the wide-use of this tool, it seems reasonable that SSA could develop a tool and deploy without any external assistance, utilizing internal resources. Additionally, SSA already devotes resources to a management review process that could be redirected to support a new process.

Implement an employee satisfaction survey process that delivers information to leadership on a monthly basis.

In addition to periodic assessments to determine the current state of the organizational culture, SSA could perform assessments through a monthly sampling of employee opinion that would seek to identify gaps between stated values and employee perception of the organizational culture. The survey tool could be a single page scaled survey, deployed to a small sample of employees, focusing questions on employee perception of management actions in daily work and on gaps between those actions and the values and mission of the program. By scaling the questions on a five-point scale, leadership can track changes in employee beliefs over time. Surveys can provide a wealth of information that is actionable by management.

- Based on survey results, management could identify areas where decision-making appears to be out of alignment with mission and strategy, and include this information in operational decision making.

Estimated Cost: No significant incremental cost.

- This process can and should be administered internally. The sample could be small, between 300 and 400 employees per month. Support for the process could be accomplished by one FTE, which may be part of a redeployed OQM (See *Option Area A*) at \$40,000-\$50,000 per year.

Develop a Quality Management University.

As the quality management system is deployed, SSA will need to make further investments in knowledge development and skill training to deploy higher-level tools and support evolving strategies. One option that other high performing organizations have successfully deployed is the development of a “Quality Management University” (QMU). General Electric has deployed a formal process to certify managers and employees in advancing degrees of quality management methods, with the highest level of competence certified as “black belt”. Attainment of a black belt is a core requirement for management advancement. Other organizations such as Federal Express, Ritz Carlton, and IBM have similar programs and make significant investments in ongoing training and education. In all of these organizations, ongoing training and skill development is integrated with performance review and management systems.

Estimated Cost:

- The QMU could be part of an overall reorganization of the training and development function within SSA, thereby utilizing existing resources. The cost of developing and deploying this option is dependent on scope and structure. However, under any possible cost structure, there should be clear cost/benefit from the additional resources deployed and improvements in performance measures and the cost of determinations. It is not unreasonable to consider spending \$1000 per employee per year on quality management training (which would translate to over \$50,000,000 for SSA) when a culture exists that supports the translation of the training investment to improvements in performance and cost at two and three fold returns on investment. Once SSA begins to see the returns from deployment of the quality management system, senior leaders should consider this option more carefully.

**Exhibit VIII.3
Option Area C: Evaluation**

| Evaluation Criteria | Option Area C: Promoting a Culture of Quality |
|--|--|
| 1. To what degree are the primary aims of the quality management system supported by this option? | |
| <ul style="list-style-type: none"> • Develop and pursue a clear operational definition of quality | <p align="center">High</p> <p>New definition of quality integrated into communications and process improvement efforts. Supports other options.</p> |
| <ul style="list-style-type: none"> • Develop and support organizational and process performance measures | <p align="center">High</p> <p>Supports data driven decision making and aligning efforts to achieve performance objectives. Supports other options.</p> |
| <ul style="list-style-type: none"> • Support a quality focused culture | <p align="center">High</p> <p>Main objective of this option. Supports other options.</p> |
| <ul style="list-style-type: none"> • Provide information that can be used to improve disability determinations | <p align="center">High</p> <p>Process improvement efforts targeted to improve disability determinations.</p> |
| <ul style="list-style-type: none"> • Provide employees with the resources to produce quality outcomes and service | <p align="center">High</p> <p>Process improvement should reduce waste, rework, and duplication and allow redeployment of resources.</p> |
| <ul style="list-style-type: none"> • Ensure that the disability programs are national programs | <p align="center">Moderate</p> <p>Supports other options.</p> |
| <ul style="list-style-type: none"> • Support statutory and regulatory requirements | <p align="center">Neutral</p> <p>Not the focus of this option.</p> |
| 2. By what measure(s) or method(s) of assessment will you know that the option is successfully deployed? | |
| <ul style="list-style-type: none"> • Develop and pursue a clear operational definition of quality | <p>Definition of quality is widely understood and reflected in employee surveys.</p> |
| <ul style="list-style-type: none"> • Develop and support organizational and process performance measures | <p>Process improvement efforts aligned with strategy? (Yes/No)</p> <p>Process improvements result in measurable improvement.</p> <p>Process improvements support improvement in overall performance metrics.</p> |
| <ul style="list-style-type: none"> • Support a quality focused culture | <p>Employee surveys that measure gaps between values and actions, satisfaction of employees, and perceptions of culture.</p> |

**Exhibit VIII.3 (continued)
Option Area C: Evaluation**

| Evaluation Criteria | Option Area C: Promoting a Culture of Quality |
|--|--|
| 2. (cont'd.) By what measure(s) or method(s) of assessment will you know that the option is successfully deployed? | |
| <ul style="list-style-type: none"> Provide information that can be used to improve disability determination | Process improvements result in measurable improvement. Performance measures for the disability program improve over time. |
| <ul style="list-style-type: none"> Provide employees with the resources to produce quality outcomes and service | Process improvements result in cost and productivity improvements. |
| <ul style="list-style-type: none"> Ensure that the disability programs are national programs | Process improvement methods used to investigate root causes of variation? (Yes/No) |
| <ul style="list-style-type: none"> Support statutory and regulatory requirements | Not linked to this option. |
| 3. To what degree will the option be supported within SSA? | |
| <ul style="list-style-type: none"> Senior Executives | High |
| <ul style="list-style-type: none"> Central Office Leadership | High |
| <ul style="list-style-type: none"> Office of Disability Leadership | High |
| <ul style="list-style-type: none"> Regional Office Leadership | High |
| <ul style="list-style-type: none"> DDS Directors | High |
| <ul style="list-style-type: none"> Union Leadership | High |
| <ul style="list-style-type: none"> OHA Leadership | High |
| <ul style="list-style-type: none"> Administrative Law Judges | Variable |
| 4. What human resources/staffing will be required by this Option? | |
| <ul style="list-style-type: none"> Requires additional human resources within SSA | Requires initial development of process improvement facilitators and coaches, and trainers. |
| <ul style="list-style-type: none"> Requires the reallocation of human resources within SSA | Yes Likely reallocation of resources to support efforts and as result of process improvements. |
| <ul style="list-style-type: none"> Will result in a reduction of human resources within SSA | Yes, over time. |
| <ul style="list-style-type: none"> Requires additional human resources at the DDSs | Some initial investment in trainers and facilitators may be required. |
| <ul style="list-style-type: none"> Requires a reallocation of human resources within the DDSs | Yes Likely reallocation of resources to support efforts and as result of process improvements. |
| <ul style="list-style-type: none"> Will result in a reduction of human resources at the DDSs | Yes, over time. |
| 5. To what degree will the option/method impact operating and program costs for the disability program? | |
| <ul style="list-style-type: none"> SSA operating cost | High reductions in excess of training and support investment. |
| <ul style="list-style-type: none"> DDS operating cost | High reductions in excess of training and performance measurement investment if used to improve. |
| <ul style="list-style-type: none"> SSA Program costs | Unknown. Dependent on projects selected and impacts on allowances, terminations and payment amounts. |

**Exhibit VIII.3 (continued)
Option Area C: Evaluation**

| Evaluation Criteria | Option Area C: Promoting a Culture of Quality |
|--|--|
| 6. To what degree is an investment in training and education required to implement the option/method? | |
| • Field Offices | High Process management and improvement techniques. |
| • Disability Determination Services | High Process management and improvement techniques. |
| • Office of Hearings and Appeals | High Process management and improvement techniques. |
| • Office of Quality Assurance | High Improvement theory, coaching, facilitation, tools and methods. |
| • Office of Disability | High Process management and improvement techniques. |
| • Regional Offices | High Improvement theory, managing change, tools and methods. |
| • Central Offices | High Improvement theory, leadership, tools and methods. |
| 7. To what degree is an investment in new equipment, facilities and or information systems required? | |
| • Field Offices | None |
| • Disability Determination Services | None |
| • Office of Hearings and Appeals | None |
| • Office of Quality Assurance | None |
| • Office of Disability | None |
| • Regional Offices | None |
| • Central Offices | None |
| 8. What regulatory or statutory change is required to implement the option/method? | |
| | None |

4. Option Area D: Quality Control and Pre-effectuation Review

a. Short-term Options

While in the long-term we think that SSA can reduce the need for end-of-line inspection via pre-effectuation review of DDS decisions by improving quality up front, in the short-run this is not possible because of legislated requirements, and not desirable because SSA will need to guard against problems that could arise as it continues to roll out the Prototype and possibly implements other short-term options we have developed. Some of those options are aimed at increasing denial accuracy, which is currently very low in many states. One way DDSs can increase denial accuracy is by allowing a larger share of difficult cases, but this will likely reduce allowance accuracy – just as PER appears to have substantially reduced denial accuracy when it was introduced in the early 1980s to increase allowance accuracy (see *Chapter V*). To guard against this, it will be important to maintain PER until such time as its value diminishes. The short-run options we develop for PER are aimed at improving its efficiency, supporting and measuring consistency across states, increasing its usefulness for policy and process improvement, and setting the stage for long-term transformation into a quality control process that would be consistent with an advanced quality management system.

Possible changes to PER for the short-term include:

- Integrate PER into the disability determination process as a joint responsibility of the Office of Quality Assurance and the Office of Disability;
- Improve the profile system for selecting PER cases;
- Improve the measurement and reporting of the net savings from PER;
- Streamline the review of selected cases;
- Develop and deploy a new process to identify and review difficult cases;
- Develop and deploy a system of Test Reviews to measure consistency and identify reasons for inconsistency;
- Begin the development of a review process that cuts across regions; and
- Expand the purpose of PER to address policy and process issues

Integrate PER into the disability determination process as a joint responsibility of the Office of Quality Assurance and the Office of Disability.

Because PER is applied to half of all DI allowances, and a larger share of those which are error-prone, it is essentially a Federal step in the determination process – all the more so if currently proposed expansion of PER to SSI allowances occurs. Currently, the value of PER is limited by the fact that it is performed by OQA, and not by those who are responsible for the process, the Office of Disability (OD).

Under this option, PER would become an integral part of the determination process under the joint oversight of OD and OQA. An OD/OQA PER Team would be assigned to lead the PER effort. For the short run, it might be efficient to continue using regional DQB reviewers to conduct PER, but PER methodology (including profiling), treatment of deficiencies, and analysis would be the responsibility of the OD/OQA PER Team. The inclusion of OD in the process will help ensure that PER is performed in a way that supports process improvement objectives. OQA will provide its considerable technical expertise, and help assure others that integrity of the PER process is maintained.

This option makes the most sense as part of a broader effort, described under *Option Area A*, to integrate quality management into the disability determination process and align the objectives of the various organization components with the program quality objectives, broadly defined.

Estimated Cost:

- Transition costs for this option alone should be small. Integration of PER into the process will require a transition effort. If SSA continues to perform PER at the Regional Offices, the primary change would be lines of reporting and central office management of the process by an OD/OQA team.

- Minimal impact on recurring expenses.

Improve the profile system for selecting PER cases.

The current PER selection system relies on an econometric model for Title II allowances that predicts the probability of a decision error on the basis of claim characteristics. Under this option, this approach would be changed to incorporate the DDS's recent performance, as measured via the performance monitoring process. How this is done will depend on how the performance monitoring system is changed. If the federal accuracy review is expanded to incorporate state decision accuracy review (see *Option Area E: DDS Performance Monitoring System*), then it might be possible to develop an econometric profile system for each DDS from its own decision accuracy data. Alternatively, SSA could continue the practice of developing econometric profiling models from decision accuracy data for all states, pooled together, but simply include indicator (“dummy”) variables for each state.

It is already true that the percent of DI allowances reviewed varies from state to state, depending on claimant characteristics that are in the profile model. Each state is not considered explicitly but it seems very likely that substantial cross-state variation remains in allowance accuracy even after controlling for claimant characteristics. The result of adding state performance to the model will increase variability in review rates across states. Relatively smaller samples would be drawn from states with high allowance accuracy, and relatively larger samples would be drawn from states with low allowance accuracy. It is possible that the states with the best decision accuracy performance might be exempt, and those with the worst might be subject to 100 percent review.

We have heard from one person that SSA has considered using state QA performance as a profile factor in the past, but rejected it on the grounds that it would make the determination process differ by state. This argument acknowledges that PER is part of the determination process already. The counter argument is that the proposed state-specific profiling approach would enhance consistency of treatment across states because it is a countervailing force to differences that would exist in its absence. All DDSs with equal performance would be treated equally.

Estimated Cost:

- Insignificant incremental costs for profile development. SSA periodically updates its profiling system. This system could be developed as part of the next update, which would make transitional costs insignificant. There is no obvious reason why implementation of the revised system would cost more, either.
- Substantial increases in program saving from PER. PER would be more focused on states where allowance error rates are relatively high. SSA's actuaries estimate program savings from PER of almost \$150 million in FY 1999 (see *Appendix G*). A 10 percent increase in errors detected would produce program savings of \$15 million.

Improve the measurement and reporting of the net savings from PER.

SSA could make several changes to the measurement of the net savings from PER that could help determine what share of cases should be reviewed to maximize net savings from PER. Such

data might support a reduction in the share of allowances reviewed, although it could turn out to support an expansion. The data could also support long-run legislative change that would make PER more efficient. Other changes in savings measurement could support improvements to the profile system. In addition, reporting changes could provide policymakers with some information about the direct cost of PER to claimants.

Currently, SSA actuaries estimate total program savings from PER, and these far exceed the cost of PER. However, the expected savings from review of an individual case varies by case, and the expected savings from every case do not necessarily exceed the cost of reviewing the case. The most important cause of variation is captured in the profile system: the probability of an error, given observable characteristics of the case. Expected net savings for each case reviewed are the probability that an error will be found times program savings if the case is denied minus the cost of the review. If the probability of an error is too low, expected savings will be negative.

Assuming (for now) that program savings and review costs for each case are constant, if SSA actuaries were provided with a distribution of error probabilities from the profiling system, they could readily generate a distribution of net savings on individual reviews. This might show that expected net savings from a substantial share of reviews are negative, which would support a reduction in the number of reviews. It might also show, however, that substantial expected net savings are obtained even for those cases with the lowest error probability, which would support expansion of PER.

Ultimately, the analysis could be turned around to support legislation that would permit SSA to set a cut-off error probability consistent with zero expected savings. This would maximize the net savings from PER, because all cases with positive expected savings would be reviewed, and all cases with negative expected savings would not be. Further, the sample size for PER would automatically be reduced as decision accuracy improves, or increased if it should fall. This provides an incentive to both the DDSs and SSA to improve accuracy.

In the above discussion, we assumed that program savings are the same for all cases denied at PER. This assumption is wrong, because lifetime benefit costs are related to duration on the rolls and monthly payment amount. Hence, factors that increase expected duration or monthly payment contribute positively to the expected benefit amount. Taking these into consideration would change the distribution of net savings under the current system. In the long-term, if these factors were considered in determining whether a case should be reviewed, or not, this approach would change which cases were reviewed, and further increase the net savings from PER. There might be equity objections to using factors not directly related to the probability of an error, however. Holding expected annual benefits and the probability of an error constant, this approach would reduce reviews of awards to older claimants; holding age and the probability of an error constant, it would reduce reviews of those with relatively low expected annual payments.

Finally, SSA should consider reporting to Congress on the eventual fate of those beneficiaries who are denied at PER. While the actuaries adjust for the fact that many of those denied at PER eventually receive allowances, SSA does not routinely report what share of cases denied at PER are in this category. As we have previously discussed, PER can impose a substantial cost on such claimants during what can be a very long appeals process. It would also be useful to have an

appellate cost estimate for appeals of cases denied at PER, which could be substantial. While these would not nearly offset the program savings from PER, they would be important in the calculation of expected net savings from an individual review, as discussed above.

Estimated Cost:

- Small if only consider fixed savings for each error detected. It would be fairly simple to perform the analysis of marginal savings from PER, given fixed savings for each error detected. OQA profile experts might be able to complete such an analysis using the actuaries' existing estimates in a few days.
- \$50,000-\$100,000 if the assessment includes an analysis of variation in savings across individuals. It is likely that the Office of the Actuary would need to play a substantial role in analysis of the relationship between potential savings and claimant characteristics. We estimate that the more ambitious analysis might require one-half of an FTE, partly from OQA and partly from the Office of the Actuary.

Streamline the review of most cases.

Because PER's current function is to identify and correct allowance errors, the review process does not need to cover all of the issues that are addressed in a quality assurance review. Our perception however, is that at least some reviewers conduct PER reviews in essentially the same way as they would quality assurance reviews. The disparity between the objectives of PER and quality assurance review will widen if SSA follows some of the DDS performance measurement ideas presented under *Option Area E*, below. Hence, it will become all the more important to assure that PER is conducted without unnecessary effort. SSA could develop and test ways to streamline the initial stages of PER, with the objective of clearly most cases at the end of the streamlined process. If problems are identified, the case will necessarily take longer.

Estimated Cost:

- Large savings possible. In FY1999, SSA spent over \$17 million on PER of initial medical determinations (see *Appendix G*) Hence, if SSA could reduce the effort required by 10 percent, which seems plausible, annual savings would be on the order of \$1.5 to \$2 million.

Develop and deploy a new process to identify and review difficult cases.

While many allowances are clearly supported by the DDS folder, and a small share are clearly not supported, it appears that a substantial, but unknown number of cases are so complex as to make determination very difficult. Identifying and giving special attention to these cases during the PER process could both improve the PER decision and provide information that would improve the determination process. We discuss how such a system might work below. In the short-term, SSA might want to design and test one or more versions of such a system, then consider implementation in the long term.

This system would require a Determination Expert Team (DET) to address difficult cases. We think the DET for each state should be a joint effort between the SSA office responsible for PER and the DDS. This supports alignment of the objectives of the two offices and development of a

quality culture. The DET would collectively decide difficult cases. The value of the DET could be enhanced, by having it play a significant role in the quality measurement process, as we discuss in *Option Area E*. The DET would become a repository of shared knowledge about difficult cases.

A challenge to implementing this type of system is the development of a methodology for identification of difficult cases. It could be derived from an analysis of test cases, which are discussed further below. A good system would permit a reviewer to accurately determine if a decision is “clearly supported,” “clearly not supported,” or “difficult,” with high reliability across reviewers. The reviewer could dispose of the first two types of cases – the bulk of all cases -- without referral to the DET; only difficult cases would be referred.

Cases denied at PER, whether by the reviewer or the DET, would be returned to the DDS for remedial action. A substantial share of those returned would be subject to a second review after the remedial action is taken.

It will take some effort to develop standards for classifying cases as “clearly supported,” “clearly not supported,” or “difficult.” One conceptually appealing approach is to use the “meeting the preponderance of evidence” standard to define decisions that are clearly supported. Any decision that meets the “substantial evidence” standard, but not the preponderance standard, could be considered difficult, and any case that fails even the substantial evidence standard could be considered clearly not supported. No matter what conceptual basis is adopted for the classification scheme, it will be necessary to translate the conceptual basis into rules for the reviewers to follow.³⁰

The DETs would need to have ready access to a complete range of relevant expertise on medical, vocational and legal issues. While some argue that it is unfair to assess DE performance using resources that are not available to DEs, this argument is misplaced when applied to an advanced quality management system. A main purpose of applying greater expertise to difficult cases in the review process is to better understand the issues that DEs have difficulty with, and use that information to improve the process.

Reviewer access to legal expertise is a departure from current PER practice. Its use might be limited to a small share of difficult cases, in which legal issues happen to be key. To enhance consistency, it is important for the medical, vocational and legal expertise available to the DETs to come from a pool of expertise that is common to reviews of both initial and appellate cases. The logistics will depend on the adoption of other options that make use of this expertise, and might be a significant challenge.

Each SSA/DDS DET would be responsible for collecting data specific to the characteristics of the types of cases that are reviewed. The data generated from the new PER process would be of considerable value to OD in its efforts to improve policy and the determination process. Data

³⁰ We understand that the Canada Pension Plan has developed a scheme for classifying cases in a similar manner, but do not have more specific information about it.

from cases that reviewed by the SSA/DDS DET will be especially useful for identifying and analyzing systemic issues that could be addressed through policy or process changes.

Selection and training of the SSA experts for the review teams and for the DETs could play a critical role in promoting both national consistency and process unification. We anticipate that many of the problematic decisions these individuals will have responsibility for will be those that are at the core of inconsistency across DDSs and between the DDSs and OHA. Hence, it will be important for SSA to appoint highly qualified personnel to these positions, to train them intensively at a national level, and to continue their training as new policies and processes are implemented. Similarly, the DDS representative(s) on each SSA/DDS DET will need to be highly qualified and trained. We think it would be best to have the SSA member for each DET report directly to a central DET office, established jointly by OD and OQA, rather than a regional office. Both the SSA and DDS members would regularly provide feedback to the central DET offices on the difficult issues they encounter.

Cases that are not supported should also be reviewed on issues likely to result in allowance on appeal. Cases found not to be supported during a review would normally be returned to the DDS for additional work. Some are allowed after additional support for the allowance is obtained, but many are denied. As mentioned above, many denied claims are later appealed, and a substantial share of the latter is allowed. It is possible that some (perhaps a substantial share) of appeals and appellate allowances could be prevented by further development of the case. The DET could consider the likelihood of reversal on appeal in making its decision, and could require the DDS to take steps that either result in allowance or improve support for those denials most likely to be allowed on appeal. The DET will learn to recognize cases that are likely to be allowed on appeal, and to initiate steps that lead to either a well-supported allowance or a well-supported denial.

Estimated Cost:

- SSA would likely want to develop and demonstrate the methodology for handling difficult cases prior to deployment. In *Appendix G*, we describe a one- to two-year project for this purpose, which we estimate would cost on the order of \$1.0 to 1.5 million.
- Recurring costs for federal employees to support long-term deployment might be on the order of \$4-5 million, because of the DETs. DDS personnel costs might be similar. However, as discussed in the next option, the DETs could serve multiple functions, which could significantly reduce costs associated with PER. DQB and DDS staff to support this option might be transferred from current DDS and DQB QA under one of the options developed in *Option Area E*.
- Substantial administrative savings would eventually be generated through improvements in DDS performance. The net increment to recurring costs would be zero if the number of cases reviewed could be reduced by 40 to 50 percent (see *Appendix G*). Ultimately, it is the value of contributions of PER reforms to quality improvements that would make this effort pay off.

Develop and deploy a system of Test Reviews to measure consistency and identify reasons for inconsistency.

National consistency could be measured and enhanced by use of a set of test claims. These could be real claims, selected from those that have already been through PER, and with those identified by PER as “difficult” or “clearly not supported” over represented. A sample set of these cases could be selected and distributed to the DDSs and SSA PER reviewers. The cases would appear just as they did when they first entered PER, absent any subsequent changes. The states would randomly select examiners to re-adjudicate the cases, and then submit them to the DDS internal review process. The PER reviewers would also review the sample set by their normal processes. The DDSs and PER reviewers would submit a report on the sample set that included:

- Case by case allowance and denial;
- Categorization of the sample set into categories of clearly supported, difficult, and clearly not supported;
- Policy questions raised in the review process; and
- Case-by-case recommendations on the development of the case and further information that would have been helpful in the determination process.

SSA central office could prepare a benchmark by: having an expert team review the set and develop an allowance rate for the sample set; develop a benchmark assignment as clearly supported, difficult, and clearly not supported; and develop a case-by-case analysis of the case development.

SSA could compare the DDS decisions and the SSA review unit decisions to the benchmark and to the means for all units. For states and review units with results that are significantly different from these norms, SSA could initiate improvement efforts that seek to understand the root cause of the variation, and work with the DDS or SSA review unit to improve.

SSA could also utilize this process to identify the potential number and characteristics of difficult cases. If one considers the determination decision a continuum that starts with clearly supported denial and ends with clearly supported allowance, difficult cases fall into the middle. As discussed above, the DET option is designed to deal with difficult cases, and the DET should be a source of information on the characteristics of cases that create decision problems. However, one of the issues that SSA faces is determining how large this set of difficult cases really is. SSA could look at the distribution of responses to the test set to help identify possible characteristics of difficult cases. This would support the three-category classification system discussed above. On individual cases or groups of similar cases, if the responses across the country indicate a significant percentage of disagreement (allowance vs. denial) then SSA could conduct root cause analysis and determine if the case characteristics and subjective dimension of disability determination is the cause of different interpretation, or if there is an issue of training, policy clarification, or regional medical practice that is the source of variation.

The test process could also produce a performance metric for the DDSs and SSA review units that could be tracked over time and included in the overall disability program performance metrics. Doing this quickly would provide a baseline against which SSA could measure progress

toward improving consistency as various quality management options are deployed. SSA might consider an initial test applied to DQB reviewers only, then expansion to the DDSs.

It is very important to note that this test is not a test of individual DQB or DE performance. No statistics will be produced for individuals because the number of test reviews that an individual will conduct is very small – 10 or so. Depending on the design, the test can produce statistics on consistency between examiners (reviewers) within a DDS (DQB), as well as consistency across DDSs (DQBs).

This idea can be seen as further development of the test bank review process that is currently being started at SSA. Under that process, a modest number of difficult cases,³¹ all of which have been previously adjudicated and described as difficult, will be distributed to all states and DQBs for independent adjudication; neither the DDSs nor the DQBs will have access to adjudicative information from the real decision. How each unit adjudicates the cases is up to the unit. Findings will be compared to central office findings. Results will be used to identify problem areas and support improvements.

The test review process we describe would differ from the case bank effort in the following ways. First, a larger number of cases would be reviewed. Second, they would be selected randomly from PER cases, with over representation of difficult cases. Third, the DDSs would be required to randomly assign the cases to their DEs, and otherwise follow the normal process for adjudication. This could include normal DDS quality review (including normal selection of cases for quality review). The DQBs would also be required to randomly assign the cases to individual reviewers, but unlike in the normal process the reviewer would adjudicate the case without benefit of the findings from the DDS.³²

Estimated Cost:

- In *Appendix G* we describe an initial test for DQB reviewers only that we estimate would cost from \$600,000 to \$1 million. The less expansive test would examine consistency across regional DQBs only, while the more expensive test would examine consistency between reviewers within regions as well. The most substantial cost of this test is the reviewer time, and only having as many reviews are required if consistency between examiners in a region is not considered. This test assumes that reviewers are not specialized; if they are, costs would be lower.
- If the test is expanded to DEs, DE time would substantially increase costs. Examining consistency across DDSs would likely cost as much as \$2 million. That figure would increase to \$3.5 million if consistency between examiners within regions is also considered.

³¹ In the first round, 62 cases were sent out.

³² See Gallichio, S. and B. Bye (1980) for an example of how the test cases could be distributed to DEs. Note that each DE would adjudicate only a very small number of test cases under their scheme, but the cases are distributed in such a way that SSA can measure reliability between DEs and across DDSs. A similar scheme could be applied to DQBs.

- The value of this test is that it would provide SSA with high quality data on consistency for DI allowances subject to PER.
- This could partly be paid for by eliminating the current system of national consistency reviews, which we think are not productive, but these savings might only be \$200,000 or so.
- In *Option Area E*, we discuss a similar test of consistency for all cases. These tests can be combined into a single test, as we discuss further in that section.

Begin development of a review process that cuts across regions.

As discussed earlier in the report, we believe that the regional review system, applied to both PER and quality assurance reviews, contributes to inconsistency across regions. Our conclusion could be verified through a test review process, as described above. Regional inconsistency could be addressed by the development of a review process that cuts across regions. This could begin in the short run, possibly with experimental efforts to address specific problems, and expanded in the long run if regional inconsistencies are found to be pervasive and persistent. At the extreme, transition to a central office PER process could be considered.

One approach to improving consistency that we think is feasible in the short run would be to distribute selected claims for PER to regional offices on the basis of criteria other than region of origin.

This process might begin by identifying profiles of PER cases that are most likely to be treated inconsistently across regions (based on the tests) and sending a large share, or all, of such cases to a special unit in a regional office, or the central office, for review. Over time, as an electronic folder system makes transfer of folders easier, this could evolve into a system where multiple specialized units review samples of specific types of claims from all over the country.

The strength of this idea is that it would likely improve uniformity within each type of case. It also seems likely that this would reduce the cost of reviews, as reviewers will become more proficient through specialization. Their focus on a specific type of case will also help SSA identify systemic policy and process problems. Following HCFA's lead, regional teams could be given leadership responsibilities for cases of specific types. This means that they would be responsible for addressing policy and process issues in a timely fashion, relying less on central office leadership, which, according to many interviewees, is often slow to respond. Each region's ownership of a certain set of issues might also support increased interactions and cooperation among the regions.

While this approach has considerable merit, it also has limitations. Perhaps the most important is that the system might replace inconsistencies across regions with inconsistencies across claims of different types. There might also be logistical problems, in part because it might be difficult to determine where some claims should go for review, particularly those with multiple impairments. Both of these problems could be at least partially addressed by consolidating reviews in a smaller number of regions, again following HCFA's example, or by fully centralizing the review process, but this would take more time. Another limitation is that it might

drain expertise in certain areas away from the regional offices, where it might be needed to support efforts aimed at improving DDS quality.

SSA is currently considering changes to its consistency reviews that cut across regions in a different way. In the past, consistency reviewers have reviewed the DDS decision and the DQB review at the same time, post-effectuation. Under the system in development, a central office review team would review a small sample of DDS cases contemporaneously with the DQB review of the same cases, and without benefit of the DQB reviewer's findings (i.e., "blind"), pre-effectuation. After the blind reviews are completed, findings from both the DQB and central office reviews will be compared. This new system could shed more light on the variation that exists in the review processes, especially on targeted complex cases, and may provide information that can be used to inform policy and ultimately improve the initial determination process. However, the focus of this effort is on increasing consistency of quality assurance review, which we believe is not as powerful as focusing on consistency of the initial determinations themselves.

Another variant that SSA might want to consider would be to send some of each region's initial determinations to be reviewed in other regions. That is, each year a few hundred cases that have already been selected for review in each region could be randomly sent for review in other regions. This would result in a substantial database of cross-regional reviews that would support in-depth analysis of cross-regional differences in both initial determinations and the review process. Note that under this system no initial determination would be reviewed twice. We recognize that there are logistical challenges in such a system, but based on discussions with a number of knowledgeable individuals at SSA, it seems likely that the challenges could be successfully met.

Estimated Cost:

- Two to three FTE of leadership effort for planning. Leaders from OD/OQA and will need to spend some effort in planning this change.
- Some transition costs because of changes in routing of claims between DDSs and DQBs would have to be changed and reassignment of some personnel. Reassignment would be small as long as each region participates. Medical consultants are likely to be the group affected most, as each region will only want to retain MCs with expertise in the region's area.
- In the long term, shipping costs will be higher until folders become electronic.
- Consolidation of reviewers into a smaller number of regions would likely generate savings from scale economies, at the expense of greater transition costs.

We cannot put a dollar figure on the value of improved consistency, which this option is designed to achieve.

Expand the purpose of PER to address policy and process issues.

As discussed further below, in the long term, the purpose of PER could be changed from error correction to support of policy and process improvements. In the short run, SSA might find it

valuable to experiment with this concept. For instance, if a specific process issue is identified through PER or in some other way, the central PER office could initiate short-term special data collection, to be performed in the course of PER reviews. The same process could be used to evaluate the effects of process or policy changes that have been designed to address specific issues. Because PER is applied only to allowances, efforts that only require data collection from allowances would be the least expensive to perform; efforts that need information from initial denials would require an expansion of PER sampling. The latter type of study might be more viable in the long run, especially if SSA can reduce the number of allowances reviewed because of quality improvement.

Estimated Cost:

- Costs for each PER study are dependent on the purpose and design of the study. If the study only requires special data from cases that would be reviewed for PER anyway, incremental data collection costs will be small. If the study requires augmentation of the PER sample, it will be substantially more expensive. At the FY 1999 estimated cost per review, a sample of 1,000 reviews would cost about \$80,000.

b. Long-term Options

In the long term, we hope that SSA will be successful in reducing the need for end-of-line error correction via pre-effectuation review of DDS decisions through up-front improvements in decision accuracy. There remains the possibility, however, that other efforts will fail to achieve sufficient improvements in accuracy. Hence, for the long term we consider two different scenarios:

- Transform PER to focus on process and policy improvement, or
- Expand PER as an error-correction mechanism.

We emphasize that the second of these scenarios is an undesirable outcome, only to be considered as a last resort.

Transform PER to focus on process and policy improvement.

The purpose of PER would be transformed to one that focuses on process and policy improvement. Error correction would be eliminated, or perhaps applied to a much smaller share of cases that remain error prone. Under this scenario, cases selected for PER and the method of review itself would depend on the purpose of the specific PER effort. While some PER projects might be sustained over very long periods, or indefinitely, we think most efforts would be time limited, with the time span depending on the purpose. PER can become one of several tools to help SSA in its efforts to continuously improve the determination process (see *Option Area C*). PER can be used to help plan such efforts and to study the impacts of such efforts.

For this transformation to occur successfully, it will become increasingly critical to integrate PER into the process. The OD/OQA team approach will support this integration in the short run, but in the long run the diminished importance of error correction and possible organizational changes designed to promote disability program quality (see *Option Area A*) will make it more

appropriate to place the PER function within the office that has ultimate responsibility for disability determinations. It might also make increasing sense to centralize PER, rather than continue to conduct it in ROs.

SSA should consider periodically studying the new PER process itself, to ensure that the changes are consistent with the objectives of PER. This review should go beyond a review of any process performance metrics that might be generated, and include an assessment of the how well the PER process works in daily operation. One method of gaining insight at this level is to periodically survey a sample of SSA employees who work in the process and DDS employees who interact with PER on a routine basis. The results of these surveys can be used to improve the work processes of PER as well as insure that the application of PER is consistent with the desired organizational culture and SSA's definition of quality.

The proposed PER system might also help support another legislative change that could improve overall program quality: establishment of a "temporary," or "conditional," status for some beneficiaries. While we think the PER process described above will contribute to narrowing of the number of difficult cases, a substantial number might remain. As SSA's knowledge of, and ability to identify, such cases increases, it might become practical to make conditional allowances for them as an intermediate outcome of PER. The applicant's impairment would be monitored for a specified period, and then a decision would be made to upgrade to regular status, continue in conditional status, or terminate.

Estimated Cost:

- Unknown. Costs could be considerably lower than today, because of reduction in the number of cases reviewed for the purpose of correcting errors, but this would be offset by expansion of PER to other cases, in line with the specific purposes of PER studies.

Expand PER as an error-correction mechanism.

So far the discussion of long-term change has been predicated on the assumption that DDS quality will improve, in response to implementation of other options, to the point where PER has limited value as an error-correction mechanism. There is, of course, a much less desirable scenario: continued low accuracy rates. Under this scenario, SSA might want to consider increased quality control, rather than reduced use of PER for error-correction. While advanced quality management systems avoid reliance on end-of-line error-correction, there is no guarantee that SSA will be successful in fully implementing such a system. Dr. W. Edwards Deming believed that if a process was sufficiently complex that the only way to prevent defects was to inspect, then all units should be inspected rather than relying on a sample, because sampling will invariably miss substantial numbers of defects.

We are particularly concerned about the possible continuation of very low denial accuracy in many states, which we think is partly due to incentives created by the application of PER to allowances only. In fact, if PER of allowances is strengthened in the short-run, as discussed above, and nothing else is done, the result in some states could be even lower denial accuracy.

An obvious approach to offset these incentives is to apply PER to denials as well. This is not the preferred approach for reducing denial errors, however, because it could lead down the path to increased, rather than decreased, reliance on PER. We offer other approaches, which we believe are more likely to lead to establishment of an advanced quality management system (see **Option Areas E** and **F**). If SSA cannot make sufficient progress in improving denial accuracy by pursuing one of these options, then expansion of PER to denials might be the best remaining option.

To assess the net cost of expanded PER and fine-tune some features of the design, the new system could be demonstrated in a few states where support rates have been low historically. While this would not take advantage of the national consistency features of redesigned PER, the demonstration would likely pay for itself by first correcting errors, and later reducing errors.

If PER becomes fully integrated with the process, but continues to play an important error-correction role, integrity of the PER process will be an ongoing concern. If the objectives of the office responsible for PER are in line with the quality objectives for disability determinations, then that office can be relied on to maintain the integrity of the process. Failure to align objectives appropriately could, however, encourage cheating, and even in the absence of cheating those outside the process might require some independent assurance of its integrity. We think this can best be accomplished through external audits of the PER process itself, rather than separating the PER process from the determination process, as is now done.

Estimated Cost:

- The administrative cost of PER expansion depends on two key parameters: the percent of cases that would be reviewed and the reduction in appeals because of allowances at the PER level. As discussed in **Appendix G**, we estimate that doubling the number of reviews would increase the cost of conducting PER by about \$18 million dollars. While expensive, the administrative costs might be more than offset by administrative savings from reduced appeals. We estimate, for instance, that a two-percentage point increase in the initial allowance rate would reduce appeals by more than enough to pay for the additional cost of PER under this scenario.
- The value of redesigned PER goes well beyond reduced appeal rates, but is not likely to be captured in short-term administrative savings. First, we think it will be a major force for improving consistency across states. It is hard to put a figure on the value of consistency, however. Second, PER of SSI allowances, like PER of DI allowances, would reduce program costs for allowances that are not supported. Third, PER of denials would prevent denial errors that have significant costs to beneficiaries – at worst, permanent denial of benefits, and at best significant delay of award, along with attorney costs of up to 25 percent of past due benefits.
- Program savings would be reduced because some allowances would now be made to individuals who might have been permanently denied benefits because of denial errors. We suspect, however, that it is not the intent of Congress or anyone else to reduce program expenditures by denying benefits to individuals who meet eligibility criteria, through denial errors. In fact, correction of a denial error that would not be corrected through the appeals

process might have just as much value to the public as correction of an allowance error that is not reversed on appeal. It might also be that, because of the extensive appellate process, very few initial denial errors result in final denials.

**Exhibit VIII.4
Option Area D Evaluation**

| Evaluation Criteria | Option Area D: Quality Control and Pre-effectuation Review |
|--|--|
| 1. To what degree are the primary aims of the quality management system supported by this option? | |
| <ul style="list-style-type: none"> Develop and pursue a clear operational definition of quality | Neutral Supports other options. |
| <ul style="list-style-type: none"> Develop and support organizational and process performance measures | High Linked to options B, E. PER measures incorporated into disability program performance measures and DDS performance Supports other options. |
| <ul style="list-style-type: none"> Support a quality focused culture | High PER method consistent with new quality management theory and methods. |
| <ul style="list-style-type: none"> Provide information that can be used to improve disability determinations | High PER function expanded to collect data for policy and improvement. Supports other options. |
| <ul style="list-style-type: none"> Provide employees with the resources to produce quality outcomes and service | High New PER improves efficiency of review process. |
| <ul style="list-style-type: none"> Ensure that the disability programs are national programs | High Design of PER should improve national consistency. Supports other options. |
| <ul style="list-style-type: none"> Support statutory and regulatory requirements | High Main objective of this option. |
| 2. By what measure(s) or method(s) of assessment will you know that the option is successfully deployed? | |
| Develop and pursue a clear operational definition of quality | Not directly related to this option. |
| <ul style="list-style-type: none"> Develop and support organizational and process performance measures | PER metrics included in DDS and disability program performance metrics? (Yes/No) Metrics show improvement over time. |
| <ul style="list-style-type: none"> Support a quality focused culture | DDS satisfaction with PER as measured by survey. Employee satisfaction with PER as measured by survey of employees in PER process. |
| <ul style="list-style-type: none"> Provide information that can be used to improve disability determination | PER data used to change policy? (Yes/No) PER data used in process improvements? (Yes/No) Cost/Benefit of per decreases over time due to improvements in the disability program. Disability program performance metrics improve over time. |
| <ul style="list-style-type: none"> Provide employees with the resources to produce quality outcomes and service | Cost/benefit of PER tracked over time. |
| <ul style="list-style-type: none"> Ensure that the disability programs are national programs | PER data used to investigate root causes of variation. (Yes/No) Decrease in decision accuracy variation over time. |
| <ul style="list-style-type: none"> Support statutory and regulatory requirements | PER Savings Report Cost/Benefit Analysis GPRA OIG audit reports. |

**Exhibit VIII.4 (continued)
Option Area D Evaluation**

| Evaluation Criteria | Option Area D: Quality Control and Pre-effectuation Review |
|--|---|
| 3. To what degree will the option be supported within SSA? | |
| • Senior Executives | High |
| • Central Office Leadership | High |
| • Office of Disability Leadership | High |
| • Regional Office Leadership | High |
| • DDS Directors | Variable. Information generated by the new process should be useful to the states, and we expect states to like the SSA/DDS DET approach. Low performing states may be targeted for high percentage PER. |
| • Union Leadership | High |
| • OHA Leadership | High |
| • Administrative Law Judges | Unknown |
| 4. What human resources/staffing will be required by this Option? | |
| • Requires additional human resources within SSA | Not significant in the short run. In the long run, depends on the alternative chosen. If PER is expanded to include denials, more cases will need to be reviewed, but case review might be more efficient. Team treatment of difficult cases may require additional, and different resources. Over time, quality improvements should reduce resources committed to PER. |
| • Requires the reallocation of human resources within SSA | Reallocation of OQA/DQB and OD resources to set up new PER. |
| • Will result in a reduction of human resources within SSA | Possible over time. |
| • Requires additional human resources at the DDSs | Possible Participation on SSA/DDS DET may require additional FTEs, but could come from existing DDS QA personnel. |
| • Requires a reallocation of human resources within the DDSs | Yes |
| • Will result in a reduction of human resources at the DDSs | Possible over time due to process improvements. |
| 5. To what degree will the option/method impact operating and program costs for the disability program? | |
| • SSA operating cost | Depends on long-term alternative chosen. PER effort could be reduced under the first, but expanded under the second. Second alternative would likely pay for itself through reduced appeals |
| • DDS operating cost | High Reductions long-term in excess of short-term investment, through improved learning from PER |
| • SSA Program costs | In short-term would reduce allowances through better profiling. In long-term depends on alternative. Could increase program cost by reducing denial errors, depending on the share of such cases currently allowed on appeal |

**Exhibit VIII.4 (continued)
Option Area D Evaluation**

| Evaluation Criteria | Option Area D: Quality Control and Pre-effectuation Review |
|--|--|
| 6. To what degree is an investment in training and education required to implement the option/method? | |
| <ul style="list-style-type: none"> • Field Offices | Low |
| <ul style="list-style-type: none"> • Disability Determination Services | High Orientation to new process Process improvement techniques to use data generated by PER for improvement. |
| <ul style="list-style-type: none"> • Office of Hearings and Appeals | Low |
| <ul style="list-style-type: none"> • Office of Quality Assurance | Moderate PER becomes joint responsibility of OD & OQA. |
| <ul style="list-style-type: none"> • Office of Disability | High Orientation to new PER Use of PER data in policy analysis and program improvement. PER becomes joint responsibility of OD & OQA. |
| <ul style="list-style-type: none"> • Regional Offices | Moderate Orientation to new PER Use of PER data to make decisions. |
| <ul style="list-style-type: none"> • Central Offices | High Orientation to new PER Use of PER data in policy analysis and program improvement. |
| 7. To what degree is an investment in new equipment, facilities and or information systems required? | |
| <ul style="list-style-type: none"> • Field Offices | None |
| <ul style="list-style-type: none"> • Disability Determination Services | Moderate May need information system changes to move claim information and design case selection profile. |
| <ul style="list-style-type: none"> • Office of Hearings and Appeals | None |
| <ul style="list-style-type: none"> • Office of Quality Assurance | May need information system changes to move claim information and design case selection profile (with OD). |
| <ul style="list-style-type: none"> • Office of Disability | Moderate May need information system changes to move claim information and design case selection profile (with OQA). |
| <ul style="list-style-type: none"> • Regional Offices | Moderate May need information system changes to move claim information and design case selection profile. |
| <ul style="list-style-type: none"> • Central Offices | Moderate May need information system changes to move claim information and design case selection profile. |
| 8. What regulatory or statutory change is required to implement the option/method? | |
| | None for short term. In long term, SSA would seek changes in PER requirements. |

5. Option Area E: DDS Performance Monitoring System

a. Short-term Options

We have developed three options for DDS Performance Monitoring in the short term. Within each option are a number of elements that work together to achieve the intent of the option. SSA can consider both the options and the supporting elements independently, with the caveat that some of the elements are interdependent and likely will not be effective if implemented in isolation. All three options would help build a long-term performance monitoring system that would be an important component of an advanced quality management system:

- Develop and test DDS performance measurement requirements.
- Develop and implement a DDS scorecard and benchmarks.
- Develop and test DDS quality management models.

All three options would entail a cooperative SSA/DDS effort, perhaps led by members of the Quality Council (*Option Area A*). In the long term, all DDSs would conform to DDS performance measurement requirements that are based on those tested in the short term, and the scorecard would be revised and expanded to incorporate measures based on data that are not currently available. All DDSs would also be required to have a quality management system. The system would need to meet certain requirements, developed during the short-term tests, but DDSs would have considerable latitude in the design and operation of their system.

Develop and test DDS performance measurement requirements.

Implementation of an advanced quality management system for the disability programs will require integration of performance measurement with the determination process. Hence, DDSs will need to assume more responsibility for performance measurement, and be held accountable for the validity of their measures. Considerable groundwork must be done to achieve that objective. Hence, in the short run, SSA and the DDSs could work to develop and test DDS quality measurement requirements. This experimentation would become the basis for a set of DDS quality measurement requirements, to be implemented by all DDSs in the long run.

Some DDSs might adamantly resist new measurement requirements. For this reason, it is very important for DDS leadership to be involved in the development of the requirements. This will help ensure that the requirements are developed in a way that will help the DDSs improve their performance. The requirements we envision would greatly reduce federal reviews of DDS decisions, which some DDSs find excessively burdensome, in exchange for the state accepting greater responsibility for measuring and improving accuracy. In the long run, we think they will also support improved relationships between SSA and the DDSs, which will afford the DDSs more flexibility in managing their work while providing measurably better service to SSA.

Some DDSs will require additional resources to implement some of the requirements. In the main, the requirements described below would take advantage of, or modify, measurement systems already in place at the DDSs. Resources freed up from the federal review process could potentially be transferred to support the DDS effort.

Elements of the new requirements that could be developed and tested in the short run include:

A new model for monitoring quality, based on self-measurement and SSA audit. This could be patterned after the model utilized by the Food Stamp program to measure state performance in the administration of the program. Each DDS would be required to have a performance measurement function that measures quality, not necessarily limited to accuracy, on the basis of reviews of a random sample of individual cases.

Each quarter, based on a sampling plan approved by SSA, the DDS performance measurement unit would review a random sample of completed cases (equal numbers of allowances and denials) for decisional accuracy. The size of the sample would likely be somewhat larger than current DQB samples, but much smaller than the samples reviewed by many DDS QA units today. The sample sizes will need to be developed based on cost information and desired accuracy for various performance measures.

The self-measurement function would be expanded to go beyond case reviews. For instance, DDSs could be required to collect cost data that are critical for measure cost performance (see above). SSA audits we again be needed to ensure the integrity of the cost data.

These reviews are not intended to be the DDS's primary means for reducing errors (i.e., quality control). Some DDSs might choose to use end-of-line reviews for quality control purposes, but they should be encouraged to use more efficient quality improvement methods and reviews by unit supervisors and specialists for this purpose. The main purpose of the review is collection of performance data. These data would be used by the DDS to monitor its own performance, and by SSA. Hence, measurement should be based on the "first-touch" review, rather than after the application has been revised in response to the first-touch review.

The reviews also serve as a primary point of data collection for the DDS. As the cases are reviewed, the quality reviewers also gather information that can be analyzed and utilized internally for process improvement, training and documentation improvement.

SSA audits of DDS data collection. If SSA is to base performance measurement on DDS data, it will need to thoroughly audit DDS data collection mechanisms on a routine basis. While this will require substantial effort, it will replace the current DQB review system and use far fewer resources than that system. The audit of case reviews might have the following features, which follow the Food Stamp model:

- On a quarterly basis, SSA performs a validation audit by randomly selecting a small sample of the DDS reviewed cases from the previous quarter. For test purposes, these audits could be done by the DQB for states involved in the test.
- The validation audit focuses on whether or not the SSA reviewers agree or disagree with the DDS internal review.
- The DDS reviewers should have the opportunity to discuss errors that affect performance measures with SSA reviewers and SSA should consider establishment of an arbitration process for unresolved disagreements.

- Ultimately, findings from the SSA review would be used to adjust the state’s estimate of percent “clearly not supported.” In the Food Stamp program, it was reported that the validation audit generally adjusted error rates about one to two percent.
- Eligibility issues that are the result of FO error are not counted against DDS performance.
- The level of effort for the validation review process is dependent on the clarity and completeness of rationales because they allow the reviewers to understand the examiners thought process and methodology to make a decision. The quality of rationales would themselves be a subject of the review.

SSA/DDS Disability Expert Teams. As discussed in **Option Area D**, joint SSA/DDS Disability Expert Teams (DET) that would work together to address difficult cases could be an important element in an advanced quality management system for disability determinations. In the short term, SSA could test the use of such teams in the context of a demonstration that tests other aspects of review methodology. The DET’s function would be to address issues in difficult cases. The SSA expert on the DET would also provide support to the DDS’s overall quality management effort, and serve a liaison to the DDS for SSA’s Quality Council.

We note that SSA is already using expert teams in its review process, to review initial claims processed under the Prototype in the Prototype test states. This seems a good opportunity for SSA to learn about types of cases that need expertise, and about the types of expertise needed. As the Prototype rollout continues, SSA might find it attractive to develop a triage method for the review process, and continue to send difficult cases to an expert panel.

As indicated in the previous section, it is important for the DETs to have access to a high level of medical, vocational and legal expertise, and that such expertise come from a pool that is common to all review processes.

Revisions to the case review methodology. Currently, case reviews focus on accuracy (i.e., the adequacy of support for the decision), reflecting OQA’s responsibility for accuracy. The case review could be broadened to reflect the expanded definition of quality that would need to be adopted under an advanced quality management system. This might be related to: due process (e.g., concerning claimant conferences); factors that might affect appeal or decision on appeal (e.g., rationale adequacy and the claimant letter); factors that might affect the evaluation of medical improvement in a CDR; productivity issues (e.g., appropriate use of MER and CEs); and customer service issues (e.g., timely ordering of MER and CEs).

In **Section D** we discuss a three-category classification system for accuracy in PER: clearly supported, clearly not supported, and difficult. SSA might find it useful to use such a system for validation audits, and/or the existing QA review process. As DDS performance measures, and potentially incentives (see **Option Area F**), might eventually be determined by the outcome of these reviews, some consideration needs to be given to how “difficult” cases would be counted for performance measurement purposes. If only clearly unsupported cases are counted against the DDS, as might seem fair, then the DDS reviewers will have an incentive to classify such cases as difficult. This system would not work well unless SSA is confident that such misclassifications can be detected through the audit process.

A three-category system would help address an issue that was raised in a number of our interviews. Several interviewees expressed the view that the DQB reviewer, like the DE, should be required to act as a single-decision maker, like the DE. Objections were raised to reviewer use of MCs and other experts as inequitable. We do not agree with this argument, because we think that it is very important for SSA to learn about difficulties that DEs have in implementing SSA policy. At the same time, however, holding DEs and their DDSs accountable for errors in difficult cases, which might require more expertise than is available to the DEs, is counterproductive and violates the principles of an advanced quality management system.

Claimant interviews during case reviews. Up to this point, we have assumed the DDS QA reviews would continue to be reviews of the application folder only, and would require no additional data collection. Following the Food Stamp model, however, the DDS review unit could interview claimants by telephone, or perhaps in-person at their home. This is a more costly approach to audit, but potentially rewarding because it might uncover important information that was not known to the disability examiner. Hence, it goes beyond a review of the folder to a more critical review of the accuracy and adequacy of the information that is in the folder.

Claimants could also be asked questions about their treatment through communications with the DDS (courteous, clear, informative, timely, etc.), and their understanding of their right to a claimant conference. This approach could also be used to obtain information for measuring Field Office performance and for measuring the performance of SSA in meeting its objective of improving economic security for the target population. SSA could also consider interviewing physicians who provided source evidence.

In the short run, SSA might want to develop this approach further and test it via a demonstration.³³

Test case analysis. In the long run, we think that SSA will find it valuable to use test cases to measure national consistency and identify issues that lead to inconsistency. In the short run, SSA could develop the mechanism for such tests and apply it to a small number of DDSs. SSA has performed such tests before, although to our knowledge there have been no tests in the last two decades.³⁴ The test set of cases should be representative of the cases routinely reviewed, so that test statistics will be valid over all claims. Additional difficult cases could be added to the test, for purposes of gaining additional insights into problem areas experienced by DDSs and the SSA review units. The sample set review process could generate a performance metric that could be used to monitor validation review accuracy.

Cost and productivity data. SSA currently uses productivity per work year (PPWY) as its main performance measure for DDSs. Review of this system was beyond the scope of this project. Under an advanced quality management system, however, costs and productivity would be considered important components of quality. Hence, measurement of cost and productivity becomes relevant.

³³ See the VBA customer satisfaction survey for examples of questions that might be asked (*Lewin and Pugh Ettinger McCarthy, 2000b*).

³⁴ See Gallichio and Bye (1980).

We are aware that there are significant issues with the measurement of DDS productivity and costs, mostly from work that Lewin has performed for SSA in support of evaluation of disability process changes. Existing data provide information about DDS labor resources and its allocation to various workloads, but conversion to costs by type of case is problematic. SSA's current productivity per work year (PPWY) measure is flawed because it does not reflect variation in compensation by worker type, or across DDSs. Another problem is that data on the use and cost of medical evidence of record (MER) and consultative examinations (CEs) is not uniformly available by caseload. A final problem is that the effect of claimant characteristics on costs is unknown.

In the short term, SSA and the DDSs could develop and test new methods for collecting productivity and cost data that would address shortcomings of the current system. This would begin with a review of SSA and DDS management needs for cost and productivity information, under an advanced quality management regime, an assessment of the strengths and limitations of current data, and the development of revisions to data collection and analysis methods that would address the limitations. These could then be tested in selected DDSs.

Audit mechanisms will also need to be developed and tested if the revised cost and productivity data collection methodology is to be used in SSA performance measurement systems.

DDS employee survey. Both DDS and SSA management would likely find it useful to have systematically collected information on the views of DDS employees about how the process is working, job satisfaction, and potential improvements. This could be done through periodic employee surveys. In the short run, a survey instrument could be developed, and tested in several DDSs.

Estimated Cost:

- The initial design phase could consume large amounts of leadership/management time if it seeks broad input from all parties.
- An alternative is to offer DDSs an opportunity to participate in a design and demonstration project. Then, a smaller SSA team might work with a smaller number of DDS representatives to design and demonstrate a system in a few states. SSA might find it necessary to bring in outside resources for design and evaluation purposes, especially under the broader process described above. The design and demonstration process would occupy a significant amount of management time over a period as long as two years – perhaps five SSA FTEs and potentially as many DDS FTEs.
- Demonstration costs would be defrayed by replacing the current DDS and DQB QA processes in demonstration states with the new process.
- We consider the long-term costs and savings from implementation under long-term options later in this section.

Develop and implement a DDS scorecard and benchmarks.

Under this option, SSA and the DDSs would develop and implement a DDS scorecard, capturing a broad range of performance indicators. Ideally, the scorecard would be aligned with the broader definition of quality for disability determinations that would be developed under **Option Area A**. That definition, however, is likely to capture dimensions of quality that are not measured in current DDS systems. Hence, this would be the beginning of a long-term effort in which the scorecard would be revised and expanded, incorporating measures that cannot be derived from current data collection systems.

The DDS scorecard could use the five-component scorecard developed by the VBA as a model. Below we list measures, by category, for consideration in the short term. We believe that all of the measures indicated can be derived from existing data systems. In some instances we comment on how the measures could be constructed. We also note deficiencies, which could be addressed in the long run.

1) Accuracy

- *Allowance accuracy and denial accuracy.* These could be the measures currently used, but a preferred alternative would be to adjust these measures for claimant characteristics. SSA already has profiling systems that are used to predict error probabilities for certain types of claims, based on claimant characteristics. A similar model could be developed for this purpose. Our impression is that adjustment for claimant characteristics could change these measures substantially. Presumably SSA would continue to use unadjusted measures to meet current statutory requirements, in the short run. Hence, both adjusted and unadjusted measures should be reported.
- *Percent of PER returned for re-determination.* This could also be adjusted for claimant characteristics.
- *Allowance rate.* A substantial share of allowance rate variation is likely due to case characteristics. Hence, the allowance rate is not very indicative of performance unless it is adjusted for case characteristics.
- *Percent of denials appealed.* Reducing appeals is an important objective of process unification. We do not recommend adjusting this measure for claimant characteristics, as the characteristics of denied claimants reflect decisions made by the DDS.
- *Percent of all allowances made at initial determination.* This is defined as initial allowances divided by total allowances, and is intended to measure a key objective of process unification – making the right decision the first time. This could be based on applicant cohorts. The measure is problematic, however, because all final decisions might take years to complete. One way to address this would be to develop hazard models for final allowances. These could be used to predict this measure once all final decisions are made, given final decisions through the current date. The scorecard could present current predictions for each of the last three or four annual applicant cohorts. At the beginning of every year, the oldest cohort would be dropped; by then, predicted and actual rates for that cohort should be essentially identical. The previous years cohort would then be added.

One issue with this measure is that it partly reflects the performance of the appellate process, as applied to the state's claimants. Hence, it should not be considered to be an indicator of the DDSs performance alone. Rather, it should be considered in conjunction with other DDS measures (e.g., the allowance rate, denial accuracy, and the appeal rate) and performance measures for relevant OHA offices.

A major issue for accuracy measures is whether or not they should be adjusted for claimant characteristics. We think this is very important, because they will otherwise be misleading when compared to benchmarks. While it would be easiest to implement the scorecard in the short run without adjustments, this information is likely to mislead some DDSs about their performance and result in some resistance to use of adjusted measures in the future. Hence, we would recommend developing and adopting adjusted measures at the beginning. As indicated above, this could be an extension of OQA's current profiling effort.

2) Due Process and Customer Service

- *Percent of initial determinations completed in ___ days.* An alternative is to show percent completed in 30-day increments (e.g., 30 to 120). This measure could be adjusted for claimant characteristics.
- *Percent of CDRs completed within ___ days.* This measure could be adjusted for claimant characteristics.
- *Percent of denied applicants who were offered a claimant conference.*
- *Percent of denied applicants who participate in a claimant conference.*

In the long run, this category could be expanded to capture information from claimant surveys.

3) Disability Program Strategic Objectives

This would include DDS measures directly related to strategic objectives and special projects of the disability program (see **Option Area A**). In the short run, all such measures might already appear in one of the other four categories. Consideration should be given to measures related to the status of Prototype implementation.

4) Productivity and Cost

- *Productivity per work year.* As discussed above, we think that PPWY is substantially flawed as a measure of DDS productivity. It is, however, the best measure available for the short term. PPWY could be adjusted for case mix by type (initial, CDR) and Title (DI-only, SSI-only or concurrent), using national estimates of time per case from the State Agency Work Sample (SAWS).
- *Cost per claim.* We recommend reporting cost per claim, as well as PPWY, to capture differences in compensation levels and staff mixes. This measure could be adjusted to reflect variation in local labor markets. As the largest component of cost, by far, is worker compensation, SSA could use HCFA's Hospital Wage Index for the DDS's MSA to

standardize adjust the cost estimate. The SAWS estimates could be used to adjust for type and Title.

5) Employee Satisfaction

- *Disability examiner retention rate.*

We think that employee retention is the best indicator of satisfaction that can be readily obtained from DDS administrative data in every state. We suggest focusing on examiners, including those who might be assigned to quality assurance or other special units, because they are the core employees, and their training represents a significant investment.

In the long run, SSA should consider adding measures that reflect information captured in routine employee surveys.

Benchmarks for each measure should also be developed. We recommend consideration of performance in other organizations with similar processes. Because most measures currently vary considerably across DDSs, some benchmarks could also be based on “best performance” among the DDSs. We know, for instance, that some DDSs achieve accuracy rates of 98 percent or higher for both allowances and denials. While this might change after adjustment, it seems clear that some DDSs can achieve very high accuracy, so it is not unreasonable to set very high rates as the benchmarks. Another alternative is to set the allowance rate benchmark at a level that would eliminate savings from PER (see *Option Area C*). As this alone might result in reduced denial accuracy, it would be important to set an equally high standard for denial accuracy.

Scorecards for each DDS would be prominently posted at the DDS, and would also be distributed to Regional and Central Office managers who have oversight responsibility for DDS performance. SSA could also create a website with DDS performance data, accessible to all SSA and DDS employees. Monthly updates would be appropriate, although producing an entirely new set of statistics could be prohibitively expensive. Some could be updated quarterly, and perhaps others only semi-annually, or even annually. Semi-annual or annual reports that review trends in the benchmark measures could also be useful to managers; trends could be routinely displayed on the website.

SSA could use such scorecard measures in many ways to assess the overall performance of the DDS. Point scores for each category could be developed from the sub-measures to produce category measures. These two could be weighted and summed to obtain a total point score, which could be used to compare DDS performance against national standards for overall point scores and category point scores. Careful consideration must be given to the weights applied, as they affect incentives that the DDSs have to perform on individual measures.

As indicated earlier in the report, we think that decisions might be very sensitive to the cost of allowance errors relative to denial errors. Hence, weights applied to the accuracy measures need to be chosen carefully. Further, the accuracy measure weights need to consider other incentives that already affect initial decisions. For instance, if SSA believes that PER creates an undesirably large incentive to deny, this could be counteracted in the scorecard by applying relatively large weights to denial errors, appeal rates, and the percent of allowances made at the initial level.

In the long run, the scorecard would become the basis for management discussions with the DDS and senior state administration officials. As contemplated in *Option Area G: Federal-State Relationships*, it could be utilized in contract negotiations with the states and for the awarding of performance bonuses and sanctions.

Estimated Cost:

- One FTE dedicated to development. Various leaders and data experts would need to be consulted during the process of scorecard development.
- Resources for deployment of the scorecards would come from offices that are currently charged with producing and distributing various performance measures in a fragmented way. Potentially, those efforts could be cut back and replaced by the scorecard effort, perhaps with some savings.
- No costs for additional performance measures.

Develop and test DDS quality management models.

In the long run, SSA might adopt a set of requirements for DDS quality management systems, as part of its advanced quality management system, as well as provide technical support for those systems. In the short run, SSA could work with select DDSs to experiment with DDS advanced quality management systems and provide input into the development of the long-term requirements. At least some DDSs have already undertaken substantial efforts to develop such systems. This effort could be integrated with the measurement and scorecard efforts described above.

DDSs participating in this effort might be asked to draft quality plans that address: the method by which the DDS will conduct its internal accuracy audits, the methods by which it will organize production to produce accurate determinations, process improvement initiatives identified by management, service improvement plans and initiatives, production improvement plans, internal measurement systems utilized to track progress and plans to deploy DDS strategic initiatives. SSA could provide expert support in the development of these plans. Quality management leadership at SSA would review the plans for consistency with disability determination objectives and the system-wide effort to develop an advanced quality management system, and negotiate changes with the DDSs as needed.

SSA and the participating DDSs would work together to evaluate the plans, and their implementation. The purposes of the evaluation would be to provide information to other DDSs that would help them implement advanced quality management systems; and to help SSA develop requirements for the long term.

It is important for SSA to look to the DDSs that have historically been most successful, in all dimensions of performance, as well as those who have had recent success in improving performance, for models that can be demonstrated and used as the basis for development of DDS quality management recommendations and requirements. The states are much more likely to

accept recommendations and requirements that reflect the best practices of their peers than others.

Estimated Cost:

- Resources needed for this effort will depend on how many DDSs get involved in the process, the nature of the models developed, and the nature of the test and its evaluation.
 - At the low cost extreme, a DDS that has already implemented what it considers to be an advanced system could review its system in consultation with SSA, make modifications as appropriate, and then produce a document that describes the system, its costs, and its strengths and limitations. Additional resources would be essentially those needed to conduct the evaluation – perhaps an FTE or so.
 - At the high cost extreme, SSA might work with a DDS that has historically poor quality to develop a new system. This could be a multi-million dollar effort, possibly requiring both outside assistance and the hiring of new personnel.

b. Long-term Options

The three options we have developed for the long run build on those developed for the short run:

- Implementation of the new DDS quality measurement system;
- Revision and expansion of the DDS scorecard to take advantage of new data collection efforts; and
- Implementation of DDS quality management requirements.

Implementation of the new quality measurement system.

The short-term effort will result in the development of revisions to the way various aspects of DDS performance are measured. The most significant of these is likely to be the use of DDS reviews in the SSA performance measurement process, and the associated SSA audit function. Expansion in the scope of reviews, interviews of claimants, test reviews to measure national consistency, revisions to the measurement of cost and productivity, and routine surveys of DDS employees, and SSA audit of other measurement processes are other possible revisions to the measurement of DDS performance.

In the long term, the measurement systems developed in the short term would be rolled out to all DDSs, to support the advanced quality measurement system. This will be a difficult task, as DDSs will vary in their readiness for implementing this system. SSA will need to provide the DDSs with technical assistance and resources for implementation.

SSA would also implement the audit process and the consistency test reviews, on a national level. While SSA could continue to have regional DQBs be responsible for reviews in their own region, a better alternative might be to have regional DQBs specialize by type of claim – following the approach for specialization in PER (see *Option Area C*). Alternatively,

centralization of the review process could be considered. Federal audit capacity for other aspects of DDS data collection would also need to be developed and deployed.

Estimated Cost:

- We expect federal spending for the quality measurement system would increase by over \$3 million per year, based on analysis that appears in *Appendix G*. The main reason for additional expense is SSA participation in the DETs. We expect that the average DDS will be able to re-deploy resources from its current QA system, but some might need additional support. Because of the elimination of redundant end-of-line reviews by the DDSs and DQB, total costs for reviews might fall, but it seems likely that most savings will accrue to the DDSs.
- Reduced appeals will likely more than pay for additional federal spending. Reduced appeals associated with an initial allowance rate increase of only 0.2 percentage points might be sufficient for SSA to break even on administrative costs.

Revision and expansion of the DDS scorecard to take advantage of new data collection efforts.

In the long term, the DDS scorecard would be revised to add measures not available in the short run. Potential modifications in each of the five suggested scorecard components are described below.

1) Accuracy

The main change in this area is likely to be that the denial and allowance accuracy estimates would be based on the DDS reviews, adjusted for findings from the SSA audit. If the measures on the short-term scorecard are not adjusted for claimant characteristics, such adjustments could be added in the longer term.

2) Due Process and Customer Service

This category could add measures based on claimant interviews. Possibilities are:

- Percent of applicants who rate their communications with the DDS as clear and reasonable;
- Percent of applicants who rate the final determination notice as clear and understandable;
- Percent of applicants who rate their interactions with DDS personnel as courteous; and
- Percent of source providers who rate their communications with the DDS as clear and reasonable.

3) Disability Program Strategic Objectives

These would reflect objectives in quality management objectives in SSA's strategic plan for the disability programs.

4) Productivity and Cost

Productivity and cost measures would be based on improved productivity and cost measurement systems.

5) Employee Satisfaction

Turnover statistics would likely be retained. In addition, findings from the DDS employee services would be reported. This might include:

- Percent of employees who think they are very well trained;
- Percent of employees who understand the mission of the program; and
- Percent of employees who rate the DDS as a very good or excellent place to work

SSA could use such measures in many ways to assess the overall performance of the DDS. Point scores for each category could be developed from the sub-measures to produce category measures. These two could be weighted and summed to obtain a total point score, which could be used to compare DDS performance against national standards for overall point scores and category point scores. The scorecard would become the basis for management discussions with the DDS and senior state administration officials. As contemplated in ***Option Area G: Federal-State Relationships***, elements of the scorecard could be utilized in contract negotiations with the states and for the awarding of performance bonuses and sanctions. As some performance measures could reflect the performance of the Field Offices that feed cases to the DDS or of the Hearing Offices that adjudicate appeals, those influences need to be taken into account when the measures are used for management purposes.

Estimated Cost:

- 35 DDS FTEs and 20 federal FTEs might be needed to conduct the surveys. This is the only significant incremental cost to the scorecard. Claimant surveys might be conducted on a continuous basis, as part of the review process described above, with DDS's reporting findings on the basis of the last quarter's responses.
- Costs could be partly offset by reduction in other claimant and employee survey efforts. SSA already devotes resources to claimant and employee surveys, but not on a routine basis.
- The value of the survey, and the overall scorecard, cannot be readily determined, but it is a critical component of quality management and should contribute to millions of dollars in annual administrative savings.

Implementation of DDS quality management requirements.

SSA would propose and adopt regulatory changes needed to implement quality management requirements for DDSs. SSA would provide DDSs with assistance in implementing those requirements, based on knowledge gained from the short-run effort to develop such systems in the select DDSs.

Each DDS would be required to develop a quality management plan that would meet the new requirements. The DDS quality plan should address the method by which the DDS will: measure performance; organize production to produce accurate determinations; pursue process improvement initiatives identified by management; hire, train, and retain qualified staff; seek to improve service delivery; seek to improve productivity; measure progress in its improvement efforts; and deploy DDS strategic initiatives. SSA would review these plans to ensure compliance with federal requirements, feasibility, alignment with SSA's quality management system and objectives, and implications for SSA's operations.

Estimated Cost:

- Resource needs for this effort will vary significantly by DDS, depending on the current state of quality management. Our expectation is that most DDSs would be able to implement their new systems with existing resources, but others will need at least transitional assistance from SSA.
- Any new expenses for these systems would eventually more than pay off over the long term through higher accuracy, reduced appeals, and more efficient operations.

**Exhibit VIII.5
Option Area E Evaluation**

| Evaluation Criteria | Option Area E: DDS Performance Monitoring System |
|--|--|
| 1. To what degree are the primary aims of the quality management system supported by this option? | |
| <ul style="list-style-type: none"> Develop and pursue a clear operational definition of quality | High Supports other options. |
| <ul style="list-style-type: none"> Develop and support organizational and process performance measures | High Linked to options B, D. Primary objective of this option. Supports other options. |
| <ul style="list-style-type: none"> Support a quality focused culture | High Performance monitoring system and DDS quality management system designed to support quality culture at DDS. |
| <ul style="list-style-type: none"> Provide information that can be used to improve disability determinations | High Primary objective of this option. |
| <ul style="list-style-type: none"> Provide employees with the resources to produce quality outcomes and service | High Process improvements should lead to efficiency and reallocation of DDS resources. |
| <ul style="list-style-type: none"> Ensure that the disability programs are national programs | High Variation in DDS performance leads to root cause analysis. |
| <ul style="list-style-type: none"> Support statutory and regulatory requirements | High Primary objective of this option. |
| 2. By what measure(s) or method(s) of assessment will you know that the option is successfully deployed? | |
| <ul style="list-style-type: none"> Develop and pursue a clear operational definition of quality | Performance monitoring metrics include dimensions of quality beyond accuracy? (Yes/No) |
| <ul style="list-style-type: none"> Develop and support organizational and process performance measures | Balanced scorecard used to gauge DDS performance? (Yes/No) Metrics show improvement over time. |
| <ul style="list-style-type: none"> Support a quality focused culture | DDS satisfaction with performance monitoring system as measured by survey. Quality and Service improvement plans in place at all DDSs? (Yes/No) |
| <ul style="list-style-type: none"> Provide information that can be used to improve disability determination | Process improvements underway in DDS (Yes/No) Disability program performance metrics improve over time. DDS performance metrics improve over time. |
| <ul style="list-style-type: none"> Provide employees with the resources to produce quality outcomes and service | DDS performance metrics improve over time. |
| <ul style="list-style-type: none"> Ensure that the disability programs are national programs | DDS accuracy rates improve over time. |
| <ul style="list-style-type: none"> Support statutory and regulatory requirements | DDS performance metrics improve over time. |
| 3. To what degree will the option be supported within SSA? | |
| <ul style="list-style-type: none"> Senior Executives | High |
| <ul style="list-style-type: none"> Central Office Leadership | High |
| <ul style="list-style-type: none"> Office of Disability | High |
| <ul style="list-style-type: none"> Regional Office Leadership | High |
| <ul style="list-style-type: none"> DDS Directors | Variable, depending on current quality management effort and views on need for improvement |
| <ul style="list-style-type: none"> Union Leadership | High |
| <ul style="list-style-type: none"> OHA Leadership | High |
| <ul style="list-style-type: none"> Administrative Law Judges | Unknown |

**Exhibit VIII.5 (continued)
Option Area E Evaluation**

| Evaluation Criteria | Option Area E: DDS Performance Monitoring System |
|--|--|
| 4. What human resources/staffing will be required by this Option? | |
| • Requires additional human resources within SSA | Might be needed to support DETs |
| • Requires the reallocation of human resources within SSA | Requires reallocation to support new monitoring process. |
| • Will result in a reduction of human resources within SSA | Likely in long term, as performance improves |
| • Requires additional human resources at the DDSs | Possible increase during implementation phase, but decreases over time as end-of-line inspection is reduced. |
| • Requires a reallocation of human resources within the DDSs | Yes |
| • Will result in a reduction of human resources at the DDSs | Possible increase during implementation phase, but decreases over time as end-of-line inspection is reduced. |
| 5. To what degree will the option/method impact operating and program costs for the disability program? | |
| • SSA operating cost | High reductions long-term in excess of short-term investment. Should reduce cost of appeals. |
| • DDS operating cost | High reductions long-term in excess of short-term investment. Will improve performance. |
| • SSA Program costs | Unknown |
| 6. To what degree is an investment in training and education required to implement the option/method? | |
| • Field Offices | Low |
| • Disability Determination Services | High: Orientation to new process Process improvement tools and methods. |
| • Office of Hearings and Appeals | Low |
| • Office of Quality Assurance | High: Share responsibility for new process with OD initially |
| • Office of Disability | High Orientation to new validation process. Use of performance measures in managing DDS relationship. |
| • Regional Offices | High Orientation to new validation process. Use of performance measures in managing DDS. |
| • Central Offices | High Orientation to new validation process. Use of performance measures in managing DDS relationship. |
| 7. To what degree is an investment in new equipment, facilities and or information systems required? | |
| • Field Offices | None |
| • Disability Determination Services | Moderate: May need information system changes to move claim information and design case selection profile. |
| • Office of Hearings and Appeals | None |
| • Office of Quality Assurance | None New Process out of OQA |
| • Office of Disability | Moderate: May need information system changes to move claim information and design case selection profile. |
| • Regional Offices | Moderate: May need information system changes to move claim information and design case selection profile. |
| • Central Offices | Moderate: May need information system changes to move claim information and design case selection profile. |
| 8. What regulatory or statutory change is required to implement the option/method? | |
| | Modification in the regulation on how DDS performance is scored. |

6. Option Area F: Federal-State Relationships

a. Short-term Options

The Federal-State relationship is critically important to the overall efforts to improve the performance of the determination process. Unless a new level of cooperation is established between SSA and the states, many of the other options will not achieve their intended aims. In the Food Stamp Program Texas Regional Office, the relationship between the Agency and the states was described as a partnership. However, this partnership did not diminish the federal responsibility for program compliance and oversight. By establishing relationships at the highest level of state government, the regional office is able to gain support for resource allocations within the states and establish a sense of urgency and importance for the Food Stamp Program. The regional office attributes their success in achieving high performance across the region to their ability to work directly with state leadership to achieve common goals.

SSA recognizes the need for such relationships and already has relationships between its Regional Commissioners and state agency leadership. It appears to us, however, that the current focus of relationships is between the disability program regional leaders and the state DDS directors, and that the functionality of the relationships between regional program leaders and state agency leaders is of variable quality. Clearly, this relationship is important and should continue to be fostered. We think, however, that SSA should invest more time and effort to develop relationships at the highest levels of state government so that state decision makers are aware of and understand the goals of the disability programs, the disability determination process, and the expectations of SSA for DDS performance. By establishing these relationships, SSA and state governments can develop a shared commitment to the mission, strategy and improvement in performance of the program.

In this partnership, SSA needs to adopt a “servant leader” philosophy, similar to that found in the VBA, HCFA, and Food Stamps. This means that SSA must recognize that state agencies have an important advantage over the federal agencies in their ability to provide services to the target population of the disability programs and to interact with local providers and others. Under this philosophy, SSA’s role is to both support their efforts and to hold them accountable for their performance. We present three short-term options for SSA consideration, aimed at improving the Federal State relationship:

- Take initial steps to redefine the federal-state relationship as a partnership, based on frequent and clear communication between the highest levels of state administrations and SSA.
- Establish a federal-state leadership group to develop terms of the federal-state relationship that will support objectives of advanced quality management system.
- Introduce financial incentives to both improve DDS performance and reduce administrative costs.

Take initial steps to redefine the federal-state relationship as a partnership, based on frequent and clear communication between the highest levels of state administrations and SSA.

The relationship described is a long-term objective. In the short-term, SSA could take steps that would lead in this direction. SSA might, for instance:

- Plan a process for developing the new relationship. This effort could be led by a DDS/SSA team from the Quality Council (see *Option Area A*). This could include:
 - Defining in concrete terms what the new relationship would be;
 - Visiting other federal agencies (Food Stamp Texas Region, for example) to learn how they handle federal-state relationships;
 - Consideration of how other options either help define the new relationship or need to be supported by the relationship;
 - Conducting a formal survey of DDS administrators and senior state officials to determine their perspectives on the existing and desired relationship;
 - Review of existing federal-state relationships and identification of opportunities for improvement; and
 - Development of protocols and communications for SSA/state agency interactions.
- Pick a few states where DDS performance has been poor, and/or Agency/State relations have been difficult in the recent past, and take steps aimed at building a better long-term relationship. This might include preliminary discussion around the establishment of a formal agreement between the state agency and SSA that would support quality improvements (see below).
- Consider assigning the task of developing a plan, based on the discussion above, to improve federal-state relationships to the new Quality Council (see *Option Area A*) or to special task force that would report back recommendations to the senior leadership.

Estimated Cost:

- Significant discussion time by senior leadership.
- Support of task force/OQM, travel, meetings, site visits to other agencies: \$20,000-\$40,000.

Establish a federal-state leadership group to develop terms and conditions of SSA/DDS agreements that will support objectives of advanced quality management system.

Under this short-term option, SSA would establish a federal-state leadership group (or SSA may want to assign task to Quality Council (see *Option Area A*) for oversight). The group would develop the terms and conditions for agreements between SSA and the DDSs that support the objectives of an advanced quality management system. This group could be led by SSA and DDS members of the Quality Council, but would likely need representation from more states and possibly other SSA components.

The agreements would essentially serve as contracts between SSA and the DDSs. The terms and conditions to be developed by this group would spell out SSA's expectations for DDSs (e.g., via attaining performance measurement objectives), DDS expectations for SSA support, performance measurement, incentives and sanctions that would be used to promote improved performance, remedial measures to address long-term performance problems, a process for periodic renewal of the terms and conditions of the agreement, and a process for negotiating unanticipated modifications. These agreements would incorporate quality management requirements, DDS performance measurement systems, and perhaps other items developed under other short-term options.

Estimated Cost:

- Senior leadership time to discuss and review
- Development cost for meetings, DDS participation, travel, administrative support, legal, communications, deployment:\$100,000-\$125,000. No ongoing incremental expense.

Introduce financial incentives to improve DDS performance and reduce administrative costs.

Financial incentives and sanctions could become an important component of SSA/DDS agreements in the long run. One significant difference between the Food Stamp Program and SSA is that the states fund 50 percent of the administrative costs of the Food Stamp program. This creates some incentive for the states to manage well, since they are at risk for 50 percent of cost overruns, even without additional performance incentives and sanctions. HCFA also uses incentives in contracting with PROs. HCFA publishes standard costs in its contracting process on which the PROs base their contract proposals. The PRO is at risk for operating at the standard HCFA payment amounts. This is a significant issue because over 90 percent of all PRO funding comes from the HCFA contracts. The DDSs and states could be put at similar financial risk for operating within the block grant budget and standard cost formulas.

In the long run, SSA and the DDSs might develop a standardized framework for such incentives and sanctions. In the short run, SSA could consider offering DDSs incentives that would:

- Be based on performance measures in the short-term scorecard;
- Pay for themselves; and
- Impose no costs or downside risks on the DDSs.

Any of the performance measures could be considered as the basis for incentives, and incentives could be individualized depending on past state performance. Accuracy, cost, processing time, employee turnover, and progress in strategic initiatives (implementation of the Prototype and process unification) all seem reasonable areas for structured incentives.

One area of performance that is particularly poor in a number of states is denial accuracy. As discussed earlier, we think that PER of DI allowances creates a substantial incentive for DDSs to deny difficult claims, and probably helps explain the downward trend in initial denial accuracy

and upward trend in allowance accuracy after the introduction of PER. Hence, it seems natural to introduce an offsetting incentive. The incentive payment should probably be based on a combination of measured allowance and denial accuracy (e.g., require maintenance of allowance accuracy and partly base the incentive on the measured improvement in denial accuracy), the appeal rate, and the share of final allowances made at initial determination. The size of the incentive could be tied to SSA administrative savings from reduce appeals. We estimate that the average appeal cost to SSA was \$1,774 in Fiscal Year 1999 (*Appendix G*). SSA might, for instance, pay the DDS some share of this figure times the difference between the number of appeals filed on initial denials from the relevant period and the expected number of appeals, based on the recent appeal rate. The share paid could depend on the improvement in denial accuracy, and the maintenance or improvement of allowance accuracy.

Other states have high costs, for various reasons, including high employee turnover. SSA could pay states on the basis of expected costs, and allow them to keep a share of any savings achieved relative to expected costs, with the share of savings determined by maintenance or improvement in other performance areas.

While individual states would likely welcome opportunities to earn incentives based on improved performance, offering special incentives to individual states could easily raise issues of fairness. States that have traditionally performed well in all areas might be the least likely to benefit from the incentives, while poorly performing states might receive the largest awards. It might also be, however, that even the DDSs with the best historical performance can improve substantially in response to incentives. Also, these should be short-term incentives; future incentives would be tied to continued improvements, rather than past improvements.

Estimated Cost:

- Unknown. Dependent on the whether incentives can be budget neutral. SSA could set a budget target for incentives. However, any incentives paid should be offset by improved performance, creating a potential for overall cost savings to SSA.
- SSA should strive to create incentives that result in overall program and administrative cost savings based on a target level of DDS performance. This option has the potential of producing significant savings to the disability programs in the short-term.

b. Long-term Options

Once a process for establishing agreements between SSA and the DDSs is developed, including the framework for the agreements, SSA and the DDSs would negotiate individual agreements with many common features. The features might include:

Capitation payments. Even though SSA funds 100 percent of operating costs for the DDSs, some shared incentive might be created by moving to a capitation payments. That is, SSA would agree to pay a fixed amount per case processed during a year. If actual costs fall below expected, the states would have a surplus and be allowed to retain a specified share of the savings. If costs exceed the expected amount, SSA would pay for only a specified fraction of the overrun.

Capitation could help support improvement in accuracy or other aspects of quality. Improved efficiency will generate a surplus. Efficiency is dependent on more than the management of operating cost. It is also created by managing the determination process in a way that increases accuracy the first time, before any end-of-line inspection. Inefficient quality management systems that depend on end-of-line inspection for quality control are expensive. High numbers of cases returned by PER create extra cost for re-examination. Capitation would create an incentive to develop process-based improvements and integrate quality management methods. Both would reduce reliance on inspection to achieve output accuracy.

Other financial incentives for superior performance, tied to the (expanded) scorecard. This could include incentive payments like those described under the short-term options in this section. Under capitation, the share of the surplus retained by the state and the share of the overrun paid by the state could be tied to other performance measures.

The Food Stamp Program includes financial incentives to the states for superior performance and financial sanctions for non-performance. The Food Stamp Program makes unrestricted financial bonuses to states for high performance (payment accuracy) above a specified target. States that perform below a target threshold are subject to financial sanctions that reduce the Federal financial support for the program and shift administrative costs to the state. In Texas, state administrators realized the importance of performance and over a five-year period have moved from a financial sanction status to achieving performance incentives that will result in an unrestricted use bonus of approximately \$23 million for fiscal year 1999/2000.

Technical assistance to be provided by SSA. Consistent with the servant-leader philosophy, SSA would be expected to provide technical assistance to the DDS. An example is SSA's support for the SSA/DDS Determination Expert Team. The agreement could specify the nature of the assistance and also specify financial sanctions on SSA for failure to perform.

Conditions for modification and renewal of the agreement. Each agreement would be renewed periodically, and unanticipated modifications might be necessary. The process for agreements and modifications would be described. This could include sanctions for documented, long-term poor performance, despite assistance from SSA. Potentially it could spell out conditions under which SSA could exercise an option to contract with another state, or contract with a private entity.

We anticipate that capitated funding, performance incentives, sanctions, and efforts to create a partnership relationship with senior state administrations could be very successful in improving initial determination quality. There is, however, no guarantee. As indicated above, agreements could include options for SSA to consider alternative arrangements to provide determination services for the residents of the chronically under-performing state. After a specified probationary period for poor performance, DDS services for states that do not implement corrective action to achieve minimum threshold performance targets could be put out to competitive bid. Bidders could include DDSs in other states.

SSA already has the statutory authority assume responsibility for conducting disability determinations for a state. It has never exercised this authority, however, despite poor performance over long periods in some states. The apparent reason for this is the possible

political ramifications. We have been told that exercise of this authority was considered under the Reinvention of Government II initiative, in 1996, and rejected for such reasons. One rationale for the effort to develop partnerships with the state parent agencies is to create a stronger foundation for an apolitical relationship between SSA and the DDSs. State administrations would have a better understanding of disability program objectives, the role of the DDS in reaching those objectives, and the rationale and fairness of the agreements between SSA and the DDSs. In this context, including a non-renewal option in each agreement might be acceptable to the DDSs, and might become more than an idle threat.

HCFA has successfully implemented this approach in the private sector. At HCFA, high performing PROs are given the opportunity to bid on additional work and are granted automatic renewals of their contracts. Contracts of low performing PROs are not renewed. Originally, there were more than fifty-five PROs with some states having multiple organizations serving specific geographic areas. Today, there are approximately thirty-eight PROs that contract with HCFA that serve the entire country, with some PROs serving multiple state contracts.

If the option is exercised, potential bidders include private determination services and other state disability programs. Given the competitive nature of state administrations and the potential financial incentives for high performance, it is very likely that states would compete for expanding their high performing programs by taking on additional groups of claimants. SSA might also explore the feasibility of contracting with private organizations to conduct the determination process. The same benchmark cost formula and performance metrics that are used in the DDS contracting process could be used to monitor private organization performance.

Short of contract termination and finding a third party to perform determination services, SSA might consider a variety of methods such as 100 percent PER review, moving cases to other DDSs, moving cases to the Federal DDS, and putting SSA employees onsite at the DDS to assist in improvement efforts. However, all of these options would be costly. SSA might therefore conclude that moving responsibility from a state to a third party is in the best interest of both the claimants and the integrity of the program.

Estimated Cost:

- Unknown at this time, but SSA should have expectations for substantial cost reductions based on improved performance.

**Exhibit VIII.6
Option Area F Evaluation**

| Evaluation Criteria | Option Area F: Federal State Relationship |
|--|---|
| 1. To what degree are the primary aims of the quality management system supported? | |
| <ul style="list-style-type: none"> Develop and pursue a clear operational definition of quality | <p align="center">High</p> <p>Relationship with state critical in deployment of a new definition of quality across the</p> |
| <ul style="list-style-type: none"> Develop and support organizational and process performance measures | <p align="center">High</p> <p>DDS performance metrics are used in contracting process with states.</p> |
| <ul style="list-style-type: none"> Support a quality focused culture | <p align="center">High</p> <p>Quality management system required element of DDS agreements.</p> |
| <ul style="list-style-type: none"> Provide information that can be used to improve disability determinations | <p align="center">High</p> <p>Creates economic incentives to improve determination process.</p> |
| <ul style="list-style-type: none"> Provide employees with the resources to produce quality outcomes and service | <p align="center">High</p> <p>Benchmark costs used in contracting based on appropriate allocation of resources.</p> |
| <ul style="list-style-type: none"> Ensure that the disability programs are national programs | <p align="center">Moderate</p> <p>Supports other options.</p> |
| <ul style="list-style-type: none"> Support statutory and regulatory requirements | <p align="center">High</p> <p>Potentially improves ability of SSA to assure DDS performance.</p> |
| 2. By what measure(s) or method(s) of assessment will you know that the option is successfully deployed? | |
| <ul style="list-style-type: none"> Develop and pursue a clear operational definition of quality | <p>Do contracts with states include requirement that DDS implement quality management system? (Yes/No). Have relationships with senior state administrations been established and do they understand the goals of the disability program? (Yes/No).</p> |
| <ul style="list-style-type: none"> Develop and support organizational and process performance measures | <p>Are DDS performance metrics implemented (Yes/No). Improvement in DDS performance metrics over time.</p> |
| <ul style="list-style-type: none"> Support a quality focused culture | <p align="center">Survey of DDS employees. DDS performance metrics.</p> |
| <ul style="list-style-type: none"> Provide information that can be used to improve disability determination | <p align="center">DDS performance metrics improve over time.</p> |
| <ul style="list-style-type: none"> Provide employees with the resources to produce quality outcomes and service | <p align="center">Process improvements result in lower cost and higher DDS efficiency.</p> |
| <ul style="list-style-type: none"> Ensure that the disability programs are national programs | <p>Variation in DDS performance investigated for root cause. PER and validation audit results.</p> |
| <ul style="list-style-type: none"> Support statutory and regulatory requirements | <p align="center">DDS performance metrics improve over time.</p> |
| 3. To what degree will the option be supported within SSA? | |
| <ul style="list-style-type: none"> Senior Executives | <p align="center">High</p> |
| <ul style="list-style-type: none"> Central Office Leadership | <p align="center">High</p> |
| <ul style="list-style-type: none"> Office of Disability Leadership | <p align="center">High</p> |
| <ul style="list-style-type: none"> Regional Office Leadership | <p align="center">Variable</p> |
| <ul style="list-style-type: none"> DDS Directors | <p align="center">Variable, depending on how incentives are structured and how they think they can improve performance</p> |
| <ul style="list-style-type: none"> Union Leadership | <p align="center">Unknown</p> |
| <ul style="list-style-type: none"> OHA Leadership | <p align="center">High. Strong interest in improved DDS performance</p> |
| <ul style="list-style-type: none"> Administrative Law Judges | <p align="center">Unknown</p> |

**Exhibit VIII.6 (continued)
Option Area F Evaluation**

| Evaluation Criteria | Option Area F: Federal State Relationship |
|--|---|
| 4. What human resources/staffing will be required? | |
| Requires additional human resources within SSA | None |
| <ul style="list-style-type: none"> • Requires the reallocation of human resources within SSA | Minor |
| <ul style="list-style-type: none"> • Will result in a reduction of human resources within SSA | Possible over time |
| Requires additional human resources at the DDSs | No |
| <ul style="list-style-type: none"> • Requires a reallocation of resources within the DDSs | Yes Creates incentives for improved performance and efficiency |
| <ul style="list-style-type: none"> • Will result in a reduction of human resources at the DDSs | Possible as performance improves |
| 5. To what degree will the option/method impact operating and program costs for the disability program? | |
| <ul style="list-style-type: none"> • SSA operating cost | Moderate reduction by establishing benchmark cost system |
| <ul style="list-style-type: none"> • DDS operating cost | High reduction by establishing financial incentives for performance |
| <ul style="list-style-type: none"> • SSA Program costs | Unknown. Dependent on mission and goals |
| 6. To what degree is an investment in training and education required to implement the option/method? | |
| <ul style="list-style-type: none"> • Field Offices | Low |
| <ul style="list-style-type: none"> • Disability Determination Services | Low |
| <ul style="list-style-type: none"> • Office of Hearings and Appeals | Low |
| <ul style="list-style-type: none"> • Office of Quality Assurance | Low |
| <ul style="list-style-type: none"> • Office of Disability | Low |
| <ul style="list-style-type: none"> • Regional Offices | Low |
| <ul style="list-style-type: none"> • Central Offices | Low |
| 7. To what degree is an investment in new equipment, facilities and or information systems required? | |
| <ul style="list-style-type: none"> • Field Office | None |
| <ul style="list-style-type: none"> • Disability Determination Services | Moderate Performance monitoring system (see Option E) |
| <ul style="list-style-type: none"> • Office of Hearings and Appeals | None |
| <ul style="list-style-type: none"> • Office of Quality Assurance | Moderate Performance monitoring system (see Option E) |
| <ul style="list-style-type: none"> • Office of Disability | Moderate Performance monitoring system (see Option E) |
| <ul style="list-style-type: none"> • Regional Offices | Moderate Performance monitoring system (see Option E) |
| <ul style="list-style-type: none"> • Central Offices | Moderate Performance monitoring system (see Option E) |
| 8. What regulatory or statutory change is required to implement the option/method? | |
| | Unknown |

7. Option Area G: Initial Disability Determination Process

a. Short-term Options

SSA is in the process of completing a major overhaul of its initial determination process, through nationwide implementation of the Prototype. Implementation follows an extensive testing phase. While these tests have been important, they have also been costly to the Agency, and a significant burden on the disability determination process.

An organization that implements an advanced quality management system will seek to continuously improve its production processes. For SSA, this means continuation of efforts to improve the determination process, indefinitely. A key difference between such efforts and those that culminated in the Prototype is that they are incremental. Because they are more incremental, testing should be less burdensome. Over time, improvement in management's understanding of the tools of continuous quality improvement (*Option Area C*), and in performance measurement (*Option Area B*) will also reduce the burden of testing.

In this option area, we describe a number of incremental changes that might improve the initial prototype process and support the deployment of the quality management system. Each idea is potentially an incremental improvement to the Prototype. In the short term, selected ideas would be developed, tested and implemented.

Some of the possible changes are already in place at some FOs and DDSs and might be considered best operational practices. Beyond the suggestions enumerated in this option area, SSA should routinely look for best practices and share them throughout the disability process.

Several of these options are FO options. As part of SSA's Vision 2010 effort, SSA has established a new field office position, technical expert for quality.³⁵ Those experts could be charged with developing other FO options and enlisted to conduct small-scale tests of some of the options described here.

The short-term options are:

- Use teams to manage workload and production in FOs. The role of FO supervisor could become coach and technical expert.
- Restrict FO responsibility for intake to non-medical information, and task the DDS with the initial medical interview.
- Share DDS electronic provider lists with FOs.
- Establish in-line quality processes at FOs and active process improvement teams that work on improving processes at every FO.

³⁵ Deputy Commissioner's Broadcast, September 8, 2000 (via e-mail to SSA employees).

- Use sampling techniques to review the completeness and accuracy of FO claim submissions to the DDSs.
- Routinely rotate FO and DDS staff through each other's offices to provide on-site expertise on process and eligibility issues.
- Identify and test DDS ideas for improving the collection of MER and the use of CEs.
- Triage initial determinations to move clearly eligible cases into a fast-approval cycle and potentially difficult cases into more intensive reviews.
- Test team approaches aimed at improving the Prototype process.
- Develop and test innovations that reduce reliance on POMS.
- Test written rationales versus checklist rationales versus intermediate formats.

Use teams to manage workload and production in FOs. The role of FO supervisor could become coach and technical expert.

Our benchmark analysis of the VBA highlighted the successful use of teams in their disability determination process. The original objective was to increase productivity by allowing the teams to manage workloads and have employees find ways to work together to improve way cases were handled. In our review of the FOs, we saw significant variation in workflows, volumes of cases, and challenges faced by CRs and managers. SSA might consider further benchmarking the VBA team approach and then experimenting with the approach in several different types of FO environments. The new technical experts (OQM, see *Option Area A*) for quality could lead development and testing of team approaches in selected offices.

In a team approach, the role of the FO supervisor becomes one of coach, trainer and technical expert in support of the team. Other individuals in the FO who are not supervisors could also fulfill this role.

Estimated Cost:

- Support for a series of small projects, deployment of internal technical experts to assist, research on VBA process, evaluation, travel, and meetings: \$20,000-\$30,000.
- SSA should expect improvements in productivity and performance that will offset the cost of deployment across the FOs. No significant ongoing incremental cost to SSA.

Restrict FO responsibility for intake to non-medical information, and task the DDS with the initial medical interview.

The prototype process includes the opportunity for formal contact between the DDS disability examiner and the claimant toward the end of the adjudication process. A claimant conference is offered when the medical decision is not fully favorable. In some prototype states, DEs are routinely making upfront contact with the claimant in a substantial number of cases to verify

medical information on the Form 3368 and obtain additional medical information. This gives the claimant an opportunity to speak to somebody with medical expertise early in the process. The DE's interview essentially repeats the medical part of the CR's interview, although it presumably obtains better information. Giving the DEs responsibility for the medical interview would not only reduce substantial rework, but also give the examiner better medical information for use in the initial development of the claim.

SSA could experiment with changing the roles of the CR and DE in administering Form 3368. An extreme version would be to make the DDSs responsible for administering the form in its entirety. This has other implications, however. For instance, the form is used by CRs to collect information of relevance for determining onset date. Hence, it might be necessary to redesign the form, with a DDS part and an FO part, or to change responsibility for some aspects of the decision that are considered to be non-medical.

Estimated Cost:

- It is possible that no significant cost would be incurred in the DDS that have adopted the Prototype, since the DDSs are finding the practice advantages to their work processes to reduce the amount of rework.
- Support of further study of best practices and series of small experiments: \$20,000-\$30,000.
- However, if you assume that in response to a formal move of the responsibility, every DDS would add an average of two FTEs to current staffing to accommodate increased workloads and no reduction in FO staffing, incremental cost would be approximately \$2,500,000 per year.

Share DDS electronic provider lists with FOs.

DDSs maintain electronic provider lists to support their efforts to collect MER. Some DDSs have already taken steps to make these accessible to FOs. Doing so means that both offices are "reading from the same page," and makes it easier for the CR to accurately identify providers and document that information for the DDS. SSA could assess how this has been working in DDSs and FOs that have already implemented such arrangements, consider how the arrangement might be improved, and encourage DDSs to work with FOs in other states to establish such systems.

Estimated Cost: No significant incremental cost to SSA. Savings are generated from better provider information in application when it is delivered to the DDS.

Establish in-line quality processes at FOs and active process improvement teams that work on improving processes at every FO.

As described in other options, SSA might consider deploying process improvement efforts at all levels of the organization. An initial area of deployment might be the FO, since it is the first step in the determination process. The work of the FOs would be organized to collect performance data at significant points in the FO process. The information, along with an active solicitation of

ideas and problem areas from FO employees, could be used to identify opportunities for improvement within each FO. Process improvement teams would be organized to identify, assess, and communicate significant improvements to all FOs. Process improvement would become part of the daily work of both employees and FO management. Rapid-cycle improvement methodologies could be utilized to obtain quick results. There should be frequent interaction between the DDS and the FOs as they jointly work on the redesign and improvement of processes that they depend on for performance. The new technical experts for quality in the FOs could play a critical role in the development and testing of such processes.

Estimated Cost:

- Significant potential cost savings.
- Support for a series of small projects, training, support from QM technical experts, travel, communication and deployment of lessons learned: \$50,000-\$100,000. Use sampling techniques to review completeness and accuracy of FO claim submissions to DDSs.

The determination of eligibility and the handoff of complete and accurate information to the DDS is an important step in the determination process. SSA might consider having the DDSs routinely review a sample of claims from each FO they serve as they come in the door. We encountered such arrangements in the Georgia and Wisconsin DDSs. In Wisconsin, the cost of data collection is probably very low because it is done by the examiner, as part of the work on the case. In Georgia, the review is conducted by a CR stationed at the DDS. From this information, an FO error rate could be calculated and used as a measure of FO performance. Support for this effort could be provided by the Office of Quality Management (see *Option Area F*), which would conduct an annual (or more frequent if problems exist) validation audit of the self-reported error rate. Types of errors could be tracked and analyzed for potential process improvement opportunities or to identify training requirements. OQM could also assist FO management and employees in developing a service improvement plan based on the overall performance metrics and challenges faced by the FO. SSA could learn from the experience of Wisconsin and possibly other states, develop improvements, and encourage other DDSs to implement similar efforts in cooperation with the FOs and with support from OQM.

Estimated Cost:

- No significant incremental cost to SSA.
- Potential for significant savings from improved processes.
- Initial support for testing a series of small projects: \$20,000-\$40,000.

Routinely Rotate FO and DDS staff through each other's offices to provide on-site expertise on process and eligibility issues.

One method of supporting a closer customer-supplier relationship between the DDS and the FO is to have FO and DDS employees rotate through each other's offices. The CRs can provide the DDSs with technical expertise on non-medical issues that arise during the course of medical

determinations, and the DEs can help the CRs with medical issues that arise during the intake interview. DEs in the FO and CRs in the DDS might be able to expedite certain claims. Such rotations will foster teamwork between the two offices and a better understanding of what each other need. This is currently practiced informally and irregularly in some regions (as noted above, Georgia rotates CRs on-site at the DDS), but perhaps should be practiced more routinely.

Estimated Cost: No significant incremental cost to SSA.

Identify and test DDS ideas for improving the collection of MER and the use of CEs.

One goal of the prototype is to reduce examiner dependence on DDS medical consultants and give more weight to treating physician and primary source information. However, obtaining pertinent medical information from treating physicians is sometimes difficult and examiners may default to the DDS medical consultant. In the VBA Disability program, if treating physician information is inadequate to make a determination, a VBA physician examines the applicant. This process is similar to the DDS process of requesting a CE from a contracted physician. However, in the VBA process, the VBA physician must complete a detailed form that contains the information required for the VBA examiners to rate the disability and make a determination. The determination process does not proceed until the VBA physician completes the forms to the examiner's requirements.

SSA might consider developing disease/body system-specific information request formats that are directly related to the nature of the alleged impairment and that can be cross-referenced to policy and listings. Although some DDSs may be utilizing such an approach, to our knowledge no systematic process or physician training exists across the disability program. This effort could begin by looking for best practices among the DDSs and other disability determination services, followed by development and pilot testing of a model approach.

Improving the process for collecting key medical information from treating sources could result in improved decision accuracy and decrease the number of denials reversed on appeal. Increased uniformity in the collection of data across states would also support national consistency. Support for this effort could be provided by the new OQM (See *Option Area A*).

Estimated Cost:

- Support for initial investigation, task forces/teams, meetings, travel, outside consultation, physician participation, administrative support, and deployment: \$100,000-\$200,000.
- No significant incremental ongoing cost.
- Potential to produce significant savings and improvement performance.

Triage initial determinations to move clearly eligible cases into fast approval cycle and potentially difficult cases into more intensive reviews.

SSA could improve processing times by developing triage functions at the DDS level that identify cases which appear to be clear allowances and clear denials as they are submitted. This change in the prototype process might decrease processing time on a significant proportion of

quick decision cases and help to identify complex cases at the front end of the DDS process. Triage should improve work flows for the DDS and reduce aggregate processing time by moving clear cut cases to decisions in expedient manner and by focusing resources and expertise on difficult cases.³⁶

Estimated Cost: No significant incremental expense to SSA.

Test team approaches aimed at improving the Prototype process.

Based on our review, it appears that disability determinations are too complex for any single examiner to be fully competent to accurately and efficiently adjudicate all cases. While the Prototype process is based on the single decision maker (SDM) concept, it also acknowledges that SDMs cannot have the expertise to adjudicate all cases on their own, through its required use of medical consultants in certain cases and its provision for DE access to medical and vocational consultants. Under this option, DDSs would experiment with other ways to use teams that would preserve the basic features of the Prototype, but improve performance.

Two benchmark organizations we visited provide models for team adjudication. Like the Prototype, the VBA model requires individual examiners to make most decisions, but examiners work in teams that function quite differently. Teams of examiners work together to manage workload and difficult cases. Teams divide cases based on individual expertise and routinely consult each other on difficult issues. A technical expert/coach supports the teams. While individual examiners make decisions, the teams are collectively responsible for all determinations and changes in information. The team, rather than the individual, is the unit that forms the basis for performance measures and assessment.

UNUM/Provident uses a similar process, but a substantially larger share of cases is actually adjudicated by an expert team. Teams are organized by area of specialization and cases are triaged. Individual examiners develop the cases and then present all difficult and gray-area cases for expert team review. The expert team meets on a daily basis, and approximately 40 percent of cases are submitted for team review. This process is very efficient for them. Cases require an average of 10 minutes before the team. Each team is assigned a technical expert/coach that signs off on all cases before they are effectuated.

SSA may want to explore several different options for developing team-based adjudication at the DDS level. Two types of teams are possible: work teams and expert teams. All cases might be assigned to a work team of examiners who might manage a random assignment of cases or might manage a specific type of claim. This seems to be the arrangement in many DDSs now; DE's within team units do not usually specialize, and supervisors have responsibility for helping the examiners when needed, and evaluating their performance. A work team could also be a resident expert team within the DDS. There may also be a need for expert teams at the DDS level that deal with difficult cases. Expert teams may be formed around age groups, medical conditions,

³⁶SSA already has adopted practices to expedite cases of terminally ill applicants and to grant presumptive allowances, subject to review, in certain fairly obvious cases. In addition, SSA has experimented with an Early Decision List, to identify cases that could be expedited.

types of claimants or other methods of stratifying case loads and types. The medical consultants and vocational consultants would likely be members of expert teams and serve as support staff to the work teams, utilized for training education and individual case assistance. Similar to UNUM/Provident, the role of the coach/technical expert could be expanded to include sign-off responsibility on all cases submitted to the team.

Another alternative to developing in-house expert teams at each DDS would be to utilize the SSA/DDS Determination Expert Teams (See **Option Area D: PER**) for difficult cases. This would help to enhance national consistency by giving the DDSs access to a single-point resource early in the case development process. As mentioned in **Section D**, expert teams could be tested for the review process, as SSA continues to roll out the Prototype, and that experience could inform the use of expert teams in the initial decision itself.

Under all of these scenarios, the bulk of claims would continue to be processed by a single examiner. One issue to study in tests under this option is which claims can be most efficiently left in the hands of a single examiner, and which need additional expertise.

It might appear that these ideas undermine the basic thrust of the Prototype model, which gives the DEs increasing authority and responsibility to make decisions. In fact, though, the use of team approaches that facilitate the adjudication of the most difficult cases, reduces the demands that the Prototype places on all DEs to be experts on all issues in all cases. Under the approaches outlined above, individual DEs would continue to be responsible for individual adjudication in a very large share of all claims.

Estimated Cost:

- Cost will be dependent on the approach taken and its success in improving performance. It might take no more team effort to determine a truly difficult case than is currently required under the Prototype, but if team effort is used on many cases that are not difficult, costs will increase. Savings will also be generated through less error correction and appeal after the initial determination.

Develop and test innovations that reduce reliance on POMS.

The POMS were developed to provide prescriptive guidance to individual examiners. As the disability determination process has become more complex and more subjective, a prescriptive approach to defining policy has become unwieldy and a source of potential error.

UNUM/Provident does not use a policy manual in the claims adjudication process. Individual examiners review the facts specific to each case, and use evidence-based medicine to either make a recommendation or submit the case to an expert team for further consideration. A technical specialist signs off on all cases. UNUM/Provident's philosophy is that a determination made by a trained examiner with a second level review by an expert team is more accurate than a determination against a prescriptive policy manual. It is also more defensible if appealed within the judicial system. Potential denials are reviewed by in-house legal counsel, prior to claimant notification, to ensure that the decision can be defended, if appealed.

The VBA disability process is guided by a rating manual and the actual regulations, documents that together, comprise about three inches of material. No equivalent to the POMS exists.

As discussed earlier, the Prototype seeks to grant more independence to individual examiners. In line with this approach, SSA might consider a demonstration project where examiner units, backed by expert teams, adjudicate claims without the use of POMS, and directly interpret the regulations. These cases could be reviewed under PER, and decision accuracy measured against decision accuracy under the traditional process. It is possible, validated by the demonstration, that the team approach may obviate the need for prescriptive policy, and decrease the complexity of the determination process. It might be necessary to introduce more demanding qualifications for the DE position if this approach is to be successful. The investment in more qualified examiners might pay for itself through a more efficient process and more accurate decisions.

Estimated Cost:

- Support for demonstration, visits to UNUM/Provident, meetings, training, research and evaluation: \$175,000-\$250,000.

Test written rationales against the current checklist rationale.

SSA might consider implementing a stronger rationale development process that supports the Prototype and many of the methods of the quality management system. Although rationales are supposed to be part of Prototype, the rationales that we saw as part of our review do not fully explain the examiner's decision process. In both the VBA Disability system and at UNUM/Provident, clearly written rationales are developed that describe the basis of the decision and the facts that support the decision. In both organizations, these rationales are provided to the claimant as part of the process of informing the claimant of the decision outcome. Developing a clear and complete statement of the rationale is critical to supporting many of the proposed options for the quality management system. Clear and complete rationale statements that explain the basis for the decision and the evidence considered would help to expedite the PER process and DDS performance review. Clear and understandable rationales might also be used to improve communication with claimants and their advisors and would be valuable for presenting SSA's position in the appellate process.

Our understanding is that SSA has previously tested written rationales, but decided to use a checklist form for rationales under the Prototype because some examiners had difficulty with writing, and it was considered too time consuming. We have encountered one Prototype DDS that participated in the rationale demonstration in which the Director of Quality Assurance expressed regret that the written rationales were replaced with the forms. It might be important to test these approaches to rationales head-to-head. In another state, we talked to a DDS Director who believed, from experience, that his examiners were not sufficiently qualified to write such rationales. An issue that might need to be addressed is whether DDSs should be required to hire examiners who are sufficiently qualified to write such rationales.

Estimated Cost:

- Unknown. SSA might select one or two DDSs and negotiate a small demonstration project to evaluate the impact on productivity and performance.

b. Long-term Options

In the long-term, continuous process improvement efforts for disability determinations would become routine, and innovations that prove successful would be adopted. Continuous improvement efforts would also be undertaken for other disability program processes.

**Exhibit VIII.7
Option Area G Evaluation**

| Evaluation Criteria | Option Area G: Initial Disability Determination Process |
|--|--|
| 1. To what degree are the primary aims of the quality management system supported by this option? | |
| <ul style="list-style-type: none"> Develop and pursue a clear operational definition of quality | <p align="center">High</p> <p align="center">Supports integration of quality into daily work of determinations. Supports other options.</p> |
| <ul style="list-style-type: none"> Develop and support organizational and process performance measures | <p align="center">High</p> <p align="center">Supports data driven decision making at FO and DDS. Supports process improvements and performance measurement systems. Supports other options.</p> |
| <ul style="list-style-type: none"> Support a quality focused culture | <p align="center">High</p> <p align="center">Team deployment at FOs and DDS support quality culture. Supports other options</p> |
| <ul style="list-style-type: none"> Provide information that can be used to improve disability determinations | <p align="center">High</p> <p align="center">Process improvement efforts targeted to improve disability determinations.</p> |
| <ul style="list-style-type: none"> Provide employees with the resources to produce quality outcomes and service | <p align="center">High</p> <p align="center">Process improvements create efficiencies. Supports other options.</p> |
| <ul style="list-style-type: none"> Ensure that the disability programs are national programs | <p align="center">Moderate</p> <p align="center">Supports other options.</p> |
| <ul style="list-style-type: none"> Support statutory and regulatory requirements | <p align="center">Neutral</p> <p align="center">Not the focus of this option.</p> |
| 2. By what measure(s) or method(s) of assessment will you know that the option is successfully deployed? | |
| <ul style="list-style-type: none"> Develop and pursue a clear operational definition of quality | <p align="center">Definition of quality is widely understood and reflected in employee surveys.</p> |
| <ul style="list-style-type: none"> Develop and support organizational and process performance measures | <p align="center">Process improvement efforts aligned with strategy? (Yes/No)</p> <p align="center">Process improvements result in measurable improvement.</p> <p align="center">Process improvements support improvement in FO and DDS performance metrics.</p> |
| <ul style="list-style-type: none"> Support a quality focused culture | <p align="center">Employee surveys that measure gaps between values and actions, satisfaction of employees, effectiveness of team approach and perceptions of culture.</p> |
| <ul style="list-style-type: none"> Provide information that can be used to improve disability determination | <p align="center">FO performance metrics and process improvement results.</p> <p align="center">DDS performance metrics.</p> |
| <ul style="list-style-type: none"> Provide employees with the resources to produce quality outcomes and service | <p align="center">Process improvements result in cost and productivity improvements.</p> |
| <ul style="list-style-type: none"> Ensure that the disability programs are national programs | <p align="center">Process improvement methods used to investigate root causes of variation? (Yes/No)</p> <p align="center">DDS performance metrics.</p> |
| <ul style="list-style-type: none"> Support statutory and regulatory requirements | <p align="center">Not linked to this option.</p> |

**Exhibit VIII.7 (continued)
Option Area G Evaluation**

| Evaluation Criteria | Option Area G: Initial Disability Determination Process |
|--|--|
| 3. To what degree will the option be supported within SSA? | |
| • Senior Executives | High |
| • Central Office Leadership | Variable |
| • OD Leadership | High |
| • Regional Leadership | High |
| • DDS Directors | Variable |
| • Union Leadership | High |
| • OHA Leadership | High |
| • Administrative Law Judges | Unknown |
| 4. What human resources/staffing will be required by this Option? | |
| • Requires additional human resources within SSA | Requires initial development of process improvement facilitators and coaches, and trainers to support FO improvements. |
| • Requires the reallocation of human resources within SSA | Yes Likely reallocation of resources to support efforts and process improvements. |
| • Will result in a reduction of human resources within SSA | Yes, over time. |
| • Requires additional human resources at the DDSs | Some initial investment in trainers and facilitators may initially be required. |
| • Requires a reallocation of human resources within the DDSs | Yes Likely reallocation of resources to support efforts and process improvements. |
| • Will result in a reduction of human resources at the DDSs | Yes, over time. |
| 5. To what degree will the option/method impact operating and program costs for the disability program? | |
| • SSA operating cost | Moderate reductions in excess of training and support investment. |
| • DDS operating cost | High reductions in excess of training and performance measurement investment if used to improve. |
| • SSA Program costs | Unknown. Dependent on projects selected and impacts on allowances, terminations and payment amounts. |
| 6. To what degree is an investment in training and education required to implement the option/method? | |
| • Field Offices | High Process management and improvement techniques. |
| • Disability Determination Services | High Process management and improvement techniques |
| • Office of Hearings and Appeals | Low |
| • Office of Quality Assurance | Moderate Improvement theory, managing change, tools and methods. |
| • Office of Disability | Moderate Improvement theory, managing change, tools and methods. |
| • Regional Offices | Moderate Improvement theory, managing change, tools and methods. |
| • Central Office | Low. |

**Exhibit VIII.7 (continued)
Option Area G Evaluation**

| Evaluation Criteria | Option Area G: Initial Disability Determination Process |
|---|---|
| 7. To what degree is an investment in new equipment, facilities and or information systems required? | |
| <ul style="list-style-type: none"> • Field Offices | <p align="center">Low May need additional information system support.</p> |
| <ul style="list-style-type: none"> • Disability Determination Services | <p align="center">Low May need additional information system support.</p> |
| <ul style="list-style-type: none"> • Office of Hearings and Appeals | <p align="center">None</p> |
| <ul style="list-style-type: none"> • Office of Quality Assurance | <p align="center">None</p> |
| <ul style="list-style-type: none"> • Office of Disability | <p align="center">None</p> |
| <ul style="list-style-type: none"> • Regional Offices | <p align="center">None</p> |
| <ul style="list-style-type: none"> • Central Offices | <p align="center">None</p> |
| 8. What regulatory or statutory change is required to implement the option/method? | |
| | <p align="center">None</p> |

8. Option Area H: Appellate Process

a. Short-term Options

Development of an advanced quality management system that incorporates the appeals process seems more problematic than development of a system for other processes because of significant organizational, management, and process issues that are beyond the scope of this project. A fundamental problem is that the ALJs must wear both the hat of an objective adjudicator, and the hat of the program.³⁷ Judicial independence has to be preserved for the first hat, but management oversight is critical for the second hat. This appears to us to be the root cause of difficulties that SSA has in managing the appeals process. We are led to the conclusion that either OHA must take lead responsibility for its own quality management, with ALJs themselves playing a prominent role, and with support from other offices as needed, or someone other than the ALJs must represent the program in the appeals process. Our two long-term options reflect that view.

As a result, our short-term options in this area are limited, but include a significant effort to examine fundamental issues with the appeals process:

- Include OHA leaders in all efforts to develop quality management leadership.
- Develop in-line HPI data collection, analysis and dissemination.
- Task the Appeals Council with the responsibility for being the primary source of information on appellate, due process and judicial issues for the disability programs.
- Develop an OHA scorecard.

³⁷ The ALJ's are also required to wear the hat of the applicant, but the applicant and, in most cases, an applicant advocate also participate directly in the appeals process.

- Establish a Task Force to examine potential reforms to the appeals process and its management.

Include OHA leaders in all efforts to develop quality management leadership.

Option Area A includes OHA leadership among those leaders who would participate in efforts to develop the leadership for an advanced quality management system. We single OHA leadership out at this point because of the judicial independence issue.

OHA leadership participation in *Option Area A* could mean that OHA leadership would: endorse the development of an advanced quality management system for OHA, as part of the Agency effort; actively participate in efforts to develop leadership skills and knowledge about quality management; help translate the disability programs' mission into OHA goals and the measurement of OHA performance; participate in the development of a communication plan, with a special focus on communications between OHA and other parts of the Agency; develop performance objectives for OHA management that are linked to OHA goals; define a new context for operational reviews and decision making based on mission and strategy; revisit the allocation of resources within SSA and develop changes that will focus resources to meet OHA's new goals; fully participate in the Quality Council; and use the Office of Quality Management as a resource to support efforts to improve OHA quality.

Estimated Cost:

- No significant incremental cost. (See *Option Area A*)

Develop in-line HPI data collection, analysis and dissemination.

The Hearings Process Improvements that are being implemented at the front-end of the hearings process provide an opportunity for in-line collection of data on findings by OHA of deficiencies with folders as they come from the DDS and reasons for allowances on the DDS record. Currently, DDSs and others have very limited information about why allowances are sometimes made on the DDS record, and the information they do have might be misleading. Producing such information could greatly promote the process unification effort. It should help identify ways in which DDSs and ALJs are treating information differently, and help SSA develop changes to both the DDS and appellate determination processes that will make decisions at both levels more consistent with the intent of policy. It will also help identify variation in the treatment of information across offices at both the initial and appellate levels.

Estimated Cost:

- Significant cost savings possible.
- SSA should consider a series of small tests prior to OHA-wide deployment. Support for these tests including training, QM technical experts, communication, meeting and travel: \$100,000-\$150,000.
- No significant incremental expense after deployment.

Task the Appeals Council with the responsibility for being the primary source of information on appellate, due process, and judicial issues for the disability programs.

As the last step in the determination process before moving into Federal Court, the Appeals Council role could be expanded to include the gathering and analysis of data on judicial/due process issues and informing the rest of the program on these issues, in a systematic fashion. Under this option, the Appeals Council would:

- Review the performance data from the appeals process, conducted analysis of reasons for allowances, identify and analyze legal/due process issues that are behind some reversals, and provide their findings to the rest of the Agency.
- Analyze court decisions and develop and options for policy changes needed to comply with them.
- Develop a mechanism to systematically deploy court decisions within OHA and track the success of the deployment through a review mechanism (see the discussion of peer review, below).

Estimated Cost:

- Support for the effort could be provided by the new OQM (see *Option Area A*) as a core responsibility and within their new budget.
- SSA should assume that additional resources will be required. It is possible that some OHA resources could be redirected. The most likely scenario is a redeployment of existing resources and the addition of supplemental resources.
- Five to seven new FTEs: \$400,000-\$500,000 per year.

Develop of an OHA scorecard.

Implementation of an advanced quality management system entails implementation of scorecards for every operational component. In the short term, OHA and OQA leaders could lead an effort to develop an OHA scorecard. As in the DDS scorecard (*Option Area E*), this might include measures of accuracy, customer service, cost/productivity, employee satisfaction, and progress toward meeting strategic objectives.

Accuracy data will be limited by the number and type of reviews that are currently conducted. QA reviews of appellate decisions have been suspended to cope with the heavy PER workload for ALJ decisions (see *Appendix D*). Our understanding is that about 7,000 cases are subject to PER each year. Another 7,000 are subject to longitudinal reviews. The ALJ Peer Report publishes findings from the longitudinal reviews. Decisions will need to be made concerning the ability of these data to support regional scorecards and national quarterly score cards. Sample sizes are clearly insufficient for office-level statistics on case reviews.

There is substantial interest in the final disposition of allowances found to be not supported at PER. Hence, it would be desirable to include statistics on dispositions in the scorecard. Statistics on the number and disposition of AC and court remands would also be of interest.

Estimated Cost:

- If the previous option is adopted, the cost of developing the scorecard could be included in the basic performance indicator review and development.
- Should SSA decide to do this independent of other options, costs might include task force expense, travel, meetings, administrative support, training, external assistance, communication, and deployment: \$100,000-\$200,000. The estimated cost for this effort is higher than other scorecard development efforts due to the amount of initial performance indicator development and basic work required.
- Once deployed, no significant incremental cost.

Establish a Task Force to examine potential reforms to the appeals process and its management.

We think that further development of a quality management process for appeals needs to be postponed while more fundamental issues with the process and its management are addressed. Hence, an important short run option is to establish a task force to address these issues. A 1992 study by the Administrative Conference of the United States, titled *The Federal Administrative Judiciary* (Verkuil et al., 1992), would be a useful resource for this effort. This study provides an overview of the federal administrative judiciary and useful discussions of a number of issues that are pertinent to SSA's appellate process. We would also recommend that the Task Force consider innovative administrative processes that have been developed by some states.

Issues to consider could include:

- *The organizational relationship between the Agency and the appellate body that reviews its decisions.* In the search for benchmarking organizations, we encountered varying organizational relationships, including complete independence (e.g., the National Labor Relations Board).
- *The limits of managerial authority over performance measurement and improvement efforts implied by judicial independence.* To what extent can SSA management exercise authority without violating the Administrative Procedures Act (APA)? Many in SSA are of the view that OHA can take a much more active role in managing the ALJs than it has without violating the APA.
- *Assignment of responsibility for appellate quality management to OHA.* This idea appeals to many because it appears to avoid issues related to judicial independence. It raises many issues, however. Performance would need to be measured in a way that SSA would have confidence in the quality of the process. This could be modeled after the process we described for the DDSs: OHA would be responsible for its own reviews, but SSA would

perform a substantial audit of those reviews. Perhaps a more difficult issue is accountability for performance. How can SSA hold OHA managers accountable for OHA performance in a way that is equitable and also promotes quality improvement? What can SSA do when ALJ decisions are found to routinely violate SSA policy, without impinging on the independence of the ALJ's?

- *Methods of providing consistent feedback and communication on types of cases allowed and an analysis of the reasons for allowances.* We present a short-term option above to provide feedback from in-line data collection in the front-end of the appeals process under HPI. But this pre-hearing feedback will not reflect final decisions in many cases, which might be quite important. One option is to require ALJs, with assistance from their staff, to provide feedback on a small set of specific issues in all cases, or in a large random sample of cases. While SSA is mostly concerned with reasons for allowances, because of concerns that too many cases are allowed on appeal, it might be useful for other purposes to collect information on reasons for denials.
- *Methods to ensure that an appeals process like SSA's which often includes a representative for one side, but not the other, can deliver consistently unbiased decisions in an efficient manner.* As discussed in **Chapter III**, adversarial processes have built-in quality improvement mechanisms. We have not encountered good examples of non-adversarial processes. As discussed earlier, a fundamental problem is that the ability of applicants to appeal denials to the courts creates an incentive for ALJs to allow difficult cases. There is no countervailing incentive for allowance errors. Would it be appropriate to use management incentives for this purpose, in conjunction with an expanded performance measurement system? Or would incentives violate judicial independence? One idea we have encountered is to replace the ALJ with a panel, including an ALJ, a physician, and perhaps one other expert (Verkuil et al., 1996, p. 55). This might be prohibitively expensive, but perhaps could be considered for some cases. Ideas that would replace the current process with a state-level hearing and a Social Security Court might also be considered.³⁸
- *Methods for introducing an SSA representative into the appeals process.* Of course, one way to address quality issues that a non-adversarial appeals process creates is to make it more like an adversarial one, by introducing an SSA representative into the process and changing the ALJ's role to one of judging the arguments presented by both sides. Are there ways this could be done without putting SSA in the awkward position of advocating against applicants who, even if ineligible, might have serious impairments and other problems? Would this add substantial costs to the process? Or could money used to support case preparation in the front-end of the current non-adversarial process be used to support the office of SSA representatives?³⁹

³⁸ Burgess (2000) supports this idea, and cites testimony of Glen Flitt and Lou Enoff before the Social Security Subcommittee of the House Ways and Means Committee, August 3, 1995. This idea raises many issues, both political and technical, which would need to be addressed.

³⁹ An interesting discussion of non-adversarial processes appears in Verkuil, et al. (1992), p. 79. The authors also state that almost two-thirds of ALJs favor an adversarial process (p. 98), based on Cofer (1985).

- *The ALJ appointment process.* Many interviewees expressed concerns that the Office of Personnel Management's rules for ALJ appointments favor those with trial experience – judges who are good at listening to both sides of an argument and making a decision. These interviewees argue that program knowledge needs to be considered because of the absence of a program advocate. The Task Force could consider whether this argument merits changing the ALJ appointment rules to give weight to experience in the SSA process and, if so, how the rules should be changed.
- *A revised open-record policy.* SSA has recently considered closing the record at some point in the appeals process, and has made the decision to keep it open. As discussed in **Chapter III**, this policy creates incentives for the claimant and the claimant's representative that some argue result in process delays and much extra work. Although this argument for closing the record has merit, given the length of the initial determination and appeals process, it seems very inequitable to only let applicants who have new evidence use it if they return to the beginning and start again. If the process were much faster, the inequity of a closed process would not be such an issue. SSA could also consider a limited open record policy, in which new evidence is only accepted if it meets standards that have been designed to encourage submission of evidence earlier in the process.

Estimated Cost:

- This is a critical issue for SSA that will require significant disability program leadership time and attention.
- Support of task force, outside expertise, meetings, travel, surveys, data analysis interviews, focus groups, administrative support: \$350,000-\$500,000.

b. Long-term Options

In the long term, it seems to us that SSA needs to go in one of two directions if it is to successfully establish an advanced quality management system in the appeals process. These alternatives are:

- Assign the responsibility for appellate quality management to OHA, measure performance, and hold the leadership of OHA accountable.
- Redesign the appeals process to include an SSA representative, and transform the ALJ's role to insurer of due process and judge of evidence presented by both sides.

Our reasoning is as follows. We think there will need to be a substantial increase in case reviews to assure the quality of adjudications in a non-adversarial process, as well as an increase in the accountability of managers for performance. The number of reviews would need to be sufficient to measure performance at the individual office level over a reasonable period. If such a system were imposed by an outside authority, objections would likely be raised concerning judicial independence, and the ALJs, activists, and others are likely to resist. Whether these objections are valid or not might be immaterial to the ability of SSA to impose such a system on the process. It seems much more likely that ALJs would respond positively to a peer-review system

that they design and control. The question is whether SSA would be confident in the performance measures produced by such a system, its own ability to hold OHA leadership accountable for performance, and the ability of the system to improve performance.

The introduction of an SSA representative would mitigate, and perhaps eliminate, the need for a separate quality review process. Each level of appeal would essentially serve as the review process for the next lower level. Performance could be measured through the appeal process; judges who make many errors, or write inadequate decisions would be identified, and remedial action could be taken – both on individual decisions and overall. SSA would be relying on its representatives' arguments and the impartiality of judges at all appeal levels to assure that policy is followed, rather than a top down review of decisions.

We discuss both of these alternatives further, below. If SSA appoints a Task Force to examine the ALJ process, it would address many of the issues that are raised in the discussion.

Assign the responsibility for appellate quality management to OHA, measure performance, and hold the leadership of OHA accountable.

Efforts to improve the quality of the appellate process that require reviews of individual cases and hold managers accountable for measured performance are likely to encounter resistance because of the judicial independence issue. Even though, in principle, such efforts might not violate judicial independence, the argument that they do will always be a significant impediment to implementation. SSA probably needs to have an arms-length relationship with OHA, permanently, if this approach to improving appellate quality is used. The terms of that relationship can, however, include performance requirements, and the managers of OHA can be held accountable for meeting those requirements. Within this context, OHA would need to develop its own quality management system. This might include its own Quality Council, which it could task with the responsibility for measuring the performance of hearing offices and helping them improve the quality of their work.

We emphasize that responsibility must be accompanied by strict accountability of OHA leadership. Otherwise there is the potential for OHA to proceed on a diverse path from the rest of the Agency in its interpretation of program rules, just the opposite of the desired outcome. To illustrate, consider the evidence from existing reviews, which indicate glaring differences between ALJs and MCs on RFC and other issues (see *Appendix C*). We are not in a position to judge whether the MCs are “right” (a wide-spread perception outside of OHA), the ALJs are “right” (a common view within OHA), the right decisions are somewhere in between, or both are right and the decisions can be reconciled in some other way. If the Agency determines, however, that such evidence reflects systematic errors in ALJ implementation of program policy, and if OHA has responsibility for quality management of the appeals process, then the leadership of OHA must be held accountable for eliminating such errors.

Under this arrangement, OHA could be required to provide information about the quality of ALJ decisions, which it would obtain through its own peer review process. OHA could obtain technical support for the process from other parts of the Agency, but the process itself would be under OHA's control. SSA would need to have authority to conduct independent audits of the

review process to ensure its integrity, which would likely include reviews of reviews, following the model described above for DDSs (*Option Area E*).

Effective peer review is achieved when professionals control and drive their own peer review process and are responsible for implementing changes in behavior among peers.

- Effective peer review is dependent on the collective standards and ethics of the professional group and willingness to participate. In medicine, law, accounting, and other professional groups who exercise independent professional judgment, individuals have a commitment first to their profession's code of ethics and second to their employment.
- Organizational quality management systems depend on peer review to reduce variation in professional practice and deal with ethical and performance issues when professionals are employed as part of the organization.
- Peer review is most effective when the professional group is given both the responsibility and the resources necessary to perform the function.
- Keys to success are control and confidentiality.

Peer review in medicine has evolved dramatically over the years as physicians have been supported with information about evidence-based medicine, variation in practice patterns, patient outcomes, and the impact that care delivery systems have on professional practice. Originally designed to find the bad doctor, peer review in health care has evolved with quality management systems and now primarily focuses on improving processes of care. When issues of individual physician performance surface, peer review deals with the performance issue and the individual physician on behalf of the hospital or clinic organization.

A process that parallels the current medical model and current bar association models could be implemented to support ALJ peer review. SSA currently has a peer review process, but that process, and the use of the information generated by that process, is not under the direct control of the ALJs. Under this option, control of the peer review process would be put in the hands of the ALJs and the resources necessary to support the process being developed within OHA. This does not preclude OHA using services from other parts of the Agency, but gives OHA the authority to decide. In fact, like the current process, the review needs to include MC/DE expertise. This is especially critical to identification and resolution of differences between decisions at the initial and appellate levels. The MC/DE expertise should be drawn from the same pool of expertise that is used for reviews of initial determinations. In addition, the legal expertise that supports the OHA review process should come from the same pool of legal expertise that supports initial reviews. How this is done will depend on the implementation of options concerning PER and QA reviews of initial determinations.

The peer review process could be organized on a regional basis, rotating ALJs from the OHA offices to serve on peer review committees that meet on a regular basis. This does not mean, however, that ALJs should only review cases from their own region, for the same reasons that SSA might want to move away from within-regional reviews.

If OHA establishes its own Quality Council (see above), that office should work with the ALJs to determine how the cases should be selected. To maximize the value of the reviews, the selection process needs to be aligned with the mission and strategy of the disability program. It should include case review of specific groups of appeals, developing metrics that shed light on variation in decision criteria, investigation and review of ethical complaints with respect to peers, and review of performance metrics deployed within OHA.

Each review of an allowance needs to address whether the initial determination was in error and, if so, why. For denials, the reviews should address whether the appeal might have been prevented or processed more expeditiously had the DDS done something differently.

One issue that needs to be addressed is the extent to which the leadership of OHA can be held accountable for performance. It seems to us that accountability can be defined in terms of specific measures that do not infringe on judicial independence. Negotiating and reaching agreement on those measures in advance should prevent efforts to undermine accountability based on APA issues.

OHA could also be required to provide information and possibly other services to the rest of the program. Especially important is information about why allowances were made on appeal and about legal/due process issues that impact appeal outcomes and are poorly addressed in the initial process. Statistics to be reported on a routine basis might include:

- Percentage of cases reversed on the DDS record and the reasons for the reversal;
- Percentage of cases reversed due to the progressive nature of the disease over time, by the types of medical conditions;
- Percentage of cases reversed because medical information introduced at the time of appeal was not used in the initial determination, but could have been available at the time of the initial decision;
- Percentage of cases reversed based on ALJ determination of claimant credibility;
- Percentage of cases reversed based on medical/vocational issues and the nature of the issues; and
- Percentage of cases reversed due to ALJ interpretation of the regulations and the regulations in question.

This information would be collected in each OHA office as a step in the processing of decisions. Data could be sent back to the DDS responsible for the initial claim, shared with the SSA office responsible for oversight of disability determinations and their conformance with program policy, forwarded to the Appeals Council for analysis of trends and characteristics of reversed decisions, and used in performance metrics for OHA. If SSA/DDS Expert teams are formed to consider difficult cases, this information would be of significant help to them in improving DDS adjudication of such cases and identifying factors in DDS decisions that are likely to lead to reversal on appeal.

A service OHA could provide to the rest of the process is input into the review of initial decisions. The important point is that reviews of initial decisions need the judicial expertise necessary to address some issues and to deter appeals of denials, and OHA is the obvious source of that expertise. Ideally, reviews of initial determinations and reviews of ALJ decisions would draw on the same pool of judicial, as well as medical, expertise.

To promote consistency, OHA leadership should also consider the use of case banks, to both provide models for ALJs to follow and to test for consistency, along the lines of the test system we have included in the options for reviews of initial determinations.

This system could be costly. Currently, the number of appellate reviews conducted is not sufficient to produce reasonably precise data on accuracy or other outcomes at the level of the individual office, except perhaps over very long periods. Without office-level performance measures, the leadership of OHA will find it very difficult to hold managers responsible for performance. Hence, it seems likely that the number of reviews would need to be increased substantially from current levels under this approach. We do not have data on the cost of appellate reviews, but presumably they are expensive relative to reviews of initial decisions, because a large share of the decisions involve difficult issues.

Estimated Cost:

- Further study required.

Redesign the appeals process to include an SSA representative, and transform the ALJ's role to insurer of due process and judge of evidence presented by both sides.

As discussed in *Chapter III* and mentioned above, adversarial appeals processes have built-in quality improvement mechanisms. We are aware that SSA has considered and rejected adversarial procedures in the past, and also understand the Agency's reluctance to be an advocate against benefits for an individual who might face many difficult problems, even if not meeting eligibility criteria for the disability programs. Other federal agencies do use adversarial processes, but of course no other federal agency conducts more than a fraction of the number of hearings on individual appeals that SSA performs.

This option might be much more attractive to SSA if the number of appeals were much smaller. Hence, adoption of this approach might be tied to success in reducing the number of appeals. We also think that the political issues raised by having a program representative can be greatly mitigated by appropriate definition of the representative's job and appropriate training of the representatives. The representative's job is not to obtain a denial in as many cases as possible. In fact, the representative could be given the authority to allow cases that meet the medical eligibility criteria, perhaps subject to the approval of the ALJ.

The "two hat" responsibility of ALJs might be the root cause of considerable dissatisfaction and variation within the appellate process. Removing the "second hat" of the ALJ, and putting it on to a representative of the program would remove what many see as a fundamental conflict between assuring the claimants right to due process and protecting the program's interest. Independence in decision-making is a critical value for ALJs. Almost all current SSA actions to

achieve consistency, rightly or wrongly, are viewed as infringement on their autonomy. Given this dynamic, it may be unreasonable to assume that ALJs can effectively represent the Agency's position in individual cases. Change to a system that allows ALJs to decide cases based on the merits of the arguments presented by both sides, the facts of the case, the credibility of the claimant and the rule of regulation and law could greatly increase ALJ satisfaction with the process.

Logistically, it seems relatively straightforward to change the Prototype hearings process into an adversarial one. Under HPI, most of the case development work on an appeal is done prior to the assignment of a case to an ALJ. This includes exchange of information with the claimants' representative and can result in an allowance prior to a hearing, although approved by an ALJ. Hence, this process is very similar to an arrangement in which representatives for two parties exchange information through the discovery process and potentially reach settlement before hearing. The real difference is that those who are developing cases for the Agency now report to the ALJ and, like the ALJ, must wear two hats.

The Agency's representative would come from outside of OHA. If SSA establishes SSA/DDS Determination Expert Teams (DETs) to address claim issues discovered via the pre-effectuation or performance measurement review of DDS decisions. To promote process unification, SSA's representation in the hearings process should come from the same organizational unit as the SSA leadership of the DETs. This office would develop and use its expertise on the difficult issues that are often the subject of appeals to both improve how the DDSs address these issues, thereby reducing the number of cases with strong grounds for appeal, and to clearly represent SSA's policy on these issues in hearings, thereby reducing the number of allowances on appeal that are out of line with Agency policy. Further, this office would be in an excellent position to identify conflicts between Agency policy and the law, and provide information that will support SSA's efforts to resolve such conflicts. Savings could be realized for denials that have been subject to PER because some of the pre-hearing work will have already have been done during the PER process.

The role of OHA would be reduced to oversight of the pre-hearing discussions between SSA and claimant representatives, hearing argument on issues that cannot be resolved before hearing, and writing decisions based on evidence presented at hearing. OHA would still need to support the ALJs in their decision writing and effectuation process.

It would be very important to support the case preparation process with quality management methods and data collection built into the workflows. Measures that would be routinely collect might include:

- Completeness of case preparation;
- Reversal rates by type of cases, processing time;
- Percent of cases reversed on the record;
- Percent of cases reversed prior to hearing and the reasons why; and

- Preparation cost per case.

If case preparation by the program representative’s office replaces much of the case preparation in the hearing office, the net impact on administrative cost could be quite small. Administrative savings are also generated by elimination of the separate review process. If the system also reduces the allowance rate, as we would expect, program savings will be generated.

Estimated Cost: Further study required.

**Exhibit VIII.8
Option Area H Evaluation**

| Evaluation Criteria | Option Area H: Appellate Process |
|--|---|
| 1. To what degree are the primary aims of the quality management system supported by this option? | |
| <ul style="list-style-type: none"> • Develop and pursue a clear operational definition of quality | High Supports definition deployment at the appellate level. |
| <ul style="list-style-type: none"> • Develop and support organizational and process performance measures | High New OHA performance metrics developed. |
| <ul style="list-style-type: none"> • Support a quality focused culture | High New OHA quality mgmt process supports quality culture. Peer review process could improve ALJ satisfaction. |
| <ul style="list-style-type: none"> • Provide information that can be used to improve disability determinations | High Role of Appeals Council expanded to collect and analyze information that could be used for improvement. |
| <ul style="list-style-type: none"> • Provide employees with the resources to produce quality outcomes and service | High Redesign of OHA processes should reduce workloads and improve efficiency. |
| <ul style="list-style-type: none"> • Ensure that the disability programs are national programs | Moderate Begin to support national consistency at appellate level. |
| <ul style="list-style-type: none"> • Support statutory and regulatory requirements | High May improve due process for claimants. Supports other options. |
| 2. By what measure(s) or method(s) of assessment will you know that the option is successfully deployed? | |
| <ul style="list-style-type: none"> • Develop and pursue a clear operational definition of quality | Definition of quality is widely understood and reflected in OHA employee surveys. |
| <ul style="list-style-type: none"> • Develop and support organizational and process performance measures | New metrics developed for OHA? (Yes/No) Data collected at OHA and given to DDSs (Yes/No) Process improvements support improvement in OHA performance metrics. |
| <ul style="list-style-type: none"> • Support a quality focused culture | Employee surveys that measure satisfaction of ALJs with quality management and peer review processes. OHA employee surveys that identify gaps between values and actions, and perceptions of culture. |
| <ul style="list-style-type: none"> • Provide information that can be used to improve disability determination | Appeals Council collects data and distributes? (Yes/No). Disability program performance metrics. |
| <ul style="list-style-type: none"> • Provide employees with the resources to produce quality outcomes and service | Process improvements result in cost and productivity improvements. |
| <ul style="list-style-type: none"> • Ensure that the disability programs are national programs | Process improvement methods used to investigate root causes of variation? (Yes/No) OHA performance metrics. |
| <ul style="list-style-type: none"> • Support statutory and regulatory requirements | Due process improved? (Yes/No) |

**Exhibit VIII.8 (continued)
Option Area H Evaluation**

| Evaluation Criteria | Option Area H: Appellate Process |
|--|---|
| 3. To what degree will the option be supported within SSA? | |
| <ul style="list-style-type: none"> • Senior Executives | High |
| <ul style="list-style-type: none"> • Central Office Leadership | Dependent on views concerning independence of OHA and non-adversarial process |
| <ul style="list-style-type: none"> • OD Leadership | High |
| <ul style="list-style-type: none"> • Regional Leadership | High |
| <ul style="list-style-type: none"> • DDS Directors | High |
| <ul style="list-style-type: none"> • Union Leadership | High |
| <ul style="list-style-type: none"> • OHA Leadership | Dependent on views concerning independence of OHA and non-adversarial process |
| <ul style="list-style-type: none"> • Administrative Law Judges | High |
| 4. What human resources/staffing will be required by this Option? | |
| <ul style="list-style-type: none"> • Requires additional human resources within SSA | Requires additional support for development of peer review and OHA quality management processes. In long term, dependent on Task Force findings and future process changes. |
| <ul style="list-style-type: none"> • Requires the reallocation of human resources within SSA | Yes Likely reallocation of resources to support OHA efforts and process improvements. In long term, dependent on Task Force findings and future process changes. |
| <ul style="list-style-type: none"> • Will result in a reduction of human resources within SSA | Yes, over time. |
| <ul style="list-style-type: none"> • Requires additional human resources at the DDSs | No |
| <ul style="list-style-type: none"> • Requires a reallocation of human resources within the DDSs | No |
| <ul style="list-style-type: none"> • Will result in a reduction of human resources at the DDSs | No |
| 5. To what degree will the option/method impact operating and program costs for the disability program? | |
| <ul style="list-style-type: none"> • SSA operating cost | Dependent on Task Force findings and future process changes. Long-term savings could be substantial. |
| <ul style="list-style-type: none"> • DDS operating cost | None |
| <ul style="list-style-type: none"> • SSA Program costs | Unknown. Dependent on effectiveness of new appellate process. May reduce number of claims that are allowed on appeal, because of earlier allowances. |
| 6. To what degree is an investment in training and education required to implement the option/method? | |
| <ul style="list-style-type: none"> • Field Offices | None |
| <ul style="list-style-type: none"> • Disability Determination Services | None |
| <ul style="list-style-type: none"> • Office of Hearings and Appeals | High Quality management theory, tools and methods |
| <ul style="list-style-type: none"> • Office of Quality Assurance | None |
| <ul style="list-style-type: none"> • Office of Disability | None |
| <ul style="list-style-type: none"> • Regional Offices | None |
| <ul style="list-style-type: none"> • Central Offices | None |

**Exhibit VIII.8 (continued)
Option Area H Evaluation**

| Evaluation Criteria | Option Area H: Appellate Process |
|---|--|
| 7. To what degree is an investment in new equipment, facilities and or information systems required? | |
| • Field Offices | None |
| • Disability Determination Services | None |
| • Office of Hearings and Appeals | Moderate May need additional information system support. |
| • Office of Quality Assurance | None |
| • Office of Disability | None |
| • Regional Offices | None |
| • Central Offices | None |
| 8. What regulatory or statutory change is required to implement the option/method? | |
| | Major Changes in regulations governing appellate process. |

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IX. CONCLUSION

A. Summary of Options

We have framed our options in the context of moving SSA to a highly advanced quality management system. The options are interdependent building blocks that together form a new, highly advanced quality management system. Some of the described methods and structures within each option could be implemented individually, but SSA will not realize their full benefit without the other changes and elements of the option. The value of all options combined is considerably greater than the sum of the values of the individual options.

Of necessity, we have addressed elements that were not the direct focus of our investigation. Some of the options have implications for program processes other than disability determinations. We have also been sensitive to the fact that SSA's responsibilities include the Old Age and Survivor's Insurance (OASI) program.

Some options also are possible incremental improvements to the Prototype process itself. Continuous improvement of all processes is a key feature of an advanced quality management system. To make such improvements without the significant costs and disruptions associated with recent process redesign efforts, SSA will need to make progress to development of a quality culture.

We have developed numerous options. Each is intended to help SSA accelerate its effort to move away from a quality management system that relies heavily on end-of-line review toward an advanced quality management system, like that described above. While the options are primarily focused on supporting the Prototype disability determination process, they also consider the larger context of the disability programs.

We divide the options into eight areas:

- Option Area A: Leadership and Organization
- Option Area B: Performance Management System
- Option Area C: Promoting a Quality Culture
- Option Area D: Quality Control
- Option Area E: Performance Monitoring Systems
- Option Area F: Federal State Relationships
- Option Area G: Initial Disability Determination Process
- Option Area H: Appellate Process

Within each area, we present both short-term and long-term options. In general, short-term options could be pursued relatively quickly, and at little cost. Most are focused on disability

determinations, but some would lay the groundwork for a broader effort to develop an advanced quality management system that serves all disability program processes. In comparison to the short-term options, the long-term options require more development, require a higher degree of organizational readiness, involve larger changes and transition costs, and are more oriented toward the entirety of the disability programs, not just disability determinations. Such long-term options will need to be pursued eventually if SSA is to achieve an advanced quality management system for the disability programs and develop a sustainable quality culture. Each option in an area could be implemented on its own, but in many instances individual options reinforce one another. In some instances options are alternatives to one another.

SSA does not need to implement all the options to achieve significant progress toward improving quality management of disability determinations, but will need to pursue many, in principle if not in detail, if it is to develop an advanced quality management system.

1. Option Area A: Leadership Options

a. Short-term Options

- Endorse the development of an advanced quality management system for the future.
- Develop disability program senior leadership skills and knowledge.
- Revisit the mission of the disability programs and create a clear vision that can be translated into the daily work of the organization.
- Create a strong link between the mission and goals of the disability programs and clearly define how the goals are to be measured.
- Adopt a broad definition of quality that reflects the mission and vision of the disability program.
- Develop and implement a communication plan that supports the understanding of the mission, vision and quality definition for the disability programs at all levels of the organization.
- Create performance objectives for all levels of SSA management that are linked with the goals and strategies.
- Define a new context for operational reviews and decision-making based on mission and strategy.
- Allocate resources based on process and customer needs to support the definition of quality, mission and strategy of the disability program.
- Develop a Disability Quality Council to guide development of the new quality management system.

- Establish an Office of Quality Management (OQM) to provide centralized support for the quality management system.

b. Long-term Options

- Utilize external benchmarking methods to set strategic targets and performance goals.
- Integrate the budget process with strategic and quality planning.
- Develop data systems to support the quality management system.
- Develop a new organizational structure that clearly establishes programmatic responsibility for the disability programs across all SSA functions.

2. Option Area B: Performance Measurement Systems

a. Short-term Options

- Define clear, unambiguous organizational performance goals for the disability program linked to the mission and strategy.
- Develop and deploy an initial set of performance metrics for the disability determination as a whole and for each major process/unit involved in the determination process.
- Create initial disability determination operating performance targets based on internal benchmarks rather than arbitrary or historical performance.
- Develop an initial balanced scorecard for the disability determination process utilizing existing or easily obtained performance data.
- Deploy performance metrics in a format that is visible and understood at levels of the organization.

b. Long-term Options

- Develop and deploy a set of performance metrics for the disability program as a whole.
- Develop and deploy a balanced scorecard to track disability program performance beyond the dimensions of the determination process.
- Benchmark external operational processes and organization and identify best-in-class processes and methods that can be translated into performance targets for the disability programs.
- Collect data at each point in the disability process to be used to inform the previous process step and improve the overall process.

3. Option Area C: Promoting a Culture of Quality

a. Short-term Options

- Develop a new set of organizational values that are aligned with mission and vision.
- Train managers and employees in the theories and methods of process improvement.
- Review training content and processes at all levels and make changes that support continuous improvement.
- Involve employees in a process to identify opportunities to improve the determination work processes.
- Identify and initiate a set of process improvement projects that have organizational learning value.
- Implement management training on coaching and team skills for front line and mid-level management.

b. Long-term Options

- Implement a process that periodically assesses gaps between current and desired culture.
- Develop and deploy a 360 Degree review process for all levels of management.
- Implement an employee satisfaction survey process that delivers information to leadership on a monthly basis.
- Develop a Quality Management University.

4. Option Area D: Quality Control and Pre-effectuation Review

a. Short-term Options

- Integrate PER into the disability determination process as a joint responsibility of the Office of Quality Assurance and the Office of Disability;
- Improve the profile system for selecting PER cases;
- Improve the measurement and reporting of the net savings from PER;
- Streamline the review of selected cases;
- Develop and deploy a new process to identify and review difficult cases;
- Create specialized review teams and consolidate reviewers;

- Develop and deploy a system of Test Reviews to measure consistency and identify reasons for inconsistency; and
- Expand the purpose of PER to address policy and process issues.

b. Long-term Options

- Transform PER to focus on process and policy improvement, or
- Expand PER as an error-correction mechanism, to include all disability determinations.

The second of these scenarios is an undesirable outcome, only to be considered as a last resort if denial accuracy continues to be low.

5. Option Area E: DDS Performance Monitoring System

a. Short-term Options

- Develop and test DDS performance measurement requirements.
- Develop and implement a DDS scorecard and benchmarks.
- Develop and test DDS quality management models.

b. Long-term Options

- Implement the new DDS quality measurement system;
- Revise and expand the DDS scorecard to take advantage of new data collection efforts; and
- Implement DDS quality management requirements.

6. Option Area F: Federal State Relationships

a. Short-term Options

- Take initial steps to redefine the federal-state relationship as a partnership, based on frequent and clear communication between the highest levels of state administrations and SSA.
- Establish a federal/state leadership group to develop terms of state/federal relationship that will support objectives of advanced quality management system.
- Introduce financial incentives to both improve DDS performance and reduce administrative costs.

b. Long-term Options

Once a process for establishing agreements between SSA and the DDSs is developed, including the framework for the agreements, SSA and the DDSs would negotiate individual agreements with many common features. The features might include:

- Capitation payments.
- Other financial incentives for superior performance, tied to the (expanded) scorecard. Technical assistance to be provided by SSA.
- Conditions for modification and renewal of the agreement.

7. Option Area G: Initial Disability Determination Process

a. Short-term Options

SSA is in the process of completing a major overhaul of its initial determination process, through nationwide implementation of the Prototype. Implementation follows an extensive testing phase. While these tests have been important, they have also been costly to the Agency, and a significant burden on the disability determination process.

An organization that implements an advanced quality management system will seek to continuously improve its production processes. For SSA, this means continuation of efforts to improve the determination process, indefinitely. A key difference between such efforts and those that culminated in the Prototype is that they are more incremental. Because they are more incremental, testing should be less burdensome. Over time, improvement in management's understanding of the tools of continuous quality improvement (*Option Area C*), and in performance measurement (*Option Area B*) will also reduce the burden of testing.

Short-term options in this area are incremental changes to the Prototype process that SSA might want to develop and test:

- Use teams to manage workload and production in FOs. The role of FO supervisor could become coach and technical expert.
- Restrict FO responsibility for intake to non-medical information, and task the DDS with the initial medical interview.
- Share DDS electronic provider lists with FOs.
- Establish in-line quality processes at FOs and active process improvement teams that work on improving processes at every FO.
- Use sampling techniques to review the completeness and accuracy of FO claim submissions to the DDSs.

- Routinely rotate FO and DDS staff through each other's offices to provide on-site expertise on process and eligibility issues.
- Identify and test DDS ideas for improving the collection of Medical Evidence of Record (MER) and the use of Consultative Examinations
- Triage initial determinations to move clearly eligible cases into a fast approval cycle and potentially difficult cases into more intensive reviews
- Use DDS expert teams for difficult cases
- Develop and test innovations that reduce reliance on POMS
- Test written rationales versus check-list rationales versus intermediate formats

b. Long-term Options

In the long-term, continuous process improvement efforts for disability determinations would become routine, and innovations that prove successful would be adopted. Continuous improvement efforts would also be undertaken for other disability program processes.

8. Option Area H: Appellate Process

a. Short-term Options

Development of an advanced quality management system that incorporates the appeals process seems more problematic than development of a system for other processes because of significant organizational, management and process issues that are beyond the scope of this project. Hence, our short-term options in this area are limited, but also include a significant effort to examine fundamental issues with the appeals process:

- Include OHA leaders in all efforts to develop quality management leadership.
- Develop in-line HPI data collection, analysis and dissemination.
- Task the Appeals Council with the responsibility for being the primary source of information on appellate, due process and judicial issues for the disability programs.
- Develop an OHA scorecard.
- Establish a Task Force to examine potential reforms to the appeals process and its management.

b. Long-term Options

In the long term, it seems to us that SSA needs to go in one of two directions if it is to successfully establish an advanced quality management system in the appeals process. These alternatives are:

- Assign the responsibility for appellate quality management to OHA, measure performance, and hold the leadership of OHA accountable, or

Redesign the appeals process to include an SSA representative, and transform the ALJ's role to insurer of due process and judge of evidence presented by both sides.

B. Moving the Process Forward

It will take many years for SSA to complete the transformation from its inspection-based quality management program to a highly advanced quality management system. We say complete, because we think that process has already begun, as evidenced by the widespread recognition of the need for change at all levels of the organization, the efforts to improve the disability determination process, and the Agency's implementation of GPRA. We note that HCFA, which decided to replace its inspection-based approach 10 years ago, has made great strides, but had significant missteps, and is still in the process of change. Some might despair that this transformation is not possible for such a large, complex federal bureaucracy. We do not pretend to know how long the transformation will take, or how far the Agency will be able to go. Yet we are certain that substantial progress can be made in a few years time.

Moving forward will require buy-in from the many stakeholder groups involved – the Senior Executives, the leadership of the various central offices, the states, AFGE, and the ALJs. They all need to be convinced that the transformation will improve SSA's performance, empower them to contribute to improvement, and make SSA a better place to work -- which it will. A key point is worth repeating here: a highly advanced system focuses on improving the process and providing workers what they need to produce a quality product, rather than focusing on the detection and correction of individual errors.

Obtaining input from all stakeholders in all phases of the development of the new system is critical, because all have valuable ideas to offer, and because it will prevent missteps that could undermine the transformation. Ultimately, however, Senior Executives will decide to implement changes that will not be popular in all quarters because some employees, at all levels, will need to change what they do, in fundamental ways. Strong, determined, and sustained leadership will be necessary to see this through. Perhaps the greatest challenge to the Agency will be sustaining that leadership through the political cycle.

The relationship between the DDSs and SSA deserves special mention here. We are convinced that significant progress cannot be made toward improving the quality of initial disability determinations unless this relationship can be significantly improved. The DDSs need to have strong incentives that align their mission with that of the Agency, and need to be held accountable for their performance. At the same time, the Agency must support the DDSs in their efforts to improve their performance, and make the management of the offices within the Agency that provide support accountable for it.

As SSA moves forward, it should do so cautiously. It should look for low-cost changes that can demonstrate early success and more than pay for themselves. It should also avoid large infrastructure investments with uncertain outcomes. While large changes are needed, they can be made carefully, in steps. One way to accomplish this is by conducting demonstrations, to prove

the viability and value of a new approach, and to refine it. When we asked HCFA PRO leadership what they wished they had done differently, the answer was “more demonstrations.”

Cost will be a significant issue as the Agency moves forward. We believe that implementation of an advanced quality management system will yield process improvements that reduce costs, in the long run. In the short run, however, it is clear that investments will need to be made to achieve that objective.

While we think improvements in the quality management system will yield both quality improvements and lower costs, it is not obvious that the Agency’s quality goals can be achieved within its current budget. Many we have talked to who have lived through staffing cuts of recent years believe they cannot. One might also make the argument that disability program administrative costs are low relative to the value of the benefits that are being awarded, and by comparison to other public and private benefit programs. We do not have an opinion on either of these points.

As the Agency moves forward, it will need to address this issue continuously. The leadership must set quality goals that are in line with the Agency’s resources or, conversely, obtain and deploy the resources required to meet its goals. Failure to do so will undermine Agency morale and defeat its effort to develop an organizational culture that is focused on quality improvement. Use of evidence-based quality improvement methods should help the Agency obtain the resources needed to achieve its goals, because it should be better able to demonstrate the benefits from additional resources.

We conclude with some suggested first steps the agency could take to move the process along:

1. Have the Commissioner endorse the objective of moving SSA toward a highly advanced quality management system.

This would be a public statement that might include:

- A renewal of the Agency’s commitment to quality in the disability programs;
- A statement of what quality means to the disability programs at a high-level, enumerating the various components of quality;
- Support for empowerment to improve, to replace, and fix;
- Support for restructuring that supports integration of quality management into the determination process;
- Support for performance measurement and management accountability;
- Support for a renewal of SSA’s partnership with the states that incorporates the principals of advanced quality management systems;
- Support for quality management innovations that will promote national consistency and process unification; and

- Indication of some of the efforts that are under way or will be launched in the near future, such as those suggested below.

2. Establish a Disability Programs' Quality Council, to plan and oversee the transformation of the quality management system.

As we discuss in the presentation of *Option Area A*, this Council would consist of program leaders from all offices that play a significant role in the disability programs, and would be designed to build cooperation between the offices. For that reason, it is important that the Commissioner establish the Council's responsibilities and appoint its members in a way that avoids even the appearance that one of the existing offices is being elevated over the others.

Short-term objectives of the Council might be:

- Plan and launch a process improvement program, as described in *Option Area C*. This could include an invitation to the DDSs, the Field Offices, and the Hearing Offices to propose small demonstration projects, alone or in teams. Selection of projects should favor ones that can result in quick, measurable gains and that contribute to the development of key quality management process, such as in-line collection and reporting of performance data, specialization/teaming approaches within the DDSs, and increased interoffice cooperation.⁴⁰ *Option Areas G* and *H* both include several ideas that could be pursued.
- Initiate discussion with DDS directors and their agency heads on restructuring the federal/state relationship, as outlined in *Option Area G*.
- Initiate discussions among SSA Central Office leadership about the relationship between OHA and the rest of the Agency.
- Plan, pilot test and implement changes to PER, as outlined in *Option Area D*. We think it is important to put an improved PER system in place early, to guard against costly allowance errors during implementation of other changes. It would also likely result in early gains in national consistency and process unification.
- Develop plans for a demonstration under which selected DDSs would take over the first-tier performance measurement review of initial claims, with second-tier DQB review (see *Option Area E*).
- Start a review of how resources are allocated to the various offices, and look for ways to ensure that each office will have the resources it needs to perform high quality work in a timely fashion (see *Option Area A*).

3. Develop disability program senior leadership knowledge of advanced quality management theory and methods, as discussed in *Option Area A*.

⁴⁰ We think a good opportunity exists to design and test in-line performance measurement at the front-end of the Prototype hearings process, in the Denver Hearing Office, based on discussions we held with the management of that office during a site visit.

4. **Initiate a review of the appeals process to address the issues outlined in *Option Area H*, and other options.**

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