

U.S. DEPARTMENT OF VETERANS AFFAIRS
ADVISORY COMMITTEE ON DISABILITY COMPENSATION

MEETING
VOLUME I

Monday, October 20, 2014

8:10 a.m.

U.S. Department of Veterans Affairs
Room 730
810 Vermont Avenue, N.W.
Washington, D.C. 20420

P A R T I C I P A N T S

MEMBERS PRESENT:

LTG James Terry Scott, USA (Ret.), Chairman

Col. Doris Browne, M.D., MPH, USA (Ret.)

Robert J. Epley

John L. Maki

MG Joseph K. Martin, Jr., M.D.

Elizabeth Savoca, Ph.D.

Michael Simberkoff, M.D.

Mark W. Smith, Ph.D.

MEMBERS NOT PRESENT:

Bonnie Carroll

CAPT Warren A. Jones, M.D., USN (Ret.)

Deneise Turner Lott, J.D.

MG Timothy J. Lowenberg, USA (Ret.)

STAFF PRESENT:

Nancy Copeland, DFO, VBA

Raymond Foreman, VBA

Eric Mandle, VBA

Gerald Cross, M.D., DMA, VHA

Mark Bowen, DMA, VHA

Patricia Murray, DMA, VHA

Danny Devine, DMA, VHA

Thomas Lynch, M.D., DMA, VHA

ALSO PRESENT:

Peter Dickinson, DAV

Garry Augustine, DAV

Todd Hunter, DAV

David Forgash, GAO

Gerald Manar, VFW

Paul Varela, DAV

Jordain Carney, National Journal

Ray Wilburn, CNA

Victoria McLaughlin, McLaughlin Reporting LLC

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P R O C E E D I N G S

CHAIRMAN SCOTT: Okay. Let's go ahead and get started. Raymond, do you have anything to talk to, to tell us? Looks like the same three forms we've always had; right?

MR. FOREMAN: Right. It's the same forms. This time here you don't have to put your Social Security number. I've got everybody vendorized. I've got everybody into the CGE system.

CHAIRMAN SCOTT: Right.

MR. FOREMAN: So I no longer need your Social Security number. Once again, if at all possible, I would like for you to book your travel through myself, send me an e-mail. At that time, I will try my darn best to accommodate whatever you want. You give me the airline, the flight number, the date, if there's any connecting flights, if you give that information to me, I can look up exactly what you see and book that flight for you.

On reimbursement, it's the same. I need receipts. We book the hotel at the government per diem rate. If at the time you give me your

itinerary for your air travel, if you have a confirmation number to the hotel, I can make that part of the itinerary when I send it to you or when you get your copy. That way everything will be there, travel, hotel, travel, and that will be your itinerary with your little kiosk numbers and things like that on it, your confirmation numbers and all.

But other than that, I have no questions. Anybody have any questions for me? Stacy was--I was preparing Stacy to take this function over, but I turned him on something else, and he's busy with that. So I guess I still have it.

[Laughter.]

CHAIRMAN SCOTT: The only thing I wanted to clarify is when I send in my proposed itinerary with flight numbers and hopefully hotel, but at least all my flight stuff going and coming, you come back and say this is what I've got. Then I come back and say that's good, go with it?

MR. FOREMAN: Yeah, and with that, then I get it authorized.

CHAIRMAN SCOTT: Yeah, okay.

MR. FOREMAN: I initially put it in based on what on you say, you confirm to me that it's okay, and then I get my supervisor to authorize it.

CHAIRMAN SCOTT: Okay. Well, what has to happen, though, which in at least one case did not happen, is you've got to come back and confirm it with him, say, yep, that will do, that's good, so he can go ahead and confirm it with the airline.

We had, one of the members had a problem, but I'm pretty sure what happened was he didn't confirm back that, yeah, this will work, and so just be sure that when you're corresponding with Raymond here on it that you get back to him with a firm yes, this is what, this will work; okay?

DR. SAVOCA: Can I just ask one question?

MR. FOREMAN: Yes.

DR. SAVOCA: I know with Amtrak, they send you the ticket to your e-mail address so if you book it, where does that ticket go?

MR. FOREMAN: If you let me know you booked it, then I won't book it.

DR. SAVOCA: Okay. I'll book it then.

It's easier because then I get the ticket directly.

MR. FOREMAN: Okay.

DR. SAVOCA: All right. Okay. Got it.

MR. EPLEY: And that's okay with hotels, too. I book my hotel and just send you the confirmation?

MR. FOREMAN: Yes, yes. You all book your own hotels.

DR. SMITH: As I recall from having booked Amtrak, you can give them alternative e-mails and they will send it to every e-mail.

DR. SAVOCA: Would I send it to Raymond's, but how would I get the hard copy? No, it should go to me.

MR. FOREMAN: Right. And with the Amtrak, if I book it, I have your e-mail address. You would get a copy of the e-mail confirmation saying you're on Amtrak No. XYZ.

DR. SAVOCA: Right.

MR. FOREMAN: And I guess it would give you confirmation numbers if you need that to board the train or--

DR. SAVOCA: You need to pick up a ticket actually somewhere either--

MR. FOREMAN: Right. You would get an e-mail.

DR. SAVOCA: Oh, you'd get the confirmation number.

MR. FOREMAN: Right, right.

DR. SAVOCA: So then you could go that way.

MR. FOREMAN: I have everybody's e-mails, everybody's work number, phone number, home phone number. I got everybody's details to put it in the system.

DR. SAVOCA: Okay.

MR. FOREMAN: Okay. With that, thank you very much.

CHAIRMAN SCOTT: Thank you.

DR. SIMBERKOFF: Thank you.

CHAIRMAN SCOTT: Okay. Well, I'm going to make a couple of opening remarks and give the other Committee members an opportunity, and I've asked Mike to give us a little update on what VA is doing

to prepare for the possibility of Ebola cases on the VHA medical side.

I thought that might be of some interest to the Committee members. Although it doesn't pertain necessarily directly to what we're doing, I thought it might be of some interest so I've asked him when it comes to his time to give us a little update on what VA is doing.

Let me start off by saying that I appreciate the hard work that's gone into drafting some of these issues. I know that Kirk and his compadres are on Version No. 4, which indicates good discussion and some work, and from what I could tell, each version got a little bit better.

So I think we're doing okay. I will start out by saying that I can work with what I have now. I would like to go over those that we have a print copy of or that people volunteered to work on with them today or tomorrow and see that we can all have some input to them, and in some cases, we probably need to edit them down a little bit where possible.

And I have drafted the cover letter and I

have drafted sort of the preamble for the report, and I was telling Kirk the one thing I haven't really figured out yet is I've got to be sure that I make some sort of a statement that says although that we, the Committee, has mentioned these issues before, that based on the Secretary's responses that here is our recast of that issue so they don't think that we just copied last time's report and sent it in.

So I've got to figure out a way to lead into that. I'm not worried about it. I can do that. So, on the one hand, I feel pretty good about where we are. I'm sorry that we had a number of members that couldn't make it. It was just a matter of conflicting schedules and bad timing and all that, but what I want to be sure is that the members that are here get a chance to read and discuss the issues that are on the table, and I will talk about two of the issues that I'm kind of waiting to see what happens here today.

One of them is TDIU, and the other one is the way that we're going to approach diabetes. You

know there was a little discussion at one of the previous meetings that they might want to punt on diabetes until a later time, and we didn't like that as a solution. So once we get a briefing today on the VASRD Update Plan, we can decide on how we're going to do that. But that's two that I will write them, and basically on TDIU, I'm going to say something like--

[Pause to address technology problem.]

CHAIRMAN SCOTT: Okay. So let me restart where I was on--I'm going to write--I've got rough drafts of the TDIU, and basically one of the things I'm going to say is that while the Secretary tasked the Committee to study the subject, that we're probably going to defer until the next report or possibly an interim report until the end of the GAO study that's going on on TDIU.

I don't think that it's necessarily a good idea to try to get ahead of them and present an issue with recommendations until we've had the opportunity to review the GAO study in the Committee.

And besides that, it might very well add some weight to whatever we come up with as a recommendation. So that's the way I'm going to-- I'm going to say that we're going to talk that in detail next time or possibly as an interim if that's okay with everybody.

And the other one is, as I said, I want to be sure that when we leave here tomorrow that we have a grip on how we're going to address the diabetes issue. Now I'm sure that the Committee members remember--the other folks in the room may not--but correct me now if I get something wrong, but in the general update of the body system, there was a thought that perhaps they would wait to deal with the diabetes issue until a later time because of some of the controversial things involved in it.

But the Committee's position when we had one last time was that, no, we don't want to wait. We want you to solve your problems now, and we have to address it. And if at the conclusion of the briefings today, we still don't think that it's nailed down, we'll just put in the report that we

just really don't think that you can kick that one down the road. It's too important.

So those are two that I really can't--I wanted to run by the Committee here and maybe get a little more information on. But I will write them.

I think we're going to probably have about six major issues: the Reserve Component; the zero percent that you drafted; the second attempt to get at presumptions, which basically you drafted.

Let's see. The one that Deneise with some help drafted up here. I'm hoping everybody has got a copy of that. We're going to discuss that in detail.

I'm not sure exactly--I'm not sure exactly how to address that. I'm hoping that some of this information on the appeals today will give us an idea of it. I think we need to be sure that we're coming up with some pretty firm recommendations. In other words, some actionable recommendations and not just VA should study or VA should think about sort of stuff.

But I don't have a solution for it. But I

really want the input of the Committee members here on the appeals stuff because I'm not comfortable with--I'm not understanding of the entirety of the issue. So I want to get some discussion of that today and tomorrow.

And then we have a few briefings here today. We're going to spend some time talking about the report and, again, what I want to get out of this is I want to--today we asked for the fully developed appeals proposal to see how that dovetails with the information that Deneise and others put into that draft issue and see what we need to plug into that or take out of it in order to make that into a developed issue that we can present.

We've got an update on the VASRD Update of the Master Plan, and one thing I want to be sure we get out of that is that, first of all, that we are current, that we're current with where they are so that we don't wind up making a recommendation they've already done or whatever.

And the second thing is that what is the

plan for dealing with diabetes as a disability?
And that's the two things I want to get out of
that.

We asked Dr. Gerald Cross to come up and
talk about C&P exam processing times and what's
going on out in the Regional Offices in that
regard, and we may very well before it's over want
to present an issue in the report that deals with
processing time.

I don't know exactly what the format would
be yet. I'm kind of looking to you, Bob, and some
of the rest of you, to give me some help here--and
John--on what should we say? Do we want to talk
about the BDD, all the other ways that they're
going about it in the context of C&P processing
times or what?

And then probably most of the day tomorrow
we're going to spend our time just refining these
issues and being sure we're all on the same page on
it, and then based on where we are on the issues, I
will take them all and fold them into the report,
and I've got, you know, all the data from past

reports on my computer, and I think I can turn it pretty fast.

When I've completed it, I will send you all a copy of it. Again, I will scan it and send--well, I'll probably scan it first, but anyway I'm going to send--Nancy is going to take care of getting it into SharePoint and to the Secretary. That's the way we're going to handle the filing of the report.

Any questions about any of that or any comments? And then I'm going to go around and ask for opening comments from everybody.

MR. EPLEY: When do we have to get that report in? Is it end of the calendar year?

CHAIRMAN SCOTT: No, it's actually due on the 31st of October.

MR. EPLEY: All right.

DR. SIMBERKOFF: Oh, okay.

CHAIRMAN SCOTT: Now in the past, we've, at least on one occasion, we made a decision--this is a time or two ago--not to do it until after the elections were over to keep from providing fodder

to one side or another. But that's not a lot of time lapse before that occurs so the way I look at it, it's as of 31 October. We will list the Committee members who are serving as of 31 October. We will say that's the cutoff for the data.

But, you know, it will be filed right about then, but I don't feel like that, you know, that we have to burn the midnight oil the night of the 31st to get the scanned version into VA. In other words, that hasn't been an issue in the past, and since it took them 14 months to respond to our last report, if it takes it us an extra week to write it, I think we probably have the latitude.

Okay. John, what's going on?

MR. MAKI: I concur with your decisions about the TDIU issue. I don't think we have enough data yet, and with GAO looking at it, it's too early for us to voice a view. So I agree with the decision to wait a bit on that.

And the diabetes issue is kind of puzzling. It's part of the Rating Schedule. Why not deal with it now? If it's controversial, deal

with it as a controversial issue, but to keep putting it down the road is just not going to serve anybody.

Earlier or later this morning, we're going to hear about a fully developed appeals proposal, which is a very unique proposal, and I have a rough draft of a recommendation for the Committee to support what we're going to hear if it's our recommendation as a unit to do that. I'll finish that up tonight and e-mail it to everybody.

CHAIRMAN SCOTT: Super.

MR. MAKI: And bring printed copies in tomorrow for us to look at.

CHAIRMAN SCOTT: Great.

MR. MAKI: Okay. But I don't have it ready yet because it is kind of complicated.

CHAIRMAN SCOTT: Well, I think you're--

MR. MAKI: If you have a fully-developed claim and you want to appeal it, I think a fully developed appeals process is another streamlined way to get it to the Board to get a quick decision. So this might be a hand-in-glove method of dealing

with those.

CHAIRMAN SCOTT: I think it will be helpful to hear from these two, from Mr. Dickinson and Mr. Augustine, before we make any sort of--so I'm agreeing, it ought to be--if you can take what they say and fold it into what you know about it and come up with a draft for us by tomorrow, we will be good shape.

MR. MAKI: You will have it in hand tomorrow and we can take a look at it.

CHAIRMAN SCOTT: Okay. Doris, I'm offering the Committee members the opportunity for opening comments is what's going on here. Since you sat down next to him, you're next.

DR. BROWNE: Oh, my goodness. Well, I don't have any opening comments. Thank you.

CHAIRMAN SCOTT: Okay. Don't mean to put you on the spot here. If you have some later, you can come up with it.

DR. BROWNE: Yes, okay. Thank you.

DR. SMITH: I don't have any opening comments. Thank you.

CHAIRMAN SCOTT: Bob.

MR. EPLEY: Good morning. No comments except it's my wife's birthday if we can get on a conference call later today and sing happy birthday to her.

CHAIRMAN SCOTT: Well, maybe we can get her on the VTC.

[Laughter.]

DR. SIMBERKOFF: You dialed up somebody so why not your wife?

CHAIRMAN SCOTT: Elizabeth?

DR. SAVOCA: I'll pass.

CHAIRMAN SCOTT: Okay. And I asked Mike when it came his turn to just give us a little brief shot of what's VA doing about the Ebola crisis, which is exciting everybody. By the way, I flew through Dallas yesterday, which is the epicenter of all that, and there was at least one person on the airplane coming out of Dallas that had their rubber gloves on.

[Laughter.]

DR. SIMBERKOFF: Well, thank you, General.

Good morning, everyone.

Well, VA obviously is one of the largest health care systems, the largest health care system in the country, and as everybody knows, veterans travel and some to West Africa, and in addition now part of our responsibility is to provide backup to the military, and the military--and I heard yesterday the Reserves are now being deployed to the area affected by Ebola in Africa--Liberia, Guinea and Sierra Leone--to help build hospitals.

So VA facilities have been preparing for Ebola. Some of us actually went to the ID Week, which took place in Philadelphia just earlier this month, and we heard from Bruce Ribner, who is the Chief of Infection Control at Emory, about the fantastic job that they did and some of the really incredible logistic problems involved in taking care of the patients with Ebola.

And, in addition, we've had conference calls on a local level with our VISNs and just last week with VACO with the leadership of all the facilities, you know, to provide some national

guidance on what needs to be put in place to deal with patients who are coming back and who may be infected.

And as you might expect, the most important thing for every facility to do is, one, to be wary and to be questioning anybody who walks into the facility about whether or not they've had travel to one of the three affected countries in West Africa, recent travel, and whether they have either a temperature--and they've now lowered the threshold as a result of the experience with the young lady who flew from Cleveland to Dallas a few days ago to over 99.5--or symptoms such as malaise, headache, myalgia, nausea, vomiting, or diarrhea.

So anybody meeting those criteria, travel and either fever or constitutional symptoms, is to be considered a possible Ebola case and immediately put into isolation with full protective gear for the staff.

So the other two major things that all of us are doing is creating the appropriate environment to care for those patients while Ebola

is either ruled in or ruled out, and, two, making sure that our staff, because that's obviously the other major concern, our staff is thoroughly drilled with how to put on and more importantly how to take off the personal protective equipment that is necessary to care for patients.

It's easy to put on PPE. It's very much more difficult to take it off in a way which does not result in the possibility of exposure, and I think the concern for the health care personnel at Dallas and perhaps elsewhere is that they may have not had adequate instruction in how to do the latter, taking off the PPE.

So we've got to, one, construct appropriate facilities that are remote from the normal patient care areas because you don't want to mix patients who are potentially infectious with those that are coming into the facility for routine medical care; and secondly, really thoroughly train staff with personal protective equipment and drill them, make sure they know how to do it.

So at New York Harbor, which is where I

work, in New York City, we have facilities, one, which are very close to Kennedy airport; two, within an area which a lot of West African immigrants actually live so it's very likely that family members or people who actually live there may be traveling; and three, obviously, that we have a group of veterans that travel. And so we're getting ready.

We are actually building the appropriate isolation rooms in wards that are empty because we want to keep this as far away from other patients or activities as possible. The director--I held some town meetings last week. My colleagues, you know, have been doing educational seminars for health care providers for the last several weeks. And the director is actually holding seminars to really--for all members of the medical staff to really get them to understand the problem and what we're doing and why we're doing it at all of our facilities.

And I think every VHA facility across the country is doing more or less the same. So it's a

robust response. I think we all are concerned. We all hope obviously that nobody gets exposed or sick, but we all have to be prepared to deal with a patient should they arrive.

CHAIRMAN SCOTT: Okay. Any Committee members got any questions or comments about that?

MR. MAKI: I don't think Ebola is a diagnostic code in the Rating Schedule so if any of these troops come down with it, we'll have to rate by analogy again.

DR. SIMBERKOFF: Well, you know, one of the interesting points is that you rate by current analogy, and, you know, I think that people who suffer from Ebola are going to go through an extremely rough period, you know, if they survive, but like a lot of other infectious diseases, if you survive Ebola, as evidenced by the miraculous duo that were treated at Emory, they may be left with no residuals of their disease after the fact.

MR. MAKI: Well, that's good.

DR. SIMBERKOFF: So they may get a temporary disability for recovery, but as I said,

you can get the same thing from dengue and Chikungunya, which are other diseases that we're preparing to deal with, but, you know, the permanent rating after the six-month recovery or one-year recovery that we give them may be zero.

CHAIRMAN SCOTT: Well, that's to be hoped for.

MR. MAKI: Hopefully, we won't have to find out that.

CHAIRMAN SCOTT: Okay.

DR. SMITH: Actually, General, actually, I do have one question.

CHAIRMAN SCOTT: Sure.

DR. SMITH: A medical question. Do you think it is helpful to give transfusions from survivors?

DR. SIMBERKOFF: I wish I knew the answer, but I think that ZMapp is, you know, a series of monoclonal antibodies, you know, created in the laboratory against various antigens of the Ebola virus. Of course, nobody knows whether that worked or didn't because there's been no actual study.

There are many diseases where antibodies will actually protect people. Unfortunately, there are some infectious diseases where antibodies do exactly the opposite and actually make things an awful lot worse. So it really is necessary to do some control trials to see whether the antibodies, whether they're human antibodies derived from patients or monoclonal antibodies, are really beneficial or not.

DR. BROWNE: I think in this case where we're giving the convalescent serum, the chances of expiring without doing anything or doing something is--

DR. SIMBERKOFF: Well, people do a lot of things in desperation.

DR. BROWNE: Yeah, so that's what that is.

DR. SIMBERKOFF: And the patients at Emory were given, you know, the FDA and the CDC gave them permission to give ZMAPP. But so the NIH is testing a vaccine right now or more than one vaccine, and again, you know, vaccines may or may not work. There are examples. Lyme disease is an

example of a disease where the vaccine actually makes things worse. That's why a Lyme disease vaccine is licensed for dogs but not for humans.

So you have to do a control trial, and I'm sure that the NIH, Dr. Fauci, is trying to get one going in Africa with the vaccines where there's enough patients to actually test them.

CHAIRMAN SCOTT: Okay. Kirk.

MG MARTIN: I might make one quick comment about the capabilities and capacities in the Reserve Component for dealing with emerging threats like Ebola because it may translate into exposure to some Reserve Component members for things that the VA will be dealing with later.

In 2010, the Secretary of Defense gave the National Guard the duty of developing a force to be the first responder, first uniform military responder to chemical, biologic, nuclear, high explosive kind of events, and since that time, the National Guard has trained, equipped and certified a force of about 10,000 people for homeland events dealing with things from--you know, ranging from

radiation exposure to biologic sort of things where the capacity is to recover people, bring them in for decontamination, immediate stabilization, life-saving kind of intervention, and then transport.

Within this framework, there is not a holding capacity. There's not an isolation capacity for numbers of people but rather for mass decontamination, stabilization and transport.

And those capacities are available to the governors and to the DoD today. We have not exercised them overseas by and large. They've been homeland based and homeland directed, inwardly directed forces, but you may see more consideration of that sort of approach from the Reserve Component, National Guard.

CHAIRMAN SCOTT: Okay.

MG MARTIN: I'll save the comments on the Reserve Component issues for later.

CHAIRMAN SCOTT: Okay.

MG MARTIN: I appreciate the Committee's feedback on the drafts.

CHAIRMAN SCOTT: Okay.

MG MARTIN: Thank you.

CHAIRMAN SCOTT: All right. We have a number of visitors here today. Some of them appear to be first-time visitors so I'm going to start with Jerry over here and ask each of you to identify yourselves and who you're with so we'll all know who's in the room here.

MR. MANAR: Good morning. My name is Jerry Manar. I'm the Deputy Director of National Veteran Service with the Veterans of Foreign Wars.

MR. AUGUSTINE: Garry Augustine, Executive Director of DAV Washington Headquarters.

CHAIRMAN SCOTT: Okay, Garry.

MR. DICKINSON: Peter Dickinson. I'm a senior advisor in the DAV.

MR. VARELA: Paul Varela, Assistant National Legislative Director with DAV.

CHAIRMAN SCOTT: Okay.

MR. WILBURN: Ray Wilburn. I'm with CNA, the Center for Naval Analysis.

MS. CARNEY: Jordain Carney, reporter with National Journal.

CHAIRMAN SCOTT: Okay.

MR. HUNTER: Todd Hunter. I'm also with DAV.

CHAIRMAN SCOTT: Okay. All right. Well, welcome all of you. What I'm ready to do whenever Mr. Dickinson and Mr. Augustine are ready is to go ahead and let you kick off the discussion of the fully developed appeals proposal.

So if you need a little setup time, well, have at it, and--

MR. AUGUSTINE: Well, good morning.

[Chorus of good mornings.]

MR. AUGUSTINE: General Scott, thank you for having us.

CHAIRMAN SCOTT: Thank you for coming.

MR. AUGUSTINE: We appreciate very much the opportunity. My name is Garry Augustine, as I introduced myself already. I'm with the DAV. And what we'd like to do is break this up into two parts. I'd like to talk a little bit about how this idea came to be, and then I will turn it over to Peter who has been the point person from the DAV

to facilitate the development of the idea.

So we got it up. Okay. As you probably already are aware, the appeals issue in the VA is growing exponentially. It's getting to be as big a problem or maybe even bigger problem than the backlog in general. And the more focus that's on the backlog to complete more decisions, the more appeals will come obviously because there is always a ten or 11 percent appeal rate of all the decisions that the VA does.

So the more they do, the more appeals, and the appeals situation is much longer. Some go as long as two, three, four years. We've had appeals that have lasted even longer than that. Very, very frustrating for the claimant, for service officers that work the appeals. The DAV National Service Program has 270 National Service Officers out there that work with claims and appeals everyday. The same with the VFW, American Legion, and other VSOs that deal with claims work.

So there's been a lot of ideas about how can the appeals issue be dealt with. I can tell

you that as many ideas as there are, there is as many opinions about those ideas. The VSOs don't always agree with the VA; the VA doesn't always agree with the Hill. There's been a number of issues that the VSOs feel are not valid in trying to deal with the appeal issue.

So as these arguments and concerns continue, it's something that we'd like to find a way to at least take a chunk out of the appeals. I personally believe that there's no silver bullet. There's no one thing that can resolve the appeal issue.

However, there are some other options that can take a chunk out of the appeals, and that's what we tried to focus on. So it started with a discussion at the Secretary's meeting with the Big Six VSOs, and as the appeals issue came up for discussion, I volunteered the DAV to host a meeting with as many stakeholders as we could get to see if we had some consensus about some ideas that we could pursue.

So this appeal proposal is still a draft

proposal. We're still working out the consensus that we need for everybody to agree before we can move forward. The VSOs that are involved are the American Legion, AMVETS, DAV, Paralyzed Veterans of America, VFW, and Vietnam Veterans of America.

We also invited to this initial meeting the Veterans Benefits Administration, the Board of Veterans Appeals, and representatives from the committees in Congress so that we could discuss what we believe might be some options to pursue that would, again, not be the silver bullet that could fix it all but maybe take a chunk out of future appeals so that they could go much quicker or be resolved at the local level.

So, as I mentioned, more claims decisions, more appeals. We do understand that three plus years from filing an NOD just to get to the Board to a decision-maker is the norm. Many of them go much longer than that. We wanted to build on some current ideas already on the Hill that we were aware of, and we also wanted to involve all the major stakeholders and find common ground and

consensus, and, as I mentioned, no magic bullet solution.

So we felt as we got together it was good to hear from everybody, and I think the first consensus we came upon was that the best idea to cut down appeals is not have appeals. If it could be resolved at the local level, that would be best, and there are options for that. We believe one of the best options is the DRO program, Decision Review Office program.

That is a program where once an NOD is submitted on a decision, a review officer from the local Regional Office can engage in the process. They have de novo review ability. They can take a look at the decision and contact the veteran. There could be a personal hearing between the veteran and the Decision Review Officer. It can be just a review by the Decision Review Officer. It can be in consultation with the representative.

There are many ways that the Decision Review Officer can take a look at the decision and make a decision on their own whether it can be

granted or if it has to be continued in the appeal process.

Our concern was that the DRO program, which was proved very successful when it first started, was not being used to its fullest extent. As we started to ask our service officers in the field, and some of our fellow VSOs started to offer their concerns, we found that many Decision Review Officers were being redirected to do backlog work, to do other work besides the decision review process that they were hired to do.

As I understand it, they were not only hired to do, they were promoted to a higher grade, given the authority to focus on these appeals at the local level to try and resolve them at the local level.

From a Veteran Service Officer perspective, a representative perspective, we found that to be very beneficial. I spent 15 years in the field in Cleveland myself and was in the field when the Decision Review Officer program first started, and I can tell you we found it to be a

great way to resolve an issue at the local level.

Many times the veteran could come into the process, sit down with a representative, the Decision Review Officer, and we could resolve the issue face-to-face, and it would have to go no further.

CHAIRMAN SCOTT: Well, you know, we presented the Secretary in our last report an issue that basically said exactly the same thing you did--

MR. AUGUSTINE: Excellent.

CHAIRMAN SCOTT: --you know, that the mal-utilization of the DROs is part of the problem. And the answer we got back was something like, well, we had to divert a bunch of them, but we're going to try to do better.

MR. AUGUSTINE: Right. So I can tell you all the VSOs are all in unison that we believe the DROs should be doing DRO work 100 percent of the time.

CHAIRMAN SCOTT: Do you think it's worth us bringing that back up again?

MR. AUGUSTINE: Absolutely.

MR. DICKINSON: Yes.

CHAIRMAN SCOTT: Okay. Because I'm not sure that--I'm not sure how much has changed from two years ago when we submitted that report.

MR. AUGUSTINE: As I understand it, they are now--at least is what we're being told--they're doing DRO work supposedly during regular work hours. On overtime, though, they're being again diverted to backlog work.

Now, I think it's case-by-case from Regional Office to Regional Office what actually happens. So we don't know. Someplaces the DROs may be doing complete DRO work; other places not.

But that's still the best option to cut down on the appeals, not all appeals. Some appeals are going to go through anyway.

CHAIRMAN SCOTT: Right.

MR. AUGUSTINE: But again if we go back to this idea of not trying to find a silver bullet to do it all, this is a area where we feel it can get to 15, 20, 25 percent of the appeals can be

resolved at the local level. That's a big chunk.

Then we looked at--yes?

MG MARTIN: How many DRO officers are there?

MR. AUGUSTINE: I don't know the answer to that.

DR. SIMBERKOFF: Are they in every--

MR. AUGUSTINE: They are in every Regional Office.

DR. SIMBERKOFF: Okay.

MR. EPLEY: When they were first conceived, there was going to be anywhere from one to about four at the Regional Offices. I don't know how that has evolved. It's more than ten years old at this point.

MR. AUGUSTINE: Right. And I'm not sure myself at this point.

DR. SIMBERKOFF: So the new Secretary has implemented a program where individuals are actually going to focus groups at I think a number of VA medical centers, and they actually visited mine last week, to, you know, we interviewed staff

about, you know, issues really involved in improving VA veteran customer satisfaction.

And one of the issues that was most strongly raised, which has been a problem, is not having members of VBA, you know, at our medical centers--

MR. AUGUSTINE: Right.

DR. SIMBERKOFF: --you know, to deal with that because we used to have them there, and then they, you know, have been pulled back, and this is an area where I think there would be a lot of benefit and traction for the patients because there are individuals, they come to us and say how can I deal with issues that are involving my claim for this disease that you're treating me for or that problem? And, you know, it's often very difficult to get them to understand that they've got to go to Ouston Street in New York City--

MR. AUGUSTINE: Right.

DR. SIMBERKOFF: --rather than the medical center to get their help.

MR. AUGUSTINE: I can tell you that the

executive directors of all the major VSOs have been having discussions with the executive staff of the VA. They are now proposing those kind of ideas so that there is more of a One VA.

DR. SIMBERKOFF: Yeah.

MR. AUGUSTINE: Because right now VBA/VHA are two different animals.

DR. SIMBERKOFF: And even the Cemetery--

MR. AUGUSTINE: Right.

DR. SIMBERKOFF: --you know, because there are issues. Unfortunately, patients die.

MR. AUGUSTINE: Not only that. The way that it's set up now, I mean there's a lot of overlapping. Some VHA areas are different than the same area for VBA. They may be in a different VISN.

DR. SIMBERKOFF: Yeah.

MR. AUGUSTINE: They may be in a different area. So there's no consistency with the areas for the different departments of the VA. They sometimes overlap. Sometimes a place such as West Virginia, one area may be all VBA area, but it may

be two different VISNs. So it's very confusing. So there is some discussion, I know about transforming that and changing that in the future.

Getting back to the appeals proposal, so we understand that there's going to be cases that are appealed. We thought after reviewing the success of the fully-developed claims process that it had some merit for the appeals arena. In the fully-developed claims process, it's a voluntary situation for veterans. Claimants that would like to get involved on their own claim do some development, submit the evidence that they have and indicate that there's nothing else that they believe is out there that is needed to be made for a decision.

And the fully-developed claims process has proved very successful. It started out very low with two percent participation. I believe currently it's close to 40 percent of claims are fully-developed claims. So keeping that in mind, as we got together with this large group, we started to kick around the idea of a fully

developed appeals process.

There's a little more difficulty with a fully developed appeals process because unlike fully-developed claims that could be put ahead of other claims without any problems, in an appeal process, it's a docket order. And in order to jump the docket, there has to be a change in the law.

So that's why we needed congressional intervention and also support and cooperation from the Veterans Benefits Administration and the Board of Veterans Appeals.

So as we started to come to some agreement on the idea, we knew that there was additional work needed, and we decided, as a group, to further that with a work development kind of group that could ferret out some of the problems that are associated with this kind of idea and see if there was an avenue for progressing.

So that brings you to how we got to the point of fully developed appeals idea, and I'll turn it over to Peter to talk about where it went from there because the big group was actually a

four-hour meeting I believe, and we had about 30 people there, I believe. So just to get consensus out of group like that was, in my opinion, success.

But then we needed to work out the details obviously. So Peter, you can take you from there.

MR. DICKINSON: Thanks, Garry. Good morning, everyone.

[Chorus of good mornings.]

MR. DICKINSON: As Garry had said, this proposal that we're going to talk about is really on behalf of all of the VSOs who participated and with the participation of the VBA and the Board, and my role in this was really to facilitate and to make this process happen. I'm not the subject matter expert. Garry is the subject matter expert. Jerry Manar, who was instrumental in this process, subject matter expert. Please, both of you, correct me if I misstate anything, which is very likely to happen at one point.

So as Garry mentioned, we did start to meet informally just to have some discussion around this and to see if we could really drill down and

try to take each issue where there's a difference of opinion and try to go down to the smallest details and work out how a new proposal like this might work.

As you can imagine, it's not only hard to get agreement among a lot of people, but each of the VSOs themselves have different not only perspectives, but they're organized differently. So some of us have our service officers work directly for the National Organization. Others, most of their service officers work for their state departments. So it's a very different situation-- what kind of representation does the VSO have at the Board? Some have more; some have less. Do they prepare arguments in the field or do they prepare them at the Board?

So really just getting consensus among the VSOs is a lot of work, and then to build it with the VA, and then to get Congress on board, as Garry mentioned.

So I'm just going to run through and just talk about very quickly what the normal appeals

process is so that by way of comparison, we can show how the fully developed appeals process would work differently.

So the normal--okay--so this is the wrong presentation, unfortunately, but, all right, we'll go with this.

MS. COPELAND: Do you want to just go with the handouts?

MR. DICKINSON: Well, no, this is it, but there was supposed to be about 30 more slides.

MS. COPELAND: Oh, really.

MR. DICKINSON: Yeah. That's what I sent over.

MS. COPELAND: So this is the one that I-- oh. This was the handout.

MR. DICKINSON: That's okay.

MS. COPELAND: Okay.

MR. DICKINSON: So instead of going step by step, we'll jump straight into the whole thing, and I'll try to break it down for you visually.

Well, what I had done on this was, as I said, break it down slide by slide, but that's

okay. We'll work through it this way.

Well, a normal appeals process--I guess I can use the pointer here. But you start off with the Notice of Disagreement. So upon a claims decision, of course, you make a Notice of Disagreement that you want to file an appeal, and in that Notice of Disagreement, you have to do that within one year of the time your claims decision comes down.

In the Notice of Disagreement form, you are able to elect either essentially what's the normal appeals process, intended to go straight to the Board of Veterans Appeals, or you can choose the DRO process, as Garry referenced just now.

MR. AUGUSTINE: If I could just put a caveat in. I'm looking at the new Notice of Disagreement form, and there is no option for DRO choice. So that's something that we're going to have to go back and discuss with them.

MR. DICKINSON: Once you've made that election, the RO, if you chose the DRO process, will take one path. The normal path to go to the

Board will then, the next step after the Notice of Disagreement is that the RO will prepare a Statement of the Case. That's the SOC--the second step here.

The SOC is essentially a longer claims decision in many respects. It includes all of the relevant laws and statutes that are part of making up that decision, and it provides more clarity potentially for the appellant. The Statement of the Case rarely changes the decision although it's possible. If in filing your Notice of Disagreement, you submit additional evidence, it's possible that could be used to change the decision, but normally a Statement of the Case comes back as just a longer explanation.

With the Statement of the Case, the third step here says Form 9. The VA Form 9 is where you make it a substantive appeal, and this is where you formally say I want to continue the process on to the Board, and you have 60 days in which to file this form.

Once you've filed the Form 9, you've

established your docket date. Your docket date would be the order in which it would be heard when it gets to the Board. That will stay with you for that appeal as long as you go through this process.

From the time of the Form 9 being filed until the time that the appeal is actually heard at the Board, there's two other things that can happen at the RO. One is that you can hold a hearing, which is down here, a little chart below. So if you elected in choosing an appellant hearing, if you choose to do it as a video conference hearing or as a travel board hearing, that will take place prior to your appeal being transferred to the Board.

MR. AUGUSTINE: By the way, both of those hearings take in excess of a year in most Regional Offices to get. So you have to wait a year for those hearings.

DR. SAVOCA: Question. Just some clarification.

MR. AUGUSTINE: Please.

DR. SAVOCA: So if you do the DRO process,

you don't have the Statement of the Case?

MR. DICKINSON: So I'll go through the DRO process second.

DR. SAVOCA: Oh, okay.

MR. DICKINSON: This would have been a lot clearer had it been the presentation.

MR. EPLEY: Garry, why is it that there's a year delay? Is it getting somebody out there to do that?

MR. AUGUSTINE: Well, even with the video hearings, because of the docket order situation, it has to wait its turn. So it used to be hearings, as you know when you were with the VA, were relatively soon. They are so backlogged right now that it usually takes about a year for each of those hearings.

DR. SMITH: But the hearing is optional?

MR. AUGUSTINE: It is.

DR. SMITH: And if you don't elect one, does that speed up the process?

MR. AUGUSTINE: Well, it speeds it up by a year that you're not waiting for a hearing. Now,

remember, once they have a hearing, it could be resolved. So that adds into it.

DR. SMITH: That's the gamble.

MR. AUGUSTINE: Yeah. But you still have to wait for that hearing. So even, it was for a long time, the video hearing was quicker, but now they are in many Regional Offices taking almost as long.

DR. SMITH: Is it a good gamble? Are many of them resolved?

MR. AUGUSTINE: From a personal perspective, when I used to represent an appeal, I used to like--if I had what I thought was evidence to win the appeal, I always liked to have a hearing because that way the veteran comes in, he understands what's going on. A big part of this is educating the veteran as to what they're entitled to and what they're not entitled to under the law.

They don't always understand that. With a hearing, a hearing officer can many times clarify that along with the representative that's in the hearing, and the veteran many times will walk away

satisfied knowing that they had their day in court, so to speak, and understanding why they got the benefit or didn't get the benefit as opposed to getting something in the mail and not clearly understanding it, and just reading the decision and then still having many questions. In a hearing that can all be resolved.

DR. SIMBERKOFF: One of the examples of things that I think is very confusing to veterans and to the doctors that take care of them is that a complication of a disease for which a veteran may be, you know, claiming service connection is not necessarily subsumed under that disease, and that they actually have to apply for disability for the complication so that things are denied, which actually they should be getting, you know, some disability compensation for because they don't understand that, let's say, kidney disease from diabetes, as an example, or arthritis from some other problem is not considered under that disease.

MR. AUGUSTINE: There is a tool now that the VA has available to them. It's called the DBQ,

Disability Benefits Questionnaire--

DR. SIMBERKOFF: Yes, right.

MR. AUGUSTINE: --that helps to clarify some of that. However, we're finding that in many VA hospitals, VA doctors do not want to complete the DBQ. So it's another battle that we're having.

DR. SIMBERKOFF: Well, I'm speaking as a doctor in a VA hospital. You know, the problem is that there are experts in doing these, you know, the people who actually do Compensation and Pension exams, and they're actually certified to do the DBQs by Dr. Cross's regulation.

MR. AUGUSTINE: Right.

DR. SIMBERKOFF: He's going to be coming here.

MR. AUGUSTINE: Yeah.

DR. SIMBERKOFF: And then there are a lot of other doctors who, you know, are the ones that are on the front line who are not certified and for whom completing these DBQs is completely foreign language.

MR. AUGUSTINE: Yeah, I can understand the

concern, but it is a step-by-step process.

DR. SIMBERKOFF: Yes.

MR. AUGUSTINE: Questions are developed to coordinate with the Rating Schedule so that now the DBQs can be used in the calculators that they're using under VBMS, and it can be very clear as to not only what they may have to know for the rating but also leads to other potential secondary conditions, other types of conditions that could be considered. So I'm a firm believer that the DBQs are a good tool and should be used.

DR. SIMBERKOFF: I'm all in favor of the DBQs. What I'm just pointing out to you is that the front-line doctors are not the ones that are most likely to be filling them out.

MR. AUGUSTINE: Understood.

MR. MANAR: Doctor, if I could address your initial point, and that is the failure of folks in the Regional Office to rate related disabilities when they show up in treatment records or on exam reports. There was a time, ten, 15 years ago, and into the past where, where rating

specialists would routinely take these findings, additional issues, as inferred based on the evidence of record.

DR. SIMBERKOFF: Yes.

MR. MANAR: However, as the workload has increased in the Regional Offices and the intention of management has become much more focused on trying to improve, give the illusion of improving timeliness, they have put more and more pressure on rating specialists and veterans to focus on the narrow claimed issues, forcing veterans to raise these additional issues separately.

That does two things. One is that it gives the illusion that the original claim was worked more quickly, but it also adds to their workload if veterans are astute enough or their service reps are astute enough to recognize these other related disabilities and claim them. So it actually increases their workload. Instead of resolving everything at one time, it increases the workload.

But it makes for resolution of those,

those now separate claims, at least in theory, occur more quickly than if you just left it all hanging at one time and trying to resolve it.

The other thing I wanted to point out for everybody was that the thousand days that's on this particular chart, talking about the appeals process, that does not include the time that's given to veterans in which to appeal. From the decision until the end of one year, they have an opportunity to appeal. That is not counted in this thousand days.

All of that is time spent in the Regional Office. Most of it, almost all of it, simply waiting for somebody to get to it.

MR. AUGUSTINE: But to add to that, the clock doesn't start ticking on an appeal until it is appealed with a Notice of Disagreement.

MR. MANAR: Yes.

MR. AUGUSTINE: So even though they have a year, they may never appeal it in that year, or if they do, and it's ten months, 11 months, the clock on the appeal doesn't start until that tenth or

11th month whenever they finally submit their Notice of Disagreement.

So there is no counting against the VA for that one year appeal period until they actually appeal the decision.

MR. DICKINSON: So let me jump back here. So we're talking about the hearings. There is something here called an SSOC also. This is the Supplemental Statement of Case. This has long been one of the biggest delays that has taken place in the appeals process. Whenever someone sent in anything new in relation to their appeal, the RO would have to examine it and then determine did this change their decision, and if not, issue a Supplemental Statement of Case.

These SOC's would essentially, as a claim, an appeal was moving, something new got mailed in, they would look at it, have to do something more, write an SSOC, issue that to the veteran. When the veteran got that, they may say, oh, let me send in something else, and they might come back. And this is what is often referred to as this churning that

goes on and on.

That's been remedied, we hope, to a large degree. There's a new statute, regulations that have been issued that say once an appeal has gone to the Board's docket, that when new evidence comes in, it stays with the appeal file. It's not necessary for the RO to write a new statement or to reexamine unless the veteran says I want the local RO to examine because they believe it will have a better outcome.

So those regulations are just taking effect now so that may reduce some of this. Once all of these steps are ready, then they file what's called the VA Form 8. This certifies that it's ready for the Board to begin its work on it, and as Jerry was mentioning, this thousand days up above here is from the NOD, which could be a year after the decision until the Form 8 is filed so it's ready for the Board to call up.

The next step then after that thousand days is the processing that takes place at the Board, and once it's certified, it's in docket

order, the Board then takes these up in docket order. The first step is to, if there is a VSO power of attorney on that appeal, then at the Board's Office, they will get the file to review, to write an argument if they want to in support of the appeal, and then return it to the Board.

Once the VSO review has been finished, there may also be Board hearings down below here where it says BVA hearing. So in addition to having a travel board hearing locally or a video conference hearing, you could request a hearing directly at the Board's headquarters, which I understand is actually faster than travel board hearings.

MR. AUGUSTINE: Yes.

MR. DICKINSON: It's a shorter wait--

MR. AUGUSTINE: You actually have to travel to Washington.

MR. DICKINSON: --to actually come to Washington, D.C. than it is to wait for a travel board to come near where you live.

So once the VSO review has taken place, if

there is a hearing that has taken place, it would then go to be reviewed by Board attorneys and Veteran Law Judges for a decision.

The decision of the Board can make, they can allow the appeal, they can deny the appeal, or they can remand the appeal. Typically if it's a multi-issue claim, or not typically but I don't know how often, but very often they may allow some issues, deny some issues and remand some issues.

The remand process from the Board is usually for two main reasons. One is for a need to develop additional evidence that the Board sees that there was not available. There wasn't a current enough exam or they need an independent medical opinion. Because they have two different pieces of medical evidence, they want to weigh it out.

Or because there's been procedural errors that they believe may have prejudiced the case along the way that they need to have corrected and the process worked through again.

Remands typically go back here to the AMC,

the Appeals Management Center, which is with the Veterans Benefits Administration. It's within VBA. Their job is to do exactly that, to take the remand orders, to process them, to do the work that's necessary, and then once they get back additional evidence or opinions or exams and correct the errors that occurred, they then review it to see if they can issue an allowance on the appeal.

So they actually look to see if they can make a new opinion based on that new evidence that's come in. There are some appeals that are remanded not back to the AMC but back to the--it says AOJ, which is Agency of Original Jurisdiction, essentially where it began at the Regional Office, and that's for some particular reasons that I won't go into, but most go back to the AMC.

When the AMC is done, if they do not grant, if they don't grant a full appeal, then the remand is returned to the Board. If they have gathered additional evidence, it will go therefore back to the VSO for their review, and once they're done with their review and adding additional

argument, it will go back to the Board attorneys, Veteran Law Judges, who will issue a new decision, which may be to allow, deny or remand again, and/or in part in each of those.

So the process that starts a year for the NOD up to a year for this appeals processing, and then about eight months from the time they pull it up from the docket to be reviewed, it can be the typical time it takes. You're talking years, three, four, five years to get a decision from the Board.

Now as Garry mentioned, there is another process that was created in 2001, which was the DRO process, and the DRO process, as Garry mentioned, had some very big advantages. The biggest is that they do a de novo review that is unlike the other steps in the normal appeals process that occurs where they wrote Statements of Case or Supplemental Statements of Case, or even what the AMC does. The de novo review means they look at it as it is fresh for the first time.

They review the entire file, and they can

make their own independent completely separate decision rather than simply reviewing does the new evidence change the decision.

The other great advantage is that it is a local process. This allows a lot more interaction. You can have a local hearing, as you had asked, in the DRO process. And this is one area in particular where having a representative from a VSO can be very helpful to work in the RO. Knowing the DROs, we can often find informal ways to help the process move forward.

So the DRO process is extremely important and one that we continue, as Garry spent some time, emphasizing how important it is, even in the era of a fully developed appeals proposal.

Little arrow looping back here is you go through the DRO process, and again you are not granted the full benefit, you can continue this appeal back in the normal track. So if you are denied, your appeal is denied by the DRO, you go right back in and you file your substantive appeal Form 9 and you continue on the process so you are

not finished, and then you go through each of the steps.

So, as Garry, as we talked about the fully developed appeals proposal, it is similar to the fully-developed claim in its conception, which is that we try to take the same model and see how it applies to the appeal, take all the evidence the veteran can gather themselves and present it up front in exchange for quicker decisions and for waiving the VCAA requirement for development of private evidence. That's sort of the basic central tenet.

MR. EPLEY: Excuse me?

MR. DICKINSON: Please.

MR. EPLEY: Would you be having the veteran sign a statement to that effect?

MR. DICKINSON: Yes, yeah, and there would be several steps that they would do. So the way you would initiate a fully developed appeal is at the NOD. So there currently are two choices as you make your Notice of Disagreement, and I think it's now a Notice of Disagreement Election Form is maybe

what they have--

MR. AUGUSTINE: Yes.

MR. DICKINSON: --subsequent to it, of the DRO process or the normal traditional appeals process. This would add a third process at the NOD. That would be the point to enter this program.

Essentially you would be making a decision that my appeal, I think, is straightforward enough, the issues are clear enough, that if I can get it before the Board, I think I can be satisfied with the decision that way.

You are allowed to--in the fully developed appeal, your package will consist of what goes to the Board of four things. The full claims record as you'd expect will travel up there. You're able to add any additional evidence that you believe will bridge the gap between the claims decision you're unsatisfied with and what you are trying to get so you can add any new evidence, and that's similar to the fully-developed claims.

You take the burden on yourself to say I

will gather all the private evidence that exists. I will get any doctors' opinions. I will get any missing records. I will get any lay statements of support. So you add any evidence. You add any argument you want to.

And then the fourth component is, as Bob's referencing, is you have to sign a certification you want to enter into this process, that you understand what's going to happen in this process, what your obligations are, what the Board's obligations are, what VBA's obligations are, that you are stating here, as you do in the fully-developed claim program, that there is no other private evidence that would affect this appeal.

That's the same certification they do in the fully-developed claim, and that, again, that you're clear on what will happen, that you know that this will eliminate all of the VBA processing. There will be no Statement of the Case issued. There will be no Form 9 filled out. You will waive any hearings, locally or at the Board, and of course, you understand there will be no

Supplemental Statements of Case because from this point forward, you will not submit any additional evidence. Just as with the fully-developed claim, you say this is it.

Yes?

DR. SIMBERKOFF: So I just have a problem with the "FDA."

MR. DICKINSON: You mean the Food and Drug Administration?

DR. SIMBERKOFF: Yes.

[Laughter.]

DR. SIMBERKOFF: So the problem is that the government acronym issue gets very confusing to the lay people and maybe the choice here of that particular nomenclature,--

MR. AUGUSTINE: That's a good point.

DR. SIMBERKOFF: --you know, could be rethought.

MR. DICKINSON: Sure. I guess the Federal Depository Corporation also doesn't like the FDC.

DR. SIMBERKOFF: Yeah.

MR. DICKINSON: But we combined the two.

DR. SIMBERKOFF: That may be less well-known than the FDA though.

MR. DICKINSON: Right.

MR. EPLEY: Could a veteran have a hearing and then say, all right, now I want to sign up for this fully developed appeal?

MR. DICKINSON: So in the way we've conceived it, no. And here's one of the key facts about this is that in our mind the fully developed appeals program is a pilot program. It has to start as a pilot. It needs to be a pilot because we need to test it to see how it's working and make course corrections, and therefore we thought let's start with the simplest process, the cleanest process with the fewest sort of exceptions, and then let's add in the exceptions from experience.

And that's what they did in the fully-developed claim program. It was conceived very clean. If you send anything additional in, that would kick it out of the fully-developed claim track and put it back in the normal one. And then a lot of ROs, they started finding from experience,

well, here's something that's just, you know, minor, or somebody filed it and forgot to sign it.

Let's not kick it out because it's a program designed to not just help the veteran but to help the VA. So we talked a lot about where do you start; right? Where is the entry point into it? And again, as with all this, this may not represent exactly what we think is the best way or the VBA or the Board, but it was that common ground that we found that we all thought would be a good way to start with it. So we decided the cleanest would be right at the NOD.

MR. AUGUSTINE: Remember, we had to get consensus from a lot of different stakeholders on this.

MR. EPLEY: I fully appreciate that.

MR. AUGUSTINE: So it was a very trying ordeal quite frankly to get everybody in agreement, and even when we did, there were some problems we had to work out between VBA and--BVA and VBA because, as Peter will talk about, there's a development phase also. I'll let him explain that.

MR. DICKINSON: Please.

DR. SAVOCA: When you thought this up, did you have some idea in advance how many appeals would be expedited through this or is this just--

MR. DICKINSON: It's always a hard thing to gauge that.

MR. AUGUSTINE: Again, remember, this is truly voluntary. No one has to go into this track. And what we have seen from the fully-developed claims process is that people that want to be involved in their claim, to help get the evidence that they need, go out there and not wait for the VA to do it, or not wait for the doctor to send it in per the request of the VA, they were more engaged in their claim, better understood what was required to win it, and were more satisfied, I believe, once they participated.

It started at two percent in the fully-developed claims process and now grew to 40 percent. We believe the same kind of success could be involved in this. It's not for everybody. It's not for everybody. There are many people that

don't want to do anything as far as go find evidence or develop their claim or be involved in it.

For those people, this is not a choice that they would make. This is strictly people that want to get involved with their own appeal.

MR. DICKINSON: And I think, again, part of it is, I think, you know, I think we talked about if this were able to be even ten percent of appeals, I think both the Board and the VBA thought that would be worth it on their end. So whether it makes ten, whether it goes higher, remains to be seen as we tweak it.

MR. AUGUSTINE: If we could get the DRO program at 15 or 20 percent, which I believe is pretty close when it's operating fulltime, and get this to 20 or 25 percent, you're talking about a big chunk of the appeal process. It's not all of it, but it could help, and that's what we're looking to do.

MR. DICKINSON: All right. So I'm going to jump ahead to the chart, which looks wildly

complicated. So, but, and of course this is all in the red area, so as we said, from the NOD election, you have no SOC, you have no Form 9. There will be no SSOCs. There's no hearings. There's no Form 8. Essentially from the NOD filing, you file it, you take a full year to gather any evidence you think is necessary to put together any argument you want. You read over the documents, certifying you want entrance to this program, and when you've made that choice, that package is transmitted directly to the Board.

Now having the transition going to digital should, in fact, make that a simple process, but there may be still operational details that have to be worked out by the Board.

When it arrives at the Board, as Garry had referenced earlier, it goes on a separate docket so there will be two dockets, much like in the claims process, there's two tracks, for fully-developed claims and for the balance of the claims. And on this separate docket, it would have to be created legislatively, and so there would be a docket order

for the fully developed appeals and a docket order for all the rest.

One of the key things that everyone felt was important was to maintain some balance and equity between the two to make sure that people who have to go through the normal appeals process and who need the normal appeals process have some balance with the new process, and that's the same balancing that goes on with the fully-developed claim program and the express lane at the ROs.

You have to have some balance. General Hickey always references it's like, you know, the express line at the checkout counter. If you go there and you've got a big, you know, checkout cart, and there is only one lane and 25 people stacked up, and there's 25 lanes for the express, you're going to feel pretty bad that you're going through the other lane.

So it seemed to us we would start up again with an aspirational goal of having it balanced four to one. For each fully developed appeal that's done, they would do four normal appeals. So

when it came to the attorneys and the Veteran Law Judges, that's what they would have to do. They would essentially get a work bundle with one fully developed appeal and four of the others, and then they would have to see how well that balanced.

The goal has to be not just to have this be a quicker process, but because it's reducing the burden on both the VBA and the Board, other appeals also have to be going quicker. If they're not, that time is not coming down, then this is not being successful. So that's an important factor.

Again, once it's received at the Board, it goes again to the VSOs for a review. Again, and that, again, the different ones are organized differently. Some may put together their argument in the field and send it together with the package that is filed, but others don't review it--the VSO, the power of attorney holder--until it gets to the Board.

And the VSOs on their part have said we will make sure these are priority cases. We will move these so that we are not holding this up to

keep this process moving quickly.

Following the VSO review, again, it goes to the Board, normal process. They review it the same way they do anything. They make a decision to allow or deny, but there's a change here now, which is the remand, and the remand is one of the biggest issues that the VBA is trying to address this churning, lack of something that comes back and back.

And so after a lot of discussion, what the group felt would be a good solution, and this was particularly a solution between VBA and the Board, but was while you certify that there is no private evidence because that's all that's in your control as an appellant, you don't have the ability to get government records, and the federal records, including Guard and Reserve, are something that still needs to be developed if the Board sees that there's a gap.

So if the Board sees in the record there is some sort of medical records or service records necessary to resolve this issue or Social Security

records or Guard records or whatever they are, they still should be able to get those. That's the same as the fully-developed claims process. And the fully-developed claims, while you say there are no private records, there is still a duty to get those federal records.

But rather than remand it back to the AMC, and then have the AMC take a second review of it independently, we thought it better to keep it at the Board. So collect the records but get it back to the person who is already reviewing the file rather than take it to someone else and have them have to review it from the beginning.

And therefore rather than going back to the AMC, it was decided they could create a Development Unit within the Board which will actually be initially people from the AMC who have been doing this work with the expertise, essentially transferring from where they're working under the AMC to the Board.

MR. AUGUSTINE: Let me just offer a little insight in the problem we ran into here.

Obviously, the BVA did not want remands on this because it slows up the process considerably. So they were saying under the new law they can keep it at the Board and develop it there, and, as Peter said, it goes right back to the same decision-maker.

So I had a broker agreement between the Board of Veterans Appeals and the Veterans--and the VBA to develop, or have this Development Unit. The Board, BVA said, you know, it's better done at the VBA. The VBA says no; it should be done at the Board of Veterans Appeals.

So I had to sit down with General Hickey and Laura Eskenazi, and they came up with an agreement amongst themselves, which I was very pleased to see after that, where the General took people from the AMC that do remands and gave them to the Board to have this separate Development Unit, and that's how it will be set up.

It will stay at the Board. They'll do the development right at the Board. It will go right back to the same decision-maker, thus making it a

much quicker process than remanding it to the AMC or to the Agency of Original Jurisdiction.

We found, the group found that that was an acceptable solution, and thus it's called the development phase now as opposed to a remand phase.

MR. EPLEY: And this group would be developing for federal evidence, including existing exam reports, but is there an option that there would still be a new exam requested?

MR. DICKINSON: Yes. Yes. And the other two main categories would be to get the current exams because that's often typically an issue that the Board is lacking, is a current evaluation or again, for independent medical opinions. So again they've got to balance the medical evidence, and they want to get an independent medical opinion, they can still call for those. So those would be the three categories that they would get.

MR. AUGUSTINE: And let me just add, a veteran can drop out of this process at any time and go into the regular appeal process, but once they do that, they can't go back. It's a one-time

shot for people that believe they have the evidence to win their case, voluntarily participate, and want to go this option after being educated about the process.

MR. DICKINSON: So if you look on this little flow chart, you see this little box that says "bump," that's what Garry is referencing. There's two ways to bump. One is, is after you file your fully developed appeal, if you send in, again, any additional evidence, you are bumped out of the process, and you're put back into the normal appeals process so you still have the full option available to you.

MR. AUGUSTINE: No harm, no foul.

MR. DICKINSON: And the second, as Garry says, is a self bump. At any point you want to that you feel, maybe you feel you need a hearing, and you're sorry you put yourself in here, you pull yourself out, you have the full option to go back into the normal appeals process.

DR. SIMBERKOFF: Got it.

MR. DICKINSON: Again, after the

Development Unit finishes its work, essentially gathers the evidence, it does go back to the VSO and the veteran for their review. It's a due process matter that if there's new evidence going to be considered, you have the ability to look at it, to comment on it, or to submit something else that you think is necessary.

So for whatever reason if the Board's Development Unit finds something, and you look at it and say, well, that doesn't seem right because I have other evidence I could have shown if I'd known this, you're able to submit that back in, and you have 45 days to do that, which is typically what they do now.

Once they've finished that cycle, again, you get your decision to allow or to deny. Again, the key elements that we're looking at in trying to turn this into a proposal is that, again, I mentioned it needs to be a congressionally authorized pilot program. Now, it's possible and the VBA has said if you just give us authorizing legislation to give us the ability to create a

separate docket, we can fill in all the details, and we appreciate that.

But this was, again, there's a lot of different competing interests, and sometimes ours are not the same as the VBA's. Don't laugh out loud, Bob.

[Laughter.]

MR. DICKINSON: So it's important to us that it be congressionally authorized with all of the key elements put into the statute, and that it be a time limited so that it can be course corrected along the way, that there's regular oversight and regular reporting. Those are important elements of law.

MR. EPLEY: For the benefit of the Committee members, am I correct in thinking that none of this affects the veteran's current and ongoing ability to reopen a claim at any time with new and material evidence?

MR. DICKINSON: That's correct.

MR. EPLEY: All right.

MR. DICKINSON: Right. Again, as Garry

has mentioned, again, rather than taking something away to make room for this, this is simply another option. We believe that like with the fully-developed claim program, as you draw more people into this as it works, as it's tweaked and works well, you reduce the workload at VBA. That frees up their resources.

It also frees up for the Board. The Board is very excited about this prospect. The idea of getting an appeal so much more quickly from the time the veteran is filing it makes their life much easier. The size of the claim is in some ways directly proportional to the length of the time that is passed from the claims decision until the time the Board attorney or Veteran Law Judge looks at it.

Saving two to three years shrinks the file down dramatically, makes it much easier for them to go through it. It makes the evidence much fresher. It's not stale. It's possible they may not need to order a new exam. As you can imagine, if your appeal involves an evaluation level, if you've

taken three or four years before a judge has gotten it, the first thing they're going to have to do is say I need a new exam, which starts that whole churning cycle, as Garry has pointed out.

MR. AUGUSTINE: So up front, it can save up to 1,000 days, 900 to 1,000 days going through this process. Now, a big part of it is educating the claimant so that they understand what they're asking for, but I think the success of the FDC program is a good indication that veterans are aware, certain veterans are aware of what they need to do if they want to help their own claim or their own appeal in this case, and that has shown to be the case, and the ones that want to participate, want to get involved and do what's necessary on their own and not leave it to someone else to do it, they find pretty good success.

We think the same can be done in this process, and I just wanted you to know that everyone that was involved, all the VSOs, the VBA, the Board of Veterans Appeals, all gave great input into--as you can see, this is not an easy process

to comprehend or to work out. It was over a number of meetings with experts like Jerry and other people that have worked in the field for many years, and to come to consensus has been what I believe a great process.

MR. DICKINSON: So there's still some more work that we're looking--please.

DR. BROWNE: Whose responsibility is it to educate the veteran on this whole process?

MR. DICKINSON: So I would say it's a shared responsibility. I think there is, in the first instance, an obligation that the program be created in a way that when you are looking to sign this form that you have gotten the best ability to be clearly educated and informed, to make an informed decision.

So you need--that form itself, the creation of that needs to be looked at very carefully to make sure you're making a well-informed decision. It's also extremely important that you understand what the decision was on your original claim. There has been a period where the

VBA had moved to Simplified Notification Letters where they gave very little information.

The stronger that letter is explaining why you weren't granted what you sought, not only will you make a better decision about whether even to file an appeal if they're done very well, but what the best route is.

You may from that letter, the more detail telling you what the gap is between what you sought and what you received, how clear that is is extremely important. The VSOs, for those of us that we represent and for others who are represented through agents or attorneys, there's an obligation on them to educate the veteran about this, and then there's an obligation that still remains with the veteran to read and make a wise decision.

MR. AUGUSTINE: Let me just tell you what we did from the DAV's perspective with the fully-developed claims. We actually had classes in our offices, in many of our offices, and invited veterans who wanted to know more about the fully

developed process to come in and sit through a class so that we could educate them.

But, as Peter said, and I think the other VSOs would agree, it's incumbent upon everyone, including the VA, to fully educate a person so that they know what they're choosing and why. It has to be a process that everybody takes responsibility for, including the claimant, and many claimants, I will tell you, will know their own limitations and will say, no, I can't do that.

Others will say, no, you tell me what I need and I'll go find it. So it's a choice, and we're in a democracy, we all have choices to make everyday, and we believe that this is a way for motivated claimants that want to participate in their own benefit will make a good decision.

MR. DICKINSON: Again, as we said, there's choices to be made. What is the best way? Do you believe that we've got the evidence; taken locally you can resolve this? Or do you feel that this is just something that's not going to be resolved locally; you know you're going to go to the Board;

you want to get there more quickly?

We're still working through details. Again, we're just trying to continue looking. What are potential unintended consequences or things we haven't thought through? As I mentioned, it's important to us that the first step is that claims decision. That sets in motion the whole appeals process. So we're continuing to discuss amongst ourselves and with the VBA how to strengthen those letters.

And as we've talked about, the importance of the DRO program. We in no way want this to appear to be the only quick way to resolve claims. That is an equally important way, and we're going to continue to emphasize that and appreciate this Committee if they would emphasize that.

MR. AUGUSTINE: Just one more point on your point because when I was in the field, we had a special unit in Cleveland called the Tiger Team, and the Tiger Team was for older veterans whose claims had been around for awhile, and they expedited those claims.

And when we used to take those claims up, and they would tell us what they needed to grant it if we were going to get it granted, many times I'd take that back to my claimant, and I'd say, well, you know, you need a doctor's statement here to say this, they would have that back to me the next day because they'd be waiting in the parking lot for that doctor that next morning--

[Laughter.]

MR. AUGUSTINE: --and say this is what I need, very motivated to do it. Not all of them, but many of them, and we would get that claim completed in a matter of days because that veteran participated in getting what was needed to win his claim or her claim.

MR. DICKINSON: So I'll just say again we're looking now to continue to reach out to the stakeholders that have interest or expertise. We're continuing to reach out to Congress. We've consulted with them regularly throughout this process.

As you know, Congress is in a time period

now where they don't make decisions until after the elections because no one knows who's going to be in charge or who's going to work where or who's going to be the chairman, or who's going to be the ranking member.

But we've kept the professional staff and other staffers on the Hill aware of this, their support for this concept, though no commitments of support until they see the details. And our goal is to take this, try to build a final consensus, work out our details for the balance of this year, and then, as a VSO community, bring up a united proposal up to Capitol Hill that has the support of both the VBA and the Board, and we'd certainly welcome the support of this Committee also.

CHAIRMAN SCOTT: Who is actually going to draft the legislation?

MR. DICKINSON: Well, it would be drafted by Congress. I mean they would use the Office of Legislative Counsel, both our--we would be very involved in that process as long as they will let us because we have certain interests. We want to

make sure we're protecting the veterans. That is crucial. But it would be done on the Hill with our input.

CHAIRMAN SCOTT: The reason I ask is that we've had the legislative liaison people from VA come in and talk to us a couple of times, and their track record on getting legislation that they've sent over to the Hill approved is not, not very good. I think there was one out of 13 a couple of years ago and that sort of thing, and so I was kind of wondering do we have a plan here to get this drafted so that all the stakeholders will be supportive and that it would be drafted in such a way that it will probably work its way through the system?

MR. DICKINSON: We think so, and I, before I worked with DAV, I actually worked on the House Veterans Affairs Committee so I'm real familiar with the process, and of course that's what DAV does, what VFW does. We do that on a regular basis, work with the Hill. So it's our view that if we have the DAV and the VFW and we've got the

American Legion and the other VSOs, and the VBA and the Board are in support of our proposal, and we think it's good, we think the Hill would be receptive to it.

MR. AUGUSTINE: But, General, it's just like any other process of getting everybody to agree, I mean you can't just go one party or another. Both sides have to be in agreement with this to make it go forward. So that's what our next step is, to get that agreement. Obviously, the election right now is kind of holding things up until we find out who the players are, but we've already made them aware of this process. They've been involved themselves in adding some tenets of it.

So we do believe that once things settle, this is a thing that doesn't cost any money.

CHAIRMAN SCOTT: Right.

MR. AUGUSTINE: And it's good for veterans, it's good for the VA, but it's not going to resolve the current backlog.

CHAIRMAN SCOTT: No.

DR. SIMBERKOFF: So has there been any thought about, you know, what would happen if Congress passed something that wasn't exactly what you wanted but forced you to do something that was, you know, in other words, be careful what you ask for?

MR. AUGUSTINE: The reason we did this process the way we did is so that we had consensus with all of the stakeholders.

I don't think ramming something down our throats that we're not in agreement with is going to work. I have to tell you the VSOs have been terrific to work with, with their expertise. VBA has been very supportive. Board of Veterans Appeals has been very supportive. All the roadblocks have been worked out, I believe, except for a couple of small details yet.

So I wouldn't, I can't imagine why they would not go along with something that was this collaborative effort by all the major stakeholders and want to change it. But you're right; it could happen.

MR. DICKINSON: But the other part of that is if the program were created in a way that we felt was not advantageous to veterans, you would have the VSOs recommending to their clients not to use this--

MR. AUGUSTINE: Right.

MR. DICKINSON: --this program.

DR. SIMBERKOFF: Okay. Yeah.

MR. DICKINSON: Therefore, it would be pointless to move forward.

DR. SIMBERKOFF: Yeah.

MR. AUGUSTINE: And I can assure you if you ask General Hickey about the success of FDC, it directly related to VSO participation, talking to their folks that get involved with it.

Jerry, did we leave anything out?

MR. MANAR: No, not really. In response to your question earlier about how is this going-- how the public, how the veterans are going to be educated in this process, the VA doesn't really have any kind of budget for advertising, and really this is, when you consider 11 or 12 percent of

veterans with decisions appeal in the first place, we're really looking at a small subset of veterans and other claimants.

So I think what would happen is the same thing that's happened with the fully-developed claim. We, of course, would brief our clients on this is an opportunity or a possibility depending on the nature of their claim. The VA would, as there is success at the Board of Veterans Appeals in moving these appeals more quickly, much more quickly. The VBA would, I'm sure, ensure that the various VA Web sites, as they're doing with fully-developed claims, they would start pushing fully-developed appeals.

Personally I'm a little distressed. I think 40 percent is probably too high for fully-developed claims. People are trading fast decisions for decisions which may be beneficial to them or more beneficial than what they're getting.

But be that as it may, as this is rolled out, as it is successful for an ever-growing number of veterans and other claimants, VBA and VA, in

general, would start pushing this. We would see it grow--I don't think it would get anywhere near the fully-developed claim numbers, but even at ten percent, it's a huge chunk out of the VBA workload. It's an even bigger effect on the Board of Veterans Appeals in terms of their ability to process claims more quickly.

There is, under the pilot, there is the upper limit. They can't--they would not be allowed to do any more than one for every four so that's a governor on the whole process, but be that as it may, I think even at ten percent, it would free up significant resources at VBA and certainly vastly improve the experience for many veterans and other claimants.

MR. EPLEY: A comment on the likelihood of success. My experience was when you put together groups to collaborate on the proposal, as you have done, the likelihood of success with the Congress and the staff there goes way up, but it's the right way.

MR. AUGUSTINE: It's just timing right now

is different, but we hope that will resolve here in the next--

MR. DICKINSON: Yeah. What we tried to do is let the Congress know we're going to clear all the minefields for you. There will be no surprises as we move forward in this. Hopefully we can clear them up.

MR. AUGUSTINE: Your support, of course, would carry a lot of weight.

CHAIRMAN SCOTT: Well, we're planning on supporting it. John, whom you may know, is going to help us draft an issue in such a way that it's clear we're supporting it. We're also going to go--I just made a note. We're going to go back and revisit the DRO thing again.

MR. AUGUSTINE: Good.

CHAIRMAN SCOTT: And so we're very supportive of the whole thing, and, you know, I think it's been hit on several times, but what generally kills proposed legislation is one or more of the stakeholders being an outlier and just saying I cannot support that, I will not support

that, and not only that, I'm going to make this very difficult for you if you do, if you do submit that legislation. And so if we can get all that out ahead of time, it might go right through.

MR. AUGUSTINE: That was the reason we tried to get consensus.

CHAIRMAN SCOTT: Well, you know, one of the things I've figured out after doing this for awhile is that the VA has not always done a particularly good job with coordinating their proposed legislation before they drop it in the box over there. So maybe in this case, you're helping them to do their job here in such a way that everybody has got a piece of the action in that the outliers have all been brought on board.

MR. AUGUSTINE: We're hoping so.

CHAIRMAN SCOTT: We hope so, too.

MR. AUGUSTINE: There is a lot of anticipation and excitement in the VA about this proposal. We think that they are looking forward to getting a tool like this to use for the future, and, quite frankly, for the FDC, when it first came

out, they thought if they got to 15 percent, they would be successful, and it exceeded that considerably.

CHAIRMAN SCOTT: Okay. Questions or comments from the Committee members?

DR. SIMBERKOFF: It sounds good.

MR. AUGUSTINE: Thank you.

CHAIRMAN SCOTT: Go ahead. Anybody from outside the Committee welcome to comment. Go ahead.

MR. WILBURN: A couple of comments. A couple of questions. You mentioned a prototype would be necessary, but could you describe what your discussions have had so far, the structure, the nature, the scope of a prototype, and also how it would be evaluated and what design you were thinking of?

MR. DICKINSON: So the pilot program, we've talked generally it would be a national pilot. We wouldn't limit it, in our view, to any region. That wouldn't make sense so it would be time limited is one of the key elements. It's not

a permanently created program.

As you mentioned, the two things. One is the reporting is very important to try to track this in as many ways as possible, not just outcomes, not just time either, but to look at the various steps.

And the measurement is going to be one, first, are they getting the decisions right, to make sure there's absolutely no decline in quality of accuracy of what the decisions are?

And then as I mentioned before, does this, in fact, become a program that speeds it up enough for the veteran to make it attractive, and does it also, though, reduce the workload on both VBA and the Board to ensure that they are seeing the benefit for everyone in the system?

I mean this theoretically frees up the resources in the RO that it can have an effect even on claims work. I mean this--to some degree. So those issues, you know, we may look at, we talked about maybe looking at how this Development Unit is working at the Board. Maybe that's an area. But

those are to be discussed a little bit further, and, Ray, if you had any thoughts, we'd welcome those at any point.

CHAIRMAN SCOTT: Other comments or questions from anyone? Okay. Well, that was very useful and very helpful, and you certainly I think have our support in doing all that we can to help you get it forward. It's pretty hard to be against this. I mean, you know, I don't know where you start on being against improving the appeals process.

MR. DICKINSON: Never underestimate the illogic of Congress, but--

[Laughter.]

CHAIRMAN SCOTT: Well, I have learned not to do that.

MR. DICKINSON: We think we've got it covered.

DR. SIMBERKOFF: That's absolutely true.

MR. AUGUSTINE: We've worked hard to get to a point where people would be supportive. It didn't start that way, I can assure you, but it's

come a long way with a lot of help and a lot of hard work by a lot of stakeholders.

CHAIRMAN SCOTT: Well, you have to assume that all the stakeholders really want the same thing. It's just a matter of how you get there, and I think you've done a great job in terms of bringing everybody on board, and we're fully supportive, and assuming our report gets forwarded to Congress in a timely way, well, maybe it will add some weight, and if I am called on to testify anywhere along the way, I'll be sure to put that in whether they ask for it or not.

MR. AUGUSTINE: Very good. Thank you.

CHAIRMAN SCOTT: Thank you.

MR. AUGUSTINE: Appreciate it.

MR. DICKINSON: Thank you.

CHAIRMAN SCOTT: Well done.

MR. EPLEY: Good job.

[Applause.]

CHAIRMAN SCOTT: Okay. Our next briefing is Current Status of the VASRD Update Plan at 10:30. We might start five minutes early or

something, but we're just going to take a break now until the next event. So be back in here ready to go at 10:25, please.

[Whereupon, a short break was taken.]

CHAIRMAN SCOTT: I think we're probably ready to start up, and as kind of a cheerleader introduction here, I think we all know that there's two parts to the updating the VASRD. There's the body systems medical part of it, and then there is the regulatory side of it and all that, and so Mr. Mandle has agreed to come and talk to us here today, and he's going to focus on the regulations project and how that's going. So whenever you're ready.

MR. MANDLE: Good morning, everybody. My name is Eric Mandle. I'm a consultant on the Policy Staff. For the past year-and-a-half, my main assignment has been working with the physicians on the VASRD Update Project. Hopefully, here I can give you kind of a brief overview for those of you who haven't been through one of those presentations before as well as provide a current

status of the regulations and where we're headed.

Briefly, our staff consists of four Medical Officers. Dr. Gary Reynolds. He has been working on the Musculoskeletal System, Skin, and then Respiratory, ENT and Audiology, which have been combined into one regulation for technical purposes.

Dr. Jerry Hersh has been working on the Cardiovascular System, Genitourinary, and Infectious Diseases.

Dr. Ioulia Vvedenskaya has been working on the Gynecological and Breast regulations, Oral and Dental, and the Mental Disorders.

And then Dr. Nick Olmos-Lau has been working on Neurological/Convulsive, Digestive, Eyes, Hemic and Lymphatic, and the Endocrine systems.

So in addition to the work that they perform, myself, Jonathan Hughes, and Gillon Marchetti have been serving as the main legal consultants for them, helping them with technical aspects of regulation writing, policy

considerations, providing our background with rating cases as well, just to help them through bridging the gap between medicine and into the regulation process itself.

And in addition to our Chief, Brian Lawrence, we also have another Chief of our Regulation Staff, Stephanie Li, who has been providing us with her expertise as well. She has a background working with BVA so she can kind of give us a view of regulations looking back from court cases as well.

A brief overview of our update projects. In 2003, GAO identified challenges that we face in keeping our disability evaluations current. Obviously, since the initial publication of the Rating Schedule, there have been several advances in medicine, technology and the labor market itself.

We also have some earnings loss studies that were focused on our Disability Compensation Program: one in 2007 from the Center for Naval Analysis; one in 2008 from Economic Systems,

Incorporated. And they took looks at the entire Rating Schedule. They looked for parity in terms of specific disabilities, specific body systems, and veteran cohorts by age, by age they entered service, all different kinds of areas, to see whether or not the current compensation system provides adequate monetary compensation for them in terms of the economic earning loss that is due to their disability.

So, in 2009, with all this data in hand, the Under Secretary initiated our revision of the VASRD itself with the goal to revise and update every body system within the Rating Schedule to present as modern of a system as we can based on medicine, technology, and again changes in the labor market and our economic data.

Our Project Management Plan itself proposes a review of each system. At least the initial review will be complete by December 2016. So again that goal is to have the final regulation for each body system published in the Federal Register by the end of 2016.

Following that publication, we'll go ahead and enter a staggered review cycle of each system. The goal is to make sure that nothing has gone more than a total of ten years without a comprehensive review, making sure that we're updating as the updates become available rather than trying to tackle an entire system at a time.

So whether it means we can in ten years review it and say we need to update two diagnostic codes, we need to add one disability or we need to completely revise how we approach this body system, the goal is to make sure we're staying on top of it and ahead of the game rather than trying to play catch-up.

And ultimately our goal is to make sure we're providing the most accurate and fair benefits to veterans based on their disabilities and the impact on their earnings loss.

Yes, sir.

MR. MAKI: I think it was our last meeting, Dr. Lau indicated that maybe the first proposed rules would be published early next year?

MR. MANDLE: Right now we are looking to get some proposed rules published early to mid-next year based on how they're going in the concurrence process right now.

MR. MAKI: If one or two of those does get a proposed rule published, would that be sort of the start of the cycle then?

MR. MANDLE: As far as the review cycle?

MR. MAKI: Well, for the ten-year thing.

MR. MANDLE: Oh, no. The ten-year review cycle is basically a complete new review of the body system so we're taking whatever the current regulation is after we've got a final rule and then constantly monitoring medical data, trends and errors, anything we can, to make sure that we're keeping that as up-to-date and user friendly for the field.

MR. MAKI: Okay.

DR. SIMBERKOFF: But, you know, if, for example, you have the Infectious Disease rule published in March and, you know, effective whenever, wouldn't the ten years start the clock

for that rule, start at that point?

MR. MANDLE: Once we have a final publication, yes, because we still, after the proposed rule, we still have to respond to comments, make any necessary changes, and hopefully not have to repropose the rule based on the changes that are made. So until that point, we're still working within the initial proposed rule.

MR. MAKI: Is the plan then to publish all of the proposed rules first and then publish one final rule once all the comments are in?

MR. MANDLE: Each body system with few exceptions will be proposed as--will be its own proposed rule. So, for example, the Cardiovascular System is a proposed rule. Infectious Disease is its own proposed rule. So once each of those goes final, then we go ahead and start the review process over.

For purposes of rulemaking, it tends to be--it allows us to focus on a single body system a little bit more in-depth by using those separately in rulemaking, and it also presents fewer

roadblocks from the final publication because we're only looking at was everything done properly for Cardiovascular, for this system, rather than trying to rewrite the whole Rating Schedule at once.

MR. MAKI: Okay.

MR. MANDLE: Thank you.

So as a part of our review, the physicians went ahead and reviewed all the 15 body systems. The main goals with--you know, certain systems have more specific information available to them. We want to add medical conditions that weren't previously covered. So whether it's something that we're seeing higher trends in the veteran population or we have additional regulations, for example, to add conditions that are presumptive for Gulf War veterans, we need to make sure that those are covered in the Rating Schedule so we can track that data properly.

We also look to revise the evaluation criteria for individual disabilities according to medical advances. So whether that was new approaches to treatment or new treatments available

that either minimize the disability or might create secondary concerns for different diagnoses related to that disability, we wanted to make sure we can incorporate that.

We also want to clarify the existing criteria so if it was up to date medically we wanted to review error trends, training trends for the users in the field, to make sure that the information that's there can be used in a consistent way. So if someone can pick up the case here in D.C., send it over to Iowa, over to Seattle, everybody can look at the same disability, the same information and the same regulation and apply it consistently across the board.

Yes, sir?

DR. SMITH: What's being done then? You know, this is an issue that we've struggled with, I think, for years, which is that, you know, fundamentally the system is supposed to make up for lost earnings, not for being sick, and yet the process is all about levels of medical illness, including in this case, I mean psychological and

medical.

And so then that leads you to the process of doing, the burden of doing some kind of crosswalk between recognizable levels of medical illness and medical treatment, on one hand, which is not what the benefit is about, over to earnings loss, which is what it is about and the only thing it's about according to the law.

It's not recompense for being sick. It's making up for lost earnings, and I'm sort of curious what's, you know, in your review, how are they approaching that? When they get to the point of saying, okay, we've now sort of caught up the terminology so that it's current medical, you know, current medical terminology and reflects current treatment, how do they crosswalk that over to ten percent, 20 percent, 50 percent, 70 percent, 100 percent?

MR. MANDLE: That's been one of the challenges, is, like you said, bridging that gap between, well, you have a diagnosis, but what does that actually mean in terms of your earnings loss?

And so we've been trying to incorporate as much as possible the earnings loss studies that we have that show--it doesn't necessarily correlate a specific disability level to a dollar amount of a percentage amount, but it does say that, for example, just hypothetically, like a knee disability rated at 20 percent, they looked at--in the past, they looked at trends in the job field as well as economic loss due to that disability on average, and they said is what you're providing now on parity with what they should be receiving? Is it less? Is it more? So we're using that as our reasons for updating as much as possible.

DR. SMITH: I'm sorry. What do you mean by "should be receiving"?

MR. MANDLE: In terms of the eco--the earnings loss so it will say the compensation we currently provide does make up for the earnings loss due to that disability, does not make up for it, or it overcompensates?

Again, these are just hypotheticals. For example, both systems identified very strongly that

the mental health evaluation system we have currently underevaluates veterans for their earnings loss, especially as you trend into more severe mental disabilities.

DR. SMITH: At the same time, as I understand it--and since we have someone from CNA here, if I'm wrong, perhaps he can correct me--the way they did was--those studies--was to say let's say you have a 70 percent rating, what's your earnings loss, and would 70 percent make up that gap?

The thing is that takes for granted whatever is the connection between the medical description and 70 percent. So now you're changing the medical description. I mean maybe not a lot in some body systems, but--and so those old studies were based not on medical descriptions but on did the percentage, was the percentage accurate?

Isn't that right?

DR. SIMBERKOFF: No.

MR. WILBURN: Yes, sir--

DR. SIMBERKOFF: It's the medical

descriptions and the medical treatments have changed dramatically so the treatment for many of the disabilities, you know, conditions that patients have had, has rendered them in some instances completely fit, in many instances not at all fit.

DR. SMITH: Right. This is sort of my point. Thank you.

DR. SIMBERKOFF: Yes.

DR. SMITH: Which is that I think what needs to happen then is another study that takes the, you know, in fact there are even two kinds-- first of all, of course, it's always true that as time passes, the labor market changes, and the relationship between disability and earnings will change. That's always true.

But now maybe with these new things, what I would like to see is a study that actually relates their sickness level to their earnings loss, not--because that's a different question from what these studies asked before, which was given that you have an "x" percent rating, does that

rating make up your income regardless of what medical conditions led you to have that "x" percent rating?

MR. MANDLE: Just to make sure I'm clear, rather than saying your percentage that VA has assigned, let's take all your symptoms or the actual, like mental, for example, you know, take the examination that we do, and before we assign a percentage, say this is what the earnings loss could be expected for that?

DR. SMITH: That's what would make sense to me; what do you think--I'm not sure they'll ever do it, but this is what would make logical sense to me.

DR. SAVOCA: But that would get--you basically want to get rid of the Schedule, the Rating Schedule?

DR. SIMBERKOFF: No.

DR. SMITH: No, no. It would be calibrating the Schedule.

DR. SIMBERKOFF: It wouldn't.

DR. SAVOCA: Oh, a way to calibrate. Oh,

yeah, I guess I would agree with that because you're going to be continually in this cycle where you change the Rating Schedule without regard to changes in earnings losses, earnings losses, and then you have to reevaluate the earnings loss. So if you incorporate it at the time.

MR. MANDLE: One approach we're taking to the future reviews is we're looking at getting specific earnings loss studies, not just saying look at our Rating Schedule. We want to approach specific disabilities and specific body systems so we can nail down deeper on that rather than getting a general overview.

Yes, sir.

DR. SAVOCA: And that wouldn't--

MR. WILBURN: I would disagree with that in the sense that--

CHAIRMAN SCOTT: Come up to a mic here, please, where you can talk into it, please.

MR. WILBURN: The only way that I know to do is to have a very large sample of, representative sample of non-service-connected

veterans, veterans with no service-connected disability.

DR. SAVOCA: That's right.

MR. WILBURN: And then compare them, their earnings, to the disabled, and because most veterans have more than one disability, and they would fall under various body systems, I can't conceive of a way that you could do it by body system. Your sample of non-service-connected veterans wouldn't be related to any body system because they don't have any disabilities, they don't have any service-connected disabilities.

So I don't know, once you run the data, I don't know of any practical way to look at one body system at a time. I mean you can analyze the data individually, but you pull the data at one time.

MR. MANDLE: Okay. So it would just kind of basically exist in a vacuum based on the question you're asking rather than--

DR. SMITH: Yeah, I mean you could still then try to do what Ray--he's saying you can't do it body system by body system, but that doesn't

mean you couldn't do a larger one.

MR. WILBURN: Right. And then analyze it by body system.

DR. SMITH: The scope would be huge, and it would be a tricky study, but, hey, that's what consultants do.

MR. WILBURN: Well, in the two previous studies, we had approximately 500,000 in the non-service-connected representative sample, and it was drawn based on age. It was drawn based on education level, et cetera. There's more that could be done with that by pulling it from DoD studies and DoD data.

But it was a large sample of non-service-connected veterans to compare with the 2.8--what is it--how many people are drawing disability comp now? 2.8 million?

MR. MANDLE: I don't know the number off the top of my head.

CHAIRMAN SCOTT: Something like that.

DR. SAVOCA: Can I ask you something?

MR. WILBURN: Sure.

CHAIRMAN SCOTT: For those of you that don't know Ray, he was involved in both studies from sort of a kind of helping set up the parameters of the CNA study and from working directly for the contractor who did the EconSystems study.

So he's probably more knowledgeable about how the two previous earnings loss studies were conducted than anybody around so that's why I asked him to sit at the table here while this discussion is going on so that he could respond to your questions or comments or what's gone before or the problems, pitfalls and difficulties with certain approaches to this, and I thought he would have said it by now, but the Social Security Administration and the IRS are very privacy oriented on individual data.

So if you're going to do this, you basically have to get an agreement from them on aggregation and privacy both. So it makes it hard to design, you know, what you might call the perfect study which lets you analyze in tremendous

detail the individual and aggregate disabilities of individuals.

So, and also the income data is imperfect whether for veterans or for the control population or the general public.

So I know you two health economists know this, but for everybody else's benefit, this is pretty complex to set one of these up where you get, you can only get so far down in the data as headed from the entire population to individual because of restrictions, and they are certainly understandable.

And then you can also go only in one direction, and that is the law says that the compensation is for average earnings loss. So once you get off of average earnings loss and start talking about quality of life, et cetera, et cetera, then you're not, it's very difficult, and we all know that SMC is one of the things that makes up for a serious quality of life issue that's associated with a series of disabilities.

But really you can't even say that because

the law says average earnings loss, and nobody is going to propose, and the Congress is not going to accept, anything going to trying to individualize the earnings loss. It has to be averaged in some way and, because apparently in years past, attempts were made for brief periods of time to do it on an individual basis, and it was just, it was so complex and so bureaucratic, and there was so much data, that they went back to average earnings loss when--in the '30s or '40s, or something they went back to it. Sometime--

MR. WILBURN: The '30s, I think.

CHAIRMAN SCOTT: The '30s they went back to it. They couldn't handle it. So Ray is a pretty good, pretty good source of information here on what's gone before and what the parameters were, and why those parameters were put in place by those two studies. My own view from having looked at both studies and been involved to some extent in setting them up is that both of them were pretty good studies.

One of the interesting things is that

there were some differences in approach, but they basically came up with pretty much the same conclusions, and I was, to be quite frank, beyond surprised that the conclusions came up about the same, such as those individuals, veterans with a mental disability suffered (a) a much greater quality of life based on quality on life survey; and they were significantly undercompensated on average earnings loss, and both studies from different directions came up with that conclusion.

Then there were some others that were not quite as dramatic as that. One of them was, and correct me if I'm wrong here, Ray, that a young veteran, seriously disabled, entering the system was probably short-changed over the, if you think about what his career might have been, over time as opposed to the older veteran who became seriously disabled who entered into the system at say age 50 or something who arguably was overcompensated for the rest of his useful work life.

But, you know, those, I considered both of those two observations to be interesting. I would

probably need to go back and look at how we think about the young veterans coming in with serious disabilities to be sure they're not disadvantaged, but, you know, the themes of those two studies were in a way quite similar, which leads me to believe that another study using whatever level down you can get in data and ever what sort of parameters you want to put on there as long as you don't go really wild in terms of a control population of veterans and all that, it's probably going to come out not too far off of that.

The difference will be, may well be what's the difference in the control population's income and all that as opposed to veterans because we know what the disability compensation rates have been, and they've increased slightly over the years and all that.

But we did recommend in the last report-- some of you may remember--that the VA consider doing another economic analysis. Basically I think the way we phrased it was you're going to either have to agree to accept the data available from the

EconSystems and CNA studies or you're going to have to do another one, and I think we're probably going to have to revisit that this time again in some way.

But that's just a little history. Ray, what did I leave out of that?

MR. WILBURN: Oh, I don't know, sir.

CHAIRMAN SCOTT: Yeah, you do.

MR. WILBURN: I would say the latter part is, and at the risk of sounding like all I'm trying to do is drum up business, but honestly we would love to do another study. CNA would love to do it. But the data from the previous Economic Systems study, the earnings information is from 2006. There's always going to be approximately a two-year delay because of how you file your claims and your income taxes and how that information is transposed from IRS to Social Security, et cetera.

But this, you know, the data is too old now. So much has changed, particularly in the economy in the last few years, that I think trying to just rely on that data. However, I think the

data that was done still has some strong clues that could be implemented, and I'm not sure how they are.

For example, our data showed that people rated ten percent, 20 percent, or 30 percent had no measurable loss of earning capacity. There was a whole list of individual diagnoses such as tinnitus is one that had no--tinnitus is only rated at ten percent still I think--but it had no loss of earning capacity. So there's a group of things like that.

The other thing is that what we found was that the formula that's used to do what's called a combined degree of disability results in people being rated too high. And I think the data on that was very clear, and that could be, I mean that formula could be adjusted and end up with a better outcome.

But I think all the indications are that there are many different diagnoses that would not, strictly speaking form a scientific earnings loss standpoint, they would not be rated at any rate.

And that goes back to what you say. Something happened to someone, but it doesn't currently impede their ability to earn a living, and of course that's very controversial to say the least.

CHAIRMAN SCOTT: Well, we make it a point not to discuss individual contractors or contracting because of our charter, but there are certainly plenty of entities with experience in this that could be, that should VA decide to offer an opportunity, that would be invited to participate in it. But--

MR. WILBURN: One other thing I might mention, sir, is that about four years ago, we had an agreement with Social Security to do a study of the impact of vocational rehabilitation and whether it helped veterans become employed and earn livings and everything.

Social Security at that time was willing to do the match just like we would do for a disability compensation because everybody to be eligible for voc rehab has to have a service-connected disability. But the data match would be

done using the same roughly 500,000 non-service-connected sample. Social Security would keep the data, would not share it. We would turn around and write the programs to do the analysis, and they would give us the results, and it could be an iterative process of doing that kind of work.

Social Security, as I say, was willing to do that then. I'm not sure that they would be now.

DR. SAVOCA: Why not?

MR. WILBURN: Well, workload perhaps.

DR. SAVOCA: Oh.

MR. WILBURN: Perhaps they've had a change of senior researchers at Social Security. They saw a lot of value in terms of the linkage with Supplemental Security Income and SSDI with voc rehab, and so they had their own reasons for wanting to do that kind of analysis.

DR. SAVOCA: I just want to say I think it's worth it because there's two streams of literature in labor economics. One is talking about how long-term--spells of long-term unemployment cause you to have like a permanently

lower earnings trajectory for the rest of your career.

MR. WILBURN: Uh-huh.

DR. SAVOCA: And the second stream is that there's analysis of young veterans, and during the financial crisis, their unemployment rate rose much higher than the non-veteran cohort. So I think there's some big structural changes in the labor market that probably should be recognized--

MR. WILBURN: Right.

DR. SAVOCA: --in a more recent evaluation.

CHAIRMAN SCOTT: Okay. Well, we co-opted your program here so back to your slides here, Mr. Mandle.

MR. MANDLE: Well, so after we go ahead and review our systems, another part of the process in addition to just the regulations is coordinating with all the other aspects of VBA claims processing that it may impact.

For example, our Disability Benefits Questionnaires, which are examinations that we use

to examine a veteran for that medical disability in accordance with our Rating Schedule, those will be updated where necessary so we can deploy those as close as possible in time to make sure there is no gap in how we're evaluating a disability and the evidence we expect to gather for that process.

Any kind of policy or procedural changes, for example, to the computer systems that are used to rate cases, we make sure that the text that's used in there is up to date. We preserve the historic text for any ratings that are protected under our provisions of law, anything that may require an historical look at it, just to make sure that, again, we've got these regulations out, but we need to make sure that everything we have is set up and designed to use those systems as soon as possible.

And again these are all dependent on the specifics of each regulation so one regulation may require more in terms of training because it's a vast change in what we've done. Some of them may require more on the technical side just to make

sure that everything is up to date on our computer systems.

Each body system review has three basic stages: the working group phase, which is basically our research and analysis of the system; a development phase--that's where the bulk of the regulation is drafted; and then the concurrence phase where we send it out of our office and to the rest of VBA, VHA, and then VA in general, as well as the Office of Management and Budget.

The working groups started with a public forum. These were held a few years ago. They involved members of the public, physicians, and basically we were seeking input, whether it's from the medical standpoint, experience with claims, and veterans representatives, just to get an idea of what the public view is on these and any kind of outside ideas we can hopefully incorporate into our systems.

And then working groups themselves were formed. They included VA physicians, VHA physicians, VBA medical officers, attorneys, rating

specialists, members of the public, private physicians, subject matter experts, as well as VSOs were later added to working groups as well, to kind of give us a sense of what they're hearing in terms of feedback, what's their experience with the claims process as well.

Moving on from the working groups, they generally met about 20 to 30 times by teleconference and a few times face-to-face, and again this was to discuss anything from the medical changes necessary to going through as a group what the proposed changes might do, what impact they might have, and then bouncing it off of representatives from VBA and attorneys to see is this the best way to approach this from a legal standpoint?

Is there another way we can incorporate this medical update and this evaluation criteria in a way that is consistent with the jurisprudence that we have so far for veterans' case work?

And the drafting stage. The medical officers went ahead and drafted initially a medical

justification for each recommended systems change. They started out basically by saying here's a mock-up of what my proposed regulation would look like. This is if all changes were accepted as written what it would like in the Federal Register and in the Rating Schedule.

We highlighted any changes, and we went through and made sure we had necessary justification for them, whether it was legal or medical or both, and we went through and then kind of reverse engineered the regulation itself. So we wrote the preamble, which is the text in front of the regulation itself that explains this is what the old regulation is, this is why we need to change it, this is how we're making the change, this is how it's going to work.

We tried to take a very systematic approach with that to make sure that each regulation can be read by members of the public and they see step by step the thought process for us. So, again, it's we're identifying the problem, here's our solution, and here's how it's--this is

why it's the best solution.

In some cases, we are also including these are the alternative criteria we considered, but in the end we went with something else, and this is why it's the best change.

The development phase also included what we call a Big Bang session, and that's where we met with the Chief of the Regulations Staff and attorneys to go through each draft before we sent into concurrence. Again, we wanted to make sure that we had as many eyes as possible on it before we send it out so we can anticipate any potential changes that need to be made and go ahead and get those done.

Once drafted, these regulations were sent up through our concurrence process for feedback from other staffs in the agency. So the concurrence process starts in VBA itself. It goes up through our Office of Disability Assistance. They review it. Again, they're looking at kind of policy issues, making sure it's consistent with where the agency is heading as well as other

business lines in the agency, and from there, it's filtered through VBA and then over to either our Office of General Counsel where the Regulations Staff there take a look at everything.

They want to make sure it's technically sufficient. We also do a legal review on it. We get questions about, you know, did you consider this; what about this? They want to make sure we're not inviting any lawsuits based on these regulations.

VHA also takes a look at it. They have specialists in each field look at these regulations so whether it's someone who specializes in renal issues, they're going to take a look at the regulations that deal with kidneys, and that goes through. They give us feedback saying, you know, you might want to consider this article based on, you know, research that shows this approach to evaluating kidney disease might be a little bit better and we see if we can incorporate that in.

DR. SMITH: Shouldn't that have been brought in early on though?

MR. MANDLE: It's brought in as a part, but the process itself is very lengthy so it's making sure we're able to incorporate it as much as possible, and then you have to remember it's gone, it starts with the medical side, and then we go into the policy and legal side, and we want to make sure it's still coming out with the same read on the other end. So from a medical standpoint, did we the consultants basically take away the meaning from the medical evaluation of this disability? So it's getting a double and triple check on everything.

Again, we have to receive approval at each level before it can move into the next stage of the concurrence process, and we have two full cycles of concurrence. Again, that's to make sure that any changes that are made are again reviewed, and we can still maintain concurrence on that draft from both VBA, VHA, and then the VA in general.

DR. SMITH: What does OMB look at?

MR. MANDLE: Office of Management and Budget, they take a look at regulations. They want

to know what the impact is going to be economically. With each regulation we prepare what's called an impact analysis so we try to anticipate how many additional claims might we receive based on this regulation change; how will it change evaluations of people coming into the system? Will it result in increased spending, decreased spending, that sort of thing?

So again it's all based on estimates, our best guess at that point, but we look at how many people are currently evaluated, how many people filed claims for discrimination last year, how many for increase, and so forth.

DR. SMITH: And are they in a position to say no, or they're just interested?

MR. MANDLE: OMB is in a position to say no. They can pass our regulation back to us, and we have to answer any questions they have, comments on it, make sure it's drafted to their standards, and it meets their goals as well. But hypothetically, yes, they can say no, and that effectively kills our regulation.

MR. EPLEY: And they do.

DR. SIMBERKOFF: You obviously haven't worked for the government recently.

MR. EPLEY: Yeah.

[Laughter.]

DR. SMITH: I'm aware of their meddling and surveying--

DR. SIMBERKOFF: Yeah.

DR. SMITH: --but--

MR. EPLEY: They take liberties. They go beyond what you just described as their part.

DR. SIMBERKOFF: Yeah.

MR. EPLEY: And they edit for "clarity."

MR. MANDLE: Sometimes it's "I think it should be worded this way." It could be an actual economic interest in it or it could be can you just explain to me and provide clarity, as you said?

MR. EPLEY: Yeah.

MR. MANDLE: In a nice way. But they want to make sure that they understand the regulation, and while they do have agency specific desk officers, there's still a certain level of

familiarity with the process. They need to know how this is going to affect claims processing. So-

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DR. SMITH: Okay.

MR. MANDLE: The next slide is just a visualization of the cycle for review. So, again, we start with the drafting. We go through all of our review stages. Concurrence, and then publication.

Current status of our regulations. There are no body systems that are in the working group phase. All of them have moved beyond that phase. Currently, the only regulation in the development phase is the mental disorders, and that's being drafted right now. As was mentioned, that one we had clear data from all of our earnings loss studies saying that we needed to make some adjustments to the levels of compensation on that.

And medically that was the most out of date in terms of how mental disabilities are evaluated from a medical standpoint because currently it's a list of symptoms basically at each

level, and so we needed to reevaluate that one, and then with the recent release of the DSM-5 as well, we need to make sure that we're adequately covering disabilities we're considering changes in diagnostic procedures as well.

And then without going through the entire list, every other regulation so far is in the concurrent phase. They're all at different steps in the concurrence phase. But they've all been moved beyond the initial drafting, and we're having other sections of the agency look at them and provide feedback.

DR. SMITH: How long is that taking or does it vary so much that you can't come up with a good average?

MR. MANDLE: Yeah, I couldn't honestly give you even an average. Some of them move much quicker because the regulations are either noncontroversial or they're smaller body systems. For example, Dental/Oral, it's a smaller body system. The changes in there don't have a greater economic impact so that one moved through

concurrence quicker than--mental is going to take the longest.

Then again it depends on is there a specific regulation or a specific diagnostic they want to dive down into and get more information on. So some of them, depending on which office it comes out of, could take a year, some could take a year and a half, some could take six months. So--

DR. SMITH: Looking ahead after the rule is proposed, and there's public comment. You know with mental there will be a lot of comments.

MR. MANDLE: Uh-huh.

DR. SMITH: Then what will the timeline be?

MR. MANDLE: Officially we have, you know, there's I think a 60-day comment period, and then we have--we want to respond to those as soon as possible at the close of that. Depending on the comments we receive, we may have to make changes to the rules. I'm assuming there's going to be minor edits made to each rule just based on public feedback that can always shine a brighter light on

things that we could do a little bit better on.

But the goal, again, is probably 120 days from the time we publish the proposed rule, but again that depends on what we receive and--

DR. SMITH: So it doesn't have to go back through two full rounds of concurrence after those changes?

MR. MANDLE: Those will go through concurrence again, but they'll be pushed through a little bit quicker than these because they've already had eyes on it.

Did you have a question?

DR. SIMBERKOFF: No.

MR. MANDLE: Okay. Again, our goal is to have all of our final rules published by the end of 2016. The timelines, as we just said, depend on what the regulation is, when it's going to be published as a proposed rule, and the public feedback.

Right now we anticipate that a few of our current drafts that are in concurrence will be undergoing a more comprehensive revision based on

feedback, whether it was for policy considerations or medical issues, and those, as listed, are the digestive, neurological, musculoskeletal, infectious disease, respiratory ENT, which includes audiology, and cardiovascular.

And in the meantime, we're also looking at additional Part 4 regulations. As was mentioned in the introduction, our Rating Schedule has two parts: one is the major medical component, and the other one is what we kind of casually refer to as rating policy so whether it's just general statements of consideration of evidence or, as was mentioned earlier, how we combine disabilities to get an overall evaluation. We're reviewing those, too, to make sure that any updates are made, any clarification that we can, based on issues we see in the field with rating and error trends.

MR. EPLEY: Question.

MR. MANDLE: Yes, sir.

MR. EPLEY: You mentioned earlier in your presentation that there are supplemental things that need to be done. You need to make changes to

procedures and the exam forms and things like that. Is there a designated time in the process that you turn a draft over to these other teams to do the supplemental work or is it wait until it's absolutely final published?

MR. MANDLE: It's before we do the final publication, but it's after, it's after the proposed publication. We get our public comments in, and we need to get a clear idea of what the final rule is going to look like. So once we have addressed those comments, made any changes necessary, and are preparing for final publication, that's when we incorporate them.

We keep the other staffs abreast of what's going on, but again we can't make any final manual policy changes until we know for sure--

MR. EPLEY: So they know it's coming, and they've got people designated to handle given body systems.

MR. MANDLE: Uh-huh.

MR. EPLEY: Okay.

MR. MANDLE: And depending on which body

system it is, it might require a work group where we have representatives from each affected staff. Some of them it could be as simple as sending it out. When they tell us what they need from us, we plug in the information and the words and make changes that way. So, again, it's rule specific.

MR. MANAR: Sir, if I might?

CHAIRMAN SCOTT: Jerry, do you mind getting a little closer to one of the mics here?

MR. MANAR: Oh, sure. Sorry. The last bullet talks about changes to other sections of Part 4. As I'm sure you all know at this point, there's a whole series of regulations before you get to the actual Rating Schedule, many of which explain things that are necessary in applying the rest of the Rating Schedule.

My question with regards to that is are the changes to those kinds of regulations being driven by the changes in the Rating Schedule itself or are some of them changes in the introductory Part 4 Regulations more gratuitous?

MR. MANDLE: It's a combination of both.

Where necessary based on our proposed regulations and where we're headed, some of the--any rating policy regulations of non-medical ones that need to be changed to reflect the updates that we're making, those changes are being made.

The rest of them, it's simply let's get a nod and make sure everything is up to date, and it doesn't necessarily change per the medical advances or economic data, but we're still making sure it's clear.

Some of them haven't been touched since the Rating Schedule was published so we need to make sure that users in the field aren't coming across when they look at that and have no idea what it means, does it apply? How does it apply? Because some of them are fairly generic or hypothetical in terms of the information they present, yet put in better terms could be very understandable to users in the field.

So again it depends on whether or not the regulations are affected by our medical changes in the first place. So it's a combination of both.

MR. MANAR: Thank you.

MR. EPLEY: To follow on that, each team, each working group understands that they have to be going over the policy section as it might relate to the--

MR. MANDLE: The policy changes are not touched by the work group. Those are only by VBA staff itself. So that's all in-house, and that's after we review--

MR. EPLEY: Okay.

MR. MANDLE: --to make sure that--and those necessarily implicate more procedural claims processing issues. So having that background is the focus on that.

The next few slides here, we've just got tables to show the most recent status of where in the process we are. Like I said, all but one are in concurrence. Here we've got more specific status so whether it's a VA wide concurrence at General Counsel or with VBA or VHA itself, and we've also got our current estimates as when we're going to be publishing the final rule for that

system.

So as you can see, not every one is going to be in December 2016, and our goal and our hope is that we can stagger them so that the changes are made in increments rather than dropping in an entire new Rating Schedule at once. That way we don't, we minimize the impact on any claims processing, any delay issues. We don't want to add to our backlog. We want to minimize that.

And we want to make sure that training can happen as they are released so, again, the goal is focusing on accuracy and our backlog issues.

Outside of that, that's pretty much all I have. Are there any questions, comments, feedback?

MR. MAKI: I wanted to follow up on some of the questions that were just asked about the policy regulations that precede the Rating Schedule. Some of those don't make specific references to the Schedule itself but are important like the regulation regarding Individual Unemployability. When does that get published if there's a change?

MR. MANDLE: Those are on their own time. There's no set timeline for those. Right now the VASRD Project focuses on the medical aspect, but these, if we have a proposed rule that we're making out of that, it just gets in line with everything else. So again there's not a timeline for those that I can specifically comment on.

MR. MAKI: No later than December 2016 though?

MR. MANDLE: That would be the hope, yes, sir. And again those changes aren't, I can't speak to every single one of them because I haven't reviewed them all yet, but those changes aren't major substantive issues. Most of them are can we clean up this language a bit without changing the meaning of it? It's for usability purposes--

MR. MAKI: Yeah. But if even one word is changed--

MR. MANDLE: Right.

MR. MAKI: --you've got to have a proposed rule.

MR. MANDLE: And those ones definitely get

heavily scoured by General Counsel and by BVA to make sure we're not going against anything. We also have our other staff saying, yes, what you say makes sense, but training this issue is going to make it worse than what it was before. So we need to either rethink what we're doing or preserve what we have now.

MR. MAKI: And I have a hypothetical question that has occurred periodically as the current Rating Schedule has been changed or revised over the last 20 years or so. There's a precedent court case that says that if the rating criteria changes during the course of a veteran's claim, that VA is required to look at the disability under both the old and the new criteria and provide a rating under the most favorable criteria.

That means that even if you make a change, there still may be a certain number of veterans that need to be--you still need the old rating criteria to review for a certain length of time. Is that going to be a training challenge for raters, RVSRs in the field, for--because it's going

to affect almost any veteran who reopens a claim for at least a couple of years after the new Rating Schedule goes into effect, that there's going to be a certain population of veterans where both Rating Schedules will apply to their rating.

MR. MANDLE: And I think the thought on that right now is to incorporate that. Rather than saying keep this court case in mind, put that in with each specific training package that's developed for each regulation, to run that home, and one of the benefits of our new rating system, VBMS, is that we can incorporate historical rating criteria, current rating criteria, any pop-up reminders as well to say did you consider this, make sure you're evaluating it with this court case in mind.

So that's actually part of our implementation strategy too is when we coordinate with the programmers for that, we review--they pull up every single reference of, for example, the DSM. When we have a DSM change, they pull every text that's generated in that system. We review it to

make sure (a) is it current; do we need to keep it; do we need to keep it for historical purposes; and then do we need to update it as well?

So that's another part of the process.

MR. MAKI: So VBMS will be tweaked to look at the potential on a rating that more than one rating criteria exists?

MR. MANDLE: I don't know. I don't know. I can't speak for the functionality of whether or not it would automatically say consider this one or apply both and see which one gives you the favorable one. They could at the very least make sure that no rating can be completed without certain steps being taken. So I think that's something that we would press for, but I can't speak to their programming abilities on that.

MR. MAKI: Okay. Thank you.

MR. MANDLE: No problem.

DR. SIMBERKOFF: So just going back to the previous couple of slides where you had these things in various stages of concurrence, is there an order in which concurrence occurs or is it sent

to all parts of VA, you know, together and then they--

MR. MANDLE: We have--there's a specific order depending on the regulation. Sometimes the order varies slightly, but it's only sent to one staff at a time so it's not going out to 15 different staffs.

DR. SIMBERKOFF: Okay.

MR. MANDLE: It starts off in VBA at the Office of Disability Assistance, and then it goes through to the--I've got it here--it goes through to the Chief of Staff. After that, it comes over to VA, at which point depending on the regulation, which body system it is, or just where workloads are, it can go to the Office of Regulation, Policy and Management, Office of General Counsel, Veterans Health Administration, over to the Board of Veterans' Appeals.

So that order isn't necessarily as strict. For the most part, they usually start off within General Counsel and then move on, but again depending on the regulation, it can go to different

staffs at different times.

DR. SIMBERKOFF: Okay.

MR. MANDLE: Any other questions?

CHAIRMAN SCOTT: The two specific disabilities that we have discussed in some detail, and I mentioned one of them to you before you started, was diabetes, and we wanted to be sure that that hadn't somehow gotten kicked down the road or out of the system or something. And the other one that I may or may not have mentioned is sleep apnea.

Those are two specific disabilities that have been discussed in some detail in the Committee, and the sleep apnea one, there was an interim report sent to the Secretary, the Under Secretary, through the Under Secretary to the Secretary--I don't know--about a year ago, I guess, with some specific questions or suggestions about that.

And then the diabetes came up when Dr. Olmos-Lau said that they were struggling with getting the I guess medical agreement is--might be

the wrong term, but anyway getting a consensus of how to update the VASRD as it specifically related to diabetes. So do you know anything about either one of those two particular disabilities right off the top of your head?

MR. MANDLE: Off the top of my head, no, I don't. Those are two of the three or four that I haven't actually laid hands on.

CHAIRMAN SCOTT: Okay.

MR. MANDLE: But I can definitely check when I get back to the office and get back to you on it.

CHAIRMAN SCOTT: Well, what--two things. One of them is I mentioned to you, we don't want to address anything in the report that you're already on top of.

On the other hand, any specific disability that the Committee members are concerned about, we are likely to put in the report that we have some concerns about how that's going inside the VASRD, and we want to call the management's attention to making sure that those are carefully looked at, and

so that's two of them that, you know, were probably going to wind up being mentioned in the report one way or another, and basically, you know, I just wondered if you had any additional data on either one of them?

MR. MANDLE: Not off the top of my head.

CHAIRMAN SCOTT: Okay.

MR. MANDLE: But like I said, I'll make sure I follow up with that.

CHAIRMAN SCOTT: Well, if there is dramatic action underway to address either one of them that you think we ought to know about, well, let us know through Nancy or whatever so that we don't misstate the problem or overstate the problem or whatever in the report. Can you do that?

MR. MANDLE: Yes, sir.

CHAIRMAN SCOTT: Okay. Other questions or comments? Go ahead, Mike.

DR. SIMBERKOFF: What is the process for the comprehensive revision based on feedback?

MR. MANDLE: It depends on which part of the concurrence process the feedback is from. Say,

for example, we get feedback from VHA physicians on specific disabilities that we didn't consider or that we need to, for one reason or another it was proposed at the earlier stages, but then, for example, one of our Policy offices sent it back and said we can't do that at this time.

So these revisions are things that either weren't incorporated into the draft or have been dropped at an earlier stage so we need to make sure that everyone is on the same page, and that, okay, we're getting pushed to include this or to not include this, and we need to take a look at it rather than saying a minor change can fix this problem.

So, again, it depends on the feedback we receive, but it's making sure that edits that need to be made that are more substantive and that will affect other issues or other areas of our regulations or require a rewrite in the preamble itself, those we pull back and spend a little bit more time on. Other ones we can address with simple fixes in the regulations themselves.

DR. SIMBERKOFF: Does it ever require that you actually go back to a work group?

MR. MANDLE: They don't--so far--knock on wood--we have not had to go back to a work group, and the plan--really that would be a last ditch effort if no other resource were available. The medical officers, you know, have basically their contacts from the groups, and if they have a specific question, they'll go ahead and shoot that over to them or call them rather than, you know, calling a meeting of the group again, and they try to get a specific answer to the question rather than saying we need to rethink this whole thing.

So far the process that we have where we get so many hands on it before we send it out kind of mitigates that happening.

DR. SIMBERKOFF: Okay. Well, two weeks ago at ID Week, I was asked by my one of my colleagues on the ID work group, which I'm also on, you know, when we were going to see the ID thing published? And I said any minute. And now I see it's going to be published in December of 2016.

MR. MANDLE: Again, these are all estimated dates. I can't give you any specific dates of when it's going to happen. So if I could do that, I would probably command a little bit more in terms of the pay scale, but I mean the process itself, as you can see, there are so many players in it and there are so many hands on it, and then even once it leaves us, it's at someone else's discretion when the final publication happens after OMB gets a look at it.

So, again, we set our goals and we've got to temper them, too, so--

CHAIRMAN SCOTT: Other comments or questions regarding the update on the VASRD that Mr. Mandle has provided? Well, thanks very much. That was a good update, and I personally feel like that now we're current enough on where you are to make valid observations on the biennial report.

MR. MANDLE: I want to thank you all for your input as well and suggestions and comments and questions. I will be following up and taking back to our staff.

CHAIRMAN SCOTT: Okay. Thank you very much.

MR. MANDLE: Thank you.

CHAIRMAN SCOTT: Appreciate it. Well done.

MR. EPLEY: Good job.

CHAIRMAN SCOTT: Okay. We're going to go ahead and take a lunch break. Please be here right on time at one o'clock for Dr. Cross. He might be five minutes early or so, but let's try to be ready to go for sure. Okay.

[Whereupon, at 11:26 a.m., the Advisory Committee recessed, to reconvene at 12:55 p.m., this same day.]

A F T E R N O O N S E S S I O N

[12:55 p.m.]

CHAIRMAN SCOTT: Okay. Dr. Gerald Cross has joined us. He and I developed an acquaintanceship and friendship back in the VDBC days when he was very supportive and very helpful for everything we were doing, and some questions came up at the last meeting, and he gratefully agreed to come to talk to us.

DR. CROSS: You're suggesting I volunteered?

CHAIRMAN SCOTT: Yes.

[Laughter.]

CHAIRMAN SCOTT: That was what I thought you did.

DR. CROSS: General, whenever you're ready.

CHAIRMAN SCOTT: Okay. Whenever your guys are ready with your slides and your chart, you know, just start.

DR. CROSS: The distinguished person standing up here is Mark Bowen, and he's very

important because he brought the candy.

[Laughter.]

MR. BOWEN: Since you already had lunch, we brought desert.

CHAIRMAN SCOTT: What a guy.

MS. COPELAND: Isn't that nice? You are very gentile, Dr. Cross. You know that blood sugar dips a little bit; right? A little caffeine to keep them awake.

DR. CROSS: I could go take a nap very easily at this point.

[Laughter.]

DR. CROSS: And Danny, our--Danny Devine, SES with my organization, say hello.

MR. DEVINE: Hi. Hi, everybody. I know some of you and worked with others. We'll get to know each other a little bit more after the slide presentation.

DR. CROSS: Patricia Murray, another SES in my office, is going to be here to cover a couple of points that I want to go over with you. And I read the bios on this Committee, at least the

snapshots. They're very impressive except for Michael.

[Laughter.]

DR. SIMBERKOFF: I'm the ringleader.

DR. CROSS: It means a lot to have a group like this in town that you can talk to in a discussion that is different from the kind of discussion we would have elsewhere in some environments where you and I have been seated next to each other, I think, on a couple of those in Congress.

CHAIRMAN SCOTT: We have.

DR. CROSS: And we don't have anybody on the phone at this point, I believe; is that?

CHAIRMAN SCOTT: No, we do not.

DR. CROSS: No phones. Okay.

CHAIRMAN SCOTT: We have successfully avoided technology that would allow somebody to miss a meeting and dial in.

DR. CROSS: Oh, good idea. I've also put my bio in there, and I think CV, in case I'm looking for a job in the future.

[Laughter.]

CHAIRMAN SCOTT: We understand that tenure is a tenuous sort of a thing around here.

[Laughter.]

DR. CROSS: It is possible to step on a landmine. So I'm actually quite pleased to be in the job I'm in and pleased, as I said, pleased to be here with you.

DMA. DMA stands for Disability Management--Disability Medical Assessment. It's my organization. I named it. I don't know what the thing stands for.

[Laughter.]

DR. CROSS: We use so many acronyms around here. We hardly ever see the words. I'm going to give you some intro in a very high level. I'm not going to get into the slides just yet. I know PowerPoints are so much fun to go through, but I just want to talk to you, and if you have questions, I very much prefer that you just go ahead and interrupt and ask them, and we'll have a better conversation as a result of that.

Mr. Epley.

MR. EPLEY: Good afternoon, Doc. Good to see you.

DR. CROSS: There's an issue of performance, and our leadership talks appropriately about performance on a routine basis, and they tie that to a specific word, and that word is "accountability," and so if you're not getting the job done, their words that they would use in that regard in terms of assessing that, "we're holding you accountable for that work."

One of those issues that we would be held accountable for is timeliness. The other one is quality. Those are the two big issues that we would be faced with defending ourselves on. Now, this is an organization that does over two million exams per year for disabilities. Is that surprising?

DR. SMITH: It's a huge number. Two million.

DR. CROSS: Yeah. What is it? About 2.2?

MS. MURRAY: 2.--I think we went up to

2.243 for FY14. Last year was 2.174 for '13.

DR. CROSS: Impressive that individuals are finding themselves in circumstances that they feel they have that degree and frequency of occurrence of disability, I guess, more so than-- more so certainly than in our recent past.

This is what we work on every single day to provide a better experience to those veterans who are going through this process.

Now what you see on that board up there is a process, and that's the IDES program, and that's a very special program. We'll talk about that when we get to one of the other pages here.

It's been a remarkable year. Early in the year--think about how things have changed over the past six or eight months--the issue that was driving us every single day--I was going to say driving us crazy--was something called the backlog. Anybody heard about the backlog?

CHAIRMAN SCOTT: Vaguely.

DR. SMITH: Yeah.

DR. CROSS: Do you think a thousand

articles have been written in newspapers about the backlog? Quite possibly. And it was this front-- it was the centerpiece of everything we were looking at. We were desperately, desperately working with our VBA colleagues to get that backlog under control and reduced, and depending on where you were looking at, the backlog was 500,000, 600,000, 800,000, somewhere in there. Do you guys remember?

MR. DEVINE: 600, closer to 700.

MS. MURRAY: 600.

DR. CROSS: 700.

MS. MURRAY: Yeah.

DR. CROSS: And I told you Patricia Murray was coming, and I introduced you before you got here, and say hello.

MS. MURRAY: Good afternoon.

CHAIRMAN SCOTT: Welcome.

MS. MURRAY: Thank you.

DR. CROSS: There are different standards for each one of those programs. The IDES program from the examination of the medical component of it

is to be done in 45 days. That does not mean that you wait, you have 45 days to get the person an appointment. We have 45 days to do everything in the process from beginning to end. So at the beginning of that process, we receive the request to do the exam. At the end of that process, we send, we can hit a button and send that exam over to VBA, and the standard for that is 45 days.

I can remember some periods of time when we were working on the IDES that we were probably, Danny, up around 70?

MR. DEVINE: Oh, yes, at least 70.

DR. CROSS: Several years ago.

MR. DEVINE: For two years now, we've been meeting that standard, and we're running about--

MR. DEVINE: We're down to 33 days in performing the examinations, and many of you might know that these are complex because we have between ten and 12 contentions per individual veteran so it's much more complicated in the standard veteran, and plus you know some of the injuries that they're coming back with make it much more complicated for

us to do.

DR. CROSS: So that's the standard. We are held accountable for it. We are meeting that standard. We're surpassing that standard. Every day that we can shave off of the work that we do collapses that process a little bit more, gets the veteran moving, in this case, servicemember moving out just a little bit sooner.

So that's a good thing. It helps with the backlog. We're not a contributor to the backlog. We're a help in reducing the backlog on the exam side.

When I'm going around talking to people about performance, they said, well, you really need some help with your exams. You're so far behind, and it takes so long to get an appointment. They have assumed that probably from the--confusing some other things with what we do. We're very proud that our timeliness has been revolutionized quite a bit.

The other standard is 30 days. This was 45 days. 30 days. 30 days is for everything else,

all of the other disability exams that we do, usually which are not quite so complicated as the one for servicemembers.

I have to tell you I was over at the Washington VA Medical Center one day in the C&P clinic, and a young soldier came in, and I was talking to his examiner, and said, well, you know, how is he doing; what's the problem?

And he said, well, there's a lot of problems. He had 160 contentions, and I somewhat jokingly told the examiner, well, the thing that surprises me most about that is that he walked in.

DR. SMITH: Yeah.

[Laughter.]

DR. CROSS: I think if I had 160 things wrong with me, I'd stay home in the bed probably, but what had happened--and this is perfectly understandable--it's not a negative thing that we harp on--his mother is a nurse. She read up on this process a little bit, and she thought, well, I'm going to help you. I'm going to go through your medical record, and everything that's in

there, we'll make a contention. So that could be he went to the troop medical clinic and had a fever one day, or he went to the troop medical clinic and he had a blister or whatever.

And so all of those got duly recorded. The examiner has to address each and everyone of those and can't say, well, the rest of these were insignificant. You've got to cover them all; otherwise, you have an insufficient exam, and we'll probably talk about insufficient exams--the one word that I particularly do not like.

So the 30 day process we're held accountable for, and with the performance that we have right now, 24 days average. Because it's an average, you'll find some that go through in 40 days. You'll find some that go through in two days.

We had just done a demonstration, but I don't know how this is going to turn out, but we did a demonstration in Little Rock, Arkansas about two weeks ago, and I did this in close collaboration with General Hickey and the VBA staff

at the ROs and so forth, and the challenge that we received was do the entire process in 24 hours.

And we did the process for a carefully selected group of veterans in 24 hours. We were not trying--we just wanted to see what all the processes, changes we would have to do to pull that off, and so it was a learning issue. It was a learning issue for us, and we're in the process of evaluating that now. I have really no--I don't want to give you any misconception that that could be the possibility for standard in the future broadly speaking, but for some, it could be.

And one of the challenges that we found was a great deal of work to make that 24 hour goal had to be done the day before or the night before. They had to do a lot of that preparatory work, and maybe that's okay, and maybe that will work for some veterans, but I was delighted that we were trying new things, that we were going out and looking at a standard that just seemed beyond reach or inconceivable, and now we were going to try and help make it happen.

The veterans who went through the 24 hours I think were ecstatic. You know, they got their entire exam and rating done, you know, and they're finished in 24 hours. I look forward to seeing where that goes in the future.

So the standard was 30 days for the standard process, the bulk of those 2.2 million exams, and we're running about 24 days typically right now.

It's been a remarkable year because of the backlog, and the absolute driven passion that our VBA colleagues have to reduce that, and so we had something this summer and spring called tsunamis, and the VBA staff went on basically emergency work schedule where overtime was mandatory. They were keeping their staff working extra hours routinely and doing so on a mandatory basis.

The consequence for us was that more exam requests were coming over faster than they would have otherwise, and they were doing that in order to decrease the backlog. And we got through those.

The first one that we did was the two-

year-old claims, and you might have seen a press release or something about that from the VBA pushing to get those completely done. And completely means we got all the ones that could be done in that time. If the individual was out of the country or some other unusual circumstance, we couldn't get to those. But the ones that we could get to, we finished.

The next tsunami was the one year and older, one year or less exams, between one and two years. And we got through those. And so they kept giving us these remarkable goals that we had to work on jointly between VBA and VHA to get this work done.

There have been some innovations in the past year, and I want to mention a couple of them. And I'll ask my colleagues, Patricia and Danny, to comment on a couple of these as well.

Camp Lejeune. Familiar with it? Huge problem. Contaminated water. Goes back to the 1953, somewhere in there, and continues on up I guess until the '80s somewhere, a long period of

time. How many individuals went through Camp Lejeune over from 1953 to 1980 something? It's a bunch. It's a bunch. And where was the water supply contaminated? Was it this area? Was it that area? Or all of the above?

And it seems like when you read the data, the water systems have been changed at times. The pipes have been changed, redirected, and so it becomes very, very difficult to say it was this contingent, this cohort of individuals at this location that we should focus on, as opposed to the whole area, but it seems like more and more we're addressing the whole area.

So these are Marines. You know, the Marines always I thought got more good publicity than the Army did. But these are Marines, and they do get publicity, and as you would expect, particularly in North Carolina, and particularly for one individual, Senator Burr, who likes to chat about this with us on occasion.

I've talked to a number of those Marines. The stories that they tell me about why they

believe that they were impacted by this and the disease that they now have is absolutely compelling--emotional, gripping, but here's the challenge. We're getting these claims. The science is not finished. The science is not complete.

So what do we do? We could say we're still waiting for the report, ATSDR, and hopefully there will be a new report coming in such a period of time. And, Marine, you have to wait until that's done, and then we'll make a judgment. We kind of went out on a limb. We started processing them now about a year, two years ago?

MS. MURRAY: About two years ago.

DR. CROSS: And I thought about how we should do this. I didn't want to send them to my routine exam process, which is often musculoskeletal and the kind of routine stuff that we do everyday. This was quite different. How much were they exposed to? What was the toxicology? What was the disease process that they want to link to that?

And so we set up a special program for the Camp Lejeune population to get their exam or medical opinions done. I looked out to our population of doctors, Mike, and I probably stole some from you, individuals who had training in environmental medicine, toxicology--

DR. SIMBERKOFF: Right.

DR. CROSS: --occupational medicine, and if that was not enough, we would then take them, send them to Louisville, Kentucky, and the reason they went to Louisville, Kentucky was that's where VBA was the RO--they were sending and accumulating all the files. So they had this room full of files, and they would sit there in those rooms like a postgraduate course and sit there and with the instructors take a case out of the pile and go through it and discuss it.

At nighttime, we would give them a stack of a research papers that relate to contamination and they would read the research papers. And so the process that I was creating was something called subject matter experts, SMEs, and I did this

again because I didn't want to just hand this over to my routine process of the generalists who do much of the exam work.

Another great thing that we're working on that is coming into being right now, and Danny can show you the graph in a moment, is the Separation Health Assessment. Patricia, do you want to talk about that?

MS. MURRAY: Here we go. Yes. So in December of 2012--it was '12--DoD and VA entered into an MOU to conduct Separation Health Assessments on all servicemembers leaving the military. If the servicemember files a claim at the time of discharge, then VHA will do the SHA in conjunction with developing and adjudicating the claim.

If they're not filing a claim at the time of discharge, then DoD conducts the Separation Health Assessment. So each servicemember is given a baseline exam as they leave the service, and so if you look at the data that's being passed out to you, VHA has moved out on Separation Health

Assessments. I think over the last 12 months we've gone from about 50 of them a week to well over 800 SHAs being completed on discharged servicemembers weekly.

And the difference in the color in that chart just really helps us recognize the templates that are being used, but we have rolled out SHA pretty well, and VHA is working with DoD as they roll out and develop their implementation plans. So we are well on our way.

DR. CROSS: On the graph, the red is the old process where we were using standard Gen Med DBQ, and now this is the, the blue is the Separation Health Assessment DBQ. Why are we doing this? Why would we start doing a Separation Health Assessment?

A couple of reasons. One is presidential commission, congressional commission, committee on this, committee on that, over the years, going back into the '90s, maybe even the '80s, were saying you guys should, you know, you do an entry one when they come into the military. When they leave,

wouldn't you like to know what their condition is? Wouldn't you like to have some objective information as to what their status was at that time?

And then we go to the services, and we find out, well, some of them are doing a lot of these already. Some of them are really not doing hardly any at all, and there's all kinds of rules and differences in the process. So there's a mishmash here of stuff that we're getting coming forward.

We'd like to standardize that, and that was--so we developed a group, a working group that including Health Affairs at DoD and myself and the VBA representatives to work on this. We've been working on this thing for four years. You know why it took four years? It's a complex--it's a complex proposal. Some people on the DoD side may have seen it just a little bit more as a VA interest as opposed to a DoD interest, but we got past that point.

And then lots of discussion about how to

exactly do this, to budget for it, what the process would be, how much workload there would be. So what this does, this provides us going forward with an objective collection of data about each individual as they leave the military or very close to their leaving, and so including one thing such as a hearing threshold test--one of the most frequent claims that we get. And so now we will have an examination that is objective recorded in our records as to what their condition was.

If it was abnormal at the time they were leaving, we would encourage them to say go see the VA before you're off Active Duty, go through the SHA program that they're offering you, and they'll fill out the DBQ for hearing, and it may be of some benefit to you down the road or even immediately.

But if they come in five years later, ten years later, 40 years later, and say the two years I spent in the Army are what caused my hearing loss, which just came on recently, we will go back and say, well, at the time you left, we have the data. Here's what it was. And unless you have

further exposure, it wouldn't have gotten worse, the audiologists tell me.

So we're meeting the requirements from all these commissions, and we're doing something that I think is providing objectivity more so than we've had before on some of these common issues that we're working with.

And then comes the ACE. Have you heard about ACE? Well, it's so much fun. Patricia.

MS. MURRAY: Sure. ACE is the Acceptable Clinical Evidence, and so we are now able to provide VBA medical evidence based on our medical records. So if VBA needs information about high blood pressure, if the veteran is being treated at the VA medical center or in the private sector or in DoD, and we have access to those records, we can complete the DBQ based on the evidence of record and send in that information to VBA without necessarily having to have the veteran come in for an exam.

DR. CROSS: So the veteran does not even have to come in for an exam. If we search the

records and find that information, and, you know, with the SHA, we'll be able to do that even more, I hope. Some of my docs out in the field, including Michael Myers in VISN 23, thinks that we should be running ACEs about 30 percent of the time.

MR. EPLEY: Can you do it for any type of illness or any type of claim?

DR. CROSS: It's really good for cancer and some of the heart disease situations. What else?

MS. MURRAY: We've sort of--that's a good question. There's a couple of conditions that we've excluded for now. Mental health is one of those conditions, but I think as we looked at it further, we will hope to expand it, but sometimes the mental conditions change very rapidly. So mental health has asked us to hold off on including those.

Some of the VBA remand exams that require an in-person exam, we still hold true to those in-person exams. So there are some exceptions, but many of the common conditions that the veterans are

being treated for can be completed by that, but there are some exceptions to that.

MR. EPLEY: Great.

DR. CROSS: And I love to tell the story about the origin of the term ACE. We were going to call it when we worked on this early in development "Exam by Exception." General Hickey was going to call it "Record Only Review," which sort of sounds like ROR, which I had trouble saying, and I said, well, let's give it a catchy name, and so how about ACE? And they said, well, what will ACE stand for, and I said we'll get back to you; we'll figure something out.

[Laughter.]

CHAIRMAN SCOTT: And so Acceptable Clinical Evidence was the thing that we attached to that.

DR. SIMBERKOFF: Designing a clinical trial.

DR. CROSS: Close enough. Close enough to have meaning, and--but my staff around the country, the examiners, all know ACE. It caught on just

like that. We had a situation in a location where a doctor quit suddenly, and we had another situation where two doctors died or got sick or whatever in one small area, and in each of those cases, situations, the clinic, their timeliness went through the floor.

They couldn't keep up. They had no way to recover. It was going to take at least six months to hire a doctor, and so what do you in that situation? Well, we can send somebody out from--

DR. SIMBERKOFF: Locum Tenens.

DR. CROSS: Locum Tenens. Now what's the problem with Locum Tenens? It's been used for years. It means that you bring in a doc for a temporary period of time to cover the practice in the civilian world. If you bring in a Locum Tenens though and you go to the commercial sector and hire one, you're going to pay three times their salary to the contractor quite often.

You will find out when they get there they don't know much what you do. And the quality may be okay but not great, in my experience. So this

was expensive, unrewarding, and you name it. We didn't like the results that much.

So what we did was, and Mike knows about this--I started this program--was create our own Locum Tenens program. We're basically the contractor, and we situated out--I hate to say this--in Phoenix. They're doing fine out there, and we had some problems, but it was the kind of problem you like to have.

We hired these folks. They were enthusiastic. They were like sometimes getting ready for retirement, very experienced, didn't want to work everyday, but they were willing to work part-time, whatever. We can use them.

And their situation was such that they would go out for--you know, we would parachute them in. I sent several to Alaska. The problem was the chief of staff at that hospital would look them over for a month or two and say this guy is okay, and they would go make an offer to them, come work on their staff and take them away from me.

DR. SIMBERKOFF: Which I did.

[Laughter.]

DR. CROSS: And actually I saw that as a badge of appreciation and that showed that we were doing something that was good when they went--it happened over and over again.

CHAIRMAN SCOTT: Gerald, is this a good time--since we're talking about fill-ins and all--at one time you had some contract exam activities. Do you--how does that relate to what you're talking about now, and what are you doing about that now?

DR. CROSS: I want to give our docs, our leadership at every facility, as much flexibility and variable capability to expand or contract with the workload that we're faced with. Locum Tenens is one way of doing that. Contract is the other. And so we developed something called the DEM contract, and I'm going to ask--Danny, you want to talk about DEM?

MR. DEVINE: Yeah. The DEM contract was one of those extra tools along with Locum Tenens to help our folks out. We had somewhat of a model over at VBA where they're using two contractors

over there, VES and QTC, maybe you're familiar with.

So we decided on the health care side we needed to have the same kind of flexibility because sometimes there were some significant limits to what VBA could do because it supposedly was narrowed to just ten sites. Of course, we have 153 plus so we needed that flexibility that folks could control immediately so we created the DEM contract.

Initially we had five contractors that were part of that effort, and what's interesting is that we were able to see over the horizon just a little bit, and preparing for the unknown is basically how we went into this. Well, that unknown became very known to us within about 12 months with the tsunamis that Dr. Cross was talking about.

So our work with the contractors sped up very quickly thereafter, and frankly they were a very important part, a very important tool, for our folks out in the field to use when they needed to get these examinations done, and that's what we

currently do. We work with them. Every facility director has the option basically. We're trying to give them the control there locally to work with those DEM contractors.

They're also responsible--it's a little bit different than VBA--my facility director is responsible for the quality of that examination so it's locally controlled and locally audited for quality before it goes back to VBA.

CHAIRMAN SCOTT: So you're still using that then?

MR. DEVINE: Oh, absolutely.

DR. CROSS: And increasingly. It gives us flexibility to manage their situation. It gives that flexibility to people like Mike Simberkoff who are there local and need that kind of help and support. It's expanding, not to say there aren't serious problems with it. It's expensive. Sometimes we get some weird situations that develop where one individual was doing them at home, and so the veteran would come knock on the door, go through the dining room, go through den, children

playing, step over the toys, and get into the room where they wanted to do the exam. You know, that's not the kind of professional environment that we are looking for.

CHAIRMAN SCOTT: Right.

DR. CROSS: We've had some problems at other times in terms of there being able to keep up. Right now one of the contractors has been unable to keep up for quite some time and is not able to meet the needs, and so those exams got kicked back all to VHA. They don't do all the exams. VHA has to do them all, and so, for instance, they don't do any of the Camp Lejeune exams. They don't do any of the POW exams. They don't do any of the sleep study exams.

CHAIRMAN SCOTT: Right.

DR. CROSS: So be real careful before you compare apples and oranges because we have to do everything and meet the timeliness standard. That is what is different for them. So sometimes that, well, that's, we can talk about some of the challenges we have with the contractors.

We're having one right now which killed my entire weekend with notes from General Hickey and the Under Secretary for Health here. We're working through an issue where they were using some, an examiner it may not have been the right person to use in that particular situation. We'll tell you more about that later.

Is there a question?

CHAIRMAN SCOTT: Well, I just wondered what--I think we all understand that you can't depend on contracts to do your business, but I just wondered what part contracting out the exams played in the overall scheme of the--

DR. CROSS: We have the numbers for you. Danny, do you have the page number?

CHAIRMAN SCOTT: Well, don't let me get ahead of you. I mean--

MR. DEVINE: This should be it right here. I think we can show you by the numbers.

DR. CROSS: What page is that? Four?

MR. DEVINE: This is page four in your slide book there, and I think it will give you

representation. Compared to what VHA does, it may pale in comparison. But, boy, let me tell you, it really makes a difference when you take care of these kinds of examinations, and it keeps our timeliness within the parameters that we need.

CHAIRMAN SCOTT: Do you have a DBQ problem with the contract examiners?

MR. DEVINE: We can go in length about DBQs and the challenges everywhere. To be fair, it isn't just the contractors that have certain kinds of challenges. Our providers within VHA have a lot of questions about DBQs and how to improve them.

DR. CROSS: We'll have a good discussion about DBQs I think as we go through here. So that was Locum's and the contract. I did a risk assessment informally based on my experience about this contract, and it occurred to me that a contract is one of the most dangerous things you can deal with in government, and IT is probably the other thing that is very dangerous too. This combines them both.

So I figured this was probably going to be

the thing that would finally get me shot for one reason or another. So I thought, well, what can I do to mitigate that risk? So I created a board, an oversight board, including two VISN directors and a couple of contract specialists and so forth, and they meet twice a year and look at what we're doing and give me some advice about maybe you shouldn't do that, maybe do this, whatever, change the requirements.

And that is certainly--I don't know if it will work out well in the long term, but it made me feel better at the time as a reasonable back-up to that situation.

I want to talk about the Certification Program. Patricia, do you want to talk about that?

MS. MURRAY: Sure. So for those providers that conduct C&P exams for us, they have to be certified based on the program that we have put together, and so all of our examiners are certified and registered in our database. Most of them are certified to do the general type of evaluation, but then we have those that are specialists.

So if you're doing mental health exams, you have to complete the mental health module. So if you're doing TBI exam, you have to complete in addition to the general certification module, you have to do the specialties type exam. So we update. We have about 15 to 20 education modules that we keep updated with the latest information from VBA, as well as in the treatment round, and so we keep those updated, and our examiners are frequently asked to update and recertify as needed.

DR. CROSS: The purpose of doing this in my mind is very simple. Examiners for C&P in our organization, the phrase comes up over and over again, were low-man on the totem pole. You couldn't go to a party with a bunch of VA folks and say I work, you know, my job is a C&P examiner and get the glory that you would get if they said, oh, I'm a trauma surgeon or I'm a dermatologist even, you know.

They had no one speaking for them at VHA in Washington. They were just out there by themselves, relatively unsupported. We would get

to them when we can, and I didn't do any better I don't think when I was a PDUSH. You know, to me that was something that was kind of foreign, I didn't like it very much, and I said what can we do about this?

So we created the Certification Program. What does that do? That means the Chief of Staff can't walk down the halls when he's in the hospital and say we've got a shortage in C&P today, hey, you, go do that. Because I put a little roadblock there that said you can do that if he's certified.

I wanted this to start to build status, professionalism. I wanted this to be a more professional program. And so we did that, and we didn't make it all that difficult. The slide, you look at the presentations on your own computer in your office, then go through and take the test, and, you know, you can do it in a day or two, depending how much time you have.

But that said, they had to meet that criteria before they could do that work, and that's up and running now. We just updated the training

modules in the past month.

Another thing that is of great interest to us, maybe more so than in the civilian sector--I'm sure more so probably because it's unique to some degree--is MST, Military Sexual Trauma. And when I first met General Hickey, it became apparent that that one thing she was going to ask me about and want to pursue aggressively.

So I got to the Under Secretary for Health at the time, Randy Petzel, and Allison, and we set some time in the studio and had them do a national broadcast together to talk about just MST. You want to comment on that, Patricia?

MS. MURRAY: Sure. So we did an initial training pilot. We had someone from the Board, from VBA, and a clinician who does a large number of MST exams for us. She was sort of our SME. They did a training module that was recorded and rebroadcast through the next several weeks.

That was about a year-and-a-half ago, and just today, we are wrapping up a new training module on MST that will be required to be taken by

all examiners so that they are familiar with MST as we begin to do the SHA.

Any examiner conducting an SHA will have taken that training on the Separation Health Assessment DBQ. There is a question about MST, and there is specific information there that needs to be communicated to the servicemember as well as information shared with the servicemember, and so we're even heightening that, and I think that course will come out, and the training should be completed by mid-January for all of our examiners.

So a lot of attention to MST. We worked with someone from the Vice President's Office to make sure that we covered all the issues that they were concerned about, and so it's been a look in the area of MST over the last several months.

DR. CROSS: And we're--

DR. BROWNE: Did you say that was mandatory for all examiners?

MS. MURRAY: All examiners.

DR. BROWNE: Okay.

DR. SIMBERKOFF: I found this.

DR. CROSS: You just went through it.

DR. SIMBERKOFF: No, I just found the slides.

DR. CROSS: Oh, found the slides. All right.

DR. SIMBERKOFF: I didn't realize that-- there you are.

MS. MURRAY: Thank you, Dr. Simberkoff.

DR. CROSS: General Scott, I would like to introduce you to Tom Lynch, Dr. Tom Lynch, from our Operations world, very close to the Under Secretary for Health, and also former Chief of Staff-- Surgery?

DR. LYNCH: Chief of Surgery, Chief of Staff. A little bit of everything.

DR. CROSS: So I've been talking about the role of the Chief of Staff in relationship to C&P.

DR. LYNCH: Okay. I'm just here for a couple of minutes, but nice to meet you, sir.

DR. CROSS: The war room was something that we developed just recently. We had to change the relationship. We had to change the

relationship between VBA and VHA, and we had to stop seeing each other as competitors. We had to start seeing each other as colleagues.

That is the one thing I have worked very, very hard in doing. We're not entirely successful in that, but we're much more successful with that than--and I think we've moved the goal line a bit quite successfully. One way that we're doing that is by meeting together over and over with my staff, their staff, and so forth, sharing information, discussing policies, and particularly discussing data.

And so we do that every Friday, and on that Friday call, we have nothing but performance data to discuss until we get through that, and then we look at policies and so forth. The data, that exchange of information makes them understand and us understand how they're interpreting performance. It's quite possible to look at sets of data and interpret it differently, and so that's something we work very hard on. And the war rooms are held every week, and I think are very well attended.

MS. MURRAY: In your slide deck, you have a picture of one of the slides that we show every week in the war room, and if you look at the bottom one, this one starts the week of January '13, January 5, 2013, and it really gives you a picture of the workflow that comes in and out of VHA up over the last--well over the last year-and-a-half.

So this is how we monitor the workflow from VHA and VBA.

MR. DEVINE: Now, as a program office, it's interesting to note that the Under Secretary of Benefits sits in on this once in a blue moon. We're about to get the Under Secretary of Health to join us. Dr. Lynch and others from 10N have also listened in. So that is part of the dramatic difference that you see in C&P. We're able to get these kinds of folks interested early on a Friday morning, for example, to listen in and go through data, whether it's IDES that we have different kinds of calls for or the war room data that you see right there on slide 20.

DR. CROSS: I have one thing to discuss,

which is the biggest of these initiatives in some ways, and then I'm going to ask you because I know we're postprandial, a little--it's a warm room. I'm going to ask you to stand up and come up to the chart and we'll take a look at that.

The thing that is the culminating bit of integration that I wanted to talk about was actually stimulated by General Hickey. Now, I want you to imagine this conversation. General Hickey calls up Randy Petzel, at that time Under Secretary for Health, and me for a discussion and says I'd like you to give me 55 doctors. Now we don't have any surplus doctors really.

55 doctors. That would be--that is an absolutely staggering request, and after we got over the shock, the Under Secretary for Health said let's do it. Let's give it a try, and we'll see how it goes. What was she going to do with them? She's going to put them at the Regional Offices, and she was going to have them develop a relationship with the staff in the Regional Office, something very specific, and this was the part

where I came in in the DMA staff, we wanted some mechanism in place to help with that word that I told you I don't like to use called "insufficiency."

And so it used to be that if you get an insufficient exam, the staff at the RO would say, ah, mark it up, put it in the mail, send it back to wherever it came from in the medical center. So that's going to kill a couple weeks right there. Now what we do is we take it to the doc in the Regional Office who gets on the phone and does some research, whatever, sorts it out in about an hour, and so the great concern that we've had about insufficiencies over time is still there, and we keep trying to improve that, but those insufficiencies no longer have the consequence, the negative consequence that they had before.

And they're still there. And we're at a little bit at risk by some proposals that may have come out just recently because we would lose all of them.

DR. SIMBERKOFF: Why would you lose them?

DR. CROSS: There's a legislative proposal among other things that would take all of the folks out of C&P and have them go back to primary care even if they were--you know, my concern, of course, is many of our C&P examiners have not done primary care either ever or for years, and so that would be a challenge for us.

But General Hickey's concern, I believe, is that she would probably lose most, if not all, of those 55. I'm not commenting on the legislation--

DR. SIMBERKOFF: Yeah.

DR. CROSS: --in a comprehensive manner. There are pros and cons. I'm not really qualified to go there right now, but that is a concern because I wanted to mention it because she expressed some concern to me about.

MR. DEVINE: Sir, one more point about the docs in the RO. You mentioned that General Hickey benefits by having the docs in the RO. Great. That works out well. VHA gets a benny because the quality of the request coming out of VBA is much

more informed, much more detailed.

They have some medical terms perhaps that they might otherwise not quite understand so there's a better understanding because it's a common language, and sometimes it is a language issue between adjudicators and medical personnel, and sometimes these docs in the RO can bridge that gap, and it makes a huge difference when they say this is how you need to go ahead, make this request because I'm one of those C&P docs. This is what I need to see in my end to get you what you need in a quick turnaround time.

DR. SIMBERKOFF: So I hired one of your persons to actually work in the RO.

[Laughter.]

MR. EPLEY: Big surprise.

DR. SIMBERKOFF: Your Locum Tenens people. And she is doing a wonderful job. But the reverse, you know, has become an issue as well. So we need VBA people in the medical centers.

DR. CROSS: Yes.

DR. SIMBERKOFF: Because the concept of

One VA, you know, has not really followed through, and there are lots of issues which are brought to the people in our facility, including me in my clinics where I need somebody at hand to deal with requests for, you know, benefits information.

MR. DEVINE: Now, Bob or Ray might be able to speak to this, going back to the future. Back in the olden days, guys, wasn't that the way it used to be?

DR. SIMBERKOFF: Yeah.

MS. COPELAND: They were together in the medical centers.

MR. EPLEY: We did an initiative where we placed rating specialists out in the exam unit of the medical centers specifically to address the concerns that Mike has elaborated, and the issue that we were told about is that those rating specialists won't be productive, and we said they have--excuse me--we said that won't be an issue, and we shipped them cases so that they were never at a loss for work, but they built a relationship with the docs.

DR. SIMBERKOFF: I mean everything is electronic these days so that's not an issue.

MR. EPLEY: Yeah.

MR. MAKI: Well, most of your Rating Boards had medical members on the Rating Board.

MR. DEVINE: Right.

MR. EPLEY: Yeah, way back, yeah, in the '70s.

MR. MAKI: So that you could, if there was a question about what an exam or a medical history was actually saying, you could take it right to the doc, and they could put in plain English.

MR. EPLEY: Yeah.

MR. DEVINE: Can I comment real quick, Doc, on what you just said about everything is electronic these days; therefore, it's not much of an issue? Let me just shift that a little bit. Almost in every single occasion, whether it's IDES or C&P, in general, or just life, in general, it seems the one common theme that when we try something new, this word comes up more often than not, and that is co-location.

Sometimes it's not a matter that I can just send General Terry something from here to here. It's I get up and I go over and we have a conversation about things, and so we're finding the most productive places have been the co-located places.

Now, Dr. Cross was talking about this fantastic thing going on in North Little Rock. Well, it was fantastic, in part, the express thing kind of worked because they were co-located. And so almost throughout the country wherever our folks are sitting with them, literally in the same kind of building, we find that they speak to each other a little bit more. They'll talk about the Giants game, you know, and then they go into C&P or the other way around, they get C&P taken care of, go to the Giants game, you know, that personal, that personal kind of thing, and it has made a real difference, electronics aside.

So I just wanted to share that. I don't mean to say no, but we found it's a--

DR. SIMBERKOFF: It actually comes up all

the time, and I think it's something that we would love to have again.

MR. DEVINE: We're going back to the VAMROC concept, I think.

DR. SIMBERKOFF: Yeah.

CHAIRMAN SCOTT: Is the notion of taking the doctors out of the ROs, is that a budgetary issue or is it philosophical issue or how would you describe it?

[Laughter.]

MR. DEVINE: I'm not quite sure what direction you're going except I suspect if we went to contracts, which is the Sanders' proposal, we'd move the VA physicians out of the business of C&P entirely, and the goal has sort of been hypothesized is that if you remove the C&P responsibilities, you can create a greater cadre of physicians to manage primary care, and you cut down on the wait list and access.

CHAIRMAN SCOTT: Oh, okay. So it's not necessarily a budgetary issue. It is as much as anything else a philosophical issue of where the

doctors should be.

MR. DEVINE: A resources issue.

CHAIRMAN SCOTT: It is a resources issue.

MR. DEVINE: Well, it's somewhat them not knowing what it takes to be a C&P doc, and/or what credentials they have to go back into primary care, and that's the piece that they're really missing. They just assume that they can go back.

DR. SIMBERKOFF: I mean there is a lot of general medical exams I'm sure everybody realizes. There are also an awful lot of very, very specialized examinations, which, you know, are not fulltime jobs for anybody, and, you know, big medical centers like ours are able to accommodate them because we have the specialists and the subspecialists, but I think if you had to rely on contracts, it would be very hard in certain areas.

DR. CROSS: When you go through your slides, you'll see a number in regard to this, that there are--how many examiners are there? And the number--how many have been certified I guess. And over the years, we've certified 8,000 thereabouts.

Some of those people have already retired and gone and all that kind of thing. We're adding a new system in place to better define that number, and we're starting on that now.

But here's the point. Those are people who got certification. I'm one of those 8,000. It probably wouldn't be a real good idea for me to go back in primary care just right suddenly. You know with some experience and training and support, getting back into those issues, fine. But that's not going to happen overnight.

Now, Patricia, you want to--

MS. MURRAY: I was just going to say to Dr. Simberkoff's point, I think when we looked at the database and where we are with folks reregistering, I think we are at about 26 percent of the providers doing C&P fulltime and the rest of them--

DR. SIMBERKOFF: Yeah.

MS. MURRAY: --are many of the specialty providers that help support us and very importantly get involved in C&P. So it is as you described.

DR. CROSS: So only 26 percent are doing fulltime, and you got the rest of them doing it on occasion. So that means if you put them, if you took them out of the C&P role, you would get less bang for the buck than you thought because you were thinking that you were going to get a fulltime person.

DR. SIMBERKOFF: Yeah. Right.

DR. CROSS: Let's go up and look at the chart. Why is this chart so big?

DR. BROWNE: Because you had lots of exams.

MR. MAKI: A good question.

MR. EPLEY: A lot of exams. A lot of locations.

MS. MURRAY: We got a big printer.

DR. CROSS: We have a printer that's so big it's in the basement.

DR. BROWNE: It's a good room divider.

DR. CROSS: This is the IDES program from A to Z and the numbers, and the reason why it's so big probably goes back to our former Chief of Staff

of the VA Gingrich, and he would come in periodically, and we met with him frequently, and you know his personality. He's very impressive. He said, Gerald, would you explain to me what's going on at this site? What about this here?

And so we sat down after, you know, in self-defense and said what are all the issues that the leadership wants to know about? And so we put this up there as a process that occurs left to right. We color-coded it so that green is--Danny, you--

MR. DEVINE: Green is the military.

DR. CROSS: Yeah, green is the military.

MR. DEVINE: Army green, of course.

DR. CROSS: I think we had an Air Force guy work on this and said--

[Laughter.]

MS. MURRAY: Blue is VA.

DR. CROSS: So we color-coded whose responsibility these things were, and now we get to this part right here, and you see across the top we've got the thing that is occurring at that point

in time, but we've also got the standard. And so you see the standard for examination for IDES is what I told you?

MR. EPLEY: 45.

MS. MURRAY: 45 days.

DR. CROSS: So here's your 45 days right here, and so I would like to know then how are we doing? And so I looked down here, and it gives me an assessment of how we're doing on it. FY14 so that's for the entire year, the last three months, and the current month. So this allows me to trend what we're doing. Again, over here, 34. And so I know that 34 is much better than the standard time, and so we're doing okay.

All right. Go back over here to the left a little bit, and you get to see how we're doing at each and every site that does IDES. And so you've got the Army up top, you've got the Air Force which has many locations, but they're very, very small numbers. And Navy and Marines.

You look at here, and you have a situation where you say how many conditions was the

servicemember referred for? Referred means the unfitting condition that the Army, Navy, or Air Force or Marines identified in that individual and said because of that condition, you cannot do your duties fully and we're going to ask you to leave the military.

But then the next column is the average number of claimed conditions. This is where the servicemember gets to go in and say, okay, Air Force, you're interested in my knees. By the way, I've got some other things wrong, too. Let me list them for you. So the average number over time we have been following, and up until last year, it was always ten. We're averaging 12 right now.

If you take this process across there, you see the standard is supposed to be for Army Active Duty Component 295 days. Can you read down there and see what the actual performance is? Look at the current month.

DR. SMITH: 323.

DR. CROSS: 323. I'm proud to say that one of the only things on here that is meeting the

standard on a regular basis for the past two years is this. We work very, very hard with lots of great people in the field, even Mike's people, and they've done just remarkable things that we didn't know if we could pull it off successfully at the time.

Why did IDES get so much attention? And I'll suggest to you that it was a strategic issue.

How many people--this chart will tell you, General, how many people are in IDES right now. Danny, where is that?

MR. DEVINE: It's the bottom.

DR. CROSS: 27,955. Now why is that a strategic issue? They can't deploy. If you can't deploy 27,000 people--what's an Army division these days--ten, 12?

CHAIRMAN SCOTT: About that.

DR. CROSS: It used to be 16. That means a couple of divisions are not able to engage in doing their job if you add that up, if you put the whole thing together. So that's why we were having regular meetings over at the Pentagon with the four

stars on a routine basis.

Got some questions on this?

CHAIRMAN SCOTT: What's the trend on reducing the total number of people in the IDES?

MR. DEVINE: We only now for the first time in over two years have seen that the numbers entering IDES has been reduced. So for two solid years, we've had an upward trend, and all the services had an upward trend.

CHAIRMAN SCOTT: Right.

MR. DEVINE: So we have finally been able to see that starting to come down.

CHAIRMAN SCOTT: Well, that should be encouraging to the service chiefs if that's the trend. It's going down.

DR. CROSS: But remember that number down at the end--the goal was 295, and I forget what was the actual number?

MS. MURRAY: 223.

DR. CROSS: Yeah. Still a ways to go, and a good part of that is VA's responsibility. Except for the medical part--there's one more important

thing, and again I'll give the guy credit. It was Gingrich, and he said who's in charge of this situation at Fort Eustis, Virginia, and so I in my best effort said, well, you know, there's several people in charge. There's the VBA person at the Regional Office, there's the medical center director over here, and then you got all these DoD guys and their chain of command, they're responsible.

He said, Gerald, that doesn't really cut it. I want one name that I can pin this thing on. And so we ended up putting the lead executive designation here, and you can see the person who got named was Dan Hoffmann. Who is Dan Hoffmann? VISN Director of Training, North Carolina, VISN 6. And I think that was pretty good because we would have a video teleconference, and the Chief would have a question, and suddenly there would be Dan sitting at his desk, and the Chief would say, okay, Dan, tell me about the situation over here, you know, whatever. And Dan would have to say, to be familiar with it, he'd have to be paying attention

not just to his work but to the VBA work and the DoD work as well.

He had to know the people in order to be familiar with it, and so that drove communication, and he would not be able to say the details about why the ratings were slow, but he would know that the ratings were slow. He would know the person who runs that program, and they would be able to collaborate, and he would say now let me hand you off to that person who knows the details. It worked pretty well.

DR. SMITH: You see in that list several names appear again and again. How did those people get to be so unlucky?

DR. SIMBERKOFF: Different branches of the service.

DR. CROSS: So within the area where Don Hoffmann is, there's also an Air Force base.

DR. SMITH: So it's by region?

MR. DEVINE: Correct.

DR. SMITH: But it's not necessarily--like I see Lisa Freeman, who, of course, directs Palo

Alto VA, and yet she's got things spread out all over that aren't near Palo Alto.

DR. SIMBERKOFF: She's the acting director for the VISN.

MR. DEVINE: She's down in 18 though.

CHAIRMAN SCOTT: I don't think that's the question he's asking.

DR. SMITH: All right. So all of those are within that VISN.

DR. SIMBERKOFF: Correct, yeah.

MR. DEVINE: Or if it's VBA--

MS. MURRAY: It's by the VISN.

MR. DEVINE: If it's VBA, VBA is responsible for the examinations in that particular location, which is why you would see a VBA Regional Office director responsible.

MS. MURRAY: So if the exams are being done by the VBA contract, then it would be VBA lead on there.

DR. CROSS: The general rule was whoever was doing the most work gets the lead.

DR. BROWNE: Because some of them I see

have both VHA and VBA. Does that mean they're doing both of--

MR. DEVINE: Right. There are some hybrids out there still.

MR. WILBURN: Did you discuss the recent report that recommended doing away with IDES?

DR. CROSS: Danny, you're Mr. IDES.

MR. DEVINE: Most of the people reading that recommendation kind of dismissed it quite frankly. Well, 323, and I think General Terry and others who have worked OPP with Admiral Cooper and Admiral Dunne, you remember like it was about 570 days in the old system, but you got to remember there was an important distinction. You have one set where it was DoD's. You had a fine line, and then the next set was all VA. That lying in between could be 40 years.

Right? How many of those Vietnam guys do you know--my dad--did his whole thing but never went to VA. Took him 40 years before he got into the system. So while this is 323 and our goal is 295, it certainly is a heck of a lot of better than

what it used to be, and they are still within the military system with pay and benefits until such time as they get their final rating and they are discharged with that rating and they start collecting their check. So that's why I think the IDES recommendation probably won't go too far.

MR. WILBURN: The thing that surprised me was that they didn't recommend specific improvements--

MR. DEVINE: Right.

MR. WILBURN: --and they just recommended killing the whole thing, which--

DR. CROSS: You know, it's never--as Danny said, it's never reached the target 295, but it's a vast difference where you had to do the entire process on one side of the room, cross the river over to VA and do a similar process entirely once again.

DR. SIMBERKOFF: Yeah.

MR. DEVINE: And it's still one set of examinations. So it makes a heck of a lot of difference, which is why our motto, especially with

IDES, is that these are our future customers coming in from DoD, and so we got to do this right. This is the first time other than maybe either a GI Bill education or maybe GI home loan that they even know what VA stands for.

So if they come in and, you know, they appreciate--

DR. CROSS: Some people think it stands for Virginia.

MR. EPLEY: That to me is key to much of what you guys are talking about. This is about building a shared fate among all of the players who previously barely would say hello. And now you're all sitting at the table together.

MR. DEVINE: I would say that IDES truly has changed dynamics from the tenth floor over to the Pentagon in conversations.

MR. EPLEY: Yeah, I believe it.

DR. CROSS: This drove a huge amount of work together between VBA and VHA, and, by the way, DoD, and, you know, we would--I would talk about this to DoD and say, I would say to one of my

colleagues who was over here, I said we were that difficult to deal with when we were DoD?

[Laughter.]

CHAIRMAN SCOTT: Probably more so.

[Laughter.]

DR. CROSS: Any questions?

MG MARTIN: Question. One of the things we've spent a lot of time worrying about in my former life and also in this Committee is the difference in RC and AC. And if you look at FY14, the RC is still well above the Active Duty component in IDES. It's better. It is better, but we're not there yet. Any comments about that?

DR. CROSS: It's the usual things. You know--Danny, do you--

MR. DEVINE: The ability to get medical records, the ability to get the examination because once they leave the RC, obviously, many of them will have their own daytime job. And so then trying to get them scheduled for appointments is challenging, and trying to get all those things when they're not on post, on base any longer is a

little more of a challenge.

So one of the things that we did make sure of how many folks we know come from Georgia, maybe they drill up in New York, whatever it happens to be, so that when they go through our process, we check to make sure that we get the examination closest to their home, what their choices are. So that there is no expectation that they have to go back to New York, for example.

And in the early days, it was a little bit complicated like that.

CHAIRMAN SCOTT: Well, I seem to recall that there was some discussion in times past about C&P problems of veterans accepting an appointment and then just not showing up. In other words, it was a statistic on broken appointments that was, at the time I thought it was appalling because it was hard for me to see how we would get from where we were and where we had to be when--and I think--what was it--30 to 40 percent in some locations were just no shows.

DR. SIMBERKOFF: Yeah, that's true.

CHAIRMAN SCOTT: They didn't call in, didn't try to change it, just--so you got a C&P doc that could be doing something else.

DR. CROSS: It's a tremendous problem for us because that's a wasted resource that expires. You can't use it because you can't get somebody else there in time.

Now, for IDES, here's how we handled it. Working with the chain of command, we'd say this soldier hasn't shown up two times. We'd send--we'd have a meeting and talk to them about their performance in terms of showing up for attendance at the VA. So we got an agreement. If they missed one time, they have to be accompanied for the next time.

You know, some sergeant probably from the Army has to go along with this individual is probably not too happy about that. And that has helped I think quite a bit.

MR. DEVINE: It has, and we're trying to get those first sergeants to come over from Army to our veteran population so we can have that same

kind of accommodation because it still is an issue for us, and it's something that Patricia has been looking at very closely.

MS. MURRAY: Yeah, we're monitoring that very closely and trying to pull out all the stops in terms of how we reach out to veterans, how we use their service officers to help us ensure that they show up for appointments. We also created something called RSVP scheduling that gives our facilities the ability to save the slot if we don't hear from the servicemember at all, and to be able to reuse that appointment. So we're trying to give them all the tools that we can think of as well as reach out to veterans to try to get them to show for those appointments, but it is a challenge.

DR. SIMBERKOFF: And it continues. Even though we call patients to remind them of exams, you know, it's not always easy to get them in and it's--

DR. CROSS: I'm surprised at that because--what do you think the percentage is right now overall--15?

MS. MURRAY: That's a cancel--let me send an e-mail.

DR. CROSS: Cancellation.

MS. MURRAY: Yeah. It's a different measure.

DR. CROSS: Different thing where the person says something, he can't come in that day-- that's not necessarily measuring--

MS. MURRAY: It is below 20.

MR. EPLEY: My guess would be that the DEM contract offers you guys a really helpful vehicle in this because a lot of times those are the guys that are 100 miles away or 150 miles away from the medical center, and under the DEM, I think you can ask the contractor to be closer to that guy, and they don't have to travel 100 miles to get there.

DR. CROSS: It does give us flexibility, and sometimes not as much as we'd like, but it helps.

MR. DEVINE: Except for wintertime in those far-flung North Dakotas.

MR. EPLEY: Yeah.

MR. DEVINE: Sometimes we just find people just can't get out or the DAV van didn't show up in time. There's a multitude of reasons, and sometimes it has to do with the process of ordering the exams, and that's an internal thing that we're fixing with VBA. That will take care of a percentage.

MR. EPLEY: Yeah.

MR. DEVINE: But it is still a challenge to get those folks in, and we don't know if it's work related. Especially on the female side, do they have child care issues? So we are trying to take all of these kinds of things into consideration and to make those accommodations as necessary.

Going back to Little Rock, one of the biggest reasons why it was successful was that the first day was Saturday clinic, and the second part of it was a Tuesday evening after work time, and when they called the veteran, when would you like, would you like to come in on Saturday, we got you covered.

If not, we can do it for you on Tuesday after your work day, and I think that's something that the folks really kind of like. And I know a lot of clinics do Saturday work. I know our D.C. one, for example, does Saturday work basically for that reason.

MS. MURRAY: Yeah, we have a lot of clinics doing evening hours and weekend hours to try to accommodate.

DR. CROSS: Indeed, in Washington, seven days a week, and every part of the exam can be done within like 40 yards of one spot, get it all done. Some of these exams might take two days to get everything completed.

I do want to say in regard to the importance of the program, I described IDES as being strategically important, but for the veterans it is personally important. It is just amazing how much emotion goes into this process, what expectations they have, what their misunderstandings are, and that's what we're dealing with everyday.

But the point is, the reason so many are coming, is because they believe based on what they've seen elsewhere that this can be a benefit to them. They know that this is very important because it's--forget the disability stuff, the money--to many of them, this makes valid the experience that they had in the military.

They come in and give their story. The VA goes out and verifies it, whatever, makes a service connection. To that individual that has now had Uncle Sam say this is what happened to you, we understand. When we say no, we don't service connect it, that seems like almost a personal affront to some individuals.

I wish I had a better way of handling that situation because it's very difficult for the veteran. We're looking at ways to try and lower the stress that a veteran may feel in coming into the organization to get this done. One way that we're doing it, Danny is working on a project to create a video that they will see at first to talk about what their expectations are. Want to

comment?

MR. DEVINE: For those who are parents, you remember the book, What To Expect When You're Expecting?

DR. SIMBERKOFF: Yeah.

[Laughter.]

MR. DEVINE: Love that book. It was great. So I got my personal ego handed to me at a recent conference in Ohio, and it had to do with the Veteran Service Officers, and what was interesting is I'd been hearing this same complaint forever so there were a couple of things. One, this one guy kept saying, well, I sent my veteran to come see you for an hour-long appointment, and it only took seven minutes.

I was up on stage, and as I said the following words, it occurred to me, do you have any clue about what kind of work goes into it before he even gets to us? And I said you don't know, do you, because we have failed to talk about it?

CHAIRMAN SCOTT: Right.

MR. DEVINE: So when you, Bob, go to the

doc, you come for treatment. You got a cold or whatever, you come out with a piece of paper that says Amoxicillin, or you're sick, and I'm sending you for X-rays. You have a concluding statement from the doc.

When you do C&P, there really isn't that. So we're going to do two things. One, we're going to have a five-minute, either in for NSO training so they can just see it on our Web site, but what should you expect? You've got to know that our doctors have already seen your medical records, and we've already started filling out your DBQ. We just need you to come in and maybe it only takes seven minutes for us to do the goniometer, do the range of motion, and that's okay. But we also need to say that to you.

CHAIRMAN SCOTT: Yeah.

MR. DEVINE: Thank you for coming in. It's going to be relatively short. I've already taken a look at all your stuff. I just need this one additional measurement from you. That's the kind of thing I want to put into the video so a

veteran/servicemember has an understanding what you folks who are treating versus those who understand the forensic side. Two different worlds.

Two different worlds, and we need to make that somewhat more clear for them, and I will tell you this, if there is anything that VBA really jumped on with the two feet, they loved this idea. They want to do their own kind of video--then what happens? We've done the examination. Now we give it back to VBA and what they do. So they're thinking along those lines as well.

DR. CROSS: The veteran comes into a clinic, has expectations, walks out of the clinic, or comes back a day or two later, has now something on his computer called "blue button." He pushes the blue button, and things get very interesting at that point. Are you familiar with blue button?

Mike, you want to tell them what it is?

DR. SIMBERKOFF: It's a way of looking at your medical record. You can look at lab tests. You can look at progress notes.

DR. CROSS: And it works.

DR. SIMBERKOFF: And you can even look at pathology results.

DR. CROSS: I'm a patient at the VA myself, and I use blue button. Finds out that some indication, probably not favorable outcome. That person can still be very--he hasn't heard from VBA yet. Hasn't heard about all the rights he has. He hasn't heard about what he can do about appeals and so forth. So he's got a partial picture.

Walks past the C&P clinic, and he's very angry. Goes into the C&P clinic and we have an incident of some kind. Some of our C&P clinics are quite small. Some of our C&P clinics are far from the hospital where they have the VA police. Some of those clinics may only have like three staff in them, a female, whatever, who is not really-- doesn't really have much in the way of a reasonable defense.

We're very concerned about them and working very hard on that. The first concern I have, the first approach that I want to take is lowering the stress level, and that's what Danny is

doing. Now we have to do some other things as well. We may have to put a code lock on the door, those kind of things that we don't have right now so that a little bit of protection there.

You want to talk?

MR. DEVINE: The blue button, just so you all know, it's part of My HealtheVet where the VA gets all the health care, and I can just--I can go into HealtheVet just right from here, and if there's a relatively quick turnaround time for the C&P exam, I can read the whole thing right there, and that's what he's talking about.

Then I can just literally take my tablet and go and have a confrontation with a doc, and we do get these reports, and there's a large percentage, and I don't mean to sound sexist, but it is concerning, most of our C&P docs, many of our C&P docs are females, and they seem to be the ones that have the evening hours or they're the ones in the far-flung CBOCs doing the examinations without the cop presence that is necessary for their own safety and security.

They're the ones on our calls on a weekly basis that are raising these concerns. I'm not feeling all that comfortable. So we're trying to address that.

MS. MURRAY: Just to add to the discussion, we are doing a couple of initiatives. One is removing the C&P exam from the blue button, and that is now in testing. The other part of this is veterans have been able go to the release of information and sign a release and get a copy of the C&P exams. We are moving the release of C&P exams over to VBA so that the adjudication can take place and VBA be responsible for the C&P exam so that is a work in progress, and I think we're moving pretty quickly on that.

The other thing, I'd like to just follow up, is that our no-show rate, including IDES, is at about 8.3 percent. I just wanted to give you that-

CHAIRMAN SCOTT: That's across.

MS. MURRAY: That's across IDES and general--about eight percent.

CHAIRMAN SCOTT: That is a significant improvement over what it was three or four years ago. Very significant.

One other question about, you know, you're talking about the stress levels of people. One of the folks in the personnel business over at the Pentagon said the first thing you got to understand about this program is that a whole lot of these people do not wish to be separated from the service, and so you're starting out, somebody says they're going to put me out, and says, well, that is one of the outcomes.

And so are you getting any help out of DoD on going after that part of the stress level by explaining, you know, what it's all about? It's not personal; we're not putting you out because you're you. You know, there ought to be some ways that that could be approached.

MR. DEVINE: You know you're right, and I hadn't thought about throwing in an IDES related kind of concept into the five minute, and that's something that I can probably speak to in ten, 15

seconds.

CHAIRMAN SCOTT: Yeah.

MR. DEVINE: So that's a really good idea. I appreciate that.

CHAIRMAN SCOTT: Well, I don't know that it would work, but at one time, not too long ago, that's what the higher-ranking civilian personnel people were telling me about problems that they had with it, with the program, was that some of these people are fighting tooth and nail to stay in the service, and they'll do anything to stay, you know, for good or bad reason.

MR. DEVINE: Which is kind of interesting-

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CHAIRMAN SCOTT: Yeah.

MR. DEVINE: --because when you take a look at this band, some of the folks tended to no show in the very beginning of the program.

CHAIRMAN SCOTT: Oh, yeah.

MR. DEVINE: Because they didn't want the examination.

CHAIRMAN SCOTT: Exactly.

MR. DEVINE: Because they haven't made up their mind, you know, what I'm going to do next. What am I--I've got two kids and the wife is now very upset and all the other thing. So they were kind of thrilled, if you will, that we weren't yet making the goal.

CHAIRMAN SCOTT: Yeah.

MR. DEVINE: So the question does have to be asked at some point, were we pushing too hard, too fast, and go up against a strategic value of having these folks taken care of.

CHAIRMAN SCOTT: Well, that's true, but I think my point was that I think that the services, you know, through the Joint Council or something, they ought to be giving you more help on talking to these folks about, you know, what the process is, and why that this an important process, and I kind of wonder if they're doing that.

MR. DEVINE: Well, they've got two locations, sir. One, the acronyms all over the place. The PEBLO and the MSCs--

CHAIRMAN SCOTT: Yeah; right.

MR. DEVINE: --are those individuals that are supposed to help them through and understand.

CHAIRMAN SCOTT: Yeah.

MR. DEVINE: And it's not just the individual member. It's for the families because, as we know, some of our members at that particular point have some challenges in receiving that kind of guidance. But that's a great point.

DR. SIMBERKOFF: I hate to say this, but what is the ethical justification for removing C&P exams from the blue button when all other exams and all other lab tests are there?

DR. CROSS: There have been quite a few threats, and on our national call, which I have every--Mike, you come on the call.

DR. SIMBERKOFF: Yeah.

DR. CROSS: All right. You come on the call with me, and we'll pick up the subject, and I'll say tell Mikey what is really going on.

DR. SIMBERKOFF: Yeah.

[Laughter.]

MS. MURRAY: So, you know, I guess, yeah,

I guess it's a question that can be--

DR. CROSS: Truthfully, Mike, you see it in the newspaper, these weird things happening frequently--

DR. SIMBERKOFF: Right.

DR. CROSS: --with some frequency around the world and in our own country. I'm scared to death that something like that was going to happen in one of these situations.

DR. SIMBERKOFF: But, you know, in all honesty, you know, things are written in charts and diagnoses are made which in the rest of the medical record--

MR. DEVINE: The exam request was made by VBA, and so this is in response to a VBA request so they can adjudicate a certain claim. Now once that's done, it then is put back into the client's records so they can see it.

DR. SIMBERKOFF: Right.

DR. CROSS: Well, there's another distinction. They're seeing incomplete results. They've got part of the picture. They haven't

really been given the overall picture. VBA hasn't come in and sent them a note and said you've got this, you can do this, you can do this, you can do that. Life is not finished yet. And that's a significant difference.

MS. MURRAY: Yeah. I think sometimes when they see them, they think that the determination about whether to grant or not is solely based on the exam, and it's not. You know, there's a whole C-file and all other kinds of information that is weighed, and so for our examiners to have to sort of be, you know--

DR. SIMBERKOFF: But the exam is the exam, and to be honest with you, very little of it should be a secret to the patient. I mean when I'm doing an exam, I'm telling the patient if--

DR. CROSS: What do you think the typical condition would be?

DR. SIMBERKOFF: I guess it's mental health issues, but, you know, they're not surprised about the fact that they're there for mental health issues.

MS. MURRAY: But if there is a request for an opinion, and the provider has to give an opinion about service connection or some very specifics, I think without having it fully adjudicated, I think our examiners feel like they're to some extent at risk.

DR. CROSS: General, I appreciate--the great thing about talking to this group is we can have discussions like that.

DR. SIMBERKOFF: Yeah.

DR. CROSS: You go over to other places, and it's not going to be that kind of a sensitive discussion. I really appreciate that.

I have a couple other things to talk about in regard to challenges that we face right now.

CHAIRMAN SCOTT: Okay.

DR. CROSS: I've talked about the contracts, and I told you I thought that was one the riskiest things I'm involved with personally, and what I did to reduce, mitigate that concern.

The second challenge is DBQs themselves. When they started out, they were very thick, could

have many pieces of paper in them, very hard to look at. DoD hated them because they wanted a standard narrative summary as opposed to this, whereas VBA wanted the minimal text possible, just tell me exactly what I need to do the rating.

And so we went back and forth on that for some period of time. I think we're reaching equilibrium to some degree now. Another issue with them--there are 82 or them, or 85, whatever the number is. Now I could understand if you go apply for Social Security, they got three forms. You know, we got 82. So which one do you use for Bruxism, you know, you're grinding your teeth at night? Is that ENT or is that Dental, you know? How is somebody going to know that?

The Mitchell criteria--if you ever heard about Mitchell, we'll talk--the Mitchell criteria were not in the DBQs, and so you had to remember to write them in, and for many times we found they were not written in fully or at all so that becomes that insufficient word, again, and it goes back.

So the current DBQs, we put the Mitchell

criteria in, and they're coming out as a new edition shortly. But the DBQs, great idea, I think. We'll see how it plays out in the end because we're designing them now to communicate to the risk, to the calculator in VBMS. And so you get to the point that you do start to get some benefits from automation if we can get them all linked up.

One other risk that I want to mention if I can read my writing is some veterans want to take these exams to their private doc. That is allowed. What is not included in that is the challenges that you're going to have when you do that. So if you're in a situation where there's not a lot of veterans and they are not getting lots of exams from this particular doctor, it's going to be an interesting discussion when the veteran comes in and says, well, doc, I'd like you to do my DBQ, and he says what's a DBQ?

And he said, well, doctor, I'll show you. You go to this Web site. Well, the doctor may not have a computer in that exam room. So you go to

the Web site, if you can, at some point, and says maybe I'll do it later and show him where the Web site is.

And then the doctor said, well, to finish your exam, we're going to need an X-ray or we're going to need some other kind of test, and this doctor is very patriotic and hasn't charged him a cent so far because he knows it's a veteran, wants to help out, very proud of him. When you start getting into the lab tests, the X-rays, that generosity starts to decline just a tad.

And so the veteran then calls me up and says the doctor charged me a thousand dollars and my insurance wouldn't cover it because it was a government administrative exam that I was getting, and the doctor wasn't too happy because it took a lot--he had to work on it at night, and plus it took up quite a bit of time.

And then it came back as insufficient because we didn't know what Mitchell criteria were. So he had to go to the VA for an exam anyway. So it's a challenge. There are other docs who have

become very--in the private practice who become very familiar with them and do a superb job.

It was the little bit the same with our primary care staff because many of the veterans wanted the primary care doc to fill it out. And so I went back and forth with our primary care doc leadership, and I said if you're not going to do it, you have to find a better way of telling the veteran than you've done so far because they're unhappy with how you explain it to them.

But if you can do it, and we sat down and picked out about ten of the DBQs that primary care would, in general, be very well qualified to do, and we got them to sign up that they would generally support those.

But if they don't know he's coming in, and they've got a 20-minute appointment, and the DBQ is going to take 30 minutes to fill out, you know, that's a challenge right there in our folks as well.

DR. SIMBERKOFF: So if you've got--now have a wonderful argument for going to C&P exams.

The new benny travel rules which allow--

DR. CROSS: Yes, yes.

DR. SIMBERKOFF: --the veteran to be reimbursed for travel for a compensation exam but not for--

DR. CROSS: I don't know if that's new.

DR. SIMBERKOFF: Well, newly enforced.

DR. CROSS: What Mike is talking about is we pay the veteran for their expense in coming to the VA at a standard rate, 41.5 cents per mile last I heard.

DR. SIMBERKOFF: Right.

DR. CROSS: And if you figure that out, and your car gets 20 miles to the gallon--I calculated this one time. I think we're paying about \$8.50 a gallon if you relate it to just that. So there's a little bit of margin for error in there to help the veteran. That's good because they've got other expenses besides gasoline.

DR. SIMBERKOFF: Right.

DR. CROSS: They've got wear and tear on the car and they've got maybe stopping to get

something to eat and so forth.

General Shinseki went out to a site one time, and I heard about this the next day because he was unhappy, and the issue was a veteran came up to him and said, well, it's almost Christmas, I need to make some more appointments at the VA, and so, you know, for money purposes.

General Shinseki did not find that funny. The veteran was just joking, but did not find that funny. So we have heard of occasion where the veteran says, you know, I've got two things to be seen by. It's okay if I don't get the same day.

DR. SIMBERKOFF: But C&P exams are specifically allowable under benny travel, but for most other things, the criteria are much more strict.

DR. CROSS: And I think they should be, you know, to help them get through this process.

We discussed a number of challenges. Funding. Funding probably this year is not going to be quite as robust as it was next year. I don't know. Patricia, you want to comment on that?

MS. MURRAY: So we have been, as we've been working over the last FY and the coming FY, VHA has been asked to take a number of budget reductions, and so we have been participating in that and understand that for '15 and '16, there will be some additional requests forthcoming.

So we were fortunate. We've rolled our IDES supplement into the VERA model. We did that this year at the FY12 level, which was the highest funded level. So IDES has been rolled in, but as we roll out SHA, under the VOW Act, we were granted some funding to support that--about \$50 million last year and this year coming so we do have that supplement.

But it is a bit of a challenge in terms of responding to the request for budget cuts, but we've managed to send out supplemental funds to our field. At the end of the year, when we were out, Finance was able to roll over some funds to support the last few sites that needed additional funding so that was taken care of. So we worked within the restraints that were given, and we've done okay so

far.

MR. DEVINE: And the big deal about the VOW Act, it mandates TAP, Transition Assistance Program.

CHAIRMAN SCOTT: Right.

MR. DEVINE: Great program but not everybody did it in the past. Sort of one of these voluntary kind of--now it's supposed to be mandated, and the concern was if and when more servicemembers go through TAP, learn about the disability process and VBA, in general, they will have more disability claims coming our way.

CHAIRMAN SCOTT: I don't think there's any question about that. I mean everything that VA and the services are doing is generating claims. Now whether that's good or bad, I guess depends on your perspective, but I think you're exactly right on that, that everything that is going on is going to generate more claims for the foreseeable future.

Now when you start looking about the services getting smaller, and farther out, it may not be so.

MR. DEVINE: And you know what the budget is for claims. I think it's 56 billion.

CHAIRMAN SCOTT: I do. Something like that.

MR. DEVINE: A big concern for VBA folks.

MS. MURRAY: I think the key for us is just having a sense of the projections of when people are coming out. As much advance notice or projections we can get from DoD, that will be beneficial to us in terms of resourcing the efforts to get the work done.

CHAIRMAN SCOTT: I think they'll know what they can--I think they'll tell you what they can know, but, you know, but the service end-strengths are, as I understand, pretty much up in the air, and so you're probably not going--it's probably going to come without a lot of learning or whatever.

Go ahead, Kirk.

MG MARTIN: One of the things that this Committee has discussed in line with Under Secretary Hickey's emphasis is Guard and Reserve

issues, and there are two issues that we've talked about today that we probably ought to just at least mention. One is Separation Health Exam, which is far from routine in the Guard and Reserve, particularly for traditional Guard members where they're not on Active Duty when they retire.

DR. CROSS: Yeah.

MG MARTIN: They may have been on and off Active Duty ten times, and maybe they've done some separation exams at the end of short periods of Active Duty, but if it's really short, 30 days or 45 days, maybe not. So that's one issue.

The other is TAP, and TAP is far from routine for Guard and Reserve members, as you're aware.

MR. DEVINE: I'm glad you brought that up. One of our employees just literally returned a few months ago from his extended tour, went through Bliss, and he's a Reservist, and because he works for us, I'm naturally going to say how was your demob at Fort Bliss, and he says there was no process. It was unfortunate.

And unfortunately the things, you know, we hear scuttlebutt is, trooper, look, you want to go home, pal? You know, you haven't seen mom in awhile. We know you want to go back and see the kids. So if you want to do anything, do it at home. And basically that was the kind of brief that he got, and he did bring that back to me, knowing full well, you know, where he works, and he says, yeah, we've got a situation, and this is a Reservist, and it was a fairly large size unit that came back.

They went through Bliss. Of course, it's going to be large. So we are concerned about that, and we know that, you know, one of the only benefits they have is Quick Start, and I'm not really sure if all the RC folks really know what Quick Start is all about. So we have a lot of work to do, and we do hope that TAP, TAP, TAP especially for those Guard folks or Reservists get out that point.

MG MARTIN: Well, that's good, and I think, my sense is, General Scott, that the

Committee is certainly supportive of SHA because that provides a great database for the future.

CHAIRMAN SCOTT: Yeah.

MG MARTIN: And TAP because it tells the members about their benefits or the way to apply for benefits or getting into eBenefits and lots of things. And so those are continuing concerns.

MR. DEVINE: Now, is it mandatory for RC folks to get into eBenefits yet? See, that's the part that they are mandating. If you're going to attend the TAP class now, you have to have an eBenefits account.

MG MARTIN: The problem is they don't attend the TAP class.

MR. DEVINE: Maybe that's something that you guys can do. If you get Title 10 orders, maybe that's one of the first things. Title 10 orders and then as part of that package, you need to get into eBenefits, which is great for us because part of eBenefits, there's HealtheVet, and--because they're going to be eligible for health care as well.

DR. SIMBERKOFF: You may not know the answer to this question, but will those Reservists who are being deployed to Western Africa be eligible for VA care in this all-Ebola era?

DR. CROSS: I would certainly hope so. I don't know why--why wouldn't they?

MR. DEVINE: They should, and actually, sir, did you want to break for a quick bio break or just go?

CHAIRMAN SCOTT: Let's keep going here. Anybody that's got to have a break just take it, but let's keep going.

MR. DEVINE: If I could jump in on that particular thing because when Dr. Cross was talking about CL, and I want to go back to Ray and to Bob because I know what you guys have done, and perhaps your work with the two admirals in the past where we had to deal with Agent Orange.

DR. SIMBERKOFF: Right.

MR. DEVINE: And, you know, looking back, the science wasn't completely there, and there was a lot of political stuff, and it was kind of an

ugly situation. There were problems. We didn't know how to connect it. And I think you can say that science has improved to the point that we're looking at Camp Lejeune exposure kinds of issues in a completely different way, and part of the system that we're setting up to look at Lejeune I think is going to be the model of the future, and it may be something that you guys want to think about.

The Ebola thing is the one that gets me quite a bit. We've still got some Gulf War issues. We still have a lot of exposure issues that more and more science gets better, the medical connectivity to service-connected, to service connection is going to be there, and we as an institution have to decide how we're going to handle this. Now, Lejeune is interesting in that it's not just the military veteran.

DR. SIMBERKOFF: It's a lot of family members.

MR. DEVINE: And it's his family as well. Is that our future?

CHAIRMAN SCOTT: We've made a couple runs

at presumptions, and so far we're batting zero with non-concurs that come back from--we're going to go at it again, you know. We're not discouraged, but it's the whole notion of what you're talking about is we have tried to talk about, you know, that--

MR. DEVINE: I share your concern because they were activated Title 10 is the way I understood so they are going to be eligible.

CHAIRMAN SCOTT: Yeah.

MR. DEVINE: And it's going to be interesting. Maybe New York has a--no, New York doesn't have any of the four--

DR. SIMBERKOFF: Yes, we do. We don't have the four, but right now we have actual--the original four are here at the NIH and Emory--

MR. DEVINE: Right. Emory. Nebraska.

DR. SIMBERKOFF: Nebraska and Missoula, but right now, there is--today, they're inspecting Bellevue, which is right next to the VA.

DR. CROSS: As a site?

DR. SIMBERKOFF: Yes.

DR. CROSS: Is it in pretty good shape?

DR. SIMBERKOFF: Bellevue is ready.
They've been preparing for--

MR. DEVINE: Maybe if we take the polytrauma kind of concept where you have the real big one, one for every VISN, something like that. This is me speaking. I personally think the exposure issue is going to be our future in disability because the science is going to be there to make that nexus. And I think Ebola has really been a--

DR. CROSS: General, we're going to talk to you about some challenges we have, including DBQs, funding, VBMS, private work, security, which I think was probably not something you were expecting.

This is an important program. It's not just the money. It does tremendous things for veterans, and if we're not good stewards of that program, I'm very concerned that we can start losing portions of that. It helps the veteran, you know, some who are very deserving, who have had something happen to them. It helps their family.

It keeps the family together.

And so every time I see a veteran, that's what I'm thinking. That's what I want my staff to think, you know, that this is very important to them. They will tell you this is more important than that primary care appointment. If you give them a choice which one to go to when they're hoping to get disability, they'll do that rather than get their blood pressure checked that day.

They told me this in cases, and we're doing over two million per year of the exams, individual exams, multiple of those per person.

I'm going to turn it over to Danny and Patricia to look at the slide set and see if there is something we haven't covered, but I'd rather than just leave this in your hands if there is something you want to talk about. If we don't have any answers today on a specific thing, you're here tomorrow, we'll send you a note.

CHAIRMAN SCOTT: Well, we'll be here. Let me mention a couple of things here before we move on. I do want to go through the slides. I want

the folks to have the benefit of seeing them. And this comes more into two things. One of them is how we might be able to help you. I think there's a lot of support among this Committee for doctors in the ROs and raters at the medical centers.

I mean that makes so much sense to us that I think that we can work that into our report in a pretty definitive fashion, say, look, you know, let's think this over before we take a shortsighted approach to this because it's clear that the larger problems we face are more apt to be solved in the longer run with docs in the ROs and raters at the medical centers. So I think we can take that on.

On the DBQs, I think we'd like to help. What I heard you say is that in some cases, they tend toward inefficiency because--insufficiency because they're too brief. In some cases, I think I heard you saying there are probably some things we're trying to do DBQs on that probably should not be done via a DBQ. So what can we say or do to support your efforts regarding DBQs?

Now Mike has given us some inputs along

the way about some of the problems, but I'd like to know what can we say or what should we say or do that might help you in the DBQ field?

DR. CROSS: You stated the concern just a little bit differently than I would.

CHAIRMAN SCOTT: Okay.

DR. CROSS: DBQs were a process of a competition that was held sometime back, and a staff member at Pittsburgh RO won, made the suggestion and said why can't we just write down a check-the-box kind of thing, exactly what we need to do the rating? That was, seemed to be and I think was a good idea, and they won the competition.

And then we faced the issue of making the DBQs in a way that is understandable and can be interpreted reasonably after it's filled out. General Hickey appropriately wants more check-the-box/less text. The Board of Veterans' Appeals over across town, they want all text. They said how did you arrive at that checkmark? What did you do? What was your, how do we know what was done on the

exam, you know, they go through that kind of point.

They have not--in conversations with me have been quite skeptical of these, and I think they have been with General Hickey as well.

They have to change periodically, and we wanted a public setting DBQ that the public could use. The challenge with that, when we have to make a change, it has to go to OMB. OMB turns it around in a little bit over a year. So if we find a mistake on a DBQ, we're going to have to get it changed or find some other way to deal with it because OMB is not going to get to it tomorrow, and we eventually had some that were over a year in getting OMB to change.

What am I missing? I'm inclined to try and make them work right now, and if we started off in some other direction right now, I think we'd just be, you know, sinking.

CHAIRMAN SCOTT: Okay. Is there anything that we can say, though, that might support the inclination to make them work, that might make them work better, or should we just let it alone this

time? We have, in the past, our reports have been generally supportive of DBQs.

DR. CROSS: That's a good way to say it this time.

MR. DEVINE: Can I just offer this caveat though because I hate to throw water on the party here?

DR. CROSS: Which way are you throwing the water though?

MR. DEVINE: Just kind of in the middle. Maybe on the recorder so they don't quite get all of what I'm about to say. The Court, however, does not like DBQs, and the Court has stated so in an opinion that was rendered in March where the Chief Judge said in a footnote that basically his opinion is that the Secretary should scrap them and start completely all over.

[Laughter.]

MR. DEVINE: That's basically his opinion, and you don't need legalese to interpret. It was fairly straightforward. The reason is, and Dr. Cross was very clear earlier, is they--it's just

like your fifth grade algebra where you had to do the test and do all your answers, but you had to turn in the other two papers to show your work because the teachers used to grade that as well.

And that's what the Court and the Board both need and that's what they do not get, and if this trend continues, there is a case wending its way through the Court system regarding the DBQs that may call into question an awful lot of things. So it's, you know, how to improve is, let's make sure that the Board and the Court both can accept the documentation of this examination as legitimate because if we're going four and five years down the pathway and the Court says just one time--this is how we give the names to all our cases.

You hear Mitchell. You hear Nehmer. It's all these guys and people who have successfully done legal cases.

DR. CROSS: DeLuca.

MR. DEVINE: DeLuca. We don't want Smith all the way on down there that's going to change our world without us either having preparations or

another way to do our documentation.

MR. EPLEY: You know if the DBQs, if it is required that they be amended to not only allow but to mandate more narrative, they still offer a benefit to the examiner in that they take you through the items that you need, the rater needs to see to make a rating. So it seems like you can do a hybrid and still get value out of it.

MR. DEVINE: This is an absolutely great document for the raters, absolutely wonderful--

DR. SIMBERKOFF: Yeah.

MR. DEVINE: --beautiful kind of thing. This is a two-prong effort.

MR. EPLEY: Right.

MR. DEVINE: And if you take a look, those who are treating physicians will take a look at the DBQs and realize that the process stated on the DBQ is somewhat backwards, reverse order, from how they conduct examinations, and so that was the issue--

DR. CROSS: You start off on the DBQ with the diagnosis.

MR. EPLEY: Yeah.

DR. SIMBERKOFF: That's what they're there for.

MR. DEVINE: Correct, and it's another reason why we should just have C&P doctors--

DR. SIMBERKOFF: Which is, so that's my point--

MR. DEVINE: Right?

[Laughter.]

DR. SIMBERKOFF: That's my point, that it's a better to have people who do this all the time do it--

MR. DEVINE: Agreed.

DR. SIMBERKOFF: --than try to ask your people, you know, people who are taking care of patients in the clinic on a regular basis.

MR. DEVINE: Perhaps, General, that may be one of the key points is we do have that expertise, and there are these subtle reasons the general public or VBA sometimes don't even quite realize that's an important factor.

CHAIRMAN SCOTT: Okay. Well, my inclination is to be generally supportive, but

mention that the courts and Board must accept the results and leave it at that because I'm not sure how much more detail that we can provide that is supportable by knowledge, in fact.

One more question here before we go to the slides. There is some concern about the diagnosis, service connection, and level of disability associated with sleep apnea, and they're working on that in conjunction with the update of the VASRD, but I was wondering if you had any thoughts on that, Dr. Cross?

DR. CROSS: We're doing a bunch of sleep studies.

CHAIRMAN SCOTT: Okay.

DR. CROSS: They're very time consuming, they're very expensive, and they typically require you go into a lab and spend the night. It's difficult for the veteran. Technology is changing, and we are finding that we may be able to use more of an outpatient take-home kit that you would use for sleep studies.

DR. SIMBERKOFF: About 50 percent of our

studies are done at home.

DR. CROSS: Okay.

CHAIRMAN SCOTT: Is it your impression that this particular disability is being abused?

DR. CROSS: There's a tenuous question that comes up in many forums why is sleep apnea a military-related issue? I haven't quite exactly thought about that yet as to what the answer might be.

CHAIRMAN SCOTT: Well, we had recommended in an interim report something like this, that probably the exam should be given by VA doctors because the conventional wisdom is that if I think I have sleep apnea and I can get a private physician to prescribe a C&P for me, then I can bring it to you, and I get 50 percent disability and that's it.

DR. CROSS: Yeah.

CHAIRMAN SCOTT: So one of the things we recommended was that VA doctors do the C&P for that. The other thing is that we were very concerned about how it was service connected.

Apparently it's beyond an assumption, a guess, something beyond an assumption if somebody says I have a sleep ailment now, and it's all the Army's fault, and the other one was why 50 percent if a C&P--I'm sorry--if a CPAP machine solves the problem?

And, you know, we're struggling with that with the VASRD, and I'm sure you're having some of your people be having some inputs to that. But on the other hand, it is kind of--it's a topic that gets a lot of conversation out in the civilian population, and, you know, you were talking awhile ago about being stewards of the VA and of the government and of the bank account and all that, and I probably get asked, the question I get asked the most is what is this BS that you people are doing regarding sleep apnea?

[Laughter.]

CHAIRMAN SCOTT: And it's pretty much out there. There are articles being written. I've gotten queried two or three different times, and I generally said, well, you know, I'm not a medical

authority so I can't help you too much, but it's an issue that we have addressed it, and basically the response we got back was we're going to look at it.

Do you think we're really looking at it?

DR. CROSS: General, I think you stated it quite well. I doubt that I could add much to it, but it does come up in lots of conversations, but let's think about this philosophically for a moment.

You point out you get better with treatment, and that's true, but we service connect blood pressure, and I can make your blood pressure perfectly normal and hopefully avoid some of the consequences that are down the road. These are deep philosophical issues that have been developed over time, sometimes maybe without as much, not having as much thought put into it as we might have.

I wonder what our stakeholders believe? Our stakeholders really probably believe that we should do everything that we can for that servicemember coming back who's injured and ill and

coming back on a stretcher from warfare.

They're surprised probably if they were told, well, much of this is something a bit different and relates to the, you know, problems that you see quite frequently elsewhere. My personal philosophy when I see that injured veteran, when I see that amputee, when I see that TBI, I wish I could do ten times more for them--

CHAIRMAN SCOTT: Sure.

DR. CROSS: --than they're getting. When I see the ringing in the ears and the hemorrhoids or whatever, I don't have quite exactly the same feeling. Did I screw that up?

DR. SIMBERKOFF: No, that was well said.

CHAIRMAN SCOTT: What about, what do we do then if we believe as an institution that proper exams are being done, proper service connection is being done, proper levels of disability are being awarded, then what do we do to convince the skeptics that those are occurring, that that's the case?

DR. CROSS: This is right down your alley.

Go ahead.

MR. MAKI: Why do we provide service connection for any disease? Because that's what the American public want and has wanted for the defenders of our nation since 1606.

DR. CROSS: And through every warfare that we've gone through--there used to be a little, a very good, historical the VA had. I'm talking about through every conflict, we've actually made it a bit better.

DR. SIMBERKOFF: Yeah.

DR. CROSS: You know recognizing what that means.

MR. MAKI: And we've gone from simple standards back in the colonial periods where it said if you were willing to defend the colony, whether it was Indian tribes or a bear that got into the garbage or whatever, if you got injured or killed, the colony would take care of you and your family for the rest of your life. And it branched from there.

DR. SIMBERKOFF: Jim Wright wrote a book

called Those Who Served, which basically traces the history.

MR. DEVINE: But having been part of the committee that wrote some of these laws, I understand that you we have to have rigorous examination of this particular program on a continuing basis. I think you were also part of the group that asked the question, why we have been using the VASRD when the rest of the medical world uses ICD codes?

Should we change? I don't think we should be afraid to have that kind of conversation, and I think almost everything in there should be questioned, whether it's sleep apnea. I mean if the standard, you're using a CPAP, therefore you have sleep apnea, therefore you're 50 percent, the argument is you guys are better.

DR. CROSS: Let me go back to this question over here. If you find a disease that is more frequent among veterans, I think that provides perhaps a bit of logic in support of that more so than you were talking about. Do you have a

question?

DR. SMITH: My point was that there are actually two things involved, which is something like is sleep apnea related to your service, and then--I mean that would, if yes, just a zero percent. Then is there any connection to earnings, which is the only thing the law is supposed to allow for money above, you know, anything sort of basically above zero percent? And then the fact that you've been treated makes a difference. That's why I don't think tinnitus should probably be more than ten percent even if it's above zero. Sleep apnea unless it's uncontrollable probably shouldn't be above zero.

I don't mind personally if they, you know, you can use epidemiologic studies you were just suggesting to prove zero, but proving above zero, I think, personally speaking as an economist, requires a study like they've done before to show there is actually some earnings loss.

DR. CROSS: You've all launched yourselves into a deeply philosophical, highly emotional,

political, medical discussion that I think many of us are aware of and hesitant to find which way to go.

MR. DEVINE: But on our side, we have an opportunity then to treat servicemembers, and we can get them into the system a little bit easier, and so for, on the VHA side, that for us makes it a little bit easier to do some of these things, and it's a little bit different being an economist and having to take a look at the \$56 billion balloon that they have over there. That can be a challenge.

Some of you may not know, but in 1898, we collapsed the entire economy based in part because the veterans' benefits at the time were 25 percent of the then federal budget, and then from that point to past World War I, there wasn't a whole heck of a lot for veterans.

So this is America. We tend to go in these drastic cycles sometimes, which is why I like the idea of a continuous vigorous honest discussion about these, whether it's at the congressional

level where we have these kinds of talks in our closed rooms frequently, and I think they should be had, and I don't think there is any reason why we should hide behind the fact, whether it's VASRD, ICD, call into question whether it's shaving bumps or if it's sleep apnea, I think each and every one of them should be called into question because it is the American public. We should be able to vigorously defend the decisions that we're doing for the folks.

I will tell you that many of those folks out there think that every single one of our disabled folks were actually warriors on the battlefield. That's not necessarily the case right now.

DR. CROSS: Well, it's not necessarily the case, but, you know, in the warfare that we're facing today, if you're anywhere, you're potentially--

MR. DEVINE: Uh-huh. That's why I think exposures is the one of the near future. I think it's a tremendous question, and sometimes the

answers are very difficult, but we shouldn't back off from them.

CHAIRMAN SCOTT: One of the other things that we recommended that was not really what you might call jumped on favorably was that IOM be asked to do a study on sleep apnea to make some determinations about some of the data that we're talking about here. Is it, is it more frequent among veterans than the non-veteran population, et cetera, et cetera, understanding that it costs money to do a study?

Okay. Well, I just wondered where you were on--where you were on that specific thing. We can either mention it in the report or we can ignore it and say, well, it's no different than any other--and it's basically at the present time sleep apnea is essentially a presumption in the sense that service connection is quite easy. It's a fairly high level of disability at 50 percent level, et cetera, et cetera. And, you know, maybe we just ought to let it alone.

DR. CROSS: I would concur with the IOM.

CHAIRMAN SCOTT: Pardon?

DR. CROSS: I would concur with your IOM idea.

CHAIRMAN SCOTT: Okay. Well, maybe we'll recommend that again. It seemed like a pretty good idea. You know, the other side of the argument about taking care of the budget, et cetera, et cetera, is that there is a segment of the American public--I don't know how big it is--that thinks that since our veterans come from--generally speaking--the lower socioeconomic strata of the country that anything that we do, we should do, to include giving them all 100 percent disability.

I've heard a number of people say something along those lines. So that's kind of the other end of it.

DR. CROSS: Yeah. I've heard all of those things from A to Z on both sides.

CHAIRMAN SCOTT: I'm sure.

DR. CROSS: We need the wisdom of Solomon-

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CHAIRMAN SCOTT: Yeah.

DR. CROSS: --on this one.

CHAIRMAN SCOTT: Okay.

MR. DEVINE: So, General Terry, we can go to the slides real quick, but really the first 13 or 14 we've already covered. So we'd like to just jump all the way up to number 14.

DR. CROSS: I'll put you in charge. If there is one you want to go, that's fine.

CHAIRMAN SCOTT: Okay. Let me let the Committee members here just look at one through 14 here, one through 13, and then if we agree that 14 is next, that's fine. If there's a question or comment about anything between here and there, let's talk about it.

MR. DEVINE: The first couple slides are basically we're bragging on ourself and why we're here. We do talk about the training efforts, and I think Patricia dealt with that. Then we go right to the picture of the DBQ, Disability Benefits Questionnaire.

Most of you probably know this, but I will point out the very last bullet here, support VA's

fully-developed claims, and we really do support this idea that try to get all the information that's possible from the veteran so that when the claim goes in, it's done.

Dr. Cross talked about the origins of the DBQs. They're on slide ten. Casey Kasem's Top 15 of the DBQs that are currently used in our process. Yeah, Bob?

MR. EPLEY: I just find it astonishing that the number one volume is medical opinions. That surprises me a lot.

MR. DEVINE: Well, that is the increased use of ACE is one of the reasons.

MR. EPLEY: Okay.

MR. DEVINE: And if there's any conflicting kinds of information that's out there, you go for medical opinion to do the clarifying examination. But then you see what number two is.

MR. EPLEY: Yeah.

MR. DEVINE: Another great reason to have the SHA on the way out.

MR. EPLEY: No surprise there, and knee

and lower leg, those make sense. PTSD. They all make sense.

MR. DEVINE: And, you know, during this whole thing, the notetaker reminds me of the audio. I keep thinking she's doing a tinnitus exam as it is right now.

[Laughter.]

MR. EPLEY: She's listening to rock "n" roll music.

[Laughter.]

MR. DEVINE: So maybe we can start right here. DBQs have been kind of interesting about who should complete them. We do think that the C&P examiner is probably the most competent individual for the obvious reasons that we think most of us can agree to.

And I too use the VA for my medical, and if Dr. Cross ever walked into, you know, primary care an hour ahead of me, and he had a fistful of DBQs, and I'm out there in the waiting room, and I'm sick or other people are sick, and he's in there doing his DBQs, I'm probably not going to be

necessarily a happy primary care camper, especially since we have a very legitimate, a very competent, and a very thorough C&P clinic right down the hall. Literally, Joyce is--Joyce is right around the corner. Dr. Joyce runs our C&P in D.C. Right around the corner, and it's a lot easier for me to do it that way.

So that's what we call the "no wrong door" policy. If a primary care doc is unable and/or unwilling, and a lot of times they either don't have the specialty competency or they just don't have the time, and given this environment right now where primary care access is the coin of the realm, it is probably better that we're able to take them down to the primary, to the C&P clinic to make sure their examination is then scheduled.

So that's what we call about the wrong-- now what we don't want to do is simply inside that room, I do not want Dr. Turner to look at me and say, Danny, I'm not going to do this and not have that closure. What we're asking then is that she call one of the folks out of the orange clinic to

take me physically around the corner to the C&P clinic and make my appointment.

Now, remember, we take care of these things in less than 28 days, and if you live in the D.C. area, more than likely you're going to have it done in less than 14.

DR. CROSS: The distinction is very important that Danny just made. If we're handing the person off, the veteran, just saying I don't do that is not adequate. You got to do the warm handoff. Make them feel like you're caring for them, introduce them to somebody down in the C&P clinic and get them on the right pathway.

CHAIRMAN SCOTT: Well, why is it that you and I when we go to a civilian medical care, say we go to our GP and he said, you know, I really can't help you with this, I'm referring you to the dermatologist, and you say, well, I don't know any dermatologists. He says, well, my assistant out front here has got a list of qualified dermatologists here in Abilene, or, you know, he may say, well, I recommend this guy; we've had good

luck with him. But we don't find that offensive, do we, when we go to see our doctor, and he says, well, you know, I just can't really do that; I'm referring you to a specialist.

MR. DEVINE: Well, in Abilene, maybe it's a little bit easier, but in Washington, D.C., if I then have to make an appointment with a dermatologist, it could be another seven, eight, nine, ten weeks if I know who one is--that takes my insurance. That is then part of the problem.

That dermatologist probably only works Monday through Friday during my work hours. So the thing is, is we're trying to consolidate and get as much of this done.

CHAIRMAN SCOTT: I'm talking, though, about why is it that we piss them off when we do that, but on the other hand, it doesn't bother us when we go in and we're told to do that?

MR. DEVINE: Because we have not managed the veteran's expectations.

CHAIRMAN SCOTT: Okay.

MR. DEVINE: There are others on the

outside.

CHAIRMAN SCOTT: So how do we do that then? It looks like it's an expectations problem.

MR. DEVINE: Yes, sir, it is.

CHAIRMAN SCOTT: Okay.

MR. DEVINE: And it's also a communications effort. There's been a communications effort to get our primary care doctors to do all the DBQs, and that word is being spread through the VSOs, the National Service Officers, as well as other folks at VBA because they want those examinations done by primary care.

DR. CROSS: There's a little bit of grass is greener, and they don't have that experience. I know that we're going to a system now where you give them the card and they can go outside to another location. Do we really know that they're going to get faster there?

DR. SIMBERKOFF: So with all the emphasis on access and, you know, getting more patients into VA, and, you know, in Arizona and wherever, the last thing that you want to do is to try to get

those limited number of, you know, providers who are struggling to keep up the demand there to, you know, take on this added burden.

MR. DEVINE: What if my fistful--you saw the top ones--

DR. SIMBERKOFF: Yeah.

MR. DEVINE: Tinnitus is one of them.

DR. SIMBERKOFF: Right.

MR. DEVINE: Well, obviously primary care folks aren't going to be able to do it anyway.

DR. SIMBERKOFF: Sure. Yeah.

MR. DEVINE: Or one of the other specialties.

DR. CROSS: Well, actually they could do tinnitus.

MR. DEVINE: I always say it wrong.

DR. CROSS: I went to school on the West Coast. But there's no test for it. You just take the history. But as a casual way of dealing with this, the audiologist--

DR. SIMBERKOFF: Yeah.

DR. CROSS: --as I said, we always do a

hearing test with it.

DR. SIMBERKOFF: And they do.

DR. CROSS: Which is probably reasonable.

DR. SIMBERKOFF: Yeah.

DR. CROSS: Because you're often going to find a hearing problem as well.

DR. SIMBERKOFF: Right.

MR. DEVINE: So Patricia in her infinite wisdom came up with the DBQ referral clinic, and this was our effort to let folks know there is a legitimate, faster, more competent place that you can get your DBQs done all in one place by the folks who know it best.

MS. MURRAY: And part of what we've done with the DBQ referral clinic is to sort of educate the clinic in terms of managing the expectations of the veteran, of the VSOs, and your providers in terms of look at your resources in your clinic and identify what you can do.

Some facilities are very small. They don't have mental health sitting in the clinic. They don't have various specialties sitting in the

clinic. So if a veteran is brought around to them, they'll have to look at the schedule and schedule them or schedule with a specialist.

Some clinics have a lot more resources, and so if a veteran is brought around by primary care, and there happens to be an open appointment for primary, for mental health, they might be able to get that exam done, but we've asked them to sit down with your directors, your VSOs, and your clinic, and really manage the expectations of your referral clinics and talk with your VSOs, talk with your veterans and provide them what is doable.

Regardless of what is doable in the clinic, we are doing it within 24 days, and even if the veteran has to be scheduled back to VBA, it's still done in a very timely way, but again it is managing expectations in the referral clinic.

MR. DEVINE: So why we take care of the technical, so that was slide 14. Now, Patricia wanted to talk real quick about slide 19.

MS. MURRAY: What is 19?

CHAIRMAN SCOTT: Well, let us work our way

to slide 19 here.

MR. DEVINE: Okay. I'm sorry.

MS. MURRAY: I think that was one slide that we did not--oh, that was the referral clinic at 12. 19. Oh, 19. Oh. So 19 is basically some of, you know, Dr. Cross talked about earlier how far we've come with VBA and the Board and DoD and a lot of our collaborative efforts. What you see on slide 19 is some of the things that we are doing on the continuing basis to ensure, you know, greater collaboration.

He mentioned the war rooms. We participate with the USB's stat reviews. We have a Friday noon call that is a joint call with VBA and VHA. We meet monthly with the Principal Deputy Under Secretary for Benefits, Dr. Cross, Danny and I to sort of bring high level issues to his attention.

We are jointly looking at concerns that are being brought by veterans or servicemembers and their families. We look at those and try to get those responded to pretty quickly. We're refining

the DBQs. We're working collaboratively automating, improving our IT system, as well as automating the DBQs.

So we have lots of collaborative efforts that we work on consistently and pretty much on a daily basis that we have joint teams that are managing among the organization. That was the other slide that we did not get earlier.

MR. DEVINE: On slide 22 you'll see the heading that's DMA and DoD. Obviously doing a lot of work. But I think the important thing for you to take away is that we are using DBQs inside IDES. So we've overcome some of their resistance, and we have worked with them to get them what they need in terms of doing a narrative summary, which is a very important part of their PEB process, and we're able to use the DBQ there.

CHAIRMAN SCOTT: Okay. For those of us that are laymen, tell me again what is the Mitchell criteria? I'm on the same slide you're on, 22.

MS. MURRAY: So the Mitchell criteria, Dr. Simberkoff, did you want to--

DR. SIMBERKOFF: No.

MS. MURRAY: Okay. So the Mitchell criteria is so if I have a problem with my elbow joint--

CHAIRMAN SCOTT: Right.

MS. MURRAY: --the Mitchell criteria says that you have to repeat the--

DR. SIMBERKOFF: Yeah.

MS. MURRAY: --so the veteran may say, well, when I bend my arm this way, it hurts pretty bad, and so you do the measurements, but then you have to sort of stress the joint and repeatedly. So if I'm doing this all day long, the C&P examiner has to some way replicate that, and then estimate what that long-term stress on the joint would be and do some type of estimate of what that would mean to the veteran in terms of function.

And so he can come in and show it to me one time, but he's not sitting there using it like he normally would through the course of the day, and so he has to explain that to me, and then I have to estimate what the impact on the disability

would be with that long-term or repetitive use.

CHAIRMAN SCOTT: Okay. And that's for any, any sort of a joint--

MS. MURRAY: Musculoskeletal DBQ.

DR. SIMBERKOFF: Musculoskeletal.

CHAIRMAN SCOTT: Musculoskeletal?

MS. MURRAY: Uh-huh.

CHAIRMAN SCOTT: Okay. All right.

MS. MURRAY: So it's a repetitive use estimate.

CHAIRMAN SCOTT: Okay. On the Separation Health Assessment, we're being told that the Active Components, Active services, are doing a pretty good job with the Separation Health Assessment, and the problems are in the Reserve Component. Is that a true statement or not?

DR. CROSS: Sir, they're not doing the SHA at all.

CHAIRMAN SCOTT: They're still--the Active Components are still not doing it?

DR. CROSS: They're starting in December.

CHAIRMAN SCOTT: They're required to start

it in December?

DR. CROSS: According to their agreement, which they have to go a committee called the JEC. The last JEC meeting was last week. Jack Smith from Health Affairs, who's my counterpart on this issue, we both sat there. When he got up and presented, he said December-January, we're rolling.

CHAIRMAN SCOTT: Okay.

DR. CROSS: We've got a couple sites in the Air Force--I think four--where they're doing some demonstration because it is not clear yet on the military side how they want to make that question, get that question answered by that veteran. Veteran--I mean servicemember-- Servicemember, do you want to go left and go to the VA and make a claim or do you want to stay with the military and get your exam done over here and not have a claim?

And they're working through the process and how they're going to do that. They don't really have it written down yet.

CHAIRMAN SCOTT: And the other services

are similar? You say the Air Force, I think?

DR. CROSS: It's variable from service to service and probably even within the service quite frankly. But they promised--they promised, the leadership in those meetings, that they will start in December, be ready to go in December.

CHAIRMAN SCOTT: Okay.

MR. DEVINE: What the services use are the 2807, 2808.

DR. CROSS: They're not going to use our DBQs.

MR. DEVINE: Now if--some of you are career military. They probably treated you folks a little bit differently, but other folks, it's simply a pencil book exercise, in that if you ever take a look at those documents, it's a straight line no on both sets of columns. It's not really a legitimate. That's my experience, and I know there's plenty of others because VBA struggles with using that document as being overly usable in terms of adjudicating claims.

CHAIRMAN SCOTT: Well, is the argument are

we doing it at all, which it used to be, or is it over using the DBQs as--

DR. CROSS: They signed the Memorandum of Agreement with us.

CHAIRMAN SCOTT: That they would do it?

DR. CROSS: Yes.

MS. MURRAY: It would be ideal if they would use our DBQ form.

DR. CROSS: They are planning on cooperating with us by gathering the same data but on a different form. It's a form that they've been using for a long time. I mean it's the form that I used when I was there.

I think they've gotten the past the issue why are we doing this? And they at least don't bring the argument up. Some of them see the value of it. I think they will do what they say.

We decided--I've got the capability--I can make this happen in the VA this week, and so when I was seeing it was taking a long time, I got a bit frustrated, and I said, okay, we're kicking off. You guys catch up with us when you can. And that's

where that chart comes from.

CHAIRMAN SCOTT: Is it--should we then let this one alone? In other words, we're going to mention the RC side of it. He's already captured that in--

DR. CROSS: I'd be very pleased to maintain momentum to indicate support from more areas to say that this is something that is quite overdue, in our opinion, and would be of benefit to the government as a good steward as well as the veteran.

CHAIRMAN SCOTT: Well, I think this is our fourth report, and if I'm not mistaken we mentioned it in all previous reports.

DR. CROSS: It may have helped.

CHAIRMAN SCOTT: But in different, you know, sort of in different words. Okay. So you're saying something like retain the momentum then would be. Okay. I got it.

DR. CROSS: And mention December.

MR. DEVINE: So heading on to DMA and DoD, I think I was just talking about that one--I think

the important point here is our work with the DoD includes using the DBQs inside the IDES process.

MS. MURRAY: And that's been well over a year now or is it two years?

MR. DEVINE: It's about a year-and-a-half.

MS. MURRAY: About a year-and-a-half.

DR. CROSS: I'm a little bit nervous since this is being recorded, but I will tell you what happened. DoD was adamantly opposed to using DBQs for IDES. When we're doing the exams, and so on one set of exams, we do the military forms. On the other set of exams, we use DBQs. So I've got to train both situations for the VA docs and monitor them, the quality in different ways.

And we met with them probably 30, 40 times, and I mean these are good people. I was one of them in a previous life. They wanted something more reasonable in a narrative summary, which was better for their Board. And they were very pleased historically with the VA's dictation of a narrative summary.

And we couldn't do that. We had to go

with the DBQs because of the calculator engine that we were developing, that VBA was developing, and we gave them more time, gave them more time, and I said finally one day, guys, I have an announcement to make. We're starting next week. And the strangest thing happened, which was nothing. We never really heard a peep out of them.

MR. DEVINE: And, in fact, really, because we use it with them, they helped us make it a little bit better and defined a lot of our examination techniques.

DR. CROSS: They've actually become better partners in that.

CHAIRMAN SCOTT: That's pretty much a good news story.

MR. DEVINE: In case you don't know, that within the IDES program that are just two Regional Offices that deal with the adjudication. Okay. The VOW Act, I went over that real quick about mandatory cap, and then the final one for us would be about VA's process, which I think Patricia has already quickly gone through. So I don't know if

Dr. Cross wanted any other closing comments and questions?

CHAIRMAN SCOTT: From your perspective, is the VOW Act working the way it's supposed to? I realize that it may be asking the wrong part of VA the total question, but from your perspective--

MR. DEVINE: Danny, you're closer to that than me.

MR. DEVINE: No, it isn't. They haven't enforced the mandatory use of--they're at maybe 50 percent of the folks are actually attending the TAP. They're not doing a real good job yet of tracking those folks because what we had wanted was a notation--

CHAIRMAN SCOTT: Who collects the statistics on that? That's too vague for me to put in a report that--who would I talk to about which services are doing it, which ones aren't, and RC versus AC, and all that? Somebody in VBA, I guess, uh?

MR. DEVINE: VBA doesn't even know because that's where we get our information. So whatever

they're getting from Manpower and Personnel, it's about as vague as that because they know they're not enforcing it and not adhering to the tenets of the law.

CHAIRMAN SCOTT: Okay. Well, I'll ask them how do they know that then. Because that's-- if we're going to--you know, for us to say something, we've got to have a pretty good idea that, you know, what are the specifics of the issue.

MR. DEVINE: We're not even allowed to survey the folks to find out whether or not they're going to file--have an intention to file a claim.

CHAIRMAN SCOTT: Okay. Well, maybe we can get a little help from them. Okay. Go ahead. Let's see. The ACE, slide 28. Everybody okay on that?

DR. CROSS: Oddly enough, our staff would really like you doing that, and the poor veteran who was going to take the day off from work and drive to the hospital, find a parking space, get to the clinic, find the clinic, just stays home or he

goes to work.

We often have to supplement the records with a phone call to clarify some issue, but, you know, that, from a veteran-centric point of view, that nails it.

MG MARTIN: Actually I had--we received a briefing from Mike McNeal, director of the VA-DoD Program Office back then. This was in April, and he, at that briefing, said that 53 percent of TAP people intended to file a disability claim when they asked him a question. So they did a survey.

MR. DEVINE: It wasn't an official survey. What they did was probably talk to them on the way out, and that's how they determined what those numbers were.

MG MARTIN: So 53 percent is kind of soft then?

MR. DEVINE: Correct.

DR. CROSS: It's very soft, and we had estimated for budget purposes 50 percent. Now, Gingrich, again, I mentioned him several times. He did some good things although he was challenging at

times because he, you know--he wanted good things for veterans as fast as we can do them, and that was fine.

He estimated that it's going over time be much, much higher. You and I have all had sergeant majors. So the sergeant major sits through this briefing and cuts to the chase and says--here's what my sergeant major might say. He said, okay, you got to make your decision, soldier. You've got to go either this--you're getting out. Go this way or that way.

Now if you go this way, you get an exam from the military; it will be very good. If you go that way, you get an exam from VA, and you get the exam and you get money. Which way do you want to go?

Now that's oversimplistic by a long shot, but, you know, some people anticipate that it will move in that direction. The truth is last I heard it was actually less than 50 percent--

MR. DEVINE: Correct.

DR. CROSS: --so far. And so, you know,

all those concerns about that have not been visible so far.

MR. DEVINE: Our real concern is they have up to a year after leaving Defense in order to file and have the one year consideration. So our concern is folks are waiting to go home to try and take care of all of that. And so I think it's going to have to be another cycle in order to determine whether that was the case.

CHAIRMAN SCOTT: Okay. All right. You had a couple extra slides there?

DR. CROSS: I'm not sure. Is there any question? I mean let's go where you want to go.

CHAIRMAN SCOTT: Okay. Well, let's--I'll ask any Committee members if they have anything they want to ask or any comments they want to make?

DR. BROWNE: I think Patricia mentioned that you're going to send the C&P exams over to VBA. Would those trained providers that you're taking through the training go with that program or would they have to--

MS. MURRAY: So what's your question

again?

DR. BROWNE: I think you mentioned something about transferring the C&P exams over to VBA.

MS. MURRAY: Oh, so, what that--

DR. BROWNE: And so you have the certified providers that you said that are now going through your training program. Would that training program be transferred as well?

MS. MURRAY: Oh, so let me, let me clarify. So what we're transferring to VBA is not the exams and the examiners, but the responsibility to release the exams to the veteran. So right now they can get them through blue button or they can go to Release of Information and sign a release and get a hand copy. VBA will in the near future be responsible for releasing all exams. I hope that clarified it.

DR. BROWNE: Uh-huh.

MS. MURRAY: Okay.

DR. CROSS: I had a couple things written down, and, Bob, you'll probably recognize this.

The requirement that we accept as a claim any kind of scribbling written on any kind of material, paper, whatever it may be, they don't have to use the form. I think the IRS would find it unusual if you filed your taxes on scrap paper, but we are legally bound, as I understand it; is that right?

MR. EPLEY: It always was when I was working there. There has been talk of changing that and requiring them to--

MR. MAKI: There's a proposed rule that was just issued that's going to do away with all of that. It will become effective March 15 of next year.

DR. CROSS: Really. I didn't know that. That's excellent.

MR. MAKI: If you don't file either a claim on a standardized form or a Notice of Disagreement, it's not going to be valid.

DR. CROSS: No time limit. In other words, you can claim something, you know, as far in the future as possible. I think that would be controversial to change. It's probably a bit

different from how lots of other things work in life in terms of, you know, attributing something to something that happened 20 or 30 years ago. It's difficult. But I don't think that will change.

IU for individuals who are whatever age-- 85. You know--

MR. EPLEY: Very familiar with that issue.

DR. CROSS: And our culture and philosophy is you don't set age limits on work anymore. But, you know, some people are questioning that that I hear from, and I just wanted to cue you in that I'm hearing those kind of questions. I doubt that that will either.

CHAIRMAN SCOTT: Well, here's where we are on TDIU. We asked some questions in the last report, and it came back from the Secretary that the Secretary directed this Committee to study TDIU and to make recommendations. Didn't say when.

They, John pointed out that the GAO is doing a TDIU study right now, and so we decided that we're going to basically punt this time and

say we're going to wait till the GAO study is over and review it, and then we'll either make an interim report on TDIU or we'll pick it up next time, but we've had a lot of discussions about it.

We've had a number of briefings from the VBA folks, and I'd say it's kind of all over the lot there. It's like everything else. Some people say that there should be no consideration whatsoever of age in determining whether or not someone should have Individual Unemployment.

And others say, well, they don't know exactly where the cutoff ought to be, but this doesn't sound right.

DR. CROSS: You know somebody would point out to me and say 85; right? You've got a surgeon on your staff that's 85.

CHAIRMAN SCOTT: Yeah.

DR. SIMBERKOFF: Not in the OR though.

DR. CROSS: Not in the OR. Well, Jerry. Of course Jerry retired, but you know who I'm talking about probably. The only one of these three things that I mentioned that I think it's

probably likely is what--and it appears that it's already done--is to at least get the application on the right sheet of paper.

MR. MAKI: That is a proposed rule that was published about two weeks ago and, or actually it's become a final rule, but it doesn't go into effect until March 15 to give everybody--VBA, VSOs, veterans--time to assimilate the information and for them to have all of the forms ready to go.

CHAIRMAN SCOTT: Well, where are you on TDIU since we're having the conversation?

DR. CROSS: The worry I have is this. We have stakeholders out there, American citizens, who are very fond of veterans, but who believe that certain things are happening that are probably a little bit different from what they expect.

An ill-tempered individual who wanted to take a couple of shots at us could say, well, here's what--you know, would you support this? You know here's a 90-year-old individual getting unemployability support. And the concern is that some people in our society would find that a bit

unusual, I guess.

My concern and my focus is I see this as a hugely important and valuable program. And I wanted to identify things that might down the road put it at some risk. So that--

CHAIRMAN SCOTT: Well, one of the ways that we hope it's addressed is that if we do a good enough job on the revision of the VASRD that it may enable people to get to 100 percent disabled without going the TDIU route, which is kind of picking and pulling from everywhere and kludging it all together.

And the other thing that I think we're probably going to come up with is that maybe we ought to change the name of it somehow and just say permanent 100 percent disability if you've been whatever, whatever for so long. In other words, try to get, get "temporary" out of it and, you know, because I don't think you can ever--first of all, you shouldn't do away with it because there's always going to be cases where, you know, nothing, nothing short of TDIU designation is going to solve

the problem, and then you get to, well, where's the cutoff?

And, well, then, you get into what you're talking about, so maybe what we want to do is--and I was just wondering--I'm going to try this on you and then we'll see what the GAO says and others. But maybe we need to rename the program, try to figure out exactly what it is, and then call it that, and try to get away from the temporary and the notion that everybody that decides that he doesn't want to work at a certain age can apply for this, quote, "temporary disability" and get 100 percent VA benefits. I don't know.

MS. MURRAY: We actually had a case recently that was an issue, and Dr. Dinesman, who was in our office, that's exactly the conversation we had, about changing the language around that, because what the veteran's claim was that Social Security says I am, you know, totally unemployable, and so why does not VA say that I'm the same thing?

Well, they're two different things. So maybe changing the language around what we call it

and how we describe it might help resolve that comparison as well.

CHAIRMAN SCOTT: Well, I don't want to prejudge how this is going to come out, but I think we've got to--we've got to think of some solutions other than saying, okay, we're going to cut it off at, you know, and then fill in the blank because I don't think--I'm not sure that is a supportable conclusion to come to.

DR. CROSS: Immediately some individual will be found who contradicts that.

CHAIRMAN SCOTT: Oh, yeah.

DR. CROSS: Yeah, I know. 100 percent disabled means what? You know you talk about changing name. How many staff in the VA Headquarters here are 100 percent disabled? It doesn't mean exactly what probably a layman in the public perceives that it's means.

Disability, 100 percent disability in VA is somewhat different from--substantially different I guess from Social Security.

CHAIRMAN SCOTT: Absolutely.

MS. MURRAY: Yeah.

CHAIRMAN SCOTT: We tried on the VDBC to draw some parallels between the different programs in Social Security and the VA, and we were just unable to do it. There was no, there was no common definitions, no common approach, and so we just kind of gave up on that. But initially it sounds enticing to say, well, we ought to use the same criteria for SSI and for these other, whatever it is, the disability part of Social Security. But you can't do that, you know.

DR. CROSS: Yeah, we went over and met with them.

CHAIRMAN SCOTT: Yeah.

DR. CROSS: General Hickey and myself a couple of times. Wonderful organization.

CHAIRMAN SCOTT: Yeah.

DR. CROSS: And fascination, trying to explain our differences, but we are different quite a ways. They were hoping that we could use our exams for their stuff or something like that.

CHAIRMAN SCOTT: Yeah, they have some

problems that are not that different from ours, but when you get into it, it's very, very difficult.

Other comments or questions from any Committee members? Okay. Any closing remarks from you three?

MR. DEVINE: Not me.

DR. CROSS: This is a wonderful Committee. I always feel comfortable talking, you know, with you and others. If I'm quoted out of the--I have to be careful if I'm--can we redact some of the?

[Laughter.]

CHAIRMAN SCOTT: Well, Gerald, we have had some astounding things said by VA employees here, and none of it has ever gone anywhere because nobody listens to the transcripts. We're the only ones that use them. So we have had things that were absolutely seditious said in here.

[Laughter.]

CHAIRMAN SCOTT: And, you know, there were no, they never, for whatever reason, it never gets out.

DR. CROSS: Thank you for reassurance.

[Laughter.]

CHAIRMAN SCOTT: Thanks very much. Appreciate it. It was very, very helpful. Really was.

DR. CROSS: It was actually very enjoyable.

CHAIRMAN SCOTT: Good. If the Committee survives another two years and you survive another two years, we'll get you to come back over.

Let's take about ten minutes here. I think everybody needs to get up and stretch or something, and then I'm going to go over a short list of things that are going on that I know about, and get your comments on them, and then we'll probably be out of here probably about 4:30 or something like that.

So take about ten minutes, and then we'll reconvene here.

[Whereupon, a short break was taken.]

CHAIRMAN SCOTT: Okay. So what I'd like to do here for the next little while is kind of review the bidding and agree on who's going to do

what between now and tomorrow or between now and whenever.

I'm talking now about the different issues in the reports. I think I said this morning I'd already drafted a cover letter, and I will draft a preamble to the thing.

The issues that we're going to have in there is the comments on the progress of the VASRD to include a comment that we cannot--we should not allow diabetes to get kicked down the road, and I will write that one.

I will also write the one recommending an economic analysis of earnings loss because I did the last one. I think I can just go into my--and change that so I will do that.

The effect of--this is an interesting one I hadn't really thought about--VRE. Mention was made this morning of--

DR. SIMBERKOFF: What is VRE?

CHAIRMAN SCOTT: Vocational Rehabilitation and--

MS. COPELAND: Employment.

DR. SIMBERKOFF: Okay.

CHAIRMAN SCOTT: And what--Employment.

DR. SIMBERKOFF: So not Vancomycin
resistant?

CHAIRMAN SCOTT: No, no.

[Laughter.]

CHAIRMAN SCOTT: The discussion was what
effect would a good VRE program have on the levels
of disability? I can't remember who brought that
up. Somebody brought that up this morning.

Do you think it's worth revisiting VRE and
say, hey, when are you going to actually assess
that program and make a determination of how it can
aid in such things as TDIU and--

MR. MAKI: We brought that up at the last
meeting we had where the Voc Rehab people were here
and they didn't even know that the law already
allows them to offer TDIU recipients voc rehab
benefits, and that they can still retain their TDIU
for a full year after they get hired before there's
any decision to make an adjustment back to a
Scheduler rating.

MR. EPLEY: Right. I remember that discussion. That was appalling really.

CHAIRMAN SCOTT: Well, and, you know, we've had them over here before a couple--

MR. MAKI: I think the thought was, well, if we're going to address TDIU, we need to address that United States Code provision as part of our recommendations, that there's already something on the book that isn't used at all.

CHAIRMAN SCOTT: Well, here's--I guess here's the question then. Since we've pretty much agreed that we're going to address TDIU by saying that we're going to wait until the GAO study is complete and we've had the opportunity to review it, and the other--the other data that's available, do we want to go ahead and say and mention VRE in this report saying that, among other things it could be used for, would be to use it as preceding the award of TDIU, and what if anything else would we say about VR&E?

Now, I guess I may be hung up on the fact that they need a really thorough study of the VRE

program. My sensing is it doesn't really work.

DR. SAVOCA: Is it a large program?

CHAIRMAN SCOTT: Pardon me?

DR. SAVOCA: Is it a large program?

CHAIRMAN SCOTT: How would you describe it?

MR. EPLEY: In terms of workload volume, their counselors are located at all the Regional Offices around the country, and I think, if my memory serves me right, that in an average year, they will work with and declare either rehabilitated or what they call maximum rehab gains to the tune of 80 to 100,000 veterans.

DR. SIMBERKOFF: That's a lot.

DR. SAVOCA: Oh.

MR. EPLEY: Does that ring true to you, John?

MR. MAKI: Well, I think at any particular time, they've got about 125,000 veterans on the roll.

DR. SAVOCA: And it's a voluntary program?

MR. EPLEY: The veteran initiates it.

DR. SAVOCA: Yeah, okay.

MR. EPLEY: They have to have a service-connected disability, generally 20 percent or more.

DR. SAVOCA: Okay.

MR. EPLEY: But they can get in at ten if they just demonstrate that they have an impediment.

CHAIRMAN SCOTT: Well, there's two major parts to it; right? There's the seriously disabled, they have a program for life skills; right?

MR. EPLEY: Yes.

CHAIRMAN SCOTT: And then there's the other part of it is the people that are not that seriously disabled that are trying to assist them with preparation for employment.

MR. EPLEY: Right, and I can't think--

DR. SMITH: That first one sounds more like occupational rehab or something. I wouldn't have called it vocational if it's not work.

CHAIRMAN SCOTT: Well, it's--

DR. SIMBERKOFF: Yeah, but it's rehab.

DR. SMITH: It's rehab, yes.

CHAIRMAN SCOTT: It's under the umbrella of VRE.

DR. SMITH: Yeah.

DR. SIMBERKOFF: Yeah. But activities of daily life is part of rehab.

MR. EPLEY: Yeah, and I can't remember what they call that program, but you're right. That's a fairly small part of the program in terms of volume, but it is out there. And the program itself has been trying to highlight that.

DR. SMITH: I mean doesn't VHA also do lots of that? I mean blind rehab centers do that, don't they, for example?

MR. EPLEY: Yeah. They have their own rehab facilities, yes, yes.

DR. SMITH: I'm a little surprised that VBA would do that rather than just sending the person to VHA for occupational rehab like that kind of ADLs, IADLs, but in any event, this doesn't matter. All we need to know is it exists.

MR. EPLEY: Yeah.

CHAIRMAN SCOTT: Well, again, I think the

question at hand is do we want to save VR&E and discuss it at the same time that we talk about TDIU or do we want to talk about VRE, and if we believe that there is a requirement for a study of the VRE program and how it is used and all that?

Maybe we want to just wait and catch it with, as a component of TDIU, which basically it's hard to find anybody that doesn't agree that there is no reason why there shouldn't be an VRE assessment prior to the award of TDIU. The only people that don't agree with it are the VR&E people, and they basically don't want to do it because it's resource intensive.

DR. SIMBERKOFF: I thought the social workers that presented that were very enthusiastic about it.

CHAIRMAN SCOTT: Well, their bosses aren't.

[Laughter.]

CHAIRMAN SCOTT: Because it's a resource-- what the chief of it has said on a couple of occasions is it takes away their people from their

current mission if they evaluate all applicants, new applicants, for TDIU, and I've never been able to really understand why they couldn't do that, but anyway--so do we want to--is it worth putting in or should we wait and talk about it in the context of TDIU and maybe try to smoke them out on some kind of a larger study based on that?

MR. MAKI: The law that I discussed with them at the meeting is specific to TDIU.

CHAIRMAN SCOTT: Yeah. Well, we know--

MR. MAKI: But it would be administered by Voc Rehab.

CHAIRMAN SCOTT: Yeah. Yeah. We know they can do it.

MR. MAKI: Right. They're not, but they can.

CHAIRMAN SCOTT: They're not.

MR. MAKI: So I would say that discussion specifically would be in relation to any TDIU.

MR. EPLEY: We've mentioned it a couple times in prior reports. I think we can wrap that into a TDIU issue.

CHAIRMAN SCOTT: Okay. I think that's probably what we'll try to do then. Okay.

DR. BROWNE: And is it more communication issue of people not being aware?

MR. MAKI: The law currently says VA may-- doesn't say shall--says may offer voc rehab to any veteran who starts receiving TDIU. The way that's currently done is on like page 56 of the award letter in a little paragraph that says, oh, by the way, you might be entitled to voc rehab. If so, call 1-800-827-1000.

MR. EPLEY: That's relatively new phenomenon. Didn't that get legislated about ten or 12 years ago? I mean it hasn't always been--

MR. MAKI: No, it's been on the books longer than that.

MR. EPLEY: Really?

MR. MAKI: Yeah. But there's no proactiveness to it. You don't have somebody--you don't have the Rating Board sending a copy of the rating to the VR&E saying here's a potential candidate. VR&E picking up the phone saying, hey,

let me tell you about something that you might be entitled to, and it might interest you, and let's discuss. There's no proactivity to it at all.

DR. BROWNE: Okay. And they don't really highlight that at TAPs?

MR. MAKI: At TAP?

DR. BROWNE: Yeah, when you're--I mean of all the things that you are eligible for at some point?

MR. EPLEY: No.

MR. MAKI: No.

DR. BROWNE: You know, I'm really getting-

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MR. MAKI: No, this is a law that goes in-

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MR. EPLEY: It wouldn't come up, not even in a sentence.

MR. MAKI: --that becomes effective once you're already rated, and then you get TDIU, that Scheduler 100 percent, even though you're rated less than that, then that law kicks in.

DR. BROWNE: Okay.

MR. MAKI: And says you can still get VR&E, you can go through that complete education program and be employed for a year successfully before we start thinking about taking that TDIU away. It's never used. I've never ever seen that used ever.

MR. EPLEY: Yeah, me either.

MG MARTIN: You know we asked back August 27 when Jack Kammerer and Theresa Boyd briefed us on VR&E, could VR&E provide additional assessments workload for IU? Mr. Kammerer said "no good answer." Ms. Boyd said "at capacity now and always have been." So, you know, if we're going to say something, we ought to address the fact that they say they can't handle any more workload.

CHAIRMAN SCOTT: Well, if the workload that we want them to handle is related to TDIU, I'm thinking we ought to just roll those two together and talk about it at that time if that's the workload that we're talking about. I guess the real question is, is the whole program in its current configuration okay except for the fact that

they don't do any sort of assessments for TDIU? Is the rest of the program okay?

If it is, then we need to leave it and put it in the context of TDIU.

MR. EPLEY: I think it could use a lot more vigor. You know, my sense. And I got to say I used to carpool with the director of the Voc Rehab program, but within VBA, anyone who doesn't work in VR&E thinks VR&E has got an easy job. Did I say that accurately?

DR. SMITH: I agree.

MR. EPLEY: You didn't get that on tape.

[Laughter.]

DR. SMITH: We need to push it more. I would think we need to get them to highlight it perhaps by asking--

CHAIRMAN SCOTT: Well, if we're going to push it, we almost have to come up with a you need to do a study, and then we need to say, okay, here's what we think you ought to study. We can't just say you're not doing enough or we need to push them.

MR. MAKI: GAO is looking at VR&E right now.

CHAIRMAN SCOTT: Who is?

MR. MAKI: GAO.

CHAIRMAN SCOTT: GAO is. Okay. Well, we could wait and see what they do about VR&E.

MR. MAKI: Because I provided some testimony--

CHAIRMAN SCOTT: Oh.

MR. MAKI: --to them last week.

DR. SMITH: And if that guy comes back--he was from GAO--tomorrow we could ask him.

MR. MAKI: They're looking at both VR&E and the Post-9/11 GI bill from the standpoint of do veterans or servicemember veterans and employers know that OJT and apprenticeship programs can also be implemented under both of those programs?

There's lots of opportunities out there, but I don't think--there's very poor communication between servicemembers, veterans, employers, schools and VR&E or the education side of VA in tying all of those strings together to help people

out.

DR. SAVOCA: Do you know when that report is coming out?

MR. MAKI: I asked that same question, and the answer was when it's ready.

[Laughter.]

MR. MAKI: Probably spring next year sometime.

DR. SAVOCA: Okay.

CHAIRMAN SCOTT: Well, that kind of pushes me in the direction of waiting till we see it, and then read it over, see what we think about it. If it addressed some of the things we're interested in, fine. If it doesn't, well, then we can say, well, now, you ought to do some sort of an analysis about these particular areas here. Is that okay with everybody?

DR. SAVOCA: Yeah, I think it makes sense.

MR. EPLEY: I'll look at a couple of their old budgets and see what they talk about in terms of outcomes and things, and just bring in some background data.

CHAIRMAN SCOTT: Okay. So I said I would, I would write up something about economic analysis of earnings loss. I will write that issue because I have done it before.

The next issue is the Reserve Component support draft. Now, Kirk and Julie and Tim, and I don't know--anybody else involved in that, Kirk?

MG MARTIN: We had a few inputs from the Committee.

CHAIRMAN SCOTT: A few other inputs.

MG MARTIN: Yes.

CHAIRMAN SCOTT: Okay. I think that version four there looks pretty good to me, but we'll talk about it tomorrow, and did anything come out of this briefing today that would make you want to change any of your recommendations or add to them?

MG MARTIN: No, sir.

CHAIRMAN SCOTT: Because you really--I was checking off. You'd already covered Separation Health Exam, TAP, and I don't know.

MG MARTIN: We could add in their FY14

numbers to the IDES program, which we didn't have numbers in there if you thought it would strengthen the argument.

CHAIRMAN SCOTT: Okay.

MG MARTIN: But otherwise I didn't hear anything special.

CHAIRMAN SCOTT: Okay. If you want to add that in as a recommendation, we can do it.

MG MARTIN: That would be easy to add. We can actually just put it in the recommendation that is there now just to clarify.

CHAIRMAN SCOTT: Yeah, okay. We can just-

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MG MARTIN: I can do that.

CHAIRMAN SCOTT: And so we can talk about--we'll go over it. We'll go over that one tomorrow--all of us will. But that looks pretty good.

Now, Bob did the zero percent disability draft, and what I want to do tomorrow is we'll all go over that together. It's on SharePoint. She can put it up on the screen.

MS. COPELAND: Yeah, I can put it up and we can look at them.

CHAIRMAN SCOTT: And we can go through them. Okay. Now I've got printed copies, I think. Some of you may as well, but we want to go through that in detail and agree what changes, if any, do we wish to make in that issue with the notion being come up with meaningful actionable recommendations which I don't mean to imply they're not there. We just want to be sure that that's the way they read.

Bob also did the presumptions draft, and we'll do the same thing with it. We want to go through it, put it up on the screen, and we want to be sure that it captures the issue, some discussion, and we're going to have to acknowledge the fact that they non-concurred last time, but that this is--that we still think that they ought to do the following. Okay?

MR. EPLEY: Right.

CHAIRMAN SCOTT: And we'll put that on the screen and do it.

I said I would take care of the TDIU. I

will draft the issue that says we're going to wait till the GAO thing is over. I'll take care of that.

Now, John is doing a draft of the appeals process. We're going to support the appeals--what is it--the--

MR. MAKI: Fully developed appeal.

CHAIRMAN SCOTT: Fully developed appeal. And he's going to do that.

MR. MAKI: And I hope to have that e-mailed to you tonight and bring printed copies tomorrow.

CHAIRMAN SCOTT: Okay.

MR. EPLEY: Wow.

CHAIRMAN SCOTT: All right. And we need to get a copy of the SharePoint so we could put it on the board, too. It shouldn't be a problem.

MR. MAKI: I'll e-mail everybody.

CHAIRMAN SCOTT: All right.

MS. COPELAND: Just e-mail me. I can-- everybody. Okay.

MR. MAKI: Yeah.

CHAIRMAN SCOTT: Okay. Now, we're going to discuss this paper that Deneise wrote. And how many of you have seen it? Has everybody seen that?

MR. MAKI: Yeah.

CHAIRMAN SCOTT: Okay.

DR. BROWNE: Except I couldn't open the Word Perfect.

CHAIRMAN SCOTT: Well, I couldn't either, but she's got it on SharePoint, and we can go through it.

DR. SIMBERKOFF: Actually I was able to open it.

DR. BROWNE: Okay. Because I tried to trans--

MR. MAKI: I think if you rename the extension from wpf to doc, it will pull up in a doc file.

CHAIRMAN SCOTT: It is a very lengthy document, and I have two thoughts on that.

DR. BROWNE: But it wouldn't open up on the Mac.

MR. MAKI: It won't.

CHAIRMAN SCOTT: My first thought would be that we can boil it down into an issue, but it may, it may replicate the issue that John is writing to the point where that's not the way to do it, or we can enclose the--we can enclose it as an appendix to the report if we think that there's enough value added in there that it ought to be put in there separately. So I'll need some thoughts on that. Or we can also just maybe extract a couple points out of it and put it into the one that John is writing and go from there.

DR. SIMBERKOFF: I--

CHAIRMAN SCOTT: In its present form, that one is way too long to put in the report as an issue. Yes, sir?

DR. SIMBERKOFF: I was going to say I think it was very well written--

CHAIRMAN SCOTT: Excellent.

DR. SIMBERKOFF: --and I think that your suggestion maybe of using it as an appendix and extracting a couple of points from it to put in the actual recommendations might be the best way of

going.

CHAIRMAN SCOTT: Okay. Well, that's kind of the way I was leaning.

DR. SIMBERKOFF: Yeah..

CHAIRMAN SCOTT: If everybody agrees with that tomorrow, but we're going to go over it and figure out what to do with it.

DR. BROWNE: And if John is adding a piece, perhaps since he could open the Word Perfect one, if you saw something in there that might be included in what you're going to send tonight--

MR. MAKI: Well, I was specifically going to draft a proposal that the VA support the program that we saw this morning.

DR. BROWNE: Uh-huh.

MR. MAKI: Because that's the one that everybody has agreed that they're okay with.

DR. BROWNE: Yeah, okay.

MR. MAKI: Which is like a major miracle in politics--

DR. BROWNE: Yay.

MR. MAKI: --in VA--

DR. BROWNE: And DoD.

MR. MAKI: --and this nation. And then anything else we wanted to tweak in there would be fine.

DR. BROWNE: Okay.

CHAIRMAN SCOTT: Yeah, well, you know, I don't know that we--the last thing we want to do is say but we think you ought to change this, that or the other thing. I think, you know, we need to support it in broad terms and talk about how important it is and what it's going to do, but I don't think we need to meddle with what the group has come out with unless there is something in there that I didn't catch that we disagree with, which I didn't see anything.

MR. MAKI: I don't think so. And they're going to take this to the Secretary and to Congress so that everybody is on the same page when a bill gets formulated at the House and the Senate.

CHAIRMAN SCOTT: That then gets us back to the question, okay, what are we going to do with Deneise's document on appeals? And we can talk

about it tomorrow. We don't have to settle it today, but we can boil it down and use it as an issue that's a bit different from the support of this particular program that these folks have put together--the fully developed appeals. I don't know why I can't remember that.

DR. BROWNE: FDA. Just say FDA.

CHAIRMAN SCOTT: So we can say, yes, we support fully developed appeals, et cetera, et cetera, and then we can say if there's something else in Deneise's document that what we need to put in there as an issue, discussion, recommendation, we can do that, or we can just add her document with maybe a couple of minor changes as an appendix to the report. That's kind of what I see some ways forward.

MR. EPLEY: Yeah, I'd like to look her paper over now in light of what we heard about the fully developed appeals, and I think it will read a little different.

CHAIRMAN SCOTT: Well, I think we'll take a look at that, and she said we could edit it any

way we needed to.

MR. EPLEY: Yeah, I exchanged a couple of notes with her, and she was very amenable to alterations.

CHAIRMAN SCOTT: Well, we will, before we quit tomorrow, we will decide how we're going to do it and what's the format going to be. Is it going to be another issue? Is it going to be an appendix? And then whichever one we decide on, we'll alter it accordingly to fit at that time.

Okay. Now this is stuff basically I picked up today that I guess we probably better talk about. DRO utilization. Apparently they're still not doing it even after they told us they were from the last report.

So I can write that one up pretty quickly. I've got the old stuff. I don't know what to do about this DBQ. The only thing that really struck me is that the fellows that were in here seemed to think there was a problem at the Board or the Court with it. That's the first I'd heard of that.

DR. SIMBERKOFF: Yeah.

CHAIRMAN SCOTT: I'm going to--maybe I shouldn't say this, but the fellow that was on the right there was a kind of rock thrower, you know. He has made--he made more than one unsupportable statement during his part of it. He's the opposite from Gerald Cross.

MR. EPLEY: Danny Devine?

CHAIRMAN SCOTT: Uh? Yeah.

MR. EPLEY: Danny Devine?

CHAIRMAN SCOTT: Right. So I am, I have no problem with disregarding some of the things he might have said that were unsupportable. I tried to call him out on some of his stats on a couple of things, but it didn't necessarily work.

So I'm not sure how far, you know, if the DBQ is not being accepted by VA doctors, then we probably need to say that that needs attention. Needs to be made either--it needs to be altered in such a way that it is or something like that. You know, support it, you know, in general, but say this is the problem with it.

I'm just really not sure I want to get

into the Board and Court part of it because I, you know, that's the first I'd heard of it, and I don't think we've really got the time to call the General Counsel in here and say is there a problem with it?

MR. MAKI: That's the first time I've heard about it, and I kind of shrugged that off as maybe just scuttlebutt of some sort. I mean the DBQ is what it is. It's a tool to allow a rating on the VBA side, and it's not a medical examination per se. It's not even close to what the old AMIE worksheets were or the older, you know, C&P exams where a doctor had to handwrite everything out. It's specific to the Rating Schedule. So it is what it is.

DR. SIMBERKOFF: But I mean, I guess the question is whether or not the issue has--he said that there was a, some statement by some judge. I don't know whether that's one judge's opinion or--

MR. EPLEY: Chief Judge, yeah.

DR. SIMBERKOFF: Is it the Chief Judge?

MR. EPLEY: That's what he said today. He said it was the Chief Judge.

DR. SMITH: But it was just a comment in a footnote.

MR. EPLEY: Yeah.

DR. SIMBERKOFF: Yeah, but footnotes are what make opinion.

MR. EPLEY: Well, we receive periodic briefings from the Board of Veterans' Appeals.

CHAIRMAN SCOTT: Well--

MR. EPLEY: Can't we just put that on the agenda for the next brief and ask--

CHAIRMAN SCOTT: I think so.

MR. EPLEY: --them to--

DR. SMITH: I agree.

CHAIRMAN SCOTT: I think so. I think we'll talk about that issue once we find out more about it.

MR. MAKI: Judges do dissenting opinions because they think a little bit differently than the way the rest of the court is going quite often. But if the ruling of the court is to go some other way, that's just the way it goes.

MR. EPLEY: Dissent has not--

DR. SIMBERKOFF: But this was a footnote, and I assume the Chief Judge--

DR. SMITH: Sometimes judges just give their personal opinions without it being, you know, the opinion of the court.

DR. BROWNE: Or was the footnote from somebody else in the court?

CHAIRMAN SCOTT: Well, you know, depending on what it said and where it was, it's not necessarily inconsequential, but we don't really have any way of determining if this is an ongoing legal issue that, you know, we should call to their attention.

MR. MAKI: I don't think the Court has a mandate to question the way VA sets up its examinations.

MR. EPLEY: Right. They should be about the substance of the result, you know, what evidence is used to make the decision. Is this an issue that the legal staff in Comp Service would be familiar with? Could they find that footnote? I mean is that crazy?

MS. COPELAND: Possibly. Possibly.
Because we have a whole, we have a whole pack of attorneys.

MR. EPLEY: You got a judicial review staff in there; right?

MS. COPELAND: Yeah, we do.

MR. MAKI: If it was precedent setting, we'd have heard flak about it already, that all the DBQs are thrown out and all that stuff. And I don't think that there is any precedent.

MR. EPLEY: Yeah.

CHAIRMAN SCOTT: Have they ever heard of that?

MS. COPELAND: Okay. Just send it--can you just shoot that to me by e-mail, and I'll shoot it right over to the judicial review staff chief and have them divvy it out and--

CHAIRMAN SCOTT: All right. I'll do it before I leave it here today.

MS. COPELAND: Okay. Very good.

CHAIRMAN SCOTT: Okay. And basically--

MS. COPELAND: nancy.copeland@va.gov.

CHAIRMAN SCOTT: Yeah.

MS. COPELAND: Just shoot it right on to me, and then I'll just move it right on over to--

CHAIRMAN SCOTT: Well, I'll shoot it to you, and then you shoot it on over there.

MS. COPELAND: Okay.

CHAIRMAN SCOTT: I'll ask you the question, and you can forward the question.

MS. COPELAND: And I'll ask if they can try and identify that and maybe get back with us tomorrow because I have e-mail access here, too.

CHAIRMAN SCOTT: All right. The next one here is doctors in the ROs and raters in the med centers, and--

DR. SIMBERKOFF: And--

CHAIRMAN SCOTT: Go ahead, please.

DR. SIMBERKOFF: I was going to say if you would like me to--

CHAIRMAN SCOTT: Well, if you would like to draft up an issue. If you would like to draft up an issue and bring it in tomorrow, it will give us a straw man to work from.

MR. EPLEY: Way to go, Mike.

DR. SIMBERKOFF: I can try to do it, yes, absolutely.

CHAIRMAN SCOTT: Well, look at one of our old reports and kind of see what the format is. It's what is the issue, what's the discussion, and what's the recommendations.

DR. SIMBERKOFF: Okay.

CHAIRMAN SCOTT: And if you can do that, I think that would be great.

DR. SIMBERKOFF: Okay.

CHAIRMAN SCOTT: All right. And then we've been--we've been over and over and over the Separation Health Exam. But I think probably the comment that Dr. Cross made that we should recommend that they continue the momentum for mandatory exams on the current schedule, which means it's to be implemented at the end of the year, for both Active and Reserve personnel. And I can work that one out pretty quick.

MR. EPLEY: Yeah, that's a good news story, and we can tell them, you know, we've seen

progress being made, keep it up.

CHAIRMAN SCOTT: Well, yeah. But, you know, I will say this. The DoD briefers indicate that there has been more--there's more progress in that arena than Mr. Devine seemed to think there was.

MR. EPLEY: Yeah, yeah.

CHAIRMAN SCOTT: And also I'm not sure that his stats on TAP were exactly right. I think, I think that it's a little bit more than that, a little higher percentage attending.

But no matter. Okay. So that's what we're going to do. We're going to talk about these issues tomorrow, and when we leave here tomorrow, I hope to have a draft of each one of them. It looks to me like we're going to have one, two, three, four, five, six, seven maybe, seven, eight, nine, about nine issues. Eight or nine issues.

MR. EPLEY: That's a lot for us; isn't it?

CHAIRMAN SCOTT: Well, that's right. We've had five, six or seven in the past, but something like that. We'll see what it looks like

tomorrow.

Again, if they're properly framed, it will take maybe a page or page-and-a-half. That's not more reading than can be done by the recipients.

Well, I would ask you to be sure you have read what you can get your hands on, either electronically or in print, by tomorrow, and I will work tonight on drafting the ones that I have agreed to draft here, and I will try to keep them in such a format as we can get on the SharePoint tomorrow too.

MR. MAKI: Awesome.

MR. EPLEY: That's why you're such a great chairman--

DR. SIMBERKOFF: Yeah.

MR. EPLEY: --General Scott, because you do a lot of work.

CHAIRMAN SCOTT: Well--

MR. MAKI: The rest of us just bask in your glory.

[Laughter.]

DR. SIMBERKOFF: That's true.

CHAIRMAN SCOTT: Well, you know, I--

DR. SMITH: Hide in your shadow.

CHAIRMAN SCOTT: I think the work has been spread out significantly more on this report.

MR. EPLEY: I think so, too.

MS. COPELAND: I would just like to ask does everyone have a copy of the different input, like the zero percent, the presumptions? If you don't, then I can just shoot it out to everybody tonight.

CHAIRMAN SCOTT: Well, everybody has got last year's report.

MS. COPELAND: I'm talking about the input for this report--

CHAIRMAN SCOTT: Oh.

MS. COPELAND: --like you're going to revise--

CHAIRMAN SCOTT: Zero percent presumptions. Oh, the ones Bob did?

DR. SIMBERKOFF: So Nancy, I'm going to try to write something on--I can actually work on, from here on my computer.

MS. COPELAND: Yeah, and you can shoot it to everybody. You can shoot your revision to--

DR. SIMBERKOFF: And save it in my computer at work, and I'll send it to you.

MS. COPELAND: Okay. All right.

CHAIRMAN SCOTT: All right. Do we all agree on what we're going to do here? We're going to read what we can find and either in print or electronics and we're going to work our way through these issues tomorrow, and what I hope is that they're well enough formed at the end of the day tomorrow that I can take them, do a final edit on them, put the report together, send it out to, you know, attach the bios and the charter and all of the--in the previous reports and all that, and I think I can do that electronically because I think I've got it all.

MS. COPELAND: Okay. Just do me a favor. If you're going to send me anything, send it before 8:30.

CHAIRMAN SCOTT: Yeah. I'm going to send you one of them here in just a couple of minutes.

MS. COPELAND: Okay.

CHAIRMAN SCOTT: Okay. That's it for today then. Adjourned.

[Whereupon, at 4:17 p.m., the Advisory Committee recessed, to reconvene at 8:22 a.m., Tuesday, October 21, 2014.]