

DEPARTMENT OF VETERANS AFFAIRS
ADVISORY COMMITTEE ON DISABILITY COMPENSATION
October 20-21, 2014

MINUTES

Members Present:

LTG James Terry Scott, USA (Ret.), Chairman
Col. Doris Browne, M.D., MPH, USA (Ret.)
Robert J. Epley
CAPT Warren A. Jones, M.D., USN (Ret.) **
John L. Maki
MG Joseph K. Martin, Jr., M.D.
Elizabeth Savoca, Ph.D.
Michael Simberkoff, M.D.
Mark W. Smith, Ph.D.

Members Not Present:

Bonnie Carrroll
Deneise Turner Lott, J.D.
MG Timothy J. Lowenberg, USA (Ret.)

Staff Present:

Nancy Copeland, DFO, VBA
Raymond Foreman, VBA*
Eric Mandle, VBA*
Gerald Cross, M.D., DMA, VHA*
Mark Bowen, DMA, VHA*
Patricia Murray, DMA, VHA*
Danny Devine, DMA, VHA*
Thomas Lynch, M.D., DMA, VHA*
Brad Houston, OBPI, VBA**
James Leiman, OBPI, VBA**
Mick Worstell, OBPI, VBA**

Ron Burke, AMC, VBA**

Also Present:

Peter Dickinson, DAV*

Garry Augustine, DAV*

Todd Hunter, DAV*

David Forgash, GAO*

Gerald Manar, VFW*

Paul Varela, DAV

Jordain Carney, National Journal

Ray Wilburn, CNA*

Victoria McLaughlin, McLaughlin Reporting LLC

* October 20 only

** October 21 only

The Advisory Committee on Disability Compensation met in public session on October 20, 2014, in Room 730, and October 21, 2014, in Room 630, U.S. Department of Veterans Affairs, 810 Vermont Avenue, N.W. Washington, D.C. 20420.

Monday, October 20, 2014

Opening Remarks

Chairman Scott called the Committee to order at 8:10 a.m., and offered Mr. Raymond Foreman, Budget Analyst, the opportunity to address the Committee on logistics related to members' travel and reimbursement. Several Committee members had specific questions regarding their travel. Mr. Foreman responded and then departed the meeting.

In his opening comments, the Chair noted: (1) the work that has been done to date by himself and other members on the Biennial Report (due 31 October), stating the Committee will continue to discuss how to address the following issues: (a) TDIU; (b) the proper approach to the rewrite/revision of the diabetes code in the VASRD; and (c) other matters relating to the Reserve Component, zero percent, presumptions, and appeals; (2) the need for the report to have firm actionable recommendations for the VA; and (3) the Committee in addition to its work on the report would also be receiving a number of scheduled briefings during this two-day session.

The Chair then invited opening remarks from the members. They are as follows:

- Mr. Maki stated: (1) re TDIU, he agrees more data is needed and he is in favor of waiting for the GAO report before the Committee voices a view; (2) re diabetes, while acknowledging it is a controversial issue, he is not in favor of delaying the rewrite; and (3) re fully-developed appeals, he is prepared to draft a recommendation for the Committee's consideration which will support the proposal in the briefing scheduled for later this morning by Mr. Peter Dickinson and Mr. Garry Augustine.
- Dr. Simberkoff described the actions that are part of a robust process now underway at VA facilities to ensure that both health care staff and the medical facilities are properly prepared to deal with any Ebola cases.
- MG Martin noted the capabilities and capacities in the Reserve Component for dealing with emerging threats like Ebola. He stated in 2010, the Secretary of Defense assigned the National Guard the duty of developing a force to be first responder to chemical, biologic, nuclear, high explosive kinds of events, and since that time the Guard has trained, equipped and certified a force of 10,000 people for dealing with such threats. Although these capacities have not to date been exercised overseas, this sort of approach may be a future consideration.

Opportunity for Public Comment

The Chair welcomed members of the public and invited them to identify themselves and, if appropriate, the organizations they represent. Following the introductions, there were no public comments, and the Committee proceeded to its first scheduled briefing.

Fully-Developed Appeals Process, Mr. Peter Dickinson, Senior Advisor, Disabled American Veterans, and Mr. Garry Augustine, Executive Director, Disabled American Veterans

Chairman Scott welcomed Mr. Dickinson and Mr. Augustine and invited them to kick off the discussion on the fully-developed appeals proposal.

Highlights of the briefing and Committee comments/questions/discussion are as follows:

- Appeals issue in VA is growing exponentially. As the claims backlog decreases, the number of appeals is increasing. At least ten percent of all VA decisions are appealed.
- Appeals may take as long as four years and in some cases even longer to resolve.
- **Fully-Developed Appeals Proposal**
 - (1) Some options are being considered by a group of stakeholders which would build on current ideas already on the Hill. These stakeholders include VSOs

(DAV, American Legion, AMVETS, Paralyzed Veterans of America, VFW and Vietnam Veterans of America), as well as VBA, the Board of Veterans' Appeals, and representatives from congressional committees.

(2) There is recognition that there is no one way to attack the problem.

(3) There is consensus among all stakeholders that the best idea to reduce appeals is to not have appeals.

(4) To reduce the number of appeals, there is consensus among the VSOs that resolution of claims at the local level can be increased by use of the DRO (Decision Review Officer) program, and they believe DROs should be doing DRO work 100 percent of the time. **Mr. Dickinson requested that the ACDC continue to emphasize the importance of using this program as it was originally intended.**

(5) The idea for a fully-developed appeals process is based upon the success of the fully-developed claims process.

(6) The proposal would allow an appeal to "jump the docket." This would require a change in existing law; thus, Congressional intervention and support and cooperation from the VBA and the BVA are necessary.

(7) In the proposal as it is presently written, the Notice of Disagreement does not list the option for the DRO choice. This omission needs to be addressed.

(8) A change in law is necessary to allow new evidence to stay with the appeal file.

(9) The fully-developed appeals program must be a congressionally mandated pilot program.

(10) The fully-developed appeal package as envisioned in the proposal would consist of (a) the entire claims record with any additional evidence gathered and submitted by the veteran, to include all doctors' opinions, missing records, lay statements of support and any arguments desired; and (b) a signed certification indicating both the veteran's desire to enter the process and his/her understanding of how the process works.

(11) Only those veterans who want to get involved in their own appeal would choose to take advantage of this option. If the choice is made and the requirements met, the package is transmitted directly to the Board. A veteran may opt out of the process at any time and go into the regular appeal process. However, once a veteran has opted out, he/she cannot reenter.

(12) Upon arrival at the Board, these cases would go into a separate docket. There are to be two dockets, one for fully developed and one for the balance of

appeals. Balancing the two dockets is critical. The desired goal would be to have 4/1 balance: for each fully-developed appeal, the Board would do four normal appeals.

(13) **Proposed Process.** A case would be received at the Board. It then would go to the VSO for review. Following the VSO review, it is returned to the Board and then follows the normal process. The Board either allows or denies, or if more development is needed, instead of remanding back to the AMC, the case remains with the Board and is assigned to the Development Unit, a new entity within the Board created to complete development of federal evidence, to obtain current exams or an independent medical opinion. Upon conclusion of the Development Unit's work, the VSO and/or the veteran is given another opportunity for review.

(14) New regulations have been issued which will allow evidence filed after an appeal has gone to the Board's docket to remain with the Board. The RO would no longer have to write a new statement or reexamine.

- **Some Potential Advantages of a Fully-Developed Appeals Process.**

- (1) Possible reduction in workload at VBA and the Board.
- (2) Evidence is fresher which may reduce need for new physical exams.
- (3) Time to decision for a veteran can be reduced by up to 1,000 days.

- **Some Questions and Discussion:**

(1) In response to Dr. Browne's question, whose responsibility is it to educate the veteran on this process, Mr. Dickinson answered it is a shared responsibility, adding that the form a veteran must sign before entering the program must be designed to allow for a well-informed decision. The VSOs also have an obligation to educate the veteran.

(2) The Chair asked who will draft the required legislation? Mr. Dickinson responded it will be done on the Hill with input from the stakeholders involved in the development of the proposal.

(3) Mr. Augustine requested ACDC support of the proposal. The Chair stated the Committee is planning to offer support.

(4) In response to Mr. Wilburn's question re how the pilot would be structured, Mr. Dickinson stated it would be a national pilot, not limited to any particular region, and tracking of all the steps in the process would be done. Two critical questions to be answered by the pilot: does it speed up the process enough for the veteran, and does it reduce the workload for both VBA and the Board?

In closing the session, the Chair thanked Mr. Dickinson and Mr. Augustine for the very useful briefing and stated the Committee would do all it could to support the effort.

The Committee took a short recess and reconvened for the next presentation.

Current Status of VASRD Update Master Plan, Mr. Eric Mandle, Legal Analyst, Policy, Part 4 VASRD Update Staff, Compensation Service, VBA

In introductory remarks, Chairman Scott stated that the focus of today's update would be on the regulations side. He invited Mr. Mandle to make the presentation. In introducing the topic, Mr. Mandle stated the presentation would include a brief overview as well as the current status of the regulations and a look at the future.

Highlights of the briefing and some Committee questions/comments follow:

- In the overview, Mr. Mandle: (1) named the doctors and the body systems for which they were responsible, as well as the legal consultants and chiefs who are helping with the technical aspects of regulation writing, policy considerations, and just bridging the gap between medicine and the regulation process; (2) gave a brief history of the Update Project, which began in 2009 and is predicted to be completed by December 2016, with the goal of having a final regulation for each body system published at that time in the Federal Register.
- Following publication in 2016, each body system will enter a staggered review cycle with the goal of ensuring no system goes more than a total of ten years without a comprehensive review.
- Ultimate goal is to ensure veterans obtain the most accurate and fair benefits based on their disabilities and the impact on their earnings loss.
- Each body system will have its own proposed rule.
- The review of each of the 15 body systems ensured: (1) medical conditions that were not previously covered are now covered; (2) evaluation criteria for individual disabilities have been revised according to medical advances; and (3) existing criteria have been clarified to ensure consistency.
- One of the challenges is bridging the gap between a diagnosis and what it actually means in terms of earnings loss. Currently available earnings loss studies are being used.
- Dr. Smith stated he believes a new earnings study is necessary because there have been labor market changes and to determine whether the "sickness" level relates to the earnings loss.

The problems with earnings loss studies were discussed by the Committee. Past studies have generally found: (1) the younger veteran with serious disabilities entering the system is more likely be shortchanged than the older seriously disabled veteran entering the system at an older age; and (2) veterans with mental disabilities were significantly undercompensated.

The Chairman stated that in its last Biennial Report, the ACDC did recommend that VA consider doing another economic analysis.

Mr. Wilburn, who had earlier involvement with both the CNA and EconSystems studies, stated: (1) data showed people rated 10, 20, and 30 percent had no measurable loss of earnings; (2) the formula used to do the combined degree of disability results in ratings that are too high; and (3) from a scientific earnings loss standpoint, there are many diagnoses that would not be rated at any rate because they simply do not impede the ability to earn a living.

- Mr. Mandle stated in addition to the regulations, another part of the review process is coordinating with all aspects of VBA claims processing that are impacted, including: (1) DBQs; (2) policy or procedural changes, for example, to computer systems that are used to rate cases so the text is up to date; and (3) preservation of historic text for ratings that are protected under law.
- Mr. Mandle reviewed the three stages each body system goes through: (1) working group phase; (2) the development phase; and (3) the concurrence phase.
- For each proposed regulation, an economic impact analysis is prepared for OMB to review.
- Current status of the regulations: (1) all body systems have completed the working group phase; (2) the mental disorders system is the only regulation still in the development phase; and (3) all other regulations are in various steps of the concurrence phase.
- After rules publication, there is a 60-day comment period for public comment. It is expected minor edits will be made based on public feedback.
- Currently, it is anticipated that some of the drafts in concurrence will have to undergo a more comprehensive revision based on feedback, whether for policy or medical issues. These include: digestive, neurological, musculoskeletal, infectious disease, respiratory ENT, and cardiovascular.
- Additional Part 4 regulations are being reviewed to make sure that updates and clarifications are made based on issues seen in the field with rating and error trends.

- Although changes to procedures and exam forms will be done after the final rule is published, staff responsible for incorporating these changes are kept apprised and know what is coming.
- Policy changes are done by VBA staff.
- Mr. Epley asked when do changes in the Policy Regulations section that precedes the Rating Schedule get published? Mr. Mandle responded those changes are not major substantive issues, and there is no set timeline.
- Mr. Maki asked whether older rating criteria will still be available for review for those veterans who will remain rated under older criteria? Mr. Mandle responded the thought is to incorporate that criteria with each specific training package developed for each regulation. He added an advantage with VBMS will be that historical rating criteria can be incorporated.
- Dr. Simberkoff asked about the order in which concurrence occurs. Mr. Mandle responded there is a specific order, which may vary slightly depending on the regulation, and the regulation is only sent to one staff at a time.
- Chairman Scott asked about the status of two disabilities of specific interest to the Committee, diabetes and sleep apnea, and noted the Committee does not wish to overstate or misstate concerns related to these topics in the report. **Mr. Mandle responded he did not have any information but will check and get back to the Committee.**
- In response to Dr. Simberkoff's question whether feedback ever necessitates going back to the working group, Mr. Mandle stated to date that has not happened. The medical officers are able to use their contacts to answer specific questions.

The Chair thanked Mr. Mandle for the update stating that he believes the Committee has the necessary current information to make valid observations in the report. Mr. Mandle thanked the Committee for its input and reiterated he will follow up with the Committee and take input back to the staff.

The Chairman announced a lunch break. The Committee recessed at 11:26 a.m., and reconvened at 12:55 p.m. in Afternoon Session.

Afternoon Session

Chairman Scott reconvened the Committee and proceeded to the next scheduled briefing. He welcomed Dr. Cross and thanked him for agreeing to brief the Committee.

C&P Exam Processing Times, VHA and VBA Regional Office Collaboration, and Update on RO and Medical Collaboration, Dr. Gerald Cross, M.D., Chief Officer, Office of

Disability and Medical Assessment, VHA, accompanied by Mr. Mark Bowen, DMA, Mr. Danny Devine, DMA, Ms. Patricia Murray, DMA, and Dr. Thomas Lynch, VHA

Dr. Cross introduced the members of his team and then proceeded to brief the Committee.

Highlights of the briefing and Committee discussion follow:

- VHA currently does over two million disability exams a year and is accountable for timeliness and quality of exams.
- **Backlog reduction.** VHA works with VBA on this issue. Different standards exist for different programs: (1) The IDES program standard is 45 days from time of receipt of request to do an exam and when the results are sent to VBA. **VHA is meeting and surpassing this standard.** (2) Other disability exams have a 30-day standard. Currently the **average** for the “other” category is 24 days.
- New things are being tried. A demonstration challenge to see if the entire process could be done in 24 hours was conducted two weeks ago in the Little Rock facility for a carefully selected group of veterans. It was successful and the results are being evaluated.
- Exam requests increased as VBA increased its work on reducing the backlog.
- A special program for individuals exposed to contaminated water in Camp Lejeune from 1953 until the 1980s has been set up for them to get exams and medical opinions.
- In December 2012, DoD and VA entered into an MOU to conduct Separation Health Assessments on all servicemembers leaving the military. If the servicemember is filing a claim at the time of discharge, VHA conducts the SHA. 800 SHAs a week are presently being conducted by VHA. **This provides an objective collection of data about each individual as they leave the military.**

MG Martin commented that the SHA is far from routine in the Guard and Reserve, particularly for traditional Guard members who are not on Active Duty when they retire.

Dr. Cross elaborated that DoD will require SHAs be performed by all service branches effective December 2014. They will not be using VA’s DBQs but will cooperate by gathering the same data. In response to the chair’s query how to show support in the report, Dr. Cross responded he would “be very pleased to maintain momentum to indicate support from more areas to say this is something that is quite overdue and would be of benefit to the government as a good steward as well as the veteran.”

- ACE, Acceptable Clinical Evidence. If VHA has access to an individual's medical records, it can complete the DBQ based on the evidence of record and send in that information to VBA without having the veteran come in for an exam. Two areas excluded from ACE are mental conditions and VBA remands.
- To give VHA leadership at individual facilities flexibility and the capability to expand or contract with the workload, the DEM contract was created to provide physicians as needed. Five contractors have been part of the effort. Some problems with DEM include: (1) it is an expensive program; (2) exams may not be conducted in a professional environment; and (3) inability of contractors to keep up with demand for exams. DEM contractors do not perform Camp Lejeune exams, POW exams, or sleep study exams.
- Chairman Scott asked if there is a DBQ "problem" with contractors? Mr. Devine responded not only contractors, but also VHA providers, have questions about DBQs.
- To mitigate the risks of the contractor program, an oversight board meets twice a year to review the program and give suggestions.
- Providers who conduct C&P exams have to be certified and registered in a VA database. Most providers are certified to do general evaluations, but specialty certifications are required for some, i.e., a mental health module must be completed to be certified to do mental health exams.
- A new training module on Military Sexual Trauma is nearing completion. All examiners will be required to take.
- Work is being done to improve the relationship between VHA and VBA so that they see each other as colleagues. Collaborative efforts are worked on a daily basis, and joint teams are managing across the organization.
- VHA has provided 55 docs to the ROs to facilitate quick direct answering of medical questions by raters. This program has proved beneficial to both VBA and VHA. **General Scott stated there is support in the Committee for doctors in the ROs as well as raters at the medical centers.** Dr. Cross stated there is concern about a legislative proposal that would take these doctors out of C&P and have them go back to primary care.

Re IDES:

- In response to General Scott's question on the trend in the numbers of people in IDES, Mr. Devine responded that for the first time in two years, the numbers entering IDES have been reduced.

- In response to Mr. Wilburn's question re whether there had been any discussion of a recent report that recommended doing away with the IDES program, Mr. Devine responded that most of the people who had read the report had dismissed it and that he did not believe that that recommendation would go "too far."

There was general discussion that this program had been partially responsible for the changed dynamics between DoD and VA, as it drove a huge amount of the work together between them. Mr. Devine added these servicemembers are VA's future customers, and it is important that VA get it right.

MG Martin commented there are still problems for the Reserve Component as relates to IDES. Dr. Cross and Mr. Devine agreed there are problems, particularly in scheduling appointments. However, there is a greater effort being made to schedule the exam appointments close to where the RC member lives.

The chair inquired about the problem of missed appointments. Dr. Cross responded this has been a challenge resulting in a huge waste of resources.

The services have now agreed that if a servicemember misses two appointments, they will be responsible for accompanying him to his next appointment. Ms. Murray added a program called RSVP Scheduling has been created which gives the facilities the ability to save the slot and reuse the appointment if they do not hear from the servicemember.

Cancellation of appointments is also a challenge. There are a multitude of reasons, including work-related, child care issues, distance, and weather. VHA is trying to take these into consideration and make the necessary accommodations.

DBQs are used inside the IDES process. DoD, despite some opposition to the use of DBQs, has become a better partner and has helped better define a lot of examination techniques.

- Other issues discussed: (1) **Managing veteran expectations** during C&P exams. (2) **Reducing stress** levels experienced by the veteran when coming in for an exam. (3) Veterans obtaining results of their exams by use of the "blue button," which only gives test results and does not represent the complete picture. (4) **Security concerns at C&P clinics**, particularly those smaller ones located away from the larger facility and which do not have a VA police presence. (5) **Those who do not wish to be separated from the service.** Work with DoD to manage stress experienced by those who do not want to be separated from the service. (6) **Challenges with design of DBQs.** Different stakeholders have different needs. Dr. Cross noted this has been worked and some degree of equilibrium has been reached. Private docs and primary care VHA physicians

may not have experience and expertise with DBQs. (7) **Funding** has been adequate but may be a future issue. (8) Mandatory TAP programs will probably result in more disability claims. MG Martin stated TAP is far from routine for Guard and Reserve members. (9) Advance notice by DoD of projections of servicemembers leaving service would enable better resource planning by VA. (10) **Will the ability to use outside doctors really provide better access for veterans?** (11) **Primary care doctors may not be the best doctors to perform C&P exams. How best to counter this demand.** (12) VOW Act may not be working as effectively as hoped. (13) Effective March 2015, claims must be filed on a standardized form or Notice of Disagreement. (14) Establishing a time limitation for filing claims is controversial. (15) **Age limits for IU. Controversial. Dr. Cross believes this is a valuable and important program and would like to identify things that might put it at risk.** The chair added if the VASRD revision is done well, it could eliminate a portion of people who go the TDIU route to get 100 percent disability. He also suggested that removing the word “temporary” and renaming the program might help.

- Future challenges: (1) **Exposure issues.** As science improves and the nexus is made between the disability and the exposure, family members as well as the veteran may be affected.

(2) **DBQs. Chairman Scott asked how can the Committee best support the use of DBQs? Dr. Cross suggested that the Committee continue to state its general support as it has done in its past reports.** Mr. Devine noted that the Chief Judge of the Court in a footnote in a recent opinion gave a fairly straightforward opinion that the present DBQs should be scrapped and completely redone. Both the Court and the Board have said for their purposes they need more narrative.

(3) **Sleep apnea: diagnosis, service connection, and level of disability.** General Scott asked is this particular disability being “abused”? Dr. Cross responded he is still studying this issue and is not ready to respond. The chair further added the Committee has previously recommended that only VA doctors do the C&P exam for sleep apnea. He noted the Committee has expressed concerns about how the condition has been service connected.

Mr. Maki added that service connection for any disease exists because that’s what the American public wants and has wanted for the defenders of our nation since 1606.

Dr. Smith asked does sleep apnea have any connection to earnings loss? He suggested an earnings loss study be done.

The Chair stated that the Committee has previously recommended that the IOM be asked to do a study on sleep apnea and asked what approach should the Committee take in addressing the issue in this Biennial Report? Dr. Cross responded he would concur with the Committee's suggestion re an IOM study.

Chairman Scott thanked Dr. Cross and his colleagues for the very helpful presentation and expressed the Committee's gratitude for his time. The Committee took a brief recess and returned to consider the final item on the day's agenda.

Committee Deliberation

Following the break, the Committee reconvened and discussed the following re the Biennial Report.

- (1) **Cover letter and preamble.** (Chairman Scott)
- (2) **Recommend diabetes should not get kicked down the road.** (Chairman Scott)
- (3) **Recommend an economic earnings loss study be done.** (Chairman Scott)
- (4) **VRE program.** Do not include in this report but wait until the GAO releases its report and then the Committee will reevaluate concerns for possible inclusion in a future report.
- (5) **Reserve Component support.** (MG Martin will review draft tonight and present to the Committee at tomorrow's meeting.) 2014 IDES numbers presented in today's briefing can be added.
- (6) **Zero percent disability.** (Mr. Epley will review draft at tomorrow's meeting.)
- (7) **Presumptions.** Acknowledge that VA non-concurred with Committee's recommendation in last report. (Mr. Epley will review draft at tomorrow's meeting.)
- (8) **TDIU.** Committee will not include in this report but will review GAO findings when GAO releases its report. (Chairman Scott)
- (9) **Fully-developed appeal.** (Mr. Maki will draft proposal tonight and present at tomorrow's meeting. Also Committee will review related material submitted by Ms. Turner Lott at tomorrow's meeting.)
- (10) **DRO utilization.** (Chairman Scott)
- (11) **DBQs.** Do BVA and the Court have problems with DBQs as they are presently constituted? Ms. Copeland will email judicial review staff chief with Committee's question.

(12) **Doctors in the ROs and raters in the Medical Centers.** (Dr. Simberkoff will draft for tomorrow's discussion.)

(13) **Separation Health Exam.** Committee will recommend that the momentum for mandatory exams be maintained on current schedule (projected implementation for both Active and Reserve personnel by end of 2014). (Chairman Scott)

Before recessing the Committee for the day, the chair stated the above items would be reviewed and those issues that are to be included in the report will be properly framed and ready for final editing before the Committee adjourns tomorrow.

There being no further business to come before the Committee, the chair declared the meeting recessed at 4:17 p.m., the Committee to reconvene at 8:22 a.m., the next day.

Tuesday, October 21, 2014

Chairman Scott reconvened the Committee at 8:22 a.m. and welcomed everyone back for the second day of the meeting.

Opportunity for Public Comment

The Chair invited comment from the public. No members of the public were present.

Opening Remarks/Committee Deliberations

After brief opening comments, the chair initiated discussion on the Biennial Report. The Committee agreed on the following topics and recommendations:

VASRD Update

- Ensure adequate resources are provided to keep the Master Plan for the VASRD Update on schedule.
- Maintain continuity of personnel dedicated to revision process
- Ensure current review includes diagnosis, treatment and level of disability associated with diabetes
- Establish an action plan for obtaining current economic loss study for all body systems.

TDIU

- The Committee will continue to study IU and will incorporate the results of the ongoing GAO study in its deliberations. Recommendations to follow in an interim report in 2015 or the next Biennial Report in October 2016.

DROs

- The Committee (1) continues to strongly recommend that DROs be utilized for appeals processing in order to reduce the average elapsed processing time for appeal activities under the jurisdiction and control of the VAROs; and (2) recommends the DRO option be clearly stated on the NOD form.

DBQs

- Analyze acceptability of DBQs among VA and civilian physicians by disability and ensure future iterations fulfill the requirements of both physicians and claims adjudicators.
- Ensure that future iterations of DBQs meet BVA and Court guidelines for sufficiency.

Station VA Medical Doctors in the ROs and Claims Adjudicators at the VA Medical Centers

- The Committee supports inclusion of VA medical doctors in the ROs and claims adjudicators in the medical centers as a way to speed claims processing and reduce the backlog.

Separation Health Exams

- Recommend VA continue to press the DoD and the services (through the Joint Executive Council, emphasis by the Secretary, and key VA leaders) to implement Separation Health Exams for all total force servicemembers.

Upon the arrival of the first scheduled briefer of the day, the Committee interrupted its discussion on the Biennial Report. The discussion will be concluded later in the day.

Veterans Claims Intake Program: Document Conversion and Document Avoidance, Mr. Brad Houston, Director, Office of Business Process Integration, VBA, accompanied by Mr. James Leiman, Office of Business Process Integration, VBA

The Chair welcomed Mr. Houston and Mr. Lieman to the Committee and invited them to give the briefing.

Highlights of the presentation and Committee questions/comments follow:

- **Document Conversion Overview:** (1) VCIP is responsible for document conversion for rating-related claims and document intake in support of VBA activities; (2) presently rating workload is in excess of 96 percent digital; (3) system of records for VBA includes paper and digital, and once paper is scanned, the digital record is the official record and the paper can be returned or destroyed; (4) VA is asking DoD to take custody of Service Treatment Records; (5) two scanners and an IV&V (Independent Verification and Validation) vendor to audit the work of the scanners have been selected; (6) scanning vendors are housing the records after they scan them; (7) government staff is on site at the

scanners location to do general oversight; (8) there are four scanning sites and all information is properly backed up; and (9) vendors are held accountable and measured on turnaround time, image accuracy, and index accuracy.

- In response to Chairman Scott's question re what is the biggest challenge in dealing with vendors, Mr. Houston answered there are two big challenges: (1) accurately indexing different types of treatment records; and (2) "language" barrier, contractor language versus VA-speak.
- Two ROs, Baltimore (eight file banks had become unmanageable) and Roanoke (building safety issues), required special file extraction projects where the scanning vendor went directly to the RO and scanned and digitized all files on site.
- DoD has committed to providing complete electronic service treatment records.
- Veterans and VSOs can upload through eBenefits and SEP.
- **Document Conversion Performance:** (1) Two million images scanned everyday; (2) turnaround time is less than five days; (3) image accuracy greater than 99 percent; and (4) index accuracy between 93-96 percent.
- MG Martin asked what is the feedback loop with an image that is not accurate? Mr. Houston responded if a problem is identified by in-line process monitoring, a rescan request is made; if the original is not accurate, it is marked as "best image available," and the field claims processor can work with the image they've got or go back to the veteran and say it is unreadable.
- Ten percent of what used to be mail is now faxed to the scan vendor.
- Centralized inbound mail processing has been started. Compensation-related mail is being directed to arrive at two vendor sites, be digitized and then made available online for the field staff to look at, examine and determine what the next step is.
- Private medical records make up a large percentage of all records. A Comp Service vendor is being employed to obtain the records through eHealth Exchanges within ten days. It is hoped these records will be in the file before the file is reviewed.
- Day-by-day data on mail patterns allows for workload prediction and business resilience between ROs.
- There have been four updates to the portal based on user feedback.
- Culture change is necessary regarding mail management.

- Re accountability, long-term, there will be centralized mail analysis with just a few facilities. Short-term, an online portal will be available where you can see your mail, you can see what's pending, and who has it, and how much work somebody did yesterday.
- In the next six months, VBA supervisors will be able to set review gates which will enable them to see much of what someone does and be able to do quality control on it.
- **Next steps.** (1) VRM is pushing to make improvements in online filing to enable the veteran to view his/her own eFile. (2) Standardization of RO mail management practices. (3) Internal process improvements upstream of mail to eliminate duplicate or unnecessary documents.
- **Questions.** Mr. Maki asked what is the timeframe for going digit-to-digit? Mr. Houston responded initial operating capacity is scheduled for December 2014.

The Chair asked what is the percentage of ROs in the mail management program? Mr. Houston responded 14 ROs, generally the larger ROs, still get initial claims in paper and keep them there.

Dr. Browne asked how eBenefits is married to the existing records? Mr. Houston responded everything ends up in the same place, different on-ramps to the same place, in VBMS.

Mr. Varela, a member of the public, asked about the process for receiving DoD Service Treatment Records. Mr. Leiman responded that DoD scans and combines and has the STRs ready, but they do not send to VA. It's a one-directional exchange unless VA actually requests them by VBMS through claims initiation.

Mr. Varela asked if the field identifies something that has been indexed improperly, do they have the ability to reindex? Mr. Leiman responded typically they do it onsite.

Mr. Epley commented that ability may impact data integrity and asked if there is a special check on fixes done at the local level? Mr. Houston responded that is being worked by VBMS.

Mr. Varela asked about size limitations for uploads by claimants and representatives? Mr. Houston responded that digits-to-digits and faxes have no size limits. Size limits do presently exist for eBenefits, and those are being worked to eliminate. **Mr. Houston offered to get a definitive answer for Mr. Varela on eBenefits size limits after the meeting.**

Following the presentation and discussion, the Chair thanked the presenters and noted the Committee's appreciation for the useful briefing on this new information.

The Committee took a brief recess and reconvened for the next scheduled briefing.

National Work Queue, Mr. Ron Burke, Director, Appeals Management Center, VBA

Chairman Scott welcomed Mr. Burke to the Committee and invited him to make the presentation.

Highlights of the presentation and discussion follow:

- The National Work Queue is a paperless workload management initiative that will take VBA's entire rating-related inventory away from the ROs and house it electronically in one centralized location.
- Mr. Burke is in the process of standing up a team whose members possess backgrounds in analytics and workload management. A "command and control center" now being constructed in the VA Headquarters will give the team complete visualization into everything that impacts VBA claims processing. All rules and filters will be dynamic. The team will be able to make changes "on the fly" without OI&T involvement.
- Work will be assigned electronically to ROs matched to their productive capacity.
- Reducing rework is a goal. The NWQ is designed to make sure workload given to employees is actionable: the system will not assign a claim out until the workload is visible to the VSRs and raters.
- NWQ will be able to prioritize VBA's workload. System rules are being written that will essentially rank and rate every pending claim in the inventory.
- **NWQ timeline: Phase 1** is scheduled for deployment March 2015 and will have automatic routing ability for rating-related end products and manual capability to assign appeals, non-rating end products and work items, as necessary. Work will be assigned to an RO work queue, not directly to employees but to the manager to assign to individuals.

The number of deferrals (claims identified as not ready for a particular action and must move backwards) is unknown. An automatic deferral process has been developed that will identify a deferral as either avoidable or unavoidable.

Avoidable deferrals count against performance and can be used as a measure of quality. Deferral actions will get routed out the next morning to make sure ROs are addressing them appropriately.

The first choice for assignment of work is the RO which has geographic proximity and would normally receive the claim as long as that RO has the capacity and amount of prioritized work to accommodate. Some workload has been

centralized to certain locations because the expertise resides there, i.e, mustard gas, radiation, and employee cases.

Phase 2 is scheduled for deployment in June 2015 and will roll out automatic routing of appeals, non-rating end products and work items.

The goal will be to do in-process, system-based quality reviews throughout the process. Employees will be alerted to potential errors which must be reconciled before moving forward.

- **Other NWQ Capabilities.** (1) Training will be tailored to quickly address newly enacted legislation and rule changes. Analytical tools will measure accuracy of training guidance. (2) Re fully-developed claims, often these claims are being “touched” more often than a claim that is not fully developed. Analytics are being used to determine the reasons so changes can be made and these cases can become actionable quicker. (3) Driving the right behavior: all assigned claims completed in five days with an accuracy level of “x” and a low deferral rate.
- **Questions.** Dr. Jones asked about security; are processes in place to protect infrastructure on a cybersecurity level? Mr. Burke responded VA is taking a minimalist approach to telecommuting, but re fundamental processing of NWQ, the team is working with IT to ensure everything meets their security threshold.

Mr. Epley asked whether NWQ will lead to more individual level specialization? Mr. Burke responded it is not being designed specifically for that, but it is being designed with the capability to do that. He added that if the shift is made to processing claims by issues, the system is ready for that.

Ms. Savoca asked if there is any plan to shift personnel based on trends showing where claims are being filed? Mr. Burke responded that an RO will be evaluated based on its ability to recruit, train, retain, motivate and empower employees, and ROs will be staffed appropriately. Decisions will be data driven. Effort will be made to limit the number of times a case is moved to another RO.

The Chair asked what will the future look like five years from now based on successful implementation of NWQ re RO structure, numbers, location, sizes, et cetera? Mr. Burke responded that data-driven decisions will be made. Because there are political ramifications to reducing the number of ROs, ROs that have performance challenges may have their missions changed. No new ROs are envisioned but more accessibility points (perhaps kiosks in malls) for claims processing may be established.

In response to MG Martin’s comment that this system has predictive capabilities, Mr. Burke agreed, adding the team will have “what if” predictive modeling

analytics for various scenarios. For example, what is the impact of adding a new presumption?

- Other topics discussed: (1) Issues with **fully-developed claims**. VSOs try to provide a fully-developed claim, but a rater's opinion may differ from the VSO. There will always be some fully-developed claims that require some development. Also what are the reasons that a claim goes away from fully developed back to traditional? **Tracking patterns and commonalities and giving feedback to VSOs may help.** (2) Need for increased education of and communication with county service officers and others less proficient in claims filing. (3) Need for increased communication from top to bottom levels.

Chairman Scott thanked Mr. Burke for the informative briefing and stated the Committee would be interested in taking a tour of the "command and control center" once the NWQ is up and running, perhaps as part of the April meeting. Mr. Burke will facilitate through Ms. Copeland.

Before recessing for lunch, the Committee resumed the discussion that was begun earlier in the morning on the Biennial Report topics.

Committee Deliberation

Biennial Report topics and recommendations (continued):

Docs in the ROs and Raters in the Medical Facilities

- Committee agreement on need for this. Points made by members included: (1) C&P trained physicians working in the ROs are available to immediately answer questions of raters, to clarify medical terminology, et cetera; (2) concern that this program may be terminated to improve access for primary care; (3) a separate rationale should be included for each, (a) docs in the VBA and (b) VBA personnel (raters) at VHA; and (4) possible inclusion of NCA personnel at VHA. **The chair will combine Dr. Simberkoff's version and his own to draft at the issue, discussion and recommendations.**

Zero Percent

- Mr. Epley reviewed the issue and suggested the following recommendation: The VASRD Update team should consider listing a zero percent evaluation level for diagnostic codes that represent diseases that have been diagnosed or manifestations of injuries where it is relatively common for the residuals to be very minor or asymptomatic with generally no effect on activities of daily living or earning capacity.

Presumptions

- Mr. Epley summarized the issue and stated the question is should the ACDC recommend any changes to the designations of the different categories to define levels of association? After extensive discussion of the issue, the Committee agreed to think how best to frame the recommendation over the luncheon recess and resume the discussion after lunch.

The Committee recessed for a lunch break at 11:58 a.m., and reconvened at 12:45 p.m., in Afternoon Session.

Afternoon Session

After lunch, the Committee reconvened and resumed the discussion on Presumptions.

Committee Deliberations (continued)

Presumptions (continued)

- Mr. Epley read excerpts from the draft as follows: ...While the VA declined to accept causation as the presumptive standard, the different categorizations could easily be adapted using association as the standard. A suggested adaptation ...would be more consistent with the language of Title 38, Section 1116.

Category 1, sufficient: the credible evidence of an association outweighs the credible evidence against the association. Category 2, equipoise: evidence of an association between exposure and contraction of the designated disease is at equipoise. Category 3, insufficient: the credible evidence against an association outweighs the credible evidence for the association. Recommendation: use these categories.

Dr. Simberkoff suggested the following language for Category 2: The evidence for and against an association between exposure and contraction of the designated disease is equal.

MG Martin suggested eliminating the language in Category 2 “between exposure and contraction of the designated disease”. **Change language for Category 2 to read as follows: Equipoise: Evidence for and against an association is equal. Committee concurred.**

The chair suggested the recommendation be reworded as follows: **VA should adopt the categories above derived from the IOM Study on Presumptions. Committee concurred.**

The chair will boil the issue statement down to one or two lines and rewrite the discussion section to include what had been in the issue section. Committee concurred.

Reserve Component Personnel, Medical Records, Access and Claims

- MG Martin stated despite this topic being mentioned in several previous reports, issues still existed. The issues were therefore framed with this in mind.
- MG Martin read the draft, including the issues, discussion, and recommendations. He noted that MG Lowenberg had reviewed the proposed draft and that he concurs with the way it is written.
- **The Committee concurred with the substance of the recommendations as presented and offered some editorial changes which were agreed upon.**
- **Chairman Scott noted a lot of the recommendations were DoD responsibilities and perhaps it would be appropriate to include a phrase such as “through the JEC emphasize the importance of it.” The Committee concurred. The chair stated he will make some small changes and do some consolidating. The Committee concurred.**

Appeals

- Mr. Maki stated that Ms. Turner Lott had submitted a recommendation entitled “Protracted Appeals Process” that had been written without hearing the briefing given the Committee yesterday which described the consensus that had been reached by outside groups. He noted basically her two recommendations are shorten and simplify the appellate process, which this proposal will do.
- Mr. Maki reviewed the draft of the issues and discussion. He followed with a recommendation which he believes reflects the pilot program recommendation that is going to be made to both the Secretary and to Congress.

Recommendation reads as follows: The Committee recommends that VA support and Congress enact a new pilot program for fully-developed appeals in order to provide appellants with a new option that would substantially reduce the time it takes to get a final decision from the Board while significantly reducing the workload on both VAROs and the Board.

The pilot program would be consistent with the proposal offered by the VSOs, must be congressionally authorized as a nationwide pilot program for a limited number of years, and to include sufficient oversight reporting requirements to ensure it operates as intended.

- **Dr. Browne suggested shortening some of the discussion pertaining to what is being done right now by VA. The chair will review and make change.**

There were no further comments or questions on the draft report. The chair promised to get the edited version back to the members within a week or two. There being no

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further business to come before the Committee, the Chair adjourned the meeting at 1:56 p.m.

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