Advisory Committee on Disability Compensation (ACDC) Meeting

Tuesday, June 27, 2023 – Wednesday, June 28, 2023

9AM – 12PM Eastern (each day)

EXECUTIVE SUMMARY

Transcription Services: Provided by Jamison Professional Services

Veterans Affairs (VA) Staff Present:

- Jadine Piper, ACDC Lead Designated Federal Officer (DFO)
- Claire Starke, Alternate DFO, ACDC
- Lisa Lotts, Alternate DFO, ACDC
- Laurine J. Carson, Acting Executive Director, Senior Executive Service, Office of Equity Assurance
- Dr. Matthew Miller, Director, Suicide Prevention Program, Office of Mental Health and Suicide Prevention
- Barbara Morton, Deputy Chief Veteran Experience Officer, Veteran Experience Office
- John Capozzi, Assistant Director, Quality, Medical Disability Examination Office (MDEO)
- Machelle Harrell, Chief, Quality, MDEO
- Kyle Timmons, Chief, Quality, MDEO
- Abigail Werner, Policy Liaison Compensation Service (CS)
- Robert Parks, Chief, Regulations Staff, CS
- Dr. Patricia Hastings, Chief Consultant, Health Outcomes Military Exposures, Office of Patient Care Services, Veterans Health Administration
- Zach Goldfine, Deputy Chief Information Officer, Office of Information and Technology
- Raymond Tellez, Executive Director, Office of Business Integration
- Nicole Dumas, VA Schedule for Rating Disabilities (VASRD) Acting Assistant Director, CS
- Olumayowa Famakinwa, VASRD Implementation Chief, CS
- Dr. Pat Mackin, SAG Corporation
- Dr. Sarah Prenovitz, Abt Associates

ACDC Members Present:

- Evelyn Lewis, Chair
- Bradley Hazell, Vice Chair
- Patt Maney
- Eloisa Taméz
- Frank LoGalbo
- Steven Wolf
- Al Bruner

Meeting Minutes

Purpose: The purpose of the Advisory Committee on Disability Compensation is to provide advice to the Secretary of Veterans Affairs on establishing and supervising a schedule to conduct periodic reviews of the VA Schedule for Rating Disabilities (VASRD).

The purpose of the meeting is for the Committee to receive presentations on various topics relating to their job as a Committee, as well as discuss the submitted biennial report and future meetings.

The committee met in an open, public session on Tuesday, June 27, 2023 and Wednesday, June 28, 2023.

Tuesday, June 27, 2023

Opening Remarks

Ms. Claire Starke, Alternate DFO, called the Committee to order at 9:00 a.m. Role was called and seven members were present. She noted the requirements were met for quorum and turned the floor over to the lead DFO, Jadine Piper.

Ms. Jadine Piper, DFO welcomed the Committee to the meeting and reviewed rules of engagement for speaking and indicated that the meeting is open to the public and being recorded. She then turned the meeting over to the Committee's Chair, Dr. Evelyn Lewis.

Chair Lewis thanked the Committee for attending the meeting and began member introductions.

Member Introductions

After self-introductions by members, Chair Lewis turned the floor back to Ms. Starke to discuss the stipend letter.

Invitation Letter

Ms. Starke reviewed the invitation letter sent to Committee members. She requested each member to sign and date the letter in the space provided to facilitate payment if they are eligible to receive a stipend, and to return the letter to the e-mail listed on the letter as soon as possible but no later than five days.

Introduction to Veterans Benefits Administration (VBA) Office of Equity Assistance – Laurine J. Carson

After a brief break, Ms. Piper introduced the first speaker for the day, Laurine J. Carson, Acting Executive Director, Senior Executive Office of Equity Assurance. She shared that she had been with VBA for 34 years, and most recently holding the position of Deputy Executive Director for Policy and Procedures in Disability Compensation Service, which she had done for six years. She came forward to be the lead for the new office for VBA Office of Equity Assurance in April of 2023.

She emphasized the reasons why the VBA needed an Office of Equity Insurance, including to look at those groups who are underrepresented, who are facing poverty and economic difficulties, and to try to create some parity where there might be systematic disparities. Her office is to look at those through the lens of data in their benefit programs to ensure they are creating parity, equity, and economic advancements for those underrepresented groups. It is not only an outreach office, but also an office that will be looking at programmatic changes to include any things they can do with policy and procedures, as well as if there are trainings that are needed to offer to their employees and partners, to including partnering in training that they are planning for employees in that space.

Ms. Carson shared how with the character of discharge regulation; Veterans have to come to the VA to make a separate determination on allowing them to receive benefits from VA if they discharge was other than honorable. She noted how outdated some of the regulations are, such as how regulation still has a bar that reads “homosexual acts.” She said they don’t apply that bar, but they adjudicate it, and make sure there are no aggravated sexual offenses. They are going to look at those types of things and make sure that Veterans who were, for example, discharged under the “Don’t ask, don’t tell” (DADT) provisions, can feel like Veterans with the help of her office.

She went on to say where she and her office will be starting, with reports and litigation related to Black Veterans and those disparities, which has also been in the news often lately. She noted that it's a long, systemic issue – social issues, historical issues, and historical contexts that surround the issues.

Her office is also in the process currently of proposing a regulation to correct the mental health regulations due to it being the only diagnostic section of disability that e-content found the VA was not compensating Veterans on par with all the other disabilities at the time of the study in 2008. The proposed regulation is available to be read on the Federal Register and creates parity for all Veterans, but particularly mental health for Black Veterans.

Ms. Carson encouraged the Committee to look at the American Thoracic Society's website and review their universal criteria that is not race-specific, because the old race-specific criteria was rooted in a belief in the medical community at the time that there was a difference in Black, White, Asian, and Hispanic Veterans that put them on different spectrums.

She also encouraged the Committee to get a briefing on a pulmonary function test (PFT) study being done through the Veterans Health Administration (VHA) currently. She shared that it is showing that for the same circumstances, same condition, because of the way it's evaluated in the clinical setting and examination criteria, that a Black Veteran might get a 30 percent service connection according to the rating schedule while a White or Hispanic-White Veteran might get 60 percent service connection for the same criteria, because it is acceptable clinical practice to use a race-specific criteria.

Ms. Carson shared how difficult it is for Veterans in freely associated states (Alaska, Hawaii, Philippines, Puerto Rico and surrounding islands) to get access to information about benefits, in addition to it being difficult to get access to healthcare that they desperately need but often have to travel in order to get that access.

She told the Committee how there is a lot in the space she's working in that she is excited about and wants to drive it with data and understanding of the historical context and times they determined a benefit was necessary for a Veteran and what their experiences may have looked at the time. Ms. Carson paused for questions.

Mr. Hazell thanked Ms. Carson for her brief and asked if her team would be sharing the data they find in the future with the Committee so they can make appropriate recommendations to the VASRD. Ms. Carson said yes, there is a lot of data that can be shared with them. She also recommended going to PA&I, Performance Analysis & Integrity, and request a briefing on the Disability Compensation Program's demographic data.

Mr. Hazell then asked if there has been any push within Compensation Service to update the regulation about homosexual acts. Ms. Carson said the proposed regulation was submitted to the Federal Register. Her colleague, Ms. Jessica Pierce, offered to give more information about the regulation. She shared how the proposed rule was published in July of 2020, to make changes to the regulatory bars under CFR 3.12. One of the changes proposed was to remove the word “homosexual” so that the rule would only refer to aggravated sexual acts. She also noted how they had been doing a lot of outreach and feedback sessions with stakeholders, and requested information from the Federal Register, held listening sessions, and received written comments during that time.

They have also participated in some stakeholder events to receive feedback. They are working towards a final path forward on all the changes being made to that regulation and are hoping the final rule will be published soon. Ms. Carson added that even since 2015 they have been working through this process to get to where it is currently but OMB has not signed off and approved the changes.

Dr. Eloisa Taméz asked a question regarding access, wondering if it would be something like a self-referral for the Veteran, or if a health care provider or service office needs to refer them. Ms. Carson shared how the Office of Transition and Economic Development (OTED), which is responsible for VBA outreach, has been partnering with department-level groups to do joint outreach across the nation to Veterans, sharing information and telling those who feel marginalized to come into VA facilities to file claims. They have also been doing a lot more in the space of transitioning service members to educate Veterans and make them aware of their benefits.

Dr. Lewis thanked Ms. Carson for her brief on the different issues and told her that she would be sending some questions along to her, particularly as they relate to Veterans who are in distant places who have difficulty obtaining and getting care. Dr. Lewis shared how she’d like to understand better the kinds of things that are being done so that as she’s talking with several various organizations in those areas, she can help translate that information. She works with several Veteran serving organizations who are trying to expedite and make it easier for Veterans in those areas to receive services and benefits.

Overview of VA Suicide Prevention Program – Dr. Matthew Miller

Ms. Piper welcomed the next guest, Dr. Matthew Miller, Director of Suicide Prevention Program, Office of Mental Health and Suicide Prevention. Dr. Miller shared that the VA Suicide Prevention includes the Suicide Prevention Program, which has oversight of all policy, programs, and initiatives encompassing suicide prevention across VHA and VBA. It also includes oversight, management, and leadership of the Veterans Crisis

Line. He gave a brief background of himself, being a clinical psychologist by training and having served in the Air Force as an officer and clinical psychologist.

Dr. Miller told the Committee that he would be walking through a quick overview of some basic principles of suicide prevention and then go through data such as the latest annual report and some other applicable data and demonstrations.

He began with the foundations for suicide prevention. First, there is no single cause of suicide. It almost always involves multiple factors, uniquely combining at unique points in time, to lead to a tragic outcome. Risk factors and prevention factors are the main issue. He shared how, when a Veteran calls the Veterans Crisis Line (VCL) and they are in crisis, they're kind of teeter tottering and going back and forth with their feelings. What they do in the VCL is try to meet the Veteran where they are at and to try to lighten the risks the best they can and emphasize the protective factors as much as they can.

Dr. Miller moved on to data from their 2022 annual report, based on 2020 population data from the Centers for Disease Control and Prevention (CDC). He noted the unique outstanding characteristics or hallmarks, such as including two full decades of information, from 2001 to 2020, making it the most comprehensive source for Veteran suicide data. It compares suicide among Veterans across that time, and relative to the U.S. adult population. It walks through data by count, average per day, and rate. It also looks at and annualizes Veteran suicide by method. The data shows that 70 percent of Veteran suicides are by firearm, which is significantly proportionally higher than the non-Veteran population. It walks through Veteran suicide by age, sex, race, ethnicity, and among subpopulations, such as those within VHA care in the year of their death or the year prior, versus those not in VHA care the year of their death and the year prior.

He shared what they call Anchors of Hope, which is solid anchors of data that say, here are things that are happening that are positive that we can latch onto to learn and grow from. In 2022, there were five Anchors of Hope:

1. From a count perspective, there were 343 fewer Veterans who died from suicide in 2020 than in 2019.
2. The number of Veteran suicides that occurred in 2020 and differentiated from 2019 gave the lowest count since 2006.
3. 2020 and 2019 together had 650 less Veterans who died from suicide.
4. That is almost a 10 percent decrease in Veteran suicides in two years.
5. This is the first year (2020) where COVID is a factor from start to end, and there was no significant impact of COVID on the rate of Veteran suicides.

Dr. Miller noted that they will probably see an increase in the data for 2021, because the CDC shared data showing that there was a 10 percent increase overall in suicide in the

U.S. adult population. The CDC also noted that there was a widening gap racially in suicide, as well as a widening gap in age, as the suicide rates of individuals 10 through 24 were significantly elevated in 2021.

He continued, sharing more data collected.

- In 2020, there were 31.7 suicides per 100,000 Veterans, to equal 6,146.
- The difference in suicide rates between the Veteran population and the U.S. adult population stands in 2020 data at about 53 percent, which is an improvement from 66 percent in 2018.
- Veteran suicide rates for all race groups decreased from 19 to 20, with White Veterans having the highest rate and Black Veterans having the lowest rate across the board across all time.
- For age, the highest count occurs in Veterans 55 plus, but highest rate occurs for Veterans 18 to 34.
- Men are higher risk for suicide and have higher rates, but when you compare women Veterans with non-Veteran peers, women Veterans have a higher rate of suicide than their peers.
- 77 percent of Veteran suicides historically and presently have been by firearms.
- VHA Veterans have a higher rate of suicide than non-VHA Veterans.
- VHA rate of growth in suicide across 20 years is lower and slower than the non-VHA growth has been.
- Those diagnosed with a depressive or anxiety disorder in VHA have a 30 percent lower suicide rate from 2001 to 2020.
- Priority group 5 has the highest suicide rate from 2001 to 2020.

Dr. Miller moved on to speaking about the public health approach and how they are addressing it. He explained that what a public health model assigned to suicide prevention means is, you are not going to significantly lower your rates across the population by addressing everything individually and clinically because suicide also includes a myriad of socioecological variables when it comes to risk factors. He shared that by taking a public health approach, their plan must include advancements in the clinical realm but also must include advancements in the community and community-based realm.

He shared two aspects of their strategy, called Suicide Prevention (SP) 2.0, which is a long range six-year strategy plan, and SP Now, which is the more proximal aspect of the plan. SP 2.0 is divided and organized according to community- and clinically based efforts. They have very specific targets and actions within the clinical realm which center around the development and deployment of over 100 trained, licensed providers, to embed within our clinical resource hubs, and offer evidence-based treatment for the

highest risk Veterans with regard to suicide, particularly those who have recently attempted and survived.

The evidence-based treatment is cognitive behavioral therapy for suicide prevention, which has been rolled out across all Veterans Integrated Services Networks (VISNs) and are in the implementation phase solidly with this aspect. The other aspect is the community-based approach, where they're working to develop the governor's challenge, and then a county and city level aspect, and then peer-based efforts. The data suggests there are five planks they can look at for lowering Veteran suicide rates today: Lethal means safety; suicide prevention in medical populations that are highest-risk, like cancer, oncology, palliative, hospice; outreach and understanding of prior VHA users, those who have left, and are being reached out to; suicide prevention program enhancements, such as Reach Vet, Risk ID, and SPED (Safety Planning in the Emergency Department); and then finally, paid media, with a focus on firearm lethal means safety.

Dr. Miller shared that one of the unique efforts within the past two years include Mission Daybreak, which was a prize challenge, first ever initiated by Suicide Prevention or VHA. They also have the Staff Sergeant Parker Gordon Fox Suicide Prevention grants, which they are in year two of implementation . They also have a lot of groundbreaking work with firearm lethal means safety through their Keep It Secure campaign.

Having completed his presentation, he opened the floor for questions.

Judge Patt Maney asked if Dr. Miller thinks their office is located bureaucratically in the right place to be effective, and what interaction does his office have with the Readjustment Counseling Service and the Vet Centers. Dr. Miller shared that he does not believe they are ideally located to maximize efficiencies, but he noted that not everybody agrees with him on that topic because they have differing perspectives.

For interaction, he said that was an ongoing situation where they need to carefully make sure and ensure that they're coordinating because it's not naturally built into the organizational structure process. He noted that they do have a very good relationship with Vet center leadership and work very closely with them.

With no further questions, Ms. Piper thanked Dr. Miller for his presentation. She told the Committee that they are working to ensure all presenters receive helpful feedback, so the next slide that will be shown contains a QR code for both presentations that have been given so far that day. She said they could take the survey during the break, but they will be active for a week. The Committee then took a five-minute break.

Veteran Experience – Barbara Morton

Ms. Piper introduced the next speaker, Barbara Morton, Deputy Chief Veteran Experience Officer from the Veteran Experience Office. Ms. Morton thanked Ms. Piper and began her presentation with giving an overview of her office and customer experience journey at VA. She shared that she had been with the VA for 17 years and was previously a lawyer at the Board of Veterans Appeals.

Ms. Morton reminded everybody that the Secretary always reminds them to keep the Veteran at the center of everything they do. She explained that for them, customer experience (CX) is the product of interactions between an organization and a customer over the duration of their relationship. VA measures these interactions through ease, effectiveness, and emotion/empathy. She shared that these three elements are the drivers of their program, which is building, retaining, and sustaining trust with Veterans and their families.

The Veterans Experience Office is considered VA's customer experience insight engine, which means they can channel the voice of the customer into VA thinking and doing. She shared that the way they do so is through surveys and qualitative and quantitative feedback through a process of human-centered design (HCD). Their vision is to be the best CX organization in Government and industry, validated by 90 percent of customers trusting VA.

Ms. Morton moved on to share some historical context of how VA has established VEO CX as a core business discipline. The VEO was established January 2015 after an access crisis at the Phoenix VA Medical Center. One of the first things they did in the new office was define what customer experience meant. They also focused on metric of trust and how to measure it to get a baseline. The first VA-wide trust survey went out in early 2016 and continues to the present, asking Veterans if they trust the Department to fulfill this country's commitment to Veterans. The answer in 2015 was that only 55 percent of Veterans surveyed at that time agreed or strongly agreed with the trust statement.

VEO also created a Veteran experience journey map in the 2015 and 2016 timeline, showing how VA might fit into a Veteran's life cycle rather than having the burden on the Veteran to figure out where they fit into VA's org chart. Starting in 2017, they had defined what CX meant and set a baseline, so they then did human centered design research by talking with hundreds of Veterans and their supporters to understand what their journey was like with VA in terms of their health care experience. This allowed them to create tangible tools that translated those insights into concrete actions the Department could take in the medical arena and execute at scale.

Ms. Morton shared that in August 2018 when Secretary Wilkie came into the role, he identified Veteran customer experience as his prime directive. VEO tied customer experience principles of making things easy, effective, and emotionally resonant to drive trust. In 2020, they turned their practice of human-centered design to the employee experience at VA, creating another HCD journey map to understand the pain points, moments that matter, and bright spots, to design solutions and tangible tools, trainings, leadership actions, et cetera, to translate those thoughts into impactful action. Currently, the customer experience surveys show that 79 percent of Veterans either agree or strongly agree that they trust the VA to help them with their needs.

She moved on to speak about human centered design and how they have translated insights into concrete action. In 2018, they heard from Veterans about how there were too many websites associated with VA and they didn't know where to find what they were looking for, or even which website to use. However, the Veterans would go to VA.gov to try to find those answers. VEO went to Secretary Wilkie with this information and redesigned the interface of VA.gov to be user-friendly and have the interactions Veterans were looking for. They found that the satisfaction went up 28 percent after the new VA.gov launch. Their next goal was to create a user-friendly mobile app that has the top 20 transactions Veterans make right there for Veterans to interact with. It has been launched and live for about two years with two million downloads, and they are getting almost five-star ratings on the app store, showing that it is helping Veterans do what they need to do.

VEO then looked at, what is the front door telephonically of the VA? Many Veterans didn't know where to call because there were hundreds of different numbers. VEO sponsored the telephonic front door with 1-800-MYVA-411 which allows Veterans and other supporters to get to a phone tree to get routed to the right place or speak to an operator or live agent 24/7 to find the correct number. Ms. Morton shared they receive about three million calls annually to that number.

She shared the different communication products that VEO has created that are understandable, where Veterans can see themselves in the communications. They have a Weekly Vet Resources newsletter online, as well as several different reports and dashboards that they try to make understandable and consumable to anybody who is interested in how VA measures trust, holds itself accountable for trust, and also different performance elements for things like the PACT Act implementation. With the PACT Act, VEO has been able to drive and influence marking digital and telephonic front doors for the VA specifically under the umbrella of PACT. They have also created PACT Act FAQs.

Ms. Morton noted that they had received a lot of feedback over many years about creating a more inclusive mission statement for VA other than "To care for he who shall

have borne the battle, and his widow and orphan." VEO spoke to Veterans and employees and had them choose which mission statement idea they resonated with the most. The one chosen was, "To fulfill President Lincoln's promise to care for those who have served in our nation's military, for their families, caregivers, and survivors."

She moved on to the third segment of her presentation, based on the President's Management Agenda and cross-agency priority goals in the administration. She noted it is the first time ever that they, across federal agencies -- VA, siblings in DoD, all service branches, Department of Labor, Department of Education, GSA, OMB, HUD -- are coming together to tackle the transition experience for Veterans and their family members.

VEO has also worked to create a prototype to codesign a way to pull the right resources from across federal agencies and allow the service member, family member, or Veteran to use a digital module to sort out what they want to find.

Ms. Morton finished her presentation by sharing that their goal is to have that 90 percent trust from Veterans, families, caregivers, and survivors. She then opened the floor for questions.

Judge Maney shared that he had received some of the surveys that Ms. Morton was speaking of, and that he never saw an opportunity to add a comment to their numerical ranking answer. He asked if that was something they would be doing in the future. Ms. Morton told Judge Maney that they do have different types of surveys, and many of them do have that free text comment field. She said that whether it has a comment field or not depends on their coordination with the business line owner because they would need somebody to be able to respond in real time to those comments.

With no further questions or comments, Ms. Morton took her leave and the Committee took a short break before the next presentation.

Exams Quality Program/Results – John Capozzi, Leigh Ann Skeens, Kyle Timmons, Machelle Harrell

Ms. Piper introduced John Capozzi, Assistant Director of Quality Staff in the Medical Disability Exams Office (MDEO). Mr. Capozzi introduced others who would be participating in the presentation, including Leigh Ann Skeens, Assistant Director over Training Staff, and Kyle Timmons and Michelle Harrel, two Chiefs on Quality in MDEO.

Mr. Capozzi began by explaining that MDEO conducts random quality audits and reviews on Disability Benefits Questionnaires (DBQs) completed by vendors. The vendor quality performance is assessed through accuracy and consistency of DBQ reviews, to include vendor's adherence to exam request instructions, DBQ instructions, and internal MDEO guidance provided in the form of Vendor Guidance Memorandums

(VGMs). Quarterly quality review outcomes are provided to vendors per contractual criteria and requirements.

He continued, sharing that they send out monthly error citation reports (ECRs) which providers notification of inaccuracies identified in DBQ audits, identifies error trends for all vendor contract regions, provides vendor with the opportunity to avoid future errors, and informs vendors of how to accurately report findings that are required for DBQs. MDEO conducts monthly quality calls to share current quality results, training issues related to errors cited during audits, and vendor improvement efforts. They also recently conducted a review of the process to identify opportunities for improvement. Based on the feedback from vendors, MDEO implemented the following changes: monthly quality call check-in, which is an informal call which will serve as an opportunity to discuss trending issues or areas of concern, in addition to a quarterly quality call, which is a formal call with a scripted agenda that focuses on vendor performance and efforts the vendor is taking to improve their quality.

Mr. Capozzi noted that they also conduct corporate onsite visits with each vendor to discuss quality error trend data to the vendors in a formal visit. The top error trends are discussed and based on data analysis on error citation reports and focus on their actions to improve their operations to improve quality, as well as vendor improvement efforts. They have an in-depth discussion of the impact of their efforts on quality.

MDEO training includes an industry-standard learning management system for delivery and tracking of vendor examiner training, including comprehensive monitoring of completion of required training and certifications. The contract requires examiners to complete the same C&P training as VHA examiners before conducting any examinations, which consists of a set of online courses developed by VHA. The MDEO vendor examiners must be recertified every five years, and vendor examiners who have not performed a contract exam in over a year must also be recertified. All vendors must provide an approved detailed training plan for all examiners, including all support staff and subcontractors who have routine contact with Veterans. Finally, the MDEO is conducting a 100 percent review of all vendor examiner compliance with training certification, with an anticipated total completion date of July 31, 2023.

The presentation finished; Mr. Capozzi opened the floor for questions. Ryan Scalmanini asked if their quality checklist had changed since the implementation of the new contract. Mr. Capozzi said was changed in FY21.

Mr. Bruner asked what the VA’s quality structure for MDEO was, and how the quality control mechanism they’re implementing is linked to training and policy and process adjustments so it’s a complete cycle of quality instead of a silo. Mr. Capozzi answered that the focus of the DBQ review quality process that they do currently is to comply with

the DBQ. With their monthly calls, OPO quality calls, and comparing trends, they are able to have a more complete picture.

Mr. Bruner specified that he was trying to see how the MDEO quality program cycles back into the contractors and vendors providing the exams. Mr. Capozzi said they have weekly meetings with contract leadership and vendors and talk about timeliness, quality, and how it's all impacted. He also said he would forward Mr. Bruner's question to his counterparts to get him a more in-depth answer.

Meredith Burns asked how they knew the DBQs are accurate. She shared she was a Veteran Service Organization (VSO) representative and some of her Veterans would say they weren't thoroughly checked in their DBQ exam. Ms. Burns asked what the individual Veteran is supposed to do in that case. Mr. Capozzi shared that part of the review process for the examiners and vendors in contract exams is that they have to review the claims file, so they get that documentation. It's reviewed, and they list that piece of evidence or list that they've reviewed the claims file. When they fill out the DBQ they reference when it's asked for either historical documents or they give a history into that piece of it. Ms. Burns said she has had too many experiences where someone has marked that they have read the records, but their DBQ showed they had not, or that they have copy and pasted something from the record and filled out the DBQ incorrectly. She asked if there was a discipline process to keep it from continuing to happen, and how they will weed out examiners that are dismissive of Veterans.

Mr. Capozzi said his office should see those issues when they are reviewing the DBQs and generally send it back to be done correctly. He shared that if they get too many of those on a particular examiner, there is a process in place where they reach out to the vendor and pull a sample of that individual examiner's DBQs to see if there is something there or if the issue found was a one-off. Once the DBQ is completed, it's used in the claims process, and the claims process is also looking at the evidence and should be comparing what the Veteran submitted and what's in the Service Treatment Records (STR) or other evidence submitted to see if that has been considered and listed in the rating schedule. He encouraged Ms. Burns to reach out to them and let them know if they're seeing anything specific from a particular examiner or in any case she feels they should be reviewing the examiner's work.

With no further questions or comments, Ms. Piper thanked Mr. Capozzi and his team for their time and reminded the Committee members about the surveys they are being asked to fill out for each presentation.

Final Thoughts and Adjournment

Ms. Piper thanked everybody for their participation and reminded the Committee members to log in by 8:45 a.m. for the next day's meeting. She then adjourned the meeting at 12:00 p.m.

Wednesday, June 28, 2023

Opening Remarks

Lisa Lotts, Alternate DFO for ACDC, opened the meeting at 9:01 a.m. Role was called and six members were present, so Ms. Lotts indicated quorum was met and the meeting can continue. She then turned the floor over to Ms. Piper.

Ms. Piper welcomed the Committee and others attending the meeting and reviewed the rules of engagement. She informed everybody that there would be time allotted for members of the public to address the Committee at the end of the day's session during the public comment period. She then turned the floor over to Mr. Hazell.

Committee Member Introductions

Mr. Hazell introduced himself and requested the Committee members introduce themselves for anyone not present to the previous day's meeting.

COVID-19: End of National Emergency – Abigail Werner

Ms. Piper introduced the first speaker of the day, Abigail Werner, Policy Liaison for CS. Ms. Werner thanked Ms. Piper and began her presentation by explaining she would be giving an overview on the impact to CS resulting from the declaration to end the COVID-19 national pandemic.

To acknowledge certain impacts in the claims process, CS issued Policy Letter 20-02, the Novel Coronavirus Claims and Appeals Processing Guidance, and issued two publications in the Federal Register about the disruption of mail services in April and August of 2020. The Federal Register Notice publication stated that the policies were effective March 1st, 2020 through 60 calendar days following the date the President ended the national emergency. During the temporary procedures for the pandemic, CS had allowed pandemic concerns to serve as a good cause basis for granting certain time limit extensions for submitting documents and responses. In addition to failing to report to a hearing or requested examination, they allowed the acceptance of a

postmark date as the date of receipt by VA. Those temporary procedures began March 1, 2020, and end on June 10, 2023.

She continued, sharing that as of June 10, 2023, they had rescinded and archived the temporary guidance and then issued a memorandum with instructions to their claims processors to resume existing regulatory and procedural guidance. They also required a mandatory training course to give a refresher on what should be applied when it comes to good cause and date stamps. CS previously had a letter that claims processors request to send out when they request an examination or hearing informing the claimant that during the national pandemic, they were able to hold their claim simply by expressing they had those pandemic concerns. However, that authority has now expired, so they can no longer hold the claim and request that the Veteran attends that needed examination or hearing.

Ms. Werner also noted that they have recognized the potential of a reemergence of COVID-19 or other national pandemics, so they would revisit and reconsider reestablishing any temporary procedure as needed to properly respond to those national emergencies. She also assured that the rescinding of the temporary claims and appeals processing guidance does not impact 38 USC 1164, presumptions of service connection for coronavirus disease.

Ms. Werner then opened the floor for questions. Mr. Bruner asked if there is still a backlog of claims, and if there has been an impact to the backlog amount with the changes. Ms. Werner shared that there were only about 300 claims being held for a needed examination, so there was a small caseload, but they don't anticipate that to be a major impact in the claims process or to add to the backlog in any major capacity.

With no further questions or comments, Ms. Werner thanked Ms. Piper and the Committee for their time and took her leave. Ms. Piper reminded the Committee of the QR codes to answer questions about the presentation, and the Committee took a brief break before the next presentation.

Part 3 Regulations – Robert Parks

Ms. Piper introduced the next speaker, Robert Parks, Chief of Regulations Staff, Compensation Service. Mr. Parks introduced himself and explained that they would be talking about the Code of Federal Regulation (CFR). Title 38 is Pensions, Benefits, and Veterans Relief, and he would be reviewing Chapter 1, Part 3, which is titled "Adjudication." He explained that 3.1(p) defines what a claim is, 3.1(k)K defines what service connection is, and so on. Part 3 talks about what periods of war are, eligibility for service, what the parameters are, what different types of service connection, and so on.

Mr. Parks shared how specific sections of the PACT Act has been added to Chapter 3, such as sections 401 and 402 which are being added specifically as radiation risk activities for consideration of the PACT Act. These can be found in 38 CFR 3.309(d)(3)(ii)(f)-(h). They are also in the process of changing several regulations. The main body of what they are implementing for the new PACT Act changes is going to be found in the regulation title currently AR75 and is a proposed rule that has not yet been submitted. This change will be implementing PACT Act sections 102, 302, 303, 405, and 406, which are sections that define toxic exposure risk activity (TERA), exposure tracking system, et cetera.

They are also working on changes under 303 to the current CFR 3.159 which has to do with exam thresholds. Section 405 will be adding six locations to 38 CFR 3.317, changing the medically unexplained chronic multisymptom illness (MUCMI) manifestation, and 302 406 will be adding new locations for the PACT Act and service period changes to 38 CFR 3.320. He shared that AR10, originally done to implement the Blue Water Navy Act of 2019, has been on his office's radar for a while but there have been several changes as new changes and laws develop, so they have not been able to fully create a proposed rule as they continued to change with the new laws. However, they do anticipate that AR10 will be coming out shortly as a proposed rule, but it is not only going to have implementations for the Blue Water Navy Act. It will also have what was previously regulation AR45, which was implementing from the 2021 NDAA, the three conditions that added bladder cancer, hypothyroidism, and Parkinson's. It will also be adding PACT Act sections 403 and 404.

Mr. Parks mentioned Title WP2023-022, which is expected to be in an interim final rule. He shared that they are going to be pulling a section out of AR10 that was originally in there, and separately implementing it. They are working to make sure they are currently framing how they do manifestation periods for each individual condition correctly.

Beyond PACT Act, the Part 3 staff is working on many projects. One is AR25, to do with Gulf War particulate matter. They implemented an interim final rule in August 2021 which added three new respiratory conditions and created 38 CFR 3.320. A44, rare cancers, had nine rare respiratory cancers added to 3.320 in April 2022, and is also an interim final rule.

For AQ95, character of discharge, Mr. Parks shared they have been working on this rule for 10 years or so. They published a proposed rule in the Federal Register In July 2020 which made several changes. They then published in September 2021 a request for information, did listening sessions, garnered additional comments on the regulation, and asked a lot of additional questions. He noted that VA leadership is weighing their options and trying to determine what the best course of action is based on the

information received for who to move forward with altering the character of discharge regulations.

He moved on to AP67, apportionments, which was published as a proposed rule in 2022 and they are now working on the final rule. He shared it would be changing the apportionment landscape a lot, especially for claims processors. They decided with the regulation that for the most part, they are going to get out of the needs-based appointments and will continue to honor all apportionments that are currently active. However, going forward, they will only do apportionments on limited cases, primarily for incarceration or people who are institutionalized at government expense who don't have a fiduciary.

Mr. Parks said they have been working on active-duty service pay for several years, specifically in terms of members who go on active duty for training or inactive duty for training who end up getting paid military pay for those training periods. As the law is clear that you cannot receive both VA benefits and military pay, they have been forced after the fact to recoup money from people and are trying to find ways to be more proactive, such as letting service members either collect a different way or find a different way the process can be done so they don't end up recouping as much.

For COVID-19, they incorporated the changes to law using Policy Letter 20-02 to implement the changes, as Ms. Werner spoke about earlier. He said they are making necessary changes the law made to the regulations with a proposed rule in the future. They are also working to update regulations to incorporate changes to do with the Military-Veterans Advocacy v. Secretary of Veterans Affairs, et al decision, which have to do with supplemental claims and intent to file (ITF).

In addition, they are in the process of drafting a regulation which is going to change how they do evidence handling for certain covered mental health conditions. 38 CFR 3.304F5 says if you have a PTSD claim, you may utilize what is called markers which can be found in your record that could indicate a claimed condition occurred during service, which helps to service connect that condition. This is currently limited to PTSD, but they are working on allowing those markers to be obtained for all covered mental health conditions and would have a lot of impact on military sexual trauma (MST) but also for personal trauma.

They are working to revise regulations on forfeitures for subversive activity, specifically related to 38 USC 6105 which limits people who participate in subversive activities and doesn't allow them to receive benefits if they are convicted. He shared they are making some changes to this. They are also working on conditional charges, clothing allowances, and auto allowances.

Mr. Parks finished his presentation but had no time for questions before the next speaker. The Committee took a short four-minute break and Ms. Piper reminded them about the presentation survey.

Military Environmental Exposures: Presumption Research – Dr. Patricia Hastings

Ms. Piper introduced Dr. Patricia Hastings, Chief Consultant for Health Outcomes Military Exposures with the Office of Patient Care Services. Dr. Hastings shared she would be speaking about the PACT Act and the work they've been doing with presumptions.

Dr. Hastings recalled how her office got a report back from the National Academy of Sciences, Engineering, and Medicine in regard to burn pits and conditions that may be associated. She said it was apparent the National Academy report did not put anything forward, but her office felt there were things to consider so they worked with their VBA colleagues to find what the top five conditions related to airborne hazards are that they're seeing in the Veteran population. The answer was asthma, rhinitis, and sinusitis.

Once they researched specific literature on those conditions, they found there was a strong association with airborne hazards and went forward with a recommendation to the Secretary that asthma, rhinitis, and sinusitis be considered for presumption, which they were. Congress asked the proposed methodology put together by her office to be looked at by the National Academy of Sciences, Engineering, and Medicine to make sure it's fair, equitable, and makes sense. Dr. Hastings said they expect to get the report back sometime in September 2023.

She shared that they are looking at issues with Red Hill, and the concern for the possibility of increased lymphoma for those people who worked in the missile silos. They are looking at a number of other concerns, including Veterans who have served in Southeast Asia, the treatment of Veterans for medical issues after deployment, a study on cancers, and mental health outcomes (specifically ADHD, dementia, bipolar, depression, et cetera) as related to military environmental exposures. They are also involved in 509, which is putting together a website with federal research that relates to military environmental exposures.

Dr. Hastings then said she would be soliciting the Committee's help, asking them to review the Federal Register Notice when it is published and give her their input, which she looks forward to receiving. She also shared that instead of 24 new presumptives added with the PACT Act, there were over 300 that were put into categories.

She gave some specifics about how everything moves through the system. She said they have a working group called the Military Environmental Exposure Sub-Council (MEESC) that sits under the Evidence-Based Policy Council, and her office are briefers

to MEESC on trends and areas of concern. MEESC will then either direct more work to be done, or if the work is completed and they believe it's ready, it will go to the governance pathway and eventually get up to the Secretary for information or a determination.

She then shared some of the workflow leading to a recommendation for presumption, including surveillance, selection of conditions and cohorts to study based on trends and early signals, steps for scientific review, administrative review of the report, and then recommendation of presumption is submitted through VA governance for SecVA.

Dr. Hastings opened the floor for questions. Frank LoGalbo asked if she could expand on what research and things they are focusing on for leukemia, and if it is one of the conditions that is going to be added or suggested in the Federal Register coming up. Dr. Hastings said they do want to do a deep dive on leukemias, and that it would be acute and chronic leukemias they would advocate for.

Dr. Lewis asked if the data about radiation and exposure for pilots is also based on civilian data, since not all Veterans go through the VA. Dr. Hastings said her office compares groups to deployed and non-deployed, but they also look at cancer rates outside of the VA. They are currently working on a project to get all of the state cancer registries tied together so they would also have that data.

Dr. Lewis then asked if there was a particular place they could find the research she had mentioned throughout her presentation. Dr. Hastings said she would put the links in the chat for them.

With her presentation complete and no further questions, Dr. Hastings took her leave.

Ms. Piper determined that Judge Maney was now in attendance of the meeting, so she updated their attendance number for the day. The Committee took a short break before the next presentation.

Veterans Service Organization Applications – Zach Goldfine, Ray Tellez

Ms. Piper introduced the next speaker, Zach Goldfine, Deputy Chief Technology Officer at the VA with a focus on benefits. Mr. Goldfine thanked Ms. Piper and introduced his colleague, Ray Tellez, with the Veteran Benefits Administration.

Mr. Goldfine shared that they want to communicate that they're taking action for technology products and tools aimed at accredited representatives and folks that work at VSOs and law offices so they can make sure the tools are useful to them to help Veterans manage their interaction and relationship with VA. He emphasized that this is something they are invested in and care about and are putting time and energy into.

He spoke about the Stakeholder Enterprise Portal (SEP), and how the most valuable part of the tool is to be able to approve, reject, or review when a Veteran submits a VA Form 21-22 looking to appoint a power of attorney. His office recognizes that if SEP were to no longer be supported or if the functionality was no longer available due to creating updated systems, it would be a problem for VSOs and there would be no alternative.

His office has worked with VSOs and others to learn how they use the tool, and how they use other functions in the tool. The first thing they are focusing on is rebuilding or replicating the functionality in a sort of more modern technology tool or space. They are working on building something on VA.gov to ensure that Veterans seeking power of attorney or accredited representation can find that easily and can submit a VA Form 21-22. They are taking action to make this by investing in a team to focus exclusively on this starting within the next two months.

Mr. Goldfine also shared that for the VSO or accredited representation facing portion that they are taking action on investing in with a team starting within four months. They are researching how it looks for a VSO to review something submitted by a Veteran, and how to make it as quick and simple as possible for them to determine whether or not they want to accept the VA Form 21-22 submitted.

He shared that they are working to help VSOs or accredited representation use alternatives that already exist to avoid issues with things like outdated forms that are rejected. He highlighted that they could use direct upload or quick submit, which may not be intuitive but will work for their needs. They have a concurrent or parallel development of a long-term strategy to ensure that the small and specific changes they are making represent the biggest needs, and are part of a larger strategy they're executing on to make sure all their needs are properly met. Having reached the end of his presentation, he opened the floor for questions.

Mr. Hazell asked if Mr. Goldfine was able to speak more about the long-term strategy and what type of things they're looking at. Mr. Goldfine indicated that he was not able to do that at this time, but when he is able to, it will be shared with the Committee. Mr. Hazell then asked if Mr. Goldfine was able to share about whether or not the plan for VSOs and stakeholders would allow them to draft forms in the new system, or if they would only be able to submit them. Mr. Goldfine said for the long-term strategy, their approach is going to be speaking with VSOs and colleagues and looking at the data of the most used features and how they are used. They will then start with the most used and most needed features, ensuring they will be able to recreate that in some way.

Mr. Wolf shared that the automation they utilize with SEP makes it quicker for them to not have to fill everything out, only the information not gathered from the Veteran. He shared how on VA.gov, they don't have a "user" role, which would make it difficult to use

automated information to fill out forms. He asked Mr. Goldfine to keep that in mind going forward. Mr. Goldfine said their measure of success will be to what extent VSOs and others are able to do the things they need to do every day as quickly, easily, and accurately as possible.

Ms. Burns shared that when she needs to add something to a Veteran's claim such as a DD-214, going through direct upload is a number of other steps and that sometimes items can get stuck in the central mail portal, where the upload feature attached to SEP is much faster and is immediately in VBMS. She was concerned that when SEP is shut off, the feature won't be recreated and that could cause confusion for Veterans. Mr. Goldfine asked for her to share in the chat a good contact for him to speak about that with, because he had not heard of the issue with the mail portal before. Ms. Burns explained that it can take a week or longer to be put into the Veteran's VBMS if uploaded to via direct upload.

Mr. Tellez commented that about 70 percent of the mail being received is automated, so if they are seeing things take longer than one or two days, to contact him with examples so he could look into that. Mr. Goldfine agreed and added that the functionality to have uploads show up immediately into VBMS already exists and he can speak with her about how to use the function for the people she works with. He also encouraged her or any of the Committee members to reach out to him if they have additional questions or concerns.

With no further questions or comments, the presentation concluded and the Committee took a brief break before the next speaker.

VA Schedule for Rating Disabilities (VASRD) – Nicole Dumas

Ms. Piper introduced Nicole Dumas, VASRD Acting Assistant Director in Compensation Service. Ms. Dumas thanked Ms. Piper and informed the Committee that she would be giving a status update to the Committee on VASRD. She began with a brief history of VASRD, sharing that in 1988, GAO advised VA to develop a plan for reviewing and revising the body systems. VA made numerous updates to the VASRD.

In 2003, GAO performed another review and determined the program was still grounded in outmoded concepts. They then added VA to the high-risk list. In 2009, the Undersecretary of Benefits (USB), on behalf of the Secretary of VA, directed the complete review and revision of all body systems, which began iteration one of the modernization plan and VA created the VASRD Program Management Office.

VA's goal is to ensure the disability rating criteria accurately reflect medical advancements and improvements in technology, because VA understands it will enable

to them ensure they are accurately compensating Veterans based on impairments and the average earning ability.

Ms. Dumas shared that it is important for them to talk about 38 U.S.C. 1155. She shared two points: the Secretary shall from time to time readjust the schedule of ratings in accordance with experience; and ratings shall be based, as far as practicable, upon the average impairment of earning capacity resulting from such injuries in several occupations.

This is the first complete update to the VASRD since 1945, and so far, VA has updated 10 of 15 body systems, with the five remaining body systems to be completed potentially in the next one to two years. VA is currently in the process of finalizing digestive; respiratory; ear, nose, and throat (seen as two body systems); and mental disorders. They are in the final rule and concurrence process. The last body system, neurological, is still in the VA concurrence phase and they hope to have it finalized in 2024.

For the future of VASRD updates, they plan to move to iteration two as soon as iteration one is completed, and that will be another comprehensive review of all the body systems, which they hope to start in fiscal year 2024. Iteration two is projected to last from 2024 to 2028, and VA will potentially be including earnings loss study data within the updates to each body system. VA's goal is to ensure they have updated medical terminology, remove obsolete conditions, and incorporate any medical advances that have occurred since the last review of each body system.

Ms. Dumas shared that one of the things they learned with iteration one was to ensure proper staffing. They now have allocation for ten regulation analysts that will allow them to have multiple rules going on at the same time without hindering any of the process. They are fully staffed and capable to perform as needed to ensure they get the proper updates to the VASRD.

They are also working to minimize the number of diagnostic codes and things that need to be updated in a single rule, then it has more potential to make sure the rules progress more rapidly than in the past. In addition, they will continue to maintain contact with their work group and subject matter experts to ensure the rules are being updated properly.

Ms. Dumas opened the floor for questions. Dr. Lewis asked if the consequences of minimizing codes would be in terms of who would be determining, and how they would determine what's going to be eliminated or not updated. Ms. Dumas said it's not the process of what needs to be eliminated, and that what they are hoping for is that because they have already done all the rules by iteration two, less would need to be updated. If there is a body system that has more diagnostic codes, they would either choose to pursue all the diagnostic codes in one rule or break the rule up into multiple

rules which will still help them reach the goal of having minimized the condition updates within a single rule.

Dr. Lewis then asked if, for iteration two, they would start the reviewing process from the beginning, utilizing the ones that have already been approved, and then move through again. Ms. Dumas said they would look at it thoroughly, and even if it is updated before, they will still look at all the body systems and the medical science related to that body system. If they had updated it the last iteration, that does not preclude them from updating it in the next iteration. The goal is not necessarily to start in the same order as the last iteration, with dental, but with the increased staff they are able to review multiple body systems at the same time.

Mr. Bruner asked if there was more information about a critical path analysis of all the different boxes shown on the concurrence dashboard for iteration one. He feels that VA needs to do a critical path analysis to see if all of the people included in the concurrence dashboard are required, and if some of the boxes can be done in parallel. Ms. Dumas said it was outside of her level to decide if they can cut down on the amount of people in the concurrence process, but they can control how many updates are included within a particular rule.

Ms. Piper thanked Ms. Dumas for her time and the Committee took a short break before the next presentation.

Earnings and Loss Study Updates – Olumayowa Famakinwa

Ms. Piper introduced their next guest, Olumayowa Famakinwa, VASRD Implementation Chief. Mr. Famakinwa shared with the Committee that in the ACDC May meeting, there were questions he was not able to answer as they were more related to the work the contractors were doing. Therefore, he invited the contractors to lead the presentation and hopefully answer the questions the Committee had. He introduced Dr. Pat Mackin and Dr. Sarah Prenovitz.

Dr. Makin told the Committee that he would be sharing some results with them. They do their work in the census environment because they match VA administrative data with census data and IRS earnings data. Any results need to go through the census disclosure review process to make sure it’s protecting the privacy of survey respondents.

He shared that the earnings loss study is headed by VA Compensation and a contractor team, SAG Corporation, which is the company he works for. There are two subcontractors, Abt Associates, which Dr. Prenovitz works for, and Juncture Counseling. They provide clinicians who have experience in the processes, but there is also a lot of interactions with other actors such as Performance Analysis & Integrity

(PA&I) and the VA Office of Enterprise Integration (OEI) who provide data for the project and serve as a liaison with the Census Bureau as far as transmitting data there and coordinating data use agreements.

The Census Bureau is the hub of the project. Data is sent from VA to match for individual Veterans to responses to their key surveys, and matched via those matches to administrative data from the IRS and Social Security Administration. This way, the VA ends up with a lot of historical information on employment and earnings for Veterans who were identified in the data with disability ratings.

Dr. Makin then shared a top-level timeline overview of the project, starting in 2017, which was a proof of concept. It was a 12-month study, followed by the second phase which ran slightly over 12 months where they tried to flesh out the methodological issues. They are now in the current phase, ELS 3, where they are in production mode and estimating earnings losses for over 100 diagnostic codes every year. They are also improving the data and models to get better precision and accuracy, as well as looking at several aspects of the complicated relationship between earnings and disability for Veterans.

In the current year of 2023, they estimated earnings losses for 127 new diagnostic codes and a couple of key improvements in the model. They are looking at estimation techniques, such as a procedure called shrinkage estimators which are ways to get more precise estimates for small sample sizes. They are working to refine how they treat the cases where Veterans have changes, usually increases in the rating levels, to make sure they're not losing any data. He said they are continually looking for additional data to improve expanding the size of the sample to improve the results and make them more precise. Getting access to clinical data helps with figuring out why when they see differences in the earnings loss experience of Veterans, such as a group of Veterans with the same diagnostic code and rating level but differences in earnings loss.

Dr. Makin said they had some additional administrative earnings and employment data available in the census environment they're looking at currently from a data set called the Longitudinal Employer Household Dynamics (LEHD). This provides them with quarterly data on earnings rather than annual data, and potentially a larger number of Veterans matching to the data. He then gave the floor to Dr. Prenovitz for her portion of the presentation.

Dr. Prenovitz showed the Committee a graph and explained that it is an example for one diagnostic code selected, the amputation of the little finger. The idea of the graph is they're thinking about the effect of the disability onset as being the difference between the black horizontal line and zero dollars and what their estimate is as they continue. Date of onset is also shown on the graph so they are thinking about how for some conditions, they can expect to see changes over time if the condition gets more severe,

or decreases over time, or has a stable pattern. They are always thinking about what the impact is of the diagnostic code at any given point.

She shared how they organized their analysis to look at the most prevalent conditions first so that as they work their way through the project, they're dealing with smaller and smaller samples. As they collect more data, they are able to conduct further refinement. They are also thinking about further refinement to handle rating changes.

Dr. Prenovitz said they have explored dispersion analysis which answers the question of how spread-out earnings losses are. They look at all the changes from pre- to post-onset for Veterans and determine the 10th percentile and 90th percentile, then graph them out. They also use a method called quantile repression which allows them to take demographics into account and control for some other things they'd like to control.

She shared that the reason they're interested and concerned about dispersion is that it's one of the reasons for variations in competence intervals, no matter how large the sample size is or how good the technology is. Also, if they have a lot of dispersion even within a particular rating level, that means the rating level contains Veterans who have very different earnings experiences.

One thing they do as part of the project is constantly refining and advancing their methods. They are currently working on ongoing efforts to extend and improve their models by increasing the accuracy and precision of the estimates, exploring additional dimensions of earnings losses, and using additional data sources. This includes the potential use of synthetic data which might allow for easier peer review of models and estimates and which could potentially allow for publicly available working papers that would allow this methodology to be reviewed more widely.

Dr. Prenovitz noted that they are also working on plans for what might be done with self-employment income, which would provide a more comprehensive picture of earnings than the current estimates that are focused on W-2 earnings. In addition to this, they are working on analysis plans which look at the impact of presumptive service connection, the effect of recessions and other labor market disruptions, and testing the quality of earnings losses for conditions that share rating criteria. She then handed the presentation back over to Dr. Mackin.

Dr. Mackin said that being in the third year of ELS, the question arises of how this information can be used for reviewing the schedule. He shared that they have been working on a proof-of-concept study that is taking some of this information and then figuring out how, in practice, that evidence can be used to improve the rating schedule. When they have imprecise estimates, what can they do with that information other than continue to try to improve and become more precise? He shared that there are a couple of possible explanations for the imprecision. Those include that the data and

models need to be improved, or there could be some imprecision in the rating criteria. This is an area where having more detailed clinical data might be useful in some cases to see if there are clinical differences to help explain some of those differences in earnings.

He shared that they show results in two ways, and those are results that are expressed in losses in terms of dollars, or in terms of percentage changes. He conceded that there are a lot of aspects of how disability affects earnings that could also explain variation. For their purposes, they are trying to isolate what is contributing to the degree of disability as it should be reflected in the rating schedule. Another issue is the effects of presumptive conditions, which is one of the technical issues they are looking at in the detailed analysis plan. When they observe data on Veterans who receive a rating for a particular condition as a result of a presumptive condition, they may look different than other Veterans historically who were rated in the absence of a presumptive condition, for a variety of reasons.

One reason could be that the presumptive service connection can induce more Veterans to be rated, such as some who have the disability but wouldn't have bothered to ask for service connection if it weren't presumptive. Another reason could be that they may be getting rated at much further from the point of actual disability than those who were rated under other conditions. They want to get a better understanding of how that evidence can be used for the schedule review, and that the research team gets good feedback on ways to give the evidence in a more useful fashion where possible.

Dr. Mackin continued, sharing that the third option year of ELS 3 starts at the end of September. With this, they have some priorities on their list. One is adding at least another 100 additional diagnostic codes to their results, which they'll focus on. Then, areas in which they are going to refine the modeling approach by looking at things discussed in the presentation. This year, they're doing detailed analysis plans that will be implemented in the following year or the year after that so they have a continuous cycle of improvement.

Having finished the presentation, Dr. Mackin opened the floor to questions.

Dr. Lewis recalled part of the VASRD presentation and how they were looking to see how they might potentially utilize the information from the study that ELS 3 is producing in their next iteration. She asked if Dr. Mackin sees that as a possibility, particularly with the variations between the confidence intervals and other areas he spoke about.

Dr. Mackin answered that there are a large number of diagnostic codes where they have very small confidence intervals and he feels there is some useful information that can be used immediately. In some cases where they see imprecision, it could be useful information for the review that there may be cases where this points to an area to

explore if the rating criteria can be improved. If there are three different rating levels for a particular diagnostic code, are the relative differences in the earnings losses largely reflective of that, or is there more or less compression than one would expect? This is one of the points that may show an area to improve. He shared that there is a lot of information that is useful now to start the process, and that's also what the proof-of-concept study is trying to figure out.

Mr. Famakinwa added that a lot of it is dependent on the outcome of the proof of concept in terms of their experience with utilizing data. They are trying to determine what level of confidence is good enough to introduce it into the wild or to have it as part of their basis for revisions. They are potentially writing a regulation that introduces ELS to help it get to a point where it's well-positioned be fully used on a regular basis.

Dr. Lewis thanked Mr. Famakinwa and concurred. She encouraged the ELS team to continue giving the Committee as many briefings as possible to not only see progress but have the potential to ask questions they might have before actual decisions or processes are made by ELS.

Ms. Piper thanked the ELS team for the updates and the Committee took a short break before moving on.

Public Comments

Ms. Piper invited any members of the public who which to speak to do so at this time.

Tracie Johnston from Smyrna, Delaware said she had more of a comment and suggestion for ACDC. She began by thanking the Committee for having the meeting. She told the Committee that if they are going to add a disability for the PACT Act that includes radiation, they should put in a request for disability ratings for depleted uranium for those who were exposed to it through inhalation, ingestion, or absorption, and not just from shrapnel. She shared that her husband was part of the Army National Guard, the 144th Service and Supply Company out of Hammonton, New Jersey and was affected by uranium not through shrapnel.

Ms. Johnston shared some information from the CDC, stating that it states extended exposure from inhaling depleted uranium can cause lung cancer from exposure to high alpha particles, and ingesting it can cause cancer of the bone or liver. Harvard International Review in 2021 about depleted uranium in the military operations in the Middle east shows long-term effects of depleted uranium in children who were exposed.

She also shared that many years ago, she attended a Committee meeting and they were given a questionnaire that had one question asking very specifically if the Veteran was deployed prior to 1991 and served with 144th Service and Supply Company out of Hammonton, New Jersey during Desert Storm. She said that after they completed the

questionnaire, they noticed that the question had been removed from subsequent surveys. Ms. Johnston thanked the Committee again.

Final Thoughts and Adjournment

With no further public comments, Ms. Piper reminded the Committee members to sign and return their invitation letters by June 30.

Dr. Lewis thanked the Committee for their attendance and engagement and felt the presentations were not only very good, but also very interesting with more in-depth information.

Ms. Piper thanked everybody for attending and adjourned the meeting at 12:05 p.m.

Elizabeth Alice Roy
Jamison Professional Services
Preparer of the Executive Summary

JADINE PIPER
Digitally signed by JADINE PIPER
Date: 2023.10.17 15:32:34 -04'00'

Jadine Piper, Committee DFO

Evelyn Lewis
Committee Chair