

DEPARTMENT OF VETERANS AFFAIRS
VETERANS BENEFIT ADMINISTRATION (VBA)
VETERANS BENEFITS, COMPENSATION &
PENSION SERVICE

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ADVISORY COMMITTEE ON DISABILITY COMPENSATION

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MEETING

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MONDAY
MARCH 21, 2016

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The Committee met in the 6th Floor
Conference Room 645A, 1800 G Street, N.W.,
Washington, D.C., at 8:30 a.m., Joseph Kirk
Martin, Jr., Chairman, presiding.

PRESENT

JOSEPH KIRK MARTIN, JR., Chairman
HAL K. BIRD*
DORIS BROWNE
GEORGE FAY
ELDER GRANGER
TIMOTHY J. LOWENBERG*
JONATHAN ROBERTS
ELIZABETH SAVOCA
MICHAEL SIMBERKOFF

*present via telephone

ALSO PRESENT

IOULIA VVEDENSKAYA, MD, Designated Federal
Officer

DESHANNA BROWN, LSU

ANNA CRENSHAW, BAS

ERIN GITTENS, BAS

ASHLEY HANAHAN, VHA

MATTHEW LABOZZETTA, American Legion

ZANETTA MIELL, BAS

JEFFREY MORAGNE, ACMO Director

JOCELYN MOSES, VBA

DIANE BOYD RAUBER, ESQ., NOVA

CARLA RIDDICK

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Adjourn

1 P-R-O-C-E-E-D-I-N-G-S

2 (8:35 a.m.)

3 DR. VVEDENSKAYA: Welcome, everybody,
4 to Washington, D.C. Thank you for coming. And
5 today we have nine members for our meeting. Mr.
6 Bird and Mr. Lowenberg are participating
7 remotely. The rest of the members are here in
8 person. Mr. Pamperin, and Mr. Maki, and Dr.
9 Jones couldn't be here with us today. Other than
10 that, we have a quorum and we are ready to start
11 the meeting, Chairman Martin.

12 CHAIRMAN MARTIN: Good. Thank you
13 very much. Welcome, everybody. I'm pleased that
14 you can be with us today for the Advisory
15 Committee on Disabilities and Compensation
16 meeting. We have two members and what I'd like
17 to do first is just kind of go around the table
18 and let everybody capsule who they are and a
19 little bit about their careers at this point just
20 so we can get to know all the members.

21 We have two by phone, I won't forget
22 you, hang on, but let's start with George Fay;

1 General Fay.

2 MEMBER FAY: Okay. My name is George
3 Fay and I currently live in Juno Beach, Florida,
4 but that's just recent. Moved there in January
5 after retiring from the CNA Insurance Company,
6 which is in Chicago, Illinois. We lived in
7 Chicago, Illinois for nine years.

8 Prior to that I was employed by the
9 Chubb Group of Insurance Companies for about 30
10 years. My business career was strictly property,
11 casualty insurance claims. So I handled all
12 types of property, casualty insurance claims for,
13 first, Chubb, and then CNA.

14 My military career was in the Army for
15 four years as an intel officer, and that was from
16 1970 to '74, then I went into the Army Reserve,
17 and I was in the Army Reserve for the next 30-
18 something years, until 9/11, and then I was
19 mobilized on that same day, I happened to be on
20 active duty that day, and was immediately
21 mobilized.

22 Spent the next four years back on

1 active duty as an intel officer, and I served in
2 a number of different places in those four years,
3 including two years here at the Pentagon, and I
4 was the Deputy Assistant Chief of Staff for
5 Intelligence for the Army for two years.

6 Then I retired from the Army in 2008
7 and completed my career at CNA, and retired from
8 them this past December.

9 CHAIRMAN MARTIN: Thank you. Welcome.

10 MEMBER FAY: Welcome.

11 CHAIRMAN MARTIN: General Granger?

12 MEMBER GRANGER: My name is Elder
13 Granger. I'm retired from the military after 37
14 years. I started off as an enlisted medic in the
15 Guard. Army paid for my education in college,
16 medical school, I did all my training in Colorado
17 as an internist, hematologist, oncologist at
18 Fitzsimons Army Medical Center.

19 Served in Europe for a number of
20 years, Fort Huachuca, was chief of medicine at
21 Landstuhl Regional Medical Center during the
22 first Gulf War, division surgeon, infantry

1 division, 4th Infantry Division, Fort Carson,
2 from there, I went to the Army War College, from
3 the Army War College I commanded at Fort Knox
4 Hospital.

5 From Fort Knox, I commanded Landstuhl
6 Hospital. From there, I went to work for the
7 Surgeon General. I started 9/11, that was my
8 first day at work, did that for a year, and went
9 back to Europe to be the senior medical commander
10 in Europe, as well as run the Military Health
11 Insurance Program called TRICARE, did that for
12 two years.

13 And after that, I deployed to Iraq as
14 the senior medical commander, 2004, 2005, with
15 the 18th Airborne Corps out of Fort Bragg. After
16 that, I came back to D.C. again and I served
17 under the Assistant Secretary of Defense for
18 Health Affairs as the Deputy Director and Program
19 Executive Officer for TRICARE management
20 activity.

21 I did that for three and a half years
22 until I retired in 1 July 2009. Since then, I've

1 been doing healthcare consulting, advisory,
2 education, quality outcomes, and disease
3 management working with some investment firms. I
4 live in Centennial, Colorado, Denver, Colorado
5 being the home of the Super Bowl champions, 2015,
6 '16, don't get confused. Glad to be here.

7 CHAIRMAN MARTIN: Thank you.

8 DR. VVEDENSKAYA: Welcome.

9 CHAIRMAN MARTIN: It's good to have
10 you here. Dr. Simberkoff.

11 MEMBER SIMBERKOFF: I'm Mike
12 Simberkoff. I actually was in the Navy from 1964
13 to '66 at the Navy Medical Research Institute in
14 Bethesda. That's the extent of my military
15 career. I am trained in internal medicine and
16 infectious disease. I joined the VA in 1970 in
17 New York, have been there ever since.

18 I started off as a research associate,
19 was planning to stay for two years. I'm actually
20 going to be retiring at the end of this academic
21 year, although I'd like to stay on this
22 committee, actually, if that's possible.

1 DR. VVEDENSKAYA: Absolutely.

2 MEMBER SIMBERKOFF: For the last 19
3 years, I've been the chief of staff, first at the
4 New York VA, and then when we integrated with
5 Brooklyn, what became known as VA New York
6 Harbor. That's since 1999, so it's the largest
7 VA in the country and we have close to 4000
8 employees.

9 I'm the chief medical officer. My
10 interest has always been in infectious diseases
11 and vaccines. I'm part of the group that brought
12 singles vaccine to the world and I continue to be
13 working on vaccines. Actually, what I'm working
14 on now is, VHA is actually mandating influenza
15 vaccination for all of its employees and I'm part
16 of the group that's actually breaking out all the
17 details of that so that it can be implemented for
18 the start of the next flu season, but that's me.

19 CHAIRMAN MARTIN: Thank you.

20 MEMBER SIMBERKOFF: Part of my
21 responsibility, by the way, is overseeing comp
22 and pen exams for VA New York Harbor.

1 CHAIRMAN MARTIN: Thank you. Dr.
2 Roberts.

3 MEMBER ROBERTS: Well, my military
4 career started as a result of being an ROTC cadet
5 in undergrad in school. Following that
6 experience, was a bright 2nd Lieutenant who had
7 his first assignment in Korea at the 125th
8 Evacuation Hospital near Seoul, and spent a total
9 of seven years in the Army as an Army officer.

10 And I switched over from the Army
11 Medical Service Corps to the Commissioned Corps
12 in the United States Public Health Service. And
13 prior to that experience, I, of course, went to
14 graduate school and earned a doctoral degree in
15 public health at Tulane in New Orleans.

16 And I had the privilege of serving as
17 Deputy Director of the National Hansen's Disease
18 Center for ten years. As most of you know,
19 Hansen's Disease is a fancier word for leprosy.
20 And that was a great experience because so many
21 people have great ideas about what Hansen's
22 Disease is, and most of it's been erroneously

1 gotten from the Bible itself.

2 As part of my tenure experience, I
3 became the CEO of the LSU hospital system and I
4 had the honor of directing the famed Charity
5 Hospital in New Orleans for seven years, which
6 was quite an experience. And following that
7 experience, I also directed the Earl K. Long
8 Medical Center in Baton Rouge, Louisiana, and
9 became the Chief Academic Officer for the
10 Healthcare Services Division at LSU.

11 And just before retiring, I spent a
12 great deal of time writing a book documenting the
13 history of the Charity Hospital system in
14 Louisiana. As you probably know, the Charity
15 Hospital has a very famed reputation all over the
16 world, and much of it had never been captured in
17 any kind of history, so I'm happy to say our book
18 has been very popular.

19 Following that, I retired some years
20 back and spent a lot of time doing some
21 consulting work and helping my son, who's a
22 board-certified internist in his private

1 practice, and so it's an honor to be a part of
2 this committee, and I'm learned a lot so far, and
3 I'm still learning, and I hope to be able to
4 contribute something.

5 CHAIRMAN MARTIN: Thank you. Dr.
6 Browne.

7 MEMBER BROWNE: Good morning. Well,
8 I have started my military career by receiving a
9 fellowship in the public health service being one
10 of the global health fellows. And this in '72,
11 yes, '72, '73, worked on -- my plan was to work
12 on HMOs, which was the new thing at the time, and
13 looking at it from a local standpoint, and
14 regional standpoint, and a national standpoint.

15 The global health fellowship was part
16 of the old HHS area and so I was in Los Angeles
17 and worked with the Watts Health Center in
18 developing its HMO, and then went to Region 9's
19 office in San Francisco, and then from there, to
20 Parklawn. And I had a degree in public health
21 and so that was my, sort of, foray.

22 Then went to medical school at

1 Georgetown on a health professional scholarship
2 program. The Public Health Service didn't have
3 the application ready so I switched to Army, and
4 that's where my career blossomed. I did my
5 training at Walter Reed and following training,
6 was sent to El Paso, Texas, unfortunately, for a
7 couple years as the Assistant Chief of
8 Hematology/Oncology there.

9 And then from, let's see, oh, yes,
10 from El Paso, I came back to Washington at the
11 Armed Forces Radiobiologic Research Institute,
12 and ran the medical effects of nuclear weapons,
13 or we call it ionizing radiation now, a course
14 that we trained people all over the world.

15 From that assignment, I also created
16 the Medical Emergency Response Team for Radiation
17 Accidents, it was called the MRAD, and of course,
18 we were involved in Chernobyl, and Brazil in the
19 Goiania, and all of the other radiation accidents
20 that had occurred.

21 And from that, did a couple of
22 consensus conferences on medical management of

1 radiation accidents. From there, I was assigned
2 to the Pentagon where we were then beginning to
3 look at women in the military and the impact of
4 all of that, so we had a -- headed the medical of
5 the women's component in looking at women's
6 health in all aspects, reporting to Congress, or
7 being the representative to DACOWITS.

8 From there, I went to Fort Detrick and
9 became the Deputy for Medical Research and
10 Development, running all of their research
11 programs for the military, Air Force, Navy, all
12 of them, because human research was actually done
13 out of Fort Detrick, the infectious diseases, you
14 name it, all of those things, in addition to
15 having a large, probably, \$350 million
16 Congressional set aside program to do breast
17 cancer, ovarian cancer, prostate cancer,
18 rheumatosis, et cetera, and so that has blossomed
19 into all kinds of programs.

20 That was a long trek driving up to
21 Fort Detrick every day, so I retired in 2000, and
22 thought I would kick my heels up and enjoy

1 myself, incorporated into a small business that I
2 was going to run, and was recruited to go to the
3 National Cancer Institute, and spent the next
4 nine and a half years at the National Cancer
5 Institute, and then thought I really should focus
6 on doing my business, which I'm still trying to
7 focus on.

8 At the Cancer Institute, I ran the
9 breast cancer portfolio, looking at cancer
10 prevention agents as well as other programs
11 there. And in-between all of that I was still
12 seeing patients in oncology and internal medicine
13 when I was allowed to have a half a day.

14 And now I'm just devoting my time to
15 my small woman-owned services and veteran-owned
16 small business looking for contracts, primarily
17 focused on education, disease prevention, health
18 promotion, where we're looking at the chronic
19 diseases as well as HIV/AIDS. And in-between all
20 of that I've done a lot of international things,
21 mostly volunteering and working with
22 organizations in Africa.

1 I should say I was the principle
2 investigator for one HIV/AIDS under the PEPFAR
3 program for Swaziland for three years.

4 CHAIRMAN MARTIN: Thank you.

5 MEMBER BROWNE: That's me and I've
6 been on the committee, I can't remember, I guess
7 this is my second term. Thank you.

8 CHAIRMAN MARTIN: Thank you.

9 MEMBER BROWNE: Glad to be here.

10 CHAIRMAN MARTIN: Glad to have you
11 here. Dr. Savoca.

12 MEMBER SAVOCA: I am Liz Savoca. I
13 have no military experience. I'm a civilian. I
14 guess the only civilian here and also, most of my
15 experience is academic. I'm an economics
16 professor at Smith College. My research focuses
17 on the overlap between health and labor
18 economics, so I got involved with the crew down
19 at Yale to study issues related to mental illness
20 and labor market adjustments, and that got me
21 drawn into a project at the VA down there,
22 looking at the civilian readjustment problems

1 with veterans.

2 And I've looked at, particularly focus
3 on PTSD and other mental illnesses, and that's
4 got me to this committee here, because I've
5 written somewhat extensively. We started writing
6 at a time when nobody cared about veterans. We
7 weren't involved in a way, and then once a war
8 started, all our work was cited and it became
9 suddenly important, and that's why I'm here.

10 CHAIRMAN MARTIN: That's a very short
11 summary of a very important career, so thank you.
12 Thanks for being here. Dr. V is our DFO.

13 DR. VVEDENSKAYA: Good morning again,
14 everybody. I have also a short career and
15 civilian career. I am a medical officer at the
16 Compensation Service here at the VBA and I
17 started five and a half years ago. And I came to
18 the VA after ten years at Georgetown University
19 at the Department of Infectious Diseases,
20 HIV/AIDS clinical trials unit.

21 We conducted numerous, numerous
22 studies with HIV-positive patients. I was part

1 of the team which developed one-pill regimen and
2 also optimized antiretroviral regimens. Was
3 extremely work and projects. By training, I am
4 an OB/GYN. I finished medical school in Moscow
5 in '89 at the oldest medical school in Russia,
6 which was put together by Catherine the Great. I
7 always promote my medical school.

8 And worked for a few years and then
9 moved to the United States in the early '90s,
10 took my exams, went to work, raised a child. As
11 I was working at Georgetown with the population
12 of patients that were severely underserved, I
13 developed an interest in public health, went back
14 to graduate school at Georgetown to study
15 healthcare economics a little bit, public health,
16 and then took this job.

17 And as I was working as the medical
18 officer in charge of rewriting the A schedule for
19 writing disabilities, the updates, I realized
20 that I needed a little bit more education, and
21 last August, at my tender age, finished MBA at
22 GW, which made me less scared of budgets and

1 financial aspects of my job.

2 And I was asked, last summer, to head
3 this committee as a designated federal officer,
4 and it's my privilege to work with all of you
5 with such distinguished careers in all your areas
6 of expertise, and thank you very much for
7 rendering that expertise to us because your
8 committee helps us to do our job better.

9 That's why when I go out and recruit
10 our speakers, I said, that's not the committee
11 which will criticize you and give you hard time.
12 This is the committee which is trying to
13 understand our programs the way we work here at
14 the Veteran Benefits Administration Compensation
15 Service.

16 And with your expertise coming from so
17 many different walks of life, my hope is that you
18 will be able to see something which maybe we
19 overlook and give us recommendations as you do on
20 every other year basis. Thank you so much for
21 being part of this committee. Truly appreciate
22 it.

1 CHAIRMAN MARTIN: Thank you. Hal,
2 would you mind giving us a little snapshot of
3 you, since we can't see you in person today?

4 MEMBER BIRD: Absolutely. Thank you.
5 Hi. Good morning. My name is Al Bird. I
6 started out in the Air Force in 1982. I flew
7 airplanes for about nine years and I wrapped that
8 experience up by flying in the F-16. And I
9 fought in Desert Storm in that capacity.
10 Following Desert Storm, I separated from active
11 duty and about nine months later I went back in
12 the reserves. I went into the Special Forces
13 Command at that point down in Tampa, Florida, and
14 was involved in Somalia in that capacity, with
15 special forces.

16 And I worked in that field for about
17 six years, did a variety of positions in U.S.
18 Special Forces Command, and then from there I
19 transitioned to become the Air Force Reserve air
20 attache in Bangkok, Thailand, and after telling
21 the people that hired me that, yes, I did speak
22 Thai, I promptly went out and learned how to

1 speak it as quickly as I could, and continued to
2 work in that capacity for about seven years out
3 of the U.S. Embassy in Bangkok, and then they
4 gave me the program.

5 And I ran the global attache program
6 for the Air Force Reserve for about another five
7 or six years. And I had people in every embassy
8 all over the world. That was a fabulous
9 experience. And worked throughout my experience
10 in both special forces and the attache world, I
11 worked with all branches of the service, and got
12 a tremendous amount of experience in that regard
13 that I've always appreciated.

14 And then I wrapped up my 30 years, I
15 spent the last three years as an emergency
16 response liaison here in the State of Texas. And
17 I retired from the Air Force Reserves in 2014 and
18 came on the committee here at the VA in 2015.
19 And time does fly by. I've been on the committee
20 now for nine months or so, I think, and it's a
21 great honor to serve with so many accomplished
22 people. Thank you, Kirk.

1 CHAIRMAN MARTIN: Thanks, Hal. We
2 look forward to having you back in person at our
3 next meeting, but thanks for taking the time to
4 call in today and be with us.

5 MEMBER BIRD: My pleasure. Thank you,
6 Kirk.

7 CHAIRMAN MARTIN: And let's now go,
8 it's a little before 6:00 a.m., I think, in
9 Washington State, but General Lowenberg is up,
10 and Tim, welcome.

11 MEMBER LOWENBERG: Thank you and good
12 morning, everyone. I retired from military
13 service in 2012 after completing 44-/12 years, 22
14 of which were at Langley. I served in the active
15 Air Force, Air Force Reserve, Air National Guard.
16 Since my military training, I continued to work
17 with the U.S. Air Command, with the U.S. Fighter
18 Command, in issues going toward policies for the
19 last two years, principally on standards policy
20 issues, because it's the White House National
21 Security Council, the Secretary of Defense and
22 Secretary of Homeland Security.

1 Hal reminded me of the work I used to
2 do for many years doing global and state
3 partnership programs. I established the program
4 in Thailand in 2002 and continued to directly
5 oversee that program until my retirement in 2012.
6 Ultimately, that established a partnership for
7 Vietnam. And we took care of the International
8 Advisory Council for just the global programs,
9 which now involves 72 countries, literally, all
10 over the world.

11 I've been a member of this committee
12 and deeply regret that I rotated to Washington
13 State, preventing me from being there in person,
14 but thanks so much for the opportunity to
15 contribute by phone.

16 CHAIRMAN MARTIN: Thanks, Tim. Thanks
17 for getting up early and calling in, and I
18 appreciate your willingness to be onboard by
19 telecon today. Thank you. I'm Kirk Martin. I
20 came to this committee in 2013, so I'm just
21 beginning a second term, and I have kind of a
22 split career. My civilian career was pancreatic

1 surgery. I did surgical oncology at Mayo Clinic
2 for almost 30 years.

3 I retired from Mayo in 2007 and had
4 been in the Air Force Reserve, Air National
5 Guard, and little bits and pieces of active duty
6 up until 9/11, then I went on active duty for
7 another three years, three and a half years,
8 following 9/11.

9 The last assignment I had was as
10 Surgeon General for the National Guard, Army and
11 Air, at the Pentagon, and also the Air National
12 Guard assistant to the Air Force Surgeon General,
13 also at the Pentagon.

14 That carried me out until about summer
15 of '14, when I retired from the Air Force after
16 almost 30 years, and since then, I have been
17 doing a lot of things on my wife's punch list, as
18 many of you probably have done the same, so I'm
19 pleased to be on this committee, it's an
20 important committee, and I'll say more about that
21 in just a moment.

22 Look, we have a few visitors here. We

1 have an opportunity for public comment later
2 today, but let me just have people around the
3 room introduce themselves.

4 MR. LABOZZETTA: Sure. My name's
5 Matthew Labozzetta. I'm here representing the
6 American Legion as their Assistant Director for
7 Claims. My only focus is benefits with the VBA.

8 CHAIRMAN MARTIN: Thank you for
9 joining us. Good morning.

10 MS. PARK: Good morning. My name is
11 Kristi Park. I'm with the Jefferson Consulting
12 Group and we help companies become better
13 partners with agencies like the VA and so I'm
14 here to learn about the work of this committee
15 and benefits from the petition.

16 CHAIRMAN MARTIN: Thanks for joining
17 us. Thank you.

18 MS. BROWN: Good morning. My name is
19 DeShanna Brown. I'm from Louisiana State
20 University. I was invited by Dr. Roberts. At
21 LSU we have become the institution of choice for
22 veterans and we are in the process of expanding

1 those opportunities through our veteran and
2 military student services program, and I work in
3 student affairs at LSU. Go Tigers.

4 CHAIRMAN MARTIN: Thank you for being
5 here. Thank all of you for being here. And our
6 recorder doing his job over in the corner. Good
7 morning. Well, by means of getting our committee
8 started, you know, I come back to Washington,
9 it's strange, I was here almost every day of my
10 life for the last four years, then I've been gone
11 now for about a year, and when I come back into
12 town it's kind of like being strangely at home
13 again, but in a different place all at the same
14 time.

15 Re-caging my thinking for the Veterans
16 Affairs is helped tremendously by something that
17 you see on the door every time you walk through
18 the main doors in the main VA building, which
19 celebrated an anniversary of sorts, it was 141
20 years ago, March 3rd, that President Lincoln,
21 whose picture is displayed over on the wall, gave
22 his second inaugural address.

1 And as part of that second inaugural
2 address, he said in there, to care for him who
3 shall have borne the battle, and for his widow,
4 and for his orphan, and those words became the
5 motto of the VA, which are emblazoned on either
6 side of the main door at the VA building. That
7 was put up in 1959 by a VA administrator named
8 Sumner G. Whittier, who kind of made it their
9 mission.

10 And I read those words and I think
11 about the honor that we all have at this
12 committee being able to think about veterans
13 compensation, veterans benefits, and try and
14 serve those who have done so much for our
15 country. We have a Congressional mandate to
16 review the ratings schedules, you'll hear more
17 about our roles and responsibilities first thing
18 this morning, which is, thank you for putting
19 that on. It's a good thing for us all to hear.

20 But personally, it's a great honor to
21 serve on this committee and to be able to review
22 and advise the Department of Veterans Affairs

1 from our varied backgrounds. Hearing everybody
2 around the table, you realize the breadth and the
3 depth of our experience, what we jointly bring to
4 this job, it's eye-watering, and the amount of
5 training and experience that all of you bring,
6 you know, it's hard to duplicate.

7 So thank you very much for your time
8 and your efforts. It's hard to get to Washington
9 from some outlying places, like Texas, Washington
10 State, sometimes Louisiana, but it is an
11 important mission and it's one that we all take
12 very seriously.

13 We currently have some projects we're
14 going to hear updates on during the course of
15 this meeting and tomorrow afternoon. Every two
16 years, this committee submits a biennial report
17 to the Department of Veterans Affairs and that
18 goes also to Congress. And we did this last in
19 2014, we receive feedback from those reports, and
20 we're looking forward to that feedback from the
21 Veterans Affairs, and we're going to hear the
22 update on that tomorrow.

1 We also, if there is reason, we'll
2 provide supplemental reports as necessary, and we
3 did one of those last fall, at the end of October
4 of last year, that interim report, we'll also be
5 getting some feedback on from the VA.

6 As you'll hear in the feedback, and
7 you can read in the old reports, the VA takes
8 these very seriously, word for word, and they
9 look at it very carefully. Sometimes it leads to
10 changes in the way they do things, sometimes it
11 leads to explaining to us how things are actually
12 working and why this is or isn't an issue, but
13 they're very good about examining them and
14 carefully considering everything we say as a
15 committee.

16 General Scott, the former Chairman of
17 this committee, had a great deal of experience
18 with the VA, with not only this committee but
19 other assignments in the VA, and his manner of
20 running these meetings was very open, which I
21 hope we will continue, most of the speakers are
22 happy to be interrupted if you have questions,

1 and all of them will give a chance for questions
2 at the end of their presentations as well.

3 And I think the committee probably
4 gains the most from this interchange with not
5 only what's presented, but then how it fits into
6 what we're concerned about and what the veterans
7 are concerned about.

8 This committee also has a charge to
9 hear from the public and we provide opportunities
10 for public comment at all of our meetings, that
11 can be in person or it can be written comment,
12 and we do have one written comment that we'll
13 discuss later today. And we take those very
14 seriously as well.

15 We read those into the record, all of
16 the meetings are transcribed and preserved, and
17 the meetings are advertised in advance in the
18 Federal Register so that people know when the
19 meetings are going to be held, where they're
20 going to be held, and they are able to physically
21 come in person if they wish.

22 So I'm thankful to all of you for what

1 you bring and for your willingness to serve on
2 the committee, and look forward to a very, very
3 good year of work for our veterans, so thank you.

4 DR. VVEDENSKAYA: I just wanted to
5 add, mostly for the new members, the minutes of
6 these meetings and the transcripts are available
7 to the public. They are posted on a public Web
8 site, which is VA, and then the general GSA Web
9 site. It's why if any one of you will ever need
10 minutes or transcripts, you can either ask me or
11 if your colleagues or anybody else who is
12 interested, you can always send them to the GSA
13 or our Web site.

14 They usually post it within the month
15 after we receive them.

16 CHAIRMAN MARTIN: Just to recap some
17 of the topics that we have been discussing, and
18 you'll see some of these on the agenda, the
19 agenda, we've tried to limit to a certain number
20 of talks per day so that we have time to discuss
21 them to fully have questions answered to the
22 committee members' satisfaction from the

1 presenters, and so we try to limit the number of
2 presentations just to give that time for ample
3 discussion.

4 The committee has been working with a
5 number of questions on individual unemployability
6 and how that program works, and if any changes in
7 that schedule or approach should be considered.
8 We have been looking at issues with the Guard and
9 Reserve, and how that fits in with the Department
10 of Defense and the active duty forces, how
11 members of the Guard and Reserve have served
12 periods of active duty and then gone back to the
13 Guard or Reserve, and retired from the Guard or
14 Reserve, how they're captured into the programs
15 of the VA, and how there are many, many DD-214s,
16 as opposed to one when I finish, how they're
17 sorted out and tracked.

18 We have been working with women's
19 health issues in the VA, we have been working
20 with presumptive diagnoses in the VA, like Agent
21 Orange, like, let's see what else we had
22 presumptive, the Camp Lejeune presumptive, so

1 that we can, basically, be up to speed with a lot
2 of the things that are currently being discussed
3 at the higher levels within the VA.

4 The National Workflow Team has been a
5 very, very big issue over the last year or so.
6 We were pleased to actually physically visit the
7 National Workflow Office in their command center,
8 if you will, and see how these operations work,
9 and it's kind of like walking into a PAOC, with
10 all the screens all over the place, and here's
11 what Division 4 is doing, and so forth, so we'll
12 have an update on that this meeting as well.

13 We have frequently discussed the
14 issues of VA homelessness and homeless veterans,
15 fully developed claims, that's on the agenda for
16 today, is another issue that we had been
17 concerned with, and then tomorrow, you will see
18 that we have some discussions about the MyVA,
19 their Web site, MyVA Web site, and some other
20 comments on the presumptives.

21 So it's a busy agenda that we have.
22 Someone mentioned, I think it was you, Dr.

1 Roberts, who said you're still learning, and yes,
2 I learn every time I come to these meetings, and
3 I think there's more than you can capture within
4 with the two, or three, or four, or five-year
5 cycle, but over the period of time, we'll gently
6 touch each one of these topics and usually the
7 more controversial ones, many times.

8 So it is something we'll try to give
9 you a running start at today, but be advised, it
10 is going to take some time to feel comfortable,
11 and I'll let you know if I get there. Any other
12 comments around the room before we get started?

13 Hal or Tim, am I missing anything that
14 I should be saying as the opening remarks here?

15 MEMBER BIRD: I think you covered the
16 past and ongoing work of the committee quite
17 thoroughly.

18 MEMBER LOWENBERG: I agree.

19 CHAIRMAN MARTIN: Okay. Thank you.

20 DR. VVEDENSKAYA: Well, I just wanted
21 to ask the committee members if you, by any
22 chance, have a copy of your new members

1 orientation booklet I sent you, probably about a
2 month ago or so. It's all right. Yes, I will go
3 ahead and print a copy for each of you because
4 the first presentation by Mr. Moragne, he
5 probably will refer back to that book, and we
6 have, probably, ten minutes before his
7 presentation. Why don't I go and bring us each a
8 copy.

9 Meanwhile, we might take this
10 opportunity to read the public comment, just
11 because you have time, while I'm -- the one which
12 I forwarded to you.

13 (Whereupon, the foregoing matter went
14 off the record at 9:14 a.m. and went back on the
15 record at 9:29 a.m.)

16 DR. VVEDENSKAYA: All right. It seems
17 like we are back to the full body of our
18 committee. Here we have our first presenter, Mr.
19 Moragne, from the VA Office -- it's Advisory
20 Management, Advisory Committee Management Office,
21 the office which indicates all of us designated
22 federal officers and all of the committees on how

1 to conduct ourselves, what our rights,
2 privileges, and how shall we function to be at
3 most -- to you, Mr. Moragne.

4 MR. MORAGNE: Thank you. Good
5 morning, everyone, again. My name is Jeff
6 Moragne. I'm from the Office of the Secretary
7 and I am the Director of VA's Advisory Committee
8 Management Office. And Ioulia said, part of our
9 responsibilities is training her, the other side
10 of our responsibility is making sure the training
11 that we gave her, she executes with, but we're
12 also responsible for the training and oversight
13 of all of VA's federal advisory committee, so the
14 training of committee members and the oversight
15 of all of VA advisory committees.

16 VA currently has 25 advisory
17 committees, soon to be 26, and they cover general
18 areas of health, research, affinity groups, like
19 minority veterans, rural veterans, women
20 veterans, and then benefits. And clearly, you
21 fall in the benefit bucket because you're looking
22 at, you know, the disability compensation and

1 things like that, and the ratings schedule.

2 For today, what I'd like to do for the
3 next, what, what you give me, about four or five
4 hours? Okay. Fifteen minutes. How about that?
5 For the next 15 to 20 minutes, if you have
6 questions, is literally go over some of the
7 duties and responsibilities you have as committee
8 members.

9 We find from time to time it's
10 important for the Director of the Advisory
11 Committee Management Office to sit at the end of
12 your table and remind you of your duties and
13 responsibilities, not just as volunteers, to wit,
14 we are very thankful for you giving up the time,
15 providing veterans with your service, and
16 investing in our future system that we have.

17 We're very grateful for that, but at
18 the same time, with that particular opportunity,
19 or privilege, comes responsibility, so I want to
20 touch upon some of those responsibilities, then
21 answer any questions that you may have of, you
22 know, any information I put out or of just VA

1 advisory committees in general.

2 In order to do that, I've provided you
3 with a four-page briefing. You can read that on
4 your own. That's got a lot of good information.
5 I'm going to touch upon some of that. But the
6 real tool I want to leave you with today, and I
7 ask for you to take it seriously, take about 20,
8 25 minutes to read, you can read it on the
9 airplane ride home, you can read it one evening
10 before the evening news, 25 minutes of invested
11 time in 15 pages of your duties and
12 responsibilities.

13 It's a brand new product. First ever
14 as far as we're concerned, for all of our
15 committee members to invest in is the New
16 Committee Member's Orientation Handbook. So it
17 says New Committee Member, so you might be
18 thinking, well, hey, Jeff, I've been doing this
19 for two, three, four years. I've been on
20 multiple federal advisory committees, that kind
21 of thing. I'm not a new person.

22 Change your paradigm. You're always

1 new. Change your paradigm. You're always new,
2 because the rules change and they change
3 suddenly. And the, I'm in trouble, is not I'm in
4 trouble, I'm kicked off the advisory. It's, I'm
5 in trouble, VA's embarrassed, and we need that,
6 right? We need to be embarrassed. VA's
7 embarrassed, and more importantly, veterans
8 survivors and families miss out, okay? That's
9 the more important, not the embarrassment, not
10 the media stuff.

11 So you're going to have invest 20
12 minutes of good reading, but you'll come away
13 with good nuggets of what your duties and
14 responsibilities are. So let me start at the top
15 of the queue. Federal Advisory Committee Act
16 covers this committee.

17 Federal Advisory Committee Act came
18 into being in 1972. And what did it do? It took
19 about 8000-plus advisory committees and dwindled
20 it down to about 1100. How did it do that? It
21 got rid of the, I'm going to say it like it is,
22 nepotism, the favoritism, and the all-inclusive-

1 isms, where we had multiple wards across the
2 Federal Government doing the same thing for the
3 same constituency, with very little results.

4 So it got rid of that in a great
5 collaboration between the Legislative and
6 Executive Branch, and whittled it down to 1100,
7 and that was in 1972. We only have about 1200
8 boards, so we've only increased 100 in about 43,
9 44 years, okay? That's not bad.

10 By the way, VA had its first new
11 committee in 12 years with my VA, with Secretary
12 McDonald, two years ago, so I'm telling you, it
13 works. FACA works. FACA put the framework
14 around how you establish a committee, how you run
15 the committee, and how you terminate a committee,
16 and then over the year, there's been a couple of
17 changes to it, but essentially, it's gotten
18 better.

19 VA then puts in a lot of its policies
20 for guiding our federal advisory committees, and
21 I'm going to hit upon one or two of those, but
22 essentially, FACA has to do with how you are

1 chartered, so that's your operationalizing all
2 your -- you're statutory committee, right?
3 Statutory-isms, all those many, many pages of
4 statutory-isms are operationalized in your
5 charter.

6 Your charter is two pages long.
7 That's a two-minute read. So if you haven't read
8 your charter, put that down as part of your
9 responsibility. It's a two-minute read. Has 15
10 paragraphs. Tells you exactly how you're going
11 to be run. That's all because of FACA, okay?

12 FACA also designated a designated
13 federal officer. Now, I don't like Ioulia and I
14 know you don't like Ioulia, but the law loves
15 Ioulia in her role as a DFO, designated federal
16 officer. She literally is, excuse the pun, the
17 bellybutton that the law goes to to make sure
18 that you are putting into practice what the law
19 says, and coming up with the great advice and
20 recommendations that you're going to pass on to
21 the Secretary, she's large and in charge, okay?
22 Don't mean that any other way except you're in

1 charge.

2 And that's who we're going to go to,
3 we being through the Secretary to me, the
4 committee management officer, to make sure
5 everything is being done in accordance with the
6 law. So enough said on that. You got questions
7 on that, 99.9999 percent of the time you go to
8 Ioulia first, she'll work with the Chair, you'll
9 get your answer.

10 And if she can't figure it out, she'll
11 come to me, if I can't figure it out, I'll work
12 with the lawyers or the committee management
13 secretariat, which is GSA, GSA has oversight
14 authority for all the Federal Government, but
15 we'll get you your answer, okay? And hopefully,
16 you'll stay involved in this responsibility, this
17 opportunity, to serve veterans.

18 Federal Register Notice. Every
19 meeting you have, every meeting you have, has to
20 be published in the Federal Register so that the
21 public, which, oh, by the way, as we know, is
22 paying for all of this, has the right to attend.

1 So the example would be, and by the way, we don't
2 play the 15-day rule here at VA. We do 30 days.
3 Any time she has a meeting, 30 days prior, she
4 has to have all the facts and details in the
5 message notice for us to put in the Federal
6 Register, as do all our federal advisory
7 committees.

8 So if you're a member of the public,
9 you're out on the sidewalk, and you say, you know
10 what? I want to visit that federal advisory
11 committee. There's nobody that can stop you.
12 The only slight requirement that we request is
13 that you have a photo I.D. to enter a federal
14 building, if that's where the advisory committee
15 is going to be, and we know the reasons behind
16 all that.

17 But any member of the public can be
18 sitting in this room. She could have them five
19 deep and you would have to move the meeting,
20 literally, to accommodate the public because the
21 public, under the Sunshine Law, has the
22 opportunity to attend meetings and add commentary

1 to the minute meetings, okay, or ask questions,
2 depending on how you set it up in your Federal
3 Register Notice.

4 You can close a meeting if you're
5 going to be reviewing proprietary information,
6 things like that, PII, private identifiable
7 information, you can have meetings closed, but
8 again, that would have to be published in your
9 Federal Register Notice.

10 If there were a disturbance in the
11 building, the Chair via Ioulia's authority,
12 could, like, adjourn the meeting and then
13 reconvene it later, and that would have to be
14 reflected in the minutes of the particular
15 meeting, but, you know, FACA is designed, along
16 with FOIA, you know, Freedom of Information Act,
17 along with the Sunshine Act, so that the public
18 has access to everything you do.

19 All of the advice and recommendations
20 that you're going to deliberate on and eventually
21 put into writing, the public has access to, all
22 right? And that was another one of the cleanup

1 items that they put into place.

2 FACA also requires that you have a
3 balanced membership. We here at VA fine-tune
4 that to mean this, your committee should
5 demographically reflect the constituency it
6 serves. Your committee shall reflect the
7 constituency it serves. So we give Ioulia a
8 little bit of leeway in defining what that
9 constituency is, whether it's all veterans or
10 whether it's disabled veterans.

11 Either way, she's going to have a
12 demographic group of so many of this, that, and
13 the other thing, and she's going to try to make
14 sure that your membership reflects the
15 constituency it's serving.

16 Clearly, and I don't want anybody to
17 walk away from the table, you've got to have the
18 right skillset, experience, knowledge, and
19 background before we get the demographics. Let's
20 just be honest. You got to be smart enough to do
21 the job before you reflect this constituency, but
22 I want you to know that it is part of FACA, it is

1 part of VA policy, to make sure your committee
2 reflects the constituency it serves.

3 To wit, you're here to serve only two
4 terms. This is not an entitlement for you to
5 serve for the next 20, 30 years, and it's taken
6 me and my team, and I consider Ioulia part of the
7 team, although 24, 25 DFOs, as well as senior
8 leadership, it's literally taken us two years to
9 cleanup all of VA advisory committees so that
10 nobody is serving more than two terms.

11 And I won't air any dirty laundry
12 because this goes in a public record, but it's
13 literally taken two years to get us here. So
14 what does that mean? If this is your day one,
15 what I'd like you to do is wrap your arms around
16 that you're going to serve two terms, and your
17 terms are what? Two years?

18 DR. VVEDENSKAYA: Two years.

19 MR. MORAGNE: Two years. Okay. So
20 four years, max, right? And somewhere around
21 year three, Ioulia, or Ioulia's replacement DFO,
22 is going to come to you and say, it's time for

1 you to do me a favor. Time for you to help me
2 out and find your replacement. Who, in your
3 Rolodex is smart enough, skilled enough, has the
4 knowledge, and wants to volunteer to be your
5 replacement? Help me out with that so that when
6 I go recruiting, it's a much easier job, all
7 right? So that's part of your duties and
8 responsibilities as well.

9 Help her out with a name, somewhere to
10 look, to find that person that's going to replace
11 you.

12 Can FACA's meet privately? I think
13 I've already answered that. What about
14 testimony? You say sometimes, I know with the
15 distinguished people that we have on this
16 particular committee, that you may be asked to
17 testify, whether it's locally, or on the state
18 level, or on the federal level, does that
19 conflict with you being a federal advisory
20 committee member? No, it does not, because you,
21 as a private citizen, can testify or go petition
22 Congress, or go visit your Congressman, Senators,

1 et cetera, et cetera, so forth and so on.

2 What you cannot do is put loud and
3 proud on your, you know, suit or clothing du jour
4 that you are an advisory committee member. It
5 can be in your resume, it can be in your
6 background, but you are not to go to any of these
7 testimony opportunities stating that you are
8 speaking as a committee member. Does that make
9 sense?

10 You are a committee member, but you're
11 not speaking for the committee. And why is that?
12 Because while you're doing this duty, you're a
13 special government employee, you're not a regular
14 government employee, so you don't speak for the
15 Secretary, all right? Does that make sense? You
16 don't speak for the Secretary.

17 So you can go testify all you want as
18 a subject matter expert, and that kind of stuff,
19 and it can be known that you're part of this
20 federal advisory committee, but you can't speak
21 for this committee, all right? I want to make
22 sure that light, dark, and shade is really

1 understood.

2 If in doubt, call Ioulia. She'll give
3 you an answer. If she can't figure it out, call
4 me. If I can't figure it out, I'll call the many
5 sources that I have, but, you know, what you do
6 matters, and we want to make sure that you do it
7 properly, so that's why I say again that you have
8 a committee member handbook, and you're all new
9 committee members, whether it's day one or the
10 last day, the Federal Advisory Committee Act,
11 should you very industrious, it's probably one of
12 the smallest acts in all of Federal Government.
13 It's eight pages long. It's eight pages long.
14 It's in English too. Believe it. Okay?

15 And then these slides and subject to
16 your questions, that's all I have. Thank you
17 very much, again, on behalf of the Secretary for
18 your service. I think I finished in 14 minutes
19 and 53, 54 seconds, but that's what you would
20 expect out of an old fighter pilot. Right, Mr.
21 Bird? Hal Bird and I served together.

22 MEMBER BIRD: Yes.

1 MR. MORAGNE: Although, he was always
2 in an inferior aircraft than I was, but I'm
3 kidding. I'm kidding, Hal.

4 DR. VVEDENSKAYA: I just wanted to add
5 to Jeff's presentation that as a committee, you
6 do have an opportunity to speak in your biannual
7 reports or in your interim reports. As a
8 committee you do have a voice and you do speak
9 all together. That's a way you speak as a
10 committee, not as a private citizen. Just want
11 to make sure that it's just a supplementary to
12 what Jeff just outlined.

13 MR. MORAGNE: Thank you. One other
14 point I'll leave with, unless anybody else has
15 any questions, is, there is an initiative under
16 way which involves advisory committee members,
17 and it's internal to VA, and it's called cross-
18 committee collaboration.

19 So the way this would work is, as you
20 look at the depth and breadth of committees that
21 we have here at VA, you might say, hey, this
22 committee might want to talk to Committee X, Y,

1 or Z because maybe we have some parallel
2 interests or issues, and we want to see what
3 they've developed over time in terms of their
4 advice and recommendations they've given to the
5 Secretary.

6 You know, so why would you do this?

7 Well, number one, you might do it because you
8 don't want to plow the same ground or you want to
9 use information that they've already harvested,
10 or you want to synchronize the recommendations
11 and advice that you're making to the Secretary
12 with something that they're doing.

13 Believe it or not, there are parallel,
14 maybe not the same, but they're parallel, and the
15 Secretary wants all of our committees to know
16 that his focus is on MyVA, the five goals of
17 MyVA, and the 12 priorities. And if your
18 recommendations don't head toward those
19 priorities, it's less likely that they'll get
20 resources.

21 Let me say that again. If your
22 recommendations and advice, and the course that

1 you do in your work, don't feed into those 12
2 priorities that he has, it's less likely that
3 they'll get enacted, at least immediately. Maybe
4 at some future point. There's a caveat, I know.
5 I know the specificity that you --

6 DR. VVEDENSKAYA: No, no, no, I just
7 wanted to say that I'm glad that you mentioned
8 MyVA because at this meeting we will have a
9 presentation tomorrow on MyVA initiative and what
10 Jeff just mentioned fits right into our
11 presentation tomorrow, where I'm sure you will
12 take notes and you will synchronize, try to
13 synchronize, your recommendations to where this
14 goes.

15 MR. MORAGNE: Yes, so, you know, part
16 of FACA and part of my role as a director here,
17 is Ioulia's role as well is, we cannot tell you
18 what to do, okay? You know, within reason, I
19 can't tell you to lie on your form or anything.
20 No, I'm sorry. We can't tell you what to do, but
21 we can heavily, heavily suggest, based off of our
22 knowledge and experience of what works and what

1 doesn't work, you know, particular paths that you
2 may want to take.

3 This cross-committee collaboration,
4 this alignment with MyVA priorities and
5 initiatives, it's a good way to go. You know,
6 that's about all I can say. Yes, ma'am.

7 DR. VVEDENSKAYA: Jeff, what you
8 mentioned to the committee members where they can
9 go on our public Web site to look for other
10 committees which we have within VA.

11 MR. MORAGNE: Sure.

12 DR. VVEDENSKAYA: This way if there is
13 a wish to come as a general public and attend any
14 of the other committee meetings, like ours.

15 MR. MORAGNE: Right. So I'll start
16 with this, oh, wow, the New Committee Member's
17 Handbook, Page 15, has all of VA's committees.
18 All of VA's committees, okay? So, you know, I
19 would start you there, just as an academic
20 exercise to understanding what the depth and
21 breadth of VA committees are, right?

22 And once that's kind of tickled your

1 fancy, you can either reach back through Ioulia,
2 to me, or we can reach directly over to the other
3 designated federal officers and the Chairman, but
4 the idea of cross-committee collaboration is to
5 get that Chair and that DFO at the end of your
6 table for 15, 20 minutes to have them brief you
7 on what they're doing in their lane.

8 Not the surface stuff here, what
9 their, you know, goals and objectives are, but
10 actually what they've looked at over the last two
11 to three years. I think you're going to be
12 surprised on how much you can cross-pollinate and
13 cross-feed, and if you want to go to the extra
14 step, which a couple of our committees have
15 already done, homeless veteran and homeless rural
16 and minority, they formed a subcommittee to drill
17 down on this because their product that they want
18 to hand the Secretary is, here's three committees
19 aligning their recommendations and advice with
20 your MyVA at 12 priorities, don't you think you
21 ought to put money against them?

22 Man, what a combination. I mean, you

1 know, that's a lay up, as they would say, for the
2 Secretary to enact on. So again, I would start
3 you off on that academic exercise, Ioulia, and
4 then we can either, between committee meetings,
5 or because you all have so many meetings, and I
6 know you have a lot on your agenda, we can get
7 the right representatives, the Chairs or the
8 DFOs, but start that ball rolling downhill.

9 And, you know, we think, you know, at
10 the Secretary's level, at my level, that this
11 cross-committee collaboration has nothing but
12 good written all over it. We already know how to
13 work the rules so we all stay out of trouble.
14 You're not doing the same thing as another
15 committee, but you are comparing notes, comparing
16 research, things like that so that veterans,
17 families, and survivors are the benefactors of
18 your work.

19 MEMBER BROWNE: You said there was a
20 new committee. Which one --

21 MR. MORAGNE: So it's not going to be
22 on here, it's in formulation, and it's going to

1 look at suicide prevention; veteran suicide
2 prevention. I think it's statutory too. Yes,
3 sir.

4 CHAIRMAN MARTIN: We do a lot of
5 communication by email among the committee
6 members between meetings, maybe you just like to
7 foot stomp again with the guidelines.

8 MR. MORAGNE: I will. So the bright
9 light in the sand is deliberating on information,
10 okay? On the right side of that line, if you are
11 deliberating on the information, the public has
12 every right in the world to observe you
13 deliberate and even comment on that. That's why
14 you have to distinguish those type of
15 interactions for committee meetings, okay?

16 When you're doing preparatory work, or
17 research, or admin work, you can communicate all
18 day long and the public has no right to that,
19 okay? If you form a subcommittee, it can even
20 drill down on information even more obscured from
21 the public, because it has every right, according
22 to the FACA, according to VA policy, to do

1 exactly that.

2 It's just that, when it comes to its
3 conclusions, guess what? You got to be sitting
4 at this table in front of the public, bright
5 light of day. So I think you put those in a
6 couple of different buckets. If you're doing
7 admin work, preparatory work, or research, the
8 public doesn't have a right to that.

9 If you're deliberating on something,
10 literally talking about the pros and the cons,
11 and all that kind of stuff, and whether you ought
12 to go this way or that way, that's bright light
13 of day. The public has every right to that. If
14 you're doing subcommittee work, the public
15 doesn't have a right to that because the
16 subcommittee, whatever it comes up with, is going
17 to bring it to the main body, you know, at the
18 table.

19 CHAIRMAN MARTIN: Thank you.

20 MR. MORAGNE: Is that where you wanted
21 to go?

22 CHAIRMAN MARTIN: That's perfect.

1 Thanks. Tim or Hal, do you have any questions or
2 comments?

3 MEMBER LOWENBERG: None from me.

4 MEMBER BIRD: None here. Thank you.

5 CHAIRMAN MARTIN: Thanks.

6 MR. MORAGNE: Okay. Thank you.

7 DR. VVEDENSKAYA: Any other questions
8 to Jeff? And again, Jeff is super easily
9 approachable via email and on the phone --

10 MR. MORAGNE: Absolutely.

11 DR. VVEDENSKAYA: -- if we ever have
12 any questions or if we deem that we would like to
13 connect with any other committees or invite them
14 to come to our committee meetings, such as
15 Chairman and designated federal officer, it can
16 be easily arranged.

17 MR. MORAGNE: And vice versa, don't be
18 surprised if someone asks you to, you know, talk
19 to their committee, whether it's virtually, or
20 even pay for you to come TDY during one of their
21 meetings. We would appreciate if you would
22 reciprocate, but, you know, again, I can't tell

1 you what to do. I just can tell you that that
2 path looks really, really good to me, you know?

3 It kind of looks like a great playing
4 field to be on.

5 DR. VVEDENSKAYA: Forgive me if I
6 missed your beginning of your presentation, you
7 mentioned it while I was doing copies, everybody
8 always asks about the ethics portion of our
9 training, and as we both, just a reminder to the
10 members, there is ethics training once a year for
11 everybody, just to keep us all abreast with the
12 newest regulations or guidelines, and that is
13 done through Jeff's office, but it is
14 administered by the Office of General Counsel
15 attorney who is specializing in advisory
16 committee matters.

17 But it's done once a year and I will
18 let everybody know when the time comes. I
19 believe it might be during our June meeting,
20 because last time we did it for the whole
21 committee, it was last summer meeting in June.

22 MR. MORAGNE: Yes, there methodology

1 is, they'd love to sit at the table and go face-
2 to-face. For one-on-ones, they can do it over
3 the phone.

4 DR. VVEDENSKAYA: Because I know new
5 committee members had few questions as they were
6 filling very voluminous forms. Thank you again
7 very, very much for your patience, but if you
8 ever need any guidance on matters related to the
9 ethics aspect of our committee work, reach out to
10 me and I'll forward your questions to the right
11 person.

12 MR. MORAGNE: I'm good?

13 CHAIRMAN MARTIN: Thank you very much.

14 DR. VVEDENSKAYA: Thank you so much.

15 CHAIRMAN MARTIN: Okay. We're running
16 a bit early here. We can probably -- any
17 discussion or additional information about the
18 ethics or the guidelines; thing with the
19 guidelines? The new handbook is something that
20 just came out and a wealth of information in it.
21 Ioulia will send it electronically to you also.
22 Now you've got both a hard copy and electronic.

1 Okay. Did you all have any comments
2 or questions about the advisory committee
3 structure as well as the way things operate?

4 DR. VVEDENSKAYA: Or any public
5 comments you wanted to make, because we have half
6 an hour before next presentation. I know we have
7 allocated some time this afternoon for the public
8 to make comments, but if you would like to make
9 any of your comments or statements now, please
10 feel free to do so, just because we have half an
11 hour before the next presentation.

12 MS. BROWN: Sure. I'd love to try
13 this out a little bit.

14 DR. VVEDENSKAYA: Please do join us at
15 the table. This way it will be easier to see
16 you, to record you --

17 CHAIRMAN MARTIN: As long as there's
18 no more Tiger cheering going on.

19 MS. BROWN: Well, thank you so much
20 for the opportunity to join you today and I feel
21 like I'm going to go to school to be a doctor
22 now, listening to all of your background and

1 enthusiasm. In my role at LSU, I bring
2 individuals closer to the mission of the
3 university as well as some of the initiatives.

4 In addition to that, my role, as
5 everybody likes to call me, I'm the fundraiser at
6 the institution.

7 DR. VVEDENSKAYA: Okay. Pardon me.
8 Will you please introduce yourself formally for
9 the record.

10 MS. BROWN: Okay.

11 DR. VVEDENSKAYA: Thank you very much.
12 Sorry for the interruption.

13 MS. BROWN: That's okay. DeShanna
14 Brown, Director of Development for Student Life
15 and Enrollment Services at Louisiana State
16 University in Baton Rouge, Louisiana.

17 Essentially for my role, I work in
18 student affairs, so that is the entity that
19 supports the co-curricular experience at the
20 university, and my role is to bring, again,
21 individuals closer to the mission of the
22 organization, as well as providing opportunities

1 for our students.

2 One particular area that's a
3 presidential priority right now is focusing on
4 bringing the opportunities for our veteran and
5 military student services, and we are in the
6 current process of building out our veteran and
7 military student services program.

8 And we have a center that we're
9 actually building out, and in that center, it
10 will be a place where our student veterans that
11 are transitioning from the military can get
12 additional programs and services, they can get
13 counseling on their VA benefits, and other types
14 of academic support services, as well as just
15 have a home on campus.

16 For some of you who may not be that
17 familiar with LSU, we started out as a military
18 institution and then have grown to Louisiana
19 State University, and wanted to just kind of chat
20 with you all today to just really get your
21 expertise on how we can bring individuals closer
22 to this opportunity.

1 So I have just a couple of items that
2 I'd like to share with you as you think about
3 ways in which to assist in bringing good
4 opportunities to LSU. I would love to get your
5 expertise as it relates to that, around different
6 types of things and programming that you feel
7 would help us bring philanthropic support to the
8 institution.

9 We were just awarded the designation
10 as a institution of choice for student -- for
11 individuals transitioning from the military, so
12 that's really, really exciting. We have some
13 great opportunities. As you all can appreciate,
14 the military provided a lot of service during
15 Hurricane Katrina to that region of the country,
16 so we just have a lot of just great
17 opportunities, essentially.

18 I do have a more detailed case
19 statement that talks about some of the academic
20 support services, as well as some of the
21 programming that we're looking to expand. Our
22 program is still fairly new. We've had it -- for

1 the last two or three years, we've had this
2 particular program at LSU and really looking to
3 grow it.

4 As you can see on the information I
5 distributed, our spring veteran enrollment at LSU
6 is around 428 students, we have 368 undergraduate
7 students, and then about 60 students in the
8 graduate and professional program.

9 In addition to that, we work with
10 veteran dependents. I found that some of the
11 military personnel that I've spoken to, they give
12 their benefits -- they allow their dependents to
13 utilize their benefits, and as you can see, that
14 number is a little higher.

15 We have about 1630 individuals
16 accessing veteran benefits and they are
17 dependents, 1530 are undergraduates, and about
18 100 are in the graduate and professional program.

19 The center that we're building out, we
20 would probably be the third institution with a
21 veteran and military center. Mississippi State
22 has a veteran and military center. I'm so

1 jealous. It is such a lovely, lovely facility,
2 and we'd like to bring that same type of facility
3 at LSU.

4 And as you can see, that's about a
5 \$1.5 million project and it is nicely laid out.
6 It'll be centralized on campus, which will be a
7 place where our veterans can really just
8 congregate together. We find that our veterans
9 do better in their own centralized areas, so they
10 don't feel the pressures of being in a larger,
11 for example, academic support center, so we do
12 have a very large center for academic success,
13 but we want to develop a space where veterans can
14 get a more hands-on experience, in particular,
15 those that experience PTSD, and so forth.

16 We just find that the more dedicated
17 time and one-on-one counseling that we can give
18 to them is much more beneficial, and then their
19 learning strategies are a bit different, in
20 particular, those that transition from war, and
21 so forth, and experience some levels of PTSD, so
22 we are doing more individualized care and

1 providing services to those individual -- to that
2 population of students.

3 I also have our case statement that,
4 I think I brought enough for everybody. It talks
5 a little bit more about some of the academic
6 support services that we also provide to our
7 students. I think I have enough for everybody.
8 Fantastic.

9 MEMBER BROWNE: Can I ask a question?

10 MS. BROWN: Yes, ma'am.

11 MEMBER BROWNE: How are you funding
12 your center?

13 MS. BROWN: So I am, as you can
14 appreciate, the fundraiser for student affairs,
15 and we, right now, don't have any funding for the
16 center. We would like to get philanthropic
17 support to build out the center, so really would
18 like your expertise today on ways in which we can
19 bring individuals closer to that as you think
20 about your circles of influence and affluence,
21 and would like to get your expertise.

22 Maybe we're not going about it the

1 right way, maybe we're not talking to the right
2 people, so I really wanted to come and just
3 really get your expertise as we would really like
4 to bring this opportunity to LSU for our
5 students.

6 We currently have a small room, it's
7 probably about this big, for our current veteran
8 students. It's in an older building. And we did
9 this work with the students to get a small grant
10 for Home Depot to kind of paint it, and get some
11 other things in the room, but we really want to
12 have a dedicated center for them so that we can
13 provide additional individualized programs and
14 services.

15 MEMBER GRANGER: Let me give you some
16 thoughts on that. I was instrumental, along with
17 the Chancellor, at Arkansas State University, a
18 group of us, started back in 2008, it's called
19 Beck Pride, B-E-C-K, Pride, P-R-I-D-E, it was
20 started by a retired reserve officer by the name
21 of Buddy Beck, alumnus of Arkansas State
22 University, he donated the first million dollars,

1 and I chairs the national committee for about
2 four years.

3 We have got grant money, donor money,
4 and we have a Beck Pride Center that have all the
5 things you mentioned here that's been going on
6 since 2008. We've got grants from Walmart, we
7 even got a fellow grant from DoD looking at post
8 traumatic stress disorder, transition of family
9 members, to including children as well, in an
10 academic environment.

11 So the person you need to put in
12 contact with, I'll give you her name and email,
13 it's Dr. Susan Hanrahan, that's capital H-A-N-R-
14 A-H-A-N. She is the dean of the School of Allied
15 Health at Arkansas State University. It's called
16 the Beck Pride Center. You go to astate.edu and
17 you'll see it right there on the main Web page,
18 or home page, there.

19 But we have done all the stuff you
20 have to go through getting state support,
21 everything else. At that time, our governor,
22 Mike Beebe, was instrumental also as an alumnus

1 of Arkansas State University, including to get
2 individuals to donate for financial support
3 scholarships, grants for grant scholarships, et
4 cetera, but I'll be glad to share that with you,
5 but that's been on going now since 2008.

6 MS. BROWN: Excellent.

7 MEMBER GRANGER: Same blueprint, same
8 approach, and everything else.

9 DR. VVEDENSKAYA: Thank you. That's
10 great.

11 MS. BROWN: Does anybody have any
12 other questions? If you'd like to -- I'm here
13 the rest of the day today, and I'm here all day
14 tomorrow, so if you'd like to meet individually
15 and talk about some ideas and so forth, I'd be
16 happy to sit down with you and we can really just
17 talk through that.

18 In addition to that, while we have a
19 lot of great ideas and so forth, we are always
20 looking for great partners in progress, so if you
21 would like to come to campus and maybe interact
22 with our student veterans, I would -- that

1 opportunity is always open.

2 Our veteran students are always
3 interested in networking, so part of our -- in
4 the spirit of my role in student affairs, part of
5 what we like to do is to connect our veterans
6 with employment opportunities, so we do have a
7 career services component where we have those
8 employers of choice for veterans, and we just
9 launched that last semester where we had
10 employers of choice for veterans only, so we had
11 a small veterans career fair.

12 So if you are tied to an organization
13 and so forth, and would like that opportunity, I
14 do welcome that. So I do have my business card,
15 so I will give that to you if you have some
16 opportunities where you would like to employ
17 student veterans or just come and do some
18 presentation and really talk about how you've
19 been successful in your transitions with your
20 military career and applying that to the civilian
21 sector.

22 We are very much open to that because

1 we find that our student veterans prefer to talk
2 to individuals with a similar type of background,
3 that can really relate to them, and say,
4 transition from the military to the academic
5 environment, and then from the academic
6 environment to being employed in the civilian
7 world.

8 So feel free to reach out to me. My
9 contact information is on the bottom of the form
10 so you can email me and I can give you my
11 business card with my cellphone number, and I am
12 here all day today and all day tomorrow.

13 DR. VVEDENSKAYA: Thank you so much,
14 Mr. Brown.

15 MEMBER ROBERTS: Just an observation
16 before she leaves. Speaking more generally,
17 Louisiana has a very long and historic commitment
18 to veterans in general, and not just, really,
19 LSU. As a matter of fact, one of the cabinet
20 members of the governor is a Secretary of
21 Veterans Affairs, after serving as Assistant
22 Secretary of Health for the State of Louisiana,

1 and that's a very important cabinet post for the
2 governor.

3 There's a law veterans home that will
4 take care of veterans who have fallen on hard
5 times and the State of Louisiana will step in and
6 take care of these veterans, so LSU has a big
7 interest in providing services and opportunities
8 to veterans, but the State of Louisiana, in
9 general, has a big commitment to veterans.

10 MEMBER SAVOCA: Have you been able to
11 drum up alumni interest in supporting them?

12 MS. BROWN: Somewhat for --

13 MEMBER SAVOCA: Because I would think
14 that would be a good place to tap.

15 MS. BROWN: We have. And as you can
16 appreciate, we're a healthy institution, but
17 we're not wealthy, and outside philanthropic
18 dollars also helps increase those opportunities
19 with our friends in the community as well, but we
20 have reached out to our alumni, so we do have
21 some things in the pipeline, but part of my role
22 is continuing to bring other individuals closer

1 to the mission of providing these opportunities
2 for our students.

3 MEMBER GRANGER: Also too, there's
4 another name I want to give you at Walmart,
5 that's Brigadier General (Retired) Porter. I'll
6 give you his email and his information. He's
7 responsible for the Walmart nationwide Hire a
8 Veteran Program. They've exceeded their goal of
9 100,000 within the first five years. They now
10 have increased their goal to a significant
11 number.

12 He loves to come out and do
13 presentations from Walmart University, how
14 they're taking veterans and putting them in
15 managerial training slots, and to the point
16 they're now running stores. A few are running
17 regions for the Walmart.

18 MS. BROWN: Okay.

19 MEMBER GRANGER: I have no bias to
20 Walmart. I'm from Arkansas.

21 MS. BROWN: I was about to say, that's
22 where it's headquartered. I would love to talk

1 to you.

2 MEMBER GRANGER: And also too, there
3 are Department of Defense grants, it's called
4 Congressionally directed medical research
5 dollars, that you can sometimes tap into, being
6 an academic institution, and the School of
7 Nursing, she took the social work and the
8 psychology department, and they applied for a
9 grant looking at transitioning to the academic
10 environment for veterans and their families,
11 especially Guard and Reserve.

12 And that's how it got started in
13 Arkansas, because I served with the National
14 Guard myself, early part of my career, and we had
15 the unit there in Iraq, and that was one of the
16 issues we observed, how they transitioned -- they
17 were pulled out of academia and how they
18 transitioned back into it having served in that
19 environment, especially them, as well as their
20 families.

21 MS. BROWN: Okay.

22 DR. VVEDENSKAYA: Excellent. Thank

1 you so much.

2 MS. BROWN: Thank you.

3 CHAIRMAN MARTIN: Well, we've got a
4 few minutes before our next discussion and let me
5 just update you on a conversation I had a couple
6 of weeks ago with a senior economist from the
7 RAND Corporation. And he called because they are
8 interested in looking at veterans issues in a
9 longitudinal study, and they have formed
10 something they call the American Military
11 Veterans Panel.

12 It's an online panel that looks at a
13 variety of surveys on topics over time, and since
14 it's the same group, they can do longitudinal
15 studies for lots of different issues. They
16 formed this in 2014, I believe, and they have
17 been looking at a number of topics.

18 And I think the reason that he called
19 to discuss things with our committee was the fact
20 that we had been looking at individual
21 unemployability. And we had actually scratched
22 our heads and wondered whether or not we needed

1 another study on individual unemployability since
2 the CNA study and some of the others are a little
3 dated now.

4 And so he was bridging the issue with
5 us just for our information. I explained to him
6 that our committee doesn't own a budget, we don't
7 employ study groups for businesses, but, you
8 know, if it came to the point where we were
9 looking for a study then, certainly, Rand could
10 compete with other companies for the bid.

11 He sent to me an abstract of a number
12 of studies that they've done recently, which I
13 can provide for you, just, if you're interested.
14 Selected Rand publications relevant to veteran
15 policy challenges, and they discuss things like
16 Social Security disability and disability,
17 veterans health and healthcare, labor force, and
18 health and disability benefits for service
19 members and military reserve personnel.

20 Those are some of the recent studies
21 that they've looked at, mainly under the guidance
22 of the Office of the Secretary of Defense, or the

1 DoD, or sometimes the Social Security
2 Administration. It was an interesting
3 conversation, I told him I would pass that along
4 to our committee, and I wanted to give this
5 information, particularly to Dr. Savoca, because
6 of her expertise in this area.

7 Comments, questions, anybody familiar
8 with this?

9 MEMBER SAVOCA: No, this is the first
10 I've heard of it. I assume this is not public
11 access data.

12 CHAIRMAN MARTIN: You know, I don't
13 think this is proprietary and I told him I would
14 like to share this, and he said, of course, no
15 problem.

16 MEMBER SAVOCA: No, I mean the
17 longitudinal survey.

18 CHAIRMAN MARTIN: I think that is
19 proprietary to RAND.

20 MEMBER GRANGER: Yes, it probably is,
21 having worked with them before in my previous
22 life.

1 CHAIRMAN MARTIN: Did you know Dr.
2 Kumar?

3 MEMBER GRANGER: Yes, I do.

4 CHAIRMAN MARTIN: So just for your
5 information, there's a wealth of information out
6 there, but there are lots of groups that are
7 looking to help with any answers if and when.
8 And I will have this information that I'll
9 provide to Dr. Savoca and Dr. V, and if any of
10 you wish to see it, go online to the RAND
11 publications and look at them, see what they've
12 done.

13 Not as a spokesman for RAND, but just
14 here's a company that does look like we might
15 need at some point.

16 MEMBER BROWNE: Because I think in one
17 of our former report, we talked about the need to
18 do a study.

19 CHAIRMAN MARTIN: Yes.

20 MEMBER BROWNE: And, of course, this
21 has not trickled down yet in terms of actually
22 moving forward, but that information would be

1 useful as they look at that, but then, generally,
2 when studies are done, it's an open bid
3 competition.

4 CHAIRMAN MARTIN: Right. And we had
5 discussed IOM and some other possible candidates
6 to do a study like that.

7 MEMBER SAVOCA: Oh, I see, they
8 haven't actually started the survey up.

9 CHAIRMAN MARTIN: Not this particular
10 survey, no.

11 MEMBER SAVOCA: Oh, okay. And they're
12 looking for funding.

13 MEMBER GRANGER: They're looking for
14 funding. Right.

15 MEMBER SAVOCA: I see. Interesting.

16 MEMBER BROWNE: But I know when we
17 talked about and we said IOM, and I said I think
18 we need to leave it open, and not that I know
19 anybody at RAND versus IOM, but rather than
20 targeting a specific entity, it should be open
21 for --

22 MEMBER SAVOCA: Yes, some kind of

1 bidding.

2 MEMBER BROWNE: Yes. So that's my
3 comment.

4 MEMBER SAVOCA: Yes, no, that's right.

5 MEMBER BROWNE: As a small business
6 person.

7 MEMBER SAVOCA: No, I think you're
8 absolutely right. We should keep it open. There
9 are lots of respectable institutions that can
10 handle this.

11 MEMBER BROWNE: Yes.

12 MEMBER SAVOCA: VA research centers,
13 Columbia, and NYU.

14 CHAIRMAN MARTIN: Okay. Tim, Hal, any
15 comments?

16 MEMBER LOWENBERG: Yes, this is Tim.
17 An open question for you then. RAND Corporation
18 is a federally funded research and development
19 corporation, like the Center for Naval Analysis
20 and others, I'm just wondering if we had
21 questions that might be supported by research
22 data at the extent to which VA has, and do at

1 least a preliminary review of the availability of
2 SSRDC studies that might be pertinent to the
3 topic we're looking at.

4 DR. VVEDENSKAYA: Tim, we can, if you
5 would like to send this request to me via email,
6 and, you know, with all the cc, with all the
7 committee members being copied, I can explore
8 what we can do from our end, and like Jeff
9 Moragne mentioned, we can explore what would be
10 the best ways to approach it. Would it be
11 through the recommendation or through certain
12 other types of requests?

13 But if you'll put it in email request
14 to me with the members copied, we shall look at
15 the venues. Yes, I wouldn't have an answer at
16 this particular point.

17 MEMBER LOWENBERG: Well, I understand
18 about the -- the reason I was asking the question
19 was, I thought it was a matter of the committee
20 process. If there was an understanding that the
21 VA Library, for example, could do an initial
22 assessment of potential relevant publications,

1 that that would be something that might be
2 helpful to us as we consider our development of
3 reports, so forth.

4 I don't think that issue has come up
5 during my time on the committee. That's why I
6 asked.

7 DR. VVEDENSKAYA: All right. Yes, we
8 do have that resource and I can explore that
9 venue. Our library is very willing to help us
10 with any research measures. We can do that.

11 CHAIRMAN MARTIN: Yes, and just for
12 the committee's information, we heard from Vivian
13 Stahl, who's the librarian at the VA Central
14 Office Library, back in September. She talked
15 about some of the research, background, kind of,
16 information that they can provide to the VA
17 committees and to the VA.

18 DR. VVEDENSKAYA: And our two new
19 members, Dr. Granger and Mr. Fay, if you are
20 interested, I can connect you with our central
21 library librarian, Ms. Vivian Stahl. She can put
22 together an account for you. This way, if you

1 are to research, because a lot of papers are
2 behind the pay wall, but if you would like to
3 pull her -- if you would like her to pull certain
4 dataset for you, unlock certain articles for you,
5 and just send it back to you via email as a .pdf,
6 she can do it.

7 Yes, I can introduce the two of you to
8 her and she'll walk you through the registration
9 process.

10 MEMBER GRANGER: Because it's been my
11 experience, when you start looking at studies
12 like this, somewhere along the line, somebody
13 within the Veteran Administration, or Veteran
14 Affairs, have done something, a similar study, if
15 nothing but a preliminary, have a look into it in
16 the past and different studies, done between DoD
17 and VA, somebody in their research institute, or
18 somewhere, has done very similar. Been my
19 experience.

20 DR. VVEDENSKAYA: We have quite
21 sizable --

22 MEMBER GRANGER: Absolutely, you do.

1 DR. VVEDENSKAYA: -- R&D. It's not
2 even stuff, it's just like subagency.

3 MEMBER GRANGER: It is.

4 DR. VVEDENSKAYA: Yes, I once looked
5 and I, you know, got lost. The breadth of their
6 research is quite enormous. Dr. Simberkoff, you
7 wanted to say something?

8 MEMBER SIMBERKOFF: Well, I was just
9 going to ask what it is that is similar to what?
10 I'm not sure --

11 MEMBER GRANGER: I'm talking about the
12 RAND study. We're passing around with the RAND
13 here. RAND had a thought. I was saying that it
14 might be something very similar. You might want
15 to share that with him. He didn't get a chance
16 to see it here.

17 MEMBER BIRD: Hal Bird here. If I
18 could just follow-up on General Lowenberg's
19 statement. That does sound like an interesting
20 study, speaking directly to the RAND study. I
21 wonder if that might not make a good speaker for
22 the next meeting, to have the individual that

1 General Martin spoke with come and speak with the
2 committee.

3 And a lot of that was interesting to
4 me, but I'm particularly interested in the tie in
5 between Social Security disability and veteran
6 disability, but there were several topics in that
7 narrative that did sound interesting and relevant
8 to the committee.

9 DR. VVEDENSKAYA: This is Ioulia. Mr.
10 Bird, what I would suggest is you, as a
11 committee, talk among yourselves. You then send
12 me a request for the speaker, which will give me
13 the right to reach out to the RAND, to Dr. Kumar
14 perhaps, and request a presentation on all
15 studies, or particular study, or particular
16 topic. I'll be happy to do that.

17 MEMBER SIMBERKOFF: Well, do we want
18 something from RAND or do we want something from
19 VA that's -- because there have been -- I think
20 we've talked about them at these meetings.
21 General Scott, you know, I think discussed the
22 most recent ones and there have been several ones

1 in the past, and, you know, he said that it might
2 be difficult to, you know, get another one, you
3 know, going now just because of expense, but it
4 might be worth at least hearing what was done in
5 the past.

6 MEMBER SAVOCA: And we should have
7 General Scott back. He was very well versed in
8 that study.

9 MEMBER SIMBERKOFF: Yes, he was.

10 MEMBER SAVOCA: Just to give a
11 presentation on that.

12 DR. VVEDENSKAYA: You can request him
13 as a speaker.

14 CHAIRMAN MARTIN: What is the life
15 extent of a study like that, IU, for instance,
16 make sure that the last CNA study was ten years
17 ago.

18 MEMBER SAVOCA: Yes. You mean --

19 CHAIRMAN MARTIN: So you think it's
20 still relevant now or is it something that's
21 changed --

22 MEMBER SAVOCA: Well, speaking as an

1 outside, the data is relevant because there's so
2 little data publicly available, so that's
3 basically -- so for someone who's studying it
4 from the outside of the VA, it's still relevant.
5 It's all we have. But, no, I mean, there is
6 better data now that should be analyzed.

7 MEMBER SIMBERKOFF: But it ain't cheap
8 to get at. That's a fact.

9 MEMBER SAVOCA: The price is infinite.
10 That's the problem. I think I mentioned before
11 that there are people, Stanford and MIT, working
12 on vet's issues, but they're using something
13 called the Current Population Survey, which is a
14 monthly survey that's used to estimate the
15 unemployment rate, and it doesn't have very good
16 health data, but they're doing the best they can
17 with it, but it's totally inappropriate for
18 answering these questions, but that's the best I
19 can do, if they want to use current data.

20 And there's a veterans supplement
21 every year that's done on the use of programs,
22 but you want to link those to health, now there

1 is some good data on veterans health, just don't
2 --

3 DR. VVEDENSKAYA: And also, as we
4 know, you can use ten-year-old data, but every
5 year, the population of veterans changes. We
6 have new wars, we have aging veterans, and you
7 remember from your previous presentation on
8 individual unemployability, the program was
9 designed with one purpose in mind, and it seems
10 like it's migrating to a slight different
11 publication.

12 That's why your committee, it seems
13 like, took a task on examining that program and
14 giving recommendations on how to proceed with
15 this program according to your expertise, but
16 again, ten years ago, it was different number of
17 veterans, different population, in terms of the
18 age, skills, different economy, absolutely.
19 There are so many variances.

20 MEMBER SAVOCA: That's right. So it
21 is dated, and as far as the IU program, no one's
22 been able to zero-in on that particular program.

1 They look more about overall, the work, instead
2 of effects of disability programs, so I mean it
3 would be good if RAND would collect data on
4 participation in that particular program. It
5 would be good if they could.

6 CHAIRMAN MARTIN: September 15th that
7 Rod Grimm, from the Compensation Service at VBA,
8 talked to us last about IU. He kind of went over
9 the history of the program and brought us up to
10 date at that point.

11 DR. VVEDENSKAYA: And of course, we
12 just finished submitting legislative proposals
13 for the 2017. If at some point you would like to
14 have just a very short update too, like 15, 20
15 minutes, on what's going on with individual
16 unemployability program when it comes to the
17 legislative proposals.

18 MEMBER SAVOCA: Oh, there are already
19 proposals?

20 DR. VVEDENSKAYA: Yes. I'm not part
21 of that stuff, but, you know, we all sit in the
22 cubicles there. Yes, I know that the system for

1 submitting legislative proposals for 2/17 just
2 finished. That's why, you know, every year we
3 have a cycle of what we would like to do, we
4 submit our wish list, and you can always have an
5 update from Rod Grimm on -- that's one of his
6 main lines of business, the legislative
7 proposals, and particularly, individual
8 unemployability.

9 MEMBER ROBERTS: It may be good to
10 have an update.

11 DR. VVEDENSKAYA: Yes, it's something
12 short and if the new members would like to know a
13 little bit more about that particular program,
14 Rod would be more than happy to talk to you in
15 addition to just an update.

16 MEMBER SAVOCA: Is that a priority for
17 the VA, revamping that program?

18 DR. VVEDENSKAYA: Yes.

19 MEMBER SAVOCA: It is a priority.

20 DR. VVEDENSKAYA: Yes. And MyVA
21 presentation tomorrow will refresh our, my
22 knowledge too, of what exactly is number 1

1 through 12.

2 CHAIRMAN MARTIN: Our goals and 12
3 priorities.

4 DR. VVEDENSKAYA: Right.

5 CHAIRMAN MARTIN: Okay. Well, we will
6 discuss that in way more depth as we go along.
7 It is a burning topic right now, so just wanted
8 to get everybody up to speed on it.

9 DR. VVEDENSKAYA: Would you like to
10 have a ten-minute break and then we'll reconvene
11 and I'll check our next presenter?

12 CHAIRMAN MARTIN: Good. Thank you.

13 DR. VVEDENSKAYA: If she's ready to
14 go, we can just go ahead and go. And for Mr.
15 Lowenberg and Bird, I will put a package for both
16 of you in the mail, in the snail mail, probably
17 on Thursday, where I would put all the materials
18 which Ms. Brown, from LSU, gave us. This way
19 you'll have a chance to have her contact
20 information and the materials she distributed to
21 the committee members.

22 MEMBER BIRD: Thank you.

1 DR. VVEDENSKAYA: Along with the
2 paperwork for your travel and meeting
3 reimbursements. Not for travel this time, but
4 other.

5 MEMBER BIRD: Right. Thank you very
6 much and we have documents regarding the duties
7 and responsibilities from Mr. Moragne this
8 morning?

9 DR. VVEDENSKAYA: Yes, I will put --
10 yes, I will put all presentations from this
11 meeting for you in that package.

12 MEMBER LOWENBERG: Right. Right. And
13 there are three tomorrow that, if they have
14 documents as well, that would be terrific if we
15 get those as well. Thank you.

16 DR. VVEDENSKAYA: Sure. Any time.

17 MEMBER LOWENBERG: Dr. Vvedenskaya,
18 are all the members present today, and/or
19 tomorrow, going to receive a copy of the New
20 Committee Member's Handbook, or is that to be
21 provided --

22 DR. VVEDENSKAYA: I actually sent it

1 to you all via email about a month ago.

2 MEMBER LOWENBERG: Okay. Thank you.

3 DR. VVEDENSKAYA: I just thought it
4 will save a little bit of paper. You can go
5 ahead and print it out, but all of you received
6 it about a month ago. And we talked about the
7 Page 12 of that handbook -- oh, I'm sorry, Page
8 15 off that handbook, and Page 15 of the member's
9 handbook has a list of all the A committees,
10 which you may want to approach for cross-
11 collaboration or, you know, if you will be
12 approached by any of these committees, you'll
13 know that it's our VA advisory committees. It's
14 Page 15.

15 All right. A little break and we'll
16 reconvene in about ten minutes.

17 (Whereupon, the foregoing matter went
18 off the record at 10:31 a.m. and went back on the
19 record at 10:58 a.m.)

20 CHAIRMAN MARTIN: Okay, everybody, if
21 we can get back to business here. We, at this
22 committee, have been interested in looking at

1 Guard and Reserve issues. That was a high
2 priority area for the previous Under Secretary
3 for Benefits, and one that we also shared the
4 concerns in, because Guard and Reserve members
5 are substantially different than active duty
6 members in terms of their data acquisition and
7 their availability of those records in various
8 systems.

9 And so we are very happy to have a
10 current update again for you today. The last one
11 was in September of last year, and I appreciate
12 Ms. Moses being back. Hi.

13 MS. MOSES: Good morning, everyone.
14 Nice to see you all again. So I just wanted to
15 give you an update of what's going on. So since
16 last September, we've had a lot more involvement
17 and participation with the Separation Health
18 Assessment Initiative. One of the gaps that
19 still remains is the communication, or the
20 notification, that the individual is separating.

21 We have identified that, specifically
22 with our Reserve and our National Guard members,

1 that they don't have enough time under the
2 current rules that we have, to be notified -- DoD
3 doesn't have enough time to notify them as far as
4 when they're going to separate in order to
5 schedule the exam.

6 So by the time the central cells are
7 notified that the individual is going to
8 separate, they're already past our 180 to 90-day
9 timeframe, and so we've taken a look at revising
10 our Separation Health Assessment Program,
11 however, we've got some IT gaps.

12 Right now, we're still communicating
13 using, like, an Excel spreadsheet. DoD is
14 developing functionality that's supposed to be
15 piloted in June of this year and it's called
16 SPORTS, some funky acronym, but the application
17 will allow DoD to be notified when service
18 members are separating and so we can have more of
19 a real-time data.

20 The information that we have now is
21 brought when the service member decides to file a
22 claim, then we provide, VA provides, that

1 information to DoD, and they then look to see
2 whether or not an exam has been completed.

3 So for our update, for our reservist
4 and our National Guardsmen, we've got like a
5 bidirectional approach we're looking at, what
6 time of timeframe can be worked out so that we
7 can accommodate those individuals for the
8 Separation Health Assessment completed by VA?

9 It does not preclude from being able
10 to have an SHPE done, however, we want them to be
11 able to get the benefit of having that one exam
12 and having that claim filed early. So we're
13 looking at the timeframe to see what,
14 realistically, would work that would still be
15 within the pre-discharge application program, and
16 then we're also looking at seeing how our IT
17 functionality is going to help us.

18 Because this is such a manual effort,
19 all of the enhancements are dependent on our IT
20 functionality, so those are our paths going
21 forward, if you will. Are there any questions or
22 --

1 CHAIRMAN MARTIN: One of the things
2 that you had told us before back in September was
3 that an issue with the Guard and Reserve had been
4 that there was no authorization for them to get a
5 separation exam, and then DoD had made the
6 commitment that they would let everyone receive
7 an exam, an SHA, the deadline was January '15 for
8 active duty, and for Guard and Reserve, January
9 '16.

10 So on that timeline, are you saying
11 that we're sliding a little bit?

12 MS. MOSES: DoD has stated that
13 they're making the separation -- their version is
14 Separation Health and Physical Examination, the
15 SHPE, that they're making that available to them;
16 to the Reserve and National Guardsmen. The
17 issue, however, is making sure that they're
18 getting that exam prior to them actually
19 separating.

20 So from both sides, we're looking at
21 the timeframe to see what needs to be realigned
22 so that they can get that exam, but also that it

1 can be done pre-discharge as opposed to, you
2 know, running out of time.

3 MEMBER FAY: So is it separation from
4 their active duty assignment or separation from
5 the Reserves?

6 MS. MOSES: The separation from the
7 Reserve is the active --

8 MEMBER FAY: From the Reserve.

9 MS. MOSES: Right.

10 MEMBER SIMBERKOFF: From active duty.

11 MS. MOSES: Right.

12 MEMBER FAY: Oh, okay. That's
13 different. So separation from active duty before
14 they revert back to reservist or their final
15 separation?

16 MS. MOSES: Correct.

17 MEMBER SIMBERKOFF: Now, it's from
18 active duty, and in some ways, there is an
19 incentive to the individual to minimize whatever
20 disabilities they have if they want to stay in
21 the reserves.

22 MEMBER FAY: Yes, because that's the

1 norm is, they don't leave active duty and then
2 leave the service. They leave active duty and
3 return to the reserve. And of course, if you
4 have a disability, you can't take the PT test,
5 and you can't stay in the reserves, right?

6 MEMBER SIMBERKOFF: Yes.

7 MEMBER FAY: So it's actually two
8 different categories of problems. One is the
9 separation from active duty, whether it be a
10 deployment or whatever, second one is retirement
11 at the end of a reserve career. And then they're
12 not coming off active duty, necessarily. They
13 may have been in the Reserves or the Guard for
14 the last X number of years of their career, and
15 how do we capture that retiring population?

16 Are they included in the DoD --

17 MS. MOSES: They are supposed to be
18 included. So we've got the active duty members
19 that are getting the Separation Health Exam, and
20 then we also have those reservists that are
21 separating that should also be receiving --

22 DR. VVEDENSKAYA: Retiring.

1 MS. MOSES: Retiring.

2 MEMBER SIMBERKOFF: Yes, but here's
3 the issue. Somebody who's retiring from the
4 Reserves is only -- if I'm, let's say, 50 years
5 old, which I wish I was, you know, and you've
6 been 30 years in the Reserves, you know, doing
7 two weeks of, you know, active duty and then
8 having, you know, one limited period when you
9 were on active duty, and most of your health
10 issues are not related to your military career,
11 so what is it that's actually assessed at the
12 time somebody retires?

13 MS. MOSES: Yes, it would still be
14 that same, yes, comprehensive exam.

15 MEMBER SIMBERKOFF: Okay. But what is
16 it that's attributed to the military duty?

17 MS. MOSES: Well, some of the
18 considerations include what that MOS was. We
19 know that, you know, there are environmental
20 factors and outside things, you know, that are
21 going to play a part as well, however, you know,
22 we still have to document. And we're also -- you

1 know, in addition to the actual examination, as
2 you mentioned, it's not necessarily going to
3 reveal everything that happened in service,
4 however, we utilize the service treatment record
5 and the events that happened, and sort of is, to
6 connect those two together.

7 MEMBER FAY: Right. And that's a
8 great question, Mike.

9 MEMBER SIMBERKOFF: But, you know,
10 people retire at 50 years of age with a whole
11 bunch of disabilities, including, you know, a
12 knee injury that they may have gotten while they
13 were skiing, and lots of other things.

14 CHAIRMAN MARTIN: But part of the
15 problem --

16 MEMBER SIMBERKOFF: You know, and if
17 you're skiing during your military career, it's
18 one thing, but if you're skiing as a Reservist,
19 it's another.

20 CHAIRMAN MARTIN: And actually, part
21 of the issue with the separation health exams is
22 to try and establish that service connection for

1 disability the Reservist of Guardsmen have. It's
2 not to necessarily come up with new disabilities,
3 but rather to link that to prior service
4 incidents.

5 MEMBER GRANGER: Absolutely.

6 MEMBER FAY: Who's doing the exams for
7 the Reservists?

8 MS. MOSES: Right now it's DoD.

9 MEMBER FAY: So who at the DoD? Is
10 that -- are they being sent to active duty unit
11 for it or are they going to a reserve unit on
12 weekend drills?

13 MS. MOSES: I can find out. I'm not
14 sure.

15 MEMBER FAY: Well, I can answer that,
16 it's probably both, right, depends on where the
17 area is, but the administration of that is, from
18 the Reserve standpoint, a nightmare.

19 MS. MOSES: Okay.

20 CHAIRMAN MARTIN: Yes, and I can
21 actually speak to this from experience here,
22 because when I retired in 2014, I was coming out

1 of the Pentagon, but I was not on active duty at
2 that point in time when I retired, and so I went
3 to my unit in Florida and said, I need my
4 separation exam, and they said, you're not
5 authorized.

6 MEMBER SIMBERKOFF: So what happened?

7 CHAIRMAN MARTIN: So I said, really?

8 And, you know, ultimately, ended up getting a
9 separation exam from the local unit, but, you
10 know, they kind of did it out of the goodness of
11 their heart, and it wasn't in regulation at that
12 point, so that's all -- all this has transpired
13 since 2014.

14 Tim and Hal, I know you've had issues
15 with this as well. Do you want to make some
16 comments about where we are?

17 MEMBER BIRD: I do. Thank you. Yes.

18 At current status on that, I would say 99 percent
19 of the time would be exactly parallel to General
20 Martin's experience where they will simply turn a
21 Reservist away after 20 or 30 years of service,
22 or even less, and simply caveat that with the

1 easy way out is, you're not authorized, because
2 right now, a separation exam is not a requirement
3 prior to separation from Reserve forces.

4 That is the starting point in my --
5 and it's to make that exam a requirement or you
6 cannot separate. That would be a starting point
7 for me whether or not sufficient notification is
8 received in time. Just simply make it a
9 requirement and then that would solve that
10 problem.

11 MEMBER FAY: So with the requirement
12 needs to be specified a funding site of who's
13 going to pay for that separation exam. Is it
14 going to be back on an active duty site or is it
15 going to be a Reserve unit, and is the Reservist
16 going to be funded additional amounts of money
17 for an additional drill day to do that, and who's
18 going to get the additional funding to continue
19 to do all of these exams, right?

20 MEMBER BIRD: Yes. More than likely,
21 it would have to -- cheapest way out, and the
22 most efficient way out, according to Reserve

1 policy and process, is to allow it to be done on
2 active duty during a two-week term or on a drill
3 day, either one, but it's got to be done and it
4 should become part of Reserve culture to get that
5 done.

6 MEMBER FAY: Right.

7 MEMBER BIRD: And it is a trick to
8 establish whether or not said injuries are
9 incurred on active duty or during active duty
10 service during the Reserve career, but the
11 starting point for that determination would be in
12 a separation exam.

13 MEMBER SIMBERKOFF: Yes, I agree, but
14 for a Reservist, I would think, is an
15 extraordinarily complicated issue to get it to --

16 MEMBER BIRD: But doable. But doable.
17 It is very doable.

18 MEMBER FAY: I was the chief of staff
19 for an Army Reserve unit for New York and New
20 Jersey, all of New York and New Jersey, and I can
21 tell you, it is an administrative nightmare
22 whenever you're dealing with these issues.

1 MEMBER BIRD: But it is doable and the
2 way that you do that is that you simply refer
3 back to --

4 MEMBER SIMBERKOFF: You have to review
5 all of the medical records.

6 MEMBER BIRD: Medical records. That's
7 exactly right, but the starting point is to
8 establish it and then let that flow back through
9 the Reserve culture and knowledgebase the way
10 people do document their injuries along the way.
11 Right now, they don't. They try to sweep it all
12 under the carpet.

13 MEMBER FAY: So who's job is it, you
14 know, to do that final exam and whose
15 responsibility is it to collect all of those
16 records before that exam is done, right?

17 MEMBER BIRD: I can answer that. As
18 in all things regarding Reserve participation,
19 Reservists know very well, and if they don't,
20 they learn it along the way, it's the Reservist's
21 job to do that, but you have to start somewhere.

22 MEMBER FAY: Yes, and as having been

1 a commander of many Reserve units, I can tell you
2 that it ultimately comes to the commander because
3 the Reservist has to be walked through these
4 things, because they only do this stuff on
5 weekends, and if you have somebody who is an
6 officer or a senior NCO, they're familiar with
7 these issues and can deal with the issues, but
8 the lower ranking enlisted, and many of them have
9 been injured on active duty, they are totally in
10 a fog when it comes to having to deal with all
11 these bureaucracies.

12 MEMBER BIRD: In the beginning, yes,
13 but as you well know, from being a commander of
14 those units, peer-to-peer knowledge over time, as
15 well as unit education, both play important roles
16 in the knowledgebase for the participant.

17 MEMBER GRANGER: Let me ask you this.
18 This is Elder Granger. What happened to the DoD
19 contract for the annual assessment that was
20 designed for the Guard and Reserve to get their
21 annual assessments administered by DoD? It's an
22 annual Reserve, Guard and Reserve, annual

1 assessment contract. Are you all familiar with
2 that? What happened to that bid?

3 That was a means of documenting the
4 actual healthcare that transpires, as a
5 requirement, of the assessment, and it still
6 exists as a DoD contract.

7 DR. VVEDENSKAYA: Dr. Granger, would
8 you be kind enough to say a few words about that
9 contract because some of the members might not be
10 familiar?

11 MEMBER GRANGER: Absolutely. Going
12 back to, probably, 2008, 2009, there was a
13 contract put out by DoD that was designed to
14 capture, what is the state of health of that
15 Guard and Reserve person, whether it happened
16 civilian or military, on an annual assessment.
17 That contract still exists. It's administered by
18 the Office of Assistant Secretary of Defense for
19 Health Affairs, out of Dr. Jonathan Woodson's
20 office, and oversight of that contract falls in
21 Retired Rear Admiral Dave Smith at DoD.

22 And that contract is administered by

1 United Health, one of the subsidiary companies.

2 It's called the --

3 MEMBER BIRD: Well, the way that flows
4 out at the unit level, for the most part, is
5 that, yes, your annual health assessment is
6 performed at the unit level through the unit at
7 medical group, whoever that may be, depending on
8 which branch of service you're talking about, and
9 you're absolutely correct, it is that annual
10 health assessment that becomes all important to
11 document over the years what you're dealing with.

12 And, you know, there's a fine line to
13 be walked between being automatically separated
14 from duty due to minor ailments versus ability to
15 continue to serve, but document your injuries
16 along the way, and that's something that
17 Reservists deal with right now, but they don't
18 realize, they have no knowledge at all of the VA
19 disability process during service. They don't
20 even think of such things.

21 So if you require at the end of
22 service, a separation health assessment

1 specifically for VA disability purposes, that
2 will, over time, filter back through into the
3 knowledgebase and at least allow some process for
4 the Guard and Reserve to get into the system for
5 a realistic disability.

6 MEMBER GRANGER: The question is --

7 MEMBER BIRD: Right now, it's nearly
8 impossible.

9 MEMBER LOWENBERG: Is there anyone who
10 would assert that a separation health examination
11 for a member of any of the reserve components is
12 irrelevant or of no value to the Veterans
13 Administration?

14 MEMBER SIMBERKOFF: No, but that's
15 absolutely not the case.

16 MEMBER GRANGER: That's not true.
17 That's not the case. But this program was --

18 MEMBER LOWENBERG: But part of it is
19 not doing this for a large percentage of the
20 combat force.

21 MEMBER GRANGER: Let me say this, I
22 used to have oversight of this program, that

1 program was put in place for a Guard and Reserve
2 unit that do not have organic or access to
3 medical units, and that person go to a civilian
4 provider somewhere near their home, or duty
5 station, or Reserve unit, or National Guard unit,
6 to get that assessment by, sometimes even, their
7 primary care provider.

8 MEMBER SIMBERKOFF: But to be blunt,
9 somebody who has no connection with the military,
10 would they be able to assess, you know, medical
11 records and make a decision that, you know, a
12 knee injury is due to something related to
13 service rather than the skiing accident that --

14 MEMBER GRANGER: No, it's not designed
15 to do that. It's designed to document your
16 current state of health. They don't get involved
17 whether it's related to the military or not, that
18 annual assessment design. And by the way, that
19 was advocated by the Guard and Reserves to make
20 it happen; put that type of assessment in place.
21 So I'd be glad to -- let me get you some
22 information on it. It's a very effective

1 program. It still exists today.

2 The key is probably, I think it's
3 lacking, is a better education of the program as
4 it exists now at the highest level in the Guard
5 and Reserve.

6 CHAIRMAN MARTIN: Mike, to answer your
7 question about how do you link the two.

8 MEMBER SIMBERKOFF: Yes.

9 CHAIRMAN MARTIN: Typically, the line
10 of duty determination will help make that link.
11 When you get a line of duty for an injury, then
12 that's part of the personnel record.

13 MEMBER GRANGER: That is. So if you
14 got injured during the time when you were on your
15 Reserve or National Guard duty, then it is
16 incumbent upon that individual, especially the
17 supervisor leadership, the NCO or officers, to
18 document, or they go back and say, line of duty,
19 it happened while they were here working on their
20 tank, whatever, getting out of the aircraft,
21 getting off the ship, whatever it might be,
22 instead of skiing at Vail. Okay. From that

1 standpoint.

2 Or it was exacerbated during the time
3 they were here from their injury at Vail.

4 MEMBER BROWNE: So how does that get
5 translated to their medical records --

6 MEMBER GRANGER: That's in the annual
7 assessment. That's in the annual assessment.
8 And if they say, well, look, this happened while
9 I was at Reserve, the unit, I was picking up a
10 big mortar round, injured my back, they must get
11 that documented as a line of duty by that unit
12 commander or leadership. That's how it gets
13 translated.

14 MEMBER SIMBERKOFF: So do we know, I
15 mean, it sounds like this is a very nice program
16 --

17 MEMBER GRANGER: It is.

18 MEMBER SIMBERKOFF: -- but do we know
19 what percent of the Guard and the Reserve
20 soldiers are actually getting the --

21 DR. VVEDENSKAYA: What's the
22 compliance?

1 MEMBER GRANGER: That's exactly right,
2 and that comes out quarterly at the highest level
3 of DoD readiness. When they look at the Guard
4 and Reserve, are you getting your annual
5 assessment, it get reported at the highest level,
6 and they can give you the stats on who's
7 complying and not complying, by unit, and
8 everything else.

9 MEMBER SIMBERKOFF: And what are those
10 stats?

11 DR. VVEDENSKAYA: Mr. Fay, yes, what
12 is your experience in New York and New Jersey,
13 what was the compliance?

14 MEMBER FAY: This came after.

15 DR. VVEDENSKAYA: Oh, it's after.

16 MEMBER FAY: Yes, this is new since I
17 was a commander in New York and New Jersey,
18 right? But I can tell you from my experience
19 when programs like this come down, this is only a
20 medical program, right? When you're a commander,
21 you got 1000 of these programs that are mandatory
22 that you must comply with, right? And the

1 reality is, just like you have, what, your top
2 ten things that you're going after this year,
3 right? The Army Reserve has their top ten.

4 And if it's not one of the top ten,
5 the likelihood of it getting done is very
6 limited, right? So, you know, you get graded on
7 your top ten. You get promoted if you accomplish
8 your top ten. If you're Number 11, might happen.

9 MEMBER GRANGER: I have a
10 recommendation. We might want to ask DoD to come
11 and brief on this program.

12 DR. VVEDENSKAYA: Okay. We can. Yes.

13 MEMBER BIRD: For all intents and
14 purposes, this work has already been done.
15 Today, in the Guard and Reserve, if you're not
16 current on your annual health assessment, by rule
17 and procedure, you simply cannot participate
18 until you get that caught up.

19 MEMBER GRANGER: Now we're talking.

20 CHAIRMAN MARTIN: Tim, maybe you'd
21 like to comment on your life as TAG and where
22 this was.

1 MEMBER LOWENBERG: Well, I can tell
2 you from personal experience, when I separated in
3 2012, I got a Separation Health Assessment at
4 National Guard Medical Center. I think only
5 because I was a General Officer. And I think
6 probably the vast majority of people separating
7 from the Army and the National Guard under my
8 command, didn't receive any Separation Health
9 Assessments.

10 MEMBER SIMBERKOFF: Did or did not?

11 MEMBER GRANGER: Did not.

12 MEMBER BIRD: Again, I'll also tell
13 you as a senior officer that, or a General
14 Officer, I never received any information about
15 the Veterans Administration. I would receive the
16 top briefing and then a person only wondered how
17 much any of that was ever accomplished in any of
18 the meetings. Because it was my group that was
19 one of the 15 forces out to Iraq and Afghanistan
20 and elsewhere, there was never anything that came
21 to my attention.

22 CHAIRMAN MARTIN: Yes, Tim, I'm glad

1 you brought up the transition Assistance Program
2 because that's been something we've been tracking
3 for the Guard and Reserve as well, and how Guard
4 members that aren't on active duty or are not co-
5 located at active bases and get TAP.

6 MS. MOSES: And I will say, our office
7 that is over -- provides oversight to the TAP, is
8 the Office of Transition and Economic
9 Empowerment, it's OTEEI. They've got a new
10 acronym now, but I contacted a young woman from
11 the office and she's going to try to step down,
12 either today or tomorrow sometime, so she can
13 give you an update on what's going on with that
14 TAP program.

15 MEMBER BIRD: Yes, I can tell you
16 that, this is Hal Bird speaking again, I visited
17 the TAP briefings prior to retirement, along with
18 100 other officers at the same time. And what
19 they did, they called in a local VA
20 representative who stated in the beginning of his
21 brief that this does not apply to you. It only
22 applies to active duty.

1 So until we make a separation physical
2 mandatory, this is all new. All of it.

3 CHAIRMAN MARTIN: Now, on the handout
4 that you brought for us today, the very first
5 paragraph refers to the Department of Defense
6 mandatory Separation History and Physical
7 Examination.

8 MS. MOSES: Correct. So as of 1/1/14,
9 yes, as of 1/1/14, a separation exam is mandatory
10 by DoD. Now, we know that some of the branches
11 have caught on quicker than others, I should say,
12 but it's supposed to --

13 MEMBER SIMBERKOFF: So that's
14 mandatory, meaning, you know, please try.

15 DR. VVEDENSKAYA: When you have a
16 chance.

17 MS. MOSES: And it has been a lot
18 about education. It's been a lot about, you
19 know, ensuring that the proper information has
20 been disseminated. We've got some locations
21 where DoD just tells their separating service
22 member, hey, just go to VA. They'll do an exam.

1 You know, so there's a little confusion in the
2 process, but we're --

3 MEMBER FAY: Don't issue the DD Form
4 214 until you do it.

5 MEMBER SIMBERKOFF: But this is for
6 service assessment, active duty, when we all
7 understand that for servicemen, it's a different
8 ball game. The question is, is this mandatory
9 for separating Guard and Reserve as well?

10 MS. MOSES: It's supposed to be, yes.

11 MEMBER SIMBERKOFF: It is?

12 MEMBER FAY: So you simply make it a
13 mandatory process in order to get your DD Form
14 214, so they all know that they have to, both
15 active Guard and Reserves, they know you have to
16 get it done. You can't get that piece of paper
17 until this happens. That, I would suggest as a
18 recommendation.

19 DR. VVEDENSKAYA: How can we help it
20 from the VA side of the business because it seems
21 like we have two partners, DoD and VA, and for
22 me, it's important to ask Ms. Moses to write down

1 or research what we need, but what can we do from
2 VA side?

3 MEMBER FAY: I suggest we first try to
4 check with them verbally, how are you doing? Is
5 this the way you're administrating that? If it
6 doesn't work, then we follow it up with a written
7 recommendation letter in saying, our committee
8 says that this is the way, you know, it should be
9 done, because we view from the VA, it's not
10 happening. Right?

11 But you don't want to go there first,
12 but ultimately.

13 DR. VVEDENSKAYA: Would you want Ms.
14 Moses to check for us, as a committee, the stages
15 of compliance --

16 MEMBER GRANGER: Absolutely.

17 DR. VVEDENSKAYA: -- with this
18 mandatory separation exam from the DoD side?

19 MEMBER GRANGER: Absolutely.

20 DR. VVEDENSKAYA: Because that's, you
21 know, can we do certain things and we cannot do
22 certain things because we're not DoD, but I want

1 us to give specific, perhaps, requests to Ms.
2 Moses what she can do. And if the recommendation
3 or the request is to check on the compliance rate
4 for this mandatory program which was put in place
5 as of January 1, 2014, that would be super
6 helpful.

7 Mr. Bird, Mr. Lowenberg, is it
8 something which I set out loud right?

9 MS. MOSES: And I said the wrong year.

10 MEMBER BIRD: Yes. No, I think that's

11 --

12 MS. MOSES: Sorry. It's 2015.

13 MEMBER BIRD: -- excellent and I think
14 that --

15 MS. MOSES: On 1/20/15.

16 MEMBER BIRD: -- it may be a scenario
17 where we need to go to DoD and see if they are
18 willing to issue a DD214 for retiring reservists,
19 because right now they don't, and that document
20 has a lot of importance in the process, so that
21 might be another step, but yes, I do like what
22 you just proposed. I think that would be

1 excellent.

2 DR. VVEDENSKAYA: And I think as you
3 just said, it is a first step for us to check
4 with DoD on the compliance rates.

5 MS. MOSES: Correct.

6 MEMBER BIRD: Right.

7 DR. VVEDENSKAYA: And then --

8 MEMBER SIMBERKOFF: Can we ask DoD or
9 does it have to go through some chain in order to
10 get to DoD?

11 CHAIRMAN MARTIN: Well, the last time
12 we asked a question, it went through our DoD
13 liaison.

14 MEMBER GRANGER: Yes, there's a DoD
15 liaison.

16 DR. VVEDENSKAYA: Do we have the
17 project where VA and DoD work together in a
18 certain workgroup or a certain -- members who
19 can, without going through the full concurrence
20 process, can we approach DoD? Do we have a
21 mechanism at the VA?

22 MS. MOSES: So we do have a Separation

1 Health Assessment Workgroup, and that has DoD
2 members, and so I'll ping them first to see, you
3 know, if you can get this information, and then
4 if I might need a little bit more push, I'll come
5 back to you guys and let you know so we can
6 elevate it if necessary.

7 DR. VVEDENSKAYA: Yes, the reason why
8 we are all asking you for details, because we
9 don't want you to task with something which is
10 way outside of your -- but that would be great.

11 MS. MOSES: Sure.

12 CHAIRMAN MARTIN: So when --

13 MEMBER BIRD: On that --

14 CHAIRMAN MARTIN: Go ahead.

15 MEMBER LOWENBERG: I'd like to ask,
16 hopefully, if we could get two data points from
17 the Department of Defense to the other agency's
18 coordination process. One would be, as we've
19 suggested, find the data on compliance rates with
20 the requirements for Separation Health Exams, and
21 the second is to get the bulk of the policies,
22 procedures, and documents on these various

1 service, Reserve compliance, as to making it
2 clear that these exams are required, just so we
3 have that information.

4 MEMBER GRANGER: Right. Because this
5 product came out as a Department of Defense
6 letter of instruction, DoDI, and then the
7 services have to implement their policy, so I
8 agree with you, this is Elder Granger, getting a
9 copy of all the policies, and the service
10 interpretation and implementation, because she
11 just stated it was 1/1/15, so we're talking about
12 just a little over a year. It normally takes
13 about three or four months just to get it down to
14 the implementation and policy level.

15 DR. VVEDENSKAYA: And just as a
16 reminder to the committee, we cannot directly
17 recommend something to DoD, however, we can,
18 because we are, at VBA, in the business of
19 delivering benefits, you cannot deliver benefits
20 if there is nobody to deliver it to. In order to
21 make our veteran populations a good recipient of
22 our benefits, we can recommend to VA, in one way

1 or another, to enhance a particular collaboration
2 between VA and DoD. That's my take.

3 CHAIRMAN MARTIN: I'll make one more
4 comment about it. Go ahead Hal.

5 MEMBER BIRD: On that point, one
6 benefit that the VA could consider to deliver
7 directly to Guard and Reserve veterans is to look
8 into the possibility of the VA providing a
9 separation exam of some type in lieu of a
10 service-provided separation exam when veterans do
11 not have access to a service-provided separation
12 exam.

13 I was told prior to my separation that
14 that might be available, but when I went to the
15 VA, because I was supposed to get that, I
16 couldn't find anybody who ever heard of such a
17 thing. So that could be one way to certainly
18 impact.

19 MEMBER SIMBERKOFF: So I can tell you
20 that if there is a format, you know, for a
21 separation exam, like the DBQ or something like
22 that, you know, it would be a whole lot easier

1 for VA to implement that recommendation.

2 MEMBER GRANGER: Right.

3 CHAIRMAN MARTIN: I'll make one more
4 comment, if I may, about the transition
5 assistance briefings, and I wasn't offered a
6 transition assistance briefing when I separated,
7 and when I retired, but specifically asked for,
8 and then did receive one, and the reason that
9 seems so key for Guard and Reserve is because
10 part of that is, they will take you through
11 signing up for MyVA, registering for it, and
12 secondly, they'll ask the individuals, do you
13 plan to file a claim?

14 And if the answer is yes, they will
15 help you get started, they will direct you, and
16 they will hopefully get the claim processed prior
17 to separation, prior to retirement, but if not,
18 at least in a streamline fashion, afterward. So
19 does that check, Hal and Tim, with your comments?

20 MEMBER BIRD: Well, I think you might
21 have been in the same category as General
22 Lowenberg, if you may have gotten a general

1 service on that, but I am hopeful that at some
2 point every Guard and Reservist would get that
3 exact same training, and really, that's about all
4 they need to get started.

5 MEMBER GRANGER: You bet.

6 MEMBER BIRD: That's phenomenal if
7 everybody would just get that.

8 MEMBER GRANGER: Absolutely.

9 CHAIRMAN MARTIN: Other comments? So
10 who in your office is liaison now to DoD for
11 Guard and Reserve issues?

12 MS. MOSES: Andrew Bodyk.

13 CHAIRMAN MARTIN: He's the one that
14 briefed us back in September?

15 MS. MOSES: Correct. Yes. And then
16 Brandy Trailer will be taking over the Separation
17 Health Assessment project.

18 CHAIRMAN MARTIN: Okay. I did talk to
19 the Surgeon General for the Air National Guard a
20 couple of weeks ago and asked her specifically
21 about the SHA, and she said, for the Guard, the
22 mandatory part really hasn't kicked in yet. Now,

1 it's supposed to start in January, by DoD intent,
2 but as far as filtering down to the Guard, Air
3 Guard anyway, it had not.

4 Did you want to make any comments
5 about the electronic data transmissions with the
6 Guard and Reserve to VA?

7 MEMBER LOWENBERG: Can I just hang on
8 for a second, I know we've been talking about the
9 lives of our uniformed services, but we did not
10 overlook the critical elements of these issues.

11 MS. MOSES: Noted.

12 CHAIRMAN MARTIN: Yes, good point,
13 Tim. Thank you. So we talked about the data
14 transmission of Guard and Reserve data, and you
15 quoted some numbers back in September to
16 resolving late inflow documents, Guard and
17 Reserve, 75 percent within 45 days.

18 MS. MOSES: Correct.

19 CHAIRMAN MARTIN: Is that correct with
20 your figures now?

21 MS. MOSES: Those are still the -- I
22 don't want to -- the standard in the DoDI as

1 opposed to in the MOU, however, like we've been
2 doing a lot better than the 45-day timeframe. So
3 as of 1/1/14, everything is supposed to be
4 electronic as far as service member record.
5 There have been many enhancements to our HAIMS,
6 DAS, VBMF interface, so we're able to get those
7 records that are needed.

8 We're actually working with DoD on an
9 electronic certification, if you will, almost
10 like a manifest, so that we can ensure that what
11 DoD placed into HAIMS is actually pulled out, and
12 that was one of our issue with the late
13 documents. And so that is all supposed to be
14 rolling out, I would say, like, towards mid-
15 summer, where we'll be able to know exactly what
16 is coming over so we can pull that, and that will
17 reduce the late documents, if you will.

18 Or at least it will put the fire under
19 DoD to ensure that, you know, we're getting
20 everything done, so the IT, I have to give kudos
21 to IT because they've been making a lot of
22 progress on that front.

1 CHAIRMAN MARTIN: Is there any update
2 that you can give the committee on the
3 computerized medical records for Guard and
4 Reserve? Do you have any information on that
5 from DoD or anything?

6 MS. MOSES: I don't.

7 CHAIRMAN MARTIN: We know that they
8 were dragging behind active duty because of
9 costs, and training, and equipment, and things
10 like that.

11 MS. MOSES: Right. Yes. I don't have
12 an update on it, but I can ask. I'll find out.

13 MEMBER ROBERTS: Is that just one
14 computer or will there be one computerized health
15 information system or will each of the services
16 have their own? Because it becomes very
17 complicated.

18 MS. MOSES: It's all one system.

19 MEMBER ROBERTS: All one system?

20 MS. MOSES: Correct.

21 MEMBER ROBERTS: So that if there's a
22 Guard person in Florida, somebody in Washington

1 can get his or her records immediately.

2 MS. MOSES: Correct. So it's called
3 the Healthcare Artifact and Image Management
4 Solution.

5 MEMBER ROBERTS: Is it working well?

6 MS. MOSES: Yes. So HAIMS was not
7 built to be a repository, and so that's part of
8 where we've got some issues, and so what DoD does
9 is, they upload the SGR into HAIMS and then we
10 have an interface, and VBA pulls the documents
11 that we need via that interface.

12 Well, we also know that in addition to
13 wanting this SGR for our benefit purposes, VHA
14 also wants to take a look at the SGR for medical
15 purposes, and we're trying to work together
16 collaboratively for the continuity of care, so
17 there are several different interfaces that will
18 allow VA to see DoD's records, one being the
19 Joint Legacy Viewer.

20 However, whatever is placed into
21 HAIMS, that can be seen nationally, at least on
22 the DoD's end. How it's seen from VA depends on

1 the system that's used, but it's a universal
2 system, if you will. I've been told that that
3 system will change in the future, however, I
4 can't speak anymore on that. But right now,
5 there's supposed to be just one system, there is
6 one system, and in the future, it should still
7 just be one system, everything transferring over
8 to something else, but yes.

9 MEMBER BROWNE: So what was that
10 called? The Healthcare Management --

11 MS. MOSES: Healthcare and Artifact
12 Image Management Solution.

13 MEMBER ROBERTS: Is it a real-time
14 system?

15 MS. MOSES: When VA gets the
16 information, it's usually a few hours when we
17 pull it over, so for example, we usually do a
18 nightly pull. With our systems, we have, like,
19 scattered the pulling, so we may do even numbers
20 on Monday, Wednesday, Friday, you know, odd, but
21 we also have developed the interface to manually
22 request documents, and that was something that

1 was really needed.

2 So we have things that are pulled
3 based on a trigger identified in the coding that
4 there should be a claim here because we have a
5 separating date. However, for our pre-discharge
6 programs, that manual trigger is what's needed,
7 and so we can pull what's in HAIMS, however, it's
8 not until we have a definitive answer that we
9 have everything in HAIMS, we will get everything.

10 So it can -- when I say real time,
11 within a few hours; about three hours.

12 MEMBER ROBERTS: Have you experienced
13 a lot of downtime with this system?

14 MS. MOSES: Not as much as in the
15 past, like, since December, things have really
16 been tracking very well, like, surprisingly well.

17 CHAIRMAN MARTIN: Maybe just to help
18 the committee understand some of the complexities
19 involved, and then, Dr. Granger, you can comment
20 on this if you will, but when I was deployed in
21 '99 to Operation Northern Watch with the field
22 hospital, did everything by hard copy, and didn't

1 have any electronic records, the Guard and
2 Reserve units, and active duty, would all
3 interchangeably rotate in and out, and
4 theoretically, then the paperwork would be input
5 into active duty systems or handed, original
6 copies, to the Guard or Reserve units so they
7 could take it back home with them.

8 But I mean, you can appreciate the
9 chance of that not happening or some paperwork
10 not getting entered, and that's just one example
11 of, I don't know how many, thousands of
12 deployments that might involve in the last 20
13 years.

14 MEMBER GRANGER: I can say since 2004,
15 2005, when we filled the electronic healthcare
16 record on the battlefield among all services,
17 that's now documented electronically. Prior to
18 that it is paper. Some of that paper was
19 uploaded into the system, but right now it is
20 pretty good real time worldwide. So if you get
21 something happen on the battlefield, they put it
22 into the system.

1 When you're getting in-route, in-air
2 care, before you at Landstuhl or on this side of
3 the water, they can already see it, to including
4 the VA, if it's going to go to one of the VA
5 polytrauma centers. It's called bidirectional
6 health information exchange. You can see that
7 information there going all the way through. We
8 filled that in 2005, 2006, a little button that
9 they click on right there. They can see if
10 they're coming to one of the polytrauma centers.

11 CHAIRMAN MARTIN: That's huge.

12 MS. MOSES: Well, thank you all.

13 DR. VVEDENSKAYA: Thank you very much.

14 CHAIRMAN MARTIN: Thanks for coming
15 down. Members, any other discussion about this?
16 I mean, this is such a complicated issue, there
17 are so many facets to it, but it's a problem that
18 we, hopefully, can at least assist with in
19 certain aspects.

20 MEMBER SIMBERKOFF: Well, I think
21 getting some data on compliance is absolutely
22 crucial.

1 MEMBER GRANGER: It is.

2 MEMBER SIMBERKOFF: You know, if
3 compliance is not good, maybe we can do something
4 to help.

5 MEMBER GRANGER: Absolutely. I would
6 agree with you. That's the issue, is compliance.

7 CHAIRMAN MARTIN: And I think the DoD
8 will is there to make the data available.

9 MEMBER GRANGER: It is. It is. To be
10 honest with you, this data is looked at the
11 highest level on a quarterly basis by the Joint
12 Staff; how are we doing in the readiness, and not
13 just equipment readiness, but most importantly,
14 human factor readiness.

15 MEMBER ROBERTS: Who has
16 responsibility for the compliance? Is it on the
17 DoD side or the VA side?

18 MEMBER GRANGER: It's DoD.

19 MEMBER SIMBERKOFF: It can't be the
20 VA. You're not in the VA until you're out of --

21 MEMBER ROBERTS: Well, until you're
22 out of service. Yes.

1 MEMBER GRANGER: It's DoD.

2 MEMBER SIMBERKOFF: Yes.

3 MEMBER ROBERTS: DoD is really not
4 doing a good job of complying, apparently.

5 MEMBER GRANGER: I don't know that.
6 As we said, in God we trust, others bring data.
7 I don't know until we see the data.

8 DR. VVEDENSKAYA: Well, it seems like
9 we have liaison, Andrew Bodyk, who would be
10 reaching out to the DoD side of that workgroup,
11 and we'll have some numbers, some data, sent back
12 to us, and I will distribute it via email. And
13 as a reminder to all the members, take note,
14 write down your thoughts, because the first email
15 you will receive from me, probably, on Thursday,
16 Friday, saying, thank you so much for coming. Do
17 you have, put it in writing, things on your wish
18 list for the next meeting, things you want me to
19 request for the committee in terms of the data,
20 speakers, papers, and things like that?

21 Just make notes now because I will be
22 asking for your input after the meeting. This

1 way we can get all the information needed for the
2 next meeting and for you to think between the
3 meetings and do your research.

4 CHAIRMAN MARTIN: There will also be
5 topics that we cover that will say, okay, thank
6 you for the data. We'd like to revisit that in
7 six months, or eight months, or something. If
8 you can jot that down as a reminder, that's
9 helpful too.

10 Hal, Tim, any other observations
11 before lunchtime, or breakfast in Washington?

12 MEMBER BIRD: No. Thanks. I thought
13 that was a great presentation. Thanks.

14 CHAIRMAN MARTIN: Thanks for your
15 input.

16 DR. VVEDENSKAYA: Shall we reconvene
17 until 1 o'clock? This way our members, remote
18 members, can just put it on mute and have their
19 lunch.

20 CHAIRMAN MARTIN: That's good. And
21 don't forget to allow yourself a few minutes to
22 go through security again.

1 MEMBER SIMBERKOFF: Yes, security.

2 CHAIRMAN MARTIN: Sometimes that gets
3 backed up a little bit.

4 MEMBER GRANGER: And will somebody be
5 outside to let us in about a few minutes before?

6 DR. VVEDENSKAYA: I'll try to do
7 something about it. Yes, I normally would do
8 that, but today the IT was failing in the
9 morning. That's why I asked my colleague to let
10 you in. All right. Then --

11 CHAIRMAN MARTIN: Did our guests have
12 any other comments about this? It's a lively
13 discussion.

14 MEMBER GRANGER: It is.

15 CHAIRMAN MARTIN: Oh, I'm sorry, you
16 didn't get a chance --

17 DR. VVEDENSKAYA: Yes, we did
18 introduce --

19 MS. HANAHAN: My name is Ashley
20 Hanahan. I'm a nurse practitioner with VHA and
21 I've been performing C&P exams for about 15
22 years, so this is a topic very near and dear to

1 our hearts.

2 CHAIRMAN MARTIN: You're well-versed
3 in this then.

4 MS. HANAHAN: Yes.

5 DR. VVEDENSKAYA: Very welcome. Thank
6 you for taking the time.

7 CHAIRMAN MARTIN: Any comments, sir?

8 MR. LABOZZETTA: No, I appreciate you
9 addressing that topic. I know the lack of
10 coordination, it seems, between DoD and VA in
11 obtaining those records, you know, has caused a
12 lot of challenges in the claims process.

13 CHAIRMAN MARTIN: All right. Thank
14 you. Everyone have a nice lunch and we'll see
15 you back. Thanks.

16 DR. VVEDENSKAYA: I'll be outside of
17 the 6th-floor doors. You can get to the 6th
18 floor. I'll be at the 6th-floor lobby five
19 minutes to 1:00 with my magic I.D.

20 (Whereupon, the foregoing matter went
21 off the record at 11:47 a.m. and went back on the
22 record at 1:00 p.m.)

1 CHAIRMAN MARTIN: One of the issues
2 that we've discussed at the committee several
3 times in the recent couple of years has been the
4 fully developed claim -- hi, Tim, is that you?

5 MEMBER LOWENBERG: It's me.

6 CHAIRMAN MARTIN: Excellent. Welcome
7 back. We're just getting started. I was saying,
8 we had discussed the fully developed claim
9 program a few times in the last couple of years
10 and we wanted an update today. And so we have
11 Carla Riddick here from VBA. Thank you for
12 coming.

13 MS. RIDDICK: Thank you for having me.
14 Hello. Good afternoon to everyone. My name is
15 Carla Riddick and I am a product analyst in the
16 procedures staff with Compensation Service, so I
17 work not that far from here. Basically, I'm
18 going to go over the Fully Developed Claim
19 Program.

20 I'm going to provide you a quick
21 overview, or description, of what it is and how
22 successful it has become throughout the years

1 that we have been implementing it. I provided
2 you all with slides if you wanted to follow that
3 up.

4 Basically, what is a Fully Develop
5 Claim or what is a Fully Developed Claim Program.
6 FDC program is an optional program that is
7 offered to veterans and survivors. Basically,
8 the premise of this is to provide faster
9 decisions from VA on claims for compensation,
10 pension, and survivor benefits.

11 This program started out as a pilot in
12 2009 and I think that was -- that started as a
13 pilot at one regional office, so 2010, it was
14 implemented throughout all regional offices
15 because of the success of the pilot program.

16 The main goals that we try to strive
17 from the FDC programs are, expeditiously
18 processing of claims submitted with all non-
19 federal evidence. So claims have to provide us
20 with anything that is non-federal -- I mean,
21 sorry, anything that is non-federal in order to
22 support their claim.

1 And also, the goal, when we first
2 initiated this program, was to have a timeliness
3 goal of 90 days and if you see on the next couple
4 pages, which I will go through, I'll provide you
5 some data to show well -- how successful it has
6 become that we have met the 90-day timeliness
7 goal.

8 For an FDC, the VA, we will still
9 retrieve relevant records from federal facilities
10 and we will also provide a medical examination or
11 medical opinion if it is needed to, or if it is
12 determined at the time that you filed the claim.

13 The next page I wanted to discuss,
14 exclusions of the FDC program. We have various
15 reasons for why we may or may not exclude
16 claimants from the FDC program. Some of those
17 exclusion reasons are, they are not to have a
18 claim or an appeal pending at the time that an
19 application is received, the claim requires a
20 character discharge determination, the claim
21 requires further development or medical evidence
22 is needed from a provider, if additional evidence

1 is received after the claim has been established,
2 then we will exclude it from the program, and
3 then the claim also does not submit some things
4 with their claim, the necessary forms, that is
5 the art they identified on the 526EZ, we will
6 exclude them from the program.

7 So for example, a claimant may submit
8 a claim, let's say, March 12th, everything is
9 there, everything that's needed to decide the
10 claim. Two weeks later they say, oh, my gosh, I
11 forgot to submit something else that is needed
12 from -- that I received from the private medical
13 physician.

14 Now, they submit that after they have
15 initially submitted the claim and that counts as
16 additional evidence. We will exclude them from
17 the program. That's because it may cause -- on
18 the 526, we already notify them that everything
19 needs to be submitted simultaneously. So us
20 providing -- the 5103 notice provides them with
21 everything that is needed.

22 So this additional evidence may

1 require a longer delay processing time when we're
2 trying to process the claim for 90 days straight,
3 so that's why we ask everyone to submit
4 everything simultaneously with that claim before
5 -- I guess, once they submit to that.

6 DR. VVEDENSKAYA: And also, I wanted
7 to -- I remember Carla mentioned this during her
8 last presentation. The Fully Developed Claims
9 Program was designed for claims which are not
10 super complex.

11 CHAIRMAN MARTIN: Right. Simple.

12 DR. VVEDENSKAYA: It is why, you know,
13 the goal is, the major goal is, to expedite
14 adjudication of the benefit on a case which
15 shouldn't be that difficult and everything is
16 straightforward. It is why, you know, everything
17 is pretty much outlined and yes, you have to have
18 an attention to detail and you need to read your
19 paperwork.

20 If you do your due diligence, VA said,
21 we'll do our due diligence and you'll have your
22 decision in 90 days. But again, it really --

1 very complex claims usually don't go through that
2 program because it's inevitable to have more
3 evidence coming at a later day, or something
4 changes and they need to adjust the initial
5 claim, and this program is excellent for not
6 complex.

7 MEMBER FAY: Who does that triage when
8 it first comes in? Who decides what's the
9 complex and what's the --

10 MS. RIDDICK: Yes, triage does on the
11 intake processing.

12 MEMBER FAY: Intake processing, so
13 there are a group of individuals that triage it?

14 MS. RIDDICK: Yes. Now, as Dr. V was
15 stating, we try to have the non-complex claims,
16 but initially, it did start out as a simple
17 process where your claim is in, your claim is
18 out. We try to have things that were not complex
19 with these claims, where, as we have grown into
20 the FDC program, we have seen a lot of claims
21 where we had to go and, we had a workgroup that
22 met last year, revamp or kind of make new

1 guidelines and rules for the FDC program because
2 we were getting cases like MST, military sexually
3 trans -- yes, claims.

4 We were getting claims that require
5 extra special issue development, which, sometimes
6 the notice isn't provided on the 526EZ, so we had
7 to go and we had to make several exceptions to
8 the rules of how a claim is being processed,
9 because like I said, with anything that you start
10 out with, you think it's going to be a simple,
11 easy process, this is one, two, three, that's it,
12 but we get a lot of questions from regional
13 offices, we get a lot of different claims in.

14 They say, well, hey, how do you
15 process this type of claim? And we had to go in
16 and say, well, even though it is an FDC, we still
17 had to make some exceptions to processing these
18 types of claims at a certain point.

19 The next slide, we have --

20 MEMBER ROBERTS: Excuse me. Can I ask
21 a question?

22 MS. RIDDICK: Yes.

1 MEMBER ROBERTS: I have a number of
2 people in my community, as well as the church I
3 attend, who complain about not having their
4 claims adjudicated in a very timely manner. And
5 so I was going to ask you, are most claims
6 completed in this 90-day period that you're
7 talking about?

8 MS. RIDDICK: No, not at all.

9 MEMBER ROBERTS: Are you all doing
10 anything to deal with the more complicated claims
11 then? Because apparently, that's where the
12 problems is and that's where a lot of veterans
13 are saying to me that I can't get my claim
14 adjudicated.

15 MS. RIDDICK: Right. So I think each
16 year with the 526EZ form, they have tried to add
17 things that may be helpful or that provides
18 assistance to the veterans with the things they
19 need to get in the claim. So I think right now
20 the 526EZ form is going through another revision
21 where we're telling them exactly what they need
22 in order to decide their claims.

1 And hopefully, this will provide a
2 little bit of insight or it will decrease the
3 goal, you know, that we try to meet the 90 days,
4 things like that, but we are -- when we talk
5 about the program, along with Ashley, that we
6 have been trying to implement, but we're trying
7 to implement now, which is easier, and somewhat
8 less difficult or complex for claimants; for
9 veterans.

10 MEMBER ROBERTS: What should a veteran
11 do when he complains that, he or she complains
12 that, they cannot get that claim adjudicated in a
13 timely manner? They seem very frustrated by the
14 whole process.

15 MS. RIDDICK: Right.

16 MEMBER ROBERTS: I don't know what to
17 tell them because it's not my responsibility. I
18 keep telling them that there's this program, the
19 Fully Development Claim Program, but that doesn't
20 seem to satisfy them. What should I tell them to
21 do?

22 MS. RIDDICK: I would tell them,

1 because we rely heavily on the VSO, Veteran
2 Service Organizations, to get up and prepare to
3 represent them. Now, when they have the VSO, the
4 VSOs know all the ins and outs of our program and
5 they have been a tremendous help in getting these
6 closed; claims processed.

7 So I would say get a VSO. I'm a
8 veteran so I do not have a VSO, but sometimes it
9 does take claims a little bit longer. We kind of
10 know how VA works, I know how to get it in, but
11 they don't know that, so I would say, get a VSO.
12 Let them represent you. Let them tell you what
13 is needed for that claim, and hopefully,
14 depending on the regional office, they're
15 supposed to process those FDCs as soon as they
16 come in.

17 MEMBER FAY: What's the percentage of
18 complex versus non-complex? How's it breakout?

19 MS. RIDDICK: I haven't really seen a
20 breakdown of that. I think that's more PA9,
21 maybe, because -- provide that data, but the data
22 I basically have is the total number of -- total

1 claims that we receive versus complicated. I
2 think there are more claims that have increased,
3 like increased evaluations, the least complex
4 ones. I'm not sure what the percentage of the
5 more complex claims are. I can get that data for
6 you.

7 MEMBER FAY: So we're just seeing that
8 the non-complex claims should be far more common,
9 right, just by definition, than the complex
10 claims.

11 MS. RIDDICK: Yes.

12 MEMBER FAY: I just given you an
13 analogy to, I ran a property casualty insurance
14 claims organization, similar triage, right? Non-
15 complex claims, easy get them, get them out, pay
16 them within 30 days, 60 percent of the claims,
17 right?

18 MS. RIDDICK: Right.

19 MEMBER FAY: 40 percent of the claims
20 needed more than 30 days. Complexity for all
21 sorts of different reasons, right?

22 MS. RIDDICK: Right.

1 MEMBER FAY: So I'm looking for
2 similar analysis from the VA. What is a complex
3 versus non-complex? How do you define that? And
4 non-complex should be a very big number,
5 percentage-wise, relative to complex.

6 MS. RIDDICK: Right.

7 MEMBER SIMBERKOFF: So there have been
8 initiatives to eliminate the claims that are over
9 a year old. So where do we stand? I mean, we
10 got some updates on those in past briefings. I
11 mean, is there still some data that are available
12 on --

13 MS. RIDDICK: That is a good question.

14 MEMBER SIMBERKOFF: Yes.

15 MS. RIDDICK: I have not worked with
16 that initiative. I do know there are some of my
17 co-workers that worked on that initiative, so I
18 don't really have the data for you, but I'm not
19 sure if they're keeping up with that now, but I
20 know that that was a big thing a couple years
21 when I first came on, that they were keeping
22 track of --

1 MEMBER SIMBERKOFF: But that over a
2 year old --

3 MS. RIDDICK: Yes, that was a priority
4 when I came in.

5 MEMBER SIMBERKOFF: But didn't that
6 include the complex, you know, claims that, you
7 know, you're talking about? So, I mean, VBA, I
8 mean, worked very, very hard to get a lot of
9 those done and, you know, what I'd be interested
10 in is to see, you know, obviously there's going
11 to be, each week or each day, a new group of
12 claims that are over a year old and maybe we
13 could, you know, see where that is.

14 To answer your question, you know, if
15 your patients or friends are over the year, you
16 get VBA to recommit to get those done and out.

17 MEMBER FAY: So in the insurance
18 world, we had all of those statistics, right? So
19 we have our entire inventory, you can tell how
20 long they've been there, what kind of claims they
21 are, can we get access to the Veterans
22 Administration statistics on --

1 DR. VVEDENSKAYA: I think we do. And
2 may I just clarify for Carla, you wanted to know
3 the percentage of complex claims versus the
4 percentage of not complex.

5 MEMBER FAY: Yes, of your whole
6 universe.

7 DR. VVEDENSKAYA: Oh, of the -- yes.

8 MEMBER FAY: Of the 100 that comes in,
9 what's the percentage of complex versus non-
10 complex.

11 DR. VVEDENSKAYA: Yes, you have
12 million claims, how many of them --

13 MEMBER FAY: Right.

14 DR. VVEDENSKAYA: And also, did you
15 want to know the percentage of fully developed
16 claims versus a percentage of old claims?

17 MEMBER FAY: Now that the doctor
18 brings it up, yes, I'm interested in hearing how
19 many claims are over 100.

20 DR. VVEDENSKAYA: Take a look at Slide
21 Number 3 here.

22 MS. RIDDICK: Yes, Slide Number 3, I

1 have --

2 DR. VVEDENSKAYA: Yes. I think that
3 question is answered. How many of total claims
4 are fully developed claims, which are considered
5 --

6 MEMBER FAY: That's only fully
7 developed. I'm interested in the whole number.

8 MEMBER SIMBERKOFF: But the question
9 that I was asking is, you know, how many are
10 still over a year old.

11 MS. RIDDICK: Yes. They had that
12 initiative that --

13 MEMBER FAY: How many of them are non-
14 complex and if it's non-complex, why would it be
15 sitting over a year?

16 MEMBER SIMBERKOFF: Right. So the
17 non-complex, they were doing by computer
18 algorithm, and, you know, they were getting
19 settled in minutes.

20 MEMBER GRANGER: That's right. They
21 were.

22 MEMBER SIMBERKOFF: Yes.

1 DR. VVEDENSKAYA: Very, very often
2 non-complex claims get delayed and delayed
3 because a veteran's submitting another piece of
4 information and they have to go back and put it
5 in and then another one.

6 MEMBER FAY: Which would be
7 acceptable, I mean, I understand that, but what
8 I'm looking for is to be educated so I know --

9 DR. VVEDENSKAYA: Exactly. We have
10 these numbers and we can --

11 MEMBER BROWNE: I think in the past
12 we've had the presentation where they talk about
13 all claims, not just the fully developed claims,
14 because that's a separate category.

15 DR. VVEDENSKAYA: Separate category.
16 Yes.

17 MEMBER BROWNE: And when you get all
18 claims entered in, we had the backlog of those
19 that were over three years.

20 MEMBER FAY: Yes, and please, this is
21 not a critique question, it's a, I'm trying to
22 understand question.

1 DR. VVEDENSKAYA: And also, we have so
2 many new programs, the goal which is to utilize
3 our workforce better and, you know, deliver.
4 That's why we have new numbers every month.
5 That's why it's a good question. We can get the
6 data for next meeting in June just to have
7 another look at what's going on in June 2016
8 versus June 2015.

9 MEMBER BROWNE: Of course, in terms of
10 the fully developed claim, that can only go in on
11 the EZ form, 516?

12 MS. RIDDICK: Yes.

13 MEMBER BROWNE: And if you're going to
14 put this in over the computer, you can still do
15 that on the --

16 MS. RIDDICK: Yes. That's still on
17 eBenefits.

18 MEMBER BROWNE: Yes, the eBenefits.

19 MEMBER GRANGER: Right. It is.

20 MEMBER ROBERTS: There are a large
21 number of veterans who've had so many
22 difficulties getting their claims adjudicated,

1 they're almost at the point of giving up because
2 they get no sympathy of what they feel, empathy
3 and understanding, from the regional VA office or
4 any other place. What do you do about those men
5 and women who are so frustrated?

6 MS. RIDDICK: Because, like Dr. V say,
7 we have different programs. We're trying to come
8 up with different ideas. We continue to try to
9 educate them and try to promote our various
10 programs that we do have. I think there are some
11 questions they can put in, or they can write to
12 their Congressmen, Congresswomen, but we do
13 sympathize with them.

14 But I mean, there are just different
15 options that they can have, and if it's still not
16 meeting that request, like I said, I would just
17 go to the Congressmen.

18 MEMBER SIMBERKOFF: No, I honestly
19 think that's one of the Secretary's 12 --

20 MEMBER GRANGER: It is.

21 (Simultaneous speaking)

22 DR. VVEDENSKAYA: I think if we get a

1 better understanding why it's happening and I
2 think the data would be helpful because there is
3 a breakdown on why certain claims are sitting for
4 so long in the queue. And we can take a look,
5 what are the legit reasons for them to stay in so
6 long, because they evidence keep coming, or, I
7 don't know, is it a lost file, which doesn't
8 happen. We don't have paper files anymore, but
9 we can take a look, because they do categorize
10 it, why certain claims are sitting in the queue
11 for so long.

12 Perhaps it will help us to understand
13 why and then it will help you to understand why.
14 It's why every time when somebody asks you, you
15 can ask specific questions in order to identify,
16 where is the problem and how we can go about it.

17 MEMBER SIMBERKOFF: So that's why it
18 would be helpful to have the data that, you know,
19 we're asking for, but it's also very helpful to
20 ask, you know, the veteran, you know, some
21 specific questions.

22 MEMBER GRANGER: Absolutely.

1 MEMBER SIMBERKOFF: Like, for example,
2 have you modified the claim?

3 MEMBER BROWNE: And do you have the
4 supporting documents to go with the claim?

5 MEMBER SIMBERKOFF: Yes, do you have
6 the documents, because, you know, for every --
7 there's two sides to absolutely every story.
8 And, you know, so, you know, when somebody comes
9 to me with a complaint, you know, the first thing
10 I always do is listen and then try to find the
11 other side of the story.

12 MEMBER GRANGER: I will tell you,
13 having worked through this process myself over
14 many years, normally there is something missing,
15 and I know from experience, the VA will
16 continually send you a written notice, or if they
17 have access to a computer, they go to eBenefits
18 and you look at the status of your claim, it'll
19 say, still waiting on document from civilian
20 provider, still waiting on records from this
21 place here, from that standpoint.

22 I helped out a veteran a few months

1 ago and his wife kept trying to get the doctor,
2 can you just put down his diagnosis and his
3 medication? It was simple hypertension and
4 diabetes. The guy runs a very busy internal
5 medicine practice. So I said, look, I'll call
6 him myself. Can you take, at the end of the day,
7 it's a very simple form, just answer the
8 question, hypertension, how long you been
9 treating it, and the medication?

10 He said, I'll do it. I said, can you
11 do it right now? Because the guy's going to --
12 we're going to push it to them. He said, I'll
13 tell you what, give me ten minutes and call me
14 back. I call him back in 15 minutes, I gave him
15 5, but he took care of it.

16 But they had been asking her to get
17 that on behalf of her husband for six months. He
18 got a busy practice. It's the least thing he
19 want to do, plus he don't get paid for that. He
20 doesn't get paid for it.

21 MEMBER FAY: So again, I don't
22 understand, why doesn't the VA ask for the

1 medical records?

2 MEMBER GRANGER: They have. He has to
3 comply.

4 MEMBER FAY: So there's no process,
5 like subpoena them?

6 MEMBER GRANGER: No.

7 (Simultaneous speaking)

8 MEMBER FAY: I come from a world that
9 if you want the doctor's medical records, you
10 subpoena them.

11 MEMBER SIMBERKOFF: But again, you
12 have to understand, A, you can't subpoena to
13 support the claim of a veteran, and B, you know,
14 like filling out the forms, those forms that, you
15 know, the DBQs, that they ask the private doctors
16 to fill out, the VA won't pay the private doctor
17 to do it, which is, you know, why 90 percent or
18 more of the forms end up getting filled out by VA
19 doctors.

20 MEMBER GRANGER: Right. Unless it's
21 one of the contractors out there doing it.

22 MEMBER SIMBERKOFF: Even when you have

1 a private doctor that you've been going to for 90
2 or 95 percent of your medical care.

3 MEMBER FAY: So if this group is to
4 have an impact, shouldn't we be making
5 recommendations based on core issues, the real
6 crux of the issues, which are those issues, as
7 opposed to trying to get people to fill out forms
8 that they don't get paid for, which they'll never
9 do, I mean, so go back to, then they should get
10 paid for it.

11 MEMBER SIMBERKOFF: But again, I think
12 this is a federal mandate.

13 MEMBER GRANGER: It is.

14 MEMBER FAY: If it's a core issue,
15 that's what we should be getting at, rather than,
16 you know --

17 DR. VVEDENSKAYA: And the number --

18 MEMBER FAY: -- the systemic issues.
19 It has to be a strategic rather than a --

20 DR. VVEDENSKAYA: When we get the
21 numbers, which will give us a split, where are
22 the delayed --

1 MEMBER FAY: I agree. That's a
2 beginning point. I just want to make sure I'm on
3 the right group here, right, that is making
4 strategic recommendations as opposed to
5 operational.

6 MEMBER SIMBERKOFF: But you do have to
7 understand that there are things that VA doesn't
8 have the control --

9 MEMBER GRANGER: That is so true.

10 MEMBER SIMBERKOFF: -- you know, to
11 change. So, you know, again, VA can only do what
12 Congress allows it to do.

13 MEMBER GRANGER: Right.

14 MEMBER FAY: But I think we can
15 recommend to Congress to do that.

16 MEMBER GRANGER: Yes, we can.

17 DR. VVEDENSKAYA: And another issue in
18 terms of the records, for example, not throwing
19 darts, but it's like over the years it seems like
20 it comes over and over and over again. When I
21 visit the regional offices and saw how hard they
22 work --

1 MEMBER FAY: So why don't you have
2 subpoena power?

3 DR. VVEDENSKAYA: The problem, for
4 example, was Reservists records.

5 MEMBER FAY: Right.

6 DR. VVEDENSKAYA: It probably is the
7 longest response time. They send a reminder once
8 a month for ten months, I don't know, three
9 months is a mandatory, but I think they even
10 extend it past.

11 MEMBER FAY: They send it to the
12 Reservist or to the doctor.

13 DR. VVEDENSKAYA: To the Reservist's
14 unit.

15 MEMBER FAY: To the unit.

16 DR. VVEDENSKAYA: Because the
17 Reservist doesn't have some sort of paperwork,
18 either military paperwork or military treatment
19 records, and the VSOs, yes, VSOs, they keep
20 sending the requests, but they never hear them.
21 That's why, while they are waiting for the
22 records, they cannot process the claim.

1 MS. RIDDICK: So at the FDC we were
2 previously telling veterans, or Reservists, or
3 National Guard to submit those records because,
4 to me, I think it's easier for them to get those
5 records versus for us to go out and get them, but
6 now we've changed it where because they are part
7 of the federal in custody -- in custody of
8 federal records, then we have decided to, you
9 know, go out and get those records for them.

10 MEMBER FAY: So would the issue that
11 we've talked about this morning where everybody's
12 on the same electronic records, would that be a
13 solution to that because you just have access to
14 the electronic records.

15 MEMBER GRANGER: No, you don't.
16 There's not a nationwide electronic healthcare
17 record.

18 MEMBER FAY: No, but I'm saying,
19 ultimately, if it's going to be all military are
20 going to be on those electronic records.

21 MEMBER SIMBERKOFF: Even DoD records
22 are not universally available to VHA. It's only

1 through, you know, the joint legacy viewer that
2 you're able, you know, to view a limited number
3 of the military records, and none of them Reserve
4 or --

5 MEMBER GRANGER: Going back to Kirt's
6 comments early in the morning there, he said that
7 the paper records, if those aren't incorporated
8 with your electronic record, they are filed and
9 go to St. Louis. You have to request those as
10 part of that process. And they have been working
11 very, very hard to improve getting those records
12 because those are historical paper records.

13 It's like early on in my first career,
14 my records got retired there in St. Louis, so
15 when I came to do all my training, when I got
16 ready to file, I had to go back and resurrect
17 those out of St. Louis.

18 MEMBER FAY: So that was after the
19 fire because there was a big fire --

20 MEMBER GRANGER: That was after the
21 fire.

22 MEMBER FAY: -- that destroyed all

1 sorts of records.

2 MEMBER GRANGER: They ruled in favor
3 of the veterans. Yes, that type of thing. You
4 got a buddy that wrote you, oh, yes, I served
5 with him. He got hurt. We got blown-up. Yes,
6 good.

7 CHAIRMAN MARTIN: The other part of
8 the problem with the Guard and Reserve is that
9 the majority of the supporting medical documents
10 are probably in the civilian sector and not in
11 the military sector.

12 MEMBER GRANGER: They are.

13 MEMBER FAY: Which they have to get
14 from the military to bring them.

15 CHAIRMAN MARTIN: Even a fully
16 computerized Guard and Reserve is not going to
17 retrieve those civilian records.

18 MEMBER GRANGER: It's not going to.

19 CHAIRMAN MARTIN: Unless they happened
20 to be scanned in for another purpose, another
21 day. Something.

22 MEMBER BROWNE: And even if it's

1 electronic, it may not be the same electronic
2 system, so you don't communicate.

3 MEMBER FAY: I'm just saying that,
4 eventually, if all the military is on one
5 electronic system, then -- and the VA is on --
6 well --

7 MEMBER SIMBERKOFF: That's not a
8 foregone conclusion.

9 MEMBER FAY: We should lend out
10 support, it sounds like --

11 DR. VVEDENSKAYA: Yes, absolutely.

12 MEMBER FAY: -- to that issue, right,
13 to make sure that that is part of the agenda
14 going forward.

15 DR. VVEDENSKAYA: And to help you to
16 give right recommendations, that dataset, which
17 we'll request, which will identify the
18 bottlenecks.

19 MEMBER GRANGER: Absolutely.

20 DR. VVEDENSKAYA: Will help us to get
21 to the gist.

22 MEMBER SIMBERKOFF: The other thing is

1 that, while VHA has access to military records, I
2 don't think DVA does.

3 MS. RIDDICK: There are programs like
4 the HAIMS, like the JLD, that they are -- that's
5 in the records.

6 MEMBER SIMBERKOFF: But who reads
7 them? Because what you don't have is what we do
8 have, which are people who are -- know how to
9 read medical records.

10 MS. RIDDICK: Good point.

11 MEMBER ROBERTS: I'm not sure that the
12 VA has a corporate body. I understand that
13 physicians in private practices are terribly
14 laden with paper these days.

15 MEMBER SIMBERKOFF: We understand
16 that.

17 MEMBER GRANGER: Yes, they do. They
18 do.

19 (Simultaneous speaking)

20 MEMBER ROBERTS: Matter of fact, as we
21 all know, a lot of doctors are out of practice
22 because they're so badly laden with paper. But

1 I'm saying, why can't the VA pay doctors when
2 they want somebody to --

3 MEMBER FAY: That goes back to the
4 kind of question that I fundamentally say, yes,
5 they should be, and make that recommendation.

6 (Simultaneous speaking)

7 MEMBER GRANGER: Now, there are
8 providers paid as part of those contracts out
9 there in the network in the civilian world.
10 There are two or three contractors who are doing
11 the disability benefit questionnaires, and if
12 they get a provider in the network say they want
13 you to fill this out, those providers are being
14 paid based on those contracts. So, yes.

15 DR. VVEDENSKAYA: But also, another
16 side of this issue is that not every treating
17 physician would like to fill disability forms for
18 his or her patient.

19 MEMBER GRANGER: Absolutely.

20 DR. VVEDENSKAYA: Different
21 relationship.

22 MEMBER GRANGER: It's totally

1 different.

2 DR. VVEDENSKAYA: Therapeutic versus
3 forensic. It's why there are many different
4 issues why certain things don't happen the way we
5 dreamed it up or designed. That's why, as Carla
6 already mentioned, in a different light, as we
7 use the system or as we use the program, we keep
8 developing it, because we just get rid of all
9 this extra nuts and bolts.

10 And I think Carla was on a slide where
11 she wanted to tell us about, and we can see the
12 dynamic and the number of days it takes to
13 process fully developed claims. Remember, the
14 goal was 90 days and I'm on slide 4. Carla was
15 telling us about the 90-day goal.

16 MS. RIDDICK: Yes, one slide is the
17 number of receipts that we receive, so I put --

18 DR. VVEDENSKAYA: No, this one is
19 Number 3. You wanted to go over the data.

20 MS. RIDDICK: Yes. So I put fiscal,
21 like I said, spend from 2009/2010, but I wanted
22 to show you from 2013, '14, on, how much it has

1 increased over time. So basically, in 2013, it
2 started out, it had a very small number, so as we
3 -- like I said, the VSOs potentially made the
4 claimants aware of what it is, we have received
5 increased receipts from those.

6 So basically, as of right now, year to
7 date, it shows that FDCs make up 51 percent of
8 all total claims. So that's a huge percentage
9 compared to 2013, which is just 3.4 percent. On
10 the next slide it shows how much -- how many
11 claims have been completed from 2013 until
12 currently.

13 So as you look again at 2013, it shows
14 we only completed 67,000 and with an average days
15 completion of 120 days. Now, as you see in
16 2014/2015, the average ADC has increased, or
17 decreased a little bit, that's because of the
18 number of claims that we have been receiving over
19 time, so we receive, then the ADC will probably
20 go up.

21 Right now, it is at 117, but that
22 doesn't count for the end of fiscal, which the

1 number may probably go up a little bit.

2 MEMBER SAVOCA: When does the fiscal
3 year start? Just remind me.

4 MS. RIDDICK: September --

5 MEMBER SIMBERKOFF: October 1st.

6 MS. RIDDICK: October 1st. I'm sorry.

7 MEMBER SAVOCA: October 1st?

8 MS. RIDDICK: October 1st. Yes.

9 MEMBER FAY: So your objective was 90
10 days and you're currently at 117?

11 MS. RIDDICK: Yes. We're getting
12 there.

13 MEMBER FAY: But you've made
14 significant progress, right?

15 DR. VVEDENSKAYA: And it was, you
16 know, a wave of claims.

17 CHAIRMAN MARTIN: Let me ask you a
18 question, back in September of '13, Christy
19 Greenwall came and briefed us on Fully Developed
20 Claims, and she told the committee that at that
21 time the turnaround goal was 75 days, so now it's
22 90 days officially?

1 MS. RIDDICK: I've always known it to
2 be 90 days. I remember the fast letter that we
3 had, I think it went out June of 2012, it was
4 always 90 days, from what I thought.

5 MS. RIDDICK: That may have been her
6 goal, but I know --

7 (Simultaneous speaking)

8 CHAIRMAN MARTIN: Okay, 90 days. Got
9 it.

10 MS. RIDDICK: So you may ask, what
11 steps or what's next for the FDC program? What
12 are we trying to do to improve this whole
13 project? But I think to improve the veteran's
14 experience with it, the C&P examination process,
15 is what we're trying to bring in, we're trying to
16 revamp the FDC. So compensation service in VHA
17 are leading a project called the Ready for a
18 Decision Project.

19 And this project is one of the
20 Secretary's 12 breakthrough initiatives that we
21 are implementing. So basically, the Ready for a
22 Decision claim has to meet the following

1 criteria, as outlined on the slide. It has to be
2 a Fully Developed Claim. And what this will
3 entail is, no additional development is needed.

4 And I know with the FDC that we still
5 do a little bit of development, which requires,
6 like, a medical examination or getting federal
7 records. With the RFD, everything has to be
8 submitted at that time. The exception is, we can
9 go out and get a medical opinion if it is
10 determined that it is needed.

11 But in order to be in the Ready for a
12 Decision, it has to be a full FDC with no
13 additional requirement. And also, you have to
14 include medical evidence sufficient for rating
15 purposes, which would include a DBQ referral
16 program, complete private use DBQ, and treatment
17 records, which will fulfill the requirements of
18 that.

19 Now Ashley, I have recently joined
20 this team with the RFD project, co-leading with
21 her, along with one of my other co-workers, she
22 knows a little bit more. She can explain the RFD

1 project, from a VHA perspective, exactly what's
2 our goal, our next steps, in trying to make this
3 project pilot succeed.

4 MEMBER BROWNE: This is VHA and VBA
5 working together.

6 MS. RIDDICK: Yes, working together.

7 MS. HANAHAN: One of the challenges
8 with the FDC project, one of the things she
9 mentioned is about records or getting DBQs
10 completed, and one of the challenges in VHA is
11 with veterans bringing DBQs to the clinic to the
12 VHA and asking for the DBQ to be completed. Part
13 of it relates to time. They can barely make it
14 to the primary care, you know, with all the
15 medications, labs, other things that need to be
16 done, and now there's a form that needs to be
17 completed.

18 Part of it relates to in private
19 sector, you've mentioned -- touched on some of
20 the issues, payment for providers, time for
21 providers, so forth. So how can we get a DBQ
22 completed for a veteran?

1 And so in VHA, we established a self-
2 referral DBQ claim process so that if a veteran
3 has a DBQ, they need help with completion for
4 filing or in support of filing a claim, a veteran
5 can actually call us to be seen in a C&P clinic
6 to get assistance with that DBQ being completed.
7 Now, there are a few exclusions to the program
8 for a variety of reasons.

9 For example, military sexual trauma
10 was one that was discussed. These are things
11 that need to be in compliance largely with the
12 FDC process, so there are certain conditions that
13 may be excluded, but by and large, certainly, the
14 musculoskeletal claims, which were a huge
15 component of the workload we do, presumptives,
16 like Agent Orange related claims, for example,
17 are all things that we can do at a self-referral
18 DBQ clinic.

19 So a veteran can contact us and make
20 an appointment to be seen in a pretty quick
21 manner, seven days, ten days, something to that
22 effect, depending on the provider that they might

1 need to see. We can complete the DBQ for them,
2 have access to the VHA records, to VMS, to look
3 through their STRs, service treatment records,
4 that are scanned and so forth.

5 The idea then is that we can help the
6 veteran submit everything to Ready for a Decision
7 so that that can help to expedite adjudication on
8 the claim. So a couple things that we're working
9 on on this project are, we've learned in
10 Baltimore, which is my home, VA Maryland
11 Healthcare System, aka Baltimore, when we first
12 started with this process, we kept a homegrown
13 spreadsheet, if you will, a list, an Excel
14 spreadsheet, of all the veterans that were going
15 through our clinic just to kind of track, you
16 know, what happened with their claim.

17 Did it work? Did it make it faster
18 for them? That kind of thing. And we found
19 that, actually, only about 40 percent of the
20 veterans that were going through our program
21 actually ever even filed a claim, so we got a
22 little information there. Learned that some

1 veterans thought that just by coming and getting
2 a DBQ, that that filed a claim and that that
3 launched a claim. They didn't understand that
4 they needed to file the EZ paperwork, go on
5 eBenefits, or so forth.

6 So one of the keystones of our project
7 is actually leveraging the partnership with the
8 VSOs. So we have Veteran Service Organization
9 presence in our clinic at least once a week and
10 also in our medical center to actually work one-
11 on-one with veterans to help them learn about how
12 to file a claim.

13 The other aspect of it is somewhat of
14 an IT solution. So we learned that in this case,
15 a lot of claims were submitted as an FDC, but the
16 VBA was having difficulty actually identifying
17 these claims in the IT world, or in the IT
18 universe. Just some of the things that we have
19 implement or changes in the IT solutions to
20 create what we call flashes, and you can speak to
21 that better than I can as a VBA person, but
22 helping the VBA to identify these claims so that

1 they can work quickly adjudicating them.

2 So that's just kind of a quick
3 snapshot, but we're excited to work with VBA on
4 this and help veterans.

5 MS. RIDDICK: Now, as Ashley has
6 stated, this is going to start as a pilot program
7 at the Baltimore regional office with, I believe,
8 two C&P clinics?

9 MS. HANAHAN: Correct. That is Fort
10 Mead and Loch Raven. Yes.

11 MS. RIDDICK: And we are hoping to
12 kick this off for April 4th.

13 MS. HANAHAN: 4th. Yes, April 4th.

14 MS. RIDDICK: With a national rollout
15 date of December, correct?

16 MS. HANAHAN: That is correct.

17 MS. RIDDICK: December 16th. This is
18 something new. This is something that we're
19 trying to provide. Hopefully, like Ashley was
20 saying, the overall objective is basically to get
21 -- make veterans aware of the DBQ referral
22 program or if they want to use the private use

1 DBQs, they can do that, because I don't think a
2 lot of those are being utilized, as you all have
3 stated before, and so we're trying to get --
4 that's some of the things that we're trying to
5 leverage within the FDC or the RFD program that
6 will hopefully be helpful to them.

7 And we're trying to process these
8 claims in -- instead of 90 days, we're trying to
9 process these claims in 30 days and under, which
10 would mean quicker decisions, faster decisions,
11 for them.

12 MS. HANAHAN: I just want to say one
13 thing about records, because I've done Enterprise
14 with primary care as well, very difficult getting
15 copies of records on veterans if they're seen at
16 other hospitals and things like that.

17 And so, partly, for me, it's not just
18 having the DBQ completed, it's really just even a
19 copy of a recent progress, you know, or a
20 discharge summary from a hospital, or something
21 like that, that a VHA commission can use that
22 information to complete a DBQ by a process we

1 call acceptable clinical evidence, or ACE, so
2 sort of a chart review, you know, for lack of a
3 better term.

4 And most VHA sites now have clinicians
5 assigned to the VBA, we have two clinicians that
6 are assigned there, so that if the VBA can get
7 records on a veteran, we can actually, in a very
8 short period of time, same day, next day,
9 whatever, having seen the clinician, complete the
10 DBQ to what extent they can, or maybe sometimes
11 it's in its totality, so that the claim can be
12 rated in a very short period of time.

13 I mean, even far less than 30 days, I
14 would say.

15 MS. RIDDICK: Ten days. We're trying
16 to get the goal to ten days for most of those
17 claims; ten days or less.

18 CHAIRMAN MARTIN: Two questions. We
19 had once before, talked a little bit about the
20 rating decisions in Fully Developed Claims versus
21 standard claims for the same medical condition.
22 Now, theoretically, they should be exactly the

1 same, is that what you're seeing when you look at
2 the data? Are you still seeing that similarity
3 for the same condition, whether it's an FDC or a
4 standard processing?

5 MEMBER SIMBERKOFF: The criteria for
6 getting a certain rating are not different.

7 CHAIRMAN MARTIN: Right. Criteria is
8 the same.

9 DR. VVEDENSKAYA: Oh, yes, different
10 process, same criteria.

11 MS. RIDDICK: Yes.

12 CHAIRMAN MARTIN: But is the VA sure
13 that's, in fact, the case?

14 MS. RIDDICK: We have -- I think there
15 is data that is out there that shows that, like,
16 I would have to get that to you, but I think,
17 like I said, it is the same process.

18 CHAIRMAN MARTIN: I think it was a
19 quality --

20 MEMBER SIMBERKOFF: They actually do,
21 you know, center-to-center reviews to ensure
22 quality assurance.

1 CHAIRMAN MARTIN: And the other issue
2 is, maybe you can comment about what happens to a
3 claim that's returned either for more information
4 or determined not to be fully developed?

5 MS. RIDDICK: So in those instances,
6 when those claims do not meet the FDC criteria,
7 we still process those claims, but it's processed
8 under the traditional claims processing. So
9 basically, the difference in the FDC, the
10 traditional claim process, means that there is
11 longer delay time in that, so instead of being
12 processed in 100 days, it's going to be extra 30
13 days or 45 days process attached to that claim.

14 CHAIRMAN MARTIN: So from a nuts-and-
15 bolts standpoint, is the claim returned to the
16 individual to submit it as a standard or is
17 electronically just transferred over?

18 MS. RIDDICK: No, we send them a
19 notification letter telling them that your claim
20 is going to be excluded from the program because
21 of such -- additional evidence is needed or
22 further development is needed. So if it is

1 determined that we need additional evidence or
2 further development is required, we will send
3 them a notification letter informing them of
4 that, but we do notify them that their claim is
5 going to be processed under the traditional
6 claims processing instead of the FDC.

7 CHAIRMAN MARTIN: Got it.

8 MS. HANAHAN: Meaning they don't have
9 to re-file, it's just going to --

10 MS. RIDDICK: No, they don't have to
11 re-file. It's just --

12 CHAIRMAN MARTIN: That's what I was
13 getting at. Thanks.

14 MS. RIDDICK: Sorry.

15 DR. VVEDENSKAYA: Moves to a different
16 desk.

17 MEMBER BROWNE: Just telling them so
18 that they can anticipate that it's not going to
19 take 90 days.

20 MS. RIDDICK: Yes, it's not considered
21 a priority claim.

22 CHAIRMAN MARTIN: Okay. What other

1 questions do the committee members have?

2 MEMBER ROBERTS: For those claims that
3 are not fully developed, is the information
4 mostly because of something the veteran didn't do
5 or something somebody else didn't do and if
6 there's something the veteran didn't do, how do
7 you get him or her to fill out the claim; do what
8 they need to do?

9 MS. RIDDICK: I think on the last
10 meeting I was in, I showed you data that showed
11 what were the most reasons the claim was excluded
12 from the FDC program, and I think one of the
13 highest number that showed was we need evidence
14 from, I think it was, a non-medical provider --
15 non-federal facility, so I think that was one of
16 the most common ones versus any other exclusion
17 reasons that we use.

18 So in that case, like I said, we ask
19 the VSOs to get involved and educate them the
20 next time on the process of submitting everything
21 all at once instead of submitting at one point in
22 time, then another two weeks later, they may

1 submit something else, but the exclusion reason,
2 like I said, needs non-federal evidence, is our
3 most common reason that most claims are excluded
4 from the program.

5 CHAIRMAN MARTIN: Is your office --

6 MS. RIDDICK: And they could be for
7 many different reasons.

8 CHAIRMAN MARTIN: Has the FDC office
9 grown in proportion to the increase in demand?

10 MS. RIDDICK: I believe it has. Like
11 I said, we formed a workgroup because of the, I
12 think, one-year retroactive, we received a whole
13 bunch of claims, I'm not sure about the number,
14 but we see the -- I think that's probably why we
15 see the influx in the numbers that we received
16 because of the one-year retroactive, which will
17 provide an incentive to the veterans, you know,
18 to submit their claims between 2013/2015, which
19 is no longer a program now.

20 But because of that initiative and the
21 benefit of them receiving a whole one year retro
22 back from the time that they received the claim,

1 that was an influx of FDCs that we did receive
2 because of that. Hopefully with the RFD, we'll
3 get the same success that we received from the
4 FDC program as well as education because of
5 making them aware of what is available to them.

6 CHAIRMAN MARTIN: Okay. Hal and Tim,
7 do you have comments about FDC?

8 MEMBER BIRD: None from Hal.

9 MEMBER ROBERTS: Is it worthwhile to
10 have the VA, through the Secretary, to ask
11 Congress to authorize payment of private
12 physicians that they need additional information
13 in order to fill out the forms necessary to
14 complete the adjudication?

15 MS. RIDDICK: I assume it has to go
16 through Congress, has to be a mandate through
17 Congress.

18 MS. HANAHAN: I think that's a tough
19 question to answer, but I think that part of it,
20 I mean, I would imagine. To me, it's akin to
21 travel pay. Okay. So we pay veterans, we
22 reimburse them for the travel expenses to a

1 claim, for example, related to this one. Should,
2 maybe, a veteran be reimbursed if they provided a
3 receipt, the doctor charged, I'm just saying, you
4 know, me \$40 for copies. Something like that.

5 MEMBER SIMBERKOFF: Yes. Why not pay
6 the -- a better solution would be to pay the
7 doctors directly. But again, I think it requires
8 a change in whatever rules or authorization we
9 have in Congress.

10 MS. HANAHAN: It was interesting, I
11 was in the doctor the other day myself, sitting
12 on the exam table there was a sign in front of me
13 that said, "\$10 for any forms to be completed",
14 and that was a general populous community of
15 physicians.

16 MEMBER SAVOCA: That's cheap,
17 actually, if that's their price.

18 MS. HANAHAN: Right. So if that's
19 like a school physical, yes, she's had a flu
20 shot, you know, whatever, but --

21 MEMBER SIMBERKOFF: So if you get a
22 flu shot and you need a certificate for if you

1 got a flu shot, 10 bucks?

2 MS. HANAHAN: Yes, \$10.

3 MEMBER SIMBERKOFF: The flu shot is
4 free, but --

5 (Simultaneous speaking)

6 MEMBER BROWNE: I think in terms of
7 answering your question, Dr. Roberts, I think,
8 for the Secretary to take this to Congress to
9 have that put into the budget, really is going to
10 depend upon what priorities he has listed. In
11 the whole scheme of the VA, where does it fall in
12 the list of priorities of paying an outside
13 provider to fill out a form?

14 MEMBER GRANGER: And then also, what's
15 the magnitude of the issue?

16 MEMBER BROWNE: Yes.

17 MEMBER FAY: So the way we could
18 approach that would be, problem is that there's
19 an excessive delay in processing the claim. The
20 solution to that is provide X number of dollars
21 that will, therefore, expedite the amount of, you
22 know, medical records that will be expeditiously,

1 you know, transferred to the VA and then we'll
2 get your 90 days.

3 So if you want all the complaints to
4 stop, Congress, this is what you got to do in
5 order to --

6 MEMBER BROWNE: Yes. But as I said,
7 in his budget, he's going to have to prioritize.
8 Is military sexual trauma going to out-rate that?
9 Is whatever? And it's going to go -- and how big
10 is the problem? And then you get it over there
11 and so he can go and see, you know?

12 It's okay to ask it, but I think you
13 got to -- you know, if you get something back and
14 say that came down to Number 75 on my list of
15 250.

16 MEMBER SIMBERKOFF: That's right. And
17 if we pay only the top ten.

18 MEMBER FAY: Or Congress inserts it as
19 your Number 2. I mean, Congress inserts stuff
20 all the time and so there are two ways to get it
21 done.

22 MEMBER SIMBERKOFF: So be careful what

1 you ask for.

2 MEMBER FAY: Oh, yes, which is what I
3 say, you know, is it going to be this group's
4 recommendation? Be careful about it.

5 MEMBER GRANGER: Yes, that would be
6 authorization without appropriation. Hey, I need
7 authority to do it. Authorization without
8 appropriation. I'd be glad to do that.

9 MEMBER SIMBERKOFF: And the reality is
10 that the VA has invested a substantial amount in
11 people like you to do C&P exams, you know, in-
12 house, and basically, provided a huge amount of
13 training so that they do it properly. So one of
14 the advantages of somebody who knows what they're
15 doing is that they've gone through the training
16 and, you know, they fill it out in a way that is
17 unambiguous.

18 MEMBER GRANGER: Right.

19 MEMBER SIMBERKOFF: Whereas, you know,
20 if you ask other people to do it, even primary
21 care doctors in VHA, you know, they have not gone
22 through the training and, you know, it's not

1 always intuitive of what the correct way of
2 filling the form is.

3 MEMBER FAY: But isn't, and I don't
4 know, some of this issue connected to the VA says
5 that, you know, so far you have not made your
6 claim, and then the veteran goes back and says,
7 but my doctor says this, this, and this, and then
8 the VA says, okay, well, get me the doctor's
9 record to confirm that.

10 MEMBER SIMBERKOFF: Right. And it's
11 very easy, speaking as a doctor, to tell this,
12 yes, you should be service-connected for this,
13 that, and the other.

14 (Simultaneous speaking)

15 MEMBER FAY: I get that, but isn't
16 that part of the delay, the fact that then it
17 goes back to the doctor not providing that
18 medical record where he said to the veteran, oh,
19 this should be service direct, which goes back to
20 why are they complaining so much, right? They're
21 complaining because the VA hasn't paid it and my
22 doctor says I should get this, right?

1 And so therefore, the core of the
2 issue is, that doctor to say that in writing, and
3 then ultimately, VA can say no anyway, and that
4 ends the claim, right?

5 MEMBER SIMBERKOFF: But the reality is
6 that 99 percent of the doctors, not just outside
7 the VA, but in the VA, you know, have no idea of
8 what service connection really means.

9 MEMBER BROWNE: So even if they say
10 it, they don't have a clue.

11 MEMBER SIMBERKOFF: You know, so if I
12 tell you that a patient is service connected for
13 diabetes, and he has kidney disease, you're going
14 to say, well, he's service connected for the
15 kidney disease. He's not. Or if he has retinal
16 disease. He's not. Even though we all know that
17 diabetes causes, you know, kidney disease and
18 retinal disease.

19 MEMBER BROWNE: But if he kept his
20 diabetes in control, perhaps the rating in those
21 complications --

22 MEMBER GRANGER: What do we say, less

1 likely than not.

2 MEMBER BROWNE: Yes.

3 MEMBER GRANGER: Yes.

4 MEMBER BROWNE: So it's not as one,
5 two, three.

6 DR. VVEDENSKAYA: Like Dr. Simberkoff
7 is saying, not every physician is C&P examiner.
8 Yes, not every physician is --

9 MEMBER FAY: I was just surprised by
10 the comment that, even within the VA, that
11 they're not.

12 DR. VVEDENSKAYA: Well, because
13 they're treating physicians. They are not
14 forensic experts.

15 MEMBER SIMBERKOFF: And all we have to
16 -- see, we know what -- we have to checkoff every
17 time we see a patient whether what we're seeing
18 them for is service connected or not, and we can
19 look up and see whether they're service
20 connected, but what you think they're service
21 connected for versus what it is are two different
22 things.

1 MEMBER GRANGER: It's the same thing
2 in DoD. We have certain doctors, if you go to
3 this clinic, you're going to get your medical
4 evaluation done. They're trained to do those
5 only. So you'll be seen by the gastrointestinal
6 specialist, and they'll grab what the
7 gastrointestinal specialist said, when you go to
8 that medical evaluation board clinic, they are
9 trained and then grab that data from there and
10 put it in a format that it can be adjudicated,
11 not the GI doctor.

12 I just fill out the consult, all
13 right. It's the same thing in all the systems.
14 It's the same thing if you're in the private
15 sector. You're doing a Social Security
16 evaluation exam, which I've done before, they
17 want you to put down the facts. Here's a form,
18 put down the facts. They have adjudicators of
19 their own.

20 DR. VVEDENSKAYA: Service connection
21 is medicine plus the rest of your life.

22 MEMBER GRANGER: That's right.

1 DR. VVEDENSKAYA: Military and non-
2 military. Examination of medical records is a
3 requirement for the C&P examiner, medical doctor,
4 you have to examine it and you have to check a
5 box, yes, I examined every piece of military
6 record this person has and I examined that person
7 and my opinion is that this corresponds with
8 that, or this is a result of that, or it's not.

9 CHAIRMAN MARTIN: Around the room,
10 questions? Comments?

11 MS. PARK: Yes, there's been a lot of
12 discussion, too, about all the things that we
13 sponsor. And I'm wondering if that's a topic
14 that this committee is going to be exploring.

15 CHAIRMAN MARTIN: Actually, it's a
16 topic that we are interested in and we discussed
17 it several times.

18 DR. VVEDENSKAYA: Yes, appeals and
19 claims, two different areas with experts on both
20 sides, and tomorrow, we'll have a chance to --

21 MS. RIDDICK: I think she's talking
22 about the fully developed appeal, so that's --

1 you know, the appeals versus fully developed
2 appeals.

3 DR. VVEDENSKAYA: Yes, yes, no,
4 appeals and claims, it's just two different
5 stuffs.

6 CHAIRMAN MARTIN: I actually just saw
7 that when I was looking back over our previous
8 meetings, but it is a topic we discussed and
9 we're interested in learning.

10 DR. VVEDENSKAYA: I just didn't want
11 you to address appeals because you're not -- you
12 are the claims person.

13 MS. RIDDICK: This initiative, I
14 think, is also one of the 12 breakthroughs that
15 they're trying to get down as part of the claims
16 initiative process, appeals initiative process.

17 CHAIRMAN MARTIN: Out there in telecon
18 land, any other comments or questions?

19 MEMBER BIRD: None here.

20 CHAIRMAN MARTIN: Okay. Thank you
21 very much.

22 MS. RIDDICK: Thank you for having me.

1 CHAIRMAN MARTIN: Just a moment here
2 until our next speaker arrives. Just a reminder
3 to the committee, everything during the meeting
4 is transcribed and when we talk over one another,
5 it's almost impossible for that transcription to
6 be transcribed, so just bear that in mind as we
7 have our lively discussions.

8 DR. VVEDENSKAYA: Ladies and
9 gentlemen, I think our next presenters are ready
10 for their briefing. Please do introduce
11 yourselves. Thank you very much for coming.

12 MS. CRENSHAW: I am Anna Crenshaw. I
13 am the Assistant Director at the Benefits
14 Assistance Service for Policy, Procedures, and
15 Outreach, or we just named ourselves Special
16 Interests and Outreach, whatever you call it,
17 it's just outreach, and I have with me my
18 Homeless Program Manager, Erin Gittens, and the
19 alternate, Zanetta Miell.

20 And thank you for inviting us and
21 having us to speak with you today.

22 CHAIRMAN MARTIN: Thank you for

1 coming.

2 MS. CRENSHAW: She was very
3 persistent. She would not let me get off that
4 phone until I committed to a date or a time.

5 MEMBER GRANGER: We thought you
6 volunteered.

7 MS. CRENSHAW: I mean, we love to do
8 what we do, information is power, and I think
9 even more powerful when you share that
10 information, so I hope what we have to say today
11 can help you in what you're doing, and I know
12 what you're doing is very, very important, so any
13 information we can share that could help you with
14 that, we're happy to do it.

15 We're both veterans, pretty much our
16 entire staff are veterans, and certainly, my
17 family members and my first immediate family are
18 all either serving or veterans, so what you're
19 doing is very, very important.

20 Okay. In front of you you do have a
21 copy of the briefing in front of you. Let's see
22 if she can find the one that just came in. Did

1 you send it to her today? Oh, there it is.

2 Briefings. The very next one. Right there.

3 And I am just going to start off, I do
4 have another call at 3:00, but Erin will take
5 over and, you know, finish up. Are you guys here
6 all week, ladies and gentlemen? Okay. Got you.
7 All right. No offense intended. So like I
8 stated, we work for, as you know, VBA, we're all
9 VBA, but we work at the Benefits Assistance
10 Service.

11 The Benefits Assistance Service falls
12 under the Deputy Under Secretary for Disability
13 Assistance. It was stood-up in May of 2010. We
14 used to be a part of compensation. And it was
15 stood-up for the purpose of doing public contact
16 and outreach in those things that did not
17 directly relate to, you know, claims processing.

18 So part of what -- I work for my SES
19 Director is Rob Reynolds, in case some of you may
20 know who he is, but the Benefits Assistance
21 Service has several programs, and I'll start off
22 with mine, because I believe that to be the best

1 and the most important, and it is the Outreach
2 and Special Emphasis Program, which governs and
3 military outreach, special emphasis programs,
4 policies, and oversight, and then we have Web
5 communication and social media business
6 application.

7 So we have Web and social media. We
8 also manage the eBenefits and the SEP Portal, and
9 for those of you who don't know the acronym, the
10 SEP Portal is the Enterprise Portal, Stakeholders
11 Enterprise Portal, for veteran service officers
12 and the ORT, which is the Outreach Reporting
13 Tool.

14 The VBA template and so they kind of
15 govern all of our social media, our Twitter, and
16 things of that nature. They say that they are
17 the VA's Web team, which, they are. There is a
18 Web site at each of the ROs that they kind of
19 govern to, so each of the 56 ROs, and even those
20 at the VA, there's really 56 that we have
21 oversight for.

22 And then we have site visit, quality,

1 and training, and the site visits, we make those
2 site visits with our team to make sure that the
3 public contact, operations of the public contact,
4 the call centers, and anything underneath our
5 purview is being managed, and implemented, and
6 followed correctly.

7 And then we have quality review team,
8 they manage the quality of the call center, and
9 we're expanding that for quality in the public
10 contact team. That's something that's in
11 development right now, and they do all the
12 training curriculum for all of the public contact
13 teams and the national call center staff.

14 And then our front office is pretty
15 busy and robust as well. That's where our
16 veteran service officer liaison resides and we
17 have a public and private partners liaison, and
18 we have our benefits executive council, which
19 better known as the BEC, liaison.

20 And so my program, which are just
21 special interests program, we have military and
22 veterans programs outreach, and that outreach

1 falls upon them. We provide direct assistance,
2 we coordinate with VA partners, and we also
3 coordinate with external stakeholders, so
4 essentially, you can say we do do a lot of
5 networking, coordination, collaboration, in
6 partnering with both private and public entities.

7 And so I'll go over just a few of our
8 -- if I'm going too fast, let me know. So at the
9 top, because this is what you're interested in,
10 one of our programs does involve veterans. We
11 also have women veterans, we have former prisoner
12 of war, minority veterans, elderly veterans,
13 rural veterans, tribal veterans, I know you guys
14 can read, but I like to hear the sound of my
15 voice, so bear with me, faith-based and
16 neighborhood partnerships.

17 We also have the lesbian, gay,
18 bisexual, and transgender veteran program.
19 That's something new that we implemented due to
20 the legislative changes. We have our overseas
21 military service coordinators. Those are
22 military service coordinators that operate

1 overseas. We have seven. They operate in EUCOM
2 and in PACOM, and in Europe, they are in -- we
3 have two in Germany, one in U.K., and one in
4 Italy.

5 And they rotate either -- in Germany,
6 they're on 90-day rotations due to some SOPA
7 issues that we're experiencing, and in Japan,
8 they rotate for six months at a time, and they're
9 in Okinawa, Yokosuka, and Iwakuni.

10 And then we have our OIF/OEF, which,
11 that's going away, so we're, actually, that's now
12 being implemented under Office of Care and
13 Communications, kind of a more integrated office.
14 We have casualty assistance, we have our
15 transition assistance advisors working with the
16 Guard and the Reserves, we have the Army Wounded
17 Warrior, the Marine Wounded Warrior, we have our
18 recovery care coordinators, our Yellow Ribbon
19 Reintegration Program, and our education
20 disadvantaged.

21 So as you can see, my staff is pretty
22 busy and each one of those programs are actually

1 a program. We also have tribal, that I didn't
2 see that on there, but we do have tribal outreach
3 as well. So this is where I'll let -- I just
4 wanted to let you know a little bit about what we
5 do at the Benefits Assistance Service to let you
6 know that the homeless outreach is one of the
7 programs that we have and it connects with
8 several of the other programs because in each of
9 those special emphasis group, if you notice,
10 there are women, there are rural, any of those
11 special emphasis group, you can almost associate
12 homeless with because there are going to be some
13 veterans that fall into that homeless category
14 out of all of those special emphasis.

15 So our homeless outreach is very, very
16 important to us. We put a lot of attention into
17 it, we put a lot of effort into it, we strive to
18 come up with policies and procedures that will
19 make our homeless outreach better. Are goal is
20 steadily on reducing that target population. We
21 hope not to have any. We know that that may be
22 unrealistic, but we do work very, very hard.

1 And we ensure that no matter what
2 time, day or night, that if we get a critical
3 case where someone is homeless, then we're going
4 to address that. You know, I have my BlackBerry,
5 all of my analysts have cellphones, and in our PD
6 actually, it says, you may be required to work
7 night, weekends, and holidays, so even though
8 they have core hours, some of our programs,
9 because of the nature of it, does require after-
10 hours care, especially when someone is trying to
11 be placed into a home and you get the call, you
12 just start to work on it.

13 And from there, I think Erin will go
14 into her program and I'd like to hear that brief
15 myself, so I'm going to sit over here, Erin.

16 MS. GITTENS: Okay. Well, good
17 afternoon, everyone. It's starting to get a
18 little air conditioning in here. Good. Okay.
19 So the Homeless Veteran Program, Title 38
20 outlines the Homeless Veteran Program standards
21 that we must follow. So I was just going to
22 discuss that it outlines the staffing outreach,

1 the program requirements, and the definition of a
2 homeless veteran.

3 The definition of homeless veteran,
4 while it's outlined under the McKinney-Vento
5 Homeless Assistance Act, VBA has expanded this
6 and made it a little bit more liberal, and that
7 does affect how we handle compensation claims,
8 which I'll get to in a minute.

9 So for staffing, each regional office
10 has a designated homeless veteran coordinator.
11 That can either be a homeless veteran outreach
12 coordinator, or a homeless veteran claims
13 coordinator, or some offices can determine that
14 they have both or even more than two, but there
15 will be at least one full-time homeless veteran
16 coordinator, either an HVOC or an HVCC, in the
17 regional offices that the Secretary deems to have
18 the highest homeless veteran population.

19 And the current ones that have those
20 are listed here, there's 20, but this regional
21 office dedication was done in 2010, so we are
22 looking at to revise the regional offices that

1 would need a full-time homeless veteran
2 coordinator this year.

3 Several of these stations have worked
4 very diligently and some of their cities have
5 declared that they are homeless free, that they
6 have ended veteran homelessness.

7 MEMBER SIMBERKOFF: They're homeless-
8 less.

9 MS. GITTENS: They're homeless-less.
10 The definition of ending veteran homelessness, I
11 know a lot of people think that that's completely
12 unrealistic to end homelessness, but really what
13 that means is that you're at functional zero. So
14 if you were to get a homeless veteran to walk
15 into any -- you'll get a referral or walk into
16 any VA facility, you would be able to place them
17 in stable housing within 30 days.

18 So if you are able to meet that, if
19 you have more beds than you have homeless people,
20 and you can place somebody within 30 days in
21 permanent housing, then you are -- you're at
22 functional zero, so that's what that means.

1 MS. CRENSHAW: So for VBA, for our
2 purposes of working the claim, even though they
3 may get housing, we still process their claim,
4 and so a lot of those, we work hand-in-hand with
5 VHA, so in terms of how the 20 full-time HVOCs
6 were first established, if you look at that now,
7 even though they may be functional zero, there
8 still may be claims at those ROs that continue to
9 be expedited in terms of working the disability
10 piece.

11 So they'll look at that and say, well,
12 some of these may have no claims. That's not
13 what she means there.

14 MS. GITTENS: Right.

15 MS. CRENSHAW: She's focusing on the
16 housing part.

17 MEMBER GRANGER: The housing piece.

18 MS. GITTENS: Right. So we will
19 continue to get folks that are at risk of
20 homelessness or are chronically homeless, and
21 they will continue to have claims in our system,
22 so it's whether or not we can get to a point

1 where we're -- that they will not be in that
2 category that have the highest number of homeless
3 veterans anymore. That's the goal.

4 But yes, we also flag claims that are
5 formerly homeless or at risk for homelessness and
6 expedite those as well. It's not just if you're
7 currently homeless.

8 So for outreach, Title 38 tells us
9 that we need to have homeless veteran
10 reintegration programs. We have several veteran
11 reintegration programs, we work with incarcerated
12 veterans so that they are integrated back in and
13 are not at risk for homelessness. We also work
14 with homeless women veterans and homeless
15 veterans with children to reintegrate them, as
16 well as substance abuse recovery, folks that are
17 going through substance abuse recovery, when they
18 are reintegrated, they are at greater risk for
19 homelessness as well. And transition service
20 members. Correct.

21 MS. CRENSHAW: That's a piece that
22 we've started to -- we talked about this, so I'm

1 not interrupting her briefing. We talked that we
2 would just kind of tag team and I would be
3 chipping in. What we are doing with the
4 transition GPS, we noticed that as service
5 members are coming out, not every service member
6 come out of the military and have a place to go
7 back to.

8 And so knowing that, we are working
9 really closely with IMCOM and Soldier for Life,
10 and developing programs that will -- where DoD
11 can actually start identifying some of these
12 young men and women that are getting out and they
13 really don't have a home to go back to. So even
14 with the money that they're transitioning out
15 with, or whatever, they're going to be on the
16 street within 90 days if we don't do something
17 about it, so we're working real, real closely
18 with DoD now to identify something that works.

19 So we're not neglecting the
20 transition, we're not waiting until they become
21 homeless and start doing something, we want to
22 put in some preventive measures with DoD to

1 ensure that service members will not be homeless
2 when they transition out.

3 MS. GITTENS: There's also a plan to
4 reduce, eliminate veteran -- reduce or eliminate
5 veteran homelessness at every regional office, we
6 coordinate outreach activities targeting homeless
7 veterans or at risk for homelessness, and provide
8 outreach and plan oversight.

9 Program operations under Title 38.
10 There's grants, grant per diem, and
11 appropriations that are outlined. Many of these
12 are owned by VHA and some of them are owned by
13 VBA, but there is a lot of overlap and
14 collaboration under each of these programs.

15 The grant per diem program is handled
16 by loan guarantee, but works very closely with
17 VHA because those are the folks that are
18 referring these veterans and they may be in
19 domiciliary care with VHA and be transitioning
20 into a grant per diem program.

21 We provide training and outreach.
22 That's mostly VBA, but every VHA facility has a

1 homeless veteran coordinator as well and they may
2 do outreach. Treatment and rehabilitation. We
3 ensure -- I'm going to get into the VA
4 overarching programs that cover treatment and
5 rehabilitation in a minute, we provide housing
6 assistance, and loan guarantee.

7 If somebody has a VA loan and they are
8 at risk for homelessness, we will work with the
9 lender to try to get them to avoid foreclosure.
10 So on a national level, the outreach that we do,
11 we attend national conferences with the housing
12 coalition, the National Coalition for Homeless
13 Veterans, and we provide that training.

14 We get folks from each district, used
15 to be areas, now they're districts, so we get
16 folks from each district to participate in those
17 national conference trainings to bring them back
18 to their districts. We participate in stand-
19 downs. Stand-downs are like kind of a one-stop
20 shop for homeless veterans or folks that are at
21 risk for homeless veteran. They can get
22 information and services on the spot.

1 Sometimes they can even get claims
2 rated on the spot, but they can get healthcare
3 eligibility requirements, all of that sort of
4 thing at a stand-down.

5 We participate in point-in-time counts
6 with HUD. Point-in-time counts are what we base
7 our homeless numbers off of, so usually in
8 January, in every major city, folks go out and
9 canvas the neighborhoods as sort of a homeless
10 census and ask folks if they have a place to stay
11 tonight, and take their demographics, so that's
12 how we know how many homeless veterans we have on
13 any given night.

14 We have homeless veteran outreach
15 coordinators and homeless veteran claims
16 coordinators. Like I said, in every regional
17 office they will have at least one or the other
18 in the 20 regional offices that have been
19 identified as having the highest number of
20 homeless veterans. They will have a full-time
21 person dedicated to those.

22 MS. CRENSHAW: And something else too,

1 we also work with state and local government. We
2 work, like here, for instance, closely with the
3 D.C. Mayor Office. They have a veterans
4 representative in almost every local government
5 entity now because I think somebody woke-up and
6 said, oh, we really need to start taking care of
7 our veterans. And so they started placing
8 veteran liaison and veteran representatives in
9 different governmental agencies.

10 So we work with them and we work with
11 our 58 homeless veteran outreach coordinators, or
12 our HVCCs, to work with their local and state
13 governments as well so that they are not just
14 focusing on the big things. They're really
15 dealing with, you know, those individuals that
16 are in the community and they know all the places
17 that they meet, so we do a lot of training.

18 And we send them to training that they
19 identify to us that they need, to attend a
20 conference, or they need to attend some training,
21 then we will get our funding, and if it's
22 feasible, try to make sure that the fields are

1 able to attend those training things that are
2 pertinent to their geographic area.

3 MS. GITTENS: Okay. So at the
4 regional office level, like Anna said, there are
5 lots of outreach events that the local regional
6 offices may connect with. What they are required
7 to report to us is shelter contact visits,
8 referrals from VHA and Department of Labor, or
9 other local non-profits, and local events, stand-
10 downs, and outreach hours that they do targeted
11 towards homeless veterans.

12 So just a little data to throw at you,
13 in 2015, there were 1893 contacts with shelters,
14 there were 1654 referrals to other community
15 support and social service agencies made by VBA
16 staff and the public contact teams, local events
17 and stand-downs, the regional office staff
18 conducted 8506 hours of outreach targeted towards
19 homeless veterans, and 46,000 homeless veterans
20 attended outreach events for VBA in 2015.

21 Actually, we get a lot of great ideas
22 from the folks that are working in the field and

1 we try to make sure that we elevate those, and
2 incorporate those, and we got a great idea from
3 New York Regional Office. So the HVCCs or HVOCs,
4 whichever, the homeless veteran coordinators in
5 each regional office are required to make shelter
6 contacts and visits.

7 And the reason that that's a good idea
8 is because we need to know, we need the shelters
9 to know, that if they have a veteran residing
10 with them, that VBA needs to know about it, VHA
11 needs to know about it. There may be funding
12 available through VA that they're not aware of.

13 So New York Regional Office had a good
14 idea to match the current pending claims with the
15 shelter addresses and run a regular report that
16 says, these veterans have a known shelter
17 address, and they have a pending claim, and they
18 have caught several, I think they caught 300 when
19 they first ran the report, 300 claims that they
20 were not aware that these veterans were homeless.
21 Once they did the match, they found out and were
22 able to expedite those claims.

1 So we have worked with PA9, sorry,
2 using acronyms. Does everybody know what PA9 is?
3 Performance Analysis --

4 MS. CRENSHAW: Analysis and Integrity.

5 MS. GITTENS: Okay. Thank you.

6 MS. CRENSHAW: They pull all of our
7 data for us.

8 MS. GITTENS: Yes.

9 DR. VVEDENSKAYA: Data people with a
10 touch of finance in there.

11 MS. GITTENS: Yes. They're the ones
12 that pull all of the compensation data for us and
13 they ran a report, and they're actually able to
14 run it into the systems that the service centers
15 and the claims -- in the offices that handle the
16 claims, they're able to run a report daily, if
17 they want, that matches these shelter addresses
18 with pending claims.

19 So each regional office could run a
20 daily report, weekly report, however often they
21 want to do it, to be able to determine how many
22 homeless veterans they have that are living in

1 known shelter addresses that they may not have
2 been aware of.

3 The other thing that that brings up is
4 that you have to make sure that you've developed
5 a local relationship with your local shelters,
6 and that's something that, really, the field
7 offices have to take charge of.

8 It's very difficult at a national
9 level to know every shelter, every homeless
10 shelter, out there in the country, so we really
11 rely on the homeless veteran coordinators to be
12 out there in the community going to, you know,
13 veteran treatment court, going to their local
14 shelters, developing that relationship with them,
15 to make sure that they know to notify, not just
16 the VHA, but VBA, every time they have a homeless
17 veteran that comes into their shelter.

18 So direct assistance to all veterans
19 on a national level, we have the national call
20 centers, which is the 1-800 number that any
21 veteran can contact at any time to get
22 assistance, we have eBenefits, which I'm sorry, I

1 misspelled on this slide, IRIS is the internal
2 inquiry system, so if somebody goes into
3 eBenefits, they can put in a formal request to
4 make an inquiry, and that goes to the regional
5 office, and then they'll give you a formal
6 answer.

7 Congressional inquiries, if veterans
8 contact their Congressman or woman about their
9 claim, that's handled at regional office, the FAS
10 has oversight of those as well, and social media,
11 we have Twitter and sometimes Facebook town halls
12 for specific questions that we can answer through
13 social media.

14 MS. CRENSHAW: And all the veterans
15 will go on the VA Facebook page and you will --
16 and we have some -- well, we have two bloggers at
17 our office, so they monitor that. You know,
18 that's their job. They just monitor. They do
19 tweet. They have a sweet job, I think, and --
20 they do have a lot of posts, not just the angry
21 ones, and people are frustrated, and it goes to
22 the veteran's experience.

1 You've got veterans that have good
2 experience and veterans that don't have such good
3 experience, so we strive to want every veteran to
4 have that great experience. Unfortunately, it
5 doesn't always work out that way, so you will
6 catch -- and, you know, I never was a social
7 media person. I think I'm past, I used to say
8 past that age, but, you know, because I have kids
9 that are younger, I've gotten a little bit, you
10 know, just snooping on their Facebook page, I got
11 a Facebook page, because I wanted to see what my
12 girls were doing.

13 And so I was actually -- and that's
14 what we do, you know, we monitor those Facebook
15 pages, and veterans will comment. And sometimes
16 we really get some that are suicidal, you get the
17 homeless ones, you get the ones that you can see
18 the desperations in their posts, so we've been
19 able to assist a lot of veterans from what's
20 being posted on Facebook, you know?

21 So it's been -- well, I used to think,
22 what's a blogger? You know, why are we doing

1 this? And then I see the real value in it more
2 and more as I get more familiar with the
3 unfamiliar, which was, you know, social media for
4 me, but I'm a little bit more comfortable with
5 it, but the people that actually monitor those
6 Facebook and respond to them, they do work with
7 the experts and the subject matter experts,
8 they're bloggers, but they don't just go out and
9 provide an answer.

10 They will actually work with subject
11 matter experts to get the answer to respond to
12 them, and some of those we have contacted
13 personally. Now, not all of them you will be
14 able to address because of -- you know, some of
15 them don't have a lot of information on there,
16 but they actually do -- it actually works.

17 MS. GITTENS: Right. And it's a form
18 of outreach that speaks to a certain demographic
19 that may not go to the public contact office at
20 the regional office or may not go to a town hall,
21 but they will go to Facebook. Okay. Next slide.

22 So direct assistance at the regional

1 office, we have a public contact team at each of
2 the regional offices where veterans can come in
3 and get services, anywhere from submitting
4 information for a claim, changing their address,
5 getting assistance and referrals for homeless
6 shelter, or VHA assistance, so again, so more
7 data for you.

8 Regional office personnel assisted
9 22,754 homeless veterans in FY15. Those are
10 visits to the regional office, we conducted
11 direct assistance at outreach events and received
12 4252 claims taken at homeless veteran outreach
13 events, and 143 veterans attending those events
14 were registered for eBenefits.

15 MS. CRENSHAW: And so here, when you
16 start talking about outreach, in every other
17 aspect we want to increase our outreach. We want
18 to increase outreach, but we hope that -- and our
19 goal is, oh, we touched this many veterans in our
20 outreach, but for homeless veterans, we want that
21 number to diminish every year instead of
22 increasing, so it's one of those where, yes, we

1 want to outreach, but we want our outreach to
2 work.

3 So the previous year, so in FY16, we
4 hope that that number will actually be reduced
5 and for us, that would be a measurement of, if
6 we're doing the same outreach and we're doing
7 even more outreach, but we're reaching less
8 veterans, we're hoping that that will, for us,
9 mean there are less homeless veterans and that
10 the data in the PIT count will show that there
11 are not as many homeless veterans as the previous
12 year, and that's our goal there, is to get that
13 number down rather than higher.

14 MEMBER ROBERTS: How many homeless
15 veterans are there in the continental United
16 States?

17 MS. CRENSHAW: I would actually have
18 -- do you have that data on hand with you? Did
19 you bring it?

20 MS. GITTENS: Yes, it's a slide.

21 MS. CRENSHAW: Okay. We're going to
22 get there.

1 MS. GITTENS: So national program
2 coordination, we have national monthly training
3 calls with all of the regional offices. We train
4 on any number of homeless veteran programs, the
5 issues that the regional offices that they need
6 training on, we attempt to provide, we get our
7 VHA partners or even our Department of Labor
8 partners to help provide training for the
9 homeless coordinators that are working this every
10 day in the field.

11 We also provide conferences and
12 trainings for -- we attend ourselves and we also
13 invite those folks from the districts to be able
14 to attend conferences and training. We maintain
15 the Web site for homeless veteran coordinators
16 and outreach coordinators. And we keep the
17 coordinator list, so anybody that is looking for
18 -- if they're VHA or any other of the business
19 lines through VBA, is looking for, who do I
20 contact in Atlanta for this homeless veteran, has
21 one place that they can go to find that
22 information.

1 So each regional office has a plan to
2 expedite homeless veteran claims as part of their
3 regional office plan to eliminate homelessness.
4 During FY2015, we processed 17,710 homeless
5 veteran claims. The national goal for an average
6 days pending for a homeless claim was 75 and we
7 beat that at 71.5 for FY15.

8 And again, that's one of those things
9 that we hope to continue to decrease, but we also
10 hope that that number goes down. We don't want
11 more homeless veteran claims because we want them
12 to be less homeless veterans.

13 Collaboration with the VA partners.

14 So we work with VHA and Department of Labor with
15 the formerly incarcerated veteran program. We
16 work with them to transition formerly
17 incarcerated veterans into the community, we
18 provide education and counseling about benefits,
19 there's also treatment courts that some of our
20 outreach coordinators go to, veteran treatment
21 courts that try to keep veterans from becoming
22 incarcerated, especially if it's an issue where,

1 maybe, they were self-medicating because they
2 have PTSD and they had an alcohol-related
3 incident, if we can keep them out of the justice
4 system and get them into rehabilitation, and get
5 them healthcare, and mental health services, we
6 can avoid having an incarcerated veteran.

7 VBA also provides honor and dignity to
8 deceased veterans that may not have any family
9 members that remain unclaimed. Each regional
10 office has a point of contact for that program.
11 On the national level, we continue to provide
12 oversight for VBA's outreach to prevent unclaimed
13 indigent veterans from being buried in pauper
14 graves.

15 The homeless shelter program, during
16 FY2015, VA sold 93 properties under this program,
17 so what that means is if a VA loan is in default,
18 it's in foreclosure, now VA owns that property,
19 and we sell it to somebody who is going to
20 shelter homeless veterans at a reduced rate.

21 VA loan guarantee, we helped 90,000
22 veterans and service members who are in default

1 retain their home and avoid foreclosure, and
2 that's a 13 percent increase from 2014. Again,
3 it's one of those increases that we hope
4 continues, but hopefully we'll see less and less
5 of that.

6 So the VA's efforts overall to end
7 homelessness, the key programs involve
8 healthcare, mental health services, housing
9 assistance, and employment services, so there's a
10 lot of overlap with VBA and VHA in these
11 programs, as well as a lot of overlap with HUD,
12 Housing and Urban Development.

13 There is also a national call center
14 for homeless veterans, 877-4AID-VET, which is
15 available at no cost and you do not have to be
16 eligible for VHA or VBA benefits in order to use
17 that resource. If you served, you can use that
18 resource.

19 There's an online chat and the Web
20 site are free and you don't need to register.

21 MS. CRENSHAW: The call center, what's
22 the hours? Twenty-four hours? Do you know?

1 MS. GITTENS: I don't think it's 24
2 hours. The crisis line is 24 hours, but I'm not
3 sure that the homeless number is.

4 MEMBER BIRD: Can you repeat that
5 number, please?

6 MS. GITTENS: Oh, I didn't know we had
7 somebody on the phone. Sorry, you can't see
8 this. So it's 1-877-4AID-VET, so that's 877-424-
9 3838.

10 MEMBER BIRD: Thank you.

11 DR. VVEDENSKAYA: And, Mr. Bird, I
12 will forward you that PowerPoint presentation
13 after the end of the day. I didn't have it first
14 thing in the morning.

15 MEMBER BIRD: Thank you.

16 MS. GITTENS: Okay. So the healthcare
17 services that are covered from VHA's program for
18 homeless veterans, community resource and
19 referral centers, or CRRCs, are our one-stop shop
20 in the community for homeless veterans. They're
21 in strategically selected areas to provide both
22 refuge and a central location to engage veterans.

1 It's essentially a one-stop center.
2 They can come in and get information, they can
3 get housing, they can get referral, they can get,
4 sometimes, emergency cash assistance, depending
5 on the circumstances.

6 MS. CRENSHAW: And VBA does have a
7 representative on that for -- we go every two
8 weeks for the meetings here in the city. We work
9 with the D.C. CRRC and we sit on that.

10 MS. GITTENS: Right. And there's a
11 lot of referrals back and forth to that program.
12 Domiciliary care for homeless veterans provides
13 time-limited residential treatment to homeless
14 veterans with mental health and substance abuse
15 disorders, or co-recurring medical concerns and
16 psychological needs.

17 Healthcare for homeless veterans is an
18 outreach service --

19 MEMBER SIMBERKOFF: It actually
20 provides more because, you know, one of the
21 criteria for discharge from those programs is
22 that you get stable housing for the veteran.

1 MS. CRENSHAW: Absolutely.

2 MS. GITTENS: Right. And the movement
3 now has been, you know, since we started the
4 whole end veteran homelessness, the approach has
5 been housing first and then offer these
6 wraparound services, but the goal is to,
7 absolutely, provide housing first and then
8 wraparound services.

9 MEMBER SIMBERKOFF: Well, I don't know
10 where the housing first is coming, because we do
11 most of the work getting the housing. We, being
12 VHA.

13 MS. GITTENS: Okay. Yes. Okay.
14 Healthcare for homeless veterans, it's an
15 outreach service that engages them to connect to
16 healthcare and other needed services. There's a
17 case manager that will work with the veteran to
18 ensure that they have mental health or substance
19 abuse rehabilitation services, if need be, and
20 that they're placed in quality housing programs
21 that meet their specific needs.

22 Healthcare for re-entry veteran

1 services, that is a program that works with folks
2 that are re-entering from -- incarcerated
3 veterans, as well as substance abuse, mental
4 health services; institutionalized veterans.

5 Homeless patient aligned care teams
6 are clinics that co-locate medical staff with
7 social workers, mental health and substance abuse
8 counselors, including, they provide nurses and
9 homeless program staff, so it's kind of
10 everything inclusive in that one clinic.

11 The homeless veteran dental program
12 helps increase accessibility of quality dental
13 care to homeless veterans.

14 MS. CRENSHAW: And for our purposes,
15 for VBA, note that it says healthcare. So, you
16 know, VBA is not healthcare. We are not the
17 experts on healthcare. So we have partnered
18 really, really closely with our VHA counterparts
19 to do warm hand-offs, you know, transfer. That's
20 why we work with them. This is not our field of
21 expertise.

22 The most we can do is refer -- once

1 they're identified to us and they need these
2 services, then we hand them off to the experts
3 and let them work with the veteran to provide
4 those services, and that's the best thing that we
5 can actually do, and it's really done -- the
6 thing that we try to get over to the field
7 employees is that you do this with -- so that it
8 preserves their dignity and with respect, and
9 always keeping in mind that, regardless of what
10 condition a person -- because nobody desires to
11 be homeless, that you refer them with that in
12 mind, and to know who your VHA counterpart is,
13 that's very important, for all of these services,
14 because they're not VBA services, they are VHA.

15 MEMBER GRANGER: I don't know what you
16 heard about Denver, but in Denver, it's working
17 very well.

18 MS. CRENSHAW: I haven't heard
19 anything bad, so it must be working.

20 MEMBER GRANGER: It's working very
21 well. It really is.

22 MS. CRENSHAW: That's great, Elder.

1 We'd like to talk to you about how you're doing
2 some of that.

3 MEMBER GRANGER: Right. It's working
4 very well.

5 MS. GITTENS: Right. And just like
6 with the shelters and the local connections, each
7 regional office homeless veteran coordinator
8 works very well with their VHA counterpart.

9 Mostly the referrals are from VHA to us. They're
10 saying, hey, this veteran was identified and they
11 have a claim in for services, or they need to put
12 a claim in for services, or they have a home
13 loan, or they need a home loan, that sort of
14 thing, so they develop a relationship with their
15 VHA partners at the local level.

16 And that's their sole focus, is to
17 make sure that they're, you know, collaborating
18 and making sure that they know that these
19 services are available to the veterans that are
20 coming into their program.

21 DR. VVEDENSKAYA: Mr. Bird and Mr.
22 Lowenberg, I just forwarded you this PowerPoint

1 presentation via email, if you would like to
2 follow. It's in the email.

3 MEMBER LOWENBERG: Thank you so much.
4 It's very helpful.

5 MEMBER BIRD: Yes. Terrific. Thank
6 you.

7 DR. VVEDENSKAYA: Thank you.

8 MS. GITTENS: So mental health
9 services, again, this is VHA services, so I'm not
10 the expert, but there is a veteran crisis line.

11 MS. CRENSHAW: Something's missing.
12 Something's missing out of it?

13 MEMBER SIMBERKOFF: Well, the number
14 is probably missing a couple of digits.

15 MS. GITTENS: What number?

16 MEMBER SIMBERKOFF: Veteran --

17 MS. GITTENS: Oh, okay. I think if
18 you text the crisis line.

19 MEMBER SIMBERKOFF: Well, it's text,
20 but --

21 MEMBER BROWNE: It's a text. You just
22 have to put --

1 MS. GITTENS: You know what? I'm
2 going to try it. This is on the VA Web site, so
3 I'm pretty sure it's correct. At any rate,
4 anyone can call the Veteran Crisis Line. I've
5 actually worked with the crisis line and done a
6 warm hand-off several times and they're just
7 excellent at making sure that they reach out and
8 ensure that every I is dotted and T is cross
9 before they move on.

10 So you can go to
11 veteranscrisisline.net or text this number, I
12 don't know. I'm going to have to check to see if
13 that -- if that number is incorrect, I will
14 forward the correct one.

15 MEMBER SIMBERKOFF: I was going to
16 say. It doesn't seem like the right number.

17 MS. GITTENS: Okay.

18 MEMBER GRANGER: Can we just text and
19 say, this is a test only?

20 MEMBER SIMBERKOFF: You're not going
21 to get through to any number if you text that.

22 MEMBER GRANGER: Well, if you don't

1 get there, then you know it's not working then.

2 MEMBER SIMBERKOFF: It's not enough
3 digits.

4 MEMBER GRANGER: I know.

5 MS. GITTENS: Yes. I'm pretty sure.
6 It's on va.gov.

7 MEMBER GRANGER: A lot of fundraisers
8 take place that way.

9 MS. GITTENS: Mental health services
10 also includes substance abuse disorder treatment
11 enhancement and maketheconnection.net is a
12 service that allows veterans to connect with
13 other veterans with mental health, and
14 particularly, PTSD issues.

15 Okay. Housing assistance, Housing and
16 Urban Development and Veteran Affairs Supportive
17 Housing, otherwise known as HUD-VASH. HUD-VASH
18 is a collaborative program where eligible
19 homeless veterans receiving a housing choice
20 rental voucher from HUD, paired with the VA
21 providing case management and supportive services
22 to sustain long-term housing stability.

1 This subscribes to the principles of
2 the housing first model, so we would allow them
3 to get the voucher first and then provide
4 wraparound services if they want them.

5 Acquired Property for Homeless

6 Veterans is a program that makes all properties
7 the VA obtains through foreclosures on VA-insured
8 mortgages available for sale to homeless provider
9 organizations. The mortgages are offered at 20
10 to 50 percent discount based on how long the
11 property has been in foreclosure.

12 Project CHALENG, which stands for
13 Community Homelessness Assessment, Local
14 Educations, and Networking Groups, has two
15 components. It's a CHALENG survey in which
16 participants rate the needs of homeless veterans
17 in their community and CHALENG meetings, which
18 encourage partnerships developed between VA and
19 the community service providers.

20 The results of the CHALENG survey as
21 used each year to develop new and unmet needs and
22 encourage new partnerships. The grant per diem

1 program funds community-based agencies,
2 transitional housing, or service centers for
3 homeless veterans. Through the program each
4 year, VA offers grants that may fund up to 65
5 percent of the cost to house that veteran.

6 Home Loan Guarantee is a VA benefit
7 that guarantees the lender the if the veteran
8 were to default on a home loan, VA will purchase
9 the property, and as I've discussed before, if
10 the veteran is at risk for foreclosure, we will
11 attempt to work with the lender.

12 Employment assistance, we have several
13 programs, compensated work therapy is a program
14 comprised of three programs, sheltered workshop,
15 transitional work, and supported employment. And
16 we actually have hired folks in the regional
17 offices under this program and they've become,
18 you know, full-time employees through this
19 program.

20 MS. CRENSHAW: And we just had an
21 initiative that we worked too last year, where we
22 worked with the transition office at DOL and the

1 support has all been -- and we had a pilot where
2 we actually went and those veterans that were
3 homeless, we actually were able to employ many of
4 them through a pilot program and it worked pretty
5 well, so we're going to probably try to see if we
6 can replicate that, but that was a program to
7 employ homeless veterans.

8 So once they get a home, that they
9 have income to sustain them in that home.

10 MS. GITTENS: Okay. VRE, Vocational
11 Rehabilitation and Education is a VBA program
12 that provides rehabilitation and education
13 assistance for veterans that have a service-
14 connected disability that requires additional
15 education or rehabilitation in order to go into a
16 career that is different from the one that they
17 were trained to do that their service-connected
18 condition prevents them from currently doing.

19 GI Bill is a program that veterans can
20 use to pay for tuition, fees, books, as well as
21 housing allowance. The Homeless Veteran
22 Community Employment Services coordinates efforts

1 between VA and non-VA employment programs, and we
2 have an employment toolkit and employment
3 information for employers to try to encourage
4 folks in any manner of business to hire veterans
5 first.

6 Okay. So where are homeless veterans?
7 On a single night on January 2015, when we did a
8 PIT count, there were 47,725 homeless veterans
9 identified nationwide. California had the
10 largest number of veterans experiencing
11 homelessness, three other states had at least
12 2000 homeless veterans reported, Florida, New
13 York, and Texas.

14 MS. CRENSHAW: And all of those are
15 currently, I think, are where our full-time AVOCs
16 are, right? Texas, I know --

17 MS. GITTENS: That's next slide or
18 slide or two down. So this map shows the
19 distribution of homeless veterans across the
20 country. The darker ones, only two states had 6
21 percent or more of the homeless veteran
22 population, and that's California and Florida.

1 The rest had up to 6 percent.

2 MEMBER SIMBERKOFF: Say that again.

3 MS. GITTENS: So there's only two
4 states that had greater than 6 percent homeless
5 veteran population.

6 MEMBER SIMBERKOFF: So is the
7 denominator being all the veterans in a state?

8 MS. GITTENS: No, homeless veterans.

9 MS. CRENSHAW: Homeless veterans.

10 MS. GITTENS: So the largest share of

11 --

12 MS. CRENSHAW: The ones that they
13 counted during the PIT count, that's where they
14 found the largest number of homeless veterans, in
15 California and Florida, which would kind of stand
16 to reason, it's warm climates. It's easier for
17 them than in the colder climates, and that's not
18 all the veterans in the state. That's just the
19 ones that they counted during that PIT count in
20 January. Those are the ones they find.

21 And I vary to say that, it's probably
22 warmer in Florida and in California in January as

1 opposed to this year when we went out to do the
2 PIT county, or when they actually did the PIT
3 count, it's so cold, most of the veterans find
4 shelter, so they're actually counting the
5 veterans on the street.

6 MS. GITTENS: They count the
7 unsheltered and sheltered veterans, so there's a
8 breakdown of how many are in shelters, but yes,
9 you're probably going to get more unsheltered
10 veterans in the warmer states, I hope. I really
11 hope. Let's go to the next slide.

12 So the good news is that the states
13 with the highest share of homeless veterans from
14 2010 to 2015 look very different. So that map
15 looked very different in 2010. There were 11
16 states that had over 15 percent of the homeless
17 veterans accounted for and now there are only 6
18 that have above 3 percent, so the numbers have
19 drastically decreased.

20 So Florida, California, Texas,
21 Georgia, New York, and Oregon, so yes, Florida
22 and California were among those.

1 MEMBER SIMBERKOFF: So I'm not sure I
2 understand that. We have, what is it, it looks
3 like at least ten states that are listed in 2010
4 -- 15 percent would be 150 percent.

5 MEMBER SAVOCA: Yes, so what's the
6 denominator in this again? It's all homeless
7 veterans in the country?

8 MS. GITTENS: Homeless veterans. Yes.

9 MEMBER SAVOCA: So ten states have
10 above 15 percent share?

11 MEMBER SIMBERKOFF: Yes, but how could
12 you have ten states that have 15 percent?

13 MEMBER SAVOCA: Or you mean in total,
14 they have 15 percent share?

15 MS. GITTENS: Right. They have above
16 15 percent.

17 MS. CRENSHAW: 15 percent of their
18 veterans in their states.

19 MEMBER SAVOCA: Oh, the denominator is
20 the veterans in the state.

21 MS. CRENSHAW: 15 percent of the
22 veterans in their state.

1 DR. VVEDENSKAYA: Each state has 100
2 percent of homeless veterans.

3 MEMBER SAVOCA: Okay. Got it.

4 MEMBER SIMBERKOFF: They're the
5 veterans counted by how?

6 DR. VVEDENSKAYA: Each of the states,
7 15 percent --

8 MEMBER SAVOCA: State.

9 MS. CRENSHAW: So if the census
10 population or the veteran population in Georgia
11 is a certain number, 15 percent of those veterans
12 in Georgia were homeless. And each state would
13 vary percentage, even though you're taking the
14 same percentage, the numbers were vary because of
15 the number of total veterans in the state.

16 MEMBER SIMBERKOFF: Oh, I see.

17 MS. CRENSHAW: California is a big,
18 big state, and so is Texas, so they're going to
19 have, probably, a lot more than Oregon.

20 MEMBER SIMBERKOFF: But this includes
21 veterans who receive no benefits whatsoever.

22 MS. CRENSHAW: Right.

1 MS. GITTENS: Right. Yes.

2 MEMBER SIMBERKOFF: So anybody who
3 ever served would be included.

4 MS. CRENSHAW: Right.

5 MS. GITTENS: Regardless of whether or
6 not they have --

7 MEMBER SIMBERKOFF: Okay.

8 MS. GITTENS: They're considered a
9 veteran for VA purposes.

10 MEMBER SIMBERKOFF: And you get that
11 data from the state?

12 MS. GITTENS: That's actually from
13 HUD, from the PIT count.

14 MEMBER SIMBERKOFF: But how do you get
15 the denominator?

16 MS. CRENSHAW: We know the number of
17 veterans that reside in the state. That data is
18 composed for census data, it's composed of the
19 data that, how many veterans are in the -- that's
20 usually census data, and then taking the number
21 of veterans that each state says -- state that
22 they have, when HUD go out and do their count,

1 how many of those veterans are homeless are
2 counted, and then the percentage is derived from
3 that.

4 MEMBER SIMBERKOFF: Okay.

5 MS. CRENSHAW: Is that clear?

6 MEMBER SIMBERKOFF: It's clear.

7 MS. CRENSHAW: I know I'm not the
8 greatest person to --

9 MS. GITTENS: The HUD annual report
10 goes into great detail about how they arrived at
11 the percentages. I just thought that it was
12 important to note that from 2010 to 2015, our
13 numbers have decreased significantly.

14 MEMBER SAVOCA: Have the number of
15 veterans risen?

16 MEMBER SIMBERKOFF: Well, the numbers
17 have. That's true, but, you know, veteran number
18 would be -- and you're sort of given that in this
19 picture here, you know, the numbers of, you know,
20 homeless veterans, and you've got, you know, say,
21 like, Vermont, for example, which has only 119
22 with this.

1 MS. CRENSHAW: You know, what works
2 for us, what we're doing, for my purposes as the
3 director over this program is, when I see that
4 change, because Congress came out and said, for
5 those veterans, we have to establish those 20
6 full-time veteran coordinators, so there are only
7 20. That's very, very little when you talk about
8 resources and resource allocation.

9 So the 20 were established in those
10 regional offices that had the highest
11 concentration of veterans. I would say, now,
12 it's time we re-look at those states. Now, we do
13 have full-time homeless veteran outreach
14 coordinators in those regional office. Are they
15 as needed in 2016 as they were in 2010 or do we
16 now need to look at our resource allocation and
17 put those resources somewhere else to start
18 working on that?

19 So for me, the importance of those
20 numbers, just from my operational purpose is,
21 where do I allocate my resources now and this
22 effort towards reaching out to the homeless

1 community.

2 MEMBER FAY: How much flexibility do
3 you have to share personnel from, you know, low
4 demand to high demand?

5 MS. CRENSHAW: Right now, I don't have
6 any because they are bargaining unit employees
7 and we have to negotiate that, but I will just
8 say, my leaders are more onboard with resource
9 allocation than they're not, so we just have to -
10 - we're looking at this data now and we will,
11 more than likely, re-shift our resources.

12 I feel 99.9 percent strong that those
13 resources will be reallocated, because it doesn't
14 make any sense to have a full-time HVOC in Boise,
15 Idaho if there are no homeless veterans there.

16 MEMBER FAY: So how long does that
17 take you? I mean, that's an obvious case.

18 MS. CRENSHAW: It's a discussion that
19 we're having right now. We're having those
20 discussions right now.

21 MEMBER FAY: So in the past, how easy
22 --

1 MS. CRENSHAW: We've never done it.

2 MEMBER FAY: Never done it?

3 MS. CRENSHAW: We've never -- once
4 those that are established in 2010 are the
5 current operating ones. They're still the full-
6 time HVOC. So what we did do is, in lieu of
7 those 20 full-time HVOCs, we have HVCC, so there
8 were only 20. Now, there's a homeless veteran
9 claims coordinator in every office, and so we've
10 put additional resources in the office other than
11 the 20.

12 Those 20 are full-time and that's all
13 they do is outreach. If I had my way, they'd all
14 be doing full-time outreach, but I don't have my
15 way and I'm not queen for a day. So what we did
16 instead is, we did the next best thing, was to
17 put a homeless veteran claims coordinator that
18 can conduct outreach and process claims.

19 Now, I'm looking at resource
20 allocation based upon the data, what do we do,
21 where do we put our 20 full-time HVOCs?

22 MEMBER FAY: So I hear your

1 challenges, right, but just --

2 MS. CRENSHAW: It won't happen
3 tomorrow.

4 MEMBER FAY: Right. So coming from
5 outside VA, outside the government, that's a hard
6 message for me to hear, that you can't allocate
7 your personal resources to where --

8 MS. CRENSHAW: They're not my
9 resources.

10 MEMBER FAY: But the VA doesn't
11 allocate its resources quickly to where the
12 demand is.

13 MS. CRENSHAW: Well, you have to think
14 about the way the government's structured. So
15 we're talking about employees --

16 MEMBER FAY: Right. I understand
17 that, I'm just saying, from an observer
18 standpoint, that's an issue that needs to change
19 because that's the way the world is.

20 MS. CRENSHAW: You're absolutely
21 right. We are talking about --

22 MEMBER SIMBERKOFF: No argument.

1 MS. CRENSHAW: Yes, you get no
2 argument from us.

3 MEMBER FAY: Okay. I don't know if we
4 can have an impact on those things, but as an
5 advisor, I'd say that it's a strategic issue
6 there, is you should have a lot more flexibility
7 in the VA to transfer your people, your
8 personnel, to where the demands are.

9 MS. CRENSHAW: I do think that -- so
10 from my standpoint, from my operational
11 standpoint, I don't have them because they're not
12 my employees.

13 MEMBER FAY: Right. I understand
14 that.

15 MS. CRENSHAW: So if they were my
16 employees I could move them around.

17 MEMBER FAY: They're the regions
18 employees.

19 MS. CRENSHAW: There are 20 employees
20 that belong to 20 different directors, and so
21 that's a discussion that's taking place, so it
22 will --

1 MEMBER FAY: Right.

2 DR. VVEDENSKAYA: And what General Fay
3 is trying to say is, Ms. Crenshaw, if you need
4 our help --

5 MS. CRENSHAW: Oh, I understand.

6 DR. VVEDENSKAYA: -- we'll be happy to
7 provide the Secretary with recommendations --

8 MEMBER FAY: Thank you for diplomizing
9 and stating my position. That's exactly right.

10 MS. GITTENS: I think I did highlight
11 some of those too in my challenges and
12 recommendations, so it's good to know. I know
13 we're over time.

14 MEMBER BROWNE: In their special
15 programs, they all have outreach coordinators.
16 Are those some of the outreach coordinators that
17 would be assigned to your program to do the
18 various kinds of outreach?

19 MS. CRENSHAW: Yes, ma'am.

20 MEMBER BROWNE: So it's not, you have
21 outreach coordinators in each of the special
22 programs like, you know, women veteran and --

1 MS. CRENSHAW: So some of them are the
2 same coordinator, so because the outreach
3 coordinators do these -- so when I opened up the
4 thing I showed you all of the special emphasis,
5 where homeless being one of our biggest ones and
6 one of our most important ones because they cause
7 all of those special emphasis programs.

8 The coordinators in the field in our
9 58 regional offices are collateral duty.
10 Homeless, being noted, are the only full-time
11 coordinators that we actually have. The other
12 coordinator duties are all collateral duties, in
13 addition to being a rater, in addition to being a
14 veteran service representative, they have that as
15 part of their collateral duty.

16 And so from my standpoint --

17 MEMBER BROWNE: Well, if the
18 collateral duty is, say, for instance, it comes
19 out of the special program of minority veterans,
20 and again, I have no idea of what percentage of
21 your homeless veterans are minority veterans,
22 perhaps having those coordinators from that

1 program to spend extra time in the homeless --

2 MS. CRENSHAW: They actually do. So
3 a lot of them are the same. So there are 20
4 full-time homeless coordinators, so now looking
5 at the other 36 are collateral, so those may be
6 homeless coordinators, minority coordinators, or
7 they may be homeless and women, they may be
8 homeless and elderly, they may wear many hats,
9 and all of the coordinators from our standpoint
10 within the Benefits Assistance Service, we have
11 them work together because we have oversight for
12 all of them, so they do a lot of their outreach
13 overlap.

14 They do a lot of their stand downs and
15 their town hall, they work jointly together so
16 that -- because we encourage that in them. We
17 kind of have oversight for that.

18 MEMBER ROBERTS: I'm trying to wrap my
19 brain around the magnitude of the problem. I had
20 asked her earlier how many homeless veterans are
21 there, and I noticed you said one night in
22 January, January '15, 47,725, which is a snapshot

1 in time, but do you have an actual number over a
2 period of time about how many homeless veterans
3 there are in the country?

4 MS. CRENSHAW: That's the number that
5 we get from HUD. That's the number that everyone
6 operates off of. If you're saying, do they have
7 real-time numbers? I would probably say no,
8 because the number that they're operating off is
9 that number that is the official number that they
10 get from the point-in-time count.

11 I would also venture to say, in real
12 time, that changes daily, and so that's where
13 they get that number from.

14 MEMBER ROBERTS: Yes, I was just
15 trying to get an average number, but one night,
16 not necessarily --

17 MS. GITTENS: Think of it like a
18 census, so when we do a census, that's what we
19 get. We get a snapshot of the demographics for a
20 point in time, so that's our homeless census.

21 MS. CRENSHAW: I have no idea why
22 January. It is what HUD has. That's the day

1 that they pick. And they do it across the nation
2 during that time in January and I don't think
3 it's just that night in January. I do think,
4 because there are different nights within January
5 across the country, but it is done in January.

6 I don't think everybody has the exact
7 same night.

8 MS. GITTENS: No, they don't.

9 MS. CRENSHAW: They do have different
10 times in January, but for each demographic
11 location, they go out and they count the
12 homeless, and then those numbers are rolled up.

13 MEMBER SIMBERKOFF: So how do you get
14 at the homeless?

15 MS. CRENSHAW: You go out and you
16 physically count them. If you've participated --
17 my staff goes out, and we get a lot of
18 volunteers, the Secretary goes out, senior
19 leaders go out, and they really physically go out
20 and count them under the bridge, wherever they're
21 at. We go and find them.

22 MEMBER GRANGER: The same thing in

1 Denver.

2 MS. CRENSHAW: Yes, you just go out
3 and you find them. If you're walking the streets
4 of D.C., you see them quite often. I used to get
5 a \$20 bill on every pay period and walk from the
6 Metro station to here, and my -- because, you
7 know, people are always asking for money, so my
8 thing is that, once that was gone, during that
9 pay period, it was gone, but I would give that
10 money away. And I know a lot of people think I
11 don't give money away, but I mean, I blow \$20, so
12 it was no big deal to me, and everybody didn't
13 have to buy hot chocolate.

14 But if you walk in and around D.C. at
15 any given time, you'll see the homeless. And so
16 when we go out and count them, we're counting
17 those and wherever they're at in the city, and we
18 don't just do this, we go out to -- they go to
19 Maryland, they go to all of the cities have a
20 point-in-time count, and they try to find,
21 physically, as many as they possibly can on the
22 street.

1 MEMBER BROWNE: In your transitional
2 housing program, is it still a requirement that
3 you provide associated programs like substance
4 abuse, and et cetera, et cetera, if they're --

5 MS. CRENSHAW: It's actually not in
6 our program. It's actually VHA, so I don't know
7 all of the requirements for it.

8 MEMBER SIMBERKOFF: The answer is yes.

9 MEMBER BROWNE: Okay.

10 MEMBER ROBERTS: Is homelessness
11 considered a service-connected disability?

12 MS. CRENSHAW: No, it's not. It's a
13 state of life. Although there are many that have
14 service-connected disabilities that are homeless
15 and a lot of mental issues.

16 MEMBER SIMBERKOFF: One of the things
17 that we talked about in the past meetings is, you
18 know, to try to accelerate, and if it's for
19 people being discharged from the military because
20 often, you know, they exhaust the limited funds
21 they have if they can't get a job, you know,
22 immediately upon discharge.

1 MS. CRENSHAW: Right. And that's why
2 we're working with the -- for the transition
3 piece, remember, I talked about it's very
4 important that preventive part, not just wait
5 until they become homeless, but when they're
6 transitioning, to have those conversations. It's
7 incumbent upon the commanders to have those
8 conversations, to have their leaders have those
9 conversations, with the service members, and I'm
10 Army, so I have a tendency to say soldier, but to
11 have those conversations and to make sure that
12 these conversations are happening, that they have
13 actual plans for them getting out.

14 The Soldier for Life program is one of
15 the programs I know that they are really honing
16 in on that, those transitional from phase 1 to
17 the time that they actually get out of the
18 military to ensure that this is not happening. I
19 think more emphasis is on it now than in the
20 past.

21 MEMBER ROBERTS: I assume you do know
22 what percentage of these military people are the

1 results of mental disability and the other kinds
2 of disability versus someone who's just down on
3 his luck.

4 MS. CRENSHAW: We can get -- we know
5 the number of people that are service connected.
6 If they're in our system, we can pull data and
7 get that. I don't know it offhand, but there's
8 certainly data that can be pulled to say how many
9 service members have PTSD, you know, how many of
10 those -- but we can get that kind of data. Am I
11 right?

12 CHAIRMAN MARTIN: For the committee's
13 comparison, Lisa Pape briefed us in June of 2014
14 and she told us at that time that she 2013 point-
15 in-time numbers that showed 57,849 homeless
16 veterans as opposed to the 47,000 now.

17 MS. GITTENS: Which was in January of
18 2015, so that's --

19 CHAIRMAN MARTIN: Two years.

20 MS. CRENSHAW: A big reduction.

21 CHAIRMAN MARTIN: It's about 10,000
22 difference in two years. When do the 2016

1 numbers become available?

2 MS. CRENSHAW: They should -- we just
3 did the point-in-time count, so it won't be in to
4 the end. Usually they come out, like, in August,
5 by the time they wrap them up, in the time that
6 I've been employed and working with the homeless,
7 we've completed it in January of this year, so we
8 won't get those numbers until later some time.
9 In the summer, usually, they come out.

10 DR. VVEDENSKAYA: We can have that
11 data available, probably, for our December
12 meeting.

13 MS. CRENSHAW: You'll definitely have
14 the data before then.

15 DR. VVEDENSKAYA: Or September.

16 MEMBER ROBERTS: Will the next point-
17 in-time be January of 2016?

18 MS. CRENSHAW: January 2017.

19 MEMBER ROBERTS: '17. Okay.

20 MS. CRENSHAW: We just did one and it
21 was really cold.

22 MEMBER SIMBERKOFF: Was it on the

1 15th? I don't remember.

2 MS. CRENSHAW: Some of them was
3 canceled because we had that ice here, they
4 canceled it because they did the -- I think we
5 had the storm or we were --

6 MS. GITTENS: Yes.

7 MS. CRENSHAW: It was a real bad --
8 the blizzard came through.

9 MEMBER GRANGER: It was cold
10 nationwide, though, in that period.

11 MS. GITTENS: It always is.

12 CHAIRMAN MARTIN: Anything in your
13 last three slides that you would like to
14 highlight for us?

15 MS. GITTENS: Some of the challenges
16 as far as claims completion, coordination with
17 multiple competing business lines, no --

18 DR. VVEDENSKAYA: Next slide or is
19 this the slide?

20 MS. GITTENS: Yes, it's on the next
21 slide.

22 MS. CRENSHAW: We're not going to

1 focus on that.

2 MS. GITTENS: Okay.

3 MS. CRENSHAW: That's internal stuff.

4 They don't need to --

5 MS. GITTENS: Okay. So no, nothing

6 that we need to --

7 CHAIRMAN MARTIN: Obviously, the topic

8 has generated a lot of interest and --

9 MEMBER SIMBERKOFF: Yes.

10 CHAIRMAN MARTIN: So I appreciate you

11 both taking all the questions.

12 MS. CRENSHAW: You know, I just want
13 you guys to know that it's a big issue for us,
14 and certainly for me, like I said, it's one of my
15 major programs, so it's a program that I have a
16 lot of empathy for. I feel, as a veteran, that
17 there should be no veterans in this country, I
18 don't feel that in America, anybody should be on
19 the street, so veteran or not, but definitely for
20 a veteran that has served this country and paid
21 those dues, I definitely -- so we really work at
22 it.

1 I don't think there is any homeless
2 event that we don't try to support. We work with
3 a lot of non-profit organizations, particularly
4 when it comes to come of our women veterans,
5 women with children, because a lot of the
6 shelters do not allow the kids of a certain age,
7 for instance, I had a young lady that, she had
8 two kids, a son and a daughter, her son was kind
9 of big, I would say, he was only 13, but he was,
10 like, 6-feet and really big, so the shelter just
11 on looks, they were like, you can't be in here.
12 He's too big.

13 And so she had to make a choice of
14 being separated from her child, who is 13, and
15 sending him to a male adult shelter by himself
16 while she and her daughter go in another. So
17 those are the heartbreaking things that we really
18 have to work on, and so we really work with the -
19 - so resources, we need all the resources we can
20 to deal with that.

21 And VHA, I do applaud them because
22 Lisa Pape, she's my hero, they do an excellent

1 job in what they do, but there's just not enough
2 resources to go around to combat the problem, but
3 we do thank you for allowing us to come and brief
4 the committee, and you can invite us back.

5 CHAIRMAN MARTIN: Thank you very much.
6 Okay. Any other input before we break here?
7 Thank you. We appreciate it. Okay. Why don't
8 we take about a five-minute break and then we'll
9 come back and public comments.

10 (Whereupon, the foregoing matter went
11 off the record at 3:13 p.m. and went back on the
12 record at 3:22 p.m.)

13 MS. MOSES: Good afternoon. I just
14 wanted to provide you guys with an update. I did
15 get some feedback from the Office of Transition
16 Employment and Economic Impact, and they're the
17 group that does the TAP briefings, and what I
18 said, you know, is the information presented in
19 the TAP briefing applicable to the Guard and
20 Reserve, and they did confirm.

21 And then also, she relayed that
22 they're providing briefings specific to Reserve

1 populations. And thus far, they've gone to eight
2 different locations and I've asked for additional
3 information as to if they plan on continuing
4 this, and the frequency, so I can get all that
5 information to you.

6 I can probably just email you the list
7 instead of me trying to --

8 DR. VVEDENSKAYA: Yes, and then we'll
9 forward it to our committee members.

10 MS. MOSES: Yes. So just FYI.

11 MEMBER ROBERTS: Can I ask you another
12 question?

13 MS. MOSES: Oh, I'm sorry. Sure.

14 MEMBER ROBERTS: I never heard you or
15 anyone else say anything about the commission
16 core of the United States Public Health Service
17 and they serve in combat zones, and wear the
18 uniform, and so forth, are they considered under
19 the veterans program?

20 MS. MOSES: No.

21 MEMBER ROBERTS: You and I were
22 talking about that.

1 MEMBER SIMBERKOFF: The Yellow Berets.

2 MEMBER GRANGER: What about NOAA?

3 They're a uniformed service too.

4 MS. MOSES: They are.

5 MEMBER GRANGER: That's what I

6 thought.

7 MS. MOSES: I don't know that. I
8 would have to look back. Right now, I would say
9 no.

10 MEMBER SIMBERKOFF: National Oceanic

11 --

12 MEMBER GRANGER: That's right. Yes,
13 they're a uniformed service.

14 MEMBER ROBERTS: But not for --

15 MEMBER GRANGER: No, there are certain
16 uniformed services that are covered by federal
17 statute.

18 CHAIRMAN MARTIN: But versus Coast
19 Guard is under TSA.

20 MEMBER GRANGER: But Coast Guard is
21 covered too.

22 MS. MOSES: Coast Guard's covered.

1 MEMBER GRANGER: Coast Guard is
2 covered. Yes. NOAA's a uniformed service as
3 well as the Public Health Service.

4 CHAIRMAN MARTIN: And to whom does
5 NOAA belong?

6 MEMBER GRANGER: NOAA belongs,
7 probably, on the EPA. It's just, a lot of people
8 don't think about it, but they are a uniformed
9 service, so we provide them TRICARE benefits too.

10 MEMBER SIMBERKOFF: But they don't get
11 veterans benefits.

12 MEMBER GRANGER: The Public Health
13 Service?

14 MEMBER SIMBERKOFF: No, NOAA.

15 MEMBER GRANGER: NOAA.

16 MEMBER SIMBERKOFF: I know the Public
17 Health Service doesn't.

18 MEMBER GRANGER: You might want to
19 check into it.

20 MS. MOSES: Yes. I'll look into it.

21 MEMBER GRANGER: Why don't you look
22 into it.

1 MS. MOSES: I'll look into it.

2 MEMBER ROBERTS: They do in combat
3 situations.

4 MEMBER GRANGER: Yes, because we had
5 a small environmental unit, they helped for the
6 healthcare of those who were taking care of the
7 oil fields when they were burning in Iraq. They
8 were Public Health Service officers.

9 MEMBER SIMBERKOFF: But they might be
10 under special law.

11 MEMBER GRANGER: They're under special
12 law, but you might want to look to see and make
13 sure for the education of all of us.

14 MS. MOSES: Okay.

15 MEMBER GRANGER: I know we take care
16 of their healthcare from a TRICARE network
17 perspective.

18 MEMBER SIMBERKOFF: But the question
19 is, you know, are they eligible for veterans
20 benefits when they --

21 MEMBER GRANGER: The question is, of
22 one of seven uniformed services, are they

1 eligible for benefits from the Department of
2 Veterans Affairs.

3 CHAIRMAN MARTIN: Same question for
4 the Coast Guard.

5 MEMBER SIMBERKOFF: Coast Guard are
6 because usually I've taken care of them.

7 MEMBER GRANGER: I've done Coast Guard
8 exams myself.

9 MEMBER SIMBERKOFF: And I've taken
10 care of Coast Guard individuals.

11 MEMBER GRANGER: Yes, I've done Coast
12 Guard too.

13 MEMBER SIMBERKOFF: So I know they're
14 carried in the system.

15 MS. MOSES: Right.

16 CHAIRMAN MARTIN: I want to thank you
17 so much for telling us. Okay. At this time I'd
18 like to invite any members of the public who
19 would like to address the committee and bring any
20 issues forward to please let us know. Within the
21 room first. Thank you for attending. The public
22 is also invited to submit written comment and Dr.

1 V sent out to you a written comment submitted for
2 us to read into the record, and I will read that
3 verbatim into the record.

4 This public comment is from Camella
5 George and it was submitted by email. It says,
6 "For public comment, I would like to make the
7 committee aware of the effects on veterans of
8 many of the cookie-cutter, one-size-fits-all,
9 approach to evaluating some medical conditions
10 within the Live Manual VBA raters use."

11 "Such an example, which has affected
12 my husband, who is a U.S. Embassy veteran, is
13 below. Although shin splints aren't on the
14 rating schedule, this tells them what to rate and
15 it leaves out the option for it being tied to
16 foot when my husband's podiatrist says his shin
17 splints are caused by his feet and plantar
18 fasciitis."

19 "Beyond that, there's a gap in logic
20 and reality between Steps 3 and 4. Step 3 says,
21 determine if the shin splints affect the knee or
22 ankle and then go to Step 4, but what if it

1 affects neither the knee or ankle, as in my
2 husband's case? It gives no direction what to do
3 in that regard. If it doesn't affect or involve
4 the knee or ankle, why would you then combine it
5 into a single evaluation with other conditions
6 involving those joints?"

7 "In my husband's case, he had a
8 separate left-knee injury of a bucket handle
9 meniscus tear, but the VA says they can't rate
10 both because it would be pyramiding, when, in his
11 records, it's two separate conditions. His shin
12 splints, as shown in his medical record, don't
13 affect his knees, but under this guidance, it
14 leaves no option for such a case."

15 "Why is a condition that isn't on the
16 rating schedule forced into one D.C. code when it
17 has possible other manifestations and can be
18 caused by the feet? Cookie-cutter approaches to
19 conditions not on the schedule, like the one
20 below, shortchange veterans and need to be
21 corrected."

22 "Why on foot conditions DBQ is there

1 no place for the examiner to note shin splints?
2 Why is it only the knee and ankle DBQ?" And then
3 she's attached what appears to be a screenshot of
4 the Live Manual VBA rating schedule, or
5 evaluation schedule, for evaluating shin splints.
6 Thanks.

7 MEMBER SIMBERKOFF: You refer her to
8 the meniscus health thing for, you know, possible
9 change. I mean, she's right, you know, but we're
10 not the experts, they are, and they should, you
11 know, take it under advisement.

12 MEMBER GRANGER: Right. I would
13 concur.

14 DR. VVEDENSKAYA: And as we remember,
15 the charter of our committee, our committee is
16 tasked to advise the Secretary on the
17 programmatic level. This committee does not
18 address individual veterans rating problems or
19 requests, however, we will keep it on the record
20 and therefore, we did our due diligence and we
21 made this veteran's spouse comment a part of an
22 official record.

1 MEMBER SIMBERKOFF: But can't we, you
2 know, we get updates from Nick and, you know,
3 others, you know, periodically about, you know,
4 the progress of the, you know, systems reviews,
5 the VASRD, and, you know, so this would seem to
6 be something that, if it hasn't already been
7 considered by the musculoskeletal VASRD, you
8 know, it should certainly be referred back to
9 them.

10 DR. VVEDENSKAYA: Well, this
11 particular request, or this particular comment,
12 addresses the past way of rating decision, and it
13 addresses the shortcomings of the electronic
14 system, which our program does not relate to, and
15 this is not really about the rating schedule, but
16 rather, the rating process.

17 We do have a mechanism of addressing
18 this particular problem in the rating, but --

19 MEMBER SIMBERKOFF: Well, it says that
20 shin splints aren't on the rating schedule.

21 DR. VVEDENSKAYA: Yes, but there are
22 other things on the rating schedule which are

1 more general in nature, which covers the affected
2 area, and tries to identify the disability level
3 based on functional impairment. Our rating
4 schedule, unlike ICD-10, is not as granular
5 because we do not need to have every condition as
6 a diagnostic code.

7 Our diagnostic codes, on a best day,
8 are more general in nature and are based on the
9 level of functional impairment due to certain
10 condition, or groups of conditions, or conditions
11 which arise from the impairment in certain
12 anatomic area. It's why we do not have every
13 single diagnosis as a diagnostic code.

14 And we can have this discussion in
15 more detail when I will give you an update on VA
16 rating schedule, review and update, however, as
17 it pertains to this public comment, it more
18 related to the rating process, the electronic
19 system which is used to enhance rating process,
20 and the absence of a particular diagnosis on a
21 rating schedule does not mean that that condition
22 is not rated.

1 MEMBER SAVOCA: So do you have an idea
2 of where it would come under, under the code?

3 DR. VVEDENSKAYA: We have
4 musculoskeletal system, which is one of the 15
5 systems, has several subsections which are
6 anatomical regions.

7 MEMBER GRANGER: But her comment said,
8 determine musculoskeletal, she said on the foot
9 conditions DBQ, there's no place where you talk
10 about foot as it relates to the shin splints.

11 DR. VVEDENSKAYA: There is a space,
12 which is called remarks, and there are fields in
13 every DBQ which the examining healthcare
14 professional can make any note which are missing
15 from the body of the DBQ, because DBQ, it has to
16 use only the language of regulation, which is
17 imperfect and lacking certain medical sense.

18 It's why, while designing DBQs, we
19 didn't want to take away an opinion from the
20 examining physician, or nurse practitioner, or
21 any other who is -- it's why there is always a
22 place on every DBQ where it can be noted whatever

1 is lacking in checkboxes.

2 MEMBER FAY: So this particular person
3 doesn't seem to know that, essentially, right?

4 MEMBER SIMBERKOFF: So shouldn't we
5 send a letter to --

6 MEMBER BROWNE: I just thought a
7 letter should get back to that person.

8 MEMBER SIMBERKOFF: To her, I mean,
9 honestly --

10 MEMBER BROWNE: Referring her to the
11 proper place for her to address that issue. It's
12 not this committee.

13 MEMBER SIMBERKOFF: Right. So I mean,
14 part of the thing of improving patient or
15 customer satisfaction is, you know, even if you,
16 you know, know something, you know, you want to
17 make sure that the person who sent this letter,
18 you know, ensures that we're not ignoring her and
19 that we're, you know, taking her seriously, and
20 that, you know, the people who do the DBQs, you
21 know, have a way of dealing with this issue.

22 MEMBER GRANGER: Right. And if this

1 was one of our internal podiatrists to the VHA,
2 he or she may not be aware they can put those
3 comments in the remarks.

4 MEMBER SIMBERKOFF: Yes. Well, it's
5 actually not usually podiatrists that do this,
6 but, you know, people who do more general
7 orthopedic evaluations.

8 DR. VVEDENSKAYA: I would be happy to
9 respond to the veteran via email.

10 MEMBER FAY: Okay.

11 DR. VVEDENSKAYA: Directing her to
12 communicate with her regional office because as
13 far as I know, my experience with regional office
14 as a non-veteran, I saw the workflow and
15 everybody is accessible by phone, and they are
16 really -- they talk to the veterans. And perhaps
17 there is some misunderstanding on the part of
18 this spouse, that's why we can figure out which -
19 -

20 MEMBER FAY: Yes. I get that part,
21 and I don't disagree with it, but your
22 explanation of how the process worked and the

1 fact that there is a body in there, she doesn't
2 know, and I think we should tell -- or this
3 committee should tell her that.

4 DR. VVEDENSKAYA: It's not this
5 committee's --

6 MEMBER FAY: Not this committee's job
7 to tell her that?

8 DR. VVEDENSKAYA: Yes, because if this
9 committee would start addressing individual
10 veterans --

11 MEMBER FAY: No, no, we're not --

12 DR. VVEDENSKAYA: -- we'll have a ton
13 of them by next meeting.

14 MEMBER FAY: No, she stated that there
15 was a systemic flow. Our position is, there is
16 not a systemic flow. In fact, there is a proviso
17 for a remarks section where comments like this
18 one could have gone, had the individual that's
19 making the rating, decided to put them in there.

20 Now, whether or not they did or should
21 have, that's back to the regional, which we could
22 refer her, but as far as the systemic flow, we've

1 analyzed it and we don't believe there is a
2 system flow. I'm just stating what I believe I
3 heard from you.

4 DR. VVEDENSKAYA: Yes.

5 MEMBER FAY: And I think everybody
6 else is agreeing with that, and I think that's
7 what the letter should say, not that we're just
8 referring this back.

9 MEMBER GRANGER: Or email.

10 MEMBER FAY: Or email.

11 DR. VVEDENSKAYA: Yes. We'll put
12 together a response, which I will send directly
13 to the veteran, and then I will forward you my
14 response to the veteran because I, obviously,
15 would not be putting committee's members' emails
16 on the copy.

17 MEMBER FAY: Okay.

18 CHAIRMAN MARTIN: One of the questions
19 that the committee could look at was, is the Live
20 Manual online update defective in some way or did
21 it not carry forth accurate information from the
22 manual, the hard copy of the manual, but in fact,

1 we have received, now, two updates in the last
2 year from Lucas Tickner and Aimee Benson on the
3 Live VA Manual, and they were very, very quick to
4 say that the content integration was complete.

5 And not only that, they go back in and
6 make all the current changes, and amendments, and
7 things in the Live Manual instead of, you know,
8 waiting for the addendum page to come out, and
9 then try to figure out where it goes, and take
10 out the old page, so it's a good product, which
11 they seem to have complete faith in, and the
12 chances of there being an abnormal section in
13 that are very small at this point, since they've
14 been doing, now, two iterations of scrubbing it.

15 Again, the committee is focused more
16 on broad systems and the rating schedule and the
17 way it affects everybody as opposed to
18 individuals. However, I know exactly where
19 you're coming from, and I feel the same way, that
20 we need to somehow close that loop and get some
21 feedback back so they don't think that they're
22 speaking into a --

1 MEMBER SIMBERKOFF: It's part of the
2 Secretary's 12 goals.

3 MEMBER GRANGER: It is.

4 CHAIRMAN MARTIN: We'll see.

5 MEMBER GRANGER: It's out there on the
6 roving board out there.

7 CHAIRMAN MARTIN: Okay. Barring any
8 other comments, Tim or Hal, any comments about
9 the public comment or any other issues at this
10 point you want to discuss?

11 MEMBER LOWENBERG: No comment from me.
12 Thank you.

13 MEMBER BIRD: No comment from Hal, but
14 I do have a question about the last briefing that
15 I didn't get to, but I'll wait for that part of
16 it; the deliberation.

17 CHAIRMAN MARTIN: Okay. All right.
18 Okay. Barring any other further public comments,
19 we will now change hats and go into our
20 deliberations. And, you know, during this time,
21 the committee has the ability to range widely
22 over any of the topics that we've been involved

1 with or concerned about.

2 We do have some further updates coming
3 tomorrow that, you know, may encompass some of
4 the questions we'll be asking, like, what
5 happened in 2014 biannual review? What happened
6 in the interim review last year? Where are we
7 with MyVA? Some things like that that we'll talk
8 about tomorrow, but as of today, and looking
9 back, what comments, what areas, would committee
10 members think we should be discussing as a body?

11 I think it's important for two of you
12 to get with the librarian and see if you can get
13 the online VA library access that Ashley came and
14 did that for us at the last meeting. That's very
15 helpful.

16 MEMBER GRANGER: Okay. We need to
17 arrange that while we're here or just do it by
18 email?

19 DR. VVEDENSKAYA: What I can do is,
20 after we adjourn today, I'll make a call to her
21 and see if she can work with you tomorrow on this
22 login information.

1 MEMBER GRANGER: Okay.

2 CHAIRMAN MARTIN: As long as, like,
3 you didn't have a CAC card or you didn't have a
4 VA I.D., there was no way to get in, but they
5 have actually figured it out so that we can
6 access the VA Web site with your home computer.

7 DR. VVEDENSKAYA: With your non-VA
8 email because our VA email usually acts like an
9 I.D., but it looks like she --

10 CHAIRMAN MARTIN: Right. Super secret
11 --

12 DR. VVEDENSKAYA: Yes.

13 MEMBER GRANGER: Okay.

14 DR. VVEDENSKAYA: And also, as she
15 mentioned, and the rest of the committee members
16 are aware, and you can talk to her via email or
17 even on the phone, she's super friendly, you can
18 put yourself on the daily or weekly alerts on all
19 the pullouts of information which pertain to this
20 or that subject, and the list of subjects, which
21 they have these pools, is on the VA library Web
22 site, and she'll guide you to that page where you

1 can choose which alerts you would like to
2 receive.

3 I receive about, you know, ten of them
4 on different subjects, and it's -- I just get
5 them every day because some information which
6 might be useful for what I do, and the same thing
7 for if you want to learn a little bit more about
8 certain programs or be abreast on what's
9 happening now.

10 MEMBER GRANGER: Okay.

11 CHAIRMAN MARTIN: Dr. V, maybe you can
12 summarize in a few words what's happened over the
13 last two years with the VASRD and the big scrub
14 with VASRD. What's going on with it?

15 DR. VVEDENSKAYA: All right. VASRD
16 stands for VA Rating Schedule for Disabilities.
17 Sorry, I don't have a slide super handy. In,
18 actually, 2008, the decision was made to
19 comprehensively review and update the whole
20 schedule. It was never done before as the whole
21 schedule, which has 15 body systems, and the
22 decision was made that the time had come to

1 review it all together, not in bits and pieces,
2 because all parts of the rating schedule connect
3 with each other, one way or another.

4 The merit of reviewing the whole
5 rating schedule was August. And then in 2010, in
6 August, four of us physicians were hired to begin
7 this review. And that's what we did since 2010.
8 We reviewed all 15 systems. For each system, a
9 workgroup containing subject matter experts in
10 this or that area of medicine were recruited from
11 VG, from academia, within, I'm sorry, VA, and
12 also a rating specialist or two, sometimes, were
13 assigned to the workgroup, and usually an
14 attorney.

15 This way, as we review it medically,
16 we were seeking guidance on what are other
17 implications of things we change because the
18 rating schedule is not ICD. It's a medical legal
19 document. It has more general approach to
20 medical conditions than clinical guidelines, and
21 it is supposed to be based on the functional
22 impairment due to various medical and mental

1 conditions.

2 And whatever is missing from a whole
3 person, because it's lost to disability, we're
4 supposed to compensate for that loss of function.
5 And the statute says that we're supposed to
6 compensate for that loss of function based on
7 average loss of earned income.

8 That's why it's both medical, legal,
9 and somewhat healthcare economics based
10 compensation. Over the years, the rating
11 schedule was revised several times, probably
12 about five or six times, since the beginning of -
13 - since 1920s, and several studies were done
14 within the last 20 years which examined the
15 accuracy of our compensation.

16 They were done by RAND, they were done
17 by U.S. Naval -- Dr. Simberkoff, I forgot the
18 name of the organization. Center for Naval
19 Analysis and another one, yes, and all of the
20 studies -- the studies, these econometric
21 studies, they didn't really analyze the whole
22 schedule, they analyzed the bits and pieces of

1 schedule.

2 And some of the studies were done
3 based on VA request to study this. It's why by
4 2008, or maybe even earlier, it was clear that we
5 have to revise it because terminology changed,
6 clinical guidelines changed, we have a whole
7 array of interventions which can alleviate
8 certain disabilities or prevent certain
9 disabilities from happening, and that's what we
10 did, what we are doing since 2010.

11 By now, all 15 systems were revised.
12 Six body systems were published in the Federal
13 Register as a proposed rule and the rest of the
14 systems are still going through the VA
15 concurrence. The way it works with regulations,
16 because VA Schedule for Rating Disabilities is a
17 regulation, which interprets the statute, which
18 tells us to compensate based on average loss of
19 earned income.

20 The regulations are drafted, which is
21 my job, based on the recommendation of the
22 workgroup and subject matter experts. I draft

1 the regulation, which is a medical legal
2 document, and then I work for compensation
3 service. And then it goes through the
4 concurrence within the compensation service.

5 Then it leaves compensation service
6 and goes to the Office of Under Secretary for
7 Benefits. And then from the Under Secretary for
8 Benefits Office, it goes through federal
9 concurrence at the Office of General Counsel at
10 the VHA, SSA, National Institutes of Health, and
11 HHS provide complementary concurrence.

12 And then after the Office of General
13 Counsel concurs, it moves to the Chief of Staff
14 and the Secretary. As soon as the Secretary
15 approves the regulation -- oh, yes, there is a
16 stop at the OMB, which takes a look at how much
17 this regulation will cost us, and the cost, to
18 simplify, includes the change in compensation for
19 veterans, based on number of veterans, levels,
20 and disability.

21 The cost includes the price of the
22 program update and, you know, you have to train

1 people, you have to change the electronic system,
2 and so on, and so forth. And once it clears OMB,
3 it goes to the Secretary. And once the Secretary
4 approves it, we can publish it in the Federal
5 Register as a proposed rule.

6 After we publish it as a proposed
7 rule, the public has 60 days of comment period
8 and the comment on the proposed rule, those
9 comments are coming into the hub, which is housed
10 by OGC, Office of General Counsel, and it comes
11 to the drafter. My regulation comments come to
12 me, other regulation comments come to the
13 physician who drafted those regulations.

14 And then it takes us, depending on the
15 gravity of comments, then it takes about three
16 months for us to draft final regulation, which
17 goes through the same concurrence process as I
18 outlined for the proposed rule.

19 On average, the timeline between me
20 finishing drafting and it being published in the
21 Federal Register is four to five years. It takes
22 about a year or year and ten months, maybe a year

1 and a half, the musculoskeletal was the largest
2 system, and it took the most time to review. I
3 had 16 orthopedists from different parts of the
4 body working with me for a year and a half. It
5 was a difficult system to review because there
6 are some other things which you cannot do; you
7 cannot change the number and you cannot insert
8 certain things.

9 That's why it's not only a medicine,
10 it's not only legal stuff, it's also office of
11 stuff, which nobody's aware until you start
12 working on it, but basically, the regulation is
13 ready, by medical standards, in about a year
14 after we start working on it, but it takes
15 another, almost five years, for it to be
16 published as a proposed rule.

17 It is why if you -- we can use your
18 help in probably optimizing the concurrence
19 process within the VBA and VA because it is very
20 important for our regulations for the VA rating
21 schedule for these regulations to be published on
22 time. It is medicine. It is science. Certain

1 things get outdated.

2 And as much as we try to use -- we
3 have to use lay language, and we approach
4 conditions from the point of functional
5 impairment, meaning we try not to tie it too much
6 to scientific markers which might change in time.

7 You know, if you have a limp, you just
8 have a limp and for us, it doesn't matter if
9 you're limping because your knee hurts, or your
10 ankle hurts, or your hip hurts, or maybe it's
11 your back, or maybe you had a stroke and that's
12 why you're limping. Functional impairment is the
13 cornerstone of what we are trying to tie to.

14 However, even with our wish to untie
15 it from exact scientific markers, it still can be
16 outdated, particularly, I have two hematologists,
17 oncologists here, how often do you revise your
18 guidelines? Probably every six months. And it
19 is why, you know, we're working very hard here.
20 There are medical officers who are in charge of
21 different systems.

22 We have fantastic support of our

1 attorneys and rating specialists who are helping
2 us to write good regulations, which are easy to
3 apply, for lay people, in regional offices, which
4 makes sense when it's translated into the
5 disability benefits questionnaires for medical
6 professionals to interpret right there on the
7 spot without calling regional office asking if
8 you say this, does it mean that?

9 That's what we're trying. Easier to
10 interpret language which is based on current
11 medical science and terminology. However, again,
12 with the lengthy concurrence, ages concurrence,
13 process, it is difficult to implement current
14 knowledge.

15 MEMBER FAY: So how much does the
16 Secretary, Honorable McDonald, right, how much is
17 he aware of this? I mean, he comes from Proctor
18 & Gamble, right? Corporate America, went through
19 business process re-engineering 20 years ago.
20 I'm sure Proctor & Gamble did that, just like
21 every other major corporation.

22 What you've outlined to us is a

1 Harvard business review case for the crying need
2 for a business process re-engineering, but in
3 order for that to happen, your chief executive,
4 whoever that is, has to be the chief sponsor of a
5 change like that, and has to start with culture.
6 Every one of those programs that failed, and most
7 of them did fail, failed because the organization
8 did not address the culture issue first.

9 So I mean, I'm the newcomer. This is
10 my first day here. What's the culture like here?
11 Is Secretary McDonald sponsoring a cultural
12 change in the organization focused on what you
13 clearly lined up as a broken system?

14 DR. VVEDENSKAYA: I do believe
15 Secretary McDonald is in the intense process of
16 re-engineering the culture, to include the
17 processes, and hopefully we'll have a clear
18 picture, clearer picture, tomorrow because MyVA
19 is Secretary McDonald's new initiative which is
20 geared solely at changing the culture.

21 I personally did not have a chance to
22 meet the Secretary and cannot talk personally

1 about his feelings, but I believe Secretary
2 Shinseki put VASRD update as, probably, Number 2
3 after exterminating the homelessness, and when we
4 started it, it was very robust, dynamic process,
5 but we have competing priorities, and we would
6 like to enhance the concurrence, VA, VBA
7 concurrence, system process for, particularly,
8 VASRD regulations, because they are --

9 MEMBER FAY: Well, it sounds like
10 something should be done in less than a year and
11 it's taking five years?

12 DR. VVEDENSKAYA: -- perishable and
13 they are much needed.

14 MEMBER SIMBERKOFF: I mean, part of
15 the problem, I don't disagree, but part of the
16 problem is that you're dealing with a system
17 where the number of concurrences, and reviews,
18 and publications, and, you know, requirements,
19 for example, a notice, are enormous. I can tell
20 you that the particular group that I was a part
21 of, which was infectious disease, we finished our
22 work in a relatively short period of time.

1 But it's taken, you know, several
2 years thereafter, you know, to get this done.
3 And honestly, I don't think it's something that
4 an individual Secretary can fix because it's part
5 of the government, and I honestly think --

6 DR. VVEDENSKAYA: It's part of the
7 transparency.

8 MEMBER SIMBERKOFF: Yes. I honestly
9 think that Secretary Shinseki tried very hard.

10 DR. VVEDENSKAYA: Very hard.

11 MEMBER FAY: I do not know McDonald,
12 you know, I just read about him, and General
13 Shinseki, I didn't work directly for him, but I
14 was at the Pentagon when he was there, right? So
15 I would believe that General Shinseki would have
16 --

17 DR. VVEDENSKAYA: Priority.

18 MEMBER FAY: Yes, would have done that
19 type of thing and starting with the culture
20 issue.

21 MEMBER GRANGER: But I want to make
22 sure I understand this now. You said this has

1 been going on since 2008?

2 DR. VVEDENSKAYA: Well, let's say
3 that, well, truly, since August 2010. That's
4 when we were hired.

5 MEMBER GRANGER: Okay, '10. I'll give
6 us two years. I come from DoD where I had to,
7 with a team of people, rewrite an entire
8 retention regulation for the Army. This is how
9 long, these are the things, we can recruit you
10 and retain you based on Department of Defense
11 putting out new retention standards and guidance,
12 and that was done within a year.

13 I mean, there were guidelines laid
14 out, this must be reviewed by this, this, this,
15 this. If there are no timelines put when things
16 should be reviewed or concurred, then it takes
17 the default of a no-timeline period.

18 MEMBER FAY: You have five days to
19 review or it is assumed that you concur.

20 MEMBER GRANGER: That's exactly right.
21 You concur.

22 MEMBER FAY: And that's the way these

1 issues are done in a year.

2 MEMBER GRANGER: That's a policy now.

3 DR. VVEDENSKAYA: I believe you.

4 That's how medicine works.

5 MEMBER GRANGER: That's in policy, but
6 if there's not a policy on internal concurrence
7 and review within Department of Veterans Affairs,
8 then they're going to default to what they think
9 is their own policy. This is my other duty
10 that's assigned to me, but it has to be in black
11 and white. This is the time you must concur and
12 non-concur or it's assumed.

13 And we send this out to the entire
14 world with DoD. We send it out to commanders in
15 Europe, Asia, all around the world, commanders,
16 and say, here's your timeline, you must concur
17 and non-concur with comments. If there's not a
18 document, if there's not a staffing document,
19 that exists within Department of Veterans
20 Affairs, this is what you'll get.

21 This is how you staff a document, go
22 from a policy to a regulation, an update. That's

1 it.

2 DR. VVEDENSKAYA: I concur with you.

3 MEMBER GRANGER: So it doesn't exist
4 then. There's not a document that tells you to
5 do that.

6 DR. VVEDENSKAYA: I'm not aware of any
7 document.

8 MEMBER GRANGER: See, that's the
9 issue.

10 (Simultaneous speaking)

11 MEMBER SIMBERKOFF: You know, to say
12 that it's the cause -- so to be honest, I work
13 for the Secretary, and the culture is what the
14 culture is. General Shinseki tried very hard to
15 change it, but we're talking about the cost of
16 the nation. You know, every time you change a
17 rating disability, you know, possibly, millions
18 or even billions of dollars, and I'm not saying
19 that DoD isn't, you know, responsible for
20 enormously important things, but, you know, it's
21 not how you're doling out taxpayer dollars --

22 MEMBER GRANGER: Well, it's not

1 different. We have to change this in order to do
2 a medical evaluation for retention. It's not
3 different.

4 MEMBER BROWNE: The one hold up seems
5 to be OMB that takes the longest time.

6 (Simultaneous speaking)

7 DR. VVEDENSKAYA: No, it's VA
8 concurrence.

9 MEMBER FAY: And before you go to OMB,
10 you got to make sure that the Veterans
11 Administration is totally in synch and you can do
12 it in 90 days or whatever the right time is.

13 MEMBER GRANGER: Yes, we have to put
14 this out to public comments too.

15 MEMBER FAY: And then you can work on,
16 what do we need to do to move OMB?

17 MEMBER GRANGER: I don't think it's
18 OMB, because we have to send all this to -- the
19 way the Federal Government works is no different.
20 Every agency must send it to OMB. OMB has
21 timelines they must respond, so the question is,
22 are there internal timelines? No, so that's the

1 answer then. Culture or not.

2 MEMBER FAY: And if it is too
3 expensive and the country can't afford it, at
4 least you've tried and you have an answer to
5 that, right?

6 MEMBER GRANGER: That's to let the
7 country decide. That's to let the 535 on their
8 Board of Directors to decide.

9 MEMBER SIMBERKOFF: Well, they
10 critique every step of the way.

11 MEMBER GRANGER: But that's okay then.
12 But again, let them do that, that's their
13 responsibility, but say we can't it out of here,
14 that's an internal issue.

15 MEMBER SIMBERKOFF: They've been
16 overseeing this process. It's not that they're
17 not aware of it.

18 MEMBER FAY: I'm sorry. I lost it.
19 Who's the they?

20 MEMBER SIMBERKOFF: They being
21 Congress.

22 MEMBER FAY: Oh, Congress. I mean, we

1 all have, all right? We get that, but you have
2 to make sure that the VA practices and procedures
3 are pristine first before you can start saying
4 Congress or the OMB.

5 MEMBER GRANGER: And I can't accept
6 that, well, we're worried about the cost of
7 America's sons and daughters, and how we're going
8 to rate them, I can't accept that being part of
9 this that, let the nation decide if they're going
10 to bear their costs.

11 DR. VVEDENSKAYA: And the workgroups
12 which reviews and advises every system, the cost
13 is not part of our work.

14 MEMBER GRANGER: No, it shouldn't be.

15 DR. VVEDENSKAYA: We are medical
16 professionals, we are regulatory professionals,
17 regulatory people are advising us on how to put
18 the language in certain ways that it's easy to
19 understand.

20 MEMBER GRANGER: Absolutely.

21 DR. VVEDENSKAYA: The cost is neither
22 our priority or even a part of our workgroup.

1 That's why, you know, we are talking about --

2 MEMBER FAY: Our expectation is that
3 you will be medically fair and unbiased.

4 MEMBER GRANGER: Absolutely.

5 MEMBER FAY: And that's all we would
6 ask, right? The cost is the country's cost.

7 MEMBER GRANGER: That's the country's
8 cost.

9 DR. VVEDENSKAYA: We believe we
10 deliver good regulations, it's just to clear it
11 through VBA takes long time and then when it
12 leaves VBA, then it takes a little bit more time,
13 and then when it come -- but it is my
14 understanding is, it is agency's decision on how
15 to concur on regulations. It's outside of my
16 paygrade, but I'm just trying to let you know
17 that we're working very hard.

18 MEMBER GRANGER: Okay. How can we
19 help you?

20 DR. VVEDENSKAYA: This particular
21 committee is almost, I mean, 50 percent
22 responsible for all of us medical doctors being

1 hired. It was the recommendation of this
2 committee to hire full-time physicians to do the
3 review of the rating schedule, which is medical
4 legal document. Because before, they had
5 consultants, one consultant at the time, and to
6 review the whole rating schedule, you needed a
7 team of people.

8 And you needed to reach out to subject
9 matter experts and not, you know, write the
10 regulations on your own. It is what we did.

11 CHAIRMAN MARTIN: And this is exactly
12 why I wanted you to discuss this and why I wanted
13 the committee to start thinking about it, because
14 our prime objective is to provide advice to the
15 Secretary on established and supervising the
16 schedule, to conduct periodic reviews of the VA
17 Schedule for Rating Disabilities. That's our
18 prime objective.

19 MEMBER GRANGER: Okay. Well, that's
20 your objective, Kirt, you got us --

21 MEMBER FAY: We're engaged.

22 MEMBER GRANGER: We're engaged.

1 MEMBER SIMBERKOFF: But the reality is
2 that, some of these systems had not been revised
3 since World War II.

4 MEMBER GRANGER: We had some
5 regulations too that hadn't been revised since
6 that.

7 MEMBER SIMBERKOFF: Yes. So, you
8 know, there were very substantial changes to be
9 in it. I'm not saying that I disagree in the
10 slightest with your, you know, dismay at the
11 length of time it's taken. I think we all are
12 dismayed, but it's not because of lack of either
13 the effort of the people that worked on the
14 individual projects, or, I think, I cannot speak
15 for the current Secretary, I can't speak for the
16 previous one, but my impression was that this was
17 one of, you know, Secretary Shinseki's most
18 important goals.

19 MEMBER GRANGER: But if we were asked
20 right now, where is it right now, where is it
21 right now being concurred or non-concurred?
22 Where is it right now? On whose desk? What

1 organization? What system? You know, where is
2 it? Can you trail it through your documentation
3 and provide whether it's concurred or non-
4 concurred?

5 DR. VVEDENSKAYA: I know exactly where
6 everything is. I don't need to trail. I have a
7 very good record keeping.

8 MEMBER GRANGER: So these are people
9 coming to work every day, they know it's in their
10 to-do box.

11 DR. VVEDENSKAYA: Yes.

12 MEMBER GRANGER: Okay. I rest my
13 case.

14 MEMBER FAY: So that's how you do a
15 business process review. You start with the PERT
16 chart, right?

17 MEMBER GRANGER: That's true.

18 MEMBER FAY: And so how many different
19 stops does it have to make and how long is each -
20 - right now, how long it, historically, have been
21 each one of those stops.

22 MEMBER GRANGER: Absolutely.

1 MEMBER FAY: And what it should be
2 optimum. Now, some of these offices should do it
3 in a day, some of them, it might take two to
4 three months, right? You have to make those
5 judgements before you can do your PERT chart, but
6 it really lends itself to a PERT chart, which is
7 no secret. Everybody does it. That's how we
8 went to the moon, right?

9 MEMBER GRANGER: Absolutely right. I
10 was getting ready to say that.

11 DR. VVEDENSKAYA: We did a good job
12 about three years ago, after all the efforts and
13 we did a good job with compensation service
14 concurrence because when I write it, it goes to
15 the official legal review by our legal eagles
16 here and their policy comes in. Then it goes to
17 my chief, then it goes to my assistance director,
18 then it goes to my director.

19 We re-engineered our process and we --
20 our compensation service concurrence is now very,
21 very quick. We got it down to, pretty much, a
22 month, because we worked together. Again, there

1 are certain systems which are more complex than
2 others, but we re-engineered compensation service
3 concurrence process.

4 But once it leaves compensation
5 service, we, unless I'm a compensation service
6 director, which I'm not, we don't have any power
7 on other people's stuff, because they have a
8 different --

9 MEMBER GRANGER: Right. But see, you
10 create a best practice, see, you re-engineered a
11 best practice, you have a model they can at least
12 look at as a yardstick for re-engineering a
13 process.

14 MEMBER FAY: So does the VA have an
15 internal office for process efficiencies, like
16 the Army did, right? I'm sure the Air Force did.

17 DR. VVEDENSKAYA: We can actually
18 check with MyVA presenter tomorrow, what they
19 have nowadays around, because --

20 MEMBER FAY: So in the Army, if you
21 didn't know how to do it, right, if you were an
22 intel guy and you needed to reorganize your

1 logistics, you had no clue how that worked, so
2 you went to this office, and they would give you
3 an expert on loan that would help you create your
4 PERT chart, right?

5 MEMBER GRANGER: Absolutely.

6 MEMBER FAY: And I would think VA
7 would have something like that.

8 DR. VVEDENSKAYA: I'm sure they do.
9 They have enough people who are veterans, meaning
10 they did go through rigorous training, but we are
11 trying our best and outside of our compensation
12 service there is, you know, the next level of
13 concurrence is the office which looks at all
14 benefits programs, not just compensation, so it's
15 retention and fiduciary, it's education, it's
16 all. It means they are looking at more programs.
17 We are just one program, compensation service
18 medical disability, then it goes to outside of
19 the compensation service, where people are
20 reviewing all sorts of regulations, all sorts of
21 programs, and it's more a load, and it's the
22 Office of Under Secretary for Benefits.

1 And then once it leaves us, it goes to
2 the office which look -- the next level of
3 concurrence, which looks not just at Veterans
4 Benefits Administration regulations, they are
5 looking at all the regulations; VA, VBA, VHA,
6 Veteran Cemetery.

7 That's why each time when it goes
8 further away from my desk, these structures are
9 getting more and more and more on their desks.
10 That's why, you know, if it was just on a
11 department level, me, being the Chair, of course,
12 I would have published everything a long time
13 ago, but this is the process which is supposed to
14 be -- it's in every agency and it translates into
15 transparency. We are not writing --

16 MEMBER SIMBERKOFF: But in fairness to

17 --

18 DR. VVEDENSKAYA: But how do you
19 balance transparency and efficiency?

20 MEMBER SIMBERKOFF: You should say
21 that there are at least two or three systems that
22 had to come back for redoing after the original

1 ones, right, including the mental health and the
2 diabetes, so it's a very complicated system.

3 DR. VVEDENSKAYA: Yes. Hematology
4 just came back for revising.

5 MEMBER GRANGER: But at the end of the
6 day --

7 MEMBER SIMBERKOFF: You're asking why
8 it's taking so long, and the answer is, it
9 shouldn't.

10 MEMBER GRANGER: It shouldn't. Okay.

11 CHAIRMAN MARTIN: Thank you. And the
12 other reason that we should talk about it is
13 because we are in a position to comment on it.

14 MEMBER GRANGER: Yes, we should.

15 MEMBER SIMBERKOFF: Well, we've been
16 commenting.

17 CHAIRMAN MARTIN: We have. Yes.
18 That's true.

19 MEMBER FAY: And where do our comments
20 go? To who?

21 DR. VVEDENSKAYA: To the Secretary.

22 MEMBER SIMBERKOFF: But they also go

1 to Congress.

2 CHAIRMAN MARTIN: Yes.

3 MEMBER FAY: We'll deal with the
4 Secretary first.

5 DR. VVEDENSKAYA: And as we work
6 together, today, tomorrow, next thing, I'm sure
7 in June, feel free to ask me where things are,
8 and formally, and formally, I always know where
9 all our regulations are. It's kind of my hobby.

10 CHAIRMAN MARTIN: Our next biennial
11 report is due at the end of September. Okay.

12 MEMBER BROWNE: Did we get the
13 comments back on the last one? Are we still
14 waiting for them to --

15 CHAIRMAN MARTIN: We did not and that
16 was 2014. It is on the agenda tomorrow. Do you
17 expect we'll have anything new or is it just
18 going to be, we haven't received anything yet?

19 DR. VVEDENSKAYA: It moved. The
20 biennial report moved to the chief of staff's
21 office. It means it's on the doorstep of
22 Secretary's office.

1 MEMBER BROWNE: And that's been two
2 years.

3 MEMBER GRANGER: I'm honored and I'm
4 blessed to be part of this group. I love it.

5 MEMBER ROBERTS: Representative of the
6 Secretary's said he was going to move it right
7 away.

8 MEMBER BROWNE: Two years is right
9 away.

10 MEMBER ROBERTS: He said he was going
11 to move it.

12 CHAIRMAN MARTIN: Okay. So other
13 items that anyone wishes to bring up today for
14 discussion?

15 MEMBER ROBERTS: I would like to see
16 some further follow-up, maybe at our next
17 meeting, or the next two meetings, on the issue
18 of veterans that are homeless. I think that's a
19 bigger problem than maybe a lot of people
20 realize. I think that's something you need to be
21 said about it.

22 CHAIRMAN MARTIN: Historically --

1 MEMBER SIMBERKOFF: So can I just say,
2 I don't disagree that homelessness is an enormous
3 problem and it's actually one of the 12
4 priorities, you know, of the Secretary, it was a
5 huge priority for General Shinseki, and really,
6 the bulk of the effort, despite what you may have
7 heard here for homelessness, has been tasked to
8 VHA.

9 MEMBER GRANGER: It has. They've done
10 a tremendous job.

11 MEMBER ROBERTS: Yes. I feel that
12 they've done a great job. I just wanted to get
13 some follow-up on whether or not it's continuing.

14 MEMBER GRANGER: Oh, okay. I
15 understand what you said then.

16 DR. VVEDENSKAYA: Well, it seems like
17 they will give the census number in August and we
18 can ask them to come back with updates in
19 September.

20 MEMBER ROBERTS: That would be great.

21 CHAIRMAN MARTIN: In 2013, when I
22 joined the committee, General Shinseki's number

1 one priority was end veterans homelessness by
2 2015.

3 MEMBER SIMBERKOFF: Yes. And as you
4 heard, there is some, you know, functional end to
5 homelessness, so it's not -- you know, there are
6 some people that will never be -- you know, who
7 don't want to, you know, go into what VA will
8 offer.

9 MEMBER ROBERTS: The other thing, is
10 it possible we could ask the Secretary himself to
11 address this committee?

12 DR. VVEDENSKAYA: I tried.

13 CHAIRMAN MARTIN: I actually asked
14 that question.

15 DR. VVEDENSKAYA: I tried. The
16 Secretary didn't have any available time in the
17 month of March. I also tried USB and his right
18 hand, and it seems like tomorrow we'll have, yes,
19 Deputy Under Secretary for Benefits, meaning, the
20 Under Secretary for Benefits right hand, Tom
21 Murphy, who used to be our compensation service
22 director.

1 He is very well versed in all things,
2 because he would be addressing the committee
3 tomorrow. And every time we have a meeting, I am
4 trying to book our Secretary. Unfortunately, I
5 was not successful to coincide our schedules yet.

6 MEMBER FAY: So you have 26 advisory
7 committees like this. Therein lays one of your
8 problems as to why you can't get the Secretary to
9 come to one of your committee meetings. You've
10 got 26 committees.

11 DR. VVEDENSKAYA: And also, he travels
12 a lot and --

13 MEMBER FAY: Right. And this isn't
14 his only priority. He's in front of Congress.
15 He's running --

16 DR. VVEDENSKAYA: And all this --

17 MEMBER FAY: But with 26 committees,
18 the reality of getting him to one of the
19 committees is --

20 MEMBER GRANGER: You have to go to
21 some location, get in front of the camera, and
22 say, hello, I just want to say I want to thank

1 you all.

2 DR. VVEDENSKAYA: Talking about
3 committee meetings, if I may get to, for a
4 second, minutiae. Looking at 2016, what I was
5 planning, with your concurrence, we'll have a
6 meeting in March, we'll have a meeting in June,
7 we'll have a meeting in September, and we'll have
8 a meeting in December.

9 They will be evenly spaced. And I
10 will send you, at the end of the week, a very,
11 very bare-bone schedule, and we shall make -- we
12 should make our schedule for the rest of the
13 year, just because this year, as Dr. Martin
14 mentioned, is the year when you're supposed to
15 work on your bi-annual report.

16 It's why I would suggest that during
17 June meeting, you can put aside three hours just
18 for yourself, I don't have to be here, I'll be at
19 my desk, and you all sit and work on your report
20 together. My personal experience working with
21 workgroup members is that you can do a lot of
22 stuff over the phone, via email, but the most

1 productive time spent is face-to-face, quick
2 bouncing, you know, when you bounce your ideas,
3 whichever, yes, I don't have to be here for that
4 particular interaction because it's yours to
5 chair.

6 But I would suggest let's put aside at
7 least three hours during June meeting.

8 CHAIRMAN MARTIN: Yes.

9 DR. VVEDENSKAYA: And take the whole
10 afternoon and sit and work together. We can
11 outline out topics of interest for June, we can
12 jam it slightly, it doesn't have to be, you know,
13 eight topics, it could be six topics, but I would
14 say, take one afternoon and just work together,
15 or one morning, either afternoon of the Thursday
16 or morning of the second day, this way nobody's
17 running to the airport.

18 CHAIRMAN MARTIN: Logistically, what
19 we did for the 2014 report was, we came up with
20 general ideas of areas that we needed us to
21 address a problem or an issue, and then from
22 that, we developed those topics a little bit,

1 perhaps additional presenters, or more questions,
2 or some fact-finding, and then we assign several
3 committee members to each of the topics to
4 generate a draft.

5 That draft would then be circulated to
6 the committee members, and then we would discuss
7 the draft at a meeting, and make some tweaks, get
8 it back on a final draft, and then see if there's
9 any change to that before it's entered into the
10 final document.

11 And so there is some spin-up required.
12 To meet that deadline of the end of September, we
13 probably should begin immediately to think of the
14 general topic buckets that we need to address.
15 We have a couple written down from last year,
16 which I can pass along to you, and we can look at
17 the -- typically, also, what happens is, if you
18 look at the last biennial review, which would be
19 2014, and if we get a comment back prior to this
20 report going in, and sometimes we re-engage some
21 of those topics that we feel necessary.

22 If, for instance, a topic didn't get

1 the attention or didn't get some action that we
2 thought would be necessary, we can re-engage that
3 and go back with it a second time. That's been
4 done some in the past.

5 But I just want to kind of lay the
6 groundwork because the deadline, in VA days, is
7 short. I mean, this is half a dog's life for the
8 VA.

9 DR. VVEDENSKAYA: I'm hoping, I almost
10 want to commit to it, because I'm not the
11 Secretary, you will have your biannual report
12 with all the comments by June.

13 CHAIRMAN MARTIN: Good.

14 DR. VVEDENSKAYA: I'm trying very hard
15 to make it all happen because it's been too long,
16 but also, for you to write your next set of
17 recommendations, you really need to know what was
18 responded to the previous one, but yes, by June
19 you'll have it.

20 CHAIRMAN MARTIN: Good. Thank you.
21 And if -- did both of you receive copies of our
22 last biannual report that we sent forward? So

1 you'll at least know what's there and the kind of
2 things we were focusing on. Okay. Good.

3 Comments around the table?

4 Hal, Tim, did you have any comments on
5 the development of items for the 2016 biennial
6 report so far?

7 MEMBER BIRD: Well, I'm -- go ahead,
8 Tim. Go ahead.

9 MEMBER LOWENBERG: Thank you.

10 CHAIRMAN MARTIN: Hi, Tim. Is that a
11 nothing? Nothing at this point, Tim?

12 MEMBER LOWENBERG: I'm sorry. I
13 thought you referred to Hal. No topics that
14 aren't on the table today, other than to
15 reiterate the process we used in the past.
16 That's been discussed, and I think it's been
17 fine. I do have a request, if and when we get a
18 special emphasis program update, it's frankly,
19 and what we typically did, haven't received in
20 this briefing today is, just that members of that
21 analysis and the titles of programs and the kind
22 of structural and organizational information, but

1 it doesn't tell me anything about the breakdown
2 of the homeless population.

3 Why -- is there any cause and effect?
4 Was it truly serendipitous? Is it possibly due
5 to anything the VA has done? Is there any
6 information, beyond the body count, you know, are
7 the demographics in the population that VA is
8 working from related to military campaigns, age,
9 gender, to service or service components?

10 Because I think what we ought to be
11 doing is focusing on how to reduce the homeless
12 population over time and anticipate if there's
13 another surge coming, because we know that the
14 vast majority of the homelessness in the past
15 have been Vietnam-era veterans, so do we have
16 another wave coming?

17 I don't think we learned anything from
18 today's briefing that would tell us whether or
19 not we anticipate if something's coming over the
20 horizon and what the cost and implications of
21 that would be.

22 CHAIRMAN MARTIN: Yes, copy all, Tim.

1 Good points and I agree that there seemed to be a
2 little lack of hard numbers and data.

3 MEMBER SAVOCA: And we don't really
4 know what they transition to, out of homelessness
5 into what? You know, did they suicide, death,
6 jail, or what? I don't know where they went.

7 MEMBER SIMBERKOFF: Many of them went
8 into HUD-VASH housing or VA, you know, housing,
9 or other things. I mean, honestly, VBA doesn't
10 know. I can tell you that. It's VHA that has
11 done all the work.

12 MEMBER BROWNE: That's why tomorrow,
13 we may get a better breakdown.

14 MEMBER SIMBERKOFF: I don't think
15 you're going to get it from VBA.

16 MEMBER BROWNE: No, tomorrow, I
17 thought somebody from --

18 DR. VVEDENSKAYA: MyVA presentation,
19 the people who will be presenting, they will be
20 the best people to mine for information and data
21 and everything. They have everything from every
22 subagency, from every staff. It's a group of

1 very energetic individuals.

2 CHAIRMAN MARTIN: I meant to bring
3 this up earlier, when we got the last brief on
4 homelessness in June of '14, Lisa Pape told us
5 that the way -- they mentioned chronically
6 homeless today, and the definition of chronically
7 homeless they use is no home in three years or
8 homeless three times in one year. So that's how
9 they define the chronically homeless.

10 And then they talk about homeless vets
11 versus unsheltered vets, that is vets in
12 temporary facilities versus people just out
13 living in boxes or under overpasses. And about,
14 in 2013 at least, half of the homeless were
15 unsheltered as opposed to the 57,000 total.
16 About 23,000 were unsheltered, but that's three
17 years.

18 MEMBER FAY: It's kind of really a
19 basic question, but when you go out and you ask
20 one of these homeless folks how do they know
21 whether they're veterans or not.

22 DR. VVEDENSKAYA: They ask them.

1 MEMBER SIMBERKOFF: They ask. They go
2 to homeless shelters and ask who -- you know, are
3 there any veterans.

4 MEMBER FAY: But if somebody's living
5 under the bridge and you ask them --

6 DR. VVEDENSKAYA: They physically go
7 and just try to --

8 MEMBER FAY: Yes, but if they say yes,
9 how do you know that?

10 MEMBER GRANGER: The database.

11 MEMBER FAY: So they take a name and
12 they check on the database before they agree that
13 that, yes, it is?

14 MEMBER GRANGER: There's a database.

15 MEMBER FAY: I was just wondering how
16 the process work, so they check it against a
17 database, right?

18 MEMBER GRANGER: Right.

19 CHAIRMAN MARTIN: The other thing I'll
20 mention is, although we haven't had the Secretary
21 talk to this committee, at least since I've been
22 here, we did have the chief of staff here, both

1 the past chief of staff and the current chief of
2 staff, several times. The current chief of staff
3 has been here twice now to talk to us.

4 DR. VVEDENSKAYA: It's the past chief
5 of staff too.

6 CHAIRMAN MARTIN: And the past chief
7 of staff was here.

8 DR. VVEDENSKAYA: Yes. The past one
9 and the past one. Mr. Nabors is a past one.

10 CHAIRMAN MARTIN: Okay.

11 DR. VVEDENSKAYA: You know, he is --

12 CHAIRMAN MARTIN: So we have been
13 fortunate to talk to the chief of staff. The
14 present chief of staff, when he was here the
15 first time to meet us, told us that his mission
16 was assigned directly from the president to solve
17 problems at the VA.

18 MEMBER ROBERTS: So is he the one to
19 tell us how to move our recommendations forward?

20 DR. VVEDENSKAYA: No. Our biannual
21 report is with the new chief of staff. The one
22 you haven't met yet.

1 MEMBER ROBERTS: This is somebody
2 different?

3 DR. VVEDENSKAYA: Yes. That's why I'm
4 saying that, Mr. Nabors, the chief of staff --

5 MEMBER GRANGER: He's no longer here.
6 The new chief of staff is acting or?

7 DR. VVEDENSKAYA: Acting.

8 MEMBER GRANGER: Acting. That's what
9 I thought.

10 DR. VVEDENSKAYA: Yes, Robert Snyder.
11 Yes, absolutely.

12 MEMBER ROBERTS: We have not met him.
13 We've met the other --

14 DR. VVEDENSKAYA: No, you met Mr.
15 Nabors.

16 MEMBER ROBERTS: We met Nabors.
17 Right.

18 CHAIRMAN MARTIN: Where is he? Where
19 did he go?

20 DR. VVEDENSKAYA: I don't know.

21 CHAIRMAN MARTIN: All right.

22 (Simultaneous speaking)

1 DR. VVEDENSKAYA: The meeting is
2 adjourned, Dr. Martin?

3 CHAIRMAN MARTIN: Unless there are any
4 comments or questions.

5 DR. VVEDENSKAYA: It's for the
6 recorder, will you please announce that our
7 meeting is adjourned?

8 CHAIRMAN MARTIN: Okay. Barring any
9 further discussion, the meeting is adjourned.

10 DR. VVEDENSKAYA: Thank you.

11 (Whereupon, the meeting in the above-
12 entitled matter was concluded at 4:32 p.m.)

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Disability Compensation

Before: US DVA

Date: 03-21-16

Place: Washington, DC

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