THE VETERANS' ADVISORY BOARD ON DOSE RECONSTRUCTION

MEETING IX

The verbatim transcript of the Meeting of the Veterans' Advisory Board on Dose Reconstruction held at the Hyatt Regency Bethesda Hotel, Bethesda, MD, on June 10, 2009.

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C O N T E N T S

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P R O C E E D I N G S
JUNE 10, 2009

(8:30 a.m.)

CALL TO ORDER AND OPENING REMARKS

MR. WRIGHT: Board members, take a seat, and we're ready to start the ninth meeting of the Veterans' Advisory Board on Dose Reconstruction (VBDR). This is a federal advisory committee, and my name is Eric Wright. I'm from the Defense Threat Reduction Agency (DTRA). I'm also the Designated Federal Officer for this meeting, and what that means, the purpose of my being here, is to make sure we follow the Federal Advisory Committee Act (FACA), the Sunshine Act, and the GSA rules and regulations that govern Department of Defense (DoD) federal advisory committees.

Welcome. We're very happy to see you here this morning. And without further ado, I'll turn it over to the Chairman, Vice Admiral (Ret.) James Zimble.

CHAIRMAN'S WELCOMING REMARKS AND INTRODUCTION OF THE VBDR MEMBERS

VICE ADMIRAL ZIMBLE: Thank you very much. I am Dr. Zimble, the Chair of this committee, and I welcome all our guests. Certainly it's nice

to see our Board back in session again. It's been a while. It's amazing, but you know, we have almost convened -- I think over the last four years this VBDR's been in existence -- and this is our ninth annual meeting of the Board. No, that's not -- I guess it's not an annual -- it's hard to get nine annual meetings in four years. But it is our ninth meeting. I think we can be very proud of what we've accomplished in addressing some of the problems and the processes of the agencies in accommodating our veterans, which is the most -- which is our vital role.

And for the guests, for the new guests, I would welcome you and hope that we can answer any questions that you have over the course of this meeting today. We'll talk about our accomplishments and where we hope to go in the future.

There are still items that need to be addressed, and we're going to enter into some serious deliberations regarding what the future of this organization should look like so that we can best accommodate the atomic veterans. That's our role.

The program for the atomic veteran is unique in one respect, and that is that there are two executive departments within the government that are responsible for carrying out the program: both the Department of Veterans Affairs (VA), which is your advocate, as well as the Defense Threat Reduction Agency. Specifically, one element of that agency, which is the NTPR, the Nuclear Test Personnel Review (NTPR), portion of DTRA, which basically examines the scenarios that -- within which you participated to determine what level of potential threat might exist, based upon the dosage of ionizing radiation.

It's a complicated procedure. It is a lengthy procedure. Hopefully we'll be able to shorten it a bit more than we have so far, but I think we have converted, in most cases, years of waiting to just a few months of waiting for a report. And that is a significant achievement, and I congratulate the Board for its excellent work in coming up with good recommendations to advise the two agencies. And I commend both agencies for their responsiveness when we provide advice. It's so nice to provide advice

to people that they actually say okay, we'll do that. And in my life that doesn't happen very often.

At any rate, we'll need to get started. I would like to go to our first set of slides and just to give you an idea about what this Board is all about.

We were created by Congress by Congressional legislation and -- if you'll show the slide on the responsibilities for the Advisory Board, it comes -- yeah. There we go. Next slide, please.

This is what Congress has asked this Board to do. And if -- you have within your folders, your information folders, you should have one or two sheets that provide the biographies of all the members of the Board, and I want you to note the level of expertise that has been assembled in order to fulfill the requirements, the mandates, of Congress.

But we are required by Section 601 of the Public Law 108-183 to do several things.

First, we're to provide gui-- providance (sic), basically we're to provide advice and oversight of two processes, the dose reconstruction

process -- the process of determining what the -- what dose you would have received of ionizing radiation in your participation with the various programs that are under the atomic -- the Atomic Veteran Act, to provide advice on that dose reconstruction program. And also to provide advice and guidance and oversight to the Veterans Administration on the way the claims are being processed.

And then we also are tasked to help with the communications, the communications between the two agencies and you, to make sure that you're getting good transmission and receipt of the information that you need to be able to get what's due.

Now let me go to the next slide and talk about what responsibilities we don't have. I think this is very important for you to know that we are not going to -- we're not in the business of reviewing any individual dose reconstruction cases for a claimant. If you have a claim and you want that review to be done, you need to seek the people who are responsible for doing that. They're the people that can best review that for you, and that would be -- well, the

office of Dr. Blake, who is -- oversight, provides the oversight and the direction for the actual processing of the reconstruction of the dose.

We can't be an appeal board. There is an appeal board. It already exists. It exists with the Veterans Administration. They have a fairly substantial appeals process, and that's the route that one needs to go if they have an appeal of a claim.

We can't really help you individually with your claim. That's not our role. Our role is to, again, advise DTRA or advise the VA.

And we can't do anything to change the law. That -- for that you have to seek legislative relief from the members and the staff on The Hill. Now we can't change and revise any of those provisions.

We can advise and recommend, to the appropriate authorities, if we think that needs to be done.

Furthermore, if you're having some trouble finding out where you should go or what you should do, we as a courtesy, we'll do what we can, share our knowledge with the process, to get you pointed in the right direction. That

we can do.

And how can you follow -- I mean, you know, for you to make a trip out here just to see what we're doing is awkward. I know that. It's not easy. But you can follow our activities. If you have a computer -- if you have access to a computer, you can follow us on our web site. We give the latest information of what we're doing and where we are in the process is always available, all the testimony, all of the minutes, all of the transcriptions, all of our bios, all of our recommendations, all of the results of the recommendations, all this is available on line. And I think you should have our URL, our address for the web, which is VBDR.org. Or you can call a toll-free line, and we give -- giving you toll-free numbers to call to get information (1-866-657-VBDR (8237). And for that all being said, again, I hope you find this meeting interesting and productive for you, and that we can help to answer your concerns, or at least address your concerns.

VETERANS HEALTH ADMINISTRATION PROCEDURES AND THE IONIZING RADIATION REGISTRY (IRR)

And with that, let's move on to our first presenter. Our first presenter is Dr. Victoria

Cassano. Dr. Cassano is new to the VA. She's -- you're new to an organization in the government until you've been there at least a year. She's been five months now with the Veterans Administration. She's an old friend, retired Navy, retired Navy captain, has done much work in undersea medicine. She knows ionizing radiation and she is a pro. This is the first time that we've had an opportunity to meet her officially on the Board, and we're delighted that you're here and you're going to tell us exactly what you do.

DR. CASSANO: Thank you very much, Admiral Zimble. It's a pleasure to be here, members of the Board. I am very happy to be here and representing Department of Veterans Affairs, Veterans Health Administration (VHA), to the Board this morning.

What I wanted to discuss pretty much is the processes and the principles involved in how VA -- Veterans Health Administration actually looks through the claim and -- and does a dose reconstruction if DTRA cannot, and also looks through the medical evidence and medical literature to determine whether, when we're

talking about a non-presumptive case, that this particular condition that a veteran is afflicted with is actually radiogenic and service-connected to their exposures as an atomic veteran.

And how does this -- the bottom -- oh, the th-- with the pretty -- with the pretty little mouse on it. Okay.

To start with some of the principles, Public Law 98-542 was signed into law 10/24/1984, and it did several things for the atomic veterans' program. It established guidelines for resolving claims. It established the Veterans' Advisory Committee on Environmental Hazards, which is a -- another advisory board that looks at the entire process of atomic veterans, but in the context of other environmental exposures. And it authorized the Secretary of Defense to prescribe guidelines for preparation of radiation dose estimates, which is done by DTRA. And finally, it established a process for independent dose estimates, as well. And the law is actually -- if you want to look for it, it's in 38 CFR 3.311 is the statute that... Okay. Presumptive -- one of the -- one of the

principles that came out of this law was the idea of a presumptive diagnosis, and those conditions that are considered presumptive for service connection for radiation exposure are leukemias and lymphomas, which excludes Chronic Lymphocytic Leukemia and excludes Hodgkin's Disease and includes multiple myeloma. And I will, on a case by case basis, you will find this, amyloidosis and multiple myeloma are so closely connected that there have been cases where amyloidosis has also been considered service connected on a case by case basis. Solid tumors include thyroid, breast, pharynx, esophagus, basically all gastrointestinal (GI) cancers, liver cancer, salivary gland cancer and urinary tract cancer. In 2002 five additional cancers were added to the list, and that included brain, bone, lung, colon and ovary.

So for -- if a veteran has a claim for a condition that is considered presumptive service connection, our office up in VHA actually does not get involved in this process. What they need to do is establish participation, which is DTRA's responsibility

and they'll talk more about that. And they have to submit to the Veterans Benefit Administration medical evidence of a diagnosis. And all of these are handled at the VA Jackson, Mississippi Regional Office (Jackson VARO).

For non-presumptive cases, however -- again, 38 CFR 3.311 applies. All cancers are included in non-presumptive diagnoses, so that any veteran who is an atomic veteran, has proved participation, if it's a cancer, it's going to come to us for a -- for adjudication at Veterans Health Administration. Some non-cancerous conditions are included, such as nodular or thyroid disease -- again, on a case by case basis, and it's going to be based on what the dose estimate is that the veteran received.

And actually any veteran who, with competent medical authority, has shown that his disease or condition is related to exposure to radiation, then they are capable of submitting a claim through the process to determine whether it is considered service connected -- again, on a case by case basis. So we do not preclude anybody from filing a claim for

service connection for exposures, an atomic veteran.

Just to quickly go through the process, if a veteran files a claim with their Regional Office, they will file a claim locally -- all of those claims then go to Jackson, Mississippi RO. Jackson VARO will request documentation from DTRA. Okay. And what DTRA does in this process is it researches the case and then responds by letter to Jackson VARO. And again, they will go through their process a little bit in more detail. When that confirmation is received by Jackson VARO and Jackson VARO then develops the claim and sends it up to the C&P Service at the Veterans Benefit Administration to continue the process. They then send the case over to me with the complete development, so I have the dose estimates from DTRA. I have all of the medical evidence. And they have given me a synopsis of the case. I actually get the entire case, so if this veter-- if the veteran has had a claim in process for a while, or if there are other conditions that he has -- or she has claimed, or other conditions that they have been compensated for, I have that

whole file. And hopefully that also includes their active duty medical records, if they are there.

What we then do is I will review that case. I will -- and there's several ways that we can do it that I'll go into later. And I render a medical opinion as to whether or not it is unlikely, as likely or not, or more than likely that this particular condition was due to the veteran's exposure to radiation as an atomic veteran. And how that breaks down is if the probability that this was related to radiation exposure is less than 50 percent, then it would be unlikely. If it were around 50 percent, it's considered as likely as not. And if it's way over 50 percent we consider it more than likely.

However, in this whole process there are about three steps in which we actually find in favor of the veteran so that if it is -- if at step one it is close to meeting a threshold, it will be put over the threshold, and this occurs several times, and I'll explain this in a little bit.

Okay. Where this all occurs is in my office.

This is VA Central Office and it's the Office of Public Health and Environmental Hazards. I am the Director of Radiation and Physical Exposures, and we -- it is myself and a health physicist. And what we use for those radiogenic cancers where there is a model or it is already shown that at a certain dose this particular cancer would be considered radiogenic, we use a program developed by NIOSH -- that's the National Institute of (sic) Occupational Safety and Health -- and it's called the Interactive RadioEpidemiologic Program -- and what we do is find -- with a 99 percent confidence interval, which means that anything that we -- we look at all of those cases that go way out to include what would be considered two standard deviations so that we are 99 percent sure that we have captured all of the -- all of the possibility that this case is radiogenic. And we also will look at non-cancers or those that are not cons-- or cancers that are considered non-radiogenic, as well. Or -- and we will look at those cases where there is no dose estimate available. DTRA does dose estimates for atomic veterans. Sometimes

they help us out with some of the more complicated dose estimates, but for veterans that believe they have been exposed, possibly occupationally for -- to radiation not within the group of veterans that are considered atomic veterans, we will actually try to do a dose estimate. There are -- there are individuals that, because of cancer treatment that they may have had on active duty, were subjected to large -- large amounts of cancer -- or large amounts of radiation, and we will look at those. We also look at more recent radiation exposure and also places like Hanford and -- and other places where known radiation exposure may have occurred above what is considered safe for the general public.

The process for us, if it's a skin cancer, we need a specific site because the dose estimate is based on characterization of the site and how much radiation would have affected that particular site. So face, hands, and exposed parts of the body would obviously receive more radiation than those that are -- tend to be clothed.

Cataracts, the only type of cataract that is

considered radiogenic -- there is only one type. The other two types are not -- and so we look at the record and we have to look to see exactly what ty-- what type of cataract the individual has -- has developed. So hopefully your ophthalmologist has actually has put -- the ophthalmologist has actually put down whether it's a posterior subcapsular cataract or a nuclear sclerotic cataract.

Tumors, again, we need a specific site excep-- unless -- for brain or central nervous system because those -- the central nervous system obviously is ubiquitous in the body, so we -- we -- we don't need a specific site for that. And obviously if it's not -- if a cancer is not specific to a target organ, then we need the site of that cancer as well.

How do we determine radiation exposure if DTRA hasn't been able to do it? We look at DD1141s which are the occupa-- the occupational exposure record for the veteran. We look at service and medical records. We try to find information from the various departments' dosimetry offices. We will go to the Department of Energy (DoE) if we have to, if

somebody was detailed to the Department of Energy. We'll look for records at individual nuclear weapons facilities. And places like Hanford, there are several documents which will help us determine what a dose estimate is for Hanford. And then the Technical Applications Center at the Air Force helps us out with Air Force doses.

How do we determine an actual diagnosis? That is based on hospital discharge summaries, operative reports, sub-specialty consultation, pathology reports, and a death certificate if it is a widow that is claiming compensation for a deceased spouse. We really look through these quite thoroughly. I mean I pull records apart. I go through military service records to see if I can find anything that would indicate either, number one, that while the individual was on active duty there was some suggestion that they may have suffered some ill effects acutely if their radiation dose was high, or that they might have been exposed to radiation in other ways while they were on active duty. So it really is a very thorough review and I'm very proud of how we do this.

My health physicist works with me and leaves no stone unturned in trying to determine a dose estimate. So you know, I think by the time we come up with a decision, it is a very well thought-out and well-researched decision. Again, looking at service records and medical records, sometimes for some of the cases we don't exactly know where someone has been, especially when you're talking Special Forces or other types of spec ops where there is no record of where an individual was at any particular time, and we take that into consideration. Medical reports since leaving active duty, obviously. And then we use a lot of professional references -- the IARC manuals, which is International Agency for Research on Cancer. We look at the BEIR reports, which is Biological Effects of Ionizing Radiation. There are seven of those, the most recent being number seven. We look through -- I am constantly in oncology and medical texts, medical literature, looking for any updated information that I can find to determine whether there is a possibility of a particular condition that is being claimed being related

to radiation exposure. And some of -- this takes time. There is one of me and there's one health physicist, so if I get a case that requires an extensive literature review it's going to take me some while in getting this done.

And then we also look for other possible reasons for service connection. I don't necessarily feel that my job is just to answer the -- the question presented to me by VBA, which is what -- is this radiogenic. If I find another reason that somebody has -- has a legitimate claim, then I'm going to put that in my medical opinion, just so that when it goes back everybody knows that there should be a different avenue taken for -- for compensation of this particular case.

Now the other benefit that we manage at VHA is the Ionizing Radiation Registry. This was established in 1986, Public Law 99-576. And those that are able to participate in this Registry are on-site participation in nuclear testing -- and that's the nuclear testing that occurred between 1946 and 1962, certain individuals that are proved to have

participated in the occupation of Hiroshima or Nagasaki, and internment as a prisoner of war in Japan within a specified radius of Nagasaki or Hiroshima, and other radiation risk activities which I've sort of mentioned before, including Hanford, Amchitka Island and other -- other radiation risk activities.

In addition, those individual who were either submariners or aviators early on -- there was a theory that if you used naso-pharyngeal radium you could reduce adenoid tissue and therefore people would have less difficulty clearing their ears, and this was used as a preventive technique for submariners and for certain aviators. These people are also entitled to participate in our Registry, and this was written into law November 11th, 1998.

And what the Registry is -- you have to show eligibility, and it is an intake medical exam that looks at specific sites that may be more prone to developing radiogenic cancers. It does -- in certain situations it does provide for Priority 6 hospital care and medical services, as well as nursing home care. In addition, it does give us some more information

on the health status of veterans that may have been exposed to radiation.

To get -- to become a participant in the Ionizing Radiation Registry you have to go through the whole health eligibility process, so when you -- when a veteran would go to a medical center they would ask to speak to the environmental health coordinator and they would do -- they would go through the health eligibility center that then sends the individual's information to DTRA to confirm that there was participation. They would then receive a medical exam, get a letter with all the findings, follow-up examinations on per-- periodically are available. And then they also receive the updates through mailings, whether it's newsletters, brochures that we send out, or other information. And finally, the possible Priority 6 enrollment, which is a very nice benefit to have.

For resources, for VHA you have my name up there, my e-mail address and my new phone number. I apologize, we had some issues with phone numbers. My office just moved two weeks ago to a different building and all of our

phone numbers were changed, so the 202-461-1024 is the correct number.

And the young lady that manages the Ionizing Radiation Registry's information is also in that -- in your briefing books.

And we are upgrading our web site, so you will see some new information on there very soon.

Thank you very much.

VICE ADMIRAL ZIMBLE: Thank you, Dr. Cassano. We really appreciate the update. It's nice having you -- it's refreshing having you representing VHA so that we are sure that we are closing the linkage between VHA, VBA and NTPR -- and the Board, of course -- so that -- that's very helpful.

For any veteran out there that is an atomic veteran and who is not in the Registry, I urge you to seek an opportunity to get into the IRR. There are benefits such as Priority 6, such as a health examination, and getting into that Registry can be of help. We keep you updated with news from the newsletter that periodically comes from the VHA.

DR. CASSANO: Thank you very much.

VICE ADMIRAL ZIMBLE: Anybody on the Board have

any questions or comments? Dr. Boice.

DR. BOICE: Well, first thank you for a very clear and comprehensive overview -- appreciate it very much.

I had two questions, one was of curiosity and the second one was one of a simple statistic. The curiosity was you mentioned Hanford a number of times --

DR. CASSANO: Yes.

DR. BOICE: -- and I was just curious. I wasn't familiar that the veterans had in any way participated in Hanford in such a way that there would be weapons exposure -- 'cause there's lots of radioac-- you know, Los Alamos and lot of other places, but you kept saying Hanford.

DR. CASSANO: Becau-- I guess because there was a lot of press about Hanford when that originally occurred, but there were active duty military personnel that were on that -- on that site for various reasons during and after the period --

DR. BOICE: When they reduced the --

DR. CASSANO: Yes.

DR. BOICE: Okay.

DR. CASSANO: Yeah, and -- and even cleanup details afterward where there was ground water contamination and other contamination. Though the levels that most people received were not high enough to show any radiogenic diseases, we still do -- we evaluate everything that comes to us, and we get several of those probably a year.

DR. BOICE: Yeah, well, that -- you know, that's interesting. I hadn't thought of it as a -- you know, a weapons --

DR. CASSANO: It's not --

DR. BOICE: -- we built weapons, of course, but was not as -- like there was detonations and --

DR. CASSANO: No.

DR. BOICE: -- like Hiroshima or Nagasaki or Bikini or --

DR. CASSANO: Right. Well, no, we -- we unfor- - even though this is the atomic veteran board, we -- my perspective, if it's ionizing radiation, we manage it.

DR. BOICE: The other quick question, too, was on your experience thus far in having positive responses to the non-presumptive claims. With regard to the presumptive claims, it's pretty

straightforward and it's to the veteran's benefit. If in fact he has this condition, all he has to show is that he has it. I have one of these conditions and I participated in one of the weapons activities, and then they are qualified for compen-- compensation or disability, so that's straightforward.
But if you have a non-presum-- supposedly, but if you have a non-presumptive, that becomes a little more problematic with the dose reconstruction and is it radiogenic and all of that. Have you had experience on whether then, you know, a series of these non-presumptive ones and what the success rate, I guess, would be?

DR. CASSANO: It varies. I don't have enough experience over the past five months to say that I have seen enough of any particular type of cancer that I might want to make a recommendation that we look at this for presumptive service connection, though there are a couple that I have looked at that may be close. And a lot of that has to do more with biological plausibility than -- than actual doses. And I men-- I think I mentioned

amyloidosis, and the reason amyloidosis falls into that category, if you look at parallel legislation and parallel situations, based on biological plausibility I think in the last Agent Orange update the Institute of Medicine determined, not based on epidemiological evidence but based on biological plausibility, that amyloidosis is so close to multiple myeloma that they would -- they recommended that probably the same biological mechanisms that produced multiple myeloma could possibly also have produced amyloidosis. And therefore, for Agent Orange vets, amyloidosis is now considered service connected.

What I did on a case by case basis is well, if the biological plausibility is there for causation in Agent Orange, because it wasn't epidemiologically based, my thinking was that the same biological plausibility applies to amyloidosis because the reasoning was that the same causation for multiple myeloma or same association for multiple myeloma and myeloid cancers in general is now being applied to amyloid. So in those situations there is a positive --

DR. BOICE: And then a practical follow-up would be but then you have to have a dose -- if you're going to put that into the probability of causation --

DR. CASSANO: Right.

DR. BOICE: -- then you would assume the multiple myeloma was the -- that it responded in the same way as multiple myeloma --

DR. CASSANO: Yes.

DR. BOICE: -- you got a probability of causation.

DR. CASSANO: Yes. And so that's how that works. Any other questions from the Board?

VICE ADMIRAL ZIMBLE: Yes, Dr. Lathrop?

DR. LATHROP: Yes, Dr. Cassano, you seem a very organized person, so let me ask this.

DR. CASSANO: You'd be surprised.

DR. LATHROP: Why the laughter?

DR. CASSANO: He knows me very well.

DR. LATHROP: Right. We would very much, on the Board, like to see -- if at all possible -- running spreadsheets of how -- how the decisions have been made in terms of awarding compensation or not. Are you keeping a running spreadsheet, are you starting to?

DR. CASSANO: We have -- we do have a log. Actually I'm -- I'm required by the other advisory committee that -- Veterans Advisory Committee on Environmental Hazards -- to produce a log. I have to tell you, though, that -- I know it sounds like we're splitting hairs, but I render a medical decision based upon whether I think it -- there is an association of as likely as not, or more than likely. The compensation decision is still made by VBA, so --

DR. LATHROP: Right, that's actually very good because we understand that the compensation decision involves several factors, and we're more interested in what -- what goes to you from the rest of the process --

DR. CASSANO: Yes.

DR. LATHROP: -- how that falls on the more likely than not scale.

DR. CASSANO: I can certainly give you that --

DR. LATHROP: That would be --

DR. CASSANO: -- that information.

DR. LATHROP: -- very helpful.

DR. CASSANO: It would obviously have to be de--

DR. LATHROP: Redacted, sure --
DR. CASSANO: -- de-identified, completely de-identified.
DR. LATHROP: -- and we don't -- and that's fine, just by number, erase all names --
DR. CASSANO: But I can give you that.
DR. LATHROP: That would be very good. Thank you.
VICE ADMIRAL ZIMBLE: Okay, I see we have two more -- two more people that have comments, and I'm going to go and -- because I have a bias, we'll go in reverse alphabetical order -- Dr. Zeman.
DR. ZEMAN: Thank you, Dr. Zimble. I'm not sure -- I guess that means maybe I have to buy lunch, I'm not sure.
Dr. Cassano, thank you for the briefing. I'm on the committee -- the subcommittee that reviews dose reconstruction cases, and one of the surprising things for us from time to time is that there are cases that are referred to DTRA for non-radiogenic diseases. And the DTRA team dutifully tries to calculate a dose, but sometimes doesn't even have dose conversion factors for internal organs that are not

radiogenic. So what I wanted to ask is what is the process for handling non-radiogenic diseases and whether you would -- for example, you mentioned cataracts. There's one type of cataract that's radiogenic and others that are not. If one of those non-radiogenic diseases came in and a veteran were claiming or asking for service connection for radiation, how -- how will you handle those cases?

DR. CASSANO: I think -- and Dr. Zimble and I sort of had a side conversation on this not long ago, so I'm a little bit prepared for the question. The -- this cuts both directions. Obviously when something is very definitely considered not radiogenic, such as nuclear sclerotic cataracts or some other diseases where there is not a lot of evidence for radiogenecity, it does increase a workload that some would consider unnecessary.

However, the amyloid case would never have come to me if we had applied that ruling across the board. So while we see a lot of -- we see a lot of non-radiogenic cancers, non-radiogenic diseases or non-radiogenic cancers, and it does slow down the processes -- 'cause as I said,

there's just one of me and one health physicist -- I think in some ways there's benefit to doing it.

Now I would -- things like Chronic Lymphocytic Leukemia, which we have never been able to show, sounds like something that could be handled at the local VARO. And unless there is, you know, a posterior subcapsular cataract, the problem is that sometimes when I go through medical records things are -- things ha-- because there has not been somebody with medical expertise looking at these records, things are missed that I sometimes pick up. So much as I'd like to -- to have an answer go back to a veteran sooner rather than later and not having it go through this rather protracted process, I'm reluctant to say that I would like these adjudicated at an -- at an earlier part in the process. There may be some way that I might be able to write a protocol for VBA to -- to determine which ones definitely can be managed by maybe Jackson VARO or the C&P office rather than coming to us. But there are costs and there are benefits to doing it either way.

VICE ADMIRAL ZIMBLE: I would just state --

would remind Dr. Zeman and the Board that we have made that recommendation already to the Veterans Administration, but they have some entity, either individual or board, of experts on radiogenetic disease review before it goes to the NTPR for dose assessment. I would say that it's obvious to me from dealing -- talking with the VA, they're very, very reluctant to refute a letter or a comment from a -- the private physician regarding the causation. So that's the main issue is the reluctance on the part of the VA to get involved with an argument with a private physician over whether or not it's a radiogenic disease.

And considering the current workload, it's my understanding from my good friend Dr. Blake that he can handle these rather expeditiously if they come over to DTRA. They get turned around and sent back very quickly without having to go through the full cumbersome dose assessment. I'd ask Dr. Blake to comment on that, if he cares to.

But bottom line is if we have such a case, we know that sending that information over to DTRA does delay the ultimate adjudication of the

claim. And so the one thing we can do is, as quickly as possible, get a determination that this is -- this particular condition cannot in any way be due to ionizing radiation and -- and get that claim resolved as -- more quickly.

DR. CASSANO: I wouldn't want to speculate on a different process here, but certainly I think that we can get people together to look at this and see if there is a -- I mean I would be willing to -- I know VHA would be willing to -- work with some people to see if there is a better way to actually do this for these particular cases.

VICE ADMIRAL ZIMBLE: Again, we know that -- we know that in -- in certain instances we're going to -- the claim is going to be denied. It's going to be denied for a very good, solid, scientific reason, and the faster we can let the claimant know --

DR. CASSANO: Yes.

VICE ADMIRAL ZIMBLE: -- that and not encourage them by delay, I think is an important thing for us to recommend.

Paul, do you have any further comments on that?

DR. BLAKE: I'd certainly look forward to if we

can work together between DTRA and VHA on these fairly rare cases now. In the past there were a lot more of them. We worked through them. But if they come up, and since they are so unusual, I think simply discussions between my program and Dr. Cassano's --

DR. CASSANO: Uh-huh.

DR. BLAKE: -- program on the few that come up, we really could then handle them more expeditiously. Instead of trying to say any policy change or anything like that, which probably is not appropriate, I think phone calls back and forth --

DR. CASSANO: Uh-huh.

DR. BLAKE: -- and obviously VBA needs to weigh in on what we're doing here. But I think we can handle them more expeditiously if we can just discuss them. And the difficulty before was I think we got tied up in regulations saying that we really had to handle them formally and we weren't -- we had to go through the formal procedures. But I think some phone calls back and forth could make it happen a little more rapidly. That would be good for -- for not only the agencies, but the veterans,

too.

VICE ADMIRAL ZIMBLE: Right.

DR. BLAKE: And since it's so -- we're only seeing cases like this now maybe one every two or three months.

DR. CASSANO: Uh-huh.

DR. BLAKE: So it's really dropped off. It's not that big a thing, and I think we could -- based on what you're offering -- we could go that way.

DR. CASSANO: Uh-huh, I have no problem with that.

VICE ADMIRAL ZIMBLE: Dr. Reimann?

DR. ZEMAN: Dr. Cassano, I just want to say thank you for a very thoughtful answer. I appreciate your perspective on managing that issue.

DR. CASSANO: You're welcome.

DR. REIMANN: Dr. Cassano, thanks very much for being here. As you may know, the Board also -- in addition to the audits of the NTPR and VA, we also have a quality management subcommittee, and Dr. Lathrop has already thoughtfully assigned something to you there which is extremely important. But I just wanted to

mention something that I think you're uniquely positioned, of all of the actors in this very important but quite complex program, and so from your vantage point you see played out in your day-to-day work the complexity, and that you have to cut through to the heart of the matter and come up with, you know, a thoughtful response. And certainly what you conveyed to us today indicates that thoughtful response. But from seeing that complexity, we'd sort of like to see you as an honorary member of the quality management team, if you can identify anything along the chain that you see as unnecessary complexity, it would be extremely valuable to pass that on to not only the agencies but this committee, and perhaps we can jointly develop some kind of a design that gets around that problem. So you see the whole thing played out, and so everything that we see along the way that is a concern in effect accumulates and -- and ends up on your desk, so clearly if that complexity were reduced, you would also be one of the primary beneficiaries of that because you would be able to apportion your time more to those cases where there's

much more of a value added in your time and the unique capability that your team brings to it to solve the -- some of these other issues. So we'd like to think of you as sort of an honorary member of our small team here.

DR. CASSANO: Well, thank you -- thank you very much. I did, in probably not the most appropriate way, appreciate the term "accumulation" because they do tend sometimes to accumulate. And again, it's the same answer as I gave to Dr. Zeman, it cuts both ways. I mean any process that you put in place that would eliminate some of the -- from our perspective -- unnecessary complexity might also end up presenting a problem with not finding something that's buried. And you know, we ca-- we would have to really think hard on how we could do this in a way that does not mitigate against the veteran because in -- the ultimate beneficiary of this whole process is hopefully the veteran, who has waited long for -- for an answer. And any way that we can speed that process up, I -- I think would help all of us.

VICE ADMIRAL ZIMBLE: Thank you very much, we

very much -- oh, wait, wait, wait.

DR. CASSANO: Right.

VICE ADMIRAL ZIMBLE: First thing -- first thing, accepting an honorary membership from -- from Dr. Reimann --

DR. CASSANO: Means I work. Right?

VICE ADMIRAL ZIMBLE: -- frequently involves a great deal of work. I just wanted you to understand that that -- that potential is there, but -- but it is -- it's -- I'm glad that you accepted.

DR. CASSANO: Well, yeah, I -- you know -- I probably -- never mind. I keep forgetting I'm on the record so I'd better -- I'd better watch it. But yeah, I appreciate being an honorary member and I will actually do some work for you, as I can. Thank you very, very much.

VICE ADMIRAL ZIMBLE: Dr. Fleming.

DR. FLEMING: This is just a question of information. Could you clarify again, after you render the medical opinion, where does it go?

DR. CASSANO: The medical opinion goes back to C&P Service over at the Veterans Benefit Administration, Mr. Flohr's shop, and they

render an advisory opinion that goes back to the local VA Regional Office (VARO), and --

DR. FLEMING: So it does not go back to Jackson VARO?

DR. CASSANO: I'm sorry, it does go to Jackson VARO.

DR. FLEMING: Oh, it does? Okay.

DR. CASSANO: Yes.

DR. FLEMING: That's what I wanted to find out.

DR. CASSANO: It goes back to Jackson VARO.

DR. FLEMING: It goes back to Jackson VARO, it doesn't -- and then does it go back to the local VARO after that? Okay, thank you.

DR. CASSANO: You're welcome.

VICE ADMIRAL ZIMBLE: The rating decision will be -- will be at Jackson VARO? Okay.

DR. CASSANO: Okay.

VICE ADMIRAL ZIMBLE: Jackson VARO will make the rating decision rather than the local VARO, but --

DR. CASSANO: Okay, sorry about that.

VICE ADMIRAL ZIMBLE: Okay.

DR. FLEMING: C&P doesn't make the rating decisions?

VICE ADMIRAL ZIMBLE: No. No.

DR. FLEMING: Okay.

VICE ADMIRAL ZIMBLE: All right. Thank you very much, Dr. Cassano --

DR. CASSANO: You're very welcome.

VICE ADMIRAL ZIMBLE: -- we very much appreciate it.

I would like to acknowledge -- first of all, welcome -- we're very honored to have Major General Randy Manner here with us today. He is the Acting Director of the Defense Threat Reduction Agency, and I'm truly honored that you could take the time from what is a busy threatening time for this nation to be able to come here and spend some time with the veterans and with the Board. Thank you very much.

BEGIN BOARD DISCUSSION OF THE FUTURE OF THE VBDR

And now there's a portion here on the agenda for us to start talking about -- a little bit about our future in the -- the future of the Board in continuing to provide support to the two agencies with the level of expertise of this Board, and I've asked for recommendations from the various Chairs, and I'm hoping that later when we have the reports from those subcommittees that their reports will include

something towards where we should be going. In the meantime, I did ask Dr. Lathrop to provide a letter. At that time I was wondering whether or not this VBDR could be transformed into a different Board to do different functions, and I asked that maybe we have a letter that would go to our two sponsors -- through our two sponsors back to The Hill to request a modification of this Board. And that letter has been prepared -- I don't know -- Mr. Bell, did we make copies of this for the Board members will all have that letter? Do you all have that letter?

MR. BELL: You need to hand them out, Doctor Zimble. I may need to make some more copies.

VICE ADMIRAL ZIMBLE: You all have copies? Okay. Okay, I won't read to you what you already have read. It's an excellent letter. It really helps to define where we should go, and I would ask Dr. Lathrop if you would mind making some comments regarding the rationale for this, the content of this letter.

DR. LATHROP: Thank you, Admiral Zimble, I'd be happy to do that. You have the letter in front of you and I won't read through the letter, but

I'll give you the gist, and that is that to date the VBDR has frankly been quite successful and really it's -- we've just been -- the Advisory Board, the real success and change has been accomplished by the Nuclear Test Review work of Dr. Blake and the VA, as has been mentioned by Dr. Cassano.

The two big changes that have been instituted by the two agencies in the -- to the great benefit of the veteran as, on the DTRA side -- I apologize, when I wrote the letter I didn't have all the information in front of me, but as is always the case, when I talked to Dr. Blake he had the numbers right off the top of his head. We've made -- as an Advisory Board we've made 47 recommendations to the two agencies, and we kept waiting for them to come back to us, to strangle us with frustration, but in fact the 47 recommendations have resulted in very significant changes to the benefit of the veteran in -- in -- there's two big ones. There's a lot of them, but the two big ones are the backlog of atomic veterans' claims used to be -- at one point, for various reasons, was as high as 1,600 claims, 1-6-0-0, and now the

backlog is about 60, 6-0. The average processing time has been reduced from something like nine months -- tellingly, we don't know quite what it used to be, but it's something like nine months -- to now something like two months. And the maximum processing time has been reduced from about four years to less than six months, and this is by a lot of very good work by Dr. Blake's group, partly in response to suggestions from the Board to institute a set of expedited procedures to work things through -- still in the veteran's favor -- when particular sort of fast-track processes could be done to get the claim processed in a very good way.

The second major improvement has been on the Veterans Administration side by consolidating all of their operations in the Jackson, Mississippi RO-- I see there now is a typo, it's Jackson, Mississippi, not Missouri -- and in that case, because it's been consolidated in one place, the handling and the expertise and the standardization has taken a marked step function up.

So those, and several other things, mark basic

changes in the two operating agencies in service of the veteran, and that's quite good. And we're now at the stage when we're -- we've handled most of the changes, and now there's just several other things that should be considered in the future operations of the Board, and they're sort of moving beyond the -- the big changes we've had so far. There's been -- 47 recommendations is plenty of recommendations. We're done with that.

Now there's three things, as is mentioned at the bottom of the first page, that in my view -- this is just my opinion, my suggestion. Those three things are the need for further work by the Board which does not involve generating yet more recommendations and large changes in the operation, but still very important changes. Those three are listed at the bottom of the page. Basically what remains to work -- and this is after a lot of significant work, especially by Dr. Blake's organization -- in getting a quality management (QM) and quality assurance (QA) system in. This is very important for these cases 'cause these cases are pretty complicated, and you

need to engage some management direction and operations procedures to make sure that the claims are all handled in a fair and consistent and documentable way, so everybody knows that every veteran gets the same -- same breaks and same judgments as every other veteran. So that involves setting up a quality management system, and that continues to be somewhat of a work in progress with both of the agencies. So the Board would look forward to, and looks forward to, working with those agencies in setting up the quality management system. That's the first of the three operations which I've suggested.

The other two are monitoring ones and would go on, frankly, for an indefinite period of time. The first one is, after you've set up the quality management system, it takes some monitoring from an external agency -- and the Veterans Advisory Board is an appropriate such agency -- to make sure that the quality management is being pursued and worked with by the two agencies in the appropriate way.

Finally, the other thing -- and we're very interested in this, too -- is it continues to

be the case that we're not confident that every atomic veteran has been reached with enough information so that he can make an informed choice on whether or not to file a claim.

Now remember, we're an Advisory Board, and all we can do or hope to do in the pursuit of our mission is make sure that every atomic veteran -- to the extent that we can, get out to as many atomic veterans as we can to give them the information so they can choose whether or not to file for a claim. And we are proposing a -- a atomic veterans' outreach campaign which would be an effort that we would be advising on and encouraging both of the operating agencies on to get the information out, the work out, to atomic veterans.

Those three things -- the setting up of the quality management, the monitoring of the quality management, and the conduct of the atomic veterans' outreach campaign -- I would suggest are three further operations of the Advisory Board that we can turn our attention to now, now that we've been so successful -- actually we've simply been advising -- now that we've had such great success by the two

operating agencies. And that's the gist of the letter and that's the gist of my suggestion for the Board's deliberation on where they should go from here.

Thank you.

VICE ADMIRAL ZIMBLE: Thank you, John. I appreciate the word-smithing that you've done to prepare this and to help clarify where you feel that the direction of the Board should go. As you know, we're talking about restructuring, but I'd hate to use that term in today's environment. We're not going into Chapter 11. We -- we're looking to restructure in terms of mission and membership that would make us more efficient and to -- and to help continue to advise regarding the two agencies for their being able to do the very best job they can, as advocates for the veteran. And I think that we can move in that direction.

As you might -- I've asked all of you to review the charter, which is at Tab 9, and I think you'll see that if you look it's a very small font so I apologize for that, but if you'll look very carefully you'll see that the membership that's been mandated by the Board --

by the charter, by Congress, and the missions that have been given to the Board, would allow us the level of flexibility necessary to do some restructuring without really having to go back and ask permission to do so. So I think, with that clarification, this is a wonderful letter, but I don't have to waste a 44-cent stamp to send one to Congress. I think we can handle that. But at any rate, I think what you've done is pretty well articulate where we need to go, and we can -- we'll be doing some more deliberation on that after we've received all the reports that are necessary.

Are there any other comments from the members of the Board at this time? If not -- oh, I'm sorry. Yes, Kris.

DR. SWENSON: Dr. Lathrop, you mentioned claims processing time reduction from four and two months. Where did you get that information?

DR. LATHROP: I'm sorry, I should have added a phrase to that. That's the claims processing from the DTRA operation, and I got that in my usual way for getting any sort of facts, I just asked Paul Blake.

VICE ADMIRAL ZIMBLE: Actually it's the process

of the dose reconstruction that's been narrowed down. A lot of -- and by the way, there's a term that you -- a qualification that you didn't mention in the process, which is "expensive" -- we have reduced the total expense of having to do those arduous, full RDAs through the expediting process. It has really been a great help to Dr. Blake.

Dr. Blake.

DR. BLAKE: Just one comment, Dr. Lathrop. When you made your discussions about outreach, you emphasized the veterans, but I think it's important to emphasize their dependents also. The average age of our atomic veteran population is 82. And if you look at the Social Security life tables of our approximately half-million atomic veterans, only about 40 percent are currently living. Even after they're deceased, though -- for instance, the spouse can still file -- and so I think it's important when we emphasize outreach not only to emphasize the veterans but also their dependents because they're also possible beneficiaries through the Veterans Administration.

DR. LATHROP: Very good point. Thank you very much.

VICE ADMIRAL ZIMBLE: All right. I see no further signals from the Board. I would ask Dr. Blake now to make his presentation.

MR. BELL: Admiral, we've scheduled a break at 9:30. I'm not sure folks might not need that.

VICE ADMIRAL ZIMBLE: Thank you. You're a very loyal conscience for us, and so Dr. Blake, if you'd like to wait until after a scheduled break --

DR. BLAKE: I'd be happy to, sir.

VICE ADMIRAL ZIMBLE: I thought you would be. Okay.

(Whereupon, a recess was taken from 9:36 a.m. to 9:57 a.m.)

VICE ADMIRAL ZIMBLE: We'll bring the meeting back. We're going to -- yeah, this is -- this is -- attention on deck. Attention on deck, the proceedings will now resume.

(Pause)

All right, thank you. Thank you very much. The Board has reassembled. I have -- as I'm sure those of you who are paying attention to the agenda have noticed, the Chairman has

deviated somewhat, and I'll continue to do so.

PUBLIC COMMENT SESSION

At this time I think it would be most appropriate to acknowledge that we have some veterans here that wish to speak and we're -- we're always anxious to hear comments from the atomic veterans. That's what this Board has been put together to accomplish, is to listen, to learn, and to see if -- if we can make a difference, if -- if a difference is necessary. So I have -- I have four -- four veterans that would like to speak. The first is Mr. Freeman Cox, and Mr. Cox, if you would step forward. Do we have a microphone? Okay.

Okay, we can bring a chair forward for you so -- what's -- here, here, he can sit right there. Okay. Now this will not be an interrogation. Okay, at any rate, the Board is anxious to hear what you have to say.

MR. COX: I'm Freeman Cox, Bristol, Tennessee. I'm Chaplain in the -- for the Disabled Veterans Chapter 39, and also Chaplain of the Veterans Civic Council of Bristol, Tennessee. A few words on my life as an atomic veteran. There's a lot of things that -- that affect the

atomic veteran that I don't think the VA recognize or consider. In 1955 I started working with the nuclear weapons, the Mark V with a separate warhead. As we loaded them we had to make a nuclear insertion each time we loaded them.

Sorry, my telephone just went off. I'll cut that off.

VICE ADMIRAL ZIMBLE: I really like that rooster. I'm going to have to figure out how you --

MR. COX: Well, I'm a far-- a goat farmer and chicken farmer from east Tennessee, so...

But anyway, I started working with nuclear weapons in 1955. We loaded the Mark V on B-45 bomber. It was the first weapon for the military, the first weapon for NATO. We were the only defense in the Cold War at that time. This was before SAC and the B-47.

But early on I started having symptoms of gastric problems, a lot of anxiety. I suffered from reflux. My food wouldn't digest and food that I would eat sometimes would stay in my stomach for three days. I had a lot of vomiting and headaches, and -- but I -- I went

for a number of years in the military. I was in 12 and a half years, and all this escalated with joint disease. I'd lost three inches in my posture by the time I was 30. But I was on my way to Vietnam and they turned me down because of the ulcer disease, and eventually they forced me out of the service.

They run some tests and my salivatory (sic) glands was producing seven to eight times the acid of a normal person. I was extremely hyper and anxious, but ended up -- after I got out of the military VA cut me back to ten percent disability and I struggled for many years trying to feed my family. They said if I didn't have a cancer, I didn't have any disease. They reduced my stomach disability to ten percent and I think I drew ten -- $10 a month for about 20 years.

But anyway, each time I would try to get something done at the VA, I wasn't eligible and what-have-you and they referred me to a civilian doctor, which I couldn't afford.

But my children was being affected by the joint disease and what-have-you. Right now three of the five are on disability. I've got a

granddaughter that's -- has a birth defect that they say is one of the rarest forms of birth defect. The hair follicles grows into the spine instead of out of the skin. They operated -- did surgery on her at three weeks or less and cut a nerve in her back and now she's got a withered left leg and she catheterizes herself to go to the bathroom and what-have-you.

After I got on this Registry nobody has monitored me or my family, and I thought that was what the Registry was for. When I tried to get on the Registry I was given a lot of resistance through the VA because they didn't think that -- that I ought to be on it. Well, I was wanting to sign up for it for the very purpose of -- of them monitoring my family to see why they were getting all these -- these effects. I think there's more -- every gland in your body is affected, your nervous system. But the VA says if you don't have cancer, you don't have a disease, and I think they're wrong and that's why I'm here.

VICE ADMIRAL ZIMBLE: I appreciate your comments. I think -- does anybody on the Board

have a comment or a question regarding this testimony?

We really don't have good scientific evidence that ionizing radiation can cause -- it can cause more than cancer, we know that. But we don't know about the dose that you received and we don't know about the circumstances, and we need a lot more information. We also don't feel that a lot of the diseases that come with aging are necessarily related to ionizing radiation above the routine exposure that we all face. So I hear what you're saying and I would ask -- we have a representative from the Veterans Benefit Administration who also -- Dr. Cassano. I don't know what sort of availability there might be in the VHA for someone who is already in the Registry. I understand there's a possibility of Priority 6. Is that not true?

DR. CASSANO: There is a possibility of Priority 6. I am not the smartest person --

VICE ADMIRAL ZIMBLE: Okay.

DR. CASSANO: -- in that whole process, and that's something that the health eligibility office --

VICE ADMIRAL ZIMBLE: Okay.

DR. CASSANO: -- would be able to help him with.

VICE ADMIRAL ZIMBLE: Could you provide Mr. Cox sometime today with a point of contact for him to get the information he would need to help him get access to -- a better access, if possible, to the VHA?

DR. CASSANO: Certainly.

VICE ADMIRAL ZIMBLE: All right. Thank you.

MR. COX: I have another -- 'nother question. I had a brother that worked from 1939 until his death at Oak Ridge. He worked in the building Y-12 and he received radiation and he died of lymphatic cancer. Now the Congress has passed laws giving the -- those workers benefits. I was instrumental in getting my sister-in-law to sign up for it and after quite a few years I think she got her compensation three years ago. She's about 93 years old and up until then all she had was Medicare. That agency there, they said they did research and they feel that radiation causes a host of diseases. I asked the VA to allow a Dr. Dolens* at Oak Ridge to check me and do some research and he had a-- he

had agreed to it and said if I could get the VA to approve it that he would -- he would do blood work on me and what-have-you. Now I don't know what -- what kind of research that he was doing, but he was with -- doing the research on survivors of Hiroshima and Nagasaki. He was doing research on cattle and what-have-you that had been shipped from over there, and he'd been at Oak Ridge for many years.

I put in a formal request to the VA at Nashville, Tennessee and got no response. How close is this Board working with -- with the research that they're doing?

VICE ADMIRAL ZIMBLE: We have members on this Board that do great -- have the same exposure, that have the same degree of expertise. If you look at the biographies of some of the individuals that sit on this Board, they have all that knowledge. They have all that competence and they are doing research all the time. You have radioepidemiologists. We have health physicists. We have faculty from teaching institutions and from some of those National Laboratories, so we do have that Board

expertise.
We need to define something, though, for you and for the other veterans here. The term "atomic veteran", although many, many veterans are exposed to ionizing radiation of some form or another, either with nuclear weapons or with oc-- in an occupation where we use medical devices that have ionizing radiation, et cetera. But the term "atomic veteran" as applied to this Board is very specifically defined as those veterans who participated in atmospheric tests of the atomic blasts, both in the Pacific and here at the Nevada Test Site, and to individuals who were occupational forces at Hiroshima and Nagasaki during a specific period of time after the detonation of the -- of those two bombs, and to prisoners of war that were also in Japan and in reasonable proximity to where those blasts went off. And that's the entire population with which the Bill that we are talking about affects. You're not included in that.
However, if you've been exposed to ionizing radiation, you are eligible for the Registry.
MR. COX: Uh-huh.

VICE ADMIRAL ZIMBLE: The Registry includes the physical, to see if there's anything that is related, and in many cases will advance your priority for care within the Veterans Administration. And that, I think, in your case, is the way you need to pursue it.

MR. COX: Yeah. And -- and in our situation, when I was in England, Anglo-American relations -- the British didn't allow nuclear weapons, they said, on English soil. So supposedly we was using dummy warheads to defend our country and we'd have to fly to Germany to arm the weapons. For two years we were told that we had dummy warheads, and most of the men pitched their dosometers (sic) in the toolbox and that's where they stayed. Well, myself and my men wore ours, and we had them checked. It ended up -- it came out on the British Broadcasting Corporation (BBC) that Suffolk, England was nuclear. Then the British started demonstrating. They was going to plow up the runway and send us home. From then on we had nuclear warheads. We had the real warheads that we'd been using all the time.

All right. These men that I worked with, none

of them hardly have anything on their record showing that they had the exposure to radiation. I did, I've got a recorded 63 rads, which is a small amount of what I actually got because a lot of times my dosometer (sic) was on my field jacket laying over beside the plane while I was working on the weapon. I've got men that's got prostrate (sic) cancer, one man's got 20 percent lungs left. Most of them that I worked with are already dead. But they have no claims because they have nothing on their records. They can prove they worked on the weapons, but they can't prove they've got radiation. And I'm here to -- to say that I think that it's lax in the way that our claims are -- are run through. If a man -- if a man worked on the weapons, it should be presumed that if he has the illness, he's got the radiation exposure. But if he doesn't have it on his records, then -- it's kind of like the man out in -- blue water vet in Vietnam that was out on the board of a ship when the atmosphere was full of Agent Orange, but he's not eligible because he was on a ship and didn't have feet on the ground. And our

nuclear weapons is the same way. If we can't prove that we were exposed, we have no claim. But if a man's in Vietnam and he's got feet on the ground and he gets -- if he gets sugar diabetes, it's presumed that it's because of Agent Orange. They get more publicity than we do as a -- as a nuclear vet.

VICE ADMIRAL ZIMBLE: Thank you. Thank you. We appreciate your testimony. We have it recorded.

MR. COX: All right.

VICE ADMIRAL ZIMBLE: Okay.

MR. FLOHR: Sir, I don't know what happened or when you filed your claim with Nashville or why you haven't received a response, but I'll give you my business card. You can call me or send me an e-mail and I will check and find out what's going on and let you know. Okay?

MR. COX: Okay.

DR. CASSANO: Mr. Cox, also, I have your e-mail address and I will -- I will send you an e-mail and we -- we may be able to communicate and I may be able to help you out a little bit as far as figuring out where -- where in this process you sit and what we can do over at VHA. And I

also do want to thank you very much for your service.

VICE ADMIRAL ZIMBLE: Yes.

MR. COX: Well, my case is pretty well established, but I kind of -- concerned about my fellow workers.

VICE ADMIRAL ZIMBLE: Right. We appreciate that and, again, I -- the whole Board wants to thank you for your service.

MR. COX: Thank you.

VICE ADMIRAL ZIMBLE: Mr. King. He stepped out? Okay.

All right -- Mr. King? We're ready.

MR. KING: Can I pass for a while? Or just pass, period -- pass out.

VICE ADMIRAL ZIMBLE: Oh, okay. Okay. The next I have is Mr. Rogers. Yes, sir.

Okay, Mr. Rogers, we've had a private conversation, but let me just tell the Board that this -- Mr. Rogers also, by definition, is -- is not within the category of a nuclear testing at the Pacific Proving Grounds (PPG) or at the Nevada Test Site (NTS) with the bomb. He is unique in coming before us. I don't think we've had anyone speak before the Board

yet who is an artilleryman, but he's going to speak about his experience.

MR. ROGERS: Thank you. I got drafted in the Army in 1950. They tore up my little playhouse, but I stayed with them for 26 years. Anyway, in 1953 the First Sergeant come up to me and says you just volunteered to go to Desert Rock. I said okay, what's that? He told me. He had a young man to go, but this guy was too anxious to get out there to get to Las Vegas, so he said he won't behave; you will. Well, I didn't behave all that well, but anyway -- so they sent me to Desert Rock and we were there a couple of days. You know, they give us a little lecture on stuff, and so then about the third day we went out into the desert there and we lined up -- there was somewhere around 3,500 of us, there was a few troops from each post -- didn't have a company of troops. But anyway, I was on the right wing and we were scattered across here and sort of to the right in front of us was where the explosion was going to take place. This was this artillery piece. And they had never used this artillery piece for atomic explosion. They had the --

they had the ammunition for it, but they were going to try it out that time. So we were supposed to be not less than a half a mile from any of the explosion, course we're up like this. And I was on the right wing, right close to it, and so it's -- it's sort of a hypnotic thing when that -- you know, they tell to go down -- go down on the ground in your trench, and at the bottom of that trench, when that thing exploded, the bottom of that trench, you could see the blue light. You know, just like somebody above you with an electric welder. And anyway, so the light goes away. Up -- we watch it, here comes the explosion, you know, comes across, knocks the guy-- some of the guys' hats off, their helmets off. And they had all these little flags sitting out here for your way to go through there so you wouldn't get in ground zero. Well, all the flags went up with everything else. It blew everything away.

So then it comes back and it hits us from the rear, which was kind of a surprise. But then it was a big ball of fire just rolling around, and it looked like it was the size of a

basketball or a half a mile wide. I mean it just -- it was just amazing. Anyway, when it goes up, we get out and we take off. And on my wing, we went through ground zero.

And people said no, you didn't. I said well, the Geiger counter -- I heard this guy -- guy with a Geiger counter over there -- they were in the -- the cadre there were in the white uniforms, had a little window here to look through, and so that Geiger counter was really screaming, and I was going over to ask him what -- you know, are we in this hot place like this. But just as I got to him, a jeep rolled up so he turns this way and I'm right behind him, so I just follow him. So the guy got out of the jeep, this guy gets there and I get there about the time they're talking, but I'm standing behind them, about two feet from them. And the guy with the Geiger counter says man, we got to get out of here, this is so hot. The guy in the jeep says well, we're in ground zero. And he says -- the guy with the Geiger counter says do we want to turn them around, try to get them out of here? The guy in the jeep says no, because if we start trying to

turn them around, they're going to be in here longer, just get them on through here. I says did you guys say we're in ground zero? Two people turned and looked, guy with the Geiger counter goes this way, the other guy goes this way and left me standing there, didn't say a word, so I went on through there.

And I -- I had a pretty good career in the Army, but they didn't want to talk to me about, you know, this episode I'd been in there in that -- I -- I might have one time, and this is kind of in the warehouse, and there's three of them there and some guy setting over in the dark. They introduced themselves, and the guy in the dark -- I never could see who he was, and -- but we talked a little bit and so they says no, no, no, that didn't happen. I says well, take a polygraph, I will if you guys will. And in fact, I'll take one. They said no, no, the Army doesn't use polygraphs. I said that's weird 'cause in the -- in -- about five years ago I was in the unit so -- you know, and they used a polygraph on everybody, even me. They said somebody steal something? I said yeah, I had two months' pay in the safe

and that's why I volunteered to get -- anyway, they -- but they would never want to talk to me about that.

And I've had a pretty good (unintelligible) with the -- with the Board on some things. I got a severe injury in basic training, had long profile all the way through the Army, so if -- and I -- I applied for disability, they said no, no, that's too far back. Oh? You know. And I don't know whether you remember the pil-- the -- what's that tra-- for the heart thing?

UNIDENTIFIED: I don't know that that's related to your --

MR. ROGERS: Well, it is. Anyway, the silent ischemia study and -- my memory's bad. Anyway, if you don't -- hadn't noticed already. But anyway, I went up there for something -- anyway, a little young doctor, he heard something on the heart and I'd been out of the Army about seven years, and -- but I'd been told before I had this heart problem. But anyway, he heard something and he -- and he kept on with them and they put me in the silent ischemia study and at -- and at night -- well, it's monitor for three days, and at night,

those three nights, there was 32 or 33 episodes happened while I was asleep. And so I was in this -- in all this study, and I was one of the first that -- you know, the -- this stents that they use now, I was one of the first on that, and I went out like a light and they almost lost me. Anyway, they wouldn't do that with -- to me anymore and told me just keep (unintelligible) around, and I -- most of the time I got a pretty good deal from the VA, and also -- but the -- the Board, you know, that does your -- determines, you know, what's this and what's that, well, they (unintelligible) the silent ischemia study, that's too far back. Well, my understanding when I went into it, I was out of the Army seven years and understanding was that under that, if -- ten years after you're retired, you're recovered. Five years otherwise with that -- anyway. Well, anyway, I didn't get anything out of it. But the biggest thing I have against them is the Board that tests and evaluates your claims in Virginia. You know, they say -- say some things are too far back, too far back, you know. Anyway -- but otherwise, I've had a

pretty good deal, so that's about all I have to say.

VICE ADMIRAL ZIMBLE: Okay. Thank you very much. Any comments or questions? Yes, Mr. Ritter.

MR. RITTER: Yes, this gentleman is an atomic veteran if he -- if he was at that particular shot. That was Upshot Knothole. That was a Mark 65 280 mm. atomic cannon, and that particular test was code named Shot Grable, if I remember right.

MR. ROGERS: Yeah, I don't remember, but --

MR. RITTER: It was a linear device, it was a Mark IX projectile and it was 15 kilotons, and it was at Frenchman's Flat, Nevada, so you are an atomic veteran and DTRA can send you a letter if you give them your service number to that effect.

MR. ROGERS: Okay.

MR. RITTER: Thank you, sir.

VICE ADMIRAL ZIMBLE: Okay, I will retract my opinion. Thank you very much.

MR. ROGERS: Thank you.

VICE ADMIRAL ZIMBLE: Yes, sir.

MR. KING: I was supposed to speak earlier and

I asked to wait a moment. Could I...

VICE ADMIRAL ZIMBLE: Okay, you may certainly -- certainly you may -- you may come forward and speak now, Mr. King.

MR. KING: My name is Robert E. King, and I'm from Arizona, came out here to see what this meeting was all about. And I think it's a real good idea that -- I didn't even know that there was a -- a committee to do anything about the atomic veterans, and I still don't know whether I qualify because, after you spoke a while ago about being -- either being at -- at an island or -- or seeing an island go or something like that, I -- I didn't see any islands go up in the air, you know. And -- but I did work on nuclear weapons. That was my job.

While working on nuclear weapons, and missiles, during the years of '60, the first -- '60, '61, '62 and '63 for the Air Force -- we had a couple of incidents that were considered to be mistakes -- or not mistakes, accidents, excuse me. And these accidents were involving a gaseous type substance which was called tritium at that time. I don't know whether it's still around or not, or been retired along with me or

what. But at that time when I was involved in it, I was taken to the hospital for a heart -- heart took off racing real fast, you know that stuff, and they took me to the hospital and said that, you know, you've got tritium. You know, you've got gas and you've got radioactive stuff in your -- in your passages below and everything so they -- and then they took me -- from Austin, Texas they took me to San Antonio to a bigger hospital it was. So I went to that hospital and I was given quite a bit of beer, and this is -- this beer was a -- was an -- said it was about the only thing they could flush your system out with for this -- for this radioactive material, and said that's the only treatment known. And I said well, it's a pretty doggoned good treatment, you know, and I -- I really -- I really liked it, and it was just any time of day, all the beer you could drink and -- and everything, but I got sick of it for breakfast.

And after that I was returned back to Bergstrom Air Force Base where I was stationed and working -- working as a nuclear weapons technician -- specialist. They said well,

you're not going to work with the weapons anymore, and that sort of broke my heart. I loved that -- that type of work. It was very -- and they said we can either retire you or you get out on your own, whatever you want to do, but you're not going to be allowed to work on weapons anymore. And I -- I wonder what the world's going on here, you know, and they said well -- I said well, shoot, you know, why hang around the Air Force? Maybe they'd put you in a kitchen somewhere washing dirty pans or something instead of working on nuclear weapons. I preferred to work on nuclear weapons, which I -- they said no more. So I was discharged as a -- on a disability, and the disability says non-compensatable, not -- no -- you know. If you get anything at all, it'll be through the Veterans Administration if -- if anything, you know, and that was it. But it was a regular honorable discharge. I have all these papers here, and I have proof here, the fact that I was -- I did go to nuclear weapons school and -- and did take care of -- of the older weapons right through the newer ones. It was -- matter of fact, the -- the gentleman

mentioned a Mark V or something. I was right in there with that old stuff, you know, and then -- and then they -- they changed the weapons to a more modern type weapon which there was not much to do on. The only thing was that if anything ever went wrong, it really went wrong big, you know, and -- but there just wasn't practically any way for anything to even go wrong, and they said that that tritium can never leak. That just -- just don't happen. Well, it happened twice, once in Turkey and once in -- once in Texas. So the first time, in Turkey, we was out in the middle of nowhere. You couldn't do anything -- I mean about it, you know. You just took the fast heart rate and stuck with it, you know.

So that's about all I have to say is -- and -- and since then I've been fighting -- not -- not fighting, more or less pleading to be heard by some type of a board, because we were told that now on your retirement here you know that this is all top secret and if you mention anything at all about it, even the word tritium, which I hear on Discovery channel now, the word tritium, all the time -- that if you even say

that word you can go to prison for ten years. And so that keeps you quiet for about ten or 15 years in itself -- of asking for anything, because how do you do it? How do you ask somebody what's hurting you -- or what -- what hurt you, or tell them what hurt you, without disclosing classified information? So --

VICE ADMIRAL ZIMBLE: Okay, that information is no longer classified.

MR. KING: Well, it sure is a mean -- I mean it is a mean substance, yeah, I'll -- I'll say that.

VICE ADMIRAL ZIMBLE: But all the secrecy around the use of tritium --

MR. KING: Uh-huh.

VICE ADMIRAL ZIMBLE: -- which is heavy -- heavy hydrogen.

MR. KING: Yeah, I understand it's called H3, uh-huh.

VICE ADMIRAL ZIMBLE: H3, but that was -- when related to a weapon, was considered classified. I served on nuclear submarines that we monitored tritium (unintelligible) --

MR. KING: Oh?

VICE ADMIRAL ZIMBLE: -- submarines, and so I'm

aware that we were told don't you use that word. But that's past. That's all past now. Secondly, you worked with nuclear weapons, but -- that --

MR. KING: Hands on.

VICE ADMIRAL ZIMBLE: -- hands on, and Dr. Fleming, is -- that's -- is that not someone who would be eligible for consideration from the Department of Justice (DoJ) if there was a presumptive -- one of the presumptive diseases?

DR. FLEMING: If that qualified under on-site participant. That's the category, is on-site participant. We'd have to look at the legislation, but it's -- as you point out, there has to be a presumptive disease, as well. So I could talk to the gentleman afterwards.

VICE ADMIRAL ZIMBLE: Bottom line, if you were directly involved with nuclear weapons, you come under a different category. Not the category where anything can be accomplished by our Board, but under the law called Radiation Exposure Compensation Act (RECA) -- RECA, R-E-C-A, there's a potential if you have -- but you have to have one of the diseases that's classified as a presumptive disease.

MR. KING: I'm quite sure I do now. It's just --

VICE ADMIRAL ZIMBLE: There -- there's a list of the presumptive diseases. If you could talk -- talk to Dr. Fleming at the -- at the next break. She'll be happy to discuss that with you.

MR. KING: And I figure that if -- if there -- if there isn't something done very soon, shoot, my age is going to kill me before any of -- any of the diseases will, you know, and so I figured it's -- it's time to speak about it and --

VICE ADMIRAL ZIMBLE: Okay. We appreciate your coming and we appreciate your testimony.

MR. KING: And I appreciate your time, sirs.

VICE ADMIRAL ZIMBLE: Okay.

MR. KING: And ma'ams.

DR. SWENSON: I just want to make a comment for the rest of the individuals here, as I spoke to Mr. King. If you did have a cancer, you're not an atomic vet so the presumptives don't apply, you would still give a claim for that cancer to the VA and -- and then the VA would send that radiation claim still to Jackson VARO, so it

would be handled by the people that know about radiation claims. They would request a dose reconstruction from the Air Force Safety Center , and we happen to have Dr. Rademacher here, who I think you spoke to, who would then recreate the dose that you could have gotten from being around these weapons.

Now in this ca-- your case, it would be very critical that you give as much detail as you can about how much you were around the weapons, what you did with the weapons, how many years you worked with weapons, for him to be able to reconstruct that. And that dose would go back to I think the -- Jackson VARO and C&P and go through Dr. Cassano for a decision that would then go back to Jackson VARO for the rating. So you still have somewhat the same chain that would occur for an atomic vet. However the presumptives don't apply. But if you had a cancer they would do a dose reconstruction.

MR. KING: That's been one of the problems, also. They said do you have a cancer, and I said no, thank -- thank the Lord, you know. I'm sure -- certainly glad I don't have cancer -- I don't believe. And I've never been

diagnosed as having cancer, but I have a bone degeneration and things like that, you know, that could go with weapons or old age, you know, whatever. And -- and I've also had it mentioned the amount of rems that they might have figured that I had taken over the -- my career period before I was discharged. And let me mention, it was a honorable discharge and there was no problems. I was moving right along in the field, but I don't know why they didn't want you around weapons anymore when -- when you -- the weapon is what hurt you. And I just don't understand. I've fought it for so long, and now we have a whole Board that takes care of guys that's been, you know, forgot about for so long that it's just amazing, and I'm so glad. And I hope -- but I heard it mentioned that there's only 60 people left.

VICE ADMIRAL ZIMBLE: No, no, no. No, no, no, there's over 200,000 people.

MR. KING: Oh, okay. Geez, okay. Excuse me then. But I thank you and then I'll -- I'll do what I can, but our VA just doesn't get things done. They've lost all my paperwork and everything two or three times. Everything's

supposed to be -- you know, well, where's your -- where's your application for this? Well, my God, here it is, I've turned it in no -- how -- well, we don't have any record of it. Well, we don't have any record of it. I've heard that three, four, maybe six times.

VICE ADMIRAL ZIMBLE: Okay, I'm sorry.

MR. KING: And everything gets lost.

VICE ADMIRAL ZIMBLE: Okay.

MR. KING: Intentionally, I think.

VICE ADMIRAL ZIMBLE: I think maybe some of that'll get corrected when we finally get to the electronic patient record, one of these days.

MR. KING: Thank you so much.

VICE ADMIRAL ZIMBLE: Mr. Ritter.

MR. RITTER: I just wanted to -- I just wanted to clarify for the sake of atomic veterans who are here, you know, we've thrown around some -- some phrases that they may not be familiar with. When he mentioned tritium in those devices, that was a point in the development history when tritium, with a mixture of duuterium, RTD gas, was used in high pressure cylinders and those devices as a boosting agent

to give the smaller weapon more kick, and that's just -- and -- and I can see where if it's encased in a 3,000 pound cylinder where they would be prone to some leaks once in a while. And so if you'll talk to a representative here, perhaps they might be able to steer you in the right direction for filing a claim, maybe under occupational.

MR. KING: Thanks.

VICE ADMIRAL ZIMBLE: All right. Okay, we have one other speaker wanted to speak now, Mr. Noel?

MR. NOEL: Yes.

VICE ADMIRAL ZIMBLE: Paul Noel.

MR. NOEL: I'd like to sit.

UNIDENTIFIED: Okay, I'll get you a chair.

MR. NOEL: My name is Paul I. Noel. I live up in Coalport, Pennsylvania. I was in the military for 23 years. I am a -- considered a -- a person who would be eligible for CS -- CR-- CRA and the new payments that was just recently enacted, and I wish to read the following if I can. It's not quite -- it's quite lengthy, but I'll start out.

The first papers are for health care treatment

instructions. It's a living will that I made out on 2 June this year, and of this fourth paragraph down the last sentence says I expressly prohibit the use of any device or implementation that includes the use of radiation. That includes X-rays, computed tomography (CAT) scans, magnetic resonance imaging (MRIs), anything. I only have two rems of radiation to mess around with.

Next on the -- next on the list, I made out a couple pages of -- written out a couple pages I'd like -- like to read to you. Radiation experience during military service. Bergstrom Air Force Base, Austin, Texas, from May 1955 through October 1956. Experience consisted of eating three meals prepared for three different meals, breakfast, dinner and supper, over a period of time from May 1955 to July 1956 as part of the U.S. Army Food Irridation (sic) Program which was conducted in the dining halls located at Bergstrom Air Force Base, Texas, as a tasting program of cooked irridated (sic) food to be used for future combat rations to be used in Korea, Vietnam and Iran. Iran -- it was -- actually these were actually used, I

believe, in Iraq, the first Persian Gulf War, and I believe that this is a possible cause of the Persian Gulf War Syndrome. Since the war to the -- the combat rations of the present wars, Iran and -- or Iraq and Afghanistan, they're probably -- they're probably using non-irridated (sic) food is now being used in the present MREs because they were -- after the Persian Gulf -- first Persian Gulf War they were -- the MREs were changed. I was assigned to the 12th Strategic Wing maintenance squadron at the time -- at this time. Records of this Wing is still unavailable to this day.

The 4080th Strategic Reconnaissance Wing (l)SAC, 4080th Strategic Maintenance Squadron from 24 December, 1956 through 1958, Laughlin Air Force Base, Del Rio, Texas. Exposure to radiation started on December 24, 1956, through August 6, 1958, by working on the engines which powered the U-2 aircraft and the assigned RB-57C, D, E and F model aircraft. There was only two E model aircraft of the RB-47 series ever made, and these were made for the purpose of being used at the Hardtack I tests. These -- which powered the U-2 aircraft and the assigned

models which were used to sample particulate and gaseous material from the detonation of atomic weapons by Russia, Communist China, and other nations. Working on the first engine change of a U-2 aircraft for which I was highly dosed with radiation because the plane -- aircraft flew through the atomic cloud formed by the explosion of a radioactive waste dump located at Kyshtym, Chelyabinsk province and Sverdlovsk province located in the Ural mountains of Russia on or about 29 September 1957. In parentheses I put this little incident down: Gary Powers lost his U-2 engine by malfunction caused by high doses of radiation when he inadvertently flew through the -- his aircraft through the remnant of the atomic cloud which formed by the atomic cloud which the accident of 29 September '57 at that site caused, which exists there today. Fifty-two rems of radiation was released by that accident.

Radiation Exposure During Military Service. The U-2 air-- the U-2 plane that went through the cloud shortly after the explosion on 29 September '57 was piloted by a very skilled

pilot whose skill as a sailplane pilot sailplaned the crew -- the craft from -- to Del Rio, Texas, 6,000 miles from Russia. As I was assigned to the -- to this job of engine change, I was privy to see the damage done to the plane's engines and records. The engine mo-- engine's moving parts were a heap of molten metal. The engine had to be cut from the engine mounts to be removed from the aircraft. The records show that only 12 flying hours was on the -- was assigned to this engine. The container in which the remains of the engine was painted with the correct yellow and purple paint with the radioactive seal as required. Records were stamped "Top Secret." I became sterile two years after working on this engine. Two days after working on this engine I went on sick call as my feet started to burn. This visit may have been recorded on the morning report for the day. The copy of the morning -- of the morning report was missing from the package that -- when the VARO asked for alternate records. When I became sterile I was out of the Air Force and working in a civilian job. I couldn't see a doctor

because I had no health benefits. And I could tell because that -- I was sterile because my semen had turned color from a bright yellow white to green. It is now clear and if any is noticed at all. In other words, I don't have no sperm. I don't have no semen at this time. The bottoms of both my feet, both soles and heels, still affect my being able to walk. The radiation first acted like a athlete's foot infection, and then presented warts, then peeling of both feet as is now burns. Warts on the feet turned out to be pathologically as warts on hands and arms and as a biopsy of testicles and testicle organ flesh. Hair was also affected by way of magnetically reso-- resonan-- resonance, shorting out nearby nerves, sending out shock waves.

VICE ADMIRAL ZIMBLE: Mr. Noel, we're getting a little -- we're getting a little pressed for time.

MR. NOEL: Okay.

VICE ADMIRAL ZIMBLE: Can you --

MR. NOEL: I'm going to have -- be done here in a minute.

VICE ADMIRAL ZIMBLE: Okay.

MR. NOEL: The third time I was heavily induced with radiation was at the 9th Weather Wing MAC 57th Weather Reconnaissance Squadron, Avalon RAAF -- Royal Air Force Base, Geelong, Australia, May -- March 1962 through 22 February '64 by way of working on the RB-47 C and D aircraft that collected air samples. I was exposed to high doses of radiation from atomic bomb testing series of Communist China 1963 and 1964 series. On the last atomic bomb blast a C-130 E engine 4-engine plane was used to sample the air cloud -- air and cloud formed by the blast. I was assigned to the post-flight this plane upon its return from its mission. The aircraft has four propellers-driven jet engines with an S-curve air -- to the air inlet of the engine. The inspector had to enter the S-type turns -- the inlets, to check for foreign object damage to the inlet or engine rotors or spacers. Upon entering I found radioactive sand in three of the four jet engine inlets. My head was less than two inches so my eyes, nose and mouth was as near as two inches from the radioactive sand. My ears and head hair was also affected and as I

breathed, so was the air I breathed into my lungs and upper respiratory system. My face and body became covered with red sores. The doctor sent me to Yokota Air Base in Japan. A skin specialist identified the cause as radioactive exposure. Upon home -- upon going to home base in Australia I found the 57th Weather Reconnaissance Squadron was disbanded and moved to -- moved to SAC headquarters. I was supposed to be on orders to return to United States. I missed unit movement to Ramey Air Force Base, Puerto Rico, on February '65, but was sent to quarters for radioactive -- radiation sickness until February 22, 1965. After 30 days leave I reported to Kirtland Air Force Base, New Mexico. I was sick with -- I was sick with radiation sickness for the whole tour of the 58th Weather Reconnaissance Squadron. In May of 1966, after seeing the Inspector General, I was assigned to Vietnam. I was assigned to -- oh. My medical records turned up missing upon return to States. During the first, second and third tours of Vietnam I was sprayed with Agent Orange. Skin diseases still plague me then and now.

Temperature -- at -- when temp-- and then when the temperature goes over 80 degrees. Body hair was electrified, leaving print of left hand on body and change of color of body hair. Body hair had a perfect -- nice body -- the perfect hair on my thing. It was the imprint of my hand on my belly, and it remains there -- it remains there today, but since the -- I shaved off the hair, I'm not getting the shock that I used to get, so...

VICE ADMIRAL ZIMBLE: And you have filed claims with the --

MR. NOEL: Yes.

VICE ADMIRAL ZIMBLE: -- Veterans Administration?

MR. NOEL: Thirty years ago -- it was 30 years ago, and today -- or in December of 2007 I received notice on December 24 that my claim was terminated by COVA*, and I have not been able to reopen that claim yet today, because I cannot get -- as I stated, I cannot get CSRC or CSRD because it is -- because this por-- because this portion of my military service, so I'm not being able to get -- get ahold of any of my pay -- real pay that I was supposed to

get -- I was supposed to get.

VICE ADMIRAL ZIMBLE: Okay. I'm looking --

MR. NOEL: I also -- in the future, sometime in the future, I live in a place where they plan on putting a 40-foot dike across my land and -- or acro-- and -- or where my house stands now, and I am 74 years old and I don't think I'm going to be able to get an-- ever -- ever get another mortgage.

VICE ADMIRAL ZIMBLE: So I -- I appreciate your testimony. I'm not sure I know where -- where you should begin making an appeal, and I don't think the -- I don't think anybo-- I don't think that this Board can assist you in any way, but I appreciate your testimony and you certainly pointed out an experience -- you have some pretty good documentation of experiences that you've had in the military which -- which were of a hazardous nature. We appreciate your testimony and we appreciate your service.

MR. NOEL: I came here with the express purpose of reading this to you --

VICE ADMIRAL ZIMBLE: Right.

MR. NOEL: -- and with the express purpose of reading that -- the first sentence in my living

will, which prohibits the use of my ever getting a good benefit -- health benefits through the VA or any -- anywhere else because I have only two rems of radiation -- lifetime radiation dosage and I'm up -- is 105 rems of radiation and so far I've already used 102 rems of radiation and it scares me like hell.

VICE ADMIRAL ZIMBLE: Okay.

MR. NOEL: And that is the reason I want it for that purpose, so I would like to see something -- maybe one of you people know what to do; I don't. Because I have tried everything in the past 30 years to get this thing going. First they told me it was medical-wise. Now they're telling me it was legal-wise. So why -- why they're -- why they keep doing this, I have yet -- I wear glasses. I've been wea-- I've been wearing glasses because the gl-- because the radiation I received in my eyes while I was in that S air -- air inlet. I can't hear for the same reason. I can't breathe properly, and nobody has ever checked my thyroid until my -- until I went to a civilian doctor the other day. They found I have high overactive thyroid gland, so what can I do?

VICE ADMIRAL ZIMBLE: I don't know. Thank you. Thank you very much. We have your testimony.

MR. NOEL: Okay. I appreciate it very much. I could leave you these -- what I read off of.

VICE ADMIRAL ZIMBLE: You can leave -- leave them wi-- leave them with the -- leave them at the desk, please. Okay. Thank you.

MR. NOEL: Oh, there was a few questions I wanted to ask. How can radia-- how can radiation disappear? I have here a copy of my radiation where it says I have a lifetime of 105 and down at the bottom here it says 120 -- 27 total.

VICE ADMIRAL ZIMBLE: We have -- we have people with -- at this Board who are radiation health physicists who are very competent to answer your questions, and they'll be happy to do so. Dr. Blake says he'll be happy to talk to you at the next break. Okay?

MR. NOEL: Okay.

VICE ADMIRAL ZIMBLE: Okay. One more testimony that I look forward to is from General -- General Randy Manner. And again, I appreciate very much your coming and --

GENERAL MANNER: Okay. All right. Now because

for some reason we have this giant thing in the middle of the room, I'm going to walk back and forth so I can address everybody at the same time. Okay? Great. Can everybody hear me? Yes. I don't need this.

UNIDENTIFIED: No, no, we're recording.

GENERAL MANNER: Oh, you're recording? I guess I do need this. All right. Actually I don't need it; you need it.

Okay. All right. So first of all, let me introduce myself. My name is Randy Manner. I am the Acting Director of the Defense Threat Reduction Agency. Now why that is important, that is one-half of the organizations that assesses your claims. The Veterans Administration, of course, receives your claim. And they're the people that, if there is found to be justification, they actually pay it out. The Defense Threat Reduction Agency -- my staff -- is responsible for applying the science and also the records that exist to determine what dose might you have actually been exposed to. Now I'm paraphrasing terribly, and I'm sure the people behind me are going oh, my God, what did he just say. But that's basically what

happens. Now -- so please keep in mind that everything I'm about to say, I'm speaking from a position of being in charge within the Defense Department for assessing the dose and the history, the historical record.

Now I want to make sure to tell all of you, I'm not a scientist. I'm a soldier, and that is from where I will be speaking. Behind you, you have a lot of soldiers, sailors, airmen and marines, and scientists, and people with tremendous background and experience. You've already heard that some of the things that you raised questions about may or may not be within the purview, by law, of this particular Board. However, when I'm done here in just a couple of minutes, I'm going to suggest the way ahead for you that if it's not within the purview of this Board.

Number one, I want to thank all the veterans and the family members who've come here today. I know that, quite frankly, especially with Washington and traffic, it's hard. And if you come from out of town, that's a long way and a great expense. But thank you so very, very much for spending the time -- your personal

time -- to be here.
I also want to thank, quite frankly, the members of the Board because they're paid a lot of money -- meaning zero -- to be here. These are volunteers, so this is very important to say that to all of you. So they do this for, quite frankly, wanting to serve you. And that is very, very important. They -- many of them are veterans that are here. And if you read their bios you can actually find out, of course, which ones are there. But they all share the common denominator of wanting to make things better than they were -- or -- or that they are.
I want to thank all of you as well because of course I know that you could be doing a lot of other things today, but you're here and I deeply do appreciate it. And I didn't have a chance to shake everyone's hand again at -- during the break, but thank you so very much for serving. Let me say I hope you continue to serve.
Okay. All right. I want to make sure also -- I appreciate very much the very good-natured perspective that each of the veterans have had

in expressing what are very, very difficult circumstances and very, very frustrating, because I know how challenging it is to deal with the government. But the fact that you're persevering is -- is a great credit to you, and to your service as a military airman or soldier.

This is one of those things where it's important to put the -- put everything right on the table. Ever since the 1940s, '50s and the very early '60s, it's been a long, long time. A lot of these topics we've not been able to talk about because they were literally, by law, classified, and we could not discuss it. That's gone now. That has been removed, so you are now free to talk.

In addition to that, let's be blunt, there's been opportunities where there was misinformation. And I'm very -- I want to be very clear, it's not the fact that perhaps somebody was lying at the time back in the '40s or '50s or '60s. Many times we didn't know -- and I mean we, none of us really knew what were the effects, what were all the consequences of the decisions that were made at that time. So

that also contributes to mistrust, and -- and that's warranted in some -- in some cases. There's also, in many areas -- while there had been a lot of research, in certain types of medical implications for what has happened, many other areas there's not as much research. So some of the things that were even mentioned today, it's still the limit of science that sometimes we just don't know.

Now that's not to say there have been many, many researchers, many -- many hundreds of millions of dollars of research to try to figure out the causes and solutions for many of the things that have happened. But still there are questions we don't have the answers to. Lastly of course, which is also very important, is that there's a lack, in some cases, of understanding and education by many people because we may think that it's one thing, but it really is not. It could be another -- another cause or another effect. And so the issue of trying to continue to learn, not only of course by these members that you see behind you, these volunteers and these researchers and soldiers and sailors and airmen, but also of

course by everyone here and by your counterparts.

The one thing that is very -- I share in your frustration. I am a soldier. I will be in your shoes at some point, perhaps on another issue since I actually am not an atomic veteran. So the frustration is something where I can absolutely understand because -- if you remember some of our history -- here in Washington back in 1932 we had a lot of veterans from World War I that were trying to get paid some bonuses that were -- had been promised by Congress, and they weren't being paid because, let's be blunt, there were other things going on during the Great Depression that required other monies. But the veterans were being forgotten and they wanted to get paid. And it was a dark side, a very dark moment as a military member, that regretfully President Hoover called out General MacArthur with the cavalry to clear all the veterans out of the low lands around Washington and to remove them because they were just someone he did not want to deal with.

That is -- that's terribly sad. Now the

battles that were fought then, in 1932, were with -- cavalry with swords and unarmed veterans. Today the challenges are being fought in the courts, and that is where all of you have a voice, and you are here. And these people, by law, represent -- within a left and right constraint of the -- the atomic veterans, as defined, that we've talked about already, they are a part of your voice to ensure that these things are dealt with in a professional, expeditious manner. That's what they're here to do.

It was mentioned earlier, we've gone from a backlog of 1,600 claims to only 60, and that is a tremendous effort which these men and women contributed to, and then of course through respective agencies followed through to actually implement them. But that doesn't solve all your challenges 'cause some of you don't fall within the purview of what has been mentioned by this particular group.

Now what I'd like to do is say three closing comments. One is that -- and I'll speak for DTRA, which meaning Defense Threat Reduction Agency. Up here we have Dr. Paul Blake and

also Eric Wright. They are also veterans. Each of them are Navy veterans. They work for me over at DTRA. I will tell you that -- and I can't say the same for the Veterans Administration, but I will challenge them, that every one of you that, before you leave, that you get a personal follow-through on your specific action. You've taken the time to come here today, and I would challenge you, sir, if you could assist to follow through with each of these handful of veterans that are here. Or from the other side, meaning the science side of that, some of the questions that were being asked earlier, sir, about radiation. We -- they'll talk to you perhaps during the break or during the lunchtime. So that way it'll be worth your time as well. And the follow-through that I'm sure the Veterans Administration will do. That's number one, is a personal follow-through for you.

The second thing is that you have a voice, as I mentioned. But there are associations that are composed of hundreds and thousands of voices, like Mr. Ritter's organization. And I would encourage you to examine those, if you are not

a member of one of those, that your voice, combined with many more, then can be heard even at a larger volume.

The last one, and I know this is a little bit difficult, but -- put it right on the table. If you are still not satisfied, then write your Congressman, because that kind of a letter does see the light of day and is responded to by the Veterans Bureau -- Veterans Administration, or by the Defense Department. So as that resort, include that in your tool bag of things to try to get resolution of your particular situation.

MR. KING: But he's a Republican.

GENERAL MANNER: Write to your Senator as well. Okay. So again, the bottom line is thank you so much for being here today and spending the time with us. Thank you so very, very much for your service to your country. And again, thank you all for the Board members as well for what you do because I know this is one more thing of many, many things you could be doing today, and it is really, truly wonderful that you're here. And that's -- sir, I turn it back to you, sir. Thank you.

VICE ADMIRAL ZIMBLE: Thank you. And I thank

you -- I know I represent the entire membership of the Board and the staff when I thank you so much for your solid support for the work we're doing and for allowing us to -- well, for actually responding so nicely to any advice we give. So thank you very much.

UPDATE ON THE NUCLEAR TEST PERSONNEL REVIEW (NTPR) DOSE RECONSTRUCTION PROGRAM

Okay. Now, Dr. Blake, if you would please make your presentation.

DR. BLAKE: Yes, sir. Today I'd like to give you an update on our Nuclear Test Personnel Review program, and we're located over at the Defense Threat Reduction Agency. Major General Manner, who just spoke, is my boss. And as he mentioned, I am a retired veteran from the Navy, and I am the program manager for the program over at DTRA and the Department of Defense.

What I'd like to cover today is an update, first on metrics, then advances on dose reconstruction, quality assurance, communications; and then give you an update on the status of recommendations from this Board that are still active; and finally just a brief look at where we -- where I envision the road

ahead.

If we look at metrics on incoming data for the program -- and that may be a little hard to see from some distance away -- that spike that's in the middle occurred back in 2003 after a National Academy of Science study occurred that questioned some of the dose reconstructions that my agency had performed. And so the VA sent back every claim that had come in before that hadn't gone to service connection. So basically everything came back. It peaked at that period of time, and that's what created a backlog in our program.

And at the same time, when that the National Academy of Science study occurred -- and some of the members of the Board were actually on that -- we needed to redo our dose reconstruction methodology. And that wasn't straightforward. That took some time. And this backlog occurred that was discussed earlier, like 1,600 case, and at that time we had a tendency to try to get the -- the easy ones out first, but some lagged. And what was frustrating to the veterans that some cases, until we could get to them, waited over four

years.

The atomic veterans at that period of time had the oldest cases in the Department of Veterans Affairs, and it became a great concern both to the Department of Defense and to the Department of Veterans Affairs. And so one thing that occurred after that study is Congress came in and said we needed to establish a Veterans Advisory Board on Dose Reconstruction to satisfy that.

And what I'd like to show you today is, from our perspective, this Board has been very effective at working with our two agencies, the Department of Defense, Department of Veterans Affairs, and helping us out. And also I'd like to possibly comment on some things that we see going on in the future.

And here's what we talked about on that backlog. You can see where it dropped off quite considerably, that little yellow block that says "VBDR Impact: Expedited Radiation Dose Assessment Process." Radiation dose assessment is also known as a radiation dose reconstruction. Based on the recommendations that came from the Board we were able to really

optimize how we process dosimetry -- excuse me, how we generate radiation doses.

What had been the difficulty was most federal agencies -- we take the Public Laws and then we amplify them through the Code of Federal Regulations. Changing those are difficult, and what we had in place before was a very lengthy and difficult process to do that was quite expensive. And so the Board's recommendations, based on scientific discussion, allow us -- allowed us to move ahead on some maximum radiation doses that were good for both the Department of Veterans Affairs, the Department of Defense, but most importantly for the veterans. It actually increased service connection.

And so where we sit today, based on those recommendations, is our mean case response time over in the Department of Defense, when items come in, is it takes us about 52 days to get a result out the door. Some go faster, some go longer. In fact, the longest case we've had since -- in 2009 is 177 days, but in fact -- for instance, this week we don't have any cases that have been greater than 100 days. We get

them out.
And why does it even take that long a period of time? And the reason it does is because we often have interactions that go back and forth with the veterans where we're trying to get the veteran's opinion on what's going on. We'll take information that is maintained, for instance, at the National Personal Records Center out in St. Louis where archived military records go. We'll prepare that with our historian staff, but then we'll send it out to the veterans to comment before we proceed 'cause we want to make sure we really understand the scenario of radiation exposure. And that period of going back and forth while we're getting information from the veteran, asking for them to sign off with what we've done or Privacy Act release statements, takes that period of time to finish. But based on that, we still have optimized our processes. And one way we've done that is by working through the two agencies, working close -- more closely together.
Another part that we do, and I would hope that you would consider using that, is we have a

toll-free line with some very good people at our agency that respond. And if you actually call in for advice, if you don't get it from us today, our people are available to discuss that. We do a lot of follow-up phone calls. I mention just in 2009, for about the first three months, we had about 230 we did outreach phone calls. But when you look over the lifetime of the program, it's tens of thousands of phone calls we've given out to assist our veteran community.

Where have we gone on dose reconstructions advances? With the help of the Board we've moved ahead on our published procedures. For instance, in just recent years we've created a NTPR Radiation Dose Assessment(RDA) standard operating procedures (SOP) that numbers over 1,400 pages. It goes into great detail. Right now it's still for official use only, but by the end of this year we hope to publish it on our web site. We have a lot of the documentation for how we actually do things on our web site, and it's certainly my goal as the program manager to have that out by the end of the year. The reason that we didn't publish it

initially was it was still, with advice from the Veterans Advisory Board, going through some changes. But based on a lot of peer review from other scientists commenting on what we're doing, we feel that it should be ready to be out there by the end of the year. That's the basis for how we do dose assessments for our veteran community.

Another report we published to increase the -- the science of dosimetry was done through the National Council on Radiation Protection and Measurements. It was known as NCRP-158, "Uncertainties in the Measurement of Dosimetry of External Radiation". In fact, another Board member, Mr. Beck, was the Chair of that particular publication. We have a lot of expertise on our Board to give advice to the Department of Defense and Department of Veterans Affairs.

We're in the process of many Technical Basis Documents being developed and nearing completion -- publication. Once again, those are the basis -- the foundation of what the Standard Operating Procedures are then based on to give out the dose assessments. They will

also be published and put on our web site, too, for people to go through them. Some of them get kind of complicated, admittedly, and they may be more focused on the health physicists and the people that do this type of work, but we try to put out fact sheets and other things that boil it down and make it simpler and be able to communicate this information to people who are using it.

We also have an extensive software products on how we track every single interaction with a veteran, and one of the things we're discussing just yesterday was how could we improve that software -- we call it NuTRIS -- on continuing to document our quality improvements. And one of the items that was brought up was -- and it'll be discussed later on today through some of our subcommittees -- on how can we actually fold in those quality metrics into our ongoing software. Because even though scientists need to analyze the data, the more that we can automate the process, capture it digitally and basically output it on a weekly basis, facilitates a better product. And I promise to go back in three weeks and come out with some

feedback for our quality group on how we're going to improve our software to actually prove the quality metrics that are done through NuTRIS.

On QA advances, quarterly -- we have a recommendation from the Board that we accepted in the Department of Defense -- that we provide them information to take a look at how we're doing. And what that includes is the program history, our projected advances, metrics, ongoing peer review, and updated Standard Operating Procedures, double-blind radiation analysis, and lessons learned. And when you do these radiation dose assessments, they're very complicated, and so how do we say that they're actually done correctly? One way we do it is we basically take three competent health physicists and the three of them independently do a dose reconstruction following procedures. And since there's some judgment calls and other issues in there, at the end of that we then look at those three independent assessments -- and some people have described them as the equivalent of a master's thesis when you go through that, on some of these complicated

cases when you look at how much it actually costs, it can actually cost on the order of $12,000 to $16,000 to do one. That's how come we tried to simplify the process, too. But when you're writing page after page of integrals and mathematical sig-- signatures, looking at different radionuclides with various half-lives decaying at different periods of time, it does get complicated trying -- and also trying to take into account the veteran's input. But through these double-blind radiation dose analysis, we've been successful as we've continued to do this to improve the consistency of what three independent health physicists actually put out so they have consistent results. And that gives us a feeling of confidence that when we then deliver a radiation dose assessment to the atomic veteran community that it -- it's accurate and it's credible, it's believable, too. And I think that's one of the great advantages of having the Board active with us on reviewing, as an independent group, on what we've been doing.

Another place where our focus has been has been

on these digital (sic) summary -- summary sheets. One of the comments that came out of our quality assurance group was what were the key decisions in when we did a radiation dose assessment, and now part of the procedure that's done through the Department of Defense -- in fact, Commander Sanders, who's one of the active duty people here, Commander Sanders is the Deputy for the NTPR program, on a weekly basis is going through and reviewing dose reconstructions and filling out these decision summary sheets on the key points. So if you asked, and the information is available when we provide it to you, we can then say here are the key decisions that were made in assigning you this particular dose. It's another quality improvement that was -- been recommended by the Board.

And finally, another focus has also been on this concept that was recommended by the Board, developing the technical basis more formally for our expedited radiation dose assessments. I was talking about the double-blind inter-- radiation dose assessment intercomparisons. We've completed five of them through March of

2009, and we're starting our sixth one here shortly. Continual improvement has been noted, and the -- the nice thing about doing these are the feedback we get from the radiation dose assessments immediately go into improving our Standard Operating Procedures. As we -- as you find difficulties, you go this is where I need to tweak something, we can make a better product, and then we follow it very religiously on how we're going to do these particular procedures in the future.

They're performed, as I mentioned, by three separate health physicists, and they're also reviewed by this Advisory Board.

Here's a schematic I laid out to try to show our processes, and let me -- since it may be a little difficult to see with the size of the screens here, let me read it off to you, if I may. There are four methods of how information comes into our program. One is through a virtual private network. That's a computer system that completely -- that links in the Department of Defense and Department of Veterans Affairs so we can send encrypted information back and forth. How we used to do

this previously is we used to send lots of letters back and forth through the U.S. Post Office between the Department of Veterans Affairs and Department of Defense. And one of the disadvantages of that -- I mean the Postal Service works great, but you take about a week on either side. When we're trying to optimize our processes, by going to a virtual private network we basically eliminate all that transit time. So by putting this virtual private network in place we cut down two weeks on the time that we can get an answer back to the veteran.

Another way that all that comes in is we still have to, with our veteran community -- does not use the internet and e-mail as much, and so one way that we still have to communicate a lot is by mail, but not so much by the agencies as back and forth to the veterans that goes back and forth.

Another way that comes in is by our toll-free line. If a veteran doesn't want to go through the mail, we're certainly happy to talk through, and then we call back to try to deal with the veteran to make -- help our processes

there, and that's -- I think -- the comments that I get back from a lot of the veterans community on the people that have been doing this for many years with the Department of Defense is they're very pleased. I think we have some very good people that help us on our toll-free lines.

And finally, on the -- we also have a generic e-mail address if you want to mail us. It's ntpr@dtra.mil, and we get a few e-mail inquiries that way also.

When we take all that input we initially process it, and based on that we may have to go out -- back to the veterans to ask for a questionnaire to get some more information, and we also sometimes have to get a privacy release, and that is when we're dealing with your private information -- whether it's medical information or Social Security information -- if we're going to release it to someone else, we need to get your permission first. And so there's a form that we'll send to you if we don't already have it from the Department of Veterans Affairs.

The next step is, what we do by law is we

verify whether you're an atomic veteran or not, and we've talked about some of those principles that are laid down in Public Law, they're amplified in the Code of Federal Regulations, but our historian staff has been doing this for years, they're very experienced, and we keep a large database so hopefully we can do that very quickly. But some of the most challenging cases come in to our agency or some of the veterans -- it was like 30 or 40 or 50 years ago, their memories are getting a little rusty, and trying to find the records -- the military kept very good records back then and we have access to most of them, but there still can be some questions on what that happens. And so what we do is we give our best answer to the Department of Veterans Affairs if we can't prove that you're an atomic veteran, and then they can finally make a decision over there if there's some missing information. And one thing that comes up is where the military retired their records to, was the National Personal Records Center in St. Louis that you may be familiar with. There was a fire there some years ago and some of the Army records

were burned, and so some of the records we actually get have little frayed edges around them where the fire was. So -- and -- and we bo-- I think we all know when we got out of the service, not all our records, as we've commented before, made it to St. Louis. So once again we need to take that into account and give the benefit of the doubt to the veterans if there's any question on do we actually have the records. But I just look -- think of my time in the service, and I retired about five years ago, and I look back at the records like the '40s, the '50s and the '60s, the records are actually kept immac-- very well back then. It -- it's amazing. Nowadays it's much more computers and so forth, but they way they documented morning reports or sick call records and so forth, it really is an excellent system when we do have to try to do verification.

Based on verification, if we verify you're an atomic veteran, we may -- who we'd present that information to has been presented earlier. One we -- one group we verify to would be to the Veterans Benefit Administration for

compensation purposes. Another group that we provide verification to is the Veterans Health Administration (VBA) that Dr. Cassano was talking about for the Ionizing Radiation Registry. Another group that we provide verification for is the Department of Justice. For our military veterans, they can file for two methods of compensation typically. One is the Department of Veterans Affairs, which many of them file for. Another group, though, that the Admiral mentioned was the Radiation Exposure Compensation Act that's administered by the Department of Justice. They can file over there. Once again, we'll support that verification.

And then some of the veterans came up to me today and asked can I just get a verification just from a personal basis, even if I'm not verified. That's certainly part of the program that we do. So if you want to call us or write us or e-mail us, whatever, we're happy to pull up records and try to get the background for you. In fact, we have two people just working out at the National Personal Records Center at St. Louis just pulling records for the

Department of Defense so we can support atomic veterans.

After the SPARE is done we then will prepare our radiation dose assessment. Once again, that can be -- if -- when we prepare all this -- every time we communicate with the Department of Veterans Affairs or Department of Justice, we always cc the veteran, so hopefully you can follow exactly what we're doing. And what's also in there at the very bottom, though, is what I call external QA -- the Board may refer to it as internal QA, but a very important part, and a part that's grown over time, especially based on the Board's recommendations, are how do we check the results that we're doing by our own group? And so typically our team that works for the Nuclear Test Personnel Review program is made up of both government and contract people. And some of our contract scientists will prepare this type of work, and then another group will actually check on them. And then the government's also checking, too, but I think what works best is this two or three different groups, each checking each other before we get

the final result out to you. And a lot of that's been based with feedback from the Veterans Advisory Board.

I think that's probably enough detail on that slide.

Decision Summary Sheets (DSSs), another input from the Board. We implemented them in March of 2008. Part of it includes background information, a synopsis of the veteran's case, and then also the major decisions made to develop that radiation dose assessment, along with a rationale, assumptions and references. We very much like to cite our Standard Operating Procedures for why we made a decision this particular way, and I believe that's important documentation as we go through the case development.

What we try to do, as I mentioned before also, was that we try to automate that product as much as we can. And so that's a continuing evolution and one of the strengths of our program is actually our information technology group, that as we give input to it and say how can we do it better, we update the software that actually outputs the product on a weekly

basis.
The present focus right now, based on how we've evolved, is on expedited or Hiroshima/Nagasaki radiation dose assessment Decision Summary Sheets that we've been presenting to the Board. And here are some statistics, and I'll show a little bit later, over the period of January 2006 through December 2008, if you count those up, how many dose assessments do we actually perform? About 1,800 were expedited, 556 full length calculations that were quite expensive, and about 173 -- well, that statistic is a little off since we didn't start tracking it till May of 2007, before that they were included in the full category. So what you see when you add that up is roughly -- maybe about 2,500, divide that in a third and you go geez, that's quite a few dose assessments, though that included a backlog. Nowadays when we look at the statistics of what we're actually doing for dose assessments for atomic veteran community, we're down to about 400 a year. So it -- that's only part of what we do besides the verification process. But as I look at the statistics I see things starting to slow down a

little bit now, both on input from VA and Department of Justice, and that may be due to our aging population.

But the -- I would like to just comment on the -- and I believe the Board's heard this before, but the impact of your recommendations to us. The backlog was eliminated based on the recommendations that you gave and we accepted. It increased the favorable VA medical opinions for atomic veterans. Before we did expedited doses it was about a 9 percent rate on medical opinions. It's now up to 29 percent, and that's a significant increase. Admittedly, many of them are due to skin cancers and a type of cataracts and so forth, but it is still a significant increase based on the Board's recommendations.

We also improved the case processing time. And another point that's probably more of a focus to me than anyone else, but we also saved about $20 million by going through an expedited process instead of the lengthy process, too. And so when we look at how much it costs us to run the Board as compared to what we're doing here, this has been a very cost effective, but

even more important, a help to the veterans and the agencies in doing business supporting our atomic veterans.

With regard to QA, one metric we track is the external review box, that yellow box I showed you before in that flow chart that was done by a group known as Oak Ridge Associated Universities. When they review it, the cases, they find some technical problems, some editorial problems, and the majority they approve and then they get signed out and released by the agency. Editorial comments may be -- for instance, there may be a missing signature or -- or something done in-- incorrectly. Technical could be a few things, but you see it's about two percent as compared to three percent. Technical could be -- they might have a recommendation that, for instance, we should not be expediting this one; it should be a full radiation dose assessment. That would be sent back, we'd re-look at that, have a consensus decision, and then move on to perhaps a different method of action. And that's part of the external review. And when you look at an external review, if you have

about five percent of your cases coming back for one reason or another, that says probably -- you pretty much right now have a -- a fairly steady state condition. The checkers are finding a few things, they're not finding a lot of things. And I think one thing that we're trying to look at from a quality viewpoint is how do we, for instance, track all those -- those concepts and how do we use them to improve our program. And I've also promised to come back in a few weeks to the Board on some recommendations on how we can improve our quality processes because we've gone through a big phase where we've spent a lot of time on science and optimized our business practices. But how do we ensure that we continue to give this -- at least for the next ten years for our atomic veterans -- that that -- these optimized practices stay in place and that we know the quality of them -- that they're credible, and that's where the Board has evolved to where they're focused on looking at the agencies. And I can just speak for the Department of Defense on how we're trying to improve our quality practices in -- in -- based on the

recommendations.
Communication advances. We're working with the Department of Veterans Affairs in trying to get an outreach to the veterans. One outreach occurred just -- this meeting where everybody was contacted by -- in the Ionizing Radiation Registry and was notified, and that number of veterans in the Ionizing Radiation Registry that's supported by Veterans Health Administration (VHA) sits around 23,000 and 24,000. In fact, postcards were mailed out. But another place where SC-4, our communications group, has asked the two agencies to work together is let's get communications out to the veterans who probably received the highest radiation exposures. And since we maintain that data within the Department of Defense, one thing that we could do was provide that information to the Department of Veterans Affairs and then they could focus on the veterans that have the highest chance of developing disease based on radiation dose. And so a number of months ago we performed that analysis, provided the information to Department of Veterans Affairs.

We also did a demographic analysis when we looked at that population.

One thing that we have in our database is we have very good -- good listings of obviously who is a atomic veteran, but also their date of birth. So for us to calculate a mean age of the atomic veteran population is fairly straightforward. What's much more difficult for us to do is to say how many surviving vets are actually there since we don't track actually when a veteran passes on, just indirectly. So what I then take a look at to try to understand the program metrics is the Social Security Administration does these life tables, and based on the average age of our veterans of a population of roughly 480,000, about 39 percent would still be surviving as of today. And that comes down to, of our original cohort, about 190,000 atomic veterans are still with us. And by definition, the atomic veteran, for instance -- the cutoff date was through 1962. If we assume that was roughly -- at that age your 18 years old, you can see that even the youngest ones are still -- like in their 70s, and most of our veterans who are

still surviving are even older than that.
So it is an aging population. It's a population that we're trying to do our best for before they pass on. But even after they pass on, we are still supporting their dependents.
We'll frequently ha-- well, I -- fairly frequently have claims come in, for instance, from a widow -- even if her husband's passed on ten years ago -- that we're still doing a claim for.
I'd like to -- before I give where we're moving ahead in the future I'd like to give you a summary of our status on recommendations given to us by the Board, to the Defense Threat Reduction Agency. We still have four out of the 18 remaining open.
The first one is the double-blind RDA effort that I mentioned earlier today, and that one is going to continue going until the end of the program. It's good idea. It's a good check on us. It's good quality assurance. And it's very similar to what actually happens in the practice of medicine and other fields where you have independent people doing the same procedure to make sure that it's done right.

Another one that's -- will continue for the lifetime of the Board is our quarterly QA metrics submission to the VBDR. We're taking suggestions on how to improve that, but we'll continue to provide quarterly information to the Board so they can take a look at what we're doing, so they don't just get information when we meet here. Quarterly they're actually reviewing our procedures.

Two recommendations, though, I hope to have shut down by -- closed, appropriately, by the end of this year. One is a recommendation that the radiation dose assessment Standard Operating Procedure includes appropriate treatment of upper bounds. These are the error rates with -- when we do dose assessments, there's -- 'cause there's always uncertainty, whether it's based on scenarios and other information, how do we assign those. That's -- that can be very, very difficult. Our scientists have been working on Monte Carlo calculations that take hours to run based on what we call probabilistic uncertainty. I think we've made some excellent progress and the Board has given us good feedback on where

we are. We hope to have that published as a Technical Basis Document (TBD), folded into our Standard Operating Procedures, and have then published by the end of the year.

And finally, the last recommendation was somewhat similar. We've been using default upper bound factors because it takes so long to do these probabilistic uncertainties. We've reached a point, though, where we can move away from that and do full probabilistic uncertainty, and we hope to have that in place by the end of this calendar year also.

So that's the status on the recommendations that the Board has given us to date.

And in closing I'd like to discuss my thoughts on the road ahead for the NTPR program at DTRA. One is to publish our Standard Operating Procedures and have them on the web site by the end of the year. If it slips by a month or two, I hope people understand. We are trying to do the science right before we do, but our goal is certainly to have them out by December 31st, 2009, and complete those two recommendations.

That leads us then to changing our Code of

Federal Regulations that we have to go through the *Federal Register* on, based on that, and we hope to have that done by the end of December, 2010.

So with that, I thank you for your indulgence and -- do you have any questions?

VICE ADMIRAL ZIMBLE: Thank you very much, Paul, appreciate the update, very, very helpful, and delighted to see that you're moving on with -- with the QA initiatives in terms of -- in terms of working with metrics. I think that as the quarterly quality reports accumulate that we -- we need very much to look at those to see whether or not the trends are -- are going in the direction of -- of expediting the processes and of -- of getting the claims completed even faster. And I find that the -- my feeling is that it's decision support information, the information where a judgment call is made or an assumption is made, that that's specifically documented in the decision summary, that that becomes essential to get folded into the quarterly report so that we can look to areas where corrective action is indicated and that corrective action is taken.

Again, all to assess a quality process.
So I compliment you for -- for your willingness to take on the -- becoming -- your willingness to become an honorary member of Dr. Reimann's... That really is essential.
I also compliment you on the initiative you've taken in -- in allowing the VPN to be utilized -- that virtual network, to be utilized between DTRA, NTPR, and the Jackson VARO. There's no question that -- I have heard, and others have heard, that the Jackson VARO people are delighted with the ability to communicate and get responses so quickly, that that is going to truly expedite the process. And so that's relatively new, and I'm delighted that you took that initiative. That's very, very, very helpful.
DR. BLAKE: Well, I would point out that came out I think from -- if not the last meeting, the meeting before that, we had discussions and Brad's predecessor, Tom Pamperin, was the one that agreed to it and, based on that, we took the action. So once again, the Board facilitated that improvement be bringing the two agencies together and working together

well.

VICE ADMIRAL ZIMBLE: Okay. Well, you guys are -- you're doing the handoff as a team beautifully.

DR. BLAKE: Thank you, sir.

VICE ADMIRAL ZIMBLE: Okay. Any other comments? There we are -- okay, Dr. Boice.

DR. BOICE: Paul, I appreciated also the clear explanation, and then again the statistics on the existing veterans' population. And I think that's very -- reinforces what we've been saying a lot today is about the aging population. If the average age is 82, that means there's a substantial number of veterans who are in their late 80s and 90s, so it behooves us to continue to work diligently because time's running out. And I just wanted to reinforce that and appreciate your -- your clear presentation.

I did have a question, though, about the estimate for the numbers alive, because you used the Social Security tables.

DR. BLAKE: Okay.

DR. BOICE: Now as we know, or as we used to know, there's selection processes that go into

being a military guy or gal. And you -- it's -- we call it the healthy worker effect or the healthy warrior effect. And this actually lasts almost throughout life. Not so much for cancer; it kind of becomes -- but it would seem that if there was this -- taking into account that veterans -- to get into the military you have to pass psychiatric and physical exams so that you were not like the general population of Social Security. So I would think that there may be more -- or if you had thought about that, or even considered that in the estimate.

DR. BLAKE: I -- for the people who are not familiar, Dr. Boice is one of the leading radioepidemiologists in the world and deals with this type of matter, and I may defer to him on that one. But the -- I -- yes, I'm aware of the healthy worker effect, and one reason I didn't put plus or minus associated with that 40 percent was because I realize -- there was a good -- it is a kind of a crude assumption, but it was based -- best that I had to work with. You're probably right; it probably is a little higher than 40 percent.

My own gut feel, though, is it's probably on the order of what, maybe five or ten percent, at maximum, so I was trying to give you a ball park figure for the percent surviving of our atomic veterans, and I -- if any -- and it may be a little higher.

VICE ADMIRAL ZIMBLE: There's no question that we have to take into account the factor that the DoD is the -- the primary -- is the best of all cherry-pickers that we have in the world. Any other question?

All right. Thank you very much.

DR. BLAKE: Thank you, sir.

VICE ADMIRAL ZIMBLE: Thank you very much. We're running a little bit behind. Dr. -- Mr. Groves has asked that he follow the presentation from our representative from the VA. I'm going to suggest that we get the presentation from the Veterans Administration from Mr. Flohr, after which you -- maybe you can include your -- we'll give you a double feature presentation under your chairmanship.

MR. GROVES: Absolutely. That's the note I just sent to you.

VICE ADMIRAL ZIMBLE: Oh, you've got a note

here?

MR. GROVES: Yeah.

VICE ADMIRAL ZIMBLE: See, I can -- I just put it like this.

Okay, Mr. Flohr, you have the floor.

UPDATE ON THE VA COMPENSATION AND PENSION SERVICE PROGRAMS FOR VETERANS & VETNET

MR. FLOHR: Thank you, Admiral Zimble. And thank you, Board members, and thank all of you who are here. My name is Brad Flohr. I'm the Assistant Director for Policy in the Compensation and Pension Service (C&P) in the Department of Veterans Affairs. I have been with VA, come next month, 34 years, all of that spent in processing claims. I was ten years on the rating board, that -- that group of individuals who actually makes the decision on the claim that is filed. The last 19 years I've been in the Compensation and Pension Service I worked closely with DTRA because my staff that I was on and my staff that I supervise now is involved in the radiation claims process, and I worked with -- as I said, with Paul and with his predecessor, Mike Schaeffer, who is in the audience today although he stepped out.

When the Advisory Board was created, some of you may not know, but I was at NCRP headquarters with Dr. Tenforde and Paul Blake and Mike Schaeffer, and -- and I gave a presentation to this group on the radiation claims process. And because of my background in radiation, then Admiral Cooper, who was the Under Secretary for Benefits, was going to appoint me as the VA representative to this Board. And I thanked him very much for that and declined, because I told him that I had decided to retire, so Tom Pamperin became the -- the member of this -- this Board, and I didn't retire.

So now it appears Tom Pamperin, who is my supervisor still, he was promoted last year and, while I have a number of things that I'm involved in, he has about triple that. And he had intended probably, I believe, to turn this Board back to me as part of my responsibilities, and I look forward to doing that and -- and working with you again, and continuing the work that Tom did with the group and giving you the best service that I can as we move forward.

With that, I'd like to apologize for coming lately to this. I don't have all the information perhaps that you had requested from Tom because I have not been able to talk with Tom to see what actually has happened, but I promise you that what you have requested in terms of any data or -- or answers, I will get that for you and be sure you get it in the very, very near future.

I wanted to just go over these recommendations very briefly. Again, I don't know all that much about them, having come lately to this. But I do know that the one that is -- was not accepted in terms of claims was to grant service connection retroactive to an initial claim, and that's -- under our current laws and regulations, is not really possible in all cases. Some cases yes; others, not.

Quality management, we did a quality review of the cases being done in Jackson VARO -- of the radiation exposure claims -- and as far as providing claims outcomes, I believe you're aware that privacy protections prohibit us from providing you with names and claim numbers and Social Security numbers, things like that.

We'll be very happy -- the outreach letters that Dr. Blake mentioned, those have been sent to our mailing facility in Hines, Illinois. They are there. I expect them to be mailed out to the -- some close to 700 veterans who recorded five rems or more, within the next few days. If not this week, early next week those will be mailed.

In terms of other types of letters, we talked yesterday with Dr. Swenson in SC-2 about things we could provide in terms of letters, and I would just say to Dr. Swenson that you should have been talking to my wife yesterday rather than me because she knows a lot more about the actual procedures in the Regional Office than I do, having been away from it for about 19 years. And in fact, my wife was at the meeting you had in Baltimore in March, maybe, and she said why didn't they ask me those question? I said well, I don't know. But in fact, the notice letters are not generated by some place out in the -- in a void somewhere. They are mailed from a Regional Office. We can put a brochure in those notice letters, or notification letters. And we'll be certainly

happy to investigate doing that. I mean it is feasible.

We can also drop a paragraph about RECA and contacting Department of Justice in some case. We can put information about IRR, whatever is needed, we can craft language that would go into certain letters. So, contrary to what I said, we can do some of those things.

VICE ADMIRAL ZIMBLE: Excuse me, Brad, if I could just interrupt for one second -- for the information of the veterans present, the difference between a VA review of compensation for a specific illness and -- and RECA, the Department of Justice, looking at compensation is -- is, I think in some cases, very, very important. The Veterans Administration provides compensation for a disability resulting from a condition which is ascribed to a cause of ionizing radiation. They will compensate for the disability.

On the other hand, RECA, Department of Justice, will compensate for having the disease, period. And they compensate with a lump sum, and the lump sum is $75,000. But it has to be for one of the conditions which is presumed to be

caused by radiation. Okay? As documented in the service. So just coming in and saying I've been irradiated, I don't know how much, I have -- my hip bone hurts and I have a heart problem isn't going to suffice. It's got to be very specific, a condition which has been cited in law as one resulting from ionizing ra-- or presumed to be resulting from ionizing radiation. That's all they have to go with, no dose assessments.

On the other hand, with the VA -- with this system, if it is a condition that is not presumed but you have had a high exposure, there is a potential for your receiving some level of recognition of that problem as being probably due to ionizing radiation. And that's what -- that's the job of Dr. Cassano and Dr. Blake, to accommodate, and that takes time.

And then the compensation will not be for your having a condition, but for the disability you currently suffer as a result of that condition. This is something -- it's difficult to explain, but it's essential for you to understand so that you have reasonable expectations. And I'm sorry to interrupt and --

MR. FLOHR: That's quite all right. Thank you for your comments.

VICE ADMIRAL ZIMBLE: Right.

MR. FLOHR: Admiral Zimble is correct, VBA's authority to provide compensation for veterans is for the average loss of earnings capacity due to disease resulting from -- or to disability resulting from disease or injury incurred in or aggravated by service. That's been our statutory authority since 1933, first actual published ratings schedule. And we review, as Admiral Zimble said, medical evidence to determine how disabling a certain disease or injury is, and that's what we compensate for.

Radiation -- one of the recommendations here was to consider non-radiogenic legislation, and VA has not -- VBA has not accepted that as -- as a possible avenue here, for -- for legal reasons. The decisions we make are legal decisions that are based on medical evidence, the best medical evidence that we can gather, but it's a legal decision on a claim for entitlement to benefits. And they're laws that we're required to follow, and they're that

protect veterans as well.
One of those being that -- we talked about presumptive and non-presumptive. In a non-presumptive type situation -- for example, under 3.311 where you do not have a presumptive disease under 3.309 wherein we require no medical evidence, what a presumption does in these cases is remove the responsibility from the veteran to show that their disease was caused by their exposure to radiation. If that presumption was not there, we would have to get some medical evidence of a causation related between the disease and the exposure in service. So even -- and 3.311 where they're not presumptive in terms of not having to get a dose reconstruction, to rate -- the diseases in 3.311, which include all cancers, includes posterior subcapsular cataracts, non-thyroid nodular disease -- all of those are presumed to be possibly caused by exposure to radiation, therefore the veteran does not have to submit evidence showing that it's radiogenic.
Any other disability, however, has to have some evidence -- some medical evidence or scientific evidence showing a relationship. So the

veteran can go to their private physician, and they can get a statement from their physician stating I believe Mr. Jones's disability -- his disease was caused by his exposure to radiation in service. Now we are required to accept that, unless it were so incredible -- and I can't think of any situation where we've had an inherently incredible claim that we could say just -- just dismiss out of hands. We, being decision-makers, are not allowed to use any medical knowledge of our own in making a decision. We can cite to medical evidence that we gather. We can cite to competent medical authority -- treatises, for example, scientific publications -- in making a decision, but -- but -- and a lot of this came about since the Court of Veteran Appeals was formed in 1988. Prior to that time we did use our own medical expertise in certain cases, and we had -- we had physicians on our rating boards that we could ask for their opinions, ask them to review the case.

VA's appellate body, the Board of Veterans Appeals (BVA), had doctors as part of their decision-makers. And a very early decision of

the Veterans Court called Colvin v. Derwinski, it was one of the first years, in 1989, the Court held that VA could not -- decision-makers could not substitute their own unsubstantiated medical opinions for medical evidence that had been submitted.

So what that meant was that BVA started getting rid of their doctors because their doctors could no longer sign decisions because it would be a conflict of interest for them to use their medical knowledge in deciding a claim. We started getting rid of our doctors as well, because our doctors could no longer look at a case, given an opinion in the decision-making process, and then sign the decision -- again, being a conflict of interest.

So when we get medical evidence we can't just discount it. We can't say that well, it's incredible to claim that -- that condition X was caused by radiation when I've got a doctor's statement here, and doctors are capable of making medical statements. So we have to accept it, and I really believe that if we were to try and go to a procedure where we could discount certain types of claims as being

radiogenic, it wouldn't get very far. It wouldn't get past the Board of Veterans Appeals to let them get to the Veterans Court, and if it did, it would -- I'm confident it would be thrown out, so we just have a system where we -- denials would be appealed to the board, they'd come back, we'd end up going to Dr. Blake for a dose reconstruction and -- and that's basically what would happen.

So, moving on from there, I was asked to provide a -- and you can't read this, it's too small, but Dr. Cassano had a larger one. It's essentially the same except the Jackson VARO is not there. But what happens in a flow diagram for adjudication of a radiation claim, when we get a claim -- any claim from any -- any individual, any veteran or survivor or dependent, we're required by law to provide certain information to the claimant. We're required to provide them with notice of what is required to successfully complete that claim, for it to be granted, what is needed.

We're required to tell the claimant what evidence VA is going to get for them. We're required to tell the claimant what evidence we

expect them to provide to us. And if we're going to get a medical examination, we're required to tell them (indiscernible) we get a medical examination as well. So all these are legal requirements under -- under law that we -- we have to do. And some of that builds in time 'cause we ask for someone to provide us a response to this letter within 30 days -- it used to be 60 days; we just changed it to 30 days to try and help eliminate some of the time of just -- the claim sets around where nothing is happening.

But once the claim is filed here -- a radiation claim -- it is to be sent to our Jackson VARO. We consolidated the radiation claims to that office, worked with DTRA and with Jackson VARO to get that done, and with our Office of Field Operations, which is over all of our field offices. I can verify -- confirm what Admiral Zimble and Dr. Blake said about the relationship between DTRA and Jackson VARO. Carol Sullivan is -- is our person in the Jackson VARO who coordinates the radiation claims activity there. She has told me that since they got a DoD computer in there with the

appropriate security and -- and all of that, said it's been wonderful. Said they could -- have the best working relationship possible, and I want to publicly thank Dr. Blake for -- for getting that done, says -- they said it's just wonderful, it's working very well.

But in a claim for a -- for a presumptive condition, for example, all that Jackson VARO will do is ask DTRA to verify that the claimant was a participant, was an atomic veteran, was either exposed to radiation in an atmospheric nuclear test or was in the occupation forces of Nagasaki or Hiroshima, or prisoner of war in certain parts of Japan. Nothing else is needed, no radiation dose; only medical evidence of the disability, confirmation of participation, and the claim is granted. Assuming, of course, we have current medical evidence which would show the severity of the disability. If not, we would get a -- an examination.

In the non-presumptive conditions, however, Jackson VARO will ask DTRA for a -- first, documentation that they -- person was exposed; and second, for a reconstructed dose

assessment. When that is gotten by Jackson VARO, if it's not one of the cases we're expediting, the types of -- like skin cancers, it will be forwarded to my staff in Washington. We will review it. We will write a request to Dr. Cassano's office for a medical opinion. They will get our request. They will review it, give us a medical opinion. We in turn will get the claimant's file back from Dr. Cassano's office. We will review it and we will provide Jackson VARO then with an advisory opinion as to whether it is at least as likely as not that the claimed condition either was or was not due to their radiation exposure. Jackson VARO then will make the decision, notify the claimant, and then the claimant's file goes back to the Regional Office of jurisdiction.

So that's the way it works. It's working a lot better now than it used to be. I know for many, many years radiation claims were the oldest category of claims that we had, and it was because of -- well, a lot of factors, but the streamlining that has been done as a result of a lot of the work of this Board and Dr. Blake's hard work and our consolidation of

claims has resulted in a much quicker process. There's still outliers. There are some cases just take a long time 'cause we either can't get evidence, the veteran can't give the evidence that we need, and -- and they just keep -- letters keep going back and forth and sometimes it just takes a long time. But we try to get them done as quickly as we can. And more importantly, we try to make sure we get the right decision.

You know, you're not always going to get your claim granted. But I can assure you we will look at it and we will do everything we can to -- to make the right decision -- grant it, if we can.

I should maybe mention that when we make decisions on claims, there are three -- three really avenues, three outcomes. When we review all the evidence that we have available, if the majority of evidence supports the claim -- there's more evidence supporting the claim than there is not supporting the claim, or against the claim -- we grant the claim, of course.

If, in reviewing evidence, there is a certain amount -- the evidence -- the favorable and

unfavorable evidence is what we call in equipoise -- that is, there is as much favorable evidence as there is unfavorable evidence -- then we grant the claim also. The benefit of the doubt applies and the claim is granted. It's called the tie goes to the runner -- you know, in baseball -- if it's a tie, the veteran wins. So the only time a claim is denied is when the unfavorable evidence outweighs the favorable evidence in a claim.

And I can tell you that right now we have almost 3 million veterans on the compensation rolls. That's the most the VA has ever had, and we're getting a mil-- we're going to get a million claims this year. It's the most we've ever received. And we're making more decisions than we've ever made, but we still don't -- we're getting more claims than we're -- we're capable of making decisions, but we are trying.

UNIDENTIFIED: (From the audience and off microphone) (Unintelligible)

MR. FLOHR: I'm sorry?

MR. KING: Is the money there?

MR. FLOHR: Is the money there? Congress has

been very, very good to us. In the last couple of years they've provided us authorization and funding to hire new staff, which we have done. We have more people in our offices than we have room for them to sit in -- in a number of cases. Recently, as part of the American Readjustment and Recovery Act, ARRA, Congress gave us $150 million to hire temporary employees, not to exceed the end of 2010. And those will be -- people will be used not in decision-making, but in taking care of some of the more -- more menial duty, like seeing where mail should go, making maybe some adjustments on marriage and birth certificates, adding a dependent, things that they can do without actually getting involved in the decision-making process. But that will free up our decision-makers to make more decisions -- at least that is the intent, and so we'll see how that works. But yes, Congress has been good.

MR. KING: What about compensation money, is it there, too?

MR. FLOHR: Oh, yes, compensation money never runs out. That's an unlimited funds. Any time it runs low, they replenish it automatically.

The -- Jackson VARO provided me with this data as of May 15th. Since they began operating in October 2006 they've accepted 4,600 claims for adjudication. I can also tell you that of that total just over 3,000 are atomic veterans, and about 1,500 are occupational claims.
They have no claims pending initial review.
All claims have been reviewed when they've been received. They have no claims that have not undergone the initial development needed. They have about 538 claims now pending development, some stage of development. DTRA is -- they're looking for 49 responses; 12 of those are presumptive. And that's, as I said earlier, just confirmation that the person was a participant. They have 40 cases ready to rate, and what that means is that a veteran service representative has looked at the file, they've looked at the development that's been done, it's all been completed, everything we've asked for from the veteran, from any other agency -- Social Security, whatever we would need to -- doctors, VA hospitals, any evidence we need has all been assembled. They certify then that the case is ready to rate, and they send it to the

rating board to be rated.
That brings us to a discussion we had yesterday about possibly granting certain issues immediately when it's found that they can be granted, while other disabilities or other claims are pending. And again, my wife was nice enough to point out that because of the rates a lot of the VSRs, the veteran service representatives, who certify that the case is ready to rate don't really -- they're not aware of that. They're not aware that that particular issue might be granted initially. So it's -- it's going to be somewhat of a -- a process, maybe training or -- or something, but it's -- it's -- it's not always going to be available. If someone doesn't recognize that there is a claim there that can be granted, a non-rating type of person, then they may not know to send it to the rating board to rate. We'll -- we'll talk about that, though, more. Okay?
Total claims that have been granted by Jackson VARO in that time -- 1,482, that's a lot. I mean before this Board started -- I mean the only thing you ever heard was VA has granted

less than 50 claims. That was the number. That was in Congress. Everybody believed it. I knew, however, my staff alone had granted more than 50 claims in just -- just two years, but that number was stuck -- 50 claims that we'd granted -- 1,482 have been granted. Now the majority of those are -- are, I'm sure, the skin cancer type cases because of our expedited processing and the improved science that has led to -- to that.

Total denied, 2,494.

In C&P Service, on -- on my staff, just in FY '09 to date, since the beginning of October of last year, we've completed 301 radiation cases, 36 have been granted, 229 denied, returned 36 for additional development. It's taken just over 68 days on average to get the case in to C&P, get a medical opinion from Dr. Cassano's office, get it back to our office and get it back to Jackson VARO. And we have 87 cases pending, and the vast majority of that -- the reason we -- we piled up so many cases when Dr. Neal Otchin, who was the predecessor to Dr. Cassano, when he retired it took us a long time to get a replacement, and so now we're working

through those and getting that done. That's it. Any questions?

VICE ADMIRAL ZIMBLE: Okay, thank you very much, Brad. We really appreciate that presentation. It's very helpful. Dr. Zeman?

DR. ZEMAN: Yes, thank you for the presentation. I just have one clarifying question. On chart 8 when you list the Jackson VARO Regional Office claims review --

MR. FLOHR: Yes.

DR. ZEMAN: -- when you say there the total granted, does that mean that it was granted as a service connection, or --

MR. FLOHR: Service connected.

DR. ZEMAN: -- or does it mean that it was compensated?

MR. FLOHR: No, that means service connected. There is -- and we talked about that some yesterday. (Indiscernible), our auditor, is going to provide a different column -- the claim is for service connection, and if we grant that, that is a granted claim. It may not be compensable. In other words, there may not be any disability associated with that particular disability, but it's still service

connected, it's a granted claim. Getting a zero percent evaluation does entitle the veteran to other certain benefits such as hospital treatment, higher level priority care, in some cases even maybe vocational rehabilitation, but that -- that's -- there are benefits associated with it. The only denials are those where there's -- service connection itself is denied.

DR. ZEMAN: And could you explain the next chart then, the C&P Service. What -- what does it mean there when service connection (SC) is granted?

MR. FLOHR: That means -- I should -- I should not say -- that might be misleading. What that means is we have provided an advisory opinion to Jackson VARO stating that, in our opinion after review of VHA's medical opinion, we believe it is at least as likely as not that the disability resulted from radiation exposure. We provide them with an advisory opinion because we don't actually make the decisions ourselves. We certainly do expect that they will take our advisory opinions under consideration when it gets back, and I think

they do. So that's what I mean by granted. We have found the claim to be -- to be favorably decided.

VICE ADMIRAL ZIMBLE: Dr. Lathrop.

DR. LATHROP: Thank you, very good pre-- presentation. I'd just like to ask a couple of clarifying things. On your chart 4, "provide claims outcomes to VBDR, problematic -- privacy". So first of all, just to clarify, that has to do with after the determination of more likely than not than what actual compensation comes, which involves the additional decisions of perhaps other parts of the claim and the percent of compensation? Is that -- is that what that means?

And if so, why does this have a privacy problem and initially, from a discussion earlier today, there's a discussion that we could be provided with the determination of more likely than not.

MR. FLOHR: With the actual determination -- you mean with names and claim numbers and --

DR. LATHROP: We are not --

MR. FLOHR: -- Social Security numbers?

DR. LATHROP: -- interested in names. The last thing we want to do is --

MR. FLOHR: Well, that's -- that's -- that's what we're talking about there.

DR. LATHROP: Well, then is privacy such an issue that -- because basically I would imagine, just straightforwardly, all you have to do is re-- is -- is redact the names. And in this day and age of databases, that's not hard to do.

MR. FLOHR: That's true.

DR. LATHROP: So therefore could you explain the "problematic, dash, privacy" here, and does that become a yes, we can do that with some -- some redaction?

MR. FLOHR: I think we could. Unfortunately, again, I -- just coming here -- here lately and not aware of these particular recommendations --

DR. LATHROP: Well, we're trying to take advantage of you --

MR. FLOHR: Yes, I understand that.

DR. LATHROP: -- and this is all on the record, so when you say "yes," it's on the record.

MR. FLOHR: I would say we'll certainly look at that further and I'll get back to you.

VICE ADMIRAL ZIMBLE: Dr. Lathrop, I -- I think

I'd like to hear from Dr. Blake as to how important it is for Dr. Blake to receive that additional feedback on a case-by-case basis. He -- we get that feedback now in -- as a statistical -- you know, format, so that we know the percentage of those cases. But on a case-by-case basis, I don't know if -- I used to think that would be very important feedback to -- to help with the subsequent RDAs, but I think -- I'd like to hear what Dr. Blake has to say to see whether or not we need to pursue that recommendation or not.

DR. LATHROP: Okay, before he speaks, let me just suggest that there's another idea that we -- we've had in the communication subcommittee, which is in the letters to the veterans we find it -- we -- we deem it very important to manage the expectations of veterans, so we're not sure quite how we'd want to do this. We've had several trial phrases going back and forth which sort of say it's up to you to claim, it's in your right to claim, please decide on your own whether or not to claim -- oh, by the way, only four percent get compensation, or something like that. We're not sure how to

word that. But part of our discussion is managing of expectations, how to (inaudible) claims, fully aware that the decisions of how much compensation to give, after the more likely than not, involves a whole host of other -- other factors. Sorry then, Dr. Blake.

DR. BLAKE: To answer Dr. Zimble's question quickly, it's not that important at this point -- point in time. It was more important in the beginning when we were establishing expedited radiation dose assessments, and the reason it was is, for instance, if we knew some of them would be service connected and ultimately compensated, we did not have to worry about the benefit of the doubt. It affected some of our -- how we actually processed the results, whether we need to put in an extra quality assurance step to make sure that we're always protecting the veteran. If they were going to go straight to service connection, we didn't need to do that, and that made some significant changes over in the Department of Defense, how we set up procedures. But those questions have been pretty much answered. And the way we got around that initial concept was we were able to

get the figures from VHA on service connection. It wasn't a direct dollars on compensation, but the service connection from VHA, those values were presented publicly at the (unintelligible) were sufficient for us to move ahead.

VICE ADMIRAL ZIMBLE: Thank you for that. Dr. Fleming?

DR. FLEMING: I have a -- I have a comment, but first I have a question for you, and it's the last slide again. If you could just clarify, the 68.7 days -- average days to process, now that is after Cassano sends the opinion to -- the medical opinion to C&P and before it goes to Jackson VARO?

MR. FLOHR: No, that is from the time we receive it in C&P. When we receive it in the Compensation and Pension Service --

DR. FLEMING: From?

MR. FLOHR: -- from Jackson VARO.

DR. FLEMING: From Jackson VARO. Okay, so it includes the time that Dr. Cassano's working on it.

MR. FLOHR: Right, exactly.

DR. FLEMING: Okay.

MR. FLOHR: Completes -- it is the total time

that we have it, from when we receive it from Jackson VARO to when we sent it to Dr. Cassano's office for an opinion, we get the opinion back and return it to Jackson VARO.

DR. FLEMING: Okay, thank you. I wanted to bring that up because you'll see in Subcommittee 2's report later today that the -- the total length of time for the processing is a little bit longer. That's just VHA's, but --

MR. FLOHR: Oh, yes, absolutely.

DR. FLEMING: -- I just wanted --

MR. FLOHR: That's not the total claims processing --

DR. FLEMING: -- just wanted to be --

MR. FLOHR: -- that's just C&P and VHA processing time.

DR. FLEMING: Thank you. The other -- the comment -- the other comment I wanted to make was because Dr. Zimble -- Admiral Zimble has -- had been bringing up RECA and the difference between RECA, which is that other legislation for compensation from DoJ and the compensation program here with the Veterans Administration. And I'm not a scientist, and neither am I a soldier. I am a professor, and a professor of

ethics. And one of the things that ethicists do these days is look a lot -- lot at this phenomenon called compensation, and they try to make some sense of what compensation is and what it's trying to rectify or what it's trying to take care of when someone asks for or seeks compensation. And there's a distinction that is made, in the ethic -- ethical work that is done, between a harm, a lost -- a loss, and the effects of a loss. And -- and sometimes that distinction is only the harm and the loss, but more recently ethicists have been wanting to make a distinction between the loss and the effects of the loss. And the way to understand that in relationship to what we've been saying earlier this morning is like this, that the VA recognizes the difference between a loss that might have occurred, which is more likely than not a medical condition; and the effects of the loss, which would be the disability associated with the medical condition. So -- so they actually provide some forms of medical support for the loss and then, in some cases, if there is an effect of the loss, then they will provide some disability payments -- but not

always -- but they do provide some form of medical support for the loss.

RECA doesn't make that same distinction. For RECA -- what RECA does is effectively give you a one-payment lump sum for the loss itself, and there are no provisions for any medical support for RECA.

So in my experience with the RECA population, what many of the folks have done that have received this lump sum payment that are not veterans, is they have gone and they have paid off the medical bills associated with the loss, and so that distinction gets collapsed.

So I said that for the record so we would have that -- that wisdom recorded.

VICE ADMIRAL ZIMBLE: Thank you, appreciate that also. For the record, the veteran who obtains a lump sum of RECA money will not get any further compensation from the VA until it -- they will get it, but it'll be off-set by the $75,000. So there is an off-set condition, but they can apply -- in certain cases, can apply to both agencies and get some level of claim from both, some level of adjudicated compensation.

Did you have anything more to say, Dr. Lathrop?

DR. LATHROP: Just one more thing, thank you. Just briefly on -- on slide 6, Brad, you mentioned "provide information on 3.309 grant information -- currently pulling data" -- so does that mean we'll be getting that at some point?

MR. FLOHR: That means I don't know about that data request and I'm going to have to check with Tom Pamperin when I talk to him and see where that is. But yes, I'll make sure that you do get that.

DR. LATHROP: Thank you.

VICE ADMIRAL ZIMBLE: Mr. Groves.

MR. GROVES: Brad, back to the same slide that Gary had a question on where we talk about the total number of claims that have been granted at Jackson VARO, and that number is 1,482. And you implied that that number was large, most likely, because of the expedited activity relative to skin cancers. I would have expected that a number of those would also be presumptive cancers --

MR. FLOHR: Oh, certainly, I don't know the number, but yes.

MR. GROVES: -- because there is no dose reconstruction process for that. It's just a matter of validation of participation, and then having one of the 22 cancers gets you granted --

MR. FLOHR: Uh-huh.

MR. GROVES: -- whether there's a disability or not, and then you --

MR. FLOHR: Oh, absolutely.

MR. GROVES: -- explained that it --

MR. FLOHR: Yeah.

MR. GROVES: -- not all grant -- grantees get a percent disability, but they do obtain a -- a benefit from being -- having a service-connected...

MR. FLOHR: Yes.

MR. GROVES: Okay. Thank you.

VICE ADMIRAL ZIMBLE: Dr. Swenson.

DR. SWENSON: Thank you. I'd like to come to Brad's aid on the question that Dr. Lathrop asked and follow on with Dr. Blake. On the privacy issue, we did originally ask for that information to be sent to Dr. Blake, and then there was more discussion within our Board where we decided basically that af-- you know,

VA was researching it, said privacy issues, and then we as a Board agreed not an issue, we don't need that information with the names. Okay?

And then kind of to answer Dr. Fleming's question and for -- when I give the report for SC-2 this afternoon, our audits are cases from probably '07 and '08. His data is after Dr. Cassano arrived, so his time -- the turnover's probably much better now that they have somebody in that position. Although we did have an interim physician, there was still some time --

MR. FLOHR: Yes, and I again --

DR. SWENSON: -- where there was --

MR. FLOHR: -- have to thank Dr. Blake for that. He was a great asset to us.

VICE ADMIRAL ZIMBLE: Dr. Lathrop. I want you to know that you are now pushing into lunchtime.

MR. GROVES: But no pressure.

VICE ADMIRAL ZIMBLE: That's true.

DR. LATHROP: For those in the audience, you should be aware -- every Board meeting sort of goes like this. Dr. Zimble has an ir-- an

increasing degree of irritation at my questions, so this is all normal, all normal. Just a quick question for Dr. Swenson. Did you say that you decided you didn't need that information with the names to mean you could use the information without the names?

DR. SWENSON: I think the Board -- we talked about it as a Board, and if you look back in probably the minutes, we decided that it wasn't so important to ha-- for DTRA to have the names and whether it was denied or compensated, but we wanted the information, the data -- not necessarily the names -- in that metric. So I think it was as a Board that that decision --

DR. LATHROP: Then we decided --

DR. SWENSON: -- was made.

DR. LATHROP: -- we would like the data without the names.

DR. SWENSON: Right, and I think that's pending.

MR. FLOHR: That's the data, right.

DR. SWENSON: Yeah.

VICE ADMIRAL ZIMBLE: All right. I think it's time for lunch, and ladies and gentlemen, please --

MR. BELL: Before we break, sir, there was one question regarding the report and the status so that we can use for Congressional --

VICE ADMIRAL ZIMBLE: Okay.

MR. BELL: -- coming up.

VICE ADMIRAL ZIMBLE: All right, I'll -- I'll take -- fine, we'll take care of that before the break. We have been asked just recently by the Senate Veterans Affairs Committee staffer -- senior staffer -- to please come and give an update to -- to the -- to the Senate, and we're going to be happy to comply with that. It'll be -- still be several weeks off, but want to make sure that we have all the results documented from -- from the session today available, and this is a great opportunity to provide that wonderful history of the VBDR that you've all looked at and you've all participated in -- in putting together a very fine publication. I've submitted that publication to both agencies, and DTRA has been -- has tab-- made very favorable comments regarding it; have not heard yet back from the Veterans Administration. And as a courtesy to the Veterans Administration, have given them an

opportunity to comment on that before I present it. But when I go to the Hill, I will be presenting the Senate with that history, so I would just take this opportunity to remind the Veterans Administration that we would encourage a comment from them, positive or negative, so -- to -- we might want to make any corrections that they find need to be corrected before we -- before we present it to the Hill.

And that -- does that cover it for you, Mr. Bell?

MR. BELL: Yes, sir. Thank you.

VICE ADMIRAL ZIMBLE: Okay, my pleasure. We are now adjourned for lunch.

Please be back at 1:30 promptly. We've got a lot of business to do before the day ends.

(Whereupon, a recess was taken from 12:30 p.m. to 1:40 p.m.)

A REPORT FROM SUBCOMMITTEE 1 ON DTRA DOSE RECONSTRUCTION PROCEDURES

VICE ADMIRAL ZIMBLE: Okay, it's now time to begin the committee reports and we're going to take those in numerical order. We'll start with Subcommittee number one. Mr. Beck, would you be so kind as to -- to present your report to the Board.

MR. BECK: Thank you, Mr. Chairman. As usual, Subcommittee 1 writes a very large report which, if I tried to read the whole thing, everybody would get very angry. So y'all have a copy and I will just sort of go through the high points. But I do want to at this time read the -- the charter or the task that this subcommittee is supposed to perform. We always put this at the beginning of our report, but it's kind of important this time because I'd like to, at the end of this report, have the Board discuss some of our thoughts about what we should be doing in the future, which are slightly different from what we're supposed to be doing right now according to this charter. So just to remind you, we're supposed to assess dose reconstruction procedures, including revisions, used by NTPR contractors, and these will include the procedures for determining exposure scenarios, the technical procedures for reconstructing doses, and related documentation, such as the Standard Operating Procedures, and we have been doing that all along and reporting that to you, and we will report what we've done in the last -- since the

last meeting on that.
We are also supposed to conduct periodic audits of a random sample of NTPR dose reconstructions to assure correct procedures are being followed and to ascertain the quality of reported doses and associated uncertainty estimates. And as I go through this report you will see, because of the way things have changed, that we may need to modify this particular task somewhat in the future and along the lines of what Dr. Lathrop said earlier.
And finally, we're supposed to prepare a summary of our findings and recommendations for the Board consideration and approval, and that's what I will now do -- tell you what we've done since our last -- since the September 2008 VBDR meeting and what we found in some of our -- looking at some of the procedures, and then give you some discussion topics and one recommendation or one proposed recommendation for the VBDR to give to DTRA.
So in terms of our activities since the September meeting, we did audit three expedited cases which we received from DTRA back in February, and we also audited one of the -- the

double-blind case that Dr. Blake talked about, which was a full dose reconstruction. It was not actually a -- it was sort of a case that was tweaked a little bit, but it was based on a real case and a real exposure scenario.

In March we met at the NTPR contractor facility in Virginia, and we do this before every VBDR meeting to review our findings of our audits with the contractors and with Dr. Blake and to receive an update from him. And we find these meetings very useful in terms of being able to informally discuss possible improvements in the program, which usually then get made before we even get to the VBDR meeting so then we don't need to make recommendations.

I won't go through the list of things we discussed at that meeting, but they're listed here and you can look at them.

One of the things that we did do is -- in terms of the looking at some of their new procedures was that Dr. Blake asked SC-1 to review the final draft of a proposed Technical Basis Document describing the development of methodology to perform probabilistic dose assessments -- and he talked about this in his

presentation. And we did give a report on that to DTRA on June 1st.

And then yesterday we met with -- SC-1 met -- had a meeting with Dr. Blake and also with the contractors who prepared this draft, and we had a very useful and productive discussion about our comments and their replies to our comments. They pointed out that several of our comments were not too good, and we recognized that. And they also accepted a number of our comments as things that they had to look at, so I thought that was a very productive meeting.

We also discussed the double-blind analysis and the implementation of the Decision Summary Sheets, and some of the other things that we had found in our -- had come up -- some of the other action items that had come up in our meeting that we'd had with the contractor a few months earlier.

Some of the findings that we have -- that we found in terms of our audits and assessments since our last meeting -- as recommended by VBDR, most dose assessments now follow these expedited procedures which Dr. Blake talked about. And because of that, there are less

than five full dose reconstructions now being performed per year out of about 400 incoming cases. This is really a startling difference, because this really changes -- it's hard for us to audit -- take a random sample of five cases per year, so one of the things we have to look at is whether that's really a worthwhile -- you know, to -- it's a requireme-- I'm not sure it's an actual requirement in the charter specifically, but if it is we would want to reword it. You know, to change it from a routine sort of regular audit to something more sporadic. Not that we want to not do occasional audits, but we certainly don't need to continue to do it as we've been doing it. And as a result, because of this low number of full dose reconstructions -- except for the audit of the double-blind case -- we did not perform any routine audits of full RDAs during this reporting period.

Our review of the double-blind case -- and for the audience perhaps, we've been throwing out the word "double-blind" and they probably have no idea what we're talking about. Not that the analysts are blind, but the -- it really means

that none of the analysts know what the other one is doing. They have no information about what the other person is doing. They don't see any of the information the other peo-- person is -- the other analyst is doing, so it assures that there's complete independence of these three audits, and they're completely independent and then you can really see whether or not they're able to follow the SOPs and come up with the same answer.

One of the things we have found with these double-blind cases, and it's been a very useful finding, is that we've been able to find that some of the versions of the standard methods are -- still need some tweaking and we -- but Dr. Blake has been doing this as a result of this and been able to improve the SOPs so that when these final SOPs get put on the web later this year they will really be much more useful than if we had not gone through these exercises. And I think if we continue to do these exercises we will continue to come up with improvements that will result in further changes, but -- to keep them up to date.

We did come up with a few questions about some

procedures that were -- that we needed to talk over about how non-radiogenic cases were handled and how doses reported to the veterans, and most of these things have been resolved through our discussions with DTRA directly and so there's no real need to bring them up in terms of specifics.

But one of the things we did find was in our review of the three expedited cases. Most of -- as I said, there were only about five out of about 400, so most of these other ones are expedited cases and so we did do this sampling of three of those expedited cases. And one of the key things with expedited cases is the Decision Summary Sheet that you've heard about, and this is sort of a brief summary that tells you why -- you know, in -- what you like to have in this summary is the specifics as to the justification for why this case should have been expedited as opposed to having a full dose reconstruction, why it could be expedited; and also the validity of the doses that were assigned, that they are truly upper limit doses.

And what we found in our audit of these three

cases was that there was a less than satisfactory explanation, let's say, of -- being written down. And I'm happy to say that between the time that we reported this in our subcommittee meeting several months ago and yesterday, DTRA has pretty much fixed this problem so there's -- they -- yesterday we went through a bunch of new cases and they -- now they're doing a real good job of explaining and putting the words into this Decision Summary Sheet that really explain their rationale for making these important decisions that -- that justify whether or not the case should have been expedited, so we're very pleased to report that.

We have -- VBDR recommended in February about these double-blinds and, as I said, we -- what we found in the latest one was that the -- the three -- the two contractors plus the DTRA contractor got very similar results for the last case, but there were some small differences which indicated some problems that needed to be fixed, and these have been addressed and resulted in some changes in the SOPs. So -- most of these were -- some of

these were just making the SOPs more clear, so that the independent -- and analysts could understand what they were supposed to do a little bit better. One of the things you have here is you have the DTRA contractors, who have years and years of experience in doing this, and so even though something may be written done, they don't even have to read it because they -- they know what it's supposed to say. Unfortunately the other contractors -- they read it and then come out with a different interpretation, so that means that we need to clarify some of these SOPs, and that is being done. And this is part of I think the QA exercises that have been talked about, and I'm sure will be talked about in some of the other committee meetings.

One of the things that Dr. Blake mentioned was this probabilistic assessment and this -- one of the outstanding recommendations of the VBDR was to justify these default upper bounds. And we have asked all along that these needed to be justified, that they truly will give you an upper bound that meets the Code of Federal Regulation requirements of the -- being at

least the 95th percentile. And what's happened since the last meeting is that there have been two very important technical basis documents that have been produced, one by one contractor that has looked at this x3 for external dose that is assigned to get an upper bound for external dose as a default, and it indeed has found that for most cases this x3 does give you a conservative estimate of the upper bound, that the actual dose is truly less than that at the 95th percent confidence level. There are a few situations where that may be -- not be true, and that will require specific guidance in the Standard Operating Procedures as to how to handle those cases and they'll require further investigation. But we now have seen pretty good indications now or pretty good documentation that -- that applying these default factors for most cases really is adequate, and the probabilistic document that we reviewed that I talked about a few minutes ago -- besides looking at the x3, also looked at the x10 factor for internal. And it again made a very strong case that for most cases the x10 was indeed very conservative, in fact. And

so I think that's -- they have gone a long way for -- toward satisfying that -- that recommendation. And as Dr. Blake said, once they publish these reports, he will consider that he has satisfied it, and I think probably we'll agree -- pending looking at what he writes.

I might mention that one of the things that came up at our SC-1 meeting when we were talking about that -- while we were still looking at justifying these x3 and x10 -- was -- the suggestion was made that perhaps it might be a good idea to go back and look at all the cases since the National Academy of Sciences report to make sure to ask whether or not it might have made a difference if the x3 and the x10 weren't good enough. And Dr. Blake has initiated an internal study to do this, and we saw some preliminary results yesterday which suggested that there probably were very few, if any, cases that it would have made a difference even if the x3 weren't quite -- or x10 weren't quite, but he's going to complete this and I imagine will report to SC-1 and also to the Board on this. So that will be an extra piece

of information that will, you know, make it more comfortable that when they do use the x3 and x10 that they really do represent a true benefit-of-the-doubt upper bound to the veteran.

It also will serve as a prelude to deciding whether, for certain cases, you need to do a full probabilistic dose assessment, if there's any question for that case that the x3 or the x10 might not be high enough. It'll tell us the kind of cases and the kind of scenarios where you might need to go, go further and really justify that x3 and the x10 factor for that particular case.

In terms of future plans for SC-1, which we mentioned at our last VBDR meeting, it of course continues to depend on the future of VBDR and what we decide VBDR should look like in the future. As I alluded to earlier, we feel there's no longer a need for VBDR to routinely conduct full audits of randomly-selected cases for dose reconstructions. There are just too few of them to do this routinely. We probably still will want to do them occasionally to make sure that everything's

fine, sort of checking the checkers. But as mentioned by Dr. Blake, they do have an internal program they call it sometimes external. It's external to Paul's shop, internal to Department of Defense, so it's a distinction you have to keep in mind, and we're supposedly external to everybody.

However, we -- we do -- assuming they're going to continue the double-blind program, which I think they will, we will continue to audit that case each time as well. So besides having the three different contractors doing the independent dose assessment, I think SC-1 would want to continue to look at that case and audit it -- all three of them, actually -- and I think that will continue.

There's also DTRA's contractor who reviews all the expedited case files and these Decisions Summary Sheets to assure that the cases were handled in compliance with the SOPs. And because, as I said, when we did that audit we did find a problem, even though now it has been fixed, because there are roughly 400 of these being done every year, most of the now dose assessments, I think that's where we would

shift our emphasis in terms of audits; that we would want to probably -- with the Board's advice -- perhaps audit a selected version -- number of those cases before each of our meetings and report on that. This is sort of checking the checkers, just to make sure that everything is kept up to snuff and there's no slippage. And it wouldn't have to be a lot of them and -- of cases to do that, you know, so we would probably do a lot fewer than we did originally.

The National Academy of Sciences report that's been mentioned a lot, that essentially resulted in the creation of VBDR, recommended that there be a continuing, independent, outside oversight of the dose reconstruction process. This was intended to include an overview of not only the RDA preparation, but also the methodology, the Standard Operating Procedures, communications, and the relationships between DTRA and VA. And I think that SC-1's view is that this still needs to continue in some form, and I think Dr. Lathrop has suggested one possible set of things that had to continue. But as far as SC-1, I think our -- our main view is that in some

form there has to be some kind of continued, completely independent oversight, whether it's as part of a VBDR or some other organization, that does some of the kind of things that SC-1 has been doing in the past. And so I think that's our -- our bottom line. And I think we would also, if SC-1 continues, as part of our -- and VBDR continues, we would want to continue having these informal meetings that we have with DTRA before the regular meetings to resolve informally a lot of these issues. Therefore we -- I doubt that there would be need for formal recommendations. I think most of that -- most of the shift would more be toward offering advice, looking at changes in procedures and assuring that procedures are being followed as they have been adopted. So in terms of the specific suggestions, we only have one recommendation and it's probably superfluous in terms of a formal recommendation because Dr. Blake has already agreed to do it, but for the record, I think we have said that one of the deficiencies that we did find in our audits and our -- also in looking at the different procedures since the last meeting was

that the SOPs documenting how and when to expedite cases, and particularly the doses assigned, are still not sufficiently justified. In other words, there's a table in the SOP says you give this dose, but there's really no explanation about where this dose -- how it was arrived at, or at least no satisfactory explanation in terms of our feelings, that we -- we need a better explanation and we need a better justification. And so we've suggested that -- we suggest that VBDR recommend that DTRA improve the current SOPs on expediting cases and also prepare a detailed Technical Basis Document justifying the assigned expedited doses. And Dr. Blake essentially has already agreed to do this, so the Board can decide whether we need to make this a formal recommendation or just take his word for it. I think we can...

The current effort by NTPR to develop a probabilistic dose assessment capability, I mentioned that we reviewed the draft. This draft is basically developing the methodology, but it is not -- in our view -- the final answer in terms of actually being able to do --

they're developing the framework. And the draft, in about another month, will be ready for publication, and it's a really great start, we feel. And it really defines the kind of framework that they will need to do this when they actually want to start doing probabilistic assessments. But we identified another number of areas where, in order to actually do a full probabilistic assessment -- and the difference between the probabilistic assessment and the types of dose reconstructions -- full dose reconstructions that are being done now is that there what you want is to come up with the actual best estimate you can of the central estimate of the mean, most probable dose and the actual distribution of possible doses. That's opposed to what they do now where they come up with a very conservative value for an upper bound, which is what is used in the dose reconstruction, which may be tens or hundreds of times actually greater. Because the important thing for the veteran's benefit for the claim, you really want to make sure that it's greater, and you don't care if it's much greater in terms of giving maximum benefit of

the doubt to the veteran.
But for the probabilistic dose assessment you want to really have an engine, so to speak, that will really enable you to calculate the best estimate of the dose. And this will -- in discussions we had with Dr. Blake yesterday, this will not only be useful for this program, but also for many other programs. So Dr. Blake has said that he has other responsibilities, and DTRA has other interests, that will make this a very useful tool besides for this program. So SC-1 really feels they should continue this development beyond publishing this report on the methodology, and so we're encouraging that that be done.
The other thing that -- in the interim, what we -- eventually it would be nice to be able to do a full probabilistic assessment for all the full dose reconstructions. I don't think we feel they're there yet, but they only have five -- five a year, don't forget, not the -- just the five. However, in the interim I think they have demonstrated that they can continue to use the x3 and the x10, but that when they do a full dose reconstruction they have to justify

that that case is not something unusual where that might not hold, until they're ready to do a full probabilistic dose assessment, and that hasn't always been done up to now, it just -- I mean they haven't had the information to do that. But now I think they have the background to be able to do that in their dose reconstruction. I think it would be desirable eventually to be able to do a full dose reconstruction, but we're not saying that that's actually necessary. But having that capability would be very nice.

So just -- I think that the bottom line is that, whether or not VBDR continues in its present form, we need some type of ongoing, completely independent oversight of the program, and I think that that should continue. And I -- if I've left out anything of this written report that my colleagues on SC-1 feel I should have mentioned, I hope they'll pipe up now.

VICE ADMIRAL ZIMBLE: Thank you very much. I appreciate your report. I appreciate the fact that -- and I congratulate SC-1 for a good working relationship with NTPR and the ability

to accomplish things without having the Board make a formal recommendation to the parent agency. I think we need to at least let the parent agency know that the cooperation is there and that progress is being made.

I understand, as best a non-mathematician can understand what you've been saying, that you're feeling more as you do these probabilistic assessments and as you refine the probabilistic assessments, we are becoming more and more confident that the upper limit factors of three and ten are appropriate to protect the veteran and to assure that we are giving the veteran the benefit of the doubt; that there may be some exceptions to that in the full RDAs that may require a probabilistic assessment is understood, and it is understood, more importantly, not only by SC-1, but by DTRA -- by NTPR.

MR. BECK: I think you said it even better than I did.

VICE ADMIRAL ZIMBLE: Well, I want to make sure I got it all down. I have a problem with understa-- with the nomenclature that we're using with the DSS, the Decision Summary Sheet.

It's really more than a summary of decisions. It's more a justification for the decision that would be satisfactory for an auditor to understand what the analyzer was thinking as he went through the process. There are many judgment calls. We want to know what judgment was used so that we know whether or not it could be refined. And therefore I think Decision -- Decisions Summary Sheet might be better replaced with a Decision Support Summary -- still using the same DSS, we don't have to -- don't have to go back through the reports. But I think it makes sense, especially if we're moving towards some more formalized, quarterly -- quarterly quality reports, that we have some substantive DSSs with which to develop those reports. And then I think the auditing of the reports over a period of time may be even more productive than auditing random ca-- random studies. But that's just the Chair's opinion. Now I'd like to hear --

MR. BECK: Let me just --

VICE ADMIRAL ZIMBLE: You -- you can respond to that --

MR. BECK: -- before Dr. Lathrop and Curt get

up and start yelling, when we started out -- don't forget. Because things have evolved, when we started out we didn't have this five a year full and close to 400 expedited. It was sort of the other way around. And the idea was that we were going to have these Decision Summary Sheets to really summarize these master theses of the key decisions in those master theses, and that is part of the -- those full dose reconstructions. The contractor who does the dose reconstruction does a Decision Summary Sheet. In fact, we've also asked the double-blind people, in their next one, to do a Decision Summary Sheet, and there it's really a summary sheet where they take the key decisions and they summarize them and -- and so that -- that followed the original idea.

Now when we got to the expedited, there you're right, the key thing was to justify the decision. And so maybe -- I mean there is a decision, a key decision, as to whether to justify, and -- and there's some sub-decisions in the sense are -- you look at the SPARE and you say are there any unusual circumstances. And if there are, why didn't I -- why doesn't -

- why does this still -- can -- can -- why can this still be expedited, or shouldn't it be? And so there are some key decisions and I'll let the QA people weigh in on whether they want to have two different names for these.

VICE ADMIRAL ZIMBLE: Okay. Any comments from the Board?

DR. LATHROP: Yeah, just a couple of -- of course, yeah, I -- I -- we might want to -- I don't think we should quibble over the name of it, but I fully agree, the point of the Decision Summary Sheet or whatever it is, is to record the justifications for the decisions in such a way that an external person, not knowing the details of the case handling, can check it for defensibility, consistency, and fairness. And so that's -- that's much more than a summary, you point out quite well, we -- we can work on the words. But that's the point, defensibility, consistency and fairness.

VICE ADMIRAL ZIMBLE: As long as that -- as long as those who are preparing those sheets know what's de-- what's desired, we don't have to do anything more.

DR. LATHROP: That's true, but as long as this

mike is on, I just wanted to ask for some clarification from the esteemed Dr. (sic) Beck, what -- because this will come up in our discussion of the future of the Board. Last night over another meeting I was maintaining -- I suppose naively and foolishly -- that if we get the quarterly quality reports and DSSs right, then checking on things is not a problem. Anybody who knows what's going on can just check the QQRs and the DSSs to make sure they're all okay.

I think -- you can correct me -- you sort of politely said "Lathrop, you fool, that you nee- - you need to do a complete audit to make sure that the QQRs and DSSs are -- are accurately done." Now is that what you were saying? And so when you talk about a carry-on thing, by audits, you mean a complete audit, ceiling to floor --

MR. BECK: Well, no, I don't -- here's what I mean --

DR. LATHROP: "Lathrop, you fool" again, right?

MR. BECK: What I -- on the expedited case, what the analyst does is they look at the SPARE which is prepared, which is the scenario -- the

veteran is supposed to. And then they look at all the -- whether or not the doses that have been assigned in this -- SOPs for that kind of scenario as expedited doses apply or whether there's some unusual exposure where it might not apply, and then they make a decision yes, it can be expedited. I think that our audits only look at whether or not that has been fully justified and whether we agree with it. We don't -- and that may require us looking at the case file, so you know -- but we don't have to check dose calculations as opposed to what we had to do before because there aren't any dose calculations so it's -- it's much simpler, but -- but there -- you know, as I said, there is an internal -- at least our view of internal -- a contractor who does look at this also. And so I do not consider that we have to do a big job, but we are basically checking the checker. We're checking the internal checker. He -- that internal checker organization really should be doing this, and so if we look at three or four of these a year and they're doing their job, that's fine. You know, that's all we would -- and then from a perception point of

view in the outside world, we have the -- we have this completely independent check to make sure that they continue to do their job in a quality way.

Now the statistics you'll be getting should -- will be the statistics of their internal quality system, and also our periodic reports as to whether we found any discrepancies -- which hopefully will be unlikely.

VICE ADMIRAL ZIMBLE: Well, I -- I'm grateful to see that you two are coming together in some form of agreement, whether -- and rising above pejoratives to do so. Dr. Lathrop.

DR. LATHROP: Yes, thank you. Dr. (sic) Beck is certainly a gentleman and a scholar. The -- my esteemed colleague from -- yeah. Okay. Maybe this -- this would be a question better deferred till later, but let me just quick -- quick ask it now while the topic is alive. The QA/QM people in the room are always concerned about when you find an error, what do you need to do to build in and lock in a systemic fix so the error's not apt to be repeated in a future month or year. Who do you think is most qualified to do that; you, Dr. (sic) Beck, I'm

hoping? To figure out the fix, the organizational fix.

MR. BECK: That's a good que-- I mean I don't -- I think that part of our present mission is to look at any proposed changes in our methodology. Now if the -- if the problem was because they didn't follow their methodology, that's a different issue than if their methodology is flawed. I mean I think that -- that our rule would be to say well, we've discovered a problem with the methodology, and that's what we do with the double-blind, we've discovered a problem with the SOPs not being clear and therefore we asked them to be fixed and we checked that they are fixed, and the same thing with the assessment. But if it's a question of just not following the methodology, I think that's something else and I don't think that would be SC-1's --

DR. LATHROP: Okay, that's more like what Curt and I would do.

VICE ADMIRAL ZIMBLE: I would think that when you find either a common cause or a special cause that needs a, quote, fix, that that -- that needs to be reported. And let's take

advantage of the expertise of the entire Board and -- and have a fix follow a deliberation of the Board. But I think we're -- we're finding that up until this point, recommendations that we've made have been -- have -- have turned out to be favorable in terms of their acceptance and their implementation, and the resultant change in the process so far, looking good. And so I think -- I think that -- that we'll probably -- now we'll be looking more at quality and errors in processes and modifications to streamline processes. We can continue in that vein.

I had one other concern. I know Dr. Blake wants -- needs to make some sort of statement in his defense, most likely, and Dr. Reimann wants to talk a little bit towards quality, but I would just like to say that the one concern I've seen is in the communication back to the veteran when -- when relaying a decision that concerns an expedited case in which we use an upper bounds dose rather than an actual dose, and the level of confusion that is created by telling a veteran that you did -- you did not have a dose that exceeded such and such, and

the veteran interprets that as their dose.

DR. LATHROP: Yeah, that -- that's an SC-4 thing.

VICE ADMIRAL ZIMBLE: It's a communication issue which I think really deserves to be addressed, and addressed fairly quickly. Dr. Reimann.

DR. REIMANN: Okay. I -- I see a real risk of clarity breaking out here, so -- as for whether it should be a DSS or DSS, I think it should be a DSSS because it really is Decision Support Summary Sheet. And as far as whether it should be SC-1 or SC-2, the answer to that is also yes. And the point is that if you look at what a DSS is, it bridges between complex documents and a routine quality system, and therefore if SC-3 is trying to -- I think I misused SC-2 in that place, SC-3. If SC-3 sees a particular pattern of problems, the proper fix may very well be highly technical and completely outside of our expertise, and then it becomes a question of how does SC-1 see that in terms of changing, let's say, the SOP document, the basis document. And we would be then proposing how would we then integrate that within a

routine, day-to-day operating system. So the point is that there's no way to separate the two roles, and there's a complete need to -- to integrate the way the two subcommittees operate in this -- in this arena.

So I think that getting -- I think the real concept, whether you change the acronym or not, is really Decision Support Summary Sheet. And a real question is to what extent is that a living document or to what extent is that something that the Board wants, once and for all, to make a recommendation that this is now the -- the DSS going forward.

My own inclination is that should be part of the improvement process. If you have something on your list as a decision support, and that decision is now routinely, 100 percent, always made correctly, why not simplify it and just get rid of that item so that the document itself evolves with the process. So it becomes part of the improvement mechanism.

So I think clarifying the two roles -- and also I think this saves me time in a few minutes 'cause this is a lot of what we were -- what we need to talk about. And then if you sort of

just translate what we're talking about now into the relationship with SC-3 and SC-2, you can kind of get the whole -- the whole picture. But the -- it is a decision support and therefore there's more of a burden on that work if it's decision support than if it's just decision summary. And if we lose the one meaning, I think we trivialize it. But really is -- it's an attempt to bridge between complex basis documents and routine, day-to-day quality assurance. And so that -- and that clarifies the roles. It says why are -- why are two groups sort of meddling on the same basic issues? Well, it isn't meddling because we've had a fantastic relationship with both other committees and with the agency, so -- but this kind of clarification, I think, at this time, can be extremely valuable in seeing not only the way we relate within the Board but also what the Board is trying to do in terms of working with the agencies.

VICE ADMIRAL ZIMBLE: Thank you, Dr. Reimann. Dr. Blake.

DR. BLAKE: Two things, and I want to go on the record on both of them. One, on all the

recommendations made by SC-1, I certainly, as the program manager, accept those and look forward to working on them. So based on -- you mentioned promises, but I want to say formally yes, we endorse it. Perhaps the most important one is creating a formal publication that we'll post publicly on the technical basis for expedited doses.

We did that, to some extent, as we presented those as recommendations to VBDR -- over the years we presented papers on whether it was the basis for skin dose or prostate dose and so forth. But what we need to do now is pull it all together, do a formal, rigorous presentation. So it's not like -- not -- some of this has been presented in public already, but we need to finalize it and pull it all together, and that's what we plan on doing. That's perhaps the most important piece of work of the ones that I agreed to sign up for, and I certainly support all the recommendations that come from SC-1.

Second and final item I'd like to mention is -- it may be a little difficult to appreciate, but the work done by SC-1 -- Harold Beck, Gary

Zeman and Paul Voillequé -- on the technical review they just did for our probabilistic uncertainty analysis was just superb technically. The scientific team on NTPR really appreciated the many hours they spent on providing us feedback and their insights and so forth. And as a health physicist representing Department of Defense, we're very appreciative. It was a very nice piece of technical work, and our team appreciates the feedback we got, so thank you.

VICE ADMIRAL ZIMBLE: Okay, thank you very much for that.

I just want to thank Mr. Beck for providing an excellent recommendation for how we should proceed further. If you look on the second page under tab 9 you'll see our charter, and I think you very well articulated a wonderful transition from what you've been doing to what we need to do in the future. And if you'll look at the item number 3, the -- under the specifics of the mandate of the Board, it's to carry out such other activities with respect to the review and oversight of the radiation dose reconstruction program as the Secretary of

Defense and Secretary of Veterans Affairs shall jointly specify.

So I think that in your report, provided the report is fully accepted by both agencies, you have -- you've specified what you and we need to do. And as long as the two agencies agree, then you've done an extremely good job and I ask for the Board's consensus in approving the report as articulated.

All those in favor?

(Affirmative responses)

Any opposed?

(No responses)

Okay. We'll now proce-- you want one last word, yeah. Okay.

MR. BECK: First of all I'd thank Dr. Blake for the kind words. I don't think we need to make a formal recommendation since he's already gone on the record as going to do this, so I don't think the VBDR need to make any formal recommendations to the agency.

I'd just like to point out, and this is sort of to think about af-- when we get to talking about the future of VBDR, but some of the discussion sort of pointed out that maybe we

need to reconsider the subcommittee structure that we have now because of the fact that some of our roles are now getting very close together, like the QA role and things like that. So I just think we need to think about this as we go forward, and I just wanted to alert you to that. We haven't put this in our report as making anything formal, but I think this is one of the things we need to talk about because -- particularly if the Board gets scaled down or changed in form, we may want to change the subcommittee structure to be perhaps more compact and so --

VICE ADMIRAL ZIMBLE: Okay, I think --

MR. BECK: -- I'd just put that out.

VICE ADMIRAL ZIMBLE: -- all the Board should keep that in mind. I would say, however, that I'd rather not contribute to the unemployment rate in this country today by laying off any members of the Board. I think that this Board's level of expertise, their participation and each coming from their own perspective and slightly and in some cases significantly, different professions has really added to the strength of the Board's recommendations. So --

but the Board -- the mandate for the Board is far less than the numbers we have on the Board -- in the charter -- so we have, again, flexibility in terms of attrition, natural attrition or whatever. But I don't feel compelled to reduce the membership just to restructure because of the change in role. Certainly not from the recommendation that I received from SC-1. So depending upon the recommendations from the other subcommittees, there may be some substantive reason for a modification in the membership, but I don't foresee that yet.

DR. LATHROP: Yeah, just to -- this may be getting of ourselves, but looking at what we've been talking about, I actually advocate keeping the four subcommittees. It sort of -- it uncannily falls into line that SC-1 works on the -- on the NTPR end, SC-2 works on the VA end, SC-3 brings the quality management and the integration across the two agencies as separate from what SC-1 and SC-2 do, and then SC-4 for the communication. I think whoever set up the subcommittee structure, perhaps accidentally, did a very good job. Probably you.

VICE ADMIRAL ZIMBLE: No, I'm not -- no, it would never be on purpose.

A REPORT FROM SUBCOMMITTEE 2 ON VA CLAIMS ADJUCICATION PROCEDURES

Okay, we'll -- with that, let's move on to the Subcommittee 2. Subcommittee 2, may I hear your report, Dr. Swenson?

DR. SWENSON: Dr. Zimble, Mr. Wright, the Veterans Board and our honored guests, our vets -- you're why we're here today. Our subcommittee is responsible to provide oversight under the VA portion of the claims process, and we'd like to recognize the addition of Dr. Cassano and Mr. McClung* to the Office of Public Health and Environmental Hazards, who render the medical opinions. That has been a definite positive addition on the VA side, and we'd like to thank you for that.

At the September meeting of our Veterans Board we decided we needed to look at 30 more audits. At that time 30 audits had been done, but that was prior to the centralization to Jackson VARO, so we wanted 30 more audits that encompassed cases and claims that were after the centralization.

We had a March meeting, and at that meeting we

reviewed 12 audits. These 12 audits were not random audits, but audits that were made available to our auditor and that happened to come through the C&P office. After we reviewed those, we wanted the next audits to be random, and we asked DTRA to provide a list of full RDAs -- cases, and we randomly selected cases from that. And at this time that auditor has then looked at eight more. So we had 20 cases, 20 audits, to look at for today's meeting.

And in our review of these 20 audits that had been accomplished, some of the things that stood out were we saw presumptive cancers not being recognized; partial compensation was not awarded, which might have helped the veteran; and excessive time delays. You can look at page 2 of the report and there's a table there. Some of the time delays were how long it took to get to Jackson VARO, and also the amount of time that it took to get to DTRA. Now there were some other time delays, too, but those were some of -- the two that stood out, with a total time average of about 400 days.

Now if you look at this table, in the first column I averaged the 20 audits. However, one

audit -- if you look at the min and max days, one had -- took 1,700 and -- you know, days to get to Jackson VARO. That particular case I think was in one of the piles from 2005 that was -- the sent back to DTRA, and then sent on to Jackson VARO. So we decided to take that out, so in the far right column we have taken that one out and so it's the average days for the rest of the 19 audits.

Now we know that they've added the virtual private network between the two agencies, between DTRA and VA. And you heard today that that has definitely made an impact at the VA Jackson VARO. And also Dr. Blake mentioned that, you know, they've decreased the mailing time, and also I think it's really increased the communication between the two, and understanding of what's important for the veteran. So the next ten claims we're holding off on because we'd like to see how this VPN has impacted the time delays and has that made a big difference. So we're going to have those ten more audits done that have been completed in August of 2009 or after, and we'll probably ask DTRA to provide some of those audits.

Another thing about the -- of the 20 audits, the last eight audits were also full RDAs. They had at least one condition that was a full RDA, which could add to the time. The first 12 were not.

Note that the shortest presumptive case took 154 days, and the shortest expedited case took 90 days -- of the ones that we saw.

Some of the comments that I want to focus on that we saw from the audits -- we're concerned that the veteran is not always aware of other compensation programs available to them. We had a particular case where the veteran was awarded, so they were -- it was compensable to zero percent for a presumptive, bladder cancer. So their bladder cancer had been resolved so they got zero percent. However, through RECA this individual would be able to get the $75,000, but they would still be able to get the medical benefit through the VA. So somehow -- how do we get that information to the veteran?

At the very least we'd like to see copies of the brochure go out in the first mailing to the veteran from Jackson VARO, because it talks

about the other compensation programs there. We also saw that the letters to the veteran from the VA and DTRA -- and we know that some of them have legalese in them, though -- are not easily understood, and we wish that SC-4 would look at those letters and try to improve the level of understanding, to include what Dr. Zimble mentioned earlier about the understanding of the dose, below -- you know, not more than -- if it's an expedited dose they're giving, if it's a calculated dose. We don't think that that's very understandable for the veteran. And also especially from a risk communication point of view, would be very helpful.

We talked -- because of some of these time delays, we talked about that additional refresher training is needed by Jackson VARO on awarding partial compensation. You may ask how does that make a difference. Well, if a veteran has filed for three different types of issues, if it's a presumptive, they're -- as you know, there's not much they really have -- information they have to get. They have to get from DTRA that they were atomic veteran, and

that rating officer can actually award that right away. How does that help the veteran? Well, the veteran can then be treated at the VA much more quickly than if they wait for the other issues to be resolved, so they can get partial -- a partial compensation earlier and then have the rest of the issues resolved. So we'd like refresher training at Jackson VARO to include that.

And also you can see it took a long time to get these cases to Jackson VARO. Now sometimes -- in a couple of these cases the individual VARO worked up the claim. Now according to the VA's regulations, or their guidance, it's supposed to be done at Jackson VARO. So it should be sent to Jackson VARO, you know, immediately as they see a radiation claim, and that's where it should be then worked -- the claim development should occur at Jackson VARO, which makes sense because now they are the trained experts in the radiation area and it should go more smoothly.

Going on to the recommendations, we have then three recommendations, and I'll go ahead and read those so I don't get those incorrect.

The first response to a veteran claim from the

VARO, or the Jackson centralized office, should include the letter of consent allowing the veterans to be enrolled in the IRR. This letter of consent should state the benefits to the veteran from their enrollment in the IRR.

We also recommend the Board ask Subcommittee 4 to draft a letter of consent.

Our second recommendation, that Section B and C of the VA MR21 -- and hopefully I got that lingo right. Maybe you can correct it.

MR. FLOHR: Actually M21-1MR.

DR. SWENSON: Okay, maybe Tom Bell can get that. Okay, thank you.

That should be updated to include the expedited process for skin cancer and prostate cancer. They have already included the centralization to Jackson VARO, but now that DTRA is going to put that in their regulations on how they do the expedited doses, we think it's time that that be incorporated into their procedure manual at the VA.

We also would like a focused STAR audit to be performed in April 2010 at the Jackson RO, and it should be for the year March to March to reflect the improvements that I think the VPN

has made, because from my understanding the VPN really was up and running by March -- is that correct, of this year?

DR. BLAKE: I think that's fair. We actually had physical connec-- we had physical connectivity before that, but it took a little while for us to just start moving the files back appropriately, so I think -- it was certainly up and running by March, if not sooner.

DR. SWENSON: Okay. So we ask that the VA then look -- do another focused STAR report, and I also think that that timing of that would be good for the Board, too, before we, you know, move on to our -- however the -- the future of the Board is going to be, 'cause they've done one other focused STAR report, I think initially when it moved to Jackson VARO, and then this would show how Ja-- how that has made improvement, so that would be great.

And then also the future role, we think that the independent audits of Jackson VARO claims should be -- continue at this time, but the SC-3 recommendation, which you will soon hear -- we support that, to prepare the quarterly

reports with corrective actions and that the VBDR should move away from individual auditing of a claims to reviewing this content and the reports from this quarterly meeting.

VICE ADMIRAL ZIMBLE: Thank you very much, Dr. Swenson. I would like to make one suggestion. You made some, I think, very important observations. The committee decided that we would make these observations, one regarding a little bit more information regarding RECA for the individuals with presumptive cancers that they don't -- that get some -- get zero or some percent compensation for the disability, that they at least be apprised of that as part of the award process, and that in the case of multiple elements to a claim, we made the observation that a partial award be made for the presumptive cancer -- presumptive condition as soon as possible rather than await the final adjudication of the entire claim.

And I'm suggesting that maybe a fourth recommendation might be to ask the agency to take cognizance of those observations and -- and perhaps make a modification to their procedure to accommodate those observations.

DR. SWENSON: Okay. From nodding of the heads of our committee, I think that would be very good. And to give it -- put it in the hands of the VA of how they might want to --

VICE ADMIRAL ZIMBLE: Give the VA the option to decide how best to modify their procedure, but at least to be aware of those -- to please review those observations and see if they can't modify the procedures to accommodate them. I thi-- I just think that we ought to make that more formal.

DR. SWENSON: I agree.

VICE ADMIRAL ZIMBLE: Okay. Any other comments? I'm looking around.

All right, not hearing any objection, we could -- we approve the recommendations. Thank you very much.

A REPORT FROM SUBCOMMITTEE 3 ON QUALITY MANAGEMENT AND VA PROCESS INTEGRATION WITH DTRA NUCLEAR TEST PERSONNEL REVIEW PROGRAM

Let's move on to -- to Subcommittee 3, Dr. Reimann.

DR. REIMANN: This being Washington, much of our report has already been leaked -- and we did a fair bit of that ourselves -- and so I hope to capitalize on that by being more targeted and so on.

So let me start from about 30,000 feet here and reiterate our role. It's to review all aspects of quality management in both dose reconstruction and claims adjudication for both agencies, so obviously we are critically tied to all of those bodies, and this has worked extremely well. So we are greatly dependent on and appreciative of the reports already made and the comments by the agencies.

Another -- and -- and also by the way we -- we make parallel recommendations that relate to the strengthening of the quality management system, and we heard reports from both agencies this morning that -- that highlighted particular aspects of the quality management system.

And by virtue of the -- of the role and the inherently integrating nature of what we do, and I think the much better integration across the agencies, another role we play is to try to focus on that quality management being as much of a bridge between the agencies, where and how appropriate, that enhances both of their roles. So that's -- that's, I think, a very, very important part that you'll hear played out

today.
Now usually we just start our report by talking about observations on NTPR and observations on VA, but I -- this time we took a slightly different tack. We started with a general observation and I'll -- I'll confess to having been slightly lukewarm about the history project early this year until I got my head into it and had a dialogue with members of our subcommittee -- Dr. Lathrop and Dr. McCurdy, who could not be here, and Dr. Swenson, a former member of our committee. But looking at that, I think that we reached a stage of what I would call taking stock of where we are, and to try to frame where we're going in a much more deliberative and much more focused way.
We want to see the agencies have some kind of a self-sustaining high quality where -- which can demonstrate routine quality of -- of output.
Part of that taking stock, we've talked often about the histor-- future of VBDR and we know that, from our estimates this morning, we're likely to see a program of this type go on for at least 20 years. As a Hoover baby, I don't see myself sticking that out the whole time,

but VBDR is not likely to be forever and DoD and VA staff, the great staff we see here, are likely to be replaced. And we would hope that whatever it is that we build that's sustaining would be like a flywheel to carry them forward. So in terms of looking at the future we really have to shape that in as best a way we can, so we've tried to look at this routinely demonstrating quality output as meaning the day-to-day output as assessed by SC-1 and SC-2 audits, and by agency data, reveal few consequential errors, timely response to veterans, and clear indication of ongoing improvement. That's a very, very important thing because that doesn't just mean correcting things that you find wrong today, but looking in patterns of data and so forth to improve the -- the performance. So even if, as we've seen, the response time has improved dramatically, there's every reason to believe that it will improve some more.

So in effect what we're looking at here is that the agencies are very good and getting better, and so our role is to try to create those systems.

I'll minimize the conte-- the content regarding our observations on the two agencies, just touch on a couple of points that -- the progress in documentation Harold mentioned is -- has moved along very well. Tremendous progress in reducing backlogs, for all the right reasons and with all of the texture in the way things are coming together that I think should be encouraging that this will continue. The use of the DSS, I think -- even the discussion this morning, even with a little humor attached to it, I think brought out some very, very important facets to it. For example, if you see it as decision support, you also see that as a very important device in training. Whereas if you see it as a decision summary, it's almost an afterthought. And so I think that by bringing out its fuller meaning we gain something.

The double-blind studies, initially we proposed that -- years ago -- when there were many RDAs being done, and now the double-blind, as we conceived it, wouldn't make as much sense. But instead it has moved very nicely from the way it was originally intended to backing up into

the SOPs and becoming a kind of tear-down lessons learned, which is a very, very important part of -- of quality. So the lessons learned from those are one of the major sources of both corrective action and future improvement.

So we see the -- the continuation of the quality system maturity. We feel that probably there needs to be some continuity that pushes us past the point of being let's say more heavily reactive to problems to more heavily preventive. But this is a natural stage in the progression. You've got to go through this stage of being reactive. Our role is to make sure that it moves past that being say merely reactive to being more preventive.

And the same thing goes for -- for the observations on the -- on the VA side. We feel that the STAR system is a very powerful system. We are a little concerned about how far down in the day-to-day operations of a VARO this actually can penetrate. And when you look at the tremendous support coming from the audits that SC-2 does, it's a snapshot on how well that's working and how much more needs to be

done to -- to create some of the day-to-day operating processes in the agency, with perhaps some decision support sheet or decision summary sheets that -- that tackle the major bottlenecks and correct problems, and also seek opportunities for improvement. So we see that we -- we have a role there in helping VA bridge between its STAR system, which is high level and affects all of the VARO -- all of the Regional Offices, and all of the veterans, the 3,000,000 veterans -- and I guess more than that -- served. So we see that as a -- as a major challenge.

So now if we look at where we're going, we had proposed -- largely based on that sort of reflections on history and trying to capitalize and focus on where we are. We're proposing something we're calling a Quality -- Quarterly Quality Report that really -- it needs to be designed. It needs to be designed in cooperation not only with -- within VBDR, but with the agencies, because if it's going to serve them, they have to -- they have to buy onto it. We would hope that this would capture all of the quality-related actions, all of the

quality-related data, the tear-down of any corrective action to indicate what's happened as a result of audits -- not only how did you correct what you saw in that audit, but how did you change processes and systems so that those kinds of problems don't recur; and the establishment of metrics that would allow the agencies to -- and their managers, by the way, to see a snapshot and then, through trends, a moving picture of how the whole thing is going. So if you have a scoreboard and you know what the game is, the transition from one group to another is a whole lot clearer and simpler, and you can see if you're -- if you're actually gaining on quality or if you're stumbling back. So we see that we have to work with -- among ourselves within VBDR in close cooperation and with the agencies to -- to try to get a quarterly report that's focused on the most important factors -- most important factors will be those that occur in audits -- that are generalized to the problems that they reflect and where not only the report includes not only the corrective action on those things, but the fixes in the processes and systems that will

then prevent those things from happening in the future. And hopefully then, by looking at trends over a period of years or something -- certainly a year -- one would get a good picture of what's happening. This would be dynamic in the sense that it's -- it all -- it demonstrates improvement -- sometimes it demonstrates so much improvement that you can safely say certain types of problems have vanished completely and now you've got some new things, maybe based on factors that come in in unique cases, that you need to look at. So it's -- it's dynamic. I don't think it's -- it's certainly not mindless. It -- it can be fairly simple in the sense that you can put it on one sheet of paper, but it's not something that you could just look at and say that -- you know, that it's -- it's so self-sustaining that you wouldn't have to worry about it or -- or to have some kind of an auditing process to -- to make sure that it's -- it really is operating as -- as advertised.

So that's the way we see it going, and so you see it's really tied in with what we see as the future as VBDR which is, in some sense, an

imponderable because there are so many factors related to the life of a VBDR that we're not in control of. But something that we have a lot to say about would be what is it that we would want to turn over so that whatever happens we would say, you know, this is -- this is the way it -- this is the way it should be.

So okay, on that note, I'll shut up.

VICE ADMIRAL ZIMBLE: All right. Dr. Reimann, do you have any -- did you plan to make any formal recommendations?

DR. REIMANN: Yes, the -- no, not -- no formal recommendations. We see the -- we see these comments that we've made as entirely within recommendations we've made in the past.

VICE ADMIRAL ZIMBLE: Right.

DR. REIMANN: So I think we -- I think we could argue that what we're doing is -- is clarifying -- based on where we are and where we think we need to go, we're clarifying recommendations previously made.

VICE ADMIRAL ZIMBLE: Did we make a recommendation to the Veterans Administration regarding the use of the QQR? I don't think we formally made such a recommendation.

DR. REIMANN: No, but I think that we've had -- we have language sufficiently general that this could be regarded as almost as -- almost as a special case.

VICE ADMIRAL ZIMBLE: Okay.

DR. REIMANN: And if not, I certainly would stand corrected and not be in any way opposed to it, but somehow I -- I somehow felt that this was close enough to the general language that we've submitted in the past regarding metrics and -- and a -- and a kind of scoreboard that this is just giving that scoreboard a name. So you know, I'll stand corrected --

VICE ADMIRAL ZIMBLE: Well, I just wonder if perhaps asking the two agencies to jointly work on QQRs that will best integrate so that we can -- we can watch the progress of quality management from both agencies contributing to the whole process. I leave it to someone else to do the word-smithing, but it seems to me that it might be wise for us to make a formal recommendation regarding the establishment of bona fide QQRs from both agencies that we can audit, something along those lines.

DR. REIMANN: Yeah, I mean I -- I have no -- I have no problem with that. I thought we were trying to avoid new recommendations that would take -- that might be seen by let's say the agency higher-ups and so forth as oops, you know, that -- now this is something totally different. I think it's more of a manifestation of what we've -- what we've said before, and the nature -- even -- even the cooperation that I'm talking about here is not like this is a new discovery. It's already taking place.

VICE ADMIRAL ZIMBLE: Okay.

DR. REIMANN: So the question is can you give some-- can you give something enough of a texture and an approach where VBDR is basically the broker where most of the work is individually with the agencies but there are cross-links, where appropriate. In other words, we're not trying to invent problems -- agency/agency problems if that is -- if that turns out to be an impediment and not a value added.

VICE ADMIRAL ZIMBLE: Okay.

DR. REIMANN: And we feel that with quarterly

meetings already conducted where -- where the agencies themselves are -- are talking, this would be the natural vehicle for them to themselves identify areas in their relationship and in the process of doing work where some kind of measure and some kind of correction -- corrective action is needed, and all -- we're serving basically as a -- as a broker for that and trying to put it in -- in terms that are as much -- as much consistent as we can make them. But I mean that's -- I mean it's still taking -- it's still taking shape because of the nature -- I mean even this meeting, there was a lot of good, frank discussion in the meetings yesterday and so on, and there's more today, so we don't want to push the thing beyond where it already is, and so I felt that -- I personally feel -- I know John, you might have a different view, but -- that the language we've already used is pretty permissive.

DR. LATHROP: John is -- John is about to speak.

VICE ADMIRAL ZIMBLE: Dr. Fleming.

DR. FLEMING: Thank you. This is somewhat related. This is actually the first time that

I am hearing the recommendation of a Decision Summary or a Decision Summary Support Sheet be created for the V-- for the VA processing, unless I've been asleep at the SC-2 committee meetings. I think that's a very interesting idea and I note here that you're -- SC-3 is willing to work with the VA to specify what both the DSSSs and the QQRs should cover. But -- but I'd like to learn just a little bit more from you about what that will look like for the VA.

DR. REIMANN: John, can I defer to you on that, because I thought that we've had -- I know that you did a gap analysis and so forth on all the recommendations, and I thought that in our hopper in the past we've had -- have had recommendations -- in our quality recommendations to VA, we have used that DSS language. Is that --

DR. FLEMING: And before John answers that, which I appreciate your answer, John, so you'll get to talk in a minute. But I also just wanted to make a -- just a real simple procedural point that in SC-2's report we mention SC-3's recommendation. So following

Admiral Zimble, if there's no recommendation in SC-3, we're going to have to rescind the committee's acceptance of SC-2, so -- just a minor procedural point.

John, the DSS?

VICE ADMIRAL ZIMBLE: My esteemed colleague, Dr. Lathrop.

DR. LATHROP: Thank you for the privilege of speaking before the Board, Mr. Chair. To answer two questions, the DSS for the VA -- I think a lot of us around this table know the tactic I'm about to take, which is we actually don't know the best form of the DSS for the VA yet, and what we would propose is working with SC-2 and the VA to develop a Decision Support Summary -- whatever -- Sheet. It would not -- it might actually look not a lot like the one for NTPR 'cause the decisions and the processes are quite different. All we will assure you, with some perhaps unfounded confidence, is that Curt and I will be able to develop a DSS, not at all in isolation but very much in close cooperation with SC-2 and our esteemed friends from within the VA. So that's answer number one.

Answer number two, or point number two, is I would propose -- although actually Curt and I, in an ideal world, would have conferred about this before being in front of the Board, but you know, what else is new -- that -- I would suggest to Curt over there that SC-3 do make a proposal, and the proposal would simply be a rewording of all but the first two triangular bullets at the end of our report, and I can almost read those, and it wouldn't take much word—word-smithing.

And it is in fact: SC-3 now proposes parallel QQRs from VA and NTPR to clarify and accelerate full deployment, in addition to a DSS from both VA and NTPR, for each case they look at; call for closer sorts of integration between SC-3 and SC-2 and SC-2, including a joint design, with the agencies, of the QQRs; particularly, QQRs would focus on quality indicator metrics; the QQRs would report not only quality data and trends, but also would present how past feedback are built into the process; notes a parallel system of QQRs for the two agencies provide a consistent technical basis for better communication, coordination and integration of

the services to atomic veterans; and an important part of strengthening this would be the cross-agency cooperation in developing reinforcing quality metrics.

It pains me to admit this, but I think all those words came from Curt. But I -- I'm serious that we can wordsmith those -- all but the first two bullets into a recommendation, and I think that's close enough for us to consider presenting before the Board.

What do you think, Curt?

VICE ADMIRAL ZIMBLE: John -- hold it. John, are you going to make that a motion?

DR. LATHROP: Yes, I -- I move that all but the la-- all but the first two bullets of the report --

VICE ADMIRAL ZIMBLE: Become a formal recommendation.

DR. LATHROP: -- become a formal recommendation.

VICE ADMIRAL ZIMBLE: Okay, and do I hear a second to that?

MR. BECK: Second.

VICE ADMIRAL ZIMBLE: Thank you. All in favor?

(Affirmative responses)

Okay, any opposed?

(No responses)

So carried.

DR. LATHROP: Good, and Curt and I will get together and wordsmith it.

VICE ADMIRAL ZIMBLE: Okay, that's good.

DR. LATHROP: I mean he -- he started out wording all the words --

VICE ADMIRAL ZIMBLE: Yeah, right. Okay. All right. Well, I -- I think that -- I think that's an excellent motion and I'm glad that that's been made into a recommendation, and I think it should be carried forward.

Okay, now, it's -- any other comments or questions regar-- yes, Dr. Swenson.

UNIDENTIFIED: (Off microphone) (Unintelligible)

VICE ADMIRAL ZIMBLE: Are you going to protest? If you're going to protest I won't let -- okay, then you can speak.

MR. FLOHR: No, I just wanted to -- to just make a comment about our quality assurance programs and workload measurements and processes, and if you all know this, then excuse me. But in addition to STAR -- the

quality assurance we do through STAR -- that's really a snapshot of workload at a given time in a given office, and we're increasing the number of cases that we review in STAR on a monthly basis from each Regional Office. We've also implemented a consistency review, at the urging of our stakeholders, many of them.

But in addition to that, every three years we go to each Regional Office. Every Regional Office is visited at least every three years. We do a top to bottom review of the work they're doing, look at what they're required to do, are they doing it, what do they need to do if they're not doing it. And we look at the processes to see if we can provide them with guidance and help on improving their processes, so each three years the radiation activity in Jackson VARO will be reviewed top to bottom to look to see how we can improve what we're doing there.

In addition to that, there are four area offices. Every area office has a certain number of Regional Office underneath that office, and the area offices, they also go on at least a yearly basis to each of their

offices and do pretty much the same thing -- not maybe quite as in-depth as what C&P does, but very detailed -- to look at their process and how they can improve it.

So it's not just STAR. STAR is a big quality exercise, but overall we're looking at how we can improve things constantly through various means.

VICE ADMIRAL ZIMBLE: Thank you for that. I -- the -- this recommendation, by the way, is really something that would be laying on just the Jackson RO, and we hope -- it's certainly not our intent that we're offering something that would be an impediment to -- to progress. And if so, if there is a real problem in implementing that, we would appreciate the feedback. Otherwise, we think it would be helpful that -- for that process to go on.

MR. FLOHR: We'll certainly be glad to look at it.

VICE ADMIRAL ZIMBLE: Okay. Dr. La-- Dr. Swenson has a comment, Dr. Baker (sic), but it's -- this related? Yeah.

DR. LATHROP: Yeah, in direct response, thank you, Brad, for that. And very much appreciate

knowing there -- those other steps besides STAR. One of the things we wrestled with in SC-3 is appropriate QM for the VA, given that only about half-percent of your cases involve atomic veterans. We're very aware of the -- of any problems that would be involved. In fact, frankly, it just wouldn't make a lot of sense for us to suggest improvements in the overall VA QA/QM process for a half-percent. So in fact we have some language in the report, just above the words "Future of VBDR": Because atomic veterans' claims are uniquely complex compared to typical claims -- that might be arguable, but I think it's generally true -- because they're all handled at Jackson VARO, we do feel it would be appropriate and helpful to suggest the DSS and QQR concepts, only for atomic vets, specifically to avoid the problems of trying to mix something in with the actually quite -- quite awesome process the VA has with your 57 VAROs and your case load, which is 200 times greater than atomic veterans. So this would be tailored to just atomic veterans and Jackson VARO, and specifically for those good reasons I just said.

MR. FLOHR: Thank you for your comments. They are complex cases, but I would also pose to you have you tried rating a TBI case lately?

DR. LATHROP: Thank goodness, no.

VICE ADMIRAL ZIMBLE: Dr. Swenson.

DR. SWENSON: Well, I hate to say this, but the letter that we complained about that is very confusing to the veteran -- and Brad, give me input on this -- I think by law it has to give all the decisions and ev-- all the input that the rating officer -- information he had to make the decision. So it's almost a decision summary letter from -- you know, where -- I'm complaining 'cause there's so much information for the veteran, but it almost covers all -- everything that they -- is that...

MR. FLOHR: Yes, the -- the actual -- the rating decision has an evidence portion where everything that's considered in the decision is listed and that -- that rating decision actually goes as part of the notification to the claimant so they can see exactly what we considered and all our reasons for the decision we made are in the decision as well.

DR. SWENSON: My second question is, when the

rating is done by the rating office does anyone review it before it goes out?

MR. FLOHR: As a general rule, the majority of our rating specialists are single-signature. They've demonstrated quality levels that are sufficient to -- to allow them to do work without review of someone else. Newer rating specialists have a two-signature requirement; someone else does review them. But -- but local offices do do a limited amount of review of each rating specialist per month also, yes.

VICE ADMIRAL ZIMBLE: Yeah, I'd like to make one comment. I happened to look at that -- one of those letters yesterday. It is one heck of a letter, let me tell you. It is many pages long. It approaches a novel in size. It is difficult to understand. It is a soporific, at best. It is required, legislatively, but I say that it would be -- it would really hinder good communication. It's a good piece of paper for someone to give to their lawyer to review and assist in an appeal, if necessary. But it really is far more information in far more depth than what the claimant really needs. And I would suggest to SC-4 to look at that letter

and see whether or not we might suggest a cover letter that -- this might be an enclosure to a cover letter, a cover letter with very simply states that the decision is such-and-such and -- and you have a very detailed explanation, if you care to read it. But understand that it was given due deliberation and consideration, and this is the finding. I think the claimant really wants to know what you decided. And when you go through all the evidence base -- you know, it's just like a trial. We want to know what the jury says, okay? I don't need the whole transcript, I -- just tell me what the -- what -- was it innocent or guilty? So they want to know is it going to be denied or is it going to be awarded.

And I can't believe that we can't work with the law and create something that is good communication to the veteran. So that's -- I think a -- my challenge, the Chair's challenge to SC-4.

Dr. Lathrop, you have another comment?

DR. LATHROP: Yes, thank you for the challenge. It's well put and well accepted. We've been whispering to each other here about gee, we're

going to be -- be doing this.
Very good points from both of you. I just want to say it's not a ques-- from all three of you. It's not a question of the content of the letter. It's a question of two things, both of which have been touched one. One is clarity of the communication to the veteran, which would follow on your very good idea of a cover letter. And the other, from the DSS point of view, a standardization into particular data fields, which Dr. Blake can quite relate to 'cause he -- his DSSs look like that, standardization of particular data fields so an outside person not given to wading through many pages of the prose can look and say this is what was done.
And by the way, none of this would be to the exclusion of the letter. My guess -- the VA has sort of a shock and awe legal department, and they probably would have great hesitation on doing anything to -- to delete or shorten the letter. That's fine, you'll just have the cover sheet which says, as you said, the verdict and maybe briefly why. And maybe, either on that first sheet or on a second

sheet, a DSS thing very related to what Dr. Blake's has. And then the rest of it is an appendix with all the good stuff. That's just thinking off the top of our heads, but that's how.

VICE ADMIRAL ZIMBLE: Dr. Reimann.

DR. REIMANN: Yeah, I wanted to add my thanks to John's for -- for Brad's comments.

And just here we have I think a great opportunity to get the next round of work done on what we're talking about. One is that two other types of review were mentioned here that -- I think that, from -- from listening yesterday, I got that -- that feeling that perhaps there were some things happening in the QA system that we probably had not properly characterized.

But one thing that I believe is quite likely in the work of the VAROs, and probably this one in particular, that you probably have something that already has DSS characteristics. And so it wouldn't be good if -- if it sounds like VBDR is trying to impose a distinction without a difference. That would be, I think -- you know, that would not be a good way to get us

going here. So it -- the idea of what it is is really not what you call it, and so if in the communications -- you know, we're not trying to induce a name or an acronym, so that's very important.

But the -- to try to build in the direction we're all going here and how this ties into the QQR, we would say okay, a couple of things.

One is, are there data that are associated with those actions that you talked about, those two other kinds of review, and are there corrective action reports that could be factored in and would be a big chunk of a QQR.

And then where you would really have an opportunity here is in what way would your -- those two levels of review capitalize on the findings of SC-2 so that you would already have a much advanced snapshot on what's going on that would, in effect, help you to know what to look for and what the manifestations of that might be. I think that that would enhance the work.

And similarly, since the ongoing work of VA would, by its nature, be much more extensive, that would also provide information to SC-2

about the nature of the work. And so it would put them and SC-3 itself in a much better position to comment in ways that help reinforce.

So I see a tremendous opportunity here, so by learning this, it's not only good to hear that it's happening, but I think there's a tremendous opportunity here to turn this into something better for everyone involved. So again, thanks very much for that background.

VICE ADMIRAL ZIMBLE: Mr. Ritter.

MR. RITTER: I'd just like to add to what the Admiral has said about simplicity and ease of understanding. There are three frightening moments in the life of an atomic veteran. The first one is when he's there, when it happens. And the second one is when he files a claim, he's got a half a pound of paperwork to look through to give the VA what they're wanting to -- or what they need, rather, to get the process moving.

And the third one is when he gets the letter saying he's either accepted or rejected, and he's got another mountain of paperwork that scares the dickens out of him 'cause he can't

understand what he's reading.

VICE ADMIRAL ZIMBLE: Dr. Blake.

DR. BLAKE: Just so I understand this recommendation, previously -- and I'll state again for the record that I've promised to get back with SC-3 within three weeks on DTRA's -- NTPR program's -- recommendations for the Quarterly Quality Reports. We're already part-way there since we're already giving submissions on digital -- Decision Summary Sheets, or the new name for them. But the -- in fact, we submitted ours yesterday to VBDR SC-3 on that, but is the recommen-- is the recommendation going to include both DTRA and VA or is it just for VA? I don't understand exactly how the recommendation's coming.

DR. LATHROP: Now the recommendation does include both agencies, with a full acknowledgment that you're already four-fifths of the way there. You, Dr. Blake, are four-fifths of the way there.

VICE ADMIRAL ZIMBLE: Yeah, my suggestion would be -- I agree. My suggestion would be that you share what you've accomplished with VA, so -- with Jackson VARO, specifically. You can use

your little virtual network to do that. But to make sure that what they -- what they come up with is something that can work in parallel with yours so that ultimately we can take a view of the entire process as it's handed back and forth between the two agencies. Okay? So I sure don't want to make you start from scratch.

DR. BLAKE: No.

VICE ADMIRAL ZIMBLE: But what I would like to do is to make sure that what VA does is -- is going to -- is going to work, it's going to be synchronized with what you're doing.

DR. LATHROP: And just to tweak on that, there is no intention here to have any additional work for you, Dr. Blake. You're pretty much -- what you've agreed to already is -- is the same as agreeing to the recommendation we've just made. And a little tweak to what the Admiral said, the coordination between the two is something that SC-3 will be doing, as opposed to asking you to -- to match up with the VA. Curt and I, and Dave McCurdy, will be talking about how -- how to coordinate it, but the coordination is a role for SC-3.

VICE ADMIRAL ZIMBLE: Okay, very good. Thank you.

Curt, you have something more?

DR. REIMANN: Oh, I'm sorry -- no.

VICE ADMIRAL ZIMBLE: Okay. Nothing more?

Okay, do -- and I think we've got approval for this recommendation.

VETERANS COMMUNICATION EFFORTS
A REPORT FROM SUBCOMMITTEE 4 ON COMMUNICATION AND OUTREACH

We're ready to move on now to Mr. Groves, and -- Chairman of SC-4, and also presenting on a topic that was to be delivered this morning.

MR. GROVES: Yes, thank you very much, Admiral. And thank those of you in the audience who are veterans and have spent a long day with us, and hopefully you'll join us even after dinner tonight for some additional deliberations, mainly on the future of the Board.

I would like to just read some of what the charter says our subcommittee does, and then I think you will see that a number of recommendations have been made -- I believe by all three of the other subcommittees -- that essentially ask our subcommittee to work with them on helping to improve communications to

the veteran community.
So we are to develop a set of recommendations on more efficient and effective communications between the Department of Veterans Affairs, the Defense Threat Reduction Agency, and the veterans. And there are a number of communication modes you've heard about.
But we also review the current mechanisms for communicating with veterans about the mission, procedures, requirements, decisions and administration of the dose reconstruction program, and I will talk a little bit about what we are doing right now in meeting that charge to our committee.
We coordinate communications and outreach functions both internal, to the Veterans Advisory Board -- and that takes the form of helping the Board when we determine when and where we're going to meet and the agenda for those meetings -- and external, to the veterans for public meetings. It is through our subcommittee that, with the help -- tremendous help through the Defense Threat Reduction Agency's Office of Public Affairs that we put ads in local newspapers when we're going to

meet. And we were pleasantly surprised at this meeting, as a result of a meeting we had in February with the VA, that Dr. Cassano took it upon herself to take advantage of the Ionizing Radiation Review newsletter mailing list and sent a number -- thousands of postcards out informing all of those veterans who are on that registry that this meeting was going to take place. And some of you received those and that may be the basis for you being at the meeting. And if it is, we think that that was another successful way of announcing the meeting of this organization because we certainly appreciate you all being here and knowing what is -- what we are all doing on behalf of a grateful nation.

Our organization -- subcommittee had a meeting in February, and I'm just going to paraphrase what is in my report and then I will read specifically some of the recommendations we have.

We had a meeting in February -- or, pardon me, in April at -- at the Veterans Administration, and I want to thank Brad -- at the time, Tom Pamperin offered his conference room and we

took advantage of that. Having our meetings here in Washington really helps us because not only do members of our subcommittee come together, but when we do meet we invite and have active participation from both the DTRA public affairs and outreach folks, as well as the outreach folks from the VA. And it certainly helps them, for a one-day meeting, not to have to travel, and so a couple of -- it's better for a couple of us to travel here than for them to travel somewhere else, so it's worked very well.

At that meeting there were a couple of very important actions that took place. One of them you've heard a number of times, the discussion about the letter that is going out to a select group of the atomic veterans' community, and it is that subset of the community who received, by virtue of what records we do have, the highest doses. And essentially it is a group of people, which is around 650 to 675, that have doses that were estimated at greater than five rem. And you heard from Dr. Blake that they have that set of records, they culled through that set of records, provided to the VA

the best information they had on where we might reach that subset of veterans. Brad Flohr and his organization generated the letter. We saw the draft letter at our April meeting. We provided some input, with Dr. Cassano's help -- to take advantage of the fact that this letter was going out and made a recommendation, and it was incorporated in the letter -- to discuss the activities of the Ionizing Radiation Review -- or Registry, because this group of people not only might be eligible to file a claim, but whether they had a claim or not, they -- as being atomic veterans -- were eligible to participate in the Ionizing Radiation Registry. So we worked -- the three organizations worked together to include that in the letter.

As you heard from Mr. Flohr, the letter is at wherever it is that VA letters are mailed out. I have a copy of that letter in my hand, and it essentially does all the things that we had hoped it would do. And again, it is going out this week or -- or early next week to almost 700 veterans.

The other big discussion item we had at our meeting in April had to do with the

distribution of the Ionizing Radiation Registry newsletter. And it has been longer than any of us would have liked for it to have been between editions of the newsletter. I'm happy to say that Dr. Cassano, who has had to leave, in addition to all the other things she does in the Veterans Health side of the house, as you heard this morning, also has the oversight responsibilities for the Ionizing Radiation Registry. And she has committed and we are working with her for there to be an edition of that newsletter essentially as soon as this meeting is over and we are able to give her an updated article for that newsletter that would discuss the outcome of tod-- of today's meeting so that when that newsletter goes out within the next few weeks or months it will be completely up to date and provide information of what we all learned here at this meeting. So we're looking forward to there being an edition of the newsletter that would go out, again, to everybody that got one of those postcards, is -- is the mailing list for the Registry.

Now the other thing we learned as a result of

Dr. Cassano's mailing of that postcard is that a number of those addresses in the Registry are no longer the right address, which would be no surprise to anybody that has a 23,000-person mailing list that has been built over the last six or seven or ten years, that a number of those addresses are no longer current. So this will also offer an opportunity to the VA to update that mailing list in some way that they can, and some of those people may -- it would be no surprise, may no longer be available to receive those.

And I'll get your question in just a minute. Okay?

So anyway, we are particularly happy -- from the communication and outreach subcommittee -- that we have active participation from the Veterans Health side of the house. We've always had that to a certain extent, not anywhere near as much as we have with having Dr. Cassano on board. We've always had tremendous support from Tom Pamperin and Brad Flohr and the Benefits side of the house, but we recognize -- as I'm sure all of you do -- that the VA is more than just benefits.

There's the health administration group that runs the hospitals, the clinics; has an active role, as you've seen and heard today, in the assisting the -- in the adjudication and the awarding of claims. So it is refreshing for us to have access to both sides of the VA house, and we look forward to that as -- as we go forward.

You've heard about the brochure, and we had a number of them here and I hope that you've all picked them up. There is, just for your information, a little piece of paper in there that corrects the phone number for the Ionizing Radiation Registry because, as you heard this morning, Dr. Cassano's office has recently moved and they got some new phone numbers.

We've also heard from Dr. Swenson that this is a useful tool in that it is a brief summary of the program and all the elements in the program, and we are -- we're looking forward to whatever the most cost-effective method is to make the brochure whole again with the right telephone numbers. We also think that this would be a useful communication tool to the veterans by having these in all the clinics and

all the hospitals, so that veterans who -- again, as you've heard, we still think there's a number of atomic veterans who don't know that there's even a program that affects them. And it's not like you can go knock on doors and ask who's an atomic veteran.

I'm going to talk about what some of our future activities are, and one of them is going to be what -- what we would call a renewed atomic veteran outreach campaign and which we discussed extensively at our meeting yesterday. For those of you in the audience, today is the formal meeting of the Veterans Advisory Board. Well, each of the subcommittees met yesterday. And so part of that was it's nice when we all come to town to get together and work on our individual subcommittee actions, and then we can -- I can talk to Subcommittee 1, Subcommittee 2 can talk to Subcommittee 3, and that really helps us set the stage for today's meeting.

But in yesterday's meeting we had some extensive discussions among ourselves about how to foster this outreach campaign, and I think we've all agreed that not only is it the

veterans who we're looking to reach to, but the survivors who are eligible for the benefits. And we also think, and it would be no surprise to you, that with the age of that community -- I think you told us, Paul, that it's 82 -- 81 or 82 years old, the average age -- that it -- it's -- our most effective means of reaching you may very well to be -- may be able through reaching your children and your grandchildren and your nieces and your nephews who are, you know, surfing the web and reading YouTube and doing all sorts of things, that they remember, you know, their father, their grandfather, their uncle talking about seeing the big blast one day. So we're not focusing our communication efforts on just the atomic veterans themselves, but we're looking at their -- their families and their offspring as a way to get the word back up to the atomic veteran who -- who may be difficult to reach in some of these modern communication means. So it's a widespread effort and we're looking forward to support from both the VA and DTRA as we go forward on that.

We are committed on -- in support of the other

committees to look at these different letters and other communication means to work very hard to make them as useful as they can be. And as you have heard, there are legal requirements that certain materials be in those documents. But as you've also heard, we're certainly prepared to write a very readable, understandable summary that can be the first page of some of those reports and some of that information that's transmitted back and forth between the -- the veterans from both DTRA and -- and from the Veterans Administration.

We are looking forward to the response to the letter that is going out to the greater-than-five-rem group of atomic veterans. Based on the response to that letter, we may be able to gauge how well that method works as reaching the veterans. And how many of those veterans, on receiving that letter and being des-- and having the program described, respond in terms of either filing a claim or registering to get on the Registry and other things. And I think that that will lead us to make a recommendation, or at least jointly a decision with the VA, as to whether or not another

mailing to maybe a larger group that received a lower dose. So again, I think -- we're starting with the highest dose. We may have information that comes out of the response to that letter that guides us in the future to additional outreaches via that mode.

I do think that we have two recommendations, and I think that they're probably soft recommendations in the sense that they -- they probably are kind of emphasizing things we've done in the past. One would be that we do see the -- do see the continued value in having a part of the Board that does work both with VA and DTRA with the responsibility for -- for outreach and communication to the veterans, and we -- so I guess we would emphasize we see that as something that we think would be very worthwhile continuing to do. I also think that we see the continued need for outreach and communication, the value of face-to-face subcommittee meetings. As I mentioned, we had what I think was an excellent meeting in April when we were able to not only have our communication and outreach subcommittee, but members of the VA and from DTRA join us to work

outreach issues. The other thing that happened at that meeting is Dr. Swenson was there, Mr. Ritter was there. We had an opportunity at that time to -- and the Chair was there, Admiral Zimble -- so we also had the opportunity to talk about communication issues that were important to the other subcommittees of the -- of the Veterans Advisory Board. So I think we would like to continue to do that; that we would like to do that in a face-to-face meeting, which I think is more valuable; and the frequency of those meetings is somewhat dependent on what we determine the frequency of the overall Board meetings are going to be. But we certainly think that, with what we are wanting to do in terms of some additional outreach activities, that the meeting of the subcommittee at least twice a year would -- would be very useful.

So I guess I would ask if you wouldn't mind putting the last slide of my presentation up, I would -- I think it has a -- my -- my last slide there says some things that I would really like to -- to say for everybody and that is my -- my final thought. And I -- and I will

read this because I think it is important and it -- and it's something that I think we feel in our heart.

There appears to be a commitment from both the VA and DTRA, with support from the Veterans Advisory Board, to work together to foster even better communication and outreach efforts and programs to inform the atomic veterans community of issues concerning dose reconstruction, compensation and medical care. And I do appreciate the commitment from the two agencies, working with the Board on these critical issues.

Thank you, Mr. Chair.

VICE ADMIRAL ZIMBLE: Thank you very much, Ken. That was a -- an excellent summary of your activities and the challenges ahead. There's no question in my mind that probably the biggest challenge this Board has, by far, is the challenge of outreach. One needs but just look at the disparity between the original 488,000 atomic veterans and the current estimate of 220,000 atomic veterans, the disparity between that number and the number of claims that have been filed, which certainly is

not representative of what we know to be the prevalence of those diseases that are listed as presumptive in a community -- in a cohort of that age group. So something's wrong. Something is -- is definitely not getting -- getting spread. The word is not getting out. There's a benefit, and it's -- and it's -- it's certainly not being seized by a number of people that are deserving. So we do need to concentrate on that.

And I don't gue-- I don't see where you have a formal recommendation, except to ask for the cooperation of both agencies to -- to assist with the resources necessary to make communications possible. And if you would like to submit that as a formal recommendation, I think we could get a consensus from the Board to do so.

MR. GROVES: I actually think we have a -- a previous recommendation that talks about us working together on a communication plan and outreach, so I think that this --

VICE ADMIRAL ZIMBLE: The -- the word -- the real engine, the fuel for that engine that I haven't heard, is the word "resource," and it

just might be -- behoove us to ask that -- that there be some level of resources made available specifically for outreach to the atomic veterans. I -- I don't -- I'm not sure how the agencies will react. I don't see cringes coming from either side. But at any rate I think it's worthwhile to articulate that we can't do that without adequate resource.

MR. GROVES: I would -- I would be happy to put our discussion of things we'd like to do in the terms of a recommendation that includes a request for resources from the two agencies and --

VICE ADMIRAL ZIMBLE: Any objection from the -- from the membership?

DR. BOICE: I would add "the veteran and their families."

MR. GROVES: Yes.

VICE ADMIRAL ZIMBLE: All right.

MR. GROVES: And it is -- and our -- and our outreach campaign is a -- not just the veteran, but their families, the potential beneficiary -- spouses and children.

VICE ADMIRAL ZIMBLE: And without objection, let's move for a recommendation to that effect.

RESUME BOARD DISCUSSION OF THE FUTURE OF THE VBDR

We're scheduled for an evening session to deliberate the future. And as I've listened to the comments of this morning and this afternoon, the comments from the chairs, the comments from the other members of the Board, I -- I think we have well articulated what we see as the future; that basically the VBDR continue in accordance with the charter; that each of the subcommittees modify and refocus to -- to meet the -- the current fine-tuning necessary for the process of the -- of the two agencies in working together and in moving along the -- these claims, and in providing for solid communication. I haven't seen any recommendation for -- from any chair that his committee be dis-- his or her committee be disestablished. I -- I have heard a recommendation that each of those committees needs -- has -- still has a mission that needs to be continued and that, with some refocusing, we can proceed with -- with the current constitution of the Board. And I would ask my esteemed and distinguished colleague for his comment.

DR. LATHROP: Thank you, Mr. Chair. And I very much agree with what you've been saying from all that we've heard today, and I would like to humbly volunteer to simply do not very much but some rewording of that -- of the last half of what I submitted last night in terms of what was referred to then as a -- as a letter requesting an alteration in the -- in the legal framework, and now it's become clear we don't need that. But in fact if you look at the last half of what I wrote, it lines up pretty well -- it's -- with in fact the recommendations that we've come up with in the last hour from both -- for -- for both the SC-3 and SC-4 subcommittees and the related work of the other two committees. I'd be happy to volunteer to do that this weekend and send it around, just to give a little body and some -- some substance what -- for what you've just said.

VICE ADMIRAL ZIMBLE: Okay, I appreciate that and think that's a wonderful idea. I would ask that you also -- in preparing that that you look at the -- at the recent publication that we have created which talks to the history, accomplishments and future directions, and make

sure that -- that what's in that paragraph is in consonance with what we have already stated in our -- in our history. Okay?

DR. LATHROP: I will do so.

VICE ADMIRAL ZIMBLE: Okay, very good. Dr. Swenson.

DR. SWENSON: This goes back to our Subcommittee 2, so do you want to -- do -- are you wrapped up on the future?

VICE ADMIRAL ZIMBLE: Sure, go ahead.

DR. SWENSON: Okay. I agreed to a last recommendation, and I just want to clarify on that last recommendation that the VA incorporate information to include -- in the veteran correspondence concerning RECA for presumptive diseases. And you also added something about the partial compensation. That is already in their guidance to do the partial compensation, and Brad Flohr has already agreed that that is going to be part of training -- retraining at Jackson VARO. So I don't think we need a recommendation on the partial compensation issue 'cause it should be handled by Jackson VARO and not, you know, thrown on the veteran in -- in any kind of letter. So I

just wanted to clarify that.

VICE ADMIRAL ZIMBLE: Okay, that's fine. Okay, I -- we -- we're scheduled to -- to resume deliberations this evening. I'm not so sure I see any need to do so, unless somebody really wants to do so.

DR. LATHROP: Unless there's a legal reason --

VICE ADMIRAL ZIMBLE: Now -- now -- now wait a minute. Okay. Recognizing that -- recognizing that we have published in the *Federal Register* that we will accept additional public comment at 6:30 -- now it needs to be additional. I don't want to hear the same thing again, but if there is additional comment, there may be additional veterans that plan to attend for an ability to testify this evening, so I'm going to resume with a quorum at 6:30 and stay until we've decided whether or not there are additional -- additional public comments. I don't think that we have any other business, except a few things -- a few final closing remarks I want to make, but no other business that would require the full attendance of the entire Board.

Mr. Groves.

MR. GROVES: One of our esteemed audience members was signaling me during my communication issues --

VICE ADMIRAL ZIMBLE: Okay.

MR. GROVES: -- and I -- and I didn't --

VICE ADMIRAL ZIMBLE: You want to communicate, is that it?

MR. GROVES: I want to communicate with that man right there.

VICE ADMIRAL ZIMBLE: Okay.

MR. KING: I was just gesturing to make a comment that you had mentioned --

MR. GROVES: Let us get you the microphone -- it'll take just a second -- so we can get you on the record and you'll be famous like the rest of us.

MR. KING: Oh, good.

(Pause)

I guess this is working, huh?

MR. GROVES: It's working fine, just --

VICE ADMIRAL ZIMBLE: Okay, Mr. King.

MR. KING: I was listening to your comments about how we were notified, John Q. Veteran here, as by our -- the extent of our rem intake. And I got some information on myself,

like I -- I had something like only 2.5, and then my eyes received 6.5. Now what -- you know, how -- what is the total intake or is that way how it's figured? Or -- now on the amount of rems, I --

MR. GROVES: Well, there are -- there were estimates made of -- on groups of veterans based on what kind of activities they were based in -- based on doing as to what their doses might be. And of course each individual veteran, when they file a claim, if it's one of the diseases that requires a dose reconstruction there would -- a detailed one would be -- would be built. We just thought we would start, in this additional outreach effort, to start with a manageable group of people and that's why we chose the group that had been identified as likely having over 5 rem. Remember, for -- there's two programs under the Veterans Administration in which you can receive compensation, and one is for if you have one of those listed disease -- diseases, and -- and if you have those diseases, the dose is not an issue. It's only the fact that you were a participant in those activities. So

that list of the presumptive diseases, the 22 diseases, you -- the dose does not become an issue if you have one of those diseases.

MR. KING: Now it's become confusing again because like I was speaking to your girl right there, now I'm not an atomic vet but I've still been given amount of rems that I had, but I'm not an atomic vet.

MR. GROVES: And if you're not an atomic vet, you -- you --

MR. KING: She said.

MR. GROVES: -- yeah, you're still eligible for the -- if you were to develop cancer or a disease, to go through Dr. Cassano's organization for -- as an occupational worker in the military --

MR. KING: I did.

MR. GROVES: -- and I believe you told me you worked on nuclear weapons --

MR. KING: That's correct.

MR. GROVES: -- so you, like people who were nuclear submariners or X-ray technicians or dental technicians that received radiation exposure as a part of your occupation in the military, if you get a disease, you are still

eligible to go through the VA. You may or may not be awarded a compensation, but there is a program in which you could go through and have your case evaluated.

MR. KING: I don't know where it's at because this is the closest they've ever come to giving me some type of an outlet to -- to speak to a board or a committee or someone to even -- that even understands what certain radiations are, you know. I mean everybody else at -- at different -- like Tucson Veterans Administration, they don't even know what I'm talking about when I said I've got a dose of, you know, this or that, and so they just look over it, you know, it's just --

MR. GROVES: Well, I'll be glad to get with you when we get -- when we go on our next break and see if there's anything I can offer. I live in Albuquerque so, if nothing else, we're neighbors. Okay?

MR. KING: But I -- I just want to mention, you know, I -- I didn't spend about $1,500 for nothing coming over here to speak to somebody saying hey, I've kind of been shafted in the past, you know, and so that's the reason --

that's the reason I'm here.

VICE ADMIRAL ZIMBLE: I think, Mr. Groves, that when you have your discussion you might point out the level of radiation absorbed and its potential effect, because this is -- that's a relatively low dose. It's no more than a one-year towards a lifetime, basically, and it's well under the what I would call a threshold for radiogenic conditions.

But at any rate, think -- I think he needs some better explanation than he has regarding the dose he's received.

MR. KING: I thought it was --

MR. GROVES: Happy to do it for my neighbor.

MR. KING: -- five that it was -- recommend to come here and -- and so my eyes got 6.5, so -- and I am having real trouble with glaucoma right now, and so (unintelligible) shut up -- I'll shut up.

VICE ADMIRAL ZIMBLE: Okay.

DR. LATHROP: Yes. Mr. Chair, were you suggesting we adjourn now until 6:30? In which case I would suggest there's one topic, very limited, that we might want to discuss while we're sure we have a complete representation of

the Board.

VICE ADMIRAL ZIMBLE: Okay. I have at least one or two more.

DR. LATHROP: Oh, okay.

VICE ADMIRAL ZIMBLE: Okay, but go ahead.

DR. LATHROP: So we could -- we could decide to break for a bit and come back.

VICE ADMIRAL ZIMBLE: No, no, no, let's not do that.

DR. LATHROP: Okay.

VICE ADMIRAL ZIMBLE: Go ahead -- go ahead with yours.

DR. LATHROP: My one topic is I think things are very clear about what we want to do, what needs to be done and how it should be done and recommendations. The one thing we haven't arrived at is pace, how many Board meetings per year.

VICE ADMIRAL ZIMBLE: Correct. Correct.

DR. LATHROP: That just came up between Dr. Groves and myself in thinking that we'd want to have at least one SC-4 meeting between, but then we said oh, that's not enough if we only meet as a Board once a year, but three times a year it's great.

VICE ADMIRAL ZIMBLE: With an oversight, I -- well, I'm going to open this up to the Board. I mean this is your -- being discommoded. We need to make a decision regarding the next meeting. It does -- we don't have to make the absolute date decision today. We can go out via e-mail to do it. But there will -- there are funds for next fiscal year, and so I would say sometime in early October might be a good time for the next meeting, and then I would ask the Board whether -- I think an oversight board has to meet more than once a year. I think if you're going to do oversight, you've got to over-- sight -- you've got to oversee, and so whether we have two meetings or three meetings, I'm going to -- I'm going to ask for recommendations from the Board for that. We can do that right now.

Mr. Groves.

MR. GROVES: You had said that we were funded. At what level are we funded? Are we funded to have multiple meetings per year and multiple subcommittee meetings per year? Because that, I believe, would -- I think -- I'd hate for us to make a decision that we'd love to have, you

know, four meetings and find out that we're only funded for two, so...

VICE ADMIRAL ZIMBLE: I think Dr. Blake can probably give us a ball -- a stadiumetric figure -- that's a ball park.

DR. BLAKE: What -- discussing with VA, and we're going into a 50/50 percent funding for the Board, but DTRA still picks up travel funds separately from that. That's just for the Board's contract staff.

What we were looking at doing initially was one full Board meeting per year and two subcommittee meetings per year, but there are ways to be much more cost effective and other advisory boards do that, too. One -- one way, for instance, our comparable board over at the energy employees group, it's called Advisory Board on Radiation and Worker Health, they actually have teleconferences sometimes instead of flying everybody in. And you can still have a Board meeting even if you don't -- it's almost a virtual meeting, too. I certainly see the basis for flying people in at least once a year and everybody getting together, but when we look at our budgets from the Departments,

obviously if we're given guidance, we can expand. I mean -- but what we've budgeted for right now is one full-time get-together meeting per year and two subcommittee meetings where people fly in and get together, too. If we want to change that, it's good to hear that because we'll have to revise our budgets and -- and go up our chain of command. But if you want to do virtual meetings, that cost is fairly minimal and we can arrange that with telephone call-in numbers and so forth, too. So I guess what I would ask is at least some consideration on some flexibility of how we do this from a cost basis.

DR. LATHROP: I would like to bring to the attention of the Board what I've now become -- come to call the Groves Doctrine, and that is that we've found that, us being human beings, actually face-to-face meetings can be quite effective. And the face-to-face meeting we had at VA a couple of months ago was quite effective. And seeing some of the work we would like to do in terms of both communication, more on the QM side for VA, and other things, I would submit that -- and all

that we've laid out -- I mean I just -- I'm pleasantly delighted with the concreteness with which we've laid out a lot of the things that need to be done. Almost all of them would benefit by face-to-face meetings -- actually, come to think of it, more at the subcommittee level than the full Board level. So I would humbly submit -- I mean it's your money, okay? But -- or the two agencies' money, but I would submit that that would be best served by a budget that would involve perhaps two Board meetings a year and several subcommittee meetings, which include face-to-face -- all in Washington, just because of the mechanics of coordination between agencies.

VICE ADMIRAL ZIMBLE: And until we can get some better definitions from the two agencies regarding the funding that will be available, I suggest that we request that we have two Board meetings per year and that we have a face-to-face subcommittee meetings of some -- I can count. I'm glad you didn't have to take your shoes off; I'd be really worried about that. But at any rate...

MR. WRIGHT: I would like to add one thing from

the Federal Advisory Committee perspective, is that the -- the meetings are open meetings, and if you were to say do them in a video teleconferencing method, we would need justification for why we would have to close -- why that meeting would not be -- be open to the public.

DR. BLAKE: If I may follow on, what our fellow boards do is they hold teleconferences, but anyone can call in, including members of the public, so they consider that an open meeting, by other -- maybe that's not -- maybe that's not the definition within the Department of Defense, but other federal advisory boards working for other agencies allow members of the public to call in and that's how they consider it a public meeting.

MR. WRIGHT: I could get a readout from the committee management office on that.

VICE ADMIRAL ZIMBLE: Okay, we'll have the agencies investigate the various alternatives, but I think at least two face-to-face meetings of the entire Board are essential, at which time we can have at least two subcommittee meetings for each of the subcommittees.

DR. LATHROP: For each of the subcommittees -- oh, I see.

VICE ADMIRAL ZIMBLE: Because they're all here. Right?

DR. LATHROP: Oh, I see.

VICE ADMIRAL ZIMBLE: And I don't think there's any need for any movement around the country. I think we can find -- I think we can find the metropolitan Washington area is best because we have the agencies' homes there so we have more concentration available to us.

Dr. Swenson and then Dr. Ritter -- or Mr. Ritter. Okay, Mr. Ritter and then Dr. Swenson.

MR. RITTER: Admiral, I just wanted to mention, for the sake of scheduling, that we have scheduled a NAAV annual convention in New Orleans this year on the weekend of October 3rd -- that's a Saturday -- so it's going to be difficult for me to make a Board meeting if --

VICE ADMIRAL ZIMBLE: Okay.

MR. RITTER: -- that conflicts.

VICE ADMIRAL ZIMBLE: The exact date will be -- will be submitted electronically and every -- we'll make sure that we -- we can accommodate every member. Okay?

Dr. Swenson.

DR. SWENSON: To follow on to that, I would say you might want to consider meeting in conjunction with the NAAV, maybe for one last time before we, you know, focus in on D.C. I think that one of the first meetings was with the NAAV --

VICE ADMIRAL ZIMBLE: Tampa --

DR. SWENSON: --in Tampa and you know, our outreach still is really not working that well. So I would say it may be worthwhile to have one there.

Now let me change the subject. We als-- SC-2 would probably like to go to Jackson VARO for one of our subcommittee meetings in the future, once the VPN, you know, is in, so -- that would not be in D.C., so we might want to have one of our meetings there instead, so if you could consider that.

VICE ADMIRAL ZIMBLE: Okay, so I'm going to modify the request to two annual meetings, to ha-- and I think -- I think we really can't afford to do the New Orleans thing -- two meetings in the D.C. area, and then we'll ask that one of the -- that one subcommittee be

funded to go to -- to Jackson VARO, at a time to be decided -- to be determined, towards the end of the next fiscal year --

DR. SWENSON: That's good, yes.

VICE ADMIRAL ZIMBLE: -- and, in addition to that, that as -- as far as the NAAV meeting is concerned, I think it would behoove us to have a representative or two from the Board go and make presentations at that NAAV meeting to help with the communications. So if you would consider those as -- resource-poor right now -- to see whether or not they could be funded would be very helpful.

Dr. Blake.

DR. BLAKE: I'll have to talk with VA, but I don't think it's going to be a big problem.

VICE ADMIRAL ZIMBLE: Okay.

DR. BLAKE: I know what the costs are and what we can do and I'll discuss with my colleague, but I think we can support the Board's request.

VICE ADMIRAL ZIMBLE: Okay, very good. Thank you very much.

Now I just want to bring up one other top-- oops, I'm sorry, Mr. Groves.

MR. GROVES: I guess the only thing I wanted to

clarify is that we have historically always had the day before our Veterans Advisory Board meeting dedicated to subcommittee meetings. I would implore you that we have an opportunity for separate subcommittee meetings between the regular meetings so that ultimately that would mean that the subcommittees could meet up to four times a year. You know, once in conjunction -- or in conjunction with each of the actual Board meetings and then separate meetings, if -- if we needed them in order to prepare for those meetings, and --

VICE ADMIRAL ZIMBLE: Well, again, it really depends on how far the funding will go. I --

MR. GROVES: Yeah.

VICE ADMIRAL ZIMBLE: And if possible -- and if that can be worked out, that's fine with me.

MR. GROVES: Yeah.

VICE ADMIRAL ZIMBLE: But don't forget that subcommittees are not subject to the FACA rulings --

MR. GROVES: Right.

VICE ADMIRAL ZIMBLE: -- and it's possible to -- it's readily available to do those with -- electronically.

MR. GROVES: Yeah. Well, for our subcommittee, for example, only two of us have to travel in order to have essentially our whole subcommittee and representatives from the VA and DTRA, so it's a -- it's, you know, relatively small cash outlay in order to do -- and I certainly agree with John that, for the kinds of things -- issues we're working right now, I think that there's certain value in face-to-face meetings. But we'll be sensitive to the issue --

VICE ADMIRAL ZIMBLE: Right, I think --

MR. GROVES: -- of cost savings.

VICE ADMIRAL ZIMBLE: -- Dr. Blake can probably fund you for a red-eye.

MR. GROVES: Red eyes are fine with me.

VICE ADMIRAL ZIMBLE: There's a -- there's one other issue I want to bring up. We talked about the future of the Board, and we talked to the two agencies and the need for the agencies to work together and to cooperate well, which they're doing. But there is one other entity that -- to whom we are behoven, and that's the NCRP.

They have -- the NCRP was -- was responsible

for the initial formulation of the VBDR in the original presentation to Congress, supported both agencies as they put together their report, and was instrumental in the selection of the candidates for membership, and has provided us remarkable support throughout the four years that we have been in session for these nine meetings, and for all the subcommittees and provided subcommittee support in terms of minutes, all the administrative support. They -- the NCRP, thanks to Tom Tenforde, drafted the original -- the first -- the first draft of the history of the VBDR. He has really been a part and parcel of this Board.

Now thanks to federal procurement regulations, there's now a request for a -- for bids for -- for contract renewal, and I would just -- the level of expertise that the NCRP is -- is unparalleled by any other organization that -- of which I am aware in terms of the numbers of people that can bring to this Board the types of information that we absolutely require, not just -- not just old information, not just current information, but they can put -- they

put together reports ongoing that deal with every level of radiation -- ionizing radiation dose exposure, safety, detection, et cetera. And I can think of no other organization that would be more vital to the best functioning of this organization than the NCRP.

So, I'm offering a plea that as the contract negotiations proceed, that either as -- either remaining as contractor or being strongly considered as the subcontractor to the new contractor, NCRP I believe to be absolutely essential to this Board. I don't know if I have a consensus from this Board on this issue. I would hope that I do. I might ask if there is an agreement from the Board as to my assessment of the role of the NCRP, but I would make a strong plea, and I would like to represent the full Board in making that plea. Any --

MR. GROVES: So is that a motion?

VICE ADMIRAL ZIMBLE: Can I -- I can't make a motion -- I can't make a motion, but somebody else could. Yes, sir.

MR. VOILLEQUÉ: I think perhaps we should consult Dr. Blake on the vagaries of the

federal procurement process.

VICE ADMIRAL ZIMBLE: I -- listen, the vagaries of the federal procurement process will remain vague. I can promise you that. The issue is, what is the desire of this Board in terms of having -- continuing some good, solid relationship -- I don't care whether -- in what form it takes, but that we have a -- that we maintain a good relationship with NCRP. I can't -- I just cannot see us being divested of that very important function.

Yes, Mr. Beck.

MR. BECK: I'd just like to point out that several of us have relationships with the NCRP so I don't think we could vote on this matter. There's a conflict of interest there, so --

VICE ADMIRAL ZIMBLE: Okay. All right.

MR. GROVES: Those of us that do can not vote.

VICE ADMIRAL ZIMBLE: Okay. Well, I don't know -- I'm not so sure I want to vote. I really want to know whether or not there's anyone opposed to that -- to that concept. If there's no opposition, then I'm satisfied that we have -- that I have stated the sense of the Board.

Dr. Swenson.

DR. SWENSON: I think this should be dropped, the whole discus-- it's a contracting issue.
VICE ADMIRAL ZIMBLE: Okay.
DR. SWENSON: You voiced your positive opinion for NCRP, which I agree with, but I think --
VICE ADMIRAL ZIMBLE: Okay.
DR. SWENSON: -- the rest should be dropped.
VICE ADMIRAL ZIMBLE: Okay, okay, I agree with that.
MR. RITTER: Dropped.
VICE ADMIRAL ZIMBLE: I hereby adjourn. I ask that there be a quorum here at 1830 -- okay? -- for -- 1830, that's -- for those that -- for the uninitiated, that's 6:30. For Dr. Lathrop, that's when Mickey Mouse has both hands...
(Whereupon, a recess was taken from 4:08 p.m. to 6:52 p.m.)
VICE ADMIRAL ZIMBLE: I'd like to reconvene. I was not planning -- unless we had someone to provide public testimony, I was not planning to reconvene. However there are several issues that have come up as I -- as I've been walking about that suggest that we do reconvene, at least get something official on the record. Number one, we -- you should each have

distributed from John Lathrop this recommendation, the one recommendation that we suggested for SC-3. It's been well word-smithed and I look to the chairman -- Mr. Chairman, is this acceptable to you?

DR. REIMANN: Yes.

VICE ADMIRAL ZIMBLE: Then we'll officially submit this as the recommendation -- the single recommendation for Subcommittee 3.

Secondly, had a discussion with the chairman of SC-1, who feels very strongly that it is -- it is a -- not a frugal use of taxpayers' money to meet too often for the total Board. And he feels that between nine months and one year -- why he picked nine months, I don't know, he's not a gynecologist, but -- but he said anytime between nine months and one year would be sufficient for the large committee; that we should use those travel resources for the subcommittees to get together and each subcommittee can perform its own oversight, and then we'll use the -- use the full Board meeting to review the results of the subcommittees' work, and then take it from there. So unless there is a rationale that's

not apparent right now for more than one meeting a year, then that's what we'll suggest. And we can time that meeting when everyone looks at their calendars -- why did I not know? Okay. Mr. Groves.

MR. GROVES: My dear Admiral --

VICE ADMIRAL ZIMBLE: Yes.

MR. GROVES: -- I would like to not disagree with Harold, but I do think that by restricting ourselves to once -- once a year frequency might not offer us the opportunity to move forward as much as we would like to on the new paradigm we discussed today, and that was the -- still maintain the Board and the four committees, but to focus on the quality management plans at both of the -- both of the different organizations that we're working with. And clearly, as I think we would all agree, there is a need to move forward on the outreach plan. And I would think that we've -- as, you know, I'm the eternal optimist. I am certainly pleased with the support we've had from the VA and I look forward if Brad becomes the person -- whether he's the person on the Board or he's the person we're going to deal

with in the benefits side of the house as I mentioned in my testimony how happy we were to have Dr. Cassano on the VHA side of the house. So I guess I would opt more for a meeting frequency of -- from a funding standpoint, looking at Dr. Blake -- of funding for two meetings every 18 months, and then funding for an additional two or three meetings of the subcommittees, if they feel they need to meet and I certainly believe that John and I and -- and I think I can speak for John Boice, the other member of the outreach committee, that at least at the front end of our process that we would benefit from that frequency of meeting. In addition to the assumption that whenever the Board meets as the full Board, that the day before that meeting would be available for subcommittee meetings, should the subcommittees choose to do that. So --

VICE ADMIRAL ZIMBLE: Well, that's interesting, two -- two meetings --

MR. GROVES: Yeah, I'd rather not (unintelligible) too tight a box.

VICE ADMIRAL ZIMBLE: -- two meetings every 18 months, I -- you know, my math is fairly

simple.

MR. GROVES: Yeah.

VICE ADMIRAL ZIMBLE: Two meetings every 18 months sounds like exactly what has been recommended as one meeting every nine months. Let me suggest this -- let me --

MR. GROVES: With some -- with some ability to move those meetings -- and I haven't even had a drink yet, so --

VICE ADMIRAL ZIMBLE: But you're driving me to one.

MR. GROVES: -- but I did stay at a Holiday Inn last night.

VICE ADMIRAL ZIMBLE: A Holiday Express?

MR. GROVES: Yeah.

VICE ADMIRAL ZIMBLE: Yeah. Let me -- let me say this. Let me propose this for the -- for the group to consider. We have put forward pretty much a concept from each of the chairs as to what they see -- and it's been accepted by the Board -- as what they see as their way forward in -- in terms of oversight and quality reviews from SCs 1, 2 and 3, and most -- most urgently exploring methodologies for outreach communication and working that issue very hard.

I'm going to charge each of those committees to work very diligently on that, and then we'll look at somewhere between six and nine months to see what products you have, because remember, it takes the full Board to make recommendations to the agencies.

MR. GROVES: Yeah.

VICE ADMIRAL ZIMBLE: In order to formally look -- if you -- if we find something in the next six to nine months that's -- that's worthy of strong recommendations from this Board to one or the other of the agencies, then -- then that's the time to convene. So we will -- we will convene somewhere within the next nine months to a year, depending upon the work product from each of the -- from each of the subcommittees and -- and a need to get consensus from the Board regarding recommendations.

How's that?

MR. GROVES: Well, I think that's fine. One of the responsibilities of Subcommittee 4 is to work with NCRP staff on meeting planning activities, and I guess I would like for us to be able to go out to the Board as a whole and

look at what available dates might be in the February/March time frame next year. Because, as -- as we have learned from history, this group -- it's not real easy to get us all together without planning in advance.

VICE ADMIRAL ZIMBLE: No question about it.

MR. GROVES: I can't imagine that by that time we -- we wouldn't have something that would be worthy of a full Board meeting. And then it might be at that meeting that it might look like maybe it might slip to ten or 11 months after that. But I guess I would like to look at the nine-month time frame from now as -- look for availability, and then we could make a decision between the Chair and the subcommittee chairs as to whether we lock a date in or not.

VICE ADMIRAL ZIMBLE: Mr. Beck.

MR. BECK: I'm happy.

VICE ADMIRAL ZIMBLE: Okay.

MR. BECK: I'll buy that.

VICE ADMIRAL ZIMBLE: Any other comments regarding the recommendation from -- from our communications chair?

Dr. Blake.

DR. BLAKE: Just speaking for the agencies, we

also support that, too. To get ready for a meeting to present really significant improvement to you, I can't do it in a few months, really -- on where we're going. In the earlier part of this group we met more frequently, things were easier to -- to make those breakthroughs in expedited dose. Now it's -- it's harder science pushing things through, and so the nine-month frequency -- and I -- Brad probably feels the same way -- we do need that time to really present substantial improvements to you based on your recommendations. If we meet too quickly as a -- as a full group, I'm not ready to discuss it. I certainly do support, though, the subcommittees meeting in between. That's where I get the feedback and the help, and I'm reporting back into you via that system, too.

VICE ADMIRAL ZIMBLE: I will give you nine months for growth and development. At the end of that gestation period we'll have --

UNIDENTIFIED: Birth a meeting.

VICE ADMIRAL ZIMBLE: -- we'll birth a meeting, right. Okay. Hopefully it will not be desultory labor, as -- as some of the previous

meetings have demonstrated.

Okay, if there's no further business -- uh oh, Dr. Fleming.

DR. FLEMING: This is related to the timing of the meeting but not -- not quite on that same topic. But I'm concerned -- you know, this is about the recommendation from SC-3, which I think -- from what I can tell -- is a -- is a really very good recommendation. But for SC-2, this is I think a -- or for the VA, I should say, and -- this is -- strikes me as quite a challenge. And so I'm just -- I'm just trying to understand how in nine months or in 18 months how -- how this is going to happen. Now I do see that SC-3 is offering to assist and guide the agencies in developing the QQR and the DSS. But I also think that in the case of the VA it's important for SC-3 to also interact with SC-2 as these are developed, and SC-2 already has quite a bit on its plate when it comes -- you know, with respect to the -- moving forward with the additional audits, stratifying some of the -- some of the data that we have from the 50 audits that have been done, and making a Jackson VARO visit. So I

don't have a recommendation, I'm just expressing a cautionary note here because I -- I'm afraid -- well, what I would not like to find out in nine months is a report from VA or from some other, you know, committee that this really didn't fly or couldn't happen or there was a substitute process already in place that effectively did this, and there wasn't enough communication in between time for us to -- to really work on -- on the -- on this whole phenomenon. Did -- am I making sense here?

VICE ADMIRAL ZIMBLE: Yes, you certainly are, and -- and I can under-- I can understand the trepidation, especially when you're -- when we're such a small portion of the workload of the VA, and the VA does have already established a fairly sub-- sophisticated system -- in fact, as we've learned, a hierarchy of systems -- for reviewing quality.

What we're looking for, though, is for this small group, which can now be concentrated in one VARO, in just Jackson VARO, a process by which they're working that could be -- that can be tied into their SOP with-- without causing -- without -- without impediment, and the only

way to learn whether or not that's going to impede them is to -- is to assess it -- its value. So I think it's -- let -- let's leave it as a trial, and if it's -- if it's not effective, then we'll discontinue it. But let's -- let's have a -- something -- have SC-3 working to try to build a process of review of the quality of the processing of the atomic veterans' claims that is -- and somehow can be integrated well with the process that's going on for the quality assessment of the -- of -- of NTPR so that we can look at a -- basically a quality process that -- that bridges the -- the two agencies. I don't know whether I'm -- I'm stating that as clearly, but my sense is that we need to be able to assess the entire process, including the handoffs back and forth, and that we need a product from Jackson VARO that -- that in somehow enhances the ability to assess that qua-- the quality of that work. What that form is ultimately going to look like, I don't know. I think you're going to have to work with it and look at it to see what works, and -- and I -- I think you've got -- got some real pros to assist.

Dr. Reimann.

DR. REIMANN: Yeah, I just want to pick up on a couple of things I heard here in the last few minutes. Paul's comment is extremely well taken that at this point the time constant of the agencies to do this work is critical, so we shouldn't really meet until they've had a chance to do it and to -- and to have something to demonstrate.

And in Patricia's comments I really heard two -- two messages. One is reinforcement, not only the fact that since we're working more together now, we have to take into account the natural work process of the different groups, and we can't just pretend that somehow this is all synchronized with the gears hooked up with one another. And so if you're going to be planning, for example, some kind of a session with the Jackson RO, we'll either have to be participating in that and, at the very minimum, we'll have to get the output of that. And then we have to deliberate on it and so on. So these are ver-- these are things that have to be stacked end-to-end in a way that makes sense, and one subcommittee can't be saying

well, in order for us to do our work, you have to have all these things you do.
But the other thing I heard within it was some question about what VA could or couldn't do.
And I -- I have that same observation, but it's based largely on just simply not knowing. But that's -- that means that that's something we'll have to get at real soon because there's the issue of not doing versus how long it takes to do, and no-- but those things have characteristics that we can also observe.
But I would also note, in the spirit of this nine months, there's so much talk about this nine months I'm thinking of buying a house near a school.
VICE ADMIRAL ZIMBLE: Okay. Any other comments?
Dr. Lathrop.
DR. LATHROP: I think you're legally obligated to comment --
VICE ADMIRAL ZIMBLE: No, I -- I --
DR. LATHROP: -- just in case you're considering not, I think there's a law somewhere --
VICE ADMIRAL ZIMBLE: No, no, I -- yeah, I

recognize you.

DR. LATHROP: -- in one way or -- or another. Just -- just a couple of comments. I -- I can see the concerns of Patricia. I would -- I would say, though, that nine months is not at all an unreasonable time to come up with designs for the QQR and DSS. I fully agree that's optimistic for implementation, but it's not optimistic for design. In fact, a significant amount of that design can be done between SC-3 and SC-2, although it should of course always involve the VA as much as possible. So I don't think nine months is optimistic at all for the design.

The second comment I would like to make is for SC-4 I would like to suggest, sort of in public, to my esteemed chair that we set a pace of about once every three months for the SC-4 meetings, which would meet twice between now and perhaps the next meeting. What do you think, Mr. -- Mr. --

MR. GROVES: I concur on that.

VICE ADMIRAL ZIMBLE: Very well, thank you very much. I accept all the recommendations that have been put forward. They seem -- they seem

to coalesce very nicely, and so that -- that will be the decision of the Chair and I will now task the one volunteer, our communications chair, to seek out a date certain for the -- for the meeting, sometime in 2010.

MR. GROVES: Yes, sir.

PUBLIC COMMENT SESSION

VICE ADMIRAL ZIMBLE: Okay, very good. I understand that we do have one individual who would like to -- for public -- individual who's just arrived, and before we -- we're just getting ready to adjourn, but I'm trying to read that -- I'm having trouble reading that name. Is that -- is that Marilyn?

I'm having trouble reading this name, but is it Marilyn?

MS. FIFIELD: Marilu?

VICE ADMIRAL ZIMBLE: Marilu, oh -- and I can't read that last name -- I'm sorry, I -- you write like -- your -- your handwriting looks like mine and I can't read mine. Please -- please come forward.

MS. FIFIELD: Hello.

VICE ADMIRAL ZIMBLE: Hello. I understand that you are the daughter of two vets?

MS. FIFIELD: Yes --
VICE ADMIRAL ZIMBLE: Okay.
MS. FIFIELD: -- an Army and Navy veteran.
VICE ADMIRAL ZIMBLE: Okay, and you have something to present to this Board. We're delighted to receive it.
MS. FIFIELD: Well, nothing of a formal nature, although with there being so much in the news lately from a health standpoint of how the effects of certain chemicals, both from World Wars I and II, as well as the Vietnam War, and how they're not really discovering the implications or the long-term effects on a lot of the veterans. What I'm concerned about, although my mother is in her 80s now, whether her Parkinson's issues may have all -- may -- possibly been related to something she may have been exposed to during the war, or whether it was just an inevitable ailment that she was going to get somewhere down the line.
And as far as my dad having early -- well, what I think was early heart issues when he was formerly a very healthy person, and having some other odd symptoms related to rashes and so forth. It always made be wonder, especially as

I got older and started hearing about all of these studies and different chemicals and different substances that the veterans were exposed to, could they have been exposed to stuff that -- 20, 30 years down the line -- caused these illnesses when they may have been chalked up to something totally different -- where they worked. They worked in -- maybe they might have worked in a factory and they chalked it up to that, but may in fact have been caused by what they may have been exposed to at some point during their service. That's just my educated supposition or guess.

VICE ADMIRAL ZIMBLE: Okay. I think that's a -- that's a reasonable -- reasonable supposition, and -- and there's work going on all the time in various areas that will discover new and -- new things that need to be brought to the attention of the veterans. And I would assure you that one of the roles of the Veterans Administration as -- as an advocate to the veteran is to constantly receive any new information and to help assist in obtaining that sort of information and making that available to the veterans. This particular

Board is very specific in dealing with one aspect of the large population of veterans. We're specifically looking at those veterans who we call atomic veterans, who participated in atmosphere -- nuclear tests --

MS. FIFIELD: Testing of atomic weapons.

VICE ADMIRAL ZIMBLE: Right, and -- and who -- both -- both in the Pacific and in the United States in Nevada, et cetera.

MS. FIFIELD: Right.

VICE ADMIRAL ZIMBLE: Or who was associated with the occupational forces in Hiroshima and Nagasaki.

MS. FIFIELD: Right.

VICE ADMIRAL ZIMBLE: And specifically directed towards the irradiation potential --

MS. FIFIELD: Towards the effects they were exposed to during either --

VICE ADMIRAL ZIMBLE: Right.

MS. FIFIELD: -- atomic testing or --

VICE ADMIRAL ZIMBLE: So that's the venue for this particular Board.

MS. FIFIELD: Right.

VICE ADMIRAL ZIMBLE: But I would -- I would just tell you that -- that there's always new -

- new and valid research going on throughout the country that the Veterans Administration is -- is -- can access and -- and does receive readily, and if there's --

MS. FIFIELD: Right.

VICE ADMIRAL ZIMBLE: -- new things that do come along, new concepts, new things, new threats. Ag-- the Agent Orange threat, the threat from -- I think one of the -- one of the latest ones that people are concerned about is the depleted uranium situation and what potential threats there may be there, constantly work between the VA and the Department of Defense -- always concerned about -- about the safety of the -- of the armed forces and the veterans. So those things are considered and as far as I am aware, there's nothing -- no exposure in -- in the military service that would lead to Parkinsonism. That is above and beyond what happens in the community as a whole --

MS. FIFIELD: Right.

VICE ADMIRAL ZIMBLE: -- and I do appreciate your concern.

MS. FIFIELD: Thank you very much.

VICE ADMIRAL ZIMBLE: And I would -- I will do my best to reassure you that -- that your government feels the same way.

MS. FIFIELD: Right. Well, thank you very much. Thanks for the time. Bye-bye.

VICE ADMIRAL ZIMBLE: Thank you. Any comments or questions?

(No responses)

Okay, do I hear a motion to adjourn?

MR. RITTER: I make such a motion, sir.

VICE ADMIRAL ZIMBLE: And a second?

DR. LATHROP: I second.

VICE ADMIRAL ZIMBLE: Hearing no objection, have a safe trip home.

(Whereupon, the meeting was concluded at 7:16 p.m.)

C E R T I F I C A T E OF COURT REPORTER

STATE OF GEORGIA

COUNTY OF FULTON

I, Steven Ray Green, Certified Merit Court Reporter, do hereby certify that I reported the above and foregoing on the day of June 10, 2009; and it is a true and accurate transcript of the testimony captioned herein.

I further certify that I am neither kin nor counsel to any of the parties herein, nor have any interest in the cause named herein.

WITNESS my hand and official seal this the 10th day of July, 2009.

Steven Ray Green, CCR

STEVEN RAY GREEN, CCR, CVR-CM, PNSC

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