Public Hearing

before

ASSEMBLY LABOR COMMITTEE

"Testimony regarding the operations of the
Division of Disability Determinations in the
New Jersey Department of Labor"

LOCATION: Committee Room 8
Legislative Office Building
Trenton, New Jersey

DATE: October 19, 1993
10:00 a.m.

MEMBERS OF COMMITTEE PRESENT:

Assemblyman Patrick J. Roma, Chairman
Assemblywoman Virginia Haines
Assemblyman Stephen A. Mikulak
Assemblyman Robert L. Brown
Assemblyman Alan M. Augustine

ALSO PRESENT:

Gregory L. Williams
Office of Legislative Services
Aide, Assembly Labor Committee

Hearing Recorded and Transcribed by
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New Jersey State Legislature

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NOTICE OF PUBLIC HEARING

The Assembly Labor Committee will hold a public hearing regarding the operations of the Division of Disability Determinations in the New Jersey Department of Labor.

The hearing will be held on **Tuesday, October 19, 1993 at 10:00 AM in Committee Room 8, Legislative Office Building, Trenton, New Jersey.**

The public may address comments and questions to Gregory L. Williams, Committee Aide, or make bill status and scheduling inquiries to Cynthia D. Petty, secretary, at (609) 984-0445. Those persons presenting written testimony should provide 12 copies to the committee on the day of the hearing.

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TABLE OF CONTENTS

APPENDIX:

TABLE OF CONTENTS (continued)

APPENDIX (continued):

* Note: pages 41 and 48 were omitted from the original printing of the Hughes Committee transcript

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ses: 1-83

ASSEMBLYMAN PATRICK J. ROMA (Chairman): We're about ready to commence this meeting. At this time, what I'd like to do is to start with the Pledge of Allegiance led by Assemblywoman Haines. (Assemblywoman Haines complies)

ASSEMBLYMAN ROMA: If we could have a roll call of our members, Mr. Williams?

MR. WILLIAMS (Committee Aide): Okay.

Assemblyman Augustine?

ASSEMBLYMAN AUGUSTINE: Here.

MR. WILLIAMS: Assemblywoman Haines?

ASSEMBLYWOMAN HAINES: Here.

MR. WILLIAMS: Assemblywoman Weinberg? (no response) Assemblyman Brown? (no response) Assemblyman Augustine?

ASSEMBLYMAN AUGUSTINE: Here.

MR. WILLIAMS: Assemblyman Mikulak?

ASSEMBLYMAN MIKULAK: Here.

MR. WILLIAMS: Assemblywoman Haines?

ASSEMBLYWOMAN HAINES: Here.

MR. WILLIAMS: Assemblyman Garrett? (no response) Assemblyman Roma?

ASSEMBLYMAN ROMA: Here.

Let me say at the outset that, on a number of occasions, this Labor Committee has conducted oversight hearings in an attempt to get additional information from the executive branch. This afternoon we will have an oversight hearing concerning the workforce development. Today we are going to get into issues involving disability claims.

It's truly shocking -- shocking -- that the Department of Labor, which has been notified, is not present here this morning. We have put in a call to them. They have been notified and there is not a representative here. In the past, we have seen representatives here. We have asked various questions. And let me tell you that as a result of the questions that will arise this morning and the information that we will take by way of this transcript, it is my intention to

have those questions answered, one way or another. If it becomes a matter of oversight by this hearing or by having subpoena power, whatever it takes to get it done, we're going to do it.

I have a short statement that I would like to read:

This administration, more than two years ago, issued its Governor's Management Review Commission Reports on State Departments, as well as many cross cutting issues across Department lines. Their goals focused on efficiency in government. Yet today the Assembly Labor Committee has the sad task of sifting through information and taking testimony that tells us that the Department of Labor has still not cleaned up its act concerning the Division of Disability Determination's processing of claims so that those disabled and truly in need can receive benefits on a timely basis.

As Chairman of this Committee, I called this meeting after receiving correspondence from workers within this Division who are CWA members. In addition, some of my colleagues in the Assembly have also sent me correspondence concerning constituent problems in this area. The CWA workers here today have detailed and firsthand stories that question the efficiency, productivity, and effectiveness of the Division's operations. Their stories are substantiated by Federal reports that have criticized the New Jersey Department of Labor's management and claim processing capabilities. In the past, this Federally assembled management strike force formulated a comprehensive report citing 57 specific recommendations to address deficiencies in the New Jersey Department of Labor's operation, especially in regard to improving claims processing.

As of August 1993, the Committee was informed that New Jersey ranks last among the more populous, more industrialized states in yearly production per employee. New Jersey continued

to have one of the worst records in the nation for the number of delayed cases pending. In addition, New Jersey ranked dead last in the accuracy of its decisions based on Federal sample reviews.

Although an internal Department of Labor task force was established in 1991 to review organizational structure, investigate other reforms, and to improve agency performance, I believe the testimony being taken today by workers at various levels within the Division indicates that improvements have been too slow in coming; that, in fact, inefficiency still exists, and the victims of these inefficiencies are those individuals whose applications for benefits have been saddled down in bureaucratic paperwork, red tape, and inaction. This must not be tolerated, and this Committee will do everything in its power to change the situation.

We look forward to hearing from you, the CWA workers who are here today, and to talk about what is happening from the inside. Unfortunately, I am told that despite formal agenda notification issued way in advance of this hearing, that no Department of Labor representative will be here to answer my questions and the questions of this Committee which they may have in reference to our inquiries. In the past, we have worked closely with the Department to launch positive initiatives like the Workforce Development Partnership Program. I was hoping to have the same cooperative spirit on an issue that deeply affects Departmental efficiency. I am deeply disappointed that the executive branch will not be testifying at this meeting, nor responding to the questions that we have posed to them.

As I indicated before, not only did the Department of Labor receive notification, as is the case in all of our Committee meetings, but a special phone call was placed this morning. Apparently, their lines are either busy, or they do not have somebody picking up the phones. I will tell you that

it's a complete disgrace, and this is the first time I have seen this lack of cooperation. I will tell you this afternoon that when we get into the workforce development, we will get into areas dealing with worker's safety where it took over a year to implement some of the regulations, and it's only now that we see that movement. Apparently, the Department of Labor only moves when somebody is pushing them, and it's our intention to push them with whatever force that is necessary.

I understand that there are a number of speakers here. We also have a representative -- I believe it's Todd Noon -- from Assemblyman Gibson's office.

Welcome to our panel.

MR. NOON (Majority Staff): Thank you.

ASSEMBLYMAN ROMA: Assemblyman Gibson, Assemblyman LoBiondo, and Assemblyman Mikulak all brought similar complaints concerning the difficulties that faced the CWA workers. Quite frankly, when I first received the correspondence -- looking over it, I checked with all of my colleagues -- all members of the Committee, Assemblywoman Haines, Assemblyman Augustine -- and I find it shocking to see that with all the recommendations that we have from the Federal government, that so little has been done. In fact, with respect to national statistics, I find it incomprehensible that this administration has not addressed these issues.

At this time, I would ask if there are any comments from the Assembly members before we proceed with the witness list?

Assemblyman Augustine.

ASSEMBLYMAN AUGUSTINE: Just briefly to echo some of your sentiments, Mr. Chairman, I must say I have been in municipal and county government for more than 20 years, and I have never seen this kind of disrespect shown on either of

those levels of government. I'm very shocked and surprised to see it on -- in this body. So I don't believe that can be tolerated, and certainly would hope that we will move forward to assure that this does not happen again.

ASSEMBLYMAN ROMA: Thank you.

Senator Mikulak.

ASSEMBLYMAN MIKULAK: Mr. Chairman, I want to thank you for having this hearing, and I want to reiterate what Mr. Augustine said. I think it's shocking and unconscionable that the Department of Labor could not show up today. I agree with your comments, and I fully support them -- that we will do whatever is necessary, including asking the Speaker for subpoena power. If that's what it takes to get them to show up before this audience, we'll do that.

Thank you.

ASSEMBLYMAN ROMA: Assemblywoman Haines.

ASSEMBLYWOMAN HAINES: I would like to echo the comments made by Assemblymen Augustine, Mikulak, and yourself. I am also very upset the Department of Labor does not feel fit to come here this morning. We are the Labor Committee, and we want to hear from them. These individuals here are able to come here today, the least they could have done is done the same thing. I'm sure there is someone there that should have been able to be present in their office today that could come over and answer any questions that we may have, or any issues that are brought before us by the people that are here today -- that they should be able to answer.

Thank you, again.

ASSEMBLYMAN ROMA: Mr. Noon, do you have any comments to bring from Assemblyman Gibson?

MR. NOON : No.

ASSEMBLYMAN ROMA: I can only say that by the absence of the Department of Labor here this morning -- and they have a fairly large Department -- they must be embarrassed, and they

have good reason to be embarrassed. In the last couple of months, I've seen reports in the newspaper indicating the number of additional jobs. Then a few weeks later, apparently, retractions in the newspaper that the numbers were wrong -- all types of information that is disseminated. When the Department of Labor wants to put a positive image forward, they certainly do so even if the facts are incorrect. What we will have here is a record which will be sent on to the Speaker. As we've all indicated, one way or another, we're going to get to the bottom of this mess.

At this time, I would like to call on Carolyn Carmon, who is the Claims Adjudicator of the Newark office.

Good morning.

C A R O L Y N C A R M O N: Good morning. My name is Carolyn Carmon. I am a Claims Adjudicator II Specialist with the New Jersey Division of Disability Determinations. I have worked in the Division for the last 18 years, and I am a 30 year employee of the Department of Labor. In addition, I am also a Shop Steward for CWA 1037.

I would like to thank the members of the Committee for providing me with an opportunity to address some of the problems in our Division. Let me say that I sincerely hope that this time it may mean something that I testified. I testified a year and a half ago about the horrible state of affairs at Disability in front of the Hughes Commission. To my great disappointment, things have actually gotten worse. I also participated in a committee to evaluate and come up with suggestions to improve our office to the Department of Labor, in which Jim King was the head of it. I was anxious to help to improve the conditions and the ability to serve the public. Unfortunately, the committee was disbanded after we did our report. I never really received a copy of the report, but I can say that the condition for the workers and the claimants have continued to deteriorate.

It really bothers me that the claimants who apply at our Division for services get such horrible treatment. As someone who hears very depressing stories daily from people who drastically need our help, it's heartbreaking to know that the individuals that need it, and in fact, deserve our services are not able to receive our full attention.

When I first came there in the mid '70s, I felt a clear sense of purpose as I performed my job. I went home every night feeling that I did do a satisfactory job helping someone receive their benefits. However, at that time, too, the jobs basically -- it was clearly defined what your job was, and the claims adjudicators did professional work in serving the disability claims from the start to the finish. However, we also had about three clerical workers for every eight to ten adjudicators. At this time, we don't have that.

We also had claims adjudicator aides who had medical training. They received lectures on the different body systems, and it made it possible for them to really assist us in processing the cases. If we had to make phone calls to a doctor or a hospital, they would at least be able to speak to the doctor or that hospital on the terms that they knew. We no longer have that. They have this title, however, and they're doing other things, like in the morning they basically open the mail, which would be like a clerk typist, and in the afternoon they're doing development for us, or the determination letters that we need to do. This was done prior to this new system. This was really done by a word processing department, which we no longer have, at a higher rate of pay. They're still doing the same thing now for less.

Now, in 1993, I am totally demoralized about coming to work. Everyone I talk to describes how they go home angry at not being able to do a decent job and being frustrated. I'm not just talking about myself, but as a Shop Steward I have an opportunity to talk to other workers who fall into many job

titles -- from supervisors and adjudicators, to doctors and clerical workers -- about the morale at DDD is still going through the basement. Stress related illnesses abound and we have to refer people at different times.

There are really no clerical workers. Almost all of our clerical workers have become adjudicator aides. This is fine, but we never really replaced the clerical group. In 1991, because our office was rated number 53, they hired new adjudicators to come in to help reduce the caseloads from -- like we used to have like 250 to maybe 305 per person, so they hired these new people to help do the cases. In the meantime, they hired 90 adjudicators, but they never hired one clerical to assist those new adjudicators with the paperwork. I also made a comment about that at the Hughes Committee's report.

At the present time, the adjudicator aides -- they really have not had any medical training, because of that they can't really assist the adjudicator in any follow-ups with the doctor, the hospital, or the mental health clinics. There are many responsibilities that the adjudicator aide used to perform which medically un-trained aides cannot do. At the job, no one really can clearly define the job responsibilities. The adjudicator, the clerical worker, the aides, everybody has to really assist with opening mail, punching holes, entering data, and xeroxing. To me, it's insane to pay someone $40,000 a year to punch holes when they could be doing a more professional job, as far as getting medical evidence together to present to the doctors. We also have to do vocational assessment to see whether or not the claimant would have the ability to return to his past job, or if he would have the ability to perform some other one.

As one of my coworkers will testify, the adjudicator aides do clerical work identical to clerk typist work, and adjudicators do clerical and aide work. It's as if management took a whole pile of papers, threw it up in the air, and said,

"Go" to the workforce. Everyone is supposed to do what they can to clean up the mess, but no one takes responsibility for deciding how to go about it. Not only are the adjudicators doing clerical work and adjudicator aide work, we are also accountants and vocational specialists. We authorize payments to doctors -- work clearly done by the accounting professionals in the past.

We have fewer doctors and psychiatrists on our staff today than we used to have to do the cases. Some of them have been reassigned to the New Brunswick office. That was part of the regionalization. Sometimes the cases are sitting there for a week to two weeks because we have no one to see us. The psychiatric cases and the children cases which we receive, because of a new law -- a court case -- a lot of the children cases came back that we have to review. A lot of them have to do with children who were in special classes or have special needs. These cases take longer to review because they are complicated, but we don't have the support that we need to do this.

Since Maryann Polaski became the Director, there have been a lot of jobs that have been created. We used to have two Assistant Directors -- one for claims and one for policy. Now we have two for claims and one for policy; these positions cost about $63,000 a year. Also, when Maryann Polaski came to Disability, she also brought along Sue Lieto, who she said was used to her management style. So she has some position there, I really don't know -- some kind of executive position that pays about the same salary, but actually what that person does we really don't know. At $60,000 per year, we could probably hire three clerical workers, or at least one and a half adjudicators to help move the cases along, instead of people being burdened down with a caseload of, say, 150 to 200, which is really uncontrollable.

So, what we have here is a big problem. We have practically no clerical support, adjudicator aides who aren't allowed to do their jobs, overworked adjudicators, and a growth in management.

In addition, we have this absentee management. Most of the workers in the Newark office don't even know what Maryann Polaski looks like. She rarely shows her face in Newark, and the coworkers feel that she's afraid to come onto the floor to see what we do. As a shop steward group at our office -- we have about 10 to 12 shop stewards -- we have sent her a letter to ask to meet with her. She never really responded until four in the afternoon, when the day was almost over, to speak to us or tell us ten minutes before to meet with someone else -- have her secretary call and say to meet with someone else, who really doesn't have -- cannot tell us about the policy that we needed to speak with her personally, because she's the only one that could do that.

Committee members, all of the above is bad. I wish I could say that the reason it is so bad is that the Department did not know how things are. Unfortunately, I and my coworkers have said it all before.

Before the Hughes Committee in 1992, I said that our work environment was characterized by stress and crisis. For the greater part of the last year, we have been working overtime in the morning, in the evening, and on Saturdays. Many of our caseloads are high, and the sheer stress of working with hundreds of seriously disabled men, women, and children is in itself overwhelming at times. They put us in a situation where we are forced to work on the easiest case first, and the most difficult case goes to the bottom of the pile in the face of the pressure to reduce processing time and push cases out the door. This is not doing our clients any favor.

Ten years ago, there were about three clerks of varying levels for every eight to ten adjudicators. Clerks opened the mail; they tracked development. Today there is an

average of one clerk for every ten adjudicators. In practice, this means that one clerk may be responsible for 200 to 3000 cases. It all depends on the person's caseload.

Despite this severe clerical shortage, the Division did nothing. Like I said, when we hired the 90 new adjudicators, they didn't hire one clerical to support them. The Division has informed us that they have no plans of hiring additional clerks, as they believe that the new computer system will eliminate any clerical tasks.

The Browde report, which was done in 1987, said that "the morale among the agency staff is not just low, it's terrible. Morale does not improve by wishing it would, or simply saying things take time to change. But at DDD, the only way morale will improve, and thus production, is through concrete systematic changes to assist the adjudicative process."

Clerical workers should be hired immediately so that we can avoid correspondence sitting in printers for a week or more because they cannot be mailed out, because it is almost humanly impossible to get all of this mail out. A lot of the claims -- they don't just have one piece of mail, because some of these people have been from hospital to hospital, doctors to doctors, and they have sometimes seven or eight pieces of development that need to be done in order to get their claim processed.

Also, with the children we have to send correspondence sometimes to the teacher, to the Child Study Team in order to find out what their scores are. How does the child get along with his classmates, and also with the teacher? Does he need definitely special attention, maybe on a continual basis? We need to have this evidence and this takes time.

Basically, nothing has changed. All of the things that I stated are still the same. I really hope that this Committee finally can put some changes into place that will

allow us to perform this extremely important job of providing services to New Jersey's disabled citizens in a fair and efficient manner.

Thank you.

ASSEMBLYMAN ROMA: There may be a couple of questions from the Committee.

Assemblyman Mikulak.

ASSEMBLYMAN MIKULAK: Yes. I want to thank you for your testimony. It's very enlightening. From what I understand-- First of all, my questions really should be directed at the Department of Labor employees in management who are not here, so I'll excuse you if you can't answer them. But you try the best you can, okay?

It's my understanding that an approved list of doctors actually handle disability claimant applications. The Division makes payment to the doctor when he notifies them that a patient has been seen. Now, our reports indicate that the doctor's actual report may not come until as late as six months after payment has been made. Do you have any information to that effect?

MS. CARMON: The report may come in six months after the case is either completed, or either that we are forced to send the claimant for a consultative examination.

ASSEMBLYMAN MIKULAK: That's intolerable. That is something that they could do with their contract employees, that the DOL could just have them submit this in a timely fashion, and then pay them after they receive the reports instead of before. I mean, it's something that simple. You talked of growth in management positions. Just roughly, approximately how many clerical workers could be hired if the Department of Labor eliminated this new growth in management positions?

MS. CARMON: I would say probably about 25.

ASSEMBLYMAN MIKULAK: There you go.

MS. CARMON: The least -- the least -- is about 25.

ASSEMBLYMAN MIKULAK: Right. There are some simple answers to these problems, but why do you think that the Department of Labor is dragging its feet on reform?

MS. CARMON: I haven't the slightest idea, because as you know and the Chairman spoke before, they first had a Federal task force that Gwendolyne King sent to our agency with people from all over the United States from different offices, that came to our office. They stayed there for quite a few weeks, and they gathered up the information or the errors that they saw in our office. They gave them -- I think it was 57 or 58 things that our office should pursue in order to clean up the act.

ASSEMBLYMAN MIKULAK: I've seen that.

MS. CARMON: Then after that, Commissioner Bramucci--

ASSEMBLYMAN MIKULAK: Yes.

MS. CARMON: --also had a task force, which was headed by, I told you, Ms. King, and we also gave suggestions. I don't have-- I never did get a copy of that report, but I know that some of the things which to me are minor, but not minor -- was just even about photocopying machines which we need in our agency, and we haven't even gotten those. I know that why I'm saying that one of the suggestions is -- because I had to do with equipment and stuff like that, and what could make our job possibly easier.

One of the things that we need is photocopying machines, otherwise we used to only have three. One was the kind that they use in the five-and-ten or the library. You're talking about heavy photocopying, because if a child is disabled or something like that, we have to refer those cases to another agency for possibly them giving some additional assistance to the parents. Well, we have to photocopy this -- our medical information or from the school, and send that to

that agency, like it's a Children's Unit here in Trenton. Our building is a city block, and if you could just imagine that if you go to one photocopy machine and it's not working, or if it's broke down, you have to walk another city block to stand in line -- with I don't know how many other people -- trying to get something photocopied.

In the meantime, our agency has a training department-- Or if they get some new directive from the Federal government that has to be photocopied, they send one. You're talking about 400 copies being stapled together. It may be 10 pages or more. So that's going on in the meantime. The person that's working that machine has to stop doing what they're doing because the other machine is broken, or they're waiting for the repairman to come to allow us to photocopy what we need. So I think that they can do a lot better with the photocopy machine. To me, that's not that expensive that you couldn't have enough--

ASSEMBLYMAN MIKULAK: Right.

MS. CARMON: --to help with the work, considering what we need to do.

ASSEMBLYMAN MIKULAK: Right. Could you provide this Committee with a list of any and all documents and reports that you requested from the Department of Labor that you haven't received so that we can request them and, if necessary, at a later point subpoena them?

MS. CARMON: Okay. I could probably get together--

ASSEMBLYMAN MIKULAK: Yes.

I would like to just remind the Committee and the public in general that in 1992 the Legislature put language in the Fiscal Year '93 budget directing government -- the Governor to cut mid-level management positions over workers, and he went to court and he won that round. That's possibly a reason why you've seen the growth in mid-level management where it hadn't existed before.

I want to thank you for your testimony and we'll work with you. Thank you.

MS. CARMON: Are there any more questions?

ASSEMBLYMAN ROMA: Assemblyman Augustine.

ASSEMBLYMAN AUGUSTINE: Thank you, Mr. Chairman.

I just have a couple of questions. Perhaps in your own words you could briefly describe the net effect of the situation on some or more of the clients that your office services. Does it create an extremely tumultuous and emotional situation on the part of your clients?

MS. CARMON: Well, not only the client, it also puts an emotional pressure on you as the worker. We have lists there, you know, whether you're good or bad, how long you keep your case there. If it's over 270 days, these cases go on a list and you're sort of harassed on a weekly basis, "Do you have this case done? Do you have that case done?" Well, sometimes you cannot get to the case, and it's not because you don't know what you're doing. But if you have very hard, difficult cases, they take time. And when you have a caseload like that, sometimes that's completely unmanageable. You cannot-- You're just wiped out by the end of the day.

The claimant, of course, is waiting, because this is money to them. This is whether they're going to have insurance coverage, whether they're going to be able to save their house. Are they going to lose their house because it's taking you a long time?

People have become homeless because we -- not that we haven't maybe done their case in a timely manner, but people also move. We serve the homeless. We also serve people that have AIDS, and sometimes it's very difficult. Families move from place to place, and it -- sometimes it's very hard because people today -- still some people do not have telephones. It's very hard to get people, or they might start out having a phone, but because of their financial situation, they no longer have a phone when you're halfway into processing their case.

ASSEMBLYMAN AUGUSTINE: In your dealing with middle management, do you find them to show any serious concern, is it indifference, or are they kind of just ambivalent about everything? Is this above them, or do they really show any degree of concern about the problems?

MS. CARMON: No, I don't really even think they understand what we're doing on a daily basis. They have no idea, no concept of what it takes to get a case from the day that it comes in until the day that you move it out of there. They don't understand the stress that you go through in order to even do a halfway decent job, and everybody basically tries to do a decent job. I don't think anybody sitting at work tries not to, because you have to talk to these people every day on the telephone. They call you, "Did you hear from my doctor yet?" Which of course it's not my fault a lot of times the doctor they've been going to for years -- they don't send in the report. I mean, to me that's hard to face -- a doctor or someone that you've been going to and spending your money for years, and they're not even willing to cooperate with the agency, or for the person, sometimes to get the report in. So this is what we have to deal with.

ASSEMBLYMAN AUGUSTINE: If that is the case, why are they still on the list of eligible physicians if they don't cooperate?

MS. CARMON: The doctors?

ASSEMBLYMAN AUGUSTINE: Yes.

MS. CARMON: They own their private practices -- the doctors throughout the whole State of New Jersey. They have offices, and people go to these offices. The doctors that work on our staff do not see any of these individuals. They just read the medical evidence that we obtain from the hospital, from their doctor, from the schools, from the mental health clinic. The doctors that are on our staff -- that's what they do.

ASSEMBLYMAN AUGUSTINE: My point is -- and I'll yield quickly, because I know we've got a lot to do here -- what degree of oversight do you have on these physicians that are not furnishing the paperwork that you need?

MS. CARMON: Well, I don't know what people could do. The only thing I think is, if they notified the medical society, like the patients -- the doctor's patients-- If their doctors don't send in the report, I think they should probably notify the Medical Society, and maybe eventually they will get these reports in.

ASSEMBLYMAN AUGUSTINE: Because if they don't comply, you're absolutely stymied?

MS. CARMON: Right, we're stymied for a while. We have a follow-up procedure that we do and, like I said, hopefully you try to give them a chance to send in the report, because he has seen this patient maybe for a year, two years, or more. So you would really rather get his report about his patient instead of having the patient sent to someone who just sees them one time, like a consultative exam.

ASSEMBLYMAN AUGUSTINE: My only point is, it would seem to me that these physicians have a certain degree of responsibility if they're going to continue to work for your Department. If they don't want to do it, they shouldn't be allowed to continue. That's just my commonsense approach to it. Anyway, we can address that.

ASSEMBLYMAN ROMA: Thank you, Assemblyman.

Assemblywoman Haines.

ASSEMBLYWOMAN HAINES: A lot of the questions I was going to ask were answered. I just want to say, when the Department of Labor -- I mean, they've made commotions with regards to the people that were clerical workers and then went on to become adjudicator aides or adjudicators, and then they did not replace the clerical people. When it was brought to the attention of the Department of Labor, what was their

response? I mean, to say-- It's very nice to promote people and it's very good, but when you're not getting the workload done and things are getting backlogged, and you go to them and say-- What is their reponse to you with respect to not hiring more people? Do they seem to be concerned, or are they just brushing it off?

MS. CARMON: No, they're not concerned. Over five years ago, we had a meeting before they even decided to make people recently into claims adjudicator aides -- a new group of people--

ASSEMBLYWOMAN HAINES: Right.

MS. CARMON: We had a meeting with the Directors in their office to ask if we possibly could hire more clerical staff, and they told us no, because at that time, they were going to be coming up with the computers, they said, which should handle the work. Yes, it handles the work as far as -- if it's working. I shouldn't say that if the computer is working, because the other day it crashed. It was out for a few days, and we were unable to do any work -- not any work, but other work and nothing on the computer. It might get the piece of development that needs to go to a doctor or hospital off faster, but then you need somebody by the printer to take that off, associate together with the authorizations, and put it in the mail. There really are no people to really -- not enough people, I should say, to really handle that.

ASSEMBLYWOMAN HAINES: I know some of the questions you're not able to -- that I'm thinking about, because the Department of Labor really should be answering. But, I mean, when they go to make promotions, normally you would have an idea of: You have "X" amount of clerical; you have "X" amount of Aides; "X" amount of adjudicators--

MS. CARMON: Right, that's what I though too, but--

ASSEMBLYWOMAN HAINES: --and then other personnel that are in a specific department. When you're going to make promotions, you normally would think, "Well, if we promote

this one, then we're going to look at the workforce and see what -- how the work is going to be able to be completed with adding, taking away, or putting in different areas." Apparently, they either did not have any type of an agenda, so to speak--

MS. CARMON: No, they didn't.

ASSEMBLYWOMAN HAINES: --to go to. They just went and promoted, and were not more or less worried about what was going to be happening with the workforce -- with the workload that was put on the individuals still there.

MS. CARMON: Right. Well, they figured that we'll all take care of the mess. Basically, they figured if you know that your letter is not going out and somebody doesn't have it, you're going to try to get to that pile of work over there and get your letters out so that they can be mailed. But that's not really what you're supposed to be doing as an adjudicator anyhow. What you're supposed to be doing is reviewing the medical evidence so that you'll be able to present this to the doctor.

ASSEMBLYWOMAN HAINES: Okay, so the other thing that was mentioned is that the doctors are usually getting paid prior -- because it was brought up -- prior to the report coming in. Well then, what is the effect on the individual themselves that are supposed be receiving claims, or any moneys, or-- How does it affect them, the individual that is being seen by the doctor? That has to have some effect on them. Do they get claims kept from them through Disability?

MS. CARMON: The thing is, the doctors that work on our staff -- they do not see any of the clients. They do not see any of the clients in the State of New Jersey.

ASSEMBLYWOMAN HAINES: So it's only the doctors that the individuals themselves go to?

MS. CARMON: The doctors that are out in the public, private -- out in private practice that sometimes delay sending us reports concerning their patients.

ASSEMBLYWOMAN HAINES: So what are the doctors on staff supposed to be doing, just reviewing?

MS. CARMON: They review what they can review. If I take a case to them, they review what they can. If they can't make a determination because this doctor or this hospital has not sent in a report, then what we do is ask if we can please buy a consultative exam, and that's what we do for the person's impairment. I mean, someone who has a severely life-threatening disease like cancer of the brain or something like that -- I would hope that some hospital or a doctor would send that report in.

ASSEMBLYMAN ROMA: I have a couple of questions, and one perhaps goes back to a letter that was sent to the Governor. I believe it was sent in September. It is my understanding that the Department of Labor broke apart the centralized Newark division, placing one quarter of the agency in New Brunswick. It seemed to be some sort of a question as to there was no need for space, or there was some sort of an issue regarding space shortage. Are you familiar with that?

MS. CARMON: No. They had basically most of the room, because we have a complete third floor, and then there was the fourth floor. They shared that with another division, which I thought at one time they said they were going to ask that division to move into a smaller space.

ASSEMBLYMAN ROMA: But there was no Federal mandate to make the move. Why was it done?

MS. CARMON: I don't know. Because to me, I wouldn't understand why you would move somewhere else at that time when you don't even have the place you're living in together yet. I don't know.

ASSEMBLYMAN ROMA: I understand. Believe me, as we've indicated here, we would have felt more comfortable trying to get some of the questions answered from the Department of Labor.

MS. CARMON: I know that other states-- When we did this study with Jim King, I know that they went to other states and cities like Boston and other places. They have offices around the State in different areas. That's okay if you have the main headquarters sort of functioning on some of those suggestions that were given by either the Federal government or by the task force that was done from the Department of Labor, but if you're just going to move some place to say, "Well, this place is working," when it's not really working because the headquarters isn't working--

ASSEMBLYMAN ROMA: What I don't understand is the Department of Labor seems to offer the high case receipts as an excuse for some of these problems, but what is not acknowledged is the fact that the Social Security Administration provides the State with many of the resources.

MS. CARMON: Yes.

ASSEMBLYMAN ROMA: One excuse is being offered for the other. We go back to that report that we referred to. There was an article in The Star-Ledger going back as far as May 24, 1991, and there should have been a clear signal as to the problems that existed. The Social Security Administrator, Gwendolyne King, described New Jersey's record of handling disability claims as the worst in the country.

MS. CARMON: Yes.

ASSEMBLYMAN ROMA: And announced that she is sending out a special management strike team.

MS. CARMON: Which she did.

ASSEMBLYMAN ROMA: Okay. By almost every index, New Jersey is the worst performing State in the nation.

MS. CARMON: They failed to say that a lot of these other states -- the people who are working in the office as adjudicators -- they have caseloads somewhere between 90 and maybe 120. They have the support staff to support them. Here

you're working with a caseload of maybe somewhere from 150 to 200, or 300 at different times. It all depends on how many cases are coming in.

ASSEMBLYMAN ROMA: My question-- You appeared before the Hughes Commission?

MS. CARMON: Yes.

ASSEMBLYMAN ROMA: When was that report issued, or when did they have those hearings?

MS. CARMON: It was a year and a half ago, and it was down in Cape May County.

ASSEMBLYMAN ROMA: You gave all of this information to the Commission?

MS. CARMON: Yes.

ASSEMBLYMAN ROMA: And none of those recommendations were implemented?

MS. CARMON: No. I mean, I not only said that the Federal government gave -- Gwendolyne King's task force gave our agency 57 recommendations that they wanted to see done for that agency. Bramucci's task force, which I was on, also gave suggestions to our agency. The only thing they did was remove one director, and they put another one there. They brought two more people in to do what one person was doing before, and then they added on some more people. That's all I know.

ASSEMBLYMAN ROMA: Well, I certainly appreciate the comments you have made. I want to thank you, especially on behalf of the Committee, for bringing this information to our attention. As you can appreciate, until this information was brought to our attention, we really thought that a lot of what we were talking about, at least as far as the Department of Labor was concerned -- that some of these areas were being addressed.

I want to thank you for bringing this information, because now we're finding out that these implementations had not been implemented and we need a course of action. What I

will suggest to you, and to all of the members that are here, is that perhaps internalize within your own operating procedure. When you're dealing with some of these superiors or managers, perhaps put it into a memorandum form so that we can keep a record as to whether or not there is an improvement. I can assure you that if we see those memorandums being exchanged, and if we do not see a dramatic change, we will have hearings, after hearings, after hearings.

MS. CARMON: Okay, I will do that.

ASSEMBLYMAN ROMA: But the bottom line is, as I meant before and as I said, there is a frustration level which you can appreciate that I have, and the other members of the Committee have that the Department of Labor should have responded. There were many questions here that we wanted to ask them in terms of the backlogs, and in terms of a lot of these issues. I'm sure if they had anything positive to say, they would have been here in this room. But one way or another, they're going to answer those questions.

So I have two requests of you: to go back, and to keep memorandum in terms of information back and forth so that somebody from the Department of Labor does not say, "I wasn't aware. I did not hear it. The dog ate the paper." Or whatever the excuse might be.

MS. CARMON: Okay.

ASSEMBLYMAN ROMA: The bottom line is that we'll have those records. Okay?

MS. CARMON: Yes.

ASSEMBLYMAN ROMA: Let's not assume anything.

MS. CARMON: Yes. Okay, thank you very much.

ASSEMBLYMAN ROMA: Thank you.

Frank Aria, of the Newark office?

Good morning.

F R A N K A R I A: This will take a minute, Mr. Chairman.

ASSEMBLYMAN ROMA: Sure.

Ms. Carmon, if you would -- any of those memorandums or information that you think might be helpful to the Committee.

MS. CARMON: (from audience) Yes.

ASSEMBLYMAN ROMA: Once you have received it, it will supplement our file in terms of having additional information. If you have additional questions that you would like answered, be assured of the fact that we will get answers.

MS. CARMON: I just wanted to say, if you think that you feel frustrated by the Department not coming today, this is how we feel on a daily basis. (applause)

ASSEMBLYMAN ROMA: Is it Mr. Aria?

MR. ARIA: Yes, Mr. Chairman.

ASSEMBLYMAN ROMA: I understand that you will have the technical details?

MR. ARIA: I would say so, Mr. Chairman.

ASSEMBLYMAN ROMA: And perhaps give us a better idea as to why we closed one office, moved to another office; why we don't have the personnel available; why the Department of Labor tells us that we don't need help? We do need help.

MR. ARIA: Yes, Mr. Chairman.

ASSEMBLYMAN ROMA: Proceed.

MR. ARIA: I'd like to read a statement first, which will take about five minutes.

ASSEMBLYMAN ROMA: Sure.

MR. ARIA: Then I'll tell you what I have, and depending on how you want to do it, you let me know.

ASSEMBLYMAN ROMA: Fine.

MR. ARIA: Mr. Chairman, and members of the Committee, thank you for this opportunity to express my views. My name is Frank Aria, and I appear before you as a private citizen. I'll add that I am an employee of the Division of Disability Determinations. I work as a Quality Assurance Specialist, and I've been with the Division since 1973.

The Department of Labor contends that its Division of Disability Determinations has achieved a record of substantial improvement since 1991, when massive Federal assistance was needed from special contingency funds. In particular, the Department emphasizes the apparent success of a DDD branch office opened in New Brunswick last December. Let us examine these assertions more carefully, bearing in mind that the three signs of success in the disability program are high productivity levels, speedy claims processing times, and high accuracy rates. Recent Federal reports reveal the following levels of performance for New Jersey:

1) As of August 1993, New Jersey ranked 44 among the 50 states in yearly production per employee, last among the more populous, more industrialized states.

2) As of August, New Jersey continued to have one of the worst records in the nation for numbers of delayed cases pending. Nationally, 27.6 percent of the pending inventory was in the "delayed" category versus 42 percent for New Jersey.

3) For Fiscal Year 1993 -- October 1992 through August 1993 -- New Jersey ranks dead last in the accuracy of its decisions based on Federal sample reviews.

What accounts for this signal failure to convert millions of dollars worth of large phased staff increases and hundreds of elaborate IBM workstations into at least average, an average level of performance for the citizens of this state? How credible is the Department's story about receiving too many cases to handle? Not very credible at all. The average caseload per examiner in New Jersey is right in line with the national average. I would add here that having seen even more recent statistics than I had when I prepared this statement, on average New Jersey had significantly less of a workload than the rest of the country for Fiscal Year 1993.

In my view, this failure to capitalize on this State's share of the 1991 Federal contingency funding can be traced to the administration's singular focus on making a showpiece out

of the New Brunswick branch office. Throughout that process, the performance of the Division's much larger operation in Newark has been allowed to decline. This has been a clear case of robbing Peter to pay Paul.

To illustrate the point, consider the workload assigned to the New Brunswick branch. The locations of the Federal intake centers linked to New Brunswick are, as a group, underrepresentative of the State's larger urban population centers. This is important to note for two reasons: First, proportionately fewer cases are sent overall to New Brunswick -- I stress the word proportionately -- compared to Newark.

Secondly, relatively fewer of the New Brunswick claims involve SSI, the more time-consuming part of the workload. This is the demographic key to understanding how management has stacked the deck to create a favorable statistical profile for New Brunswick over Newark put into effect from the day the branch opened on December 14, 1992. From that day to this, caseload sizes in New Brunswick on average have not approached those of Newark. With respect to workload distribution, the paying field has always been tilted.

The other key to understanding the true nature of the productivity success of New Brunswick is the level of accuracy management accepts for claims decisions made there. The results of internal quality assurance reviews over time confirm markedly higher error rates in New Brunswick than in Newark. Management's toleration of lower accuracy rates in New Brunswick has quietly facilitated the boosting of that branch's output necessary for the creation of the success story now being told.

To summarize, with respect to speedy processing of claims, it is fair to conclude that the disability program in this State, as presently administered, is following an unwritten policy of discrimination against many people who live in urban centers, especially those filing SSI claims, by

diverting a portion of their fair share of the Division's resources to New Brunswick -- the showpiece office. Conversely, many claimants from the New Brunswick region would likely receive more accurate decisions if they received service from Newark.

To conclude, the regionalization and decentralization policies of the Division of Disability Determinations have exacted a heavy price in terms of overall agency performance. The administration proposes more of the same, rationalizing the proliferation of branch offices with contrived tales of great improvement and success. Surely something can be done here to raise the level of public policy above routine executive self-interest.

Thank you for listening to me. I would be pleased to answer any questions you may have, or if you prefer, I can present much more detailed information from my notes.

ASSEMBLYMAN ROMA: Sure.

Are there questions from the Committee?

ASSEMBLYMAN MIKULAK: Just one question. Can you speculate as to why DOL made this move?

MR. ARIA: New Brunswick?

ASSEMBLYMAN MIKULAK: Yes.

MR. ARIA: Not in one or two sentences. But if you would give me the time, I would try and lay it out. I think that is a very important question, and I would not like to gloss over it by giving you a one-liner.

ASSEMBLYMAN MIKULAK: Right.

MR. ARIA: Much of the information you see here concerns your question. (indicating testimony)

ASSEMBLYMAN ROMA: Proceed.

MR. ARIA: I have--

ASSEMBLYMAN ROMA: And could you indicate -- was that an existing facility?

MR. ARIA: New Brunswick--

ASSEMBLYMAN ROMA: We're always concerned with the ownership of facilities in this State.

MR. ARIA: New Brunswick was a building -- 506 Jersey Avenue -- that was renovated into a DOL one-stop shopping center -- a cluster of DOL offices. Now, it is my understanding that there was space available in that building, but nobody to put into it. That's my understanding. This Division at first was going to stay in Newark, but then it was decided to put -- fill up that building at 506 Jersey Avenue.

ASSEMBLYMAN ROMA: The reason why I ask the question -- and you can appreciate where I'm coming from -- is that often we read about in the newspaper that someone owns a particular piece of property--

MR. ARIA: Yes. I attempted to try and find out who owned it. I was not successful. I only heard speculation, which I don't want to put in the record because I have no way of verifying it.

ASSEMBLYMAN ROMA: Okay. I'm going to direct staff to make an inquiry concerning the ownership of the property.

MR. ARIA: I think that would be--

ASSEMBLYMAN ROMA: Because there may very well be some cause or relationship as to why there is a shift from the Newark office to New Brunswick. I would like to do that with all deliberate speed, but if we have to convene another hearing with subpoena power, we will do so.

Proceed, please.

MR. ARIA: Yes, Mr. Chairman. I did attempt to find out specifically who owned the building. I had heard rumors that I could not substantiate, so I was not successful in determining who owned the building. I was told by people who looked into it that there was one story from the Department of Labor, and another story from the municipal level. Who owns this building? The municipality says one thing, and the DOL said something else. That's what I was told by people who tried to look into this.

Now, just to outline for you what I have here, I have a series of notes which I'd like to go through, and I also have the supporting documents for what I say in the notes. If there is anything that is not understood, or anything you would like clarified in terms of the original source-- For example, if I say Sharpe James, the Mayor of Newark, wrote to me that there was no space problem in Newark, and he got that from Commissioner Bramucci -- I can produce the letter that Sharpe James wrote that in. Now--

ASSEMBLYMAN ROMA: Have you received a response -- and I don't mean to interrupt you, but I understand that you directed a letter to the Governor, September 26, 1993. I believe it was a three-page letter.

MR. ARIA: Correct.

ASSEMBLYMAN ROMA: Have you received any response at to all of those questions?

MR. ARIA: The September 26 letter is the last letter I wrote to the Governor, and I have not received a response. I would add, though, that I have found the Governor's Office to be responsive in that it does refer things to the Department. I don't feel I've been ignored. I feel the problem is in the Department in terms of answering things, not in the Governor's Office.

ASSEMBLYMAN ROMA: You still have not received an answer?

MR. ARIA: I have not received any correspondence concerning this letter.

ASSEMBLYMAN ROMA: I guess what I was asking -- have you received answers to your question? Whether you sent it to the Governor's office and they sent it over to the Department of Labor and it's sitting on someone's desk over there, to this date have you received answers to your inquiries?

MR. ARIA: Yes. I would like to discuss those answers.

ASSEMBLYMAN ROMA: Sure. Go right ahead.

MR. ARIA: In sequence, just to put a focus on all of this, I think the two issues here are the level of performance of the agency, first of all; and secondly, the issue of decentralization, because it pervades everything.

Now, to discuss letters: I send letters to the Governor. I get responses back from the DOL and other sources. The letters I send-- I began sending them on February 2, 1990, which was, I believe, the first month of the administration -- first full month. The letters that I wrote described serious problems in the Division in terms of its performance, processing time, and accuracy. We had thousands of continuing disability review cases stored in files for years, and it was actually called CDR storage. CDR, meaning Continuing Disability Review, it's a type of case. I explained about the pressure that the examiner's staff was under to meet production quotas at the sacrifice of accuracy. I went into great detail about these things. They weren't just conclusions.

I would say that over the course of time, I wrote approximately 50 letters numbering some 200 pages, with charts showing New Jersey was last in processing time and accuracy. Most of the time I was writing, I made the charts so detailed so you knew the rank of every state in the country, and New Jersey was always written down last. I explained that the accuracy assessment being done by the Federal government was subject to manipulation, and that New Jersey had a very low accuracy. It might even be worse due to the manipulation factor. We really don't know what the bottom is.

I explained to the Governor that there was an elaborate ploy to raise the accuracy rate shortly before the Federal strike team came in, a ploy involving withholding the less accurate cases from Federal review until a critical period passed, so that management could be safely through that critical period. I explained this in great detail in a

letter. I pointed out the relationship between the accuracy rate of the agency and publicity; between the accuracy rate of the agency and bureaucratic targets; between the accuracy rate of the agency and the threshold level that endangered management. I clearly demonstrated that when there was adverse publicity; or when there was a report that said that a target that had to be made; or when this threshold level was approached, the accuracy rate shot up. To my way of thinking, it defies logic to think that these rates would be normally rising practically only when there was adverse publicity, danger to management, or some similar situation.

Now, I also explained that there was a great deal of assistance rendered to this agency in 1991 in terms of tens of thousands of overtime hours -- well over 100,000 overtime hours in 1991. Federal details coming into the agency, sitting down, taking over desks, and moving cases -- actually doing the cases. We had a four-man detail there for approximately a year and a half doing CDR's -- the ones that I spoke of that were in storage -- Federal people assisting the agency to do its work. We had the Quality Assurance Unit put on production during late '91 and throughout '92 -- the whole year -- put on production with the Federal people taking over the State quality function. So the Fed's were doing the Fed quality and the State quality, so the State quality could be thrown into production.

All of these things were designed to improve the agency's performance profile. These things are not recognized today when management says they worked wonders. They don't mention the overtime, the Federal assistance, and these staff shifts.

I also discussed in great detail New Brunswick: the move, why I felt it was more or less the same thing we had done in the 1980s with the Camden office, regionalization -- same

thing we did in the 1980s, all of which was abandoned. This was a repeat. I explained the reasons why it failed then, and I explained the parallels between what was being done now and what happened then.

Perhaps the most consistent theme of these letters was the performance record of the agency. At one point in February of 1991, I wrote in one of these letters that New Jersey was the worst performing State in the country. This attracted attention. I received a letter back agreeing with the statistics behind that conclusion, oddly enough, but disagreeing with the conclusion, which I thought was very illogical. Approximately three months later, the Commissioner of Social Security said the same thing in the press, that New Jersey was the worst in the country -- in May of '91. I make the point not to say, "Well, I was right." I make the point to stress the attitude and the evolution of the Department's response to all of this. In the beginning, their responses to me were, "Well, there's a problem. We're aware of it. We're working on it. Improvement is right around the corner."

They made excuses, this or that adhoc problem of the moment. That type of letter I received early on -- one about processing time and one about accuracy, one letter from the Commissioner himself, and a second letter from an Assistant Commissioner. Then after I wrote that we were the worst in the country, I received a letter in March of '91 from the then Director of the Division disagreeing with the fact that we were the worst. And then the more recent letters focus on the Department's story of improvement and the success of New Brunswick, which of course I disagree with. That is an overview of what I sent to the Governor and to other officials in the Office of the Governor, and what I got back.

I would call attention specifically to a letter I referred to earlier from the Mayor of Newark, Sharpe James. The Department was insisting that there was a space problem in

Newark, so I wrote to the Mayor and I said, "The Department is planning to move one-quarter of the Division out of Newark because of a space problem. I don't believe there's a space problem," and I explained why.

The Mayor looked into the matter and wrote back to me in May of '91 -- excuse me, in '92. He said in the letter, "The article in The Star-Ledger"-- This is after the Mayor explained that he had contacted Commissioner Bramucci, so what he is saying is based on what Commissioner Bramucci told him. Commissioner Bramucci is named in the letter. The Mayor was assured. He writes that, "The article in The Ledger (sic)"-- He's referring to an article in The Ledger about the space problem. "The article in The Ledger was somewhat misleading in that it stated that the move was based on space concerns and high rent. I have been assured that this is not the case."

The Department went before the Hughes Subcommittee on Aging -- The Committee on Aging, the Subcommittee on Employment and Retirement Income. At the hearing, it was stated by Commissioner Bramucci, "We simply don't have the room in Newark to expand with those 90 people or so." Those are the adjudicators that you heard spoken of earlier. The 90 were hired in phases in 1991. So now we're here in 1992 in May, with him telling the Mayor there's no space and within days telling the Hughes Subcommittee -- the letter from Mayor James is dated May 8, the Subcommittee took place on May 22 -- telling the Subcommittee that there was no room.

In actuality, if you divide the agency-- If you divide the location up of the agency, you have us on the third floor and the fourth floor of 124 Halsey Street -- the old Two Guys building in Newark, which is very large. We have the entire third floor. We have half officially assigned to us on the fourth floor, the other half is also Department of Labor space on the fourth floor -- a cluster of offices are in that half of the fourth floor.

During '92 we took over space -- the Division of Disability Determinations took over space in the half of the fourth floor that was assigned to the cluster of other offices. A wire man came in, wired the place for our computers all on a temporary basis. Workstations were set up. Thirty to fourty adjudicator trainees were housed there at a time. Then when the class ended, they would come down to the third floor where there was available space. There was also more space in the half of the fourth floor that the Division had itself, and some were put in there.

So, in my view there was never a space problem if you were willing to use all of the Department's space on the fourth floor. Today, we have five trainees and three clerical personnel working in that half of the fourth floor not assigned to the Division of Disability Determinations. The description I would give you of the half of the fourth floor that is not occupied formally by the Division of Disability Determinations is that the space is underused to empty. There's a large area that's completely empty. Perhaps they'll change this if they read this testimony, but at least up to today, there's a large area where there is nothing. There's a large reception area which is obviously more than you would need, because they don't even have enough chairs to fill it up. You're talking about a few people walking in and going over to a desk, not a crowd sitting that needs chairs.

There are offices that are empty, smaller management-type offices. There is a large office -- a large room, I should say -- where the trainees are now -- our trainees -- and the space that is being used cubicle-style is underused. There are a number of cubicles that are being used just to store things. That is also the case on the half of the fourth floor that the Division does formally have, where I work. I'm in the Quality Assurance Unit. We have empty cubicles. Next to me there are several empty cubicles.

If you look at the third floor and compare it to the fourth floor, the space utilization on the third floor is a 10, the space utilization on the fourth floor is a 5 -- lesser. So, with this type of argument coming back from the Department to what I write, I think you can understand that I am very skeptical when I get their responses.

ASSEMBLYMAN ROMA: From what you're saying, there was no need to move?

MR. ARIA: Precisely, not spacewise. Precisely, no need.

ASSEMBLYMAN ROMA: What we don't know is that, in fact, it may have added to the cost.

MR. ARIA: There was an expense of $8000 recorded in the 1993-94 budget for the Division, which was written in 1991 -- December of '91 -- in December they write the budget. December of '91, you would be in Federal Fiscal Year '92 already, because their Federal year starts in October. So, in December of '91, you were in Fiscal '92. The budget they wrote then was for Fiscal '93 and '94. The moving expense is listed as $8000.

Also, there is a lot of staff time from the Department involved in the move. The budget documents, which I obtained under the Freedom of Information Act, describe the square footage -- the cost per square foot between Newark and New Brunswick. The plan was to retain all of the space in Newark and add the space in New Brunswick. That would be approximately 13,000 square feet of space in New Brunswick. The square feet in Newark was 77,290 and they have the years '91, '92, '93 -- this Newark space stays constant at 77,290 square feet. The New Brunswick space is 13,000 square feet.

I would like to add some more information about the whole issue itself -- decentralization. There was a study done by a former staff member of the Social Security Subcommittee by the name of Frederick B. Arner. Mr. Arner received a Sloan

Foundation Grant in 1988, and in 1989 he produced a study that touches on decentralization. Mr. Arner offers a map of the U.S. showing that most states are not decentralized -- the ratio being about two to one in '89. Things may have changed from '89, but not dramatically.

There is no strict correlation between geographic size of the state -- whether or not it's decentralized. There is no strict correlation between population size and whether the state is decentralized. It's a political decision. SSA has switched its favor back and forth from centralization to decentralization, depending on political climate.

ASSEMBLYMAN ROMA: Mr. Aria, I don't want to interrupt you, but sometimes a question comes into mind.

MR. ARIA: Sure, fine.

ASSEMBLYMAN ROMA: I guess the area that I want to get into was the closing of the Camden office.

MR. ARIA: Okay. Camden was--

ASSEMBLYMAN ROMA: In your opinion, why was that done?

MR. ARIA: Okay. Before I give an opinion, I'd like to give some--

ASSEMBLYMAN ROMA: I'm sorry, but as we're following through that--

MR. ARIA: Camden was cited by Mr. Arner as being closed by SSA for, "budget considerations at the urging of SSA." The Browde Report, which was referred to earlier, is approximately a 100-page report -- was delivered to then Commissioner Serraino in 1987, recommending principally that the Camden office be closed because of the fact that it was draining resources from Newark to the point that the overall performance of the agency was decreased.

So, in terms of efficiency, the Browde report recommended closing the Camden office -- and there were a lot of charts and tables -- productivity tables. During that period, Newark had to constantly send personnel down to Camden

to assist that office. Cases from Camden had to come up to Newark to be done, all of which was very inefficient. Doctors were not in the right place. You had to shift them back and forth. Actually, you have some of that happening today, which I'll describe.

ASSEMBLYMAN ROMA: When was the Camden office closed?

MR. ARIA: The Camden office was closed in early 1987. It opened in 1981.

ASSEMBLYMAN ROMA: Are there any other offices serving the disabled in the southern part of the State?

MR. ARIA: Today or then? Today?

ASSEMBLYMAN ROMA: Today.

MR. ARIA: There is only Newark and New Brunswick at the present time. Newark was centralized from the '60s to -- well, actually the late '50s until '81, when Camden opened, then we went decentralized '81 to '87. Then we recentralized at 1100 Raymond Boulevard, and we were supposed to be there forever, but that lasted a year. Now we're in Two Guys.

ASSEMBLYMAN ROMA: There are no offices in the southern part of the State?

MR. ARIA: No. There are only Newark and New Brunswick; that's it. One of the reasons that the Department gives for decentralization is the need for face-to-face or personal contact. This is not an accurate description. The Federal government is not in any way pushing decentralization for face-to-face contact. In fact, former Secretary Louis Sullivan, of Health and Human Services, in a letter in 1991 summarized a study of face-to-face as being totally inconclusive in terms of the benefits of it, and the budget considerations were such that it was not feasible.

Also, the way the system is set up, the claims are filed at the local Social Security Disability offices, of which there are 31 throughout the State and eastern Pennsylvania. Three in eastern Pennsylvania because they're closer, and

twenty-eight of them in New Jersey. Those are your intake centers. So there is no need for face-to-face contact in our Division. That's not to say that an occasional claimant won't walk in -- we have to see them -- but it's not a formal part of the process.

Decentralization is not a mandate of the Federal government and, in fact, as I stated before, most states are not decentralized. When they have a pilot project at SSA to do with face-to-face, if the state is not centralized, they use Federal personnel to run it. There's no need.

ASSEMBLYMAN ROMA: I don't want you to lose your train of thought, but we have so many questions. So, if I happen to jump in once in a while--

MR. ARIA: Fine.

ASSEMBLYMAN ROMA: Even though this is an area that we are aware of, and becoming more aware of through your testimony, perhaps during your discussion you might give us an idea of some of the claims -- the types of claims, the severity of the claim, and the length of time in terms of processing.

MR. ARIA: Yes, I have statistics. First of all, there are about half a dozen key statistics here. There is inventory, these are statistics that are looked at to compare the states -- compare their performance and ranking. First is the inventory. Now, the Department--

ASSEMBLYMAN ROMA: Does it give you the nature of the claim?

MR. ARIA: There are initial level claims, reconsideration level claims, and continuing disability claims.

ASSEMBLYMAN ROMA: But in terms of the type of disability, for example--

MR. ARIA: Neurological versus cardiac?

ASSEMBLYMAN ROMA: Well, a severe -- perhaps I should pose the question in this manner: a severe neurological problem or a problem of that nature, and there being an extended response in terms of processing that claim.

MR. ARIA: There are statistics on that. They're not very well distributed. That's a level of fine-tuning that we normally don't see. That would be a special statistical study. That's not a regular recurring analysis.

ASSEMBLYMAN ROMA: Okay. I guess what I'm saying is, all the claims are important--

MR. ARIA: Sure.

ASSEMBLYMAN ROMA: --but do we have instances of very severe claims that require an extended processing period?

MR. ARIA: There are very many claims that take a very long time. In New Jersey in particular, our processing time is far worse than the national average.

ASSEMBLYMAN ROMA: But can you give us an idea of some of those types of claims, as to what areas they relate to?

MR. ARIA: No, not in terms of specific types of impairments. No, that would be specialized study information that I don't have.

ASSEMBLYMAN ROMA: Is that information that we would get from the Department of Labor?

MR. ARIA: They would have to ask SSA for it, and it might be difficult to get that information. It's not tracked as well as the global indexes of productivity and accuracy.

ASSEMBLYMAN ROMA: In addition to the request for the status of the ownership of the property in New Brunswick, I would also ask staff to make an inquiry to SSA and the Department of Labor in terms of tracking of those severe cases -- for that matter, all cases -- but in terms of delays with respect to processing of the claims.

Please proceed. I didn't mean to interrupt you.

MR. ARIA: That's okay. Fine, Mr. Chairman.

In terms of the inventory, there's a direct relationship between overtime and the size of the inventory. When we get overtime, the inventory drops. When we don't have overtime and we have to rely on regular time, the inventory

rises. For example, in January -- from January through mid-July of this year -- the inventory went up 1500 cases from approximately 21,000 to approximately 22,500. Then when we did get overtime on July 17 through the end of the fiscal year -- the end of September -- for that three-month period, the inventory dropped by 1400 cases with the help of 7710 hours of overtime.

So the Department would have you believe that the agency is constantly more productive, but if you're not talking about how much overtime you use to do that, you're not getting a productivity index, you're just-- It's like a person who's short and wants to wear elevator shoes for a time and make themselves feel a little taller, but then when you take the shoes off, forget it. When the overtime stops, the inventory goes up again.

So our inventory-- Well, let me say one more word about overtime. It's doled out in the central office of SSA roughly according to how productive you are. New Jersey being one of the less productive states, we get -- we have gotten, on average, less overtime than many other states. So, if you're not doing well productivity-wise, you additionally are hurt by getting proportionately less overtime.

Now, just a note about these continuing disability reviews. They're on the rise in the inventory. They went from approximately 210 in April, and now they are up to 834. We're getting a lot of claims in, which is something to watch closely in the near term, because, as you'll recall, I stated that we had thousands of them years ago that were put in storage -- these are the continuing disability cases. I certainly hope that we are not revisiting that experience, because at this point, management seems reluctant to put enough of the Division's resources into this part of the workload.

Now, in terms of accuracy, we rank 49 as of the August '93 quarter. We rank dead last, as I said earlier, in the Fiscal Year '93. Management there tries to focus on something

that they've called "net accuracy," which is, if you make a mistake and you go and correct it and the decision doesn't change, then we'll remove that deficiency. But in reality, you're just working with numbers doing that. You're not recalling all of the cases that had errors and correcting them for all of those people. Net accuracy that they're using is a numbers game. The accuracy rate that you use to rate the states is in the regulations, and we are last for the fiscal year, and we are 49 for the quarter ending August '93.

In terms of our own quality assurance review -- our internal quality assurance review -- it shows a marked disparity, as I noted in my opening, between Newark and New Brunswick. I have the figures here for August '93. I have them for July '93, and for April '93. So over time, you can see a pattern here. In terms of the overall sample, which includes both a random sample and the more high-risk cases, the three regions of Newark-- Newark is divided into three regions. New Brunswick is the fourth region. For August '93, the random plus high-risk error rate for the three regions of Newark were 16.9 percent error rate, 11.4 percent error rate, and 14.9 percent error rate, respectively. For the New Brunswick, the error rate was 29.1 percent error rate.

With respect to the random only errors -- random sample only, on which is really your most telltale review because it's completely random -- you're not throwing in any high-risk stuff that you know is going to have a problem. The random for April '93 for Newark region shows 21 percent error rate, 16 percent, and 11.5; New Brunswick, 31.1. For July, the error rate: Newark, 22.4, 17.0, 12.1; New Brunswick, 35.4. And finally for August the random: 18.2 for Newark, 14.9 for Newark, 10.8 for Newark; New Brunswick 27.7. So, when I say there is a marked discrepancy in the accuracy of the two offices, that's where I'm taking that from.

In terms of workload, New Brunswick versus Newark, the caseloads that were sent down to New Brunswick last December were extremely low with relation to Newark. There were very few cases -- caseloads that were even above 100. Many were in the 50s, 60s, 30s, 40s. Some people were trainees, so you could explain why some of them were so low. But the overall picture was one of a very low workload, and that has remained the same right through current statistics. The average caseload in New Brunswick is approximately 30 to 35, maybe 40 cases less than the average in Newark. Plus the Title 16 ratio -- the SSI claims ratio -- Newark and New Brunswick are reversed. Newark has always more Title 16s cleared -- more of the SSI claims, more of the more time-consuming claims than New Brunswick. The ratio is reversed in New Brunswick -- more Title 2, which are faster to do. National statistics always show that Title 2 is faster to do.

So the DOL will tell you New Brunswick's processing time is faster. Their workloads are smaller; their ratio of the more time-consuming cases is more favorable; and you're told that New Brunswick is processing cases faster with fewer aged cases.

If you look at the district offices, the Federal offices, the intake offices serviced by New Brunswick and compare them to the ones serviced in Newark, you see all of the State's major urban areas -- with one exception, Elizabeth -- being served in Newark. Newark is served in Newark; Jersey City is served in Newark -- Passiac, Patterson, Trenton, Camden. This is why Newark has all of the SSI cases in relation to New Brunswick, because there are more disadvantaged people in these population centers who are more likely to file these more time-consuming cases. So the deck has been stacked for New Brunswick's better processing time.

ASSEMBLYMAN ROMA: What about -- again, I am interrupting you, but -- accessibility in terms of New Brunswick versus Newark; in terms of having access to be able to utilize your services? All the arguments you have raised have indicated that there should not have been a move; that, in fact, Newark was doing far better than the New Brunswick facility.

MR. ARIA: Well, in terms of-- I would look at it this way, Mr. Chairman--

ASSEMBLYMAN ROMA: Or perhaps New Brunswick was a good facility for certain types of claims, and what Newark was doing they should have been allowed to proceed with.

MR. ARIA: With the geographic breakdown the way it is, it's not really possible to make the type of adjustments you would want to make in order to ensure that the overall agency's performance is uniform.

For example, in my own small unit -- the Quality Assurance Unit -- this week we were told we could no longer review neurological cases in our own office. They would be shipped to New Brunswick because the neurological doctor is in New Brunswick. Cases from New Brunswick to be reviewed are being sent to us -- have been sent in the last week -- approximately 50 New Brunswick quality assurance sample cases were sent by courier -- that's another thing, we have a daily courier -- sent by courier to my office -- my Quality Assurance Unit in Newark. This type of thing went on all the time when we had Camden.

In the New York State agency, which is decentralized, earlier this year some of our National Association of Disability Examiner members met with some people from New York State. They were shifting cases from office to office. So it's a problem of it's extremely difficult to get the resources and the workload at the same place at the same time most efficiently if you're in more than one location. This is

basically why Camden was closed. It has nothing to do with the need for face-to-face contact. There is no prospect of Federal mandate for widescale face-to-face. The inventories are too high; the resources that would be drained are not there; and the inventory is getting even higher. There is no valid reason to have a decentralized office if your argument is face-to-face.

This is telephone and mail work, which is precisely what Commissioner Serraino said in the press when Camden was closed in 1987. "This is basically a mail and phone operation. It is not productive to have two locations." Now, this is not to say that people from a particular region will not argue to have an office in their region. People will always do that. It's a political consideration. In terms of the necessity for doing the job, it is absolutely irrelevant. Most of the life of this agency has been centralized; most of the states are centralized. In Illinois, as Mr. Arner points out, the state Legislature stopped decentralization because they saw it was wasteful. In Florida, as he cites, they wanted 11 offices when the decentralization genie was out of the lamp, and they politically settled on 6. It's purely politics.

ASSEMBLYMAN ROMA: If I may, I'd like to introduce an esteemed member of our panel.

Assemblyman Brown, thank you for joining us.

Please continue.

MR. ARIA: I would like to discuss the staffing of our agency as it compares to the rest of the country, if I can find it.

ASSEMBLYMAN ROMA: It may also be helpful that with some of the key correspondence that you have referred to, where letters were sent back and forth -- as you can appreciate, some of the information that we are putting together is helpful -- perhaps you can provide us with certain information. I'm not sure if we have the Hughes Report--

MR. ARIA: I have a copy.

ASSEMBLYMAN ROMA: --or the 57 recommendations. Okay, but with some of the information that we have here, I want to make sure that all of it is together, and then the remaining information that is requested -- that we can make a formal request again to the Department of Labor.

MR. ARIA: Mr. Chairman, from my point of view, I could make available to you copies of all of my letters, copies of all the responses, anything from Mr. Arner, anything concerning the budget information that I quoted from, the management promotions -- the series of them -- which was the first order of business when the change took place.

ASSEMBLYMAN ROMA: Anything you think might be helpful in terms of our quest to get to the bottom of this problem and to expedite a solution, put it together and we'll go through the information.

MR. ARIA: Fine. In terms of the staffing, what I've done is worked out percentages of what -- how many staff are in a particular function, comparing New Jersey with the rest of the country. How many managers in New Jersey, how many managers in the rest of the country, for example.

For the United States, let's start with the big picture. For Fiscal Year '93 -- Federal Fiscal Year '93, which runs from October 1, 1992 to September 30, 1993, that 12-month period the percent-- Well, I'll say there were 12,000 employees nationwide doing what we do in the 50 agencies. New Jersey had 358 as an average for the fiscal year. Now, out of the 12,000 nationally, there were 9.8 percent in supervision, 43.4 percent as examiners, 26.2 percent were clericals, and then there are a couple of other categories here. I'd like to make the comparison so I don't get lost in all these numbers. The supervisory is about the same for us and the national average. The examiners-- We were much higher after we made those hires in '91.

Our examiner staff was, by Federal standards, overstaffed, so they came up with an action plan for the Fiscal Year 1993. They came up with an action plan to reduce our examiner staff. Several of our newly hired examiners lost their jobs because of this decision to drop the number of examiners because we were over. The rest of the loss of examiners has been done by title to get down to the number they wanted, which was 160. We started with about 195 at the beginning of the fiscal year, and they wanted to get it down by the end of the fiscal year to about 160 examiners. Most of that was done by shifting them to the title of case consultant, and three were made quality assurance specialists. So you shifted titles away from the examiner title.

So now we are more in line with the country, but we're still somewhat over that national norm. The case consultant figure nationally was 1.6 percent, and we're over that; we're at 2.2 percent. Administratively, we have more people in administration. We have 13.5 percent, the nation has 10 percent. Quality assurance people were about the same, but the thing I want to focus on is the clericals. The nation has 26.2 percent of its staff engaged in clerical activity supporting the examiner staff primarily. New Jersey has 13.8 percent, approximately half. This is the biggest discrepancy in our staff versus the rest of the country. We are operating with half a clerical staff. So we have more administrators and less clericals in proportion to the rest of the country. These figures hold up for current, shorter periods. That's our staffing profile.

I would like to discuss the chief productivity index, which the Department will say to you has been going up. I'd like to make--

ASSEMBLYMAN ROMA: Is this an example of what Voltaire said, that there are, "liars, damned liars, and statistics"?

MR. ARIA: Yes, precisely.

ASSEMBLYMAN ROMA: Please proceed.

MR. ARIA: Let me make an analogy. The great long-distance runner, Roger Banister, who was the first man to break the four-minute mile, did so in 1954 at the age of approximately 25. His time was about 3 minutes and 59 seconds, a little less maybe. If Mr. Banister ran a race against today's world-class mile runners, and ran 3 minutes and 59 seconds, he would come in last. He would be considered slow. So the point I'm making is, Mr. Banister was the greatest runner of his time, at least that we had clocked at that time.

New Jersey with these productivity statistics likes to point to increases, but they don't give you the relationship between New Jersey and the rest of the country. Everybody is getting more productive. When you spend millions of dollars to automate an operation, you should be more productive. When you hire more people on a nationwide basis, you should be more productive. When you throw millions upon millions of dollars into overtime, you should get more for it. But if you look at the relationship between New Jersey and the rest of the country's national average for productivity, you see that as we go up, they go up, but they go up higher.

So our rank remains 44 even though if you do look at the absolute change, it does show improvement. It shows improvement from one point in time to another point in time if you only look at New Jersey. But if you look at the relationship, we are one of the worst in the country in terms of production per staff member, which is the keystone index of productivity.

Now, there are other productivity indexes which are being manipulated. For example, they will tell you that our week's work pending -- inventory in terms of how many weeks would it take for you to clear out the whole inventory -- that has improved. We have dropped that figure. You want to drop that as low as you can. But why? Overtime. As you get more

overtime-- As you're in a period of more overtime, your week's work pending drops. When you go back to regular time, what happens to your week's work pending? In New Jersey it goes up. So that's a false picture of improvement if you don't include overtime.

Let's take production per examiner. I mentioned before a figure on case consultants when I was going through the staff. Case consultants, the way they operate in this agency at least, do the same job as the adjudicators do. You're just labeling them as something else. You're not calling them examiners anymore, you're calling them case consultants. They produce the same amount of clearances. If you shift that title, then your production per examiner, which is just a fraction -- a ratio of how many cases you close per how many examiners-- If you decrease the number of examiners by calling them case consultants, you improve your statistic even if you keep your production, in terms of clearances, constant. If I have a 1000 cases and 100 examiners, and then the next week I have 1000 cases and only 50 examiners, I'll increase my production per examiner by 100 percent without having any more cases cleared. So each of these statistics has a story behind it.

The Department, in its responses to me, has always thrown back at me, "Look at this statistic," without relating it to the rest of the country. I'm not interested in arguing against absolute improvement in numbers. I'm interested in showing the Department, you, anyone else, that relatively, the people of this State are not getting the same level of service that the rest of the country is, and we're all doing the same job -- all the 50 states. So productivity -- three measures I've spoken about -- inventory and, of course, accuracy are very easy to manipulate. You have a subjective standard that the Feds use called probability of reversal. Probability judgement -- it's right in the definition of that standard that the reviewer has to use judgement.

There are administrative pressures during periods of adverse publicity to raise the agency's accuracy rate. There are numerous quotes from Federal hearings over the years by Federal employees, all saying that the accuracy rates are subject to manipulation. One incident is described where the head of an agency was handed -- the head of a State agency was handed an accuracy report from the Feds and threw it in the wastepaper basket. He said, "This is useless" -- described in Federal testimony.

Even with that, we are still at the bottom -- even with what I feel strongly is the possibility of manipulation. I can't for the life of me believe that when you have an article appearing in The Star-Ledger, and you have an accuracy rate of 89; that just by diligence and hard work we raise it 5 points in 3 or 4 months and become one of the best in the country, particularly at a time when we were training 90 people. If anything, that has an adverse impact on your accuracy rate. I mean, we have a fine staff, but even our own staff did not believe -- the people I spoke with, everyone jokes about it.

There's never a mention of accuracy by management. It's like it doesn't exist. Close 130 cases every quarter or you will get harassment like you won't believe. New Brunswick? Close 160. Close 160, not 130 like in Newark. We want a record in New Brunswick of success, so we have to push productivity -- 25, 30, 35 percent error rates, double Newark, never mentioned. I had to dig those statistics out of a report. It's not mentioned. They don't want to recognize how much you're giving up in accuracy. Those numbers indicate it's a lot. It's not close.

ASSEMBLYMAN ROMA: Something that you said is deeply disturbing to this Chairman and members of this Committee in terms of harassment. As you're aware, we have many Federal and

State laws, including whistle-blower statutes. Certainly, if there is information that should be brought to the attention of any authority, that should also be part of your report.

MR. ARIA: Well.

ASSEMBLYMAN ROMA: And I realize that you're not here specifically with that aspect, but let me tell you that the jurisdiction of this Committee does cover harassment and various other areas. So, while we are finding out why certain things are not happening in terms of the processing of the complaints, or the claims that we have here, I would also like to extend the opportunity that if there is additional information that the Committee can look into, we'll be glad to do so.

ASSEMBLYMAN AUGUSTINE: Mr. Chairman?

ASSEMBLYMAN ROMA: Yes.

ASSEMBLYMAN AUGUSTINE: Certainly, at some point in time -- just to amplify what you said -- any part of a so-called hearing like this would have to deal with any possible incidents of harassment, or intimidation, or reprisal, or whistle-blowing, so certainly I'm glad that that has been raised because--

MR. ARIA: May I--

ASSEMBLYMAN ROMA: I anticipate that that's the next part of your testimony?

MR. ARIA: Well, I'm going on the direction of Assemblyman Augustine. Since you brought the subject up, I will answer it. May I take 30 or 40 seconds to read this letter?

ASSEMBLYMAN ROMA: Surely, and I think Assemblyman Mikulak is gearing himself to ask a question.

MR. ARIA: This is a letter to Commissioner Raymond L. Bramucci. Subject, retaliation for whistle-blowing, Frank Aria. This letter is dated February 2, 1993. It's from the legal office of the Communications Workers of America, signed by Counselor Steven P. Weissman. Counselor Weissman writes:

"Dear Commissioner Bramucci, Please be advised that I represent Frank Aria, a Quality Assurance Specialist employed by the Division of Disability Determinations. Mr. Aria, an employee with DDD since 1973, has a long history of whistle-blowing activities. He has written a number of letters to various public bodies, including the House Ways and Means Committee, critical of DDD's operation.

"On or about December 1991, Maryann Polaski was appointed as the Director of DDD. Previous Directors had knowledge of Mr. Aria's whistle-blowing and First Amendment activity, and understood that he was legally entitled to engage in such activity free from coercion or retaliation. It seems Ms. Polaski is of a different mind in this regard. Specifically, in March 1992, Ms. Polaski called Mr. Aria into her office and stated that if he continued to write letters critical of the Division, she would 'deal with it' and that she would not tolerate any 'challenge to (her) authority'. She also used profanity and threatened Mr. Aria with violence 'if she thought the letters were personal'.

"Following that meeting, Mr. Aria sent out several additional letters critical of DDD operations. As a result, he was directed to attend a second meeting on December 16, 1992. When he arrived in the management conference room, 11 senior level management officials were seated around a table, including the Director and Assistant Director of the Division and the Chief of the Quality Assurance Unit. Everyone at the table had a copy of Mr. Aria's most recent letter. Ms. Polaski interrogated Mr. Aria for approximately 20 minutes as to the sources of his information, while the Regional Director inquired as to his motives for writing the letter.

"Both the March and December 1992 meetings were coercive and retaliatory of rights protected by the First Amendment of the United States Constitution: Article One of the New Jersey Constitution" -- excuse me, let me read that

again -- "Both the March and December 1992 meetings were coercive and retaliatory of rights protected by the First Amendment of the United States Constitution, Article One of the New Jersey Constitution, the whistle-blower provisions of Title 11:a, and the Conscientious Employee Protection Act. All interference with Mr. Aria's right to engage in First Amendment and whistle-blowing conduct, and all retaliation for such conduct must cease immediately. Any further meetings held with Mr. Aria concerning letters he writes, or statements he makes which are critical of DDD's operation may necessitate legal actions. Further, management has no entitlement to the sources of Mr. Aria's information.

"Rather than attempting to silence Mr. Aria through intimidation, Division management should be investigating the problems brought to light by Mr. Aria and initiating corrective action.

"Questions concerning this matter should be directed to my attention. Very truly yours." Signed, Steven P. Weissman, District Council.

Copy to Congressman William J. Hughes; copy to the Commissioner of the Department of Personnel, Mr. Skip Cimino; a copy to the Director Mel Gelade of OER; and a copy to my Union Local.

ASSEMBLYMAN ROMA: Thank you. As you can appreciate, copies of the correspondence would be helpful.

MR. ARIA: I will send them, Mr. Chairman.

ASSEMBLYMAN ROMA: I believe that's part of the packet, and I believe I referred to a report earlier -- the Hughes Report -- I think we have a transcript of the report. However, we may not have the full report, as I understand.

MR. WILLIAMS: We have a transcript of the hearing, but we have the report as well.

MR. ARIA: This is everything. I tried to characterize the Department's position on things from that transcript as much as I can because it's the single most

comprehensive statement I've seen from the Department. The hearing, of course, is now over a year old, but the story hasn't changed much in terms of their reponse to criticism. The hearing includes a 10-page statement made by Commissioner Bramucci, which -- the highlights of which are-- Now, this is both the oral and the written statement by Commissioner Bramucci and Maryann Polaski on May 22, 1992.

"We sent in"-- This is, I believe, Commissioner Bramucci speaking. "We sent in the best DOL management from other agencies. We sent in DOL managers from training, from unemployment insurance, from temporary disability insurance. They had no experience with Social Security/Disability program. This program is absolutely unique. I have worked in the employment service. There is no disability program. There is no other program as complex as this program. There is no other single entitlement program that causes so many constituent complaints at the Federal level. Someone coming in at the top to run this agency would have an impossible task. They don't even understand the basics of the fundamental job of adjudication, and today they still don't."

ASSEMBLYMAN ROMA: I wonder if it may be possible-- Many of the documents that you have by way of testimony, perhaps they could almost be made part of the record. I in no way want to curtail your testimony, but if you can give us an idea of the additional areas that you'll be covering, because I understand that there are three additional witnesses.

MR. ARIA: Yes. I'm nearing the end.

ASSEMBLYMAN ROMA: I don't want to curtail your discussion, but if there are some documents that you have that we can review, that might be helpful.

MR. ARIA: I think it might be useful to go over the management positions that sprang up as soon as the changes were made in December '91.

ASSEMBLYMAN ROMA: Okay. If you could do so briefly, we'd appreciate it.

MR. ARIA: They have the salaries, the position titles, how many. I think you get an idea of why we have more management than other states.

ASSEMBLYMAN ROMA: Okay. That has been made part of the package?

ASSEMBLYMAN AUGUSTINE: Real quickly, these management positions -- not to interrupt you, but just for clarification -- have these been new managers that have been brought in from the outside, or have they come up through the ranks?

MR. ARIA: In the statement that I just referred to about training UI, TDI, these other areas, some of these -- the top positions went to people from outside the DDD. A few of the people who were already there in management positions received promotions and were a second or third level below. The top positions were taken by outsiders who were on the Commission that studied the Department in the fall of 1991.

It's my understanding-- First of all, the newspaper account of that time tells us that the Department wouldn't even name the people who were on the Commission. Ms. Carmon, in her earlier testimony, referred to that Commission. She wasn't able to get a copy of the report. The newspaper was not able to get a copy of the people who were, in effect, running the management -- running the Division at that time.

The Director would eventually come from that group, so they were studying the Division, making recommendations to decentralize it, and then coming in with their people and taking over the structure that was built on their own recommendations. This was the Department's study. This was not the Federal study. The Feds came in and said, "too little output" -- excuse me, yes -- "too little output for the input we're giving you", basically. They gave targets to reach. The State came in and said, "Let's look at the management

structure. Let's look at the centralization versus decentralization." There have been plans to open an office in New Brunswick since the late 1980s. It was scrapped -- the plan was scrapped in the late '80s because it was inefficient. Camden was closed and New Brunswick was stillborn at the same period of time.

Then this team comes in in '91. They want to obviously change Directors because they had, at that point, taken so much heat in the papers over our being called the worst. They had to change at the top, so that gave them an opportunity to do a study, recommend this huge new structure, which results -- as I've shown you in the statistics -- of us being top-heavy in the adminstrative area when we have half the clerks we should have. This was a plan. It was part of a plan.

ASSEMBLYMAN ROMA: We understand that we have half as many clerical, but using that management perspective with relation to the whole, meaning other states, where do we compare in terms of upper level?

MR. ARIA: Upper level?

ASSEMBLYMAN ROMA: Just a percentage.

MR. ARIA: I cited it earlier. It's-- Okay, for August '93 -- just the month of August -- only upper-level management, not supervisors-- Supervisors are a separate category. They're considered management, but we're only concerned here with upper-level management. The national percentage of staff out of 12,000 employees nationwide -- the percentage of upper management administrative is 10 percent. We're at -- at that point, August '93 -- 12.3 percent. We're over the average. Now, those percentages are rather small, so when you figure it -- break it down into the number of people, though, it's a sizeable number of people. It is the only ratio where you have -- except for this group of case consultants used to lower the number of examiners -- it's the only area where we are considerably outside a national -- above a national norm.

The administrative area is where we're above. We have more than the national norm. In terms of-- To compare the clerical, we're about half. The percentage on clericals, as I said before, in the Fiscal Year '93: national, 25.8 percent were clerical and New Jersey was 14.3. That's September '93 quarter. For the year, we had 26.2 percent clerical nationally; for the entire fiscal year, New Jersey had 13.8, almost an exact half -- 26 versus 13.

ASSEMBLYMAN ROMA: Keeping in mind that, again, a lot of that information was kept in the package, are there any closing thoughts that you may leave with us?

MR. ARIA: Mr. Chairman, I would like to focus -- if I can find this piece of paper here -- I would like to focus on two overriding concerns -- two overriding issues. One is the performance level of the agency itself. Management will tell you it's been improving, and I am telling you that in relative terms, we're still way down. We've got all of these resources and we're still way down. Somebody has to be held accountable. It's not the staff. How can the staff work with half of the clerical support that the rest of the country has and compete with the rest of the country?

The other thought would be decentralization. The issue of decentralization as a management policy is a failed policy of the past. It's being repeated here. It's dragging down the overall performance of the agency, because you're robbing Peter to pay Paul. This is one State; this is one agency. There is no reason why a person at desk "A", can only handle cases from Glassboro without a backlog, and a person sitting servicing Camden has to have a backlog -- the people in Camden getting far less of a level of service because the resources are not in balance.

If there's a physician backlog in New Brunswick where cases have to reviewed by physicians, the physicians in Newark are instructed to do the New Brunswick cases first. Newark

waits. You are discriminated against by your home address. If a doctor has 100 cases over here and the doctor has 50 cases over there, they should both be doing 75 cases. Not so under this setup. Because of the need to create a success story, the doctor with the 100 gets no help. Because of the need for the success story, New Brunswick cases go first in that situation.

ASSEMBLYMAN ROMA: Thank you, and thank you for your testimony.

MR. ARIA: Thank you, Mr. Chairman.

ASSEMBLYMAN ROMA: You will remain available in case some questions come up a little later, or do you have to leave at this point?

MR. ARIA: I can stay as long as you like, Mr. Chairman.

ASSEMBLYMAN ROMA: Fine.

Karen Johnson, Newark Claims Adjudicator Aide?

For all those in attendance, this is an extremely difficult topic -- a complicated topic, and I appreciate the consideration and your patience. Sometimes as we are inquiring into one topic there are additional areas that we get into that we were not previously aware of, and I thank you for the testimony.

Karen Johnson?

Thank you, Mr. Aria.

According to my list, following Ms. Johnson we have Lionel Leach, we have Renee Brown and Virginia Wolf. Is that correct?

Please proceed.

K A R E N J O H N S O N: Good morning, Committee members. My name is Karen Johnson. I am a Claims Adjudicator Aide in the Division of Disability Determinations, Department of Labor. I began work at the Division in 1981 as a Clerk Typist. In 1984, I became a Senior Clerk Typist, and in March of 1993 I became a Claims Adjudicator Aide.

I think there are two basic reasons why the Newark Department office is in such a mess. First, we don't have enough clerical workers. In 1990, the Division hired 90 new adjudicators, which we really needed. The problem is that they did not hire any clerical workers to do -- to help along with the adjudicators in the support work. This is ridiculous.

Second, no one -- not clericals, not claims adjudicators aides, not claims adjudicators -- are working in their job titles. We are all doing a lot of everyone else's jobs, and so we don't have enough time to do our own.

My title is Claims Adjudicator Aide. In my job description, it says that I am to assist claims adjudicators in compiling medical and nonmedical evidence. I telephone claimants, and complete specific forms, and obtain essential background information. I call district offices of Social Security, make appointments with Vocational Rehabilitation Centers, visit homes and hospitals, and contact anyone necessary to obtain medical and/or nonmedical evidence to help move a case along. I don't do any of these things. Why not?

First, I am too busy punching holes, stamping mail, and waiting around for printers to spit out forms. Second, management has not given me or any of the other claims adjudicator aides the medical training we need to actually assist the adjudicators.

So while my title has changed, I really do the same things I did as a senior clerk typist. I sort mail, punch holes, date stamp, mail out forms, etc. I work right along with the few clericals we do have, and we all do exactly the same thing. Even the adjudicators get in on the hole punching, xeroxing and data entry.

Not only do they have me doing all this out of title work, they now have me doing accounts work too. I actually confirm in the computer whether or not to pay doctors. Sometimes the doctors have seen a claimant but have failed to

send in the reports we need to process the claim. When that happens, we are told to pay the doctors even though they have only done part of their job.

I want to close by saying that management always tries to get us to blame each other for the problems in our office. You might hear management say that the clerical workers and adjudicator aides don't work hard enough. Well, it's really management that's causing all of the problems. We are all frustrated and depressed. We know that we could do a better job serving the public if the work was organized better. We have a Director who we never see. The next in line hides in her office all day, and some of the line supervisors have a false sense of authority. We all truly want to do our jobs well, but someone who has some authority has to show management how to do a good job so we can start doing ours.

I hope that this Committee can help us get some management that really understands the disability system so we can get back to getting disabled people what they need.

Thank you. (applause)

ASSEMBLYMAN ROMA: Thank you.

The applause is appropriate.

Lionel Leach?

Were there a couple of questions?

Very briefly, I think -- Ms. Johnson? One or two questions? No, I was mistaken.

Lionel Leach, New Brunswick Claims Adjudicator. Good afternoon.

L I O N E L L E A C H : Good afternoon. My name is Lionel Leach, and I am a Claims Adjudicator III in the Division of Disability Determinations of New Jersey, in the Department of Labor. I was one of the 90 adjudicators hired in 1991, and I am currently serving my working test period. Up until today, I have received good ratings from my supervisors for my job performance, and I hope my testimony today will not change all that. I am a Shop Steward of CWA Local 1037.

I think I bring a unique perspective to this hearing because I have worked at both the Newark and New Brunswick offices. Let me assure you, there is quite a difference between the two.

When I worked in Newark, my caseload was very heavy. In one week, from June 25 to July 1, I received 42 new cases in addition to the current cases I was already carrying. While I was on vacation, new cases continued to be assigned to me. By the time I came back from my vacation, many of these cases were five days old.

When I worked in Newark, I felt incredibly stressed because if I gave something to a clerical worker to do, I could not have it back for another week or two. Why, you may ask? Because the clerical workers are very overworked. There are not enough of them to go around for all of the adjudicators; therefore, we have to wait until they have time to do it. This, in turn, slows down our cases, but the adjudicators get blamed because the caseloads are so long.

Another factor which slowed my cases was the lack of doctors. We wait sometimes for a week to see them.

Newark is like a factory, and everyday you feel so much pressure. One day I was working in Newark, and I had been waiting a long time to go over a case with a doctor. Finally, I had my chance to speak with this doctor about this particular case. When break time occurred, which is 10:00 a.m., I was still involved in discussing this case. At 10:20 a.m., when I finished this case, I decided to take my break. The Regional Manager became enraged because I was on break at 10:20 and accused me of loafing. Instead of asking me why I was on break at this time, he reported me to my supervisor.

What's the message I get from management? Don't go the extra yard or mile for claimants because you'll probably get in trouble for it anyway.

To compare, New Brunswick is much more relaxed. There is a cap on the number of cases each adjudicator is assigned. When we have a shortage of doctors, we borrow doctors from Newark. When our caseloads get backed up, most of the time they are sent to Newark.

We don't have to deal with any of the real hard geographic areas; they are all assigned to Newark. For instance, one particular region that the Newark office deals with: Irvington, Elizabeth, the two Newark areas, and Jersey City. Of course, all of these areas are pretty economically depressed. That means that a lot of the claimants do not have phones. There are more AIDS cases and more homeless people. In addition, poor people often cannot -- and I stress cannot -- afford to go to their own doctor. This means that they have to go to clinical medical appointments. It is more difficult to receive medical information from a clinic than from a private doctor. This really slows down our cases, and there are just more cases coming in from these areas.

Adjudicators in Newark refer to New Brunswick's office as a country club. No wonder. When I worked in Newark, I always had a steady stream of new cases. However, I came to New Brunswick on September 7, and I did not receive my first case until the week of October 10. Why, you may ask? Because they don't like adjudicators to carry more than 160 cases. They wanted me to finish up my old caseload before moving on to new ones. This would not have happened in the Newark office.

Now, instead of waiting a week to see a doctor, I can get four cases received -- reviewed on the same day I request it. Instead of waiting a week for a letter to go out, it may be mailed the same day it was submitted. The New Brunswick office has hired Kelly Girls to do our clerical work so that our claims adjudicator aides can really assist adjudicators.

One aspect I would like to focus on is the computer system. When I was hired in August of 1991, one of the main concerns of hiring the 90 adjudicators was that we were

freshmen in college and we knew, basically, about the computer system. My experience in computers -- I have a minor degree in computers. I basically can say the people that are in the MIS Department really know nothing about computers. They have no computer experience, and they were formerly adjudicators that were pushed up into these titles.

I would like to finish by telling you a story. When I was still in Newark, I sent a letter to the computer to be sent out to a claimant on August 22. Just last Wednesday, October 13, the claimant called to say that he had just received this letter. What happened? Newark's printer spits out all kinds letters, forms, and documents. It gets lost beneath a pile of papers because there are not enough clerical workers to go to the printers and sort things out. I was really embarrassed.

This level of chaos is constant at the Newark office. The entire office lacks structure and organization. It is incredibly demoralizing and frustrating to work in that type of environment, because it is impossible to do a good job.

I would like to thank you again for giving me the opportunity to speak, and I will be happy to answer any questions you may have.

ASSEMBLYMAN ROMA: Thank you for being here, Mr. Leach.

Assemblyman Augustine.

ASSEMBLYMAN AUGUSTINE: What does a person in the MIS Department do if they are not computer literate?

MR. LEACH: They're not. That's the point I'm trying to make. (laughter)

ASSEMBLYMAN AUGUSTINE: I mean, what other -- how can you function in an MIS Department without computer knowledge?

MR. LEACH: That's a good question that needs to be answered by somebody from the Department. I really can't answer that question.

ASSEMBLYMAN AUGUSTINE: I realize that. It was kind of a rhetorical question. But it just boggles the mind how you can do that in the today's world and not be computer literate.

MR. LEACH: Especially when there are qualified computer programers in that area that cannot, let's say, get into that area of the computer field.

ASSEMBLYMAN ROMA: Further questions?

ASSEMBLYMAN BROWN: I have a question.

ASSEMBLYMAN ROMA: Assemblyman Brown.

ASSEMBLYMAN BROWN: Who is the head of the Newark office?

MR. LEACH: Well, it's structured where we have one head, and she is the head of both offices. Her name is Maryann Polaski.

ASSEMBLYMAN BROWN: The kinds of concerns that you articulated today are very disturbing to me. Newark is part of my district. I think what you're telling me is, a lot of people are not receiving service because of lack of organization in the administration. In the past, have you taken any steps to communicate these kinds of concerns? I would like to know when the last time that was done, and what the responses have been?

MR. LEACH: There was an instance where the 90 adjudicators-- We have to serve a working test period when we are first hired. They hired us basically off of the street. Then the Civil Service exam we were told, "Don't worry about. It's easy. You'll pass it. Don't take any heed to it. When it comes, it comes." After finally about a year and a half, it finally came. This is an open competitive exam that is basically open to anyone with a college degree. Out of the 90 adjudicators that were hired, mainly, I would say, about 95 percent were at the bottom level of a 435 list, which was the highest in New Jersey's history for open competitive exams.

There was a situation where in order to keep adjudicators, they would have to let go adjudicators. She made arrangements to have adjudicators go into the New York office. Some people just transferred because they didn't want to get

into this situation. I was more or less the ringleader of the 90 adjudicators, and I addressed the situation to her. On one particular occasion, she asked me to come into her office and I spoke with her.

The same day, Commissioner Bramucci came to the Newark office, and they were giving out awards to the adjudicators of the Month and different things of that aspect. When at the end of the ceremony they were asked if there were any closing comments, the 90 adjudicators went to address Bramucci about the situations and problems that were going on. As one of the Shop Stewards raised their hand, the microphone was pulled out of the speaker. They were structured so he could get away, but eventually the 90 adjudicators surrounded him and asked him the questions. (laughter) The very next day I was pulled into the office, together with two other -- three other Shop Stewards -- and again we addressed the problems. Nothing has occurred.

The 90 adjudicators, they were hired in three different classes, which consisted of basically three to six months. The first class was hired in August; the second class was hired -- no, it went May, August, and December. The last class, which was hired in December, they felt when they were put on the floor that they were being mistreated. They sent a letter to Polaski demonstrating the different situations and problems they were having. What she did -- she passed the buck, so to speak, and gave it to the ones under her. They in turn individually pulled everyone from the 30 -- the 30 adjudicators from that class and tried to use a pressure move toward them -- asking them why did they go about doing this, they should have come to them first. But she made it point-blank, because she came in to see them also. But the adjudicators -- the last class -- if they had any questions, if they had any problems, they could see her. That type of tactic was used.

There have been many, many times that I have approached her about situations. She tells me that, yes, she will work on it. The same instance about Bramucci -- the day he was coming, she pulled me into the office with three other high-level managers and they had me surrounded, basically trying to intimidate me about things that were being postered about Bramucci: Bramucci's son being hired and there was a waiting list, and things of that nature. This is the type of things that go on at times. But, yes, memorandums have been written, words have been said, and nothing more has been done.

ASSEMBLYMAN BROWN: That's all I have, Mr. Chairman. Certainly, I'm going to take some follow-up steps myself with what I'm hearing here, because, obviously, Newark is in my district and it seems just a lot of people are not being serviced as a result of what we are hearing.

ASSEMBLYMAN ROMA: Thank you for the question. But I understand-- I realize it's not unusual that Commissioners or members of the family might be employed, but the Commissioner's son is within the Department of Labor?

MR. LEACH: What happened was-- (laughter)

ASSEMBLYMAN ROMA: My question is, what Division is it that he oversees? What is his capacity?

MR. LEACH: Unemployment, I believe it was. There was a waiting -- there is a list that consists of three years that people are on before they can be hired. The list expired -- let's give an example -- on Monday the list expired. Tuesday his son was hired permanently in that position, the very next day.

ASSEMBLYMAN ROMA: I understand. Thank you very much for your testimony.

MR. LEACH: Thank you.

ASSEMBLYMAN ROMA: Renee Brown, a Newark Claims Adjudicator. Good afternoon.

R E N E E B R O W N: Good afternoon.

ASSEMBLYMAN ROMA: And again, thank you for your patience.

MS. BROWN: Sure, I looked forward to being here.

My name is Renee Brown. I am a Claims Adjudicator III, and what a Claims Adjudicator III does is handle the initial claims that come first from the Social Security office. So we handle the claims right from the Social Security office. It is the client's very first level of working with the Division, and I work at the Department of Labor. I am also a Shop Steward for CWA Local 1037, and we represent approximately 400 workers at the Disability Office. I want to thank the members of this Committee for the opportunity to speak about the problems of the disabled people in the State of New Jersey that I try to serve.

I was hired by the Division in July of 1980. I worked for eight years in the Newark office from 1980 to 1988, then I took a leave of absence to work full-time as a Union Representative for CWA Local 1037. I returned to my job at Disability in January of this year.

When I left, Commissioner Serraino was the Commissioner, and when I returned, Commissioner Bramucci was the Commissioner, and I think this is significant because when I returned from Union leave this January, I found an entirely different office than the one I left in 1988.

The job of Claims Adjudicator, I would like you to know, has always been difficult and challenging. I liked it. I happen to like that type of work. I like working with people, and I found it very rewarding. However, when I returned to the Division, the work became nearly impossible to do. It was very difficult to process a claim efficiently. It took longer and the day was very tedious. And, as I have indicated, it was an entirely different place. Instead of spending a few minutes, as in 1988, maybe paying a consultant for a visit or an examination he did with one of our doctors, I

was now taking hours -- partially half the day -- working on the computer, doing inputting, paying vendors, paying some of the clients' doctors for the reports that they had submitted. I want you to know that we only work a seven-hour day, so when three and a half hours are spent on the computer, I would like you to know that services to the citizens and to the disabled are just not getting done.

In preparation to come here, I took a few examples over the last couple of weeks of my work that I would like to share with you. Because of the Privacy Act, I cannot give you names of these clients. But I want you to know that these situations were very disturbing to me, and although I had bumped them up through my chain of command, literally nothing has been done about them.

In one instance, I purchased a consultation for a gentleman who was poor and blind. He happens to live in East Orange, New Jersey. He kept that appointment on July 21, 1993. I received the consultation report on October 12, 1993. In another instance in Bergen County, I was working with a disabled child who was HIV positive. She also needed a pediatric exam. That examination was scheduled for August 3, 1993. We have yet to receive that report.

On October 4 of this year, I had a client who was on allowance by the Federal Standards For Disability. I walked that agency for a day and a half trying to find a doctor in my region and throughout the other regions who would sign off on that case. In order for a case to move, a physician and a claims adjudicator like myself has to sign that case. There were no physicians in my region, and there were no physicians in the other two regions that were available to me that would sign that case because they had a long list of other adjudicators with cases that they were going to see. Subsequently, this gentleman's claim did not get signed off and moved through the agency until the following late afternoon. These are some of the things that I have to put up with.

Additionally, it was mentioned by Ms. Carmon already, you should know that on last Friday our entire computer system went down. Now, the ramifications of that for the citizens are that literally no work went on. But more importantly and probably significantly, is that in preparation for overtime next Saturday, all the new cases that had come in on Thursday and Friday had been saved for Friday and Saturday overtime. These cases were not done. On Monday, our computer system did not come up until the afternoon. So we were already working -- and this is a recent example -- in a backlog of clients who have applied for disability benefits, but didn't have their cases initially developed until probably sometime today, if then.

These are the kinds of situations that we have to work with. It is extremely frustrating and difficult to work under these circumstances and, as another one of my colleagues had mentioned, clients are calling us. They have our phone number; it's on all the correspondence. It gets very difficult to explain to someone whose relative is dying, or who is dying themself that you've got their case sitting in a basket trying to find a doctor for two days.

Now, I'm not alone in these feelings. (applause) I'm a Shop Steward, and I also have to filter through several complaints that come from my coworkers. What we decided to do was, we decided to poll our coworkers because everybody was very enthusiastic about us coming here today. We look at this Committee as being a Committee that will be able to change the organizational structure, and to be able to help us get the work done that the citizens of New Jersey deserve.

So, when we polled our members, we wanted everyone to have an opportunity to have an opinion. The results of our poll are as follows, and I think that they're very revealing:

Of the claims adjudicators like myself that responded, 75 percent indicated that they were doing work other than claims adjudication, out of title work. They consistently

named clerical duties such as punching holes into the information that comes in, date stamping incoming mail, and data entry as duties that they perform. How much time they are spending on these clerical duties has averaged three to four hours per day, and as I indicated, we only work a seven-hour day.

I want you to also understand that we are in the Professional Bargaining Unit, and what that means is that on the average we make $40,000 a year. So what you're talking about is people who make $40,000 a year, instead of being able to make decisions and move through claims through the Social Security Act at the Division of Disability Determinations, they're doing word processing; they're doing inputting; and they're punching holes in records.

Of those claims adjudicators who have been around since 1985 like myself, 80 percent of us have indicated that the office is less efficient than what it was in 1985. We also asked claims adjudicators whether or not they could process their cases in a timely manner if they worked 12 hours a day. Two-thirds said no. Now, the reason why we feel that this is significant is because this demonstrates the severity of the problem. Since management's response to our backlog into our problems has been overtime, it is a problem when the people who do the work indicate that even if they had a 12-hour workday, they still couldn't get the work done in an efficient manner. It also shows that overtime really does not accomplish the efficiency that management says it does, as well as during this overtime period, we're also doing -- guess what -- data processing, stamping mail, and punching holes, which is not our mandate.

When asked whether or not they had been asked to sacrifice accuracy for production, two-thirds of claims adjudicators indicated yes. And you've heard very eloquently from Mr. Aria and Ms. Carmon that we're told to push cases out,

especially when it becomes close to a quarter. Now, some cases are allowances or denials on the basis of how much in-depth you look at a case, whether or not you reread the information, or whether or not you wait for additional information. When you're just pushing it out, trust me, you're not doing an accurate job.

The answer to the question of, "How would you rate management's ability to intervene in and solve problems"?, The majority gave management the lowest possible rating of one.

Let me also make a side comment here. I heard you ask my colleague, Mr. Leach, about the responses from this Division Director:

In May of this year, I asked for a meeting with this Division Director regarding a policy change that was going to significantly change a lot of things going on in the office, and it was quite controversial. I asked for that meeting on a Thursday. I received absolutely no contact from that Division Director's office until Monday, when her executive secretary called me and asked if I would meet with her two subordinates. I indicated that because the policy was set by the Division Director, I and my colleagues who were Shop Stewards would like to meet with the Division Director. We got no further response until 4:15 that afternoon. The Division Director called me and wanted to reprimand me -- not to discuss the policy change, not to set up a meeting, but to solely say how dare Union representatives ask to meet with her and not her subordinates. That's the kind of communication we have going on at DDD.

To continue, there are some interesting differences between the Newark and New Brunswick offices, many of which you already heard. The most noteworthy is the area of clerical support. The clerical support in New Brunswick is twice the amount of clerical support in Newark -- at least twice -- mostly because they also have Kelly Girls. They are using temporary workers in that office, and certainly we have permanent classified workers in Newark.

The most glaring difference between the two offices is morale. When workers were asked to indicate what their morale was, one being the lowest rating, was the majority given by the respondents. The New Brunswick workers, however, indicated that their morale was mostly in the five to six range. This improvement over Newark's morale is not difficult to figure out if we consider the availability and accessibility of the physicians, added clerical assistance, a cap on caseload size, and relatively economically privileged regions of New Brunswick.

Frankly, I have to tell you, members, that we have had it. My job has become much more difficult. I was absolutely astonished to find out the kind of work environment that I was asked to adjudicate disability claims in. We're tired. I'm tired as a Shop Steward. I'm dealing with mental health issues with my colleagues. People get frustrated. They are not doing their best work because they're working under a lot of that pressure. I also have to handle some of that. There is no need with this management's closed-door policy to try to buck those kinds of things up to management, because they just ignore you.

It's obvious from the testimony that you've heard that there does need to be some changes at DDD. I very much-- In preparing for this meeting today and in talking to my colleagues, I didn't want it to be a situation where I was just griping the entire amount of time that I had to speak. We did want to provide some concrete suggestions, and they are as follows:

We would like immediately to hire more clerical workers. The ratio of clerical workers to claims adjudicators should be no more than 4 to 1, as was suggested in some previous reports.

The claims adjudicator aides, like Ms. Johnson, need to be trained so we can utilize them the way their job specifications indicates they are to be utilized, and this is to assist the claims adjudicator.

There needs to be an elimination of top-heavy management. Quite frankly, we can hire a whole bunch of clericals and adjudicators for the salaries that are going on on our fourth floor, and I have to tell you that those people there are not doing claims adjudication. They are not serving the public. They are not processing claims.

We need to have the doctors who do our consultations -- there needs to be some kind of oversight committee, or their responsibilities need to be monitored. They take up a lot of our time. It is ridiculous to continue to ask the citizens of the State of New Jersey, when they go to a consultation that we set up and we pay for, that they now have to wait six months for that report to come through. That's outrageous.

We also feel that there should be equal distribution of the resources in all regions. If you haven't heard already, there is a lot of competition that goes on in the regions. As I have indicated by my examples, in my region very often there are no physicians. That means that there is literally no one for me to review with. If it wasn't for tenacity and real aggression, the cases would sit there until some physician appeared. That, again, is outrageous.

Management must find a way to improve morale, communication, and reduce stress. You have workers like myself and my colleagues that have spoken before you who are under a lot of stress; who feel like they're not going to ever be promoted; who feel like they're going to be fired at any minute if they don't just move those cases along. Those are the very same workers that are working on the cases for your constituents. I'm sure you know the impact of that.

It is my hope that this Committee will finally force the Division to change. We have talked often and loudly in meetings and in demonstrations, yet things have not improved. I am asking you Committee members to help us change DDD so that we all can do a better job, and that we don't have to continue to look at the statistics to show that we are the worst in the nation.

Thank you very much. (applause)

ASSEMBLYMAN ROMA: Thank you.

I don't know if this question would be posed to you or to the next speaker, but to give us a better idea in terms of those upper-management people that you had referred to, do we have an idea of the number and also the salary ranges?

MS. BROWN: That can be provided to you, I'm sure. Yes, I can say that in leaving in 1988 and coming back, it seems to me to be at least triple the number of people I left with in '88.

ASSEMBLYMAN ROMA: Triple the number of people at the upper level?

MS. BROWN: At least, yes.

ASSEMBLYMAN AUGUSTINE: Mr. Chairman, real quickly, because I know that time is of the essence here. Ms. Brown mentioned what they were not doing on the fourth floor.

Maybe you could tell me what they are doing?

MS. BROWN: Well, that's very interesting that you asked that, because last week I went upstairs when I was-- Actually I had gone ballistic because I had a client who was to be approved, and I had no physician. I had asked my supervisor to help me. She had bumped it along and nothing was going on. I found people reading the newspaper, so I really don't know what they're doing up there. It's supposed to be Policy and Planning, but the fact of the matter is, we're down there in the trenches trying to move these cases along for the citizens. I really don't know what they do.

ASSEMBLYMAN AUGUSTINE: Apparently they're up on current events anyway. (laughter)

MS. BROWN: Yes, sure.

ASSEMBLYMAN MIKULAK: Just briefly, have you pursued unfair labor practices?

MS. BROWN: We've pursued grievances and, as a Shop Steward, I have to tell you that -- and it should be no surprise from the testimony that has come forward -- this is not a worker-friendly environment by any means. Even grievances about health and safety, where people can't breath because there is poor air quality -- our grievances are ignored and get bumped to the Department, who sends us bizarre letters and doesn't process our grievances. I mean, we're in the process of going to Departments like the Department of Community Affairs and the Department of Health, and bringing forward violations because our Department doesn't even deal with simple grievances.

ASSEMBLYMAN ROMA: That might be another area that the Committee would want to look into in terms of the type of complaints that have been filed, the status of those complaints, and what's being done about it.

MS. BROWN: Sure.

ASSEMBLYMAN ROMA: It's a legitimate area for us to pursue.

MS. BROWN: I would be happy to provide you with any information, sir. Thank you.

ASSEMBLYMAN ROMA: Thank you. Thank you for your testimony. It was most helpful.

Virginia Wolf.

V I R G I N I A A. W O L F : Good morning. I thank you very much for the opportunity to come here and speak with you.

ASSEMBLYMAN ROMA: We started out in the morning. (laughter)

MS. WOLF: Yes. That's okay. Fine with me. I've never had the opportunity to conduct a postmortem on the closing of the Camden DDD office, so I will wait as long as it takes to do that. I am the Executive Vice President of CWA Local 1038, which is the southern New Jersey Local. We represent people from Burlington County down to Cape May.

In 1987, the DDD regional office in Camden was summarily closed. I say summarily because all our protestations, rallies, lobbying, speaking with the Department, writing to people were to no avail. Probably the worst part of the closing was that the reason given to us was that it was an inefficient office. The onus for the closing was put on the worker, not any other reason was given to us.

As a result of that closing, 127 people were either lost to the Department of Labor or were bumped into some other facility. In fact, for about a year after the closing of that office, there was a mild case of confusion and panic in the Burlington Unemployment Office because the claims adjudicators were in the same series as claims examiners in unemployment offices, and they bumped claims examiners from the UI Office to take a job.

The difference between a claims examiner in an unemployment office and the work they do, as compared to a claims adjudicator in a DDD office, is night and day. It's a simplification, but there is no other way I can put it. It's an entirely different operation, so that the folks that came into the UI office as claims adjudicators had to be retrained as claims examiners. Those people that were claims examiners were bumped into other offices, mostly up into Trenton into the Central Office. Another consequence of that closing was that the City of Camden, which can ill afford to lose any jobs, lost 127 jobs.

A third consequence is that -- and it's still going on -- is that the people in South Jersey-- Let me just correct a misconception that obviously is operating in Trenton, and I am

originally a North Jersey native, so I can see both sides of this. New Brunswick is not South Jersey, folks. It is not South Jersey. South Jersey starts somewhere below Bordentown and goes down to Cape May, so that saying that you're going to service people from Cape May, Burlington, Salem, Gloucester, Cumberland Counties with an office in New Brunswick, or an office in Newark is ludicrous. It's not going to happen. The people that live in South Jersey do not get what little modicum of service the other people get. We've lost that connection with the Camden office that we had. Imagine yourself as an elderly, needy SSI recipient who doesn't have a telephone trying to call New Brunswick or Newark. How do you do that? How do you do that?

I have to disagree respectfully with Mr. Aria. I believe that decentralization is essential in this operation, and saying that you're going to decentralize by putting an office 20 miles away from Newark in New Brunswick is not decentralization. That's politics. What we need in this State -- in the southern part of the State-- We're always the stepchildren, twas ever thus. We just don't have the numbers, but we need another office in Camden.

When the New Brunswick was opened -- it was planned to be opened -- I went to the Department of Labor and asked them why they were putting it in New Brunswick and not back in Camden, where it should actually be. I could give you a list of the excuses, but I can't remember them all, and that's the truth. I was told that there was a lack of space in Camden. Well, now we know on the face of it that that's not true. I was told it would be more efficient in New Brunswick than it was in Camden, and the list goes on and on and on. I think breaking up the offices into north, central, and southern areas would be more efficient. I think the workers in the Newark office-- And believe me, I've been in that Newark office, it is a zoo. That's the only way you can describe it. It's a

terrible way to work. The work isn't getting done. The public isn't being served. We desperately need a contact office in the southern Jersey area, whether it's in Camden, which would be the ideal, but we desperately need one in the southern area.

The Department of Labor is arrogant, overbearing, uncaring, and unfeeling. There is no other way to describe what they do. The fact that they ignored this Committee today, as a citizen, I'm outraged. I am outraged that they did that. How dare they do that? And on top of ignoring you, our representatives -- they are ignoring a segment of the State of New Jersey that desperately needs services.

Anything you can do-- I have a file on the closing of the Camden office. Anything you need from it, anything I can do to help you, I would be more than happy to do so. I welcome the opportunity to do so. I congratulate you on what you are doing here today, and I desperately hope that you can help us in South Jersey.

ASSEMBLYMAN ROMA: Ms. Wolf, thank you.

Let me say that as the Chairman and member of the Committee, this is a very hardworking Committee. The members are extremely dedicated, and we have acted as a group in order to pass a number of initiatives. Some of the difficulties that we run into sometimes are that we pass the legislation, pass it onto the Department, and then we find that the Department is not implementing the legislation. I can assure you of the fact that we will be monitoring this, and I would direct OLS to prepare a transcript of this testimony at the earliest possible time so that all the members will have copies. They will be made available so that we can continue to monitor the situation.

MS. WOLF: Do you, in fact, have subpoena powers that you can subpoena Mr. Bramucci?

ASSEMBLYMAN ROMA: What we must first do-- There is a process to follow in terms of gathering the information. What I have learned here this morning is shocking. It is

unconscionable, and as a result of what we have learned, what I will do is to make a formal request for the Commissioner to come back here and to give us some answers. If the Commissioner does not do so, and we do not receive the information that I feel is appropriate, I will make that request of the Speaker.

MS. WOLF: Thank you so much. I really-- This is the first opportunity we've ever had to talk about what happened in the Camden office.

ASSEMBLYMAN ROMA: Let me also ask you -- and sometimes we assume too many things -- but in terms of the location of the offices and in terms of processing of applications, I would assume that the Office has the ability to install TDD devices so that applications can be processed without someone physically being present who has a hearing impairment?

MS. WOLF: Yes, absolutely.

ASSEMBLYMAN ROMA: Thank you very much.

MS. WOLF: Thank you so much for this opportunity.

ASSEMBLYMAN ROMA: Is there anyone else that is scheduled to speak before this Committee? (no response)

Again, I want to thank everyone. Particularly the Union members, the officials of CWA, all of the individuals who are here, the employees.

It is extremely important to be able to bring this information to the attention of government because, as I said before, there are a number of initiatives that we have worked on, and sometimes as legislators -- without your input, we are not in a position to be able to monitor what is happening.

We are extremely distressed not only at the fact that there is not a representative from the Department of Labor -- many excuses might be offered, but as I indicated at the outset, in the past we've always had a representative here. I'm sure they have a couple of people over there that they

could have spared this morning or this afternoon. I must only take it that perhaps they were not prepared, and did not want to be here. In any event, we are going to pursue why that happened. We did have a formal notification that was sent out, and we placed a phone call. It's not as though they had to travel that far, so you can appreciate the concern that we have.

But I will assure you that this Committee is here to stay. The members that are here are very dedicated, and it took us a long time to do some other things. Just like in "Poltergeist", we're coming back.

ASSEMBLYMAN MIKULAK: Mr. Chairman, I want to thank you for holding this hearing. I think the hearing today actually raised more questions than it answered. We've heard some shocking testimony, and we've heard a sordid story. This is a classic example of bureaucratic incompetence, mismanagement, and political manipulation. I truly hope that this Committee gets to the bottom of this mess and we get these questions answered.

I'm bitterly disappointed that the Department of Labor has abdicated its responsibility into this matter and chose to avoid this hearing today. After hearing some of the testimony, I now understand why they ducked this hearing.

Thank you.

ASSEMBLYMAN ROMA: Thank you, Assemblyman Mikulak

Any other comments from the Committee?

ASSEMBLYWOMAN HAINES: I would just like to say I'm glad that this meeting was called, and I just want to thank each and every one of you for coming. Too many times State workers, as I hear as a legislator -- people are saying that they don't want to work, that they're lazy. That is not the case with the individuals that showed up today. You showed the dedication of the many State workers that are out there.

In every phase of employment, you are always going to have a certain amount of workers that do not want to do the job, but what you have proven to us and shown is what we have been saying all along to many of the people out there. There are many State workers out there that are concerned with getting the job done. You did not come here to complain about that you wanted more salaries, or more days, or more benefits, or anything like that. You came to us to let us know what is going on in your particular division in the Department of Labor; to let us know that they are not listening, that they are not concerned with getting the job done; to help the individuals in the State of New Jersey that need your help.

You came to us to let us know what is-- I do appreciate you taking the time. I'm sure you had to take the time off through vacation or personal days, and I do appreciate it. Thank you for giving us the testimony you gave us today, because it was quite enlightening and it just proves that there are a lot of problems that are going on -- not to make it political, but -- in the administration that need to be addressed.

I just want to thank you all.

ASSEMBLYMAN ROMA: Assemblyman Brown.

ASSEMBLYMAN BROWN: Mr. Chairman, I would like to thank you and the members of the Committee for making this forum available to these workers from the State. Obviously, the client group that they service is one of the most critical and needy in our society. I would hate to think that in servicing those that need it the most, that in some ways the people providing the service have one hand tied behind their back. I'm certainly disturbed by what I've heard here today. I really wish I had had an opportunity to hear the other side, frankly, so I could come to a little bit more firm conclusions about it.

What I do say, Mr. Chairman, is, given this opportunity and obviously the concern that has been exhibited here by these workers, I'm certainly going to follow it up beyond this meeting to try to find out what that other side is, and try to sift both sides so we can come to some resolution, because obviously the disabled need the best form of service that they can get from government. If there is something that we can do to improve some of the situations that we've heard here today, I am certainly willing to try to do that. I would hope that at some point, Mr. Chairman, we can get from the other side some responses to some of these very critical and significant things that have been put on this record today. I would certainly like to hear that.

ASSEMBLYMAN ROMA: Thank you, Assemblyman.

You can appreciate that whenever we have tried to put together our legislation, we have worked as a team with this Committee. In some cases, when we send information over to the Department of Labor, we get it back in bits and pieces. It is only when we have these oversight Committee hearings do we find out that perhaps something that we implemented or legislated is not being implemented. There are always different reasons why we cannot have certain things happening at a certain pace, but what I've heard this morning and this afternoon covers a period of two or three years. It seems to me that not only did we have Commission meetings, not only did we have Federal reports, but what has been done is to knowingly set up a showcase for one facility in order to alter the statistics. I think that is regrettable.

I think the mere fact that we don't have a representative here from the Department of Labor, when they've always wanted to be here to quote a success story, is an indication that they were embarrassed to be here. I am

troubled by the fact that even if there were questions that could not be resolved this morning or this afternoon, they had a statutory obligation to be here. I am going to take it up with the Speaker.

I thank you for your comments.

ASSEMBLYMAN AUGUSTINE: Mr. Chairman.

ASSEMBLYMAN ROMA: Yes, Assemblyman.

ASSEMBLYMAN AUGUSTINE: I just want to echo comments of my colleagues, but also in that process to express my appreciation for all of you taking the time to come down here. To have the courage to come down here and say what you said is certainly very commendable. I would just ask you to remember-- Those of you who remember the movie, "Network", when you saw the gentleman open up the window and say he was angry, he wasn't going to take it anymore, well, I don't blame you for not wanting to take it anymore. We certainly aren't going to take it any more, so maybe you can feel some degree of satisfaction that we've heard you; that we're going to try to be responsive to you; and-- We already have several subpoena actions already going on now, so for those of you who go back and tell the people on the fourth floor who are reading the newspaper, they know we have subpoena actions in this Legislature going on now. (applause)

Thank you.

ASSEMBLYMAN ROMA: Thank you, Assemblyman.

Anyone further? (no response)

Again, I want to thank each and every one of you for taking the time to be here. Your testimony has been extremely important. We've opened up additional areas that we were not even aware of in terms of the insensitivities, whistle-blowing practices, other areas that perhaps may serve as hearings for additional days. But we will need your support and help in terms of the documentation that you have available, in terms of memoranda or other types of documentation that could augment

our records. As you can appreciate from this morning and this afternoon, the difficulty of putting all of the pieces of the puzzle together so that we can put a spotlight on this problem is extremely evident by the fact that additional information is required.

With your help, we will be able to do that, and we will put together the information that we have. A transcript will be prepared. You can obtain a copy from one of our offices. We will make that available to you.

Again, I emphasize that those rights that are your legal, statutory rights -- whether it be whistle-blowing, or any of the remedies that are available -- no one should put you in a position to keep you from lawfully exercising those rights. You have your First Amendment freedoms; you have your rights of redress. From the standpoint of anyone that is prohibiting you from doing so, that will possibly be the subject of another hearing.

Thank you, once again, for being here.

(HEARING CONCLUDED)

APPENDIX

Good Morning. My name is Carolyn Carmon. I am a Claims Adjudicator II Specialist with the New Jersey Division of Disability Determinations, Department of Labor. I have worked in the Division for the last 18 years. I am a 30 year employee of this Department. In addition, I am a Shop Steward for CWA Local 1037.

I would like to thank the members of this committee for providing me with an opportunity to address some of the problems in our Division. Let me say that I sincerely hope that this time it may mean something that I testified. I testified a year and a half ago about the horrible state of affairs at DDD in front of the Hughes Commission. To my great disappointment, things have actually gotten worse since that time. I also participated on a committee to evaluate and come up with suggestions to improve our Division. I was very anxious to help to improve this agency's ability to serve the public. Unfortunately, the committee was disbanded and I have never even seen a copy of the report. But I can with all honesty say that conditions for workers and claimants have continued to deteriorate.

It really bothers me that the claimants who apply to our Division for services get such horrible treatment. As someone who hears very depressing stories daily from people who drastically need the help of our office it is heartbreaking to know that individuals who are in dire need and in fact deserve our services

IX

are waiting for a full year to receive benefits. I can tell you that this is true, and I am furious about it. All I can say is that management has set up a situation where we cannot give people what is coming to them. This is the real reason for the incredible demoralization at DDD.

When I first came to DDD in the mid-seventies, I felt a clear sense of purpose as I performed my job. I went home every night with the satisfaction of knowing that I had assisted disabled New Jersey citizens in getting the benefits they truly deserve. This was possible because of a number of factors.

At that time all workers had clearly defined job responsibilities which pretty much conformed to their job description. Claims Adjudicators did the professional work of seeing disability claims through from start to finish with the assistance of efficient support staff.

When we had documents to be typed, mail to be opened, and other clerical functions to be performed, the clerical workers did that work. We had 3 clerical workers for every 8- 10 Adjudicators. The clerical workers also did some follow up. They would pull cases and send out additional forms as needed. They would call doctor's offices, hospitals and other institutions to find out whether they received the form and when we might expect to have it returned to us.

2X

Our Adjudicator Aides had medical training. This made it possible for the Aides to really assist on cases. They made follow-up calls to doctors and hospitals and could converse with medical professionals in the language they are accustomed to using. They also could follow up with psychiatrists, cardiologists---you name it. After making calls, they would simply write up the results. This kept Claims Adjudicators from being on the phone all the time. Their medical training enabled them to truly be part of the team in moving a case through to closure. In addition to all of this support, we had many more doctors. It was much easier to find a doctor or a psychiatrist to consult with to get a claimant approved.

Now, in 1993, I am totally demoralized about coming to work. Everyone I talk to describes how they go home angry at not being able to do a decent job, frustrated that they can't help the disabled, and many are confused about what their actual job responsibilities are. I am not just talking about myself here. As a Shop Steward I have the opportunity to talk with workers who fall into many job titles. From Supervisors and Adjudicators to doctors and clerical workers the morale at DDD is through the basement. Stress related illnesses abound.

This is clearly a change from how DDD employees used to feel. So what has changed?

There are no clerical workers. Almost all of our clerical workers have become Adjudicator Aides. This is fine, we need Adjudicator Aides. But they never replaced the clerical group. In 1991, we hired 90 new Claims Adjudicators, but NO new clerical workers to support them.

The Adjudicator Aides have not had any medical training. Because of this, they cannot assist the Adjudicators in any follow-up with doctors, hospitals, or specialists. There are many responsibilities which Adjudicator Aides used to perform which medically untrained aides cannot do.

No one has clearly defined job responsibilities. Claims Adjudicators, Clerical Workers and Claims Adjudicator Aides ALL open mail, punch holes, enter data, xerox, get MERS off printers, pull files, confirm appointments....and so on. Imagine the insanity of paying someone $40,000 a year to punch holes! Not only is this way of doing business highly inefficient, it is demoralizing and leaves all workers with the feeling that no matter how hard they try they can't get the job done.

As one of my coworkers will testify, Adjudicator Aides do Clerical work identical to Clerk Typist work, and Adjudicators do Clerical and Aide work. It is as if management took a whole pile of papers, threw them up in the air and yelled "GO!" to the workforce. Everyone is supposed to do whatever they can to clean

up the mess, but no one takes responsibility for deciding how to go about it. Not only are Adjudicators doing Clerical work and Adjudicator Aide work, we are also Accountants and Vocational Specialists. We authorize payments to doctors--work clearly done by accounting professionals in the past.

We have fewer doctors and psychiatrists today than we used to have, but many more cases. Even though we have much more work to do and serve a much more economically depressed area, management will take doctors away from our office and reassigns them to New Brunswick so that they can make it look like regionalization is working. Then we get stuck and have to wait around for a week to see a doctor to close our cases because they have been reassigned to the New Brunswick office.

But the most foolish use of resources is in the cancerous growth of upper level management. Since becoming Director, Maryanne Polaski has created lots and lots of jobs for her friends. We used to have 2 Assistant Director titles, one for Claims and one for Policy. Now we have 2 for Claims and one for Policy. That position alone costs this department approximately $63,000 per year. When Polaski came to DDD, she brought with her Sue Lieto. She seems to have created a position for her. None of us know what she does, but that position, some kind of an Executive Assistant position pulls down around 60 grand also.

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Those of us who actually do the work think we have close to 11 high paid management people where we used to have 3 or 4. I wonder if Ms. Polaski realizes that for every $60,000 per year employee, you can hire 3 Clerical Workers or 1 1/2 Adjudicators. This is clearly a more efficient use of resources.

So, what we have here is a big problem. We have practically no clerical support, Adjudicator Aides who aren't allowed to do their jobs, overworked Adjudicators, and a growth in management.

In addition, we have absentee management. Most of the workers in the Newark DDD office do not even know what Maryann Polaski looks like. She rarely shows her face in Newark and my coworkers think she is afraid to come onto the floor to see what we do. She has even refused to meet with our Shop Stewards.

Committee Members, all of the above is bad. I wish I could say that the reason it is so bad is that the department did not know how bad things are. Unfortunately I and my coworkers have said it all before.

Before the Hughes committee in 1992, I said:
"Our work environment is characterized by stress and crisis.

For the greater part of the last year we have been working over-time in the morning in the evening and on Saturdays. Many of

our caseloads are unconscionably high and the sheer stress of working with hundreds of seriously disabled men, women and children is in and of itself overwhelming at times."

"They (management) effectively put us in a situation whereby we are forced to work on the "easiest" cases first and relegate the most difficult cases to the bottom of the pile in the face of the pervasive pressure to reduce processing time and push cases out the door. This is not doing our clients any favors."

"10 years ago there were about 3 clerks of varying levels for every 8 to 10 adjudicators. Clerks open the mail associated with cases, track development and other correspondence and perform other day-to-day tasks. Today there is, on average, 1 clerk for every 10 adjudicators. In practice this means that 1 clerk may be responsible for 200 to 3,000 cases."

"Despite this severe Clerical shortage the Division did not hire one new clerk to support the 90 new Adjudicators. The Division has informed us that they have no plans to hire additional clerks as they believe the new computer system will eliminate many clerical tasks."

And I Quoted from Sanford Browde's 1987 Report:

"Morale among the Agency Staff is not just low, it's terrible." "Morale does not improve by wishing it would or simply saying things take time to change. At DDD the only way morale will improve and thus production is through concrete, systemic changes to assist the adjudication process."

"DDD should direct its limited resources to providing the

adjudicative staff the necessary technical and support resources required to speed the process along Clerical Workers should be hired immediately so that we can avoid correspondence sitting in printers for weeks simply because there's no one around to retrieve it."

Nothing has changed. All of the things which I stated here are still the same. I really hope that this committee finally can put some changes into place that will allow us to perform this extremely important job of providing services to New Jersey's disabled citizens in a fair and efficient manner.

TESTIMONY OF FRANK ARIA BEFORE THE NEW JERSEY GENERAL ASSEMBLY, COMMITTEE ON LABOR, OCTOBER 19, 1993:

Mr. Chairman, and members of the Committee, thank you for this opportunity to express my views. My name is Frank Aria, and I appear before you as a private citizen.

The Department of Labor contends that its Division of Disability Determinations has achieved a record of substantial improvement since 1991, when massive federal assistance was needed from special contingency funds. In particular, the Department emphasizes the apparent success of a DDD branch office opened in New Brunswick last December. Let us examine these assertions more carefully.

Bearing in mind that the three signs of success in the disability program are high productivity levels, speedy claims processing times and high accuracy rates, recent federal reports reveal the following levels of performance for New Jersey:

(1) As of August 1993, New Jersey ranked 44th among the 50 states in yearly production per employee-- last among the more populous, more industrialized states.

(2) As of August, New Jersey continued to have one of the worst records in the nation for numbers of delayed cases pending. Nationally, 27.6% of the pending inventory was in the "delayed" category versus 42.0% for New Jersey.

(3) For fiscal year 1993 (October 1992 through August 1993) New Jersey ranks dead last in the accuracy of its decisions based on federal sample reviews.

What accounts for this signal failure to convert millions of dollars worth of large, phased staff increases and hundreds

of elaborate IBM workstations into at least an average level of performance for the citizens of this state? How credible is the Department's story about receiving too many cases to handle? Not very credible at all. The average caseload per examiner in New Jersey is right in line with the national average, and has been all year. In my view, this failure to capitalize on this state's share of the 1991 federal contingency funding can be traced to the administration's singular focus on making a showpiece out of the New Brunswick branch office. Throughout that process, the performance of the Division's much larger operation in Newark has been allowed to decline. This has been a clear case of robbing Peter to pay Paul.

To illustrate the point, consider the workload assigned to the New Brunswick branch. The locations of the federal intake centers linked to New Brunswick are, as a group, under-representative of the state's larger urban population centers. This is important to note for two reasons: first, proportionately fewer cases are sent overall to New Brunswick compared to Newark; secondly, relatively fewer of the New Brunswick claims involve SSI, the more time-consuming part of the workload. This is the demographic key to understanding how management has stacked the deck to create a favorable statistical profile for New Brunswick over Newark, put into effect from the day the branch opened on December 14, 1992. From that day to this, caseload sizes in New Brunswick, on average, have not approached those of Newark. With respect to workload distribution, the playing field has always been tilted.

The other key to understanding the true nature of the productivity "success" of New Brunswick is the level of accuracy management accepts for claims decisions made there. The results of internal quality assurance reviews, over time, confirm markedly

higher error rates in New Brunswick than in Newark. Management's toleration of lower accuracy rates in New Brunswick has quietly facilitated the boosting of that branch's output necessary for the creation of the success story now being told.

To summarize, with respect to speedy processing of claims, it is fair to conclude that the disability program in this state, as presently administered, is following an unwritten policy of discrimination against many people who live in urban centers, especially those filing SSI claims, by diverting a portion of their fair share of the Division's resources to the New Brunswick showpiece office. Conversely, many claimants from the New Brunswick region would likely receive more accurate decisions if they received service from Newark.

To conclude, the regionalization and decentralization policies of the Division of Disability Determinations have exacted a heavy price in terms of overall agency performance. The administration proposes more of the same, rationalizing the proliferation of branch offices with contrived tales of great improvement and success. Surely something can be done here to raise the level of public policy above routine executive self-interest.

* * * * *

Thank you for listening to me. I would be pleased to answer any questions you may have.

* * * * *

Frank Aria
31 West Street
North Arlington, NJ 07031
(201) 648-7798

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Good morning, Committee Members my name is Karen Johnson.

I am a Claims Adjudicator Aide in the Division of Disability Determinations, Department of Labor. I began work at DDD in 1981 as a Clerk Typist. In 1984, I became a Senior Clerk Typist & in March of 1993 I became a Claims Adjudicator Aide.

I think there are two basic reasons why the Newark DDD office is such a mess. First, we don't have enough Clerical Workers. Not long ago, the Division hired 90 new Adjudicators, which we really needed. The problem is that they did not hire even one new Clerical Worker to do support work. You don't have to be a genius to see that this spells disaster.

Second, NO ONE - NOT Clericals, NOT Claims Adjudicators Aides, NOT Claims Adjudicators is working in their job title.

We are all doing a lot of everyone else's job and so we don't have enough time to do our own.

Take me for example. As I said, I am a Claims Adjudicator Aide. In my job description, it says that I assist Claims Adjudicators in compiling medical and non-medical evidence. Do I do that? NO. It says that I telephone Claimants and complete specific forms and obtain essential background information. Do I do that? NO. My job

description says that I call District Offices of Social Security, make appointments with Vocational Rehabilitation, visit homes and hospitals, and contact anyone necessary to obtain medical and/or non-medical evidence to help move a case along. Do I do any of these things? NO. Why not?

First, I'm too busy punching holes, stamping mail and waiting around for printers to spit out form.

Second, management has not given me or any of the other Claims Adjudicator Aides the medical training we need to actually assist the Adjudicators.

So, while my title has changed, I really do the same things I did as a Sr. Clerk Typist. I sort mail, punch holes, date stamp, mail out forms, etc. I work right along with the few Clerical Workers we do have and we all do exactly the same thing. Even the Adjudicators get in on it with hole punching, xeroxing and data entry.

Not only do they have me doing all this out of title work, they now have me doing accountant's work, too. I actually confirm in the computer ~~whether or not~~ to pay doctors. Sometimes the doctors have seen a claimant but have failed to send in the reports we need to process the claim. When that happens, we are told to pay the docotrs, even though they have only done part of their job.

I want to close by saying that management always tries to get us to blame each other for the problems in our office. You might hear them say that the Clerical Workers and Adjudicator Aides don't work hard enough. Well, its really management that's causing all these problems. We are all depressed and demoralized. We know that we could do a better job serving the public if the work was organized better. We have a Director who we never see. The next in line hides in her office all day. And everyone in that office knows that if you get called into any management person's office, its probably to get told you are doing a horrible job.

Honestly, I think we all really want to do our jobs well. But someone who has some authority has to show management how to do a good job so we can start doing ours. I hope this committee can help us get some management that really understands the Disability System so we can get back to getting disabled people what they need.

Thank you.

CLAIMS ADJUDICATOR AIDE

DEFINITION

Under the direction of a Claims Adjudicator of some grade, Division of Disability Determinations, Department of Labor, compiles medical and non-medical data for use in the determination of disability insurance claims; does related work as required.

EXAMPLES OF WORK

Assists Claims Adjudicators in compiling non-medical and medical evidence.

Extracts data from files and codes relevant information on the appropriate forms.

Telephones claimants and completes specific forms and obtains essential background information.

Receives and makes telephone calls to District Offices of the Social Security Administration in situations involving routine requests for status, earnings, records and other information.

Receives and processes notifications of lack of insured status, death of wage earner, and other pertinent claimant data.

Makes appointments with the Division of Vocational Rehabilitation Services or other public and private agencies when it is felt the claimant may be able to benefit, if given the necessary training, rehabilitative or other supportive services.

Contacts non-medical sources to ascertain any additional evidence a Claims Adjudicator may need to make a final determination.

Contacts claimants to obtain their written permission to obtain additional medical evidence.

Visits homes, hospitals, clinics, public or private agencies to obtain or photocopy any required information or reports.

Maintains and keeps current reports, records and files regarding claimants' status and services rendered by the Division of Disability Determinations.

If assigned to a Quality Assurance Unit

Conducts a technical review of determination forms to assure accuracy and completeness of entries. Corrects errors that are identified.

Completes sampling distribution for specific claims categories and the various S.S.A. components to include internal Quality Assurance sampling.

Reviews Title II and Title XVI claims to determine if appropriate vocational rehabilitation procedures are being followed. Refers claimants to the Division of Vocational Rehabilitation Services or other public and private agencies when it is felt that the claimant may be able to benefit, if given the necessary training, rehabilitative or other supportive services.

Records and tallies errors found during technical case review and prepares reports that present findings and trends.

Tabulates the results of substantive internal quality sample and high risk case reviews.

Assists Quality Assurance Specialst II in compiling medical and non-medical data to be used in preparation for Special Studies.

REQUIREMENTS

Education

Completion of 60 semester hours at an accredited college.

Experience

One year of experience in a large public or private agency in the collection and recording of medical and non-medical data which shall have included interviewing members of the public.

Applicants who do not possess the required one year of experience may substitute an additional 30 semester hours of college credits.

Applicants who do not possess the required 60 semester hours may substitute additional experience as indicated above on the basis of one year for each 30 credit hours.

License

Appointee will be required to possess a driver's license valid in New Jersey only if the operation of a vehicle, rather than employee mobility, is necessary to perform the essential duties of the position.

Knowledges and Abilities

Ability to comprehend and apply the standards and procedures for collecting and recording of non-medical and medical data.

Ability to acquire basic knowledge of the specific forms used in the Division and the kinds of information necessary to complete them properly.

16X

Ability to maintain essential records and files containing reports on claimants' progress.

Ability to gain the confidence of claimants, employers and other sources in order to arrange consultative examinations.

Ability to prepare simple reports of completed actions.

Ability to use appropriate codes in order to extract medical and non-medical data from files.

Ability to work with claimants, hospitals, clinics and/or other agencies in order to obtain medical evidence, reports and other information.

Ability to read, write, speak, understand, or communicate in English sufficiently to perform the duties of this position. American Sign Language or braille may also be considered as acceptable forms of communication.

Persons with mental or physical disabilities are eligible as long as they can perform the essential functions of the job after reasonable accommodation is made to their known limitations. If the accommodation cannot be made because it would cause the employer undue hardship, such persons may not be eligible.

Code: A12-64942 WPC-E BETH BW 1-31-85

Good Morning my name is Lionel Leach. I am a Claims Adjudicator III, in the Division of Disability Determinations, New Jersey Department of Labor. I was one of the 90 new Adjudicators hired in 1991 and I am currently serving my working test period. Up until today I have received very good ratings from my supervisor for my job performance. I hope my testifying here today does not change all of that. I am a Shop Steward for CWA Local 1037.

I think I bring a unique perspective to this hearing because I have worked at both the Newark and New Brunswick offices. Let me assure you, there is quite a contrast between the two.

When I worked in Newark, my caseload was very heavy. In one week from June 25 - July 1, I received 42 <u>New</u> cases in addition to the cases I was already carrying.

While I was away on vacation, new cases continued to be assigned to me. By the time I got back from my vacation, many cases were already 5 days old.

When I worked in Newark, I felt incredible stress because if I gave something to a clerical worker to do, I couldn't get it back for a week or two. Why? Because the clerical workers are <u>very</u> overworked. There are not enough of them to do the work for all the Adjudicators. Therefore, we have to wait until they have time to do it. This, in turn, slows down our cases. But, the Adjudicators get blamed because the cases take so long. Another factor which slowed down my cases was the lack of doctors, we waited sometimes a week to see them.

18X

Newark is like a factory. Everyday you feel so much pressure. One day, when I was working in Newark, I had been waiting a long time to go over a case with a doctor. Finally, I got my chance to speak with him about the case. When break time (10 AM) came we were still involved in discussing this case. At 10:20 a.m. when we finished, I took my morning break. The Regional Manager became enraged because I was on break at 10:20 and accused me of loafing. Instead of asking me why I was on break at this time, he reported me to my supervisor.

What's the message I got from management? Don't go the extra mile for claimants because you will probably get in trouble for it.

To compare, New Brunswick is much more relaxed. There is a cap on the number of cases each adjudicator is assigned. When we have a shortage of doctors, we borrow them from Newark. When our cases get backlogged, they send them to Newark.

We don't have to deal with any of the really hard geographic areas, they are all assigned to Newark. For instance, one of the regions in the Newark office deals with Irvington, Elizabeth, two Newark areas, and Jersey City. Of course all of these areas are pretty economically depressed. That means that lots of the claimants don't have phones. There are more aids cases, and more homeless people. In addition, poor people often can't afford to go to their own doctor. This means that they have to go to clinics for their medical appointments. It is much more difficult to get medical information from a clinic than from a private doctor. This

19X

really slows down cases and there are just more cases coming from these areas.

Adjudicators in Newark refer to the New Brunswick office as a country club. No wonder! When I was in Newark, I always had a steady stream of new cases. However, I came to New Brunswick on September 7th and I got my first <u>new</u> case the week of October 10th. Why? Because they don't like Adjudicators to carry more than 160 cases. They wanted me to finish up my old cases before giving me new ones. This would not have happened in the Newark Office. Now, instead of waiting a week to see a doctor, I get four cases reviewed on the same day I put in the request. Instead of waiting a week for a letter to go out, it is mailed the same day as I submit it. The New Brunswick Office has hired Kelly Girls to do our clerical work so that our Claims Adjudicators Aides can really assist Adjudicators.

I would like to finish by telling you a story. When I was still in Newark, I sent a letter to the computer to be sent to a claimant on August 22. Just last Wednesday, (Oct 13) the claimant called to say that he had just received the letter. What happened? Newark's printer spits out all kinds of letters, forms and documents. It got lost beneath a pile of papers because there are not enough clerical workers to go to the printers and sort things out. I was really embarrassed. This level of chaos is constant at the Newark office. The entire office lacks structure and organization. It is incredibly demoralizing and frustrating to work in that environment because it's impossible to do a good job.

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Thank you for giving me the opportunity to speak. I will be happy to answer any questions you may have.

21X

TESTIMONY OF RENEE BROWN

Good morning. My name is Renee Brown. I am a Claims Adjudicator II in the Division of Disability Determinations, New Jersey Department of Labor. I am a Shop Steward for Local 1037 of the Communications Workers of America. We represent approximately 400 people who work in DDD. I want to thank the members of this committee for the opportunity to speak about the problems we face in trying to serve disabled people in New Jersey.

I was hired by DDD in 1978. I worked for 5 years in the Newark office from 1978-1986. I then took a leave of absence to work full time as a Union Representative for Local 1037. I returned to my job in DDD in December of 1991.

In 1986, when I went on Union leave, the job of Claims Adjudicator was a difficult and challenging one. I liked my work. It could be difficult, but I knew that if I was conscientious, I could get the job done. However, when I returned to the Division, doing the work of processing claims efficiently was no longer possible. DDD had become a totally different place. Now, instead of spending a few minutes a day doing out-of-title work, we are spending nearly half of our time on clerical duties.

As Shop Stewards, we hear so many complaints every day that we decided to poll our members. We wanted everyone to have an

22X

opportunity to express their opinion about DDD. The results of our poll are very revealing.

Of the Claims Adjudicators who responded, 3/4 indicated that they are doing out-of-title work. They consistently named clerical duties such as hole punching, date stamping and data entry as duties they perform. How much time are they spending on these clerical duties? The majority answered 3 or more hours a day. Please take note that we are talking here of workers who make $40,000 a year spending nearly half of their workday punching holes.

Of those Claims Adjudicators who had been around since 1985, 80% indicated that the office is less efficient now than it was in '85.

We asked Claims Adjudicators whether or not they could process their cases in a timely manner if they worked 12 hours a day. 2/3 responded "no". This demonstrates the severity of the problem. Since managements' response to our backlog is to have us work overtime, it is a problem that 12 hours a day would not solve the crisis. All overtime accomplishes is that we now can spend more time date stamping and xeroxing.

When asked whether or not they had been asked to sacrifice accuracy for production, 2/3 responded "yes".

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In answer to the question "How would you rate management's ability to intervene in and resolve problems?" the vast majority gave management the lowest possible rating-- 1 out of a possible 10.

There were some interesting differences between the Newark and New Brunswick offices on some questions. Most noteworthy, in answer to the question, "Is there enough clerical support?", Newark Adjudicators answered 3-1 "no", while 2/3 of the New Brunswick workers said "yes". It is not difficult to understand this discrepancy since the New Brunswick office has hired "Kelley Girls" to do the clerical work.

The most glaring differences are in morale. We asked workers how they would rate their morale on a scale of 1-10; 1 being the lowest rating. Many respondents in Newark went out of their way to write in a zero so they could indicate how demoralized they are. The overwhelming response from that office was a 1. The New Brunswick workers indicated that their morale was mostly in the 5-6 range. This improvement over Newark's morale is not difficult to figure out if we consider the availability and accessibility of the physicians, added clerical assistance, cap on caseload size, and the relatively economically privileged regions New Brunswick is serving.

24X

Committee Members, frankly, we have had it in Newark DDD. As a Shop Steward, I'm tired of dealing with the mental health and stress problems caused by our work environment. It's obvious from the testimony that you have heard that there need to be some changes at DDD.

My co-workers and I did not want to come here today and merely complain. We came with some concrete suggestions about how to improve services. They are:

1. Immediately hire more Clerical workers. The ratio of Clerical to Claims Adjudicators should be no more than 4-1 as suggested by the Browde Report.

2. Train Claims Adjudicator Aides and utilize them according to their job description. They should be assigned to assist Adjudicators, not doing Clerical work.

3. Eliminate top heavy management and replace them with Adjudicators, Aides, and Clerical who do the actual work of processing claims.

4. We need to have doctors' responsibilities monitored. Since we need their reports to process our claims, they should not receive payment until we receive their paperwork.

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5. Equally distribute DDD resources among the regions. Each region should have an equal share of economically depressed areas, doctors, clerical assistance and cases.

6. Management must find a way to improve morale, communication, and reduce stress immediately.

It is my hope that this committee will finally force the Division to change. We have talked often and loudly, in meetings and in demonstrations, yet things have not improved. I am asking you, Committee Members, to help us change DDD so that we can serve our claimants well instead of poorly.

AFL-CIO CWA Local 1037
COMMUNICATIONS WORKERS OF AMERICA

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Testimony
of
Communications Workers of America

October 19, 1993

Before The

New Jersey General Assembly Committee on Labor

27X

AFL-CIO CWA Local 1037

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October 8, 1993

Dear Assemblyman Roma,

Members of this Local, who also work in the Division of Disability Determinations in the New Jersey Department of Labor, will be testifying before your Committee on Tuesday, 10/19/93 about the serious problems the Division is experiencing.

Enclosed please find some materials we will be using. We submit this now to facilitate discussion during the Hearing.

Any questions, comments, suggestions, just call. Thank you.

Respectfully,

Michael J. Hopkins

Michael J. Hopkins
President, CWA Local 1037

mjh:kc

encl: hearing materials

28X

MEETING 9/12/91

General Background

Organization
External

Management

System

Laundry List

Reorganization

Conclusion

Laundry List

Phone Bank
Medical Evidence
Doctor Pay
Xper. Unit
Copiers/Equipment
Reclass./Unit Scope
Advisory Council
Internal Council
Adjudicators - Camden
~~Language Variant~~
Space

29X

I. Organization

II. Management

- Communication
- Vacancies - Key Positions
- Planning
- Training
- Policy & Procedures
- Supervision

III. External

IV. System

30X

Introduction

In July, the Commissioner of Labor convened a Department Task Force to review the operations of the Division of Disability (DDD) located in Newark, N.J. The call for a task force was in response to the repeated negative publicity that the DDD has attracted due to its inability to process claims for Social Security Disability benefits in a reasonable period of time. Gwendolyn King, Commissioner of the Social Security Administration, has critized New Jersey for its lengthy processing time (nearly twice the national average) and its extremely high backlog of cases. To address these problems, Commissioner King in June, assembled a 10-member management strike force from various states to review the management and claims processing capability of the N.J. DDD. Under the direction of the SSA Regional Office in New York, the management strike force developed a comprehensive report including fifty-seven (57) specific recommendations to address deficiencies in N.J.'s operation. While the recommendations contained in the federal review focused primarily on ways to improve claims processing, particularly in light of N.J. efforts to install an automated claims tracking system, the federal report did not contain recommendations concerning the current organizational structure of the DDD nor comments on the agency's ability to initiate the necessary reforms to dramatically improve agency performance. Therefore, Commissioner Bramucci's charge to members of the Department Task Force was to review the DDD organization and management structure and recommend

solutions that would facilitate a more efficient processing of claims and strengthen management and accountability for production at all levels.

Division of Disability Determinations - Mission and External Issues

The fundamental reason for the existence of the DDD has not changed over the years. Its primary responsibility continues to be the documentation, evaluation and adjudication of all claims filed for disability benefits in New Jersey under the provisions of Title II and XVI of the Social Security Act.

Despite this relatively straightforward mandate from SSA, the DDD is confronted with a number of external issues that have a significant impact upon the ability of the agency to deliver services. There are some examples worth noting. Frequent policy or procedural changes from SSA in Baltimore relative to types and number of cases selected for more intensive quality review necessitate a removal of these cases from the normal processing stream. This delays the final adjudication of cases resulting in increased processing time and fewer closures.

New Jersey's capacity to process a high volume of claims is constrained by the limited funding received from SSA. In 1984, New Jersey handled approximately 59,000 claims with a staff of 402. In fiscal year 1992, SSA has projected our workload to be 62,000 claims yet staffing has been reduced to 264 which amounts to a loss of 34%. Emergency funding has only recently been authorized by SSA for the

hiring of 80 new adjudicators over a six month period in an effort to decrease processing time and eliminate case backlog.

The impact of the Zebley decision will also effect workload. In February, 1990, the U. S. Supreme Court ruled in Zebley vs. the U.S. Department of Health and Human Services that the SSA must consider the functional limitations of children when assessing their eligibility for SSI disability benefits. This translates into an estimated 5,000 new cases for adjudication by our DDD agency.

The concentration of persons with AIDS in New Jersey and a large homeless population also impacts DDD. It is believed that New Jersey ranks fourth in the nation in the number of adults stricken by AIDS. Of the total number of cases of AIDS in New Jersey since 1982, approximately 58% of the people have died. As a priority, DDD is attempting to meet the needs of this population by the expeditious determination of disability. In addition, the concentration of homeless people, whom often have multiple disabilities that may entitle them to benefits, provides a different challenge for the DDD agency. Extraordinary efforts are made through the cooperation with local shelters, to speed up the processing of claims for benefits. The obvious difficulty in working with this highly mobile population is identifying treating sources and documenting evidence before a determination can be made.

Finally, the competition for qualified workers is fundamental to producing a good product. The location of DDD in downtown Newark forces it to compete with surrounding private industry to attract a

skilled and reliable workforce. While a problem at the professional level, it is more acute in the clerical occupations. The skill level of the workers (or lack of) impacts the ability of the DDD to meet the rising workload demands.

Internal Issues

During our review, it became evident that the Division does have a number of internal weaknesses which contribute to the problems currently facing the organization. These problem areas are very much interrelated and feed off each other to further exacerbate the poor working atmosphere and the morale of the staff. These key internal problem areas include: communications, staffing, workload, and production; relationship between adjudicators and Quality Assurance and clerical support. We have attempted to briefly summarize each of these problem areas and their impact on the organization. It must be reiterated that none of these stand alone. The sum of all of these combine to form an organization that does not appear to be working together as a team with a common mission.

Problem Areas

Communications

From our interviews and the results of the survey, it is obvious that the perception of the DDD staff is that communications within the organization is weak. This was a common theme in our discussions with various staff members.

The perception of a lack of a good communications network between management and staff and between various operations within the organization has lowered morale and created a somewhat contentious work environment.

A common complaint from supervisory and line staff was that there is little feedback from top management regarding ideas and suggestions for improvement. It was also alleged by some staff members that they were afraid to speak up. Other complaints focused on the perception that directions from top management to supervisors are not filtered down to the operating staff. Finger pointing between units, e.g. (adjudicators vs. medical review staff), (Quality Assurance vs. adjudicators), (management vs staff) have all contributed to an adversarial setting which contributes to poor production and lowered effectiveness.

The review team also noted that the floor plan at the new work site appears to have hindered work flow and communications. Most adjudicators and physicians are physically separated, and in quite a few instances, unit supervisors are also physically separated from the adjudicative staff.

The size of the third floor (a city block long) and the fact that there are hundreds of cubicles (without identification) contribute to a breakdown in communications within the organization.

We have concluded that the "communications barrier" is one that must be removed as soon as possible in order to foster an improved work environment.

Staffing, Caseload, and Production

This is an extremely serious issue which can be attributed partly to the external factors of federal budget reductions and the poor economy. Since 1984 the Division has suffered a 34% loss of staff while having to process significantly higher claims loads each year. Presently, the national case load average per adjudicator is approximately 120 while New Jersey's average is close to 200. Average production (cases closed) per week is 11.9 nationally while New Jersey's average is 7.2. Average processing time nationally is approximately 80 days while New Jersey's average is approximately 138 days.

The high average caseload for New Jersey's adjudicators does impact production negatively. Telephone inquiries and the volume of mail to be handled increase proportionately with a higher caseloads thus reducing the amount of time available for an adjudicator to close cases. Other factors such as word processing delays in the development of cases, backlogs in medical review, and quality assurance contribute to the high average processing time. Adjudicators complain that they should not be held accountable for poor production because of factors which are beyond their control.

It is anticipated that the new computer system will significantly reduce the processing time case development correspondence to be mailed to doctors, hospitals, and other sources. It is also anticipated that most telephone inquiries will be handled much faster once the computer system is fully operational

Medical Review

The current organization has approximately 40 physicians (in addition, five new doctors who have just been hired) who review cases received from approximately 140 adjudicators. Most physicians work part time four hours a day. There are approximately 2,000 cases currently awaiting medical review. This unit is headed by a medical director and three supervising medical examiners.

All cases (allowances and denials) have to be reviewed and signed off by a physician before it can be closed. There are a number of significant problem areas that have been brought to the attention of the review team. These are summarized as follows:

- The perception of the adjudication staff is that doctors are not held accountable for case closures and that some physicians review cases with the objective of moving it to someone else for action rather than closing it themselves.

° Face to face reviews are very rarely done, adjudicators are removed physically from the medical staff and are not aware of who is actually handling his/her case.

° Doctors refer cases back to adjudicators for more information (telephone calls) when they could make the call themselves.

° Doctors' reviews, rather than productivity standards are geared towards case closures.

° Adjudicators are not documenting cases properly, which wastes doctor's time and delays processing.

° A "we vs. them" mentality has developed between adjudicators and medical review staff.

° The floor plan was poorly conceived. In addition, doctors were provided work stations that were not comparable to those of adjudicative staff.

° It is difficult to find cases which are in the medical review area.

° Adjudicators perceive that there is no sense of urgency exhibited by medical review staff to close cases.

° There are insufficient doctors or staff. With over sixty new adjudicators due on board within the next four months additional medical staff will be needed.

° New adjudicators are supposed to have face to face interviews as part of their training. This is apparently done at a minimum level (if at all).

° Most of the part time doctors work during the morning hours. This results in reduced medical coverage in the afternoons. More flexibility in scheduling physicians is desirable in order to provide adequate medical coverage during the work day.

° It was the review team's conclusion that the current organization is far too large and unwieldy to promote a sense of teamwork and accountability. In the past, doctors and adjudicative staff worked together as a team to develop and close a case. That is impossible under the current framework.

Quality Assurance

In any organization, there is the threat of an adversarial relationship between the "quality" staff and the "production" staff. Although both units have the same goal, unfortunate schisms can develop for a number of reasons.

° Personality conflicts sometimes exacerbate what should be an objective review of a case.

° A "we vs. them" attitude has developed between Quality Assurance and adjudicative staff.

° A backlog of Quality Assurance reviews results in delays in case closures which increase case processing time.

° It appears that more emphasis should be placed on mid-line reviews (before the case is actually determined) rather than on end-line reviews.

° Quality is the responsibility of all staff. Supervisors have to take a more active role in reviewing claims, following up on Quality Assurance bounce cases and in training. Supervisors and case consultants must be coaches, advisors, mentors, and work leaders.

° The Quality Assurance Unit on the fourth floor is physically separated from the production units on the third floor. This may have contributed to the perception that Quality Assurance is too far removed from the operation to effectively understand and relate with adjudicative staff.

Clerical Support

There are approximately 32 clericals who are under the supervision of a head clerk. These individuals are assigned to various units but do not report to the supervisors of these units. It appears that this "pool" arrangement has resulted in a sense of disenfranchisement among the clerical staff. Although they support adjudicative staff, they do not feel as if they are part of the unit. It was also indicated that the ratio of professional staff to clerical support (ten to one) is too high. In addition, clerical staff question what their role will be under the new automated system.

All of these factors have contributed to poor morale and high absenteeism.

° Some clerical employees appear to be overworked while others were perceived as not having any work to do.

- Unit supervisors were also critical of the fact that they had no direct control over clerical support.

- It was concluded by the review team that the current organizational scheme has resulted in the inefficient utilization of the clerical staff and that they should be formally assigned to work units under the direct supervision of the unit supervisor.

Internal Issues

Strengths

While there is no question that the DDD organization faces a very difficult period due to external and internal factors, the Review Team noted several key reasons (or optimism) that the operation will be improved dramatically during the coming months. We note the following:

Staff

During its review the team had the opportunity to meet with a number of individuals from the supervisory, technical support, adjudicative, and clerical support areas. We also received over 200 responses to the questionnaire which was distributed to the entire staff. The responses we

received and the discussions that were held repeated that the Division has a substantial number of very dedicated employees who care deeply about their jobs and their organization.

We note that while morale may not be as good as it should be, staff members from throughout the organization were more than willing to offer advice and recommendations. Our perception is that the staff has a deep routed and understandable interest in the turnaround of the Division. This positive attitude is a major resource which should be utilized to the greatest extent possible in order to effectuate appropriate changes to improve and enhance the effectiveness of the Division.

New Computer System and Hiring of Additional Staff

The new computer system is discussed in detail in another section of this report. While the system is still in the early stages of implementation, there is also a good deal of optimism that it will (in the long run) have a major impact on processing time, case tracking, case management, and handling of telephone inquiries.

In addition, approximately eighty new adjudicators will have been hired by the end of 1991. These trainees will obviously require a substantial training period before they become productive but it is anticipated that a more than 50% increase in the adjudicative staff will place the Division in the position of being able to reduce processing time, lower average case loads, increase productivity, and improve quality.

Supervisory Vacancies

At present, due to retirement, there are four vacant supervising claims adjudicator positions, and two vacant claims adjudicator I positions. This presents the Division with an excellent opportunity to develop a core of highly qualified and motivated individuals in these crucial positions. Given the fact that the review team is proposing a major reorganization of the Division, the importance of placing the best people possible becomes paramount since they will be the key elements in the success or failure of the new organization.

Of course, as these positions are filled, other mid-level supervisory positions will become vacant, which will provide additional opportunities for advancement for the staff.

Conclusion

While there are many negative internal and external factors which inhibit the effectiveness of the Division in meeting its goals, there are a number of very positive factors which can reverse the current course.

SYSTEM

In the Spring of 1990, the Division of Disability Determinations (DDD) with the promise of financial support from the Social Security Administration submitted Request for Proposal for an Integrated Disability Determination System. This was to be a microcomputer based automated case management system. The bid was advertised on June 6, 1990 with replies due July 6,1990. Two bids were received from IBM/Versa Management System the other Wang Laboratories in partnership with I. Levy Associates. After careful review by an evaluation committee composed of N.J. DOL, Purchase Bureau and O.T.I.S. employees, a recommendation to award the contract to IBM was made on July 24, 1991. The contract was issued with the system to be operable 118 days later or . From the beginning DDD encountered problems from which they have yet to recover.

PROBLEMS

DDD did not have personnel with experience in automation of the size or scope about to be undertaken.

The window of opportunity for the development of the proposal was too narrow resulting in too little user input into the proposal.

The contract award was delayed due to disagreement between IBM/VERSA and the Treasury Department over the requirement to use Spectrum Methodology.

The requirement to follow Spectrum Methodology was not retained which hindered the evaluation and acceptance of system modules.

DDD was to be relocated from 1100 Raymond Blvd, Newark to 124 Halsey St., Newark. The Division was moved August 16, 1990.

The case load has continued to increase.

Until March 1991, DDD was under a hiring freeze.

STATUS

The system is partially operational with the expectation that it will be fully operational by November 1991.

Eight adjudicator units (80 employees) are utilizing the system for development of cases.

LOCAL INTEGRATED COMPUTER SYSTEM (LINCS)

The case receipt update and closure process is operational. The entering of personnel data has been completed. New codes for the State Agency Work Sample (SAWS) are being entered for use in October.

DETERMINATIONS

The Personal Denial Notice (PDN) canned text and denial notices have been entered into the system. Testing to determine the completeness of confirmed medical evidence of record (MER) sources and its inclusion into the body of the letter is to be tested theweek of September 23, 1991.

CONSULTATIVE EXAMINATIONS (CE)

CE panalist and examination data is in the system. Payment information has not yet been entered into the system nor has accompanying correspondence because the accounting problems have not yet been resolved. Although this was expected to be completed by November, it appears that Versa may not have a programer available to work on the problem until December 1991.

QUALITY ASSURANCE (QA)

The system is indentifying initial QA samples and generating reports. However, there is a problem as regards pulling samples involving concurrent cases. This appears to be outside of the contract and will need to be addressed as an enhancement.

ENHANCEMENTS

In the course of operating the system, DDD personnel are identifying changes they would like made to the system's programing. These changes where within the scope of the contract are being persued. If it is determined they are outside of the contract's paramitors, they will be submitted as enhancements to attain greater efficiency and a more "user friendly" system.

CONCERNS

The original proposal called for the acquisition of 150 terminals and 28 printers. These numbers are insufficient to provide equipment to all adjudicators. A subsequent request for 150 terminals and 28 printers has been submitted but has still not been processed. It is not expected that the terminals will be available when and if the system is completed in November 1991.

Spectrum methodology was not followed which has caused delays in the systems definition, design and implementation stages.

The system was developed with very little user input which has resulted in a system which requires, in some instances, additional keystrokes and processing time. Only recently has a "user group" been formed to review, prioritize, and suggest changes.

The placement of printers away from the units they service causes additional supervisory problems for the clerical supervisors and additional time loss for the clerks as they transport output back to the adjudicators.

The system is regarded as a cure for the processing time that is crippling DDD. It will result in definite time savings by eliminating many of the word processing functions which in the past resulted in several weeks of processing time lost to backlogs. It has the potential to eliminate manual tracking systems. In these respects, it will move cases through the system more quickly; however, these gains will be lost unless other areas within the process which are bottlenecks are not opened wider. These areas: photocopying, medical review and quality assurance are discussed elsewhere in this report.

Staff interviewed have indicated that very little has been told to them regarding the system, its capabilities and its effect on their positions. This has resulted in anxiety for employees especially clerical employees who see their functions in jeopardy. This is an example of the break down in communications elaborated on elsewhere in this report.

The physical distance between DDD in Newark and the central office system support services magnifies the gap in technical expertise because oversight of the DDD automation by central office personnel with experience in programming is not as available as it would be if DDD were located in Trenton.

The system still does not have the capability to be used as a tracking system. Until it can be used to monitor accountability for processing time, it will be difficult to assess the productivity of all individuals involved in the flow of claims from point of arrival in DDD to the point of departure.

RECOMMENDATIONS

Because upper management has a great expectation that the automated system will result in great processing savings and because the system is not yet assembled, a meeting should be held by upper management with members of the project team, IBM/VERSA representatives and the Office of Programs and Systems Development. The subject of the meeting should be an assessment of the systems capabilities (areas where it will help and where it will not), when the system will be fully operational and what future enhancements should be sought.

The additional equipment for DDD should be given a high priority. Without the additional terminals and printers DDD will have to continue on a dual system (automated and manual) even when the system's programming is completed.

The Office of Programs and Systems Development and the Division should work together more closely to help bridge the gap in expertise and to hasten the system's completion. To this end, it would be advantageous to have someone from the Office of Programs and Systems Development assigned to DDD full time until the project is completed.

The newly formed users group should formulate with the project manager a list of program changes needed to make the system more "user friendly". They should prioritized these requests and submit the list to DDD's upper management for approval.

Information regarding the systems, its abilities and its impact on all employees should be communicated to DDD employees on a regular basis. This information should not be dispensed on a unit per unit basis as the unit is to go on line. It is not necessary, although it would be preferable, to communicate this information through staff meetings. The newly formed user/project management team can publish periodic system up date bulletins for distribution to all personnel.

Employees whose functions will be absorbed by the system need assurances that other duties will be made available to them. However, they must also take responsibility for seeking out new opportunities and requesting skills upgrading. They must also demonstrate a willingness to learn and to adapt to the new situation.

The automation of DDD processes will result in significant changes for all personnel involved. These changes need to be assessed and where necessary positions required upgrading should be identified and reclassification sought as early as possible.

The placement of equipment specifically printers should be reexamined. These should serve to maximize the efficiency of clerical and supervisory personnel. This should be a component of the space utilization recommendation elsewhere in this report.

The systems capabilities as a tracking system must be utilizes as quickly as possible to achieve accountability in processing time. Currently processing time is chargeable to the adjudicator who has little or no control over the time the claims are not in his/her possession. This has made it impossible to recognize good adjudicators for their performance and identify weak adjudicators requiring more training, guidance or assistance. Tracking by the system will make the foregoing possible while also identifying weaknesses in work flow.

COMMENT

DDD project personnel and management in spite of their lack of automation experience and the problems out of their control have done a remarkable job of advancing DDD automation to the point at which it stands.

LAUNDRY LIST ITEMS

MEDICAL EVIDENCE OF RECORD PAYMENTS

DDD currently pays each physician, hospital, clinic etc. $10 for providing medical information pertianing to the claimant in order to adjudicate cases. This reimbursement rate is too low. It is felt that a higher rate will result in reports that are more timely and more informative. This should result in a decreasing need for consultive examinations. While the increasing payment may cause the quality of the reports to improve, it may have no impact on response time. DDD may wish to consider a sliding fee schedule whereby reports submitted within XX number of days will be reimburse at a higher rate than reports submitted later. A three tier schedule should be more effective than a two tier system yet should be easy to manage.

PAYMENT OF PHYSICIANS ON STAFF

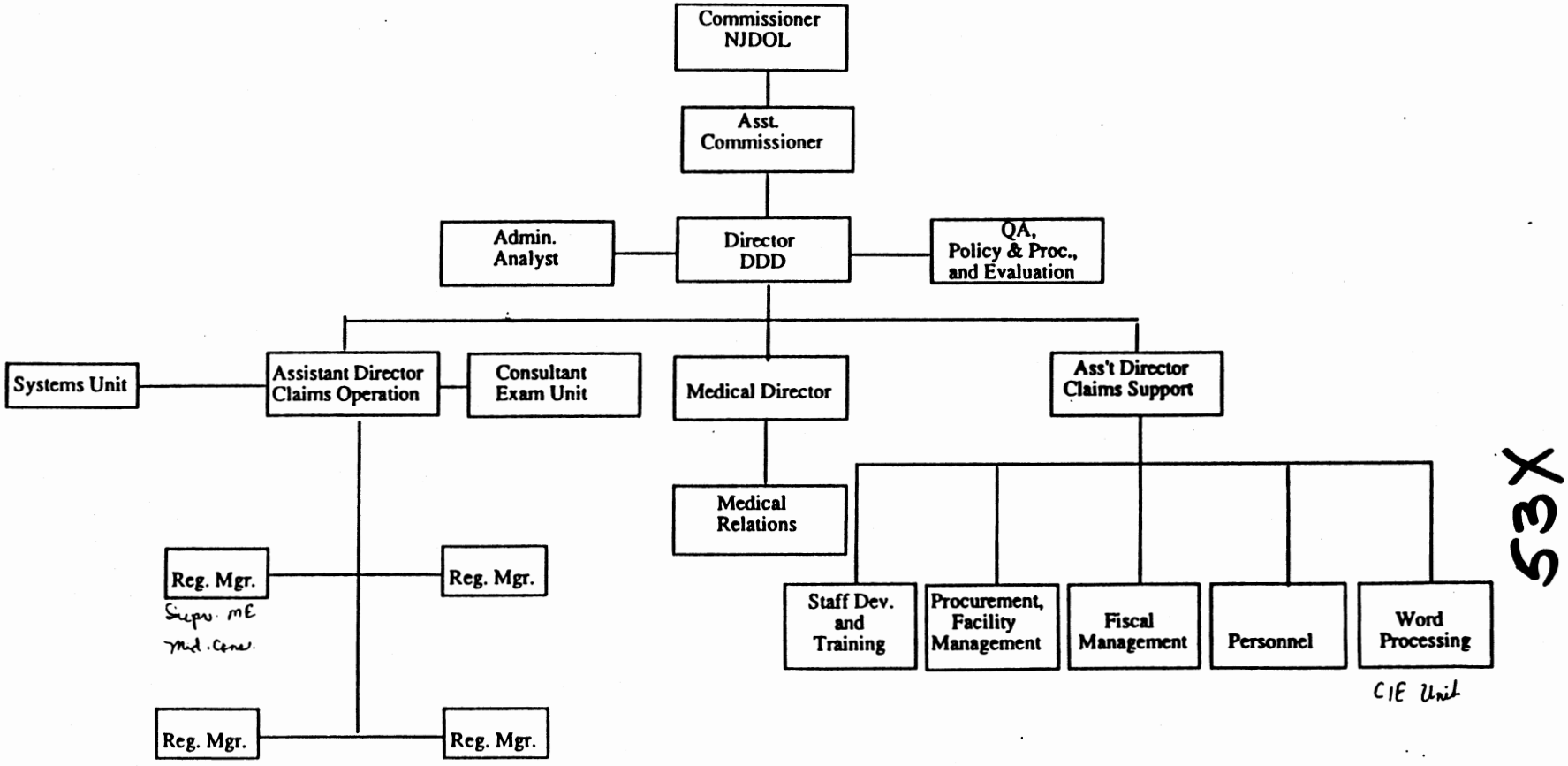
DDD utilizer physicians both full time and part time. The rate of compensation for physicians should be reviewed. Particular attention should be given to the manner of payment of the part time physicians. These are paid on a per diem schedule which does not permit DDD management to fully utilize their medical staff. Consideration should be given by the Department of Labor to change the method of compensation from a per diem to and hourly and eventually a per case basis. The hourly basis will permit DDD to utilize physicians for a full day or just an hour based upon the needs of the agency and the availability of the physicians.

Eventually, the system could be enhanced to the point where the physician could review all medical evidence and sign off on the claim via the system. The system would monitor the physicians closures and compensate him/her on a per closure basis. Different rates could be established to cover different "classes" of cases. It may even be possible, in the future, to contract with physicians to review cases via terminals at remote sites.

SPACE

There is an urgent need to examine the space needs of the Division of Disability Determination for both production and system requirements. Current space as configured does not provide suitable work areas for the current class of trainees. DDD has plans for an additional 25 trainees by November 1991. Space must be identified or the current space reconfigured to accommodate the increase in personnel. The current lack of space is also a valid reason for considering the decentralization of DDD operations as discussed elsewhere in this report.

Proposed Reorganization of DDD--Plan "A"



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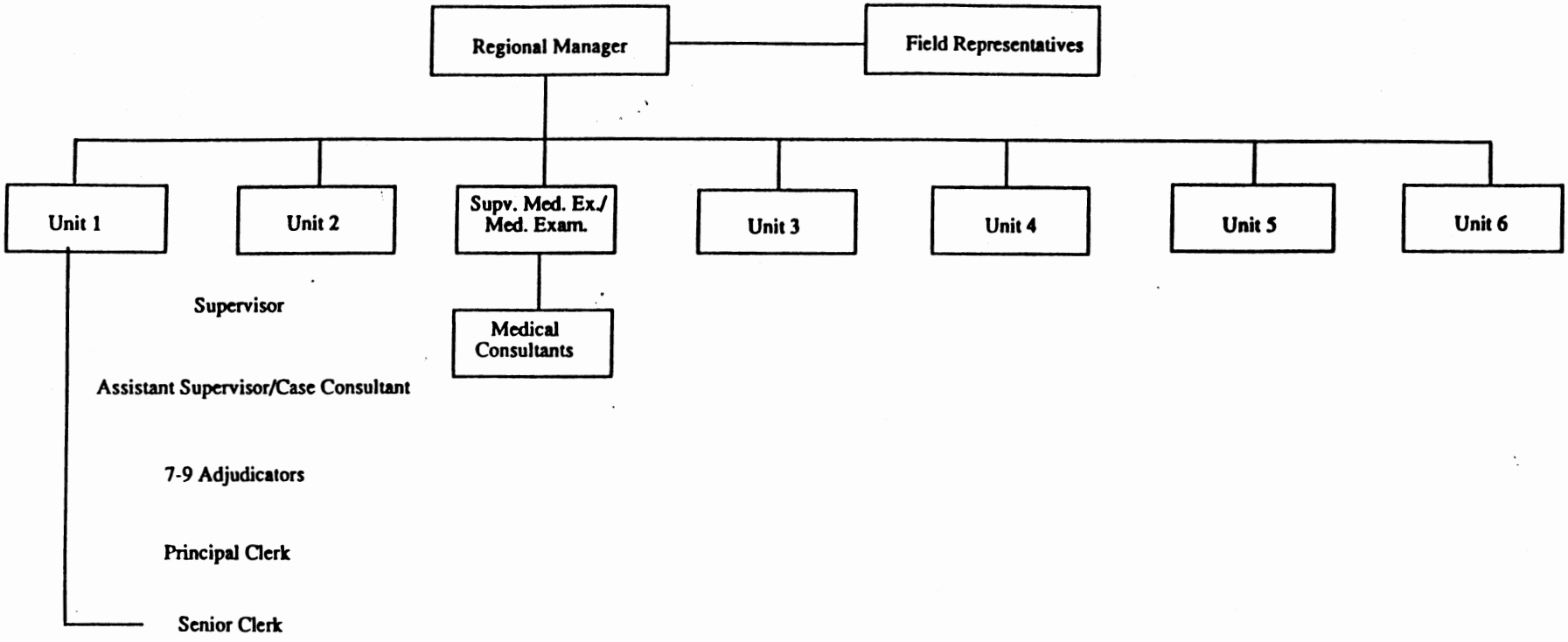
Regional Manager
Field Representatives
Unit 1
Unit 2
Supv. Med. Ex./ Med. Exam.
Unit 3
Unit 4
Unit 5
Unit 6
Supervisor
Medical Consultants
Assistant Supervisor/Case Consultant
7-9 Adjudicators
Principal Clerk
Senior Clerk

54X

February 28, 1993

Hon. James Florio
Office of the Governor
CN 001
Trenton, NJ 08625-0001

Hon. William J. Hughes, Chairman
Subcommittee on Retirement Income & Employment
House Select Committee on Aging
714 O'Neill House Office Building
Washington, DC 20515-6362

Dear Governor Florio and Congressman Hughes:

In February 1990, I wrote that there were "serious" operational problems" at the New Jersey Division of Disability Determinations. The response from the State Labor Department was a list of excuses. In February 1991, I wrote that the Social Security disability program in New Jersey was the "worst" in the nation. The response was an indignant denial which was disproven in public within three months. Today, once again, considering claims processing time, decisional accuracy and productivity, in the aggregate, **New Jersey is the worst performing state in the nation for the processing of Social Security and SSI disability claims.** Consider these developments:

* Despite large doses of federal assistance throughout 1991 and 1992, New Jersey's **mean processing time per initial level case**, for both Social Security and SSI, has remained **significantly worse than comparable national averages.**

* The Division is still loaded down with a high number of **delayed initial level cases far in excess of national averages** for both SSDI and SSI. The number of cases being held for **double, triple,** and even **quadruple** national average processing times is extraordinarily high in New Jersey. Recent Congressional testimony from the Social Security Administration shows a reluctance to acknowledge that even a few cases are held in any state for as long as double the national average. In terms of delayed claims, therefore, New Jersey is a basket case.

* The average processing time for an **appellate claim** in New Jersey for the past year has been about **double the national average.**

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* Decisional accuracy figures for initial level claims for the quarter ending January 1993 show New Jersey ranks **51st out of 52 agencies nationwide** for overall accuracy. In particular, a very high percentage of New Jersey decisions to **deny benefits** are **incorrect or not adequately documented** to show what the correct decision is. [Caution: These figures are subject to sudden shifts due to administrative manipulation in the face of publicity.]

* The Division's internal quality assurance review of completed cases presently shows **very high error rates.**

* A relatively high percentage of **appeals of initial denials** are **allowed** by the agency's own senior examiners. This high reversal rate confirms the large number of errors made when cases are initially denied.

Below is a chronology of events, with comments, designed to explain why disability claimants from New Jersey have not received a level of service comparable to that received in other states in recent years.

May 1991

The State Department of Labor told the press that it had not been informed by the Social Security Administration that the performance of the State Division of Disability Determinations was poor in any way except for having a backlog of cases. Twenty days later the Commissioner of Social Security declared New Jersey's record of handling disability claims to be **the "worst" in the nation**, particularly in terms of **processing time delays** and **low accuracy of decisions.** Within a week the State Labor Commissioner said he was "in the dark" about federal figures showing New Jersey to be at the bottom. The news was "a lightning bolt."

Comment

On February 22, 1990, Governor Florio, I wrote the first of a series of letters to you detailing the extraordinarily poor performance of the Division of Disability. My letters were referred to the Labor Commissioner who wrote to me on April 6, 1990, stating he knew about the problem and was working on it. However, nothing really changed.

I kept writing to you-- 11 more letters from March 2, 1990, through September 17, 1990-- most of which contained excerpts from SSA reports providing conclusive evidence that New Jersey was consistently among the poorest states in terms of timeliness and accuracy in handling disability claims. In

letter after letter, I used terms such as "completely out of step," "one of the worst," "the worst," "among the poorest," "one of the poorest," and "last (place)" to describe the Division's processing time and decisional accuracy record. On November 1, 1990, an Assistant Labor Commissioner wrote to me that all this trouble was due to circumstances beyond the control of the Department of Labor.

My letters to the Office of the Governor continued from November 30, 1990, right up to the time of the newspaper articles in May 1991. In fact, on March 4, 1991, I received a letter from the Department, at the request of Brenda Bacon, Office of the Governor, specifically noting that I had "asserted" on February 12, 1991, that the State's performance was "the worst in the nation" and that my "statistical review" was not being challenged.

In light of this correspondence, is it not fair to characterize the Department's public denial of any knowledge of the Division's profound problems in May 1991 as lacking all credibility?

June through December 1991

During this crucial period the following events took place:

(1) In June the Social Security Administration conducted and reported on a review of the state agency's operations. The Division was allocated $3.3 million to hire 90 more claims examiners and five physicians. Funding was continued for a large scale automation of claims processing operations, for unlimited overtime during both weekdays and Saturdays, and for the assignment of federal personnel to help the state process claims.

(2) In July the Star-Ledger published a lengthy article exposing the Division's problems.

(3) In August a Department of Labor "management team" arrived to study the Division.

(4) In September the agency's chronic accuracy problem just up and disappeared off the statistical charts.

(5) In October the Division's entire internal quality assurance unit was ticketed to the production units.

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(6) In November the Department announced that it would move one-fourth of the Division to New Brunswick in about eight weeks. (Lease politics would cause a delay of 11 months.)

(7) In December the Department exchanged Division leadership and submitted a budget to Social Security emphasizing the need for more managers and more operational offices.

Comment

The **June 1991 SSA review** of the Division was a shallow effort. Two goals were imposed on the state agency: make the backlog disappear and raise the denial accuracy rate dramatically by the end of the year-- all at a time when a large number of new employees was being integrated into the staff. Once these bureaucratic goals were announced they became ends in themselves, to be achieved regardless of the methods used. Management simply required a success story.

The **$3.3 million staff increase** began in May (28 claims examiners), continued in September (29 more examiners), and ended in December (33 examiners). This represented an expansion of the claims examiner staff of 66%, the largest in 18 years. The new people would be pushed from the day they completed their last training class to close as many cases a week as possible and damn the documentation requirements of the procedures manuals. Their presence would also be used, misleadingly, as a rationale for resurrecting a decentralized configuration for the Division, the fondest goal of the Department and the new Division bosses.

The Division grew increasingly dependent on **overtime** in 1991 to meet its basic production goals, not to go beyond them. The existance of so much overtime money masked the lack of productive capacity and hid the mismanagement of resources underlying that lack. **Automation**, ever the panacea of choice, floundered for lack of efficient programming. (One Trenton systems maven met with a group of complaining supervisors at the Division and told them the system would be [obscenity] for a year and maybe for even five years.) The Department's battles with the systems vendors (IBM hardware/VERSA software) over "program change requests" have been fought behind the scenes and remain largely unresolved today. Most importantly, due to insufficient live clerical assistance, the routine claims processing procedures are cumbersome to the point of driving examiners nuts. The Division paid for Big Blue and got Rube Goldberg.

The August/September **Department of Labor management review team** was a vehicle for imposing the Department's self-serving plans for bureaucratic restructuring, reorganizing, regionalizing,

and decentralizing. The review became, in part, a game to see who would grab the leadership of the demoralized Division with its expanding budget. In an era of "fiscal restraint" visions of dollar signs danced in their heads-- $$A.

In September the agency's **negative publicity** over its **low decisional accuracy** had its predictable effect. The July-August-September 1991 quarterly federal accuracy statistics for the Division showed a 180-degree turnaround. After being the worst in the nation for denial accuracy for the period 1/88 through 6/91 the numbers showed New Jersey had risen from the dead just like that. One of the best. Above the national average. Actually, the miracle was wrought by **shifting more of the Division's errors from the Group I category to Group II or Group III** using a subjective review procedure known to disability technicians as the "probability of reversal rule." In essence, federal managers, themselves in an inter-regional competition to show good performance results, can control the accuracy rates of their assigned states by determining which errors are "chargeable" on the public record (Group I) and which are deemed "non-chargeable." Sort of like a cop who can give you a verbal warning or write you out a ticket. In just three months time, the absolute minimum valid reporting period for statistical purposes, the negative publicity for the Division inspired a two-thirds reduction in the number of Group I chargeable returns to New Jersey. What had been a basic three-year trend of poor performance ended, statistically speaking, overnight. (There would be no accuracy problem until November 1992, as explained further below.)

In October 1991 **the entire internal quality assurance unit of the Division was reassigned** to the line production units. The quality goal having been "met", it was time to push harder on the backlog. The idea was to facilitate production by removing the inhibiting effect of accuracy reviews conducted on a regular basis onsite. The new examiners cut their teeth in a period of prolonged documentational laissez faire.

Ending months of speculation, the Labor Department announced in November its plans to open a **decentralized office in New Brunswick** as early as January 1992. Just a year prior to the arrival of the Department of Labor management review team, in August 1990, the Division had moved from its centralized 1100 Raymond Boulevard location in Newark to 124 Halsey Street, also a centralized Newark address. The Halsey Street building, formerly the Kresge Department Store and then the Two Guys Store, had been renovated by the State and rented for tens of millions of dollars. The Division was to remain there for the foreseeable future following a failed decentralization attempt lasting from 1981 to 1987. The Department once more had the green light: go forth with

the people's FICA taxes and build thee an empire, starting in New Brunswick.

December brought the **changing of the Division's leadership**. The team prepared a **budget** which was a **blueprint for quartering the Division** and shipping three pieces out of Newark by 1994. Naturally you needed **more managers** to do this. (Should we ever decide on an upper middle class welfare system in this country, the DDD Fiscal Year 1993, 1994 budget request should be mined for ideas.)

1992

The Division's focal event was the **Congressional hearing** entitled "New Jersey's Disabled: Has the Promise Been Broken?" held on May 22 in Ocean City, NJ, before the Subcommittee on Retirement Income and Employment of the House Select Committee on Aging. The hearing record shows that officials representing the Labor Department made these four points in their key testimony:

(1) The **management team** which took over the Division of Disability was taken from the cream of the crop at the Department of Labor.

(2) There simply was **not enough room in Newark** to house the Division after the 1991 staff increase. Since the Department already had **space available in New Brunswick** it made sense to move part of the Division there.

(3) The centerpiece of the Division's restructuring effort would be **a regionalization plan creating four discrete geographic jurisdictions**, one of whose operations staff would be moved 20 miles to New Brunswick. This new branch office would **increase face-to-face contact** with both claimants and sources of medical reports, while allowing management to test initiatives to **increase office productivity.**

(4) **The Division would process about 3,500 continuing disability reviews** during 1992.

Comment

The **management team** installed after November 30, 1991, had **no prior experience** at any level with the Social Security disability program. (The U.S. Department of Labor's "Dictionary of Occupational Titles" notes that it takes two to four years to become proficient at the position of disability claims examiner,

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the basic professional occupation at the Division.) Thus, not only did the team take over an organization whose basic functions were unknown to them, they were charged with making dramatic improvements in its chronically poor performance in a short period of time. That effort has failed.

One more point: to equate the skills and knowledge that are necessary to run a state SSDI/SSI program with Unemployment Insurance, Employment Service or state plan Temporary Disability is farfetched. The complexity of the issues and the problems involved in the one far surpass those found in the others. Indeed, few government benefit programs of any description generate the number of complaints SSDI/SSI does. You are dealing with people who have lost their independence, lost their mental faculties, or have reached the edge of death. Upon their arrival, the team imagined that things could be managed nicely by remote control from Trenton or through subordinates. Today, they still mutter, "Why can't this place run like UI?"

* * *

Just weeks before the Congressional Hearing, the Labor Department was questioned about the **Division's space needs** by the Mayor of Newark. The Mayor was told that **"space concerns and high rent" were not a factor in moving to New Brunswick.** The Mayor got the truth; the Congress got a fictional story about a "space problem." Here is the background:

In 1981 the Division set up a decentralized Camden branch office. This satellite office was not able to operate without draining significant resources from the larger Newark office. After a critical Labor Department study was released in 1987, the branch office was closed since it had contributed disproportionately to an overall lack of agency efficiency.

As mentioned earlier, in 1990 the entire Division was moved two blocks, from 1100 Raymond Boulevard to 124 Halsey Street in Newark. The new location was a former department store with eight floors, renovated by the state and leased from a private corporation. Division employees were told they would stay there indefinitely under a long-term lease. A year later, however, the New Brunswick deal was moving on paper between the Department and Social Security. Why New Brunswick?

While every Division employee knows who owns the Newark building, the owner, or owners of 506 Jersey Avenue in New Brunswick remain the subject of speculation. Some say the owner lives in Florida while others feel politicians have an interest in the property. One thing is clear: the conversion of a large

industrial warehouse in a relatively inaccessible, relatively isolated part of the city, to the renovated home of a cluster of state government offices is not your everyday real estate story. In 1991 the Department of Labor succeeded in getting Social Security to fund the lease for 13,000 square feet at $17.30 for the Division.

Simultaneously, the Department has continued to lease the third and fourth floors of 124 Halsey Street in Newark. The Division has always utilized the third floor to capacity, but not all available space on the fourth. The 1991 new employees were shifted about for a year on the fourth floor even though, with some reconfiguration of the space (something done whenever there is the political will), all the Division's personnel could have been accommodated. In the wake of the New Brunswick move on December 12, 1992, much of the fourth floor has remained empty or under-utilized @ $19.08 per square foot. (This applies to both the southeast quadrant of the floor, which is formally assigned to the Division, and the southwest quadrant (the area used temporarily by the Division in 1992) which the Department has assigned to a cluster of non-Division mini-offices. The whole floor is leased by the Labor Department.) As the Mayor of Newark was told in May 1991, there was never a space problem for the Division at 124 Halsey Street. The Labor Department has preferred to leave much of the fourth floor unused.

* * *

The current **geographic regionalization plan** is a retread from the 1980's. If the Division had preserved its institutional memory, the current management might recognize that reconfiguring the agency in this manner is ineffective. Such artificial compartmentalization creates unequal caseloads, intra-agency communication problems, wasteful duplication and unproductive bureaucratic turf battles. Regionalization, except for New Brunswick, has proceeded very slowly since the personnel arrangements are problematic. The Division favors regionalization for its value as a rationale for paying more managers more money to run more offices. Regionalization is about spending.

The need for face-to-face contact with claimants and medical sources using branch offices like New Brunswick is highly contrived. The Social Security Administration operates 31 local field offices to serve the needs of New Jersey disability applicants in person. Nationally, each state disability agency decides, with the concurrence of SSA, on the number of branch offices and their locations in the state according to local experience and, of course, politics. After 35 years of experience with the program, the ratio of centralized to decentralized state agencies is 2:1 in favor of centralization, without any strong correlation to state population or geographic size, or performance

results. And in September 1991, after Social Security's umpteenth study of the personal contact issue, HHS Secretary Louis Sullivan informed the Senate Finance Committee and the House Ways and Means Committee that:

> Regrettably, no statistically verifiable results were produced through the personal appearance demonstration project. In particular, we can not determine whether a personal appearance had any effect on the quality of the disability determination--the main purpose of the study.

The argument that the New Brunswick branch office is needed to increase face-to-face contact has no basis in fact. The Labor Department admitted as much in 1987 when it abandoned decentralization, recognizing that the program functions primarily through mail and phone contacts at the state agency level once preliminary interviewing, when necessary, has taken place at a local federal Social Security office. Current Labor Department decentralization doctrine is rooted in the desire to justify federal spending on state management and selected lease property.

* * *

The primary goal established for the Division by the June 1991 Social Security management review team was **case backlog reduction.** In 1992 SSA decided to redirect state agency resources from processing **continuing disability reviews** (medical investigations to determine whether those currently receiving disability benefits based on past claims have improved and regained their ability to work) to processing new initial level claims. (See SSA testimony before the House Ways and Means Committee's Social Security Subcommittee, August 12, 1992.) For years New Jersey had failed to do enough of these review cases, so that 5,000 of them had backed up in the files from about 1987 to 1991. In 1992 Social Security told the Division to transfer the bulk of these cases back to federal offices without actually doing any work on them. Thousands of these continuing disability review folders were put in boxes and removed by federal employees working Saturdays on overtime during the period preceeding the May 22 Congressional hearing and in the summer months thereafter. To say the agency "did" 3,500 of these reviews in 1992 is like saying Milli Vanilli cut an album. Management was handed an inventory reduction and the major element in a "success story."

1993

This February 8th marked the official opening of the New Brunswick branch office. According to the Labor Department, this event has ushered in a new era of "top quality service" to the citizenry.

Comment

New Brunswick is the key to further decentralization. The Division's FY 1993-1994 budget request makes it plain that **further decentralization depends on a declaration of success for New Brunswick.** Accordingly, prior to the official grand opening ceremony, the Department moved to tilt the playing field to assure that the branch office could evolve into a showpiece. This is what was done in the months preceding the ribbon cutting:

(1) Caseloads of the examiners chosen to relocate to New Brunswick were either manipulated downward, or at least not allowed to rise as high as the Newark staff levels **before the move.** By moving day (December 12) there was a significant disparity in the average caseload size, favoring the new branch staff.

(2) Instead of staffing the New Brunswick office like Newark, with only state employee clericals, the Department called in a private sector **clerical employment contractor**, Kelly Temporary Services, "The Kelly Girl People." These temporaries were given **added assignments**, not performed in Newark, to give the branch examiner staff an edge.

(3) There have been widespread **mistakes in crediting production statistics** for the months of December and January. According to many Newark examiners, work performed in Newark during that period was somehow recorded as having been done in New Brunswick. A "systems problem."

(4) The **volume of claims** received by the New Brunswick office is so controlled as to assure that whatever backlogs develop will be the responsibility of Newark and not New Brunswick. To pay Paul, you rob Peter.

* * *

New Brunswick has a second purpose-- to serve as a focal point for spreading positive comments about the Division in the media. The Department arranged for TV coverage so that a story would be shown the night of the grand opening ceremony. A highly complimentary newspaper story appeared the next day. The gathering was used as a forum to give the impression that the Division is well managed and to push the line that performance is improving each month. Beneath this deception lie the following realities:

* Due to ongoing criticism over the Division's inability to

achieve **mean case processing times** consistent with national averages, management has relentlessly pressured the examiner staff to bail out the bosses by meeting weekly production goals by focusing efforts on processing the easier, less complex claims, as they are newly received in the agency each day. **This unsound management maneuver generates increasing numbers of delayed claims, even as it fosters misleading processing time declines. This is because only cases being closed <u>at the moment</u> are counted in the national processing time statistics for any given month.** Those claims still pending in the agency, **no matter how long,** do not get counted in processing time data until they are finally closed out. As a cohort, they are statistically invisible. Desks and file cabinets are loaded down with these case folders-- neglected losers in management's drive to look good on paper right now. Many wait for **double, tripple, and quadruple** the mean national processing time. Instead of serving all the people equitably, this management-driven adjudicative climate creates thousands of victims while affording management a "processing time decline" defense against any criticism over delayed case totals. There is no more important management survival tactic employed at the Division today.

* The **average processing time for New Jersey "reconsideration" claims** (appeals of first-time denials handled for a second time in the state agency) has soared. This represents a "double hit" for many claimants: first they are pushed through the initial level claims process without obtaining adequate documentation and turned down for benefits. Then they wait and wait for a second decision, because these appeals cases are **politically less sensitive** than new claims and therefore **less threatening to management**. Resources are not "wasted" on a non-threatening workload.

* Another major consequence of management's "production quotamania" is **poor accuracy-- particularly when claims are denied.** Many cases are rushed through the process, under management pressure, without obtaining essential documentation. The true dimensions of the accuracy problem are **effectively ignored at the state level** and **masked at the federal level.** The overall message to the examiner staff is that **"Quality Is Job 2."** More specifically:

  (A) The day-to-day findings of the **state agency quality assurance unit** are effectively disregarded by Division managers. Far from being the intended focal point of efforts to improve accuracy, the small unit operates largely for appearance, with several quality reviewers assigned to either production or administrative tasks unrelated to the unit's mission of detecting, correcting, and reporting on errors in specific claims decisions.

(B) **Federal accuracy statistics for New Jersey** are carefully managed by the Social Security Regional Office in Manhattan. Stripped of the statistical carapace, the "quality assurance" game is a deception. Behind such impressive sounding terms as "stratified random sample," "weighted average," and "95% confidence level for the sampling variability range" lie subjective administrative procedures used to put "improvement" on New Jersey's accuracy record whenever it is politically expedient. **New Jersey's accuracy rate is never allowed to sink below a bureaucratically set "threshold level" of 90.6% for two consecutive calendar** (not rolling) **quarters because that would require action by management and an acceptance of responsibility.** New Jersey fell to precisely 90.6% in the January 1993 rolling (not calendar) quarter. Phony "improvement" will break that trend as surely as the sunshine follows the darkness. Damage control.

* * *

Epiloque

From Social Security's June 1991 management review of the New Jersey Division of Disability Determinations:

> Based on interviews with adjudicators...the pervasive attitude was that if management did not care enough about the claims processing conditions within the agency, then it was beyond the efforts of the adjudicators to improve the disability claims process and serve the claimants.

From a February 1993 report to Division management by a committee of adjudicators who conducted an office-wide survey:

> General comments were also solicited and were indicative of a general dissatisfaction with management policies. Many respondents felt that management is not only out of touch with the realities of the agency, but also doesn't care that it is out of touch. It is interesting to note that many of the people who refused to respond to the questionnaire told individual members of the adjudication committee that they refused because they felt it didn't matter what they said, management would continue to do as it pleased and would skew the results of the poll to suit their own agendas.

Sincerely yours,

Frank Aria

Frank Aria
31 West Street
North Arlington, NJ 07031-5544
(201) 648-7798/(201) 991-5417

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Postscript

Nearly all the victims of the mismanagement at the Division of Disability Determinations-- those claimants who experience long delays in getting an initial level or reconsideration decision or are denied benefits based on inadequate documentation-- remain anonymous sufferers, unknown to the public at large. Their privacy is rightly protected by law; their medical records are properly kept confidential. Many hire attorneys for a quiet fight against their government, often for a substantial fee and expenses in the form of medical examinations the state agency should have purchased for them. Many threaten to go to the press; few ever do. **These natural circumstances of the program serve as a passive defense for management against the negative publicity it seeks to avoid at all cost.** However, each week, a number of applicants do contact **federal and state elected and appointed officials** to complain about delays and errors. For these cases, management has an **active defense** against publicity. First, Division policy calls for the special, expeditious handling of any "public relations problem case" under the direction of management. Secondly, any case involving a written or verbal inquiry from a public official is formally labeled "sensitive." A quality assurance specialist is assigned full time to compose letters of response to all written inquiries. The examiner must handle all such cases on a priority basis-- ahead of other cases-- under threat of criticism or disciplinary action from management. Through this combination of active and passive defenses, management has kept the level of negative publicity as low as the performance of the agency it directs.

****

31 West Street
North Arlington, NJ 07031
September 26, 1993

Hon. James Florio
Office of the Governor
CN-001
Trenton, NJ 08625-0001

Dear Governor Florio:

As you know, I have been writing regularly to you since 1990 concerning the poor performance and mismanagement of the Social Security disability program in this state. Current federal reports again confirm the comparative underproductivity, slowness, and inaccuracy of the Division of Disability Determinations of the New Jersey Department of Labor. Here is what the latest data show:

* As of August 1993, New Jersey ranked 44th among the 50 states in yearly production per employee-- last among the more populous, more industrialized states.

* As of August, New Jersey continued to have one of the worst records in the nation for numbers of delayed cases pending. Nationally, 27.6% of the pending inventory was in the "delayed" category versus 42.0% for New Jersey.

* For fiscal year 1993 (October 1992 through August 1993) New Jersey ranks dead last in the accuracy of its decisions based on federal sample reviews. This state is rated below the acceptable minimum accuracy requirement of 90.6% for the most recent three-month period (June, July and August 1993).

In my view, the administration's focus has drifted away from improving service to the public in favor of serving its own interests. Let me describe several key management actions which I would characterize as both unsound and deceptive:

(1) Last December the Department of Labor broke apart the centralized Newark Division, placing one-quarter of the agency in New Brunswick. When questioned, the Department admitted to the Mayor of Newark that there was never a compelling space shortage or leasing cost problem in Newark. There was no federal mandate to make the move; indeed, most state disability agencies nationwide remain centralized. The move was strictly political, benefiting principally the expanded top management group.

Under these circumstances, New Brunswick has had to be declared a rousing success to maintain the momentum for further decentralization. Management has tilted the playing field:

(a) From the outset, caseloads in New Brunswick have been carefully controlled to fix it so that New Brunswick case processing time averages would look better than those in Newark. There has always been a marked disparity in the workload per staff member between the two locations by management's design.

(b) Whenever medical review backlogs have developed in New Brunswick, Newark has had to handle them, and on a priority basis ahead of Newark's own backlogs.

(c) New Brunswick has received more intensive clerical support, including private sector temporaries, giving the branch office an advantage over Newark.

(d) Management has tolerated exceptionally poor claims accuracy in New Brunswick, as measured by the agency's internal quality sample reviews, to avoid damaging the branch's productivity record.

This is just a short list of some of the more obvious administrative ingredients that have become part of the recipe for success in New Brunswick.

(2) Management invariably mislabels overtime usage by calling it a "productivity gain." For example, from mid January 1993 through mid July, with no overtime, the overall caseload increased about 1,500 cases. From mid July through this month, a reduction of 1,400 cases was made using 7,710 hours of OT. New Jersey's regular-time productivity level has remained one of the lowest in the nation.

(3) Management has created so much pressure for "presumptive disability" awards for SSI applicants that New Jersey has the highest error rate (decisions finally reversed to denials) in the country for fiscal year 1993. In other words, up to six months of cash benefits, in many instances, are being paid to people whose claims do not fit the procedural profiles established for these payments. Why so? Management benefits by creating a better SSI case processing time record for the agency since the claims paid in this manner are not fully "counted" on the processing time records.

One final note. The Department of Labor consistently offers high case receipts as the excuse for New Jersey's problems. What is not acknowledged, however, is that the Social Security Administration has provided the state with adequate resources

to cope with the level of claims received. As a result, the average caseload per examiner compares favorably in New Jersey with the national average. In fact, in recent weeks this figure has been reported as 131 cases per examiner nationwide versus only 127 for this state. The Department's excuse is, if I might borrow a recently used phrase from one of your cabinet officers, both "misleading and erroneous."

Sincerely,

Frank Aria

Frank Aria
Citizen
(201) 648-7798

c: Janice Mays
Chief Counsel
House Committee on Ways and Means

Renee Brown
Shop Steward, Local 1037
Communications Workers of America

70X

FULL TIME POSITIONS		FISCAL YEAR 1992		
TITLE	#	WK MOS	WORKYEAR	FY'92 FUNDS
DIRECTOR	1	12	0.875	$74,682
MEDICAL DIRECTOR	1	12	0.875	$76,110
REGIONAL DIR, CLAIMS	2	14	1.750	$66,665
ASST DIR, OFC DIR	1	12	0.875	$71,590
SUPV ADMIN ANALYST	1	8	0.583	$42,945
SUPVG MED EXAM	4	48	3.500	$314,120
MEDICAL EXAM	4	48	3.500	$261,712
EXEC ASST II	1	12	0.875	$55,821
ADMIN ANALYST I	2	19	1.383	$88,383
CHIEF, POLICY	1	7	0.510	$34,614
REGIONAL MANAGER	4	28	2.042	$138,458
CHIEF, QA	1	12	0.875	$59,339
MED REL SPEC I	1	12	0.875	$53,162
CA SPEC I	26	312	22.750	$1,348,026
QA SPEC I	0	0	0.000	$0
HEARING OFC I	1	12	0.875	$53,162
CA I	0	0	0.000	$0
ADMIN ANALYST II	3	36	2.625	$151,890
EXEC ASST III	1	3	0.219	$10,849
PRIN PROC ANALYST	1	3	0.219	$9,839
ADMIN ASSISTANT	1	3	0.219	$7,341
QA SPEC II	12	135	9.84375	$492,008
MED REL SPEC II	4	48	3.500	$183,644
SR PROC ANALYST	1	3	0.219	$9,563
CA SPEC II	31	372	27.125	$1,193,254
CASE CONSULTANTS	20	140	10.208	$569,578
CA II	58	636	47.198	$1,984,879
CA III	125	1480	106.458	$3,699,960
SEC ASST I	1	12	0.875	$36,375
SEC ASST II	2	24	1.750	$62,852
SEC ASST III	2	24	1.750	$54,274
ADMIN ASST II	1	7	0.510	$19,833
CA FIELD REP	20	240	17.500	$545,244
CA AIDE	65	455	33.177	$829,465
TECNICIAN, MIS	4	12	0.875	$26,597
PRIN CLK TYPIST	11	132	9.625	$251,552
TECHNICAL ASST	10	30	2.188	$57,440
SR CLK STENO	0	0	0.000	$0
SR CLK TYPIST	3	15	1.094	$25,333
SR CLK BOOKKPR	1	5	0.365	$7,505
SR CLK TRANS	0	0	0.000	$0
CREW SUPV, LABORERS	1	12	0.875	$23,154
CLERK TYPIST	2	10	0.729	$14,180
SENIOR CLERK	4	20	1.458	$35,030
CLERK	0	0	0.000	$0
TOTAL	435	4425	322.747	$13,040,427

FULL TIME POSITIONS		FISCAL YEAR 1993		
TITLE	#	WK MOS	WORKYEAR	FY'93 FUNDS
DIRECTOR	1	12	0.875	$78,416
MEDICAL DIRECTOR	1	12	0.875	$79,916
REGIONAL DIR, CLAIMS	2	24	1.750	$119,996
ASST DIR, OPC DIR	1	12	0.875	$75,170
SUPV ADMIN ANALYST	1	12	0.875	$67,638
SUPVG MED EXAM	4	48	3.500	$329,826
MEDICAL EXAM	4	48	3.500	$274,798
EXEC ASST II	1	12	0.875	$58,612
ADMIN ANALYST I	2	24	1.750	$117,224
CHIEF, POLICY	1	12	0.875	$62,306
REGIONAL MANAGER	4	48	3.500	$249,224
CHIEF, QA	1	12	0.875	$62,306
MED REL SPEC I	1	12	0.875	$55,820
CA SPEC I	26	312	22.750	$1,415,427
QA SPEC I	0	0	0.000	$0
HEARING OFC I	1	12	0.875	$55,820
CA I	0	0	0.000	$0
ADMIN ANALYST II	3	36	2.625	$159,485
EXEC ASST III	1	12	0.875	$45,565
PRIN PROC ANALYST	1	12	0.875	$41,322
ADMIN ASSISTANT	1	12	0.875	$30,833
QA SPEC II	9	108	7.875	$413,286
MED REL SPEC II	4	48	3.500	$192,826
SR PROC ANALYST	1	12	0.875	$40,166
CA SPEC II	31	246	22.313	$1,036,447
CASE CONSULTANTS	20	240	17.500	$1,025,241
CA II	69	679	60.375	$2,463,489
CA III	125	1500	109.375	$4,046,831
SEC ASST I	1	12	0.875	$38,194
SEC ASST II	2	24	1.750	$65,995
SEC ASST III	2	24	1.750	$56,988
ADMIN ASST II	1	12	0.875	$35,700
CA FIELD REP	20	240	17.500	$572,506
CA AIDE	65	780	56.875	$1,493,037
TECNICIAN, MIS	4	48	3.500	$111,707
PRIN CLK TYPIST	7	84	6.125	$156,967
TECHNICAL ASST	10	120	8.750	$241,248
SR CLK STENO	0	0	0.000	$0
SR CLK TYPIST	0	0	0.000	$0
SR CLK BOOKKPR	0	0	0.000	$0
SR CLK TRANS	0	0	0.000	$0
CREW SUPV, LABORERS	1	12	0.875	$23,154
CLERK TYPIST	0	0	0.000	$0
SENIOR CLERK	0	0	0.000	$0
CLERK	0	0	0.000	$0
TOTAL	429	4872.46	370.563	$15,393,483

92X

FULL TIME POSITIONS		FISCAL YEAR 1994		
TITLE	#	WK MOS	WORKYEAR	FY'94 FUNDS
DIRECTOR	1	12	0.875	$82,337
MEDICAL DIRECTOR	1	12	0.875	$83,911
REGIONAL DIR, CLAIMS	2	24	1.750	$125,996
ASST DIR, OPC DIR	1	12	0.875	$78,928
SUPV ADMIN ANALYST	1	12	0.875	$71,020
SUPVG MED EXAM	4	48	3.500	$346,317
MEDICAL EXAM	4	48	3.500	$288,537
EXEC ASST II	1	12	0.875	$61,543
ADMIN ANALYST I	2	24	1.750	$123,085
CHIEF, POLICY	1	12	0.875	$65,421
REGIONAL MANAGER	4	48	3.500	$261,685
CHIEF, QA	1	12	0.875	$65,421
MED REL SPEC I	1	12	0.875	$58,611
CA SPEC I	26	312	22.750	$1,486,199
QA SPEC I	0	0	0.000	$0
HEARING OFC I	1	12	0.875	$58,611
CA I	0	0	0.000	$0
ADMIN ANALYST II	3	36	2.625	$167,459
EXEC ASST III	1	12	0.875	$47,843
PRIN PROC ANALYST	1	12	0.875	$43,388
ADMIN ASSISTANT	1	12	0.875	$32,375
QA SPEC II	12	144	10.500	$433,951
MED REL SPEC II	4	48	3.500	$202,468
SR PROC ANALYST	1	12	0.875	$42,174
CA SPEC II	31	372	27.125	$1,088,269
CASE CONSULTANTS	20	240	17.500	$1,076,503
CA II	66	649	57.750	$2,867,801
CA III	113	1356	98.875	$3,841,252
SEC ASST I	1	12	0.875	$40,103
SEC ASST II	2	24	1.750	$69,294
SEC ASST III	2	24	1.750	$59,837
ADMIN ASST II	1	12	0.875	$37,485
CA FIELD REP	20	240	17.500	$601,132
CA AIDE	60	720	52.500	$1,447,097
TECNICIAN, MIS	4	48	3.500	$117,293
PRIN CLK TYPIST	7	84	6.125	$164,815
TECHNICAL ASST	10	120	8.750	$253,310
SR CLK STENO	0	0	0.000	$0
SR CLK TYPIST	0	0	0.000	$0
SR CLK BOOKKPR	0	0	0.000	$0
SR CLK TRANS	0	0	0.000	$0
CREW SUPV, LABORERS	1	12	0.875	$24,312
CLERK TYPIST	0	0	0.000	$0
SENIOR CLERK	0	0	0.000	$0
CLERK	0	0	0.000	$0
TOTAL	412	4801.44	360.500	$15,915,783

73X

AFL-CIO CWA Local 1037
COMMUNICATIONS WORKERS OF AMERICA

30 Clinton St 3rd Floor
Newark, N.J. 07102
Phone:(201)623-1828
Fax:(201)623-3777
X-623

October 6, 1993

Mr. Greg Williams
OLS
CN 068-LOB
Trenton, NJ 08625-0068

Dear Greg:

Please find enclosed copies of documents addressing problems in the Division of Disability Determinations. Mr. Frank Aria recently sent these to Assemblyman Roma's Paramus Office.

I hope you find the information useful. If you have any questions, please call.

Sincerely,

Denys Everingham

Denys Everingham
Staff Representative
CWA Local 1037

DE/LCS

ENCL:

74X

31 West Street
North Arlington, NJ 07031
October 5, 1993

Hon. Patrick J. Roma
Assemblyman, 38TH District
40 East Midland Avenue
Paramus, NJ 07652

Dear Assemblyman Roma:

It is my understanding that the New Jersey Division of Disability Determinations of the state Department of Labor is to be the subject of a legislative hearing shortly.

Enclosed are copies of letters and other materials which may be of interest to you. Please let me know if you have any questions about this information.

A word of caution. This is a very complex subject. In my 20 years with the program I have yet to witness a reasonably successful legislative effort at breaking through the thick statistical defenses invariably thrown up around the executive agency.

Good luck!

Sincerely,

Frank Aria

Frank Aria
(201) 648-7798

Enclosures

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

WASHINGTON, D.C. 20515

SUBCOMMITTEE ON SOCIAL SECURITY

November 26, 1980

Mr. Frank Aria
31 West Street
North Arlington, New Jersey 07032

Dear Mr. Aria:

Fred Arner and Janice Gregory have informed me of the enormous amount of time, effort and money for postage that you have expended over the past three and a half years in working with our Subcommittee in trying to improve the administration of the disability program. They tell me that you have risked your livelihood in a continuing effort to bring examples of mismanagement and ineffective administration to our attention.

Although our efforts may not yet have improved the administration of the program in New Jersey to any perceptable degree, the Social Security Administration and the State now know that they have a problem on their hands which must be dealt with. In addition, your assistance has greatly increased the Subcommittee knowledge of quality assurance in the disability program in general, and therefore has had an important effect beyond the confines of one state.

We appreciate your dedication to a well-run social security program.

With best wishes, I am

Sincerely,

J. J. Pickle, Chairman
Social Security Subcommittee

JJP/ab

76X

LEGAL OFFICE
Communications
Workers of America
AFL-CIO, District One
One Executive Drive, Suite 200
Somerset, New Jersey 08873-4003

N.J. District Counsel
STEVEN P. WEISSMAN
LISA MOROWITZ
CLARE M. PESSOLANO

JAN D. PIERCE
Vice President, District 1
TEL. NO. 908-563-4565
FAX NO. 908-560-9779

February 2, 1993

Raymond L. Bramucci, Commissioner
Department of Labor
John Fitch Plaza
CN 110
Trenton, New Jersey 08625

RE: Retaliation for Whistle-blowing - Frank Aria

Dear Commissioner Bramucci:

Please be advised that I represent Frank Aria, a Quality Assurance Specialist employed by the Division of Disability Determinations. Mr. Aria, an employee with DDD since 1973, has a long history of whistle-blowing activities. He has written a number of letters to various public bodies, including the House Weighs and Means Committee, critical of DDD's operation.

On or about December, 1991, Maryann Polaski was appointed as the Director of DDD. Previous directors had knowledge of Mr. Aria's whistle-blowing and First Amendment activity and understood that he was legally entitled to engage in such activity free from coercion or retaliation. It seems that Ms. Polaski is of a different mind in this regard.

Specifically, in March, 1992, Ms. Polaski called Mr. Aria into her office and stated that if he continued to write letters critical of the Division she would "deal with it" and that she would not tolerate any "challenge to (her) authority." She also used profanity and threatened Mr. Aria with violence "if (she) thought (the letters) were personal."

Following that meeting, Mr. Aria sent out several additional letters critical of DDD operations. As a result, he was directed to attended a second meeting on December 16, 1992. When he arrived in the management conference room, 11 senior-level management officials were seated around a table, including the director and assistant director of the Division and the chief of the Quality Assurance Unit. Everyone at the table had a copy of Mr. Aria's most recent letter. Ms. Polaski interrogated Mr. Aria for approximately 20 minutes as to the sources of his information, while the Regional Director inquired as to his motives for writing the letter.

Both the March and December, 1992 meetings were coercive and retaliatory of rights protected by the First Amendment of the United States Constitution, Article 1 of the New Jersey Constitution, the whistle-blower provisions of Title 11A and the Conscientious Employee Protection Act.

All interference with Mr. Aria's right to engage in First Amendment and whistle-blowing conduct and all retaliation for such conduct must cease immediately. Any further meetings held with Mr. Aria concerning letters he writes or statements he makes which are critical of DDD's operation may necessitate legal action. Further, management has no entitlement to the sources of Mr. Aria's information. Rather than attempting to silence Mr. Aria through intimidation, Division management should be investigating the problems brought to light by Mr. Aria and initiating corrective action.

Questions concerning this matter should be directed to my attention.

Very truly yours,

Steven P. Weissman/db

Steven P. Weissman
District Counsel

SPW:db

cc: Frank Aria
Hetty Rosenstein, Executive Vice President - CWA Local 1037
Mel Gelade, Director - OER
Skip Cimino, Commissioner - Department of Personnel
Congressman William J. Hughes

BILL BRADLEY
NEW JERSEY

United States Senate

WASHINGTON, DC 20510-3001

COMMITTEES:
FINANCE
ENERGY AND NATURAL RESOURCES
SPECIAL COMMITTEE ON AGING

August 18, 1993

Mr. Frank Aria
31 West Street
North Arlington, New Jersey 07031-5544

Dear Mr. Aria:

Thank you for your recent letter and documents pertaining to the New Jersey Division of Disability Determination.

Please be assured that I have referred this matter to the appropriate officials at the New Jersey Department of Labor for their information and whatever action they deem appropriate.

I appreciate this opportunity to be of assistance to you.

Best wishes.

Sincerely,

Bill Bradley
United States Senator

BB/lrh

80K

STATE OF NEW JERSEY
DEPARTMENT OF LABOR

RAYMOND L. BRAMUCCI
Commissioner

CN 110
TRENTON, NEW JERSEY 08625-0110

August 24, 1993

Honorable Bill Bradley
United States Senator
731 Hart Office Building
Washington, D.C. 20510

Dear Senator Bradley:

Thank you for your note dated August 17, 1993 in which you forwarded materials you received from Mr. Frank Aria, an employee of this Department.

Mr. Aria's protestations are well known to us. We have, on numerous occasions, attempted to provide Mr. Aria with an explanation and facts regarding the performance of the Division in which he works. Unfortunately, he either cannot or will not be dissuaded from his campaign of writing misleading and erroneous correspondence.

It has reached a point where it would be inappropriate for us to continue expending time and resources to respond to Mr. Aria, given his unwillingness to be persuaded by the realities of the situation in his Division.

Thank you for the opportunity to respond to you.

Sincerely,

Raymond L. Bramucci

COMMISSIONER

August 1993

Delmar D. Dowling, Director
Office of Public Inquiries, SSA
4100 Annex Building
6401 Security Boulevard
Baltimore, Maryland 21235

Dear Mr. Dowling:

This is to request, under the Freedom of Information Act, one copy of the following reports:

(1) New Jersey DDS Monthly Profile report for July 1993, prepared by Disability Programs, New York Region.

(2) National monthly report entitled DDS Performance Report for July 1993.

(3) State Agency Operations Report for Month Ending 0793 (pages headed "USA" and "New Jersey" only) produced by Office of Systems, Office of Information Management. (FD:14/3-S4KB).

(4) Disability Determinations Services Staffing and Workload Analysis Report (FD-15) Week Ending 073093 (Week 44) (37-S4KB) produced by Office of Systems, Office of Information Management.

(5) Federal Quality Assurance Review, Initial Disability Determinations, July 1993, prepared by the Office of Program and Integrity Reviews.

(6) Approved New Jersey DDS Budget Request, Fiscal Year 1994 and 1995.

Please inform me in advance if there is a fee.

Sincerely,

Frank Aria

Frank Aria
31 West Street
North Arlington, NJ 07031-5544

82X

EXHIBIT 2

NEW JERSEY

SUMMARY OF BUDGET DATA RELATED TO PERSONAL AND NONPERSONAL SERVICES

	FY 1991	FY 1992	FY 1993	FY 1994
I. TOTAL PERSONNEL COSTS	$15,606,614	$20,301,601	$23,646,623	$24,386,043
a. Direct Wages	$12,418,597	$15,942,645	$18,540,126	$19,120,609
b. Benefits	$3,188,017	$4,358,957	$5,106,498	$5,265,434
II. TOTAL MEDICAL COSTS	$3,942,029	$5,326,567	$9,151,564	$9,230,747
1. CE Costs	$3,000,359	$4,116,663	$7,567,905	$7,567,905
2. MER Costs	$941,670	$1,209,904	$1,583,659	$1,662,842
III. TOTAL INDIRECT	$3,490,356	$5,668,207	$6,602,137	$6,808,583
Rate To Personal Costs (A.3.)[%]	22.36%	27.92%	27.92%	27.92%
IV. TOTAL OTHER COSTS	$3,213,335	$3,930,250	$4,442,025	$4,665,206
a. Occupancy	$1,514,230	$1,645,143	$1,759,593	$1,759,593
b. Contracted Out	$550,362	$663,976	$945,113	$1,039,624
c. EDP/WP Costs	$147,460	$154,833	$162,575	$170,703
Ongoing	$147,460	$154,833	$162,575	$170,703
d. Equipment	$61,164	$195,544	$67,000	$67,000
Purchases	$16,308	$153,544	$25,000	$25,000
Rental	$44,856	$42,000	$42,000	$42,000
e. Communications	$685,201	$889,451	$1,192,398	$1,294,399
f. Applicant Travel	$17,054	$32,853	$49,485	$54,433
g. DDS Travel	$36,393	$42,950	$56,250	$65,650
h. Supplies	$156,569	$139,700	$162,894	$166,152
i. Miscellaneous	$44,902	$45,800	$46,715	$47,650
V. TOTAL COSTS	$26,252,334	$35,126,626	$43,842,349	$45,090,579
VI. TOTAL WORKLOAD	52,966	63,900	78,750	78,750
VII. COST PER CASE	$495.65	$549.71	$556.73	$572.58
VIII. WORKYEARS	289.86	355.25	402.72	393.00
IX. PPWY	182.73	179.87	195.55	200.38
X. AVG PERSONNEL COST PER WORKYEAR	$53,841	$57,147	$58,719	$62,050

98X

E. INDIRECT TIME

1. TRAINING

FY 1991

The DDD hired 28 adjudicators in May 1991 and another 29 in September. Formal training is conducted for 14 weeks, during which the trainees receive the basic concepts and medical background needed to process disability claims.

The learning curve for a new adjudicator is considered to be 65% production in the first thirteen (13) weeks following formal training, 75% in the next thirteen (13) weeks and 100% production thereafter.

Ongoing training for adjudicators and review physicians includes weekly unit meetings and formalized training on medical issues and adjudicative issues that have been affected by changes in the program and or have been shown to be problem areas in FY 91. This has included phone mail training, AIDS awareness, extensive automated system training, disabled widow claims handling, case preparation for medical review, various medical lectures, procedural reviews, workshop evaluations and system test validation.

New Adjudicator Training

Group # 1 (May 1991)

28 Trainees	
+ 3 Instructors	
31	
x 14 weeks	
434 weeks	
x 35 hrs/wk	
15,190 hours	15,190 hrs

"Lost Productivity Hours"

28 Trainees	
x 13 weeks	
x 35 hrs/wk	
12,740 hours	
x .35 reduced productivity	
4,459 hours lost	4,459 hrs

99X

018 FISCAL YEAR 1992

In order to reduce case backlogs and replace staff lost to early retirement in 9/91 a class of 33 claims adjudicator trainees was hired on December 2, 1991.
The continuing implementation of an automated case processing system will also have a significant impact on training hours in FY 1992. Twelve claims units and various support groups will be brought on-line. All systems users will require update training following implementation of planned enhancements.
Finally, training on revised SSA regulations will be conducted on the following topics: CE/MER development; AIDS/ARC claims; Revised Cardiac Listings; Pain evaluation; Telephone Techniques; Vocational Analysis; Respiratory Impairments; "Whereabouts Unknown" claims; and "Failure to Cooperate" claims.

Group # 3 (December 2, 1991)

33 Trainees	
+ 3 Instructors	
36	
x 14 weeks	
x 35 hrs/wk	
17,640 hours	17,640 hrs

"Lost Productivity Hours"

33 Trainees	
x 13 weeks	
x 35 hrs/wk	
15,015 hrs	
x .35 reduced productivity	
5,255 hours	5,255 hrs

33 Trainees	
x 13 weeks	
x 35 hrs/wk	
15,015 hrs	
x .25 reduced productivity	
3,754 hours	3,654 hrs

New Physician Training

6 Physicians	
+ 2 Instructors	
8	
x 3 weeks	
x 18 hrs/wk	
432 hours	432 hrs

100%

018 FISCAL YEAR 1993

A new class of thirty-five (35) adjudicator trainees will be added on October 1, 1992 to cover attrition and increased receipts. Ongoing unit meetings and update sessions will continue to take 2 hours each week. Anticipated program changes resulting from Program Operations Manual System (POMS) and SSA regulation revisions will require an estimated 10,500 hours of training time.

Group # 4 (October 1 1992)

35 Trainees	
+ 3 Instructors	
38	
x 14 weeks	
x 35 hrs/wk	
18,620 hours	18,620 hrs

"Lost Productivity Hours"

35 Trainees	
x 13 weeks	
x 35 hrs/wk	
15,925 hrs	
x .35 reduced productivity	
5,574 hours	5,574 hrs

35 Trainees	
x 13 weeks	
x 35 hrs/wk	
15,925 hrs	
x .25 reduced productivity	
3,981 hours	3,981 hrs

Systems Training
(Classroom and OJT for Local Integrated Computer System - LINCS)

(289 professionals x 35 hrs) =	10,115 hrs
(73 Support/MD staff x 28 hrs) =	1,533 hrs
	11,648 hrs

DATES OF OCCUPANCY

TIME FRAME	10/90 09/91	10/91 03/92	04/92 09/92	10/92 09/93	10/93 09/94
SQUARE FEET					
Newark	77,290	77,290	77,290	77,290	77,290
New Brunswick	0	0	13,000	13,000	13,000
COST/SQ FT					
Newark	$19.08	$19.08	$19.08	$19.08	$19.08
New Brunswick	$0.00	$0.00	$17.30	$17.30	$17.30
COST					
Newark	$1,474,693	$737,347	$737,347	$1,474,693	$1,474,693
New Brunswick	$0	$0	$112,450	$224,900	$224,900
SPACE COST TOTAL	$1,474,693	$737,347	$849,797	$1,699,593	$1,699,593
REPAIRS	$39,537	$25,000	$25,000	$60,000	$60,000

SUMMARY	FY 91	FY 92	FY 93	FY 94
SPACE COST	$1,474,693	$1,587,143	$1,699,593	$1,699,593
REPAIR COST	$39,537	$50,000	$60,000	$60,000
MOVE COST	$0	$8,000	$0	$0
GRAND TOTAL	$1,514,230	$1,645,143	$1,759,593	$1,759,593

X201

OCCUPANCY
****

The DDD currently occupies 77,290 square feet of space at 124 Halsey Street, Newark, N.J. at a cost of $19.08 per sq. ft.. We have exceeded our projected five-year growth pattern and must retain sixty of our new Claims Adjudicator Trainees in the Auditorium because insufficient work-stations exist in the established claims areas.

New Jersey's Department of the Treasury has negotiated a lease agreement at 506 Jersey Avenue, New Brunswick, N.J.. If approved, the DDD will relocate 25% of its workforce to this site on or about April 1, 1992. We will occupy 13,000 square feet at a cost of $17.30 per sq. ft.. This action will establish closer ties to the medical community and claimant population consistent with the master plan of the New Jersey Department of Labor, since the facility is shared by other NJDOL agencies. At the present time there is no plan to reduce space use in Newark.

MOVE COSTS
****

Minimal files, desks, automated systems hardware and other equipment will be moved to our new location in April, 1990. A projected $8,000 will cover Newark realignment and moving of cases and supplies, to be done by NJDOL employees. This amount includes an overtime appropriation so that the move can take place on the weekend to minimize disruption of services.

The following chart details occupancy costs in both locations.

3. DECENTRALIZATION
FISCAL YEAR 1992

Effective April 1, 1992, the DDD will open a decentralized office in New Brunswick, New Jersey. Office site selection, layout and design, the development of new procedures for remote site, and the establishment of all appropriate accounts and services is being done by NJDOL. This will save the DDD an estimated 1,282 hours of administrative time in FY 92.

7 employees x 21 days x -7 hr (saved) = -1,029 hrs
-1,029 hrs/ 1749 hrs per WY = -0.59 WY

FISCAL YEAR 1993

Monitoring of the New Brunswick operation will be done during FY 93. The anticipated success of this initiative will determine whether further decentralization will occur to the northern and southern parts of the state. We optimistically project that we will be involved in site selection and related activities for a second decentralized location by April 1, 1993. This time we will commit DDD resources to the task to ensure that enhancements required in the New Brunswick experience are initiated in the new site.

7 employees x 21 days x 7 hr (saved) = 1,029 hrs
1,029 hrs/ 1749 hrs per WY = 0.59 WY

FISCAL YEAR 1994

It is anticipated that one additional decentralized office will be opened in New Jersey in FY 94. We project that DDD will commit the same amount of time performed by the parent agency in FY 93.

7 employees x 21 days x 7 hr (saved) = 1,029 hrs
1,029 hrs/ 1749 hrs per WY = 0.59 WY

104X

EQUIPMENT PURCHASE

A planned move to a renovated building in New Brunswick, New Jersey is scheduled for April 1990. As part of the renovation, modular workstations will replace standard desks and file cabinets for most of the DDD staff. This will permit optimum use of allocated space and standardize workflow throughout the agency. A cost benefit proposal has been submitted to the Social Security Administration under separate cover which outlines the relative expenditures between Newark and New Brunswick modular furniture. There will still be a need for minimal free-standing equipment such as conference and sorting tables, chairs and centralized file cabinets. An estimated list of equipment is attached for consideration.

Installation of the Local INtegrated Computer System is nearly complete. During the development and testing stage it has become apparent that it is most advantageous for each workstation to have its own terminal and tailored" access to LINCS for specific functions. In an effort to provide this access we have proposed, under separate cover, the expansion of the IBM AS/400 (central processor) capacity to enable us to attach up to 449 terminals to fully automate the professional, support and medical staff workstations and position New Jersey to accommodate enhancements in the development stage at the Social Security Administration. At present we have 300 terminals on hand. Seventeen personal computers previously used for word processing functions will be connected to the AS/400 through emulation boards. We are currently awaiting funding approval for these items:

82 IBM 3477 "dumb" terminals @ $1,102 each =	$90,364
5 IBM 5207 "Quickwriter" printers @ $1,211 each =	$6,055
5 Printer cables for above @ $38 each =	$190
3 IBM 5299 Controllers @ 1,995 each =	$5,985

In addition, expansion of the administrative staff of the DDD will require the purchase of five IBM PS/2 Model 70 computers @ $5,500 each.

5 x $5,500 =	$27,500

Establishment of the New Brunswick office will require the purchase of twelve communications modems @ $833 each.

12 x $833.33 =	$10,000
Total EDP hardware cost:	$140,094

Free-standing furniture and equipment:

20 folding-leg tables @ $210 each =	$4,200
5 executive desks @ $450 each =	$2,250
5 three-shelf open bookcases @ $300 each =	$1,500
10 three-drawer lateral file cabinets @ $250 each =	$2,500
15 Coat trees @ $200 each =	$3,000
Total free-standing:	$13,450

Grand Total of projected equipment costs in FY 92 = $153,544

No significant equipment purchases are anticipated for FY 93 or FY 94.

COMMUNICATIONS
****

Postage, facsimile, telephone, mailgram and communications forms (envelopes, flyers, etc.) costs are included in this line item.

Effective April 1992 the decentralized New Brunswick will process all of its workload using communications modems connecting it with the IBM AS/400 central processor in Newark. Ongoing communication costs will increase by $3,000 per month. An increase in the use of telefacsimile equipment to receive medical evidence has been offset for the most part by a reduction in the number of followup calls required on those cases.

New postal regulations will require envelope redesigns and postage increases in FY 92. An annual postal rate increase of 10% has been projected into this document.

	FY 91	FY 92	FY 93	FY 94
Clearances	52,966	63,900	78,750	78,750
Postage	$292,885	$388,681	$526,909	$579,600
Cost/Case	$5.53	$6.08	$6.69	$7.36
% Change from PY		10.00%	10.00%	10.00%
Telephone	$353,174	$452,603	$604,941	$653,040
Cost/Case	$6.67	$7.08	$7.68	$8.29
% Change from PY		6.22%	8.45%	7.95%
Forms	$39,142	$48,167	$60,548	$61,759
Cost/Case	$0.74	$0.75	$0.77	$0.78
% Change from PY		2.00%	2.00%	2.00%
Totals	$685,201	$889,451	$1,192,398	$1,294,399
Cost/Case	$12.94	$13.92	$15.14	$16.44
% Change from PY		7.60%	8.78%	8.55%

F. OTHER PRODUCTIVITY

1. FACE-TO-FACE INTERVIEWS

It is proposed that, during the second half of FY 1994, a pilot study be conducted involving holding face-to-face interviews with claimants at the point a determination of denial of benefits is evident. This pre-denial interview will be utilized on a selected number of claims involving body systems with a traditionally high risk factor for reversal of the decision. An error profile will be developed to identify the types of claims to be included in the sample. The New Brunswick office will be used to conduct this pilot study, thereby controlling the sample within a specific region servicing 25% of the total DDD caseload. We estimate that each claim will take one hour of increased preparation time and that 8% of all initial denials will be affected in FY 1994.

78,750 claims x .48 (initial claims denial rate) x .08 = 3,024 claims
3,024 claims x 1 hr = 3,024 hrs/ 1749 hr per WY = 1.73 WY

In addition, there will be instructional sessions conducted by SSA staff to prepare the adjudicators for face-to-face hearings. This will cost the DDD 1,200 hours of non-productive time.

200 employees x 3 hrs/day x 2 days = 1,200 hrs
1,200 hrs/ 1749 hrs per WY = 0.69 WY

Grand Total - FY 94: 2.42 WY

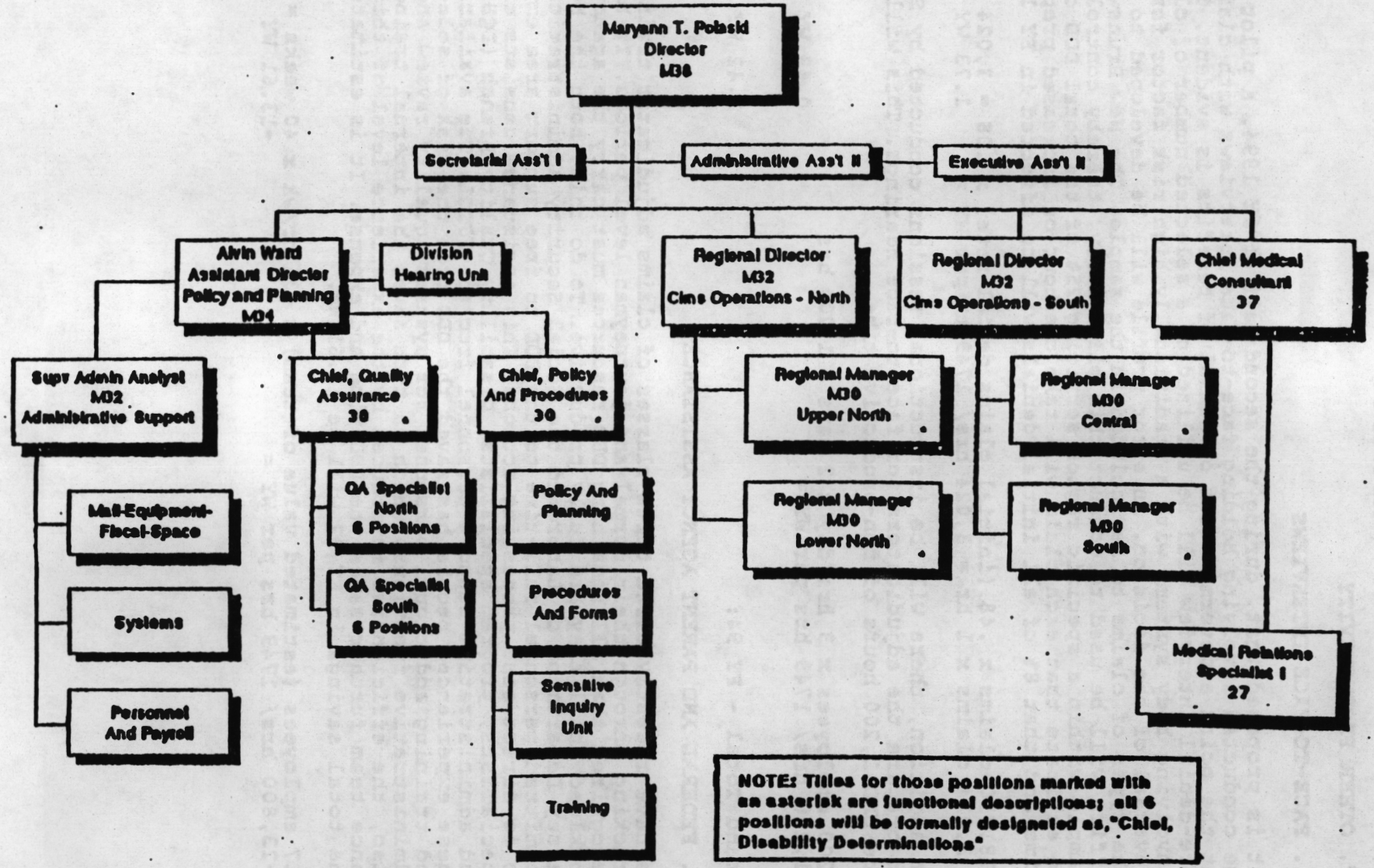
2. FEDERAL AND PARENT AGENCY ASSISTANCE

We have recently hired three classes of claims adjudicator trainees who are tracking through their formal and journeyman level periods. It has been recognized that all remaining DDD resources must carry the agency's workload until they are fully productive. To do this, both the New Jersey Department of Labor and the Social Security Administration have committed personnel full-time to the DDD to free support area employees to do direct case processing actions. This assistance consists of systems specialists, program specialists, Disability Quality Branch (DQB) members and administrative support personnel from the NJDOL. The availability of these experienced people has saved the DDD from the task of selecting and training additional personnel for systems, quality review and various administrative functions, which in turn saves the internal trainers' time. Also, the efficiencies introduced by the experience level of this assistance team further saves the DDD time and expense. It is estimated that the total savings in FY 92 will be 13.61 WY.

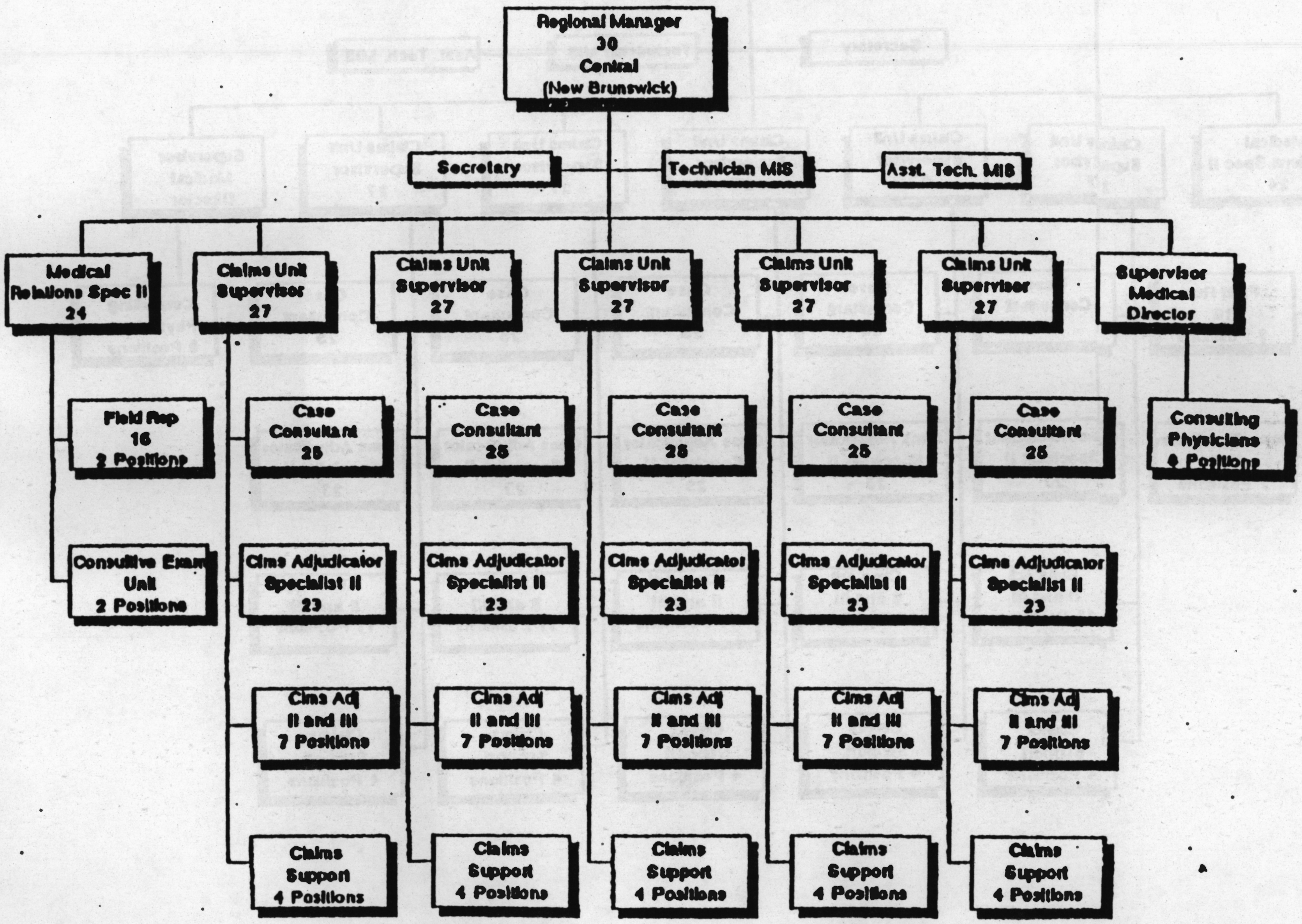
17 employees (estimated value of team) x -35 hr/wk x 40 weeks = -23,800 hrs
-23,800 hrs/ 1749 hrs per WY = -13.61 WY

X801

Division Of Disability Determinations

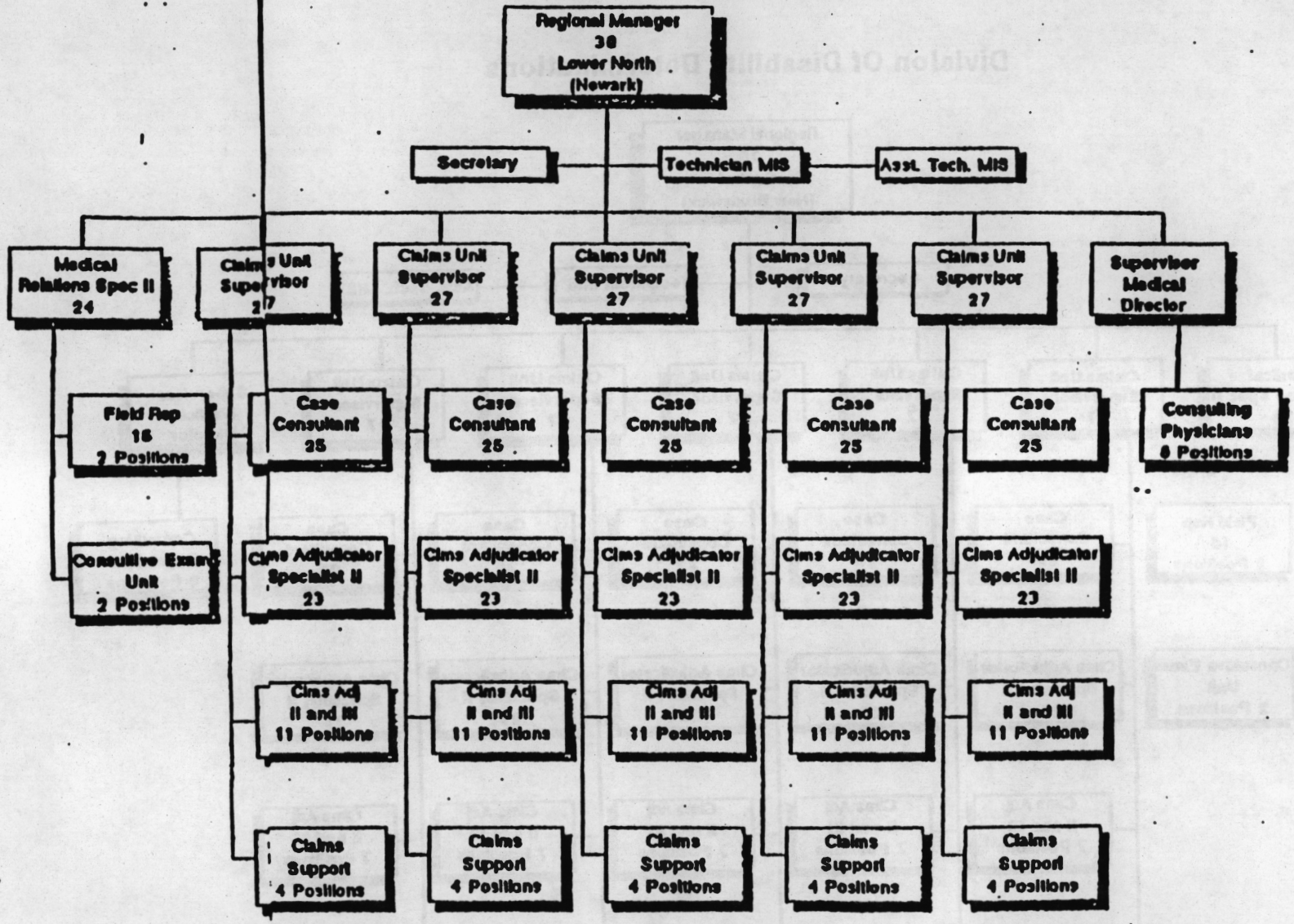


Division Of Disability Determinations



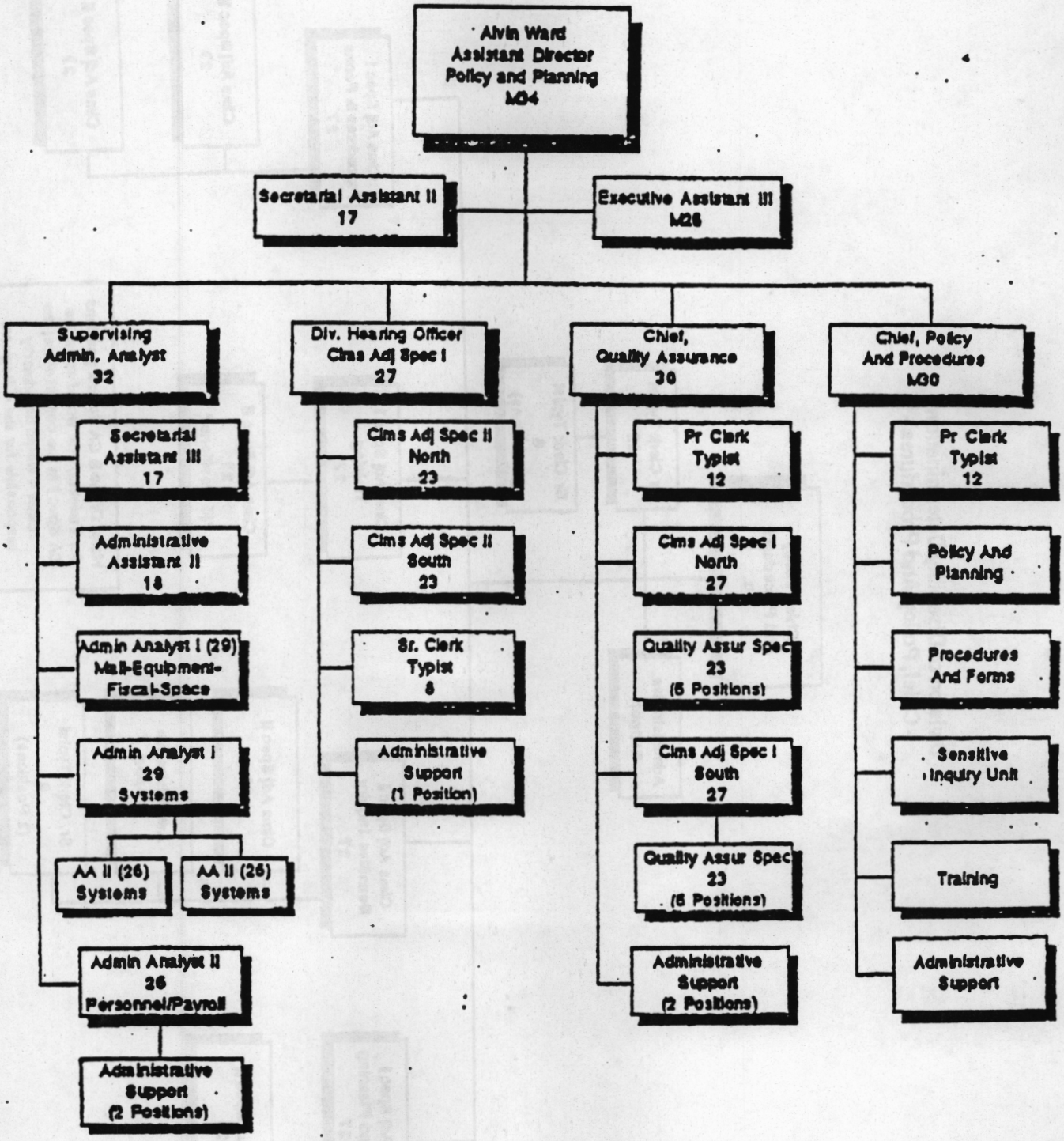
109X

Division Of Disability Determinations

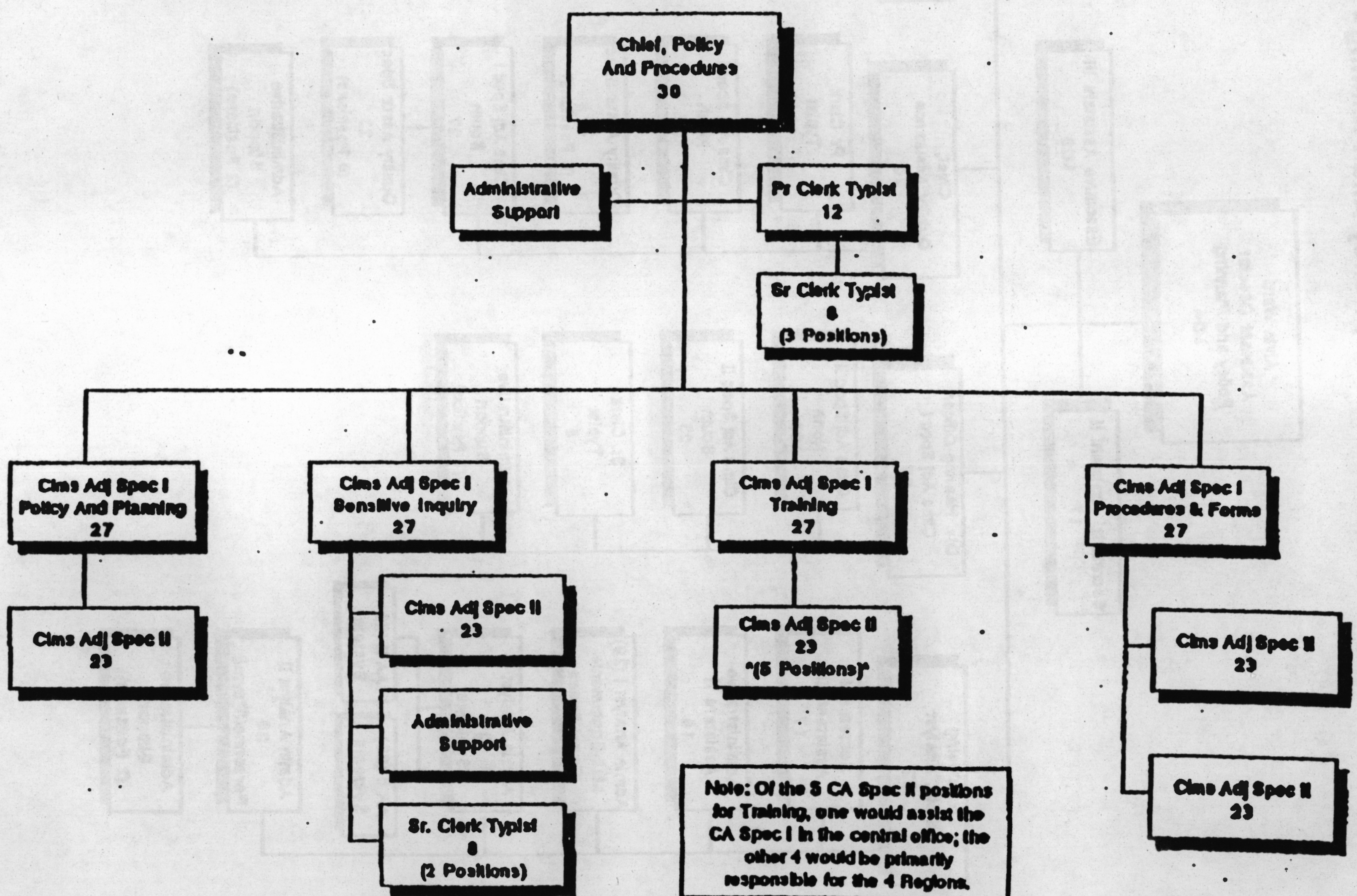


110X

Division Of Disability Determinations
- Assistant Director, Policy And Planning -



Division of Disability Determinations
- Chief, Policy And Procedures -



112X

NEW JERSEY DEPARTMENT OF LABOR

NOTICE OF JOB VACANCY

TITLE	EFFECTIVE DATE OF THIS NOTICE
Supervising Administrative Analyst	January 6, 1992

SALARY M32	AUTHORIZED HIRING RATE	POSITIONS AVAILABLE	LOCATION(S)
$48,461.38 $67,851.46		1	Newark

JOB DESCRIPTION:

Per Job Specifications on file with NJ Department of Personnel.

CIVIL SERVICE REQUIREMENTS:

Open to employees in the Division of Disability Determinations who have been permanently functioning in Range 29 for one year and who meet the open competitive requirements for the above position.

IF INTERESTED WRITE TO THE PERSON AND ADDRESS LISTED BELOW WITHIN SEVEN (7) CALENDAR DAYS FROM EFFECTIVE DATE SHOWN ABOVE TO BE CONSIDERED FOR THE ABOVE POSITION:

Maryann Polaski, Director
Division of Disability Determinations
P.O. Box 649
124 Halsey Street
Newark, NJ 07102-0649

POSTING AUTHORIZED BY CHIEF OFFICE OF PERSONNEL SERVICES ROOM 1213 LABOR AND INDUSTRY BUILDING TRENTON, NEW JERSEY 08625	

This is not a promotional announcement. Any appointments resulting from this posting will be of a temporary nature pending a Civil Service examination and certification.

This naming may result in personnel actions which will require final approval by the Department of Labor

113X

NEW JERSEY DEPARTMENT OF LABOR

NOTICE OF JOB VACANCY

TITLE	EFFECTIVE DATE OF THIS NOTICE
Regional Director (Proposed)	January 21, 1992

RANGE & SALARY	POSITIONS AVAILABLE	LOCATIONS
$48,461.38 - $67,851.46	2	Disability Determinations

JOB DESCRIPTION:

Under the Director, Division of Disability Determinations, Department of Labor, has administrative and management responsibility for the planning, direction and evaluation of two regions of personnel engaged in the adjudication of claims filed under Title II and XVI of the Social Security Act.

DEPARTMENT OF PERSONNEL REQUIREMENTS:

Open to employees in the Department of Labor who served in a permanent capacity for one year in a range 28 or above, and who meet open competitive requirements of six years of professional experience in a large scale benefit claims program, including three years of supervisory experience in the administration of an area of a benefit claims operation.

OVER

IF INTERESTED WRITE TO THE PERSON AND ADDRESS LISTED BELOW WITHIN SEVEN (7) CALENDAR DAYS FROM EFFECTIVE DATE SHOWN ABOVE TO BE CONSIDERED FOR THE ABOVE POSITION:

Maryann T. Polaski
Director
Division of Disability Determinations
P.O. Box 649
124 Halsey St.
Newark, N.J. 07102

POSTING AUTHORIZED BY ASSISTANT DIRECTOR
OFFICE OF PERSONNEL AND TRAINING - ROOM 912
C N 044
DEPARTMENT OF LABOR
TRENTON, NEW JERSEY 08625-0044

This is not a promotional announcement. Any appointments resulting from this posting will be of a provisional nature pending a Department of Personnel examination and certification.

This posting may result in personnel actions which will require final approval by the Department of Labor and Department of Personnel.

PS-95 (8-7-90) New Jersey Department of Labor - Division of Administrative Services

114X

ADDENDUM TO REGIONAL DIRECTOR JOB ANNOUNCEMENT

As the result of a reorganization in the Division of Disability Determinations, there are two new Regional Director positions being established. Under the Director, DDD, individuals selected for these positions will have management and operational responsibility for ensuring accurate and efficient processing of disability claims for multiple regions located in Newark and New Brunswick.

In order to be considered for the position(s) of Regional Director, you are asked to reply to the following question:

Please describe what experiences, skills, and abilities you possess that lend themselves to managing a large, production-oriented claims processing organization.

In addition to your response to this question, please enclose a copy of your resume.

NEW JERSEY DEPARTMENT OF LABOR
NOTICE OF JOB VACANCY

TITLE	EFFECTIVE DATE OF THIS NOTICE
Regional Manager (Proposed)	January 21, 1992

RANGE & SALARY	POSITIONS AVAILABLE	LOCATIONS
— $43,955.29 - $61,536.57	4	Disability Determinations Newark (3) New Brunswick (1)

JOB DESCRIPTION:

Under the direction of a higher level management position in the Division of Disability Determinations has management responsibility for the planning, direction and evaluation of a decentralized region of personnel engaged in the adjudication of claims filed under Titles II and XVI of the Social Security Act or manages personnel responsible for defining and implementing policies and procedures; conducting staff training and processing sensitive inquiries or manages staff responsible for a federal Quality Assurance System and a State Internal Review.

DEPARTMENT OF PERSONNEL REQUIREMENTS:

Open to employees in the Division of Disability Determinations who have served in a permanent capacity of one year in range 26 or above and who meet the open competitive requirements for the above position.

IF INTERESTED WRITE TO THE PERSON AND ADDRESS LISTED BELOW WITHIN SEVEN (7) CALENDAR DAYS FROM EFFECTIVE DATE SHOWN ABOVE TO BE CONSIDERED FOR THE ABOVE POSITION:

Maryann T. Polaski
Director
Division of Disability Determinations
P.O. Box 649
124 Halsey St.
Newark, N.J. 07102

POSTING AUTHORIZED BY ASSISTANT DIRECTOR
OFFICE OF PERSONNEL AND TRAINING - ROOM 912
C N 044
DEPARTMENT OF LABOR
TRENTON, NEW JERSEY 08625-0044

This is not a promotional announcement. Any appointments resulting from this posting will be of a provisional nature pending a Department of Personnel examination and certification.

This posting may result in personnel actions which will require final approval by the Department of Labor and the Department of Personnel.

PS-95 (5-7-90) New Jersey Department of Labor - Division of Administrative Services

116X

ADDENDUM TO REGIONAL MANAGER JOB ANNOUNCEMENT

The restructuring that is occurring in the Division of Disability Determinations will now provide the new Regional Managers (4) with the responsibility and authority to manage a relatively large claims operation consisting of multiple adjudicative units and supported by a pool of medical consultants. Given this regional approach to managing claims processing, please state why you feel you have the necessary experience and leadership skills to assume this new management position.

In addition to your response to this question, please enclose a copy of your resume.

NEW JERSEY DEPARTMENT OF LABOR
NOTICE OF JOB VACANCY

TITLE	EFFECTIVE DATE OF THIS NOTICE
Executive Assistant II	January 21, 1992

RANGE & SALARY	POSITIONS AVAILABLE	LOCATIONS
$41,861.66 - $58,610.70	1	Newark DDD

JOB DESCRIPTION:

Per Job Description on file with Department of Personnel.

DEPARTMENT OF PERSONNEL REQUIREMENTS:

Open to employees of the Department of Labor who have been permanent in range 26 or above.

IF INTERESTED WRITE TO THE PERSON AND ADDRESS LISTED BELOW WITHIN SEVEN (7) CALENDAR DAYS FROM EFFECTIVE DATE SHOWN ABOVE TO BE CONSIDERED FOR THE ABOVE POSITION:

Maryann T. Polaski
Director
Division of Disability Determinations
P.O. Box 649
124 Halsey Street
Newark, N.J. 07102-0649

POSTING AUTHORIZED BY ASSISTANT DIRECTOR
OFFICE OF PERSONNEL AND TRAINING - ROOM 912
C N 044
DEPARTMENT OF LABOR
TRENTON, NEW JERSEY 08625-0044

This is not a promotional announcement. Any appointments resulting from this posting will be of a provisional nature pending a Department of Personnel examination and certification.

This posting may result in personnel actions which will require final approval by the Department of Labor and the Department of Personnel.

PS-66 (8-7-90) New Jersey Department of Labor - Division of Administrative Services

118X

NEW JERSEY DEPARTMENT OF LABOR
NOTICE OF JOB VACANCY

TITLE PROPOSED	EFFECTIVE DATE OF THIS NOTICE
CHIEF, QUALITY ASSURANCE CHIEF, POLICY & PROCEDURES	March 9, 1992

RANGE & SALARY PROPOSED	POSITIONS AVAILABLE	LOCATIONS
$43,955.29 - $61,536.57	2	Disability Determinations

JOB DESCRIPTION: Under the general direction of the Assistant Director, Policy, Planning and Programs in the Division of Disability Determinations, has direct responsibility for professional and administrative support staff.

If assigned to Quality Assurance: Directs the evaluation and analysis related to the performance of Adjudicative staff and those methods used in cases processed under SSA's Titles II and XVI, Disability Insurance Programs; is responsible for the maintenance of a Quality Assurance System as prescribed by the Social Security Administration, and directs the development and coordination of special evaluations or program improvement studies as requested by the Director. Acts as liaison with regional medical, educational and governmental authorities to communicate agency goals and requirements.

continued see attached sheet

DEPARTMENT OF PERSONNEL REQUIREMENTS:

Open to employees in the Division of Disability Determinations who have served in a permanent capacity of one year in range 26 or above and who meet the open competitive requirements for the above position.

*NOTE: IF YOU APPLIED TO THE JANUARY 21, 1992 POSTING FOR THE REGIONAL MANAGER POSITION, YOU DO NOT NEED TO REAPPLY.

IF INTERESTED WRITE TO THE PERSON AND ADDRESS LISTED BELOW WITHIN SEVEN (7) CALENDAR DAYS FROM EFFECTIVE DATE SHOWN ABOVE TO BE CONSIDERED FOR THE ABOVE POSITION

MARYANN POLASKI
DIRECTOR
DIVISION OF DISABILITY DETERMINATIONS
P.O. BOX 649
124 HALSEY STREET 4TH FLOOR
NEWARK, NEW JERSEY 07102

POSTING AUTHORIZED BY ASSISTANT DIRECTOR
OFFICE OF PERSONNEL AND TRAINING - ROOM 912
C N 044
DEPARTMENT OF LABOR
TRENTON, NEW JERSEY 08625-0044

This is not a promotional announcement. Any appointments resulting from this posting will be of a provisional nature pending a Department of Personnel examination and certification.

This posting may result in personnel actions which will require final approval by the Department of Labor and the Department of Personnel.

PS-95 (8-7-90) New Jersey Department of Labor - Division of Administrative Services

119X

CHIEF, QUALITY ASSURANCE
CHIEF, POLICY & PROCEDURES

JOB DESCRIPTION (continued)

If assigned to Policy and Procedures: Is responsible for directing the review and analyzation of current operating procedures and overseeing the development and dissemination of new and/or revised operating instructions; directs a unit of personnel responsible for the training needs of the Division and directs and monitors the receipt of and response to sensitive inquiry correspondence to ensure timely and accurate replies. Acts as liaison with regional medical, educational and governmental authorities to communicate agency goals and requirements.

120X

NEW JERSEY DEPARTMENT OF LABOR
NOTICE OF JOB VACANCY

TITLE	EFFECTIVE DATE OF THIS NOTICE
ADMINISTRATIVE ANALYST I	November 18, 1992

SALARY	AUTHORIZED HIRING RATE	POSITIONS AVAILABLE	LOCATION(S)
R29 $41,861.66 - $58,610.70		1	Division of Disability Determinations Newark

JOB DESCRIPTION:

Under the supervision of a supervisory official in a State department or agency, performs duties of significant difficulty and/or supervises staff involved with the review, analysis and appraisal of current department administrative procedures, organization and performance and prepares recommendations for changes and/or revision therein; does related work as required.

CIVIL SERVICE REQUIREMENTS:

Open to employees in the Division of Disability Determinations who have served in a permanent capacity for one year and meet the open competitive requirements in ranges 26 and 27.

IF INTERESTED WRITE TO THE PERSON AND ADDRESS LISTED BELOW WITHIN SEVEN (7) CALENDAR DAYS FROM EFFECTIVE DATE SHOWN ABOVE TO BE CONSIDERED FOR THE ABOVE POSITION:

Maryann T. Polaski
Director
Division of Disability Determinations
124 Halsey Street 4th floor
Newark, New Jersey 07102

POSTING AUTHORIZED BY CHIEF
OFFICE OF PERSONNEL SERVICES
ROOM 1213
LABOR AND INDUSTRY BUILDING
TRENTON, NEW JERSEY 08625

This is not a promotional announcement. Any appointments resulting from this posting will be of a temporary nature pending a Civil Service examination and certification.

This posting may result in personnel actions which will require final approval by the Department of Labor and the Department of Civil Service.

PS-96 (4-82) N. J. Department of Labor - Division of Administration

121X

NEW JERSEY DEPARTMENT OF PERSONNEL - STATE SERVICE

PROMOTIONAL ANNOUNCEMENT

$5.00 PROCESSING FEE REQUIRED for Each Application Filed (See Below)

SYMBOL: PS7994N(A) WEIGHT CODE: •

TITLE: Executive Assistant 2 SALARY: $41,861.66-$58,610.70

TITLE CODE: 59917/OPAXR4 CLASS CODE: 29

ISSUE DATE: March 1, 1993 CLOSING DATE: March 15, 1993

DEPARTMENT: Labor S9300312

UNIT SCOPE: N535 Office of the Director/Disability Determinations

APPLICATIONS MAY BE OBTAINED FROM AND MUST BE RETURNED TO:

DEPARTMENT OF LABOR CN385
Personnel Office, 12th Floor, Trenton, NJ 08625
ATTN: Raymond Robertson, Director of Human Resources

TITLE SCOPE: Open to employees in the competitive division who are currently serving in a title to which the announcement is open and have an aggregate of one year of continuous permanent service as of the closing date in the following title(s):

Supervising Unemployment Insurance Technician

Executive Assistant 3

Administrative Analyst 2

Administrative Analyst 2 (Data Processing)

Claims Adjudicator Specialist 1

Medical Relations Specialist 1

In accordance with Public Law 1992, Chapter 197, a $5.00 APPLICATION PROCESSING FEE is required for each application filed. A separate application must be submitted for each examination. The examination symbol and your social security number must be written on the payment. Payment must be stapled to the front of the application. If the fee is NOT received, your application will NOT be processed. Refunds will NOT be given to applicants who do not meet the eligibility requirements.
MAKE CHECK OR MONEY ORDER PAYABLE TO "NJDOP". DO NOT SEND CASH.

Department of Personnel Approval: Susan Brennan Date: 2/10/93

IMPORTANT INFORMATION

1. N.J.A.C. states that all requirements listed (Unit Scope and Title Scope) must be met as of the closing date.
2. The following information is available from your Personnel Office: class code and category definitions and designations; and the job specification, which includes a description of the position.
3. If an Unassembled Examination (UE) is held, you will not have to report to a test center. Your score will be based on a comparison of your background with the job requirements. Since your application may be your only "test" paper, be sure it is complete and accurate. When describing jobs held, be sure to indicate full dates of employment (month/year), whether the job was full-time or part-time, and the number of hours worked per week for each job. Failure to complete your application properly may lower your score or cause you to fail. You may not add new information to your application after the closing date. One type of UE is based on an evaluation of applications; only applicants who meet the education and experience requirements listed in the official job specification will pass. For another type of UE, you may be asked to complete a survey which asks specific, detailed questions about your education and work experiences. To pass this type of UE, applicants must meet minimum standards which are derived from essential job activities affiliated with the announced job. In the latter case, MEETING THE MINIMUM REQUIREMENTS IN THE OFFICIAL JOB SPECIFICATION WILL NOT AUTOMATICALLY GUARANTEE A PASSING GRADE.
4. This examination is open to full-time and part-time permanent employees. The resulting employment list may be certified to fill both full-time and part-time positions. If 35- and 40-hour positions are used within the unit scope, the resulting list may be used to fill either work week position.
5. N.J.A.C. 4A:4-1.5 states that any employee who is serving on a provisional basis and who fails to file for and take an examination which has been announced for his/her title SHALL BE SEPARATED FROM THE PROVISIONAL TITLE.
6. Make-up examinations are administered in accordance with N.J.A.C 4A:4-2.8. All requests for make-up examinations must be requested within 5 days of the original test date.

DPF-256A • Revised 1/93

122X

NEW JERSEY DEPARTMENT OF PERSONNEL - STATE SERVICE

PROMOTIONAL ANNOUNCEMENT

$5.00 PROCESSING FEE REQUIRED for Each Application Filed (See Below)

SYMBOL: PS7296N(A) WEIGHT CODE: *

TITLE: Supervising Administrative Analyst SALARY: $48,461.38-$67,851.46

TITLE CODE: 50077/OPAXR4 CLASS CODE: 32

ISSUE DATE: March 1, 1993 CLOSING DATE: March 15, 1993

DEPARTMENT: Labor S9202201

UNIT SCOPE: N535 Office of the Director/Disability Determinations

APPLICATIONS MAY BE OBTAINED FROM AND MUST BE RETURNED TO:

DEPARTMENT OF LABOR CN385
Personnel Office, 12th Floor, Trenton, NJ 08625
ATTN: Raymond Robertson, Director of Human Resources

TITLE SCOPE: Open to employees in the competitive division who are currently serving in a title to which the announcement is open and have an aggregate of one year of continuous permanent service as of the closing date in the following title(s):

Administrative Analyst 1

Administrative Analyst 1 (Data Processing)

Chief Quality Assurance and Skills Assessment

Executive Assistant 2

In accordance with Public Law 1992, Chapter 197, a $5.00 APPLICATION PROCESSING FEE is required for each application filed. A separate application must be submitted for each examination. The examination symbol and your social security number must be written on the payment. Payment must be stapled to the front of the application. If the fee is NOT received, your application will NOT be processed. Refunds will NOT be given to applicants who do not meet the eligibility requirements.

MAKE CHECK OR MONEY ORDER PAYABLE TO "NJDOP". DO NOT SEND CASH.

Department of Personnel Approval: Susan Wannie Date: 2/10/93

IMPORTANT INFORMATION

1. N.J.A.C. states that all requirements listed (Unit Scope and Title Scope) must be met as of the closing date.
2. The following information is available from your Personnel Office: class code and category definitions and designations; and the job specification, which includes a description of the position.
3. If an Unassembled Examination (UE) is held, you will not have to report to a test center. Your score will be based on a comparison of your background with the job requirements. Since your application may be your only "test" paper, be sure it is complete and accurate. When describing jobs held, be sure to indicate full dates of employment (month/year), whether the job was full-time or part-time, and the number of hours worked per week for each job. Failure to complete your application properly may lower your score or cause you to fail. You may not add new information to your application after the closing date. One type of UE is based on an evaluation of applications; only applicants who meet the education and experience requirements listed in the official job specification will pass. For another type of UE, you may be asked to complete a survey which asks specific, detailed questions about your education and work experiences. To pass this type of UE, applicants must meet minimum standards which are derived from essential job activities affiliated with the announced job. In the latter case, MEETING THE MINIMUM REQUIREMENTS IN THE OFFICIAL JOB SPECIFICATION WILL NOT AUTOMATICALLY GUARANTEE A PASSING GRADE.
4. This examination is open to full-time and part-time permanent employees. The resulting employment list may be certified to fill both full-time and part-time positions. If 35- and 40-hour positions are used within the unit scope, the resulting list may be used to fill either work week position.
5. N.J.A.C. 4A:4-1.5 states that any employee who is serving on a provisional basis and who fails to file for and take an examination which has been announced for his/her title SHALL BE SEPARATED FROM THE PROVISIONAL TITLE.
6. Make-up examinations are administered in accordance with N.J.A.C 4A:4-2.9. All requests for make-up examinations must be requested within 5 days of the original test date.

DPF-256A • Revised 1/93

123X

HARD LABOR

A CWA Union Publication for

news the boss doesn't want you to know

FLASH

DOL charged in Unfair Labor Practice on Part Timers.
See Page 2

Lionel Leach, Carolyn Carmon, Renee Brown.

BRAMUCCI'S BIG DAY

☐ On the first Sunday in June of this year, the Bergen Central Labor Council [BCLC] held a luncheon honoring none other than the DOL Commissioner Ray Bramucci as Labor Leader of the Year! The event did not take place exactly as planned. Stationed at intervals around the hotel parking lot, approximately 40 members of CWA leafletted most of the attendees, missing only the usual percentage of gutless wonders who sneaked in through a back door several hours earlier.

As a former organizer and leader of the ILGWU, Bramucci's credentials would seem impeccable to qualify for the job of New Jersey's Labor Commissioner. However, somewhere along the line, Bramucci switched from representing labor to fronting for management. His recent behavior surely qualifies him for a prominent spot in "Who's Who in Management Goons". A few highlights:

- Converted hundreds of full time jobs with benefits and job security into hourly and/or "temporary" positions having no benefits and no job security.

Continued on pg 3

. . . AND WE DO WINDOWS TOO!

What if you ordered an expensive meal and the waitress served it to you with 35% of it missing? This is essentially what is happening when William Parikas of the NJ Dept of Personnel states that it's okay for Disability Adjudicators to spend as much as 35% of their time doing clerical work.

In an Out-of-Title Work Appeal filed by CWA Local 1037 in October 1992, 130 unhappy Workers made known their displeasure at being forced to spend hefty amounts of time (anywhere from 10-35% of their day) on routine clerical work in addition to their extensive job responsibilities for which they underwent 6 months of specialized training. Predictably, the Department of Labor initially tried to stonewall all complaints by refusing to acknowledge the situation in the first place. This is known as the "Ostrich Approach" and, unfortunately, it demonstrates the outer limits of the DOL's nearsighted management practices.

However, as a buried ostrich periodically needs to come up for air, so too does the DOL and in mid-December, Bob Bocci of DOL Personnel surfaced, met with Local 1037 and discussed the matter, focusing particularly on nine examples of specific activities which constitute clerical work.

Continued on next page

124X

DDD Continued

While a November 1992 memo states that the DDD's intention is to provide "adequate clerical coverage" for all units, no Adjudicator realized this meant that they themselves were to provide this coverage.

WHO USES THE D.D.D.?

People who are on permanent disability and unable to work because of physical or mental problems apply for D.D.D. help through Social Security. Up to 1500 cases are submitted each week, with an annual total of approximately 55,000-60,000 cases a year. When New Jersey Labor Commissioner Raymond Bramucci noted that the state's 6 month backlog of uncompleted cases was twice that of the rest of the nation, he expected that the application of $3.3 million in federal funds would take care of the problem. Two years later, in spite of the use of all that money, the problem has not gone away. In fact, it has worsened. To find out why, we talked with three Adjudicators to hear about the problems firsthand: Carolyn Carmen has been with the D.D.D. for over 19 years, Reneé Brown for 13 years (minus 5 years as a Staff Representative for CWA Local 1037) and Lionel Leach is the newest Adjudicator at 2 years.

When the long-awaited federal funding arrived, much of it was used to rearrange things at the management level: titles were changed, paper was shuffled around and more management people were added to an already top-heavy situation. On the plus side, computers were purchased and ninety trainees were hired - with Lionel among them -but even though the system was already short on Clericals, *not one new Clerical was hired to assist with the incoming 90.* "We did our own clerical work until we were totally overwhelmed", Lionel recalled, "and then the D.D.D. pulled Clericals from other areas to help." After awhile, the clerical tasks were rotated and the Adjudicators became, in effect, a hands-on part of their own secretarial pool! Today, Adjudicators struggle through their workloads with the help of one Clerical for every five Adjudicators - formerly, the ratio was one for every three, or at most, every four.

Reneé stated that, "By definition, the word Adjudicator means decision-maker. And I believe that is what most of us came here to do. But we are all key punchers now. We are spending 50% of our day as word processors." Carolyn was told when she was hired that could forget all about needing any skills she might have as a typist - that her job would be strictly analysis. She is glad that she maintained her typing skills because "I'd be in big trouble without them today."

Lionel remarked, "The caseload is supposed to be 10 new ones per week. Now we're getting 18-30 new cases a week. One Adjudicator

Continued on next page.

A typical desk in DDD overwhelmed by files from backlog.

125X

DOL Charged On Part-timers

☐ A significant hurdle was cleared on June 4, 1993, when P.E.R.C., [the Public Employment Relations Commission] heard unfair practice charges filed by CWA against the Department of Labor, in agreement with CWA, decided that the issues warranted further pursuit. A hearing has been scheduled in Trenton on November 23, 1993 to present evidence on the following Unfair Practice charge: that the State has replaced full-time Workers with temps and part-timers in order to avoid paying the benefits that only full-timers are entitled to. Further developments on this case are sure to be fascinating - watch for them! ■

DDD Continued

recently received 44 cases! Other agencies handle 85-120 caseloads but we are carrying caseloads of 185-300. We are doing 2 1/2 times the work that other agencies are."

Other barriers to efficient processing of claims involve newly enacted laws which change the rules about who is entitled to what . . . not only for current cases but for past ones as well. Often, neither the Adjudicator or the clients cases but for past ones as well. Often, neither the Adjudicator or the clients hears of these changes until months down the road as this information is not always front page news and the D.D.D. has done nothing to keep people apprised of the facts. Change also comes about due to increased medical knowledge - known as Current Medical Evidence - which means that the case must be constantly updated in light of the new information. After 6 months, the doctor must be recontacted and asked for an update. Additionally, it is often necessary to research back 1 or 2 years for information that may have been destroyed. Often, the Adjudicator finds that the patient has died while waiting for the endless paper process to be carried out. This is especially unpleasant to hear directly from the grieving family whom the Adjudicator has called for an update.

Both Carolyn and Reneé agreed that the complaints are the same that they have been making for years, and yet the improvements have not been forthcoming. "Basically", says Reneé, "Nobody *gets it* - they just don't see what the job is and what it requires in order to get it done." In comparing the Adjudication job today with what it was before her five year leave, Reneé says that the difference is "phenomenal". All three feel that the responsibility they take on as Adjudicators is a heavy one. As Lionel says, "During this determination process, people's lives are literally in our hands."

WHAT'S NEEDED

"The D.D.D. is the largest division in the D.O.L.", observes Reneé. "Because of the nature of our work as well as the size of our department, we need an on-sight nurse, services of a psychiatrist and a decent counseling service. We also need a Division Director that has come up through the ranks. We ourselves are the best judge of who can do the work."

"We need state of the art equipment. If we can afford computers, we can afford to get ones that do the job", says Carolyn. "The D.D.D.'s computers are so bad that I'd be better off using a manual typewriter and carbon paper. Moreover, our software stinks - it does not do what we need to have done."

Continued on next page.

HARD LABOR

Editor: Sue Speck
Production: Alfonzso Holmes

Hard LABOR is a publication of Communications Workers of America, Local 1037, AFL-CIO, which represents Workers employed by New Jersey Water Supply Authority, Palisades Interstate Park Commission and New Jersey Ste Workers in the counties of Bergen, Essex, Hudson, Morris, Passaic, Sussex, Union, Warren, Hunterdon, Middlesex, Monmouth, Ocean and Somerset; with the exclusion in all counties of Institutional workers in the New Jersey Department of Corrections and Human Services and workers in the Departments of Higher Education and Transportation.

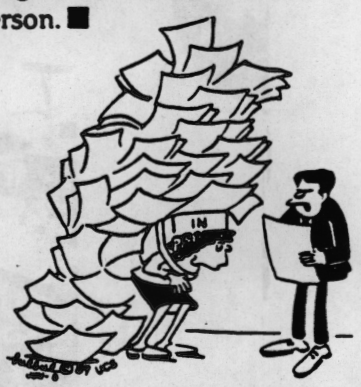
Local 1037's office is at 30 Clinton St, 3rd FLoor, Newark, N.J. 07102 Telephone: (201)623-1828

Bramucci Continued

- Took millions of Federal dollars allocated to improve processing time on Social Security Disability claims and spent it instead on new management titles, office space and glitch-ridden computer system.
- Hired his son to a full time job in Unemployment Insurance just weeks after 1,000 State Workers (many Clericals) were laid off. Bramucci then filled these positions with Kelly Temporaries.

While some of the luncheon guests had no idea who the Real Ray is, they weren't in the dark for long. After reading the leaflets which detailed Bramucci's anti-union behavior, many became curious and open to discussion with the demonstrators. When one guest charged, "You're hurting Labor by doing this", he was quietly answered by one leafletter who said, "You're hurting Labor by honoring him. We need to show responsibility and clean out Labor's house first."

In an effort to encourage Bramucci to consider doing a little housecleaning of his own, two members of CWA Local 1037 leafletted not only the building where Bramucci Jr works but also dropped leaflets on desks throughout his work area of Paterson. ■



WHAT'S THIS COMPLAINT ABOUT CASE OVERLOAD?

126X

DDD Continued

Lionel notes that "The current computer software was issued under contract. The programs are faulty and although the original has been improved, it won't be installed until contract is up - so we're stuck with it."

The three Adjudicators also feel the need for recurrent training. Renee is aware that Lionel has received information and updates that she doesn't have as it wasn't available when she was last trained. Time and stress management training would also be of great benefit. Renee admits that while she probably shouldn't get so upset, it nonetheless, "just wrecks my day when I hear that a client has died". Help dealing with this would be very useful.

"Basically, this administration has no idea of what it is that we do", said Renee. "Originally our main tool was just a phone. We used it to obtain lay evidence, doctor information, etc. With the addition of the computer, management maintained that this was simply changing one tool for another. But the phone work, which takes up a lot of time, still continues. And the computer is a dinosaur while the software is achaic as well. It doesn't do anything that an Adjudicator needs for it to do. Worse, you can spend maybe 3 minutes waiting for the screen to change!" The D.O.P.E. likes to believe that they helped by adding a useful tool but in truth, this particular tool is outdated and - in the estimation of the three Adjudicators - dimishes job performance by as much as one third to one half. While 'Computer-Typist' is not part of the job title, the D.O.P.E. doesn't seem to have noticed.

For one brief and shining moment, it appeared that the D.D.D. actually noticed that additional Clerical help was sorely needed. It was soon obvious that the D.D.D. hoped to prove by example that everything was just fine as it was. Unfortunately for all who were involved, the attempt backfired and the Adjudicators were left to clean up the mess when a Management flunky was sent in to help stuff envelopes - the kind with those irritating little plastic windows that invite mistakes. Sure enough, the Management whiz stuffed 200 of the letters in backwards! She then dealt with the situation by throwing up her hands and stalking out of the room.

Is this as good as it gets? Is this the finest example of responsible and responsive direction that the D.D.D. has to offer? ■

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October 28, 1993

Deborah Smarth
Senior Policy Advisor
New Jersey State House
LB 142
Trenton, NJ 08625

Dear Deb,

As promised, I am sending you follow-up materials which you may wish to include in the record of the Assembly Labor Committee Hearing on the Division of Disability Determinations, October 19, 1993.

Enclosed are:

1. The transcript of the hearing on DDD of the Hughes Committee, March, 1992.

2. A report done by the Department of Labor on needed improvements in the DDD office.

3. A letter to Tom Bird, Regional Director from the Adjudicator Committee concerning the results of a worksite questionaire conducted by the committee.

4. An appeal by our office on behalf of 130 Claims Adjudicators to the New Jersey Department of Personnel (headed by Anthony Cimino) concerning Out-of-Title work. As you can see, the appeal was denied by DOP. We appealed their decision on May 14, 1993. We have not heard from DOP since that time. They have refused to deal with our appeal eventhough DOP is clearly responsible for enforcing regulations regarding Out-of-Title Work.

5. The Browde Report.

If there are any other materials which you feel the Committee may be interested in, I will be happy to get them to you.

As I said to you, our members were very enthusiastic about their experience before the Committee. They have all expressed to me their strong hope that this issue does not get buried beneath bureaucratic answers and official DOL smokescreens.

Sincerely,

Denys Everingham
Staff Representative
CWA Local 1037

cc: Greg Williams, Senior Research Associate

128X

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October 28, 1993

Janet Zatz
Department of Personnel
Div. of Appellate Practices & Labor Relations
CN 312
Trenton, New Jersey 08625

Dear Ms. Zatz,

Enclosed please find a copy of an appeal of Out-of-Title Work sent in June 2, 1993.

We have gotten no response.

Please explain.

Yours truly,

Hetty Rosenstein
Executive Vice President
CWA Local 1037

HR/LCS

Encl:
c: Assemblyman Roma
All DDD Shop Stewards

129X

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June 2, 1993

Janet Zatz
Department of Personnel
Div. of Appellate Practices & Labor Relations
CN 312
Trenton, New Jersey 08625

Dear Ms. Zatz,

We hereby appeal the enclosed decision of William Parikas, received in this office on May 14, 1993.

We believe that Mr. Parikas' response does not address the fundamental issue in this appeal, that is, that the out-of-title work complained of is essentially clerical in its nature and that Professionals are spending anywhere between 10% and 35% of their time doing this work.

The example Parikas gives of a Data Entry Machine Operator (DEMO) emphasizes the out-of-title work nature of the duties rather than argues against our position. In the case of the DEMO "Application of computer technology" has not caused "the fundamental job" to change. That is because the DEMO job is essentially a clerical job in which the computer allows the Worker to perform these clerical "operations faster, to achieve greater volume, and in many cases greater accuracy." But Claims Adjudicators never engaged in the disputed activity before. They are not being asked to now use computer technology to accomplish what they formally accomplished manually. This is not a case where the tool has merely been changed - this is a case where the work has been changed.

The Parika s response gives no analysis of work that includes opening and collecting of mail, date stamping, punching holes, filing and sorting of disability claims materials. This type of work is, by definition, clerical work. It should be performed by someone paid between Range 6 and Range 13, not by someone paid at a Range 19 through Range 23. To state that the Definition section of the Job Specifications does not preclude such work and, therefore, that the work is not out-of-title is pure sophistry. If one is going to argue that the clerical work necessary to process a claim comes under the definition of related work, one could also argue that Claims Adjudicators should make Medical determinations because such determinations are related to the appropriate determination of entitlement to disability benefits.

The purpose of the Classification and Compensation System, as well as the system in which work is catagorized as Clerical, Professional or Supervisory, is, at least in part, to insure a proper allocation of Tax Payer resources. It is a waste of such resources to give specialized training to Adjudicators for 6 months and pay them between $30,000 and $45,000 a year to do the work of someone who had no need for the special training and who earn between $15,000 and $29,000 a year. This is particularly ridiculous when one considers that the Division of Disability Determinations is so back logged with aged cases that the Federal Government, last year, allocated additional funds to hire Adjudicators. This money is obviously best spent having Adjudicators do what they are supposed to, that is, adjudicate, rather than punch holes, date stamp, etc.

Please use the good services of your office to correct this matter.

Yours truly,

Hetty Rosenstein
Executive Vice President
CWA Local 1037

cc: All DDD Shop Stewards

Raymond Robertson, Director of Human Services
Office of Personnel & Training
Department of Labor Relations
John Fitch Plaza, CN 044, Rm. 912
Trenton, NJ 08625

131X

Jim Florio
Governor

State of New Jersey
DEPARTMENT OF PERSONNEL
CN 313
TRENTON, NJ 08625

Anthony J. Cimino
Commissioner

Linda M. Kassekert
Deputy Commissioner

William E. Parikas
Administrator
Office of Personnel Management

May 10, 1993

Raymond P. Robertson, Director
of Human Services
Office of Personnel & Training
Department of Labor
John Fitch Plaza, CN 044, Rm.912
Trenton, New Jersey 08625

Everlyn Liebman
Staff Representative
C.W.A. Local 1037
30 Clinton Street 3rd Floor
Newark, New Jersey 07102

Re: Out-of-Title Work Appeal
Claims Adjudicator II, D.D.
Claims Adjudicator III, D.D.
Claims Adjudicator Specialist II

Dear Mr. Robertson and Ms. Liebman:

This is to inform you of my determination, upon review and analysis of the material submitted, concerning the out-of-title work appeal referenced above.

Issue: Ms. Everlyn Liebman, Staff Representative, C.W.A. Local 1037 represents one-hundred and thirty (130) appellants including thirty-two (32) Claims Adjudicator II, Disability Determinations (P21) positions, sixty-eight (68) Claims Adjudicator III, Disability Determinations (P19) positions, thirty (30) Claims Adjudicator Specialist II (P23) positions, and alleges that the positions at issue are performing out-of-title work.

The alleged out-of-title work includes the following:

- Types various assigned disability claims correspondence on the computer.
- Opens, date stamps, punches holes, and obtains all incoming mail concerned with assigned disability claims.
- Files assigned disability claims to relevant case files.
- Collects and sorts disability claims material from printer.
- Obtains follow-up disability claims material from files.

- Processes disability claims information and confirms the receipt of assigned disability claims via the computer.

- Inputs medical information into the computer to produce checks for physician services.

The appellants also maintain that the above work has increased their use of the computer which they consider out-of-title work.

Background Information: Theresa Sturdivant, et al. filed a contractual group grievance with Raymond P. Robertson, Director of Human Resources, Department of Labor alleging out-of-title work.

On November 9, 1992, the Department of Labor responded to Theresa Sturdivant, et al. out-of-title work grievance by stating Article IV, C.1. (Scope of Grievance) of the Professional Bargaining Unit Agreement which directed the out-of-title work appeal to the Department of Personnel. Ms. Everlyn Liebman, Staff Representative, C.W.A. Local 1037 was copied on the letter.

On December 3, 1992, Ms. Liebman submitted the out-of-title work appeal to Janet Share Zatz, Director, Division of Appellate Practices, Department of Personnel. The appeal was forwarded to the Office of Personnel Management, Department of Personnel on January 5, 1993.

On January 22, 1993, Audrey Duess, Personnel Management Analyst, Department of Personnel granted an extension of time to Ms. Liebman to supplement the file with the Position Classification Questionnaires (DPF-44s) representing a sampling group of the one-hundred and thirty positions at issue.

Organization and Function: The Claims Adjudicator II and III, Disability Determinations, and Claims Adjudicator Specialist II positions are located in the Newark office. The Newark office is divided into three Claims Regions, each with a supervisor using the working title, Regional Manager.

The Claims Regions are divided into units with Region I and Region II having five units each and Region III having seven units. Each unit is supervised by a Claims Adjudicator I, Disability Determinations (R26) position.

Discussion: On April 14, 15, and 16, 1993, members of my staff audited the positions at issue.

The audits included interviews with twenty (20) representatives of the Claims Adjudicator II and III, Disability Determinations, and Claims Adjudicator Specialist II positions.

The audits revealed that the Claims Adjudicator I, Disability Determinations positions have supervisory responsibilities for the Claims Adjudicator II and III Disability Determinations, and the Claims Adjudicator Specialist II positions.

The Claims Adjudicator II and III, Disability Determinations and Claims Adjudicator Specialist II positions' primary duties are adjudicating various disability cases. This includes performing the following duties:

- o Review, define, analyze, and evaluate medical, non-medical, and educational documentation concerning disability claims.
- o Determine type of consultative services to be rendered to claimants.
- o Relate information concerning claimants' disability to physician for final decision.
- o Complete various forms for functional assessments of children being considered for disability.
- o Analyze vocational needs of claimants.
- o Use the computer to type initial claims, reconsideration claims and decision letters.

Analysis: The definition section of the class specification for the Claims Adjudicator II, Disability Determinations states:

> "Under the direction of a Claims Adjudicator I, Division of Disability Determinations, Department of Labor, reviews, analyzes, develops, and evaluates medical and vocational evidence in order to make determinations on the more complex Initial and Reconsideration claims in accordance with the provisions of the Social Security Disability and Supplemental Income Disability Programs; does related work as required."

The definition section of the class specification for the Claims Adjudicator III, Disability Determinations states:

> "Under the direction of a Claims Adjudicator I, Division of Disability Determinations, Department of Labor, and in accordance with the regulations of the Social Security Act, analyzes both Title II and Title XVI initial disability applications; develops medical and non-medical data; evaluates all evidence compiled and makes an appropriate determination of entitlement to disability benefits; does related work as required".

The definition section of the class specification for the Claims Adjudicator Specialist II states:

> "Under the direction of a Claims Adjudicator Specialist I or a Claims Adjudicator I, Division of Disability Determinations, reviews, analyzes, develops, and evaluates medical and vocational evidence in order to make determinations on the more complex and specialized claims for Social Security disability including CDI, Special Study, Informal Remand, and out-of-state claims; analyzes vocational issues; develops and conducts skill assessment and training; acts as a technical expert and expediter in a claims adjudication unit; does related work as required."

There is nothing in the definition section which would indicate that the work assignments contested by the appellants are out-of-title. Simply because the definition statements do not include specific verbiage to reference the alleged out-of-title work does not indicate that the performance of such work assignments constitute out-of-title work.

The task of typing various correspondence concerning assigned disability claims, processing the mail related to these claims, and following-up on their assigned disability cases with the results, in some instances, of producing checks for physician services through the computer system are considered duties related to Claims Adjudicator II and III, Disability Determinations, and Claims Adjudicator Specialist II positions.

The performance of these tasks does not evidence substantive change in job content in that the tasks being performed by the appellants are related to their individual titles and positions.

The second issue involves the appellants' increase use of the computer. The standards for the Data Entry Machine Operator title series, revised May 11, 1981, are applicable here. They state:

> "Most office operations have been affected by the presence of the computer. Application of the computer technology has provided the means to perform many of these operations faster, to achieve greater volume, and in many cases greater accuracy. However, there is a tendency to lose sight of the fact that the fundamental job has not changed. What has changed is the medium."

The increase use of the computer by the appellants is a result of the advancement of the computer technology which allows a larger application of the computer in processing disability claims. Most of the class specifications have updated examples of work to include the following phrase:

> "May be required to learn to utilize various types of electronic and/or manual recording and information systems used by the agency, office or related units."

Determination: It is my determination, based on the comparative analysis stated above, that the positions at issue are not performing out-of-title work.

Therefore, the out-of-title work appeal is denied.

Please be advised that in accordance with New Jersey Administrative Code 4A:3-3.9, you may appeal this decision, within 20 days of receipt of this letter, to the Division of Appellate Practices and Labor Relations, Department of Personnel, CN 312, Trenton, New Jersey 08625. Please note that in an appeal of this nature the burden of proof is on the appellant. Therefore, your appeal must include a detailed basis with documentation and/or written argument substantiating the merits of your appeal.

Sincerely,

William E. Parikas

William E. Parikas
Administrator
Office of Personnel Management

WEP/BNR

136X

February 8, 1993

To: Tom Bird

From: The Adjudication Committee

Subject: Results of Work Station Questionnaire

One hundred and fifty-six questionnaires were distributed throughout the agency, seventy-six of the questionnaires were returned. The questions dealt with phone mail, satisfaction or dissatisfaction with cubicle layout, equipment needed, and general suggestions for improvement.

Regarding phone mail: the overwhelming response was to keep phone mail. Of the seventy-six responses received, sixty-three wanted to keep phone mail, four respondents did not have phone mail but wanted it, and only three wanted to dispose of phone mail altogether. The only suggestions made regarding phone mail were to increase the number of message units and to re-establish the busy signal.

Regarding cubicle size: Forty-three respondents wanted to keep the cubicle lay out as it now exists (high walls), four did not respond to the question at all, and five felt that the layout should be altered. Specific suggestions for change included more file cabinets, more drawer space, larger sized cubicles, better lighting, and locked over head cabinets for personal belongings.

The questionnaire also asked for comments on the type of equipment needed to facilitate the adjudication of cases. Suggestions included: better access to stationary supplies, copy machines for each unit, more printers, printers that work reliably, a current and centralized DOT and POMs kept up dated by the supervisor in his/her cubicle, better chairs, two chairs per cubicle, new telephones, new typewriters, and one fax machine per unit.

General comments were also solicited and were indicative of a general dissatisfaction with management policies. Many respondents felt that management is not only out of touch with the realities of the agency, but also doesn't care that it is out of touch. It is interesting to note that many of the people who refused to respond to the questionnaire told individual members of the adjudication committee that they refused because they felt it didn't matter what they said, management would continue to do as it pleased and would skew the results of the poll to suit their own agendas.

there were suggestions for improvements with in the agency, these included: more clerical support (or Kelly Girls), a return

to silent review, better air quality, piped in music, improvements in the computer program to make it more user friendly, shifting the computers for left handed people, less management, and that management should learn the job that is done by adjudicators.

The results of the questionnaire were enlightening. It revealed that adjudicators wish to keep phone mail and the cubicle's as they currently are while revealing the need for changes in other areas.

BROWDE & ASSOCIATES
MANAGEMENT CONSULTING
HUMAN RESOURCES - LABOR RELATION
409 Hillside Place, South Orange, NJ 070
201-761-5515/761-05

April 7, 1987

Honorable Charles Serraino
Commissioner
Department of Labor
CN 110
Trenton, NJ 08625

Dear Commissioner Serraino:

I am pleased to submit this final report on the Division of Disability Determinations. The results and findings of the Study, together with recommendations to accomplish greater efficiency and increased productivity, are contained in the body of the report.

I wish to record my appreciation to members of your staff for their cooperation in the study.

I consider it a privilege to have performed this assignment. I believe the implementation of these recommendations should result in benefit to the Division and to the Department of Labor.

Respectfully yours,

Sanford Browde

cc: George M. Krause
Lawrence L. Arcioni
Robert J. Yokavonus
Mary Jane Meehan
William McGann

139X

The functions which should be performed by the Aides, as stated above, are clerical in nature.

(2) A new job title of clerical above the Senior Clerk or Senior Clerk Typist position should be established for those who funciton in the clerical support of the Adjudicator, but have additional competency in gathering and recording medical evidence and interviewing medical sources.

This will require an understanding of medical terminology, but will not require 60 semester hours of schooling or its equivalent.

D. The Job Functions of the Unit Clericals

There is a question of whether the Division is (1) properly utilizing its total clerical staff and (2) properly staffed in the Claims Areas with clericals. The question to be answered is: "Is there a proper proportion of Unit clericals in Claims areas to Adjudicators?"

Looking at national statistics, the percentage of Adjudicators and clericals to the total work force is as follows:

	National Percentages	N.J. Percentages
Adjudicators	31.4	39.5
FT Clericals	27.9	23.9

The Adjudicator Aides are not included in these clerical figures, as the Aides do not identify themselves as clericals, but consider themselves "para professionals" and, in fact, are not performing the necessary clerical duties.

The clerical functions in the Claims Units are essential to the timely and efficient processing of Claims.

In Newark, however, the percentage of Unit clericals to Adjudicators is 22.4%.

RECOMMENDATION

(1) The ratio of Adjudicators to clericals should be established at no more than four to one.

This may be accomplished by reassigning clericals from other areas to work in units, and assist the Adjudicators.

(2) Clerical personnel should be transferred from staff support areas into Claims Operations to perform the duties of the Unit clericals.

Of the 78 clericals in Newark, only 39, or exactly 50%, are in the Claims Operations area, with 26 assigned to Units. The other 50% are all in support functions.

The division should review the exact number and proper allocation of personnel, but there appears to be an imbalance of clericals in non-production related work.

5. Organization of Staff and Administrative Functions

A. Overview - The present organization shows a disproportionate build-up of the staff and administrative areas. The emphasis in the Division should be placed in the Claims area, as the need for production increases.

In addition, there are a number of staff functions which are closely involved in the Claims process. These functions include (1) training; (2) the medical relations unit; and (3) the consulting examination unit.

141X

A Performance Assessment Review Program (PAR) has been established for the Department's personnel. If properly implemented by Division personnel in Newark, the system is in place for proper evaluation of employees. But in order for the program to work, the Division must establish "Performance Standards" for each position. As noted in the previous section, performance standards for SCA's were not clearly defined.

In the case of Adjudicators, the following performance standards have been established:

Performance Standards

Productivity	15 closures per week for caseload of 100 or more. 15% of inventory for caseloads less than 100.
Aged Cases	45 day cases (18-24%) 70 day cases (5-8%)
Internal Quality Accuracy	91% decisional accuracy below 80% will result in Supervisory review of cases on a more intensive basis.
PER Accuracy	No more than 2 per quarter.
Federal QA Accuracy	No more than 1 per quarter.
Processing Time	Title II-59.9 days Title XVI 67.9 days
Consultative Exam Purchase Rate	45%
Adherence to Agency Personnel Procedures	Punctual and regular in

142X

	attendance. Adheres to office regulations.
Maintenance of Work Station and Manuals	Keep desk clean of extaneous material. Files, POMs and AI regulations on a timely basis.

The performance standards raise some issues:

(1) With respect to "Productivity" - a standard of 15 closures per week when applied to a caseload of 101, is far different than applying it to a caseload of 180.

(2) The "Consultative Exam Purchase Ratio" for the Division is now much lower than 45%. The goal of the Division is now in the 30-35% range. Therefore, this standard should change as Divisional goals change.

RECOMMENDATION

(1) The standards in the area of production should be established as a percentage of pending caseload in ranges, in the following manner:

13%	**-**	**Above**	**-**	**Excellent**
11.0%	**-**	**12.9%**	**-**	**Very Good**
9.0%	**-**	**10.9%**	**-**	**Good**
7.5%	**-**	**8.9%**	**-**	**Fair**
Below		**7.5%**	**-**	**Unsatisfactory**

The percentages could be changed by the Director as he evaluates agency workload and policy changes which may adversely affect examiner performance during a given time period. For example, if there is a "hold" on certain type of cases, this

143X

might be considered a workload/policy change that would adversely affect production from the date of the "hold" to the date of the release of these cases.

The percentages should not be set at a point which is unattainable by a majority of Adjudicators. Therefore, if the situation arises where the majority of Adjudicators fall in the less than good category, the need for an adjustment should be reviewed by management.

(2) **The standards should be reviewed periodically to determine their accuracy and correctness.**

As pointed out with respect to the Consultative Exam percentage standard, there should be a process in place for changing the standard as the goals of the Division change. The changed standard of performance should then be communicated to the Adjudicator and sufficient time given for them to adjust to the new standard and have a reasonable chance of its achievement.

(3) **Punctuality, regular attendance and adherence to office regulations should not be part of the performance standards.**

Any deficiencies in these areas should be handled by disciplinary action.

B. **The Job Function of the "Adjudicator Aides"**

In addition to the Adjudicators, the Units are staffed with "Adjudicator Aides". The job functions of the Aides varies between North and South. In the North, the Aides were responsible for the initial development of a case, writing to the

144X

treating source.

On the basis of this report, the Medical Director and his staff should attempt to close those cases by phone calls. Very often, one doctor will speak to another doctor, when the Adjudicator was not able to get through to the doctor and was not able to get the needed information to close the case.

6. Morale within the Division

On the basis of the interviews with personnel, the vast majority feel that morale within the division is poor. The consensus is that this had developed over a number of years. The causes are numerous, but involve (1) distrust of management; (2) poor communications downward from management to Supervisors and from Supervisors to staff; (3) constant changes within the SSA Disability Program itself, which keeps the staff confused and frustrated and (4) inequitable application of discipline. Many of these areas have been discussed previously.

In addition, from my experience and background, there is a "negativism" among the staff which I have rarely observed previously. It is an attitude of mind marked by skepticism about nearly everything attempted by management. This attitude is shared by the Supervising Claims Adjudicators as well. Since they are the second level management in the Division, this frame of mind of the total staff is destructive and must be changed.

The most important factor in initiating change and in overcoming resistance to change is to build a relationship of trust among managers, supervisors and employees. In the paranoid world of the Division's work arena, the key to

developing trust is to be sensitive to employee needs. The need to know is primary. The need to be involved is equally important.

RECOMMENDATION

The new Director should start the process of change by recognizing that the key to effecting change is honest commitment, communications and feedback.

The formula which should be followed is:

(1) There must be a personal commitment and belief in the change needed.

(2) Total, honest and clear communication is the hallmark of successfully implementing change. Therefore, he should begin by holding group meetings in which the reasons and details of the change can be explained.

(3) Follow these group meetings with smaller ones in which he can explore with employees specific problems and concerns and attempt to lessen the apprehension that will always be present in one form or another.

(4) He should develop a feedback loop in order to fully appreciate whether his message has gotten across. If he develops a continual flow of reliable feedback, he can then decide whether or not his instructions to effect change have been understood and implemented. He can then, also, make any changes that may be indicated.

(5) The change should be implemented, in small doses, with positive verbal reinforcement to the staff for accomplishment at each stage.

(6) Positive acclaim when someone is doing someth.ng righ: is essential to change the negativism which exists. It will be helpful in promoting a more prideful atmosphere. This positive reinforcement and acclaim should be uniformly and consistentl: applied in all areas.

REPORT OF THE
NEW JERSEY DDS
ONSITE REVIEW

Conducted April 25-29, 1988

148X

TABLE OF CONTENTS

149X

NEW JERSEY ONSITE REVIEW

Background

SSA is required by law to ensure the effective and uniform administration of the disability programs. To meet this requirement, each disability determination services (DDS) is expected to meet performance standards of claims accuracy and processing time. During the past year, the New Jersey DDS has had continued problems in meeting these standards (see exhibit 1, DDS Performance Chart). An onsite review was conducted April 25-29, 1988 in the DDS to identify the underlying causes of these problems and to develop measures to help the DDS perform at acceptable levels in the future.

The following items represent major items for State and SSA management consideration and implementation.

Administrative/Personnel Management

The Division of Disability Determination (DDD) is part of the New Jersey Department of Labor. The DDD is located in Newark and is under the management of the director, Bill McGann. Support services, e.g., budget, personnel, and word processing, are provided by the Department, with offices located in Trenton (see exhibit 2, DDS Organization Chart).

The director and top staff seem committed to making improvements in productivity and cost effectiveness. Tough management decisions (closing the Camden office and eliminating flextime) were made and carried out smoothly to achieve productivity gains.

Findings

Production requirements, budgetary restrictions, and quality goals are understood at all levels. Unit supervisors and adjudicators have performance assessment plans to meet these goals, but no overall agency workplan exists. Problem identification and corrective action initiatives focus on one problem area at a time, rather than taking a comprehensive, balanced approach to the entire claims operation.

Staffing since the closing of the Camden office has been under budgeted levels. New hires have been slow to come on board, especially adjudicators positions which are critical vacancies.

The amount of space the DDS has seems more than adequate, but the layout is inefficient and not conducive to a good working environment.

Recommendations

DDS management should:

1. Expand emphasis on production to include a balance of all performance areas, especially quality and timeliness of case development and adjudication. First and foremost, management should address staffing shortages and critical adjudicator vacancies as soon as possible.

2. Establish overall agency plans that spell out DDS goals and address problem areas identified. Individual staff responsibilities in implementing these plans should be detailed:

   a. Region managers and their subordinate supervisors should have specific workplans that include trackable action items with timeframes.

   b. The State performance assessment review (PAR) should include uniform performance standards, as much as is permissible, for physicians, clericals, and examiners to maximize their contributions to the overall agency effort.

3. If a move to another building is not imminent, reconfigure space to provide for a more efficient operation. Use movable partitions to provide privacy for supervisors and to cut down on noise levels.

Quality Assurance (QA)

Overview

The QA unit is a specialized function of the New Jersey DDS and is separate from the claims operation units. The QA unit is located in the Bureau of Planning and Evaluation and is headed by the QA chief, a second level supervisor, who reports to the supervising administrative analyst (see exhibit 2, Organization Chart). There are two QA units; each a first-level supervisor who report to the QA chief. Seven QA specialists are in each unit.

The primary responsibilities of the QA unit are quality review of sample cases (the "core" function) and a midline review of error-prone cases. The QA unit also performs an end-of-line review of high-risk cases such as sensitive inquiries, initial J1 denials, and AIDS cases. The QA function has varied historically in the New Jersey DDS ranging from heavy emphasis on case review to an emphasis on special studies and more recently to the midline review.

At all levels of personnel, the QA staff demonstrated proficiency in performing the QA function. The staff also indicated an interest and a willingness to get involved in special studies and projects designed to enhance adjudicator skills and overall agency performance.

A technical review component is also located in the QA unit and is under the direction of the QA chief. There are two technical reviewers who review the determination forms (SSA-831/832/833) for technical accuracy before cases leave the DDS. Sample selection of QA cases is done in the QA unit by the dispatch clerk.

The QA medical staff has two full-time and two part-time physicians who participate in case reviews, face-to-face case discussion, and midline reviews.

Sampling

The QA clerical supervisor is responsible for sample selection for the internal QA review. Sampling occurs after each case pickup (5 times daily) and is done by the dispatch clerk using a card system method. This is a manual system that has been in place for years. No problems have been detected in protecting sample integrity. Federal QA and preeffectuation review (PER) samples are automatically selected through the National Disability Determination Services System. Cases not selected for QA undergo technical review before closure.

Sample intervals are determined in conjunction with the regional office (RO). The current sampling scheme is 1/7 initial denials; 1/12 initial allowances; 1/8 reconsideration cases; 1/7 continuing disability review (CDR) continuances; and 100 percent of the CDR cessations.

QA Supervisor Responsibilities

QA supervisors review a sample of the QA specialists' cases, discuss troublesome cases, prepare statistical reports and analyses, identify trends/problems, and make appropriate recommendations. They intervene in resolving disagreements with line supervisors over QA returns to the units. The QA specialists are evaluated yearly with an interim evaluation at 6 months. Thirty cases per specialist are reviewed each quarter and performance records on the volume and accuracy of each specialist are kept on a weekly and monthly basis.

QA Specialist Functions

The QA specialist's primary responsibilities are end of line quality review of sample cases and midline review of error-prone initial cases. They also review nonsample cases such as sensitive inquiries, AIDS cases, and initial denials coded J1 (capacity for other work). Folder realignment of reconsideration CDRs being sent to the disability hearings unit is also done by QA specialists. Specialists also assist in special studies, preparing reports, and reviewing Federal QA returns.

The QA specialists are permanently assigned to the QA unit (i.e., they are not rotated in and out from operating components). Since 1984, there has been a State administered test to qualify for selection into the QA unit. Two or three specialists currently are considered temporary pending achievement of satisfactory test scores. However, these employees have been in QA for several years. Training is mostly on the job.

Salary is at the CDR adjudicator level, which is the highest adjudicator level in the agency. All the specialists have at least several years of QA experience. They rotate monthly between QA case review and midline review.

QA Medical Staff

The QA unit has two full-time medical consultants--one psychiatrist and one internist. Another internist and a psychiatrist work part-time in QA. Front-end medical review is done on all initial denial sample cases. The medical staff review and sign off on all the other cases they review but not on a front-end basis. All writebacks contain a written analysis of the medical deficiencies. The medical staff provide face-to-face feedback to the QA specialists when necessary.

QA medical staff are also available for consultation with DDS adjudicators, supervisors, and other review physicians as needed. Priority, however, is supposed to be given to QA duties. Disability quality branch (DQB) and central office returns are reviewed and analyzed as a training tool as well as for determining if a rebuttal is appropriate. Disagreements over internal QA returns are resolved with the review physician face to face. Dr. Birenbaum, the DDS Medical Director, is the final word on unresolvable disputes.

QA Clerical Support

The QA clerical staff supervisor reports to the QA chief. The clerical staff is responsible for pulling the QA sample, packing cases (i.e., associating printouts, etc., before mailing) and collecting statistical data for the weekly, monthly, and quarterly reports. Data are kept on the number of QA cases reviewed and approved and the type of deficiencies, the number of cases reviewed by the QA medical staff, and the number of cases reviewed by each DDS physician and their accuracy.

The technical reviewers are co-located with the QA clerical staff but they work under the QA chief. All determination forms are reviewed for technical accuracy before leaving the DDS. Errors easily corrected are fixed by the technical reviewers. The others are returned to the adjudicators for correction.

QA Case Review

Each specialist reviews, on the average, 8-12 cases per day. Case assignments are random and include all body systems at all levels and types of cases (except disability hearing decisions). Average processing time for cases in QA is 2.5 days. Writebacks are handwritten to avoid delays associated with typing.

Case review emphasis is on decisional/documentational accuracy (i.e., substantive issues). Technical deficiencies, significant developmental delays, etc., are noted and informational returns sometimes occur. However nonsubstantive issues are not normally noted because of heavy caseloads.

Interaction with QA medical staff is mostly face to face, although written questions are acceptable if a doctor is not available. All writebacks have written medical staff comments and are signed by the supervisor.

Midline Review

Midline review is currently the second major QA function and has been in effect since February 1988. This is a review of error-prone cases (determined from Federal and internal QA statistics) before a determination is made. This innovation is designed to improve agency quality, provide training to DDS adjudicators on developmental and telephone techniques, and enhance the image of the QA unit within the agency (i.e., to be viewed as a partner with the operating units rather than as a "watchdog").

QA specialists work side by side with adjudicators and review physicians in the operating units on selected categories of cases offering input and advice. If additional medical evidence of record (MER) is needed and is available by telephone, the QA specialist will often make the call. The purpose is to correct errors before closing the case, improve processing time, serve as training for the adjudicator, and improve QA relations with the claims units.

The two QA units rotate duties monthly alternating between the core function and the midline function. A monthly report of midline activities and findings is issued to unit supervisors. QA errors are not charged during the midline review.

The midline review has been successful in preventing erroneous or poorly documented cases from leaving the DDS before being corrected. The effort seems to be improving the relationship between the QA unit and the claims units.

QA Reporting

A quarterly QA report is distributed to the agency director and the superintendents of disability claims operations. The report charts agency performance in terms of total cases sampled, total cases with substantive and technical deficiencies, documentational and decisional error rates, and medical evaluation errors. Substantive errors are also broken out by level of claim, by decision, by basis code, and by body system. Federal PER and QA returns are charted similarly.

The quarterly report provides an analysis of the findings, identifies problem areas and recommends solutions. The report also serves as a basis for determining the error-prone cases to target for midline review.

A rolling 13-week report, a calendar 13-week report, and a rolling 52-week report are also prepared measuring agency performance, adjudicator performance, and physician performance.

Findings

The New Jersey DDS QA unit functions in accordance with SSA regulations in monitoring internal agency performance.

QA case review places emphasis on documentational and decisional accuracy (substantive issues) but does not appear to place sufficient emphasis on nonsubstantive issues such as developmental delays.

The QA unit produces substantial data on agency performance. This information does not appear to be fully utilized as a source for feedback to unit supervisors in measuring unit/adjudicator performance against agency standards.

The midline review function appears to have favorably impacted on agency quality. We could not determine, however, if midline review provides an effective source of feedback to unit adjudicators and review physicians on processing error-prone cases and for improving case development techniques, particularly for obtaining MER by telephone.

Recommendations

Management should:

4. Support quality efforts by placing greater emphasis on the use of QA sample results and encouraging more feedback by:

   a. Issuing QA reports timely, e.g., the December 1987 quarterly report was not released until March 1988.

   b. Distributing the QA reports and the results of QA unit reviews--correct as well as incorrect--to managers and unit supervisors to use in assessing and improving adjudicator performance through early detection of problem areas. Review physicians should receive a copy of the report as well.

5. Expand the scope of QA activities with special studies of problem areas. Structure the midline review so that it becomes more instructional and provides feedback to the supervisor and adjudicators in taking necessary action(s).

6. Place more emphasis on the nonsubstantive aspects of the QA case review, particularly developmental delays. The internal QA review should focus on agency standards (i.e., agency guidelines for followups, etc.) instead of modeling case review on Federal QA.

Production/Workload Management

Case Processing

The New Jersey DDS has two operating units: Disability Operations, North and Disability Operations, South. These units are headed by regional superintendents. There are two supervisory claims adjudicators (SCA) for each operating unit. Disability Operations, North, is composed of five initial units, two CDR units, and two reconsideration units. Disability Operations, South, is composed of five initial units, two reconsideration units, and two CDR units. Each processing unit is supported with claims adjudicator aides (assist the adjudicators with claims development) and clerical units, that are supervised by a principle clerk typist.

In the New Jersey DDS, as of March 1988, over 28 percent of the initial disability cases were over 70 days old. Processing time was among the highest in the nation (with 79.5 and 89.3 days for title II and title XVI, respectively). The presumptive disability (PD) allowance rate was one of the lowest in the country, while the PD reversal rate was one of the highest. (See exhibit 1, DDS Performance Chart.)

High workloads and significant changes, such as closing the Camden office, have resulted in low morale among many of the operations staff, particularly the adjudicators. No incentives exist for accurate and timely case processing. Supervision places emphasis on the number of dispatches per week. Processing time and pending caseload are all but ignored. The adjudicators perceive case receipt assignments as inequitable. Once adjudicators allow their pending caseload to become too high, they are exempted from new receipts. Thus, the better adjudicators with lower pendings receive more cases to process.

Findings

There are considerable unexplained delays in claims processing not so much between workstations but at particular workstations and when awaiting subsequent action (e.g., followups, medical referral). (See exhibit 3--Elapsed Time Study.)

Workload management and controls, e.g., aged case processing, vary greatly from unit to unit. There does not appear to be any uniform control of aged cases or any systematic approach in attacking this workload. This lack of control of aged cases is being aggravated, and in some cases caused, by unmanageable workloads close to or in excess of 200 cases in some breakdowns.

Use of examiner pending listings, both as a management and examiner control, varies greatly from unit to unit and examiner to examiner. There are cases, some very aged, on the individual examiner listings that cannot be accounted for or have already cleared the agency. There is no uniform nor consistent method for reconciling these cases.

Aged cases are highlighted on pending listings yet there is no concerted effort to work these cases on a priority basis. There are substantial gaps, in some cases several months, in taking any kind of action.

There is considerable variations between the regions concerning supervisory reviews. Some unit supervisors are doing virtually no case reviews, while others are reviewing a prescribed number of certain kinds of cases every week. The level of effort, the focus of the reviews, the recordkeeping, and feedback from these reviews differ from supervisor to supervisor

Recommendations

7. Use systems support as much as possible and institute standardized practices to foster expeditious case processing:

   a. Institute uniform management controls and procedures for attacking the problem of aged cases with appropriate priority and resources devoted to this workload. The Office of Systems can produce a management control listing of 180-day cases, by examiner, at DDS management request. This listing is available on a weekly and/or monthly basis and useful as a management control.

   b. Institute a uniform procedure for reconciliation of cases on examiner pending listings. Line units must work with the systems unit in removing previously cleared pending cases from pending listings. The systems unit should provide feedback to the line units when reconciliation transactions are input.

8. Continue to explore incentives to reward adjudicators who have better productivity along with good accuracy and processing time.

The unit supervisor should:

9. Expand inline reviews and implement spot checks of each adjudicator's caseload, in various stages of processing, to assist the examiner before their pending caseloads approach the level where new receipts are not assigned. In conducting these case reviews, the supervisor should document all cases they review.

Case Development and Adjudication

Findings

In some units, the disability examiners did not review cases upon their receipt in the agency nor did they complete any required first or second follow-up actions. Instead, aides initiate initial MER requests, as well as first and second follow-up letters to the claimant. All initial development requests and most followups are done by mail. Telephone contact is minimal. While the elapsed time study revealed that half of first followups occurred within 11 working days, numerous followups were not conducted timely. There were several significant unexplained development gaps ranging up to 64 working days. These delays significantly impact on overall DDS performance.

Under this system it is possible to delay review of the case by the adjudicator until medical evidence arrives or the second followup is not productive. More accurate and timely adjudication of cases could be accomplished if the adjudicator were required to review the case file upon its arrival in the unit and again before any followup requests are initiated. Review of cases prior to followup and encouragement of phone usage by examiners may result in lowered processing time and fewer aged cases.

It is the exception rather than the rule that the internal DDS progress record is completed or used as a control on outstanding development. As a result, it is impossible to determine the status of a case without reviewing the entire folder.

Clericals pencil in followup dates on folder tabs. When followups are updated, old dates are erased and new dates repenciled. When multiple sources of evidence are involved, the followup dates become almost illegible because the multiple erasures and entries on the folder tabs.

During the course of our unit reviews, we found a number of cases which could not be located. Case files can leave the line units when a consultative examination (CE) is involved, sensitive inquiry, medical relations problem, etc.

Recommendations

The DDS should institute standardized practices to promote more efficient case development including:

10. Consider the use of worksheets (DDS progress records) to better document claims development such as followups on MER, CEs, and to pose questions to medical consultants and to document physician response.

11. Consider the use of out cards when folders leave the adjudicator's workstation for nonclosure purposes, and color coded flags/tags to identify aged cases at all workstations for priority processing.

12. Require adjudicators to review all initial cases upon their receipt in the agency, initiate all appropriate development actions, complete/control first and second followup of MER requests via telephone contact with treating sources. Minimize unnecessary processing delays by encouraging increased involvement by the adjudicator in all case development and increased review by the unit supervisors.

13. Require adjudicators to document all cases for physician review with appropriate questions or comments before the case is taken or routed to the physician. Likewise, the file should contain the physician responses.

14. Require examiners to use individual pending listings on a regular basis to assist them in managing their caseloads. Follow through and feedback by the first-line supervisor is important.

15. Evaluate latest initiative to consider presumptive disability (PD), when appropriate; monitor PD usage and reversals.

16. Consider the use of a task force (along with overtime) as a short term means to reduce aged cases and weeks work pending to assist the most heavily impacted examiners.

Mental Impairment Case Processing

Findings

We noted several problems in adjudicating mental impairments. There were inaccuracies and inconsistencies in the completion of the Psychiatric Review Technique form (PRTF) and the Mental Residual Functional Capacity (MRFC) form. Development of activities of daily living was initiated at the same time as medical development and was not directed at addressing specific issues in the medical development.

Mental impairment development was often done prior to development of physical impairments, there were inconsistencies in completions of the PRTFs and RFCs, and the development of activities of daily living (ADL) was often prematurely done and not directed to resolving specific issues in the medical development.

The PRTFs are completed by psychiatrists and psychologists only. However, the physician that completes the PRTF and the worksheet may not necessarily sign the SSA-831. The reason given, is the DDS medical consultant does not like to sign a blank 831. So, when the 831 is completed, the adjudicator takes it to any psychiatrist/psychologist for signature.

Recommendations

17. The DDS should review mental impairment case processing and:

    a. Conduct refresher training with RO assistance to ensure that psychiatric consultant staff understand the use and completion of the PRTF and MRFC forms in mental cases;

    b. Redesign the ADL form(s); shorten, devise, and organize the questions in a systematic fashion. Telephone contact with the medical source and/or the claimant should be encouraged to clarify the claimant's functional limitations before considering contact with a collateral source;

    c. Develop ADL questions based on the evidence in file; avoid general ADL questions; ask specific questions to resolve specific issues in the medical evidence; and

    d. Provide refresher training on the proper timing and use of ADLs to ensure that development for ADLs is being done only when necessary.

Caseflow

Teletype Unit

During the course of our visit, we found the teletype unit current and up to date despite serious systems outages the previous week. The teletype unit staff seemed knowledgeable and hard working. Adjustments are made when appropriate and work is well organized according to agency priorities, particularly:

a. Receipts and Case Assignments

Receipts are keyed every morning as folders are received and are usually in the units by the afternoon. Case assignments are tightly controlled and are made on as equitable a basis as possible by the assignment clerks.

b. Case Clearance

As noted above, priorities are well organized in the DDS teletype unit. Clearances are keyed immediately after receipts and every effort is made to keep them as current as possible. However, the time study indicates that three or more days usually elapse between the last signature and case clearance.

Mailroom

Mail flow through the mailroom is smooth and current. Internal pickups are made five times daily. Incoming mail is picked up at 7:30 a.m. and cases are delivered to the assignment clerks first thing in the morning. All outgoing mail is sealed and packaged by close of business.

Claims Units

While some units were encountering serious problems, other units, e.g., unit 2, seemed to have their workload under control with comparable receipts.

Word Processing Unit

Both the elapsed time study and review of work stations showed significant delays in word processing--particularly in effectuating first action requests for MER. On average over five working days elapsed between case receipt and request for MER. Similarly, 5 days elapsed between the CE request and actual mailing. According to DDS management, the problem began with the closing of the Camden office and has been further exacerbated by attendance problems resulting from illnesses and other employee absences. The word processing unit gives priority to preparation of personalized denial notices which are delayed only about 2 days, in comparison to first actions which we estimate current backlogs of 5-7 days.

Recommendations

The DDS should:

18. Develop both short and long term plans to improve the word processing unit's efficiency and eliminate lengthy delays. The plans could include reviewing the capabilities of the present equipment and developing a proposal on procurement of new state-of-the-art equipment, if warranted.

Training

The training staff completed training of 16 adjudicators in February 1988. Two of the 16 adjudicators returned to their former positions because the job of adjudicator was too difficult.

In 1985, there were 3 full days devoted to training on mental case adjudication, subsequent to the training received by the training staff and medical staff in the RO. The DDS used the old and new video tapes and the case studies provided by SSA for mental training.

There has been no mental refresher training for adjudicators; however, the same mental case adjudication was given to the new adjudicators who completed the disability course in February 1988.

Whenever a new physician is added to the medical consultant staff, Dr. Birenbaum and the MRO is responsible for providing the necessary training. Staff has been quite stable so there has not been a need to train physicians.

The training staff has not been involved in an ongoing technical training program.

The training staff perform other duties, such as adjudicating decision review (DR) cases--Riveria Court Case. They also handle tuition reimbursement for DDS staff; keep track of personnel taking training courses, etc. In the past, the training staff did seminars for the clerical staff. There have been no new hires recently; hence, no need for clerical training.

The adjudicator aides are given a "watered down" version of the disability examiner training. They primarily perform clerical duties for the adjudicator, such as making followup telephone calls to doctors and hospitals for medical evidence of record.

Course evaluations are not completed by new adjudicators upon finishing the basic examiner training. The training unit informally asks about problems the new adjudicator is experiencing. New adjudicators sometimes come back to the training staff to ask questions concerning specific cases. Supervisors may or may not provide training feedback to training unit. There is no formal feedback from the QA Unit on areas that may require training based on internal QA results, DQB returns, or observations from supervisors, based on case reviews.

Three new adjudicators were asked to comment on their course. All three adjudicators volunteered the following:

- More training needed in vocational evaluation/assessment of claims since a majority of the cases involve a medical/ vocational decision.

- Prefer making their own telephone calls for medical evidence rather than the adjudicator aide.

- Training needs more organization, and there should be enough materials for all trainees.

Trainees liked the idea of staying together as a unit. It provides support for each of them.

No training has been given to adjudicators on how to obtain and read queries. There are queries the adjudicator can get that are no problem to read. The CDR adjudicators were given POMS instructions to read the "coded" queries.

Findings

Course evaluations are not done by the training unit. There is no formal system for feedback on areas that may require training based on internal QA feedback, DOB returns or recommendations from supervisors based on observations from case reviews.

Recommendations

(See also recommendations 18a and 18d.)

The DDS should:

19. Establish mechanisms to evaluate the training courses of new adjudicators and institute a formal system to share feedback from deficient areas and trends from various levels of case review to all adjudicators.

20. Assess the vocational assessment training given to new adjudicators and increase the emphasis and/or case practice in this area. Refresher training for experienced examiners may also be in order.

21. Provide systems training to examiner staff in terms of availability of disability related information from the federal system. In addition, examiners should be familiar with the internal DDS query (DDSQ) and know how to use it to assist in adjudicating and tracking cases. In addition, the DDS should consider providing examiners with systems access.

CE/MER Monitoring

New Jersey has done an excellent job in monitoring CE usage. CE requests are reviewed by a physician prior to referral to the CE unit and again after arrival in the unit. It appeared the second review caused very little delay in scheduling CEs and contributed to the lower CE rate. The current CE rate is 25.8 percent.

Address information is stored on the word processing equipment for most of CE providers of medical evidence. This central location of address information allows easier, more efficient and accurate updating and ensures that the correct address and procedure is used in requesting medical information.

Findings

There is no central file maintained for all CE providers showing the date of the last visit, the results of the visit and the date the next visit is due, as well as all information on any complaints or reporting problems.

There is also no mechanism to supply information on the results of the Medical Relations staff efforts. Such a mechanism might include comparative data to show accuracy, completeness and timeliness of reports, the number and nature of any complaints or problems along with the number, dates and results of all visits and training efforts. This information could be used to determine how effective training efforts are and could identify those that are more successful.

Use of Liaison Staff--Liaison staff is used to pick up medical evidence from hospitals, etc., and to get ADLs from claimants that cannot be reached any other way. Use of the liaison staff and the arrangements with certain hospitals have not been fully reevaluated for some time.

Recommendations

The DDS should:

22. Maintain a central file for all CE providers showing the date of the last visit, the results of the visit and the date the next visit is due, as well as all information on any complaints or reporting problems.

Vocational Assessment

Background

Case reviews have suggested that weaknesses in handling vocational issues disproportionately contribute to the New Jersey DDS' error rate. With this in mind, the review team specifically evaluated the DDS' practices and procedures with regard to vocational assessments.

We learned the position of vocational specialist is no longer used in the New Jersey DDS. At one time the position was a viable one.

New adjudicators are trained in vocational assessment. However, if the adjudicator needs to consult with someone about a medical/vocational issue, he/she comes to the training unit or consults with their supervisor.

Discussion included how cases are handled in QA when the reviewer disagrees with the vocational assessment of the adjudicator.

Apparently, this type of situation has not occurred very often. Usually, the person in QA with strong vocational background reviews the case and makes the call as to whether the assessment of the adjudicator is right or wrong.

A vocational specialist is really needed when there is a "bounce" from the DQB and there is a need to prepare a successful rebuttal when the DDS QA disagrees.

Finding

Based on interviews and QA data there seems to be a lack of expertise in the vocational area, especially among new adjudicators. Persons interviewed felt that all adjudicators could benefit from ongoing vocational assessment training, especially new adjudicators.

Recommendation - See recommendation 20

VR Referrals

Lin Jenkins was interviewed; a VR employee stationed in the DDS, at length about how VR referrals are handled within the New Jersey DDS. His permanent work station is located on the second floor of the same building.

Findings

Mr. Jenkins does all VR referrals for the DDS. In reviewing several SSA-831s, it was apparent that the DDS adjudicators arbitrarily checks block 21 (VR block) screen out. It was obvious that some of the cases were screen-ins instead of screen-outs. DDS adjudicators sometimes make a VR referral; however, the percentage of referrals by adjudicators have decreased since he has been onsite in the DDS.

Mr. Jenkins refers mostly denials. One of three referrals becomes a client of VR. He has referred 5,400 cases to VR in the past 3 years he has been stationed in the DDS. Lin did not have good information on how many referrals were closed VR code 26 (closed rehabilitated) and VR was reimbursed by SSA.

Recommendation

23. So that adjudicators are more alert to possible referrals, conduct brief training on the SSA VR reimbursement program and the VR referral screening criteria contained in POMS DI26520.001-26520.035.

CDRs

The DDS is doing a very good job processing its CDR workload. Through May 6, 1988, (62 percent of the fiscal year completed) New Jersey had processed 67 percent of its budgeted CDR dispositions. They project that for the entire fiscal year they will realize about 125 percent of budgeted CDR clearances.

In the course of the review we found that all CDR receipts have been assigned to adjudicators. The very significant progress in CDR case processing can we attributed to the high caliber of the CDR supervisors and by the technical knowledge and aggressive development techniques of the CDR adjudicators.

The DDS shortly plans to implement formal CDR "fast tracking" procedures, utilizing the experience of the joint DPB-DDS experiment in New Jersey. This should further enhance CDR productivity. The process essentially involves special handling of cases where a continuance is likely and the claimant has a current treating physician, and is geared to speedy, high quality processing of these cases. An important part of the process involves review physician telephone calls to treating physicians to secure MER. After gaining experience DDS management should consider extending the fast tracking concept to help process initial and reconsideration cases.

New Jersey

Exhibit 1

ACCURACY	12/86	3/87	6/87	9/87	12/87
Combined Initial	90.4%	93.6%	91.1%	90.9%	90.9%
(Rank)	(44)*	(35)*	(47)*	(49)*	(52)*
Initial Allowance	100.0%	95.6%	97.9%	96.90%	96.3%
Initial Denial	83.3%	92.0%	85.8%	86.4%	86/5%
Mental	N/A	80.0%	77.3%	79.5%	77.4%
Mental (122 Cases)	79.0%	93.0%	97.0%	98.0%	99.0%
Combined CDR	N/A	89.0%	91.9%	99.0%	97.8%
CDR Continuance	N/A	88.9%	93.2%	98.8%	98.7%
CDR Cessation	N/A	89.3%	85.4%	100.0%	91.9%
All (I, R, and CDR)	N/A	93.2%	88.2%	89.0%	91.5%
PROCESSING					
Title II (days)	93.1	88.6	70.5	72.5	75.5
(Rank)	(46)*	(46)*	(43)*	(45)*	(48)*
Title XVI (days)	100.5	97.0	79.3	83.0	84.2
(Rank)	(46)*	(44)*	(43)*	(46)*	(47)*
WORKLOAD					
Receipts (YTD)	N/A	26,365	41,986	54,713	15,166
% Realized		81.1%	86/1%	84.1%	102.6%
Dispositions (YTD)	13,928	28,686	44,105	58,242	13,636
% Realized	88.8%	91.9%	96.7%	95.8%	91.1%
Aged Cases	37.2%	26.5%	26.6%	33.5%	27.6%
(over 70 days)	(44)*	(44)*	(45)*	(50)*	(43)*
Weeks' Work	14.1	12.2	12.0	11.9	14.0
Pending	(49)	(42)	(42)	(44)	(51)
PERFORMANCE					
Initial Allowance Rate	40.8%	42.1%	42.7%	45.2%	43.9%
CDR Continuance Rate	90.6%	87.9%	84.8%	87.3%	86.8%
Consultative Exam	37.6%	30.2%	14.1%	12.0	25.7
Rate (quarterly)	(35)*	(20)*	(2)*	(1)*	(7)*
MER Rate	61.4%	59.5%	55.2%	39.6%	72.4%
(quarterly)	(23)*	(18)*	(9)*	(3)*	(40)*
Cumulative PPWY	157.4	164.5	173.0	182.3	202.6
(annual target)					
FTE On Duty--end of qtr	371.6	357.2	345.3	272.6	274.6

*( ) = Rank ** (N/A) = Not Available

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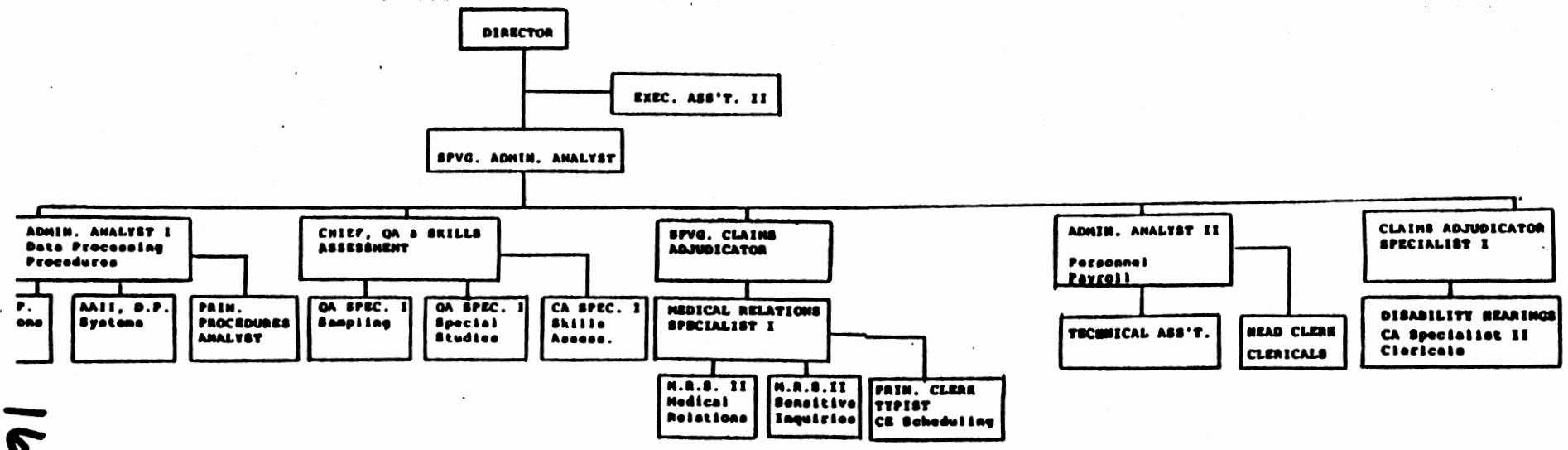
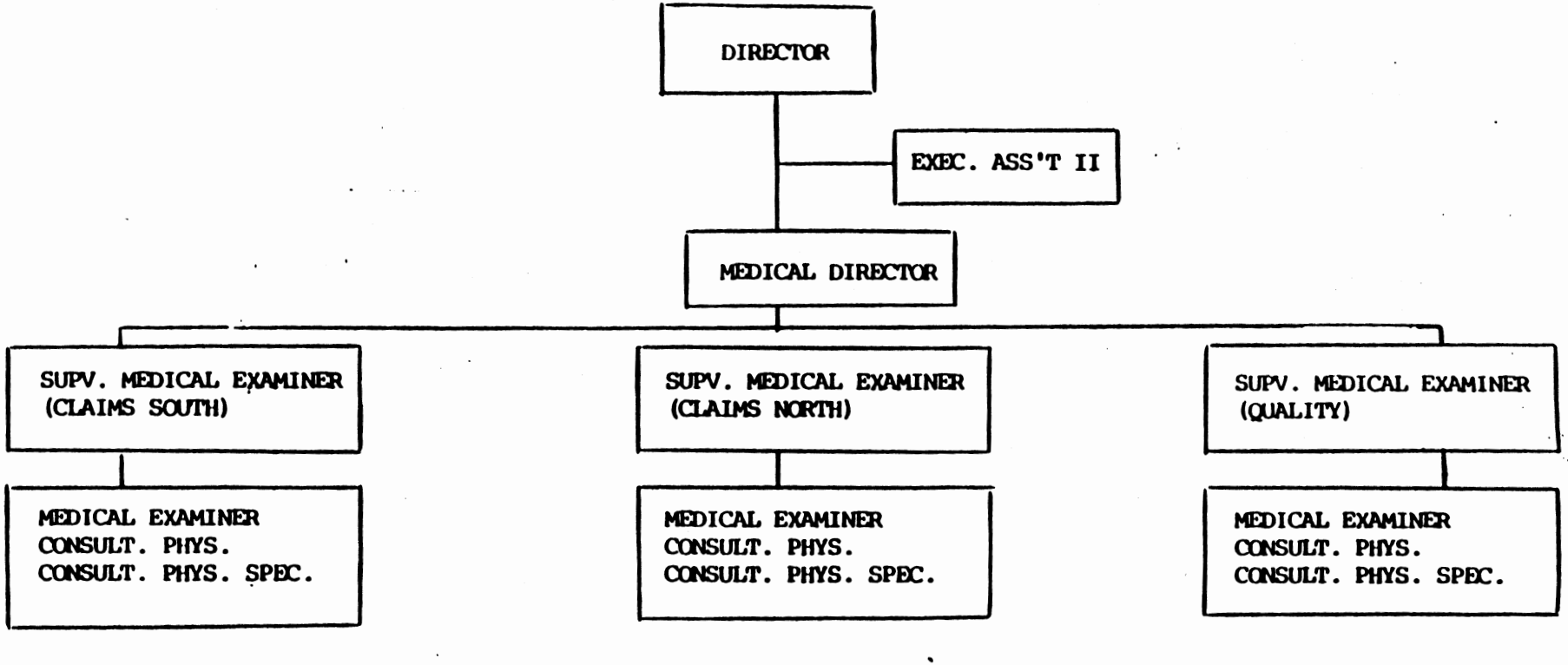
NEW JERSEY DDS
OFFICE OF THE DIRECTOR



169X

Exhibit 2

NEW JERSEY DDS MEDICAL STAFF



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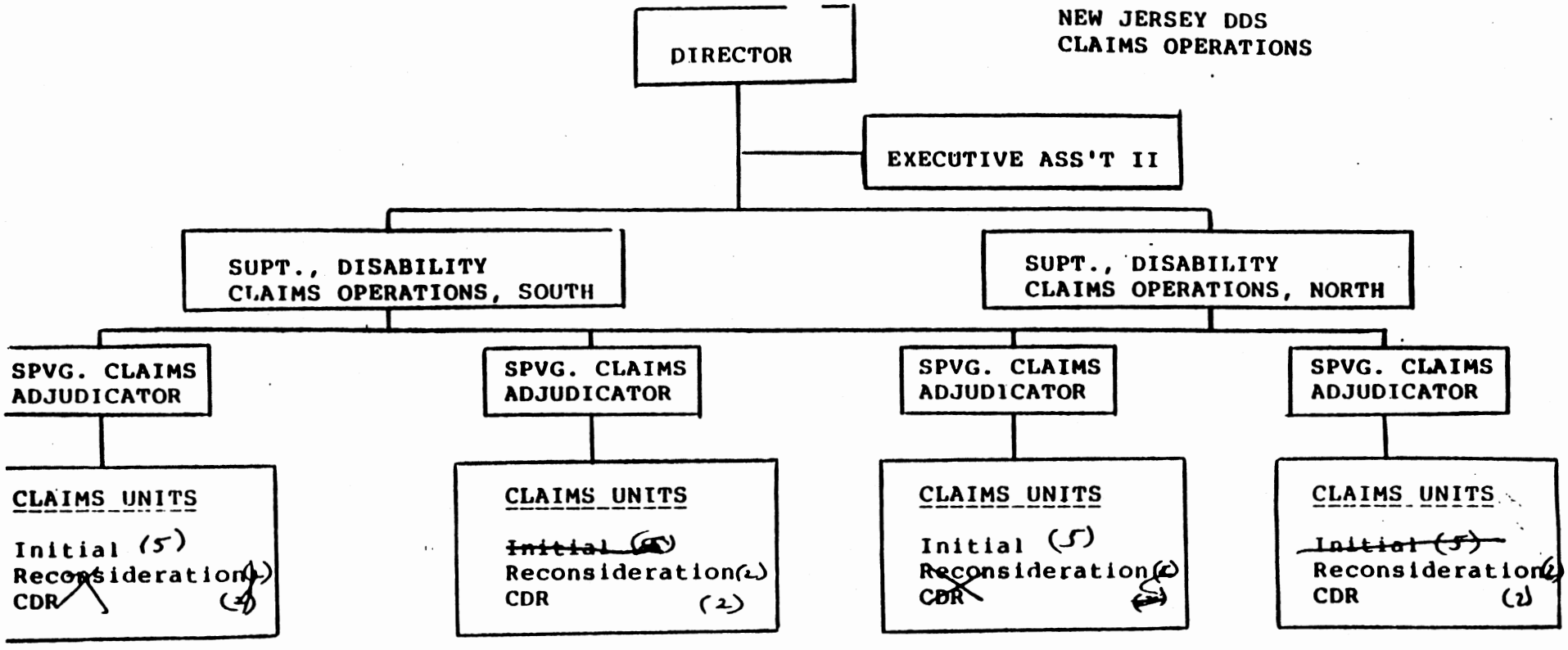
NEW JERSEY DDS
CLAIMS OPERATIONS
DIRECTOR
EXECUTIVE ASS'T II
SUPT., DISABILITY CLAIMS OPERATIONS, SOUTH
SUPT., DISABILITY CLAIMS OPERATIONS, NORTH
SPVG. CLAIMS ADJUDICATOR
SPVG. CLAIMS ADJUDICATOR
SPVG. CLAIMS ADJUDICATOR
SPVG. CLAIMS ADJUDICATOR
CLAIMS UNITS
Initial (5)
Reconsideration (1)
CDR (3)
CLAIMS UNITS
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Reconsideration (2)
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CLAIMS UNITS
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Initial (5)
Reconsideration (2)
CDR (2)

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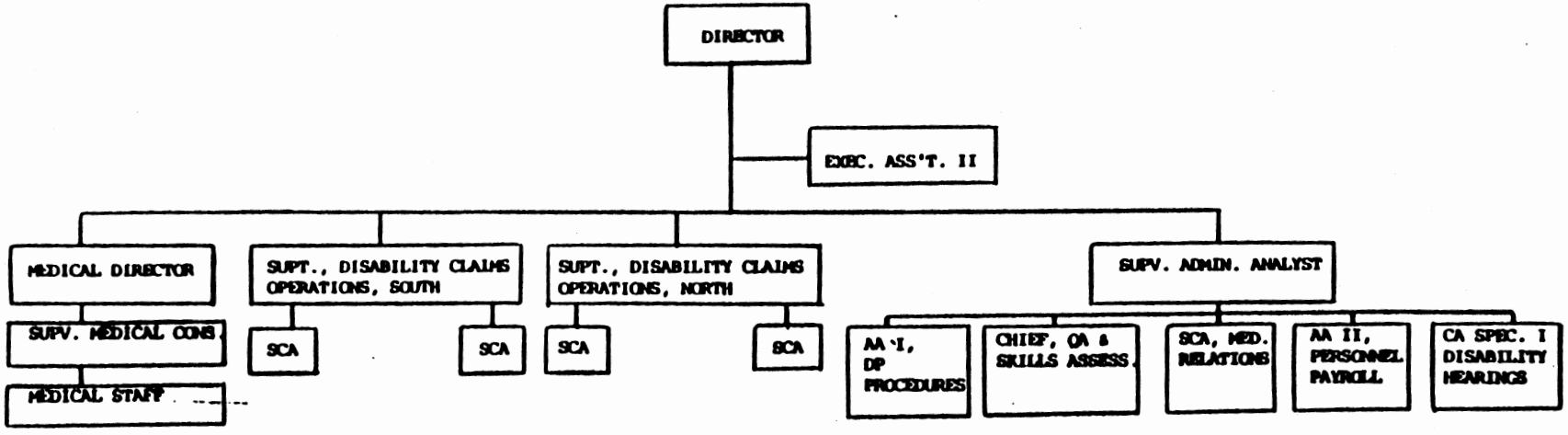
NEW JERSEY DDS



172X

New Jersey DDS FAMR
DDS Elapsed Time Study

Sixty end-of-line cases were reviewed. The average age at the time of review, which was held between April 25 to 29, 1988, was 48.1 days. The charts below list the DDS actions and the corresponding processing times in working days, i.e., holidays and weekends were not counted. The first panel provides the summary data for all cases combined, and the other two differentiate cases based on the presence of a consultative examination.

ACTION	MEAN	MEDIAN	RANGE	CASES
I. All Cases				
Cases Received to First Action	5.3	5	1-14	60
Cases Received to First Evidence Received	21.7	21	5-88	56
First Action to First Followup	14.0	11	7-61	41
CE Report (or Last Evidence Received) to MC for Signature*	5.5	2	0-64	59
Last Signature to Clearance	3.7	3	0-12	60
Total Elapsed Days	48.1	40	16-144	60
II. Cases Without CEs				
Cases Received to First Action	5.9	6	2-11	39
Case Received to First Evidence Received	21.7	18	7-88	38
First Action to First Followup	12.5	11	0-30	26
Last Evidence Received to MC for Signature*	2.6	2	0-15	38
Last Signature to Clearance	3.8	3	1-12	39
Total Elapsed Days	37.3	33	16-96	39

ACTION	MEAN	MEDIAN	RANGE	CASES
III. Cases with CE Request				
Cases Received to CE Request	30.5	27	1-94	21
No MER	1.3	2	1-2	3
MER	35.6	32	8-94	18
CE Request to CE Request Mailed	5.0	4	2-11	21
CE Mail to CE	9.5	9	7-14	17
CE to CE Report Received	10.7	9	4-23	17
CE Report (or Last Evidence) to MC for Signature	3.5	2	0-9	17
Last Signature to Clearance**	3.5	3	0-6	21
Total Elapsed Days	68.2	68	26-144	21

* In 20 cases, the MC signed 831 before DE (average days before was 1.7).

** In one case, the CE report was received after 831 signatures but before the case cleared.

New Jersey Onsite Review Recommendations

Administrative Management

Disability determination services (DDS) management should:

1. Expand emphasis on production to include a balance of all performance areas, especially quality and timeliness of case development and adjudication. First and foremost, management should address staffing shortages and critical adjudicator vacancies as soon as possible.

2. Establish overall agency plans that spell out DDS goals and address problem areas identified. Individual staff responsibilities in implementing these plans should be detailed:

   a. Region managers and their subordinate supervisors should have specific workplans that include trackable action items with timeframes.

   b. The State PARS should include uniform performance standards, as much as is permissible, for physicians, clericals, and examiners to maximize their contributions to the overall agency effort.

3. If a move to another building is not imminent, reconfigure space to provide for a more efficient operation. Use movable partitions to provide privacy for supervisors and to cut down on noise levels.

Quality Assurance (QA)

Management should:

4. Support quality efforts by placing greater emphasis on the use of QA sample results and encouraging more feedback by:

   a. Issuing QA reports timely, e.g., the December 1987 quarterly report was not released until March 1988.

   b. Distributing the QA reports and the results of QA unit reviews--correct as well as incorrect--to managers and unit supervisors to use in assessing and improving adjudicator performance through early detection of problem areas. Review physicians should receive a copy of the report as well.

5. Expand the scope of QA activities with special studies of problem areas. Structure the midline review so that it becomes more instructional and provides feedback to the supervisor and adjudicators in taking necessary action(s).

6. Place more emphasis on the nonsubstantive aspects of the QA case review, particularly developmental delays. The internal QA review should focus on agency standards (i.e., agency guidelines for followups, etc.) instead of modeling case review on Federal QA.

Production/Workload Management

The DDS should:

7. Use systems support as much as possible and institute standardized practices to foster expeditious case processing:

   a. Institute uniform management controls and procedures for attacking the problem of aged cases with appropriate priority and resources devoted to this workload. The Office of Systems can produce a management control listing of 180-day cases, by examiner, at DDS management request. This listing is available on a weekly and/or monthly basis and useful as a management control.

   b. Institute a uniform procedure for reconciliation of cases on examiner pending listings. Line units must work with the systems unit in removing previously cleared pending cases from pending listings. The systems unit should provide feedback to the line units when reconciliation transactions are input.

8. Continue to explore incentives to reward adjudicators who have better productivity along with good accuracy and processing time.

The unit supervisor should:

9. Expand inline reviews and implement spot checks of each adjudicator's caseload, in various stages of processing, to assist the examiner before their pending caseloads approach the level where new receipts are not assigned. In conducting these case reviews, the supervisor should document all cases they review.

The DDS should institute standardized practices to promote more efficient case development including:

10. Consider the use of worksheets (DDS progress records) to better document claims development such as followups on MER, CEs, and to pose questions to medical consultants and to document physician response.

11. Consider the use of out cards when folders leave the adjudicator's workstation for nonclosure purposes, and color coded flags/tags to identify aged cases at all workstations for priority processing.

12. Require adjudicators to review all initial cases upon their receipt in the agency, initiate all appropriate development actions, complete/control first and second followup of MER requests via telephone contact with treating sources. Minimize unnecessry processing delays by encouraging increased involvement by the adjudicator in all case development and increased review by the unit supervisors.

13. Require adjudicators to document all cases for physician review with appropriate questions or comments before the case is taken or routed to the physician. Likewise, the file should contain the physician responses.

14. Require examiners to use individual pending listings on a regular basis to assist them in managing their caseloads. Follow through and feedback by the first-line supervisor is important.

15. Evaluate latest initiative to consider presumptive disability (PD), when appropriate; monitor PD usage and reversals.

16. Consider the use of a task force (along with overtime) as a short term means to reduce aged cases and weeks work pending to assist the most heavily impacted examiners.

17. The DDS should review mental impairment case processing and:

    a. Conduct refresher training with RO assistance to ensure that psychiatric consultant staff understand the use and completion of the PRTF and MRFC forms in mental cases;

18. Develop both short and long term plans to improve the word processing unit's efficiency and eliminate lengthy delays. The plans could include reviewing the capabilities of the present equipment and developing a proposal on procurement of new state-of-the-art equipment, if warranted.

177X

b. Redesign the ADL form(s); shorten, devise, and organize the questions in a systematic fashion. Telephone contact with the medical source and/or the claimant should be encouraged to clarify the claimant's functional limitations before considering contact with a collateral source;

c. Develop ADL questions based on the evidence in file; avoid general ADL questions; ask specific questions to resolve specific issues in the medical evidence; and

d. Provide refresher training on the proper timing and use of ADLs to ensure that development for ADLs is being done only when necessary.

Training (See also recommendations 18a, 18d, and 23.)

The DDS should:

19. Establish mechanisms to evaluate the training courses of new adjudicators and institute a formal system to share feedback from deficient areas and trends from various levels of case review to all adjudicators.

20. Assess the vocational assessment training given to new adjudicators and increase the emphasis and/or case practice in this area. Refresher training for experienced examiners may also be in order.

21. Provide systems training to examiner staff in terms of availability of disability related information from the federal system. In addition, examiners should be familiar with the internal DDS query (DDSQ) and know how to use it to assist in adjudicating and tracking cases. In addition, the DDS should consider providing examiners with systems access.

CE/MER Monitoring

The DDS should:

22. Maintain a a central file for all CE providers showing the date of the last visit, the results of the visit and the date the next visit is due, as well as all information on any complaints or reporting problems.

VR Referrals

23. So that adjudicators are more alert to possible referrals, conduct brief training on the SSA VR reimbursement program and the VR referral screening criteria contained in POMS DI26520.001-26520.035.

178X

NEW JERSEY'S DISABLED: HAS THE PROMISE BEEN BROKEN?

HEARING

BEFORE THE

SUBCOMMITTEE ON RETIREMENT INCOME AND EMPLOYMENT

OF THE

SELECT COMMITTEE ON AGING HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

SECOND SESSION

MAY 22, 1992, OCEAN CITY, NJ

Comm. Pub. No. 102-883

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180X

CONTENTS

181 X

NEW JERSEY'S DISABLED: HAS THE PROMISE BEEN BROKEN?

FRIDAY, MAY 22, 1992

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON RETIREMENT INCOME AND EMPLOYMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:07 a.m., in the Ocean City Council Chambers, Ninth Street and Asbury Avenue, Ocean City, New Jersey, the Honorable William J. Hughes (chairman of the subcommittee) presiding.

Members present: Representatives Hughes and Saxton.

Staff present: William Johnston-Walsh, Professional Staff Member.

OPENING STATEMENT OF CHAIRMAN WILLIAM J. HUGHES

Mr. HUGHES. The Subcommittee on Retirement Income and Employment of the House Select Committee on Aging will come to order.

Good morning and welcome to this morning's hearing. The subcommittee has received a request to cover this hearing in whole or in part by a television broadcast, still photography, or by other similar methods. In accordance with the rules, permission will be granted unless there is objection. Is there objection?

[No response.]

Mr. HUGHES. Hearing none, permission will be granted.

Today we will examine a very serious national problem that is forcing thousands of disabled Americans to wait over half a year to receive their insurance benefits and it costs the taxpayers nearly $250 million in incorrect benefit payments over the last 3 years alone. I am greatly concerned that disabled Americans, retirees, and taxpayers are paying a heavy price for massive reductions in the administration of the Social Security and Disability Programs.

Over a 6-year period, social security staffing was put through a rapid downsizing process, eliminating about one-fourth of its personnel. While steps were needed to streamline and improve the agency, the evidence is overwhelmingly clear that we have gone much, much too far.

Despite completing more casework with fewer staff, the nation's disability program is barely treading water under a sea of 800,000—that is 800,000—unprocessed cases, a 250 percent increase in just 3 years. The average disabled applicant now must wait 7

182X

ıonths in some areas of the country to have a disability insurance laim reviewed.

What is worse, according to the fiscal year 1993 budget submitted y the President, we can expect the pending caseload to balloon to total of nearly 1.4 million cases within a year. It will take an unrecedented 213 days to process an initial claim—that is, if everyhing goes right, but the fact is that this initial decision is often rong.

The General Accounting Office recently found that in two-thirds f these appeals, an administrative law judge will overturn the enial and rule that the person is in fact disabled. The situation is imply unacceptable. People who have paid disability insurance axes have a right to expect that when they or their dependents ecome disabled, the Government will live up to its part of the conract and pay the benefits that are due.

Ironically, while disabled Americans are waiting several months r even years for their casework to be processed, persons who are ıo longer eligible for disability insurance assistance are costing axpayers tens of millions of dollars a year, people that are no onger disabled that we are not reaching because staff can't reach he continuing disability review cases that are piled on their desk n mountains along with new claims.

The situation is occurring because there are simply not enough taff to review these cases as required by law. The Agency's lack of ıbility to conduct these reviews has cost the taxpayers nearly $250 nillion over the last 3 years. While our own State of New Jersey ıas one of the highest backlogs of cases, totalling some 30,000, I am ncouraged by recent efforts at the national level and among our New Jersey State officials to address this very serious problem. The good news is that New Jersey has just received additional resources ınd 90 new adjudicators. I am proud of the efforts being made by ›ur Commissioner, Ray Bramucci and others within the New Jersey Department of Labor who are working very, very hard to reduce the backlog.

I think the recent reforms initiated by Commissioner Bramucci ınd his staff are an important step in the right direction, but my fear is that the scope of this national problem is so large that his efforts may only help to slow the crisis, not eliminate it.

Moreover, I have some additional observations that I would like to make and hopefully some additional reforms that the Commissioner and his staff will consider which I think will really help move the process forward in New Jersey.

The purpose of today's hearing is to gather a range of realistic and practical solutions to this serious and costly problem from our distinguished witnesses today. I look forward to their excellent testimony and thank those that have travelled a long distance to be with us today.

[The prepared statement of the Chairman Hughes follows:]

Opening Statement

Honorable William J. Hughes, Chairman

Hearing of
The Subcommittee on Retirement Income and Employment
Select Committee on Aging
May 22, 1992

"New Jersey's Disabled: Has The Promise Been Broken?"

Good morning, Ladies and Gentlemen. Today we will examine a serious national problem that is forcing thousands of disabled Americans to wait more than half a year to receive their insurance benefits.

I am greatly concerned by previous testimony provided to the Subcommittee which reveals that disabled Americans, retirees, and taxpayers are paying a heavy price for massive reductions in the administration of the Social Security and disability programs.

Over a six-year period, Social Security's staffing was put through a rapid downsizing process, eliminating nearly one-fourth of its personnel. While steps were needed to streamline and improve the agency, the evidence is overwhelmingly clear that we have gone too far.

The Nation's disability program is barely treading water under a sea of unprocessed claims and paperwork. Despite completing more casework with fewer staff, the nationwide backlog of unprocessed disability cases is approximately 800,000, a level which is more than 250% larger than it was just three years ago. The average disabled applicant must wait six to seven months in some areas of the country in order to have his or her initial disability insurance claim reviewed.

What is worse, according to the Fiscal Year 1993 "bare bones" budget submitted by the President, even if the Congress provides all the funding the administration is requesting, we can expect the pending disability caseload to total nearly 1.4 million cases by the end of the fiscal year. It will take an unprecedented 213 days to process an initial claim in even the average state. That is if everything "goes right."

But the fact is that even after these lengthy delays, tens of thousands of disabled applicants who are initially denied benefits must wait several more months while they appeal the decision. The General Accounting Office recently found that in two-thirds of these cases where benefits are initially denied, the decision was wrong. Sixty-six percent of the time, an Administrative Law Judge eventually rules that the person is in fact disabled and eligible to receive benefits.

184X

This situation is simply unacceptable. People who have paid ocial Security Disability Insurance taxes have a right to expect iat when they or one of their dependents becomes disabled, the overnment will live up to its part of the contract and pay the enefits that are due. A disabling accident or illness is tragic ough. We should not, and can not, make our friends and neighbors ait more than half a year to receive their insurance benefits.

Ironically, while disabled Americans are waiting several onths or even years for their casework to be processed, persons io have improved to the point that they are no longer eligible for isability assistance are costing taxpayers tens of millions of ollars a year. This situation is occuring because there are imply not enough staff to review these cases as required by law. ne Social Security Administration estimates that about eight ercent of the time, an individual will improve enough medically hat he or she can return to the labor force. If this estimate is orrect, the agency's inability to conduct these Continuing isability Reviews has likely cost the taxpayers a total of nearly 250 million over the past three years.

Clearly we are not saving money in this situation. We ought o admit we made a mistake by cutting back too far on essential ersonnel. This system is now creating severe and undue hardships or many of our most vulnerable citizens and it is not effectively sing our limited tax dollars.

While I am encouraged by recent efforts at the national level nd among our New Jersey state officials to address this very erious problem, I am afraid that these improvements will only help o slow the crisis, not correct it. I do not believe a day goes y that I do not receive another letter from a New Jersey resident ho feels wronged or frustrated by the system.

The purpose of today's hearing is not to assess blame for the erious problems we have. Rather, we have invited a very listinguished panel of experts who I believe can help provide us ith a range of realistic solutions.

It is clear that we need to work to eliminate these costly nefficiencies in the system and discuss how the disability program tself might be reformed. Perhaps there is a need for an earlier "face-to-face" meeting between the applicant and those making the ulings on benefits.

At any rate, I am convinced that we can, and must, do better. t is to that end that I have called for this hearing today. I ook forward to the testimony and I wish to thank those who have aken the time to travel long distances so they could be with us oday.

185X

Mr. HUGHES. It is my pleasure now to welcome to Ocean City a colleague of mine who I have worked with for a number of years, not just on aging matters, matters that affect the disabled, but a whole host of ocean policy matters. In fact, Jim Saxton and I are truly partners in working on behalf of the State of New Jersey, the southern part of the State. I am happy to report that it was Jim Saxton who was my ally in ensuring that we finally passed the Ocean Dumping Bill, the second one, so that we could force all the dumpers out of the ocean and we worked together in a true bipartisan fashion to advance the interests of not just southern New Jersey but the State and the country and I am very happy that Jim, who is very well respected as a distinguished member of the Aging Committee, can be with us today.

Jim?

Mr. SAXTON. Thank you, Mr. Chairman. It's my pleasure to be here in Ocean County this morning. The ride in was marvelous. The weather is great. It sounds like it is going to be over 90 today but I think it will be cooler in Atlantic City than Ocean City.

I would just like to submit my opening statement for the record. Many of the same things that Mr. Hughes had included in his opening statement are included in mine and I would just like to say additionally that this is an opportunity, and I thank Mr. Hughes very much for giving me the opportunity to be here to hear testimony as to the problems that are faced by the State and Federal officials who are responsible for administering the Social Security Disability Program.

This is certainly an important issue to many Americans and Mr. Hughes and I know full well through our constituent service offices and our activities in our offices how frustrating it is for individuals who come to us for help with regard to disability claims to find that we can look at their applications, we can suggest that perhaps something is not quite right with regard to an application or a reapplication, or a submittal for one purpose or another and then of course the papers, the applications are re-submitted and we then tell our constituents that we are a month or 2 months or sometimes 4 or 5 or 6 months away from some kind of determination.

So it is frustrating and at the same time, as Mr. Hughes very clearly pointed out, we recognize the limitations because of staffing shortages and the huge amounts of work that are involved in their determinations with regard to applications for disability, so we are here today to seek information that will help us or put us in a better position to help rectify problems which exist with regard to these determinations, so I am pleased to be here today and look forward to hearing from and talking with our witnesses. Thank you.

[The prepared statement the Mr. Saxton follows:]

H. JAMES SAXTON
12TH DISTRICT, NEW JERSEY

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Congress of the United States
House of Representatives
Washington, DC 20515-3013

Statement of Representative Jim Saxton
before the
Select Committee on Aging
Ocean City, New Jersey
Friday, May 22, 1992

I am pleased to make the trip to Ocean City today to discuss an issue of importance to thousands of New Jersey residents -- disability benefits.

The federal government made a promise to Americans to provide benefits to persons with disabilities. To 80,000 New Jersey residents, this promise has come true.

But unfortunately, hundreds of state residents are waiting for their disability cases to be reviewed. The number of disability cases pending is intolerable. Although the federal government was able to give New Jersey added financial assistance to hire 90 new adjudicators, the caseload has not decreased.

The New Jersey Division of Disability Determinations has seen a rise in new case claims. This increase in volume may be due in part to the economy, but nonetheless, improvements upon how our nation reviews disability benefits must be made.

In addition, I am concerned with the inability of the program to conduct continuing disability reviews. Certainly we must determine whether rehabilitation can allow a person to return to the workforce. The intent of continuing disability reviews is to determine whether their condition has "medically improved."

I was shocked to hear Social Security Commissioner Gwen King testify that because of the lack of resources to perform continuing disability reviews, some 34,000 persons should not be receiving disability benefits. This costs the system an estimated $200 million annually.

Mr. Chairman, I am pleased to see the panel of state experts which you have assembled for this hearing. I look forward to their testimony and hope that they can provide insights in to the disability claim process.

Thank you.

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187X

Mr. HUGHES. Thank you, Jim. I would like to introduce and welcome to today's hearing our first witness, the Honorable Raymond Bramucci, Commissioner of the New Jersey Department of Labor. Accompanying Commissioner Bramucci is Ms. Maryann Polaski, Director of the New Jersey Division of Disability Determinations. We are very happy to have you both with us today.

We have your statements, which, without objection, will be made a part of the record in full. We hope you can summarize for us but you may proceed as you see fit.

Ray, we welcome you today.

STATEMENT OF RAYMOND L. BRAMUCCI, COMMISSIONER, NEW JERSEY DEPARTMENT OF LABOR; ACCOMPANIED BY MARYANN POLASKI, DIRECTOR, NEW JERSEY DIVISION OF DISABILITY DETERMINATIONS

Mr. BRAMUCCI. Thank you, Mr. Chairman. Yes, my statement is in the record and I would just like to hit a couple of points that I think bear some repetition in a less formal way.

You know, I come from a family whose father was a social security disability recipient, and after a series of illnesses and injuries—he was a man who made fun of people who needed alarm clocks to get up in the morning because he was always there because he had to be there—and my sister similarly, 36 years of work getting up at quarter to 5 every morning, only to become disabled and is presently receiving disability benefits under social security, so it is close to home. I think we do poorly, even while we're making progress.

Because our clientele is so at risk, we can't afford to be blase or even comfortable with progress since 91 days, which is the turnaround time in the country, is not very reassuring when someone is seeking adjudication to a claim that is central to the future, to their lives, and it bothered me to take over an agency that was not doing that well and seeing that several physical moves with the same troops didn't yield much that you could say gave one reason to hope, and so that when we were on the road we could look at an elderly person or a disabled person and say we are on your side, we're going to try to help you and we are going to do it rapidly.

So this has effected not only the bureaucratic reality of those numbers but me personally, that to be associated with something that was not sensitive and not doing as good a job as we possibly could for people who had real needs to be respected is a fundamental issue that we are beginning to address now.

Social Security sent in their team and made some recommendations. Well, we also sent in our team. Since it is not always simply important to say we don't have the resources, and we didn't, and I quarreled a little bit with the Commissioner since I thought there was some unfairness in some remarks that were made, yet at base we didn't seem to have the morale and the sense of purpose and the professionalism to turn this around and so our team that went in there were the best people that we have in the Department of Labor, people that had demonstrated their ability to efficiently and sensibly deal with such issues as training and unemployment insurance and disability insurance under our TDI law.

We made some real changes. Maryann, who is sitting to my right, has been a long-time professional, a person of great integrity, and she was put in there and given carte blanche to select the people she needed to begin to turn this thing around. We then began to move on a parallel course with the Commissioner, Ms. King, who not only made funds available to us to enable us to hire those 90 people and to hire the five medical experts, the doctors, to begin to break this logjam, but she took the time to come to our office in Newark, and stand in a receiving line with me for better than 2 hours to greet every single employee in that place and encourage them to do better.

We are beginning to move in the right direction. We have reduced the backlog 4,000 cases but the onslaught continues so those numbers are only relatively important.

We have now an idea in place that would seek to regionalize our approach. I know that people will say, well, you go from centralization to regionalization—if you had regionalization, you'd centralize, but our team from the Department of Labor made that recommendation to us, that we seek to break up the caseload to reflect more closely face-to-face connection with applicants and it would also give us a yardstick to measure productivity and so as a first step we opted to move to New Brunswick, where we had a physical location with all of our other units—DVR, UI, ES—a place where the Department of Labor had a flag and we thought demographically and in terms of our people it would be an attractive place to set up a store so that we would basically take the 90 new people and our overage and move that into New Brunswick as a way of focusing our performance and not just painting it all with one brush.

I think that the New Brunswick move is a very critical move for this Department. It has gotten caught up in a understandable need to review the leases that were granted and the irony of course is that this is a lease that the State of New Jersey doesn't pay a nickel for and it's been endorsed by the Social Security Administration specifically. We have done the on-site inspections of our real estate in Newark and looked at the spot in New Brunswick and they are on-board totally.

I have received assurances from the new Republican majority, not so new now, that they will be sympathetic and the first lease that gets unloosened will be that one, but I would say to you that this is a critical part of our ability to come back to you in the future, Mr. Chairman, and give you some good news because we think that this move will give us great opportunity to try something new and to install a new system and a new appreciation for the importance of efficiency and sympathetic and effective handling of these claims.

I am not happy. You are not happy. Our staff that cares is not happy and we want to make it better! But I will end this statement with this observation: I would hope that people would give us an opportunity to do it our way. If you are going to hold me responsible, which I am responsible, then give me a chance to do it the way I think it should be done and then if it fails, then I am just not efficient or I am not with it, or I am over my head, but we need that move in order to serve New Jersey people better, so I think it's as forcefully said as I can make it. I think there is reason for

hope. A year ago if I were here, I would not be as hopeful because we have done some reductions. We have closed cases. We do have a little bit of a better spirit but we do have a problem with the "them and us" mentality among too many of our people and we are working on it.

I welcome the opportunity to answer whatever questions I can and Maryann will help me when I am a little deaf.

[The prepared statement of Mr. Bramucci follows:]

Testimony of
New Jersey Labor Commissioner Ray Bramucci
to the Subcommittee on Retirement Income and Employment,
U. S. House of Representatives'
Select Committee on Aging

May 22, 1992

Thank you very much for the opportunity to appear before this committee and outline the priorities that I have set at the Department of Labor for improving the operations of the Division of Disability Determinations, as well as my plans for carrying out those priorities.

I have personal reasons as well as professional ones for wanting DDD to succeed, thrive and flourish.

As a youngster growing up in Massachusetts, I saw first-hand how a Social Security benefit check can impact upon the quality of life of people who suffer disabling injuries or illnesses that keep them for earning their livings in the workplace.

My late father received Social Security benefits when an injury prohibited him from working and my sister is presently receiving Social Security disability benefits. Neither of them wanted to stop working, but when circumstances forced them to they had no qualms about applying for benefits because they knew they had contributed to the insurance system all of their working lives.

Let me start my formal testimony by telling you candidly that, although we are beginning to see improvement, I am still not satisfied with the productivity of our DDD. It takes far too long for claims to be processed. Our disabled citizens deserve better, and our performance needs major

improvements in efficiency if it is to become more deserving of public confidence.

Our record today is somewhat better than it has been in the recent past, and that is something on which we can build for the future. But we have set our sights higher and we will keep pushing until this program is one of the best in the nation.

As you know, DDD was the subject of an on-site management and process review by the Social Security Administration in June, 1991, and my own management review team reported directly to my office in October of last year.

These reviews determined that the system was in dire need of overhaul. They cited problems with communications, medical review, staffing, workload, production, relationships between adjudicators, quality assurance and clerical support.

In response to recommendations made by the review teams, we have implemented a wide range of program improvements in the areas of workload management, staff and management development, and quality of service. Also, as a result of those recommendations, there has been a considerable increase in the level of support provided by the parent agency and regional office staff, and our restructuring of the division which is well under way, will be completed in the next several months.

Let me list some of the steps we have taken:

–We hired more adjudicators. All of the 90 adjudicators that we have hired since May, 1991 have been trained and are assigned to caseload management. I'm happy to report that the more experienced ones are now beginning to make a noticeable contribution to the DDD's weekly productivity. As part of their training all of the trainees were involved in an

191X

initial case development project that provided valuable assistance to the agency so that experienced adjudicators could spend more time closing cases.

--We added five review physicians to the staff to evaluate medical evidence.

--We appointed a new director and assigned some of the top managers in the Department of Labor to be part of DDD's new management team.

--A new computer system was put on line to help us improve productivity levels. Additionally, modern copying equipment has been installed.

--The consultative examination (or CE) process was streamlined to avoid case delays.

We also revamped overtime schedules. Where previously overtime was scheduled without setting specific goals, it is now scheduled by management whenever it can maximize the overall productivity of the unit.

The Social Security Administration has directly provided valuable staff assistance and support to our agency. This help includes providing clerical assistance on Saturdays to work in the consultative examination unit to reduce the number of cases awaiting appointments and to conduct telephone interviews with clients.

Mandated quality review is now conducted by SSA staff, enabling the DDD to reassign the internal quality staff to directly assist claim operations. The SSA also recently embarked on a project which will relieve our adjudicators of the need to initiate requests for medical evidence for about 15 percent of our case load. That will improve our processing time and free up staff to work on the aged cases.

The final piece of the equation--and the one I consider the most important--will be the opening of our first regional office, in New Brunswick.

192X

We anticipate that this operation will give us a yardstick for measuring the caseload performance of our staff and management in two diverse operating environments.

We are somewhat behind our schedule for the opening of this office because of the hold placed on new lease signing pending the State Legislature's review of all state leasing arrangements and procedures. I will keep you informed about our progress on getting approval for our lease.

The New Brunswick office will represent an important phase of our restructuring program which is based on the concept of regionalization.

We've divided the State into four parts to handle incoming cases. One will be in New Brunswick and for the time being at least the other three regions will be housed in the Newark Office. Each region will have its own consultative examination scheduling unit; field personnel, medical relations specialist, case consultants, and physicians who will report to the regional manager. The regions will also have sufficient paraprofessionals whose primary function will be to assist the adjudicators in obtaining medical evidence and information from claimants themselves.

Even if three of the regions remain in Newark, they will receive cases from the designated district offices and will relate to facilities under their geographic jurisdictions.

We anticipate that regionalization will result in improved and more personal relationships with doctors, hospitals, clinics, consultative examination sources, workshop facilities, claimants and SSA district offices.

Our staff will need all of the additional assistance it can get if it is to meet the challenges of the anticipated future workload.

As a result of the Zebley decision, which expanded the number of factors that must be considered in determining children's claims, we

193X

anticipate that DDD will receive 5,610 cases in Fiscal Year 1992 that will require special handling and involve a unique set of adjudicative principles. In order to process this large and complicated workload, we have assigned these cases to the most experienced members of the DDD staff.

The Wilson decision, which prohibits denials without consideration of a claimant's vocational background, also will have a significant impact on our workload by adding 6,000 to 7,000 new cases. We are awaiting instructions for the handling of Wilson cases from the SSA in order to adequately plan for the processing of these claims.

In response to the committee's question about the SSA's Plan for Disability Program Initiatives, I must state that these initiatives have had a positive effect on our DDD because they have helped the staff to process claims more expeditiously. The initiatives eliminated the need for specific medical documentation and reduced the number of form entries a physician must make. That sped up the processing time for those case situations.

If I learned anything by my experience in the labor movement, it is that when people feel good about their jobs, they take more pride in their work and productivity increases. One of the biggest issues for me is to eliminate any "us vs. them" attitude between management and workers. I have made it a personal priority to address this situation. What we need is teamwork not confrontation.

Almost immediately after coming on board as director Maryann Polaski began conducting weekly meetings with all eighteen unit supervisors. These meetings provide the director with an excellent sounding device to receive feedback from workers and in the long-run help dispel the we/them attitudes.

194X

Let me give you an example of the problem. We had a sign reading "administration" which artificially separated management from the workers. Maryann took that sign down.

It is my feeling that staff morale has been improving steadily. All of us have gone to great lengths to tell DDD staff that we care about them and value their hard work.

We have established two adjudication committees and a workforce committee to provide employees with opportunities to discuss issues of concern with supervisors, managers and directors.

Maryann also has held briefings to introduce the staff to the members of the new management team and to review the state and federal reports. More of this is planned for the future.

Meetings also have been held by management to inform staff members of career advancement and training opportunities within the agency.

In the list of questions you forwarded to me, Mr. Chairman, you noted that the state review team had "concerns about the high expectations management staff have that the new computer system will be a major factor in reducing case processing time."

Mr. Chairman, I want to assure you that we understand the importance of computers. But we also understand that they are no panacea. We do have high expectations for our computers to help with the work, but I know that it is our people who will make the decisions -- and the difference.

I think you will agree that we have made substantive changes at DDD.

The Division is no longer conducting "business as usual" and we are seeing tangible results from our efforts. Since May, 1991 there has been a steady and sustained improvement in the quality of the Division's

195X

determinations, with the initial denial accuracy rate increasing from 80.6 percent to 93.9 percent. In fact, the division's overall initial claims accuracy rate for the first quarter of this year was 95.4 percent, a rate higher than the national average.

Thanks to the assistance from the SSA and our own restructuring, our pending workload has declined by over 2,400 cases since the beginning of this year. The drop in the pending caseload has been achieved in spite of a steady rise in new cases. The division received 39, 286 cases for the seven-month period from October, 1991 to April, 1992 compared to the 32,286 cases received in the same period in the previous year.

Commissioner King and I have had some disagreements, but they are behind us now. And I must say unequivocally that without the financial assistance she provided we would have been hard-pressed to find the resources for new staff and equipment and to put in place the recommendations of the federal and state review teams.

I've stated publicly that thanks to Ms. King's help, the days of excuses for DDD are over and if we fail now, we do so on our own. No longer can we use the excuse that all the problems with DDD were inherited ones. We are the masters of our fate and I hope we will have the support and opportunity to make this operation succeed on our own terms, or fail trying.

But I feel good about what we're doing. Our speed is still too slow, but our quality and accuracy levels are above the national norm and our backlog is decreasing.

Our experience has shown that adequate funding levels, and good management do make a difference. The return on investment by the SSA in New Jersey has been profitable and positive and we are proving that quality and productivity can be compatible and achievable goals.

Our goals and objectives are necessarily high and they are not limited to national averages. I don't think it is fair to tell a disabled person that he or she has to wait 91 days before they are notified of their eligibility.

My staff designed and implemented the programs that let us pay unemployment benefits to thousands of jobless workers the first day they were eligible to receive them under the nation's first state-funded extended benefits program. We achieved the same thing when a federal program took its place.

I believe our disabled citizens deserve no less than the same kind of effort. And I am determined that they will get it.

Our concern for our disabled citizens extends beyond the limits of DDD's responsibilities. For instance, we have directed DDD staff to identify and refer to our vocational rehabilitation program disabled persons who with the proper assistance and training are capable of becoming productive members of the workforce. Things like that may not show up in the statistics, but they mean a lot to the people who benefit from the process.

In our efforts to improve the disability determinations program in New Jersey, we have learned a great deal about the SSA program and the big, important and complex issues that this committee must consider.

With your permission, I would like to offer to you some suggestions for changes in the program that could benefit disability agencies in all states.

I believe we need a means of providing contingency funds when our programs face unanticipated increases in their caseloads. We need a mechanism that responds to these needs quickly before the weight of new cases bogs down the entire system. Such a model exists already within the unemployment insurance system and could be easily modified for this purpose.

The funding for disability agencies should be off budget to enable them to deal with the reality of caseloads as they occur without being hampered by arbitrary budget constraints. This also would enable agencies to reinstate the continuing disability reviews, as well as provide for other activities.

Next I would suggest that the temporary changes by the SSA that eliminated some excessive and unrealistic documentation requirements should become our permanent method of operation. If we can do a good job without them let's not slow the system with extra and unnecessary steps.

Another important point I would like to make is that to my knowledge there has never been a comprehensive study on what really constitutes adequate reimbursement to doctors for the kinds of requests we make. A national study could examine the impact of these medical costs on various disability programs. That information could help all agencies determine how best to allocate their funds.

For example, the amount paid for consultative examinations and medical requests varies from state to state. We pay $10 for each medical request in New Jersey, an amount that seems unrealistic in today's economic climate to say the least. But there is no hard evidence to show that we would see faster turnaround times if we spent more of our limited resources in this area.

One of the things we plan to take a look at is the difference between lapsed time and actual processing time. For us, lapsed time means the number of days that pass from when a case comes into the IN basket and finally goes out the OUT basket. If it turns out that we are spending too much time waiting for information rather than evaluating data and making decisions, we will know better where to attack the problem.

198X

Finally, there should be a way to assist disability programs to explore and develop innovative methods to speed the processing of claims.

Possibly, a grants program like those used to fund pilot programs in the unemployment insurance system could help in the development of a common data base of medical information from welfare agencies, vocational rehabilitation services, hospitals, mental institutions and clinics to be used in the processing of Social Security disability claims.

There does not seem to be one solution nor one program that will work in all states. I believe the entire program needs the ability to experiment at even local levels with funding for reasonable and sound activities provided by the SSA.

I offer these suggestions from a state that has made a very serious commitment to improve its services.

We applaud the efforts of Commissioner King who, along with her staff, has worked closely with us to make the improvements we have talked about. The rest is up to us. We must maximize our creative talents and explore every alternative to provide the disabled community with the prompt, efficient, dignified and respectful service it expects and deserves.

199X

Mr. HUGHES. Thank you very much, Commissioner. Did you want to add anything at all, Ms. Polaski or are you just going to respond to questions?

Ms. POLASKI. I think I just would like to add that I had the opportunity this past week to attend a meeting in Baltimore where all of my other colleagues across the country were in attendance and that the feeling from all of them was great concerns echoing your concerns about where we're going, yet realizing the difficulty with funds and basically most people spent a lot of time talking about what they could do about the situation that was within their control and I came away with some good ideas, some new things that may help us in our processing time and things that hopefully then will let the staff see the effect of what we are doing.

The staff very much needs to recognize that this is a difficult process, one that is not going to turn around over night, but yet we can't give up because I always feel that folder that's sitting there isn't a folder. It's a person who really doesn't care about our budget problems, our computer problems, our staffing problems. They want to know when will they receive the decision and we have to constantly try and focus on that part of the problem. That person deserves a response.

Mr. HUGHES. Thank you. Well, my colleague alluded to what we see day in and day out in our own offices and we do see it anecdotally. Like my colleague, I sign my mail every week. It's ready for me when I return on Fridays, and I see the letters coming in and the letters going out and some of the frustrations that disability claimants suffer.

I also see the number of reversals. I don't think a week goes by that I don't sign two or three letters indicating that an Administrative Law Judge has reversed a decision. In my own humble judgment, part of the problem is the lack of face-to-face meetings. I think that would help considerably.

Another part of the problem is unfortunately when you have a caseload of 200 to 250, you are going to experience a certain amount of burnout and morale problems. I mean it's because they are being hammered, the adjudicators are being hammered on all sides. They want to do right. They sense that there are a lot of cases that they can't reach. They are going to end up with people dying before they can even reach them, and so they have an awful lot of responsibility. They leave often at 4:30 or 5, realizing that there are more cases in the pile than they started with that morning because of the incoming cases, it shouldn't be surprising that we have such a morale problem.

I am encouraged by your suggestion that you want to regionalize. I do have somewhat of a problem with when you regionalize and you take it to New Brunswick, you are not regionalizing it and taking it to the people in areas like southern New Jersey.

My colleague and I have pretty much maintained our Congressional districts intact. We had to pick up—I had to pick up a few thousand people, whereas my colleagues in northern New Jersey had to pick up 100,000 or 110,000. That is because of demographic shifts in population.

This area is growing by leaps and bounds and it's—and I am going to get to asking you about the possibility of making some

200X

changes in the regional approach. It would be far better, would it not, to have an office in the southern part of the State where you could have that face-to-face contact, where you would have some degree of familiarity with the medical examiners, evaluators that are called in, and you'd have that personal understanding that often exists. I mean they are small communities, by and large, and people know a lot about what is happening in their communities and it seems to me it would facilitate the process.

What is your response to that?

Mr. BRAMUCCI. There is a lot of truth in what you said. In the real world we are dealing with our employees and with our leases and all of that, it was our judgment that it was more doable to do, in terms of geography, a minor move to this area. I mean it's not as dramatic as going to Atlantic City or Camden or someplace in more rural south Jersey, but it was more doable. We could get it done. We had a piece of real estate and we had people who would not contest the issue of reassignment. We could more easily deal with the issue of reassignment internally.

Now I grant you that all the arguments you make are valid and we certainly have four regions in mind in the State of New Jersey in our reorganization plan that we have in effect. One of them is south Jersey, because I do believe that the concentration of people in one area does make anonymity and a lack of personal touch—a feeling of being out of touch with large groups of people around the State of New Jersey who are moving to places and living in places that were not envisioned 20 years ago.

Congressman, I can only tell you that within the bounds of what is possible to do, we will be moving in that direction.

Mr. HUGHES. I am sympathetic to the concerns that you are locked into a lease and I know that when you have a morale problem that when you suggest that you are going to be regionalizing, that doesn't help the morale problem.

But in the final analysis, don't you agree we need to look at the long-term solutions and, frankly, that means biting the bullet and while it may mean some disruptions, we've got 90 new adjudicators coming on board. That is an ideal opportunity to really begin that process.

New Brunswick isn't that far. I went to school in New Brunswick from Newark. The problem is that we have altogether different problems in southern New Jersey and frankly a lot of the people who make that trip to Newark have a difficult time. They are disabled, seriously disabled. Many of them have terminal illnesses, so it is a hardship to begin with but more importantly it seems to me it is not very efficient, if we agree that we need to decentralize, just to move to New Brunswick Center, although I think your concept of decentralizing is probably the right approach. I think it was perhaps, while a noble experiment, a mistake to try to centralize.

Mr. BRAMUCCI. Well, I'd just reiterate, at this point we need a yardstick. We need an alternative to centralization that can be put into effect as quickly as possible with the troops we now have which does not do damage to our commitment to Newark. I am not talking about an emotional commitment but a legal commitment, because we simply don't have the room in Newark to expand with

those 90 people or so—maybe 90, maybe 80, maybe 100. We'll see how it works out.

So in this case, Mr. Chairman, this move is less responsive to your need for local recognition and local adjudication than it is for our attempts to establish some efficiency in the general picture, so that I don't discount what you are saying at all, but in terms of what we could do under the circumstances given the enormity of this problem, it is a reasonable attempt to deal with the case load issue and the lack of speed.

By the way, our rate of being correct is among the highest in the country. We are slow but we are correct. Our rate is up near 95 percent, which puts us in the top 10 percent. It is kind of ironic, but I would say that putting all the light of day and sunlight on the issue that that was a prudent move to New Brunswick without discounting at all the concerns that you have that regionally were not present.

Mr. HUGHES. How many continuing disability reviews, CDRs, are you doing?

Mr. BRAMUCCI. Well, I saw a couple of numbers and I'd ask Maryann to respond to that.

Ms. POLASKI. We have proceeded in fiscal year '91 about 2,300 and this year so far we have done around 2,100 and anticipate that we would be doing about 3,500 this year.

Mr. HUGHES. How many should you be doing?

Ms. POLASKI. Probably a lot more than that. I don't even think that we can project because some of those cases have not really been properly flagged by SSA. We know the number is high. There's definitely a concern and a need to do them and that is an area where resources becomes relevant.

Mr. HUGHES. I'm not being critical because you have got a terrible problem. I mean you have got a tremendous backlog—30,000 cases—but the difficulty is that we need to make it very clear to those that craft budgets in Washington, the administration and in the Congress, that we have a serious problem and that we are being penny wise and pound foolish.

We probably should be doing four times that, five times that.

Mr. BRAMUCCI. Given the nature of the program.

Mr. HUGHES. And we are losing not tens of millions of dollars but hundreds of millions of dollars because people are no longer disabled collecting benefits, so we have at the back end people taking monies away from the fund that are not entitled to.

At the front end we have people that are often dying that we can't reach because of a backlog at the front end, and that brings me to my next point.

How many additional adjudicators do you need in New Jersey to clear up your backlog and do the disability reviews that you need to do?

Mr. BRAMUCCI. I would like to take a crack at that one. If we keep getting different rulings on what our clientele is, like the Zebley decision and the Wilson decision, there is no rational person that could ever answer you because we keep broadening the scope of the law and what we are now doing is simply catching up with what we had, so that every day there seems to be a new concern.

This gets us, this 90 gets us in a reasonable mode to keep up under the present rules but it doesn't allow us to do the reviews that you so reasonably point out we should be doing, nor does it give us time, for instance to refer people that we see as being employable to our disability vocational retraining. That would be a very good linkage to get people into the workforce.

Mr. HUGHES. See, part of the problem is that Commissioner King, whom we both admire and who I think is trying to do a good job, goes in like a good soldier and tells the Appropriations Committee that she doesn't need any more money.

Mr. BRAMUCCI. Well, I don't know—

Mr. HUGHES. And our colleagues this past week had awful time trying to get a number out of her just because the Office of Management and Budget doesn't want her to give any numbers.

I am sure she would probably challenge me but I believe that she wants to try to do right and it's all because even though the administrative expenses are around 1 percent in the social security area, we don't spend a lot of money on administration.

We cloak the magnitude of the budget deficit once again by not spending monies that should be spent for administrative expenses, and it is being penny wise and pound foolish. That's why I am asking what you need really—forget Zebley—and what would you need just to clear up your backlog? Put aside Zebley and put aside the Wilson case.

Okay, Maryann?

Ms. POLASKI. I was going to say, with the staff that we have right now, the new staff, and their ability to assimilate into the process and the overtime that we are currently getting, we feel that we would have been able by the end of the year to clear up the backlog. We are projecting that we will be doing about 70,000-71,000 cases.

The problem right now is unfortunately that was based on receipts that we thought would be in—maybe between 1000 and 1200 each week. They have been a lot higher.

Mr. HUGHES. Like how much?

Ms. POLASKI. They have been averaging 1400-1500 a week so when you take that into account, we would need maybe another 10 or so adjudicators or overtime hours—

Mr. HUGHES. How about to get to—

Ms. POLASKI.—to deal with that.

Mr. HUGHES.—continuing disability reviews at the same time, the ones you should be doing? How many would you need to do that?

Ms. POLASKI. That I am really not sure of.

Mr. HUGHES. See, we need to get some numbers.

Ms. POLASKI. Okay.

Mr. HUGHES. We need to start getting some numbers so that we can as policymakers start developing a consensus for additional research.

Mr. BRAMUCCI. We've got to get back to you with the number of what would be a reasonable percentage of the CDRs in terms of case load because you asked that question—

Mr. HUGHES. That's right.

Mr. BRAMUCCI. I think that is a reasonable question and I think it would yield savings that would not be unreasonable in terms of the recipient of the benefit. We'll need to get back to you as to the specific number—I am reluctant at this point since we have a respectful and understanding relationship with the Feds presently—they have responded to us, I am reluctant to throw any dirty water out because Ms. King has been terrific and we are now finding less and less reason to give you our excuses because now we are being given some funds to move ahead in a reasonable way.

But you are raising a different question. You are saying let's not talk about just progress. Let's talk about how we get control of this thing and I want to be responsive to you and we'll get back to you.

Mr. HUGHES. All right, thanks. The gentleman from New Jersey.

Mr. SAXTON. I wonder if I could just ask Maryann if she would walk us through what it's like with a case which you receive initially and the initial processing of that case and then how it might be reconsidered, or submitted for reconsideration and the process from the beginning to the end of a normal case.

Ms. POLASKI. An individual first goes to their local Social Security office, and they are spread throughout the State, and they file their claim for disability, where the claims representative in that office attempts to gather as much information as they can about the individual, particularly what are they alleging is their disability and who have they seen in the recent past, what medical treatments have they received.

They then forward that application to our offices, where, of course, we have the computer input for tracking purposes, and then they are assigned to an adjudicator, and at this point, they are assigned randomly.

When we talk about that regionalization, that is point number one. They will by assigned by geography.

That individual then reviews the application and begins to request all the medical evidence that is available and then must wait for the response of that medical evidence in order to be able to make a decision.

We do have a follow-up system within our computer that generates followups, but that is an area that we need to attack, because often, the longness of the processing relates to receiving that information back from a physician.

If the information we first receive makes it very clear that it is an allowance and it is good documentation, you are in pretty good shape. You can move forward and close that case.

If the initial information does not appear like an allowance, it appears to be a denial, but there are two or three other potential sources, I have to go and contact those sources, because perhaps that information is what the claimant is alleging.

That is very often why denials take longer than allowances, and so, for your issue of reconsideration, if I am that individual who wants a reconsideration, I don't agree with your denial, I am already taking longer to get notification in the first place, because of the laborious job that is necessary for the adjudicator to do to gather all the medical evidence.

This is an area where we have begun to reach out to our human services department to see if the general assistance program that is

referring individuals to us, if that social worker can be of assistance to us in getting better information; those who are being released from mental institutions, if we can be working with their case worker there, who, again, would have access to that information, because we are dealing with many, many individuals who—they do not have one doctor or they are dealing with a clinic.

It is just not always easy to get the information that we need, and I know that is a very frustrating part for the adjudicator, because without the medical information, they are nowhere.

It does not matter how efficient they are, it does not matter how good they are; they cannot make a decision without it.

Mr. SAXTON. Are physicians responsive, generally?

Ms. POLASKI. Yes and no. It varies tremendously. We pay $10 for a medical report, and quite frankly, that is—I do not know how you would feel about it if you were a physician.

In some cases, they are copying a report, and it is probably fine. In other cases, we are asking them for different types information, but that, again, becomes a budget issue.

If we were going to give you a real figure of what we need, we really need to address what is reasonable in the medical area to have physicians cooperate, and there is a tremendous need, as I said, to see if we cannot reach out to other sources.

At this meeting I referred to, that I attended, some of the agencies are working very closely with their workers compensation agencies, where an individual may have already gone through that process and the medical documentation is available.

That seemed to me like a good thing to reach out, since that is in our own department, because anything that we can do to get that medical as quickly as possible is going to assist the claimant.

Mr. SAXTON. Let us say we have an original approval.

Ms. POLASKI. Okay. The approval is done, and then that is forwarded back to the district office, who, at that point, will do whatever verification is required in terms of their wage history as to the actual entitlement.

My understanding is that there are backlogs in that area as well right now, and that can take several weeks. I do not know the exact number, but it is certainly behind.

As we have begun to clean up and send more cases out each week, we are drowning the district office, Social Security offices, with our work.

If an individual could be selected for what they call the quality review, that will also delay them receiving the benefits, because they have been selected in the pool that will be checked to determine if, indeed, it was a correct decision.

Mr. SAXTON. In the case of a denial, it goes back to the local office, also?

Ms. POLASKI. Yes, again for the—there is also final review of the denial.

Again, basically, we are the conduit for reviewing the medical information. We are not the final decision-maker.

Mr. SAXTON. When a denial is made, then the applicant has the opportunity to resubmit.

Ms. POLASKI. Right.

One of the things we are seeing right now, it is like this waterfall, I think. Because, again, we have been getting more of our cases out a little more timely, now we are seeing our reconsiderations increase.

So, the adjudicators that we recently promoted at that reconsideration level are starting to get higher caseloads, because people are coming back in again, either because they do not understand what we told them about the denial or, indeed, there is more medical information there than we realized, or it was not presented to us properly. It is very difficult to say.

Mr. SAXTON. So, then a resubmission is made, and in the case of a denial of the resubmission, then there is an opportunity to appeal to an administrative law judge. Is that right?

Ms. POLASKI. Correct.

Mr. SAXTON. You are not part of that process, correct?

Ms. POLASKI. No.

Mr. SAXTON. My staff has conveyed to me from time to time that, as they put it, almost everybody gets rejected the first time. Is that an accurate statement?

Ms. POLASKI. No. Our allowance rate is about 58 percent.

Mr. SAXTON. Is that right?

Ms. POLASKI. Yes. It is a little higher than the national average, which is probably around 45 percent, 48 percent.

In fact, recently, as our production was getting a little bit better and our allowance rate was going up, I became a little concerned, thinking, oh my goodness, now we are probably just sending out things that are incorrect.

Fortunately, as Commissioner Bramucci already mentioned, our accuracy level is very high, and I think that our allowance rate probably also relates to some of the types of people we are seeing in our case file. We have many AIDS cases, many with psychiatrics.

The proportion of our cases that are psychiatrics is very high, and I think, again, high unemployment rates, the stress, family situations, etcetera, just what is happening in communities right now, is contributing to that.

Mr. SAXTON. The situation that you describe is certainly one that we understand what you have to deal with in terms of the quantity of cases that you have, as well as the difficulty that you must have in securing information that makes it possible for you to make a valid judgment one way or the other.

If you were able to say that there are three things that should be done as national policy to make things better and you more able to deal with these issues that we have been talking about, what would they be?

Mr. BRAMUCCI. Well, the first thing would be a recognition that the physician's role in this is critical and we have treated it in a cavalier way.

As an example, in New Jersey's worker compensation law, the doctor's allowance for an examination is $250. We are talking about $10. My own physician called me and said, hey Ray, are you guys kidding? Ten dollars to do a kind of detailed analysis of this poor guy's life? I get $50 for an office visit, and then I spend 5 minutes most of the time. So, that is one of the areas, I think, in stat-

ute, that we ought to address, a reasonable fee so that that is not the reason why somebody's file is sitting there, because a physician is putting that—and understandably so—at the bottom of his pile.

We have this dilemma: If we increase our physician charge, that is possible, but that means we cannot do overtime. It means we cannot do some of the things we need to do administratively to attack the caseload. So, we have a Hobson's choice. We do a reasonable remuneration of the doctor, and we fall back because we do not have the man-hours put in to do the job. So, that would be one thing, because in all other parts of social service schemes, the doctor's fees are specifically accounted for.

Ms. POLASKI. I would see that one as a significant one. The other is really just the whole area of funding needs to be changed. There has to be the ability for contingency funding that does not take forever to know if you are going to get it.

It is not too difficult right now to see that receipts are higher than anyone planned for in the budget process, and we really cannot be looking to fiscal year '94 to resolve that problem. There has to be an immediate way to deal with it, and I think we would be really strong advocates of taking the caps off, not being in the discretionary pool. It is not reasonable, when every citizen is being taxed so that Social Security can be effectively administered, that we cannot get those dollars out. So, I would see that as really one of the other significant keys.

I think the third one that I would like to see, particularly—I felt this way before, but I believe it even more after attending this meeting this week; it was the first opportunity that I have had to meet with all the other directors. There also has to be some special funding that you can apply for if you want to try a new way to approach something, and again, that is not something that should take you four budget cycles in order to be able to do it.

If I feel, right now, that I need more advanced personal computers, software packages, it should not be a major project to get that done if I can reasonably show that it is going to provide an improvement, and I think there need to be some of those on the national level.

On medical documentation, as we said, not only the cost of it, it is a very big issue. We need strides to go forward with some kind of computer bank, because we are not the only program that looks for medical documentation. I mean there is Medicaid, there are all sorts of welfare agencies. Lots of people need that medical documentation. Why can't we find, as a national effort, a more efficient way, so the cost of that isn't strangling us and preventing us from doing other things?

Mr. SAXTON. Thank you very much. I have no further questions.

Mr. HUGHES. Why aren't we doing that? I mean, for instance, in many instances, there is medical information available, particular if it is a very clear diagnosis.

Is it because we do not have clear-cut national policy formulated to be able to accept, for instance, a determination that somebody has a particular disease that has been diagnosed very clearly?

Ms. POLASKI. From listening to some of the discussions in Baltimore this last week, some of it also is that just the information is not even kept in some kind of uniform fashion, so that we need to

get to the point where, if I called a doctor and he had a report on someone's EKG, as an example, that I could really just say give me A, B, and D. We do not have to get into a lot of details if people were keeping it in one way, and also, you are right about the uniformity.

Is there a uniform criteria of what is disability? Not really. Vocational rehab has one. We have another one. Other people have something else. So, sometimes the type of information you need is not the same, but we do have to work harder that, if it is there, we ought to at least look at it and see if it is what we need before we go asking a physician again for something, and that is something that I am going to work on as much as possible.

Mr. HUGHES. Is the information being shared with an applicant for disability clear as to what is required of them? I have seen a lot of applications completed that were inadequate; they did not have sufficient information. They have been to a doctor, but the doctor was not very clear on what basically was expected of him, and that engenders additional delay, because then an evaluator has to send it back and wait for the doctor to get to it, and that may take 2 or 3 months. In the meantime, it goes back in the pile again. Are we clear on what we require of the applicant, what is needed on the first contact?

Mr. BRAMUCCI. I think that, Congressman, you would be apt to have a much clearer delineation of the claim when the doctor knows the patient, and so often, in the State of New Jersey, frequently, there is no such relationship, you will see a doctor; however, he may not be articulate and clear in expressing himself. So, where we really have the problem is where we have the third party, sort of a stranger, reviewing some piece of paper or whatever, and so, there is not this need to be exact or understanding about what the issue is.

Yes, there is a breakdown, generally, in this area, and I think that the loser gets to be the recipient.

Mr. HUGHES. Okay. Let me ask you another question. When my staff was up visiting your offices, he observed the absence of support personnel.

Often, you had one person trying to take care of the caseload for 10 evaluators, and I remember those difficulties when the pecking order was a little different, when I worked for an office, and I ended up basically having to compete with my senior and junior partners in the firm, how difficult it is to get your work out, particularly if, in fact, you are overwhelmed, as is the case.

What is being done to try to rectify that, because if you can do the work but it just sits there for 3 weeks or a month because the support personnel is inadequate and you cannot get it out, you really have not accomplished very much. What is being done to rectify that problem?

Ms. POLASKI. One of them is, when the 90 new adjudicators were brought on board, there was an expectation that the computer system would be completed a lot faster and that there would be functions that previously had to be performed by clerical staff that would be done by the computer, but that probably was not good planning, since, of course, the computer did not move as quickly as anticipated. So, we kind of had a little dilemma there.

Secondly, we have some of our staff who are doing some functions in the accounting area and what we call word processing that we will be shifting to provide support in the clerical area once the computer system is functioning properly. We are also looking to take the staff and make them into paraprofessional positions. In fact, we just this week began some initial training of some of the staff, because we think we also need to provide them with some skills.

Lastly, what we have just asked from our regional office is the ability to hire perhaps some temporary staff through the end of this year, some temporary clerical staff, so that we can begin a kind of weeding out the backlogs and deal with the fact that everything did not catch up in quite the way we had hoped.

So, the mix is not what we had hoped for, because we agree that that is really an important area that has to be addressed. Then, from there, we are going to have to evaluate whether all the expectations from the automation system are accurate. Maybe they were not. Then we would have to make some shifts in staffing.

Mr. HUGHES. My colleague asked you about the process. When a decision is made, is it reviewed by the regional office?

Ms. POLASKI. On a sample basis.

Mr. HUGHES. Just a sample basis. Does that engender very much delay?

Ms. POLASKI. Right now, they are doing it for us pretty promptly. In fact, we are dealing with a courier that brings them over, so that we are not dealing with the mail, because we have been, obviously, trying to eliminate anything within our control that is not going to add to processing time. So, they have been giving us very good turnaround time.

Mr. HUGHES. I have some additional questions, but I am going to leave the record open for 10 days and submit them in writing, and maybe you can respond to them, rather than take additional time.

Mr. SAXTON. I would just like to thank both Maryann and Ray for very, very good testimony, and it should be of interest that everybody here know that this testimony is made part of the permanent record, and when we are back in Washington, we will be able to share this information with our colleagues who are also on the Select Committee on Aging or on other committees which—obviously, there is a great deal of concern about this issue. So, we thank you very much for helping us understand much better the situation in which you find yourselves.

Ms. POLASKI. Thank you.

Mr. HUGHES. Thank you, Commissioner and Maryann. We appreciate your being with us today, and you have been very helpful. Thank you.

Ms. POLASKI. Thank you.

Mr. BRAMUCCI. Thank you for the opportunity.

Mr. HUGHES. I would like to welcome our second panel of witnesses here this morning.

The first panelist is Ms. Barbara Kressman, a Social Worker with the Early Intervention program in Cape May County, and our second panelist is Ms. Doreen Wirzman from Absecon, New Jersey, who will discuss the experience she has been through in her application for disability.

We welcome you, Ms. Kressman, once again, and Ms. Wirzman, welcome.

Why don't we begin with you, Ms. Kressman?

STATEMENT OF BARBARA KRESSMAN, SOCIAL WORKER, EARLY INTERVENTION PROGRAM, CAPE MAY SCHOOLS FOR SPECIAL SERVICES, CAPE MAY COURT HOUSE, NEW JERSEY

Ms. KRESSMAN. It is my pleasure to testify today on behalf of my clients and their families.

I am a Social Worker at the Early Intervention program at Cape May Schools for Special Services. My clients are babies, ages birth to 3 years, with development delays.

The problem I am here to discuss is the fact that it is taking 6 months to process SSI and disability claims. This delay, in my opinion, is unnecessary and is causing financing hardships on families who are already emotionally drained due to their medical problems. The delays are occurring during the medical review process in Newark. Currently, huge amounts of documentation are requested from many doctors and hospitals, which is holding up the determination process.

In cases where a client has a clear-cut diagnosis such as cerebral palsy or Down syndrome, I feel that a simplified form sent to a patient's doctor and maybe one specialist would surely be enough to make a decision. In cases where there is no clear-cut diagnosis, then I feel the client needs to be seen by a local medical reviewer, who could request the appropriate documentation. If reviews were handled locally, there could be a dialogue between the doctors and evaluators, which could speed up the information process. Some information could be obtained over the phone and by talking to parents, rather than waiting for records through the mail. Many reviews take so long that, by the time a determination is made, the patient's condition may be totally different. When Social Security makes an error, the mistake, many times, is not picked up for another 6 months, when it is time to review.

An added concern is that, when clients are eligible for SSI, they are also entitled to Medicaid. This insurance coverage is as important or more important than the financial payment. These clients are not only waiting for the SSI approval but then have to wait for Medicaid to issue them a card and a number once Social Security advises them of the client's approval. Many times, this is their only insurance coverage. Sometimes families are waiting for this insurance so that they can have certain medical procedures done or go to different specialists. This application process has them on hold.

Medicaid also pays for prescription drugs. So, while this application is pending, the family must lay out this money, also. Although SSI will pay retroactively back to the date of application, Medicaid begins when the application is approved. This presents yet another financial hardship on the family. I feel, with some simple changes, this application review process should take only a few weeks, not 6 months.

Thank you.

[The prepared statement of Ms. Kressman follows:]

TESTIMONY OF BARBARA KRESSMAN TO
SUB-COMMITTEE ON RETIREMENT INCOME AND
EMPLOYMENT OF THE US HOUSE OF REPRESENTATIVES
SELECT COMMITTEE ON AGING
(Friday May 22, 1992)

It is my pleasure to testify at this hearing regarding the status of processing SSI claims in the state of New Jersey.

I am employed as a Social Worker with the Early Intervention Program at Cape May Schools for Special Services located in Cape May Court House, New Jersey. My client population consists of babies, ages birth to 3 years, who exhibit developmental delays. These delays could be caused by a specific birth defect such as spina bifida, cerebral palsy, etc., or the delays could be caused by environmental factors such as drugs and alcohol, or physical and/or emotional abuse. Some of our clients have clear cut medical diagnoses while others may have problems caused by neurological involvement but with no specific diagnosis.

Children are referred to Early Intervention by parents, hospital staffs, and medical professionals. I handle all new referrals and meet with the families first to assess their needs. If I feel a child may be eligible for SSI I refer the parent to Social Security as well as set up developmental evaluations with the Early Intervention team. As you can well imagine, this is a very stressful time for the parents as they are looking for answers to their child's problem and assurances that they will be able to live a normal and productive life.

The Early Intervention team is comprised of developmental teachers and various therapists. Should a child show a significant delay in one or more areas of development, he or she is eligible to receive services until the child's third birthday. The program is state and federally funded with some added monies coming from the Special Services School District. When a child turns 3, the

local school district then takes responsibility for that child's programming needs.

During my initial home visit following the referral, I advise all parents who have a child with a disability/delay to contact the Wildwood Social Security office to see if they qualify for SSI. The Wildwood Social Security office handles nearly all my clients' SSI applications. They now have the computer capability to let the client know over the phone whether they financially qualify for any benefits. The medical determination is another story altogether.

Occasionally I have a client who applies for SSI and is scheduled to be seen at the Pleasantville Social Security office. The application process is usually more time consuming as the Pleasantville office is much larger and much more impersonal than Wildwood. When parents apply for SSI for their children, they are informed that the time between application and final approval takes between 4 and 6 months and that they will be paid retroactively if approved, back to the date of the initial application. I have found the process to be taking 6 months for most of my clients. Once they learn if they are financially within limits for application, the fiasco begins for medical approval. The problems are now more complicated since the Zebley case with the increased volume of applications due to the many children with developmental delays with unspecified diagnoses.

I will begin by taking you through this process as I have experienced it pointing out its problems and concluding with some possible suggestions to expedite the medical approval process.

After the family has made the initial contact by phone, they are usually given an appointment to go to the Social Security office to fill out applications. At that time, parents sign permission slips for release of information from all medical and educational providers who have seen the applicant. Once these releases are signed, then requests are sent to all listed medical doctors and specialists. The

list can be lengthy with many hospital records being requested. I feel the biggest delay begins during this procedure as many times a request can go unanswered for weeks or months, therefore holding up this applicant's review. The requests also may include a questionnaire to be filled out by the doctor, specialist, teacher, parents, etc. These too, are frequently returned on an untimely basis or not returned at all. To complicate matters, many times the delay in receipt of these requests is so long that the applicant's condition may have changed, therefore creating more new requests for information. All records are sent to the Division of Disability Determinations in Newark, New Jersey.

To expedite this process, I have had parents bring important medical reports and evaluations to their application interview at the Social Security office, only to have them misplaced during their re-routing to Newark. The request process then has to begin again.

In my caseload, I find that approximately half of the SSI applicants have a specific diagnosis. When this is the case such as a child with Down Syndrome, C.P., or Spina Bifida, then I do not understand why requests need to be sent to 5 or 6 providers. I do feel that maybe a report from the applicant's primary physician and possible school or early intervention records would be enough to provide the information needed to make a determination. The other half of my cases without a clear cut diagnosis are more difficult to assess. These are the children that require much more documentation. Even with medical reports and records I would imagine that a determination is many times a really difficult task. Many things can happen over a 6 month period to change that child's condition. For example, we evaluate many children for speech delays beginning at age 2-2 1/2. We find many children to have re-current ear infections which may cause mild hearing losses and therefore the child may be delayed in his speech. When a child has a delay in one area such as speech at age 2 1/2, it is

difficult to assess him in other areas such as cognition since his is unable to communicate. Many times when these children have their hearing difficulties corrected they begin normal speech development. In the course of this child's interventions, this documentation does take months to send to Newark and then many times the information is outdated therefore possible qualifying a child on the basis of old records. The behavioral problems with unknown cause such as "autistic-like" behavior or attention deficit disorder children are difficult to assess as their behavior changes in response to their environment. Many times the best informants of these children are their parents or care givers. These children are frequently seen by psychologists and/or medical doctors and their behavior may be inconsistent or difficult to catagorize. These reviews generally take a long time. Also when reports are received on these many times additional questionnaires are also sent out following receipt of medical records. These additional requests only add to processing delays.

As you can see, the reasons for these processing delay are numerous. I feel the following suggestions may be helpful to expedite the process:

I suggest a regionalized medical review system to alleviate processing delays in Newark. By utilizing a loca medical review I feel the bureaucracy and red tape involved in dealing with Newark would be eliminated. I feel that a local reviewer has many advantages such as personalized contact with doctors, medical personnel, and school officials. This personalization can eliminate much time and paperwork.

First, regarding the applicants with a clear cut , non-reversible diagnosis, I offer the following suggestion:

- Sending a simplified form to the applicant's primary care physician and/or one specialist in the appropriate discipline to document the applicant's diagnosis. I do not feel that complete records from numerous hospitals and specialists are needed when th

applicant has a clear cut diagnosis. All these reports tend to be redundant and therefore cause unnecessary delays.

-Next, regarding undiagnosed applicants and/or applicants with special emotional/social problems, I feel that by keeping these files in their local social security office applicants could then be seen by a local reviewer who could evaluate the child and parent and determine what type of documentation is appropriate. This reviewer could then request this information on a local basis with parents assisting in obtaining some reports rather than waiting for months of unanswered requests. Many times applicants have in their possession much of the needed information. By getting this basic information locally and then either making the determinations locally or forwarding this information to Newark, at least some of the unnecessary redundant paperwork is eliminated. Additionally, a local review system could utilize some phone contacts with professionals instead of more paperwork. If clients can do much of the information over the phone, there is no reason why phone consults could not be arranged between revievers and doctors to expediate determinations. When a mistake is made by Social Security on a determination, the appeal process only extends a lengthy process to a lengthier one. On the other hand, when Social Security approves a client in error, many times it is not detected or corrected for 6 months to 1 year.

The outreach attempts by Social Security are limited. I did recently attend a program which was held at our school district for the parents of the pre-school handicapped and Early Intervention children. Bob Mazotta from Social Security presented an informative program regarding SSI. This program was arranged by the psychologists at Special Services School District. I also attended a workshop last year in Hammonton for professionals explaining the new SSI guidelines following the Zebley case. That, too, was quite informative.

215X

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The outreach efforts should be extended to hospitals, medical providers, and schools so that referrals could be made on a timely basis. They should also provide communit based in-services for local county residents to make Socia Security information available to all.

Mr. HUGHES. Thank you, Ms. Kressman. Ms. Wirzman, welcome.

Ms. WIRZMAN. Thank you.

Mr. HUGHES. We have your statement, which, without objection, will be made part of the record. You may summarize or whatever you would like to do. We welcome you today.

STATEMENT OF DOREEN WIRZMAN, PUBLIC WITNESS, ABSECON, NEW JERSEY

Ms. WIRZMAN. Thank you. Well, I was just asked to come here and recount my experience with my application for the disability benefits.

In March of 1990, when I was approximately 3 months pregnant, I began having severe headaches on the left side of head, and I began to hear my pulse in my left ear, very loudly. Thinking that I had an ear problem, I went to an ear specialist and found that I did not have an ear problem, and after approximately 6 weeks of various tests, they found what they call an arterio venous malformation on the left side of my brain.

It is a disfigured blood vessel. It was approximately the size of a half-dollar and could rupture at any moment. I was sent to several specialists. Finally, I was sent to the New York University in Manhattan, where I was told that I would be unable to have it surgically removed because of the location. If that were the case, I would have been left paralyzed.

There were other procedures that they could perform to alleviate the problem. However, because I was pregnant, they could not do it at that time. I was told I had to go home, rest, stay off of my feet. I could undergo no physical or emotional stress, no work whatsoever.

I was told I would have to have my baby by a C-section approximately a month early so that there was no chance of me going into labor. After that, approximately 6 weeks after the baby was born—well, immediately after the baby was born, I was placed on anti-seizure medication. During my entire pregnancy, I also had seizures, but I could not take the medication, because I was pregnant.

In September of 1990, a few weeks after my child was born, I applied for Social Security disability. The entire year of 1991, I was in and out of the hospital up at New York for procedures, surgical procedures, to close this malformation, also at the University of Virginia.

My initial denial for Social Security was—I think it was in January of 1991 I received my first denial, although I had, at that time, I think about five physicians' reports stating my case, my illness. I was told there was not enough evidence, and it was denied. I asked to have it reviewed. I applied for the review, and again, the adjudicator, who I was in touch with on the phone, said there was not enough evidence. At that time, I had added—there were about three more physicians who I had seen at NYU, and their reports were also included for that review, but again, I was told there was not enough evidence. After some of the surgical procedures that I had done, my right arm is numb and partially paralyzed. I still remain on anti-seizure medication.

I was on phenobarbital for most of 1991, I could not walk from here to there without someone else's help. This was how debilitat-

ing the medication itself made me. I am now on dilantin, and I take such a high dosage that it usually makes me very, very groggy. I did not take it today. Aside from that, I live with horrific headaches and take very strong painkillers, prescription, for that. I undergo various tests. I still go to NYU for angiograms.

They have told me it will take another 2 years of these procedures and radiation treatment I have undergone down at the University of Virginia to close up and irradiate these lesion to shrink it so that the risk of a hemorrhage will be eliminated. Again, I was in touch with the adjudicator all through 1991, all through that spring, to find out how my case was going. Not good, he said. He just did not think that I would be eligible for the benefits. He said I did not have enough evidence. I said, well, what could I do? What can I do now? He said, well, you could see one of our physicians.

My primary physician in New York, who had filled out a form that Social Security sent him, he personally filled out the form and sent it back to them. My adjudicator told me we never received it, and yet, my doctor told me he most certainly did send it. Then the adjudicator told me maybe I should see one of Social Security's physicians. I agreed. I said fine. Whatever it takes, that is fine with me.

He told me he would set up an appointment but that it would take approximately 6 weeks before I would be able to see a physician. He said he would call me and let know when and where. Two weeks later, I received another denial in the mail. No appointment was made for me. I just received another denial.

At that time, an attorney, who was a personal friend, said to me, 9 times out of 10, it is denied, do not bother with it. Until you see an administrative law judge, you are not going to get the benefits. So, rather than call them and say that I had not seen their physician, I just went ahead and let it go and continued with the appeal until I did see the administrative law judge, and I received my first check last month from my initial application, which was September of '90. So, it was a year-and-a-half from the time I applied until I received my first check.

Mr. HUGHES. Ms. Wirzman, were you employed prior to your difficulties?

Ms. WIRZMAN. Yes, I was.

Mr. HUGHES. In what capacity?

Ms. WIRZMAN. I was a blackjack dealer here in Atlantic City.

Mr. HUGHES. In one of the casinos?

Ms. WIRZMAN. Yes.

Mr. HUGHES. I see. At any time, did you have a face-to-face meeting with the adjudicator?

Ms. WIRZMAN. No. The only face-to-face contact I had was here in Pleasantville, at the local office where I initially applied.

Mr. HUGHES. Did you determine—I presume you talked on the telephone from time to time with the adjudicator.

Ms. WIRZMAN. Several times.

Mr. HUGHES. Did you determine whether he had the medical evidence in the file that was submitted by your physicians?

Ms. WIRZMAN. Yes, several times. Most of the physicians I myself called to make sure. I called my physicians and said you will be notified and asked by Social Security for certain information, and

they were most happy to give it. In fact, the one primary physician, as I said, took the time himself, not one of his nurses or receptionists but himself, to fill out the form, and then I was told that it was never received, and when I asked is it possible it could have gotten lost in the mail, the adjudicator said yes, very often things get lost in the mail here.

Mr. HUGHES. Did you confirm that he had other medical reports?

Ms. WIRZMAN. Yes.

Mr. HUGHES. I think you related six or seven, maybe eight doctors, at one time or another, treated you.

Ms. WIRZMAN. Yes, that is right. By July of '91, there were at least eight or nine physicians who had sent reports, and he had it and told me there was still not enough evidence.

Mr. HUGHES. Was he specific insofar as what he needed from the physician?

Ms. WIRZMAN. No, just stating my condition, what my illness was, what the diagnosis was, and all of that was very clear. Many of them sent copies of my medical report. When I finally went to Toms River in January, this past January, for the administrative law judge hearing and they showed me my file, that was the first time I had seen the file that they had. It had to have been at least an inch-and-a-half thick of information that they had that finally found itself before the judge, and I thought to myself, if they have had all this information all this time, why was it still denied?

Mr. HUGHES. Did the evaluator ever say to you this is what I need from the physician; he has never addressed this question as to whether you are permanently disabled or totally disabled?

Ms. WIRZMAN. No. He just said we need this information regarding your condition and why you are disabled, why the doctor feels you should not be working.

Mr. HUGHES. Did any of your physicians ever talk directly to the evaluator?

Ms. WIRZMAN. I do not believe directly. Oh, wait, no. The one doctor in New York did speak directly with the adjudicator. He told me he did. He told me he spoke directly with him, and the adjudicator told me, yes, I spoke with Dr. Choi in New York, and I told him what we needed, and finally, they ended up just sending all of my records. There were records from both hospitals and from eight or nine physicians.

Mr. HUGHES. During that period of time, how many surgical procedures did you undergo?

Ms. WIRZMAN. Three.

Mr. HUGHES. I see. Okay. Ms. Kressman, how many Zebley cases do you see coming into Cape May County?

For those that may not know, Zebley cases deal with adjudications involving young people because of some court decisions requiring additional consideration being given.

Ms. KRESSMAN. The population that I deal with is birth to three. So, I usually recommend parents making application for their child as soon as there appears to be a problem. Early Intervention is one part of Cape May Schools for Special Services. The rest of the school district deals with children that are preschool handicapped up through and including the alternative school.

Many of the cases which would fall under Zebley would be the older children who may have been rejected a few years ago. So, I do not really see that much.

Mr. HUGHES. Let me ask you about something you may see, transportation for people in southern New Jersey to get to Newark. How much of a problem is that?

Ms. KRESSMAN. It is impossible. The county transportation system in Cape May County is wonderful, fare-free transportation, and it goes within Cape May County. My parents have problems getting to medical appointments in Camden, have problems getting to medical appointments in Philadelphia. Getting to Newark is virtually impossible.

Mr. HUGHES. I hear the complaint all the time myself. The gentleman from New Jersey, Mr. Saxton.

Mr. SAXTON. You both have had many experiences or long experiences in trying to accomplish your objectives, on the one hand personal objectives and on the other hand professional objectives in trying to help others, and we have heard this morning that there are a number of reasons that the situation which currently exists, which is unsatisfactory to all of us, reasons as to why it may exist. In some cases, apparently adjudicators have too many cases, or there are too few adjudicators, a different way of saying the same thing. In other cases, perhaps the correct information is not made available to adjudicators, which is another problem that we have pointed to, and there may be others.

I am just curious to ask each of you, from your experiences, personal and professional, how do you see these issues? Do you believe that these are the true issues that we need to deal with? Are they important? Are there perhaps other things that we have not identified here this morning?

Ms. KRESSMAN. Well, I am not totally convinced that the problem is the fact that there are not enough adjudicators. I think the problem is the documentation that is requested from physicians, from schools, from hospitals, doctors, whatever. The request form says please send all pertinent information regarding this individual to our office.

Now, when we enroll children into our program, we also send for medical records, and when you send a request for medical records to a hospital, you receive a packet which is tremendous, which includes all nurses' notes, any type of documentation, every aspirin that person has taken from the time that they entered the hospital until they left, plus all these added reports from specialists.

Number one, you usually can't read them, because they have been copied and recopied. The scribbling is hard to read, and no one ever reads it. So, you basically do not need that information. What you need is the diagnosis and certain pertinent questions answered. I have heard this morning that maybe doctors should be compensated at a greater amount than $10. I do not feel that is the problem. I feel, if you gave them a form that was simplified, you would not have to pay them anymore, because it would take them less time.

The information that is needed to make a determination is clear-cut information. I think the problem is there is too much information. The adjudicator has packets of information on individuals

which is unnecessary, and I also think that, if there was communication, one to one, with adjudicators speaking to doctors and physicians and if it was done in a localized region, it would speed it up.

I testified in Washington about having clients call on an 800 number to make their application. This is clients who are disabled, clients who have psychiatric problems, clients who do not have a phone, who are calling from a phone booth, and that seemed to be okay, to let clients make this call on the 800 number. Yet, there seems to be a breakdown where a medical evaluator cannot pick up a phone and say I need to know this, this, this, and this about this client. So, that is the problem that I see. I think it is just these enormous amounts of paperwork that are requested.

When I get a request for a child's developmental reports to go to Social Security, I know the amounts I am sending. I do not need to send that amount to make a determination. I do, because the form says please send them all, and if I do not send them all, I am going to get a second request saying that you did not send them all, but I think that, basically, that is the problem

Ms. WIRZMAN. I agree. Here I had eight or nine physicians all sending different reports, all saying the same thing, and was still told it was not enough, and somehow, I just felt that I was being put off, and I was being told we do not have the money, we are going to say no.

So, no matter how many physicians you have send a report saying that you are disabled, forget about it, and I felt very discouraged, and it was a year-and-a-half before I saw any money, and I just felt there was no need for it, no need for that many doctors, that many reports, and to still be told there was not enough evidence of my illness.

Mr. SAXTON. Thank you.

Ms. KRESSMAN. I would like to just add one thing. We have a lot of cases where there are not clear-cut diagnoses. We have children who have attention deficit disorder and children with autistic-like behavior and children who just basically are not functionally normally, and requests are sent to doctors where they are sending their immunization records. I mean it just adds to the paperwork.

Mr. SAXTON. What you are saying is that there may be an overload of information that is in the system.

Ms. KRESSMAN. I think that is what is backlogging it. I think, if you hit the key people and got the key reports, you would have less work. You would not need to hire more people. You would have your people working on a more efficient basis.

Mr. HUGHES. Well, I gather that you really never had a face-to-face meeting to begin with, and that is always helpful. Any face-to-face meeting you had was when the administrative law judge took testimony and could see for themselves.

Ms. WIRZMAN. Yes.

Mr. HUGHES. That is why I asked the commissioner much more about how much information is being given at the front end as to what is needed, so that we can get a clear-cut picture of what is needed.

Ms. WIRZMAN. I was fortunate enough that I had a family and friends who helped us when we were going through the difficult time emotionally and financially, but I am sure many people do

office and Newark. I mean that, in itself, if somebody would have been there locally to look it and review it there—it just gets lost in the paperwork. You can get the families to do a lot of the work for you. I mean a lot of the stuff can just be done differently and accomplished much quicker.

Mr. HUGHES. Thank you very much. We appreciate your testimony. You have been very helpful to us. I would like to welcome our third and final panel this morning.

Ms. Susan LaMorte is an adjudicator with the New Jersey Division of Disability Determination and is also the Northeast Regional Director for the National Association of Disability Examiners.

Our second panelist on our third panel is Ms. Carolyn Carmon, who is a claims adjudicator with the Division of Disability Determination in New Jersey. She is also a shop steward with the Communication Workers of America, Local 1037.

Our final panelist on this third panel is Mr. Joe Rippman. Mr. Rippman is a claims representative with the Social Security Administration and is also a member of the American Federation of Government Employees. We have been joined also by Evelyn Liebman and Renee Brown, and we welcome you this morning. We thank you for coming.

We have your statements, which, without objection, will all be made a part of the record, and we hope you can summarize for us, so we can get right into questions, if we can do that.

Mr. SAXTON. Mr. Chairman, unfortunately, I have an appointment in Cherry Hill at 1 o'clock. I am just saying this because, if I get up and leave, it is not because I am not interested, and I do not mean to be rude, but I just wanted to say that ahead of time, because come about 12 o'clock, I'm going to have to leave.

Mr. HUGHES. We are happy the gentleman could join us for this morning's session, and we are probably going to finish fairly close to that time anyway. Let me begin with you, Ms. LaMorte. Welcome.

STATEMENT OF SUSAN LaMORTE, NORTHEAST REGIONAL DIRECTOR, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS

Ms. LAMORTE. Chairman Hughes and Mr. Saxton, I am Susan LaMorte, Northeast Regional Director, the National Association of Disability Examiners, and I am employed with the New Jersey Division of Disability. I appear before you today representing Martha Marshall, the President of National Association of Disability Examiners. We appreciate the invitation extended to our Association to offer comments regarding the status—the processing of Social Security Disability claims in New Jersey.

As stated in the written testimony you have before you, the Social Security Disability Program is facing perhaps the greatest crisis in its history, with excessive cases pending, projections for continued excessive filings and long delays in processing time. Currently there are approximately 800,000 claims pending nationally, and projections are that this number will increase to more than 1.3 million claims pending by the end of fiscal year 1993.

The current situation in New Jersey DDS is not unlike that which is being experienced in many other States. Each State has

its own unique problems incidental to its own operation. The current manifestations of heavy workloads, delayed processing time, and job stress are very similar to most other DDS's. The States are unable to recruit, hire and train disability examiners as quickly as needed. We are seeing the byproducts of a national problem.

The National Association of Disability Examiners has consistently called attention to this growing crisis in our testimony before various committees and subcommittees of Congress. NADE believes the following four factors have contributed to the current situation. First, insufficient funding by Congress; second, phenomenal increases in disability workloads nationally as a result of multiple cases, such as national recession, joblessness, homelessness, court decisions, and administrative, mandated outreach initiatives.

It is interesting to note that New Jersey may be especially hard hit with case receipts of homeless claimants and those with AIDS. The 1991 edition of the Statistical abstract of the United States shows New Jersey to have the fifth highest incident of AIDS cases. A count of persons from shelters and streets shows that New Jersey is one of the top six States in terms of street people and shelter people.

The third contributing factor is the increase involvement of the courts. At the present time, every State is operating under at least one court order, Zebley. Some States, however, are adjudicating cases under four or more different court orders. Not only does this dramatically affect case processing, it virtually destroys the concept of a uniform national program.

The last contributing factor is SSA's lack of national policy to deal with crisis-level workloads. We have perceived SSA's strategy at times to be a divide and conquer reaction. SSA crisis management actions of moving cases from one State to another, or seek volunteers from one DDS to be detailed to another, and pushing the DDS's to implement overtime, are nothing more than short-term solutions at best.

Further, SSA's previous threat to send in a strike force to New Jersey and California DDS's further contributed to the erosion of staff morale, rather than providing a positive contribution to the ongoing efforts of management and staff.

Our association offers the following five proposals for the consideration, as steps that can improve the processing of disability claims nationally as well as in New Jersey. First, Congress must provide adequate funding if we are to be successful in carrying out our mission. NADE has testified in favor of removing the administrative costs from the discretionary budget cap. We appeal to Congress to provide adequate funding for the next fiscal year. The Association believes that at least $1.3 billion is necessary to begin to reduce anticipated workloads.

Second, procedures should be developed for controlled case flow to the DDS's.

Thirdly, in view of the phenomenal increased workloads, as previously stated, there should be a temporary moratorium on the recently-instituted outreach initiatives. All these initiatives have good intent. They further contribute to the inability of the States to process pending work or searching out additional clinics to add.

SSA should negotiate with advocates and the courts to reduce strenuous procedures.

Fifth, SSA should consider restructuring the quality review process. There needs to be a national consistency and interpretation of adjudicative standards.

The National Association of Disability Examiners is not in a position to comment specifically on the working conditions of adjudicators in the New Jersey Division of Disability Examinations. It is our understanding the caseloads in New Jersey, as in probably all other States, have experienced significant increases. Again, a higher than average number of homeless or sheltered applicants would have a negative impact on both productivity and processing time as these claims are traditionally more labor-intensive and difficult to adjudicate.

NADE had consistently testified that when individual examiners have caseloads of about 80 to 100 range, they begin to lose effectiveness and work productivity. When caseloads exceeds 200 they become unmanageable. Results are that the disability examiner experiences decreased morale, increased stress and burnout. The claimant does not receive the prompt decision they deserve.

Until actions are implemented to bring caseloads to a manageable level, these problems will continue to exist in New Jersey and elsewhere.

We appreciate the interest you both have demonstrated in the crisis facing the disability program. We urge your consideration of the actions we have proposed to deal with this crisis. Again, I would like to thank you for being able to appear on behalf of the National Association of Disability Examiners.

[The prepared statement of Ms. LaMorte follows:]

TESTIMONY

OF

THE NATIONAL ASSOCIATION OF DISABILITY EXAMINERS

BEFORE THE

SUB-COMMITTEE ON RETIREMENT INCOME AND EMPLOYMENT

OF THE

SELECT COMMITTEE ON AGING

US HOUSE OF REPRESENTATIVES

HONORABLE WILLIAM J. HUGHES, CHAIRMAN

ON

THE STATUS OF PROCESSING SOCIAL SECURITY DISABILITY CLAIMS IN NEW JERSEY

PRESENTED BY

Susan LaMorte, Regional Director

Friday, May 22, 1992

Ocean City, New Jersey

Martha Marshall, President

Carroll D. Moore, Legislative Chairman

225X

Chairman Hughes and Members of the Sub-Committee:

I am Susan LaMorte, Northeast Regional Director for the National Association of Disability Examiners. I am employed in the New Jersey Division of Disability Determinations. I appear before you today representing Martha Marshall, President of the National Association of Disability Examiners. We appreciate the invitation extended to our Association to offer comments regarding the status of the processing of Social Security disability claims in New Jersey.

PROBLEMS CONFRONTING THE DISABILITY PROGRAM

The Social Security Disability Program is facing perhaps the greatest crisis in its history. The volume of claims being filed and the pending backlogs in state DDSs is greater than at any time in the history of the program. Whereas in 1988 we had approximately 300,000 claims pending nationally, in 1992 there are in excess of 800,000 claims, and by the end of next fiscal year that number very likely will surpass 1,300,000 claims awaiting decision. The inordinate number of claims receipts, building backlogs and delayed processing time is not unique to the state of New Jersey. It is a national phenomena.

The National Association of Disability Examiners has consistently called attention to this growing crisis in our testimony before various committees and sub-committees of

the Congress. We are not alone in sounding the alarm. Other groups also have pointed to the impending disaster and have appealed for action to be taken.

Briefly stated, there are four factors that are contributing to this situation. They are:

1) Insufficient Funding. The funding restrictions of the past decade resulted in approximately 17,000 staff reductions in Social Security. Restricted appropriations to the Disability Program resulted in the states being unable to replace staff lost by attrition. As a result, the staff (work years) decreased, and the states have not been able to re-build their cadre of experienced, seasoned disability examiners who are capable of handling the heavy receipts now being realized.

2) Increased Workloads. The phenomenal increase in the disability workload nationally is a result of multiple causes. This includes the current recession, joblessness, homelessness, court decisions and specifically the Zebley Supreme Court Decision, and last, Commissioner King's "outreach" initiatives. All of these factors have caused the spiraling workloads in DDSs throughout the country. It is interesting to note that New Jersey may be especially hard hit with case

convey to any state in "trouble", individually, that they are not doing as well as other states. While some states may not be staging cases, no state is doing all that well at present. SSA's crisis management actions of moving cases from one state to another, or seeking volunteers from one DDS to be detailed to another, and pushing for the DDSs to implement overtime are nothing more than short-term solutions at best. They do not, and will not address the long-term needs of this program. Further, SSA's previous threat to send in a "strike force" to New Jersey and California DDSs further contributed to the erosion of staff morale rather than providing a positive contribution to the on-going efforts of the management and staff.

RECOMMENDATIONS FOR ADDRESSING THE PROBLEMS

At a Field Hearing held in Austin, Texas, July 12, 1991, Vernon W. Arrell, Commissioner, Texas Rehabilitation Commission testified: "It is obvious that the gap is growing between budget/staffing allocations and workload expectations. Furthermore, that gap is being magnified by increased program complexity which has significantly expanded the amount of time DDS staff must spend in processing each case...Traditionally top-performing disability examiners now struggle to manage their caseloads

while average examiners have lost control in a morass of paper and cases. Increased use of sick leave and incidents of interpersonal conflict in the workplace are seen as manifestations of unrelenting stress.

With the increase in the complexity of the adjudication process, the length of time for a new disability examiner to assimilate the skills to manage a caseload has also increased."

This situation was not then, and is not now, unique to Texas and is even more true today throughout the country. Our Association offers the following five proposals for the consideration of the sub-committee as steps that can improve the processing of disability claims nationally, as well as in New Jersey.

1. <u>The Congress must provide adequate funding</u>.

   Adequate long-term funding for this program is the first requirement if we are ever successful in carrying out our mission. NADE has testified in favor of removing the SSA administrative cost from the discretionary budget cap. We appeal to the Congress to provide adequate funding for the next fiscal year that must be <u>at least</u> $955,000,000, but should be closer to $1,307,000,000 if we are to begin to reduce the workloads.

2. Procedures should be developed for controlled case flow to the DDSs.

The claimant must be afforded the opportunity to protect their filing date, but the taking of new claims and forwarding to the states must be on some type of controlled case flow as the DDSs are able to handle them. While this is not a recommended long-term procedure, it would afford some temporary relief over the next 12 to 18 months thereby permitting the states to work out from under their current pending backlogs.

3. Place a temporary moratorium on the recently instituted "outreach" initiatives. While these initiatives have good intent, they are further contributing to the inability of states to process pending work by searching out more claims to add to the backlogs. We believe that these outreach initiatives may actually be "over reach". Unfortunately, both the "successes" and the "failures" of SSA's outreach have disadvantaged the applicant. The "successes" have resulted in unmanageably high backlogs and unacceptably long delays in development and adjudication. The "failures" have produced an inability to adequately assist applicants in filing and processing claims which, in turn, contributes to the backlog and processing time crises.

4. Social Security should negotiate with advocates, and the courts, to reduce superfluous procedures.

These procedures are not having the desired effect. In fact, they are contributing to the morass we are seeing in case processing. There are now so many procedures to follow that the disability examiner does not have the time nor the necessary exercise of professional judgement to efficiently manage the adjudicative process.

5. SSA should consider restructuring the quality review process.

There needs to be a national consistency in interpretation and adjudicative standards. This would go a long way in enhancing expeditious processing. The lack of a national quality review process has produced inconsistent application procedures in case adjudication. This has created the climate that prompts advocacy groups to challenge decisions in various states. As a result, the courts have ruled against SSA in various circuits, but still with inconsistent application of adjudicative standards both among SSA regions and court circuits.

The National Association of Disability Examiners is not in a position to comment specifically on the working conditions of adjudicators in the New Jersey Division of Disability Determinations. It is our understanding that caseloads in

New Jersey, as in practically all other states, have experienced a significant increase. There has been a 19% increase in receipts in New Jersey between October, 1991 and May, 1992. A higher than average number of homeless or shelter applicants will have a negative impact on both productivity and processing time as these claims are traditionally more labor intensive and difficult to adjudicate. Disability examiners work effectively when caseloads are in the 80-100 range, but begin to lose effectiveness as that number increases. Caseloads above 200 become unmanageable. It is impossible to give timely review to all the claims files and to initiate development at appropriate stages. The net results are that: 1) The disability examiner experiences <u>increased stress</u>, <u>decreased morale</u>, and "<u>burnout</u>" and the claimant does not receive the prompt decision they deserve. Until actions are implemented to bring caseloads to a manageable level, these problems will continue to exist.

We appreciate the interest this sub-committee has demonstrated in the crisis facing the Disability Program, and we urge your consideration of the actions we have proposed to deal with this crisis.

Mr. HUGHES. Thank you very much. Ms. Carmon, who's an Adjudicator with the New Jersey Disability Determinations, Communication Workers of America, we welcome you.

STATEMENT OF CAROLYN CARMON, CLAIMS ADJUDICATOR II SPECIALIST, DIVISION OF DISABILITY DETERMINATION, STATE OF NEW JERSEY; AND SHOP STEWARD, COMMUNICATION WORKERS OF AMERICA, LOCAL 1037, NEWARK, NJ

Ms. CARMON. I want to thank you for inviting us to present our views on the situation in New Jersey. We care very deeply about the disability program and the clients we serve. Rather than last in the nation, we would like to see New Jersey to be number one in its service to the citizens.

Our work environment is characterized by stress and crisis. For the greater part of last year, we have been working overtime in the morning and in the evenings and Saturdays, many of us volunteering to work during our lunch or break. Still, the caseloads are unconsciously high, and the sheer stress of working with hundreds of seriously disabled men, women and children is, in itself, overwhelming at times.

Most adjudicators have caseloads between 200 and 300. This situation exists despite the availability of overtime and the addition of 90 new adjudicators. These caseloads are absolutely unmanageable. They effectively put us in the situation whereby we are forced to work on the easiest case first, and relegate the most difficult cases to the bottom of the pile, in the face of pervasive pressure to reduce processing time and push the cases out the door. This is not doing our clients any favor.

We are also continually advocating for a caseload cap of no more than 150 cases which, even at that level, stretches to the limit the talents and skills or our staff.

We recommend that when caseloads begin to approach these levels, management immediate take the necessary steps to train and hire additional staff rather than wait until caseloads reach the crisis portions they are now.

Yes, we do have new adjudicators, 90, however, we do not only evaluate and process these cases on our own; much of the day-to-day work surrounding the adjudication of the claim is done by administrative or clerical workers. Not only that. It normally takes from the beginning of hire to at least 2 years to become proficient as a new adjudicator.

Just as caseload sizes have reached crisis portions or us, so has the situation of our clerical staff. Ten years ago, there were about three clerks of varying levels for every 8 to 10 adjudicators. Today thee is an average of 1 clerk for every 10 adjudicators. In practice this means that one clerk may be responsible for 2,000 to 3,000 cases. Despite the severe clerical shortage, the division did not hire one new clerical to support the 90 new adjudicators. The division has informed us that they have no plans to hire additional clerks, as they believe the new computer system will eliminate many clerical tasks.

For example, the new computer system is designed to speed up the processing and issuance of the development needed to adjudi-

cate a claim. Development used to be handled by a traditional word processing unit and it was not common for it to take probably 3 to 4 days to generate a letter to a doctor. However, with the computer system in place, we now can generate such a letter in 10 minutes, admittedly, a vast improvement, but because there are so few clerical workers, there is actually no human being available to physically remove the letters from the printer. I have received complaints that some letters have sat around in the basket for 30-plus days before they are mailed out. This is really understandable, when you realize that one clerical worker may be responsible for the development, however, they also have to open up letters and do other clerical duties to support us.

While we support the administration plan to upgrade clerical workers to claims adjudicator aides, we have two concerns. It is not the job of the aide to be a clerk. Basic clerical functions will still be required. To ask an aide to perform two jobs for the price of one is not fair.

The lack of clerical support is not a new issue. In 1987 an independent management consultant advised the Department that New Jersey was below the national standard for the percentage of clerical workers to adjudicators. There is a report attached to this. This issue has never been satisfactorily addressed.

The administration has informed that, after years of being stuck in low-paying, dead-end jobs, clerical workers will be upgraded to the claims adjudicator aides, a paraprofessional, who assists in the follow-up on medical and non-medical issues, telephoning claimants, et cetera. This title was abandoned 5 years ago, and it felt that the job was not necessary. This had the effect of depriving adjudicators of invaluable assistance and was deeply demoralizing for clerical workers who viewed the job as a real opportunity to be something other than a clerk.

Mr. HUGHES. Ms. Carmon?

Ms. CARMON. Yes?

Mr. HUGHES. We have made your statement a part of the record. It is a good statement, comprehensive. What we would like to hear from you is a little summary.

Ms. CARMON. Okay.

Mr. HUGHES. You hit the high points for us.

Ms. CARMON. Okay.

Mr. HUGHES. That is what we would like you to do. We have the benefit of your statement, which we have read.

Ms. CARMON. Okay. Also we did have a decentralization. There was an office that was located in Camden at one time. In 1987 the management decided to close that particular office. It was my understanding that the workers there did have a relationship with the doctors and the hospital in the areas and were able to establish some kind of rapport by getting the reports sooner and stuff like that.

Our union fought very hard to keep that office open. However, they decided to close it, and it did not have anything to do with the money situation.

Also, we used to have a long-standing workers' benefit of flextime. That also attributed to the morale of having to change your

lifestyle and created many problems for a lot of people there—some having to leave because of not having the flexible hours.

We continue to have serious problems with the way that our work is performed and evaluated. These evaluations affect our salary, our promotional opportunities, and we continue to be evaluated year after year about these impossible standards and, again, circumstances over which we have no control.

Despite years of hostility toward the workers, we agreed to work with the Department when they, in the face of growing media attention, decided to send in an audit review team. However, I participated in the meetings with those teams and I worked hard and in good faith to represent the interest of my coworkers. However, despite our willingness to cooperate, we have not even been extended the courtesy of a copy of this report, which is supposingly based, in part, on my recommendations.

Unfortunately, management has never been willing to open up direct lines of communication with the staff, some of them have not formally been introduced to the different management teams that are now in place in our office, and one of the recommendations from the Browde Report was to improve the staff relationship with management, and it still holds true today.

Workers should not have to hear about our changes through the grapevine or through newspaper articles concerning our agency. As a caseload must be implemented, this is the only way that adjudicators, aids, clerks and supervisors will believe that management truly recognizes that a person can only do so much with the resources at hand.

Moreover, we are forced to develop ongoing systems to address rising caseloads before they reach a crisis level. Management should reevaluate its decision to relocate the staff to New Brunswick. The reality is, we do not have face-to-face contact with clients; our work is done through written correspondence and the telephone.

In closing, I would like to say that we are deeply concerned about the services we provide to disabled citizens. We want to see a real change where they count, among the hundreds of workers who struggle every day to do a good job. Unfortunately, top level management, reorganization every 5 years and buzzwords like "regionalization and centralization" will not, in the long run, turn things around.

We stand ready to assist this administration in developing and implementing proposals for a real change. Thank you.

[The prepared statement of Ms. Carmon follows:]

AFL-CIO CWA Local 1037
COMMUNICATIONS WORKERS OF AMERICA

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TESTIMONY OF THE COMMUNICATIONS WORKERS OF AMERICA
LOCAL 1037

Concerning the Processing of the Social Security Disability Claims in New Jersey

Before the US House of Representatives
Select Committee on Aging

Subcommittee on Retirement Income
and Employment

May 22, 1992
Ocean City, New Jersey

236X

Summary of CWA Local 1037's
Testimony Concerning New Jersey's
Division of Disability Determinations

I. The current working conditions for Adjudicators is not conducive to improving services. Caseloads are unmanageably high - two to three hundred per Adjudicator. There is not enough support staff to facilitate the processing of claims in a timely manner. There is currently only one Clerk for every 10 Adjudicators, on average. The Division has not and will not hire additional Clerks to replace those who will be upgraded to Claims Adjudicator Aides. This policy is detrimental to our work and should be changed.

II. Caseloads should be capped at a manageable level for Adjudicators. This would let Adjudicators know that the Division recognizes that a Worker can only do so much with the time and resources at hand. It would also force the Division to address caseload sizes before they reach crisis levels.

III. Despite a new management team, morale continues to be extremely poor. There is no open lines of real communication; top level management operates with in a "closed door" policy. changes that have been implemented over the last six to seven months have only revolved around the creation of a new management team. Nothing has been done to alleviate the stresses of the adjudicative and support staff in a meaningful way. While the new computer system has been installed we don't even have the support staff necessary that the system requires to improve processing time.

IV. The Division should re-evaluate the use of its resources within the confines of a tight budget. we have yet to be convinced that simply moving one quarter of the office, along with all of the systemic problems of the Newark office, will improve services. Being physically closer to clients doesn't improve processing time - more Adjudicators and more support staff does.

Good Afternoon. My name is Carolyn Carmon. I am a Claims Adjudicator II Specialist with the Division of Disability Determinations in New Jersey. I have worked with the NJ Department of Labor for 30 years, the last 16 with the Division. I am also a Shop Steward with the Communications Workers of America, Local 1037. Local 1037 represent approximately 6,000 NJ State Workers; at DDD we represent Administrative/Clerical Workers, Professional and Supervisory Workers. With me today are Renee Brown a fellow Adjudicator currently on a leave of absence to work full-time with our Union and Evelyn Liebman, a Staff Representative with Local 1037.

At the Outset I would like to thank Congressman Hughes and the Sub-Committee for this opportunity to present our views on the situation in New Jersey. We care very deeply about the Disability Program and the clients we serve. Rather than last in the nation we would like to see New Jersey #1, in its service to our citizens.

You have or will hear from members of DDD's Administration that things are getting better. Production is up, regionalization and centralization is moving forward. I wish I could say the same.

For those of us who do the day-to-day work things are not better. In many ways things are worse and absent a genuine effort to fundamentally change the way work is produced at DDD we cannot see things changing for the better.

Our work environment is characterized by stress and crisis. For the greater part of the last year we have been working over-time in the morning in the evening and on saturdays many of us volunteered to work during our lunches and breaks. Still, the caseloads are unconscionably high and the sheer stress of working with hundreds of seriously disabled men, women, and children is in and of itself overwhelming at times.

Most Adjudicators have caseloads of between 200 and 300. This situation exits despite the availability of over-time and the addition of 90 new Adjudicators. I don't ever remember caseloads being this high, and quite frankly don't see any end in sight.

These caseloads are absolutely unmanageable. They effectively put us in a situation whereby we are forced to work on the "easiest" cases first and relegate the most difficult cases to the bottom of the pile in the face of the pervasive pressure to reduce processing time and push cases out the door. This is not doing our clients any favors.

We have continually advocated for a caseload cap of no more than 150, which, even at that level, stretches to the limit the talents and skills of our staff. We recommend that when caseloads begin to approach these levels management immediately take the necessary steps to train and hire additional staff rather than wait until caseloads reach the crisis proportions they are now. Otherwise we will again find ourselves during the next crisis bringing on large numbers of new staff who won't be adequately trained to assume full caseloads for up to two years from the date of initial hire.

While we certainly applaud the recent commitment of funds to hire 90 new Adjudicators. We do not evaluate and process cases on our own. Much of the day-to-day work surrounding the adjudication of a claim is done by an administrative or Clerical Worker. Yet just as caseload sizes have reached crisis proportions for us so has the situation with our Clerical staff.

10 years ago there were about 3 Clerks of varying levels for every 8 to 10 Adjudicators. Clerks open the mail associated with cases, track development and other correspondence and perform other day-to-day tasks. Today there is, on average, 1 Clerk for every 10 Adjudicators. In practice this means that 1 Clerk may be responsible for 200 to 3,000 cases.

Despite this severe Clerical shortage the Division did not hire one new Clerk to support the 90 new Adjudicators. The Division has informed us that they have no plans to hire additional Clerks as they believe the new computer system will eliminate many clerical tasks.

However, things haven't worked out that way. For example, the new computer system is designed to speed up the processing and issuance of the development needed to adjudicate a claim. Development used to be handled by a traditional word processing unit and it was not uncommon for it to take 3-4 days to generate a letter to a doctor of a claimant. The computerized system in place now can generate such a letter in 10 minutes, admittedly a vast improvement, but because there are so few Clerical Workers

there is actually no human being available to physically remove the letter from the printer. I have received complaints that letters have sat in printer baskets for 30 days because no one was available to retrieve it from the printer or mail it out. This is readily understandable when you realize that one Clerical Worker may be responsible for the development (which in and of itself may represent 5 to 10 letters at any one time per case) of 2-3,000 cases.

The work for Clerks is even more exasperating when you realize that the system utilizes 6 printers which are scattered throughout the Division, housed on two floors of a building in Newark the size of a city block. When the computer generates a piece of development we don't know which printer it is sent to. Somebody then has to walk the equivalent of as much as a city block to find the letter. Or as an alternative, one of the few Clerical Workers is taken away from an Adjudicator's unit to staff the printer. This is not an efficient use of resources.

While we support the Administration's plans to upgrade Clerical Workers to Claims Adjudicator Aides, we have two concerns.

1. It is not the job of an Aide to be a Clerk too. Basic Clerical functions will still be required. To ask an Aide to perform two jobs for the price of one is not fair, is not efficient and will only increase the level of stress for our staff. While there may be a need for fewer Clerical Workers, from our perspective there will not be no need at all.

The lack of clerical support is not a new issue for DDD. In 1987 an independent management consultant advised the Department that NJ was below the national standard for the percentage of Clerical Workers to Adjudicators (see Browde Report). He recommended that the ratio be established at one Clerical Worker for 4 Adjudicators. This issue was never satisfactorily addressed then and has certainly contributed to our current caseload crisis now. We recommend the administration utilize its current resources to finally address this problem now.

2. The Administration has informed us that after years of being stuck in low-paying dead-end jobs, Clerical Workers will be upgraded to Claims Adjudicator Aides - a para professional who assists in the initial development of a case, following up on medical and non-medical sources, telephoning claimants, etc. The Division, with obvious shortsightedness made the decision to abandon this title five years ago as it felt the job wasn't necessary. This had the effect of depriving Adjudicators of invaluable assistance and was deeply demoralizing for Clerical Workers who viewed the job as a real opportunity to be something more than a Clerk. Despite our continual protest over the years over this decision the Division refused to re-establish the title. When we were informed last year by current management that these jobs would be resurrected we were certainly supportive. The job is necessary and provides much needed career advancement for low paid Workers.

Today, months and months later not one Worker has been upgraded to an Aide and we have no basis to believe these upgrades will occur anytime soon. Yet a new "management" team has been put in place, new management titles created, new managers hired. If the Division has a real commitment to moving the day-to-day work through the process we recommend they spend more energy and resources on those who move the work than on creating a new bureaucratic structure. Until such time as that happens we question this Administration's commitment to making the systemic changes necessary to improve our operations and provide better services to our clients.

The staff's working relationship with management is poor. For this committee to understand why, a little background is necessary.

In 1987, Sanford Browde documented severe morale problems within the Division. He noted that there was a consensus on the causes: (1) distrust of management; (2) poor communication on many levels; (3) constant changes within the program (4) inequitable application of discipline. He also characterized the Division as "paranoid" and skeptical about nearly everything attempted by management.

Despite a series of recommendations offered by Browde, management did almost everything in its power to further fracture our relationship.

1. In 1987, management closed our sister office in Camden. This was not done for financial reasons. Management said "Centralization" will fix DDD's ills and make way for a more efficient operation. (It's hard to believe that a short 5 years later management now says decentralization is the answer.) As a result of this closing, 164 Workers lost their jobs, hundreds of other were either reassigned or demoted. The then Division Director held meetings with Newark Workers and told us we were to blame for the closing of the office.

Our union fought very hard to keep that office open, introduced legislation to appropriate additional money to keep the office open only to face a brick wall erected by the Division's own Administration and then a veto by then Governor Kean.

2. In 1987 Division management also eliminated a long-standing Worker benefit - Flex-Time. This forced a disruption of hundreds of Workers lives, prompted widespread protests from the staff and added to the already pervasive "us against them" atmosphere. We have continually fought for the re-implementation of this benefit. Finally, last year, the Division's then Management Transition Team stated that the Division would be willing to institute a small scale pilot project as a first step towards restoring flex-time. However when we followed up with Director Polaski we were informed that Management would not be in a position to address this area of concern until after her "management team" was in place. Again, we find a management insensitive to the needs of those of us who do the day-to-day processing of work at the expense of what might or might not be good for management.

3. We continue to have serious problems with the way our job performance is evaluated. As NJ Civil Service Workers we are evaluated annually pursuant to a Performance Assessment Review Process. These evaluations affect our salaries, our promotional opportunities and our seniority rights. We continue to be evaluated year after year against impossible standards and against circumstances over which we have no control. Despite grievances, labor management meetings and consultant recommendations (see Browde) management continues to ignore this problem.

Despite years of hostility towards Workers we agreed to work with the Department when they, in the face of growing media attention, decided to send in an Audit Review Team and created the Management Transition Team to replace then Director William McGann. I was part of the Audit Review Team - I thought. From August 7, 1991 to October 4, 1991 I participated in seventeen (17) meetings with this team whose mission it was to review operations and recommend changes. I worked hard and in good faith to represent the interests of my co-Workers, our clients and the Department of Labor. Despite our willingness to cooperate, despite my good faith effort, the Department has not even extended me the courtesy of a copy of this report, which is supposedly based in part on my recommendations. I have repeatedly tried to secure a copy of this report only to at best be told "I don't Know;" at worst my phone calls are not returned.

Unfortunately I shouldn't be surprised. Management never has, and if this situation is any example of what the future holds, never will be willing to open up direct lines of communication with staff. Thus, I wasn't surprised to learn that our current Director essentially has a "closed door" policy and has yet to make the so called "rounds" on the floor or formally introduced herself to the entire staff. While we would not presume to be in a position to manage the Department, this type of management style is not going to go far in improving the staff's relationship with management.

Many of Sanford Browde's 1987 recommendations for improving the staff's relationship with management hold true today. Perhaps if they had been implemented then our relationship would not have grown from bad to worse. We suggest the following.

1. A personal commitment on behalf of the Director, Regional Directors and Regional managers to a change in the relationship. An open door policy would go a long way in alleviating some of the deep rooted mistrust of management.

2. Honest, clear and timely communication on issues involving the agency. Workers shouldn't have to hear about agency changes through the "grapevine" or from the newspaper concerning such significant issues as when and if twenty-five percent of the staff is being relocated to New Brunswick. If large single group meetings are cumbersome, smaller unit-type meetings can be accommodated.

Morale among the Agency Staff is not just low, its terrible. Over the last week we have taken an informal survey of our members as to their opinions concerning the morale level. Many can't even believe we have to ask. Moreover, low morale is not characteristic of just one group of Workers - Clerks feel demoralized, Adjudicators feel demoralized and supervisors feel demoralized.

Morale does not improve by wishing it would or simply saying things take time to change. At DDD the only way morale will improve an thus production is through concrete, systemic changes to assist the adjudication process.

As we have not been privy to much of the documentation, reports, and statistics the Administration has shared with this Committee to support its proposals and progress we are unable to critically evaluate their analysis. (Would they be willing to share their information, we would provide that analysis.) However, there are several steps this Administration could take that would immediately improve working conditions, morale and production.

1. DDD should direct its limited resources to providing the adjudicative staff the necessary technical and support resources required to speed the process along. Clerical Workers should be hired immediately so that we can avoid correspondence sitting in printers for weeks simply because there's no one around to retrieve it.

2. The upgrade of Clerical Workers to Claims Adjudicator Aides or some other like title should be put on a much faster track. It was a serious mistake to get rid of the Aides in the first place. There is no good reason for the current delays in re-establishing these positions. After all, management was very successful in creating and filling new management positions in short order. 65 Aides will go a lot farther in reducing case processing time then a handful of brand new mangagers.

3. A case load cap must be implemented. That is the only way Adjudicators, Aides, Clerks and Supervisors will believe that management truly recognizes that a person can only do so much with the resources at hand. It will improve services to our clients who are desperately in need of more attention than we can now give them. Moreover, it will force the Division to develop ongoing systems to address rising caseloads before they reach crisis levels. After all, what are we going to do when over-time money is not available, and new class actions send thousand of additional claims to the Division.

4. Management should reevaluate its decision to relocate 25% of the staff to New Brunswick. Again, given limited financial resources (not to mention the current scandal in the State over the state's leasing program) we must question whether or not this is the wisest way to spend the resources of an already tight operation. Despite the claims of the Division that New Brunswick will improve services because we will be closer to clients, the reality is we do not have much face-to-face contact with clients. Our work is done through written correspondence and the phone.

Perhaps, rather than move to New Brunswick we should hire Workers who would simply be responsible for answering routine questions from claimants, thereby freeing up the time of the Adjudicator. Claimants may well be better served this way than by an office in New Brunswick which, even if they wanted to visit, is barely accessible by train or bus.

In closing, I would just like to reiterate that we are deeply concerned about the Services we provide to disabled citizens. We want to see real changes where they count, among the hundreds of Workers who struggle every day to do a good job. Unfortunately top level management reorganizations every five years and buzz words like regionalization and centralization will not, in the long run turn things around. We stand ready to assist this Administration in developing and implementing proposals for real change.

Thank you.

REPORT ON THE DIVISION OF DISABILITY DETERMINATIONS OF THE NEW JERSEY DEPARTMENT OF LABOR

(EXCERPTS)

250X

BROWDE & ASSOCIATES
MANAGEMENT CONSULTING
HUMAN RESOURCES - LABOR RELATIONS
409 Hillside Place, South Orange, NJ 07079
201-761-5515/761-0504

April 7, 1987

Honorable Charles Serraino
Commissioner
Department of Labor
CN 110
Trenton, NJ 08625

Dear Commissioner Serraino:

I am pleased to submit this final report on the Division of Disability Determinations. The results and findings of the Study, together with recommendations to accomplish greater efficiency and increased productivity, are contained in the body of the report.

I wish to record my appreciation to members of your staff for their cooperation in the study.

I consider it a privilege to have performed this assignment. I believe the implementation of these recommendations should result in benefit to the Division and to the Department of Labor.

Respectfully yours,

Sanford Browde

cc: George M. Krause
Lawrence L. Arcioni
Robert J. Yokavonus
Mary Jane Meehan
William McGann

The functions which should be performed by the Aides, as stated above, are clerical in nature.

(2) A new job title of clerical above the Senior Clerk or Senior Clerk Typist position should be established for those who funciton in the clerical support of the Adjudicator, but have additional competency in gathering and recording medical evidence and interviewing medical sources.

This will require an understanding of medical terminology, but will not require 60 semester hours of schooling or its equivalent.

D. The Job Functions of the Unit Clericals

There is a question of whether the Division is (1) properly utilizing its total clerical staff and (2) properly staffed in the Claims Areas with clericals. The question to be answered is: "Is there a proper proportion of Unit clericals in Claims areas to Adjudicators?"

Looking at national statistics, the percentage of Adjudicators and clericals to the total work force is as follows:

	National Percentages	N.J. Percentages
Adjudicators	31.4	39.5
FT Clericals	27.9	23.9

The Adjudicator Aides are not included in these clerical figures, as the Aides do not identify themselves as clericals, but consider themselves "para professionals" and, in fact, are not performing the necessary clerical duties.

252X

The clerical functions in the Claims Units are essent .l to the timely and efficient processing of Claims.

In Newark, however, the percentage of Unit clericals to Adjudicators is 22.4%.

RECOMMENDATION

(1) The ratio of Adjudicators to clericals should be established at no more than four to one.

This may be accomplished by reassigning clericals from other areas to work in units, and assist the Adjudicators.

(2) Clerical personnel should be transferred from staff support areas into Claims Operations to perform the duties of the Unit clericals.

Of the 78 clericals in Newark, only 39, or exactly 50%, are in the Claims Operations area, with 26 assigned to Units. The other 50% are all in support functions.

The division should review the exact number and proper allocation of personnel, but there appears to be an imbalance of clericals in non-production related work.

5. Organization of Staff and Administrative Functions

A. Overview - The present organization shows a disproportionate build-up of the staff and administrative areas. The emphasis in the Division should be placed in the Claims area, as the need for production increases.

In addition, there are a number of staff functions which are closely involved in the Claims process. These functions include (1) training; (2) the medical relations unit; and (3) the consulting examination unit.

A Performance Assessment Review Program (PAR) has been established for the Department's personnel. If properly implemented by Division personnel in Newark, the system is in place for proper evaluation of employees. But in order for the program to work, the Division must establish "Performance Standards" for each position. As noted in the previous section, performance standards for SCA's were not clearly defined.

In the case of Adjudicators, the following performance standards have been established:

Performance Standards

Productivity	15 closures per week for caseload of 100 or more. 15% of inventory for caseloads less than 100.
Aged Cases	45 day cases (18-24%) 70 day cases (5-8%)
Internal Quality Accuracy	91% decisional accuracy below 80% will result in Supervisory review of cases on a more intensive basis.
PER Accuracy	No more than 2 per quarter.
Federal QA Accuracy	No more than 1 per quarter.
Processing Time	Title II-59.9 days Title XVI 67.9 days
Consultative Exam Purchase Rate	45%
Adherence to Agency Personnel Procedures	Punctual and regular in

254X.

	attendance. Adheres to office regulations.
Maintenance of Work Station and Manuals	Keep desk clean of extaneous material. Files, POMs and AI regulations on a timely basis.

The performance standards raise some issues:

(1) With respect to "Productivity" - a standard of 15 closures per week when applied to a caseload of 101, is far different than applying it to a caseload of 180.

(2) The "Consultative Exam Purchase Ratio" for the Division is now much lower than 45%. The goal of the Division is now in the 30-35% range. Therefore, this standard should change as Divisional goals change.

RECOMMENDATION

(1) **The standards in the area of production should be established as a percentage of pending caseload in ranges, in the following manner:**

13%	-	Above	-	Excellent
11.0%	-	12.9%	-	Very Good
9.0%	-	10.9%	-	Good
7.5%	-	8.9%	-	Fair
Below		7.5%	-	Unsatisfactory

The percentages could be changed by the Director as he evaluates agency workload and policy changes which may adversely affect examiner performance during a given time period. For example, if there is a "hold" on certain type of cases, this

might be considered a workload/policy change that would adversely affect production from the date of the "hold" to the date of the release of these cases.

The percentages should not be set at a point which is unattainable by a majority of Adjudicators. Therefore, if the situation arises where the majority of Adjudicators fall in the less than good category, the need for an adjustment should be reviewed by management.

(2) The standards should be reviewed periodically to determine their accuracy and correctness.

As pointed out with respect to the Consultative Exam percentage standard, there should be a process in place for changing the standard as the goals of the Division change. The changed standard of performance should then be communicated to the Adjudicator and sufficient time given for them to adjust to the new standard and have a reasonable chance of its achievement.

(3) Punctuality, regular attendance and adherence to office regulations should not be part of the performance standards.

Any deficiencies in these areas should be handled by disciplinary action.

B. The Job Function of the "Adjudicator Aides"

In addition to the Adjudicators, the Units are staffed with "Adjudicator Aides". The job functions of the Aides varies between North and South. In the North, the Aides were responsible for the initial development of a case, writing to the

256X

treating source.

On the basis of this report, the Medical Director and his staff should attempt to close those cases by phone calls. Very often, one doctor will speak to another doctor, when the Adjudicator was not able to get through to the doctor and was not able to yet the needed information to close the case.

6. Morale within the Division

On the basis of the interviews with personnel, the vast majority feel that morale within the division is poor. The consensus is that this had developed over a number of years. The causes are numerous, but involve (1) distrust of management; (2) poor communications downward from management to Supervisors and from Supervisors to staff; (3) constant changes within the SSA Disability Program itself, which keeps the staff confused and frustrated and (4) inequitable application of discipline. Many of these areas have been discussed previously.

In addition, from my experience and background, there is a "negativism" among the staff which I have rarely observed previously. It is an attitude of mind marked by skepticism about nearly everything attempted by management. This attitude is shared by the Supervising Claims Adjudicators as well. Since they are the second level management in the Division, this frame of mind of the total staff is destructive and must be changed.

The most important factor in initiating change and in overcoming resistance to change is to build a relationship of trust among managers, supervisors and employees. In the paranoid world of the Division's work arena, the key to

257X

developing trust is to be sensitive to employee needs. The need to know is primary. The need to be involved is equally important.

RECOMMENDATION:

The new Director should start the process of change by recognizing that the key to effecting change is honest commitment, communications and feedback.

The formula which should be followed is:

(1) There must be a personal commitment and belief in the change needed.

(2) Total, honest and clear communication is the hallmark of successfully implementing change. Therefore, he should begin by holding group meetings in which the reasons and details of the change can be explained.

(3) Follow these group meetings with smaller ones in which he can explore with employees specific problems and concerns and attempt to lessen the apprehension that will always be present in one form or another.

(4) He should develop a feedback loop in order to fully appreciate whether his message has gotten across. If he develops a continual flow of reliable feedback, he can then decide whether or not his instructions to effect change have been understood and implemented. He can then, also, make any changes that may be indicated.

(5) The change should be implemented, in small doses, with positive verbal reinforcement to the staff for accomplishment at each stage.

(6) Positive acclaim when someone is doing someth.ng right is essential to change the negativism which exists. It will be helpful in promoting a more prideful atmosphere. This positive reinforcement and acclaim should be uniformly and consistently applied in all areas.

259X

Mr. HUGHES. Thank you, Ms. Carmon. Ms. Liebman is with the communication Workers of America. We welcome you today. Do you have a statement?

STATEMENT OF EVELYN LIEBMAN, COMMUNICATION WORKERS OF AMERICA

Ms. LIEBMAN. Congressman, I don't have a statement, and in the interest of time, I would just respond to questions.

Mr. HUGHES. All right, thank you very much. Rene Brown, who is an Adjudicator, also a member of the Communications Workers of America. We welcome you today, Rene.

Ms. BROWN. Thank you. I also don't have a statement, but I would like to highlight a few points.

STATEMENT OF RENEE BROWN, ADJUDICATOR, NEW JERSEY DDD, COMMUNICATION WORKERS OF AMERICA

Ms. BROWN. I've been a Claims Adjudicator since July of 1980. During that time, Congressman, I would like you both to know that there have been numerous committees, there have been a variety of different kinds of ideas, we have gone from face-to-face review with physicians to silent review numerous times, almost two or three times per year.

Face-to-face review is wonderful. It is very helpful, I feel, to our clients, but it's tremendously time consuming and would certainly would insist that there be both more adjudicators and more clericals. Also, I've heard the two clients and advocacy people speak in terms of their needing to have a direct person in the local offices. We have also done that, gentlemen.

We have had an outstation person in some of our more urban areas, and that was very helpful, but, again, that was also stopped. What is needed here is everything.

We certainly need support staff, we need to have more adjudicators, but there had to be the complementary support staff—clerical workers and claims adjudicator aides. There certainly had to be adequate physician help. We have a very difficult time recruiting doctors that want to work.

Another point, and maybe my final point until questions come; I think that a lot of people get the impression that both claims adjudicators and clericals have no interest in their work. The point that I would like to make to you here is that we are bound by the Federal Guidelines for Disability, and these are very, very frustrating for adjudicators.

I certainly have had clients die on my caseload. Sometimes I needed to take the next day off. If you have really worked hard to advocate for a client and to have them die before they got the benefits, it's a horrendous experience. The same thing is true in terms of a child case, and people think that we are doing—making these decisions arbitrarily and capriciously. Clearly, it's not the case.

There also needs to be some redoing of those Federal guidelines. That's my final point before we have questions.

Mr. HUGHES. Thank you very much. Mr. Rippman, we welcome you today.

STATEMENT OF JOSEPH A. RIPPMAN, JR., CLAIMS REPRESENTATIVE, SOCIAL SECURITY ADMINISTRATION, BRIDGETON NEW JERSEY DISTRICT OFFICE

Mr. RIPPMAN. Thank you. I welcome the opportunity to testify in front of this Committee. I guess this is the third go-around for our office. Twice before, Linda Thomas, a Claims Representative in our Office, has been called to testify and she has.

This time, I was asked to testify. I am also a Claims Representative in the Bridgeton Office. I take both SSI Disability Claims, process them. I also take Social Security Disability Claims and am responsible for processing them.

Some of the points I want to cover—I'll just highlight my written testimony to bring up some of the key issues. When I started working for the office—now, this is close to 6 years—part of the application that we take, the most painful part of the application, has been to tell the client in response to the question; how long is it going to take before I hear something, how long will it take before I can expect a decision on this claim—6 years ago, that figure was 60 days. It increased to 80 days, gradually to 90 days, to 120 days we were told to tell them, and now at this point, the figure local management has instructed us to tell the clients is 180 days; that's 6 months, a ballpark figure, if you might.

What I normally tell them, Congressman Hughes and Congressman Saxton, is that this is an average waiting time, comprised of some kind of average statistic on all claims filed. Your claim may take a month; it may take up to a year.

Granted, this is a disability insurance program, an earned right that these people have due to their paying FICA taxes.

People who come to our office are coming here as a last resort for them, whether it's because they've been thrown out of their job due to the economy going bad, but most likely, these people generally just have nowhere else to turn. They're disabled. What do you mean, 6 months?

I mean, I can remember 6 years ago, what do you mean 2 months? What do you mean, 3 months? Now it's 6 months? People just practically faint. Six months? And you have to tell them this.

You can't make excuses for them, but you're the Claims Representative and the face-to-face liaison to the public. They come to the Social Security Office to file and we are their contact, very often their sole contact with the Agency.

And it's been tough. What's been compounding the problem recently is that the amount of disability claims that have been filed—and I know, Congressman Hughes, this has been brought to your attention and brought to the attention of the Committee—we've seen a tremendous rise in the amount of disability applications over the last 2 to 2½ years, and especially over the last years.

We have to repeatedly tell people, 6 months. This is very upsetting to them. Very often, they're temporary disability benefits. Their unemployment has run out. They just have nothing left.

We send them to local welfare offices, we send them to the County welfare offices, and these people—what do you do? What do you tell them?

To compound the problems, the workload has been increased—I can't even give you a figure. The Zebley court case decision, a recent court case decision in the Supreme Court, offices throughout the State, throughout the country, have been assigned a certain number of cases that we are required to review.

Our office alone is responsible for a total of 256 additional cases as a result of the Zebley court case review. Out of this, these 256 cases, and additional cases that we have to process, it's required that our office take a complete new disability application and send it to New Jersey DDS for adjudication.

Out of these 256 cases that have been assigned to our office, we have only been able to get to a scant amount of these number of claims so far. We have at the current time, about 60 cases pending in New Jersey DDS. Ten cases that I know of, that we've been able to identify in the office over the last couple of weeks, have only been worked to completion, so we have a lot of work left still to do.

As Ms. Thomas may have brought to your attention in the past, the outlook for staffing in Social Security Offices is not good. Nationwide, we were given a figure—I'd like to bring this to your attention. You may already have this figure—October of 1990, 28,736 in duty in field offices full time permanent employees.

The projection for September of 1992, 28,562. Now, that's an overall drop in the number of employees, and yet we're going to be responsible for not only what's been happening with the disability cases now, the increased workloads which we have seen no dropoff in these cases. In addition, the Zebley cases which we have to review, and not only that, the regulations have now changed with the children's claims and we're seeing just an incredible influx of applications over the last, I'd say 12 months to 2 years, even in anticipation of these new rules coming out.

It's compounding the waiting times of clients, the frustrations that they feel and the Claims Representative, you know, like I had said, we have to deal with all of this and it's tough. These people—I mean, if—say you were the Insurance Commissioner of the State of New Jersey having to tell clients filing an insurance claim, this is 6 months. Six months to get my insurance claim filed?

You just have to treat them politely and with respect and say, that's the best that I can tell you. Offer them some assistance: go to your doctor, get medical reports, get what you have and we will forward these up to the State agency.

Very often, they'll come back and tell you, the doctor wants $50 or $60 or $70 for these reports and I don't have it in my pocket. So, they're stuck.

With that, I'll just leave the rest up to your questioning.

[The prepared statement of Mr. Rippman follows:]

WRITTEN TESTIMONY FOR A HEARING OF THE SUBCOMMITTEE ON RETIREMENT INCOME AND EMPLOYMENT OF THE U.S. HOUSE OF REPRESENTATIVES' SELECT COMMITTEE ON AGING

In opening, I would first like to thank the members of the subcommittee for affording me the opportunity to testify at this hearing. My name is Joseph Albert Rippman, Jr. and I have been employed for six years by the Social Security Administration's Bridgeton New Jersey District Office.

I have been called here, in fact, to update the subcommittee on several issue areas, and to address the subcommittee on other related issue areas. Specifically, I will address the following issue areas:

- .Current working conditions for a Social Security Claims Representative in New Jersey
- .Increases in the number of disability cases coming in
- .The Claims Representative's role in the disability process
- .The impact of the recent Zebley court case decision and the resulting workload
- .Other related issue areas such as Congressionally-mandated Continuing Disability Reviews; and field office staffing that continues to decline while overall workloads continue to increase dramatically

I will begin with a description of the Claims Representative role in the disability process. It is the job of a Claims Representative (CR) to conduct an in-depth interview of each applicant, either in person, or by telephone, and to complete the required Federal and State forms. This interview can last up to an hour or longer in some cases. The forms must then be reviewed carefully before they are sent to the New Jersey Division of Disability Determinations (DDS). Once DDS has the necessary forms, it is often the responsibility of the Claims Representative to act as a conduit of information between the applicant and DDS.

Once the decision has been made on a disability claim, it is often the responsibility of the Claims Representative to effectuate payment or to complete appeal forms in the case of a denial. The Claims Representative in a lot of cases can become the sole contact between Social Security and the applicant/beneficiary. In a majority of cases, decisions on payment amounts, representative payee decisions, and auxiliary benefits are made in the field office by the Claims Representative.

In the past 2-2 1/2 years, the agency has endured a doubling of disability cases. In the last year alone, there has been a 32 percent rise in the number of claims pending. Unprecedented writing times on disability claims has occurred throughout the nation and, in particular, New Jersey. As of this date, there are at least 13 disability claims taken in our office that are pending a decision by New Jersey DDS that are at least one year old.

In addition to the already burdensome workload, the Bridgeton District Office has been informed that it must review a total of 256 cases as a result of the Zebley vs. Sullivan Supreme Court decision. Our central office in Baltimore, Maryland has released 186 of these cases to our office to date. There are 70 additional cases heading our way in the near future. Of the 186 cases released to our office, about 60 of these cases are pending at New Jersey DDS. To date, our office has only worked about 10 of these cases to completion.

The New York Regional Office has indicated that there will be no additional staffing to handle this workload. The Regional Office also has indicated that they also miscalculated the amount of funds that were to provide overtime hours to help offset the increased workload. The end result has been that very few of these court-mandated claims reviews have been completed in our office. Travel money has been almost non-existent. Training is not being provided as it was in the past.

What this all adds up to is a very bad situation for the Claims Representative in New Jersey. More is being requested in the way of documentation on disability forms. More forms are necessary to complete most disability applications, especially SSI disabled children's applications. Moreover, since the Claims Representative is often the sole contact between the applicant and the agency, increased disability waiting times have resulted in more complaints and inquiries from the public and often other social service agencies.

To compound these problems, communication between the field office and New Jersey has been suffering of late. NJ DDS has instituted the use of "voice mail" for its disability examiners and supervisors. Telephone messages are often not answered. Applicants who attempt to contact disability examiners from Southern New Jersey often must call collect. In numerous instances, their attempts to contact DDS are in vain, as they often cannot speak to a "live person" who can take information and answer questions. These applicants often become frustrated and phone or visit our office with their complaints. The field office often receives the same "voice mail" service and no live person to contact and messages go unanswered.

264X

Better communication between the field offices and NJ DDS is sorely needed to say the least. Fax machines would help. I do not know of any Social Security offices that have fax machines. As a matter of fact, my invitation to testify had to be faxed to my wife, Michele, who works for an ad agency in Philadelphia. A copy of this written testimony was also faxed from her office to subcommittee. This is sad commentary, indeed. Field Offices have no fax machines, inadequate telephone systems, obsolete office equipment and finally inadequate staffing levels. "Lack of funding" we are being told time and time again. "We're over our staff ceiling." We are told repeatedly by regional and local management, "we'll have to make do with what we have" and "we better hope no one quits or retires" is another recurring statement I've heard over my six year tenure with this agency. I've seen a staff of about 40 persons reduced to a staff of less than 30 over the course of my tenure. I've gone six years without being given a hand-held calculator which is necessary to do my job. I bring one in from home. I often bring my own pens. Again, this is due to lack of funding. This is unfortunate, because over the last six years I have observed with great pride the dedication of our staff who have somehow managed to provide good quality service to a public whose demands on our resources have increased dramatically. And I take pride in knowing that I have been part of the staff.

Thank you again for this opportunity to testify before the subcommittee. I am sure the subcommittee has listened to similar testimony in the past. Not long ago, another employee of the Bridgeton District Office, Linda Thomas, also testified before the subcommittee on similar issue areas. I never read her testimony but I am sure she emphasized topics such as lack of funding, staffing shortages, erroding levels of service, and the like. I would like to close this testimony with two words -- PLEASE HELP.

Sincerely,

Joseph A. Rippman, Jr.

265X

REPORT ON THE DIVISION OF DISABILITY DETERMINATIONS OF THE NEW JERSEY DEPARTMENT OF LABOR

(EXCERPTS)

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BROWDE & ASSOCIATES
MANAGEMENT CONSULTING
HUMAN RESOURCES - LABOR RELATIONS
409 Hillside Place, South Orange, NJ 07079
201-761-5515/761-0504

April 7, 1987

Honorable Charles Serraino
Commissioner
Department of Labor
CN 110
Trenton, NJ 08625

Dear Commissioner Serraino:

I am pleased to submit this final report on the Division of Disability Determinations. The results and findings of the Study, together with recommendations to accomplish greater efficiency and increased productivity, are contained in the body of the report.

I wish to record my appreciation to members of your staff for their cooperation in the study.

I consider it a privilege to have performed this assignment. I believe the implementation of these recommendations should result in benefit to the Division and to the Department of Labor.

Respectfully yours,

Sanford Browde

cc: George M. Krause
Lawrence L. Arcioni
Robert J. Yokavonus
Mary Jane Meehan
William McGann

267X

The functions which should be performed by the Aides, as stated above, are clerical in nature.

(2) A new job title of clerical above the Senior Clerk or Senior Clerk Typist position should be established for those who funciton in the clerical support of the Adjudicator, but have additional competency in gathering and recording medical evidence and interviewing medical sources.

This will require an understanding of medical terminology, but will not require 60 semester hours of schooling or its equivalent.

D. The Job Functions of the Unit Clericals

There is a question of whether the Division is (1) properly utilizing its total clerical staff and (2) properly staffed in the Claims Areas with clericals. The question to be answered is: "Is there a proper proportion of Unit clericals in Claims areas to Adjudicators?"

Looking at national statistics, the percentage of Adjudicators and clericals to the total work force is as follows:

	National Percentages	N.J. Percentages
Adjudicators	31.4	39.5
FT Clericals	27.9	23.9

The Adjudicator Aides are not included in these clerical figures, as the Aides do not identify themselves as clericals, but consider themselves "para professionals" and, in fact, are not performing the necessary clerical duties.

The clerical functions in the Claims Units are essential to the timely and efficient processing of Claims.

In Newark, however, the percentage of Unit clericals to Adjudicators is 22.4%.

RECOMMENDATION

(1) The ratio of Adjudicators to clericals should be established at no more than four to one.

This may be accomplished by reassigning clericals from other areas to work in units, and assist the Adjudicators.

(2) Clerical personnel should be transferred from staff support areas into Claims Operations to perform the duties of the Unit clericals.

Of the 78 clericals in Newark, only 39, or exactly 50%, are in the Claims Operations area, with 26 assigned to Units. The other 50% are all in support functions.

The division should review the exact number and proper allocation of personnel, but there appears to be an imbalance of clericals in non-production related work.

5. Organization of Staff and Administrative Functions

A. Overview - The present organization shows a disproportionate build-up of the staff and administrative areas. The emphasis in the Division should be placed in the Claims area, as the need for production increases.

In addition, there are a number of staff functions which are closely involved in the Claims process. These functions include (1) training; (2) the medical relations unit; and (3) the consulting examination unit.

Mr. HUGHES. Thank you. Let me just say that one of the purposes of hearings like this is to try to hear firsthand from those that have to deal with the cases. That's helpful because it helps identify a whole host of problems. It helps us understand what is needed in policy changes. It also helps us make the case for additional resources before the Appropriations Committee. You may know I've appeared the last several years and have testified before the Appropriations Committee, attempting to get additional resources.

Every time Commissioner King comes in, I make an effort to basically get some more information from her as to what is needed nationwide so that we can build a case for getting resources. But resources is not my only concern. It's how we can make it more efficient.

Let me tell you, I have a very positive impression of the people that work in the Social Security Office. I deal with them directly, my staff deals with you every day on issues, and so my impression is favorable. I have the sense that we have a lot of dedicated people. We have some that are burned out, and that's easy to do, particularly when you have caseloads of 250-300 cases.

The procedures are convoluted and unfortunately, it's easy to put the tough cases at the bottom of the stack. The tough cases are often the more serious cases, too, the more difficult cases, but that's human nature. I understand that.

My first question for you, basically, is, what do you think we can do to simplify the process? I get the impression that we are asking for a lot more information than we need, and we build up those files with a lot of information that is not very helpful, that maybe we don't even look at. Am I wrong? Is my sense wrong? Are we getting too much information and is that making it more difficult? Anybody on the panel?

Ms. BROWN. I think one of the problems, Congressman, is that we often get information we haven't requested. I heard two of the prior individuals testify about medical records. Some medical records are particularly difficult to get. Often, what's required for final diagnosis is a discharge summary. The discharge summary is often not even released until 2 weeks to a month after the client has left the hospital.

So, while a physician that we're working with may require this, you, quite frankly, are not going to get it. Now, that does not stop the Medical Records Department for sending you what the have, and often what they have is certainly not what you need. There are a variety of different other tests that fall into the same category.

Mr. HUGHES. Let me just back up a little bit. Why don't you, for the record, walk me through just exactly what you're looking for in making a determination. What are you looking for in the statute? What are you looking for? When you receive an application, initial application, what is it that you look for in that file to be able to make a final determination that this person is entitled to disability insurance?

Ms. CARMON. Basically, if it's the medical records from the hospital or the doctor, it depends on the person's impairment, but what we need most of the time, which I ask the hospitals for, is lab stud-

ies. I also ask for the discharge summary. If I need EKG tracings, rest or stress, I ask for those things. Most of the time, we do not get them.

Ms. BROWN. I was going to say, additionally, on the case, Congressman, is the onset date, so you have to have medical information to meet that onset date, as well as being current.

Mr. HUGHES. Well, that's one of the questions that they must respond to, first of all, when they make the application; do they not? Do they indicate to you when the disabling condition occurred?

Ms. BROWN. When it occurred.

Ms. CARMON. A lot of times, the application isn't completed as far as the correct address that the doctor is—the person that he's going to, the doctor that he's going to, telephone number or any of those things. Especially, I notice with the children's cases, if they're a student, they don't have the teacher's name or either they'll just have—that will be missing or either they'll just have the school without having the town that needs to be there. So, you have to either call the parent back or either call to the school to try to find out who the teacher might be.

Mr. HUGHES. You actually call, or do you write?

Ms. CARMON. I call first, because where am I going to send it? I don't have the address, so I would need to call before I waste time sending it someplace and let it come back undeliverable.

Mr. HUGHES. You mean you don't even have the address to respond to?

Ms. CARMON. No. Sometimes we do not have the address, the correct address of the doctors.

Mr. HUGHES. How many of your applications are deficient in even giving you basic information?

Ms. CARMON. I would say quite a few.

Mr. HUGHES. Well, 10 percent, 20 percent, 5 percent?

Ms. LAMORTE. I would probably say closer to 40 percent.

Mr. HUGHES. Forty percent are deficient?

Ms. LAMORTE. Right, where they would require additional information where before you stated to initiate any development, you would probably have to call the treating sources or the claimant to find out if the—you know, the doctors that they had seen or get more information on their allegations and all. Especially with the Zebley cases that we're receiving, they require a lot of documentation. Because we're under the court, there are certain procedures that have to be met for it.

Mr. HUGHES. Well, the Zebley case is special. Let's separate out Zebley. How about on regular disability cases? You say 40 percent of the applications are deficient.

Ms. CARMON. Right.

Mr. HUGHES. Is that representative? Does anybody want to quarrel with that figure?

Ms. BROWN. No.

Mr. HUGHES. Mr. Rippman?

Mr. RIPPMAN. I can only speak for our own office, but there has been a problem in the past. I agree with her. Looking at applications that go out of our office, they are being reviewed now. We keep and maintain a list in our office which was prepared by local management. The list of names, address and telephone number of

every doctor in our service area, a list of every hospital in New Jersey, a list of the names, addresses, telephone numbers of the hospitals in New Jersey, Philadelphia, Pennsylvania and nearby areas of Delaware, Puerto Rico, the names of hospitals, so at least in our office, a concerted effort has been made. We've heard these complaints from State agencies about this, and apparently it is a problem.

Mr. HUGHES. Do you have that information available to you, Ms.—

Ms. LAMORTE. I don't have it available now, but I will get it for you. We do—Joe was on the committee with the district offices when we did do a spot check of the applications coming in. There were reports made on it where people from the SSA office came in and helped go through it.

Mr. HUGHES. Let's assume that they forgot on the application to indicate the name of the teacher. What is the general practice, Ms. Carmon? What do you do when you find that the application is fairly complete, except they haven't given you the name of the teacher? What is your response?

Ms. CARMON. I could try to call the parent to find out who the teacher is, if they have a telephone.

Mr. HUGHES. You call on the telephone?

Ms. CARMON. Yes, I would call the parent to try and find out who their child's teacher is. I find that a lot of parents don't even know who their child's teacher is.

I have to call sometimes to the school to find out who the teacher might be, so that I could properly address the letter to them, and if not, I find that that's becoming time consuming. I'm just sending it to the school with teacher for the student of so and so; that's what I've been doing, to no further delay of doing that particular case.

Mr. HUGHES. Ms. Brown, what do you do?

Ms. BROWN. Congressman, I have been on leave of absence to work for my union since January of 1988, so Zebley cases are not relevant to my current vocational experience, however, in the past when I've had a gap of any kind—it could have been a discharge date—then I certainly did call.

Just to follow up on something Ms. Carmon said, often people do not have telephones. Then you are forced to write and go through the regular followup dates which are about 12 days.

Mr. HUGHES. We run into the same problem in my own office operations. Many times you don't have a telephone or they haven't given it to you, it's unlisted or they don't have one.

Ms. Liebman, is that your experience? How do you handle a deficiency in the application?

Ms. LIEBMAN. Congressman, just to clear up the record, I'm not an adjudicator. I'm a representative from the local union that represents clerks, adjudicators and supervisors.

Mr. HUGHES. Okay, I see. Let me ask you this: In how many instances do you find that the physician's report is deficient in that it doesn't address the question of whether or not the individual is totally or permanently disabled, providing enough information? What do you do?

Ms. CARMON. I think it's around 50 percent. A lot of time, the octor just States that my patient is disabled without really giving ıformation.

Mr. HUGHES. What do you do? What do you do, though, when ou get a report from a physician that doesn't give you the kind of ocumentation such as a diagnosis, discharge, prognosis for the ıture, doesn't indicate the disabling conditions that exist with ıat particular patient? What is your response, Ms. Carmon; what o you do?

Ms. CARMON. I would have to call the doctor to clarify if I asked im certain questions that he did not respond to. I would have to all him for that additional information. Then, if he's not able to ive that information to me, and I wasn't able maybe to get it back om the hospital or whatever, then normally I would suggest that consultive examination be purchased so that we could have this ıformation to process the person's claim.

Mr. HUGHES. Anybody else want to comment?

Ms. LAMORTE. In agreement with what Carolyn said, as trainer f the division, we do instruct the adjudicators that if they don't eceive sufficient information from the doctor, to get the doctor on ıe phone. A lot of times, most of the adjudicators run into the roblem that the doctor won't come to the phone or they'll be able) leave their questions with the nurse and get them answered. I ould say most adjudicators do make the attempt to get the addi- onal information, and rather than it going through the mail, ıey'll get on the phone and get the information.

Mr. HUGHES. I just got the sense, Ms. Brown, when you testified, ıat you're a little concerned over the change in policies over the ears. First, we went from a decentralized system to a centralized ystem. Now, there's an effort to decentralize again. Was I—am I ı error in gleaning that you have some concerns whether a face-)-face meeting between the adjudicator and the applicant is of ıat much value? Did I misread that?

Ms. BROWN. No. I think that what you read, Congressman, is learly my frustration with the vacillation that has gone over the ears. There have been several things that have been done by man- gement which, quite frankly, have worked. The Camden office, m assured, did, indeed work. I think outstationing worked. We ad claims adjudicator aides in the past; they worked. We had di- ided our organization into North and South and that worked.

What has happened is that I think that people want to fix some- ıing that isn't broken and pull something out and make a new ave. All of these things are needed, all of those were solutions nd they were solutions that I think really lower the processing ime and kept the quality the way it was.

So, what I see is management's attempts to go back and forth. low, I am assured—and I've done it myself— that face-to-face eview with a physician, where you as a claims adjudicator can tell ıe work that have done and the communications you have had ith medical practitioners in the State; that works. It is very time onsuming. Things like Susan and Ms. Carmon have talked bout—calling the physician, calling the parent, calling the teach- r. It works, but it's very time consuming and so there's been an

effort to cut the time in areas where, quite frankly, the time should not be cut.

Mr. HUGHES. Well, let me just start with—so that everybody is clear—I think it was an absolute mistake to close the Camden office, period. As far as I'm concerned, that's beyond debate. That was supposed to be a cost saving move and it hasn't cost us anything. Frankly, I'm happy that management's taking a look at the picture and talking decentralization because I think it's an acknowledgement that it isn't working very well and that we need to take a look at the system.

I understand the concerns of those who live and work in Newark about decentralization and what that means. But in the final analysis, we're all professionals and we want to try and make the system work better. We don't save any money when we keep seeing these de novo reviews resulting in reversals. We're not saving any money when people are taking disability benefits that they're not entitled to because we can't reach them and review the cases and take them off the disability rolls so that the funds are there for the people that need them.

I believe in face-to-face meetings. I think you can learn a lot about a person by talking to them. Seeing for yourself now, I realize, that doesn't always say everything about the individual because some people basically walk in crippled, and 2 hours later, walk around pretty well.

So, you know, that's not always the case, but you can learn a lot about people face-to-face, and you get a lot more done when you can pick up the telephone and call a local doctor, you know. You learn a lot more about the individual that way.

Frankly, so decentralization, while it does create some pain—we always like the status quo—is going to work in your ultimate benefit because if I hear you correctly, one of your concerns—and I think it's correct—is that you're not doing the job you want to do. I know the kind of pain that's involved when you become familiar with a case and you're going to get to it, but unfortunately they die on you in the meantime, and so the never had the benefit of the monies they were entitled to.

So, what we need to do is try to change the system, and it's going to require some sacrifice, but if it, in the final analysis, professionalizes what you do and serves the public interest, then it seems to me that that is something we should support.

Ms. LIEBMAN. I do not want to leave you, Congressman, with the impression that workers are against regionalization. We have not been informed that a move to New Brunswick is so much for an increase in face-to-face contact but, rather, is a move premised on a need for more space and lower rents.

We would also question New Brunswick in terms of its accessibility both to the workforce and to the clients that it would ostensibly serve. New Brunswick, as you said, is not far from Newark. It is really only about 20 miles away, and the location, just in terms of mass transit and speaking as a person who takes the trains every day, is much less accessible than even Newark. I think only one train stops in New Brunswick near the area where the office would be, which is not even in downtown New Brunswick, is some miles away, on the outskirts of town.

When we were first informed that the administration was considering regionalization, our first reaction was, well, why not Camden again, if there is some realization that perhaps that was a mistake, and at the time, the administration took the position that they were not closing that office for a cost saving.

Mr. HUGHES. When was it closed?

Ms. LIEBMAN. In 1987—that they did that strictly for efficiency's sake, that there was no cost savings involved, and in fact, had said that, even if the money was appropriated to keep it open, they would not use it to keep it open. So, our initial reaction, now, in 1992, was why not Camden again? After all, Camden is a distressed city, could certainly use the jobs, and would be that much closer to real south Jersey claimants. We were told that, well, the department has some space in New Brunswick.

So, while we are not opposed to it, we would ask the administration to really look carefully at what it is trying to accomplish, and if what it is trying to accomplish is simply housing 90 people somewhere else, what we would rather see is those limited resources—and we are certainly willing to fight and realize we need to increase the resources to this program to make it the effective program it really must be.

If we have got limited resources now, let us apply those resources to those areas that will really improve the work, and we think that what will really improve the work is more adjudicators, more support staff, and more open communications with the staff, not simply a geographic move where you are moving the same problems in Newark to the area in New Brunswick.

Mr. HUGHES. Well, I think that the increase in adjudicators without increase in support staff is of dubious value. I mean it all goes hand in hand. You have to have support staff to get the work out. Let me ask about the morale problem that I hear about.

How can we improve that, aside from the fact that, with a workload of 250 or 300 cases, with that kind of a burden, any conscientious person is going to suffer some serious psychological concerns, and that has got to weigh very heavily on the workforce?

It is obvious we need to provide more resources, do a better job, perhaps, of streamlining the system, perhaps a little better job of trying to, at the very beginning of the process, indicate to those that are applying what is needed. Maybe we need to take a look at the information that we are getting to them.

The medical profession needs to understand what is needed. That might mean more education, perhaps, meetings with medical societies to try to get to them exactly what is needed to make out a disability claim. I think there is a lot of confusion there. We need to do a better job there. Those are the obvious things. What else can we do to improve morale?

Ms. LAMORTE. We are trying to find some streamlining procedures that would help the adjudicator get the job done, and I think that will be a big step, because we are at least getting the groups together that are doing the work and having some input in some change, in some policy, and I think that has been a positive step. We have different committees together and have had meetings with management, listening to whatever suggestions they have, and I think that has had a positive effect.

275X

However, I do think, with the caseloads, that that is the down side on it, because you do not have that much time to be able to sit in meetings and discuss things.

Mr. HUGHES. Anybody else?

Ms. BROWN. Yes. With all due respect to Ms. LaMorte, I do feel that there needs to be—and this is not a cliche. Most adjudicators have been on one committee or another over the years, and I think, additionally, most adjudicators, barring the new class, have at least 5 to 7 years of tenure. There needs to be open and honest communication with management.

This division has been through tremendous traumas over the last few years. They have seen, way back in 1987, a division director leave and replaced and several promises made, many things they were not involved in, they were not asked for their input, and no input was had by them.

Currently, they have seen another division director leave, another division director now come in with a full complement of her own administrative staff. Many adjudicators and friends of mine, quite frankly, have reported to me they have not even met the new division director and have not a clue as to what policies and procedures or plans for the division is going on.

Now, this is fundamental, that you want to have an open-door policy, you want to encourage workers to communicate with you and share their ideas, and I really am skeptical as to whether or not the current environment includes that.

Mr. HUGHES. Has a request been made for that type of communication? Has that been communicated?

Ms. BROWN. I am not sure, but people have reported to me that there was a reception, but other than that, they feel fairly isolated from the division director and her staff.

Mr. HUGHES. I see. Ms. Liebman?

Ms. LIEBMAN. Yes. I would hope that we would not have to request those things, that they would come naturally. I just wanted to say that—

Mr. HUGHES. You know, that reminds me of a story. Tip O'Neil used to relate it. I will never forget it.

He said that, every time he went in to vote, he would put his arm around his wife, Millie, and he'd said, Millie, I hope you are going to vote for me today. So, sometimes you do have to, and they should not have to ask, but sometimes you do have to communicate. Communication is a two-way street.

Ms. LIEBMAN. Well, as representatives of the unions, we have had several meetings with Director Polaski and have made many of these concerns known. I would just like to add, on top of what Renee has said and Susan, that, unfortunately, I think morale is so low in the office—and this is based on my 5 years of experience with dealing with DDD workers on a day-to-day basis—that we just have to have some action.

Committees just will not do it anymore. We need to see some support staff on the floor. We need to see if a caseload cap is not possible, given the situation in Washington. We at least need to see some recognition that workers are not going to get failing performance evaluations because they cannot manage a case load of 300.

There has to be some recognition that workers can only do so much in an 8, 10-, 12-hour day with the resources at hand, and I think that, if there was a commitment to that and if that was communicated to the staff very openly and honestly, I think that people would say, well, maybe they really do care about what we are doing out here on the floor and what the conditions are like.

Mr. HUGHES. Let me just change gears a little bit. Is there any effort to identify those cases that are coming in that are terminal and process them as a priority?

Mr. RIPPMAN. Yes. These cases are flagged. They are called TERI cases. Any terminally-ill case has to be flagged to the district office before it is sent to the State agency, and it should be readily identifiable.

Mr. HUGHES. Let me move to a case that is a very clear debilating case, where the diagnosis is pretty clear, it is a degenerative disease that leaves them totally and permanently disabled, unquestionable. How long does it take to process that kind of a case? Is that just thrown in with the rest of the pile, where it is a clear case? An application comes in, it is rather clear from the medical evidence, has been diagnosed having a serious disease, prognosis totally permanently disabled. What do you do with that case?

Ms. LAMORTE. If it does not come in with some information, usually the adjudicator will just pick up the phone and just get some information from the doctor, and then send it out for signature, and it is usually right away.

Mr. HUGHES. Well, I have some other questions, but I am going to direct them to you in writing and leave the record open. Let me just thank you very much for coming in today.

I know we have serious problems, and I have had a series of hearings on the disability issue, because it is an important issue, and I think that we need to continue to focus some sunshine on the problem, try to build the consensus we need to get the resources we need and make the changes we need to make this program work. It is inexcusable. People pay into this program, monies are set aside, trust fund monies. Our administration expenses are very low, around 1 percent to administer Social Security programs. It is not as if we are abusing trust funds.

We just need to keep at it until we get the resources, make the policy changes we need to make this program work, and with your help, we are going to do that. Thank you very much.

Let me thank Bill Walsh of my staff. He does a very good job. He visited your office, as you know, in Newark, not very long ago, and came away very much impressed by the commitment but also understood a lot more of the frustration that exists.

We are going to see if we cannot be of some help.

That concludes the hearing for the day, and the subcommittee stands adjourned.

[Whereupon, at 12:21 p.m., the hearing was adjourned.]

APPENDIX

(APP)

STATE OF NEW JERSEY
DEPARTMENT OF LABOR
DIVISION OF DISABILITY DETERMINATIONS
POST OFFICE BOX 048
NEWARK, NEW JERSEY 07101-0048

RAYMOND L. BRAMUCCI
Commissioner

MARYANN T. POLASKI
Director

June 24, 1992

Mr. Bill Johnston Walsh
U.S. House of Representatives
Subcommittee on Retirement Income
and Employment
714 House Annex
300 New Jersey Avenue, S. E.
Washington, D. C. 20515

Dear Mr. Walsh:

Thank you for the opportunity to respond to your questions regarding disability evaluation in the New Jersey Division of Disability Determinations.

Attached please find a copy of your request and our responses to same. If you have any further questions or comments, please do not hesitate to contact me.

Sincerely,

Maryan. Polaski
Director

AD-16.8 (1-96)

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1. **The Social Security Administration believes that the Zebley cases (nationwide) will be completed by the end of this year? Do you believe that this is the case in New Jersey?**

It is unlikely that New Jersey will complete its budgeted projection of 5,610 clearances in Federal Fiscal Year 1992. Through week ending June 19, 1992 we have realized only 4,202 of the projected 8,300 Zebley receipts. If we were to receive the remaining 49.4% of Zebley claims in the last three months of the year, it would compound an already excessive receipt pattern. In addition, national processing time for these claims is over ninety days, which would exclude most claims received after June 30, 1992 from possible closure action.

2. **In April, 1989 the General Accounting Office recommended that the Social Security Administration have selective face-to-face interviews with disability claimants at the reconsideration stage. Do you agree with this recommendation? Do you think that this option would reduce reversals by the Administrative Law Judge? Can this recommendation be implemented with the current staff level? What about a face-to-face on an initial level of the disability process?**

New Jersey agrees with the position of the National Association of Disability Examiners (NADE) and the National Council of Disability Determination Directors (NCDDD) with regard to the effectiveness of face-to-face interviews. We believe reversals would be reduced since as with the ALJs, we would have previously unavailable evidence or even evidence which may have been overlooked.

The existing caseload pending in New Jersey, coupled with an overrealization of new claims, would make this initiative difficult to implement with the current staff. While training needs would be minimal, since we have a cadre of staff who have done face-to-face interviewing, we would need to reduce their individual caseloads to permit time for the interviewing and reporting of their findings. There are no excess adjudicative staff members available to absorb this additional work. We would require additional adjudicative staff.

Face-to-face on the initial level could be most beneficial to the claimant. A potential denial could be reversed to an allowance due to evidence previously unavailable or overlooked. This eliminates a great deal of anxiety and delay in claims processing. It must be recognized that an elevated allowance rate at the initial level, while raising the cost of the SSA Disability Program, is offset by the savings in the more costly reconsideration and appellate stages.

3. Nationally 60% of initially denied disability cases are being approved by the Administrative Law Judges. Why do you think this is occurring? What can be done to change this at an earlier level?

The 60% reversal rate occurs as previously stated because at the hearing, evidence is presented which may not have been available at the initial and/or reconsideration level. Also, the ALJ's hearing gives the judges the opportunity to question the claimant closely on their symptoms and any treatment the claimant may not have previously reported.

Of course, this can be changed at the initial level through a face-to-face process but this requires additional staff and or the concomitant requirements of either branch offices and/or hearing sites.

4. What is your working relationship with the Social Security field offices in the State? What can be done to improve this relationship?

The New Jersey DDS enjoys close ties with the Social Security Field Offices (FOs) through ongoing dialogue both directly and indirectly through the New York Regional Office of SSA. At the present time three of the FOs are conducting a summertime project to complete initial development of disability claims prior to sending them to the DDS for medical determination. Known as FORME (Field Office Request for Medical Evidence), this pre-screening of disability applications and early development action has proved to be helpful in the adjudication process.

Automation plans at both the DDS and SSA include the eventual sharing of electronic files which will enable the offices to communicate and, conceivably, introduce folderless flow of information regarding disability

claimants. This will tie the agencies together in the common process of disability determination. As a first indication of this success, the sharing of data screens on the National NDDSS System has proved to be beneficial in reducing telephone contacts for claim status.

5. **Will New Jersey be able to deal with the backlog of cases with its current funding?**

Significant steps have been taken with the funding provided to date. Hiring of much needed adjudicative staff, enhancement of our integrated automation system and the purchase of specific equipment and supplies to improve work flow have been accomplished. Extensive use of overtime has enabled us to improve our performance while unprecedented staff development took place. Trainee development has been accelerated and we are beginning to realize increases in productivity, reduction of aged cases, and maintenance of a high degree of accuracy. However, backlog reduction has been slowed by an overrealization of receipts to date. If we are not funded to continue overtime through the end of the fiscal year we will likely see a decrease in productivity and an increase in the caseload pending until the trainees are fully functional. Additional staff will be required to maintain a lowered backlog and keep abreast of increased receipts.

6. **What are some of the restraints that you have and would like to see changed by the Social Security Administration (example: cost of medical information, clarification on confidentiality, etc.)?**

We will continue to encourage SSA to extend and expand temporary expedient measures which have been implemented on a limited basis in the New Jersey DDS. Decisions have been expedited without impact on accuracy.

New Jersey has not raised its payment of $10 for Medical Evidence of Record (MER) since 1985. The existing fee schedule for consultative examinations (CEs) is also outdated in comparison with private and public sector insurance agencies. Budgetary constraints continue to limit our ability to pay for needed medical

evidence. This places us in a secondary position when competing for the attention of the medical community at large.

The medical community should be directed to accept that the DDS has proper authorization to pursue any existing evidence on the claimant's behalf. It should not be necessary to delay processing while we secure and forward multiple copies of authorization letters to all medical sources for evidence which may or may not be essential to our decision.

A pre-screening of disability claims to eliminate nonessential sources and identify allegations more clearly would speed the development process. To a degree, the FORME project has met this need, but it could be expanded to other types of claims which were excluded from FORME.

7. **Where do you see the Division of Disability Determinations in three years?**

Within the next three years we expect our reorganization to be completed, establishing four geographic regions to serve New Jersey residents, at least one of which will be operated at a decentralized location. Adjudicator trainees added at the beginning of Federal fiscal year 1992 will be fully productive. Workstations will be automated to the degree necessary to comply with State and Federal regulations.

Given these successes we expect to reduce caseload pending to the point where it will again be feasible to conduct Continuing Disability Reviews (CDRs).

nade

May 28, 1992

Honorable William J. Hughes
U.S. House of Representatives
341 Cannon House Office Building
Washington, DC 20515-3002

Dear Congressman Hughes:

We appreciate the opportunity afforded the National Association of Disability Examiners to offer testimony at your hearing on the problems in the Disability Program in New Jersey.

As a follow-up on our statements, I would like to also make available to you the enclosed article entitled "ALJs and DDS: Different Premises, Different Decisions" written by Robert Burgess, a Hearings Officer in the Texas DDS and a member of the NADE Legislative Committee. This paper very succinctly sets forth the differences between the adjudicate procedures at the two levels, and why decisions denied at the state level are frequently reversed at the ALJ level. The NADE Board agrees with and has endorsed this paper.

Please feel free to contact me if we can supply any further information for your inquiries into the problems of the SSA Disability Program.

Very truly yours,

Carroll D. Moore
Legislative Chairman
PO Box 775
Nashville, TN 37202

CDM:pc

Enclosure

c: Martha Marshall, NADE President
Robert Burgess

National Association of Disability Examiners

283X

ALJs AND DDS: DIFFERENT PREMISES, DIFFERENT DECISIONS

The ALJ reversal rate has always been high (currently around 60%): that fact has growing significance due to the high rate of appeals: 72,202 in 1973; 121,504 in 1974; 363,533 in 1983; 289,421 in 1988.[1] If the high ALJ reversal rate reflects realistic decision making, the function of DDS, by implication, is to contain entitlement costs by making it as difficult as possible for claimants to appeal to ALJs. Therefore, Advocates argue for the elimination of the reconsideration step[2] to open access to ALJs and that DDS should adopt the procedures and make decisions similar to ALJs.

But if DDS decisions, generally, are more realistic, overly generous ALJ reversals may be costing taxpayers over 2 billion dollars annually.[3] ALJs, generally, are 30 - 50 degrees to the left of center while some DDSs, may be up to 15 degrees to the right, but one thing is sure: the reversal rate has created a gap wide enough, i.e., lucrative enough, to turn disability advocacy into a growth industry. Some explanations that purport to account for the size of the gap merit exploration.

PART I: EXPLANATIONS FOR THE SIZE OF THE GAP

1. ALJs go by the Act and the Regulations; DDS goes by the POMS, i.e., the Residual Functional Capacity Guidelines (RFCG).

a) After a DE had observed a hearing, she was asked what she thought. She said that the impairment was non-severe. The ALJ told her he intended to allow the claim. When asked how, in view of the testimony and the medical evidence of record (MER), the ALJ responded, "When you have been around as long as I have, you learn to read people. This person is going to apply and apply until she gets benefits, so we may as well allow the claim now." Another ALJ says, "What I look for is character. When I determine a person's character, I know whether s/he is lying to me or not." Others in a different region tell of an encounter with ALJs who advised, "You don't need to know anything about medical evidence. All you need to know is the law." The decisional approach in each instance deemphasizes the importance of the MER, and that conflicts with the Act.

b) The adjudicative climate was excessively stringent in the early '80s,[4] but a few years ago, before the current initiatives, SSA allowed DDS more latitude with regard to residual functional capacity assessment.[5] Because the program lacks *national* consistency, that latitude has been slower in coming to some Regions,[6] but DDS does have a little more room to make realistic decisions now. Some individual DDSs already have the necessary latitude, so it is not altogether accurate to say that DDS, in practise, is rigorously bound to the POMS.

Explanation 1, though popular, does not survive objective scrutiny because neither statement is entirely true. Not all DDSs adhere rigidly to the RFCGs and not all ALJs follow the Act's requirement to evaluate medical evidence substantively.

2. ALJs get to see claimants; DDS does not.

a) In 1981, Senator Bellmon prompted a study of ALJ decisions.[7] Part of the study included 1000 hearing decisions by 48 ALJs; the reversal rate was 63%. Later, transcripts were prepared for each case but edited to remove any evidence related to the hearing. The transcripts were distributed to ALJs who had the same grant rate as the ALJs who had heard the cases originally. This second group of ALJs, relying on the written record alone, reversed only 46%. FTF made a difference, but which way? Instead of making decisions more accurate, FTF may have contributed to overly liberal decisions. ALJ subjectivity seems to be reflected in the wide variation of individual reversal rates (10 - 90%).

Hearing Officers' (HO) reversal rates are fairly consistent, comparatively speaking. HOs have both FTF contact and as much latitude as ALJs in making decisions, but their reversal rate does not approach that of ALJs. This is doubly significant because HOs deal exclusively with Continuing Disability Review cases (except for special studies), so HOs' reversal rates are inflated by the medical improvement review standard (MIRS). My own reversal rate is 40%, but half of that is due to no MI; A "MIRS" reversal is based solely on a paper review. FTF has been *pivotal* in only 3 - 5% of my reversals. HOs are less influenced by the claimants' demeanor. This latter point was made obliquely in testimony before the Social Security Subcommittee of the Committee on Ways and Means.[8] FTF has convinced me that the RFCAs I made during the 60s and 70s were more realistic than many I have had to make from the 80s to the present (as a DE, not as an HO).

b) In a non-government study,[9] physicians drew up a list of 12 clinical variables that they deemed most significant in determining the severity of rheumatoid arthritis. The list included such things as morning stiffness, sed rate, functional capacity, etc. Using the list, nine rheumatologists rated the disease activity over a two-week period. Weeks later the same doctors were given copies of the forms of the patients that they had examined. Some forms were duplicated. All of the forms were interleaved with those containing information from the patients of the other physicians as well. The correlation of disease severity between the real patients and the "paper patients" was extremely high (r=+0.901). The correlation was higher for duplicates of paper patients (r=+0.971). The study concluded, "...'Paper patients', while simple in design and apparently unlike clinical circumstances, are in fact a valid representation of real patients and provide a useful tool for the further investigation of actual clinical judgment." *A realistic three-dimensional portrait of claimants was conveyed on paper over 90% of the time without a hands-on, clinical examination, i.e., FTF. If paper patients are fine for scientific medical studies, paper review is adequate for the vast majority of disability claims.*

c) In a study,[10] by non-government physicians, forty-eight "paper patients" with back pain were created to be assessed by State Agency Medical Consultants (SAMC) and Medical Examiners who performed consultative exams for DDSs (CEMD). Each "patient" was to be evaluated for: pain, mobility, physical

examination. X-ray findings, and occupational history. All physicians said that they needed a high degree of certainty before they were willing to call an applicant disabled; the severity of pain experienced by the patient did not affect the level of certainty of disability. The result was that CEMDs "...had a significantly greater mean certainty of disability than agency physicians, 0.37 vs. 0.07 (p <0.01)." SAMCs' estimates of the certainty of disability were almost uniformly quite low, and virtually unaffected by any of the vignettes. The different results were due to the CEMDs freedom to use their medical knowledge and clinical experience, whereas SAMCs assessed patients according to the "recipe." *FTF could not have been the factor in the uniformly higher disability ratings by the CEMDs.*

Explanation 2 may hint at the reason for the high ALJ reversal rate, but it fails to explain the much lower HO reversal rate – even though HOs have the same latitude as ALJs. Studies, purporting to demonstrate that FTF is the main reason for the wide gap between ALJs and DDS, *presume* rather than establish that conclusion.

3. FTF helps to establish credibility.

Establishing credibility is what decision making is all about. "X has never lied to me," or "I wouldn't trust Y at all," are assessments of credibility based on what an observer has seen and heard over *time*. The credibility of disability claimants cannot be tested over time, because the clamaint is a stranger. An ALJ or an HO would be recused from hearing the case of a long-time acquaintance. Does FTF help to establish the credibility of a stranger who *believes* that s/he is disabled?

In yet another non-government study[11] ten people were videotaped either lying or telling the truth about their feelings. The subjects (housewives, police, college students, judges, psychiatrists, Secret Service agents, etc.) watched the tapes and tried to identify the truth tellers vis-a-vis the liars. Only young Secret Service agents scored better than chance at detecting the liars. Judges, psychiatrists, police, and attorneys scored no higher than one would score by random guessing. Professionals scored no higher than non-professionals. Those who claimed great skill in detecting liars scored no higher than those who made no such claim. According to the researchers, "Lies fail for many reasons. *The lie may be exposed by facts* that contradict the lie or by a third party who betrays the liar's confidence. Sometimes, such outside information is not available or is ambiguous. Then the lie succeeds or fails solely, or primarily, on the basis of the liar's behavior, which the legal profession terms *demeanor*..." [Italics mine]. If someone is truly convinced that s/he is disabled, his/her testimony will appear to be credible. *FTF, apart from the ability to weigh MER substantively, is insufficient to establish credibility.*

Explanation 3 may furnish a basis for the high ALJ reversal rate, but it fails to explain why the "true" HO reversal rate has not risen that much beyond the regular DDS reconsideration reversal rate. When one fails to recognize that "Severe Vaginitis" or "Squomous (sic) Cell Metoplasia (sic) of the Prostate" or "Statutory

blindness, left eye," (the right eye being normal) are not medically disabling, the intent of the law is circumvented when claimants with these kind of impairments are allowed.

When the merit of FTF is treated as a hypothesis to be tested instead of an axiom, the non-government studies, which cannot be accused of bias, support NADE's contention that FTF would not raise the DDS allowance rate significantly. Much is made of the value of FTF in pain cases; however, more often than not, one can only see the projected effects of pain, which may or may not be credible. FTF does not permit a look inside a knee joint or a heart; FTF may be helpful in a few cases, more so for mental cases, but it would not change over 90% of DDS decisions. So; how is the size of the gap between ALJs and DDS to be explained? That brings us to PART II.

PART II: WHAT ACCOUNTS FOR THE SIZE OF THE GAP BETWEEN ALJS AND DDS?

The disability decision is a blend of both medical and legal requirements, and the experts in each of these fields are poles apart in their training for service. The passion of the legal mind is upholding due process of law to ensure one's rights. Knowledge of the law is the major weapon against the abuse of rights, and correct procedures guarantee rights.[12] If ones rights are perceived to have been violated, the legal mind may not stop to consider whether a claimant is truly disabled. Legal minds are not experts at assessing RFC.

The passion of the medical mind is healing people and getting them back to their optimum level of function. Knowlegable physicians are experts at assessing disability. One of the studies above noted that all physicians needed a high degree of certainty before they would call a patient disabled; more than anyone, physicians know that the patient's *attitude* toward a disease is often more debilitating than the disease itself. It is a disservice to the claimant to allow him/her when s/he is not disabled.

The point is that DDS works more closely with physicians than with lawyers. DDS works more closely with physicians than do ALJs. Experienced DEs are trained to weigh MER and assess RFC. Throughout their career, DEs are reviewed by physicians. DDS decisions are *MEDICAL/LEGAL* in character. ALJ decisions are *LEGAL/medical*. By means of sequential analysis, the vocational grid, etc., SSA has done extremely well in guiding DDS to correctly apply the law to the established facts of a case. *It is the DDS emphasis on substantive medical evaluation, vis-a-vis the ALJ deemphasis of substantive medical evaluation which explains the size of the gap between ALJs and DDS.*

To conclude PART II, the difference between ALJs and DDS is based on the different levels of MER evaluation. The difference between ALJs and DDS, therefore, is not just a procedural difference; we are operating on different *premises*. If the size of the gap is due to different premises, rather than procedures, DDS decisions

will not change substantially if we adopt all ALJ procedures. This brings us to PART III and a slight shift of gears.

PART III: The Role of the Advocates.

a) The Advocates in the early days of the Periodic Review (PR).

Advocates are to be commended for calling attention to the overly stringent decision making that started soon after January, 1981, but their attempt to redress the SSA/DDS stringency of the early 80s has taken the program on a legal/procedural course, i.e., the wrong direction. Here are some examples from the early days of the PR.

1) Mental Cases: Advocates thought that the policy for mental case adjudication was too stringent. Actually, the policy for mental case adjudication (SSR 83-15) provided excellent guidance for making realistic assessments. All Congress had to say was, "SSA, you have a good policy for adjudicating mental cases, just follow it." Instead Advocate action led Congress to call a moratorium on mental cases. SSA cranked out new listings (which only made academic changes, but were hailed as revolutionary), came up with lengthy mental evaluation forms, which only psychiatrists or psychologists could complete, restated in different words the same written policies that existed before the moratorium (for example, SSR 83-15 is still in effect) and hyped a new day in mental case evaluation; in substance it was the same Christmas tree, with different ornaments.

When the moratorium was lifted, it seemed that one could be allowed simply by alleging a mental impairment. Then came the Mid-course Correction, and mental case evaluation gradually "recidivized," but this may be a Regional observation. Advocates, placing faith in legal/procedural adjustments, could not know that the reform only made a temporary change in the medical evaluation of mental cases.

2) Physical Cases: Advocates got side-tracked on the issue of non-severe impairments, multiple non-severe impairments, and stopping at the non-severe step of sequential analysis, etc. For example, Advocates persuaded the Ninth Circuit to mandate DDSs under its jurisdiction to go through the whole sequential trail, even for non-severe impairments (Bowen v. Yuckert, which was overturned by the Supreme Court, 1987). If an impairment(s) is truly non-severe, going through the entire sequential trail will never result in an allowance, even if a claimant is 64 years old. B v. Y made more work for DDSs in the Ninth circuit but changed no decisions.

It is ironic that Advocates managed to have SSR 82-55 (for non-severe impairments) struck down early on, but SSR 82-51 (RFCGs for cardiovascular and musculoskeletal impairments), which caused many more unjustified denials, was allowed to stand until just a few years ago. It is also ironic, judging from

newspaper reports, that many Advocates suspected that claims were being denied based on "secret" instructions, but SSR 82-51 was right out there in the open. The disturbing part about the "secret" instructions senario is that DDS was made to look like a *willing* participant in the denials and removal of countless disabled people from the roll.

Advocates' lack of medical expertise side-tracked them to peripheral issues in the early days of the PR and severely compromised their sincere efforts to restore program integrity.

b) The current influence of the Advocates.

Advocates assume that the high ALJ reversal rate proves that DDS is too stringent and that ALJ decision making is more realistic. Lack of medical expertise leads Advocates to attribute what they believe to be more realistic decisions to the procedures that ALJs employ. Here are a few of the ALJ procedures DDS is using already plus a consideration of the current impetus for FTF.

1) FTF: Regarding FTF the pertinent questions here are: How could the DDS allowance rate be at its highest in the mid 70s – *without FTF?* Why is FTF being touted so highly at *this* time, even though the disability program managed to do well without it until the last decade?

During the early 80s when the disabled came limping, wheeling, hallucinating, etc., into law offices, Advocates' reaction was understandable from their limited perspective, "If you could just see these people!" Advocates took many of these claimants/beneficiaries to ALJs who reversed erroneous decisions. It would be natural for non-disability experts to conclude that FTF and all of the other procedures helped ALJs make more realistic decisions. So, the current impetus for FTF grows out the unfounded belief that it would make decisions better in the vast majority of cases because it seems to work that way for ALJs.

Caveat: In the early 80s DEs did not need additional procedures or FTF to know that they were denying/ceasing many claimants erroneously. We tried to warn Congress of the impending disaster, but we were the ones who had erroneously allowed a multitude in the 70s, so we had lost credibility with Congress. To see it from Congress' point of view, why should they have listened to DEs, especially when Federal QA showed DDS to have a 98% accuracy rate. How could Congress know that the 98% accuracy rate reflected conformity to fiscal goals, rather than realistic medical assessment? DDS was under the threat of being federalized (PL 96-265), if quality fell below a certain level, so the scene was set for disaster. DDS would have had to make the same decisions if they FTF'd all claimants.[13]

2) ADLs (activities of daily living): ALJs ask a lot about ADLs, so DDS must now obtain ADLs on almost everyone. ADLs are present in many of the files without resorting to a special form. More importantly, the MER often contains complaints such as, "he can't sit or stand for prolonged periods," or "she has extreme fatigue toward the end of the day," etc. With functional statements like these, knowing

whether the claimant can brush his/her teeth or go shopping becomes superfluous. (If one cannot evaluate MER substantively, more significance is attached to the ADLs.) A form which, by design, captures superficial data, is not useful enough to obtain *routinely*. The form, merely an amplified version of the ADL section of the SSA-3368, is now necessary to grant safe passage through quality appraisal, i.e., it receives little attention but must be in the file.

3) Treating physician opinions: ALJs give more weight to the opinions of treating physicians (TP). Now DDS must consciously weigh opinioned evidence. When ALJs weigh opinioned evidence, they ask questions like: "What is the specialty of the TP? How long has s/he treated the claimant? Is s/he boarded or not?" and very importantly, "What does the medical functional assessment form say?" etc.

Now DDS must take time to call the TP when a conflict of opinion arises, but if we had already decided not to accept the TP's position, the call is pointless except to serve appearances. The new POMS instructions makes no substantive change, except to add another documentation requirement. DDS starts with no assumption about an AP opinion, but DE/SAMCs weigh the MER, case by case, based on its internal consistency. The ALJ and DDS approach to weighing MER are very different.

A related issue is consultative exams by TPs. Advocates in another state were delighted when PL 98-460 mandated that DDS make, "every reasonable effort to obtain from the individual's treating physician all medical evidence including diagnostic tests necessary prior to evaluating medical evidence obtained from any other source on a consultative basis." But, it soon became apparent that TPs were not lining up to perform CEs, and the Advocates could not understand. Some TPs were(are) not beating down the doors to perform CEs because they do not wish to deal with their patients when they are denied. TPCEs were tried in the 60s as a public relations move; the effort failed for the same reasons that it is unproductive now, i.e., excessive delays, poor quality reports, etc.

The conventional wisdom, again held by non-disability experts, is, "No one knows the patient like the TP." A very interesting statistic here in Texas establishes that, for fiscal year, 90, the highest denial rates were for claimants whose cases were adjudicated based on *treating source records alone*. Allowances *rose* when CEs were purchased. Disability evaluation is too complex to reduce to simple formulae, which non-disability experts tend to do.

4) Getting MER from every source: ALJs get MER from every treating source (TS). DDS now has to get MER from every TS for at least one year, but if a claimant fractures an ankle, and a current report from his AP shows that the fracture has healed within 12 months of onset, nothing is gained and much is lost by going through the motions to send a follow-up and waiting for the hospital report that describes the injury at onset. When attorneys do not know how to get their clients allowed, the strategy is to flood the file in hope that something will trigger a favorable decision. This may be part of the motivation behind this procedure. A

290X

strong case can be made that this requirement had resulted in increased processing time, cost, *and* lower quality.

5) Attorneys: Attorneys are frequently involved in reversals at the ALJ level, so Advocates conclude that they would aid the claimant at the DDS level. In reality attorneys make no positive difference at the DDS level. If DDS allows the case, it is incidental to attorney involvement.

In Texas a definite increase in attorney participation has been noted at the reconsideration level due to the added attorney statement on the PDN. The attorney's fee is money that should have gone to the claimant, *so it would be better to restrict the "attorney statement" on the PDN to the recon notice.* We could go on, but this is enough to show how the Advocates have mediated these ALJ procedures and more into DDS through the Courts and Congress.

To conclude PART III, we said above that the difference between ALJs and DDS was one of premises not procedures and that the taking on of ALJ procedures would not change DDS decisions. This is the case. DDS is going into pulpwood failure secondary to procedural overload without producing changes in decisions. In July, 1988, our mean processing time in Texas was 50 days. In July, 1991, Texas hired 89 new DEs. In spite of this our mean processing time today is 90 days. It is interesting to watch DDS move heaven and earth to incorporate a new procedure, only to see it fade in significance a month later. DDS must ignore procedures to survive. If DDS went by the book to perform every procedural requirement, mean processing time would be out of sight. POMS is rapidly becoming a cemetary for procedural corpses, but, still, the residue of many procedures take their toll on efficiency. *DDS certainly needs additional funding, but Congress will only be putting more and more money into a failing system, unless the program is overhauled.* This brings us to Part IV.

PART IV: SUGGESTIONS TO OVERHAUL THE PROGRAM:

1) A rigorous reexamination of every development procedure mandated by the POMS is needed – even those rooted in the PLs and Court rulings. Advocates should be invited to sit down with us, to understand why most of the procedures are not working, so that SSA/DDS can have access to the solid contributions Advocates can make. Eliminate every procedure that does not contribute to realistic decision making. This will both expedite decisions and increase realistic decision making.

2) Restore the professional status of DEs by:

a) *Eliminating the Residual Functional Capacity Assessment Forms (RFCF).* Reagan Administration operatives did what they could to reduce the status of DEs to justify salary cuts, by making SAMCs solely responsible for the RFCA, but nothing has eroded DEs' professional status or destroyed the infrastructure of good decision making like the RFCF. It has greatly reduced the time DEs and SAMCs can

spend in consultation. DEs have less opportunity (or incentive) to learn about medical evaluation; SAMCs have less opportunity to learn about policy.

Caveat: Advocates insist that physicians complete the RFCF. Adherence to this procedure causes a tremendous production backup in the DDS, but something else is noteable here. An ALJ, like the DE, is a medical layman. Would consistency not require physician completion of the RFCF at the *ALJ* level as well? Most disability appeals to ALJs are primarily medical issues. If these appeals were heard by *Administrative Hearing Physicians* (AHP) instead of ALJs, the gap between AHPs and DDS would narrow quickly. If AHPs had been hearing cases during the early 80s, the RFCGs would have been exposed for their oversimplification and quickly dropped without resorting to Court action. This is not a suggestion to replace ALJs with AHPs. The issue raised here is one of consistency.

b) *Returning to the rationale.* It goes without saying that DDS cannot write rationales unless superfluous procedures are jettisoned first. Rationales could be helpful for the following and other reasons: 1) Writing a rationale makes the DE go through the sequential trail which provides some internal impetus to quality. 2) It is much easier for a reviewer to return a decision that rests on a few checked blocks and a few handwritten scribbles on an RFCF, but a well written rationale would be tougher for a reviewer to substitute his/her judgment. 3) It would help the SAMC to better understand a DE's thinking on a case. 4) A copy of the rationale could be sent to the claimant instead of the personalized denial notice (PDN). The PDN is good in theory but specious in practice. It aggravates more claimants than it enlightens. The PDN has been a source of frustration to the DDS since its inception. In the mid-60s, we used to write denial paragraphs; they flopped, and the PDN is no better. The rationale would enable us to jettison the counterproductive PDN with benefit to all, including the claimant.

3) Restructure DDS. If production is desired, the structure must support that end. It is exciting to think that the program truly *can* be returned to its former status as the most competent, efficient agency in the Federal government by blending an effective organization with 90s technology. The computer is hailed with messianic passion as the solution to program problems, but that puts the cart before the horse.

According to MIS guru, Paul Strassman, when interviewed, "...you have to consider the strategy before you design the structure, and the structure before you design the information system...most companies don't step back and figure out what the real problems are. In the guise of modernity, they simply take what is usually a rigid bureaucratic structure and ossify it further by enshrining it within a layer of computer code. Consequently, the organization becomes more rigid, more costly, more time consuming. After a while computer programs become enormous, unwieldy monsters. Whenever you want to make a...change...it becomes a major software project."

Richman: "...one of the raps on the Japanese is that they have been so slow in introducing technology."

292X

Strassman: "Which is precisely the point. The most productive manufacturing economy in the world is concentrating on *changing organization first* rather than buying big computers first...They're continually innovating organizational forms. Then, when they need to support those new forms with technology, they buy it...."[14] [Italics added].

How could DDS be structured for effective production? In the 60s the FOs obtained MER; in the 90s the 1-800 number, combined with computer technology, makes it possible for each DDS to have a development unit to take the bulk of disability background reports *and* initiate MER requests. DE assistants can be trained to ask the right questions regarding work and medical issues (questions could be programmed for that matter) and compile the pertinent data; they would not be trained to make disability decisions. If desired, the unit could be staffed with enough DEs to monitor the work, render presumptive disability decisions, take over a phone if a claimant became difficult or distressed, review evidence to expedite TERI cases out of the unit, etc. In any event the case would be sent to a DE whether MER was received or not after the follow-up diary matured.

Advantages: The background reports would be qualitatively better because DE assistants could receive ongoing training that CRs could not. DEs could be relieved of many of the clerical duties that they have accumulated, allowing more time to concentrate on substantive issues. It would maximize the use of DEs, which would be especially helpful to DDSs who are unable to hire new personnel because of state hiring policies. A DE assistant could be a useful career ladder position into a DE position for secretaries without college degrees, state hiring practices permitting.

Disability claims constitute a small percentage of the workload for FOs, but disability background reports consume almost 50% of their office time. This restructuring would help alleviate the overburdened FOs as well. (We have started noticing an increase of recon cases received in the DDS as much as 90 days after the SSA-561 is signed.) Terminals in the FO could be linked to tell the DDS development unit to contact the claimant after s/he had been determined to meet I & R, insured status, etc., requirements. With this organization in place, and the technology to support it, SSA would be on the way to restoring first rate public service.

4) Restructure quality review (QR). If quality is desired, the structure must support that end. Budget cuts imposed by the 71-72 Administration forced SSA to reduce and decentralize QR; that change is the main reason for today's program degeneration. QR should be like the house lights in a theatre, lighting the way for everyone to find their seats. Instead it has become a spotlight that focuses first on a dignitary in the audience, then the curtain, then a thespian, etc., while the rest of the theatre is left in the dark. The mass of unwarranted allowances in the 70s would have been prevented by an adequate QR; ergo, the fiasco of the 80s would never have happened.

During the 80s we have seen two major Congressional reform bills (PL 96-265, 98-460), the PR debacle, a law in response to the public relations disaster of the PR

(PL 97-455), a moratorium on CDR cases, a moratorium on mental cases, a virtual moratorium on Zebley cases, and so many adverse Court rulings that PR has come to stand for Periodic Recall. Today, disability decisions seem to hinge less on the MER and more on whether the *impairment is a sensitive issue* at the time of filing, and *where* it is filed.

The lesson of the last 20 years? Remove QR from the DDSs and ROs. Centralize QR in Baltimore to make this a national program again. Stabilize the program by reviewing 40% of all allowances *and* denials. The message for the program is inescapable: QR must *maintain quality*, not just *report statistics*. The last 20 years have shown that the program cannot be stabilized with temporary initiatives responding to symptom-crises of the underlying disease. Surely, the difficulty of making appropriations must increase in the face of program instability. A first-rate QR would be much more effective and far cheaper in the long run than spending 6-7 billion dollars to institute FTF at the initial level and then trying to sustain it.[15]

PART V: ABOUT THE GAP_

Two different programs now exist, and the gap between ALJ and DDS decisions will never be reduced unless both make decisions from the same premise. If DDS rendered "ALJ" decisions, entitlement costs would become prohibitive. The media is fickle; Prime Time, 60 Minutes, 20/20, etc., have aired some shows lately exposing workers' attempts to defraud Workers' Compensation and insurance companies by feigning disability. That could happen in the future of our program (and probably could today). If DDS were required to make ALJ type decisions, DDS would have to forget much of what it has learned from physicians about medical assessment.

On the other hand, if ALJs adopt the DDS premise, they will have to learn more about weighing MER substantively for RFC assessment. Congress was concerned with the high DDS allowance rate in the mid-70s, but if the ALJ reversal rate was higher still and remains high currently, is it not time to take a more substantive look at ALJ decisions? 1) ALJs should be subject to the same review as DDS. We all make mistakes. Disability decisions are not personal but Administrative. They are to be made according to the Act and the Regs. Unless medical assessments are realistic, the law will be applied to erroneous findings of fact. That can only be prevented by a first-rate QR. 2) SSA should request funding for ongoing in-depth medical training for ALJs to increase their medical expertise. This would reduce the ALJ reversal rate *legitimately* (as opposed to reducing it artificially to please fiscal conservatives), which will justify the cost of the training. Until the problem of the different premises is addressed, the situation will remain – ALJs and DDS: Different Premises, Different Decisions.

Disclaimer: This paper is my own reflection but makes no claim to originality, nor does it represent the policy of the Texas DDS.

294X

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[1] "Social Security Hearings and Appeals: Pending Problems and Proposed Solutions," WMCP: 97-24, October 27, 1981, p. 19. "Selective Face-to-Face Interviews With Disability Claimants Could Reduce Appeals," GAO Study, Apr., 1989, p. 14.

[2] Advocates refer to reconsideration as a "rubber stamp." The Appeals Council (AC) is viewed the same way, and some want the AC abolished to open access to the Courts. It would be less pejorative and more accurate to say that the reconsideration and the AC simply reflect a consistent approach to adjudication at their respective levels.

[3] The 2 billion dollar figure is based on the following:

Number of appeals to ALJs in 1988	289,421
Allowances if 60% reversed	173,653
Allowances if 40% reversed	115,768
Potential annual erroneous additions to the roll	57,885
	57,885
Multiply by average monthly benefit	x 400
Monthly loss to taxpayers	$23,154,000
Multiply by 12	x 12
To obtain the annual loss to taxpayers	$277,848,000
Multiply by 9.3, the average length of time on the roll for	x 9.3
Title II, to obtain the cumulative per annum loss to taxpayers	$2,583,986,400

In 1988 appeals to ALJs reached 289,421. A 60% reversal rate represents 173,653 grants. A more realistic, but still very high 40% reversal rate represents 115,768 grants. The difference between the two figures would mean that roughly 57,885 people, who did not meet the DOD, went on the roll that year.

The average Title II monthly benefit is $610. The maximum SSI benefit is $422 ($442 for concurrent claims). For calculation purposes, $400 is used here as a conservative overall monthly average. So, 57,885 x 400 = the average monthly loss. Multiplying that figure by 12 gives the average annual loss.

The vast majority of these beneficiaries will remain on the roll; therefore, the annual loss becomes cumulative, provided that a comparable number of ineligibles are placed on the roll annually. Title II beneficiaries remain on the disability roll an average of 9.3 years, and SSI beneficiaries remain on the roll an average of 16 years. The shorter period is used to obtain the cumulative total. By the ninth year, the loss will total 2.6 billion dollars annually.

These figures are obviously very rough but the figures have not been inflated for effect, because the 2.6 billion dollar figure does not consider cost of living allowances, auxilliaries, medicare/medicaid, etc.

The ALJ reversal rate may also be too high in non-disability areas that concern the FOs, e.g., questionable retirement, relationships, overpayments, etc.

[4] "Reagan Administration Proposals," WMCP: 97-23, October, 20, 1981, p. 1. The Reagan Administration proposed to save 48.4 billion dollars through 1986 by a) changing the 20/40 test to a 30/40 test for insured status b) increasing the waiting period to six months, c) increasing the duration requirement to 24 months, and d) setting aside non-medical factors for all claimants, i.e., one must meet or equal the medical listings to qualify for benefits. The projected savings was to be 21.9 billion. The remaining 26.5 billion represented the adjustment for the interaction and effects on Medicare. It was a very stringent climate.

[5] SSA has said that DDS misunderstood the RFCGs; they were intended as guides, not recipes. If that is true: a) Why did SSA take *years* to recognize that DDS was using the RFCGs as recipes? b) The RFCGs were writ-

295X

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ten primarily to curb the ALJs' subjectivity. How then could DDS assume the latitude theoretically forbidden to the ALJs? But that is all in the past.

6 "Status of the Disability Insurance Program," WMCP: 97-3, March 16, 1981, p. 2. What was said in March, 1981 still holds true, "The States have sometimes had to fly by 'the seat of their pants,' watched over by regional offices who often have varying interpretations in these policy areas" [i.e., interpretations of adult and childhood listings, etc.]. During fiscal year 90 the allowance rate by Region was as follows: Boston, 45.6%; Seattle, 42.2%; San Francisco, 41.5%; Denver, 40%; Kansas City, 38%; Philadelphia, 36.5%; New York, 36.3%; Chicago, 36.1%; Atlanta, 33.5%; Dallas, 28.6%. Statistics are "glitchy" so to speak, e.g., if Puerto Rico were thrown out of the mix, New York region's allowance rate would be 43%. Individual DDSs vary from 58% all the way down to 23%. There may be good explanations for the variation in the allowance rates. Statistics can be are misleading, but variant adjudicative practices among the DDSs are uncovered during conferences, when DEs get together. Such stats can indicate, however, why the call for increased examiner discretion is coming primarily from the Southern regions.

7 "Selective Face-to-Face Interviews With Disability Claimants Could Reduce Appeals," GAO Study, Apr., 1989, pp. 18-19.

8 Rudolf Patterson, Attorney, Testimony before the Social Security Subcommittee, WMC, May 2, 1991. "...We have been involved in several face to face hearings at the reconsideration level...during the last 10 years. In almost all occasions, we have been impressed with the quality of the hearing and the hearing officer. The disagreeing part of the process has been the same thing as we experienced in all other initial and reconsideration reviews by the Social Security Administration." I take that to mean that the decisions were adverse.

9 Dr. J. R. Kirwan, et. al. "Clinical judgment in rheumatoid arthritis. I. Rheumatologists' opinions and the development of 'paper patients'," Annals of the Rheumatic Diseases, 1983, 42, pp. 644-647.

10 Timothy Carey, M.D., et. al. "Medical Disability Assessment of the Back Pain Patient for the Social Security Administration: The Weighting of Presenting Clinical Features," Journal of Clinical Epidemiology, 1988, Vol. 41, No. 7, pp. 691-697. Though published in 88, I am not sure when the data for the study was gathered.

11 Paul Ekman and Maureen O'Sullivan, "Who Can Catch a Liar?" American Psychologist, September, 1991, Vol. 46, No. 9, pp. 913-920.

12 Eileen Sweeney, Attorney, Testimony before the Social Security Subcommittee, WMC, May 2, 1991, has been the exception to the usual Advocate's understanding, at least that I have read, "One additional area needs to be considered: having better procedures and better evidence, the decisions will still be flawed if SSA does not use...its quality assurance process to return inappropriate denials to the states...[and again]...The importance of the quality assurance process can not (sic) be understated." My only disagreement is that most procedures are counterproductive now. Procedures are no substitute for a first-rate quality review.

13 A GAO study on a different occasion found that if a DE, based on the FTF, wanted to reduce the RFC, it could not be done if the SAMC refused to go along. "Observations on Demonstration Interviews With Disability Claimants," GAO Study, December, 1987, p. 19. It would be the same if Federal review did not wish to go along.

14 Paul Strassman, interviewed by Tom Richman, "Face to Face," Inc., March, 1988, pp. 27-40.

15 During the last NADE Conference, it was said that 6-7 billion dollars would be necessary to start up FTF at the initial level. One GAO study, tracking the results of FTF at the reconsideration level of a large DDS, noted that 15,774 claimants had requested reconsideration during a three month period. If only 80 percent of them had requested FTF, an estimated 17 staff-year increase would have been required to handle the load. That estimate did not include travel costs, loss of productivity during travel, or office space

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costs in remote areas. "Observations on Demonstration Interviews With Disability Claimants," GAO Study, Dec., 1987, pp. 19-20. What would that look like for initial cases?

Another significant problem is that a 17 staff-year increase would mean that the great majority of DEs would start FTF with little or no experience.

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Hearing Officer
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297X

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ALJs and DDS: Different Premises, Different Decisions

by Robert Burgess, Hearing Officer, Texas DDS

THE ADMINISTRATIVE LAW JUDGE (ALJ) REVERSAL rate has always been high (currently around 60%); that fact has growing significance due to the high rate of appeals: 72,202 in 1973; 121,504 in 1974; 363,533 in 1983; 289,421 in 1988.[1] If the high ALJ reversal rate reflects realistic decision making, the function of DDS, by implication, is to contain entitlement costs by making it as difficult as possible for claimants to appeal to ALJs. Therefore, Advocates argue for the elimination of the reconsideration step[2] to open access to ALJs and that DDS should adopt the procedures and make decisions similar to ALJs.

But if DDS decisions, generally, are more realistic, overly generous ALJ reversals may be costing taxpayers over 2 billion dollars annually.[3] ALJs, generally, are 30-50 degrees to the left of center while some DDSs may be up to 15 degrees to the right, but one thing is sure: the reversal rate has created a gap wide enough, i.e., lucrative enough, to turn disability advocacy into a growth industry. Some explanations that purport to account for the size of the gap merit exploration.

"What accounts for the size of the gap between ALJs and DDS?"

PART I: EXPLANATIONS FOR THE SIZE OF THE GAP.

1. ALJs go by the Act and Regulations; DDS goes by the POMS, i.e., the Residual Functional Capacity Guidelines (RFCG).

a) After a disability examiner (DE) had observed a hearing, she was asked what she thought. She said that the impairment was non-severe. The ALJ told her he intended to allow the claim. When asked how, in view of the testimony and the medical evidence of record (MER), the ALJ responded, "When you have been around as long as I have, you learn to read people. This person is going to apply and apply until she gets benefits, so we may as well allow the claim now." Another ALJ says, "What I look for is character. When I determine a person's character, I know whether s/he is lying to me or not." Others in a different region tell of an encounter with ALJs who advised, "You don't need to know anything about medical evidence. All you need to know is the law." The decisional approach in each instance deemphasizes the importance of the MER, and that conflicts with the Act.

b) The adjudicative climate was excessively stringent in the early '80s,[4] but a few years ago, before the current initiatives, SSA allowed DDS more latitude with regard to residual functional capacity assessment.[5] Because the program lacks *national* consistency, that latitude has been slower in coming to some Regions,[6] but DDS does have a little more room to make realistic decisions now. Some individual DDSs already have the necessary latitude, so it is not altogether accurate to say that DDS, in practice, is rigorously bound to the POMS.

Explanation 1, though popular, does not survive objective scrutiny because neither statement is entirely true. Not all DDSs adhere rigidly to the RFCGs and not all ALJs follow the Act's requirement to evaluate medical evidence substantively.

2. ALJs get to see claimants; DDS does not.

a) In 1981, Senator Bellmon prompted a study of ALJ decisions.[7] Part of the study included 1000 hearing decisions by 48 ALJs; the reversal rate was 63%. Later, transcripts were prepared for each case but edited to remove any evidence related to the hearing. The transcripts were distributed to ALJs who had the same grant rate as the ALJs who had heard the cases originally. This second group of ALJs, relying on the written record alone, reversed only 46%. Face-to-face (FTF) made a difference, but which way? Instead of making decisions more accurate, FTF may have contributed to overly liberal decisions. ALJ subjectivity seems to be reflected in the wide variation of individual reversal rates (10-90%).

Hearing Officers' (HO) reversal rates are fairly consistent, comparatively speaking. HOs have both FTF contact and as much latitude as ALJs in making decisions, but their reversal rate does not approach that of ALJs. This is doubly significant because HOs

cont'd on page 8

IN THIS ISSUE:

298X

ALJs, cont'd from page 1

deal exclusively with Continuing Disability Review (CDR) cases (except for special studies), so HOs' reversal rates are inflated by the medical improvement review standard (MIRS). My own reversal rate in my position as a Hearing Officer, is 40%, but half of that is due to no Medical Improvement (MI); a "MIRS" reversal is based solely on a paper review. FTF has been *pivotal* in only 3-5% of my reversals. HOs are less influenced by the claimants' demeanor. This latter point was made obliquely in testimony before the Social Security Subcommittee of the Committee on Ways and Means.[8] FTF has convinced me that the Residual Functional Capacity Assessments (RFCA) I made during the 60s and 70s were more realistic than many I have had to make from the 80s to the present (as a DE, not as an HO).

b) In a non-government study,[9] physicians drew up a list of 12 clinical variables that they deemed most significant in determining the severity of rheumatoid arthritis. The list included such things as morning stiffness, sed rate, functional capacity, etc. Using the list, nine rheumatologists rated the disease activity over a two-week period. Weeks later the same doctors were given copies of the forms of the patients that they had examined. Some forms were duplicated. All of the forms were interleaved with those containing information from the patients of the other physicians as well. The correlation of disease severity between the real patients and the "paper patients" was extremely high ($r=+0.901$). The correlation was higher for duplicates of paper patients ($r=+0.971$). The study concluded, ". . . 'Paper patients,' while simple in design and apparently unlike clinical circumstances, are in fact a valid representation of real patients and provide a useful tool for the further investigation of actual clinical judgment." *A realistic three-dimensional portrait of claimants was conveyed on paper over 90% of the time without a hands-on, clinical examination, i.e., FTF. If paper patients are fine for scientific medical studies, paper review is adequate for the vast majority of disability claims.*

c) In a study[10] by non-government physicians, forty-eight "paper patients" with back pain were created to be assessed by State Agency Medical Consultants (SAMC) and Medical Examiners who performed consultative exams for DDSs (CEMD). Each "patient" was to be evaluated for: pain, mobility, physical examination, X-ray findings, and occupational history. All physicians said that they needed a high degree of certainty before they were willing to call an applicant disabled; the severity of pain experienced by the patient did not affect the level of certainty of disability. The result was the CEMDs ". . . had a significantly greater mean certainty of disability than agency physicians, 0.37 vs. 0.07 ($p<0.01$)." SAMCs' estimates of the certainty of disability were almost uniformly quite low, and virtually unaffected by any of the vignettes. The different results were due to the CEMDs freedom to use their medical knowledge and clinical experience, whereas SAMCs assessed patients according to the "recipe." *FTF could not have been the factor in the uniformly higher disability ratings by the CEMDs.*

Explanation 2 may hint at the reason for the high ALJ reversal rate, but it fails to explain the much lower HO reversal rate - even though HOs have the same latitude as ALJs. Studies, purporting to demonstrate that FTF is the main reason for the wide gap between ALJs and DDS, presume rather than establish that conclusion.

3. FTF helps to establish credibility.

Establishing credibility is what decision making is all about. "X has never lied to me," or "I wouldn't trust Y at all." are assessments of credibility based on what an observer has seen and heard over time. The credibility of disability claimants cannot be tested over time, because the claimant is a stranger. An ALJ or an HO would be rescued from hearing the case of a long-time acquaintance. Does FTF help to establish the credibility of a stranger who believes that s/he is disabled?

In yet another non-governmental study[11] ten people were videotaped either lying or telling the truth about their feelings. The subjects (housewives, police, college students, judges, psychiatrists, Secret Service agents, etc.) watched the tapes and tried to identify the truth tellers vis-a-vis the liars. Only young Secret Service agents scored better than chance at detecting the liars. Judges, psychiatrists, police, and attorneys scored no higher than one would score by random guessing. Professionals scored no higher than non-professionals. Those who claimed great skill in detecting liars scored no higher than those who made no such claim. According to researchers, "Lies fail for many reasons. *The lie may be exposed by facts* that contradict the lie or by a third party who betrays the liar's confidence. Sometimes, such outside information is not available or is ambiguous. Then the lie succeeds or fails solely, or primarily, on the basis of the liar's behavior, which the legal profession terms *demeanor*. . ." [italics mine]. If someone is truly convinced that s/he is disabled, his/her testimony will appear to be credible. *FTF, apart from the ability to weigh MER substantively, is insufficient to establish credibility.*

Explanation 3 may furnish a basis for the high ALJ reversal rate, but it fails to explain why the "true" HO reversal rate has not risen that much beyond the regular DDS reconsideration reversal rate. When one fails to recognize that "Severe Vaginitis" or "Squomous (sic) Cell Metoplasia (sic) of the Prostate" or "Statutory blindness, left eye," (the right eye being normal) are not medically disabling, the intent of the law is circumvented when claimants with these kind of impairments are allowed.

When the merit of FTF is treated as a hypothesis to be tested instead of an axiom, the non-government studies, which cannot be accused of bias, support NADE's contention that FTF would not raise the DDS allowance rate significantly. Much is made of the value of FTF in pain cases; however, more often than not, one can only see the projected effects of pain, which may or may not be credible. FTF does not permit a look inside a knee joint or a heart; FTF may be helpful in a few cases, more so for mental cases, but it would not change over 90% of DDS decisions. So, how is the size of the gap between ALJs and DDS to be explained? That brings us to Part II.

PART II: WHAT ACCOUNTS FOR THE SIZE OF THE GAP BETWEEN ALJS AND DDS?

The disability decision is a blend of both medical and legal requirements, and the experts in each of these fields are poles apart in their training for service. The passion of the legal mind is upholding due process of law to ensure one's rights. Knowledge of the law is the major weapon against the abuse of rights, and correct procedures guarantee rights.[12] If ones rights are perceived to have been violated, the legal mind may not stop to consider whether a claimant is truly disabled. Legal minds are not experts at assessing RFC.

The passion of the medical mind is healing people and getting them back to their optimum level of function. Knowledgeable physicians are experts at assessing disability. One of the studies above noted that all physicians needed a high degree of certainty before they would call a patient disabled; more than anyone, physicians know that the patient's attitude toward a disease is often more debilitating than the disease itself. It is a disservice to the claimant to allow him/her when s/he is not disabled.

299X

The point is that DDS works more closely with physicians than with lawyers. DDS works more closely with physicians than do ALJs. Experienced DEs are trained to weigh MER and assess RFC. Throughout their careers, DEs are reviewed by physicians. DDS decisions are *MEDICAL/LEGAL* in character. ALJ decisions are *LEGAL/medical*. By means of sequential analysis, the vocational grid, etc., SSA has done extremely well in guiding DDS to correctly apply the law to the established facts of a case. *It is the DDS emphasis on substantive medical evaluation, vis-a-vis the ALJ deemphasis of substantive medical evaluation which explains the size of the gap between the ALJs and DDS.*

To conclude Part II, the difference between ALJs and DDS is based on the different levels of MER evaluation. The difference between ALJs and DDS, therefore, is not just a procedural difference; we are operating on different premises. If the size of the gap is due to different premises, rather than procedures, DDS decisions will not change substantially if we adopt all ALJ procedures. This brings us to Part III and a slight shift of gears.

PART III: THE ROLE OF THE ADVOCATES.

a) The Advocates in the early days of the Periodic Review (PR).

Advocates are to be commended for calling attention to the overly stringent decision making that started soon after January, 1981, but their attempt to redress the SSA/DDS stringency of the early 80s has taken the program on a legal/procedural course, i.e., the wrong direction. Here are some examples from the early days of the Periodic Review (PR).

1) Mental Cases: Advocates thought that the policy for mental case adjudication was too stringent. Actually, the policy for mental case adjudication (SSR 83-15) provided excellent guidance for making realistic assessments. All Congress had to say was, "SSA, you have a good policy for adjudicating mental cases, just follow it." Instead, Advocate action led Congress to call a moratorium on mental cases. SSA cranked out new listings (which only made academic changes, but were hailed as revolutionary), came up with lengthy mental evaluation forms, which only psychiatrists or psychologists could complete, restated in different words the same written policies that existed before the moratorium (for example, SSR 83-15 is still in effect) and hyped a new day in mental case evaluation; in substance it was the same Christmas tree, with different ornaments.

When the moratorium was lifted, it seemed that one could be allowed simply by alleging a mental impairment. Then came the Mid-course Correction, and mental case evaluation gradually "recidivized," but this may be a Regional observation. Advocates, placing faith in legal/procedural adjustments, could not know that the reform only made a temporary change in the medical evaluation of mental cases.

2) Physical Cases: Advocates got side-tracked on the issue of non-severe impairments, multiple non-severe impairments, and stopping at the non-severe step of sequential analysis, etc. For example, Advocates persuaded the Ninth Circuit to mandate DDSs under its jurisdiction to go through the whole sequential trail, even for non-severe impairments (Bowen v. Yuckert, which was overturned by the Supreme Court, 1987). If an impairment(s) is truly non-severe, going through the entire sequential trail will never result in an allowance, even if a claimant is 64 years old. B v Y made more work for DDSs in the Ninth Circuit but changed no decisions.

It is ironic that Advocates managed to have SSR 82-55 (for non-severe impairments) struck down early on, but SSR 82-51 (RFCGs for cardiovascular and musculoskeletal impairments), which caused many more unjustified denials, was allowed to stand until just a few years ago. It is also ironic, judging from newspaper reports, that many Advocates suspected that claims were being denied based on "secret" instructions, but SSR 82-51 was right out there in the open. The disturbing part about the "secret" instructions scenario is that DDS was made to look like a willing participant in the denials and removal of countless disabled people from the roll.

Advocates' lack of medical expertise side-tracked them to peripheral issues in the early days of the PR and severely compromised their sincere efforts to restore program integrity.

b) The current influence of the Advocates.

Advocates assume that the high ALJ reversal rate proves that DDS is too stringent and that ALJ decision making is more realistic. Lack of medical expertise leads Advocates to attribute what they believe to be more realistic decisions to the procedures that ALJs employ. Here are a few of the ALJ procedures DDS is using already plus a consideration of the current impetus for FTF.

1) FTF: Regarding FTF the pertinent questions here are: How could the DDS allowance rate be at its highest in the mid 70s - *without FTF?* Why is FTF being touted so highly at *this* time, even though the disability program managed to do well without it until the last decade?

During the early 80s when the disabled came limping, wheeling, hallucinating, etc., into law offices, Advocates' reaction was understandable from their limited perspective, "If you could just see these people!" Advocates took many of these claimants/beneficiaries to ALJs who reversed erroneous decisions. It would be natural for non-disability experts to conclude that FTF and all of the other procedures helped ALJs make more realistic decisions. So, the current impetus for FTF grows out the unfounded belief that it would make decisions better in the vast majority of cases because it seems to work that way for ALJs.

Caveat: In the early 80s DEs did not need additional procedures or FTF to know that they were denying/ceasing many claimants erroneously. We tried to warn Congress of the impending disaster, but we were the ones who had erroneously allowed a multitude in the 70s, so we had lost credibility with Congress. To see it from Congress' point of view, why should they have listened to DEs, especially when Federal QA showed DDS to have a 98% accuracy rate. How could Congress know that the 98% accuracy rate reflected conformity to fiscal goals, rather than realistic medical assessment? DDS was under the threat of being federalized (PL 96-265) if quality fell below a certain level, so the scene was set for disaster. DDS would have had to make the same decisions if they FTF'd all claimants.[4]

2) ADLs (activities of daily living): ALJs ask a lot about ADLs, so DDS must now obtain ADLs on almost everyone. ADLs are present in many of the files without resorting to a special form. More importantly, the MER often contains complaints such as, "he can't sit or stand for prolonged periods," or "she has extreme fatigue toward the end of the day," etc. With functional statements like these, knowing whether the claimant can brush his/her teeth or go shopping becomes superfluous. (If one cannot evaluate MER substantively, more significance is attached to the ADLs.) A form which, by design, captures superficial data, is not useful enough to obtain routinely. The form, merely an amplified version of the ADL section of the SSA-3368, is now necessary to grant safe passage through quality appraisal, i.e., it receives little attention but must be in the file.

3) Treating physician opinions: ALJs give more weight to the

cont'd on page 10

58-107 O - 92 - 5

300X

ALJs, cont'd from page 9

opinions of treating physicians (TP). Now DDS must conaciously weight opinioned evidence. When ALJs weigh opinioned evidence, they ask questions like: "What is the specialty of the TP? How long has s/he treated the claimant? Is s/he boarded or not?" and very importantly, "What does the medical function assessment form say?" etc.

Now DDS must take time to call the TP when a conflict of opinion arises, but if we had already decided not to accept the TP's position, the call is pointless except to serve appearances. The new POMS instructions makes no substantive change, except to add another documentation requirement. DDS starts with no assumption about an attending physician (AP) opinion, but DE/SAMCs weigh the MER, case by case, based on its internal consistency. The ALJ and DDS approach to weighing MER are very different.

A related issue is consultative exams (CE) by TPs. Advocates in another state were delighted when PL 98-460 mandated that DDS make, ". . . every reasonable effort to obtain from the individual's treating physician. . . all medical evidence including diagnostic tests. . .necessary. . .prior to evaluating medical evidence obtained from any other source on a consultative basis." But, it soon became apparent that TPs were not lining up to perform CEs, and the Advocates could not understand. Some TP's were (are) not beating down the doors to perform CEs because they do not wish to deal with their patients when they are denied. TPCEs were tried in the 60s as a public relations move; the effort failed for the same reasons that it is unproductive now, i.e., excessive delays, poor quality reports, etc.

The conventional wisdom, again held by non-disability experts, is, "No one knows the patient like the TP." A very interesting statistic here in Texas establishes that, for fiscal year, 90, the highest denial rates were for claimants whose cases were adjudicated based on *treating source records alone*. Allowances rose when CEs were purchased. Disability evaluation is too complex to reduce to simple formulae, which non-disability experts tend to do.

4) Getting MER from every source: ALJs get MER from every treating source (TS). DDS now has to get MER from every TS for at least one year, but if a claimant fractures an ankle, and a current report from his AP shows that the fracture has healed within 12 months of onset, nothing is gained and much is lost by going through the motions to send a follow-up and waiting for the hospital report that describes the injury at onset. When attorneys do not know how to get their clients allowed, the strategy is to flood the file in hope that something will trigger a favorable decision. This may be part of the motivation behind this procedure. A strong case can be made that this requirement had resulted in increased processing time, cost, and lower quality.

5) Attorneys: Attorneys are frequently involved in reversals at the ALJ level, so Advocates conclude that they would aid the claimant at the DDS level. In reality attorneys make no positive difference at the DDS level. If DDS allows the case, it is incidental to attorney involvement.

In Texas a definite increase in attorney participation has been noted at the reconsideration level due to the added attorney statement on the Personalized Denial Notice (PDN). The attorney's fee is money that should have gone to the claimant, *so it would be better to restrict the "attorney statement" on the PDN to the recon notice*. We could go on, but this is enough to show how the Advocates have mediated these ALJ procedures and more into DDS through the Courts and Congress.

To conclude Part III, we said above that the difference between ALJs and DDS was one of premises, not procedures, and that the taking on of ALJ procedures would not change DDS decisions. This is the case. DDS is going into pulpwood failure secondary to procedural overload without producing changes in decisions. In July, 1988, our mean processing time in Texas was 50 days. In July, 1991, Texas hired 89 new DEs. In spite of this our mean processing time today is 90 days. It is interesting to watch DDS move heaven and earth to incorporate a new procedure, only to see it fade in significance a month later. DDS must ignore procedures to survive. If DDS went by the book to perform every procedural requirement, mean processing time would be out of sight. POMS is rapidly becoming a cemetery for procedural corpses, but, still, the residue of many procedures take their toll on efficiency. *DDS certainly needs additional funding, but Congress will be putting more and more money into a failing system, unless the program is overhauled.* This brings us to Part IV.

PART IV: SUGGESTIONS TO OVERHAUL THE PROGRAM.

1) A rigorous reexamination of every development procedure mandated by the POMS is needed - even those rooted in the Public Laws (PL) and Court rulings. Advocates should be invited to sit down with us, to understand why most of the procedures are not working, so that SSA/DDS can have access to the solid contributions Advocates can make. Eliminate every procedure that does not contribute to realistic decision making. This will both expedite decisions and increase realistic decision making.

2) Restore the professional status of DEs by:

a) *Eliminating the Residual Functional Capacity Assessment Forms (RFCF).* Reagan Administration operatives did what they could to reduce the status of DEs to justify salary cuts, by making SAMCs solely responsible for the RFCA, but nothing has eroded DEs' professional status or destroyed the infrastructure of good decision making like the RFCF. It has greatly reduced the time DEs and SAMCs can spend in consultation. DEs have less opportunity (or incentive) to learn about medical evaluation; SAMCs have less opportunity to learn about policy.

Caveat: Advocates insist that physicians complete the RFCF. Adherence to this procedure causes a tremendous production backup in the DDS, but something else is notable here. An ALJ, like the DE, is a medical layman. Would consistency not require physician completion of the RFCF at the *ALJ* level as well? Most disability appeals to ALJs are primarily medical issues. If these appeals were heard by *Administrative Hearing Physicians* (AHP) instead of ALJs, the gap between AHPs and DDS would narrow quickly. If AHPs had been hearing cases during the early 80s, the RFCCs would have been exposed for their oversimplification and quickly dropped without resorting to Court action. This is not a suggestion to replace ALJs with AHPs. The issue raised here is one of consistency.

b) *Returning to the rationale.* It goes without saying that DDS cannot write rationales unless superfluous procedures are jettisoned first. Rationales could be helpful for the following and other reasons: 1) Writing a rationale makes the DE go through the sequential trail which provides some internal impetus to quality. 2) It is much easier for a reviewer to return a decision that rests on a few checked blocks and a few handwritten scribbles on an RFCF, but a well written rationale would be tougher for a reviewer to substitute his/her judgment. 3) It would help the SAMC to better understand a DE's thinking on a case. 4) A copy of the rationale could be sent to the claimant instead of the PDN. The PDN is good in theory but specious in practice. It aggravates more claimants than it enlightens. The PDN has been a source of frustration to the DDS since its inception. In the mid-60s, we tried to write denial paragraphs; they flopped, and the PDN is no

301X

better. The rationale would enable us to jettison the counterproductive PDN with benefit to all, including the claimant.

3) Restructure DDS. If production is desired, the structure must support that end. It is exciting to think that the program truly can be returned to its former status as the most competent, efficient agency in the Federal government by blending an effective organization with 90s technology. The computer is hailed with messianic passion as the solution to program problems, but that puts the cart before the horse.

According to Management Information Systems guru, Paul Strassman, when interviewed, ". . . you have to consider the strategy before you design the structure, and the structure before you design the information system. . . most companies don't step back and figure out what the real problems are. In the guise of modernity, they simply take what is usually a rigid bureaucratic structure and ossify it further by enshrining it within a layer of computer code. Consequently, the organization becomes more rigid, more costly, more time consuming. After a while computer programs become enormous, unwieldy monsters. Whenever you want to make a . . . change . . . it becomes a major software project."

Richman: ". . . one of the raps on the Japanese is that they have been so slow in introducing technology."

Strassman: "Which is precisely the point. The most productive manufacturing economy in the world is concentrating on *changing organization first* rather than buying big computers first. . . They're continually innovating organizational forms. Then, when they need to support those new forms with technology, they buy it . . ."[14] [Italics added].

How could DDS be structured for effective production? In the 60s the FOs obtained MER; in the 90s the 1-800 number, combined with computer technology, makes it possible for each DDS to have a development unit to take the bulk of disability background reports *and* initiate MER requests. DE assistants can be trained to ask the right questions regarding work and medical issues (questions could be programmed for that matter) and compile the pertinent data; they would not be trained to make disability decisions. If desired, the unit could be staffed with enough DEs to monitor the work, render presumptive disability decisions, take over a phone if a claimant become difficult or distressed, review evidence to expedite TERI cases out of the unit, etc. In any event the case would be sent to a DE whether MER was received or not after the follow-up diary matured.

Advantages: The background reports would be qualitatively better because DE assistants could receive ongoing training that claims representatives (CR) could not. DEs could be relieved of many of the clerical duties that they have accumulated, allowing more time to concentrate on substantive issues. It would maximize the use of DEs, which would be especially helpful to DDSs who are unable to hire new personnel because of state hiring policies. A DE assistant could be a useful career ladder position into a DE position for secretaries without college degrees, state hiring practices permitting.

Disability claims constitute a small percentage of the workload for field offices (FO), but disability background reports consume almost 50% of their office time. This restructuring would help alleviate the overburdened FOs as well. (We have started noticing an increase of recon cases received in the DDS as much as 90 days after the SSA-561 is signed.) Terminals in the FO could be linked to tell the DDS development unit to contact the claimant after s/he had been determined to meet I & R, insured status, etc., requirements. With this organization in place, and the technology to support it, SSA would be on the way to restoring first rate public service.

4) Restructure quality review (QR). If quality is desired, the structure must support that end. Budget cuts imposed by the 71-72 Administration forced SSA to reduce and decentralize QR; that change is the main reason for today's program degeneration. QR should be like the house lights in a theatre, lighting the way for everyone to find their seats. Instead it has become a spotlight that focuses first on a dignitary in the audience, then the curtain, then a thespian, etc., while the rest of the theatre is left in the dark. The mass of unwarranted allowances in the 70s would have been prevented by an adequate QR; ergo, the fiasco of the 80s would never have happened.

During the 80s we have seen two major Congressional reform bills (PL 96-265, 98-460), the PR debacle, a law in response to the public relations disaster of the PR (PL 97-455), a moratorium on CDR cases, a moratorium on mental cases, a virtual moratorium on Zebley cases, and so many adverse Court rulings that PR has come to stand for Periodic Recall. Today, disability decisions seem to hinge less on the MER and more on whether the *impairment is a sensitive issue* at the time of filing, and *where* it is filed.

The lesson of the last 20 years? Remove QR from the DDSs and regional offices (RO). Centralize QR in Baltimore to make this a national program again. Stabilize the program by reviewing 40% of all allowances *and* denials. The message for the program is inescapable: QR must *maintain quality*, not just *report statistics*. The last 20 years have shown that the program cannot be stabilized with temporary initiatives responding to symptom-crises of the underlying disease. Surely, the difficulty of making appropriations must increase in the face of program instability. A first-rate QR would be much more effective and far cheaper in the long run than spending 6-7 billion dollars to institute FTF at the initial level and then trying to sustain it.[15]

PART V: ABOUT THE GAP.

Two different programs now exist, and the gap between ALJ and DDS decisions will never be reduced unless both make decisions from the same premise. If DDS rendered "ALJ" decisions, entitlement costs would become prohibitive. The media is fickle; Prime Time, 60 Minutes, 20/20, etc., have aired some shows lately exposing workers' attempts to defraud Workers' Compensation and insurance companies by feigning disability. That could happen in the future of our program (and probably could today). If DDS were required to make ALJ type decisions, DDS would have to forget much of what it has learned from physicians about medical assessment.

On the other hand, if ALJs adopt the DDS premise, they will have to learn more about weighing MER substantively for RFC assessment. Congress was concerned with the high DDS allowance rate in the mid-70s, but if the ALJ reversal rate was higher still and remains high currently, is it not time to take a more substantive look at ALJ decisions? 1) ALJs should be subject to the same review as DDS. We all make mistakes. Disability decisions are not personal but Administrative. They are to be made according to the Act and the Regulations. Unless medical assessments are realistic, the law will be applied to erroneous findings of fact. That can only be prevented by a first-rate QR. 2) SSA should request funding for ongoing in-depth medical training for ALJs to increase their medical expertise. This would reduce the ALJ reversal rate *legitimately* (as opposed to reducing it artificially to please fiscal conservatives), which will justify the cost of the

cont'd on page 12

302X

ALJs, cont'd from page 11

training. Until the problem of the different premises is addressed, the situation will remain - ALJs and DDS: Different Premises, Different Decisions.

Disclaimer: This paper is my own reflection but makes no claim to originality, nor does it represent the policy of the Texas DDS.

(Editor's Note: This position paper has been endorsed by the NADE Board.)

Footnotes

[1] "Social Security Hearings and Appeals: Pending Problems and Proposed Solutions," WMCP: 97-24, October 27, 1981, p. 19. "Selective Face-to-Face Interviews With Disability Claimants Could Reduce Appeals," GAO Study, Apr., 1989, p. 14.

[2] Advocates refer to reconsideration as a "rubber stamp." The Appeals Council (AC) is viewed the same way, and some want the AC abolished to open access to the Courts. It would be less pejorative and more accurate to say that the reconsideration and the AC simply reflect a consistent approach to adjudication at their respective levels.

[3] The 2 billion dollar figure is based on the following:

Number of appeals to ALJs in 1988	289,421
Allowances if 60% reversed	173,653
Allowances if 40% reversed	115,768
Potential annual erroneous additions to the roll	57,885
	57,885
Multiply by average monthly benefit	X 400
Monthly loss to taxpayers	$23,154, 000
Multiply by 12	X 12
To obtain the annual loss to taxpayers	$277,848,000
Multiply by 9.3, the average length of time on the roll for	X9.3
Title II, to obtain the cumulative per annum loss to taxpayers	$2,538,986,400

In 1988 appeals to ALJs reached 289,421. A 60% reversal rate represents 173,653 grants. A more realistic, but still very high 40% reversal rate represents 115,768 grants. The difference between the two figures would mean that roughly 57,885 people, who did not meet the DOD, went on the roll that year.

The average Title II monthly benefit is $610. The maximum SSI benefit is $422 ($442 for concurrent claims). For calculation purposes, $400 is used here as a conservative overall monthly average. So, 57,885 X 400 - the average monthly loss. Multiplying that figure by 12 gives the average annual loss.

The vast majority of these beneficiaries will remain on the roll; therefore, the annual loss becomes cumulative, provided that a comparable number of ineligibles are placed on the roll annually. Title II beneficiaries remain on the disability roll an average of 9.3 years and SSI beneficiaries remain on the roll an average of 16 years. The shorter period is used to obtain the cumulative total. By the ninth year, the loss will total 2.6 billion dollars annually.

These figures are obviously very rough but the figures have not been inflated for effect, because the 2.6 billion dollar figure does not consider cost of living allowances, auxiliaries, medicare/medicaid, etc.

The ALJ reversal rate may also be too high in non-disability areas that concern the POs, e.g., questionable retirement, relationships, overpayments, etc.

[4] "Reagan Administration Proposals," WMCP: 97-23, October 20, 1981, p. 1. The Reagan Administration proposed to save 48.4 billion dollars through 1986 by a) changing the 20/40 test to a 30/40 test for insured status, b) increasing the waiting period to six months, c) increasing the duration requirement to 24 months, and d) setting aside non-medical factors for all claimants, i.e., one must meet or equal the medical listings to qualify for benefits. The projected savings was to be 21.9 billion. The remaining 26.5 billion represented the adjustment for the interaction and effects on Medicare. It was a very stringent climate.

[5] SSA has said that DDS misunderstood the RFCCs; they were intended as guides, not recipes. If that is true: a) Why did SSA take years to recognize that DDS was using the RFCCs as recipes? b) The RFCCs were written primarily to curb the ALJs' subjectivity. How then could DDS assume the latitude theoretically forbidden to the ALJs? But that is all in the past.

[6] "Status of the Disability Insurance Program," WMCP: 97-3, March 16, 1981, p. 2. What was said in March, 1981 still holds true, "The States have sometimes had to fly by 'the seat of their pants,' watched over by regional offices who often have varying interpretations in these policy areas" [i.e., interpretations of adult and childhood listings, etc.]. During fiscal year 90 the allowance rate by Region was as follows: Boston, 45.6%; Seattle, 42.2%; San Francisco, 41.5%; Denver, 40%; Kansas City, 38%; Philadelphia, 36.5%; New York, 36.3%; Chicago, 36.1%; Atlanta, 33.5%; Dallas, 28.6%. Statistics are "glitchy" so to speak, e.g., if Puerto Rico were thrown out of the mix, New York region's allowance rate would be 43%. Individual DDSs vary from 58% all the way down to 23%. There may be good explanations for the variation in the allowance rates. Statistics are misleading, but variant adjudicative practices among the DDSs are uncovered during conferences, when DEs get together. Such stats can indicate, however, why the call for increased examiner discretion is coming primarily from the Southern regions.

[7] "Selective Face-to-Face Interviews With Disability Claimants Could Reduce Appeals," GAO Study, Apr., 1989, pp. 18-19.

[8] Rudolf Patterson, Attorney, Testimony before the Social Security Subcommittee, WMC, May 2, 1991. ". . . We have been involved in several face-to-face hearings at the reconsideration level. . . during the last 10 years. In almost all occasions, we have been impressed with the quality of the hearing and the hearing officer. The disagreeing part of the process has been the same thing as we experienced in all other initial and reconsideration

cont'd on page 17

303X

Humor in the Workplace

by Anne Graham, Mid-Atlantic Regional President
(Coverage of 1991 National Conference training session)

ARMIN STEEGE, A GRADUATE OF LUTHERAN School of Theology, and trained in marriage and family therapy, is a private psychotherapist and the program director of an adult psychiatric unit. He gave an excellent and timely talk on ways to relieve stress at work.

Mr. Steege believes that if you have a sense of humor, it is harder to be stressed. He underscored the importance of humor by sharing several amusing stories about himself. His response was to laugh at himself rather than being stressed.

In his experience, when there is an increase in stress there is a decrease in humor. Some of his patients in the psychiatric unit have no humor at all. Although we were all given a sense of humor from birth, bits and pieces have been eroded by socialization.

He discussed the views of Albert Ellis concerning Rational Emotive Structure. The childhood messages we received directly and indirectly from our parents have to be updated as adult "facts." We were told about Santa Claus but this information was modified as we got older. If there is something we can change, do so; however, don't worry about things over which we have no control, e.g., a traffic jam. Acknowledging this can make a difference in our level of stress.

Mr. Steege believes most people know how to relieve stress by taking a nap, reading, fishing, taking a long walk, etc. The problem is that on the job when your work may be overwhelming (e.g., a caseload of 200+, QA returns), your boss doesn't say, "Why don't you take a nap." In our busy lives, we often do not take the time to rid ourselves of built up stress. Having a sense of humor lets you see everything from a different perspective which can make things even more tolerable.

ASSOCIATE, cont'd from page 13

federal components utilizing Regional Office's operational assistance for troubled DDS's. Initiatives also included implementing procedures for Field Office/Teleservice Centers to request medical evidence, strengthening of Federal/State relationships, better management of CDR processing and the refinement of development/documentation procedures to expedite cases that have a high probability of a final allowance decision.

NADE Board members voiced their concerns for adequate funding when the budget is prepared. Susan Parker explained how the budget is proposed two years in advance and gave information on the rules and regulations governing the proposed budget. As for the budget, Ms. Parker stated that the real debate in Congress will be removing the "fire wall." The "fire wall" is a mini-domestic cap that would prohibit using savings from defense spending cuts for domestic programs. The "fire wall" would allocate all the savings from defense cuts toward paying off the federal deficit, rather than using them for domestic needs in FY'93.

The NADE Board, along with Susan Parker and her staff, recognize that the disability program faces significant and unique challenges; but by continuing to work together, utilizing our knowledge and expertise in the disability process we can achieve our common goal of providing the public the best possible service.

In closing, Ms. Parker emphasized that SSA welcomes NADE's input and respects the examiner's perspective as the most valuable resource.

ALJs, cont'd from page 12

reviews by the Social Security Administration." I take that to mean that the decisions were adverse.

[9] Dr. J.R. Kirwan, et. al. "Clinical judgment in rheumatoid arthritis. I. Rheumatologists' opinions and the development of 'paper patients,'" Annals of the Rheumatic Diseases, 1983, 42, pp. 644-647.

[10] Timothy Carey, M.D., et. al. "Medical Disability Assessment of the Back Pain Patient for the Social Security Administration: The Weighting of Presenting Clinical Features," Journal of Clinical Epidemiology, 1988, Vol. 41, No. 7, pp. 691-697. Though published in 88, I am not sure when the data for the study was gathered.

[11] Paul Eckman and Maureen O'Sullivan, "Who Can Catch a Liar?" American Psychologist, September, 1991, Vol. 46, No. 9, pp. 913-920.

[12] Eileen Sweeney, Attorney, Testimony before the Social Security Subcommittee, WMC, May 2, 1991, has been the exception to the usual Advocate's understanding, at least that I have read, "One additional area needs to be considered: having better procedures and better evidence, the decisions will still be flawed if SSA does not use . . . its quality assurance process to return inappropriate denials to the states . . . [and again] . . . The importance of the quality assurance process can not (sic) be understated." My only disagreement is that most procedures are counterproductive now. Procedures are no substitute for a first-rate quality review.

[13] A GAO study on a different occasion found that if a DE, based on the FTF, wanted to reduce the RFC, it could not be done if the SAMC refused to go along. "Observations on Demonstration Interviews With Disability Claimants," GAO Study, December, 1987, p. 19. It would be the same if Federal review did not wish to go along.

[14] Paul Strassman, interviewed by Tom Richman, "Face to Face," Inc., March, 1988, pp. 27-40.

[15] During the last NADE Conference, it was said that 6-7 billion dollars would be necessary to start up FTF at the initial level. One GAO study, tracking the results of FTF at the reconsideration level of a large DDS, noted that 15,774 claimants had requested reconsideration during a three month period. If only 80 percent of them had requested FTF, an estimated 17 staff-year increase would have been required to handle the load. That estimate did not include travel costs, loss of productivity during travel, or office space costs in remote areas. "Observations on Demonstration Interviews With Disability Claimants," GAO Study, Dec., 1987, pp. 19-20. What would that look like for initial cases?

Another significant problem is that a 17 staff-year increase would mean that the great majority of DEs would start FTF with little or no experience.

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31 West Street
North Arlington, N.J. 07031
May 12, 1992

Hon. James Florio
Office of the Governor
CN-001
Trenton, N.J. 08625-0001

Dear Governor Florio:

Fifteen months ago, showers of federal dollars began falling on the state Division of Disability Determinations in Newark to improve its unusually poor performance in processing Social Security disability claims: Dollars to hire one hundred more examiners and physicians. Dollars for hundreds of high-tech automated workstations. Dollars for overtime, Monday through Saturday, morning and evening. Dollars to send weekday and Saturday details of federal examiners, doctors and reviewers. And dollars to create new management positions while upgrading old ones. The extended forecast calls for more such showers for the remainder of the federal fiscal year.

In the aftermath of this spending spree

305X

SSA and NJDOL managers have publicly declared, as they must, at least partial victory in these yearlong campaign to "turn the Division around." Perhaps an independent viewpoint would be useful

Federal reports show that for the quarter ending March 1992 New Jersey ranked at, or very near the bottom in mean processing time for all case categories; in production per work year; in weeks work pending; and in delayed cases as a percentage of pending workload. In the aggregate, considering all 53 agencies which adjudicate these claims nationwide, these results mark New Jersey as still the worst performing state in the U.S. (Note: SSA's "Project FORME" has just begun in three federal offices in New Jersey. Some claims will now be partially processed federally and then sent to the state agency for completion. The weeks spent in the federal offices will be eliminated from processing time statistics (both federal office and state agency), thus giving the desired appearance of greater efficiency in the state agency. A crafty ploy.)

In recent months, management has

pointed to markedly improved federal accuracy ratings for the Division as proof of the turnaround. But these results are highly suspect given the subjective nature of the review procedures and the administrative pressure applied. A 1987 report by the Auditor General of the State of California gives a clear picture of the weaknesses of these reviews. Last year a federal examiner and union leader testified before Congress that these accuracy reports are based on meaningless reviews and were once tossed in the trash by a state administrator who deemed them useless. (Division employees joke about these suddenly miraculous figures.)

New Jersey's accuracy rate was poor (and ignored) for years. Then last May, June and July the media spotlight fell on the agency and S.S.A. quickly made the press vanish from the review. Roughly speaking, for every three or four case returns the agency received pre-publicity, only one was received thereafter. New Jersey will remain "accurate" until the next shift in the political wind regardless of what is in those case folders.

One can gain a better perspective on the Division's shortcomings by focusing on a series of contradictions stemming from a lack of accountability for how the agency is managed and budgeted:

1. While officially promoting cost efficiency and quality service nationally, SSA tolerates the opposite from management in New Jersey. Ask the federal and state attitudes are, "Where do I sign the check?"

2. As performance has declined, management positions and salaries have increased sharply.

3. Despite the complexity and uniqueness of the Social Security disability program, the N.J. DDS has turned the operation over to a top management team with no experience in the program.

4. Decentralization, the administrative fad of the '90's, was the failure of the '80's, marked by intra-agency turf wars. (The signs point to a repeat.)

5. Management claims it will do in four locations what it has failed to do in just one.

6. Office space roughly twenty miles away in New Brunswick is available.

across the hall or up the stairs in Newark.

7. If you process complex claims and cope with backlogs in a hectic atmosphere all day you are called a "line worker" and earn under $50,000. But if you scribble memos and go to meetings at a more leisurely pace you are called a "manager" and you earn more than $50,000.

8. Much of what is gained by using computers is then largely lost through a lack of clerical staff.

9. The management push for quick case closures concurrently creates aged case backlogs. There is no "first in - first out" policy. The easy cases are closed; the hard cases age.

10. While managements talk process to the press claimants write complaints to their congressmen.

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"There is a seeming impropriety in leaving any set of men without control to put their hand into the public coffers, to take out money to put in their pockets."
(James Madison, 1789)

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"The U.S. spends $4 for every $3 it takes in" (New York Times story, May 8, 1992)

The essence of bureaucratic power is the capacity to spend public funds for one's private ends and those of one's friends.

Sincerely yours,
Frank O'Brien

Distribution:
Hon. Donald DiFrancesco, President, New Jersey State Senate
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310X