

To: Joint Hearing on Commissioner of Social Security's Proposed Improvements to the Disability Determination Process

September 23, 2005

Dear Members of the Joint Hearing,

I am a licensed physician, board certified in Internal Medicine, and was a medical consultant for Florida's Department of Disability Determination Services (DDS) for seven years. I also worked for Georgia's department of Disability Adjudication Services for fifteen months.

I'm disturbed by the fact that Social Security's proposed rule for the "Administrative Review Process for Adjudicating Initial Disability Claims" does not outline an enhanced training program for its decision-makers. Ask any successful major corporation, and they'll tell you that having an effective training program for its workers is as important as having money to perform its daily functions. I argue that Social Security's failings at prior attempts to redesign the adjudicative process are, in part, based on the lack of an effective training program; and that this ongoing oversight will play a role in the possible failure of this current attempt.

The Commissioner's new plan proposes that State agencies will better document and explain the basis for determinations so as to result in more accurate initial determinations. The Commissioner told the "National Association of Disability Examiners" that state DDS examiners would be responsible for development and review of the medical and vocational input, writing the RFC, and preparing the denial following a legal decisional logic thought process. The examiner will be required to fully document and explain the basis for their determination.

This reflects what the Commissioner has said about administrative law judges expressing concern about the quality of adjudicated records they receive. Clearly, many claimants' cases are not fully developed and documented by disability examiners. This is due to multiple reasons. I have discussed this situation with examiners in Florida and Georgia after I found that a significant number of cases that had not been properly developed were routinely routed to medical consultants. The main reasons stated for not doing so were that caseloads were excessive and unmanageable, job expectations were unrealistic, and training was woefully inadequate.

Case management by disability examiners, from the medical perspective, is sometimes inadequate, partly due to their lack of understanding of the clinical and functional aspects of claims. Inconsistency in training, and the lack of sufficient ongoing medical training once examiners reach their assigned units, produces a core group of examiners who do not understand the clinical aspects of cases. This results in examiners who can't develop medical issues with any significant degree of consistency or efficiency. This is part of the reason why

some examiners admittedly don't attempt to read or develop the medical evidence in some complex cases. They route those cases to a medical consultant to unravel the issues, and subsequently complete the proper form, or return the case with recommendations for further development. This problem is only magnified in the significant number of DDS offices that have a high turnover of examiners, as those offices are relying on a large group of novices with little training and experience. It is well-known that examiners can't perform their jobs efficiently until they have had one to two years of training.

Examiners are expected to act as medical detectives and determiners of functional ability relating to physical and mental impairments. They are expected to have this capability despite a training curriculum which is essentially a crash course of very limited medical terminology and pathophysiology. The training they receive is very basic with an emphasis on anatomy and medical terms. This training emphasizes terms rather than clinical concepts, and is given in a relatively short time frame without sufficient ongoing medical education. This limits their ability to think critically in applying that knowledge to complex medical issues found in many cases.

Some States have been designated "prototype" States, in which examiners are allowed to adjudicate claims without input from medical consultants. In one review, it was found that approximately 70% of examiners sought input from medical consultants anyway. That is a strong indication that those examiners, who supposedly had been trained to adjudicate claims without medical consultant input, did not feel qualified to do so. In fact, I have spoken to examiners in Florida, who were not happy with the fact that they had been instructed by supervisors to do "Single Decision Maker (SDM)" claims in an effort to reduce case loads and decrease cost. Common statements made by them included, "I am not a doctor" and "I don't have the training to do this."

The concept behind SDM is that examiners in these prototype States would decide which cases were easiest to adjudicate, and make SDM decisions on those without input from medical consultants. As with most good intentions undermined by poor planning, this experiment morphed into a short-cut for examiners to expedite clearance of cases without proper oversight by medical experts. When many DDSs in these prototype States formed units to do "Quick Decision" cases even before the Commissioner touted this concept, that left examiners on regular units with the more difficult cases to adjudicate. With SDM being praised by the SSA leaders as a way to save millions of dollars by not having to pay medical consultants for their input, these States felt obliged to press examiners to perform SDM claims even though many no longer had access to the easiest cases. The result is that many difficult claims that should have had expert medical input before being adjudicated were decided by examiners without proper insight or training.

In relation to the purely medical aspects of disability claims, this practice is comparable to letting a medical assistant in a doctor's office complete the

Residual Functional Capacity (RFC) form or Psychiatric Review Technique Form (PRTF). The irony is that while medical assistants and examiners have similar non-clinical medical training, medical assistants, unlike most disability examiners, have clinical medical experience. Theoretically, this clinical experience would let medical assistants do a better job of completing those residual function forms. This fact is clearly a disservice to disability applicants, as well as improperly trained disability examiners.

The majority of examiners I spoke with in Georgia and Florida made it clear to me that they do not feel they have been properly trained to complete an RFC or PRTF, much less write a detailed rationale for their decision. They admitted they do not have a clear grasp on how the physiologic issues relating to medical impairments impact functional abilities. This type of application of knowledge requires critical thinking. Critical thinking involves solving problems, formulating inferences, calculating likelihoods, and making decisions when the thinker is using skills that are effective for a particular context and type of thinking task. In the role of the examiner, it requires judging ambiguity and judging whether statements made by authorities are acceptable in the context of complex medical issues. It also requires examiners to have the ability to respond to material by distinguishing between facts and personal opinions, judgments and inferences, and the objective and subjective.

Compound this issue with the fact that some States don't require examiners to have more than a high school education, and you are looking at a set-up for failure. This issue of State job requirements for disability examiners, which plays a role in the inconsistency of decision-making between different States, is only one example of the many problems associated with the current federal-state relationship in the Social Security disability program. See the GAO's January 2004 publication, "Strategic Workforce Planning Needed to Address Human Capital Challenges Facing the Disability Determination Services" for more information on this topic.

The current DDS training program, which I was a part of, in no way adequately prepares disability examiners for their job duties. Issues of inadequate training have been voiced by numerous organizations providing oversight for the SSA. The Social Security Advisory Board's (SSAB) August 1998 report "How SSA's Disability Programs Can Be Improved," stated "The most important step SSA can take to improve consistency and fairness in the disability determination process is to develop and implement an on-going joint training program for all of the 15,000 disability adjudicators, including employees of State disability determination agencies (DDSs), Administrative Law Judges (ALJs) and others in the Office of Hearing and Appeals (OHA), and the quality assessment staff who judge the accuracy of decisions made by others in the decision making process." It went on to say "We urge the Commissioner to make a strong ongoing training program a centerpiece of the agency's effort to improve the accuracy, consistency, and fairness of the disability determination process, and to see that the necessary resources are provided to carry it out."

The General Accountability Office's (GAO) March 1999 report "SSA Disability Redesign Actions Needed to Enhance Future Progress," stated "Training has not been delivered consistently or simultaneously to all groups of decision-makers." The SSAB's September 1999 report "How the Social Security Administration Can Improve Its Service to the Public," stated "SSA may also be underestimating staff training needs."

The GAO's January 2004 publication, "Strategic Workforce Planning Needed to Address Human Capital Challenges Facing the Disability Determination Services," noted that the Social Security Advisory Board has cited training as one of the issues associated with inconsistencies in disability decisions. It went on to say that gaps in key knowledge and skill areas were part of the key challenges DDSs face in retaining disability examiners and enhancing their expertise. Reflecting my concerns, that report went on to say that DDS directors reported that many examiners need additional training in key analytical areas that are critical to disability decision-making, including assessing credibility of medical information, evaluating applicants' symptoms, and analyzing applicants' ability to function. Finally, that report noted that under SSA's new approach for improving the disability determination process, these same knowledge and skill areas will be even more critical as DDS examiners take responsibility for evaluating only the more complex claims and as they are required to fully document and explain the basis for their decision.

There is a recurring theme among professional organizations that provide oversight to the SSA showing a persistent and uncorrected problem of inadequate training in the Social Security disability program. Every proficient business model contains an effective training program to address the training needs of its workforce. Could inadequate training be at the heart of why SSA's previous attempts at redesign failed to obtain most of its objectives? I don't think it's a stretch to say that inadequate training significantly contributed to those failures. Based on SSA's failures at prior attempts of redesign in which none of those initiatives successfully integrated a consistent and enhanced training program, it would be wise to consider the recommendations made by both the GAO and the SSAB; and attempt to formulate a better training program.

The SSA should establish an enhanced training program for examiners that emphasizes the clinical application of medical knowledge relating to medical impairments and their physiologic impact on a claimant's function. This training should be ongoing for old and new examiners, and should be provided for all levels of the decision-making process who must reason through a disability decision, including administrative law judges (ALJ).

If adjudicators at all levels aren't effectively taught the mental and physical issues relating to an impairment's impact on function, how can they be expected to accurately reason through a decision? I was amazed at the lack of emphasis the SSA and DDSs placed on this type of training, which has directly contributed to

the inconsistency in disability decisions across the program. Some DDS leaders voiced concern that such ongoing examiner training given in more frequent increments would be disruptive as it would take examiners away from case development. That type of reasoning clearly reflects an emphasis on case development of quantity over quality.

Other DDS leaders told me they didn't want to offer more standardized training for fear of being accused by the SSA of typecasting impairments as it relates to an individual's function. They were afraid of stereotyping impairments with a set level of function, and let that fear override common sense when it came to the concept of standardized training. Training related to medical impairments and function can be standardized, yet presented in a way to allow the understanding of how it is possible for two claimants with the same impairment to be impacted differently from a functional standpoint. Training can be standardized, yet still incorporate development of critical thinking skills to encourage individualized adjudication of disability claims.

Not only have examiners been given inadequate training, but ALJs have been given even less medical training. I do not understand how ALJs are supposed to reason through a decision relating to medical issues based on a legal education. I acknowledge that a claim is supposed to be fully developed from a medical perspective by the time it reaches them, but by that time, months, if not years, have passed; and there may be a whole new slew of allegations or alleged worsening of prior allegations.

My experience with some ALJs was that they basically just started from scratch developing medical allegations by ordering multiple specialized exams. Some also ordered multiple diagnostic tests when they weren't even sure how to interpret the results. These practices are not cost effective. Some relied on medical experts for advice, but others did not. Calling in medical experts can be time consuming and adds to case processing times. This is partly due to finding a convenient time for a medical expert to be present, and providing time for a claimant's attorney to cross-examine the medical expert.

In some cases, ALJs just relied on what the treating physician opined as a level of residual function, regardless of whether the objective evidence supported the opinion. That is an example of selective interpretation of Process Unification rulings. But ALJs are just trying to do the best job they can, given the limitations and flaws inherent in the program.

What follows is a description of my proposed enhanced training program.

Develop clinically applicable training modules focused on the listings and most common types of impairments examiners see. Functional application of medical knowledge will allow examiners to better understand clinical concepts in claims, resulting in more efficient case development. Modules emphasizing "most common" cases let examiners become better skilled in the types of cases that

make up the bulk of their work. Initiating training with “most common” scenarios provides a starting block for examiners from which they can start to establish critical thinking skills and hone these skills through repetition, i.e., by frequently seeing and reasoning through these types of cases. Modules focused on the listings let examiners become more proficient with use of the listings, which will facilitate “quick decisions” for applicants who are clearly disabled.

Examiners will learn to individualize case assessments when they begin to see that despite a possible common variable, the impairment, the impact of that impairment and its associated residual level of function can be vastly dissimilar for different individuals.

These modules should be implemented early in the training process to supplement the existing components of basic anatomy and physiology. Once a solid knowledge base is established, training modules can be advanced to more difficult and less frequently seen disease states and conditions.

Training modules should address what tests are necessary to adjudicate cases and explain why. Modules should also explain at what point in a claimant’s condition a test may become necessary and why. When examiners begin to understand the pathophysiology of a condition, it will be easier for them to remember what test result to look for in the medical records, or possibly to order with a Consultative Exam (CE). Rather than just providing a checklist of labs or tests for each disease or condition as is currently done in some DDSs, the reasoning for each test should be given to help the examiner associate the test with the condition, thus providing easier recall.

Training modules should address disease prognosis and possible expected outcomes of certain conditions, injuries, and surgeries, which is especially important in durational decisions.

Process Unification rulings should be integrated into these modules to demonstrate how to reason through a decision. Each ruling should be applied to case modules to enable writing a well-reasoned rationale.

Clinically based training should be extended to experienced examiners as continuing education. Hold monthly training updates in small groups so productivity won’t be disrupted. These training modules should focus on issues recognized as recurring problems found in Quality Assurance reviews.

Encourage better utilization of medical consultants through increased interaction with examiners. Establish a series of short lectures by different medical consultants on topics in which they are interested or specially trained. This lecture series should be given to more experienced examiners to supplement prior training by covering aspects of case development and adjudication that are more relevant to their level of experience and understanding.

I found that due to a high turnover of staff in DDSs, some examiners were prematurely promoted to supervisor positions. By default, this resulted in a small number of supervisors who lacked adequate medical knowledge to be able to sufficiently guide examiners in their unit on medical development of certain claims. Thus, this enhanced training program should encompass all levels of the decision making process, including unit supervisors.

For this concept to work, it will be necessary to establish Operations support of regular and mandatory clinical training once newly trained examiners reach their units. Establishing an effective and consistent training program will improve the quality of decisions, establish consistency in decision making, and save the program millions of dollars.

This training program should be introduced with the emphasis that this new style of learning, while taking a little extra effort up front, will result in examiners establishing control over a better product (a more accurate decision) through improved learning. While this concept will initially take time away from case development for some examiners, retaining well-trained and proficient examiners will be the reward for this investment.

This enhanced training program should be linked to a pride-based initiative through which the SSA can improve the morale of examiners and all other personnel. Improved morale will help decrease examiner turnover, which according to a recent GAO report, is twice that of other SSA employees.

Including the OHA in this initiative will help improve some of the issues contributing to the adversarial relationship between the SSA and the ALJs as they will see the SSA providing key support for their needs. This initiative will allow ALJs to make better informed decisions regarding the medical aspects of disability claims. Ultimately, this concept will help revive the long-lost Process Unification initiative, which, in my opinion, is integral to maintaining the disability program's integrity in the eyes of the public.

The SSA cannot afford to ignore the repeated warnings and suggestions made by individual stakeholders and professional organizations about making a strong ongoing training program the centerpiece to improve the disability determination process. The SSA should start focusing on one of the core issues of why its attempts at redesign keep failing; and that core issue is training.

Sincerely,
Keith R. Holden, M.D.