

DEPARTMENT OF VETERANS AFFAIRS  
ADVISORY COMMITTEE ON DISABILITY COMPENSATION

September 1-2, 2020

MINUTES

Members Present:

Thomas J. Pamperin, Acting Chairman  
Al Bruner  
Bradley Hazell  
Joyce Johnson  
Evelyn Lewis  
James Lorraine  
Michael Maciosek

Members Not Present:

Jean Reaves  
Jonathan Roberts  
Robert Sprague  
Robert Wunderlich

Staff Present:

Janice Stewart, Management Analyst, Designated Federal Officer (DFO) for Advisory Committee on Disability Compensation (ACDC), Veterans Benefits Administration (VBA)  
Claire Starke, Alternate DFO, ACDC; Program Analyst, VBA  
Tonita Cannon, Program Analyst, Budget Office, Compensation Service, VBA\*  
Jane Che, Director, Veterans Affairs Schedule for Rating Disabilities (VASRD) Program Management Office (PMO), Regulations Staff, Compensation Service, VBA\*\*  
Anna Crenshaw, Director (Acting), Records Research Center, Compensation Service, VBA\*\*  
Victoria Davey, Associate Chief Research and Development Officer, Epidemiology and Public Health, Veterans Health Administration (VHA)\*\*  
Rodney Grimm, Program Analyst, Legislative Staff, Compensation Service, VBA\*\*  
Jennifer Moser, Senior Scientific Program Manager, Veterans Affairs (VA) Genomic Medicine Program Advisory Committee, Office of Research and Development, VHA\*\*  
Beth Murphy, Executive Director, Compensation Service, VBA\*  
Gary Reynolds, Medical Officer, VASRD PMO, Part 4, Regulations & Implementation, Compensation Service, VBA\*\*

Also Present:

Michael J Church, Veteran\*  
Jill Dilgard, Surviving Family Member (Daughter)\*  
Michelle James, Surviving Family Member (Spouse)\*\*

\*September 1 only

\*\*September 2 only

The Advisory Committee on Disability Compensation (ACDC) met in public session on September 1-2, 2020, by Teleconference.

**Tuesday, September 1, 2020**

Opening Remarks/Member Intros

Ms. Stewart called the Committee to order at 8:54 a.m. She made some administrative remarks and turned the meeting over to Acting Chairman Pamperin.

Travel Admin

Ms. Cannon discussed with Committee members steps for receiving compensation.

Public Comments

Mr. Church read the comments he had submitted before the meeting. During his two stints at Camp Lejeune in the 1980s, he was never advised that there might be a problem with the drinking water. Seven years after his discharge, he developed a periodic tremor in his left hand and was eventually diagnosed with Parkinson's. Mr. Church thanked VA for finally recognizing Parkinson's as a service-related disability linked to the massive contamination at Camp Lejeune but pointed out that countless Veterans had been diagnosed with rarer and much more devastating illnesses. He asked that VA broaden the scope of acceptable requests for compensation. Acting Chairman Pamperin assured him that the contaminated water issue at Camp Lejeune was of significant interest to the Committee.

Ms. Dilgard shared her written comments with the Committee. Her father had been stationed at Camp Lejeune during the Korean War. When he was just 45, he began to develop myriad health issues, including bladder cancer, to which he succumbed in 2018. When he learned that he had been poisoned by the water at Camp Lejeune, he felt shocked and betrayed by the country he had served. Ms. Dilgard felt it was pathetic that there were only eight diseases and illnesses on the presumptive list for Camp Lejeune. She described the subject matter expert (SME) program as a huge failure and questioned why there was no disease registry for the Camp Lejeune victims. She demanded compensation, justice, and truth for the affected victims and their families. Acting Chairman Pamperin noted that

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one of the purposes of the Committee was to advise VA on how to be responsive to Veterans and their families.

The Acting Chairman read a statement by Michelle James, whose husband had served at Camp Lejeune in the 1980s and passed away in 2019 from colorectal cancer, bladder cancer, multiple sclerosis, kidney disease, depression, and other psychological issues. When he enlisted, he knew he was putting his life on the line, but he never dreamed he would be poisoned by the people who were supposed to protect him. While in the service he developed alcohol dependency and mental health issues, which led to his early discharge and cost him his first marriage. The nature of his discharge meant he was not entitled to benefits. Ms. James felt like she was cheated out of a husband because he never got the support he needed from the military.

Acting Chairman Pamperin read a statement from Frances Robles, whose father, an 89-year-old Veteran once based at Camp Lejeune, had been diagnosed with bladder cancer. Ms. Robles was requesting her father's records to see if he could get an increased pension. She was hoping for a speedy response due to his advanced age. The Acting Chairman reported that the staff was trying to identify Ms. Robles' father.

Acting Chairman Pamperin read a comment by Robert Burke, who had been stationed at Camp Lejeune in the 1970s and 1980s and was diagnosed with bladder cancer and kidney disease. He had been denied a service connection a few months before bladder cancer was made a presumptive service connection. He asked everyone to keep an open mind with respect to the various health issues and toxic chemicals that Veterans were exposed to. The Acting Chairman assured Mr. Burke that staff was working to determine the status of his claim.

The Committee recessed from 9:26 a.m. to 9:35 a.m.

Acting Chairman Pamperin noted that the Committee had received 11 additional written public comments, which he read into the record.

Kimberly Jensen wrote that her husband, who had been stationed at Camp Lejeune several times in the 1980s, was diagnosed with lung cancer in January and passed away on August 6. Although VA denied that his claim was service-connected, his doctors believed otherwise and had provided Ms. Jensen with medical evidence to support their findings. Acting Chairman Pamperin promised that VA would consider any evidence submitted.

Beverly Ivie wrote that her husband had spent over 100 days at Camp Lejeune and had died in 2018 after battling metastatic gastric cancer for almost three years. Ms. Ivie filed a Dependency and Indemnity Compensation claim, which VA had denied and was currently pending appeal. She had not received a satisfactory explanation why stomach cancer was not on the list of presumptives. She felt that too many people had died, and changes needed to be made.

Elizabeth wrote that she had been affected by the toxic water at Camp Lejeune and asked for reform, claiming that mishandling within the VA system was evident. She agreed that her claim was complicated but maintained that SMEs should not have the authority to write "not

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possible” in regard to a Camp Lejeune claim, and that complicated cases should warrant higher level review.

David Elliott wrote that tongue cancer should be added to the list of proscribed diseases, noting that contaminated water, when drunk, passed over the tongue. Acting Chairman Pamperin invited Mr. Elliott to follow up with staff so his inquiry could be referred to VA for an appropriate response.

Gary Tisdale wrote that the toxic water at Camp Lejeune had caused him to have stomach pains. He had been denied the proper medical attention for four years and finally had to go to the emergency room, after which he received a bad conduct discharge.

Gregory Dolezal wrote that he had received a 100 percent disability rating due to myelodysplastic syndrome contracted as a result of drinking the water at Camp Lejeune. He was found to need a stem cell transplant, but was told VA was not involved with that. Most of Mr. Dolezal’s expenses were covered by Medicare, but many in similar situations did not have outside insurance.

[Rired1968@msn.com](mailto:Rired1968@msn.com) wrote that a health registry was needed for Veterans contaminated by the water at Camp Lejeune.

Denis Burns shared that he had been stationed at Camp Lejeune twice in the 1970s and developed stomach problems, which had required an operation and medication.

John R. Moody asked why the disability appeal adjudication process took so long. When checking the status of an appeal he had filed in May, he found 134,000 disability appeals in the queue ahead of his that had yet to be adjudicated. He suggested VA hire more personnel to address the backlog.

Ken Partlow wrote that his military career in the 1980s had been cut short by a series of health issues that first manifested themselves shortly after he left Camp Lejeune. He filed for VA disability in 2011, but multiple subject matter opinions failed to adequately address exposures or medical history, resulting in additional subject matter appeals or Board of Veterans Appeals remand. Mr. Partlow felt the scientific community had failed those exposed to contaminated water at Camp Lejeune by relying heavily on mortality data for health assessments. He challenged the Committee to prove that scientific and medical integrity still existed.

William Shultz wrote that he had served as a Reservist at Camp Lejeune for almost five months, but the government did not consider him a Veteran under Title 38, and thus he was ineligible for the healthcare benefits he felt he deserved. Acting Chairman Pamperin said that it would be interesting to determine what kind of orders Mr. Shultz was on at Camp Lejeune and whether something could be done in his situation. Ms. Stewart promised to follow up with Mr. Shultz in an email.

The Committee recessed from 9:55 a.m. to 10:01 a.m.

Executive Address

Mr. Tucker said that he had served in an oversight capacity on Capitol Hill before coming to VA. His three years at VA had showed him the importance of groups like ACDC because they could focus on important issues like disability compensation at a level of detail that Congress could not.

One of the Secretary's objectives was to make VA an example of positive and constructive customer, i.e. Veteran, service. This was not an easy task for an agency the size of VA, but Mr. Tucker felt there had been progress. He cited appeals modernization as an area of significant improvement on the benefits side. A record number of appeals had been heard and decided that year. On the health side, there had been considerable progress in terms of healthcare delivery. In the wake of the COVID-19 pandemic, VA was using technology like never before to reach out to Veterans. Since February, telehealth appointments had increased by 1,261 percent. Many Veterans in rural areas struggled to get broadband access, so VA would need to work closely with cell providers, the Federal Communications Commission, legislators, and others to expand the reach of telehealth and virtual hearings.

VA was planning to launch a new electronic health record, which would transform the way its clinicians did business at a local facility level, the way they interacted and communicated with the Department of Defense (DoD), and how they interacted with local providers outside the VA. It was planned to roll out first in the Pacific Northwest in October. Also scheduled for the fall was an expansion of the caregivers program, which until recently only covered post-9/11 Veterans but would now cover World War II and Cold War-era Veterans as well.

Mr. Tucker said one of VA's priorities was exploring how it could better empower Veterans to not see themselves as disabled in the fullest sense of the word, but rather to focus on improving their lives and livelihoods regardless of their physical and mental limitations. The purpose of disability ratings was to support Veterans, not define them.

Acting Chairman Pamperin noted that one of the Committee's upcoming recommendations concerned the issue Mr. Tucker raised about not defining Veterans by their disability. He asked if the VA had scoped out anything that would be helpful to ACDC while addressing this issue. Mr. Tucker said he did not have many specifics, but that there had been extensive dialogue within VBA leadership on making sure disability rating criteria were in sync with modern clinical practice and rehabilitative service.

Ms. Murphy reported that VA had responded with resilience to the COVID-19 pandemic. The agency continued to provide service to Veterans and transitioning Servicemembers, while the Regional Offices (ROs) continued to process claims. The main hurdle had been Compensation and Pension exams, which VBA had shut down in early April, but was able to phase back in towards the end of June. At this point, it was almost back up to speed. The Compensation Service valued productivity, but not at the expense of quality. Ms. Murphy suggested the Committee might be interested in a briefing from Edna MacDonald, whose "REAL Team" was helping to improve claims processing.

Compensation Service's goal for 12-month issue-based rating quality was 96 percent; currently it was at 95.91 percent. For non-rating quality, its goal was 91 percent, which it

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exceeded at 92.5 percent. For the first time that Ms. Murphy could remember, claim-based quality was over 90 percent.

Since the onset of COVID, Compensation Service had performed seven virtual site visits. Normally it could only visit 10-12 ROs in one year, but for fiscal year (FY) 2021, it was planning to hit about 20 with a hybrid of in-person and virtual visits. On that pace, it would be able to cover each RO every three years instead of every five or six.

In FY2019, Compensation Service trained just over 1,000 Veteran Service Representatives and Rating Veteran Service Representatives. In FY2020, it was able to train almost 2,300 via virtual training. The service was changing its training model so that it would continue to develop the curriculum but the ROs and the Office of Field Operations would oversee the on-the-ground instruction. Delivery of training would also be more frequent.

Hospital adjustments had long been a top priority for the Compensation Service. After a review of 85,000 adjustments in FY2018-19, it was able to direct about \$7 million in retroactive payments. It had implemented a more automated process so that the adjustments would be delivered to the field through the National Work Queue.

The Under Secretary for Benefits was aggressive about reducing improper payments. In FY2019 Compensation Service reduced its error rate to the point where it was removed from the improper payments watch list. The error rate was further reduced to 0.037 percent in FY2020, subject to Inspector General (IG) review.

Compensation Service was migrating from eBenefits to VA.gov, a process expected to be complete by FY2022. It had processed over 100,000 online claims in the past fiscal year, a 63 percent increase in online submissions over the previous year. In August, it built out the ability to submit Benefits Delivery at Discharge (BDD) claims online; so far, it had processed about 25,000 BDD claims. Its goal was to start benefits flowing within 30 days after discharge, and it had been successful about 65 percent of the time. Compensation Service had been hindered in its ability to process Integrated Disability Evaluation System claims because of the pandemic, but it was getting back up to speed.

VBA was expanding its focus on pre-discharge. The Office of Transition and Economic Development (OTED) was leading the charge on Military to Civilian Ready, a process that would start running 365 days prior to discharge and conclude 365 days after. Through the Solid Start Initiative, which began at the end of December, VA made three phone calls with each transitioning Servicemember in the first year after discharge.

Acting Chairman Pamperin cited a recent article in the Military Officers Association magazine that stated new Veterans were leaving the employ of the Federal Government at higher rates than had been typical and asked whether that was true of VA as well. Ms. Murphy suggested someone from VA Human Resources would be better able to answer that question but noted that the attrition rate in VBA had remained under four percent.

The Acting Chairman mentioned *Lang v. Wilkie*, a recent case before the United States Court of Appeals for the Federal Circuit on constructive custody of VA records. He thought the court made a logical decision but feared it might lead to process problems. Ms. Murphy

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pointed out that the court had only issued its decision in the middle of August, and she would need more time to review it thoroughly with VA leadership and the Office of General Counsel.

Acting Chairman Pamperin noted that the Committee had received 16 different comments on Camp Lejeune, all of which expressed an enormous sense of betrayal, and asked how the process would move forward for new disabilities. Ms. Murphy said it was really VHA that took the lead on the science and medicine behind various exposures, but that Compensation Service worked closely with Post-Deployment Health. Compensation Service was scheduled to take part in a four-hour conference call on Camp Lejeune that afternoon. Dr. Lewis remarked that one of the comments called for a registry of those exposed to the contaminated water at Camp Lejeune and asked what the process was for establishing such a registry. Ms. Murphy said VA's registries were mostly on the VHA side, under Post-Deployment Health. Dr. Lewis proposed having the appropriate person from VHA brief the Committee on this issue.

Acting Chairman Pamperin said he would try to obtain briefings from Ms. MacDonald; from Richard Hartman, the new director of OTED; and from someone in Post-Deployment Health.

Dr. Lewis acknowledged that VA's new transition programs looked good on paper but expressed concern as to how well they would work in practice. Ms. Murphy said VA was capturing Servicemembers' phone numbers and email addresses upon separation. Prior to calling the Veteran, VA would send him/her an email reminder. This practice had increased the connection rate to over 50 percent. Since December VA had made over 85,000 successful contacts with Veterans.

Mr. Lorraine said he ran a national community-based program focused on reducing Veteran suicide, among other things. His organization had briefed Dr. Hartman twice, but he had refused to move forward. Mr. Lorraine asked Ms. Murphy to check up on this issue and promised to raise it with Dr. Hartman when he met with the Committee. Ms. Murphy said she would be happy to talk with Dr. Hartman.

Mr. Bruner asked Ms. Murphy to comment on perceived roadblocks on getting VA back to pre-virus in-person examination rates. Ms. Murphy replied that Dave McLenachen, who had spearheaded VA's appeals modernization efforts, had been running a program integration office to look for efficiencies. VA had just started to get back to its pre-COVID throughput about two weeks previously. The main obstacle at this point was the virus. VA's local contract vendors were monitoring the situation for spikes in cases.

Acting Chairman Pamperin asked if there had been any discussion about when people would return to work in the office. Ms. Murphy said it varied according to location. In some ROs, people had already returned to the office; in others, they were still teleworking.

The Committee recessed from 10:59 a.m. to 11:10 a.m.

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Committee Discussion on Biennial Report

The Committee reviewed a draft of its 2020 Biennial Report. Acting Chairman Pamperin invited members to make comments at the meeting or by email. If he did not hear anything by Friday, September 11, he would assume that all members concurred on everything, and would turn it over to Ms. Stewart and Ms. Starke, who would send it to the Secretary and House and Senate Veterans Affairs Committees. The Committee's Recommendations were as follows:

*Issue 1: The Systematic Review and Update of the VASRD*

- 1-1. Fully staff this activity for completion (clinicians, reg writers, analyst staff, and program management staff)
- 1-2. Aggressive Management of the Review Process
- 1-3. Earnings Loss Studies
- 1-4. Prioritize the Mental Health
- 1-5. Advance the Schedule for Diabetes

*Issue 2: Total Disability Individual Unemployability (TDIU)*

- 2-1. Complete the Analysis Started in 2017
- 2-2. Comprehensively Assess the Impact of TDIU Determinations
- 2-3. Define the Goal of TDIU Redesign
- 2-4. Quantitatively Define the Impact of TDIU
- 2-5. Program of Accountability

*Issue 3: Transparency*

- 3-1. Public-Facing Disability Benefit Questionnaires (DBQs)-Conduct a Study
- 3-2. Modernize the DBQ Update Process
- 3-3. Removal of Veteran Service Organization (VSO) Rating Review

*Issue 4: National Guard and Reserve Access*

- 4-1. Establish a VA/DoD Task Force to Implement Separation History and Physical Examination/Separation Health Assessment for Guard and Reserve Members
- 4-2. Institute VA Transition Assistance Program (TAP) or TAP-like Briefings for All Guard and Reserve Members, During Their Service, at Separation from the Reserve Components, and, When Applicable, at Retirement

*Issue 5: An Abilities Approach to Independence*

- 5-1. Create a Center of Excellence
- 5-2. Formally Include Capabilities into VA's Program Design

Dr. Maciosek thought that creating a center of excellence was broader than just an abilities approach to independence and suggested it should be its own separate issue. Acting Chairman Pamperin offered to take some of the discussion relating specifically to the center of excellence, peel it off as a separate recommendation, and share the revision with the Committee.

Adjournment

The Committee recessed for the day at 11:31 a.m.

**Wednesday, September 2, 2020**Opening Remarks/Member Intros

Ms. Stewart called the Committee to order at 8:55 a.m. She made some administrative remarks and turned the meeting over to Acting Chairman Pamperin. The Acting Chairman asked members to introduce themselves.

Public Comments

Acting Chairman Pamperin read into the record a supplemental statement submitted by Kimberly Jensen, whose husband, a Camp Lejeune Veteran, had passed away from lung cancer on August 6. In her letter, Ms. Jensen cited a list of publications that supported her contention that her husband's cancer was service-connected.

Ms. Stewart informed the Committee that Michelle James, whose comments the Acting Chairman had read into the record the previous day, was on the line. Ms. James repeated her statement. Acting Chairman Pamperin asked Ms. James if she had met with a VSO to discuss what options might be available. Ms. James said she had, but that her husband's early discharge meant that her options were considerably limited.

VASRD Update

Ms. Che gave the update. Seven of the 14 VASRD body systems had been updated. A continuous project management and maintenance process was in place to manage the remaining seven body systems. In the concurrence process were four Proposed Rules: Respiratory, Mental, Digestive, and Neurological; and three Final Rules: Musculoskeletal, Genitourinary, and Cardiology.

The Musculoskeletal Final Rule was currently with the Office of Management and Budget (OMB). VA intended to update the Veterans Benefits Management System (VBMS) with the new Musculoskeletal VASRD criteria on September 13, but if OMB had not completed its review by then, VA would "toggle off" the VBMS functionality so that claims processors could continue to adjudicate current criteria. Once the rule was published and a new effective date was established, VBMS would "toggle on" the functionality.

Mr. Hazell noted that, on the PowerPoint presentation's Release Schedule slide, the VBMS release and effective date for several body systems was listed as "4," and asked what that meant. Ms. Che explained that it referred to a footnote indicating that the VBMS release date had not yet been determined by the Office of Business Process Integration. He apologized for the lack of clarity.

Mr. Bruner asked for a status update on the Infectious Diseases body system. Ms. Che said the policies Compensation Service was trying to establish for COVID were difficult to back

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up with evidence, and VA did not want to tie itself prematurely by publishing a regulation that it would have to change later. The Under Secretary for Benefits (USB) would likely issue a policy letter instructing the field on how to handle COVID-19 cases. Mr. Bruner asked if there was an expected date for publishing the policy memo. Ms. Che said Compensation Service hoped to get the letter out for the USB's review by the end of September.

### Hypertension Overview

Mr. Grimm gave the overview. There were 440,246 Veterans with service-connected (SC) hypertension, 96.1 percent of which had a disability rating for hypertension of 10 percent or less. For FY2018-20, there had been 208,976 initial SC claims, with a grant rate of about 29 percent. 91.05 percent of those awarded initial SC claims were male. Race was unknown for 84 percent of awarded initial claimants; Mr. Grimm noted that race was not a data field on the application.

Acting Chairman Pamperin said VBA had considered adding race to the application at one point but had been informed that it could not because race was not relevant to disability evaluation. He added that data on race was available in VHA, and that it might be useful to analyze the applications together with VHA data, but he was not sure how long that would take. Mr. Grimm offered to follow up. Dr. Lewis agreed that would be beneficial. Dr. Maciosek was surprised the applications did not ask for race because that meant there was no way to determine if certain races had claims denied at higher rates than others. Acting Chairman Pamperin asked Mr. Grimm to report back to the Committee by March.

Mr. Hazell asked if there were any updates on the Vietnam Era Health Retrospective Observational Study (VE-HEROeS) or the Vietnam Mortality Study. Mr. Grimm said he would need to follow up with VHA, but he had not received any. Ms. Stewart noted that VHA's Dr. Davey would address the Committee after Mr. Grimm's presentation.

The largest age range for initial SC claims awarded in FY2018-20 was 40-49, which constituted approximately 35 percent of awarded claims.

Mr. Hazell relayed to the Committee an email he had received from Jerry Manar, a member of the public. Mr. Manar said that a lot of Vietnam-era Veterans were filing claims in the hopes that even if their claims were denied at first, they could be approved retroactively in the wake of the Nehmer decision.

The largest age range for initial SC claims denied in FY2018-20 was 70-79, which constituted approximately 26 percent of denied claims.

### VE-HEROeS Presentation

Dr. Davey gave the presentation. Prior to VE-HEROeS, it had been 30 years since the last large epidemiologic research study on Vietnam Veterans. The objective of the study was to compare the overall health of Vietnam War theater Veterans to Veterans who did not serve in theater, as well as age- and gender-matched members of the U.S. public. The steering committee was composed of Vietnam Veterans, their families, and experts. VHA hoped the

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results of the study would add to knowledge of health issues and differences in Vietnam War-theater Veterans at age 70 and have policy impacts.

The VE-HEROeS research study was approved by an institutional review board (IRB). A survey of health, lifestyle, and health behaviors was mailed to a random sample of all Veterans who served from 1961-75, and non-Veterans born before 1958. The survey was sent to 42,393 Veterans and 6,885 non-Veterans. 67 percent of the non-Veterans and 45 percent of Veterans overall returned the completed survey.

To measure health, the study used a combination of validated instruments and questionnaires, including Short Form-8, and specific questions regarding health and neurological conditions, drug use, health of children and grandchildren, and sociodemographics.

The average ages for theater, non-theater, and non-Veteran survey participants were all around 70. All three groups were overwhelmingly (99.68 percent) male. Only 7.14 percent of theater participants were black, and just 5.19 percent were Hispanic; the rates of minority participation were even lower for the non-theater and non-Veteran cohorts. 16.23 percent of theater respondents had a bachelor's degree, as opposed to 25.90 percent for non-Veterans. The percentage of participants married or living with a partner was almost equal (78-79 percent) across the three groups.

67.81 percent of theater Veterans and 72.85 percent of non-theater Veterans had volunteered for the draft or chosen to enlist. The average age of theater Veterans entering into military service was 19.93; for non-theater Veterans, it was 20.30. 54.40 percent of theater Veterans and 43.40 percent of non-theater Veterans served in the Army. 69.59 percent of theater Veterans and 74.16 percent of non-theater Veterans served less than five years. 73.06 percent of theater Veterans and 59.89 percent of non-theater Veterans entered military service between 1965 and 1970.

70.89 percent of theater Veterans, 65.32 percent of non-theater Veterans, and 56.75 percent of non-Veterans reported physician-diagnosed hypertension. Ischemic heart disease, stroke, diabetes mellitus type 2, post-traumatic stress disorder (PTSD), and depression were also more prevalent in theater Veterans. A greater percentage of theater Veterans had an AUDIT-C score of 9 or more, indicating risky alcohol use. Theater Veterans were 12 percent more likely to report hypertension in the survey than non-theater Veterans, and 32 percent more likely than non-Veterans.

Dr. Lewis asked if ethnicity and race were factored into participants' likelihood of reporting hypertension. Dr. Davey said she would need to reexamine the study's findings with regard to race. She expressed concern about drawing too much significance given the low response rate of African-Americans and Hispanics.

Dr. Davey noted the limitations of VE-HEROeS: it was a study of survivors, and there could be many differences in those who had already passed away. Self-reporting raised concerns about accuracy of memory, and whether participants understood the survey questions. Some health conditions of Vietnam Veterans were found to be too rare to allow comparisons or to draw conclusions about differences. A percentage of the sample declined

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to participate, citing sensitive questions, the length of the survey, and/or a lack of trust in VA. Lastly, epidemiologic studies determined association, but not necessarily causation.

Acting Chairman Pamperin asked if there was anything that could or should be inferred from the fact that VE-HEROeS was a survival study. Dr. Davey reiterated that there could be a lot to learn from deceased Vietnam Veterans that the study was not picking up on. She added that VHA was performing a mortality study as a companion to VE-HEROeS.

VHA was conducting a series of analyses and briefings and had submitted papers for peer review and publication. The mortality study sought to determine rates, causes, and patterns of mortality from 1979-2017 of all Vietnam War theater Veterans and determine if there were differences when compared to all non-theater Veterans.

Dr. Lewis suggested that one reason the response rate was so low among African-Americans was that many of them did not live to 70 because of various health issues. Dr. Davey agreed that that was quite possible. Dr. Lewis added that it was well-known that the participation rate would be low for certain populations unless one was willing to oversample and expressed an interest in speaking with those who worked on VE-HEROeS. Dr. Davey said she could arrange for the study authors to brief the Committee if it so desired.

Mr. Hazell noted that one of the slides included a footer stating that the information was pre-decisional and should not be shared outside of the Committee and asked if it applied to the other slides as well. Dr. Davey assured him that the footer was included in error, and that the entire presentation could be shared with anyone.

The Committee recessed from 10:40 a.m. to 10:54 a.m.

#### Million Veteran Program (MVP)

Dr. Moser gave the presentation. VA's research mission was to improve Veterans' health and wellbeing via basic, translational, and clinical health services and rehabilitation research; to attract, train, and retain the highest caliber investigators; and to assure a culture of professionalism, collaboration, accountability, and the highest regard for research volunteers' safety and privacy. VA's historical research accomplishments included the implantable pacemaker, the first liver transplant, antihypertensive medication use, aspirin use to prevent heart attacks, a shingles vaccine, and the VA-DEKA prosthetic arm.

The goal of MVP was to enable precision medicine in the VA, and to prevent and treat disease in Veterans by using environmental, lifestyle, family, and genetic information to guide choices by patients and healthcare providers.

VHA was partnering with Veterans to establish one of the world's largest and most comprehensive databases of genomic, clinical, lifestyle, and military exposure as a discovery platform. It hoped to enroll at least one million Veterans by 2022. It sought to establish a pipeline for translating genomic discoveries into the clinic and enable precision medicine in the VA healthcare system.

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VA's assets included 30-plus years of electronic medical record data, an integrated healthcare system with world-class researchers and clinicians, an established research infrastructure, and Veteran partners.

Enrollment in MVP involved a one-time visit, informed consent and authorization, a blood sample for future research, and survey completion. The consent allowed authorized MVP staff access to medical records and re-contact for additional research. Participants would receive MVP updates.

Before COVID hit in March, VA had 60 active sites recruiting, had sent out over 10 million total mailings to over five million Veterans, and enrolled over 830,000. VA had opened up an online enrollment portal, where one could complete the consent process and schedule an MVP visit to provide a blood sample.

MVP enrollees were 91 percent male, 18 percent African-American, and 6.5 percent Hispanic. The largest age cohort was 60-69, comprising 35.8 percent. Approximately 47.5 percent served during the Vietnam era (August 1964-April 1975).

Current research areas using MVP data included PTSD, mental health, cardiovascular disease, diabetes, traumatic brain injury, and cancer.

VA had partnered with the Department of Energy (DOE) to leverage DOE's high-performance computing capabilities and big data to drive discoveries that could transform healthcare. Exemplar projects focused on suicide prevention, prostate cancer, and cardiovascular disease.

Every blood sample collected had been genotyped. VA had invested in 100,000 whole-genome sequences and had funded 31 projects. It employed over 200 researchers across 40 different VA sites.

A massive study of 200,000 Veterans using the MVP database identified genetic links to anxiety. The American Heart Association had recognized VHA for advances in peripheral artery disease in the last year. One MVP research group did a study on cholesterol and found a novel gene variant, which could lead to new treatments for heart disease and diabetes.

VHA was piloting return-of-results projects, one on familiar hypercholesterolemia and one on metastatic prostate cancer.

MVP's Measures Investigating Neuropsychiatric Disorders initiative focused on mental health and substance abuse. Recruitment would center on VA Mental Health and Substance Use Disorder clinics. The launch was scheduled for October.

A COVID-19 survey had been sent to over 700,000 MVP participants by mail and online.

Acting Chairman Pamperin observed that both VE-HEROeS and MVP tended to be clinically focused, and that there seemed to be a real dearth of that kind of analysis on the VBA side. He asked if there was anything VHA was doing that would be of particular use to

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the benefit delivery side of the house. Dr. Moser felt there were a lot of ways VBA could benefit from these studies. She agreed that a robust pipeline between VBA and VHA was a good idea.

Mr. Lorraine asked about the role of biomarkers in MVP. Dr. Moser said VHA could use the blood to perform a wide variety of testing. Mr. Lorraine asked what the timeframe was for biomarker work, and whether it was all internal to VA. Dr. Moser said VA had outside contractors doing an ongoing large-scale analysis of the biomarkers, genotyping, and genome sequencing.

Dr. Maciosek asked if the approved consent process would allow VHA to ask Veterans for permission to connect the data collected with their service records. He also wanted to know if there had been any collaboration or discussion with the National Institutes of Health All of Us study. Dr. Moser said VHA could connect service records with MVP data, and that it was working closely with All of Us. Some of the main MVP investigators were also on All of Us study teams, and a couple of the All of Us recruiting sites were at VA hospitals.

#### Earnings Loss Studies Executive Overview

Dr. Reynolds gave the overview. Prior to FY2018, VBA relied on relevant medical desk references, peer-reviewed medical journal articles, along with internal VA research as the underlying justifications for update revisions to the VASRD. This worked best when the medical research for disability had some proxy for earnings capacity, such as returning to work, as an endpoint. Unfortunately, very few medical research studies employed proxies for earnings capacity.

In FY2018, VBA completed its first Earnings Loss Study focused on eight diagnostic codes (DCs): six prosthetic joint replacements, hearing loss, and tinnitus. These codes were chosen because recent medical advances had a measurably favorable effect on disability for the prosthetic joint codes, and hearing loss and tinnitus were both within the top three DCs for receiving disability compensation. The American Community Survey (ACS), a yearly Census survey that captured around two percent of the population, provided economic data. ACS data limited analysis because it was extremely rare for one Veteran to be in more than one survey, so it was necessary to utilize a “pseudo-panel.”

Acting Chairman Pamperin asked Dr. Reynolds how confident he was that he would get a large enough sample size. Dr. Reynolds explained that VBA was using the results of this study as a proof-of-concept approach to help shape the design of future studies.

Late in FY2019, VBA commissioned the second Earnings Loss Study, which broadly examined labor market outcomes and sources of income of service-disabled Veterans compared to non-service-disabled Veterans and non-Veterans. The data source for earnings information was from ACS and other Census surveys.

An important task within the second study was obtaining data access agreements to individual longitudinal earnings information from the Internal Revenue Service, so future earnings loss studies could be conducted at the individual DC level for most, if not all, DCs.

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Dr. Maciosek expressed concern that there was no IRB involved. Dr. Reynolds assured him that when VBA started to incorporate research that involved patient information an IRB would be involved, but for the moment it was dealing with economic, not health-related, information.

Access to survey data was authorized by the Census Bureau in early August. Minor adjustments to VA data from the Office of Performance Analysis & Integrity were still required. Five examples for demonstration projects had been developed and were pending senior management review and approval. Editing continued on the predominant purpose statement for longitudinal earnings data access.

### Records Research Center (RRC)

Ms. Crenshaw gave the presentation. In FY2019, the Army decided to realign its current Joint Service Records Research Center mission and discontinue researching all records belonging to other services, as well as Army records older than 30 years. The effective date of the realignment was September.

Recognizing the criticality of a successful mission transfer, VA established a VBA RRC within Compensation Service to continue providing timely delivery of military service departments' verification research to properly adjudicate Veterans' disability claims. VBA had established a new staff with 15 full-time equivalents, developed a new record repository and workload management tool which interfaced with VBMS, and awarded a contract for on-site researchers. Implementation of the RRC improved the claims process and Veteran's experience by streamlining the evidence gathering process, reducing the lifecycle of claims, trimming the backlog, and reducing the systems needed to complete research tasks from four to one.

Acting Chairman Pamperin asked about the strategy for maintaining the database going forward with new information from more recent service. Ms. Crenshaw said Compensation Service was developing and refining a process of adding data to its repository. The Acting Chairman said he was concerned about more recent records. Ms. Crenshaw pointed out that records less than 30 years old were held and maintained by the services, not archived.

Mr. Hazell asked if RRC would now handle stressor verifications. Ms. Crenshaw confirmed that it would. Mr. Hazell then asked about the procedures being put in place. Ms. Crenshaw said that Compensation Service had developed the necessary Position Descriptions, filled each position, gotten a contract in place, and developed a workflow management tool.

### Adjournment

Acting Chairman Pamperin adjourned the meeting at 12:02 p.m.

Toby Walter  
Neal R. Gross & Company  
Preparer of the Minutes

Janice Stewart, Committee DFO

A handwritten signature in cursive script, appearing to read "Thomas J. Pamperin".

Thomas J. Pamperin  
Acting Committee Chairman