

Regional Office Action Review

2025 Louisville, KY Report May 19th – 21st

The American Legion

National Veterans Affairs & Rehabilitation Division

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Background

The Louisville Regional Office Action Review (ROAR) was conducted from May 19th to May 21st, 2025, by Policy Analyst Brandon McClain to assess operational efficiency, training, quality control, productivity, and employee relations. The site was chosen due to its special mission identifier; Camp Lejune toxic exposure claims. This Regional Office (RO) specifically highlights the claims staff face challenges uniquely specific to veterans who served at Camp Lejune from August 1st, 1953, to December 31st, 1987. The team met with Executive Director Michael Fairchild and key claims processing staff, as well as local American Legion Department of Kentucky leadership. The office has processed a high number of claims, demonstrating efficiency and success, particularly in outreach and claims accuracy rates.

Preliminary Findings and Observations

Veterans Affairs Regional Office (VARO) challenges and key areas of concern include:

- 1. Compensation and Pension (C&P) medical examination inaccuracies.
- 2. Effective date errors and special issue annotations Toxic Exposure Risk Activity (TERA) and PACT Act.
- 3. Procedural inconsistencies in training and delivery.
- 4. Morale and burnout driven by twenty-five hours of mandatory overtime and staffing constraints.
- a. Case Analysis Fifty cases were randomly selected by the VARO before the visit. The American Legion's review team reviewed the 50 cases. The top three categories of errors for Veterans Service Representatives (VSRs) were: Effective date errors and special issue annotations, duty to assist, and legal errors. Findings indicated a high error trend related to TBI claims, improper ratings for secondary conditions, and the handling of bilateral conditions. A lack of consistent examiner guidance and conflicting interpretations of internal policy were also noted. Errors were identified in 18 (40%) of the 50 cases. Additionally, our review found VA will deny Veterans the benefit for not appearing to a C&P examination when adequate evidence exists in the file to generate a positive finding and issue a benefit.

listed are the errors found:

- Eleven (11) cases had Veterans Affairs (VA) duty to assist errors.
- Four (4) cases had ignored evidence.
- *Nine (9) cases had incomplete findings or ignored evidence.*

The case analysis was shared with Louisville Regional Office leadership, including the Assistant Director and Veterans Service Center Manager. The case samples indicate a 56% accuracy rate. 44% had a legal/procedural error.

b. *Director's Questionnaire* - Prior to the visit, a questionnaire was sent to the Regional Office Director. In response to the questionnaire, the RO Director provided information as follows:

The Louisville Regional Office reported no anticipated budget shortfalls for fiscal year (FY) 2025 and confirmed it has been authorized to meet all essential needs and contractual obligations, with a process in place to request additional funding if necessary. As Veterans Benefits Administration (VBA), Regional Offices do not manage or allocate funds for community care. Things like debt mitigation and community care are out of scope and are typically managed by the Veterans Health Administration (VHA). The RO maintains full training compliance and even supplements mandated training with monthly station improvement training (SIT) focused on administrative updates, claims challenges, and error trends seen in development.

Other notable highlights stated from the RO leadership meeting include:

- The RO maintains a 93% quality rating.
- There is a rotational return to office plan in place of 86 employees to mitigate overcrowding due to logistical and operational challenges of the Return to Officer (RTO) mandate.
 - o This seemed to have an impact on morale among the staff.
- 90-day Mentorship program for new hires.

Interviews

During the visit, the ROAR Team conducted ten interviews with VA employees. The roles of the interviewees were: Veterans Service Representative (VSR), Supervisory Veteran Service Representative Coach (SVSRC), Rating Veterans Service Representative (RVSR), Supervisory RSV Coach, Authorization Veterans Service Representative (AVSR), Authorization Quality Review Specialist (AQRS), Quality Review Team Coach/Supervisor, Assistant Veterans Service Center Manager, Veteran Service Center Manager, and Regional Office Director.

Overall Impressions

The Louisville RO has a healthy work environment in which its employees describe the office as a good place to work that prioritizes its employees' needs. The executive team and mid-level managers received high praise for their dedication to staff continuity, morale, training, and achieving all their goals to meet or surpass the key performance metrics (KPMs) and goals set the previous year. Despite the recent changes to the Veterans Affairs (VA) organizational structure, early retirement submissions, and the hiring freeze across the entire federal government, the RO has managed to maintain a 93% quality rating with an average day pending (ADP) of about 117 days. The claims backlog seems to be manageable and under control, however the wide gap in institutional claims knowledge, the improper development of Camp Lejune/agent orange claims, TERA memo inconsistencies, and the mandatory 25-hour overtime could have an impact on the RO's productivity and efficiency in the near future.

Best Practices: training & outreach

Training is the most effective area the RO focuses on and is clearly shown in the internal knowledge shared across the different sections. In addition to the monthly, quarterly and yearly mandated VA training through the Training Management System (TMS), the RO has implemented SIT training which focuses on individual areas of improvement for Veteran Service Representatives (VSRs) and Rating Veteran Service Representatives (RVSRs) that include error trends identified by coaches and quality review staff.

With the creation of an internal quick reference training library, Question, and Answer (Q&A) portal the RO has been able to amplify its training impact by creating training materials that directly support the areas of concern for VSRs and RVSRs in real time. Training nearly benefits

everyone equally due to gaps in claims experience and ever-changing internal rules that govern PACT Act claims. This is what enables the Q&A portal to be so effective. It allows the quality team and coaches to respond to questions, providing real time feedback, and direct evidence from public law and federal regulation that will improve claims efficiency and confidence.

The ongoing informal training done by the RO has served as a consistent professional development tool, and improvement tool for leadership. The use of informal training and correction can serve to redirect and educate claims staff without them obtaining derogatory reviews that impact productivity and efficiency requirements that are required for employment. Micro training and informal process review (IPR) have focused primarily on the rating side as well as on new hires to promote efficiency.

The RO has also improved their outreach in the community as well as strengthening their relationship with veteran service organizations. The RO had participated in two conventions and provided claims clinics that allowed them to adjudicate claims on the spot for veterans. They have also expressed an interest in including veteran service officers in their training courses so that we can improve at the point of service delivery High-quality claims clinics and VSO collaboration, with on-site submission and completion within 72 hours.

Areas of Needed Improvement

The Louisville Regional Office continues to experience a variety of persistent problems, that if not addressed, have the potential to undermine its capacity to provide prompt and accurate benefits to veterans.

Amongst the most significant problems is the persistent variability in the quality of medical examinations that are contracted out. Staff consistently reported problems with non-bilateral exams, inconclusive results, and diametrically conflicting conclusions requiring revisions, delaying adjudication, and undermining confidence in the examination process. These defects are not only procedural but systemic, demonstrating a breakdown in both training examiners and monitoring vendors specific to VA standards.

Added to this issue is the overdependence on online training modules, particularly in the aftermath of the COVID-19 pandemic. Even with mandatory Training Management System (TMS) requirements coupled with complementary Station Improvement Training (SIT),

employees at all levels have pointed out that these formats do not meet the complexities and dynamics of claims development under the PACT Act. The lack of scenario based, face-to-face training has denied many claims processors, particularly newly appointed ones, the pragmatic mechanisms, or statutory context necessary to effectively adjudicate complex claims involving toxic exposure TERA memos, and multidimensional conditions such as Traumatic Brain Injury (TBI).

Automation and artificial intelligence, while having theoretical promises, have introduced more layers of inefficiency rather than resolving existing workflow problems. Automated Decision Support (ADS) systems are not designed to manage the legal complexity or evidentiary nuance required in most claims. Far from streamlining processing, they instead generate incomplete or irrelevant outputs that contribute to staff workload and result in unnecessary development delays or additional exams.

For example, while automated decision letters have helped expedite some aspects of the development process, they have done nothing to aid in easing the bottlenecks further downstream in the lifecycle of the claim. Systemic inconsistency in the application of evolving policies, particularly with respect to TERA memo guidelines and Military Occupational Specialty (MOS) exposure determinations, is a major obstacle. Staff suggested there was no clear centralized policy on the conditions and process for applying TERA criteria, especially for National Guard and Reserve veterans for whom periods of exposure may not necessarily align with active-duty service thresholds. This lack of clarity has resulted in lopsided exam referrals, missed service connections, and a cascade of unnecessary denials, exacerbating an already heavy workload.

Additionally, Systematic Technical Accuracy Review (STAR) review and quality assurance feedback loops that enable performance improvements do not seem to be consistently utilized. Most RVSRs indicated that they have never received feedback on reoccurring errors, making them unaware of how to enhance their accuracy of decision rules. Coaches concede that although Informal Process Reviews (IPRs) are in place, they do not reach the leadership with sufficient regularity to achieve lasting change.

Lastly, the effect of Return to Office (RTO) mandates, and increasing overtime cannot be deemphasized or overlooked. Although leadership has put a rotational schedule in place and made some accommodations, most staff members conveyed that the transition has decreased

morale, raised commuting expenses, and presented new obstacles for caregivers and employees. Some employees reported being provided with little notice of 25-hour overtime requirements, which interfered with childcare arrangements, imposed a financial burden through longer parking fees and increased burnout. Morale issues are compounded by personnel attrition and apparent loss of institutional knowledge through early retirements and vacant positions.

Recommendations

These inefficiencies in operations, training deficits, and work stressors constitute a high risk setting that could further exacerbate the backlogs and undermine confidence in the claims process. For the Louisville RO to sustain progress and ensure timely, accurate, and consistent outcomes for veterans, it needs to implement reforms in training, vendor management, automation policy, and support systems for personnel. To address the challenges noted during the ROAR visit, The American Legion makes the following recommendations:

- a. Provide focused retraining on PACT Act, TERA, and bilateral condition examinations.
 - As complicated as claims are, VBA should mandate required refresher training sessions, both in person and online, specifically addressing PACT Act provisions and adjudications.
 - ii. The training courses must be scenario-based and tiered to meet staff levels of experience to benefit both new and seasoned employees.
- b. Increase quality control and oversight of contracted C&P examinations.
 - VA must institute a more robust oversight structure for third-party exam vendors. This would include regular audits of exam quality, examiner compliance with DBQ procedures, and diagnostic and nexus opinion accuracy.
 - ii. A centralized complaint tracking system should be established to document exam deficiencies received from both staff and veterans, and vendor contracts need to have performance-based metrics with penalties for low quality exams or excessive rework.
- c. Improve transparency of procedural change and issue clearer implementation guidance.

- Staff consistently expressed frustration with unclear or constantly evolving procedural expectations, particularly automation, TERA criteria, and workload prioritization.
- ii. VBA needs to publish internal guidance explaining procedural changes in understandable language, outlining rationale for change, and describing expected operational impacts. Clear and readily accessible implementation guidance will reduce confusion, facilitate accountability, and enhance employee trust.
- d. Reconsider increasing overtime requirements.
 - i. Enforcement of the RTO policy and 25 hours mandatory overtime have decreased morale and challenged staff's ability to maintain a healthy worklife balance. VBA should reconsider telework possibilities for top performing employees and investigate alternative models for overtime that are more flexible. When overtime cannot be avoided, workers should have advanced notice and parking allowances.

Conclusion

The Louisville Regional Office is an overall great model for best practices in internal training, community outreach, and operational innovation. However, these strengths are offset by chronic structural problems in development validity, and staff sustainability. By addressing these challenges with scheduled reforms in training, process oversight, and employee morale, the office can be more effective in conducting its mission to deliver timely and accurate compensation benefits to veterans.