DEPARTMENT OF VETERANS AFFAIRS

VETERANS BENEFITS ADMINISTRATION (VBA)

VETERANS BENEFITS, COMPENSATION & PENSION SERVICE

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ADVISORY COMMITTEE ON DISABILITY COMPENSATION

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MEETING

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MONDAY
MARCH 6, 2017

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The Committee met in the Eighth Floor Conference Room 870, 1800 G Street, NW, Washington, D.C., at 8:30 a.m., Joseph Kirk Martin, Jr., Chairman, presiding.

PRESENT

JOSEPH KIRK MARTIN, JR., Chairman
HAL K. BIRD*
DORIS BROWNE
GEORGE R. FAY

ELDER GRANGER*

TIMOTHY J. LOWENBERG

THOMAS J. PAMPERIN

JONATHAN ROBERTS

MICHAEL SIMBERKOFF

ALSO PRESENT

IOULIA VVEDENSKAYA, Designated Federal Officer
STACY BOYD, Alternate Designated Federal Officer
THOMAS J. MURPHY, Acting Under Secretary for
Benefits
DAVID FORGOSH, GAO
BENTON GAMMONS, VBA
VICTOR F. KALASINSKY, VHA
JENNY KIM, Jefferson Consulting
JERRY MANAR, Veteran
BETH MURPHY, VBA
PAT MURRAY, VFW
GREGG ORTO, VFW
DIANE RAUBER, NOVA
JIM SAMPSEL, VBA

*via telephone

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1 P-R-O-C-E-E-D-I-N-G-S

2 (8:29 a.m.)

3 CHAIRMAN MARTIN: Welcome to the

4 Veterans Affairs Advisory Committee on Disability

5 Compensation, the first meeting of 2017.

6 We last met in December of last year

7 and I've got a couple of issues I want to bring

8 you up to speed on but first we will just

9 introduce ourselves around the table. And let's

10 start with our VSO comments. Good morning.

11 MR. MURRAY: Good morning. Yes, hi,

12 my name's Pat Murray. I'm from VFW Legislative

13 Service.

14 CHAIRMAN MARTIN: Good to see you.

15 MS. KIM: I'm not from a VSO. My name

16 is Jenny Kim. I represent Jefferson Consulting

17 Group.

18 CHAIRMAN MARTIN: Welcome.

19 MS. KIM: Thank you.

20 CHAIRMAN MARTIN: Yes, sir?

21 MR. MANAR: I'm no longer with a VSO.

22 CHAIRMAN MARTIN: Enough of a

1 disclaimer.
2 MR. MANAR: I retired on Friday from
3 the VFW. My name is Jay Manar.
4 CHAIRMAN MARTIN: Good to see you.
5 MR. ORTO: My name's Gregg Orto with
6 the VFW.
7 MEMBER ROBERTS: Jonathan Roberts,
8 ACDC Committee.
9 MEMBER LOWENBERG: Tim Lowenberg, with
10 the committee.
11 MEMBER FAY: George Fay, with the
12 committee.
13 MS. BOYD: Stacy Boyd, VA.
14 DR. VVEDENSKAYA: Ioulia Vvendenskaya,
15 DFO.
16 CHAIRMAN MARTIN: Kirk Martin with the
17 VA.
18 MEMBER SIMBERKOFF: Mike Simberkoff,
19 on the committee.
20 MEMBER PAMPERIN: Tom Pamperin, with
21 the committee.
22 CHAIRMAN MARTIN: Thanks to everybody

1 for being here. Hal Bird is online, as well as
2 Elder Granger and both with the committee.
3 And did we collect Warren Jones yet?
4 Okay, yes. I think he'll be joining us. And
5 Doris Browne's with the committee and she is due
6 to be here in person. Liz Savoca, another
7 committee member, is ill and unable to attend.
8 Well, there are two things I wanted to
9 update you on in this opening segment. First of
10 all, I had a chance to meet with the USB, the
11 Acting Under Secretary, Thomas Murphy, on
12 December 8th, after our last meeting and I want
13 to go over the things that I discussed with him.
14 But I'd really like to open with an
15 event that I had the privilege of attending,
16 representing this committee and it was on January
17 18th. It was the VFW Medal of Honor Reception
18 here in Washington D.C.
19 My host was the VFW Commander in
20 Chief, Brian Duffy, and his Deputy Director of
21 National Legislative Services, Carlos Fuentes.
22 This was an amazing event and brought

1 together about 40 living Medal of Honor winners
2 who attended this reception. It was eye
3 watering.
4 The Medal of Honor of course as you
5 know, is the highest award for valor in action
6 against an enemy which can be bestowed on a
7 Department of Defense member by this nation.
8 It's 155 years old, created in 1861,
9 December of 1861 was when legislation was passed.
10 Since that time, there have been a total of 3498
11 Medals of Honor awarded by this nation.
12 Of those 3498, there are only 75
13 living Medal of Honor recipients. And to have
14 about 40 at this reception was stunning. It
15 really was.
16 There are six members still living
17 from World War II decorations and I'm going to
18 tell you about one of them, in fact, he'll tell
19 you about himself in just a moment.
20 I had the privilege, Rick and I had
21 the privilege of sitting at the table with Donald
22 E. Doc Ballard, who was a Navy corpsman who was

1 assigned to the Marine Corps in Vietnam in May of
2 1968. For action he received, taking care of
3 injured, he received the Medal of Honor in 1970
4 from President Nixon.
5 The story, and so familiar this was
6 just in the discussions with these Medal of Honor
7 winners that I was privileged to have, the story
8 repeated itself time and again.
9 They, A, didn't want to talk about
10 what they did, B, they all to a man, said we
11 carry this Medal forward in honor of those who
12 didn't come back and we're representing them.
13 And C, they were all the nicest people in the
14 world that you could hope to meet.
15 Doc Ballard was tending to a number of
16 Marines fallen including one who had bilateral
17 leg injuries from a grenade. And as he was
18 kneeling over taking care of this Marine, another
19 grenade landed close to the men he was caring for
20 and he knew that if the grenade went off that it
21 was going to kill everybody.
22 And so he jumped on top of this

1 grenade and he sat there for a minute or two and
2 nothing happened. And, you know, it had to be
3 every second, it just had to be an eternity.
4 But he finally got up, tossed the
5 grenade away and it exploded in the air. It's
6 incredible. And he was wounded I think a total
7 of six more times, survived his wounds. He is
8 quite the gentleman and very unassuming. But
9 it's also the -- yes?
10 MEMBER ROBERTS: Excuse me. To the
11 best of your knowledge, are there any women who
12 are Medal of Honor winners in the history of that
13 honor?
14 CHAIRMAN MARTIN: Yes. In fact, the
15 very first Medal of Honor was awarded to a
16 civilian woman surgeon doctor, in the Civil War
17 and that Medal was then rescinded later and then
18 finally restored by Congress subsequently. So
19 yes, and there have been.
20 There's one living survivor Medal of
21 Honor recipient from Iwo Jima. There are only, I
22 mentioned, what, six from World War II but one of

1 those is from Iwo Jima, action on Iwo Jima.
2 And his name is Hershel W. Woody
3 Williams. He is now 93 years old. He was at the
4 reception and he received the Medal February
5 21st, 1949, for action on Iwo Jima presented by
6 Harry Truman.
7 And at the time he told people that
8 the Commandant of the Marine Corps whispered to
9 him as he saw him the next day after the Medal
10 was presented, that he was the caretaker for the
11 Marines, the caretaker for the Medal in honor of
12 the Marines that didn't come back in Iwo Jima.
13 He was at the reception and it was just an honor
14 to see him there.
15 I found this, he gave a, we made a
16 video actually from Woody Williams and he can
17 tell the story better than I can relay it to you.
18 Thanks.
19 (Whereupon, the above-entitled matter
20 went off the record at 8:37 a.m. and resumed at
21 8:41 a.m.)
22 CHAIRMAN MARTIN: Okay. So we'll put

1 that on hold for the time being. It's worth six
2 minutes of the time to listen to.
3 MEMBER SIMBERKOFF: So I'm curious.
4 Who was the female surgeon in the Civil War?
5 CHAIRMAN MARTIN: I honestly can't
6 recall her name.
7 MEMBER SIMBERKOFF: Because there are
8 not that many women who --
9 CHAIRMAN MARTIN: Apparently not.
10 MEMBER SIMBERKOFF: -- went to medical
11 school this early.
12 CHAIRMAN MARTIN: Yes, right. Right.
13 Yes. I have it --
14 MEMBER SIMBERKOFF: It would be a
15 great thing to look up. She must have been, if
16 not the first --
17 DR. VVEDENSKAYA: Here she is.
18 MEMBER SIMBERKOFF: Mary Walker.
19 CHAIRMAN MARTIN: Mary Edwards Walker.
20 Prohibitionist. Golly.
21 MEMBER SIMBERKOFF: What's that?
22 CHAIRMAN MARTIN: She's a

1 prohibitionist.

2 MEMBER SIMBERKOFF: Oh. From

3 Syracuse.

4 (Simultaneous speaking)

5 CHAIRMAN MARTIN: Careful.

6 DR. VVEDENSKAYA: Wow. Was born in

7 1932.

8 CHAIRMAN MARTIN: 1832.

9 DR. VVEDENSKAYA: Oh, sorry. 1832.

10 Way before anybody would be allowed to step into

11 medical school of any sort as a woman. All

12 right.

13 MEMBER SIMBERKOFF: The only woman to

14 receive the Medal and only one of eight

15 civilians.

16 CHAIRMAN MARTIN: Yes.

17 DR. VVEDENSKAYA: Yes.

18 MEMBER SIMBERKOFF: It was restored in

19 1977. Wow.

20 DR. VVEDENSKAYA: Oh, wow.

21 CHAIRMAN MARTIN: But it was a

22 wonderful ceremonial, real privilege to have a

1 chance to attend. Thanks to the VFW for making
2 that invitation possible. Thank you.
3 Let me just recap quickly the meeting
4 with Tom Murphy that I had, the Under Secretary,
5 on December 8th.
6 There was a meeting that followed our
7 meeting, December 6th and 7th, and a chance to
8 sit down with the Under Secretary one on one with
9 no specific time frame. He had plenty of time to
10 talk and I was grateful for that.
11 We started out by talking about the
12 state of the Advisory Committee on Disability
13 Compensation, the fact that we actually were
14 short a member with John Maki's passing, and that
15 we currently had 11 members, although we wondered
16 if we should add a few more members perhaps
17 another VSO member, another economist or maybe
18 some other mix of people.
19 I went down the list of the current
20 committee members, what kind of backgrounds all
21 of you have and the amazing capabilities and
22 experience that all of you bring to the

1 committee.
2 I discussed with him the Advisory
3 Committee Management Office and the impacts that
4 we operate under and discussed that for a few
5 minutes.
6 I talked about the biennial report
7 that we submitted in October of 2016. The major
8 parts of that including the VASRD and the ways
9 that it slowed implementation of the new rules.
10 The IU question that we've been
11 wrestling with for some time, the appeals
12 process, and the headway that we hope will be
13 made there. Guard and Reserve issues, the
14 National Work Queue.
15 We gave the VA, the committees a pat
16 on the back for the VBA Live Manual which is up
17 and running now. And basically spent a little
18 bit of time talking about the Separation Health
19 Assessments and TAP program, Transition
20 Assistance Program.
21 I had asked Mr. Murphy for his
22 guidance for the committee and our 2017 and '18

1 deliberations for the next Biennium and he said
2 that he would present that to us.
3 We talked about the committee's
4 activity including the three interim reports. In
5 October of 2015, the VA concurred with two of the
6 issues in the interim report and the biennial
7 reports, dating back to a 2010, 2012, 2014, and
8 the current one in 2016.
9 And then we finished up the time
10 talking about the presumptives the VA is involved
11 in, including Agent Orange, the question of IU,
12 VASRD, and the progress we hope to see there and
13 the other issues surrounding our deliberations
14 over the past several years.
15 It was a really good meeting. He has
16 fully read into everything that we've been
17 working on as you would imagine. Offered some
18 support and hopefully we'll see him again.
19 DR. VVEDENSKAYA: Yes, this afternoon.
20 CHAIRMAN MARTIN: Good. We also had
21 the chance to extend to the new Secretary of the
22 VA, an invitation to join the committee. I was

1 interested in your invitation that you noted the
2 committee had never actually heard from a
3 Secretary of the VA at the meeting, personally,
4 which is interesting.
5 Now understandably, he was unable to
6 make it today, Dr. Shulkin. And hopefully he
7 will get that on the calendar when it will be
8 convenient for his schedule and our schedule in
9 the very near future.
10 We had asked for some guidance from
11 the top office on the directions for VA, what are
12 the VA priorities under a VA Secretary Shulkin
13 Administration and so I think we're going to,
14 hopefully we'll hear something about that during
15 the course of this meeting.
16 So that kind of brings us up-to-date
17 on where we have been since we last met. I'm
18 happy to see you all here today. I think we have
19 a busy agenda this week. And as we go through
20 the next several meetings, we're going to have to
21 more clearly formulate where our interest and
22 intention will be directed toward the 2018

1 Biennial Report, and if there's any need for
2 interim reports prior to that.
3 Opening comments? Any around the
4 table of Committee Members? Any opening
5 comments?
6 MEMBER LOWENBERG: What is Mr.
7 Murphy's permanent position and where will we
8 expect him to be in the Administration when a USB
9 is appointed?
10 MEMBER PAMPERIN: He's actually the
11 Deputy Under Secretary, the Principle Deputy
12 Under Secretary.
13 DR. VVEDENSKAYA: Mr. Murphy is the
14 Acting Under Secretary for Benefits.
15 MEMBER PAMPERIN: Right, right. Yes.
16 His name went forward for the Under Secretary but
17 that was no guarantee.
18 CHAIRMAN MARTIN: So the answer is,
19 don't know at this point if he'll stay there.
20 MEMBER SIMBERKOFF: But it's
21 interesting. One of the things that was raised
22 in the confirmation hearing for Dr. Shulkin was

1 the issue of IU so he actually spoke at some
2 point for that and was trying to resolve that
3 problem as well.
4 MEMBER ROBERTS: Great report.
5 MEMBER SIMBERKOFF: Yes.
6 CHAIRMAN MARTIN: Do you have any
7 opening comments?
8 MEMBER SIMBERKOFF: No.
9 CHAIRMAN MARTIN: Hal? Any opening
10 comments, questions?
11 MEMBER BIRD: No. I'm looking very
12 much forward to the next publication on the Gulf
13 War. Thank you.
14 CHAIRMAN MARTIN: Good. Thanks for
15 being here.
16 Elder, any opening comments?
17 MEMBER GRANGER: No. I'm good to go.
18 CHAIRMAN MARTIN: Doris, I missed you
19 at the end of the table down there. Welcome.
20 MEMBER BROWNE: Thank you. Yes, no
21 comments. I think that this is a good report.
22 Looking forward to seeing what we bring to the

1 list of priorities.
2 CHAIRMAN MARTIN: Good. And Warren,
3 did you make it online yet? Okay. Warren is
4 recovering from surgery and hopefully he'll join
5 us later.
6 Any opening -- we have a section
7 reserved for public comments but if any of you
8 have any issues that you would like to briefly
9 unfold at this point I'm happy to hear them.
10 DR. VVEDENSKAYA: If I may, I just
11 would like to engage as a committee on two items
12 which Dr. Martin mentioned.
13 One is the state of the 2016 Biennial
14 Report. As of last week, the report and almost
15 made it to Mr. Murphy's office, and currently it
16 is with the Office of Disability Assistance,
17 otherwise known 20P, and being reviewed over
18 there.
19 VA response is that it was supposed to
20 be moving to the Office of Under Secretary for
21 Benefits either Friday or today since we are
22 moving.

1 And the second item was the, as
2 General Martin mentioned, that we are looking for
3 new members for our committee. And on February
4 17 we placed a solicitation of nominations for
5 the appointment to our committee in the Federal
6 Register.
7 I forwarded this information to all of
8 you for further distribution among your
9 colleagues and interested persons.
10 I also informed the Veterans Service
11 Organizations community that we placed such
12 solicitation and the deadline is on March 31st.
13 And all interested persons should
14 submit their letter of intent, their full CV, and
15 a short bio to the Advisory Committee Management
16 Office.
17 And then they will catalog all the
18 interested persons and then they will forward it
19 to us to the DFOs to put the package together for
20 everybody to review and make their, select the
21 recommendation and selection.
22 And again, the committee members are

1 selected by the Secretary of Defense and we
2 usually prepare for package with these three
3 documents, the letter of intent, short bio and
4 full CV. Please feel free to again alert all
5 interested persons about that posting in the
6 Federal Registry.
7 CHAIRMAN MARTIN: During the course of
8 the Medal of Honor reception, I had a chance to
9 meet with a gentleman named Jared Lyon, who is
10 president and CEO of Student Veterans of America,
11 who represents over 1.1 million Veterans who are
12 using the GI Education Bill.
13 Now the reason that our discussion
14 extended a little bit was because their
15 organization has done some data collection and
16 analysis on their members. And I was very
17 interested to learn that 25 percent of them are
18 disabled.
19 And the Student Veterans of America is
20 also helping to assure that the VA benefits
21 briefings are provided to members who did not
22 have the chance to receive TAP, Transitional

1 Assistance Program.
2 That's one of the things our
3 committee's worried about, how are these people
4 that kind of fall through the TAP net learning
5 about VA benefits, how they get enrolled and MyVA
6 and things like that. So they are working on it.
7 I had invited Jared Lyon to present to
8 the committee on their data acquisition and some
9 of the things that they've found out about the
10 student Veterans but I think he was unable to get
11 it scheduled so that he also could be with us
12 today. Maybe that'll be a future meeting for us.
13 The invitation was extended by Dr. V and just
14 didn't work out for this meeting.
15 MEMBER LOWENBERG: Mr. Chairman, thank
16 you for arranging our meeting with Mr. Murphy. I
17 think we're going to see an extended period of
18 time in which actings are now served throughout
19 the Administration.
20 I've been following the nomination
21 process very closely in the Departments of
22 Defense and Homeland Security and, you know,

1 there aren't any nominees yet for Under
2 Secretary, especially Deputy Under Secretary or
3 Assistant Secretary, in those two major
4 departments.
5 Some of the appointment, some of the
6 nominations from the White House that were made
7 immediately following the inauguration, I'm not
8 even anticipated to get a hearing until late
9 April. So this could be a very protracted period
10 of transition.
11 MEMBER PAMPERIN: I did also, I forgot
12 to mention, I watched the hosts here on the
13 National Work Queue --
14 CHAIRMAN MARTIN: Yes.
15 MEMBER PAMPERIN: And that was kind of
16 interesting. It was fairly amiable. But the
17 committee was expressing concern that the
18 inventory of disability claims is rising. Not
19 substantially. It's up maybe 20 or 30,000 but
20 still it's not going down.
21 And they put that off to a large
22 degree on focus and on getting rid, reducing the

1 inventory of what I generally call ancillary
2 claims, dependency issues and other non-rating
3 claims, which I thought was a little curious
4 since generally speaking, people who do those
5 don't do ratings. So I don't understand why it
6 would necessarily prevent them from reducing it.
7 But there was also something I had not
8 heard before. One of the congressmen indicated
9 that there is a replacement for VBMS which is the
10 foundation of the Natural Work Queue supposedly
11 in the works. And I had never heard that before
12 and it wasn't refuted. So it'll be interesting
13 to see what happens from that.
14 CHAIRMAN MARTIN: Sure will. I have
15 not heard any of it.
16 MEMBER PAMPERIN: Yes.
17 MR. MANAR: If I might interject for
18 a moment, if that's allowed?
19 CHAIRMAN MARTIN: Yes, sir.
20 MR. MANAR: One of the other reasons
21 that disability claims and those pending are
22 increasing is because the VA has not just shifted

1 to doing ancillary claims, such as dependency
2 issues which have decreased in the last year by
3 well over 100,000, but also because Tom Murphy
4 has built a wall around the appeals teams.
5 During the last four or five years
6 with this push to get down to disability claim
7 backlog, managers in the field would take every
8 single person who ever rated a claim, including
9 those on the appeals team, and have them rate
10 claims.
11 And in the last nine months or a year,
12 Mr. Murphy has told people in the field with no
13 uncertain terms, they're going to process
14 appeals.
15 And the consequence, the total number
16 of appeals currently pending in the regional
17 offices now, this doesn't mean they've all gone
18 away, but the number I'm going to give you is,
19 it's about 25 or 30,000. It's increased over the
20 last year.
21 Now because of the two-step appeals
22 process, once a statement of the case is issued,

1 only about half of those come back and file a
2 formal appeal.
3 So many of those 25 or 30,000 that
4 have decreased in the regional offices have
5 either not perfected their appeal or they've gone
6 to award. So but the critical thing here is that
7 there's movement on appeals for the first time in
8 four or five years.
9 CHAIRMAN MARTIN: One of the things
10 this committee discussed and heard about at our
11 last meeting in December was the fully developed
12 appeals discussion, kind of how that might
13 forward a number of pending appeals and speed up
14 the process of appeals.
15 MEMBER PAMPERIN: There was, I was
16 reading yesterday the Department's 2017 summary
17 of its budget submission and the briefing that we
18 had gotten about the appeals process and raising
19 the number of employees from BVA to 900 then an
20 additional 300 in staffing and appeals. All of
21 that was in the budget submissions.
22 MEMBER FAY: Which is part of the

1 question I had risen that when you asked for
2 issues to be discussed, how is the freeze
3 affecting issues like that?
4 DR. VVEDENSKAYA: And now we have the
5 best person today to present on that. I think
6 that and because that certain time had passed
7 since that question was asked, there were more
8 developments. I think you will have the most up-
9 to-date information.
10 MEMBER FAY: Up-to-date, great.
11 MEMBER SIMBERKOFF: So VHA was
12 excluded. Did BVA not be excluded from the
13 freeze?
14 DR. VVEDENSKAYA: There are many
15 positions which are excluded from that freeze but
16 I cannot speak to the particulars of that
17 decision because it changed and also I don't have
18 a depth of knowledge of that subject.
19 CHAIRMAN MARTIN: One of the issues
20 that we've discussed at our December meeting on
21 December 6th was the question of presumptives
22 including Agent Orange. And that discussion led

1 to Gulf War illness and some other issues
2 surrounding that period of combat for American
3 fighting men and women.
4 And we were lucky enough to have Jim
5 Sampsel available. We sort of kidnaped him and
6 brought him into the room and he gave a marvelous
7 recap of kind of where we were with the Agent
8 Orange picture and what was going on with that
9 presumptive.
10 And we wanted to, I know Mr. Bird, you
11 were one of the committee members that wanted to
12 look into that a little more in-depth and so Dr.
13 V was kind enough to arrange two opening segments
14 this morning, dealing with Agent Orange Gulf War
15 illness and those studies. So we're happy to
16 have that time to look at those issues in a
17 little more detail.
18 MEMBER BIRD: Bravo.
19 CHAIRMAN MARTIN: Yes. We'll look
20 forward to that.
21 (Off the record comments)
22 CHAIRMAN MARTIN: So Dr. Jones won't

1 be able to join us by telecon today.
2 All right. Just take a quick look and
3 see if there's anything else we needed to follow-
4 up from last time around.
5 All right. I'll relate one
6 interesting sideline that many of the committee
7 members probably have experienced between
8 meetings and their own careers and lives.
9 I was sitting in a reception following
10 a promotion, a military promotion, in the little
11 town of St. Augustine, Florida, the oldest city
12 in America. 1565 is when that town was born.
13 And the mayor of St. Augustine was
14 sitting at this small table and we started
15 talking and she said something about the VA and
16 that led to some discussions about the VA
17 Advisory Committee.
18 And she said we just finished last
19 month, doing our point-in-time counts. Remember
20 the PIT counts that we've talked about here, the
21 Hope for Homeless?
22 DR. VVEDENSKAYA: Yes, yes.

1 CHAIRMAN MARTIN: They pick a night in
2 January and they go out and everybody counts the
3 number of homeless people they can find in their
4 cities and they report them.
5 And they actually did that in little
6 St. Augustine, Florida. And her data this year
7 was that the count was significantly lower than
8 it had been in prior years.
9 Don't know nationally what that
10 count's going to be. We have asked for that
11 number as soon as it's available and we'll visit
12 that issue again in this committee fully. But it
13 would be nice if that were an experience we saw
14 repeated over many cities in the United States,
15 including some much bigger cities.
16 MEMBER FAY: Yes, I just read that the
17 Hope for all Homelessness is down considerably
18 except in the major cities like New York, Los
19 Angeles and Miami.
20 CHAIRMAN MARTIN: Whether that shows
21 the migration pattern or whether it's just, I
22 don't know, a pattern of them --

1 MEMBER SIMBERKOFF: Well, homelessness
2 in New York City among Veterans at least has
3 been, has plummeted. I don't know what the
4 figure is for --
5 MEMBER FAY: Over all it has down in
6 New York City.
7 CHAIRMAN MARTIN: But that triggers --
8 MEMBER FAY: Yes. It's better.
9 MEMBER SIMBERKOFF: Yes. And actually
10 I think the White House recognized that New York
11 City as being one of the places where the
12 Veterans probably, where it worked most
13 effectively.
14 CHAIRMAN MARTIN: When I first joined
15 this committee, I know some of you that were here
16 at that time, the SECVA's number one priority was
17 to end Veteran homelessness --
18 MEMBER SIMBERKOFF: Right.
19 CHAIRMAN MARTIN: -- by 2015.
20 MEMBER SIMBERKOFF: Right.
21 CHAIRMAN MARTIN: That was the number
22 one priority. So the --

1 MEMBER LOWENBERG: Well, that's very
2 encouraging because homelessness is rising in the
3 major metropolitan areas around the country so
4 that's a counter trend that we can take credit
5 for.
6 PARTICIPANT: They should.
7 MEMBER LOWENBERG: Yes.
8 MEMBER SIMBERKOFF: Unfortunately,
9 good publicity almost never happens. You know,
10 makes its way to the, you know, to the outlets,
11 you know. It's a sad reflection of what the news
12 industry is interested in.
13 MEMBER LOWENBERG: Yes. And even if,
14 you know, there's an internal assessment of what
15 was in that VA portfolio of activities that's
16 been most consistently successful in driving
17 those numbers down.
18 DR. VVEDENSKAYA: Ms. Bradshaw, who
19 has this department within the Veteran Affairs,
20 she presented to us I think twice. And I believe
21 she indicated that the count which is done in
22 January, all the numbers are ready and, you know,

1 sorted out in, by August. We can ask her to
2 comment and give us this feedback.
3 MEMBER LOWENBERG: I guess I'd be
4 particularly interested in the analytic
5 assessment.
6 DR. VVEDENSKAYA: Yes. What it
7 comprises, yes. Can put up.
8 MEMBER LOWENBERG: You know, if
9 there's a cause and effect, the way it affects
10 them, or.
11 MEMBER PAMPERIN: Well, there's a
12 program that the VA participates in with housing
13 and urban development called HUD-VASH --
14 MEMBER SIMBERKOFF: Right.
15 MEMBER PAMPERIN: -- where you can put
16 people in apartments to get them stabilized and
17 stuff like that. That's a big contributor.
18 MEMBER SIMBERKOFF: There are actually
19 targets that are set for each area, each, you
20 know, medical center where they're given a
21 certain number of vouchers. And if you fail to
22 meet that target of getting them, you know,

1 distributed and acted on that goes against your
2 performance managers.
3 CHAIRMAN MARTIN: We actually have the
4 VetPop study people here, that the director
5 briefed us back in September on the demographics
6 of the Veteran population.
7 And for those of you who weren't here
8 I'll kind of briefly review this. In 2014, the
9 top Veteran location was California, followed by
10 Texas and Florida.
11 By 2020, they're predicting that Texas
12 will be the top Veteran location, followed by
13 California and Florida.
14 And by 2030, Texas is the top
15 location. By 2040, Texas is the top location,
16 with California eventually falling to third place
17 behind Florida. So it's kind of a sunshine belt,
18 is where the Veteran population they see
19 migrating a little bit.
20 Illinois and New York, previously very
21 large Veteran populations, is now out of the top
22 ten. Interesting data. That's Peter Ahn and

1 we'll have them back again. They had some
2 amazing data that they follow.
3 DR. VVEDENSKAYA: Yes, I brought that.
4 CHAIRMAN MARTIN: Oh, good.
5 DR. VVEDENSKAYA: Yes.
6 (Off the record comment)
7 CHAIRMAN MARTIN: So we've got just a
8 couple of minutes before our next speaker is due
9 to arrive and we can either have quiet time of
10 personal reflection or a little break, some
11 coffee, or very --
12 DR. VVEDENSKAYA: Little break and I
13 can try to reach --
14 CHAIRMAN MARTIN: Anybody need any
15 caffeine fragments or anything? You're welcome
16 to get some coffee or water or take a short break
17 here. And we'll reconvene here as soon as our
18 speaker arrives.
19 (Whereupon, the above-entitled matter
20 went off the record at 9:10 a.m. and resumed at
21 9:18 a.m.)
22 DR. VVEDENSKAYA: Good morning,

1 everybody. I think we are all back to our seats.
2 And I would like to introduce our morning
3 speakers, Dr. Victor Kalasinsky, from the Office
4 of Research and Development, and Mr. Jim Sampsel
5 from Compensation Service, VBA, whom you know
6 well.
7 And this morning we'll have a
8 comprehensive presentation on the issues of Gulf
9 War illnesses and injuries. And we'll take a
10 look from the research point of view and we'll
11 take a look at this issue from the point of view
12 of policy and the benefits for the Veterans.
13 With this I will pass the torch to Dr.
14 Kalasinsky. Thank you very much for making time
15 and present to this committee.
16 DR. KALASINSKY: Sure. Thank you.
17 Thank you very much. And believe it or not,
18 that's one of the first times someone hasn't
19 stumbled over my last name and that's easy
20 compared to yours.
21 Anyway, I'm with the Office of
22 Research and Development in VHA. And I'm the

1 designated federal officer for another advisory
2 committee. It's called the Research Advisory
3 Committee on Gulf War Veterans' Illnesses.
4 And so I'd like to give you a little
5 background of our office, what we do, and then
6 transition that into especially what the
7 committee does for us and some of these issues
8 that we have with the healthcare and the research
9 that goes into informing that healthcare into the
10 VHA for the Gulf War Veterans, specifically.
11 So next, our Office of Research and
12 Development, obviously a vision and mission of
13 the managers, but I didn't tell you what they
14 were. And again, just a little background on our
15 office.
16 We provide funding for an intramural
17 research program at the VA, which means that it's
18 only VA investigators who are funded. So that
19 means that the same folks who are taking care of
20 Veterans by and large are the ones doing the
21 research.
22 And so the point is or the idea is

1 that the research is driven by the needs of
2 Veterans and the needs of the healthcare
3 providers who are dealing with Veterans. And so
4 it's sort of a process of feeding so long on the
5 other.
6 So researchers are typically providers
7 who see the Veterans and so they know what the
8 problems are. So more than half of our
9 investigators sort of by, not by statute but by
10 design, are medical docs. The others are
11 typically PhDs who are doing some more basic
12 science that feeds into what the medical doctors
13 are doing.
14 So of the 150-some VA medical centers,
15 116 of them have been funded for research by our
16 office and at any given time, maybe 90 of them
17 are receiving research funds.
18 2400 projects again, at any given
19 time, for the annual budget that's typically
20 around 580 to 600 dollars in six, 580 to 600
21 million dollars in research funds that go to the
22 VA medical centers.

1 So the idea that I again emphasize
2 that it's an intramural program. We have people
3 working on the problems that are specific to
4 Veterans. You know, we get asked a lot why don't
5 we just give that money to NIH and let NIH put it
6 into their big pot of money and do the work that
7 we fund in our office.
8 And the point is that NIH has a lot of
9 funding but none of their programs specifically
10 target the problem with Veterans and so that's
11 why we have this separate program within the VA.
12 So 3000 researchers, a broad
13 portfolio, like I said, 2400 projects at any
14 given time, from rehab processes to basic studies
15 across whole gamut.
16 Next slide gives you an idea of how
17 our office is structured. This has part of the
18 Veterans Health Administration. We come under
19 one of the Deputy Under Secretaries. So my boss
20 answers to Deputy Under Secretary, who answers to
21 the Under Secretary, who until recently was Dr.
22 Shulkin and of course now we all report to Dr.

1 Shulkin.
2 But we have four what we call research
3 services. The largest are the clinical science
4 and rehabilitation services. Obviously, this
5 suggests that we've had Veterans in clinical
6 settings and research is being performed
7 addressing the problems that they have.
8 If we're talking about what we call
9 preclinical, that falls into the biomedical
10 laboratory R and D. Those would be animal
11 studies or studies on tissue cultures or blood
12 specimens, any sort of study that's not involving
13 a person in place who's talking to the
14 researcher.
15 Health Services, Research and
16 Development, looks at processes that go into the
17 healthcare delivery. So how efficiently or
18 effectively a particular treatment is working in
19 one group or another to how well Veterans can
20 navigate the system to get the kind of healthcare
21 they need within the VHA.
22 Rehabilitation R and D I suppose is

1 probably the most self-explanatory. The
2 artificial limbs and other things, so
3 reintegration from Veterans into society after
4 they've been in the combat situations, for
5 example. So all those kinds of things, go into
6 rehab R and D.
7 Down below in clinical science we've
8 got another little box called Cooperative Studies
9 Program. And this is a program by which
10 individual studies are expanded into multi-site
11 studies and multi-site anywhere from five to 40
12 different sites where as you can imagine,
13 thousands of Veterans can be involved.
14 So anytime there's a new treatment
15 that's being rolled out, it's because, it's
16 likely that there was a Cooperative Studies
17 Program that was run in many, many, places and it
18 was determined that was a good procedure to put
19 into general practice.
20 So those are the very, very large
21 studies. The rest of these tend to be individual
22 investigators or teams of investigators at

1 usually one site, sometimes two or three sites,
2 but small relative to the Cooperative Studies
3 Program. Next.
4 This just gives you some idea of the
5 kinds of projects that we've had going on and
6 some of the websites where you can get some
7 information about our office.
8 So we have three advisory committees
9 that feed into our office and one is called the
10 National Research Advisory Council, NRAC, we call
11 it.
12 This one provides input
13 recommendations on researching all of the areas
14 that we touch in the Office of Research and
15 Development.
16 Middle one, Research Advisory
17 Committee on Gulf War Veterans' Illnesses.
18 Lovingly known as the RAC because nobody can
19 pronounce that whole thing. So the RAC provides
20 specifically about Gulf War Veterans. And I'll
21 go into more detail about this information here.
22 And then third, we have the GMPAC.

1 It's not too bad to pronounce, the Genomic
2 Medicine Program Advisory Committee.
3 That was created when the Million
4 Veteran Program was started in our office. A
5 program to enroll a million Veterans and any era
6 of many eras and collect survey information about
7 the Veterans as well as blood specimens.
8 And as part of that Million Veteran
9 Program, the VA is contracting out genetic tests.
10 They're being done and the data or the genetic
11 data that's being collected then will be used to
12 do all sorts of things.
13 But the important thing is that we'll
14 be able to send the data to researchers inside
15 the VA, outside the VA. They won't have to know
16 which Veterans by name that they're dealing with,
17 but they'll get the de-identified bulk data that
18 they can do various kinds of analysis of.
19 And so the idea is that this is a way
20 to get more people involved in the research that
21 specifically the genetic research.
22 And given that there will be

1 ultimately a million Veterans that means that
2 there are lots of Veterans from every era,
3 whichever group you want to study. There will
4 likely be plenty of information.
5 We're at I think 540,000 now so we're
6 more than halfway to a million, and we're
7 actually a little bit ahead of schedule on that
8 so we're excited about actually getting all that
9 information.
10 And interestingly enough, with the
11 emphasis now on precision medicine as it's
12 called, this is the kind of information that's
13 going to be important for that.
14 And the VA, with 500,000 plus people,
15 has the largest genomic database in the world,
16 basically. And some of the folks who are
17 interested in precision medicine were a little
18 surprised that the VA was ahead of the curve.
19 And so you were saying we've got to
20 take advantage of all the good news stories that
21 we have out there and this is certainly one of
22 them.

1 So this, the Genomic Medicine Advisory
2 Committee also advises, works with this committee
3 to give us advice about more Veterans issues when
4 it comes to genetics genomics.
5 So anyway, we have all three of these
6 as it said on the DFOs. There's a new federal
7 officer for the Iraq and -- let's go to the next
8 one.
9 So just some background. I think
10 probably everybody knows this but just as a
11 reminder.
12 So we got started in 1990. We sent
13 troops over to Saudi Arabia. The air war started
14 in January. I got home in just in time to watch
15 it on the news as I was eating dinner that
16 evening.
17 The ground war started in February.
18 It was a hundred hours, four-day war. Cease fire
19 was declared. And technically the end of Desert
20 Storm was not until April but as I think I
21 already heard in the realm, the Persian Gulf War
22 as it was called in those days, continues until

1 the ended by Presidential proclamation of the
2 law. So the Gulf War technically is still going
3 on.
4 My emphasis is on the Desert Shield,
5 Desert Storm Veterans and that's also been the
6 focus of this advisory committee that I'm the
7 DFOS for.
8 But because the Gulf War still goes
9 on, I also get involved in things like OIF OEF.
10 And since I'm a chemist slash toxicologist, I get
11 pulled into Agent Orange issues as well. But
12 anyway this is -- next.
13 And as we all remember, returning
14 Veterans reported a variety of exposures. And
15 when I came in I picked up the sheet I guess Mr.
16 Sampsel put together and I did not collaborate on
17 these, but everything I've got on my list are on
18 his list as well.
19 But obviously, there's plenty of sand
20 and dust in a desert environment with the oil
21 wells and the damaged rig blown up. There was
22 plenty of oil, there was oil in the well, fire,

1 smoke, soot, all kinds of things.
2 There were pesticides, pyridostigmine
3 bromide pills. These were used to counteract the
4 effects of some of the nerve agents that Saddam
5 Hussein was known to have.
6 Fuels and solvents, vaccinations,
7 chemical weapons. Both the nerve agents and the
8 mustard agents that again, Saddam Hussein was
9 known to have.
10 It's not an exhaustive list of course.
11 So one slide. There were other concerns as well.
12 Liquid uranium, all these things have been in the
13 news.
14 I just wanted to give you an idea.
15 And I was amazed to see this same list that Mr.
16 Sampsel used and we did not dress it down and
17 collaborate on this. Next slide.
18 And then there were many symptoms
19 reported by your returning Veterans. The
20 musculoskeletal pain, fatigue, having the
21 problems finding the right words, remembering
22 things, all sorts of problems like that.

1 Gastrointestinal problems, respiratory
2 disorders and conditions, rashes, sleep
3 disorders, a lot of sleep apnea reported from the
4 Gulf War Veterans.
5 The biggest problem with all of these
6 symptoms is that they're aren't really any tests
7 for muscle pain, joint pain, or fatigue. There
8 are some certain things that can detect cognitive
9 problems.
10 But many, many of the things that Gulf
11 War Veterans were reporting are just hard to
12 test. And so that led to some of the problems
13 that we've had for the past 25 years. Next,
14 please.
15 So given that, there are few or no
16 abnormal laboratory tests in these returning
17 Veterans. Gulf War syndrome was the first name
18 that was applied to the health problems and their
19 various combinations of unexplained, undiagnosed
20 and all the symptom chronic Gulf War illness,
21 Gulf War Veterans' illnesses.
22 Veterans and many researchers prefer

1 this term, Gulf War illness, describing that
2 whole set of conditions that Gulf War Veterans
3 have, as one single thing.
4 The VA took the approach early on to
5 use the term at the bottom, Gulf War Veterans'
6 illnesses, recognizing that many Gulf War
7 Veterans had diagnosable illnesses and
8 undiagnosed illnesses as well.
9 So VHA has to take the view of
10 treating the whole Veteran, the Veteran, whatever
11 kinds of problems he or she may have.
12 So if it's Gulf War illness, fine, the
13 VHA's going to treat that person. If it's
14 irritable bowel syndrome, chronic fatigue
15 syndrome, multiple sclerosis, whatever else that
16 might be diagnosable with these, the VHA is still
17 a device for people to get the treatment.
18 So that's one of the issues that we've
19 had with the Gulf War Veterans and I'm sure you
20 can imagine.
21 We're very focused on Gulf War
22 illness, whatever that means, whereas VHA has to

1 deal with everything that's of a medical concern
2 to Veterans of any era, specifically the Gulf War
3 era. So, next.
4 Getting back to the Research Advisory
5 Committee. There was a lot of trouble early on
6 and I think and everybody here around the room, I
7 think most of you remember as I do, that the DoD
8 was the first office returning service members
9 that started complaining of problems.
10 A lot of them were told that they
11 weren't ill because there were no abnormal lab
12 tests. And you know we've got great technology,
13 all kinds of machines and everything else and
14 none of those were indicating any problems.
15 So the Veterans were treated pretty
16 badly by DoD initially. I know that one of the
17 earliest studies of a National Guard group in
18 Indiana determined that the problems they were
19 having were simply from having been deployed and
20 then redeployed home.
21 So there's an increase in their
22 symptoms each time they were transitioning from

1 home to theater and then from theater back home.
2 And so the notion was that most of the
3 problems were psychosomatic, psychological.
4 You're imagining these problems, you'll get over
5 them. And that obviously didn't sit very well
6 with the returning service members.
7 Many of course wanted to stay in the
8 military and so they didn't report some of their
9 symptoms because they didn't want to be mustered
10 out.
11 So there was almost an immediate
12 butting of heads when Veterans came back and
13 started reporting the problems they were having.
14 As some of those transitioned to the
15 VA, the VA line was not very different from what
16 the DoD had been saying. And so that all
17 culminated in Congress passing some laws in the
18 90s. 1988 in particular.
19 Congress mandated the formation of an
20 advisory committee in '98. That committee was
21 chartered by the VA in 2002. Congress gave this
22 responsibility to the Executive Branch.

1 The President was to assign it to an
2 agency within the Executive Branch and two
3 obvious possibilities, of course, would be DoD or
4 the VA.
5 And since many of the folks were
6 moving from DoD into the VA, I think the obvious
7 choice and the most logical choice was the VA.
8 So we have this advisory committee.
9 Another piece of that legislation
10 required annual reports to Congress and those
11 were required through 2014. We've also done a
12 report for 2015. We haven't sent it to Congress
13 since they didn't ask for it. But it's about to
14 be put up on our website so the information will
15 still be there.
16 The same year there was also a law
17 that required reports by the Institute of
18 Medicine or the National Academy of Sciences.
19 The Institute of Medicine is now called the
20 National Academy of Medicine since the middle of
21 2015.
22 And these reports were required every

1 two years by the Gulf War and Health. We've got
2 ten of those and they're required through 2016 so
3 the last one was released in February of last
4 year. And so we have the Institute of Medicine
5 giving us recommendations in the same way that
6 the Institute of Medicine does the biennial Agent
7 Orange, Veterans and Agent Orange reports which I
8 suspect you've dealt with in the past.
9 So I mean this law was based very much
10 on the Agent Orange law. So we get advice from
11 the Institute of Medicine. We get advice from
12 the Advisory Committee.
13 My phone number and email address is
14 in the Federal Register. I get advice from
15 Veterans all over the country.
16 So that's the kind of thing that
17 informs what we do in the Office of Research and
18 Development. Next slide.
19 Oh, I wanted to divert you for a
20 second to talk about the Institute of Medicine
21 Reports. Next.
22 This is the one that was released in

1 February of last year, is Volume 10. We are,
2 actually even though this one's not required by
3 the law, we have decided to go ahead and request
4 a Volume 11 from the National Academy of Medicine
5 specifically to study intergenerational effects.
6 These are issues that have come up, I
7 think you probably know, with the Vietnam
8 Veterans concerned about their children and
9 grandchildren. And there are actually a few
10 presumptives that the VA has for children of
11 Vietnam Veterans.
12 So there had been concern from the
13 very beginning in the early 90s about Gulf War
14 Veterans transmitting whatever they had to their
15 spouses and their children. So we're having the
16 National Academy of Medicine look into this for
17 us so we had the kickoff meeting in January.
18 (Whereupon, the above-entitled matter
19 went off the record at 9:43 a.m. and resumed at
20 9:47 a.m.)
21 DR. KALASINSKY: So the three reports
22 that are up there, one last February, Volume 10,

1 one that we just kind of got kicked off in
2 January, the Volume 11. But there's also a third
3 one that's sort of in the middle there, assessing
4 burn pits. That one is still going on, but there
5 was an interim report and we were briefed at VA
6 on the 28th of February, which is just last week.
7 And then the day after I sent these
8 slides to Dr. V, that's when I got the link to
9 the actual report. So it's on the National
10 Academy of Medicine website, if anybody wants
11 that and, you know, the links there will get to
12 the right places. So as I said, we get advice
13 from a lot of folks.
14 The next slide gives you some idea of
15 the Advisory Committee. This is kind of a stream
16 capture from the Advisory Committee Management
17 Office website, and the address is given there.
18 And you see, as I said, my name, address, phone
19 number are all out there, so I get lots and lots
20 of fan mail I think you call it.
21 In addition to this brief information
22 that's on the Advisory Committee Management

1 Office website, you see at the bottom of that
2 slide there's an address for a web page for our
3 committee, and it is fairly extensive. It has
4 the minutes from all the meetings from 2002 up to
5 the present, slides that were presented at those
6 meetings, all sorts of things, various documents,
7 all the recommendations that we've gotten from
8 the Committee, a couple of reports that the
9 Committee has submitted over the years. So it's
10 a pretty extensive website.
11 Next slide gives you just an excerpt
12 from the charter, which is probably no surprise.
13 That's pretty standard stuff, but the Committee
14 is charged to provide advice to the Secretary,
15 and as you can imagine whatever advice comes to
16 the Secretary filters down to the DFO and we have
17 to address these things that come through.
18 Just to give you an idea of how our
19 Committee operates, we have up to three meetings
20 a year and they're open to the public. It's
21 interesting when we were renewing the charter,
22 one of the lawyers pointed out that it said we

1 could have up to three meetings a year, but it
2 didn't say we had to have any meetings per year.
3 So the charter was changed from simply
4 three meetings, up to three meetings per year to
5 at least one and up to three meetings per year.
6 There were some folks who claimed that that was
7 limiting the number of meetings that the
8 Committee could have.
9 And so I had to stop doing useful
10 things and respond to those kinds of complaints.
11 So it can be challenging when your phone number
12 and email address are out there on the web.
13 Anyway, we have a segment for public
14 comments, as you do here of course, and I just
15 wanted to point out that very often, the veterans
16 who come to these meetings and make public
17 comments are telling us about problems they've
18 had with getting health care through VHA or
19 getting benefits through VA.
20 I guess that's no surprise to anybody.
21 VBA and VHA get a lot of grief from veterans who
22 are upset with the responses that they get. So

1 as you can imagine, our Committee is making
2 research recommendations and that research and
3 their recommendations are supposed to translate
4 into research that then provides information to
5 providers who are giving them care and of course
6 that information feeds into VBA as well.
7 As I sort of indicated, there are
8 Committee reports that are on the web page we
9 have. In 2004, they produced a 430 page report.
10 DR. VVENDENSKAYA: On my goodness.
11 DR. KALASINSKY: I should have brought
12 those and --
13 DR. VVENDENSKAYA: When you said that
14 you can have between one and three meetings a
15 year, our Committee knows how much labor and time
16 goes into every biannual report we make, and
17 that for you to produce an annual report which is
18 filled with up to date scientific information.
19 DR. KALASINSKY: Yes.
20 DR. VVENDENSKAYA: Thank you very much
21 for doing it, but that is a gargantuan amount of
22 work.

1 DR. KALASINSKY: Yes, and of course
2 the 2004 report covered the time from 1990
3 through 2004, so 430-some pages. In 2008, it was
4 an update, so only four years and it was only 200
5 and some pages. In 2014, 130 pages. So you
6 know, we may be getting a handle on the
7 literature that's coming out, the research
8 literature that's coming out.
9 In addition to those reports, of
10 course we get recommendations, not necessarily
11 from every meeting but from most meetings we'll
12 get a few recommendations. There was one list of
13 recommendations a few years ago that it was a 46
14 page list of recommendations. So as I said, that
15 then keeps me busy for long periods of time after
16 the meetings, as you can imagine.
17 Next slide. Since I knew Mr. Sampsel
18 was going to be here, I thought I'd put
19 presumptive conditions up. But again, he's got
20 the same words on the sheet that he put together.
21 MR. SAMPSEL: That's because it's
22 common knowledge.

1 DR. KALASINSKY: Yes indeed. So you
2 see there are some conditions that are
3 presumptive diagnosable, but then others that are
4 not diagnosable, and that's one of the really big
5 problems that we have on the research side, that
6 physicians have on the health care side and
7 obviously the VA has on the benefits side.
8 Diagnosed illnesses that are symptom-
9 based are just very, very complicated to deal
10 with. It was just -- it's just a fact of life
11 unfortunately.
12 The next slide gives you a list of our
13 own members. See, we've got a pretty -- it's
14 actually a large committee. We expanded it from
15 12 to 16 at the request of our chair. He
16 requested me to request to the Secretary and the
17 Secretary approved that. We got busy and it's
18 more folks, but as you can see we've got a lot of
19 different kinds of expertise there, medical docs,
20 Ph.D.s, researchers, nurses, lawyers, all sorts
21 of folks.
22 Our chair is Stephen Hauser, who's

1 chairman of the Neurology Department at the
2 University of California-San Diego, the largest
3 neurology department in the country. Kim Adams
4 is a lawyer, a former respiratory tech turned
5 lawyer who works in a legal aid facility in Ohio.
6 Jim Bunker is a mathematician, so we
7 always have pretty stiff statistics when we start
8 looking at research projects. Fiona Crawford's a
9 geneticist researcher who runs a private research
10 foundation and splits her time with the Tampa VA.
11 So she's kind of got her feet in both fields or
12 both approaches to doing the research.
13 Marylyn Harris, a nurse who deals with
14 veteran -- well veteran-owned businesses, but
15 mostly women veteran-owned businesses. Steve
16 Hunt is a medical doc in Seattle who's been
17 running what's now called a deployment health
18 clinic, but it started out as a Gulf War clinic
19 back in the early 90's, and he's still running
20 that clinic. Of course now he also sees OIF/OEF
21 veterans in addition to Desert Shield/Desert
22 Storm veterans.

1 Nancy Klimas is a researcher and
2 primary care provider with the Miami VA, who had
3 been on the faculty at the University of Miami as
4 well. Now she has moved to a different
5 university in Fort Lauderdale, but she still
6 treats patients at the VA and does research at
7 the university and the VA.
8 Katherine McGlynn is with NIH. She's
9 actually with the National Cancer Institute.
10 She's an epidemiologist, cancer epidemiologist.
11 Now that we're 25-26 years out from Desert
12 Shield/Desert Storm, that latent period for
13 cancers to develop has come, and it's beginning
14 to -- well, we're beginning to see more concerns
15 about cancer so we now have a cancer
16 epidemiologist on the panel.
17 Jeff Nast is a lawyer with the
18 Environmental Protection Agency. So he deals
19 with the laws surrounding environmental problems.
20 He's in the Philadelphia office, so he's very
21 familiar with environmental exposures. Steve
22 Ondra is a neurosurgeon and I'll tell you more

1 about him in a second.
2 Fran Perez works for the state of
3 North Carolina, and she runs their veteran
4 business -- veteran-owned business agency, if you
5 will, for the state of North Carolina. North
6 Carolina's got plenty of veterans with Fort Bragg
7 and other facilities down there. So he's working
8 with veterans who want to start their own
9 businesses.
10 Martin Philbert's a toxicologist who
11 is also dean of the School of Public Health at
12 the University of Michigan. Scott Rauch is an
13 M.D. who's president of a hospital in Boston and
14 on the faculty at Harvard. Carolyn Tanner,
15 Caroline Tanner is an M.D. Ph.D. She runs the
16 Parkinson's disease research facility for VA out
17 in California.
18 Mitch Wallin is a physician who runs
19 the multiple sclerosis clinics here in D.C. and
20 in Baltimore, so he splits his time. Scott Young
21 runs the Northern California version of Kaiser
22 Permanente. So a very large health care

1 operation. So we've got a lot of subject matter
2 expertise.
3 But I want to also tell you that Kim
4 Adams who's a lawyer, as I said was a respiratory
5 therapy was in the Air Force and a Gulf War
6 veteran. Jim Bunker was enlisted and got his
7 math degree on the G.I. bill and then went to
8 Desert Storm as an officer. He was a captain,
9 and he had to be medevac'd out because he got
10 sick in theater some of you who have been around
11 the VA for a few years might remember former
12 Chief of Staff John Gingrich.
13 Colonel Gingrich was Jim Bunker's
14 commanding officer in the Gulf. So Jim brings a
15 lot of expertise in addition to his mathematical
16 skills. Marylyn Harris is an Army veteran. Jeff
17 Nast is an Army veteran. Steve Ondra served in
18 one of the combat support hospitals doing surgery
19 at the front, if you will, a neurosurgeon.
20 Let's say, then Scott Young, Navy
21 flight surgeon. So he was in the Gulf as well.
22 So we've got the scientific and medical

1 expertise, as well as the veterans' perspectives
2 in a lot of different ways, having physicians who
3 are also veterans along with the enlisted folks
4 who are lawyers and nurses and the like. We feel
5 like we've got a lot of useful -- we will get or
6 continue to get a lot of useful recommendations
7 from this group.
8 Anyway, next slide. This information
9 comes from our strategic plan, our research
10 strategic plan, and it identifies the eight focus
11 areas for the research. So it's these areas that
12 we expect our Advisory Committee to give us
13 advice on what kinds of things should we be doing
14 in each of those categories, and the emphasis in
15 all of the research is on treatments and
16 diagnosis.
17 Gulf War veterans don't have a good
18 treatment that works for all of them, and we're
19 25-26 years out. That's frustrating obviously to
20 the veterans, but also to the physicians who are
21 trying to treat them. There's no simple game
22 plan. It's a matter typically of treating

1 symptoms that the veterans have, so treatments
2 are different for different veterans and that
3 just makes it very, very complicated.
4 Some of these other things, as you can
5 see, genetics of biomarkers using animal models
6 to try and understand what was going on, all very
7 important as a means of getting to the
8 treatments, but also to the diagnosis of what the
9 problem is. I think, I think the research is
10 getting there.
11 There are a lot of -- a lot of studies
12 that have pointed to changes to the -- well,
13 changes to the central nervous system and the
14 autonomic nervous system, the part that sort of
15 operates on its own and if we don't know it's
16 working, the part that controls the heartbeat,
17 the respiration and those kinds of things.
18 So the nervous system has been
19 affected by whatever folks were exposed to, and
20 of course one of the big challenges is try to
21 explain why two people in the same tent were
22 affected differently, and that's where the

1 genomics has probably come in. So we're glad
2 that we've gotten some genomics studies started,
3 one in cooperation with that Million Veterans
4 program that I mentioned earlier.
5 So and then with treatments and
6 diagnosis, all of that then has to -- number 5.8
7 says "Be translated from the research part of
8 what we do into practice," so that the docs
9 treating veterans can use the information that we
10 get from the research. So translation is what
11 that's called these days.
12 Anyway, the next line, let me just
13 jump a little bit outside of the Committee, but
14 something that's related to the Committee. We
15 work pretty closely with -- with the VA, of
16 course we do, with the DoD. There's also a DoD
17 program in Gulf War research. Part of their
18 -- on that first line list acronym,
19 Congressionally-Directed Medical Research
20 Programs.
21 So these are programs that Congress --
22 anybody from Congress in the room? Staffers,

1 nobody? Congress obviously didn't trust the NIH
2 to do some of the targeted research that Congress
3 thought needed to be done, and so they gave these
4 programs to DoD.
5 One of the programs within the CDMRP,
6 the P in CDMRP is programs plural, is what they
7 call the Gulf War illness program, and the
8 difficulty that DoD has is that these programs
9 are funded year to year, and if Congress for some
10 reason decides not to fund a particular project,
11 then there are no funds or another really bad
12 possibility is that if the government works on a
13 continuing resolution for the entire year, there
14 will be no funds for this program that DoD runs.
15 So it's troublesome. But we try to
16 work as closely as we can with the DoD, to make
17 sure that what they're doing and that we're doing
18 kind of go together, as opposed to work at odds
19 or obviously we don't want to duplicate anything
20 unnecessarily. So I meet fairly regularly with
21 my counterpart at DoD. We go over what each of
22 our portfolios have, the investigators who are

1 being funded by our respective programs to make
2 sure we're not double-funding somebody, because
3 there are VA researchers who also apply to the
4 DoD.
5 Many VA folks, as you probably know,
6 have appointments at University medical schools,
7 so they can apply for DoD funds through their
8 university, VA funds through the VA. But if it's
9 the same project, it can't be double-funded and
10 we have to be very careful about that.
11 DoD contributes to that annual report
12 to Congress that I mentioned earlier, and there
13 are a number of working groups that VA and DoD
14 cooperate through. I belong to the Deployment
15 Health Work Group and to the Medical Research
16 Work Group, and those two groups report to what's
17 called the Health Executive Council.
18 That council is co-chaired by a VA and
19 DoD higher up person, the undersecretary for
20 Health chair is the VA co-chair, and whoever his
21 counterpart is in DoD is the other. Then that
22 group reports to what's called the Joint

1 Executive Council, the JEC we call it, J-E-C, and
2 that's chaired by -- co-chaired again by VA and
3 DoD folks.
4 The VA co-chair is the deputy
5 secretary. So it's pretty high level, really
6 high level from my perspective. So we in the DoD
7 get together and make sure that we're doing
8 things that are useful and we've got oversight
9 from the higher-ups who are really interested in
10 all of these things.
11 MEMBER LOWENBERG: Dr. Kalasinsky, let
12 me ask a question. Is this collaborative effort
13 that you've been describing for the Gulf War
14 period replicated at all for OIF/OEF Vietnam?
15 DR. KALASINSKY: You know yes, I
16 should mention. In that fourth bullet, the
17 Deployment Health Work Group and Medical Research
18 Work Group, we cover all eras. There is -- you
19 know, there's not a person like me assigned to
20 OIF/OEF. There's not a person like my
21 counterpart at DoD who's assigned to OIF/OEF.
22 So Gulf War gets, you know, some very

1 pointed treatment. I mean we're -- that
2 operation, Desert Shield, those operations Desert
3 Shield/Desert Storm I think are the only ones
4 that have their own advisory committee.
5 MEMBER LOWENBERG: Right. You
6 described at the outset what I interpreted to be
7 skepticism on the part of DoD and VA initially to
8 claims of symptoms that veterans thought were
9 related to their service in the Gulf War. Are
10 these subsequent working groups for OIF/OEF kind
11 of reflective of perhaps more acceptance that
12 sort of in that region of the world or in those
13 kinds of combat conditions, deployment
14 conditions, warrant some special attention?
15 DR. KALASINSKY: Yes, absolutely. I
16 think the attitude has changed markedly since the
17 early 90's, and so you know, I think VA and DoD
18 are working, both working on trying to get things
19 right and make up for mistakes that were made in
20 the past. There's no question that that's the
21 attitude of both agencies these days.
22 MEMBER SIMBERKOFF: So before we go

1 on, is it known to the extent to which the
2 illnesses that constitute this spectrum, you
3 know, are shared by the civilian populations or
4 the other military groups that joined with the
5 U.S. in the Gulf War in the other?
6 DR. KALASINSKY: Yes. There actually
7 have been some papers about, research papers
8 published about OIF/OEF veterans showing up with
9 the same kinds of symptoms that Desert
10 Shield/Desert Storm veterans have. So there's
11 obviously some concern about that. But if you
12 look at the environment, there's still sand and
13 dust out there. Burn pits maybe have taken the
14 place of the oil well fires.
15 So there are lots of things on common.
16 There are also lots of things that aren't in
17 common. For example, no one since Desert Storm
18 has taken the pyridostigmine bromide pills
19 because, you know, those have been well targeted
20 as one of the really bad exposures that people
21 had.
22 You know, the problem with those pills

1 of course is that they can't protect you against
2 nerve agents. What would people have said if we
3 hadn't used them and we had casualties from nerve
4 agents?
5 MEMBER SIMBERKOFF: So what about the
6 other, the allied veterans that --
7 DR. KALASINSKY: Yes. The veterans in
8 those countries, let's say the UK, Australia, the
9 Dutch have all reported the same kinds of
10 symptoms. Not to the extent necessarily that the
11 U.S. has, but certainly the same symptom sets
12 appeared in their troops.
13 Now we even had veterans from
14 Australia and UK visit us on occasion, and make
15 statements during our public comments at our
16 Advisory Committee meetings.
17 So obviously took the opportunity
18 afterwards to talk to these guys, and their
19 health care system is very different from ours.
20 They've got a national health care, National
21 Medical Service I think they call it. So they
22 get -- everybody who's enrolled in the National

1 Medical Service gets a card of some kind.
2 Well, if you're a veteran you get a
3 different colored card and if you're a Gulf War
4 veteran you get still a different colored card.
5 So there's at least an acknowledgment that
6 there's a difference, but the veterans are not
7 satisfied with the kind of health care they get.
8 They still feel like they're not being heard by
9 the docs, even though there's a --
10 MEMBER SIMBERKOFF: And the civilian
11 population?
12 DR. KALASINSKY: The civilian
13 population, that was one of the big problems
14 initially, the kinds of symptoms that we see in
15 the Desert Shield/Desert Storm OIF/OEF veterans
16 are the same kinds of symptoms that occur in the
17 general population.
18 Some of the early studies, early
19 epidemiology studies on Desert Shield/Desert
20 Storm show somewhere in the 10 to 15 percent of
21 the non-deployed folks having the same sets of
22 symptoms that the deployed folks had.

1 The difference was that the deployed
2 folks had those symptoms at a rate of 30 to 40
3 percent. So it's that differential that was the
4 concern, the differential between what you might
5 call a baseline where everybody has, you know,
6 symptoms that everybody has and then that jump in
7 the deployed.
8 So that differential of maybe 25
9 percent, that's the number you'll probably hear
10 about Desert Shield/Desert Storm, that 25 percent
11 of the veterans have these problems. But it's
12 that 25 comes from a differential between the
13 baseline, which is at 10 or 15 percent and 40
14 percent that we see in the Desert Shield/Desert
15 Storm veterans.
16 So yes, those symptoms are in the
17 general population, but they seem to be elevated
18 in the populations that we've sent into that
19 region, the southwest.
20 MEMBER PAMPERIN: Taking off of what
21 he just asked, what about the Iraqi civilian
22 population?

1 DR. KALASINSKY: You know, we don't
2 hear much about them. I only hear from the Iraqi
3 civilian population is that depleted uranium is
4 causing all kinds of problems. But we don't see
5 this other set of symptoms. I don't know if they
6 just don't report them or if they've grown
7 accustomed to dealing with things that in their
8 desert environment. But we don't hear a lot
9 about these kinds of symptoms.
10 MR. SAMPSEL: I've got a question.
11 I've taken a look at most of the IOM National
12 Academies research papers, reports. There's not
13 much evidence in those reports for long-term
14 health risks, based on my review of them. Would
15 you agree with that?
16 DR. KALASINSKY: Yeah, yeah.
17 MR. SAMPSEL: So what does the
18 Committee have to say about that? I mean we're
19 talking about medical conditions. Part of the
20 issue is the fact that a veteran needs to get
21 service connected sometimes in order to get
22 treatment by VHA, and these IOM reports have

1 tried to address that, but we don't see too much
2 evidence for long-term health threats. What do
3 you think about that?
4 DR. KALASINSKY: Well, let me get the
5 microphone here. The Institute of Medicine,
6 National Academy of Medicine reports typically
7 deal with research that's been published, and so
8 I'd like to make the distinction between what
9 they do for us and what the Advisory Committee
10 does for us because -- in a way that suggests
11 that our Advisory Committee looks at what's
12 happening and sees what's happening in the
13 technology world, in the medical field and, you
14 know, is looking forward at what we can do to
15 maybe understand what's happening to, in Gulf War
16 veterans, whereas the Institute of Medicine looks
17 at what's already been published.
18 So they're kind of looking backwards
19 and we expect the Advisory Committee to look
20 forward.
21 MR. SAMPSEL: Do you have
22 recommendations for long-term health effects, I

1 mean, that might get, I don't know, into the
2 general knowledge, public knowledge or medical
3 knowledge that will be translated into benefits
4 for those veterans?
5 DR. KALASINSKY: Yeah. One of the
6 problems, excuse me. One of the problems with
7 looking at published research is that there
8 aren't many published studies that the Institute
9 of Medicine can look at. So there will be one or
10 two or three in any given area, and you know, in
11 science and in medicine, when we're looking at
12 research, we like to see replication. We like to
13 see things that have been done and verified and
14 validated and everything else.
15 So the Institute of Medicine takes
16 that view. If they're presented with a pilot
17 study of a dozen or 20 people, that doesn't carry
18 as much weight with them as a study that's
19 involving two or three hundred or a thousand
20 people or 15,000 people. So they have to weigh
21 all of that.
22 But at the same time, we ask our

1 Advisory Committee to look at the published
2 research and tell us what to do next, so that we
3 can get some folks to do the research that will
4 inform the IOM, so that they can make their
5 reports and make their reports useful for exactly
6 what we said, the benefits side and health care
7 side.
8 So it's difficult because it takes a
9 long time to do research. It's not easy to do.
10 We need veterans to volunteer to participate in
11 the research studies. Believe it or not, some
12 veterans don't like the VA and so they're
13 hesitate to get involved with the study.
14 Those who do will often complain well,
15 I was in that study but nobody ever told me
16 anything. Well, the research studies are not
17 clinical care and so we don't -- we don't use
18 that as a diagnostic tool for an individual
19 veteran who might be in the study. We're looking
20 at the population to see what works for a group
21 of veterans, what works, what doesn't work.
22 So there's a lot of frustration on the

1 side of veterans with the pace of research, the
2 kinds of research that gets done and ultimately
3 what happens to that research. And any time I
4 say well, it's going to take time for this study
5 to be completed, and the response I get from
6 veterans well, it's been 25 years.
7 Well, we only started the project last
8 week. You've got to give us two years, three
9 years, four years for this to happen. Okay,
10 we'll be up to 30 years by now.
11 MR. SAMPSEL: Now I'm --
12 DR. KALASINSKY: That's the way
13 research works.
14 MEMBER SIMBERKOFF: So part of the
15 frustration, and I'm entirely sympathetic to what
16 you say though is that, you know, I think the
17 veterans are concerned I think, you know, about
18 the very limitations that you mentioned at the
19 very start.
20 The reality is that there's a far
21 bigger pot of money out there, which could be
22 used to, you know, study these problems if, you

1 know, if there were some way of getting other
2 agencies to fund them, you know, and I don't know
3 if there's a way of doing that but --
4 DR. KALASINSKY: Anybody from HHS in
5 here? No, okay. Health and Human Services
6 doesn't provide funding for Gulf War research
7 anymore. They did in the 90's, but that tapered
8 off.
9 So it's just VA and DoD. VA's got a
10 budget that well, the set-aside that we have
11 internally is $15 million a year for Gulf War
12 research, and it's difficult. It has been
13 difficult for us to find research studies that
14 are scientifically valid and safe enough for the
15 veterans to spend that $15 million.
16 So what we don't spend on Desert
17 Shield/Desert Storm will go for OIF/OEF or some
18 of the other programs. So there's 15 million.
19 At least it's sort of quote-unquote guaranteed,
20 and then the DoD has either $20 million for this
21 year, and they won't know until the budget's
22 passed, and we're already in March.

1 So we're already in the second quarter
2 of the year and they don't even know if they've
3 got a budget yet. So there are some serious
4 problems with the mechanics of doing the
5 research.
6 CHAIRMAN MARTIN: Does that budget
7 number have to be carried over -- carried over to
8 the next year, or does it have to be used by the
9 end of that year?
10 MEMBER SIMBERKOFF: No, it's about a
11 year so --
12 MEMBER BROWNE: Is there any follow-up
13 that was done on the depleted uranium group that
14 was sort of first ones to come out, and so that
15 nothing really was going on now that we're 20
16 years down the line? Anything on that?
17 DR. KALASINSKY: The folks who thought
18 that they had been exposed to depleted uranium
19 were all sort of put into a list and then
20 examined and the Baltimore VA is still running
21 the surveillance program, yes. So anybody with
22 embedded fragments is a certain part of that, and

1 anybody else who had high levels of uranium are
2 part of that as well.
3 So they're still monitoring those guys
4 and they publish two or three research papers a
5 year on various aspects of what's going on. So
6 the kidney is one of the targets of uranium, so
7 they've published some papers on kidney function
8 in a lot of these veterans, and so far so good.
9 There haven't been any problems with kidneys. So
10 it seems to be a non-issue.
11 Now there are some veterans who have
12 contacted me who claim that they inhaled fine
13 depleted uranium dust and that they haven't been
14 treated adequately. Anybody who had concerns
15 about that is supposed to sign up and be followed
16 by the Baltimore VA. So I'm not sure how that
17 happened. I mean I've tried to get those folks,
18 those veterans in touch with the Baltimore group,
19 but I don't know if -- how often they do and how
20 often they get involved. I'm way over time.
21 MEMBER BROWNE: On the internal
22 studies that the VA is doing when you were doing

1 the earlier slides, how do you determine what
2 they're going to look at since it's based upon
3 what the clinicians within the system finds if
4 it's X number of patients coming in complaining
5 of whatever.
6 They determine that if they are -- if
7 it's a veteran that says repeatedly I'm having
8 these kinds of symptoms and this is something
9 that should be looked at, that would stimulate --
10 DR. KALASINSKY: It's more the former,
11 although obviously if veterans come in
12 complaining of an issue, that kind of piques the
13 curiosity of the docs who are treating them. But
14 it's only if a doc sees a few patients that have
15 the same problem that he or she can say this
16 seems to be a problem and we need to do something
17 about it.
18 So it's -- the veterans have to be
19 involved and coming in and talk to the providers,
20 and then providers have to take the next step and
21 request research funds.
22 MEMBER BROWNE: Thank you.

1 CHAIRMAN MARTIN: Hal, do you have any
2 questions at this point?
3 MEMBER BIRD: Yes, thank you. I
4 wonder, excuse me, I wonder what the perspective
5 is on how the presumptive aspect has been
6 received at the veteran experience level out at
7 the VA facilities?
8 MALE PARTICIPANT: How the presumptive
9 aspect?
10 MEMBER SIMBERKOFF: Is there
11 presumptive diagnostics?
12 DR. KALASINSKY: There are some
13 presumptives, but no, I think I might just hand
14 that one off to somebody.
15 MR. SAMPSEL: Well that's a whole
16 topic. That's a whole topic. I have had to talk
17 about presumptive -- shall I talk about
18 presumptive now?
19 DR. VVENDENSKAYA: Well, pardon me
20 Hal. Mr. Bird, would you table that question for
21 Mr. Sampsel's presentation, because that would be
22 a little bit more in his area of expertise --

1 MEMBER BIRD: Yeah.
2 DR. VVENDENSKAYA: And we can carry on
3 Dr. Kalasinsky's presentation for now. Is that
4 okay with you?
5 MEMBER BIRD: Terrific.
6 DR. VVENDENSKAYA: Great.
7 MEMBER BIRD: Yes, terrific. Thank
8 you.
9 DR. KALASINSKY: I can wrap up in less
10 than 30 seconds.
11 MR. SAMPSEL: I have one quick
12 question though.
13 MALE PARTICIPANT: Will it take more
14 than 30 seconds?
15 (Laughter.)
16 MR. SAMPSEL: It's related to that
17 question that we just got. Do you work at all
18 with other, the other offices in VHA, the C&P
19 examiners, for example, and post-deployment
20 health, Loren Erickson's group?
21 DR. KALASINSKY: We work very closely
22 with Loren Erickson's group. They're in the

1 Post-Deployment Health Services, which is part of
2 Patient Care Services in the VHA. They used to
3 be called the Office of Public Health, and they
4 do many of the epidemiology studies, the large
5 surveys, 15,000 exposed, 15,000 non-exposed and
6 we've been following a group of those for a
7 number of years.
8 They do other epidemiology studies.
9 So we work very closely with them and we don't --
10 MR. SAMPSEL: Research on the
11 assessment group.
12 DR. KALASINSKY: Right. We don't work
13 with them very much at all because we're the
14 research side. So post-deployment health is kind
15 of in between us and them. So they, you know,
16 they look at the public health side of things,
17 and that feeds into the C&P examiners and that
18 side of things. Post-Deployment Health also does
19 some research. So we do deal with Loren and his
20 crowd quite a bit.
21 I should say that Dr. Erickson, Loren
22 Erickson that Mr. Sampsel just mentioned is -- I

1 think he said he's a 32 year veteran, a retired
2 colonel. I got to know him when I was at Walter
3 Reed Army Medical Center and he was at the Walter
4 Reed Army Institute of Research. So some of
5 these connections that we have with folks go a
6 few years back.
7 Let me see. To wrap up, where are we
8 on the slides? What's after that? Yeah.
9 DR. VVENDENSKAYA: Slide 19.
10 DR. KALASINSKY: This can be 30
11 seconds' worth. The next slides, four or five
12 slides are projects that we funded. If there was
13 plenty of time, I could give you an idea of what
14 was going on with these projects. But I just
15 want to give you a sense of the kinds of research
16 projects that are going on that we're funding
17 through the Office of Research and Development at
18 many, many different VA medical centers.
19 Here is a slide of treatments, a slide
20 -- the next one is biomarkers and the mechanisms
21 of the health problems. The next line is model
22 systems. These are the ones that are animal

1 studies or cell cultures or blood studies, things
2 like that.
3 The next slide gives you an idea of
4 some of the projects that we've recently selected
5 for funding. Oh, here we go, and then the next
6 slide gives you an idea of some of the projects
7 that were recently completed, and so we're
8 expecting publications to come out with other
9 studies. That's all I wanted to cover. I also
10 put two slides at the very end that give you some
11 of the text from the public laws, but that's just
12 for morbid curiosity more than anything else.
13 MEMBER PAMPERIN: Could I just ask
14 one question? Have you ever actually looked at
15 the rating data that DVA has created now from a
16 research perspective, you know? You know the
17 cohort People who work in the Gulf War. DVA
18 could tell you how many of those people have
19 applied or participated, and it will tell you to
20 the extent that they have been, even if they've
21 been totally denied, the issues that they have
22 dealt with.

1 Has anybody looked at that for any
2 kind of thing other than well that's what
3 veterans do, you know? Is it all the same or not
4 the same or --
5 DR. KALASINSKY: I'm not aware of
6 anybody having been funded to do that kind of a
7 look at DVA data. There is a group, Joe
8 Salvatore's group basically called the National
9 Center for Veterans something Statistics, and
10 they did pre-9/11 report and they did a post-
11 9/11. They're involved somehow with the reports.
12 So DVA tabulates this information, but
13 we've not done any research on that, primarily
14 because it's, you know, it's already tabulated.
15 There's nothing for us to have people do with it.
16 So the answer is no, we haven't done anything
17 with that, primarily because DVA tabulates them.
18 MEMBER PAMPERIN: And the DVA doesn't
19 know what it means. I mean it's tabulated to
20 make payments, not for health care.
21 DR. KALASINSKY: I'm certainly not
22 going to answer that one.

1 MEMBER PAMPERIN: Well no. I mean
2 realistically, it's accumulated for an entirely
3 different reason and you know, it knows -- it's
4 the justification for payment. But whether or
5 not contained within it is something, you know,
6 some strand that might be meaningful or not is,
7 you know --
8 DR. KALASINSKY: Well, we do fund some
9 folks to look at VHA data, to see what kinds of
10 treatments Gulf War veterans are getting, how
11 difficult it is for Gulf War veterans to navigate
12 the VA system of health care. So our focus is
13 generally on the VHA side. We try not to step
14 into the VA side.
15 MEMBER SIMBERKOFF: To what extent are
16 the data that are produced by your studies and so
17 forth shared with the individuals at the medical
18 centers, clinics, etcetera that, you know, are
19 actually seeing patients, you know, other than
20 the fact that they're published and available,
21 you know, if you happen to get into ARETHA
22 (phonetic)?

1 DR. KALASINSKY: Sure, if you happen
2 to have the time to read the literature, yeah.
3 MEMBER SIMBERKOFF: Yeah.
4 DR. KALASINSKY: There's a whole --
5 the whole issue of provider education is
6 something within the VHA. We don't do provider
7 education per se in the Office of Research and
8 Development, but we partner or at least work with
9 the Post-Deployment Health folks at the old
10 Office of Public Health.
11 They do have a number of education
12 programs, and there have been -- well, there are
13 monthly --
14 MEMBER SIMBERKOFF: Webinars?
15 DR. KALASINSKY: Webinars,
16 teleconferences. I'm trying to remember what
17 they call them, but they're organized actually by
18 one of the members of the Committee, Steve Hunt
19 who's at the Seattle VA Medical Center. So
20 they -- Community of Practice they call it. So
21 they invite providers to sign up for a one hour
22 seminar every month, and different topics come

1 through there.
2 Gulf War has certainly been on there.
3 One of other members, Jim Bunker, and another
4 veteran were the presenters for all the
5 teleconferences that they held. So there are
6 conferences like that that are run monthly for
7 practitioners, primary care providers.
8 And then there are webinars from what
9 we call the WRIISC, W-R-I-I-S-C, the war-related
10 information study centers. They have a monthly
11 seminar/webinar as well, and theirs can be
12 clinically oriented or research-oriented. So
13 many of the researchers who we fund have been
14 provider centers on those webinars.
15 So I get to call into all of these
16 things to see what's going on, so that I can
17 answer questions like that for veterans in
18 particular. So there is an effort to do this.
19 It's not required and that's one of the things
20 that veterans keep telling us. It's got to be
21 required of everybody, and then of course the
22 clinicians tell us that they've already trimmed

1 down the amount of time they spend with each
2 veteran.
3 If they have to cut out some more time
4 from their day for our monthly seminar, they're
5 going to be seeing fewer and fewer veterans. So
6 it's a tradeoff that is really a no-win
7 situation. And so hopefully if there can be more
8 providers in VHA, and I think I heard a
9 conversation about the hiring freeze earlier
10 today, and VHA has exemptions for hiring
11 providers.
12 MEMBER SIMBERKOFF: Part of the
13 problem is that, you know, the individuals that
14 deal with this at the medical centers are often
15 not -- this is a collateral duty, you know. It's
16 not their sole responsibility, and again it's
17 part of their budgetary problems, you know, in
18 the facility.
19 But if you've got somebody who is, you
20 know, a part on this Gulf War specialist who
21 doesn't have time to, you know, actually listen
22 to the webinars, I can understand why that might

1 produce some frustration on the part of the
2 patients that he's trying to take care of.
3 DR. KALASINSKY: Sure. There are
4 countless veterans who let us know in no
5 uncertain terms that they take information to
6 their providers and it's ignored. I must add
7 though that there are some providers who do an
8 excellent job in dealing with veterans, you know.
9 We just have a whole spectrum of attitudes, and
10 we know veterans sometimes see a good provider,
11 sometimes see one who's too busy.
12 CHAIRMAN MARTIN: Since the original
13 Congressional mandate for your Advisory Committee
14 just ran through 2014, what's going to become of
15 the committee now?
16 DR. KALASINSKY: Oh no, no, I'm sorry.
17 The 2014 was reports to Congress from me, from
18 the VA and DoD actually. The Committee has no
19 deadline, I mean no end date.
20 DR. VVENDENSKAYA: Expiration.
21 DR. KALASINSKY: Expiration date,
22 sunset. Sunset.

1 CHAIRMAN MARTIN: Not a used, used by
2 date or anything. Any other questions or
3 comments for Dr. Kalasinsky?
4 MEMBER ROBERTS: Yes. Doc, I want to
5 ask you a quick question. Are the kinds of
6 illnesses you're seeing coming out of the Gulf
7 War significantly different from illnesses that
8 come out of other wars, such as the wars in
9 Southeast Asia and elsewhere, or are these just
10 illnesses that are unique to any war?
11 DR. KALASINSKY: You know, illnesses
12 that follow any war was one of the things that
13 was said in the 90's, and it's just not that
14 simple. It's just not that simple. Because of
15 the elevated numbers of folks with these symptoms
16 and issues, it's not just that they were
17 deployed. It's that they were deployed to this
18 particular really terrible area, and the other
19 things that happened there.
20 Maybe vaccinations we don't know,
21 maybe the pyridostigmine bromide pills, we're not
22 sure. But certainly sand and dust and my God oil

1 fires and plumes and all that kind of stuff are
2 not good for you.
3 It's just, and you know in the initial
4 days after the fires started, I don't know if you
5 remember, but there was a group of government
6 folks who went over there, somebody from EPA,
7 somebody from HHS, somebody from DoD, probably
8 VA.
9 I've forgotten who all went over, six
10 or so and they reported back that the pressure of
11 the oil was such that the flames and the soot
12 were flying high enough up to get dispersed and
13 not be a problem for the troops on the ground.
14 Frankly, I didn't buy that.
15 So I was working for DoD at the time
16 and I arranged to go over there, and it was a
17 mess. It was just a mess. So it's a lot more
18 complicated than anybody expected.
19 MEMBER SIMBERKOFF: So these are the
20 same folks that gave us that it's safe to clean
21 up after 9/11.
22 CHAIRMAN MARTIN: Thank you. Thank

1 you very much on behalf of the Advisory Committee
2 for talking with us today and dealing with
3 questions. I appreciate you being here.
4 DR. KALASINSKY: I'm glad to be here.
5 CHAIRMAN MARTIN: The Advisory
6 Committee Management Office talked about cross-
7 pollination between advisory committees, and I
8 appreciate you coming to bring us up to date on
9 your committee, Dr. Kalasinsky.
10 DR. KALASINSKY: This is one of the
11 committees that our committee members wanted to
12 bring into our meetings. So I hope I --
13 CHAIRMAN MARTIN: Any time.
14 DR. VVENDENSKAYA: Thank you so much.
15 Yeah. Do you want to switch places?
16 MR. SAMPSEL: Should I just switch
17 places? Okay.
18 DR. VVENDENSKAYA: Yes.
19 CHAIRMAN MARTIN: Jim, thanks for
20 coming back and for being here.
21 MR. SAMPSEL: Should I just -- we're
22 going to take a break? You don't want to take a

1 break?
2 DR. VVENDENSKAYA: General Martin?
3 CHAIRMAN MARTIN: Whatever.
4 MALE PARTICIPANT: I think we're good
5 to go.
6 CHAIRMAN MARTIN: If anybody needs to
7 step out, you're free to do so. We'll press
8 ahead if that's okay.
9 MR. SAMPSEL: Well, I passed out a
10 handout with slides, so you can follow along I
11 guess.
12 (Off mic comments.)
13 MR. SAMPSEL: If you have any
14 questions for me, just let me know. Well, okay.
15 We just heard about research and the problems
16 that Gulf War veterans face. Well, I think we
17 all know that and there's a lot of frustration
18 among individual veterans. But VBA has to
19 address the issue from the point of the law that
20 we have in place, and whatever --
21 I'll say this. One reason why I asked
22 about the other offices in VHA, there's a

1 Disability Assessment Group that conducts
2 compensation and pension examinations. Oh, I've
3 got a lot of stuff up there. They're the ones
4 that conduct an exam when there's a claim for
5 Gulf War illness, and whether --
6 Their decision pretty much dictates
7 whether we provide a service connection. So I
8 just wanted to mention that at the outset here.
9 How up to date are they on the research that's
10 going on? I'm not sure. We have to rely and I
11 think the statement was already made there's a
12 variety of C&P examiners, medical examiners.
13 Some are probably more informed than others, and
14 we regularly get statements that there's no
15 consistency so we have to deal with that.
16 Anyway, what I'm going to do is
17 present the statutes and the regulations and
18 there's a number of court cases going on right
19 now. As everyone probably knows by now, lawyers
20 can represent, legal groups can represent
21 veterans and they're moving into certain areas
22 which are very interesting to me. But I don't

1 know -- they're not specifically related to
2 research.
3 OPERATOR: Someone has entered the
4 conference.
5 MR. SAMPSEL: So anyway, let me give
6 the background here. I think we already got a
7 background. You can read the kind of exposures
8 that the Persian Gulf, first Gulf War 90-91
9 veterans were exposed to, you know. In terms of
10 the oil well fires, I've seen photos and I've
11 talked to -- I have a colleague in Comp Service
12 who was in the Marine Corps and he was involved
13 in the first Gulf War.
14 He said the oil droplets were
15 everywhere and they had some difficulty
16 breathing. But I think the issue was maybe they
17 weren't small enough to get into the bronchi.
18 I'm not sure but it was a big problem. There's
19 also information about the nerve gas pills and
20 flea collars and local infection, potential
21 infectious diseases in the area and so on. So
22 that's the first Gulf War.

1 The second Gulf War, OIF/OEF, they did
2 not have the oil well fires, but as was mentioned
3 before, the statute, 38 U.S.C. 1117 and 1118 were
4 written for the first Persian Gulf War. The term
5 "Persian" is still in there and the Persian Gulf
6 War is ongoing. It has not -- it has not ended.
7 So the problem we have with the
8 regulation and the statute is that we have a
9 group of people that were exposed to certain
10 environmental hazards in the first Gulf War, and
11 the information, the law about that continues
12 through the second, essentially the second Gulf
13 War period post-9/11.
14 The only difference I want to say at
15 the beginning is that Afghanistan activity,
16 Operation Enduring Freedom, they are not included
17 in 38 1116, 1117 and 18 and also our regulation
18 3.317. They're not included because they were
19 not involved in the first Gulf War activity. But
20 there are certain parts of the current 3.317 that
21 they are included in.
22 So I guess as I put up here, 38 U.S.C.

1 1117 is modeled after the Agent Orange Act and
2 it, the Agent Orange Act included a method, a
3 research method, use of the National Academy of
4 Sciences. It used to be called the Institute of
5 Medicine, now the Academy of Medicine. They did
6 research on the Gulf War and they produced ten or
7 eleven reports and as I mentioned earlier,
8 there's not much evidence for a lot of the long-
9 term health effects that the veterans complain
10 about.
11 That's what we have to deal with in
12 VBA. As a result of 1117, 3.317 was produced and
13 I'll go into that in a little more detail here.
14 As I said, Afghanistan is not included, although
15 most recently the IOM added nine infectious
16 diseases to 3.317 and the Afghanistan veterans,
17 yes they are included in that.
18 It's interesting. Some of those
19 diseases are related to mosquito-borne diseases,
20 and normally you think about the environment
21 there as being a desert environment. But I think
22 the Tigris and the Euphrates Rivers were there

1 and so on. Anyway, they're listed in the
2 regulation.
3 So the general approach is there's
4 what's called a disability, chronic disability
5 pattern. That's the language in 1117 the
6 statute, and there's a list of those symptoms,
7 signs and symptoms that apply to these chronic
8 disability patterns. The chronic disability
9 patterns fall into two categories: undiagnosed
10 illnesses and medically unexplained chronic
11 multi-symptom illnesses that can be diagnosed.
12 So you can read up there what they
13 are. I presume that self administration was
14 involved in the original identification of these.
15 It's quite a list. I won't bother to read that.
16 Anyone can see that. Now was -- the challenge is
17 that there are two categories.
18 So there's an undiagnosed illness, and
19 any one of these symptoms could be an undiagnosed
20 illness or this pattern. Apparently, these signs
21 and symptoms show up in a cluster. So the
22 original statute was only for undiagnosed

1 illness. But subsequent to that, apparently
2 there was a recognition of diagnosable
3 conditions.
4 So there are three identified
5 diagnosable conditions called medically
6 unexplained chronic multi-symptom illnesses.
7 That's quite a mouthful, but that's the
8 definition language, and they include chronic
9 fatigue syndrome, fibromyalgia and originally it
10 was irritable bowel syndrome but now it's
11 functional gastrointestinal disorders.
12 So those are the identified medically
13 unexplained chronic multi-symptom illnesses, but
14 they're not exclusive. They're not exclusive and
15 another disability pattern can be identified by a
16 C&P examiner, by a VHA examiner as falling into
17 that category. That's a challenge for them. I'm
18 well aware of that.
19 Then there's the infectious diseases,
20 and I didn't put a list of those but they include
21 leishmaniasis, which is some kind of a -- I think
22 it's a bacteria that lives in the desert

1 environment from a bacterial source.
2 VOICES: Parasites.
3 MR. SAMPSEL: Parasites. Okay, it's
4 like an amoeba maybe.
5 FEMALE PARTICIPANT: It's a creature.
6 MR. SAMPSEL: A creature, okay. The
7 one that's interesting to me is malaria's in
8 there, so and I think West Nile disease is in
9 there, diseases that are mosquito-borne diseases.
10 At any rate, those -- Afghanistan is included in
11 those. So when it comes to disability
12 compensation, we have 3.317 and we also have
13 3.303, which is the general -- and I'll go into
14 3.317 and the special categories that are
15 required, the requirements for that.
16 But it's important to remember that
17 3.303, that's the general regulation for
18 disability compensation, and that requires
19 evidence of a current disability, evidence of an
20 event, disease or injury in service and a medical
21 link between the two. So when it comes to burn
22 pits, burn pits are not part of 3.317, and

1 they're not part of the original Persian Gulf
2 War. I think the war was moving too fast to have
3 burn pits.
4 So but they are part of OIF/OEF and
5 any claim based on burn pits has to be evaluated
6 under a different regulation, 3.303. We try to
7 make that clear to all our examiners and our
8 raters and adjudicators. So what doesn't
9 qualify, and if I haven't made it clear yet, this
10 is a very confusing regulation.
11 I'm sure it is a compromise bill based
12 on a lot of input from veterans and Congress did
13 something and they felt like they had to do
14 something, and unexplained, medically unexplained
15 illnesses and undiagnosed illnesses are not
16 readily acknowledged by the medical world. So I
17 think you have to be in the VA system to even be
18 aware of these kind of things.
19 So when a veteran comes in with a
20 claim from maybe he's been diagnosed with
21 something, a lot of times there will be a
22 diagnosis. And so adjudicators have to be aware

1 that the outside physicians don't recognize an
2 undiagnosed illness. So service connection
3 requires that, but evidence submitted initially,
4 it doesn't always show that.
5 Anyway, let me see. There's other
6 certain requirements in order to be service
7 connected under 3.317. First of all, there has
8 to be six months' duration of the disability, and
9 there has to be at least six months' duration
10 with some kind of evidence for that and several
11 others, qualifications.
12 (Off mic comments.)
13 MR. SAMPSEL: Well, you can put them
14 up. I can just talk about them. I don't know
15 that we have to go into great detail on those.
16 There has to be generally -- well let me go, let
17 me explain. I might be a little disorganized
18 here. I'm trying to adapt to our first speaker
19 here.
20 C&P examiners, this is probably the
21 most important issue. For the incoming veteran
22 who's filing a claim, they will -- there's a

1 liberal approach to giving them an examination.
2 If they served in the Gulf War, Persian Gulf War
3 or post-9/1, OIF/OEF, we will give them an
4 examination. As long as there is some evidence
5 from them of potential undiagnosed illness or
6 medically unexplained chronic multi-symptom
7 illness.
8 If it's a claim based on
9 musculoskeletal injury, then they won't get an
10 exam. If it's cancer or an Agent Orange-related
11 disease, then they won't get an exam. But if
12 it's anything else, we're very liberal and give
13 them an exam. So the onus for what happens is --
14 and by the way also there has to be some evidence
15 that the disability is manifested at ten percent.
16 In other words, it can't be some kind of latent
17 thing with no apparent symptoms.
18 At any rate, the charge to the C&P
19 examiner, which is really critical, is they have
20 four options when they examine the veteran.
21 Number one is an undiagnosed illness, and the
22 undiagnosed illness, as I think we already heard,

1 is something that shows up in signs and symptoms
2 but there's no diagnostic test that shows clearly
3 that it can be diagnosed and so on.
4 The second thing is a diagnosable but
5 medically unexplained chronic multi-symptom
6 illness with partially understood etiology. This
7 is another confusing aspect. The regulation
8 requires for a medically unexplained chronic
9 multi-symptom illness, requires that there is no
10 clear etiology or pathophysiology. That is part
11 of the definition of a medically unexplained
12 chronic multi-symptom illness.
13 However, the statute says that if it's
14 partially understood, then that does not qualify
15 under 3.317 for service connection under Gulf War
16 illness. So this is a complicated area and the
17 examples given by the statute are diabetes and
18 multiple sclerosis.
19 I'm not sure why they came up with
20 those, but that's what they came up with. I'm
21 presuming that by virtue of diabetes, you know,
22 involving the blood sugar system, multiple

1 sclerosis involving the neurological system, that
2 there's identified pathophysiology there, and as
3 a result that is excluded.
4 So it's up to the examiner to
5 determine whether this is a medically unexplained
6 chronic multi-symptom illness with no known
7 etiology and pathophysiology, or with a partially
8 known. If it's partially known, it can't be
9 service connected. Then the third is a medical
10 -- there is an undiagnosed illness.
11 There's diagnosable, medically
12 unexplained chronic multi-symptom illness with no
13 pathophysiology or etiology, and then partially
14 understood, and then finally a disease with a
15 clear, specific etiology and diagnosis. That's
16 where the Afghanistan service comes in and the
17 burn pits.
18 So those four examples are potential
19 identification by the C&P examiner, those are
20 given to the examiner up front, and it's up to
21 that examiner to examine the veteran and
22 determine which one of those, if any, that the

1 veteran can be identified with.
2 So when the examiner produces a
3 report, then the adjudicators will pretty much
4 rely on that and they'll service connect or not
5 service connect based on that. So there's been a
6 number of issues that come up along these lines.
7 Anyone having questions on the four potential
8 criteria for the examiners and essentially these
9 are followed by all the raters in all the
10 regional offices.
11 I've done a couple of trainings and
12 for what it's worth, a lot of the regional
13 offices are overworked. They think that we're
14 too liberal with our examinations, but that's the
15 policy and pretty much that's what we stick to.
16 So some of the issues that have come up legally,
17 I want -- also I want to -- maybe I can use, I
18 think sleep apnea came up a little bit ago, sleep
19 disturbances.
20 This illustrates some of the problems
21 that we have. Sleep apnea, we've gone around and
22 around with general counsel and with VHA about

1 this, but here kind of shows -- this issue kind
2 of shows the problem that we face. Sleep apnea
3 is a diagnosable condition, and therefore it
4 can't be service connected under 3.317.
5 However, sleep apnea, two of the signs
6 and symptoms of sleep apnea are sleep disorder
7 and breathing disorder. Both of those are signs
8 and symptoms under the regulation and the
9 statute. So the issue is should this be service
10 connected, and the way we've kind of dealt with
11 it is that if the veteran files a claim and his
12 file, his record shows a diagnosis of sleep apnea
13 with a CPAP device or some kind of assistance or
14 breathing device, then it's a clear diagnosis.
15 On the other hand, if the veteran says
16 I have sleep problems. I have breathing
17 problems. Maybe he's heard the word sleep apnea
18 and that gets into the claim as a word, but
19 there's no evidence that he's ever been diagnosed
20 or treated for that, then we'll generally give
21 them an examination and leave it up to the
22 examiner as to whether this is diagnosable or

1 whether it's not diagnosable.
2 If it diagnosable, then we can't
3 service connect it. So these are the kind of
4 things that come up and as I said, there's a lot
5 of confusion about this. For example, there's
6 confusion among C&P examiners. I gave a
7 presentation to some C&P examiners several years
8 ago. I got several questions about -- from the
9 examiners, from the VHA examiners.
10 For example, one examiner said do we
11 have to -- do we have to diagnose? Do we have to
12 produce an undiagnosed illness? Do we have to
13 produce -- do you want us to be liberal about
14 that? My response was it's up to you. You're
15 the medical person. It's up to you, and this
16 examiner gave an example.
17 He said that a veteran came into him
18 with a complaint of chronic fatigue syndrome, and
19 the veteran had been in the Gulf War and he was
20 married. He had several children. He was
21 working part-time, going to school part-time and
22 based on his lifestyle, the examiner thought this

1 is a normal situation with this kind of
2 lifestyle.
3 (Off mic comment.)
4 MR. SAMPSEL: So the question, this
5 illustrates the problem, and we in DVA, we have
6 to go with the C&P examiners. I just want to
7 make that clear.
8 Any questions?
9 MEMBER BROWNE: Two. You said a
10 condition if it's diagnosable, it can't be
11 related to the service --
12 MR. SAMPSEL: It can't be service
13 connected under the regulation that addresses
14 Gulf War illness.
15 MEMBER PAMPERIN: But it could be
16 service connected.
17 MR. SAMPSEL: It can be service
18 connected, under the general regulation, 3.03.
19 MEMBER BROWNE: Oh, under that
20 particular regulation.
21 MR. SAMPSEL: Yeah. I want to make it
22 clear that 3.317 is a special regulation outside

1 of the regular disability claim process. It's
2 special for the Gulf War situation.
3 MEMBER BROWNE: Okay. So it's not
4 service connected under 3.317, which is
5 specifically for Persian Gulf?
6 MR. SAMPSEL: Yeah. 3.317 is
7 specifically for undiagnosed illnesses, and
8 medically unexplained chronic multi-symptom
9 illnesses which are a pattern, a disability
10 pattern. Three of them are presumptive. I think
11 this goes to an earlier question that came in.
12 The three presumptive are the ones that I
13 identified, fibromyalgia, irritable bowel
14 syndrome and functional yeah, gastrointestinal.
15 So one of the issues that we've had in
16 the past, coming in from advocates for Gulf War,
17 Gulf War claimants and veterans is that C&P
18 examiners don't recognize the idea of a
19 presumption, and even though the word
20 "presumption" is not in this statute or this
21 regulation, essentially these are presumptive
22 diseases, because if you get diagnosed, you're

1 automatically service connected. The only thing
2 you have to have is service in the Gulf War
3 theater of operations.
4 So if it turns out that the veteran
5 served there or they get a diagnosis, then it's
6 not under 3.317 anymore and it's up to the
7 examiner to say that okay, there's a diagnosable
8 condition here, let's say asthma, because I want
9 to talk about asthma in a minute. It's a new
10 legal issue. So if it's that, then 3.317 does
11 not count, because it's not undiagnosed.
12 So then it has -- if it's going to be
13 service connected, it has to be under the general
14 regulation, and there has to be a medical link
15 between service in the Gulf War and this
16 diagnosed condition, and the medical link is the
17 compensation and pension exam. If the examiner
18 says no, maybe it's based on smoking, too much
19 smoking or something, then no service connection.
20 DR. VVENDENSKAYA: So if we had just
21 to make a very bold, simple statement for the
22 medical doctors examiners, because we deal with

1 it all the time, the biggest difference for
2 medical examiners, medical professionals in the
3 3.17 and 3.03 is 3.17 does not require you to
4 make medical judgment. It's done for you by the
5 VA. 3.03, we ask you to make that nexus.
6 MR. SAMPSEL: Well, there's -- you
7 still have to --
8 DR. VVENDENSKAYA: I mean to simplify,
9 yeah. Just in terms only what Jim mentioned,
10 that medical examiners can look at this
11 presumptive concept, and what I'm trying to say
12 is don't worry about presumption for 3.17; that's
13 not medical examiner's job. That's a policy
14 decision which was based on maybe --
15 MR. SAMPSEL: Yeah. It's based on the
16 law, as stated.
17 DR. VVENDENSKAYA: Yes.
18 MR. SAMPSEL: However, the examiner
19 still has to come up with identifying an
20 undiagnosed illness or a medically unexplained
21 chronic multi-symptom illness.
22 DR. VVENDENSKAYA: Yes.

1 MR. SAMPSEL: But they don't have to
2 link it to service once they come up with that.
3 That's the difference between a presumptive and
4 the regulation 3.303 disability process.
5 MR. MANAR: I'm sorry. There's
6 something else to keep in mind here, and it goes
7 to the various methods of how you grant service
8 connection. I'm sure the Committee has gone
9 through it ad nauseam in the past.
10 But we've seen with hundreds of
11 thousands of service members over the last
12 several years, as they're getting out of service,
13 many, many of them are experiencing sleep
14 disorder for instance, and if they haven't
15 already had a sleep study we encourage them to
16 get one, to see if they have in fact sleep apnea.
17 At that point, whether they've been in
18 the Gulf or not, and many of them have served in
19 the Gulf War, then if they're diagnosed with it
20 they can be granted service connection on a
21 direct basis as they're getting out of the
22 service. They don't have to rely on, you know,

1 post-service presumptive.
2 MR. SAMPSEL: Well that's true.
3 Anything that shows up in the service is going
4 to be service connected.
5 MR. MANAR: Yeah. So we're likely
6 talking about people who have been out of the
7 military for some time, and are now claiming
8 these disabilities.
9 MR. SAMPSEL: That's the majority of
10 claims, for Agent Orange and Gulf War many years
11 out, and now they're coming back. It's rare when
12 a recently discharged veteran will make these
13 kind of claims, because you know, they get
14 thoroughly examined now prior to discharge. They
15 didn't always -- that didn't always happen. So
16 yeah. Generally these are older. They've been
17 out of the service for quite a while.
18 CHAIRMAN MARTIN: Hal, did you have a
19 question for Jim?
20 MEMBER BIRD: I'm actually out of
21 questions for Jim, yes. Thank you. Mr. Sampsel,
22 could you go back to the first paragraph under

1 Claims Processing, and it says "No need for
2 veterans whose specifically claimed disability in
3 any stage of service and get into that a little
4 bit please first."
5 MR. SAMPSEL: Well, that's true. We
6 had an issue with the regional offices where they
7 thought that the veteran, if the veteran just
8 came in and claimed something, they're not going
9 to get a 3.317 exam. We had to clarify for them
10 that they don't have to claim that this is due to
11 the Gulf War. If they served in the theater of
12 operations, then we will give them an exam.
13 So that was -- I put that in there
14 because several years ago, this was an issue. We
15 try to be very liberal with providing the
16 examination, and that's part of it.
17 MEMBER BIRD: This whole thing is
18 stunning to me. I just wrapped up my claim less
19 than a year ago, but I was at it for three years
20 and I have 10 of the 13 conditions listed under
21 the disabilities that are involved. One of them
22 a applies only to females, so I would not have

1 that one.

2 MR. SAMPSEL: I understand that.

3 MEMBER BIRD: At least not normally.
4 However, I spoke with everybody at every step
5 along the way and I was rejected at every turn,
6 and I fit classically, and everybody I talked to
7 treated me like a leper and like I was after
8 something that I did not deserve, and was never
9 given exams even in spite of the fact that I had
10 in the end two C&P examiners on other issues and
11 one of them was just emphatic that I should get a
12 Rule 4 exam, and I said please help me do that.
13 I can't get anybody to listen to me about that.

14 She said well, I can't. I want to
15 give you an exam, and I can't give you an exam on
16 anything that I wasn't -- I can't get out of my
17 box. I can't do that. I can tell you that this
18 is still a big problem today.

19 MR. SAMPSEL: Well, I know there's a
20 problem. We're trying to grip these problems.
21 That's why we have an appeal process.
22 Unfortunately, there's not total consistency

1 throughout the regional offices and that's not
2 just because of Gulf War issues.
3 MEMBER BIRD: That Jim is the
4 understatement of this weekend's meeting right
5 there. I would say -- I would take that a step
6 further and say there is a disdain for the term
7 presumptive in both wars. That's from my
8 experience.
9 MR. SAMPSEL: Well, I don't know about
10 that. I can't address that. I will tell you
11 that we had -- a while back we had this issue,
12 the issue of presumptions. There's a Gulf War
13 advocacy group that raised this. The issue
14 really was that an examiner would come up with a
15 diagnosable medically unexplained chronic multi-
16 symptom illness like fibromyalgia. They would
17 come up with that diagnosis, based on the
18 examination.
19 But then they would say that this is
20 not due to Gulf War. This is due to something
21 else, maybe you know, a particular lifestyle or
22 whatever. So as we modified and we made it clear

1 to the field that there's no nexus required for a
2 presumptive.
3 The examiner -- so in other words, we
4 modified our exam request so to take out the
5 sentence "please provide an opinion about this,"
6 because the opinion applies to the 3.03 issue.
7 It does not apply --
8 MEMBER BIRD: But what happens, what
9 happens when they won't even give you an exam
10 before, and you served in the Gulf War? How do
11 you overcome that?
12 MR. SAMPSEL: Well, you file an
13 appeal, I guess, for the DRL. I don't know why
14 you didn't get that exam. Anybody who served in
15 the Gulf War theater of operations should get a
16 Gulf War exam.
17 MEMBER BIRD: It's not happened and I
18 can tell you that I was pretty aware of all this,
19 being in my position on this Committee and in
20 both of the facilities in the North Texas
21 Regional Office, I talked to everybody there I
22 could come in contact with, and I couldn't get

1 anybody that would say yes, you need to get one
2 of these and we have to get one.
3 MR. SAMPSEL: Well, did you get -- did
4 you get your exam?
5 MEMBER BIRD: Not a Gulf War exam.
6 Nobody would give me one.
7 MR. SAMPSEL: Well if you need a Gulf
8 War exam, contact me after this and we'll look
9 into it.
10 MEMBER BIRD: I'd just say -- I will,
11 and I just want you to tell them that this is not
12 happening. At least in North Texas it's not
13 happening, and I want to thank you.
14 MR. SAMPSEL: Okay. Well like I said,
15 we try to get all the regional offices to be on
16 the same page when it comes to this. We've made
17 many statements and given many trainings saying
18 be liberal on Gulf War exams. There's a DBQ.
19 There's a special -- you guys have talked to DBQ.
20 There's a special DBQ for the Gulf War exam, and
21 it lists for the examiner the four options that I
22 talked about here.

1 So I'd like to address, if we have
2 time here, a couple of the legal issues that are
3 coming up right now. As I said, the advocates
4 are concerned because there's a very low grant
5 rate on 3.317 Gulf War claims, and that's not an
6 issue for VBA.
7 That's essentially a VHA, Veterans
8 Health Administration issue because they're the
9 ones that conduct the examinations, and their
10 medical opinion is what generally what raters
11 will go with. So I don't know.
12 MEMBER SIMBERKOFF: So do you have the
13 numerator and denominator? Do you have any --
14 how many people are requesting exams, how many
15 are getting it and then what are the, you know,
16 the percent getting them and we can see what the
17 percent of --
18 MR. SAMPSEL: Well, there is --
19 there's statistics. The grant rate is pretty
20 low. I think it's around 20 percent, 30 percent.
21 The grant rate in general is around 50 to 60
22 percent for all disabilities.

1 MEMBER SIMBERKOFF: So when you say 20
2 percent, is that 20 percent of vets or 20 percent
3 of --
4 MR. SAMPSEL: That's a 20 percent
5 grant rate for the claims, the number of claims
6 filed for 3.317.
7 MEMBER SIMBERKOFF: Filed and all of
8 those people are getting exams, or are some of
9 them not getting them?
10 MR. SAMPSEL: No, they're getting
11 exams.
12 MEMBER PAMPERIN: The fact that they
13 aren't granted under 3.317 doesn't mean they
14 haven't been granted, right?
15 MR. SAMPSEL: Well, PA&I does the
16 research and I'm sure there are some that were
17 granted under 3.303 and like I said, Afghanistan
18 veterans wouldn't fall under 3.317. They're
19 still going to get an exam. Basically, they get
20 the 3.317 DBQ, but the only issue for the
21 examiner is whether number four, do they have a
22 diagnosis. Unless we're talking about one of the

1 presumptive diseases.
2 MEMBER SIMBERKOFF: So well, the
3 question then is --
4 MR. SAMPSEL: But I would say --
5 MEMBER SIMBERKOFF: Of those people
6 that are filing the request, are they being
7 diagnosed with one of the three things that you
8 listed --
9 MR. SAMPSEL: Well, there's only two
10 that can qualify.
11 MEMBER SIMBERKOFF: Pardon me?
12 MR. SAMPSEL: There's only two things
13 that can qualify.
14 MEMBER SIMBERKOFF: I thought there
15 were three.
16 MR. SAMPSEL: Undiagnosed illness and
17 diagnosable medically unexplained chronic multi-
18 symptom illness with no pathophysiology or
19 etiology. If there's partially understood --
20 see, that's where it comes in for the examiners.
21 I am not sure how they evaluate these kind of
22 things. That's a kind of a very nebulous issue

1 in my mind.
2 But anyway, if they have the medically
3 unexplained chronic multi-symptom illness pattern
4 but somewhere in there, the etiology is there or
5 the pathophysiology is there, they're not going
6 to get diagnosed. They're not going to --
7 (Simultaneous speaking.)
8 MEMBER SIMBERKOFF: What does the DBQ
9 actually say?
10 MR. SAMPSEL: Well, the DBQ says these
11 three things, four things.
12 FEMALE PARTICIPANT: I've looked at
13 the DBQ.
14 MR. SAMPSEL: You can pull up the DBQ
15 some time and take a look at it.
16 MEMBER SIMBERKOFF: I haven't looked
17 at it.
18 MR. SAMPSEL: Oh okay.
19 MEMBER SIMBERKOFF: So the question is
20 do they want to admit that they can't make a
21 diagnosis?
22 MR. SAMPSEL: I think the problem

1 comes in where the Committee on the Gulf War is
2 looking at things and is very sympathetic to
3 neurological problems and so on and so on. But
4 it hasn't translated into any law or any
5 regulation yet, and DBA is obligated to follow
6 3.317.
7 DR. VVENDENSKAYA: Letting everybody
8 take an exam.
9 MR. SAMPSEL: Yeah.
10 MEMBER SIMBERKOFF: Is there a
11 possibility you can print it, have somebody print
12 this out so we can look at it a little bit more?
13 DR. VVENDENSKAYA: During my lunch
14 break. We don't have any printers here.
15 MR. SAMPSEL: These were developed to
16 promote consistency among examinators, excuse me,
17 examiners. But examinators. I'm thinking of the
18 Terminator, right? Anyway --
19 (Laughter.)
20 DR. VVENDENSKAYA: I'm just going to
21 scroll past all these categories.
22 MEMBER SIMBERKOFF: So you've just got

1 to stop now, because we're getting down to, you
2 know.
3 MR. SAMPSEL: These are --
4 DR. VVENDENSKAYA: I just want to go
5 to the last section which asks you --
6 MR. SAMPSEL: Yeah, where they're
7 supposed to -- what are they supposed to do.
8 (Simultaneous speaking.)
9 MR. SAMPSEL: Say no etiology, okay.
10 And you know, I would like to see -- one reason I
11 asked about whether the science or the research
12 being done on Gulf War issues has filtered down
13 to the C&P examiners. I mean it's still --
14 MEMBER SIMBERKOFF: That's a question
15 that we asked.
16 MR. SAMPSEL: It's filtered down to
17 Loren Erickson's group, which I work with
18 regularly, Post-Deployment Health, the Office of
19 Public Health. But I don't see that it's been
20 communicated to the average C&P examiner, and
21 there's so many medical facilities around the
22 country, and yet they get this DBQ.

1 MEMBER PAMPERIN: Jim when -- you
2 know, when undiagnosed illness first came out,
3 people actually filed claims for undiagnosed
4 illness. But do they file claims for undiagnosed
5 illness today, or they just say, you know, I have
6 chronic something?
7 MR. SAMPSEL: I think there's an
8 awareness, based on the VSOs and based on, you
9 know, general -- the VA's public website --
10 MEMBER PAMPERIN: But my question is
11 if they -- do we know that they in fact -- do we
12 know how many times this DBQ is actually used, as
13 opposed to the normal process of my back hurts,
14 my knee hurts, I can't hear, you know, where the
15 claims are symptom-based things, not disabilities
16 per se and as a result you get a general med and
17 a couple of other specialized things if you can't
18 hear?
19 And so that my question is really what
20 would lead somebody, unless you put the magic
21 words in a claim to even go here?
22 MR. SAMPSEL: Well, I think the key to

1 that is service in Gulf War. We told people in
2 the field if somebody served --
3 MEMBER PAMPERIN: So it's a standard
4 procedure that if it's Southwest Asia, you must
5 include the undiagnosed illness DBQ?
6 MR. SAMPSEL: Okay. If they have
7 service in a Gulf War, in a Gulf War theater
8 which excludes Afghanistan under 3.317, then we
9 told the field they don't have to claim this is
10 something from the Gulf war. They're going to --
11 presumably the intake people will see that they
12 served in the Gulf War, they have a claim.
13 Whatever the claim is, they're going to get a
14 Gulf War exam, according to our policy, unless
15 we're talking about a musculoskeletal problem or
16 an Agent Orange-related disease or a cancer.
17 MEMBER PAMPERIN: But I know you can
18 get both from the contractors to give you exams
19 and from VHA.
20 MR. SAMPSEL: Yeah, from the
21 contractor.
22 MEMBER PAMPERIN: But the frequency

1 with which a specific DBQ is actually used, and
2 do you know how often it's used?
3 MR. SAMPSEL: No, I don't know about
4 that. I mean --
5 DR. VVENDENSKAYA: Maybe that would be
6 a good question for Ms. Murphy, Beth Murphy who
7 is our Compensation Service Director.
8 MR. SAMPSEL: Yeah. We have
9 statistics, but I don't know. I don't know about
10 those statistics. Sometimes we have to ask for
11 that kind of thing before, you know. Maybe it's
12 not readily available right now. But I know the
13 grant rate's low because we track the grant rate.
14 How many of them are DBQs, how many didn't get an
15 exam I'm not sure.
16 MEMBER PAMPERIN: Well I mean quite
17 frankly just from the contractor perspective, it
18 should be fairly easy to get because they get
19 paid by DBQ.
20 MR. SAMPSEL: Well, the contractor,
21 there's a huge new input coming out on contract
22 exams. I don't -- I'm not up on that, but

1 somebody else might want to address that.
2 DR. VVENDENSKAYA: Beth.
3 MR. SAMPSEL: There's a whole new --
4 yeah. There's a whole new group --
5 DR. VVENDENSKAYA: And Pam Miller is
6 presenting tomorrow.
7 MR. SAMPSEL: Okay, well that might be
8 something for them because I don't know the
9 contract medical people's training. I don't
10 know. I don't know if they're getting specific
11 Gulf War stuff because the average medical doctor
12 doesn't have any clue about an undiagnosed
13 illness.
14 MEMBER SIMBERKOFF: So the question I
15 was going to ask, there was a meeting some place
16 in New Mexico, Arizona or one of those places a
17 year or so ago that a lot of C&P chiefs were sent
18 to. Were any of these issues discussed at that
19 meeting?
20 MR. SAMPSEL: I'm not sure. I wasn't
21 there.
22 DR. VVENDENSKAYA: I wasn't there, but

1 it might be a great question for Pam Miller, who
2 will be presenting on C&P exams.
3 MEMBER SIMBERKOFF: Okay. It was
4 probably a year and a half ago, and it's sort of
5 --
6 MR. SAMPSEL: Was it on the Gulf War
7 specifically? I don't think it was.
8 MEMBER SIMBERKOFF: No, it was on C&P
9 exams.
10 MR. SAMPSEL: C&P exams, yeah.
11 MEMBER SIMBERKOFF: Yeah, but if this
12 is, you know, such an important issue on the
13 currency of the exams, I would have thought that
14 it was one of the issues --
15 MR. SAMPSEL: If you're a Gulf War
16 veteran it's important, that's for sure.
17 MEMBER SIMBERKOFF: Yeah.
18 MR. SAMPSEL: I don't know. I don't
19 know what percentage of claims coming in are Gulf
20 War veterans. I'm not sure. There's a lot of
21 Vietnam veterans, a lot of Agent Orange. There
22 aren't as many Gulf War claims, because there

1 weren't as many Gulf War veterans.
2 But it's definitely an issue and it's
3 difficult for people in the field because it's
4 very nebulous, you know.
5 MEMBER BIRD: May I inject here, the
6 term "presumptive" should not be nebulous.
7 MR. SAMPSEL: Well, an undiagnosed
8 illness --
9 MEMBER BIRD: It's got to be -- there
10 has to be clarification on that term.
11 MR. SAMPSEL: Well that's true, but a
12 presumptive has to be identified, okay. If it's
13 an undiagnosed illness, it has to be identified.
14 If it's a medically unexplained chronic multi-
15 symptom illness, it has to be diagnosed. So that
16 has to happen before there's going to be service
17 connection.
18 That's different than the Agent Orange
19 presumptives, I think. The Agent Orange
20 presumptives are laid out clearly and they're
21 diagnosable diseases, and the word "presumptive"
22 shows up in 1116 for Agent Orange. But it

1 doesn't show up here in 1117, but they are
2 presumptives.
3 And as I was saying earlier, we have
4 told the field, we have told the developers who
5 order the exams don't put a request in there for
6 an opinion if we're talking about a presumptive.
7 Don't put a request in there for an opinion as to
8 whether that presumptive is related to Gulf War,
9 because it automatically is.
10 We put out a training issue on that.
11 I hope they're following that, because that was a
12 big issue before. But I haven't heard much about
13 it lately.
14 MEMBER BIRD: It was not much there.
15 It's in the process.
16 MR. SAMPSEL: How long ago was that?
17 MEMBER BIRD: That was about a year ago
18 or less.
19 MR. SAMPSEL: Well, I'll tell you. We
20 can add something to our Compensation bulletin
21 about that, the Compensation Service bulletin. I
22 don't know if you're interested in a couple --

1 you want it on the DBQ?
2 MALE PARTICIPANT: Yeah. We need to
3 look at it.
4 MR. SAMPSEL: Okay, and if anybody has
5 any questions that I can answer later, that's
6 okay. I thought you might be interested in some
7 of the legal work, legal issues that are going on
8 right now. By the way, there's recently Congress
9 passed a public law on mandating essentially
10 studies on toxic exposures.
11 It's a very broad, very broad
12 terminology and I think it encompasses Agent
13 Orange issues and Gulf War issues, and I know I'm
14 sure you're in on that. I know Dr. Erickson's
15 group is conducting certain studies, and I might
16 add the latest, you referred to it but I don't
17 think you mentioned the content.
18 The IOM just came out with -- the
19 Academy of Medicine just came out with a report
20 very recently, like this week. They were asked
21 to evaluate the burn pit registry. The burn pit
22 issue is a big issue for basically the post-9/11

1 group, including Afghanistan veterans.
2 A lot of it -- as was mentioned, a lot
3 of the disabilities are the same, even though the
4 environmental exposures weren't the same. So I
5 don't know where that leads, but the issue in
6 this study was can a self-reported burn pit
7 registry contribute to any kind of science on
8 long-term health effects.
9 My understanding is the IOM said no,
10 this is not -- this is not something that you can
11 use for -- to determine any long term health
12 effects because they're self-reporting and
13 anyway, that was their conclusion. So I don't
14 know where they're going to go. I know there's
15 new studies being generated all the time, but I'm
16 a little -- in my own mind I'm a little
17 frustrated because that doesn't really translate
18 into currently assisting DBA adjudicators.
19 Down the road, things may change. But
20 we are stuck with the law as stated and the
21 current examination process, and whatever the VHA
22 examiners come up with. So I kind of mentioned a

1 couple to me interesting court cases that are
2 coming up with general counsel. The lawyers for
3 veterans, needless to say, are trying to get more
4 service connection for particular veterans.
5 So there's two court cases pending
6 right now. One of them has to do with the
7 definition of medically unexplained chronic
8 multi-symptom illness as having no identifiable
9 etiology or pathophysiology. So the issue is
10 whether one, just one of those is sufficient or
11 both of them have to be sufficient to exclude a
12 veteran from service connection.
13 The advocates, Chisholm Law Group
14 basically, is saying that you only need one of
15 those. But the VA position right now from
16 general counsel, and I think our VBA position is
17 that you need both of those in order to qualify
18 for a diagnosable medically unexplained chronic
19 multi-symptom illness and get service connected
20 for it.
21 Basically, the rationale is that the
22 partially understood is excluded. So if

1 partially understood is excluded, then it appears
2 to us that both of those are needed for service
3 connection. Anyway, that's pending in court
4 right now.
5 Another issue that came up was related
6 to this. Once again, it's a medically
7 unexplained chronic multi-symptom illness issue.
8 MEMBER SIMBERKOFF: So the issue in
9 the latter is what constitutes an unassigned
10 pathophysiology?
11 MR. SAMPSEL: Yes.
12 MEMBER SIMBERKOFF: So if you again
13 take the example of fibromyalgia, you know --
14 MR. SAMPSEL: Well fibromyalgia is a
15 presumptive.
16 MEMBER SIMBERKOFF: Yes.
17 MR. SAMPSEL: So that's already in
18 there.
19 MEMBER SIMBERKOFF: Yeah, but doesn't
20 that -- does that require pathophysiology or not?
21 MR. SAMPSEL: Those are -- there's
22 three identified medically unexplained chronic

1 multi-symptom illnesses that are presumptive, and
2 the door's open for some other that a VA medical
3 examiner might come up with. But if it's
4 partially understood, not one of those three and
5 the examples of partially understood are diabetes
6 and multiple sclerosis, if it's like that --
7 MEMBER SIMBERKOFF: Those are pretty
8 broad, are they not?
9 MR. SAMPSEL: Yeah. Well, and so
10 here's the secondary issue, based on this
11 etiology issue. We have a court case pending
12 where it's front of the Court of Appeals for
13 Veterans Claims, where the veteran had asthma and
14 the veteran had -- which served in the Gulf War,
15 and he's diagnosed with asthma, so it's
16 diagnosed.
17 However, the issue is according to the
18 veteran's lawyer, his particular asthma has an
19 unknown etiology. Asthma -- and so what this
20 boils down to is does this regulation and this
21 statute, is this talking about an etiology
22 recognized by the medical community and put into

1 medical dictionaries, or is it specifically
2 applied to each claimant?
3 So the claimant here is arguing that
4 his asthma, you can't tell where his asthma came
5 from, even though asthma has a known etiology in
6 all medical treatises, dictionaries and he got
7 the diagnosis. So we're arguing, I mean VA OGC,
8 general counsel is, that the specific origin or
9 etiology of a particular disease or whatever, if
10 it's diagnosed, not one of the presumptives, if
11 it's diagnosed and there's known etiology in
12 general, then it doesn't matter whether you know
13 about this particular veteran's origin of his
14 asthma.
15 MEMBER SIMBERKOFF: So like in this
16 case, he's arguing that the asthma was not
17 diagnosed while he was in the military?
18 MR. SAMPSEL: Well that doesn't matter
19 because we're talking --
20 MEMBER SIMBERKOFF: But if it was,
21 what difference does it make?
22 MR. SAMPSEL: Well, if it was

1 diagnosed in the military, automatically it's
2 service connected.
3 MEMBER SIMBERKOFF: The service
4 connected --
5 MR. SAMPSEL: Yeah. We're talking
6 about claims long after separation from service.
7 That's common. That's the most common claim. I
8 mean the way things are now, the VA sends people
9 to every military base and helps them fill out
10 their claims. So it's going to be a rare day
11 when somebody develops something in service and
12 they don't get automatically service-connected.
13 It's the claims now, coming in now
14 from, you know, veterans who served in the
15 original Persian Gulf War and in the post-2001
16 OIF/OEF, those claims continue to come in now.
17 They're the claims that we're talking about that
18 raise these issues. Anything that happened right
19 after service, it's already been service
20 connected.
21 So anyway, this is really interesting
22 as to whether -- and by the way, this veteran,

1 he's a long time smoker and there were several
2 other factors that pretty well contributed to his
3 asthma. But he's claiming you can't pinpoint my
4 asthma, the specific etiology of my asthma.
5 Anyway, that's pending and we'll see what the
6 Court does about it.
7 I mean if the Court goes with him,
8 we're going to have a whole new agenda to address
9 and the Gulf War issues are in flux, you know.
10 They're in flux based on what the Court does,
11 what the medical evidence, scientific research
12 comes up with and how that effects the claims
13 process. So anyway, any questions?
14 MR. ORTO: So you said the 20 percent
15 grant rate was for 317 and 3.03, is that correct,
16 the 20 percent grant rate is for -- was for both
17 of those, for 317 and 313, I mean 303?
18 MR. SAMPSEL: No, I think it's 3.317.
19 MR. ORTO: Okay.
20 MR. SAMPSEL: Don't quote me on that
21 grant rate. It fluctuates and all I really know
22 right now is that it's a very low grant rate, and

1 the DSOs and the anecdotes point to that all the
2 time. So Jerry, do you have a question?
3 MR. MANAR: I did, and it's along
4 these lines. If you know it's been a truly low
5 grant rate and if I heard you correctly, you said
6 it's the result of the examination process, has
7 Comp Service or DHA done any kind of an
8 investigation to see if it's uniform, nearly
9 uniform across the country or whether there's
10 high and low outliers which might indicate a
11 training problem at certain hospitals or a
12 cultural problem at a certain hospital?
13 MR. SAMPSEL: Well, I don't think
14 we've gotten to that point, but that's -- that's
15 come up under other issues. That was an issue
16 with MST, it's been an issue with PTSD. I'm not
17 aware that that's been done yet. That might be
18 something coming in the future. But I know that
19 that -- there's a STARRS staff, a quality review
20 staff based in Nashville. They do these kind of
21 reviews. So they did a review. I think they
22 recently did a review on the Gulf War and they --

1 but the review was really to see whether the
2 examiners were, you know, consistent.
3 Anyway, they thought if there was fair
4 consistency. But I don't have the details on
5 that right now.
6 CHAIRMAN MARTIN: Jim, I know you're
7 going to be back with us to talk about Agent
8 Orange after lunch. Any other questions on Gulf
9 War illness for him before we move on? Hal, any
10 questions at this point about Gulf War illness
11 that we haven't addressed?
12 MEMBER BIRD: No. I just want to
13 thank you, Jim.
14 CHAIRMAN MARTIN: Okay, and Elder, are
15 you back online?
16 (No response.)
17 CHAIRMAN MARTIN: Okay. Dr.
18 Kalasinsky, you need any other remarks and
19 comments?
20 MALE PARTICIPANT: Any questions for
21 Jim?
22 (Laughter.)

1 MR. SAMPSEL: Yeah, I wish he had
2 some.
3 DR. VVENDENSKAYA: Any questions, Dr.
4 Kalasinsky?
5 DR. KALASINSKY: Well, the only thing
6 I would add is that I'm going to bring up some of
7 these questions about the exams C&P with our
8 leadership, get back together and see what we can
9 do about it.
10 MR. SAMPSEL: Yeah that --
11 DR. VVENDENSKAYA: That would be
12 great.
13 MR. SAMPSEL: More communication is
14 always better.
15 CHAIRMAN MARTIN: I noticed that the
16 DBQ, the top says "For Internal VA Use Only." So
17 private practitioners shouldn't be filling out
18 the DBQs.
19 MR. SAMPSEL: No, they don't get this
20 DBQ because who -- what private practitioner even
21 thinks about an undiagnosed illness, you know?
22 That's -- that's not medical training.

1 CHAIRMAN MARTIN: Asked to provide a
2 diagnosis for an undiagnosable condition.
3 MR. SAMPSEL: That's right and that --
4 in my original training letter, I made a point of
5 telling or making a point to adjudicators, you
6 know, if you rely on a diagnosis from a private
7 medical person of the claim, the original claim,
8 you shouldn't do that because there will be a
9 diagnosis. You can have a respiratory problem
10 and it may turn out to be --
11 MEMBER SIMBERKOFF: And it may be
12 right or wrong. There's going to be a diagnosis.
13 MR. SAMPSEL: Yeah. There's going to
14 be a diagnosis, and so the --
15 MEMBER SIMBERKOFF: Even in the VA,
16 because otherwise you don't get workload rights.
17 MR. SAMPSEL: Oh, okay. I don't know
18 about that. It's a strange area, and it's all
19 based on symptoms reported by Gulf War veterans,
20 you know. Anyway, we've got to do what we can
21 with what we have.
22 CHAIRMAN MARTIN: Okay, thank you very

1 much. We'll see you after lunch.
2 DR. VVENDENSKAYA: Thank you very
3 much.
4 MR. SAMPSEL: I will be back later.
5 (Applause.)
6 CHAIRMAN MARTIN: Okay. We will
7 reconvene at one o'clock, have some lunch and
8 come back. It's a rather short lunch period, but
9 we've got a lot of material to cover this
10 afternoon and the Undersecretary will be here.
11 MR. SAMPSEL: One o'clock.
12 DR. VVENDENSKAYA: One o'clock.
13 (Whereupon, the above-entitled matter
14 went off the record at 11:49 a.m. and resumed at
15 12:59 p.m.)
16 CHAIRMAN MARTIN: I had mentioned the
17 Medal of Honor Recipient Reception, that I had
18 the opportunity to go to, and the only survivor
19 of Iwo Jima, the only surviving Medal of Honor
20 winner from Iwo Jima is Woody Williams. And I
21 ran across this video that he did, actually did
22 it for the VA. The VA video, and recorded this

1 back in the fall of last year.

2 He's 93, and I just wanted you to take

3 a look at this video. We have sound now. Ready?

4 (Video plays.)

5 CHAIRMAN MARTIN: Well, I appreciate

6 your time looking at that. I tried to provide a

7 really good re-focus on our privilege to work for

8 the veterans who are, many of them, on disability

9 compensation. So I'm glad we had the chance to

10 look at that. Jim, I'm sorry to take time away

11 from your presentation.

12 MR. SAMPSEL: No, that's okay.

13 CHAIRMAN MARTIN: Thank you for being

14 back with us.

15 MR. SAMPSEL: Yes. I just want to

16 say, that is inspirational, and you know, from my

17 point of view, I will do anything to help

18 veterans, any legitimate veteran, and I've done

19 it plenty of times. Unfortunately, when it comes

20 to this Agent Orange, we have to have a lot of

21 denials. And, you know, what can I say?

22 So, I just want to say that before we

1 get started. Well, Agent Orange is a big issue
2 that's related to the war in Vietnam. Couple of
3 us are Vietnam veterans. Tom, for example, me.
4 So, I somehow got trapped into taking care of
5 Vietnam veterans' issues, which included PTSD and
6 Agent Orange issues.
7 So, at any rate, Agent Orange was an
8 herbicide used in Vietnam, primarily by aircraft,
9 C-123 aircraft during Operation Ranch Hand, from,
10 I think they got stared in '62, at the request of
11 the Vietnam Government, South Vietnam, Republic
12 of Vietnam, prior to the Marines landing in '65.
13 So there was a lot of activity before that.
14 And the purpose was to destroy enemy
15 food crops, originally. And also to -- a lot of
16 activity on the Ho Chi Minh Trail, where the
17 North Vietnamese were running supplies and
18 personnel down along the western border of
19 Vietnam, Cambodia and Laos.
20 And that area was a heavy jungle, and
21 they were protected by the canopy, and they were
22 supplying the Viet Cong in the South. So that

1 was the primary mission of Operation Ranch Hand,
2 to eliminate some of that vegetation, and reveal
3 those enemy positions.
4 So, at any rate, that's the
5 background. The science of Agent Orange -- you
6 got my pen up there?
7 PARTICIPANT: Mm-hmm.
8 MR. SAMPSEL: The science is, Agent
9 Orange is one of what they called a rainbow,
10 group of rainbow herbicides, that was the term
11 used early on. There was, originally there was
12 Agent Purple, then there was Agent White, Green,
13 and Blue. But Agent Orange was the most commonly
14 used from, like, '65 onward.
15 It consisted of 2,4,5-T, 50 percent
16 2,4,5-T, and 50 percent 2,4-D. And the 2,4,5-T
17 had a bi-product, TCDD/dioxin. I think it's
18 important to realize that the amount -- and, by
19 the way, 2,4-D, which I'll talk about a little
20 bit later, is a commercial herbicide on its own,
21 still in use, still approved by the EPA.
22 I think it's important to realize that

1 the amount of dioxin in any given volume of Agent
2 Orange was only five to 13 parts per million.
3 There's a lot of talk about how many gallons of
4 Agent Orange were sprayed, and how deadly it was
5 and so on, but very, very small amounts of actual
6 TCDD was involved.
7 Additionally, TCDD had a very short
8 life span in sunlight. It was destroyed by
9 sunlight, destroyed by an open air environment.
10 That's not commonly acknowledged by advocates.
11 And the other issue is that the dioxin in TCDD is
12 present in our environment, it's ambient in the
13 environment. There's a question?
14 MR. MURRAY: What's a very short life
15 cycle?
16 MR. SAMPSEL: Pardon me?
17 MR. MURRAY: What's a very short life
18 cycle?
19 MR. SAMPSEL: According to various
20 studies --
21 MR. MURRAY: You mean, like, an hour
22 or 24 hours, or --

1 MR. SAMPSEL: Yes. Several hours. In
2 sunlight, several hours only. One of the issues
3 in the Blue Water Navy arena is that, if the
4 Agent Orange gets into the water and isn't
5 destroyed immediately by sunlight, it will bind
6 to organic matter. Agent Orange is not water-
7 soluble. It's mixed with jet fuel, primarily,
8 when they spray it, when they aerially sprayed
9 it.
10 So there's a very small amount, and
11 it's destroyed in sunlight. You know, there are
12 couple other issues that I'll talk about when we
13 get to, maybe, the C-123 regulation that we
14 recently passed. But, at any rate, so there's
15 ambient dioxin, everyone has it in their
16 bloodstream -- their tissue, their blood,
17 according to all medical people.
18 It's produced by burning plastic, it's
19 produced by diesel fuel, it's produced by
20 electrical transformers. And the people in VHA
21 have said regularly that there's quite a bit in
22 the environment.

1 So I don't think that's acknowledged
2 by the public, by the media, and so on. Anyway,
3 it's worth noting. Then, in terms of the long-
4 term health effects. I'll talk about the
5 Institute of Medicine, which was there and
6 published, was created by public law on Agent
7 Orange, the Agent Orange Act.
8 But the only long-term health study,
9 long-term health effect was done by the U.S. Air
10 Force, it was a 30-year study. And it was done
11 on Ranch Hand pilots and Ranch Hand crew members
12 that handled Agent Orange. And, after a 30-year
13 study, there's no evidence that they have a
14 higher rate of cancers or any of the diseases
15 that have been associated with Agent Orange.
16 So those are basically the background
17 facts. But when it comes to Agent Orange, the
18 facts don't always matter. So we have to deal
19 with the law as written, and so that's what I'm
20 going to talk about here.
21 The law is based on 38 United States
22 Code 1116, which does several things. It

1 provides a presumption of Agent Orange exposure
2 for anyone with "service in Vietnam." Service in
3 Vietnam. The regulation that addresses that
4 talks about duty or visitation in Vietnam. And
5 the regulation is 3.309, 3.307.
6 Code 1116 gave that presumption, but
7 also created diseases that can be service-
8 connected presumptively. There are different
9 ways to service-connect a disability, and when we
10 refer to them this morning, we refer to
11 presumptives versus the general 3.303 regulation,
12 where you have to have a current disability, a
13 current chronic disability. You have to have an
14 event disease or injury in service, and you have
15 to have a medical link.
16 When it comes to presumptives, you
17 don't need that medical link. The event and
18 service, in this case, service in Vietnam, is
19 sufficient for the presumption of service
20 connection.
21 The other thing that, the third thing
22 that the 1116 did, it brought the Institute of

1 Medicine, now the Academy of Medicine, into the
2 picture, and they've done studies. Every two
3 years, they conduct a study on diseases
4 potentially associated with Agent Orange
5 exposure.
6 And their criteria is association, not
7 causation. They have a -- they developed a sort
8 of hierarchy of associations. The highest level
9 is called "an association." And there's only,
10 like, chloracne is, like, the only one.
11 The next level is "limited or
12 suggested evidence of an association," and that's
13 the criteria for almost of the diseases,
14 including the big ones, ischemic heart disease,
15 diabetes, prostate cancer, lung cancer, and so
16 on.
17 And then they have another category,
18 "insufficient evidence to make a determination of
19 association," and that's the one they apply to
20 most of the ones that are not on the list.
21 And then finally, they have "evidence
22 of no association," and I think the only one in

1 that is some sort of birth problem. But anyway,
2 there's -- they really haven't been inclined to
3 use that.
4 So their reports were essentially
5 mandated by 1116. But as of this past year,
6 2015, that section of the statute has sunset, has
7 expired, and Congress did not renew that. So
8 there's one more that's currently in the process,
9 one more Agent Orange report, and that will be
10 it.
11 And for what it's worth, several years
12 ago, there was another task given to the
13 Institute of Medicine, to determine -- to
14 basically analyze the process, the presumptive
15 disease process, and offer some kind of
16 recommendations for how to deal with
17 presumptives.
18 And that report recommended a two-
19 stage committee. But the big punch line was,
20 they recommended a causation, a scientific
21 causation, not an association. And there's a big
22 difference there.

1 I don't think any of these diseases
2 would fall under causation, but they do fall
3 under association, limited or suggested evidence.
4 So where are we now? The latest IOM
5 report listed bladder cancer, hypothyroidism and
6 Parkinson's-like symptoms to be limited or
7 suggested evidence of an association. And right
8 now, it's pending for the new Secretary, on
9 whether those will go forward as part of our
10 regulation.
11 The other one is hypertension, which
12 was put forth several years back, but VA never
13 acted on it. General Peake was the Secretary at
14 that time. He's a medical doctor, and I believe
15 he felt that, and according to the work group,
16 there were too many risk factors related to
17 hypertension to say that Agent Orange was
18 associated, or was somehow a cause of that.
19 So hypertension came up again this
20 cycle, and the Veterans Health Administration
21 recommended that the Secretary make that one of
22 the associated diseases. However, just about a

1 week ago, Brad Flohr, who works for Comp Service,
2 wrote up a report and everybody in Comp Service
3 basically said, that was a bad idea.
4 And I believe the Secretary, the
5 information I got recently, is not going to go
6 with hypertension. As to the other ones, there's
7 the likelihood that they'll become added to the
8 list.
9 For what it's worth, when a disease is
10 added, the Nehmer court case kicks in, and VA has
11 to go back, all the way back, review records all
12 the way back to 1985, to discover anybody who
13 made a claim for the newly added disease. And
14 that's a huge enterprise.
15 When ischemic heart disease came in,
16 and B cell leukemia, that was a huge effort, and
17 it set the claims process back. The backlog was
18 -- a huge backlog was created. So anyway, if
19 hypertension would come in, almost everybody has
20 hypertension later in life.
21 So that would be trouble, process-
22 wise, for VA. But I don't think hypertension is

1 going to be included.

2 MEMBER SIMBERKOFF: So when you say,

3 Parkinson's-like symptoms --

4 MR. SAMPSEL: I don't, I can't define

5 that for you.

6 MEMBER SIMBERKOFF: Yes. I was going

7 to say, Parkinson's, you can -- is relatively,

8 you know, that's a --

9 MR. SAMPSEL: Parkinson's Disease is

10 already on the list.

11 MEMBER SIMBERKOFF: Okay. But what is

12 "Parkinson's-like"?

13 MR. SAMPSEL: I don't know. That --

14 you'd have to look at the IOM report. I think --

15 I believe the source of that was a lot of

16 veterans had symptoms, but not a complete

17 diagnosis of Parkinson's.

18 MEMBER SIMBERKOFF: And an awful lot

19 of people --

20 (Simultaneous speaking)

21 MR. SAMPSEL: Well, if you have

22 Parkinson's Disease and you're a Vietnam veteran,

1 you automatically get service-connected. Now, it
2 looks like if you have Parkinson's-like symptoms,
3 whatever exactly that is, you know, you can look
4 at the report to determine what that is.
5 But that looks likely that that will
6 be service-connectable too.
7 MEMBER SIMBERKOFF: And does -- when
8 you say you have to go back through the records,
9 many of these patients may have already died.
10 MEMBER PAMPERIN: So their survivors
11 may have a --
12 MEMBER SIMBERKOFF: Yes, so their
13 survivors are --
14 MR. SAMPSEL: Their survivors -- I
15 mean, it's a complicated process. Tom knows a
16 lot about it. I think he dealt with the court
17 out there, the Ninth Circuit.
18 MEMBER PAMPERIN: The judge even
19 threatened to put me in jail.
20 (Laughter.)
21 MR. SAMPSEL: Yes. Now it's history,
22 there. But, at any rate, those who have died,

1 their surviving spouses or their surviving
2 dependents will get the benefit. And not only
3 that, but there's some kind of progression of
4 descendants are involved.
5 So, and this is NVLSP's work. This
6 the National Veterans Legal Service Program that
7 pretty much has a lot to do with this. But
8 that's another issue, that's a service-
9 connectable issue. And, you know, it is what it
10 is, so.
11 Where did all the Agent Orange
12 hysteria, what I would call hysteria, in the
13 media, come from? There's no doubt that Vietnam
14 veterans may have been exposed, because they were
15 spraying.
16 Now I will say that based on my
17 research and based on information from DR. Alvin
18 Young, who I think I'll mention a little bit
19 later, DR. Young is a retired Air Force colonel.
20 He was involved with development of the Agent
21 Orange and spray nozzles during the '60s and
22 '70s.

1 He then worked for the VA and for the
2 Department of Defense in D.C. in the '80s. When
3 he retired -- he has a PhD in toxicology -- he
4 has a business, a scientific business. He
5 publishes in journals and several years ago, we
6 had a contract with DR. Young, and he did some
7 reports for us on Agent Orange.
8 And, at any rate, I'll discuss that a
9 little bit more when we get to the C-123s. But
10 it's pretty clear that, in Vietnam itself, there
11 probably wasn't very much exposure to the spray,
12 because the Ranch Hand planes did not spray when
13 there were American troops in the area.
14 And it wasn't because anybody thought
15 it was harmful. It was because where there were
16 U.S. troops, there were enemy troops, and they
17 shot down planes. Probably, according to what
18 I've read, the highest shot-down plane rate was
19 among Ranch Hand planes in Vietnam.
20 So anyway, there's not much evidence
21 for bona fide exposure, but there's a law that
22 presumes exposure. So that's what we deal with.

1 And I don't know. The media -- when we get to
2 outside of Vietnam, there's a lot of controversy
3 about Agent Orange use. And primarily it's media
4 hype, in my opinion.
5 And Congressional action, based on
6 veterans who feel like they were exposed to Agent
7 Orange. I'm sure a lot of veterans saw
8 herbicides being used, because herbicides were
9 used.
10 The question is, is it a "tactical
11 herbicide," like Agent Orange, or was it a
12 commercial herbicide like was used on every
13 military base? And used on many lawns in the
14 United States?
15 So, at any rate, that's the background
16 on Agent Orange. But, I want to explain how we
17 service-connect, how do we service-connect
18 veterans, based on Agent Orange exposure? And
19 I'll start off with the Vietnam veteran, because
20 that was the original focus.
21 A Vietnam veteran is a person who
22 served in Vietnam or went TDY. All they had to

1 do was be there for a very short time and they'll
2 get the presumption. So we look for their DD-
3 214, does it say, "Vietnam service"? And we look
4 to see whether they got a Vietnam service medal.
5 If there's no record -- a lot of
6 veterans say they went TDY to Vietnam, from
7 Thailand or from Guam, or wherever, and I'm sure
8 that happened. I know that happened regularly
9 during the first part of the war.
10 Especially before the Marines landed
11 in '65. So we'll try to find those records in
12 their personnel file. We look for things like
13 the Army post office APO boxes, there will be a
14 stamp and a record. And we have a record of
15 where all the numbers and which ones were
16 Vietnam, which ones were Thailand, which ones
17 were Guam, and so on.
18 So we look for anything like that to
19 service-connect and give the presumption to any
20 Vietnam veteran. However, one class of Vietnam
21 veterans are the Blue Water Navy veterans. And
22 that's a special class, and there's a lot of

1 activity going on with Congress and with
2 advocates right now about the Blue Water Navy.
3 Blue Water Navy, in a nutshell, during
4 the Vietnam war there was a large number of what
5 are called Brown Water Navy vessels. And I think
6 Jerry Manar was involved in it, personally.
7 So they operated on the inland
8 waterways of Vietnam, inside the boundaries. So
9 they were potentially exposed to this strain of
10 Agent Orange. So they get the presumption, Brown
11 Water, because the waters inside Vietnam were all
12 brown. There wasn't any mountain springs. Dark
13 brown rivers.
14 Now, that's distinguished from the
15 Blue Water Navy, which are vessels that operated
16 on the open ocean, primarily destroyers,
17 cruisers, aircraft carriers. Those vessels that
18 normally would not be inside the boundaries of
19 Vietnam.
20 However, quite a few destroyers and
21 supply ships went into the inland rivers and
22 inland waterways, the destroyers to provide

1 gunfire support for ground troops, and the supply
2 ships to deliver supplies to the inland bases.
3 They went into the interior, and we
4 make a distinction between offshore waters and
5 waters that are inside the coastal boundaries of
6 Vietnam.
7 And the open water harbors, which
8 would include Da Nang, Qui Nhon, Nha Trang, Cam
9 Ranh Bay, and Vung Tau, those are the primary
10 ones, going down from north to south. We do not
11 consider them inland waterways, because they are
12 directly open to the ocean.
13 So the Blue Water Navy veterans feel
14 like they should be getting the presumption of
15 Agent Orange exposure, just like the troops that
16 served inside Vietnam. But, and there's at least
17 three legal cases pending right now.
18 I don't know if I need to go into
19 those. But, at any rate, we get -- through the
20 years I developed a ship's list, a list of ships.
21 It goes back a long way to the USS Ingersoll, the
22 first ship, we got a letter from the Executive

1 Officer right after the Haas case. There's a lot
2 here.
3 But originally, NVLSP again, the same
4 group that dealt with Nehmer, a legal group, they
5 filed a case with the Court of Appeals for
6 Veterans Claims, for a veteran by the name of
7 Haas. In that case, the veteran was on an
8 ammunition ship, he was off the coast, and he
9 claimed exposure.
10 It got to the court, the Court of
11 Appeals for Veterans Claims. I went to the
12 hearing, actually. The presentation by the NVLSP
13 was good, the presentation by the VA wasn't so
14 good. And the Court ruled in favor of NVLSP and
15 the veteran, and said anybody within, like, a 30-
16 mile radius offshore should get the presumption
17 of exposure.
18 So VA appealed that to the federal
19 circuit, and the federal circuit nullified that
20 decision, and said the VA had, under the Chevron
21 case, which has to do with regulatory agencies
22 can interpret statutes, as long as they're not

1 irrational, the interpretation is valid.
2 And they determined that VA's
3 interpretation of inland waterway versus offshore
4 waterways was valid. So currently, offshore
5 doesn't count. But there's quite a few ships
6 that went inside the inland waterways, and we
7 have a ships list. There's over 300 ships and
8 categories on that list by now, and anybody who
9 was on one of those ships when that ship went
10 inside the boundaries of Vietnam, the land
11 boundaries, they get the presumption of exposure.
12 In a nutshell, that's the situation.
13 And there are numerous cases pending, like I say,
14 to have all Blue Water Navy get the presumption,
15 because they were Vietnam veterans, and they did
16 a job. They did a good job.
17 But as to whether they get the
18 exposure or not, that's the issue.
19 So that's, that's the Vietnam. Any
20 questions about that? Okay. Another big area of
21 concern is the Korean DMZ. We have the documents
22 that show that during the, during 1968, '67 or

1 '68, there was major concerns in Korea. The DMZ
2 was a hot point.
3 There was a, slips my mind, but there
4 was a ship, North Koreans kidnaped a crew of a
5 ship. Anybody remember that?
6 Pueblo. USS Pueblo. The crew was
7 kidnaped, the Department of Defense was on high
8 alert, and they determined they wanted to try
9 using Agent Orange along the DMZ to cut down on
10 the potential for the North Koreans sneaking up
11 and attacking.
12 So Agent Orange was applied. I think
13 we have records that say, like, 200 yards, 300
14 yards both ways along the DMZ by Korean troops.
15 U.S. troops never did it, according to all the
16 records.
17 So initially -- this is a little
18 complicated, but we -- the whole approach of
19 Agent Orange exposure for Korean veterans came
20 from a statute for spina bifida. Spina bifida is
21 a disease, a childhood disease, that that statute
22 said was associated with Agent Orange exposure,

1 and it gave a date range.
2 And I know who is responsible for
3 this, Mary Ellen McCarthy, if anybody knows who
4 I'm talking about, besides Tom. She worked for
5 the Senate Veterans Affairs Committee, and as a
6 result of that, we had a statute that gave a
7 benefit to the offspring of a veteran who was
8 supposedly exposed to Agent Orange, but we didn't
9 have anything for that veteran.
10 So we had a policy where we gave it
11 under an acknowledgment of exposure, not a
12 presumption. But about 2010, we passed a
13 regulation, VA passed a regulation giving a
14 presumption of exposure to certain -- to veterans
15 who were in certain units on the Korean DMZ,
16 primarily infantry and artillery units.
17 Any veteran who was in one of those
18 units between April, 1968, through, I think,
19 August 1971, gets the presumption. And we have a
20 list that we got from DoD, and I did some
21 research and added some units, so we had that
22 list.

1 Now the latest development has to do
2 with Senator Blumenthal and Congressman McCarthy,
3 who sent letters to us, to the VA. They got hold
4 of some documents that referred to testing that
5 was done in 1967.
6 And I might say that the spina bifida
7 statute uses a 1967 date. And I've had to answer
8 many times from VSOs and so on, that '67, why
9 don't you give the presumption from '67?
10 Well, that's because we don't have any
11 evidence for any actual Agent Orange use during
12 '67. But we do have a record of a test of 2,4-D
13 and Linuron. See, those were commercial
14 herbicides that were tested in '67.
15 So we spent quite a bit of time
16 recently, we've had meetings, teleconferences,
17 and so on, with Senate Veterans Affairs
18 Committee, trying to explain this to them.
19 They wanted us to take the presumptive date
20 back to '67, September, 1967. But I don't think
21 we have the evidence for that. So that's the
22 latest on the Korean DMZ.

1 Then we got a letter from Congressman
2 Latta, from Ohio, who felt like we should extend
3 a benefit to veterans who were on the DMZ in the
4 1980s. And our response to that one was that, as
5 I said earlier, TCDD does not stay in the
6 environment. It's destroyed by sunlight in the
7 open air, and there's no evidence that it's still
8 in the environment.
9 So, many years later in the '80s,
10 there's no real chance for exposure. So those
11 are some of the issues for Korea.
12 MR. MANAR: Could I mention something
13 here?
14 MR. SAMPSEL: Yes.
15 MR. MANAR: I'm aware of at least one
16 Board of Veterans Appeals case, and I understand
17 that it's not precedent, but a veteran was able
18 to show that, because of the half-life of dioxin
19 if it's buried in the soil, exposure could still
20 occur if that soil is disturbed.
21 And he was in a construction unit on
22 the DMZ. And they did grant service connection

1 for his presumptive disabilities at that point.
2 MR. SAMPSEL: Yes. I'm well aware of
3 the BVA. BVA is, can do anything they want. I
4 don't know if everybody understands BVA. BVA has
5 caused a lot of, what I would call misinformation
6 about Agent Orange issues, and this has to do
7 with what Jerry just mentioned in Korea.
8 It also has to do with Guam and
9 Okinawa, especially. Guam has come back, big
10 time, in the past couple of months. But BVA is
11 an independent group of veterans law judges, not
12 associated with VHA, not really associated with
13 DVA, except that they have an independent ability
14 to look at an appeal and come up with any
15 decision they want.
16 And their decisions don't have any
17 precedential value for anybody, and they're very
18 sympathetic. Numerous -- the appeal you're
19 talking about, half-life in a soil -- I don't
20 think there's much evidence for that. Although
21 advocates would say, take a look at our C-123
22 regulation. And that somehow shows persistence

1 of dioxin in the environment.

2 MR. MANAR: If it's not exposed to

3 sunlight, if it's, for instance, on the C-130s,

4 if it's buried under layers of paint. If it's

5 worked into the soil before it's had a chance to

6 degrade, there are studies, I've seen one or two

7 and I'm sure you've seen many more. But I've

8 seen a couple of studies that indicate that

9 dioxin can exist in certain environments for a

10 very long time, sometimes even years after it's

11 been sprayed or otherwise applied to a certain

12 area.

13 MEMBER PAMPERIN: Jim, to be fair, the

14 BVA is the Secretary's final decision.

15 MR. SAMPSEL: Pardon?

16 MEMBER PAMPERIN: A decision by the

17 Board of Veterans Appeals is the Secretary's

18 final decision. I mean, we can't distance

19 ourselves from the Board of Veterans Appeals. It

20 is part of the VA.

21 MR. SAMPSEL: Well, it isn't a final

22 decision if it's appealed to CAVC. But --

1 MEMBER PAMPERIN: It's the final
2 decision of the Secretary.
3 MR. SAMPSEL: Oh, oh, it's the final
4 decision.
5 MEMBER PAMPERIN: -- of the Secretary.
6 MR. SAMPSEL: In terms of finality,
7 yes. In terms of regulatory finality, yes,
8 that's true.
9 MEMBER PAMPERIN: And, I don't know,
10 Jim, but just to -- I'm looking at a website
11 right now that indicates that dioxin in the
12 subsurface soil is believed to last for a half-
13 life of a hundred years.
14 MR. SAMPSEL: I've seen those studies.
15 I don't think that most scientists would go along
16 with that. Even if that were true, that's only
17 part one. Part two is, will that -- first of
18 all, did you get exposed to that? Were you
19 somehow exposed to something that's in the soil?
20 And number two, did you develop long-
21 term health effects from that? Those were the
22 big issues with the C-123s. And, just by virtue

1 -- there's a lot of, in the late '80s when the
2 base realignment thing occurred, EPA, when they
3 turned over bases to civilians, there was a lot
4 of these Superfund things.
5 And, invariably, there'll be some
6 evidence for dioxin in some location. And
7 whether it came from Agent Orange is
8 questionable. But, as I said before, dioxin is
9 in the environment, and almost every one of those
10 Superfund site things, I've read, identify some
11 dioxins and says there's no health hazard.
12 So, what can I tell you? I don't
13 know. I'm not the scientist. But I know that
14 DR. Alvin Young and the majority, the vast
15 majority of scientists don't think that anybody
16 gets any harmful effects from something that's in
17 the soil, buried in the soil.
18 If it was on the surface, it would
19 have been long gone. How -- you know, I'm just,
20 for argumentation purposes, how is somebody going
21 to get exposed to something underground? I don't
22 know how.

1 PARTICIPANT: Dig a foxhole.
2 MR. SAMPSEL: What?
3 PARTICIPANT: Dig a foxhole.
4 MR. SAMPSEL: Oh, dig a foxhole.
5 Okay. Well then, okay. Then, you have the U.S.
6 Air Force study that shows the guys that really
7 were exposed with high levels of TCDD in their
8 body, did not develop long-term health effects.
9 Okay.
10 MEMBER BROWNE: I'm puzzled about the
11 spina bifida.
12 MR. SAMPSEL: Spina bifida.
13 MEMBER BROWNE: You said that the
14 birth defects and the exposure, mostly males that
15 were in, that you were talking about Korea and
16 the DMZ. So, if you're saying that that is a
17 presumptive point of exposure, explain the
18 science behind this --
19 MR. SAMPSEL: Explain the science?
20 MEMBER BROWNE: Yes. I'm --
21 MR. SAMPSEL: Well, let me tell you
22 this. This is interesting because, as I said,

1 spina bifida, the spina bifida statute is the
2 origin of us providing a regulation, a
3 presumptive regulation for the parent of the
4 child.
5 Now, the latest, the latest IOM
6 report, the same report that said bladder cancer,
7 hypothyroidism, and Parkinson's-like symptoms are
8 related to Agent Orange -- the same report said
9 the spina bifida study was faulty.
10 The original spina bifida study was
11 faulty, and they recommend removing spina bifida
12 from any kind of association with Agent Orange.
13 Now, VA's not going to do that, but that's what
14 they recommended. So, I mean, we're talking
15 about, I don't know, legal confusion, scientific
16 confusion.
17 But spina bifida will stay, but -- the
18 other thing, as sort of a, you know, I mean, I
19 don't like to be in a position where I'm saying
20 that some veteran doesn't deserve a benefit,
21 based on Agent Orange exposure.
22 But I'm obligated to take a look at

1 the facts and the science, you know. And the
2 issue is whether you want to follow that or some
3 kind of compassionate approach, based on the
4 service of the veteran. You know, I don't know
5 where we go on that.
6 But, at any rate, there's, like I
7 said, there's the issue of actual exposure,
8 there's the issue of long-term health effects,
9 there's not much evidence.
10 And so, spina bifida, what I did want
11 to mention is, associated with the spina bifida
12 regulation and statute, is that female Vietnam
13 veterans, the offspring of female Vietnam
14 veterans, if those offspring develop an entire
15 list of birth defects, they can get a benefit for
16 that.
17 We don't call it service connection,
18 but it's a benefit. And yet that is not linked
19 to Agent Orange by the statute, by the
20 regulation. It's just Vietnam veterans, female
21 Vietnam veteran. That was based on an early
22 study by the VA, and there's been discussion on

1 that.

2 There have been a lot of men, males,

3 who say, how come my children don't get this

4 benefit? How come only female veterans, Vietnam

5 veterans? Well, that's VHA, those are issues,

6 those are issues for VHA.

7 And along these same lines, the latest

8 from Vietnam Veterans of America and Congress is

9 the issue of inter-generational effects of Agent

10 Orange exposure. That's part of the new toxic

11 law that I mentioned this morning.

12 I attended a town hall meeting of

13 Vietnam Veterans of America out in Des Moines,

14 about eight months or so ago. And it was an all-

15 day session of Vietnam veterans from the area

16 brought in their offspring, their children and

17 grandchildren. And they gave testimonies about

18 their own physical and mental problems.

19 It was a long day. And is this the

20 evidence for long-term health effects inter-

21 generational? I don't know. But I know Congress

22 is interested in it now, and that's the latest

1 move.
2 So that's where we're headed. Anyway,
3 I don't know. I have to follow, we have to
4 follow the law as written, and try to balance
5 that with the evidence that we have and the
6 scientific evidence we have.
7 And, you know, right along those
8 lines, probably the best example of that is what
9 I'm going to talk about next here, the C-123
10 issue.
11 I presume you're interested in these
12 kind of things, because this is really what Agent
13 Orange, the development of Agent Orange here,
14 Agent Orange exposure claims -- for those who
15 don't understand or don't know about this, maybe,
16 I don't know, for the past several years, there's
17 been an advocate by the name of Wes Carter.
18 He's a retired reservist Air Force Colonel.
19 He was a pilot, a C-123 pilot. After the C-123
20 Ranch Hand planes were retired from Vietnam, they
21 came back to the U.S. and they sat in mothballs
22 for a while.

1 And then they were distributed to
2 reserve units in Pennsylvania, Massachusetts and
3 Ohio. And they were flown for several years.
4 And Wes Carter was an advocate for this group,
5 the C-123 group, and he claimed that they were
6 exposed to Agent Orange by virtue of dried,
7 solidified Agent Orange that was still active in
8 those planes.
9 So VA's position, based on VHA, based
10 on every VHA medical doctor and scientist over
11 there at VHA, told DVA that, there's no way. The
12 Agent Orange has dried, solidified, the vapor
13 pressure, CIF 600 degrees Fahrenheit to release
14 it into the environment. There's no way they got
15 exposed.
16 We had a contract with DR. Alvin
17 Young, who did, as I mentioned before, he did a
18 lot of research in the'60s and '70s. He worked
19 at Eglin Air Force Base, where they developed the
20 spray nozzles. They sprayed Agent Orange over a
21 two-square-mile area for years, and used the
22 technology in Vietnam. So he did all the work

1 for the Department of Defense.
2 Let me say that -- back up slightly.
3 In Comp Service, Compensation Service, we get a
4 lot of claims for Agent Orange exposure outside
5 of Vietnam and outside of the Korean DMZ. And
6 they all come in from the regional offices to the
7 central office, and I monitor that mailbox.
8 It's called the Agent Orange mailbox.
9 Everyone that makes a claim, the policy is that
10 the regional office has to send it in and I take
11 a look at the claim. And then I take a look at
12 the Department of Defense documents that we have
13 on Agent Orange use, testing, storage, and so on
14 and so on.
15 And I will send back to them and say
16 there's no evidence for this, or maybe there is
17 evidence. And what I use to determine that is
18 Department of Defense documents. And who
19 produced those Department of Defense documents
20 was DR. Alvin Young.
21 So he's got a long history of working
22 with the Department of Defense, and he also

1 worked for us. He was involved in the C-123
2 issue. He represented VHA's point of view that
3 there was no real evidence for, number one, for
4 exposure, because we were talking about dried,
5 solidified TCDD.
6 And by the way, the whole thing is
7 based on one airplane, that's at Wright-Patterson
8 Air Force Museum. One C-123, by the name of
9 "Patches," called "Patches," because it was shot
10 up so much, and was the oldest of the C-123s that
11 were used in Vietnam.
12 Anyway, it's there, and years and
13 years ago there was some controversy about, when
14 they brought it into the museum was, were the
15 workers there going to get exposed? They did
16 some studies. They took a strong solvent and,
17 like, sandpaper, and scraped off some little
18 sections and various parts of the plane, and they
19 were able to find some TCDD.
20 It took a solvent and a strong
21 abrasive to find a sample. But that's the only
22 evidence. So the argument from VHA and the

1 argument from Alvin Young was, this dried,
2 solidified TCDD did not emanate into the air.
3 And your -- they called it bio-
4 availability -- there was no bio-availability,
5 because it can't get through the skin. There
6 wasn't anything to inhale, and so on.
7 Anyway, that was the argument that was
8 presented to the Institute of Medicine. VHA
9 commissioned the Institute of Medicine to look
10 into it. I went to the hearings. One scientist
11 from Harvard or somewhere said that dried,
12 solidified TCDD never stops emanating molecules
13 into the air.
14 Hardly anybody bought that at the
15 time, but the IOM went with it. And they
16 determined that there was a possibility of Agent
17 Orange exposure based on service in those
18 airplanes. That led to a regulation by VA giving
19 a presumption of exposure to reservists who flew
20 in those planes or mechanics who worked on them.
21 Not only that, reservists do not
22 qualify under VA law for Agent Orange long-term

1 benefits. That's a statutory thing. If you're a
2 reservist, any disability you get has to occur,
3 be directly related to your period of active or
4 inactive duty or training, because that's what
5 their service is called.
6 Under VA law, that doesn't count for
7 some disability that occurs 20 years later, 30
8 years later.
9 So the regulation not only gave the
10 presumption, but it also gave, essentially, a
11 waiver to reservists. By virtue of that, I think
12 a lot of this thing that Jerry raised, the Agent
13 Orange being in the soil, being attached to metal
14 and so on and so on, I think that revived a lot
15 of that kind of thinking and advocacy thinking.
16 I don't think the science supports it.
17 Most scientists don't think the science supports
18 it, but the law is what it is. So, any questions
19 about that?
20 Okay. Now, another big problem we
21 have, probably the biggest problem we have right
22 now, is Thailand. The Thailand issue -- there's

1 a lot veterans that served in Thailand.
2 Thailand was a major Air Force area,
3 where B-52s and other aircraft were bombing North
4 Vietnam, and they were stationed in Thailand.
5 There were about five major air bases
6 there, occupied by the U.S. during the Vietnam
7 war. Maybe five of six years ago, I'm sure Tom
8 remembers this, Mary Ellen McCarthy came over
9 from the Senate Veterans Affairs Committee, and
10 she produced this document called the CHECO
11 Report, a DoD document from 1973.
12 Essentially, there were numerous
13 reports, CHECO reports coming from, I think it
14 came from MACV in Vietnam. This one was called
15 "Base Defense in Thailand," and it specifically
16 was, in my mind, it was produced in '73.
17 That was when President Nixon had
18 ordered, in '72, he ordered an increase in
19 bombing to bring the North Vietnamese to the
20 compromise table, the Paris peace agreements.
21 And so there was a big buildup of
22 Thailand air bases at that time. They were

1 originally built up in '65, then it kind of
2 slacked off and then they were rebuilt in '72.
3 And this document was essentially a
4 reprimand to the base commanders, telling them,
5 you need better security on your perimeters
6 because you can expect some kind local Communist
7 activity.
8 Up until that time there was very
9 little activity against those bases, a few minor
10 attacks. I think maybe one American was killed
11 in the course of, you know, eight years.
12 Anyway. So this report referred to
13 the desirable fenced-in perimeters with some kind
14 of herbicide used in the middle. That's what it
15 talks about and it has illustrations.
16 So Mary Ellen showed us this, Mary
17 Ellen McCarthy, and she conveyed the fact that
18 the guard dogs that were walking the perimeters
19 of the Thai bases were dying, and we documented
20 that to be true. She said that was due to
21 sniffing Agent Orange.
22 Well, I think we were kind of naive at

1 that time. At least I was. Brad Mays was the
2 Director at that time and he agreed that we would
3 -- Mary Ellen wanted a presumption of exposure
4 for everyone in Thailand, just like Vietnam. But
5 there certainly was never any spraying there, by
6 aircraft.
7 And so we compromised with her, I
8 guess you'd say, and we agreed to, and we did, we
9 gave a non-presumptive acknowledgment of exposure
10 on a case-by-case basis to guard dog handlers and
11 security guards that walk the perimeter of the
12 bases.
13 They get an acknowledgment and they
14 get the same, almost the same as a presumption,
15 that can get service connection.
16 MEMBER SIMBERKOFF: So -- I'm sorry.
17 What is the reason for the guard dogs dying?
18 MR. SAMPSEL: Yes. We subsequently
19 found out there was a viral infection --
20 MEMBER SIMBERKOFF: Okay.
21 MR. SAMPSEL: -- an animal viral
22 infection that killed those dogs.

1 MEMBER SIMBERKOFF: Okay. It's not an
2 --
3 MR. SAMPSEL: It wasn't Agent Orange.
4 MEMBER SIMBERKOFF: -- not a
5 malignancy --
6 MR. SAMPSEL: Things, you know, things
7 evolve. Things evolve. When you're first
8 confronted with an issue, you address it, and
9 then as you get more details, things change, so.
10 Anyway -- are we okay? So anyway, we
11 had this policy. And for various reasons, the
12 number of claims coming in has increased
13 dramatically in the last couple years from
14 Thailand veterans.
15 They claim that -- all the claims are
16 that, "I was near the perimeter. They were near
17 the perimeter." And most of the perimeters on
18 Thai air bases, they were huge bases, were not
19 security perimeters. There were villages on the
20 perimeters, there were all kind of, you know, all
21 kinds of things, but not security.
22 And so, you know, if they walked by

1 the flight line, they saw a perimeter, they said,
2 "I was near the perimeter." And so we had
3 multiple, multiple claims coming in and we had to
4 deny those claims. And now we're getting a lot
5 of feedback.
6 And I might add that BVA has granted
7 several of those, too. Everybody know that. BVA
8 decisions get posted on the Internet, the
9 veterans see them and they say, "How come this
10 guy got it and I didn't get it?"
11 So anyway, the latest, I contacted the
12 Department of the Air Force History and Heritage
13 Center. I won't go into the details behind that.
14 But the head researcher over there, we had a long
15 conversation.
16 And he, when there's a BVA remand --
17 okay. BVA is an appellate group, and they,
18 before they make their decision, sometimes they
19 make a remand, back to the original regional
20 office, and they say, you go to the Service
21 Department, in this case, the Air Force, and you
22 ask if Joe Smith got exposed to Agent Orange on

1 the perimeter of Udorn or Ubon or Utapao in 1967.
2 This researcher will send back to
3 them, there's no evidence. So anyway, we
4 discussed it. I discussed it with him for
5 various reasons and he doesn't like doing this
6 all the time, because he constantly gets those.
7 And I said, "Okay, if you don't like
8 that, if you don't want to have to answer these
9 all the time, why don't you provide a memo from
10 the Department of Defense, the U.S. Air Force,
11 and make a statement that there's no evidence?"
12 So he did that, it was vetted by their
13 general counsel. We have a memo from the U.S.
14 Air Force saying there's no evidence for any
15 Agent Orange use on Thai bases. He also provided
16 me with 200 pages of research that he has
17 personally done. And he went through all kinds
18 of supply records, all kinds of unit records, no
19 evidence.
20 So the dilemma that we have in Comp
21 Service, VBA, is that we have a policy that gives
22 it to a specific group of veterans, but we don't

1 have any Agent Orange, we don't have evidence for
2 Agent Orange use.
3 So that's what we're grappling with
4 right now. I'm not sure how that's going to work
5 out, but there's a lot of pressure for expanding
6 it to all kinds of other veterans, but we really
7 don't have any evidence to do that. Any
8 questions about that one? No?
9 MR. MANAR: Have you published that
10 memo or any of the evidence associated with it?
11 MR. SAMPSEL: Well, I don't think I'm
12 revealing anything confidential that there's
13 Chisholm Law Groups got a petition for rule-
14 making pending, and they got it. They got it
15 under a FOIA, from DoD, not from me. Not from
16 us. So it's pending. I don't know what the
17 outcome's going to be.
18 Okay. So then, I can just mention a
19 couple others. Probably we're running out of
20 time, right?
21 PARTICIPANT: No, we're good.
22 MR. SAMPSEL: Oh, we're okay?

1 PARTICIPANT: Mm-hmm.
2 MR. SAMPSEL: Okinawa, Okinawa is very
3 interesting, because we have a lot of claims. We
4 had a lot of veterans who were in Okinawa during
5 the Vietnam period, and they're convinced they
6 were exposed to Agent Orange.
7 I'm sure a lot of them saw commercial
8 herbicides being used around their bases. At any
9 rate, there is a journalist by the name Jon
10 Mitchell, who lives in Japan, he's Welsh. He
11 lives in Japan and he writes regularly on Agent
12 Orange exposure in Okinawa.
13 And he gets it published in the Japan
14 Times. And his journalism has led to trouble in
15 Okinawa with the local people and the military
16 bases there, and it's a political issue in
17 Okinawa, just like Guam.
18 But anyway, we have no evidence
19 whatsoever. We have -- Alvin Young did a report
20 on it and he researched every supply manifest
21 going into Okinawa. And there's no ship ever
22 delivered any Agent Orange there.

1 All the Agent Orange was delivered
2 from -- it was produced in U.S., shipped by rail
3 to Gulfport, Mississippi, Naval Construction
4 Battalion.
5 It was loaded on -- it was then
6 shipped over to the coast and loaded on merchant
7 ships, and sailed -- by merchant ships, not U.S.
8 Navy ships -- directly either to Da Nang or
9 Saigon. Never went to the Philippines, never
10 went to Okinawa, never went to Guam.
11 At all those locations, veterans who
12 were there think it went there.
13 MR. MANAR: Could I mention something?
14 MR. SAMPSEL: Yes.
15 MR. MANAR: And this is lawyer part of
16 me that's bothering me about some of the things
17 that I'm hearing, and that is, when you say, "It
18 never went," what you're really saying is --
19 MR. SAMPSEL: There's no evidence.
20 I'm sorry. I'm sorry. Yes, yes. You're, you're
21 absolutely correct.
22 MR. MANAR: Okay.

1 MR. SAMPSEL: And if evidence does
2 show up, we'll certainly change our policy. And
3 normally, I don't say that. I'm sorry. You're
4 right. There's no evidence. Currently, there's
5 no evidence.
6 But the problem is journalist Jon
7 Mitchell, who publishes these things, and I have
8 had to respond to him. And DoD, once again, the
9 problem is a BVA decision is posted.
10 There's several BVA decisions posted
11 on the Internet, and Jon Mitchell turned that
12 into, in his journalist articles, that's the
13 United States government confirming and admitting
14 Agent Orange use on Okinawa.
15 That's problematic, because there's no
16 such admission and there's no evidence so far.
17 But Jon Mitchell says that. He also, he's
18 published -- he has what I thought was very
19 interesting. He has a photograph of what he
20 calls an "Agent Orange Hot Spot."
21 This goes to your thing about Agent
22 Orange in the soil. He's got a photograph of

1 what appears to me, based on my outdoor
2 activities, to be a dry creek bed which has an
3 orange color.
4 Basically, probably from clay there.
5 And in the background is the jungle. But this is
6 obviously a dry creek bed. And he's calling this
7 an Agent Orange hot spot and identifying it as
8 evidence for Agent Orange use on Okinawa. That's
9 the kind of thing we run into.
10 So needless to say, there's no
11 evidence right now, but we continue to get a lot
12 of claims. I can also mention Guam. This is
13 very interesting, because Guam is very similar.
14 The latest from Guam, we have a particular -- we
15 have received numerous -- all of a sudden --
16 letters from Congress about Guam.
17 And there's some teleconference coming
18 up end of this month on that issue. We've
19 already written several letters, and our response
20 is, there's no evidence, currently. But there
21 continues to be unbelievable reporting, so on and
22 so on.

1 In this particular situation, there
2 was a Hawaiian Science Journal published an
3 article, written by -- this is a very lengthy
4 article claiming that, here's scientific evidence
5 that Agent Orange exposure causes birth defects
6 on Guam.
7 And you read through this entire list
8 of, I mean, pages and pages of data and so on and
9 so on. And then you get to the punch line.
10 Where did this evidence for -- and the article
11 says, Agent Orange was used in this village on
12 Guam, but not this village on Guam.
13 And this village where it was used has
14 a higher rate of birth defects than this other
15 village. And so when you get to the bottom of
16 the article you find out where did this evidence
17 for Agent Orange come from?
18 One veteran claimed that he sprayed
19 Agent Orange in this village. That's it. That's
20 the basis for this entire "scientific article."
21 It's ridiculous beyond belief. And this veteran,
22 by the way, well, I can't go into his claim but,

1 you know. Anyway.
2 There's no evidence for this, and yet
3 here's a scientific article saying that Agent
4 Orange causes birth defects. So I might add that
5 the Department of Defense wrote an extreme
6 criticism of this. They published that in a
7 scientific journal also. And I don't know where
8 we are on that.
9 Okay. Then I guess I can wrap this
10 up. I mentioned the Agent Orange mailbox. Now,
11 the DoD has provided us, through DR. Alvin Young,
12 actually, for locations where Agent Orange was
13 actually tested and developed and stored.
14 And I'll just briefly mention a couple
15 of them. Gagetown was a big deal a while back.
16 Gagetown is a Canadian base. Canadian Base
17 Gagetown, where they wanted to test some early
18 on, I think it was 1959, they did a one-month
19 test on some trees up on that base.
20 And the Maine National Guard sends
21 their national guard members up there for summer
22 training. Several years back, we got numerous

1 claims from the Maine National Guard. Ultimately
2 I went up there with some VHA personnel. And we
3 explained to them that Agent Orange doesn't stay
4 in the soil from 1959 until the '80s, when they
5 were up there.
6 And not only that, but they're in the
7 reserves. They're in the National Guard. Agent
8 Orange doesn't count for them. So at any rate,
9 we went to a lot of trouble to explain that. But
10 we still get claims from Gagetown for Maine
11 National Guard personnel. Another one --
12 MEMBER LOWENBERG: Why doesn't it
13 apply to them?
14 MR. SAMPSEL: Pardon me?
15 MEMBER LOWENBERG: Why doesn't it
16 apply to them?
17 MR. SAMPSEL: What?
18 MEMBER LOWENBERG: Didn't the claim of
19 exposure occur overseas?
20 MR. SAMPSEL: You mean in Canada?
21 MEMBER LOWENBERG: Mm-hmm.
22 MR. SAMPSEL: This is in Canada.

1 MEMBER LOWENBERG: Yes. Anywhere
2 outside the continental United States. National
3 Guard's legal status is identical to that of
4 every other active-duty serviceman, when you're
5 outside the continental United States. By
6 federal law, you are an indistinguishable member
7 of the Army or the Air Force.
8 MR. SAMPSEL: Well, that's
9 interesting. That's true for deployments to Iraq
10 and Afghanistan.
11 MEMBER LOWENBERG: It's true for any
12 military service outside the United States.
13 That's the only legal status in which a guard
14 member may leave the United States and perform
15 military duty. That includes --
16 MEMBER BIRD: And anyone on active
17 duty orders, as well.
18 MR. SAMPSEL: Yes. Active duty is
19 different yes. Active duty --
20 MEMBER LOWENBERG: But they are on
21 active duty if they're under Title 10 orders.
22 MR. SAMPSEL: To Canada?

1 MEMBER LOWENBERG: Yes. Of course.
2 That's not --
3 MR. SAMPSEL: Okay. Well, we never
4 made a issue out of that, because they weren't
5 exposed. I mean, they went there 20 years later.
6 You know. But that's, I'm glad you mentioned
7 that, yes. I thought there was some agreement
8 with Canada, by virtue of being our bordering
9 neighbor. But no, I guess not, huh?
10 MEMBER SIMBERKOFF: There's no wall.
11 (Laughter.)
12 MR. SAMPSEL: There's no wall, free
13 access.
14 MEMBER SIMBERKOFF: We lost that
15 battle in 1812.
16 MR. SAMPSEL: Yes, you're right.
17 MEMBER LOWENBERG: There's in fact a
18 mutual assistance agreement between U.S. Northern
19 Command and Canada, in which any U.S. military
20 personnel in Canada fall under the operational
21 command and control of the Canadian military in
22 Canada.

1 MR. SAMPSEL: Well, that's
2 interesting. But, you know, one of the arguments
3 made by the Maine National Guard people was that
4 the Canadian Government paid any troops that were
5 their troops at Gagetown during the period of
6 testing.
7 So, you know, that was one of the
8 arguments they used. But irrespective of the
9 National Guard issue, there's no evidence for
10 their exposure that long afterwards.
11 CHAIRMAN MARTIN: As an aside, I'll
12 just mention that this committee has discussed a
13 fair amount of, and spent a fair amount of time
14 discussing the duty status of guardsmen and
15 reservists through various aspects of their
16 careers. And so that's an important issue.
17 Thanks, Jim.
18 MR. SAMPSEL: Oh, okay.
19 MEMBER PAMPERIN: I would point out,
20 too, that Canadian soldiers who received
21 compensation for exposure to Agent Orange --
22 MR. SAMPSEL: Yes, they do.

1 MEMBER PAMPERIN: -- are very small,
2 less than 20. And the way the test was
3 conducted, the soldiers had, were out in the
4 field, holding a large stake with mesh on it.
5 And the plane came over and sprayed them.
6 MR. SAMPSEL: Oh.
7 MEMBER PAMPERIN: You know, so it's
8 direct, obvious and, you know, specific.
9 MR. SAMPSEL: Yes. We try to make a
10 distinction between active exposure, I mean,
11 active Agent Orange versus dried, solidified or,
12 you know, Agent Orange that's been photolysis has
13 eliminated, and so on and so on.
14 Anyway, I can mention Eglin. Eglin
15 was where they tested spray nozzles on a two-
16 square-mile area through the '60s and early '70s,
17 until Agent Orange was terminated in '71
18 everywhere. Then it was shipped to Johnston
19 Island in the Pacific and it was stored there
20 until 1977. All the remaining stores of Agent
21 Orange were incinerated at sea in 1977 by
22 merchant ships.

1 So we get claims for a veteran who
2 might have gone there and worked with Agent
3 Orange. Actually, we granted a couple where the
4 veterans went there and they re-barreled Agent
5 Orange for the incineration process.
6 So we gave them acknowledgment of
7 exposure. Several in Gulfport, where they also
8 stored it at Gulfport prior to shipping to
9 Vietnam. And when use was terminated in '71,
10 there was a lot still left in Gulfport.
11 And they incinerated it out in the
12 Gulf of Mexico. We've given acknowledgment of
13 exposure to a number of guys that were involved
14 in that. So I don't want to say that we never
15 give it to anybody, but we have a criteria for
16 giving it and we try to follow that.
17 There's one other wrinkle that I want
18 to mention and that has to do with the law of
19 Agent Orange exposure, that 1116 Agent Orange Act
20 of 1991. That legislation refers to "certain
21 herbicide agents." That's the term they use.
22 And then, in the statute when they

1 define what that means, they say they identify
2 TODD or dioxin, and 2,4-D. 2,4-D is identified
3 as a herbicide associated with all the diseases
4 that VA associates with Agent Orange exposure.
5 But 2,4-D is a commercial herbicide,
6 still in use, still EPA-approved, probably used
7 in Roundup, used on people's lawns in the U.S.
8 And yet there it is, and the statute
9 associated with all the diseases, ischemic heart
10 disease, prostate cancer, diabetes and so on.
11 And so we've had a number of lawyers, court cases
12 already, that were settled because we don't want
13 to address it right now.
14 But various law groups realize that
15 2,4-D was used on all military bases. And yet
16 there it is, listed as contributing or
17 presumptively associated with all the diseases.
18 So I'm not sure where we're going with
19 that, because we've got several pending lawsuits
20 on that. Several have already been essentially
21 settled, gave it to the veteran so it didn't get
22 to the court. And I wrote several legislative

1 proposals to Congress to eliminate that 2,4-D and
2 explain that it's a commercial herbicide
3 Can't we eliminate that from
4 consideration as a certain herbicide agent
5 causing all these diseases?
6 But they haven't done anything with
7 it. So that's an issue we've got to face coming
8 up in the future. So anyway, that's about all I
9 have unless anybody has any questions.
10 And I want to emphasize one thing.
11 Jerry is absolutely right. I didn't mean to say
12 -- I want to make it clear. If there's any
13 evidence that comes in we will definitely change
14 our policy. Any questions?
15 CHAIRMAN MARTIN: Jim, thank you.
16 Thank you very much for your expertise and your
17 long work in this area. I appreciate it. Sounds
18 like it's getting longer every day.
19 MR. SAMPSEL: Yes, it is.
20 CHAIRMAN MARTIN: Any other questions?
21 PARTICIPANT: No. Thank you.
22 MR. SAMPSEL: Okay. And we're all

1 done.

2 CHAIRMAN MARTIN: Thank you all very

3 much.

4 (Applause.)

5 (Whereupon, the above-entitled matter

6 went off the record at 2:21 p.m. and resumed at

7 2:34 p.m.)

8 CHAIRMAN MARTIN: Okay. Ladies and

9 gentlemen, thanks. We -- we are very delighted

10 today to have the Acting Under Secretary for

11 Benefits, Thomas Murphy, with us. I mentioned

12 that he was kind enough to meet with me back in

13 December, and kind of discuss a ranging array of

14 topics.

15 And, Mr. Under Secretary, thank you,

16 sir, for being here today.

17 MR. MURPHY: Thanks.

18 I've got a few questions. You guys

19 let us know we're coming, so we'll start with

20 those, and then we'll go wherever you want to go

21 from there. How's that?

22 So the first one was given, "The

1 workload is starting to climb again, is it being
2 caused by the focus on appeals? Unsettled nature
3 of contracting exams contribute to the rise, and
4 the last time we had a briefing, the contract was
5 in protest and litigation?" so that's actually
6 multiple questions.
7 The contract is still in litigation.
8 It did go to GAO. We prevailed. The next day,
9 it was filed in Federal Court, and now this
10 contract is in the hands of Department of
11 Justice. The court date is June, and we're doing
12 some things in the meantime to see if we can get
13 it going.
14 However, there's very little risk
15 there, because what we have now is the five prime
16 contractors, five prime competitors on the
17 contract can do any exams anywhere in the nation,
18 in the world for that matter, because we've also
19 -- we're also doing it internationally, so it's
20 an open, wherever we feel like assigning to,
21 whichever contract is under the bridge, which is
22 good through next December at this point.

1 When I say "good," meaning it's not
2 awarded that way, but under the current authority
3 we have, we can put extensions in place through
4 next December. The bottom-line on that one is
5 there's no risk that we have veterans waiting to
6 have it.
7 The other part of the question is --
8 oh, "Why is the backlog at 101,000 right now?"
9 The answer is going to appeals, and I locked down
10 the appeal's people, 1,495 of them, and said,
11 "You're not allowed to work claims anymore."
12 The good news is, for the first time
13 in a decade, the appeals' inventory has stopped
14 climbing. It essentially started decreasing the
15 last four months, and those 1,495 people only
16 work appeals, so if all of a sudden we have
17 capacity to take the appeals inventory down, what
18 happened? It means they stopped working on a
19 rating bundle, and about that time, we started to
20 grow from 70,000 at the beginning of the year to
21 right at, we go between 98 and 101,000, 102,000
22 on any given day, so that's what happened with

1 that.

2 It's not tied to the fact that we

3 can't get exams. The contractors that we have, I

4 just got numbers from one of them, they're doing

5 exams in 17 days, better than 98 percent of the

6 time, and that's probably one of the better

7 performing ones, but the others aren't far

8 behind. Even VHA compared to where they were a

9 few years ago is meeting their numbers of 30 days

10 as their standard.

11 Exams, while they're a factor and we

12 can shorten the overall process a little bit by

13 shaving a little time off of it, they're not the

14 reason that we're sitting at the 100,000 in

15 backlog right now.

16 MEMBER PAMPERIN: Is the 100,000

17 affected average days completely?

18 MR. MURPHY: Yeah. We're down to --

19 MEMBER PAMPERIN: So it hasn't

20 affected it?

21 MR. MURPHY: Has not affected it?

22 MEMBER PAMPERIN: Yes. In the sense

1 of causing average days to complete --
2 MR. MURPHY: Oh, no. No. AVC's down
3 and holding pretty good. We're sitting at 119
4 and falling right now, so the -- depending on the
5 day, we're watching the work coming in the door,
6 and I'm looking for each week, how many end of
7 the week, we've completed more than is in the
8 inventory, and we're seeing that our overall
9 inventory is starting to decrease a little bit, a
10 couple hundred a week, so the age of the
11 inventory is getting a little bit younger, but
12 we're seeing some surges.
13 Like this weekend, we were -- on a
14 Sunday morning, we had an inventory of -- a
15 backlog of 98,000, but Monday morning came
16 around, and from a year ago, the rollover was
17 3,200 cases rolled over in the backlog over the
18 weekend, so that pushed us up to the 101,000.
19 We are moving some folks around
20 internally to drive more people into the rating
21 and development world. I got to get down below
22 95 and on my way to 90 and keep going in that

1 direction. I can't keep hovering around 100,000,
2 so we're looking at moving some folks around
3 internally, and then you're going to hear a flack
4 with some people in Congress and some other
5 notifications going on.
6 We just told the union and others that
7 mandatory overtime is back on the table, so we're
8 real specific on this one. We are not saying
9 mandatory overtime for all people always. What
10 we're saying is by telling the union now that I
11 can do overtime on a two-week notice at any point
12 as we need it, we have problems in development,
13 we have problems on appeals, we have problems in
14 post, wherever it is we need it, we'll use the
15 overtime for the length of time that we need it
16 to get back on track, and then stop it again.
17 So what we're doing is pre-notifying
18 the union that we're going to do overtime on an
19 as-needed basis. And there'll even be a
20 particular regional office, because they're
21 falling below their goal for the year. The RO
22 director will be given the time and the authority

1 and the money to go in and use overtime in their
2 office so they can get back on track to meet
3 their objectives as well.
4 Now, that doesn't mean there hasn't
5 been overtime. We've already spent -- I can't
6 remember the number, but $25-$35 million of
7 overtime has already been spent this year, but
8 we're still going with a voluntary individual
9 basis, we're doing it that way, but we are
10 pushing some to say, "You need to be working."
11 The choke point is not the
12 development. We have plenty of cases that are
13 waiting for the rating board action, but they
14 don't have enough raters in there to do it, and
15 then authorizers is where the overtime needs to
16 be spent, on the rating board and authorization
17 and award.
18 Question two is, "VA now has authority
19 to contract all regional offices, you're talking
20 about exam?" Yes, as of October last year, we
21 did a briefing in when, how this will happen.
22 We're already doing -- we cut the nation up into

1 12 different districts. Each of the five
2 districts with two awards and two suppliers in
3 each was the plan, plus a national mission,
4 meaning IDES and pre-discharge, plus an
5 international mission.
6 The national mission is being done by
7 QTC. The international mission is being done by
8 VES. And VES is averaging 24 days on their
9 international exams. They're doing them all over
10 the Pacific Rim, and all over Europe, so Germany,
11 Italy, and Great Britain.
12 Over in Asia, they're doing them in
13 the Dao Islands, they're doing them in Korea,
14 Japan, and a couple other places around the
15 Pacific. And, like I said, they're doing them in
16 24 days, which is pretty darn good considering
17 not that long ago that was a 6 to 9-month process
18 to get an exam done.
19 "Work is now distributed through the
20 National Work Queue, how will one office know
21 what is available to schedule at another office?"
22 The tool is called, "ERRA," E-R-R-A.

1 Beth, did you talk about that already?
2 MS. MURPHY: No. I'm after you.
3 MR. MURPHY: You're after me, okay.
4 Beth is going to talk a little bit
5 about the ERRA tool. VSR that's ordering, has
6 the ability to select from the contractors that
7 we tell them they can choose from, or from VHA
8 depending on where the capacity and timeliness
9 is.
10 So we thought about that. We thought
11 we had that such that when you start distributing
12 work everywhere, the first case you touch may be
13 for someone in Georgia, the second one for
14 California, the third one for Idaho, and how
15 could you possibly know how to do those exams?
16 That's what the tool is for. You put it in where
17 the veteran lives, it tells you what capacity you
18 have, what performances, etc., and then it tells
19 you where to order the exam from.
20 "Could we get a general update on the
21 National Work Queue and what steps are taken to
22 manage the workload in light of the increased

1 inventory?" Inventory hasn't changed. We're
2 still sitting at around 1,000 and we're holding
3 pretty steady there. Even in spite of the fact
4 that we're seeing about eight percent more claims
5 this year, our inventory is not climbing. It's
6 holding steady.
7 So we're talking about the increase,
8 the backlog. How is the NWQ doing that? It's --
9 NWQ has made it possible for us to work in the
10 right next case.
11 In the world prior to NWQ, we did --
12 we literally put files in boxes and shipped them
13 around the country. That was a form of NWQ. It
14 was $50 a box when we did it. Now we just do it
15 at night without anybody knowing about it,
16 because we set the rules in the machine and it
17 does the distribution for us.
18 What's happened is, we no longer have
19 the pockets that we saw before in places like
20 Baltimore, Oakland, Detroit that was there for a
21 while as well where cases there, in one of those
22 locations, then you'd wait for 450 days to get a

1 rating decision, while if you were in one of the
2 other better offices, you got your case done in
3 125, 135, 150, something like that, days.
4 Bottom-line was if you're in a good
5 office, you got it done in half the time, so with
6 this, all of the inventory is pushed out each day
7 starting with the oldest cases working to the
8 newest cases, and then the prioritization is
9 still in there, so if you're an SBI case or a
10 homeless veteran case, all those priorities that
11 we have, are still in the rule first, so the
12 priority cases go out the door first.
13 We are doing some program changes in
14 distribution, which go into effect this month
15 later in March, which will drive up the
16 percentage of cases back to the home station, the
17 SOJ, where the veteran lives. So if you're from
18 Southern Texas, it's most likely that your case
19 will go back to Houston when it's assigned out of
20 National Work Queue.
21 MEMBER PAMPERIN: Tom, at the hearing
22 that you just testified with, one of the

1 congressmen made a comment about replacing VBMS,
2 and can National Work Queue be done with a
3 replacement, and nobody really, from the witness
4 stand, contradicted him. Is there -- are there
5 plans to replace VBMS?
6 MR. MURPHY: They're like this.
7 They're --
8 MEMBER PAMPERIN: Are there plans to
9 replace VBMS?
10 MR. MURPHY: No. No. The world has
11 evolved in the last five years while we were
12 programming VBMS. And what we had done before
13 was you start completely over with a new program,
14 and 30 years from now, you might have everybody
15 transferred over.
16 Now, there's companies out there,
17 which will allow you to take the database that
18 you have and you build an application over it,
19 which would replace VBMS. There's no plans
20 anywhere to do that.
21 And the other part of that question
22 was, "Can you separate one so that if we replace

1 this, can you just plug NWQ?" No, they're one.
2 It's like the left and the right hand of a single
3 body. There's no way to extract one and put in
4 another.
5 One of the other comments about NWQ.
6 Right now, the work we send out every day is
7 based on -- called, "The WIT." The regional
8 office comes back and tells us, "These are the
9 number of people that I have on production and in
10 what discipline, what job do I do in the
11 process."
12 Each night, we take those numbers,
13 which they're only updated once a week, but we
14 look at those numbers, and then we push work out
15 to the regional offices based on the manpower
16 they're telling us they available to produce that
17 work. And we know a VSR grade 7 equals this many
18 cases, a VSR grade 9, grade 10, grade 11, same
19 thing with the raters, they each have their own
20 standards that they're working against. And we
21 push the work out to bring them up to
22 approximately three days' worth of work.

1 So what does that mean? When we're
2 sitting on 390,000 cases that we're at today, of
3 the cases that are ready to be worked, meaning if
4 you have an exam pending and your exam is in a
5 week, that's not a case that's ready to be
6 worked.
7 We'll hold it at the national level
8 until the exam results come back, but once the
9 exam results come back, it goes back to a VSR to
10 look at and make sure all the evidence is there.
11 So of all the cases that are ready to be assigned
12 out, anything that's 90 days or older, plus any
13 of those high priority cases, is pushed out every
14 single day.
15 So if I were to go downstairs and say,
16 "Push more work out," the next thing we'll do is
17 we'll start getting cases that are 85 days old or
18 80 days old, and we'll start injecting those --
19 we'll push out more work. And then what happens
20 if I start pushing out more work is people will
21 start working out of their bucket, and I'll have
22 them working on cases that are 85 days old, and I

1 may have one in there that's 130, 150, 180 days
2 old, so we got to be careful with how much work
3 we push out.
4 The regional offices each have a
5 number that they need to produce based on the
6 people that they have, and they have a
7 timeliness. It's called a, "Timing Queue
8 Measure."
9 Of the work that you have in your
10 hands in your office, how long has it been there?
11 The standard is the five-day average. Just about
12 every RO in the nation is sitting at about
13 between -- average is about -- let's see, the
14 last one I looked at was 2.99 days, and that was
15 office number 30 in the process, so that's just
16 about the middle of the pack, so the average is
17 just under 3 days on a 5-day standard.
18 There was only one or two offices in
19 the whole nation that wasn't pushing their stuff
20 through under five days. That's just the
21 development steps.
22 The award and authorization, one step

1 has got three days, and the other step has two
2 days, and all ROs in the nation are beating both
3 of those. So the bottom-line is when we give
4 them work with a very specific time, they're
5 turning it around appropriately.
6 I also have the ability to see based
7 on the number of people that you reported in
8 cases that I sent you, there's an expectation of
9 how many transactions you should do, how many
10 development steps, how many rating steps, etc.
11 And I have the ability to see that every day down
12 to the individual office level. Through another
13 screen, I can dig down and look at each
14 individual employee.
15 NWQ has given us so much data on our
16 cases and our employees, we don't even know what
17 to do with it all yet, and we're six months into
18 it, but this is data rich. Before, it was all,
19 you had to make educated guesses, because we
20 didn't have the data, we didn't know. Now, I
21 know. I know exactly what's happening with every
22 case. I can see it.

1 I can go back in and look at a case
2 the day it was developed and every single person
3 that's touched it and how long and what they did
4 with it, and all the way to the end and out the
5 door. We've never been able to see that before.
6 We're seeing a 30 percent rework in
7 certain steps in the process. Ten percent of
8 that is because the veteran takes an action which
9 causes the case to go backwards, added an issue,
10 sent some evidence in that we weren't looking
11 for.
12 For some reason, the veteran initiates
13 an action, which sends the case back. The other
14 20 percent is an individual that we, we read it
15 and say, "This one didn't necessarily need to go
16 back," but you elected to send it back, meaning
17 an avoidable deferral. So some of our people are
18 sending it backwards, that we're saying, "There's
19 enough in the case for it to go forward."
20 That is not in the individual employee
21 standards, because we don't have a level of
22 consistency, an accuracy that I can use for an

1 accountability performance aspect with employees
2 yet. Give it a year or two, then maybe we will,
3 then we can go back in and start subtracting when
4 you could have rated a case and you decided
5 develop further and send it backwards.
6 We'll start subtracting that from your
7 production numbers so that we disincentivize that
8 kind of behavior, but it's not there yet. I
9 can't do that accurately now, so I can't use that
10 against employees at this point.
11 The other side of it is we do a lot of
12 data mining out of there so we can see who's
13 sending work back, and feeding that information
14 back to first-line leaders and the coaches, the
15 service center managers in a report that they're
16 seeing each week that tells them, "These are the
17 avoidable deferrals." And that's being made
18 available to the first-line leaderships, so they
19 can go back and have discussions with their
20 employees.
21 MEMBER LOWENBERG: At what point will
22 the data allow you to draw correlations there

1 when we put in the rate of case adjudication is
2 completion and appeal rates? In other words, the
3 quality control analysis.
4 MR. MURPHY: There's still -- and I've
5 been looking for seven years now. I've been
6 looking for the link between the quality of what
7 an office does and the rate of appeal. It's not
8 there. There is no correlation.
9 And I'll give you some offices that
10 are traditionally our best offices in the nation,
11 Milwaukee and Lincoln. They have the exact same
12 appeal rate as the bottom three to five offices
13 in the nation in terms of quality. They're both
14 --
15 MEMBER LOWENBERG: Well, actually, I
16 would find that reassuring, because you really
17 increase the pace with which you're pleading
18 these cases.
19 MR. MURPHY: Yes.
20 MEMBER LOWENBERG: There doesn't
21 appear to be a breaking point where the quality
22 is going down because of the pace in work.

1 MR. MURPHY: If you look, you see our
2 quality has dipped a little bit, but the quality
3 has dipped a little bit not because of what NWQ
4 has done. There's some other actions in there.
5 Beth will be up here in a little bit.
6 Her folks just came in and did a root cause
7 analysis and some other things on it, and we have
8 some process stuff that we can fix from the
9 national level, which we think will turn that
10 quality back up again.
11 We're down to half a point from where
12 we should be right now. We need to be back up at
13 that 96, that 96 mark on the issue-based quality.
14 So her team did some analysis on it,
15 they did look at it, and a little bit of systems
16 stuff, a little bit of process change, and I
17 think we're going to see the quality go back the
18 other way again pretty quick.
19 But there's no -- back to your comment
20 about the quality of what a station is producing
21 and the appeals rate. It's not a correlation
22 between the two. It's -- what we are finding out

1 is the correlation between when you appeal and
2 why, and it's got to do with your confidence that
3 you got an accurate decision.
4 When we first started, NWQ -- not NWQ,
5 excuse me, a fully developed claim, we saw a
6 significant drop. You think, "Oh, it's not a big
7 drop, it went from 12 to 10." No, that's two-
8 twelfths. It's a big drop. So we saw a big drop
9 in the reduction of people that were filing
10 appeals, and the only correlation I could find
11 was when I gave you a fully developed claim with
12 the evidence, I didn't question whether or not my
13 evidence was considered, because I gave it to
14 you, I know it was considered.
15 So there's also a correlation between
16 the time, from the time I filed to the time I get
17 a decision, and my confidence that I got an
18 accurate decision. As it drags on, I have less
19 and less confidence that I got a good decision,
20 which is why you're going to see -- you're going
21 to hear -- some others have already heard it, the
22 decision ready claim process.

1 We're kind of rearranging the sequence
2 steps, so a veteran can go get their own C&P exam
3 in our facilities or contractors, doctors at our
4 expense, and then you submit that along with your
5 526. In return, we'll do some screening on it
6 and we'll send it right to the rating board.
7 If you elect into that process, you're
8 looking at a rating decision in 30 days. It
9 won't be for everybody, so -- but some will
10 select to stay in the normal process, okay,
11 that's fine, that's up to you, but if you want to
12 get actively involved with it, and you want to be
13 able to see your evidence that's going in front
14 of a rater, you'll have the ability to do that
15 under this system.
16 I think that's the formula for a lower
17 appeal rate. There's a value step here that
18 happens in the process. Because we're the VA,
19 when you're talking to a Veteran, what we say is
20 suspect when you're talking about the outcome of
21 the case, so you need the disinterested third
22 party that's educated in the process to say,

1 "You're not going to get anything here, can't be
2 us."
3 A trained veteran service officer that
4 sits down and has that conversation that can see
5 the exam before it's submitted, read it, and tell
6 them, "I got -- the news is you have tinnitus,
7 and you're going to get ten percent. Don't
8 expect 20, 30, 50, so don't even appeal this.
9 Here's your effective date, here it is, you
10 submit it, a month later you get it back, and it
11 comes back with tinnitus ten percent. There's no
12 appeal."
13 And I use tinnitus on purpose, because
14 it's a yes/no question and it's ten percent or
15 it's not at all. But that level of expectation
16 is set by a trained service officer that the
17 veteran has elected to have represent them. I
18 think we get that higher of confidence coupled
19 with the speed.
20 So if you've got an educated person
21 and telling them it's not the VA, plus the speed
22 of process and an ability to review the evidence

1 by a rater, I think that's what turns a 12
2 percent appeal rate into an 8, 7, 6 percent.
3 Six months from now, you can ask
4 again. A year from now, I'll be able to give you
5 details, because we're driving to have this thing
6 rolled out nationwide no later than September.
7 MEMBER LOWENBERG: You just touched on
8 a very important point to the committee, and
9 we've made the recommendation. I know the
10 chairman has shared it through the administrator
11 that when positions are filled on this ACDC that
12 there is an important role to be filled by a VSO
13 representative. As a member in this community,
14 we found that to be extremely valuable over the
15 past two years.
16 MR. MURPHY: Yes. Well, that's why
17 Tom's here.
18 MEMBER LOWENBERG: Yes.
19 MR. MURPHY: We're looking around and
20 I'm trying to remember who was here before, but
21 who understand the business from the inside, then
22 I say, we --

1 MEMBER LOWENBERG: Tom, turn that
2 down.
3 MR. MURPHY: Yes. I said, "We need
4 that." That skill set needs to be at the table,
5 somebody that understands the sausage-making that
6 can sit down and have a conversation, and then
7 quite frankly, then when you guys get together
8 and ask us questions, they come from an educated
9 standpoint.
10 MEMBER LOWENBERG: Yes.
11 MR. MURPHY: And the same thing comes
12 with a VSO at the table where you get a different
13 perspective on things than just what we're
14 telling you, so I'm completely in agreement. The
15 right mix on the committee here makes life better
16 for everybody.
17 MEMBER PAMPERIN: Tom, I think the
18 committee is -- while it appreciates the
19 complexity of the work is a little impatient at
20 the pace of the rollout of the rating schedule
21 limitations.
22 Having said that, how do you propose

1 to deal with that once it actually starts since
2 you'll have to pull all pending claims, have to
3 evaluate them under the old handling schedule?
4 MR. MURPHY: Yes. That's going to be
5 a nightmare. Yes, that's -- when do you file
6 your claim pending, you get the old, you get the
7 new. If you file after the date, you get the new
8 only. This is going to be -- this is going to be
9 a while. Not to mention that the new rating
10 schedule needs to be programmed into, and it's a
11 hard program, into VBMS, which means it's not
12 going to be fast.
13 I got to switch back to the part, I do
14 have some confidence and knowledge about, and
15 that's the status of where we are on all of the
16 different body systems. What is it? A third, a
17 half roughly, I've done? There's none that are
18 sitting in this building, meaning it had to be
19 written. They're all going through either the
20 final stages of the occurrence or publishing in
21 the Federal Register or several have already been
22 published.

1 DR. VVEDENSKAYA: Five final rules are
2 in the end stages of its development. And just
3 as these are going through the limitation versus
4 like right now. We are programming stuff with
5 VBMS information to the final rollover option.
6 MR. MURPHY: So we had a conversation
7 on Friday with the GAO on this very topic. They
8 were talking about the high-risk report. And VBA
9 is on the high-risk report for two items. One is
10 appeals' modernization, and the second one is the
11 VASRD.
12 And they told the Secretary, "If you
13 went off the high-risk report, complete those
14 two." So all of a sudden, the VASRD just jumped
15 up much higher, which is music to our ears. Like
16 I said, it's going through -- it's past us. Now,
17 it's going through the stages.
18 Tom, I don't have all the answers on
19 how we're going to fix that on the rollout. I do
20 know that --
21 MEMBER PAMPERIN: Clearly, the
22 automation will help. It is Sunday --

1 MR. MURPHY: Yes. We may have to --
2 who knows? We end up with two calculators. You
3 got to run each one of them or an output and come
4 up with which one is the more advantageous, so
5 you have another step in there for a rater.
6 You take your same DBQ, you run it
7 under an old system, you run it under new system,
8 compare the two, pay the rater, but even that
9 goes away. The way we're going now on a 120-day
10 average, it's really a six-month process.
11 Within six months, everybody that's
12 subject to the dual rule, their cases are
13 decided, except for the ones that go into appeals
14 and live on, but for the majority of the rating
15 board, it's about a six-month process, and then
16 any of the new cases that come in, get run under
17 just the new rule.
18 "I heard rumor that the new
19 administration might have different ideas about
20 the VASRD redesign?" No, they're right on board.
21 It was literally the first conversation with Dr.
22 Shulkin was going to be able to publish the

1 VASRD.
2 He's not questioning anything in there
3 about medical, especially since I sat him down
4 and explained to him that it was his doctors that
5 represented medically for VHA and were on the
6 team that did the writing, and then I got the
7 buy-in from him.
8 So I explained to him we had doctors
9 from inside, we had doctors from outside, we had
10 better service officers during the information
11 gathering phase, and then writers, and then our
12 own medical types here, the VBA, and he was on
13 board with that.
14 We did have some conversation about
15 there are some costs with this. Some will go
16 down, some will go up, and others will go up a
17 whole lot. So there's -- the story may be it's
18 not -- we are cutting veterans' benefits over
19 here. No, we're redistributing veterans'
20 benefits.
21 We were overpaying here, and now
22 we're, been told we were underpaying here, and

1 we're increasing. And mental health, I mean,
2 there's no secrets here, we've been told since
3 the '80s that we're underpaying for mental
4 health, right?
5 Well, this new regulation makes very
6 big changes in mental health. It lines it up
7 with how you're treated in the private sector,
8 and the activities of daily living, etc., so it
9 lines up better with how we treat people in the
10 mental health world today, which makes private
11 evidence more useable than it has been in the
12 past, but it also changes the numbers and
13 increases the payouts there.
14 So there's not enough in the
15 conditions, such as reducing the time you pay for
16 hip or knee replacement surgery. There's not
17 enough in those decreases to offset the other
18 increases in there, so there's some conversation
19 now about, "Do we go out with one at a time or do
20 you go out with, 'Hey, everything is ready,
21 here's all that are left and publish them at
22 once.'"

1 It's kind of nice to be at the point
2 where we're talking about how we're going to go
3 about implementing, and stop talking about
4 whether we're going to implement or not. So that
5 kills number four.
6 Number five, "Would it be possible to
7 get a briefing on where I see things and what
8 metric is used in VBA?" I'm looking at -- if I
9 could just explain to you about the appeals
10 inventory. I'm also looking about, at the WIT
11 tool. How many -- I'll give you some examples.
12 We are given a budget to fund for
13 15,000 people in the compensation world,
14 compensation in pension, excuse me. Ten thousand
15 of those people are in direct labor positions,
16 which means there's 5,000 analysts, executive
17 assistants, you name them, but not touching a
18 case.
19 Why are we at a 2:1 ratio? Why is it
20 12,000 are on production and 3,000 admin? So the
21 question is, "Do we have the right people in the
22 non-direct labor positions or should we do some

1 shifting to move more people into direct labor so
2 I can turn 100,000 case backlog into 70,000 like
3 we were at the end of last year?"
4 We're on a hiring freeze right now.
5 Fortunately, the people that we did lose, and a
6 good percentage of them, left by going to other
7 federal agencies. When there's no place to go,
8 you stay here.
9 So our people that were going out the
10 door, we were losing about -- or just the last
11 month or two before, we were losing 61 people a
12 pay period. That number has dropped to below 40
13 a pay period right now.
14 And so the ones we're seeing now are
15 retirements, and a couple of terminations for one
16 reason or another, but for the most part, the
17 ones that were driving out the door and going to
18 other federal agencies, they're not leaving
19 anymore, so my rate of decrease of people leaving
20 has dropped.
21 The other part of that is we had made
22 some decisions long before, even before the

1 election, on two big ones. One is we constantly
2 needed to be staffed at 100 percent, but because
3 of our hiring process, we always never really got
4 above the 95 percent mark.
5 Bottom-line, I had 1,000 empty
6 positions at any given time, so I said, "Okay,
7 the artillery guys out there, it should hit data,
8 and did hit data." So what do I do? I adjust
9 the point of aim, and I adjusted the point of aim
10 to 105 percent, and that took us up to the 100
11 percent mark.
12 So bottom-line was I took five percent
13 more of the total manpower and allocated it out
14 to select regional offices across the country and
15 told them to hire more bodies. We did that last
16 summer, so you all know the way we did that was
17 we took that 5 percent and concentrated it in the
18 top 25 percent performing offices.
19 So if you were, I don't know,
20 Milwaukee and you were number three on there, you
21 got bust up. I think it came out to be 12 or 14
22 percent more headcount in each of those offices,

1 so if we're going to hire, and in this office, I
2 get 10 a day out of you, but in this one, I get
3 20, why would I hire somebody in 10? For the
4 same money in a different office, I get 20,
5 right? So we put those extra bodies in the
6 offices that had the better production.
7 Then, we took 50 percent of our
8 overtime, which is about $40 million, and said,
9 "Overtime is the most expensive flavor that we
10 have, so let's hire entry level employees with
11 that, and instead of 400 employees, I can now
12 hire about 500 employees for the same pay that I
13 was paying -- more like 600 employees, for the
14 same pay that I was paying my own people to be
15 working overtime, and I'll just spend less money
16 on overtime throughout the year."
17 So bottom-line was based on the 1,000
18 plus the overtime conversion that we had, when we
19 started the hiring freeze, we were nearly 300
20 people over authorized sensory. So even today,
21 here it is a month later, I haven't even trimmed
22 it down to my authorized sensory, so that turned

1 out to be a wise decision on our part.
2 There is a letter pending over at VACO
3 right now. I asked for an exception to the
4 hiring freeze authority for the direct labor
5 positions. And this is Tom's direct labor
6 definition, not ORM's direct labor definition.
7 My definition of it is, you actually
8 touch a case and move it forward. You're in the
9 pension world, you're in the legal instrument
10 examiner world, you're a rater, you're a VSO, or
11 you're in public contact, you're on the phone
12 talking to a veteran. If you're not talking to a
13 veteran or directly touching a case, you're
14 considered overhead.
15 So I asked for exception for all of
16 those job descriptions across the VBA, and it's a
17 very specific list. And the argument is if DHA,
18 the hospitals were declared to be an essential
19 function and had to continue, therefore, they
20 were excluded, but on the entry point, if I don't
21 do my work, you can't get in to see a hospital,
22 then we need to be on that same exclusion list,

1 because if you're not coming through us, you're
2 not getting into the hospital, but the hospital
3 is a critical function, therefore, we're a
4 critical function, otherwise, we turn off the
5 hospital's access point.
6 I think that's going to fly. I don't
7 know. It's looking good right now. I'll let you
8 know in another week or so. I'll find out. If
9 we do that, we'll get right back on track with
10 the hiring.
11 And, again, the hiring is only for
12 those positions that are direct hands-on, so if
13 we lose management, analysts, and other positions
14 like that, those will stay, and won't get to
15 rehire those.
16 Other matrix that I'm using. I use --
17 it's a combination. We call it the Time & --
18 "T&T," Time & -- what's the other T? Not Time &
19 Material. There's a report that talks about
20 based on the number of cases that I'm sending you
21 to be done every day, how many of those that
22 you're doing -- it's a productivity report?

1 You've got 100 people --
2 MEMBER PAMPERIN: Time & Turnaround?
3 PARTICIPANT: Time & Task.
4 MR. MURPHY: T&T is the acronym, Time
5 and something. I can't remember what it means.
6 It might be Time & Task, but it measures how many
7 people do you have, how much work should you have
8 done with those people, and then it just gives me
9 every office on a chart, every single day, red,
10 yellow, green.
11 Green you hit your standard, yellow
12 you were close, and red you just flat missed it,
13 and then I click a button, and it rolls out at
14 the district level, and I don't have to call
15 regional offices. I call district directors now,
16 "You were supposed to be this, you missed it by
17 500 yesterday, what are you doing about that?"
18 And --
19 MS. MURPHY: Are you talking
20 turnaround time?
21 MR. MURPHY: Time & Turnaround?
22 What's the --

1 MS. MURPHY: Turnaround time, T&T?
2 MR. MURPHY: Time & Turnaround. That
3 might be it.
4 MS. MURPHY: Turnaround time?
5 MR. MURPHY: Time & Transaction, T&T.
6 MS. MURPHY: Time & Transaction?
7 MR. MURPHY: Yes. The transaction is
8 I gave you, "Order exams for this individual."
9 The transaction was you went in and you ordered
10 the exams and you send it back to NWQ that night,
11 so Time & Transaction report.
12 I look at that each day, and it comes
13 up color-coded. And as I just scroll across the
14 screen, it's getting to the point now where
15 everything was red, now it's mostly green with a
16 little bit of yellow here and there. And when I
17 see a red, there's a phone call.
18 We're flying all of the district
19 directors' staff in in two weeks to sit them all
20 down and go through the -- they call it, "The In-
21 Box Exercise." You come in in the morning and
22 open up your screen and look at your reports,

1 what do you do?

2 And these are the folks that are

3 driving the business for the district director.

4 You should be looking at how many people are you

5 assigned, how many showed up yesterday, how many

6 hours of direct labor? You're paying each person

7 to be working eight hours, but they only work

8 four, how come?

9 And just that bleed of pulling off

10 direct labor to go do other things has to stop,

11 and that's how I get another 10 or 15 percent.

12 We put a standard out that said, "No regional

13 office across the nation is allowed to be below

14 75 percent availability rate," so 25 percent

15 excluded time.

16 And I'm hearing people screaming

17 about, "Oh, that's just crazy, we can't do that,"

18 and then I tell them, "That means that 500 hours

19 a year they're doing not work, but we're paying

20 them." Seventy-five percent is really rather

21 generous, so we're tracking to that, and just

22 looking at the behavior over the last four weeks,

1 it's gone from a whole lot of yellow to almost
2 green everywhere with one or two that are not
3 just because I started focusing on it and asking
4 people why.
5 So how many -- how many people you're
6 assigned, how many are on direct labor, and then
7 how many are working for the hours that were
8 paid, then I start looking at how many people are
9 productive at the level to the standard that they
10 have.
11 We just did new performance standards
12 a couple days ago, last week. We also put a tool
13 called, "The EPR," Employee Performance Report.
14 Every employee can look at where they are against
15 their standard every single day.
16 You come in and work and yesterday you
17 had six hours of direct labor. It gives you 75
18 percent of a day's -- you can look at it, and it
19 gives you every day you're rolling back for
20 months. "Here's your standard, you had six hours
21 of direct labor, you should have done ten
22 widgets, so you get 60 percent of 10."

1 And it tells you, "You met your
2 standard/you didn't meet your standard." If you
3 work overtime, it adjusts your standard for the
4 day up, so you work 10 hours instead of 8, it
5 puts an extra 25 percent in there and it tells
6 you whether or not you are performing against
7 that number.
8 And on that same screen, it tells you
9 what your training hours are. It tells you what
10 your quality numbers are. It tells you your
11 rework number. And then each -- across the top
12 of the screen, there's tabs. Every case you
13 touch, it's all right there. You click on it,
14 and everything you want to know about your
15 production is on one screen, total in the power
16 of the hands of the individual that they can see
17 every single day.
18 No employee can come in and say,
19 "Well, I didn't know how I was performing, nobody
20 told me." This is pushed into your email box
21 every single morning. When you come in to work,
22 it's sitting there waiting for you.

1 Yes.
2 MEMBER ROBERTS: Question. It would
3 appear that you all are really on top of things.
4 Do you really know what's going on? Why is it
5 every time, I pick up the newspaper, I see a
6 black ice for the administration? It doesn't
7 make sense to me.
8 MR. MURPHY: You know, I asked a
9 reporter that one time when I was being nice and
10 picked him up at the airport, and his response
11 was, "Good news doesn't sell."
12 MEMBER ROBERTS: Oh, that old adage.
13 It's true.
14 MR. MURPHY: Yes. That was his exact
15 words. I said, "You know, we've done some really
16 good stuff here. Why don't you come in and I'll
17 do an interview with you, but you need to tell
18 some of the good stuff we're doing?" He said, "I
19 won't waste my time with that. Good news doesn't
20 sell."
21 MS. MURPHY: Tom, you also asked us to
22 focus on customer satisfaction and call center

1 feedback, so that's something else you might want
2 to speak to.
3 MR. MURPHY: Let's go down to call
4 center. Block call rate used to be 60 percent.
5 In August, it was 60 percent, so let me just
6 explain what that means, and then you'll really
7 see the impact here.
8 We didn't kick a block call in until
9 the whole time for the call hit two hours, then
10 the next call that came in, we just simply hung
11 up on you, the line just went dead after the
12 waiting list got to two hours. Last month, we
13 had a zero block call rate, and all calls were
14 answered in less than a minute.
15 PARTICIPANT: That's great.
16 MR. MURPHY: Fifty-three seconds.
17 After a long weekend, it bumped up to a minute
18 and a half, two minutes time frame, but we're
19 running in that sub-two minutes range all the
20 time. The other goal we had -- the task was, get
21 to under 30 seconds answer time.
22 MEMBER LOWENBERG: How did you drive

1 that change? It didn't just happen.
2 MR. MURPHY: I hired 300 people. Yes.
3 And, look, this is what happened. It was really
4 that simple, okay. Now, there's a whole process
5 that comes with getting 300 people hired and
6 credentialed and trained and computers and desks,
7 that's a whole other nightmare, so it took months
8 to do, but it was -- we threw bodies at it.
9 And here's what happened. In August,
10 it was 950,000 calls came in in the course of a
11 month, and the block call rate was 60 percent.
12 We put extra bodies in. By the time we got to
13 October, we were down less than two minutes. The
14 block call rate was gone on all but one or two
15 days. The abandoned call rate was, I don't know,
16 three percent, four percent, meaning I was on
17 hold during that minute, and then hung up and
18 walked away.
19 And our call volume dropped to 175,000
20 calls, so just do the math on that, each veteran
21 called six times over the course of the month,
22 right, because the call -- and it's staying

1 steady below 200,000 rate.
2 MEMBER FAY: I can tell you compared
3 to the commercial world, right, those are
4 excellent numbers. We're in call centers for
5 commercial claims organizations, and having
6 abandonment ratable three or five percent is
7 excellent, and to have a wait time of less than a
8 minute is standard.
9 MR. MURPHY: I just went back -- the
10 standard that Deputy Secretary Gibson put in
11 there was 30 seconds with less than 5 percent
12 abandoned call rate. And I just went back and
13 explained to him, I said, "I can get you to 30
14 seconds. It's going to cost you another 300 FTE
15 or $30 million a year. However, is the juice
16 worth the squeeze here? Because all indications
17 we're getting from the veteran, I'm happy with
18 56-second answer time in the abandoned call
19 rate."
20 You got a whole other question about
21 when I do get somebody on the line, am I
22 satisfied with the answer I get? But that's a

1 different conversation. Do we really want to
2 spend that much, or can we take those 300 people
3 and put them over here and turn 100,000
4 backlogged into 70,000, 60,000, 50,000?
5 MEMBER FAY: My suggestion is that
6 just goes to the, to the culture of the
7 organization and starting the culture with the
8 first phone call, and getting the right mind set
9 in the veteran's mind relative to service. My
10 belief is it's well worth your investment to take
11 care of the call center issues.
12 MR. MURPHY: To get it down to 30 or
13 the investment we made to get it down?
14 MEMBER FAY: The investment you made
15 to get it down to a minute. Whether or not the
16 extra 30 seconds is worth it or not, I cannot
17 tell --
18 MR. MURPHY: I argued for we can
19 guarantee a less than two minutes with the below
20 five percent. We're doing it. We got some
21 lessons out of this. Before we just knew it was
22 block call.

1 Here's the other lesson. After a
2 three-day weekend, we see a 50 percent increase
3 in call volume, so we adjusted the way we're
4 hiring people. We brought some part-time in, we
5 put some flexes in, and we started loading
6 holidays after big sporting events, Super Bowl,
7 other big events like that, we also plussed it
8 up, so we managed, even at that time, the call
9 time, the hold time only went up to four minutes,
10 so we started adjusting our people so that we're
11 now staffing a phone center to the expected call
12 volume. We've never been able to do that before.
13 MEMBER FAY: So that brings me to the
14 question that I had, which was, I don't know if
15 you remember, Tom, but you came to when I ran the
16 C&A Claims Organization.
17 MR. MURPHY: I do, yes.
18 MEMBER FAY: You came and we showed
19 you our predictive analytics' capabilities and
20 our data finding capabilities, and what you just
21 talked about, about knowing when the calls were
22 going -- that all goes to predictive analytics.

1 So you could just talk a little bit
2 about what's the VA going to do into the future
3 to use such things as predictive analytics and
4 data mining in a whole process, not just a call
5 center, but in how you handle claims and how do
6 you predict which claims are going to in which
7 direction, which claims are going to have to --
8 which claims are going to result in an appeal
9 rather than not result an appeal, those types of
10 things? Who's working on that?
11 MR. MURPHY: We got FFRDC, MITRE
12 Corporation. They've got some really, really
13 smart guys. These are the kind of guys that they
14 don't know enough to handle the reign, but
15 they're pretty -- right?
16 We gave them everything we have
17 already in data for the last 20 years. We
18 sterilized it so it doesn't have the right
19 information in it and they can't correlate it
20 back to a person, but -- and we have the ability
21 that when I pull that data back from them, I can
22 turn it back into people again.

1 But I gave them this data under a big
2 data analytics' contract, and they did come back,
3 and the first term we were using was called,
4 "Statistical Adjudication," and now we're talking
5 a statistical support tool. And the idea being
6 doing just what you said.
7 Well, I have 20 years of data on
8 everything we've done for somebody. I have the
9 ability now to look at, "You were 22 here, you
10 filed here, you did this, the outcome is here."
11 And they did three body systems. One of them was
12 knees. And I didn't say anything to them about
13 how it all works. I just said, "Map this whole
14 thing out."
15 And they came back in here and said,
16 "This thing -- it doesn't make any sense. We did
17 this analytics," and they started saying, "We can
18 predict 85 percent accuracy on this type of claim
19 when it comes in the door what the outcome is
20 going to be, but we don't understand why this
21 person is going along, it increases, and then it
22 spikes to 100 percent, and then it automatically

1 just drops down to 30 percent and stays there."
2 And I said, "I'm sure glad you brought
3 that up. It's called, 'Knee replacement
4 surgery.'" Then he asked me some questions about
5 the rule. He said, "Well, here it is," and he
6 mapped it right on your chart. That's what I
7 said, "Okay, this isn't smoking mirrors. It's
8 something to deal with."
9 He did the same thing with hearing
10 loss, a couple other conditions, and we fed him
11 more data, and we have them doing more. And what
12 I have them looking at right now is, if you look
13 at, there's a combination of five conditions that
14 occur most frequently. And those five conditions
15 occur in some form in 80 percent of the claims
16 that come in.
17 If I get them to give me the
18 predictive analytics on those conditions, after
19 we get some refinement data and we figure out
20 exactly what the triggers are, I should be able
21 to have an individual command and determine what
22 the outcome is going to be when you first tell me

1 who you are and what you're claiming.
2 With the data that we have, I think we
3 can do that into the high 90 percent accuracy.
4 It all depends on -- right now, we can do that
5 with hearing loss. We can do it with knees.
6 Depending on how -- I want to do it so that I'm
7 only looking at two percent of the conditions
8 that come for the knee, I can do that at 98
9 percent accuracy.
10 If I want to look at an 85 percent of
11 the ones that come in -- and so it all changes.
12 It's a sliding scale, and you just come across
13 the bottom and there's the -- you get an idea of
14 where you're at.
15 But the tool that we can use in the
16 short-term is with those conditions, I can run
17 that as a parallel system, I'll run you through
18 the regular process, and then I use this as a
19 checking device. If you came up with something
20 different than this, you've got a problem, and
21 then that allows us to put some reassurance that,
22 "Hey, we have the right thing."

1 And when you do exception reporting,
2 we know, "Stop that case, do a second signature
3 on it, have another set of eyes look at it,
4 because there's a high probability that there's
5 an error in there," and then we can drive the
6 quality up.
7 MEMBER FAY: We found you can never
8 take the human out of it entirely.
9 MR. MURPHY: Right.
10 MEMBER FAY: There always had to be a
11 fail/safe that no matter what the system was
12 telling you, there always --
13 MR. MURPHY: The visit to your company
14 and a couple of others that we hit, we made the
15 rounds around the country, is the reason why we
16 had the checks and balances, because we learned
17 lessons from your guys that said just that. You
18 got to have that human factor at the end to say,
19 "Does this pass the smell test, yes or no?
20 And then the other part of it is
21 people get really nervous when you say, "We're
22 just going to let the machines make decisions

1 like that." And, okay, so we'll just use this as
2 a decision support tool so that I have the
3 ability to say, "Something's wrong here, pull
4 that one out and have another person look at it."
5 So we actually got somebody turning
6 one of the MITRE analytics into a desktop tool so
7 that we can practical application of that. What
8 they have done is they come back after six months
9 a couple of times and they've taken the new
10 rating data and ran that data against their
11 support tool to see is their model accurately,
12 they tweaked their model a little bit depending
13 on what their seeing.
14 MEMBER FAY: Yes. So as the ratings
15 changed, you should be able to, based on past
16 data, what -- how's that going to change the
17 numbers, right?
18 MR. MURPHY: Yes. We should see -- we
19 should be able to see the change in there, but
20 what really nailed it for me was they had no idea
21 about knee replacement, and then they come in and
22 they point it out on the chart.

1 I actually told Dr. Shulkin when he
2 was still Under Secretary of Health, "Look, I can
3 tell you how many knee replacement surgeries
4 you're going to do in a decade." He said, "Wow!
5 What do you mean? How can you do that?" Once I
6 explained it to him, he looked at the guys at VHA
7 and said, "Are you getting this data from him,
8 because we know how many doctors we have to have
9 ten years from now with this information?"
10 And so others are catching on. And we
11 wrote this big data analytics' contract broad
12 enough so that anybody else in VHA can come in
13 with a little bit of money on a task order, put
14 their data in, and they'll look at it as well, so
15 I'm pretty impressed. Those guys are -- they're
16 pretty sharp on the big data analytics.
17 House subcommittee hearing next week.
18 Oh, no, we did that one. Yes, that was a bad
19 meeting. I made a big mistake. That was an
20 amateur move on my part. We got down with the
21 hearing table, and I left.
22 MEMBER FAY: You did go up and --

1 MR. MURPHY: I did. I had to go back
2 and eat a big giant piece of humble pie twice,
3 once with the subcommittee chairman, and once
4 with the ranking member. I told them both. I
5 said, "I will never make that mistake again. I
6 will be there from gavel to gavel from now on, so
7 you can put me first or last or whatever, but
8 next time somebody comes up and says something
9 like that, please call me back to the witness
10 table, because I would like to rebut what they
11 said, and seeing how I didn't now, let me tell
12 you," and I walked through some of the comments
13 that this is what was said, here's the rest of
14 the story. And they said, "Well, we'd like to
15 have you back in a couple of months to go over
16 this again." "I look forward to it. Thank you."
17 So we'll have another hearing probably in the
18 summer.
19 CHAIRMAN MARTIN: So we have two
20 people online teleconference.
21 Bird or General Granger, any other
22 comments for the Under Secretary?

1 MEMBER GRANGER: I just want to thank
2 you, Tom. This is Elder Granger. Thank you for
3 helping out with that veteran a week or so ago.
4 Everything is on track, so thanks a lot.
5 MR. MURPHY: You're welcome.
6 That's it? We're ahead of schedule.
7 CHAIRMAN MARTIN: It's a great
8 pleasure to have you here. We appreciate your
9 time. Thank you very much.
10 MR. MURPHY: Thank you.
11 CHAIRMAN MARTIN: I know your calendar
12 is busy these days.
13 MR. MURPHY: Yes, it's kind of crazy
14 right now.
15 CHAIRMAN MARTIN: Thank you.
16 MR. MURPHY: Thank you.
17 DR. VVEDENSKAYA: All right. I shall
18 introduce to you our next speaker, Compensation
19 Service Director Beth Murphy.
20 MS. MURPHY: Hello, everybody. I'm
21 Beth Murphy. I'm the compensation service
22 director. You might have seen McCoy as my last

1 name in the past, so I'm the same person, just a
2 different situation in life.
3 And, George, I knew you looked
4 familiar. I was out there as well, and I was
5 like, "Oh, I know that guy," so it's nice to see
6 you again.
7 MEMBER FAY: Nice to see you.
8 DR. VVEDENSKAYA: Did you have a
9 chance to meet our committee chairman, General
10 Martin?
11 MS. MURPHY: Thank you.
12 PARTICIPANT: You may have seen me in
13 your formal life.
14 MS. MURPHY: I think so probably.
15 So having been on the operation side
16 for a bit now, I'm in the policy, procedure,
17 training, quality, exam management side of
18 things. And I wanted to be here, so thanks for
19 inviting me. I wanted to be here when Tom spoke,
20 because I just -- you never know, you don't just
21 want to repeat. You want to supplement what the
22 boss says.

1 So I'll get right into it. I'll make
2 a few remarks to supplement what Tom talked
3 about, and then I'll just open it up for any
4 questions you have.
5 So I want to talk a little bit about
6 the exam contract. I know that you'll have some
7 of my folks here tomorrow to talk about that, but
8 just to frame it up in like a big picture
9 historically.
10 So we have done, we, VBA, comp service
11 has been in the exam contract to exam business
12 since about 1998. First, we had authority to do
13 contract exams through ten regional offices, then
14 a couple of years ago that was expanded to 12
15 regional offices, last year, we had authority to
16 order through 15 regional offices, and as of this
17 fiscal year, beginning of 20 -- FY17, we can --
18 we have the authority to order through any of our
19 regional offices, all 56 locations.
20 So that gives us more flexibility, and
21 we like to be nimble. We have a lot of
22 nimbleness with our National Work Queue, our

1 paperless processes, just continues to take it to
2 the next level.
3 MEMBER LOWENBERG: Is there a cost-
4 effect or a cost impact of expanding contracting
5 for exams?
6 MS. MURPHY: Well, I think there -- so
7 we're talking about two different sources of
8 funding too. Ours has been primarily a mandatory
9 funding contract and discretionary on VHA side.
10 Also, I think from the coordination
11 effect, once we get there and once we get this
12 contract off the ground and through all the
13 protests and the appeals, then we'll kind of be
14 the overall contracting view from one
15 organization's standpoint, so synergy and owning
16 the whole contract piece.
17 I would say generally, overall VHA
18 historically has, internally had the capacity to
19 complete about 60 percent of the exams that, exam
20 -- C&P exams for veterans. On their side of the
21 house, they've also had contract authority under
22 discretionary spending, and they supplemented, it

1 was about 20 percent of exams that they did under
2 their contract.
3 So in total, VHA, either internally or
4 with their contract, took about 80 percent, they
5 managed about 80 percent of the C&P exams that
6 were completed. DVA side, ours was about 20
7 percent, so the other 20 percent.
8 So with this new contract, the
9 internal VHA capacity isn't intended to change.
10 We still let them use their 60 percent internal
11 capacity. We take all of the contracting under
12 our side, so the external kind of around the
13 edges, the extra 40 percent, we manage.
14 So the tool that Tom talked about, the
15 ERRA tool, is a tool that is fed with VHA data on
16 a daily basis -- well, even more frequently than
17 that, and our claims processors open up that tool
18 if they need to order an exam, and it tells them,
19 it directs them, "VHA has capacity to take this
20 sort of examination in this location, so send it
21 to VHA." If they don't, it then directs the
22 claims processor to order it from a vendor.

1 It's as simple as that. We try first
2 to send it to VHA, because we want to make good
3 use of our internal VA capacity and that we
4 supplement with a contract.
5 I will say that that has been a
6 learning experience to figure out where they have
7 the capacity and keep up with that, and then
8 supplement with the exam, but we're becoming more
9 fluid all the time.
10 We have -- we have maintained steady,
11 pretty steadily the cancel, exam cancellation
12 rate that we had previously. We had a little bit
13 of a spike as we were figuring this out, but it
14 settled back to where it has been historically.
15 There are cancellation reasons, such
16 as the veteran can't make it, you know, snow,
17 something happened, the doctor didn't make it,
18 you know, the equipment wasn't available. There
19 are various reasons for cancellations, so that
20 has, that has started to level back out.
21 MEMBER LOWENBERG: Will your ability
22 to contract for exams be affected at all by

1 continuation of the CR --
2 MEMBER SIMBERKOFF: What CR?
3 DR. VVEDENSKAYA: Continuing
4 resolution.
5 MEMBER FAY: Continuing resolution.
6 MEMBER PAMPERIN: It shouldn't if it's
7 mandatory funding.
8 MEMBER FAY: Okay.
9 MS. MURPHY: Right. And right now,
10 we're still operating under our bridge contract,
11 so this is our interim solution while the pull-up
12 contract is still going through protest and now
13 appeal.
14 MEMBER SIMBERKOFF: You said earlier
15 that you have the ability to contract out at all
16 of the regional offices. What percent are you
17 actually doing it as? Is it -- are you actually
18 using the contract throughout the regional
19 offices who are still expanding into --
20 MS. MURPHY: So we have turned it on.
21 We've flipped the switch in every regional
22 office. All the claims processors and all the

1 regional offices use that tool before they order
2 an exam. They go in and they say, "Can VHA do it
3 first?"
4 And if VHA can't do it, they don't --
5 for whatever reason, their radiologist is
6 pregnant and went on a maternity leave, you know,
7 for whatever reason. If they can do it inside in
8 VHA, we try to send it to VHA. If not, then we,
9 then we direct it secondarily to the contract
10 vendor.
11 So different locations have different
12 internal capacity. Sometimes they lose folks and
13 they don't put them behind them as quickly,
14 hiring freeze, you know, whatever the impact is,
15 we just follow VHA's internal capacity.
16 MEMBER SIMBERKOFF: Beth, and I'm not
17 saying that this is a bad thing, but is there a
18 potential here that hard to fill specialties like
19 neurology that will by default go to contract?
20 MS. MURPHY: We follow VHA's internal
21 capacity. If there -- there are different places
22 in the country that it's really hard to keep

1 different specialties hired up. And we're most
2 concerned to making sure the veteran gets the C&P
3 exam when necessary, and we're just going to
4 supplement what VHA can't do.
5 So we have some visibility. I would
6 say we have about like front the car length.
7 Indication sometime if they're not going to have
8 the capacity, so it's a little bit of we're
9 chasing that capacity, but having that data feed
10 from VHA at all times, and a communication of,
11 "Hey, this is happening, we're losing somebody
12 here," that's important.
13 Now, it's also important because with
14 National Work Queue, we are more fluidly moving
15 work around the country, so that case -- that
16 right next case that's ready to work, could be
17 sent to any regional office that has capacity.
18 MEMBER SIMBERKOFF: But the veteran
19 can't go anywhere.
20 MS. MURPHY: That's correct, but it's
21 still --
22 MEMBER SIMBERKOFF: So I mean the

1 veterans are tied to their -- wherever their
2 geographic care is.
3 MS. MURPHY: Absolutely, but if, you
4 know, if you're a veteran who's here in Virginia,
5 your claim could be picked up and opened up, you
6 know, in the system by somebody in Montana. That
7 Montana claims processor will say, "Michael needs
8 an exam," so he will, he or she will go in the
9 system, look to see, "Does -- does the Virginia
10 facility closest to you have capacity? If so,
11 we'll send you to VHA. If not, "We'll send you
12 to a contract vendor that is in close proximity."
13 So the reason I'm saying this is that
14 when historically wherever the state you lived
15 in, usually your home regional office was the one
16 that did all that work for you, and they became
17 familiar. They knew the facilities. They had
18 the, the local relationships.
19 That's almost impossible to maintain
20 when you're talking the entire country. So
21 that's why we needed to build this tool to help
22 the claims processor wherever they are in the

1 country who opens up the next case to work, they
2 know how to order the exam anywhere in the
3 country for that veteran.
4 MEMBER SIMBERKOFF: One of the factors
5 that, that the facilities have, the VHA
6 facilities, is that they have the multi-specialty
7 group already at that site, and if a veteran
8 goes, for example, to a contractor, would he have
9 -- if an exam needs to be expanded to include
10 things more beyond what was originally thought,
11 would the contractor have that similar capacity?
12 MS. MURPHY: It depends on the
13 location and what they need. And not every VHA
14 facility has every single type of exam able to be
15 done right at the same place. There are times
16 when they have to go to different places as well.
17 The more specialized the clinical requirement is
18 for the examination, they might have to go to a
19 couple different places or they may have to come
20 back.
21 MEMBER ROBERTS: One of the issues
22 that we hear all the time is that it takes a long

1 time for the veteran to get mental health
2 services. Could that be because of a regular
3 compensation in order to pay contractors that you
4 can't contractors get psychiatrist and other
5 kinds of specialists?
6 MS. MURPHY: Well, I can't speak too
7 much for VHA, because I don't know a lot about
8 how they decide how to staff, who does, who does
9 what for them. What I can say is that,
10 generally, it's my understanding that VHA has
11 these folks over here who tend to do the actual
12 clinical treatment, and then a different set of
13 folks over here who tend to do the forensics C&P
14 review assessment exams.
15 Now, sometimes there'll be some
16 sharing. I think as VHA has situations where
17 they need more mental health practitioners, and
18 they've had to hire them over the years, it's not
19 one-size-fits-all. And if they have to borrow
20 from their C&P exam unit, they're going to do
21 what they have to do to treat veterans and keep
22 them healthy and happy and thriving.

1 MEMBER SIMBERKOFF: So the question
2 that Member Roberts was asking is, now, it is
3 difficult to hire practitioners in certain
4 specialties in certain areas. So how does -- how
5 does VBA do that if VHA can't?
6 MS. MURPHY: Well, VBA hires a
7 contractor and they go out and do what they have
8 to do to see if they can take care of that
9 business that we send them in that location.
10 MEMBER SIMBERKOFF: So just, just for
11 the example of mental health, you've been -- in -
12 - in Bismarck, North Dakota, you know, if you
13 can't -- if there's a shortage of mental health
14 providers, can VBA find them if VHA can't?
15 MS. MURPHY: Well, again, I'm not
16 hiring them as VBA employees. We're -- we are
17 contracting out with a provider who can then go
18 and do what they have to do to do that. It could
19 be a brick and mortar facility that they stand
20 up. It could be a local tenant sort of model
21 that VHA has used. I mean, they might fly them
22 in temporarily.

1 DR. VVEDENSKAYA: That's what I was
2 going to say that -- yes. I cannot speak for
3 VHA, but -- because I went and got board
4 certified as an independent medical examiner, and
5 our auditorium had about 500 folks almost the
6 physicians, some PAs, who do forensic medical
7 exams for various reasons, not VA's industry.
8 And that's what they're saying to
9 remote locations to the locations where there is
10 a shortage of certain specialties, QTC or any
11 other contractor, we'll just fly them in, and
12 that's what they're going to do, yes.
13 And in terms of the mental health
14 providers, unfortunately, as all physicians, I
15 think, there is a huge shortage of physicians and
16 social workers, and it's hard to recruit actually
17 medical students to go to a psychiatry resident.
18 It's unfortunately nationwide, not really
19 specific --
20 MEMBER SIMBERKOFF: I thought it may
21 be related to compensation. If you aren't
22 willing to pay, for example, psychiatry who got

1 the money. Obviously, you can't hire them,
2 because their contractor won't. And sometimes,
3 the government tends to be naive in terms of what
4 it wants to pay people to do things.
5 MEMBER PAMPERIN: My experience is
6 data to be sure, but one time when I went on a
7 site visit to QTC, they -- they mistakenly left a
8 three-binder in the office that they planned this
9 in, and it had their fee schedule.
10 MS. MURPHY: And it just happened to
11 fall on the floor, right?
12 MEMBER PAMPERIN: It just happened to
13 fall on the floor. And the doctor who was with
14 us said, "It was about 20 percent better than
15 Medicare and payments were pretty decent."
16 MEMBER SIMBERKOFF: That's the answer.
17 And contractor, is his license good anywhere?
18 DR. VVEDENSKAYA: That would -- all
19 depends on what kind of contract they have, yes.
20 MS. MURPHY: That's a medical --
21 that's on the contract and that's --
22 DR. VVEDENSKAYA: Yes.

1 MEMBER PAMPERIN: The vendor has to
2 credential the person that they can practice in
3 that area.
4 MEMBER SIMBERKOFF: Oh, okay. So you
5 can -- so if you apply in South Dakota, you can
6 practice in South Dakota.
7 MS. MURPHY: So one of the things I
8 wanted to point out is, it's funny, so I've been
9 -- I'm coming up on 23 years in VBA, and I would
10 say in the last five years, we have rocketed
11 forward in our technology and our ability to be
12 nimble and our data mining that we've done and
13 just -- we -- I was -- I was telling someone the
14 other day that folks are asking us, folks like
15 you, Congress, VSOs, are asking us questions now
16 that they wouldn't have even asked us two or
17 three years ago, because we had no chance of
18 answering them.
19 So now, we have better data, better
20 tools. And you've heard a lot of what Tom was
21 talking about, so our bureaucratic kludginess is
22 kind of being supplemented with some coolness.

1 Like we're just -- we're getting glimmers of
2 being cool.
3 You know, no paper -- no paper. You
4 know, we scan everything. If we don't get it
5 electronically, we move it around fluidly, we're
6 utilizing different sorts of systems and
7 techniques that we haven't before, so that little
8 bit of coolness is contagious.
9 And our field folks and people in
10 headquarters are coming up with ideas, and,
11 "Please add this to the system, automate this,
12 put this check and balance in." We have -- I
13 have a list -- we -- VBA has a list probably five
14 arm's length long of things we would build into
15 our systems tomorrow if we had enough bandwidth
16 to do it.
17 And that is kind of frustrating
18 sometimes because then we're stuck picking what
19 goes in next among 20 things that all should be
20 going in next.
21 I think there's a question in the
22 back.

1 MR. GAMMONS: Yes. So I'm more like
2 a VA right now, but on the civilian side, I'm a
3 disability rater at 317 in St. Pete. So the ERRA
4 tool is a fantastic tool as a rater, but my
5 question is, are we doing anything to better
6 train the physicians?
7 One thing that a lot of raters get is
8 we get better things back from VHA than they from
9 the contractors, and just seems to be sort of a
10 training thing because we'll get back an exam,
11 and it's not completely filled out or it's not --
12 it doesn't give us what we need to actually rate
13 it, so then we have to request an addendum, send
14 it back, sometimes request a different examiner,
15 and that happens at VHA sometimes, but it happens
16 a lot more with contractors.
17 So is this a trend that you all are
18 seeing at this level and is there anything being
19 done to kind of address that?
20 MS. MURPHY: So I think, historically,
21 VHA has had the responsibility of doing the
22 training about how to fill out DBQs internally

1 and providing those same materials externally.
2 It's our intention in my shop that once we get
3 everything stood up and have a real contract and
4 have all of our staffing and get out of this
5 hiring freeze that --
6 MEMBER SIMBERKOFF: We never have
7 trained external people.
8 MS. MURPHY: Well, we provide the same
9 training materials to them that we, that we
10 prepare for our own folks.
11 MEMBER SIMBERKOFF: Maybe it's --
12 MS. MURPHY: Well, that's what VHA
13 tells me, but it's our intention that we are
14 going to, and deviate, take over the, both the
15 ownership of updating the disability benefit
16 questionnaires themselves, which VHA currently
17 does, and doing, preparing the training materials
18 and pushing out the training materials to support
19 the vendors.
20 DR. VVEDENSKAYA: And may I supplement
21 your answer to you, sir? If you will have an
22 opportunity to join us tomorrow, Ms. Pam Miller,

1 who is in charge of contract exams for DVA, will
2 be presenting. And this is an excellent question
3 for her, because it's more about the mechanics,
4 and Ms. Miller would be able to answer that
5 question for you tomorrow for sure 100 percent.
6 MR. GAMMONS: And in general, just a
7 caveat, it just seems to be a familiar area with
8 DBQs and, you know, it can frustrating because
9 that just increases the timeline where we have to
10 go back and provide options. Thank you.
11 MS. MURPHY: Sure.
12 And then Ioulia is also kind of
13 nudging me probably nicely to like move on to
14 other topics, because there are folks that will
15 cover that tomorrow.
16 I wanted to mention though that we're
17 using two -- a product that was really a
18 financial accounting system as an interim
19 solution to order some, these exams until we can
20 get all of the linkups between the vendors and
21 VBMS.
22 So, you know, the coolness that we

1 want to have is a little bit stifled by the
2 ability of systems and support to get us there,
3 so there's more automation, more linking between
4 systems, adding some fail/safes in as far as, you
5 know, prompts to raters to say, "Hey, this
6 situation is here, did you remember to check
7 this, and are you sure you want to add this,
8 don't want to add this, you know, extra schedule
9 or stuff in?"
10 We'll get there. It's just -- it's
11 just a slower process than any of us would like
12 it to be.
13 MEMBER FAY: So can I suggest that you
14 will never -- once you get into this world, it
15 never stops.
16 MS. MURPHY: You're right, it never
17 stops.
18 MEMBER FAY: I mean, the innovation
19 that you will find that's just opening the doors,
20 and so it's all, you know, process improvement
21 and continuous process improvement, and so that
22 leads me to my question, which is, how much

1 communication is the management level having with
2 the worker level to let them know that the world
3 is changing and they need to be getting
4 themselves prepared for the world to change,
5 because their jobs as they know them today, what
6 they do at 8:00 to 5:00, right, is not going to
7 be the same in two years, three years, or four
8 years, and they need to start thinking about, and
9 VA needs to starts helping them think about the
10 new world and how are they going to get ready for
11 it, because I know VA, like most organizations,
12 have a lot of people that are used to doing the
13 same thing day in and day out in their jobs,
14 haven't changed very much, right.
15 These new capabilities, I think is
16 going to lead to significantly different ways of
17 doing the work. What kind of work is -- I heard
18 about the MITRE Corporation from Tom, right. Is
19 there similar things going on in how you actually
20 process work or communication with the employees?
21 MS. MURPHY: Before I answer that, I'd
22 like to check in with a gentleman in the back of

1 the room.

2 Has your job changed much in the last

3 two or three years?

4 MR. GAMMONS: It has. I don't think

5 it's, that's a huge issue. I've been with the VA

6 for 10, 11 years now, and they do a good job of,

7 I guess, messaging when things are about to come

8 down the pipe. And beforehand, it was most

9 things, like implementation of VBMS or exam or

10 anything else that comes.

11 It's really on-the-job training until

12 you, like you do some training for it, but until

13 you're using the system and getting into it,

14 that's when you really figure out the kinks and

15 how it works, so they do a good job, I think, of

16 pushing out what to expect, but until the big

17 changes kind of go into effect, that's when we

18 kind of learn --

19 MEMBER PAMPERIN: But the question

20 really -- the question really is, and I don't

21 mean this as a disparagement at all, but, I mean,

22 if the reliance is always on what kinds of

1 improvements the workers would like to see, as
2 opposed to what is capable of being done, I mean,
3 that's the thing where, you know, when you're in
4 the trenches every day, your area of influence
5 and your control is fairly small. And maybe you
6 don't realize that there are certain kinds of
7 things that don't need second signatures, don't
8 do this, don't do that.
9 MS. MURPHY: Well, and to that point
10 too, Tom, there's a quote from Henry Ford that I
11 love. It's something along the lines of, "If
12 I've given people what they wanted, I'd have
13 given them faster horses." You know, so that
14 idea that to think bigger than just what you know
15 and see what the possibilities are beyond just
16 what you have been doing for, you know, 5 or 10
17 or 11 years, those are the things that we're
18 trying to prioritize, so, you know, the big
19 picture impact, and then really there's -- and
20 this is -- there's always the smart people on the
21 ground who -- we can't get there fast enough,
22 they build their own workaround, and then we take

1 some of those workarounds and we locate them into
2 the system.
3 MEMBER FAY: What we did was, excuse
4 me, we set up an office of the future, right, so
5 we put all the new technology and put it in one
6 place, and then fictitiously ran offices for two
7 years and figured out new systems, new
8 methodologies. It eliminated jobs. It created
9 new jobs. It changed the way people did business
10 on claims dramatically.
11 We went from 47 offices to 3 offices,
12 radical changes, right. So that, when I say,
13 "Does the world know that that's coming where you
14 can't avoid those kinds of changes?" how much --
15 MS. MURPHY: No. That's true, but we
16 also operate in a different, the echo system than
17 you have in private industry.
18 MEMBER FAY: I know, and it takes
19 Congress to close an office, I get that, right?
20 MS. MURPHY: Yes. Right.
21 MEMBER FAY: But at some point in
22 time, these -- the productivity enhancements are

1 mind-boggling.
2 MS. MURPHY: Sure. And I think that
3 there -- there's also another long list of things
4 that we wish we did better. And just because we
5 have 56 regional offices or places that veterans
6 go around the country, doesn't mean they all have
7 to be processing claims.
8 So those are some of the questions
9 we've been asking. So you still have -- again,
10 back to your point, you have to examine the
11 veteran where they live, you have to provide
12 locational rehabilitation and counseling where
13 they live, you have to have a public intake,
14 public contact location where they live, but that
15 doesn't mean we have to process claims
16 everywhere.
17 In fact -- no, I think we would hanker
18 to have more places where veterans could come see
19 us in the communities rather than, you know, in
20 Ohio. I'm from Ohio. We have one regional
21 office in Cleveland. Everybody else in the whole
22 rest of the state is kind of out of luck if they

1 want to go to, you know, in-person to a regional
2 office. Just so to set up more places around the
3 country, partner with with where VHA is, --
4 MEMBER FAY: So we all get the concept
5 of eliminating the brick and mortars to the
6 extent possible, but, again, you know, there's a
7 tradeoff of, you know, again, where things can be
8 done most conveniently for the veteran versus
9 where it can be done most efficiently, --
10 MS. MURPHY: Sure, but --
11 MEMBER FAY: -- you know, for -- to
12 get the --
13 MS. MURPHY: But I'll tell you right
14 now, even under brick and mortar --
15 MEMBER FAY: -- the entire thing
16 weeded.
17 MS. MURPHY: You go to a regional
18 office, and there are a lot of empty desks these
19 days. We gave back a lot of space for empty file
20 cabinets, and we have -- I haven't checked
21 lately, but I would say at least half of the
22 employees work from home part- or full-time, so

1 they're already virtual to their own regional
2 offices for half the time, and we can take it
3 from there.
4 DR. VVEDENSKAYA: May I just
5 interject?
6 MS. MURPHY: Sure.
7 DR. VVEDENSKAYA: To put the
8 committee's heart at ease, because we didn't have
9 as a committee to get acquainted with Beth Murphy
10 that much, I just wanted to let you know that
11 Beth was the regional office director for years
12 in Pittsburgh, and she comes to Comp Service from
13 the Office of Field Operations, meaning she has
14 hands-on experience on how to communicate with
15 her employees on the regional office level, and
16 also the national office level. I just wanted to
17 bring up this part of her work history this way
18 you understand that Beth does come from the
19 hands-on kind of experience.
20 Back to you.
21 MS. MURPHY: Thank you.
22 And we have had some practice with

1 change management in the last five years in all
2 of the things we've done, and our brains are open
3 wide to other possibilities. And as you know
4 rather than to try to make it up ourselves, we go
5 to others out in the community to see how, see
6 how it's done and what the successes are and
7 learn from that.
8 A couple of other things. I just want
9 to throw this out. It might be something
10 different than what you would expect a Comp
11 Service director to talk about, but it's
12 something that I feel very strongly about, so I
13 just wanted to share it with you.
14 We -- I have a conference, a training
15 event twice a year with our service center
16 managers, so these are the heads of the claims
17 processing division and compensation across the
18 country. And, so this was my first conference in
19 January for those folks.
20 And part of the agenda included a
21 segment on suicide awareness and prevention. It
22 is one of the breakthrough initiatives or

1 management initiatives for the Secretary, and
2 it's something that is very much on the
3 forefront.
4 And it started probably almost a year
5 ago where, where we heard that suicide awareness
6 and prevention was part of the initiatives and
7 they were staffing up that office. I think the
8 VBA side has usually looked at it, "Well, that's
9 a VHA thing. That's what VHA takes care of."
10 And at one of our leadership
11 conferences, we said, "You know what? Fifty,
12 almost fifty-five percent of our employees are
13 veterans, they have difficulties, we work with
14 veterans every day, and we need to go beyond just
15 public contact and the call centers and suicide
16 awareness."
17 So we had initial training. We had
18 VHA come over and talk to us about, for about an
19 hour and a half. I'll tell you, I think it's
20 something we're going to continue on the VBA
21 side. I said, "Look, VHA has 330-some-thousand
22 folks, we have 20-some-thousand folks, but if we

1 get the word out and we spend more time talking
2 about this, just like we helped bring down the
3 homeless veteran numbers, I think we can have an
4 impact here too."
5 And you never know. It just takes one
6 person with a little knowledge of this to come in
7 contact with someone who's in need and be armed
8 and be equipped to have that conversation, and I
9 said, "I'm convinced we're going to save
10 somebody."
11 So it's something we're talking about
12 on the VBA side, doing more training in our
13 regional offices, and afterward, I had -- there
14 were spontaneous stories among the regional
15 office folks about how they had had someone
16 commit suicide, an employee in their office, and
17 I think some of those stories about what
18 happened, what was the aftermath, how did their
19 management staff deal with that, how did VHA come
20 and help with some of the sadness that comes
21 after that, was really powerful.
22 And they know who they are, who've had

1 experience with that now, and they are tapping
2 into each other when they have these situations,
3 so I think it's, unfortunately, it's a topic we
4 have to talk about, but wanting it to go away and
5 hoping it doesn't happen is not a strategy, so
6 we're embracing it on the VBA side as well.
7 MEMBER SIMBERKOFF: But do you have
8 data on the veteran suicide what pending claims
9 are?
10 MS. MURPHY: You know what, I don't
11 have -- I don't have that with me. I will tell
12 you that the VHA folks that gave us some data,
13 and I should have brought it with me, anybody who
14 has had interaction with VA of some sort, the
15 predominance goes way, way down, and in
16 particular in the female veteran population.
17 So it doesn't matter if it's a claim,
18 if it's a visit, you know, some interaction with
19 VHA or VBA or somebody, just having had contact
20 with VA brought the incidents rate like down
21 significantly, like it was in the 90 percentile
22 or something in women veterans, so it's making a

1 difference.
2 A couple of other things. We talked
3 about -- Laurine Carson will be here, she's our
4 head of policy, tomorrow. She'll talk about the
5 update on the VASRD, kind of high-level. We're
6 on track to get all of the proposed rules
7 published that aren't already published by the
8 end of this fiscal year, and all the final rules
9 by the end of FY18.
10 You know, Tom, your -- your question
11 to Tom about the rollout and how do you manage
12 that and how do you bake it into the systems, and
13 you said, "That's going to be a nightmare." It
14 is going to be a very challenging situation to
15 have both of those running parallel.
16 The good news is we're turning over,
17 I think, our average days to complete this
18 morning was about 112 days, so, you know, we're
19 getting claims through the system faster, and
20 that tail won't be dragging out hopefully as
21 long. Now, on the --
22 MEMBER PAMPERIN: Clearly, there's a

1 potential for a, for a fail site edit since you
2 have data claim in the mess, and, you know, if
3 you have that tied to a diagnostic rule that
4 says, you know, "This is the dual rating type of
5 situation."
6 MS. MURPHY: Sure. If we can get that
7 program in. We're just going to have to watch
8 it. Folks, talk about change management and
9 training, that'll be a big piece of it.
10 MR. MANAR: Beth, if I might ask?
11 MS. MURPHY: Yes.
12 MR. MANAR: With regards to each new
13 section or rewritten section of VASRD, in order
14 to properly evaluate veterans under the new
15 system if they already have a claim pending, you
16 may have to do a second VA exam.
17 MS. MURPHY: It's possible. Every --
18 every situation, every plan will be different
19 depending on where it is in the process and what
20 the circumstances are.
21 MR. MANAR: It is -- I think it's
22 possible. The question is whether you think it's

1 worthwhile doing to alter the, the exams for --
2 PARTICIPANT: DBQ.
3 MR. MANAR: The DBQs to, now, to
4 incorporate the new criteria, as well as, you
5 know, the new questions, as well as the old so
6 that you have at the time the new law, or new
7 regulation goes into effect, you've got an exam
8 that gives you the information for both.
9 DR. VVEDENSKAYA: May I ask -- it's a
10 two-part question from you. First part talks
11 about, can we put new writing criteria alongside
12 with old one before publishing the final
13 regulation? The answer is no. Oh, okay.
14 MR. MANAR: I'm saying, can you ask
15 questions to the answers which would answer the
16 new criteria?
17 DR. VVEDENSKAYA: We -- DBQs are what
18 is called, "Rule-based." It can ask questions,
19 which are part of the current regulation, current
20 rating schedule. It cannot ask questions which
21 are not part of the current rating criteria.
22 However, even now, DBQs are asking

1 more questions than the regulation states,
2 because you have to fulfill the requirement not
3 only regulatory, but also medical practice. We
4 have to ask certain questions even though they're
5 not mentioned in the regulation in order to
6 practice good medicine.
7 And in terms of the second part of
8 your question is, "Well, how do we jump from old
9 DBQ to new DBQ?" As I mentioned a little bit
10 earlier, two of the final rules, which I drafted,
11 are very close to publishing in the Federal
12 Register.
13 And two months ago, we already started
14 implementation process, which is a very
15 structured process which involves all the
16 stakeholders, including the VBMS programmers,
17 including people from the office which designs
18 DBQs. We're all working together. They have the
19 draft. They have an opportunity to ask me any
20 questions they need the answers for.
21 By the time Federal Register publishes
22 that final rule, our -- the design is that VBMS

1 and DBQs will be ready --
2 MR. MANAR: I anticipated that from
3 what you said earlier. I was just trying to see
4 if there's a way to avoid that second examination
5 for people who are, already have a claim pending
6 under the existing rules, and now there's new
7 language, there's new terminology, there's --
8 there may be new, a new way of evaluating a
9 particular disability, so that was the point of
10 my question is whether it's possible to avoid --
11 DR. VVEDENSKAYA: That is directed by
12 the administered law, which is outside of the VBA
13 and it is applicable to every single federal
14 government agency. We cannot, in our case, we
15 cannot examine patients based on the not
16 published rule.
17 MS. MURPHY: So, Jerry, I think, I
18 think it'd be fair to say we can look and see how
19 ways we can be more proactive, but I think it's -
20 - we have to be careful, because -- now, we have
21 to go through OPM for changing these rules, and
22 you have to demonstrate what the additional

1 administrative burden is, so it's a fine line and
2 you have to be careful of that, but we can take a
3 look at that. We can take a look at that.
4 And, again, you know, you propose a
5 rule, and then things change before it becomes
6 final, and then you're changing your DBQs back
7 again. We can look at it.
8 DR. VVEDENSKAYA: We're trying to make
9 this transition as smooth as possible, and doing,
10 like Beth said, a lot of proactive way ahead of
11 time work. This way when the time comes, it
12 doesn't take us more than, you know, flipping of
13 a switch.
14 MS. MURPHY: Right. So I think Tom
15 also mentioned appeals has been fenced off, so
16 there's a brand-new kind of head of appeals.
17 Dave McLenachen is overseeing both the policy
18 procedural part of appeals, and also the
19 operational oversight of appeals.
20 So if you, if you think about it, the
21 appeals' folks still live and work in the
22 regional office and they're evaluated by their

1 coaches and they're under the oversight of the
2 regional office director, but they get their
3 marching orders and claims processing orders from
4 headquarters down through the districts, down to
5 the regional office, and then over to the appeals
6 team.
7 They, like literally, if you could
8 just draw a fence around them, and we don't
9 borrow them for training or second signature
10 reviews or anything like that. We don't, we
11 don't work them. I don't even think we're
12 working them on overtime for rating any longer.
13 If they're doing any overtime, they're doing it
14 on appeals.
15 We've been borrowing from appeals for
16 a long time as you know. We've had all these
17 conversations, we need the modernization, but in
18 the meantime, this is something we can do to
19 maintain -- like so by not borrowing from it,
20 it's really increasing the amount of time claims
21 processors are spending on appeals, so yes,
22 that's having a positive impact on the appeals'

1 side and we're noticing some of that loss of
2 productivity throughput on the rating side.
3 All right. I don't really know how
4 long my time goes, so I'm going to stop talking
5 and see if there are other questions that you all
6 have, that you all brought.
7 CHAIRMAN MARTIN: We have two members
8 online.
9 See, Hal, are you -- are you back with
10 us, and Elder?
11 MEMBER BIRD: I am. I don't have --
12 I don't have any questions at this time.
13 CHAIRMAN MARTIN: Okay.
14 MEMBER GRANGER: No, I don't have any
15 questions. Excellent presentation.
16 CHAIRMAN MARTIN: Thank you. I
17 enjoyed this.
18 MS. MURPHY: Thank you. And -- and,
19 I guess, the 60 days is up on the Camp Lejeune
20 final rule next week, so we're anticipating that
21 going live so that we can start processing those
22 new presumptives. Of course, those will be done

1 through our Louisville Regional Office, who's had
2 jurisdictional over those for some time.
3 We don't -- we don't anticipate
4 changing that, so they have the expertise.
5 They've processed those claims for a long time,
6 and if they need additional capacity to do that,
7 we now have NWQ, and we can move their other work
8 out that they normally would process and have
9 them just focus on Camp Lejeune cases, so --
10 MEMBER PAMPERIN: Do you have any idea
11 how many claims you're expected? What's the
12 population? A couple hundred thousand? It's
13 like 20 years, isn't it?
14 MS. MURPHY: Yes. It's -- yes, right.
15 Off the top of my head, I cannot remember what
16 the population number is.
17 MR. MANAR: I think I heard something
18 north of a million people went through Camp --
19 MS. MURPHY: But then you have to
20 establish the 30 days contiguous or
21 noncontiguous, so there's a little bit of
22 filtering that goes on there.

1 CHAIRMAN MARTIN: Any other questions
2 from the members?
3 (No audible response.)
4 CHAIRMAN MARTIN: Thank you.
5 MS. MURPHY: All right. Well, thank
6 you. Thank you very much for your work with the
7 --
8 CHAIRMAN MARTIN: Thank you very much.
9 MS. MURPHY: Thank you.
10 CHAIRMAN MARTIN: We appreciate your
11 time.
12 (Applause.)
13 CHAIRMAN MARTIN: It's been a day of
14 lots of information and a busy day. What other
15 items do we need to revisit before we adjourn
16 tomorrow?
17 We've got a good lineup tomorrow of
18 speakers. We're going to cover some topics that
19 we've been looking at very carefully, including
20 the National Work Queue, VASRD, the contract
21 exams, and we'll have our time for a couple of
22 comments tomorrow at 11:15 as well if we have any

1 additional people joining us for those.

2 DR. VVEDENSKAYA: All right. Great.

3 And I would propose in terms of the organization,

4 let's leave our name tags here for just for if

5 people would like to address the committee

6 members by name, it's here.

7 CHAIRMAN MARTIN: Thank you. Thank

8 you very much.

9 DR. VVEDENSKAYA: Good.

10 CHAIRMAN MARTIN: Thank you, visitors.

11 Thank you for being here.

12 VSOs, thank you for being here. Thank

13 you.

14 We are officially adjourned.

15 (Whereupon, the above-entitled matter

16 went off the record at 4:09 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

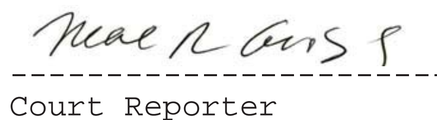
In the matter of: Meeting of the Advisory Committee on Disability Compensation

Before: US DVA

Date: 03-06-17

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.



Court Reporter