THE VETERANS' ADVISORY BOARD ON DOSE RECONSTRUCTION

MEETING VIII

DAY ONE

The verbatim transcript of the Meeting of the Veterans' Advisory Board on Dose Reconstruction held at the Westin Baltimore Washington Airport Hotel, Linthicum Heights, MD, on Sept. 10, 2008.

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NATIONALLY CERTIFIED COURT REPORTERS
404/733-6070

C O N T E N T S

Sept. 10, 2008

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P A R T I C I P A N T S

(By Group, in Alphabetical Order)

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REIMANN, CURT W., PH.D.
NIST

RITTER, R.J., FORMER NCO, USN

SWENSON, KRISTIN N., PH.D.

TAYLOR, GEORGE EDWIN, COL. USA (ret.) (via telephone)

VOILLEQUE, PAUL G., CHP

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GANZ, JOHN D., ATOMIC VET
GARRIDE, JACQUELINE, HVAC
GOCHNAUR, TIM, DTRA
GUIDRY, MARK, DTRA
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IRBY, ANNE, U.S. SENATOR BEN CARDIN
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PROCEEDINGS
SEPT. 10, 2008

(9:00 a.m.)

CALL TO ORDER AND OPENING REMARKS

BRIGADIER GENERAL MANNER: We'll actually get started, and the good news is, on time. And I appreciate everyone of course being here. Welcome to the eighth meeting of the Veterans' Advisory Board on Dose Reconstruction. My name is Randy Manner. I'm the Designated Federal Officer for this federal advisory committee. I'm also the Deputy Director of the Defense Threat Reduction Agency at Fort Belvoir. My purpose here is to ensure the meeting is held in accordance with the Federal Advisory Committee Act and the Sunshine Act.

I think we have a great agenda and we have -- I'm very pleased that we do have some veterans here. I appreciate you very much for coming. I'll now turn over the conduct of the agenda to the Chairman of the advisory committee, Admiral James Zimble. Sir.

CHAIRMAN'S WELCOMING REMARKS AND INTRODUCTION OF THE VBDR MEMBERS

VICE ADMIRAL ZIMBLE: Well, good morning, everyone. I'm delighted to see all of our

Board members are here and -- and they look fresh and rejuvenated from whatever, and I'm very happy to have every one of you here. First I would like to welcome General Manner. This is his first -- his first Board meeting. He's -- he's just come to us as the new Designated Federal Official and we're delighted to have a general in uniform in our midst. Makes me feel very comfortable.

I would also like to welcome -- I understand we have two atomic veterans here today and I'd like to welcome you. I hope you find this Board meeting informational and I hope that when you talk to your fellow atomic veterans that you'll pass the word as to what has transpired.

But I would ask the guests to please not ask questions or make comments during the course of the discussions. There is an appropriate time in this meeting -- in fact, several appropriate times -- when we will open the meeting up for public discussion. And if either of you would be inspired to want to testify or to talk about your experiences or your concerns regarding this program, we'll be happy to hear you. We

have opened -- during all of -- all of our previous seven meetings, we have always had some veterans who -- who were members of that unique cohort called the atomic veterans who have been here and who have testified as to their appreciation and perceptions of the work we were doing and of their relationship to the Veterans Administration and to the NTPR. So welcome, and we certainly will welcome any comments you care to make at the appropriate time.

I'm also very happy to welcome a -- one of the professional staffers of the House Veterans' Affairs Committee, the Subcommittee on Disability Assistance and Memorial Affairs, and that's Ms. Jackie -- Jacqueline Garride, and we are delighted to have her here. We think that at this particular meeting we have some good news that we would like to share, and we -- we have some -- some thoughts about how we should proceed, and we would certainly look forward to some direction from the House Veterans' Affairs Committee.

I would also like to introduce Ms. Cheryl Flohr. Cheryl, are you here? Is that --

Cheryl. Cheryl Flohr is a representative from the -- from the Service Center at the VA Hospital in Baltimore, and if any of the veterans here have any concerns about access or any medical problems whatsoever, we have a representative from the VA that you can speak with. And I'm -- we've had -- we've had a rep at every one of our meetings, and they have been extremely helpful -- some of the veterans' problems and I'm very grateful for the VA for their advocacy for all veterans.

MR. PAMPERIN: Admiral, just to clarify --

VICE ADMIRAL ZIMBLE: Oh --

MR. PAMPERIN: -- Cheryl is in the -- she's the Service Center manager for the Baltimore Regional Office that does the disability awards. However, you know, certainly she can address and -- and funnel --

VICE ADMIRAL ZIMBLE: -- okay.

MR. PAMPERIN: -- questions regarding health care.

VICE ADMIRAL ZIMBLE: Okay, but she can't prescribe. Is that what you're saying?

MR. PAMPERIN: She can't prescribe.

VICE ADMIRAL ZIMBLE: Okay. I would wel-- I

welcome all of the Board members. We are -- we are one -- missing one member due to health reasons. Colonel Ed Taylor unfortunately cannot be with us today, nor can he be with us by telephone. So we will -- we miss him. He was a very, very strong advocate -- a -- one of the atomic veterans and a very strong advocate for their program.

In addition, we will at some point have a telephone consultation from a consultant for risk communication, Ms. (sic) Elaine Vaughan will hopefully be here for part of the meeting in case we have any -- any need for her assistance.

And with that, I'd like to call the meeting to order and -- and I would like to introduce the Board members. Not that we don't know each other, but I think it's a good idea, for the record, to go around the room. I'd like to start with Dr. Zeman.

DR. ZEMAN: Good morning. I'm Gary Zeman. I'm the radiation safety officer at Argonne National Laboratory. I'm a retiree of the U.S. Navy. I was -- spent 20 years as a radiation health officer and have broad experience in

radiation health and radiation safety matters.

MR. VOILLEQUÉ: I'm Paul Voillequé. I'm a certified health physicist who's done work in dose reconstruction in various contexts.

DR. SWENSON: Good morning. I'm Kristen Swenson. I'm a medical physicist. I retired from the Air Force as a health and medical physicist.

MR. RITTER: I'm R. J. Ritter. I'm ex-U.S. Navy, a Korean veteran, retired marine engineer. I'm the second atomic veteran on the Board and I'm very pleased to be here.

DR. REIMANN: Curt Reimann, retired from the National Institute of Standards and Technology --

Sorry. Curt Reimann, retired from the National Institute of Standards and Technology where I served as a chemist for a number of years, and I chair the subcommittee on quality and quality management for the Board.

DR. MCCURDY: I'm David McCurdy, consultant to various government agency in the -- in the radioanalytical laboratory areas and measurement uncertainty and quality assurance. And I am a member of the SC-3 subcommittee.

DR. BLAKE: Good morning. I'm Paul Blake. I'm the Nuclear Test Personnel Review Program Manager at the Defense Threat Reduction Agency. I'm one of the two government representatives actually on the Board, in my case representing DTRA, the Defense Threat Reduction Agency. I'm a retired Naval officer, also a health physicist.

MR. PAMPERIN: I'm Tom Pamperin. I'm Deputy Director of the Compensation and Pension Service of the Department of Veterans Affairs. We're the ones who pay disability benefits, and I am a retired Reserve Army officer.

DR. LATHROP: I'm Dr. John Lathrop. I am a risk analyst and decision analyst in the systems and decisions sciences part of Lawrence Livermore National Laboratory, and my fields of specialty are risk management and risk analysis.

MR. GROVES: My name is Ken Groves. I'm a retired Naval officer. I spent 26 years both as an enlisted man and a radiation health officer. I was the first Director of the Navy's Nuclear Weapons Radiological Controls program, went to work at Los Alamos National

Lab, and now have my own consulting business.

DR. FLEMING: Good morning. I'm Patricia Fleming. I'm the Vice President and Dean of the Faculty at St. Mary's College in Notre Dame, Indiana. I am a philosopher by training and I have worked on the interface between radiation issues and ethical concerns.

DR. BOICE: I'm John Boice. I'm professor of medicine at Vanderbilt University and Scientific Director of the International Epidemiology Institute. I'm a radiation epidemiologist. I study populations exposed to ionizing radiation. I've done so for the last 35 years. I've also retired -- officer in the United States Public Health Service, and I've had a military ID card my entire life. My father was in the military, served in World War II and the Korean War, and my -- my brother was a Navy officer in the Persian Gulf war.

DR. BLANCK: Hi, I'm Ronald Blanck, internist, former Army Surgeon General, retired as the President of University of North Texas Health Science Center, and currently the partner and vice chairman of Martin Blanck & Associates.

MR. BECK: Good morning. My name's Harold

Beck. I'm retired from the Department of Energy's Environmental Measurements Laboratory. I'm a radiation physicist specializing in dose reconstruction, and I'm the chairman of the subcommittee on dose reconstruction.

VICE ADMIRAL ZIMBLE: Thank you. And I guess I should introduce myself. I'm Jim Zimble. I'm retired Navy. You've heard about -- you've heard all the expertise that's around this table. I don't have any of that expertise. I'm a physician. But the -- since I don't have any -- any special talents, they asked me to chair this committee, so I'm happy to do so. With that, I think -- oh, I would ask -- I would remind the Board members that when they need to speak, if you'll recall, we have the custom of placing our -- our name plates in an upright position, and when you don't want to speak, you put them back down. And I'll do my best to -- to catch that, and I've asked General Manner to assist me in making sure that I don't miss anybody with their name plate up and then we'll open things up for discussion. I think the first item on the agenda -- and by the way, the -- you veterans have folders and

the folders should contain the agenda for today. It should also contain a copy of the public law that created this Board and -- and our charter, so that you can understand what the purpose of this Board was and what we can and -- what we -- what we can do, and I'll explain later, if -- if you need to know, what we can't do.

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

And with that, I would ask Dr. Paul Blake to please give us a presentation of the work that's -- that has preceded this meeting at the NTPR.

DR. BLAKE: Thank you, Admiral. I'd like to give a brief update on the Nuclear Test Personnel Review program at the Defense Threat Reduction Agency, with a focus on what we've done since the last meeting. What I'll try to cover is, first, where we are, what the status is of our program, with updates on some of the technical issues; then go over the recommendation status from the Board of where we are on the recommendations that have been proposed; and finally, brief thoughts on the

road ahead for the program.

If you look at this slide right here, you notice back in about 2003 we had a significant peak on incoming cases, coming in from -- mostly from the Veterans Administration from atomic veterans on claims for radiogenic disease. And what had happened back then, just for a little history, was there had been a GAO study and then a National Academy of Sciences study that looked at the dose reconstruction program at DTRA and it questioned some of the methods they were using. And based on that study, there was a decision made at the VA to return all dose reconstructions to DTRA that had not gone to service connection. And so we had a large peak on incoming cases at that period of time.

After that period of time, incoming cases have been fairly steady. And people often ask why is it still steady? Obviously our population of atomic veterans is aging, wouldn't that drop off? But as you may expect, as people age they develop more disease and therefore are more likely to file for compensation based on that disease. We have yet to see any significant

drop-off in work level coming in. And I expect that will happen in a few years, but we're still at the point where it's a fairly level workload coming in.

Right as of now, over the last four months, we averaged about 97 cases coming in per month. Of that, probably about two-thirds were from the VA and the other third was based on personal inquiries and responses to the Department of Justice where veterans can also file for compensation. Of the VA cases coming in, probably about 30 of them were actual requests for dose reconstruction where we had to do a significant amount of work.

I do have one other highlight up there I think that's very important, and that is when the VA Regional Office came on line. And one of the recommendations that came out from this Board, which was a great benefit I believe to both the VA and DTRA, was to centralize all the radiogenic disease claims in one VA Regional Office instead of I believe the 57 or 52 offices they had. And that helped us tremendously on interfacing between the two agencies, so a really significant breakthrough,

from our viewpoint at DTRA, when VA centralized their claims office. And we work very well with them on almost a daily basis on -- back and forth with phone calls, e-mails and clarification. Having just singular points of contact is -- is great.

I would like to show you, at least from a graphical viewpoint, of the impact of what this Board has done for us. If you look back on when that public law was actually passed, and then after the public law occurred we started having meetings -- I believe the first meeting started in 2005 from this Veterans' Advisory Board. And at the first meeting we simply introduced concepts, no recommendations came out. But by the second or third Veterans' Advisory Board meeting, we started getting recommendations.

And our agency was in problems at that period of time with regards to this program in that we'd had a large backlog of veterans' cases and we were trying to solve the problem. And the difficulty was, we basically doubled our budget and, as you can see, the cases -- caseload was not coming down that quickly, even with

throwing money at the problem.
What we needed was a different approach, and the challenge in changing approaches within a federal agency is we have to follow the public laws and our Code of Federal Regulations. And the Code of Federal Regulations that we were following at that period of time said we had to complete dose reconstructions in this very rigorous manner, and it turned out to be both very time-consuming and expensive, and not necessarily the appropriate way to go.
And so what the VBDR did for us, through discussions and public recommendations, allowed us to develop an expedited dose processing. And basically what we switched from was doing mean doses and the associated uncertainty with that, going to an approach of upper bounds. Based on our large historical repository of dose assessments we could say here's what the worst possible case is, and then assign that to the veteran. And that greatly improved the program, and you can see the dramatic drop-off based on those VBDR recommendations.
And as of now, total cases that are at DTRA -- we're a little less than 150. Our mean

response time is about 44 days. Some cases come in, go out fairly quickly. But the cases that are more challenging, why the -- the maximum right now is 128 days, are we have to do a number of interactions with our veterans. And with our veteran population, most of our interaction's done by telephone or mail. We don't use the internet and e-mails as much for what we have to do.

And for instance -- on a dose case, for instance, typically we receive the case from the VA. We send out a letter to collect history from the veteran. We have to send that out, receive the response. We also have to get a Privacy Act release form. That takes a period of time. That information comes back. We then develop a Scenario of Participation And Radiation Exposure that takes that individual's -- veteran's history. We do a lot of research on the particular unit they're associated with. We put that all together. We send it out to the veteran again to get input. Based on that input, once again it comes back to our agency, then we can start the dose reconstruction, whether it's a non-expedited or expedited. And

as you expect, that takes some period of time. So I believe even though we've reached an optimized system, the mean response time will truly stay around 40 to 50 days. And our metric for success is to make sure that no cases take longer than six months to go through. And right now you can see that even the -- the worst possible case is only about 128 to 129 days. So from our viewpoint, the recommendations of the Board have really optimized the business processes at the Defense Threat Reduction Agency for the NTPR program. So as I point out, the recommendations have significantly improved our responses to veterans, to VA, Department of Justice. They've significantly increased favorable medical opinions. And where I can't speak for the VA on compensation, the VA does present data in a public forum, without Privacy Act material, that discusses medical opinions. And when you analyze that data, the impact that occurred from this Board on VBDR recommendations was to increase favorable medical opinions for atomic veterans from nine percent to 29 percent, basically a 20 percent

improvement. And that was based on primarily service connecting skin cancers and cataracts that can also come about from skin contamination going into the eyeball.
And that was the significant increase because primarily through the compensation program when radiogenic diseases -- cases come over to DTRA from the VA, they come over from either a presumptive or non-presumptive compensation roll, and the cases that we primarily see that require dose reconstruction at this point are primarily skin cancers and prostate cancers, making up over 80 percent of the workload 'cause we're dealing with primarily a male population.
The expedited savings within just a two-year period, Fiscal Year '06 and '07, saved us between $15 and $16 million, our agency, as we're able to expedite. I no longer quote cost savings anymore because it's become the standard of how we have done that, but it would be significantly less because that -- that was based on backlog and now we're in a steady state condition.
It significantly dropped inquiries from

Congress based on veterans' interest to the -- asking their Congressmen to ask DTRA what was going on. We were averaging, in that period of time, about six Congressional inquiries per month. We're down to one or less now. There was a significant backlog in responding to those Congressional inquiries, too, as we tried to get the information.

We've also, as I mentioned, reached an optimized and steady state condition.

I'd like to speak a little bit about where we're going with our program, and the first thing is we are updating our Radiation Dose Assessment procedures, and perhaps the most important part of that procedure is how we deal with uncertainty. When we look back 50-plus years and try to look at -- to calculate doses for our veterans at that period of time, some of them were wearing film badges, some of them weren't. But even if they wore a film badge, how do you take into account the inhalation of radioactive material from fallout and a resuspension, what fell on their skin -- the film badge doesn't give you all the information in that case. It's a very challenging

calculation, and perhaps the biggest part that drives the program is the uncertainty associated with that calculation, and that's where we're focused now.

We're in the process of getting ready to publish a DTRA Technical Report on "Probabilistic Uncertainty Analysis in the NTPR Radiation Dose Assessments." The initial report's been prepared. It's undergone the initial external peer review. We're revising those comments. My hope is -- once we have the draft report ready to go that's gone through the first layer of peer review -- is to forward it to my fellow VBDR members for a peer review and chop, too, before we finalize and publish it.

Technical Basis Documents are the foundation that our Standard Operating Procedures are based on that we then do the dose reconstructions, and so the science is really based on these Technical Reports that people chop on, say are they effective. Then based on that we say here is the step-by-step procedure of how we actually do a dose reconstruction.

From a quality viewpoint, another place where

we're much more focused now at this period of time in the program -- a recommendation that came from the Board, from our quality assurance group, was to undertake double-blind radiation dose assessments in our comparisons. And we recently just finished our fourth one. We did them in both June of 2007, January, April, and just recently in July of 2008. And how these double-blind assessments were performed was an NTPR health physicist completed one through the standard operating procedures where one health physicist will do the initial workup, a peer will do a technical review on that, and finally a senior health physicist will then review that; and then it's sent down to another external group to do a review. So there's a lots of checks and balances in this process because they're complicated to do. And -- but we also brought in two non-NTPR health physicists to completely independently perform these dose reconstructions, but using the NTPR standard operating procedures. And I think what we've noted is, one, significant progress in the documentation to do these procedures; and two, that -- I realized after we started

this that we needed to actually do a formal training program for our non-NTPR health physicists, which we conducted, and that certainly was beneficial. But even with all of that, it's challenging for credible health physicists who are knowledgeable in this area still to produce a credible dose reconstruction that's similar to what the SAIC, our contract staff, does at DTRA for the government health physicists. So it's an ongoing, continuing QA feature of our program, and we received some recommendations from some of the panel members at a technical level yesterday that we look forward to implementing in the future. Another area where the Board has focused us through recommendations is an independent review of the expedited radiation dose assessments. And there the concept that has come has been a Decision Summary Sheet. Can we -- can we write down exactly what were the key points in this decision tree that made us decide to go from an expedited process versus a full radiation dose reconstruction. And the DSS concept has actually morphed, based on recommendations from the last meeting, into two

parts. One is done by the government health physicist where we go through and basically triage the case -- does it look like it is a normal case or is it an exceptional case that we require a much more rigorous calculation. That information is pulled from our centralized database. We look at all the previous radiation doses or film badge information and then make a decision, and then it's sent down to an external entity to actually review the government physicist's decision. And finally it comes back to the government to actually sign that out. In all cases the government is ultimately signing out the dose assessments, making the final decision. But we've instituted, based on the Board's recommendations, some -- an external chop on some of the decisions that the government's actually doing, which is -- which is fine. That's part of the peer review process. But we've also implemented a different -- a second part to the Decision Summary Sheet where when we do a full radiation dose reconstruction now we write a summary of the key decisions that were actually involved in that, too. And

we find that very useful, at least when we go through the audit process.

I would mention to you when you add this type of quality assurance to any type of business plan, it does take some more time, take some more dollars to put it through. And so my estimate was when we put this in place it would take -- it would add an extra one to two weeks onto our bottom line. So I was somewhat concerned that our average 44 days would grow by one or two weeks. It's grown a little bit, but where we also gained some significant savings in through-put was an arrangement that Mr. Pamperin, my counterpart from the VA, offered was we hooked up our virtual private network so we could move data back and forth between the VA and DTRA through an encrypted method over the internet -- 'cause we deal with Privacy Act material. And what that will do, and we're in process of moving ahead on that, is basically it'll cut down our through-put time 'cause we no longer have to count for the mail moving back and forth.

And if both agencies were digitizing in the first place, why duplicate that information?

It should be dup-- it should be -- the data should be digitized at one facility, then shared with the other facility. So obviously we put very strong controls on what information can be shared and so forth that's appropriate, but there is a certain amount of information that is passed back and forth through the agencies for us to do our work. And if we can move that faster, we can improve our business practices.

Here is a follow-on slide showing the graphics from when we actually did the Decision Summary Sheets from our -- by our external contractor. And the terminology I would show there is the -- we used reject. I think the more appropriate term would be a technical comment, and then an editorial comment, which is more a comment on judgment. And for instance, two examples of that yellow -- or yellow block on when we're reviewing dose reconstructions.

For instance, the technical comment there in red would be based on -- an example was we were reviewing a Hiroshima/Nagasaki dose reconstruction and the government analyst stated the period of time that the exposure

actually occurred, and was off by one day. And so the external reviewer looking at that says -- noted that problem, said that's a mistake -- it's not a judgment call, it's actually a mistake. That came back and that was corrected before the actual dose reconstruction was signed off, so there would be a technical problem.

And editorial concern is more of a judgment call, and one of the areas where we often have to use judgment is we're reporting doses to a specific organ. How much energy is actually deposited in there is the risk factor that determines the probability of causation. In some cases, for instance, a veteran may file a claim -- let's say for a disease that wouldn't typically be considered radiogenic, let's say arthritis. How do you determine where you're going to report that dose to arthritis that deals with cartilage throughout the body is a challenge. And the other challenge, from a physics viewpoint, there are factors known as dose conversion factors that aren't necessarily there for certain types of organs. So there's some judgments that'll have to be made on

occasion, and in some cases that's not appropriate by health physicists. We actually bring in a -- a very well-trained clinician, a physician, to help us determine how to make those judgment calls. And in that case the editorial was a question, did the government -- DTRA -- basically make the right judgment there; and if not, what should be documented is the actual medical opinion by the physician on saying which organ we're actually going to use and what was the basis for that.

This Virtual Private Network between the two agencies is basically moving secure PDF documentation, scanned in, between the two groups. It certainly sped us up, and it also allows for a weekly case status exchange so we both know exactly where -- where each case is at what period of time. So if the VA has any inquiries or DTRA has any inquiries, we're both on the same page.

I'd like now to move into the status of the VBDR's recommendations specifically to my agency. There've been a total of 18 formal recommendations that have come over from Chair -- signed out by the Chair to the Director of

my agency. The first ones started coming in June of 2006. They followed in November, March, April and September of 2007. And for the first time, at the last meeting we didn't receive any formal recommendations. And as of last meeting when I briefed you, 11 of those recommendations had been completed and seven were ongoing, and I'd like to give you now the status of the seven ongoing recommendations. Here's a summary of which recommendations are still ongoing, and the first one deals with NTPR undertaking a comprehensive analysis of uncertainties for all beta dose exposure scenarios. And when this recommendation was originally made back in June of 2006, we had not developed and implemented the expedited skin dose methods, and so this was -- this recommendation had a much greater impact. Now it has a -- a significantly less important impact on our program since many of these cases are basically released based on an expedited dose, but it still does impact some of the Hiroshima/Nagasaki cases and some of the exceptional cases. So it -- it's an ongoing event where we've -- we've published -- well,

we've drafted DTRA Technical Reports. We've actually sent them out to an external contractor -- in this case it was the National Council on Radiation Protection -- and they came back, after months of review by senior scientists looking at our Technical Basis Documents, came back with a good, thorough peer review of that. That's come back to our side. We've come back with our recommendations, and so we bounce back and forth once or twice before we finally resolve it and go forward to technical publication. And we're in the process of finally publishing this Technical Basis Document, but the -- the peer review process in science takes time for people to do things, and that's where we are on this one. But we hope to -- within a few months to have this finally published and move on.

The next recommendation was a recommendation -- after NTPR's implementation of a QA Plan, Program and Procedures Manual -- which has been completed -- NTPR submit the following key QA tracking results to Subcommittee 3 on a quarterly basis. And this has been done somewhat informally, but the -- for instance,

yesterday I released formally to SC-3 the performance and QA metrics, the QA corrective actions and audit reports. But we've been briefing these at various meetings to SC-3. And once again, this is a little bit of evolving process. As we present the metrics, they come back with some recommendations on how to improve them where -- where we're moving. The next recommendation is that a detailed Standard Operating Procedure (SOP), including incorporated Standard Methods, be developed that ensure the appropriate treatment of upper bounds. Well, we have published that procedure. It runs to over 1,400 pages of very great technical detail on how we do dose reconstruction. And the initial publication of the uncertainty section was in March of 2008. But I will tell you that is still an area that is undergoing revision and peer review, and so when we once again complete that, we'll be forwarding -- as I mentioned earlier -- to members of the VBDR to take a look and give us some final feedback before we actually publish it on the internet -- on the web to show how we actually do our methods.

The next recommendation, number 14, was for NTPR to discontinue the use of default upper bound factors for non-expedited radiation dose assessments and develop procedures to perform full probabilistic uncertainty analyses for these assessments. NTPR standard operating procedures should specify whether uncertainty estimates from individual sources are independent or correlated, and when and how uncertainty should be propagated. A significant part of this has actually been done and is in our Procedures Manual, but -- as I mentioned before, this is similar to the previous one -- we're still undergoing some peer review and revision to that procedure. The next recommendation was for NTPR to ensure its external review entity conducts spot checks of specific -- of specific calculations and computer programs. Example, our MathCAD template output. MathCAD is the software that we use to complete a radiation dose assessment, the actual calculation. For people who've used Excel, MathCAD is somewhat similar to that, but all your dimensions, your units, are incorporated into that and it has some

significant other features where we do different fits and interpolations and extrapolations in our data. For more complicated calculations, the MathCAD calculations can run 70 to 80 pages. This is where the complexity gets involved that -- when a nuclear weapon goes off many types of radionuclides are produced, decaying at different rates, and some of our veterans were marching through periods of fallout and areas where it was more than just the initial weapon fallout. There was previous weapons where they were marching through. The complexity becomes very significant on some of these calculations, and then trying to determine, many years later, what was the actual scenario; where did they march or where were they located. This is what makes these calculations extremely time-consuming. And part of that was -- we were requested was to do a validation and verification of the software that we'd done -- that we use on a daily basis, and that's in the process down through an external contract group known as Oak Ridge Associated Universities is now completing their -- the initial validation

and verification of our software program. We have a senior health physicist working with a commuter staff reviewing what we've done. Obviously we've done our own reviews internally looking at this program, but we're in the process of using an external contractor to validate and verify our software.

With regards to spot checks, those spot checks you saw are ongoing, some of those are in the graphical chart I showed you before, if you remember that like yellow, red and so forth showing the -- it was actually the results -- summaries of some of those spot checks that are ongoing.

Recommendation number 16 in September of 2007 was that NTPR document its justification to expedite a case in the case file and that external quality assurance audits comment on the appropriateness of the decision to ex-- to expedite. I discussed this with -- somewhat earlier in the concept of the Decision Summary Sheets. I think we've made some significant progress and success on this. There are -- we're still tweaking and still releasing to SC-3 where we are, and yesterday I promised to --

over the next few months to give them a complete analysis of all the Decision Summary Sheets that we've been releasing, so I -- I think we're most of the way there on this one, but we're still looking for the final tweaks before we declare victory.

September of 2007 recommendation number 17 was NTPR to expand its technical bases and criteria for expedited case processing. We drafted a -- a lot of this material was in our previous policy and guidance manual. We're -- moved it down to our Radiation Dose Assessment SOP and released a chapter, though it's not been incorporated yet, on assessment of these expedited cases. One of the recommendations that came through previous SC-1 meetings was to include how we did this process for non-radiogenic disease, and I believe we've included that in there, but we've yet to release it to SC-1 and SC-3, and I hope to get that out in the next month or two to you.

So in summary, DTRA accepted for action all 18 VBDR recommendations that have -- that have been delivered to us from June 2006 through September 2007. We've acted on all the

recommendations. And for the recommendations that are still ongoing, we certainly support continuing those. Some of the recommendations are open-ended. For instance, providing quarterly NTPR quarterly metric summaries to VBDR SC-3, and SC-1 and we're happy to support that. We'll continue providing that information.

So the road ahead. We still have one major challenge in front of us, and that is to take all the recommendations and how they have affected our procedures and basically revise our Code of Federal Regulations under the Department of Defense that's entitled, briefly, the "DTRA Dose Reconstruction Policy," and hopefully we can -- that's been pushed back a little bit as we continue to see some technical challenges and feedback from the Board. But I hope within the next year to actually have that occur.

From a viewpoint of the NTPR program, even though we've optimized our business practices, from a technical viewpoint in refining our SOPs, we're still busy, very much so, over the next year. I hope after about a year that

things will calm down, but we're still -- based on your feedback and input, we're still very busy on publishing our Technical Basis Documents and getting ready to post all our procedures on the web. And I see that as at least another full year of effort before we feel like we're -- we're satisfied where we are.

And there's been some discussions on possible transitions to the Veterans' Advisory Board on Dose Reconstructions, and we certainly will support whatever the agency directors feel comfortable and stand behind that.

So at this point in time, I'm finished with my brief comments.

BOARD DISCUSSION

VICE ADMIRAL ZIMBLE: Dr. Blake, thank you so much for that presentation. That -- you've brought everything together very well and I'm really very pleased with the way both agencies have accepted recommendations that -- that worked with the Board to -- to expedite process and -- and move things along. And it's been a -- it's been a good experience for the Board. It's been a good experience, as far as I can

tell, by the agencies. And although we haven't heard from Mr. Pamperin yet, I would say the same with Mr. Pamperin, that -- that the cooperation that this Board has received from both agencies has been outstanding.

The Board -- for those of you who don't know, the Board meets here -- this is the eighth -- eighth session in three years, but in between these sessions subcommittees are working with dose reconstruction or with the claims processing or with quality assurance and quality control, or with communication, these four subcommittees have worked very hard, many times both electronically and -- and traveling together to meet, and put in some really long, hard hours to come up with recommendations that we hope will help the process.

This is a truly dramatic event that we really ought to have some fireworks and -- and drop down some balloons because the -- the -- the steady state that you've reached is certainly an acceptable one to the veteran. To get a response back on -- at -- on average of only six weeks is remarkable. I mean we're talking about the government. We're talking about the

bureaucracy. We're talking about lots of in and out baskets that have to happen. But -- and what has to be accomplished in -- in trying to ascertain what an individual atomic veteran received in dosages when he doesn't -- when he did not have a dosimeter or a film badge and have to look at the fingerprint of the particular atomic test in terms of the types of isotopes it will produce -- the calculations are ominous. They require a great deal of precision. There's a great deal of uncertainty. And I would tell you that every time an assumption is made there's one very strong edict, and that is that assumption will be made to the benefit of the doubt of the veteran. So we've always moved in the direction of giving the veteran the benefit of the doubt. The process was like a master's thesis. The process cost a lot of money and the process produced finally a best estimate of a dose received many, many, many years ago in unusual circumstances. And what was the usual response time when we started this process and before we started this process?

DR. BLAKE: Well, before we started the process

we had cases backed up because of that period of up to four years, and that --

VICE ADMIRAL ZIMBLE: Right.

DR. BLAKE: -- was simply unacceptable. The res-- the mean response time was certainly less than that, but that's the worst case analysis, and I -- and I don't quote the mean response time because it was -- it was -- it so varied. What we ended up doing when we got behind was we pushed the tougher cases to the back. We got the easier ones out, but then those tougher cases hung on for a while.

VICE ADMIRAL ZIMBLE: Right. The -- the genesis of -- of this Board, the creation of this Board was specifically because of the problems that were recognized on the Hill by the Veterans' Affairs Committees in the House and Senate, delays that were just unconscionable for the veteran. And so we came up with some recommendations and we -- we gave -- we gave Dr. Blake 18 recommendations. I'm sure he welcomed them all and wanted a lot more. But -- but the bottom line is that we have made a significant stride in terms of both the -- the way that we did the expe-- expedited

doses is -- looking at worst case scenarios, though, is -- I don't think there's a single case where, if you did an actual dose reconstruction, it would match the number that we expedited and gave them -- gave them a worst case dose. And for that reason, a lot of veterans who had certain types of skin cancers received a very positive feedback from -- from their claim.

I -- I'm delighted that the staff -- professional staff member, Ms. Garride, is here from the House Veterans' Affairs Committee. I'm -- I'm -- I know the Board is disappointed. We were hoping that Congressman Filner, who's the chairman of that committee, ha-- he had intended to join us, and -- and we were going to enter into a dialogue with him. Unfortunately there -- this is -- these are trying times on the Hill and he had some things that demanded his attention that had a higher priority. But I am delighted that you're here, Ms. Garride, and I sure hope that you relay back to him the great success that has occurred with the veterans' Board in terms of this.

And I -- I'm going to open up now to the Board

for any comments or questions you have. I'm going to save my comment - I have one question and I'm going to save it to the very end.

DR. BLAKE: Yes, sir.

VICE ADMIRAL ZIMBLE: Dr. Boice?

DR. BOICE: Well, Dr. Blake, I'd also like to reiterate what Admiral Zimble said on congratulating you on all the accomplishments that you very nicely summarized in this short time of a very complex subject and what you've done over the last three years.

I was also impressed with what you said, if I understood properly, that early on, before we started, the favorable reviews for compensation was on the order of nine percent and now they're up to around 29 percent, and that seemed to be also a -- an accomplishment in favor of the veterans.

I -- there's -- I say -- perhaps you -- my one question, though, and I was impressed, of course, going -- that the -- that the dose reconstructions from beginning to end on average take about 44 days now. And I thought that -- and -- and this is my question, if that's -- my question is, is that in fact from

when you receive the request for the dose reconstruction it takes 44 days, or is it -- the 44 days the entire time from when a veteran makes his request for consideration and before he gets a yes or no response? What is the -- seems to me that is a -- an appropriate time of ad-- from the request being made to when he gets an answer yes or no.

DR. BLAKE: Dr. Boice, two points there. One, that metric's defined on when we receive it at DTRA, so we date stamp it when we receive the request from VA. But the -- the second thing is, that overall metric of 44 days looks at all incoming -- the average for all incoming -- dose reconstructions are usually the ones that take a lot longer, so they're sitting at the -- more the 128-day case. That includes historical reviews for presumptive compensation, personal inquiries and so forth on the 44 days. So the more challenging dose reconstructions are sitting more on the -- the farther side, but we're still getting them out within four months, and under the six-month metric that we use -- that we declare is what we need to do with -- at our agency.

VICE ADMIRAL ZIMBLE: I might add also that the -- that you're only now having to, despite getting about 100 cases a month, now doing only doing about two or three full dose reconstructions.

DR. BLAKE: It might be even a little less than that, but that's right, sir.

VICE ADMIRAL ZIMBLE: Is that right R. J. Ritter?

MR. RITTER: Dr. Blake, I sit here wearing two hats, one as a member of the VBDR and the other representing America's atomic veterans. And I know you don't get any good news phone calls in your office, but -- but we do. And since you have started improving the system and shortening the time between filing a claim and at least getting some word back to the veteran, we've heard from the community and they're very pleased. And on their behalf, I want to thank you again for this presentation.

DR. BLAKE: Mr. Ritter, thank you very much, but I -- I have to tell you, we do get some good news from the veterans, too. For the -- for the most part, they're a respectful group to deal with. Lieutenant Commander Sanders,

who's my deputy in uniform out there, is often on the phone with them, so they're dealing with an active duty officer, so they can interface-- on a personal basis. He is the one who is signing out all the decisions at this period of time. So even though it's a combination of civil servants like myself, or retired, active duty, contract group working it, the interface that the agency sees for the most part is our uniformed service representative who's there, so -- and we do get positive feedback from the veterans' community.

VICE ADMIRAL ZIMBLE: Dr. Swenson.

DR. SWENSON: I kind of have a follow-on to John's question. That 44 days, you date stamp it when you get -- receive it from the VA, and then you send your result to the veteran, but you then don't include the time that the VA takes to respond because you have no idea how long they will take to adjudicate the claim. Correct?

DR. BLAKE: That's exactly correct.

VICE ADMIRAL ZIMBLE: Mr. Beck, you changed your mind? Oh, Jeez, okay.

It's obvious from -- from where we stand now

that there's going to -- there needs to be a look at a change in direction of the VBDR. I think you -- you welcomed the fact that at the last meeting we offered you no recommendations, and the way you're going I'm not sure that it's going to be any more recommendations that are going to come, at least for a while. And so one of the major thrusts of this meeting is to look at where we are and to look at what you've described as the road ahead. We've reached an acceptable steady state in dose reconstruction efforts and in reporting back to the VA, and the VA has -- has made some big strides in -- in moving things along, especially with the regionalization -- the -- moving all cases that involve ionizing radiation to one particular VARO instead of leaving it disseminated among 57 VAROs. So we've come a long way and now we need to examine what -- the direction we should take in -- in order to move forward. And that's going to be the primary subject of the remainder of this meeting after we get a report from Mr. Pamperin, after we look at what's left to be done, and then we're -- we will get the reports from the four subcommittees and then

we'll open up some discussion regarding the strategy and -- and what is the vision for the -- for this Board.

My one question, one final question to you, Dr. Blake, what more do you feel the Board can do for you? Not to you, for you.

DR. BLAKE: The 18 recommendations for the most part, as you know, have been extraordinarily helpful to our agency and to our -- the NTPR program. But I -- I think we're reaching a point where recommendations are not so much what we need, and I indicated that at the last meeting. And even the strong audits that have been ongoing on our dose reconstruction program probably aren't needed as much because of the way we've evolved.

What I still need support from the Board, though, is the technical expertise, the peer review process, and the ongoing looks at what we're doing. Getting that feedback is invaluable to us. I think any scientist needs, or clinician needs, that feedback, and the expertise that's on this Board is unique. One, you've been working very hard for three years looking at -- in depth at what we do. You're

very familiar with what we do. And certainly the scientists and the physicians are world-renowned who are providing this expertise, and specifically in this area. And I don't look forward to losing that. I -- I need that at least for another year plus, a peer review of what we're doing, so that's where, from my viewpoint, this NTPR program (unintelligible) and I would look forward to help from the VBDR.

VICE ADMIRAL ZIMBLE: Okay, thank you very much. Dr. Reimann.

DR. REIMANN: Paul, could you -- could we pull up slide number nine a minute?

DR. BLAKE: Okay, I think it's -- we've lost the -- maybe they can put it back up for us.

DR. REIMANN: It's the one that says program update, quality, and it mentions --

DR. BLAKE: Yeah, we'll try to get that in a second.

DR. REIMANN: Number nine?

DR. BLAKE: They've got to bring up the -- the PowerPoint for a second.

DR. REIMANN: Oh.

DR. BLAKE: They went back to the introductory comments. There we go -- okay, there.

DR. REIMANN: There we go. You mention the external DSS review and so on. I think on -- some points of clarification on your -- on your index or -- or bar code on the right --

DR. BLAKE: Okay.

DR. REIMANN: -- reject and so on, that's really something that's hard to be actionable because it -- it sort of reflects internal jargon. All of these that are not approved are reworked in some way so --

DR. BLAKE: Right.

DR. REIMANN: -- this has nothing to do with a rejection from the point of view of the veteran and so on. But what we'd like to -- to see or discuss is more of the dimensions that -- from the DSS review point of view that show up as -- as error types that reflect the kind of --

DR. BLAKE: Sure.

DR. REIMANN: -- improvement cycles that would then speed up the process and also reduce the burden of quality and so on. So could you comment a little bit on -- on how that DSS review is done, the items looked at and how they translate into the code so that, for example, we have a better sense of, as you

become more and more operational and -- and we certainly appreciate that you are doing these DSS reviews.

DR. BLAKE: Thank you.

DR. REIMANN: -- becoming more and more operational, but that the kinds of learnings that are taking place in a very complex program get reflected in the kinds of actions that are taken early on so that errors aren't propagated and so on with great delay and -- and cost to everyone involved. So if you could just say a few words about how that is moving forward, sort of on a concept basis, with all of your uses of the DSS and how that process of quality metrics and so on are falling into place so that as we discuss going forward we can see how the engines of -- of corrective action and improvement are really working. That's a long introduction, but it was this overhead that really triggered it in our minds.

DR. BLAKE: Sure.

DR. REIMANN: -- brief side conversation with Dave and myself here.

DR. BLAKE: I'd be happy to, Dr. Reimann. I will tell you, and I think the Board members

realize, this is an evolving process. When we started our external review process it was different than this Decision Summary Sheet. What we originally had was about a five-page check-off of about 90 different items the external reviewers looked at, and what we found over periods of time were we standardized our process and we didn't focus on the check-off blocks defects basically -- the comments on that went down to fairly minimal. We then embraced the recommendations from your group on where that external quality review ought to go, not so much all those little check-off blocks that we basically optimized our report process, but we went and started looking at how we reviewed on the Decision Summary Sheets. And even though we've been doing this information and correcting based on that, we haven't done a formal lessons learned. And one of the things I released, for instance, to -- where we take those lessons, where we saw problems and we corrected based on that, but we didn't publish here's where our trends were. We simply did a chart like this, and I think what we need to do is a more in-depth lessons learned and how do

we continue to improve the process. And the only reason I say that we aren't there yet, it is still evolving, is -- as I pointed out, one thing I did promise your subcommittee was over the next few months to collect that information, provide it to you. But I think you saw an example that I released yesterday and earlier this week on lessons learned on the radiation dose assessment was that comparison on the double-blind study was extremely extensive and in depth. And where I may not be able to quite go to that -- quite that depth on here, it's certainly our goal to do something similar here on -- from lessons learned on our quality review, how do we take those lessons learned and optimize our processes. So I guess my response back to you is we think that's a great idea. It's been evolving and I'm still catching up a little bit from that viewpoint, but I hope to show you within the next two or three months exactly what you asked for as feedback to the subcommittee on quality assurance here and the group. Hopefully that answered where you were going.

VICE ADMIRAL ZIMBLE: Mr. Beck?

MR. BECK: I'd just like to clarify that, Paul. Your external reviewer actually does two reviews. This one which you just talked about, not just the expedited, but they -- I understand they still do this extensive check sheet on the full RDAs and double-blind studies.

DR. BLAKE: He does. I didn't show those statistics because they've basically improved -- for the most part, it's more of a nominal thing where before it was catching more errors initially.

MR. BECK: But again, you could, as time goes on, collect that information as well.

DR. BLAKE: Okay, that -- that's straightforward to do. It -- it's not a problem. And from a cost basis on implementing quality, it's not been an overll burden - I mean it -- it's part of the program and one of the things I would take a look at was to say, you know, of the total cost of the program, how much is quality costing us, but I think it's only a -- truly, it's only a few percent, you know, on -- on total costs, and so it's -- it's the right way to go with where we're going. My

concern initially was when you came up with these -- some of these recommendations was the delay in the response to the veterans, and that's not been overwhelming yet.

VICE ADMIRAL ZIMBLE: Right. Thank you again, Dr. Blake.

DR. BLAKE: Certainly.

UPDATE ON VA RADIATION CLAIMS COMPENSATION PROGRAM FOR VETERANS

VICE ADMIRAL ZIMBLE: All right, Mr. Pamperin, could we hear from the VA?

MR. PAMPERIN: I can only deal with two buttons. Good morning, ladies and gentlemen -- happy to be here and give you an update on what's going on in VA, what's been going on with respect to the -- the recommendations of the VBDR for VA. In this presentation I wish to accept full responsibility and apologize for an error in this slide. In my preparing these slides I, for a totally unexplainable reason, failed to include the recommendations from the last Board, and I will include those as a discussion. Suffice it to say that based upon the recommendations, including the last Board, there have been 29 recommendations to the VA,

of which seven relate to claims procedures, nine to quality, seven to communications and six to alternative dose reconstruction. Of those recommendations, and I'll explain at greater depth, unlike DTRA there were three of those recommendations that we did not accept, and I will go into those.

On the claims procedures, the -- there was a recommendation for centralization of adjudication. That was accomplished in the Jackson Regional Office. And all radiation claims, to include not only those from ionizing radiation from Hiroshima and Nagasaki and from atomic tests, but those from people who are involved in nuclear activities such as submarine forces with occupational radiation were referred there as well. This has been a really useful thing for us because we had always assumed that we got about 400 radiation cases a year when they were distributed over -- over 57 regional offices, and we realize now that in fact we get over 1,000 cases a year of any kind of radiation. And we've built the expertise in Jackson to do that.

They asked for a -- the Board asked for a

centralized database, and this has been accomplished. Jackson maintains an Excel spreadsheet of all claims and their ultimate outcome in terms of grants and denials.

The Board also recommended that we grant service connection on a retroactive basis to the initial claim, and this we did not accept. The concept here is that when a veteran files a claim, if that claim is initially denied for whatever reason -- and many of them were, in the sense that there are -- there have been a significant number of disabilities that have moved from the category of requiring a dose reconstruction to what is referred to as a presumptive disability -- and if they had been on the presumptive list initially, the veteran would have been immediately granted service connection. We are unable to accept that recommendation because that would require legislation. There -- it's a well-established procedure in law that any changes in regulations and any changes in law are always prospective, and only Congress can make such an application retrospective.

Ensure that Jackson has adequate resources --

again, when the -- the team was established, we provided -- carved out a staff for them. However, there are three of the current recommendations from the last conference relate specifically to the adequate resources at Jackson. When part of Subcommittee 2 visited Jackson, they found that the Jackson Regional Office had disbanded their workgroup and had put the work out into the general work flow. That -- there was a recommendation to ensure that that dedicated staff was re-established. Based on that recommendation, the workgroup was re-established and is currently functioning. In addition to that, one of the recommendations was that the staff get specialized training, and we sent a member of the C&P Service down to Jackson to provide that training.

There was also a recommendation that 34 percent of the cases that Jackson received from other regional offices were not in fact radiation cases, or failed to document that there was any evidence of radiation. As a result of that, in June of this year we, on our monthly Service Center Manager call, reminded everybody, and published it in our Service Center Manager

minutes, of the requirements for transfer of cases to Jackson and of the specific manual citations that -- about when you would do this. From a quality management perspective, the -- there was a request for establishment of an SOP for centralizing claims. And that was accomplished by -- VA has a procedures manual referred to as M-21-1MR, and we placed in the manual the specific guidance for when cases would be transferred to Jackson.

The Board also asked for a timetable and status of the QA program at VA, and that was provided by Ms. Edna MacDonald at the presen-- the meeting two meetings ago. But since then we -- VA has -- and C&P Service has modified our quality review program further. Our QA progam at the time when Ms. MacDonald was giving her briefing, she would reference the fact that we have a quality review program called STAR, Statistical Technical Accuracy Review, and that that program involved the review of approximately 10,000 cases yearly so that at each regional office we would have a statistically valid measure of the quality of that office.

In addition to that, we conduct special reviews and we conduct site surveys. A site survey is sort of like an old military command inspection. We show up on Monday with about six people and we stay for the week, looking at processes and procedures. But prior to that we do a -- substantial assessments of statistical data so that when we come in and we have very focused issues about why it is this like that, or why it is that like something else.

Since her briefing we have done the following things: We have expanded our quality review program so that we now do twice as many cases. For FY'09 we will review over 21,000 cases to increase the assurance that we know what our quality is.

In addition to that, we have instituted what's called a consistency review. And in the consistency review we take particular disabilities -- we're starting with the most frequent -- and we compare individual station distributions of the assignment of evaluations with what the national average is. And when a station falls more than two standard deviations above or below what is normal, we do a focused

analysis and study of that station on that particular issue to see if there are reasons why such a variance would be appropriate and, if not, conduct the appropriate training. And most recently we have initiated what we refer to as inter-rater reliability. We have conducted two inter-rater reliability tests so far, one on low backs, which is a common disability among veterans, and the other on Post-Traumatic Stress Disorder where we took a statistically valid sample of all of our rating specialists and decision review officers across the country and gave them a case, the same case that we had determined what the correct answer was, and evaluated that -- that case. What we have found in our inter-rater reliability was that in the low back issue there is a court decision called DeLuca where we have to factor in the consequence of pain and -- and fatiguability and reduced capacity because of pain, and in the vast majority virtually all of the error or disagreement we had among stations focused on the application of DeLuca. It was a -- a good test because, since it wasn't scattered and diffused and it was focused, it

enables us to train on that particular issue. On Post-Traumatic Stress Disorder, the -- I must confess, for such a subjective disability, we were surprised at the relatively high degree of consistency among people and that we didn't see any particular problems there. But now we have increased quality assurance. We have our site surveys. We have special reviews. We have inter-rater reliability, and we have consistency as measures of the test.

We have also conducted a special quality review of the Jackson Regional Office and provided that to the panel, and will continue to do that -- perhaps not on such a large scale, but at least annually we will take a snapshot of Jackson to make sure that things are still going the way they are.

Again, we -- Ms. MacDonald provided a status update on STAR, and we provided adjudication status in December of 2007. Adjudication timeliness in radiation cases does take longer than most cases because of the requirement to go outside the agency for reconstructed doses. However, because of the actions of the House and Senate Veterans' Affairs Committees and the

Congress as a whole, we have been very, very fortunate in that until the beginning of FY'08 there were across the country about 7,500 people who did decisions in claims processing. And with the 2008 budget we received an infusion of 3,000 additional employees. That is a tremendous infusion, particularly when a large number of our people are of my generation who are also leaving. But the -- and it -- it didn't reflect any improvement in quality or timeliness until the last couple of months. On a 12-month rolling cumulative average, it still takes us about 181 days, on average, to do a disability evaluation, unless you're going -- recently getting out of the military, going through a program called Benefit Delivery at Discharge. But in the last three months the processing time for claims has dropped about 15 days, which is significant because it is trending fairly dramatically lower. And more importantly, the average days pending or how long a case is pending for decision has been dropping as well.

There was a request that we provide outcome-based data to NTPR. We have done that in

aggregated -- on an aggregated basis. The specific recommendation was to give information to NTPR about the specific claim outcomes of specific veterans, and we did not feel that that was appropriate because of Privacy issues. We did not see how what the eventual outcome in a specific case, how - how that should in any way impact the method of calculation of -- of the disability. The disability calculation or the dose estimate comes first and the -- the claim outcome comes last, so we are very sensitive to providing information about individual veteran-specific information unless it's absolutely necessary. We compromised by giving the - the dose estimates that we received, what that ended up being in terms of grants, without associating it with a particular veteran.

We are working on a presumptive and non-presumptive data pull for the VBDR. I hope to have that within the next four to six weeks. It is a little complicated because the diagnostic codes that we use can be used for other things as well, so we have to -- for example, cancers -- some cancers are not -- are

-- go under a very generic diagnostic code, so whether or not we can identify -- we can identify who has that -- who has a generic cancer, but we would then have to sort that against DTRA data to see if they were a - a nuclear participant, and then still caveat it because, without actually looking in the file, we don't know if the claim was based upon radiation versus some other service occurrence. The communications, the automatic IRR registration, this is slightly changed from when I prepared these slides. It was pending coordination and last week I received some information from the Veterans' Health Administration that they're not sure that they can do this. Participation in registries is a voluntary act, and the -- the question of whether or not you can, without permission, place somebody on an IRR -- on -- on a registry is one that we're working through right now. I think if that were to happen, we would have to get release from - from the veteran first. Okay, advise veterans that there are no security issues because of the security oath that many veterans took. We have done that by

- by making announcements and including that in the letters that are sent to veterans when we receive their claim.

Newsletter use, we publish a newsletter; there are a couple of these on this issue. We do publish an ionizing radiation newsletter. It typically occurs annually. There has been a delay in -- in that one was not produced last year, but it is produced by the Veterans' Health Administration and Steve Sloan from VHA is working with the communications subcommittee to get that out.

The committee also asked for two newsletters a year, and our position is that we would be happy to do that pending, you know, funding requirements and having sufficient information to include into.

And formalize a VBDR role in letters. The VBDR committee did provide us with a suggested letter which -- although I thought it was pretty good, when we sent it across our staff that's responsible for letter-writing, they -- they found problems with it. So we did not accept the format that was actually provided, but will provide the VBDR with drafts of

additional -- of new letters to be commented on and developed.

And at this point I would like to diverge into one of the areas where -- one of the recommendations from the last Board meeting, actually from about three of the Board meetings. And that is regarding a generalized outreach to all atomic veterans. In the past I have been the major person who has had concerns about doing a generalized outreach. And my concerns had really to do with two things. One was the capacity of the organization to deal with a large volume of claims if -- we currently believe there is approximately two and a quarter million (250,000) atomic veterans who are still alive. Our experience with direct mail is that we will get between 15 and 17 percent response rate, which would translate into approximately 40,000 claims. And the capacity of the organization to deal with those in the face of unprecedented claims activity that we have been experiencing, and at least as important -- if not more important than the claim activity -- has been my personal concern about building expectations and soliciting

claims that will inevitably be denied. In the current environment of those cases that have to go to the NTPR for dose reconstruction, they are split what, 50-50 between skin and prostate?

DR. BLAKE: Just a little skin and prostate.

MR. PAMPERIN: Yeah, mostly -- mostly skin and prostate. You know, if you take it from a macro level, it's about 50-50. There's about four or five percent that are other things, macular degeneration and -- or subcapsular macular degeneration and a variety of other conditions, some of which are radiogenic, some of which appear not to be. The concern that I had was that to solicit claims from prostate cancer and then turn around and get a dose estimate that would inevitably result in a denial, because all of the science seems to suggest that if you're exposed to radiation, if it's due to radiation, if you develop prostate cancer, it's typically due to radiation if you develop it between a specific age range that all the atomic veterans now are well, well past that age range. So if they develop prostate cancer now, it's highly unlikely that it would

have anything to do with radiation.
We've talked this over. Last Thursday I met with General Manner about this issue. I think we have an approach that is sensible and -- and one of the things that we will look to the committee for help with in taking an approach to outreach that is basically three-tiered. One is to seek the assistance of NTPR to identify those particular tests that are, you know, the -- the most aggressive or dirtiest or has the highest fallout, and start with -- start with those people. Concurrently, using NTPR information checking with Veterans' Health Administration about veterans who are test participants who may be currently being treated for conditions that are presumptive disabilities, and addressing those people. And then from there, assessing the situation and making further decisions on outreach. And when we do that, one of the things we will be looking to the -- to the Board for is guidance on the language that we don't build unreasonable expectations from veterans who may be suffering from prostate cancer.
Alternative methods of dose reconstruction,

grant service connection for basal cell cancer regardless of dose. We -- we did not accept that -- that recommendation. We -- we believe that it's fairly clear that of the three kinds of skin cancer that it would be inappropriate to do that.

Do not refer non-radiogenic conditions to NTPR. We do get claims from veterans who will have a statement from their local doctor saying that it's possible their particular condition may be due to their exposure to radiation, when in fact there is no scientific evidence to suggest that that particular condition can be affected by radiation. Our law says that when we have medical evidence of an association, we will refer it to NTPR for action and review. This recommendation was that we would not do that. We did not accept it because it's required by law. But what we did say is that if a particular condition -- and I forget which one it is right now, but there's one we had a couple of recently wherein the IREP model, which is how you produce a probability of causation, the particular condition isn't even in the IREP model. You know, it's so certain

that that's not related to radiation. But what we've said is that if NTPR will provide us with a letter explaining the scientific basis as to why this is not a radia-- a radiogenic disease and that they're unable to calculate, you know, a dose that would be appropriate since it's not in the IREP model, we can use that evidence to weigh against the other medical evidence in making our decision.

We are also pulling the data regarding information on those people who we have granted.

And the -- the next one, VA will accept a DTRA letter, that refers to the non-radiogenic diseases. We will accept that letter.

And the recom-- another recommendation was that we consider seeking legislation that would enable us to independently not refer radiog-- non-- clearly non-radiogenic diseases to NTPR. And we have decided that we will not seek such legislation. We -- we believe that it is not appropriate for us to limit -- Title 38 is a -- is unique in that it makes the Secretary of Veterans Affairs not only the administrator of the program but, by statute, an advocate for

veterans. And we don't believe it would be appropriate for us to do this.

Additionally, although radiation has been around for a long time and I'm assured by, you know, people I well respect that we know an awful lot about this topic, our experience in herbicide Agent Orange and other kinds of disabilities is that over time things that are pretty certain turn out, you know, with additional evidence that there is -- there are other considerations. So we did not accept that one.

I believe the only other recommendation that we had is that we develop a standardized operating procedure with respect to operating and interpreting the results of the IREP computer model so that it -- it can -- you know, outsiders can come in and take a look at it and see that we're doing that appropriately. We currently have the physician who used to do this -- Dr. Neil Otchin has retired. The development of this SOP, which isn't on this list, would be a function of the Veterans' Health Administration, and when the new physician is put on board we will ask the FHA

to prepare such a -- an SOP.
Current issues. Dr. Otchin retired several months ago and there has been a lag in getting a replacement for him. Veterans' Health Administration has been attacking that problem in two manners. This is seeking a physician physically to replace him, but has also been pursuing contract to do these assessments. If anybody has ever been involved in contracting in the federal government, it is something to behold. It takes a very long time. However, I'm -- I'm told that we're expecting to have a contract within another month, and then similarly that we're supposed to be getting a physician in approximately a month.
At the last meeting DTRA, NTPR, made an offer because they have health physicians who are capable of doing these dose assessments, who are not involved in the development of scenarios, that are -- that work in different branches of the DoD, and we were offered the opportunity to borrow Dr. Reeves, who is a contractor for DoD, and we were able to use him for about eight weeks. And during that period of time he did 115 dose assessments for us that

were signed off by other responsible officials in VA, and his tenure with us was discontinued recently. And again, based upon the meeting we had with General Manner last Thursday, General Manner was gracious enough to allow us to continue to use him for the next month or two until we have a replacement.

As a consequence, right now we have about 180 cases still pending dose assessments -- correction, IREP assessments, that we have the dose assessment from NTPR. If we get -- based upon the performance of Dr. Reeves in the past, it would appear that we will clear our backlog of cases probably by mid-October.

And that's my presentation for right now. I would tell you that what is going on in a larger context in VA is an unprecedented claim rate. In the past, for example, in -- and I've said this before -- in 2001 VA did just over 500,000 disability ratings. In 2007 we did 836,000. Last year we peaked at 70,000 rating decisions in a particular month. In August of this year we did 83,000 decisions. And yet with that level of -- of output, we have been able to drop our over-six-month cases by about

a third. But our total pending has dropped by about ten percent. We -- we are projecting that we will end this year with about 860,000 cases being decided, and we're projecting that next year we will receive and decide over 900,000. So there is a -- the -- the volume of cases is -- has been a real challenge for VA, but the last three months has been improving. And at the same time, we're engaged in a con-- the final stages of converting to a new payment system and we're engaged in a major effort with the Department of Defense to facilitate the transition of wounded, ill and injured service persons, whether they are war-wounded or -- or service persons who just developed disease, through a fairly significantly changed DoD disability evaluation system. Each year about -- in this period of war, about 25,000 service persons are referred for what's called the Medical Evaluation Board, the first step in potential separation due to disability. And of that number, on the back end, about 19,000 people are actually separated.

That particular process inside DoD, as an outsider, is obscure, arcane and lengthy. And

in the past a service member would go through that process only to be separated -- from date of injury to date of first VA check was calculated to be about 570 days. Now most of that time you were still on active duty and getting paid, and what it meant was that about 180 days you'd be waiting for a check from VA. In our National Capitol Region pilot where we have almost 600 people going through the process, of those who have been separated all but three had their benefits awarded on the day that they were separated. And the three who weren't paid on that day, two of them are incompetent and it's taking about 30 days for us to get a fiduciary together for them, and one of them there was an issue of severance pay and we didn't quite know what we were doing, so it took about 30 days to get that person awarded.

We are in the process and likely to be expanding to a number of additional sites as early as the end of this month, and with the expectation that this revised process will occur nationally sometime in the 2009/2010, maybe 2011 at the latest, time frame. It's

different in that as soon as a soldier is -- is put into the DES system, we take a claim from him. It's different in that in their other normal caseload, but the examinations are done according to VA protocols. And it's different in that when the physical evaluation board determines that the person is unfit, rather than the physical evaluation board assigning the disability evaluation, VA assigns the evaluation. And with one exception thus far, which was within -- well within the prerogative of DoD, they have accepted our evaluations, and those evaluations tend to be higher than what DoD has done in the past.

So that is a huge, huge process that we're engaged in, trying to coordinate 134 military treatment facilities, and so things are -- are very busy in VA right now.

VICE ADMIRAL ZIMBLE: Thank you very much, Tom.

MR. PAMPERIN: Yes.

BOARD DISCUSSION

VICE ADMIRAL ZIMBLE: I -- I have to tell you that -- that with all those -- those figures, extremely challenging, overwhelming numbers of claims and all of the other projects that you -

- that you face, we're very grateful that you still attend to our recommendations. Even though you -- you've rejected some of them, our feelings aren't hurt because subsequent to that we've -- we've worked out -- we've worked out appropriate compromises and -- and I'm -- I'm very grateful for the level of cooperation that we've received and the veterans -- the atomic veterans should also recognize that, despite the pressing demands of a current war and more recent wars, we're still accepting and looking and trying to do better for these veterans that go back to World War II and to the testing beyond that. And so I -- I think you're doing a great job and I appreciate the idea of looking at a pilot program for a specific cohort that are most likely to have radiogenic conditions and -- and make sure we get the word out to them.

I also appreciate very much that your letter-writer doesn't care to have other people writing letters for her. We've -- we have one individual on the Board who I would term our official scribe, who has drafted the brochure -- working with others, but has put together the

brochure, who's put together some of these sample letters, and we fully understand this arrangement. And I think in the future what we would like to do is review letters and make sure that the letters that come from -- from DTRA and the letters that come from the VA don't have conflicting statements or -- statements that are going to lead to confusion for the veteran, and we -- we want to make sure we can have a risk communicator look at those letters and make sure that we have made them as -- as simple as ionizing radiation can be made. So we'll -- we'll work with you with that, if you don't mind.

MR. PAMPERIN: And I would point out that on the table outside are some brochures that we just recently got that were developed through the Advisory Board and with NTPR. They're -- those will be shipped to Jackson this week and will be included in the initial development letter that goes out to all people. It explains the whole process of dose reconstruction and presumptions versus non-presumptions and what's available from the Advisory Board.

VICE ADMIRAL ZIMBLE: Thank you very much. Dr. Blake, you have a question or comment?

DR. BLAKE: More a comment. In support of what Mr. Pamperin mentioned on DTRA's NTPR program providing the data on the veterans who received the highest doses within the atomic veteran community, that's basically three cohorts. And what I'd like to do is, I can provide that to the VA within a few weeks, but I'll also provide a summary without the Privacy Act data to the Board so you can see what we're providing. We're -- the highest dose group fell under 100 rem whole body. It's basically three cohorts, and the three cohorts -- and if people would care to comment when I provide it, I'll provide that data with the doses that were in there.

One cohort was the group that was involved in Operation CASTLE BRAVO where we exploded a weapon that went larger yield than we expected and the fallout went into a place we didn't expect then, our -- our weather group got significantly high exposures and that group has the highest exposures of the atomic veteran community.

Another group that received very high exposures were our forward volunteer observers at some of the tests at Nevada Test Site. And so once again, they actually received some acu-- acute doses by -- from fallout, immediate doses, and we'll provide that information. We know those cohorts.

And there was a third group that received significantly high doses and those were the pilots and the aircraft crews that were in our radioactive cloud samplers where we actually flew planes through the clouds to pick up radionuclide data. So once again, we'll provide that data to you.

So I would also mention to you that the NTPR program is supporting ongoing radioepidemiology studies of our atomic veterans, and one of our world-renowned members here, Dr. Boice, is actually the principal investigator on a follow-up study of the -- some of the highest exposures in the program, working with VA and other scientists to take a look at that. So we're in the process of recovering some data from the National Academy Science, and then he'll continue looking at that.

Why radioepidemiology studies looking at disease associated with radiation continue, even if you've done the study, is you have to, at a certain period of time -- in the previous one I think was -- I believe -- John can correct me, but the data went through what, 1986 or -- I forget --

DR. BOICE: I think mid-19-- early 1990s.

DR. BLAKE: -- early 1990s, but since then we've obviously -- it's now 2008. We've accumulated a lot more data. It's worth taking another look at it. In fact, Dr. Boice is following -- what I certainly appreciated was he was looking for funding from the National Institutes of Health, not the Department of Defense, and so I certainly was very enthusiastic and supporting if he was bringing in money from other federal agencies to help on that type of study, which is the right thing for our veterans to do and that's part of our mission, too, so we're looking forward to supporting an ongoing study on radioepidemiology.

But with regards to that other thing, we will provide that data to you in a summary, with

non-Privacy Act material, to the Board members.

VICE ADMIRAL ZIMBLE: Dr. Boice.

DR. BOICE: I also wanted to thank Tom for considering the more global outreach to the atomic veterans. That's something I've been most interested in over the years, as you know, and the approach you've suggested in working with General Manner sounds very appropriate to -- to go after those that are more -- are most likely to receive some compensation because they're in the high-dose cohort, and also to make sure there's a realistic expectation so that there is not this unnecessarily con-- condition where they would expect something which is not going to happen.

I did have a comment, though, too, on -- on this prostate cancer and just what the issues are. And this was recently summarized in the United Nations report that came out last week. Prostate cancer is not established as a radiogenic cancer, and that's really the scientific issue. And so even though you can go through the IREP program and all that and get a probability of causation, the risk coefficient is so very low, you need a really

whopping dose to get even a 99 percent, you know, credibility limit. So it's -- it's not -- the issues that you said about latency, yes, that's true. But the -- the real issue, it's just got a really low pos-- possibility that it's caused by radiation, and that's demonstrated in the programs.

I did have a question, and I should know this, so it's -- it's about the radiation newsletter. Who receives the radiation newsletter? Is it only the people in the IRR then, the Radiation Registry? Who actually gets it?

MR. PAMPERIN: It's -- it's people in the IRR, people who ask for it. There are copies of the newsletter that are placed in Regional Offices, Medical Centers, in the waiting rooms and things like that. The -- am I leading to the assumption that if we got a list from NTPR --

DR. BOICE: Yes.

MR. PAMPERIN: -- and then went to somebody such as the IRS or somebody to get addresses, that perhaps we could -- we could mail it further. We -- we can -- we can look at that. I mean we can look at that.

VICE ADMIRAL ZIMBLE: Okay, and Mr. Groves?

MR. GROVES: Just a follow-up to that. We were very fortunate, we had Steve Sloan join us by telephone yesterday for our subcommittee meeting and this was of course one of the subjects we spent quite a bit of time on. And we feel that there is a good distribution within the system of the newsletter. We did encourage Steve that when they do go out to the Medical Centers that they're put in -- in numerous locations, and especially those locations that you would expect the veterans to visit, which are normally on the lower floors because of the -- the age group. And we would also hope that the brochure -- and that you very much for bringing the -- ones to the meeting -- but those would get distribution as well in the -- in the Medical Centers and the clinics as -- as yet another way to introduce the program and, you know, tell people where they can go to get additional information. So whether we would -- I think a part of the larger question of the outreach and what's appropriate, once we've identified the folks, to send them, the newsletter I think is an excellent tool, as well as the brochure, to

kind of start the process with those folks.

MR. PAMPERIN: Right, I -- the initial printing was 5,000 of those forms, and if you make the assumption that we only get, you know, no more than a thousand a year, there -- there is more than an adequate number to send to the Regional Offices and the Medical Centers, and reproducing it is not expensive so we can get some more.

I -- in terms of the, you know, a larger scale accessing NTPR, the issue of distribution, the issue there of course is finding people. Depending upon the -- the level of identification, if -- if Social Security numbers are available, there are a variety of ways of -- of getting addresses. You can get addresses from IRS, but only if it is a public health issue or a research issue. But on the other hand, we utilize a company called Choice Point, which is basically a credit-checking company, that we use to -- when we get returned mail, when people haven't told us where they move, we can look them up and get their most recent address and send it on to them. It is possible. We have done that in the past, not -

- I don't know how much of a cost on that, but I know we have given them relatively small files of 1,000, you know, up to 5,000 files, to get addresses. You know, if -- if it was 50 or 60,000 files, I don't know how many -- how much that -- so we're going to have to assess that, but we'd be glad to work with NTPR on that.

VICE ADMIRAL ZIMBLE: Mr. Ritter?

MR. RITTER: Tom, I just wanted to add to Ken Groves's statement, since the inception of the Ionizing Radiation Review we have forwarded our -- our membership mailing list to -- to your people and they've been kind enough to send -- send those out to our folks as well.

VICE ADMIRAL ZIMBLE: Okay. Dr. Zeman.

DR. ZEMAN: Tom, you mentioned a multi-tiered approach to outreach, and one of the -- one of the approaches that I -- I believe you mentioned was to try to identify atomic veterans that are currently being treated for presumptive diseases.

MR. PAMPERIN: Right.

DR. ZEMAN: Could you explain how you would do that? Would that be just within the VA system or would --

MR. PAMPERIN: Yes.

DR. ZEMAN: -- there be something --

MR. PAMPERIN: No, it -- it --

DR. ZEMAN: -- broader than that?

MR. PAMPERIN: -- it would -- it would only be in the VA system. If -- VHA of course uses ICD-9 codes which -- ICD-9, International co-- Classification of Diagnostics, is a manual -- there's a IDC-10 that the United States doesn't use, but this is a list of 10 or 11,000 numbers. It's -- I believe -- it's either four or five-digit numbers with a period and up to three or four numbers after it that is used for a variety of purposes, for classification, but most commonly for billing purposes. And you know, there's -- there always, when you get into such a complex coding system, there's always potential for -- for error in the coding. But what -- what it does do is it perhaps get you to a lower level of granularity where you can target specific disabilities. We would do this, you know, as a -- as an -- a specific outreach to atomic veterans. We do not -- it's a fairly clear standard that a claim for health care is not a claim for

benefits. And in fact, we have experience with people who have health care who decline to file claims for benefits. But even on a more practical level, with five and a half million veterans enrolled in veterans' health, with upwards of, you know, 20,000 out-patient and in-patient -- or 20 million out-patient and in-patient visits a year, it would be physically impossible to consider every visit to a VA as a claim. I mean you would have to have a workforce of hundreds of thousands to keep track of something like that, so -- but in a -- in a specific group, it would be possible to do this and, you know, we'll -- we're taking a look at how that can be accomplished.

VICE ADMIRAL ZIMBLE: Thank you very much. Dr. Reimann?

DR. REIMANN: Tom, thanks for that update on those quality practices increasing the number of cases you're looking at from about 10,000 to 21,000, the consistency review, the inter-rater reliability, use of knowns in particular cases to identify areas of training. All of these are very, very positive steps and ones I think are important for us to know about because

there's got to be a good linkage between what is proposed for a particular veterans' group and the overall system you use for all veterans. We're -- we're sensitive to that. But you recall in our discussions early on about the -- the consolidation at Jackson, the issue there was that, because of the specialized nature of the -- of the claims, having a pocket of expertise would be a real benefit and -- because errors would more likely occur with a diffuse nature and also they would be less likely to be detected, even in a good quality system, because of how few they are. Now, with concentration, there's more opportunity, but I would note that even with the 21,000 there -- it's still a low rate of looking at particular radiation cases. So it would appear that the 34 percent that you were referring to there in the cases being referred from other VAROs to Jackson would be a very good metric to use in the short run because that really puts a major spotlight on cases related to the community that we're trying to serve here. So that's an example of sort of an ad hoc metric, but I think one that you could

really use effectively that might actually be more useful or -- or would be a great adjunct to the other mechanisms that you're using, which are all extremely positive steps, it seems to me. So you -- we might sort of squirrel that in some of our recommendations here or comments or observations because I think that that sort of wraps around everything you've said in a way that would appear to be compatible with what you're trying to do. And the last thing in the world you need at this stage, with coming up to a, you know, 900,000 cases to -- to review are additional things of work, so this would be -- appear to be a good integration and maybe something actually that would spill over and help support some of the other kinds of quality efforts that you're obviously putting into effect here with your STAR system.

MR. PAMPERIN: I -- my -- Curt, just so that I understand, are you saying that you use the metric of improper referrals as a -- a measure of quality, as -- as the percent of improper referrals goes down, that -- or -- I'm not quite --

DR. REIMANN: Well, tha-- that obviously is probably related or similar to the kinds of problems you were having when you had very few cases per VARO and the delays caused in those office because the specialized knowledge was hard to build up with few cases per year. Now that you -- you still have that problem at the local level because they still have to classify something to send it to Jackson.

MR. PAMPERIN: Right.

DR. REIMANN: So if you have some tracking of the number of cases coming to Jackson that shouldn't have, that's a very sensitive indicator of -- of the kinds of training that needs to be done and information that needs to be sent to the individual VAROs, so it's -- it isn't just that -- 34 percent is bad; at this point 34 percent knowing it is good --

MR. PAMPERIN: Right.

DR. REIMANN: -- and it means that something that if you track that ought to --

MR. PAMPERIN: And similar to our low back inter-rater reliability, if there's a common -- it would be bad if it was 37 one-percent different reasons, but if --

DR. REIMANN: Right.

MR. PAMPERIN: -- if half of them are all the same reason, you can train something like that.

DR. REIMANN: Right. Just to sort of throw in -- there's a little folklore here that at one point advancing quality practices in Japan, which were very badly needed, some of the Japanese leaders were quoted to say we cherish our defects because they tell us something about the imperfection in our process. And so in a way that's a defect to cherish at this point because you now know what it is and you can drive that down, and that would be a very, very important indicator to keep track of how the other VAROs are doing as -- as an additional kind of -- of feedback to them on how the -- on how things are working. And that -- and that's -- it simply parallels a lot of other things that I would assume you're doing from --

MR. PAMPERIN: Uh-huh.

DR. REIMANN: -- what you reported here.

MR. PAMPERIN: Okay, got it.

VICE ADMIRAL ZIMBLE: Okay, I -- I -- oops, all right, Dr. Fleming.

DR. FLEMING: Tom, this is a question about the improved timeliness of the disability evaluations. You had mentioned it was 181 days, had been reduced to -- by 15 days, and I assume that that figure is for claims in general --

MR. PAMPERIN: It's for claims in general, and that's on a month-to-month basis. We -- the way we measure quality is on a 12-month rolling cwm, so when you box yourself into that as opposed to starting over at October 1st of each year, it means that if you've had poor performance, that poor performance stays with you for a long time until you start getting good performance, and then you hit a critical mass and things drop fairly quickly as -- as poor performing months drop off.

DR. FLEMING: Right. You also mentioned earlier, in response to one of the Board's recommendations, an Excel database was created in Jackson. So I'm wondering if we can get more specific figures, perhaps drawn from that database, about the average time it takes to process an atomic veteran's claim, figuring in of course --

MR. PAMPERIN: The referral time --

DR. FLEMING: -- the reduction at NTPR for the -- to 44 days, because this is a figure, while interesting, it seems to me we now have a database that -- from which we could draw much more specific information about atomic vet processing, and that would be helpful for the Board to know.

MR. PAMPERIN: Okay. I can do that.

VICE ADMIRAL ZIMBLE: Dr. Boice?

DR. BOICE: Just a -- another comment on the global outreach. I thought it was very innovative, if not brilliant, to consider going after those atomic vets who are being treated for presumptive diseases, particularly those within the high dose exposure cohorts, but -- but those with presumptive diseases. And as -- you know, one of the unique things about the VA BIRL system, what -- the Beneficiary Identification --

MR. PAMPERIN: Records Locator system.

DR. BOICE: -- Locator system is that it can be accessed on military ID --

MR. PAMPERIN: Yes.

DR. BOICE: -- and you don't need to have a

Social Security number. And what DTRA has --

VICE ADMIRAL ZIMBLE: It's the same number.

DR. BOICE: No --

MR. PAMPERIN: No, it's not -- not for this period of time.

DR. BOICE: -- no, and so that was a main -- the problem with the DTRA database is that most of the veterans served before 1968, and it was '68 when the ID became the Social Security number, so -- but the atomic veterans in the DTRA database, they all -- practically all have a military ID, so they could be identified -- go to the BIRL system and checked using, you know, the ICD-9 codes for what the presumptive diseases were. I think that's -- you know, on a focused group, on a pilot sample, that just seems like that was a very excellent idea for outreach.

And a second thing is -- and then a comment, too -- is the Social Security Administration will give a government agency, such as the Department of Defense or Veterans Affairs, Social Security numbers if you make the request.

MR. PAMPERIN: Yes.

DR. BOICE: You -- you have to -- you would supply the name and date of birth and say this is an official request, and they would then provide Social Security number, and then, with that, the addresses that they have in the -- within their system. So I appreciate that it's -- the process takes a long time and it's not -- it's easy to say but not easy to accomplish, but that is another way to easily get Social Security numbers for those that you don't have, if needed, particularly on that focused group that you were saying. You know, not all 250,000 perhaps, but on --

MR. PAMPERIN: Right.

DR. BOICE: -- a focused group.

MR. PAMPERIN: Well, we would have all the Social Security numbers for people who are treated in VHA. And given the age of this particular population, Social Security has the same problems we have in that we have about 80 per-- 86 percent, I believe it is, of all of our beneficiaries are on direct deposit. And as long as people are getting their check, there is a significant number who fail to advise you that they've in fact moved. So the

-- the value of using somebody like Choice Point is even if you move you still buy a car, or still have something else, so -- and that has an address associated with it, so...

VICE ADMIRAL ZIMBLE: Right. Thank you very much. And Tom, I -- I won't ask any more questions. We -- I had neglected to give everyone the break -- I know that -- as noted in the agenda because I really wanted to get the two agency reps equal -- equal time and -- without the break. But now -- now I know that you're all eager -- we will now take a 15-minute break and then come back for a -- some time with public discussion. Thank you.

(Whereupon, a recess was taken from 11:08 a.m. to 11:35 a.m.)

PUBLIC COMMENT SESSION

VICE ADMIRAL ZIMBLE: It's now 11:35 and we would like to begin the -- the public session. We're anxious to hear comments and I would like to -- to -- to show you just a few slides. Could we have the next slide, please?

This -- this slide shows -- demonstrates what -- what are the responsibilities of an advisory board. Now an advisory board is a board that

advises, and our advice is directed to two agencies. It's directed to the -- DTRA, Defense Threat Reduction Agency, specifically to the NTPR within DTRA, the Nuclear Test Personnel Review program; and advice to the -- to the Veterans Affairs organization, primarily to the VBA, Veterans Benefit Association -- not association, what is it -- Affairs.

MR. PAMPERIN: Veterans Affairs.

VICE ADMIRAL ZIMBLE: Veterans Affairs, yes. And do we -- we're -- we are designated by public law to provide guidance and oversight in dose reconstruction at NTPR, and in the claims compensation program that is at the Veterans Administration. And -- and it -- and also we are charged with -- with commenting and assisting in making recommendations to both organizations in their means of communications to the atomic veterans.

Could we have the next slide?

Now there are -- is a -- two ways that you can keep updated regarding the activities of the Board. If you go to the web site, vbdr.org, you will find the information that goes way back to the first Board meeting. We -- the

summary of the minutes, the full transcript of the minutes, the members of the -- of the Board and their -- their affiliations and their levels of expertise, their professional activities, et cetera, are all on that site, as well as many -- much more information. So if any -- if you have any information or if any of your colleagues need any information regarding the activities of the Veterans' Board on Dose Reconstruction, I urge you to visit that site. Also if you have specific questions regarding Board activities, we have a toll-free line that you can copy down that number -- you probably already have it in your -- in your folders, you can call that line and get some -- get some information.

Okay, next slide. Finished -- that's the end of the slides here. There should be one more slide. And there's one slide that says what we cannot do. The one thing that we -- we -- maybe you can go back one -- there it is. The one thing we can't do, we don't have the authority nor the capabilities, the resources to review individual dose reconstruction cases for the claimants. We don't -- we do not do

those reviews. They're -- that review should be done at the NTPR.

We are not an appeals board. We -- we're interested in information if there are problems, and we certainly document it, and if these are problems about which we can make positive, significant recommendations, then we're happy to do so. But we -- we -- we're not the appeals board. There is an appeals process and the VA handles the appeals process. Now we can also direct you to the individuals within the VA who can assist you with -- with a claim, but we -- we can't do that. We don't -- we don't have that authority.

And we cannot change or revise any of the provisions that are in the law. You have a representative in Congress, you have a senator and -- on the Hill, as well, that -- that you can contact if you would like to see laws changed. There's lots of laws I'd like to see changed.

But at any rate, that's the Veteran's Board on Dose Reconstruction, and that's -- that's what we do. And with that in mind, we're very happy to take public testimony. And the first -- I

see we have two individuals who would like to speak. The first one is Mr. Ed-- Edward Shaller, and if he could come forward now.

MR. SHALLER: Do you mind if I sit down?

VICE ADMIRAL ZIMBLE: By all means.

MR. SHALLER: Beg your pardon?

VICE ADMIRAL ZIMBLE: By all means, you may sit down.

MR. SHALLER: Thank you.

VICE ADMIRAL ZIMBLE: Absolutely, you betcha.

MR. SHALLER: All right. All I want to address today is the fact that I never knew about -- I'm a nuclear vet by -- I was at the nuclear bomb test, Johnson Island, 1961/'62 called Dominic I and participated as part of Joint Task Force 8 in the Marine Corps helicopter squadron. Didn't know anything about nuclear vets until the other day when I looked in the newspaper, saw an article in the paper about this meeting and I figured I'd come down and find out. Now since I've been here I've learned a lot. I learned that people have been receiving benefits for nuclear mishaps or whatever since 1970s, that's what I was told. I never heard about it. I even -- I've been in

and out of VA facilities through my life just, you know, being a -- having a regular veteran's card, and I've even asked about it on occasion, if there's any situations for veterans that were at nuclear tests, and they said -- I never got any answer about it. And -- and since I've been here today I've heard people explain that it's like -- it's hard to find a person's Social Security number through their military -- military active duty number -- serial number, and I don't think that's true because I know that when I was -- get my tax form, you know, tells you how much you're going to get, how much your tax history -- how much you earned in this year and that year, I noticed all the years that I served in the Marine Corps were all listed there under the tax -- you know, to have the money that -- from that year and -- when I was on active duty and -- and I was only using the military number at the time, so obviously there's some connection between a military number and a Social Security number. I mean logic tells me there is, because otherwise Social Security system wouldn't have known about it.

But anyway, I also want to make a point that I think everybody that was involved in the nuclear tests -- I've met a few through the years because of my experience -- that they didn't volunteer or ask to be there, government required them to be there. There was situations where I was at Johnson Island and I saw the nuclear bomb test for the first time and -- kind of scary, young man, facing away from the bomb, dark goggles on, eyes closed, detonation -- I could see all of my fingers through the lens, the bones in my fingers. After that, another test day comes up, a few of us on the ship decided that we didn't want to be there, we didn't want to see the next test, the detonation, flash or whatever you call it, so we stayed below. Regular military personnel came down, sergeants, what-not, ordering us up on deck to experience the nuclear blast. We told them we didn't -- we didn't want to go up on deck to -- to see the blast because we'd already seen it and we didn't want to necessarily be exposed to radiation any more than we already had been. But direct orders said get up on deck.

All right. Sit down and I think well, this is like Russian roulette now, we're talking about all this nuclear vets and how much energy -- how much benefits they should receive for being exposed, what not. I say if you line a bunch of men up in a line and they all experience the same thing, they all get the same dose, the same -- see the same tests, some of them get diseases, some don't. Well, I mean don't they all deserve the same benefit in the end? I mean some -- some of them, you know, maybe aren't even alive to get it anymore. It was 47 years ago that I experienced nuclear energy and I'm -- this is the first time I've ever got a chance to sit around and talk about it. That's my point.

VICE ADMIRAL ZIMBLE: Well, I -- I appreciate your -- your comments and it -- it -- you have underscored one of the issues about which the Board has had great concern, and that's being able to get the word out to the atomic veterans. And we have -- we are working -- you know, the number of atomic veterans for all those tests, and in -- and in addition, the occupied -- the occupying forces in Hiroshima

and Nagasaki and the prisoners of war that were in Japan at the time, the -- the people that are exposed to atmospheric testing, both at the Nevada Test Site and in the Pacific, amount to close to half a million people. And to -- and to get the word out to those people after a long period of time is not easy, but -- but we're -- we're -- we are trying to find methodologies to get the word out. I'm glad you got it. We -- we've gone to now -- we've gone to -- this is the --

MR. SHALLER: If I could suggest, sir -- if I could suggest, I think it would be very easy to locate people. It was a military test. It was documented. There's a document from the test.

VICE ADMIRAL ZIMBLE: Yes. Oh, yeah, we have -- we have many, many, many records.

MR. SHALLER: And I think everybody's name was on the -- in that Marine Corps squadron that day, or aboard that USS Iwo Jima --

VICE ADMIRAL ZIMBLE: Right.

MR. SHALLER: -- or the scientists and everybody else that was there, for the six or seven tests we saw. I believe it wouldn't -- you know, I don't see how it could be that

difficult to -- to go and look at the records and -- they don't have any trouble telling me when I'm $5 short on income tax.

VICE ADMIRAL ZIMBLE: No, they sure don't. Unfortunately, the income tax people didn't know about your experiences in the war.

MR. SHALLER: No, but the IRS did.

VICE ADMIRAL ZIMBLE: At any rate, we have -- one of the members here is -- Mr. Ritter, Mr. R. J. Ritter -- and on the telephone, by the way -- hello, Ed, I'm glad to hear that you're -- you're -- you're able to listen in on our conversations today -- we have both Colonel Ed Taylor and R. J. Ritter here, and R, J. is the -- is the president of the NAAV, National Association of Atomic Veterans, and he's very interested in making outreach to all atomic veterans. R. J., you going to make -- any comments to make to Mr. Shaffer (sic)?

MR. RITTER: Yeah, I spoke to the gentleman earlier on, just bef-- before we got officially started this morning, and gave him some information. I'm pretty well familiar with the tests that he was involved in and I will communicate, either later today or via some

other method, before -- before the next week.

VICE ADMIRAL ZIMBLE: Okay. You have any other comments, Mr. Shaller?

MR. SHALLER: I have many, but I think I'd better shut up.

VICE ADMIRAL ZIMBLE: Okay. If you have a condition which you feel may be related to your radiation, you ought to at least discuss that with somebody at a VA hospital. And if you're perfectly healthy, then I congratulate you. Also --

MR. SHALLER: So you get -- you don't get any kind of prize for being healthy.

VICE ADMIRAL ZIMBLE: No prize for being healthy other than your health, which I think is pretty significant. No, one thing you can do, though, is -- is go to the -- your local VA hospital and get yourself registered in the IRR, which is the Ionizing Radiation Registry. That will give you a -- the privileges of a physical examination and some opportunity to be evaluated, and I think that's -- that's certainly worth doing, and you'll also be sure to be a recipient of the IRR newsletter, and hopefully we can, through you, get to

communicate with some other atomic veterans as well.

Any other comments from the Board? Ah, yes, Dr. Lathrop.

DR. LATHROP: Yes, I want to tell you I appreciate your comments, and one comment you made caught my ear and it was a -- a very astute one, that gee, maybe that everybody who was exposed to the tests -- I mean they're all -- it's all a probability thing, but so they were all exposed to a particular risk. What I want to emphasize to you is this Board doesn't make laws, we're not congress people -- thank God -- but we're executing public laws and somebody some years ago made what I view a very -- as a very key decision about the ethics of all this, and that public law reads that if you have a medical condition that has a 50 percent chance or greater of having been caused by your military service, then you can be considered for compensation.

Now we didn't do that. We're sitting here trying to figure out the best way to serve the veteran under that law. But I want to emphasize that we didn't make any of those

laws. We're just trying to figure out how best to apply these laws, and the particular point I wanted to respond to you about 'cause you brought up the issue is we're figuring out the best way to apply the law that says you get compensation if, and only if, we can crank the numbers and figure out that you had a 50 percent chance or greater of getting the condition that you have, which we all regret, due to your military service radiation exposure.

MR. SHALLER: I forgot my point -- oh -- oh -- I forgot. I had a good point and I just forgot it. It was about -- it was about mili--

VICE ADMIRAL ZIMBLE: I -- I get some of --

MR. SHALLER: -- VA.

VICE ADMIRAL ZIMBLE: -- those every day.

MR. SHALLER: A senior moment?

VICE ADMIRAL ZIMBLE: Yeah, you bet.

MR. SHALLER: Maybe it's a nuclear moment.

VICE ADMIRAL ZIMBLE: When it comes back we'll let you come back up and -- and -- and provide that. We have -- by the way, I -- since we've -- talking about Congress, I would let you know that at the break I -- I met Ms. Anne Irby, who

is a caseworker for Senator Benjamin Cardin who is a senator in -- in Maryland, and we're delighted to have -- oops -- oh, there she is -- and she -- her job -- I think she said -- she said it was a long time, it was over a decade that she's been doing this and she's been specifically looking at veteran issues for the good senator, and has been doing it for some time. And -- and she might take back to the senator the fact that -- that you'd like to see some modifications of the law. That could happen. Okay.

Now we have one -- one other speaker, Mr. Ken -- Kenneth Desmar-- Desmarais?

MR. DESMARAIS: Yeah.

VICE ADMIRAL ZIMBLE: Ah, good aftern-- is it afternoon yet? No, good morning.

MR. DESMARAIS: Good morning to you and to everybody else in the room. My name is Ken Desmarais. I'm the -- as I explained to one of the representatives on the telephone the other day, I'm the -- I'm the kid brother who on a very warm summer day, I think it was in 1943, proudly -- I was 11, going on 12 -- walked my older brother to a bus stop in my hometown of

Lowell, Massachusetts and he had the big duffle bag and he was headed for Fort Sill, Oklahoma. And to me, Oklahoma was like 10,000 miles from anywhere, and I was so proud of him when he got on the bus and I waved goodbye to Jim and -- and I had tears in my eyes. I didn't see Jim until about January or February of 19-- I think it was 1946, after the War ended. He was with the 41st Division. Certainly not the same Jim that I waved goodbye to and, unlike many veterans, he had a difficult time getting back into the civilian groove, as many did. Never talked about his experiences, as did my other four members of my family. They were just reticent and that's -- many veterans, and I'm a veteran of the Korean Conflict, but I'm cur-- I was curious over the years because he passed away at the age of 49 of cancer, and all we knew that, with the 41st Division, he was in either Nagasaki or Hiroshima, not quite sure. I recall taking to school, in the fall of that 1946, pictures that he had sent, those little Brownie 127s, standing with other buddies and -- and showing them to the teachers and we talked about it and that sort of thing.

I fast forward because all these years later I've learned, as other members of my family did, that Jim was involved in something -- as a volunteer, I assume, and -- and this is where it gets fuzzy because it was always shrouded in secrecy and our Congressperson tried to find out about it and all he would say, it's security and all that. I believe it was an advance group of people went in with nurses and maybe some people here can verify that. So over the years we've tried to find out what -- just what did go on, not because we wanted medals or compensation, just family curiosity. Eventually we just let it die. His son, my nephew, who I happened to be with this past weekend, is now in his -- heavens, he has grandchildren, he's early 60s and I'm a spirited 76 and I spent a career in broadcasting and I still have a program on Friday nights which appeals to a lot of the people of World War II that are left, and Korean -- I do Big Band-era music and that sort of thing. So up until that ad in the paper, that announcement, I, over the years, said has anybody ever looked into a possible link

between what my brother passed away from and -- and other veterans, especially those of the 41st, the Sunset Division, which I pulled up some information on. And lo and behold, on the eve of a commemorative -- at the memorial service for a member of my family, I'm looking through the *Sun*, as I do every morning, and bingo, there's this.

So this is my purpose of being here, primarily to say I'm grateful that the wheels are turning, albeit slowly, but at least there are people like you who have answered a question that I have posed for so many, many years is does anybody care? And I'm sure Jim and others didn't go in there with having somebody say well, you know, this is what could happen to you. I'm sure he did like everybody else, as I did. I never questioned an officer, I just did things, you know. And so I'm glad. I'm just -- this is a compliment to all of you -- that efforts are being made to find out and perhaps those -- Jim has passed on, as have other -- all other four members of my family, 8th Air Force, 41st, 28th and I've read up on that because I'm a historian of sorts. So I commend

you. I thank you. As I noted, the wheels do turn slowly. The only time they've turned quickly, as I recall in my almost four years in the Air force, was a break at lunch for the mess hall. That was a rush. But other than that, everything just moved in sway.

So thank you, and I hope -- not for Jim, my nephew, Jim, Jr., or my brother or my personal family, just because I'm glad that hopefully someone may benefit from undergoing what they did.

And those are my comments and I appreciate what this gentleman went through, and any other veterans who are in the room. Thank you for your time.

VICE ADMIRAL ZIMBLE: Well, thank -- thank you very much. We -- for your gracious and thoughtful comments. I would just say that, you know, we're dealing with a very specific population, a population of individuals in the -- in the military who served during -- at a test site for -- an atmospheric test site, both at Nevada or in the Pacific, or who were part of occupational forces in Japan during a specific time period, '46 to '47, and those who

were prisoners of war in the vicinity of either Hiroshima or Nagasaki. It -- it's a -- it's a -- it's a very well-defined group of individuals, and the NTPR has the capability of verifying those individuals that did serve there. So if you have some question about where your brother was and -- and the potential that he might have been part of the occupying forces, you could get together with the NTPR, with -- with Dr. Blake, we'll get his -- his Social Security number or serial number or whatever information you have, and we can verify whether or not he did participate. Does he have -- did he have a surviving spouse?

MR. DESMARAIS: His wife passed on just within the last year actually, and so we -- and as I said, the -- it wasn't an issue in the family as much -- they tried and --

VICE ADMIRAL ZIMBLE: Right.

MR. DESMARAIS: We primarily want to find out just what he did and --

VICE ADMIRAL ZIMBLE: There was a --

MR. DESMARAIS: The compensation factor, quite truthfully, when I mentioned it to Jimmy, Jr. over the weekend, he said Dad -- Uncle Ken,

that's so long ago and they -- they've just accepted it and moved on with their lives, as obviously I have.

VICE ADMIRAL ZIMBLE: We may be able to -- NTPR may be able to answer your question for you. The other thing is that -- that all of the participants were -- were instructed that this was -- this was a highly secret matter and -- and so there was a great deal of security, and we've just recently sent a brochure, I believe, that said you have been relieved of the responsibility of keeping this a secret anymore, and that -- I can't remember what year that was -- '96, since 1996 that -- that -- the -- the security issue has been dis-- dismissed, so I appreciate your bringing that up.

Did you mention that you were a broadcaster?

MR. DESMARAIS: Yes, I've spent all of my life in broadcasting.

VICE ADMIRAL ZIMBLE: Okay, so you're still doing it.

MR. DESMARAIS: Friday nights, but -- I was full time and then six years ago when I retired --

VICE ADMIRAL ZIMBLE: Okay.

MR. DESMARAIS: -- probably at the request --
VICE ADMIRAL ZIMBLE: You know, I --
MR. DESMARAIS: -- my listeners I was asked to host a program on National Public Radio here in -- in Baltimore on Friday nights and I --
VICE ADMIRAL ZIMBLE: Okay.
MR. DESMARAIS: I appeal to the Glenn Millers and the Frank Sinatras and the Tony Bennett crowd, no Whos or --
VICE ADMIRAL ZIMBLE: Should you decide to do something again --
MR. DESMARAIS: Yes.
VICE ADMIRAL ZIMBLE: -- you might find the opportu-- if you just listen to our previous testimony from Mr. Shaller who says he never heard anything about this program for so long until just recently --
MR. DESMARAIS: Yeah, precisely.
VICE ADMIRAL ZIMBLE: -- how many more of those 400-and-some-odd-thousand have not heard --
MR. DESMARAIS: Well, there are ways to do it -- honestly, if somebody would have picked my brain in a blue sky session, there's -- there's ways. I've been in media all of my life.
VICE ADMIRAL ZIMBLE: Well, if you ever want to

mention what we do on -- on the -- on the airwaves, please feel free to do --

MR. DESMARAIS: I will do it probably either this Friday or -- or next Friday, I'm going to ask if anybody served at the -- with the -- with the 41st, to touch base with me.

VICE ADMIRAL ZIMBLE: You just might want to talk to our PA officer, who happens to be here. This young lady -- this young lady right here --

MR. DESMARAIS: Okay.

VICE ADMIRAL ZIMBLE: -- is Public Affairs from DTRA, and we're always looking for ways to make an outreach to all the --

MR. DESMARAIS: I'll do --

VICE ADMIRAL ZIMBLE: -- atomic veterans.

MR. DESMARAIS: -- anything I can. This'll be --

VICE ADMIRAL ZIMBLE: Okay, thank -- thank you --

MR. DESMARAIS: -- an honor for me to do so.

VICE ADMIRAL ZIMBLE: Very good. Dr. Fleming, you have a comment?

DR. FLEMING: Yes, I'd just like to point out to you that on this brochure as well, on the

very back, is the question: Is there any other way for me to seek compensation? And I know that you've -- you've shared with the -- with the Board here that you're not sharing your information because you're interested in compensation, but there's another piece of legislation, it's called RECA, and it does apply to the children of the individuals if they are shown to be service-connected, and to their children. So when -- when Admiral Zimble asked you about a surviving spouse, I think he was thinking primarily of veterans' benefits. But this is another program that extends beyond a surviving spouse to any surviving children, and if they have died, then any surviving grandchildren. So I would recommend that you send -- give this information to your nephew, and then that's the route to which you can find out.

VICE ADMIRAL ZIMBLE: And Ed, you have another -- you remembered?

MR. SHALLER: Yeah, I remember what I forgot -- my senior moment. There was film badges at the test. Okay? Two of them. And I just want to know if the records were kept of the

individuals that were at the tests and of how many rads they received and what-not. And I also want to know -- when I got out I think I had something wrong with me 'cause I -- I remember I was at the El Toro -- discharged from El Toro Marine Base and they wanted to keep me around for a couple of weeks or something about something -- I can't remember what it is, but I signed a waiver because I just wanted to get -- get out of the service, you know. I had enough and I was very anxious to continue on with my civilian life. So I remember that I had to sign a waiver. I was just wondering if there'd be any record of that with the VA, too, as well. If we started scratching around, will we find anything or -- I mean nobody's mentioned anything yet in all these, you know, years I've been associated with VA, so I was just curious. I mean I've got a feeling if I go in there and I'm going to say I want to get on the IRR program and blah, blah, blah, they're going to look at me like I'm nuts and somebody's just going to wa-- you know, say forget it, see ya later, we don't have any record of that or we don't know

anything about it. That's what I think would probably happen.

VICE ADMIRAL ZIMBLE: Well, it may or may not. If it does, you need to talk to somebody else at that VA hospital and -- and I -- I would tell you that -- that the people in the VA at -- that -- that set the policies want very much for you to get those benefits which you have earned. And so I -- I would pursue it. I wouldn't -- I wouldn't be too cavalier about it.

As far as records of film badges, my short answer would be yes, they have them. But I have Dr. Blake over here who's going to give you a far longer answer to that question.

DR. BLAKE: Our -- our records are very good in the Department of Defense from the viewpoint of historically we -- we kept very good records back then. We probably can find out that answer for you within a few minutes. Lieutenant Commander Sanders is right behind you, can call back to our staff and just inquire into the database. But we've actually kept copies of the film, too, and they're centrally archived out at the Nevada Test Site

so we could actually go back to the dosimeter, not -- some -- some film badge results were lost. I mean it was a military action out in Pacific Proving Grounds where you were and getting stuff passed back occasionally things were lost, but for the most part our databases are -- are very good, and we're happy to look that up for you.

And the same thing, Mr. Desmarais, we're happy to look up your brother's military records if you want to speak to Lieutenant Commander Sanders back there. We'll get the information. We're happy to follow up. We'll pull -- we'll pull the records from your brother in the national personal records center, his military records, and we can -- if we get a -- we have to get a Privacy Act release statement from you, but we can then -- or his -- his wife, if that's the case, but we can still provide those to you just as long as we follow the law.

So in both cases, we're happy to do that. That's what we do and -- and we can get you fairly quick responses for both of you.

VICE ADMIRAL ZIMBLE: Yes, General Manner.

BRIGADIER GENERAL MANNER: As possibility of

compensation for people who are just participated and, as you heard, it's not, regretfully, permitted under the law. However, something that you may want to engage your representative or senator on is that there was a -- a bill that was introduced to the 109th Congress that -- as you know, there are various service medals for personnel that have served overseas in various conflicts or times of service, and there was a bill introduced to the 109th Congress by Representative Filner. Regretfully, it was not approved by the Congress. However, you may want to talk to the representative here that it's a medal that'll be proposed to be awarded to people who participated or observed the nuclear testing. And that may be something -- although very small, it is a public recognition for those folks that did that. Granted, it's not something in compensation in your pocket. For some people it will mean nothing. For other people it will be a small -- it's a -- an expression of appreciation. But I just mention that in passing.

VICE ADMIRAL ZIMBLE: Mr. Ritter.

MR. RITTER: I'd just like to add to Dr. Blake's comments, and that is if you're going to go down to the VA, which I suggest, to -- to get on the Ionizing Radiation Registry and have your exam, it's a no-cost situation, the DTRA people -- given the fact that you supply them your service number, the ship you were on, that sort of thing -- will issue an official letter of participation. You can then take that letter, or a copy of that letter, to the VA and that will prove to the VA people that you speak to that you were there and you participated in those events, and that will get your -- your -- it will get you into the system. And should you develop any anomalies beyond that point, then they'll know who you are.

MR. SHALLER: (Off microphone) (Unintelligible)

MR. RITTER: Right, but unfortunately your 214 didn't say anything about your participation in those tests because, as -- as the Admiral said, it was more or less classified. But having a -- an official letter from the Defense Threat Reduction Agency saying that you were there carries a lot of weight when you walk through the door and talk to the VA service officer.

MR. SHALLER: Where do you get that letter?

DR. BLAKE: Lieutenant Commander Sanders behind you will take the information and then we'll -- we'll provide it to you --

MR. SHALLER: Very good. All right. Thank you.

MR. RITTER: Thank you, Admiral.

VICE ADMIRAL ZIMBLE: Okay. Seeing no further questions or comments from the Board, and recognizing the hour -- oops, I'm sorry. Dr. McCurdy.

DR. MCCURDY: I -- I just wanted to know how you're handling -- whether it's a public comment or not -- what was in our packet we -- with respect to Mr. Thomas Cafer-- Caferlo* and what -- what's -- what the disposition will be on this.

VICE ADMIRAL ZIMBLE: Okay. Let's -- let me table that until after lunch and we'll -- we'll get back to you. And I think, looking at the hour and looking at -- at the hungry faces that surround me, I think it's time for us to break for lunch. We will reconvene at 1330.

(Whereupon, a recess was taken from 12:08 p.m. to 1:34 p.m.)

VICE ADMIRAL ZIMBLE: It's past 1:30 so I believe it's time that we begin, and we'll -- we'll take our subcommittee briefs -- oh, no, wait. We're not ready to start yet. Where -- where's --

John -- John's on the phone?

UNIDENTIFIED: (Off microphone)

(Unintelligible)

VICE ADMIRAL ZIMBLE: No, I'm looking for John -- John Lathrop. Okay. Well, let's take another five -- let's say another five minutes till John comes 'cause I really would like John to begin the discussion by talking -- before we get the subcommittee reports I would like him to briefly go over the gap analysis and talk to -- to the gaps that we believe still remain, get his perceptions of that, then we'll listen to the reports from the -- from the four subcommittees. And the four subcommittees, of course, have recommendations for how to proceed, and they also have identified or addressed those gaps, so I really would like to start with -- with John Lathrop. We'll give him five more minutes.

(Pause)

I -- I have mentioned to the group that it would be best to start -- I would -- I must tell you -- I'm sure you all know, but for the record, John Lathrop has done truly Herculean work and put in a great many hours and a great deal of thought in putting together where we are, what we've done, where we still need to go in various areas, and basically looked at this gap that still remains.

UNIDENTIFIED: And how.

VICE ADMIRAL ZIMBLE: And how the Board should address that. And so with -- without any further ado, I would turn the meeting over to our scribe, Dr. John Lathrop, for his comments.

DR. LATHROP: Thank you. One thing to keep in mind is I'm a decision analyst, and one of the things decision analysts are supposed to do is analyze a decision and do the divide and conquer about what goes on and not make recommendations. So if you hear something I say and it sounds like a recommendation, it always should be preceded by -- and I will forget to say -- in my humble opinion. Okay. And you know. So there you go.

To go through this, just to give you a

foreshadowing, this will be a brief little talk about what we've done, what we're -- perceive as things that need to be carried forward, and considerations for how best to do that.

Started out with what we call the gap analysis that we did earlier in the calendar year. But you know, gap has a little bit of negative connotation so I changed it over to needs for continuing functions. And that's just -- again, to keep things very neutral here, this is just a brief little overview of where we've been, what we've done -- the Board, working with the two agencies -- and what remains to be done.

To begin with, let's re-- let's remind ourselves about sort of our key accomplishments. You know, people get up here and they have many slides and there was 17 recommendations and we did this with 16 of them -- I don't know, I think sometimes we lose the forest for the trees, so let me just briefly say let's look at the key goals of the Board and what we've done.

Key goal of the Board: Look at the NTPR RDA and expedited RDA processes and audit it and

recommend some improvements. And Subcommittee 1 has done a marvelous job at developing a relationship with NTPR and auditing their RDAs and their process and developing suggestions -- the Board as a whole also has developed suggestions -- for expediting the process. And as Dr. Blake has pointed out, that's done very good things for the veteran in terms of backlog and through-put and effort per claim and consistency.

Equivalently, on the VA side, some auditing and looking at the process and recommended they centralized claims.

On the quality assurance end, worked -- worked with NTPR and they've done a Herculean job, to use that word again. Dr. Blake mentioned the 1,400 pages, and looking at that and seeing what might be most effective and most efficient, recommending and outline Decision Summary Sheets as a summary way to do that, and Dr. Blake is moving forward on Decision Summary Sheets for both RDAs and the expedited -- expedited process.

Communication and outreach, press releases, media links, the brochure we now have, working

with the IRR newsletter -- all those are quite a bit of accomplishments and they certainly have accomplished or gone a great deal toward accomplishing the missions of the Board. Remaining challenges and tasks, I've listed just a couple here. There's a whole bunch of them, but again, it's sort of a long list. Let's look at the two -- what, in my opinion, are the two most important ones, and that is continue to work with NTPR and Dr. Blake on the -- on the double-blind tests and what those mean for improving the -- the SOPs, identifying shortfalls and how best to fix them, and it's all a let's go around and do it another time, another time. The other thing is the proactive outreach we've been talking about and how best to do that. And Tom Pamperin has laid out a very interesting strategy which we'd love to work with him on.

At the more detailed level, the general continuing functions that need to be carried forward are general monitoring and oversight of the QA and the process. Dr. Blake mentioned a -- a "lessons learned," the need for -- for expertise, support. Looking over the

interactions between NTPR and VA, monitoring the communication and outreach, advising in the development of the Decision Summary Sheets and the further work on Standard Operating Procedures, working with the letters to veterans. I'll be the first to admit I'm -- I'm behind on advising Dr. Blake and Mr. Pamperin on those -- those -- those letters and the whole process of -- of communicating most clearly to the veteran what's going on. Frankly, it's a very analytically complicated process and it's quite a challenge to fairly and comprehensively communicate to the veteran what's going on. Questions of documentation, methodolgy and an-- and analysis, a lot of de-- of details. The bottom line is, in my humble opinion, the VBDR, working with NTPR and VA -- specifically working with Paul Blake and Tom Pamperin -- has really -- I think we can be proud of ourselves. I think we've made many important accomplishments in the timeliness and systematizing, giving the benefit of the doubt to the veteran, reducing the backlog.

Now here's where I really go out on a limb. It's just my opinion but, you know, I've talked

with some people and there's some agreement. I would say that the Board as a whole, as a FACA -- Federal Advisory Committee Act board, has made -- here's the big word -- all -- okay? -- effectively all the strategic decisions that we can and should for accomplishing the Board's mission and specifying a whole set of actions -- you saw all those recommendations -- that we found to be feasible and effective. Some of this is back and forth. Sometimes we make a recommendation and in interaction with the agency -- well, that's not feasible or that's not -- we can't look at the changes in law to do that. So we've worked out, from all of that, feasible and effective sorts of actions and activities. Now it's a question of implementing them or seeing -- some of them are implemented, a lot of them are -- and initiating an ongoing sort of implementation. So I would say that the strategic and decision-making work has been done. A lot remains to be done, but let's call those tactical things, tactical implementation monitoring.

So here's the big leap. It could be that continuing activities from here on in don't

require a board like this Board at the scale of this Board, meeting as frequently as this Board.

One of the things I've noticed, maybe you've been able to put together from some of the presentations, is we established, as a very reasonable and appropriate and legally and ethically appropriate way to do the work of the Board is to make formal recommendations to the two agencies, and to respond to those recommendations. What you might also have noticed is there's somewhat of shift in that, more in particular with Paul Blake with than (sic) Tom Pamperin, but in both cases of going sort of beyond recommendations to basically say hey, can we do this, can we try that, and this is done or tried or attempted -- ah, let's look at this and talk it over. Which is maybe less legalistic, but actually is very -- very effective. And by the way, can only work because of the relationship of the Board with Paul Blake and Tom Pamperin. I can't tell you how much it has involved a very human, well-intentioned, collegial, mutually respectful interaction between the Board and these two

people. We've been extremely fortunate in that.

So now what is before us, and we want to be considering over today and tomorrow, is should we keep going the way we are -- which is fine -- or a smaller FACA Board, perhaps meeting less frequently. Or maybe a different board entity or working group that doesn't have the Federal Advisory Committee Act system around it, supported by consultants.

I do -- if you remember all the stuff we've been talking about, what needs to be done, there's a lot of work to be done. For instance, not the work that you can expect from a bunch of volunteers meeting on a weekend. Okay?

The oth-- the other thing I want to say, and then I'll stop talking, is if you listen carefully to what I've been saying and we've been saying about ongoing activities, they do need to be pursued and advised and implemented and monitored by an outside board that -- I don't know what the polite term is, but a board that has teeth, a board that can actually say you know, I think you should -- perhaps

advising -- that you should do things this -- down Path B and not Path A, and have that listened to and complied with appropriately by the committee. We can't dictate anything, but we do want to make sure that anything that carries on, whether it's this very same Board the way you're looking at it or another -- another entity, that it has the same quality that we've developed so successfully so far as a collegial, cooperative and well-intentioned and responsive interaction with both agencies. Got a little more to say, but I'm going to stop talking now because it's up to the -- let's hear what the -- let's carry on.

VICE ADMIRAL ZIMBLE: Thank you very much, John. I think what you really described is basically a tipping point for the -- for the Board, that we can now look to continuing our current activities -- basically waiting until a light bulb goes on and we suddenly have a eureka moment and think of a new recommendation to make; or sitting back and waiting until we hear some complaints from somebody that suggest there may be a problem that we have not addressed. But I think a -- a better plan

would be to relook at our structure, relook at our mission, look to something that's more in a surveillance oversight mode looking to the correction of the -- not correction, but the -- the full implementation of the accepted recommen-- looking to compromises for some of the recommendations that are just too hard and -- and, for example, looking for a -- a cohort for outreach that makes good sense, for example. And I -- I think that means that we might want to relook at the constitution of the Board, et cetera.

Now we've had a lot of informal discussions about that, but it -- it -- I think I would like to see as a result of today's and tomorrow's meeting, this session, I'd like to see some formal recommendations coming from the Board having reached a consensus -- some formal recommendations that would come forward to the two agencies offering ways that we think the Board should go. Okay?

DR. LATHROP: Or -- or would that be recommendations to the Congressional Oversight Committees? I'm unclear.

VICE ADMIRAL ZIMBLE: I think we have to work

with our sponsoring agencies. Okay? We -- we're a mandate of the Congressional Committee. We might, at some point in time, want to have some direction from the Veterans Affairs Committee since they -- they created us, and they will have opportunity to review the full recommendations that we make. But I think that we need to direct our recommendations to the two agencies that we support.

BRIEFINGS BY SUBCOMMITTEE CHAIRS

With that, each of the -- each of the subcommittees will -- is -- at each meeting provide a report, and they're going to be doing so at this meeting. But I think each one of them will give a flavor of where their committee has achieved a consensus about what we should be doing so we can take that into consideration. And we'll start with -- we're using a technique of going in numerical order, we'll start with Subcommittee 1.

A REPORT FROM SUBCOMMITTEE 1 ON DTRA DOSE RECONSTRUCTION PROCEDURES

MR. BECK: Thank you, Mr. Chairman. As usual, this is a -- we have a very long report, we're a very verbose committee -- or subcommittee, but I'm going to read perhaps more of it today

than I usually read because -- so all of you have a copy -- particularly when we're talking about our recommendations for the future. I want to make sure I say what we agreed to and not -- not editorialize at this point.

First I will remind you, and I think it's important that -- for this particular report, what our mandate is as far as the task that this committee -- subcommittee is supposed to perform.

We're supposed to assess dose reconstruction procedures, including revisions used by NTPR contractors, and these will include the procedures for determining exposure scenarios, the technical procedures for reconstructing doses, and related documentation such as Standard Operating Procedures and so forth.

We're supposed to conduct periodic audits of a random sample of NTPR dose reconstructions to ensure that correct procedures have been followed, and to ascertain the quality of reported doses and associated uncertainty estimates.

And then we're supposed to prepare a report, as I'm doing here, and present it to the Board.

First I'll start out with our activities since the last VBDR meeting. In April we circulated to members of the Board our draft reports on the sixth set of our randomly-selected audits for your perusal and comments.

In June we chose some additional cases for audits to report on at this meeting, and these cases were chosen from an updated list of Radiation Dose Assessments that were completed between November 20, '07 and June 20, '08. And in order to see if the improved methodology being developed by NTPR as a result of the various recommendations that we've been told about were being properly implemented, an emphasis was placed on selecting more current RDAs. And you know this has been a -- they've rapidly been changing their methodology, so we have a moving target. So it doesn't make a lot of sense to audit old cases where they no longer are using those procedures.

Unfortunately, though, because of the fact that we've been so successful, as Dr. Lathrop has said, there aren't too many cases left for us to audit. And in fact, for this particular period there were only three new cases, or four

new cases, of full Radiation Dose Assessments that we could audit -- one of which was a case that was a double-blind that we'll talk about a little later. So we could not pick six cases as we usually do.

But aside from these cases, we also did pick six cases of expedited cases. And in that case, for those cases, we do not do a full audit, but we were looking at whether or not the procedures that are in their Standard Operating Procedures could decide whether or not to -- to apply the expedited dose assessment were followed correctly and whether these cases were actually expedited as they should have been.

And then we also looked at one Hiroshima/Nagasaki case, which is somewhat different in that that dose assessment is done -- rather than by contractor, it's done by a government employee, one of Dr. Blake's staff. The report -- if you want information on the specific cases, the report gives you details that you can read.

Then, as usual, what we do is between each VBDR meeting we try to meet at least once at an NTPR

contractor facility, and we did that in -- July 30 and 31st, to discuss these cases with the analysts who performed them, and also to be briefed by Dr. Blake on specific issues of interest to Subcommittee 1 and to have informal discussions about the -- what's going on in terms of the methodology. These are all discussions. We do not make any formal recommendations, obviously, at these meetings since it would be against the FACA regulations. But we have found these meetings very useful in terms of exchanging ideas and understanding particular cases that we're trying to audit and being able to ask questions of the actual people who performed the dose reconstruction. I might mention that at these meetings, as we frequently do, we have a member from -- one or two members from SC-3 often attending these meetings. At this -- that meeting we did have two members of SC-3 who attended, as observers, to participate.

Some of the activities that were discus-- or the topics that were discussed at this meeting were we received an update from Dr. Blake on the SOP development and the status of the

uncertainty analysis proce-- improvements and the status of the double-blind QA studies. We also received a update from Dr. Ingram at the time on the DSS development.

The audits -- we were presented -- the audit cases were presented by the particular person who did the -- or persons who did the dose assessment and then we discussed these various cases. And we also received a briefing on the significant progress made by NTPR in using probabilistic uncertainty analysis to validate the current default upper bound estimates used for full dose assessment, and Dr. Blake spoke about that.

And we also had a full discussion of the results of one of those four cases, which was the double-blind case, where we heard not only from the con-- the DTRA contractor who did the dose assessment, but also from the two NCPR -- NCRP health physicists who did independent dose assessments.

And finally, yesterday we met again to prepare this report and discuss -- as the Admiral said, reach a consensus on some of the recommendations that we're going to make to the

VBDR regarding where we should go in the future.

Just a few notes on the audit assessment findings. As I said, because most dose assessments now follow the expedited procedures recommended by VBDR, there are only a few full dose reconstructions performed per month. Actually at the present time it's more like one, but we're allowing for uncertainty.

The current audits continue to demonstrate that NTPR is generally providing the benefit of the doubt in development of the SPAREs, in close cooperation with the veteran. We did not find any significant errors that would impact the decision in any of the cases that we looked at.

We found that significant progress has been made by NTPR in documenting procedures and correctly referencing the documentation used in the RDAs and annotating the calculations.

However, we found that final versions of standard methods are still not in place for some of the methods used in the RDAs, and Dr. Blake mentioned this was ongoing. And we found that some of the documented SOPs are not always specific enough and do not always provide

specific references to the Technical Basis Documents, but this is all part of the ongoing work that Dr. Blake has pointed out is being -- is going on to complete these SOPs.

We did note that there were -- some apparent new procedures were being implemented by NTPR regarding the reporting of results of RDAs and expedited doses that are not documented in the current SOPs. And we were told yesterday that that is being taken care of and the SOPs are being revised. And particularly this had to do with radio-- non-radiogenic disease cases and how the doses are assigned for them, and there was also an issue of whether or not -- when a full RDA is performed, whether the dose -- the expedited dose is still given to the veteran, even though there was a lower dose that was actually calculated.

The RDA reports to the VA and veteran, as well as other communications, are much better but SC-1 believes they still can be further improved. We've found that some of the letters to the VA or the veteran -- actually the same letters -- that provided expedited and calculated doses were still confusing. And

particularly we saw if a particular dose estimate is provided to the veteran, the IDA or cover letter should discuss why the new estimate differs from any previous estimates. Often the veterans receive, over the course of many years, many different letters and doses that they've been given, and it's very important that they not confuse expedited doses and not confuse doses that were given by the military 20 years ago with an actual calculated dose under the best current situation. So we've discussed this with Dr. Blake and this is part of their ongoing improvement in the SOPs. We noted that case file documentation continued to improve, and Dr. Blake spoke of the MathCAD program that -- software that they use to do these calculations. And one of our recommendations early on was to improve the documentation so that an outsider or an auditor could really follow these MathCAD calculations, and they have really made a lot of progress in that extent in their latest versions of the MathCAD calculations, even though, as Dr. Blake pointed out, are hundreds of pages, are very well-annotated now and we can understand them

much better. We might not agree they're perfect yet, but almost -- really much -- much improved.

As requested by VBDR, a Decision Summary Sheet is now being prepared by the DTRA dose reconstruction contractor when he does a full RDA. And this is a little different from the Decision Summary Sheet that's done by the DTRA staff in order to decide whether or not to expedite a case or not, so we actually have two different Decision Summary Sheets being prepared, and both are very important.

Based on our review of the six expedited cases we found that the -- these Decision Summary Sheets -- that the documentation of them and the way they justify the decision to expedite or not expedite is -- a case is still evolving, and so we're going -- we agreed with Dr. Blake that we're going to look at how these Decision Summary Sheets evolve over the next -- course of the next several months and that will be done in conjunction with SC-3.

And we also identified the need for additional clarification of the SOPs regarding these expedited processes, as well as, as I

mentioned, additional explanations in the letter sent to the VA and veteran.

On February 27 VBDR recommended that NTPR extend their QA programs to include carrying out the selected duplicate blind RDAs by independent health physicists. And I mentioned that one of the cases reviewed was such a case where, independently, two health physicists reviewed and actually did their own dose reconstruction of a case that was done by the DTRA contractor. The results of this exercise were that the independent contractors, in this particular case, failed to duplicate the prime contractor results. And this was very interesting in the sense that it was important then to find out reasons for this.

I should note that this had no effect whatsoever on the claim. The doses in this case were very small, so we're not talking about doses that in any way would affect the claim at all, but in terms of a perception, you know, we want to get to the point where we get the same doses because that is very important to demonstrate that somebody from the outside can actually follow the SOPs and come up with

pretty much the same dose. So we were shown yesterday that the contractor for NTPR -- for DTRA actually did a lessons-learned analysis, a very detailed lessons-learned analysis to identify exactly why each of these calculations differed. And it was very enlightening in the sense that part of it was due to actual errors on the part of the independent people, and the reasons for this were varied, but some of it was also due to -- admitted by the contractor -- lack of clarity in the SOPs. And -- and so it showed that there is a need to improve the SOPs, and this is one of the things that comes out of this, which is a very good plus for doing this if it can identify where the SOPs need improvement.

We continue to think this is an important exercise because the ability of an independent health physicist to duplicate the NTPR RDAs strengthen confidence in the whole dose reconstruction process.

Now let me get to the part that the Admiral is most interested in, the future plans.

Of course, as far as SC-1 is concerned, the future plans will depend on the discussions

that are taking place in the next -- this afternoon and tomorrow morning. But SC-1 feels that there's no longer a need for VBDR to conduct full audits of randomly-selected cases. The number of full RDAs performed by DTRA is down to only a few a month, and these cases are reviewed both internally by DTRA -- Dr. Blake mentioned that their contractor has three different levels of review there alone -- as well as by an outside contractor, Oak Ridge Associated Universities, so there's already four levels of review outside -- some of which is outside, or independent. In addition, if DTRA continues the double-blind program described above, the double-blind cases will provide an effective, ongoing, independent review of at least some of the RDAs. Thus we feel that SC-1 does not need to continue to routinely audit expedited cases, either. Again, because of the fact that we have an outside -- that DTRA has an outside entity doing a review of the DSS and the decision to refer expediting as well. So basically what we're saying is we don't feel the need for routinely -- for this Board routinely auditing

any of the dose reconstructions anymore. However, we point out that the National Academies' report to Congress that essentially resulted in the creation of VBDR recommended that there be continuing, independent, outside oversight of the dose reconstruction process. And this was intended to include an overview of not only the RDA preparation, but also the methodology, the Standard Operating Procedures, communications, and the relationships between DTRA and VA. Thus we feel to fulfill these requirements there still is need for some organization, independent of DTRA, to quote/unquote check the checkers, to assure that these outside reviews are being performed adequately and thoroughly, to assure that the SOPs are maintained up to date, and to review any new NTPR methodology or procedures and assure that all decisions have been adequately documented in the case files.

I might mention as an aside, Dr. Blake pointed out in his going forward that one of his needs will be to continue to have somebody review proc-- new -- these procedures.

I'd like to also point out that these informal

meetings that I mentioned with NTPR staff and contractor analysts have proved very beneficial to identifying problems and potential problems, and discussing these issues with NTPR management. And we believe that these meetings have been useful not only to VBDR in fulfilling its mission and helping us develop recommendations to make to the Board, but also to DTRA in identifying issues that can be corrected without formal recommendations to DTRA upper level management. Dr. Lathrop sort of just mentioned that sort of concept.

Thus, even if the missions and organization of VBDR and SC-1 changes as a result of the discussions at this meeting, we feel that these informal meetings should continue to be a part of any future organizational entity.

SC-1 emphasizes that independent QA audits done on both full RDAs and expedited cases are -- by the -- DTRA's contractor are very beneficial and should be continued -- this is the outside contractor I'm referring to -- and we have recommended that these audits should be expanded to include quality checks on specific calculations and codes, and Dr. Blake pointed

out this is indeed in progress.
So our suggested issues for discussion by VBDR and our recommendations are as follows: As far as continuing issues, since NTPR is already in progress to address most of the issues that I've just talked about, we're not proposing any new formal recommendations on dose reconstruction to DTRA at this time. However, we'd like to point out that in particular NTPR has made considerable progress in implementing VBDR's previous recommendation about the default upper bound guidance factors, and we recommend that this continue to receive a high priority. The probabilistic uncertainty assessment underway has demonstrated that the upper bound factor of times three for external dose that they have been using is adequate for most cases. Similar analyses still need to be performed to validate the upper bound factor of times 10 that they have been using for internal dose.
However, we note that there is still a need to send more consistent and understandable messages to veterans. Radiation dose assessments should be written for veterans to

understand. Letters to the VA/veteran regarding the results of an expedited RDA need to be very clear about the meaning of the assigned dose so that any future claim for a different disease resulting in a different assigned dose will not be underst-- misunderstood.

As far as our recommendations for the future, we would observe that the major reasons for formation of VBDR and for audits of the dose reconstruction process have been successfully addressed by NTPR. In particular, the backlog of cases awaiting dose reconstruction and the delay in completing dose reconstructions have been greatly reduced, primarily due to the expedited dose assignment process recommended by VBDR and implemented by NTPR. Concurrently the periodic random dose reconstruction audits by SC-1 have helped to stimulate significant improvements by NTPR in the methodology and documentation of cases for which full dose reconstruction is required. While NTPR continues to make ongoing improvements to these processes, SC-1 believes that the major future dose reconstruction-related oversight

requirement needs to be directed primarily towards QA oversight. This oversight should include independent review of the contractor double-blind analysis, periodic review of the Oak Ridge Associated Universities' QA activities to ensure they're being performed correctly and thoroughly, and periodic review of new or revised NTPR procedures.

SC-1 believes that whether or not VBDR continues in its present form, some type of continuing independent outside oversight of the NTR (sic) program is essential. We believe that the continuing functions recommended above could be more efficiently carried out by a non-FACA advisory committee that meets at least once a year with NTPR program staff. This advisory committee would communicate its findings or recommendations directly to upper level management. In order to assure that the new organization is perceived as completely independent, the members should be appointed and supported by an outside independent non-government entity. A smaller non-FACA organization will allow a much-needed flexibility to rotate experts and thus provide

focused expertise for current issues.
SC-1 also believes that there will be a continued need to monitor communication and outreach issues, as well as to maintain VA/DTRA coordination with respect to atomic veteran issues. These activities could be coordinated by a similar non-FACA advisory committee via perhaps an existing joint DoD/VA entity.
SC-1 therefore suggests that VBDR recommend that the current VBDR FACA committee be disestablished and that one or more non-FACA advisory committees be established instead to provide continuing oversight and DoD/VA coordination of the dose reconstruction and claim adjudication procedures for atomic veterans.
Thank you.

VICE ADMIRAL ZIMBLE: Thank you very much, Harold. That was a very complete and -- review of -- of your proceedings and excellent recommendations. I -- I just have -- I had one question. If there are so few dose reconstructions now being performed thanks to the ex-- ex-- expedited processes, would it be wise to recommend that all dose reconstructions

-- full dose reconstructions be double-blinded as an -- as an effort to -- to get the -- to validate -- each of the results would validate one another or, if there is a difference, be subject to further study and I -- and I think that would tend to prove quality.

MR. BECK: Before Dr. Blake has a heart attack, I -- I should point -- I mean to be fair about this, we -- in discussing the 12 or 15 full dose assessments that now are being done --

VICE ADMIRAL ZIMBLE: A year.

MR. BECK: -- are usually the most complicated -- very complicated cases, which cost a lot of money to do.

VICE ADMIRAL ZIMBLE: Got it.

MR. BECK: And so this would be a considerable expense. I certainly -- I wouldn't want to make a formal recommendation myself, and we haven't discussed this as a committee, but I -- I do think -- we have recommended that the double-blind continue. We have not said how many, and Dr. Blake, as this improves and as he gets better training, he may well consider doing more than one or -- you know, the number that he could do a year would -- I think is --

it probably could be more than one, and probably should be two or three of those, and I don't think there's any problem with this and I think this could be agreed upon in a formal way. Certainly we think it's a valuable exercise, even -- we should point out, and I think everybody should appreciate this -- we discussed this, and I think if you listen to some of the words that have been said, the -- the contractor who does these full dose assessments has a very experienced team, a lot of history. They've done this and they work as a team, and it's very hard to expect an outside health physicist to be able to do what they do in exactly the same level. And it will take them quite some time to even get near that, I think.

VICE ADMIRAL ZIMBLE: Okay.

MR. BECK: Notwithstanding that, we still think that we get valuable results from this, but I -- I think it would be naive to expect them to be really equal in terms of the expertise and effort and time that -- the cost of, for instance, his contractor doing some of these is -- runs to the $20,000 type cost, you know. I

don't think our NCRP people are getting paid quite that much to do it.

VICE ADMIRAL ZIMBLE: Probably got the -- got the DFO to squinch (sic) a little bit when I made that comment. I didn't realize we're talking about that much money.

Okay, you have a comment, John?

DR. LATHROP: Yes, just to follow up on that, and this is always sort of a hard subject to deal with, but I wonder if I would just -- directly following from the last five minutes of conversation -- ask Dr. Blake, what is the situation within NTPR and DTRA in terms of establishing and maintaining expertise in dose reconstruction and, as a member who does a lot of counterterrorism and -- at Lawrence Livermore, I'm always interested in the country's capability for dose reconstruction, headroom, surge capacity for that, because some of this could play into a longer strategy for NTPR and DTRA, maybe.

DR. BLAKE: Well, to answer your question, Dr. Lathrop, the -- the NTPR team at the Defense Threat Reduction agency is about 40 Full Time Equivalent personnel. A small part of that is

actually government staff; myself as civil service, long-term there. The active duty officer will have a typical two to three-year tour, then go on, do other type of stuff. But it -- that officer comes in with a strong health physics background and -- and the next one will come in that way, too, but the active duty are always going to turn over.

On the contract side, historically some of our contract team has been working with us in one phase or another for 20-plus years, so we have a lot of long-term continuity in what we do. But it's still a contract process and what we did on the last major award where anyone can bid, it's -- it's certainly not -- selected was we set it up to do for -- a -- a base award with seven option years, so what we saw was a lifetime on this program going on for about 15 years more and we said let's do one more major contract award, which we did about a year ago, so we have about a 8-year lifetime on that contract, and then we do one other one, because I think at that time the workload's going to start dropping off.

So we've looked at the long-term vision where

we -- where we've been, and I think we have in place continuity of a well-trained team. But with your -- regards to your other question on bigger impact besides just atomic veterans, within my chain of command there is a concern. It's something that we look at certainly at Defense Threat Reduction Agency if a weapon was to go off in this country. And part of what our function is would be to support something called consequence management. That doesn't help immediately, but there are compensation decisions if an accident happened. There's two major groups that do dose reconstruction in this country. There's my team, and there's a slightly larger team over at the National Institutes of Occupational Safety and Health, but they're not weapons-focused. They're more industrial controlled-group focused. And so even though I've participated and assisted there on -- when they've done weapons, we're the one group that's uniquely focused on dose reconstruction in this country, and perhaps the world, in this area. So we have a small team. If, all of a sudden, we got a lot -- a large -- more work -- workload, we can, based on that

core team, expand. And that's one reason the training we've gone through on standardization and the procedures are very important. So the chain of command looks at it more than -- certainly our veterans are a primary concern, but we see a peripheral concern here that we do, too. And if nothing else, we want to keep doing a few full dose reconstructions simply to keep that -- that strength in place. So I would argue, from our viewpoint at our agency, that there's a long-term funding commitment, not only to our veterans but also to the other concerns we have as an agency. And certainly from programming and budget purposes, I don't see any problem at the current levels of where we've gone and how we would continue that program. I hope that answers your question.

DR. LATHROP: That's perfect, just what I was looking for.

VICE ADMIRAL ZIMBLE: Okay. Dr. Swenson. Dr. Swenson?

DR. SWENSON: Thank you. In reference to Dr. Beck's finding on communications -- Mr. Beck's finding on communications, and also what John said before in his gap analysis, I would

suggest that Elaine Vaughan be involved in the communications that go to veterans. She is really the expertise -- expert on risk communication. I think, you know, it would behoove us to have her involved in that communication.

VICE ADMIRAL ZIMBLE: Yes, well, as you may know, Elaine Vaughan is currently a consultant to this Board and we certainly would -- would ask her to -- to help in that regard. Dr. Fleming also has had a great deal of experience in that regard, so I think we have two individuals that -- that -- of whom we are well aware and know what experience and talents they can bring to the scene. So I agree wholeheartedly with you.

Now Elaine -- is Elaine on -- Elaine, are you there?

(No response)

Okay, she -- well, if you're there, I hope your ears are burning because -- there she is.

DR. VAUGHAN: Well, thank you very much for the --

VICE ADMIRAL ZIMBLE: Okay.

DR. VAUGHAN: -- nice words.

VICE ADMIRAL ZIMBLE: Okay. Yes, you're excusing us-- you continue to be held in very high regard and we will continue to need your services, so we thank you very --

DR. VAUGHAN: Well, I'm very happy to do whatever I can.

VICE ADMIRAL ZIMBLE: Okay, and we thank you very much for being there today.

DR. VAUGHAN: Thank you.

VICE ADMIRAL ZIMBLE: Right. Dr. Fleming.

DR. FLEMING: I just have a question, Harold, about number three on page 4. This is the apparent new procedures for implementing -- were implemented by NTPR on -- to expedite non-radiogenic diseases. Could you just tell us a little bit more about what that's a-- what -- what the issue is there and -- and could you just remind -- at least me -- the results of Subcommittee 5 -- Subcommittee 5 on the discretion that NTPR has for determining which diseases should be expedited?

MR. BECK: Well, I'll say a little and then I'll let Dr. Blake correct me.

As far as the Subcommittee 5, we did not consider in Subcommittee 5 non-radiogenic

diseases. In fact, if you'll remember, at that time the Board was hoping that the -- that it can go to DTRA.

As far as the non-radiogenic diseases, what -- what we were seeing is that they were sending over a -- they were not doing a full dose reconstruction, and you can correct me if I'm wrong, they were just -- they were assigning an expedited dose. If you'll remember, in Subcommittee 5 we recommended that the expedited doses be based on the PC tables as well as their past experience in -- well, it's dose reconstructions of that type of -- not the particular illness, but the -- where they were, as a rule. So what they have done, I believe, is based -- they -- they do not have -- they do not assign the expedited dose the same way as they would for the -- a Subcommittee 5 disease where there actually is a PC. And maybe Dr. Blake will explain a little bit more how they come up with that, but basically what Subcommittee 1 noticed was that this was the first time we had actually seen that they were sending out letters with these assigned doses.

DR. BLAKE: Dr. Fleming, to just follow up on

Mr. Beck's comments there, we had a challenge here as an agency. As you know, we've had a lot of discussion on the non-radiogenic disease -- let's say arthritis or general lethargy -- that there's no indications in some of these diseases that they're caused by radiation, but -- and a lot of discussions with the VA how to handle these cases 'cause we can spend a lot of money doing something that basically it gets over to the VA and they can't -- how do you do a probability of causation? There's no way to do it. Unfortunately, the VA is also in the position of -- they don't have a good option, too, and so they ask us to go ahead and do those cases, even though we realize -- in the early years we were averaging about $12,000 to do one of these cases and now when we do a full case it sometimes get as high -- gets as high as $40,000, not including some of the additional -- NCRP looks at it, too. So it's a lot of money to do a full case out, and the question is does this make any sense if it's not going to go to service connection, they can't even do a probability of causation. So we -- when we came up with the expedited

process, the -- the data that we presented to SC-1 and other groups were, one, based on the probability of causation, dependent upon which organs are more radiogenic, but the other strong color was based on was a complete review of every dose reconstruction that NTPR -- NTPR had done over the years, you know, thousands and thousands of them, which established upper bounds for us along with analysis. And so our thoughts were here we are, caught in a little of a tough place. How do we -- how do we resolve this case? We didn't agree that we should be forwarding these cases on, non-radiogenic. But on the other hand, who's left suffering as a veteran. So we needed to come up with a method to resolve how we handled non-radiogenic doses at our agency. And so the conclusion was we are going to release a dose to the VA. We're going to move ahead. Mr. Pamperin just recently gave us some -- some other information here at this meeting where we may be able to resolve that a little bit, but the way we could do that is we look at the highest possible dose that could have gone for that category, and when we look at cohorts we

look at the -- for any of that particular -- let's say that sailor on that ship, what was the highest possible dose that we could get, we assigned a dose larger than that, and that's what we release. So we're not saying that's the dose the sailor got. We're not even saying that's the associ-- you know, the uncertainty associated. We say it's simply an upper bound. It can't be greater than that dose. We get it out the door. It's -- we don't keep that veteran hanging and I don't -- when it gets over to the VA side, I'm not quite sure what they're going to do with the dose, but I -- I believe it's going to go out -- truly, the physician can't use the probability of causation tables. He'll do a -- a medical opinion and basically say no matter what the dose was, this is not going to be service connected. So at least the veteran is getting a timely response and it's how we worked in between the different regulations that we're caught in to get it out. So we took the regulations from the VBDR and probably took it one step -- a little more than they originally discussed, and now we're reflecting our SOPs,

revising them to reflect what we're exactly doing.

VICE ADMIRAL ZIMBLE: Okay, as I -- as I understand it, and I do note that Dr. Reeves has written several letters explaining the non-radiogenecity of a particular condition, that still does on, does it not? So basically we have a physician expert stating that you receive -- you, Mr. Atomic Veteran, have received a dose that could not possibly have exceeded this number, and this number -- and there is -- there is no way that a dose of that number could have caused your condition such -- there's -- there's no scientific evidence for that. And -- and I think that's probably the best way we're going to be able to handle that. And the -- the mo-- the thing that distresses me the most is that all this takes time, and so we -- we have a claim that comes in that obviously is going to be denied on the basis of being due to exposure to ionizing radiation and it has to go through this process. The faster it can go through this process, the better. And -- and I would hope that there are some advisors to the veterans at the very beginning

of the process who can look at this claim and advise the veteran that this claim is most likely, 99 percent chance, going to be denied and he'd best go buy a lottery ticket.

Any more comments? Oh, Dr. McCurdy.

DR. MCCURDY: Dr. Blake, when you assign this dose, do you associate any organ with it?

DR. BLAKE: It -- it depends on -- the VA is asking us for an organ dose, but how do you assign an organ -- for instance, arthritis, or there are many other types of diseases that come over that there's no organ -- it's ill-defined when it comes to us in the first place, so we come back with here's an upper bound dose associated with what you've asked, but it is -- I -- it's an unclear picture on how we respond.

DR. MCCURDY: Is it an upper bound from all organs for that particular scenario? I mean is that -- is that the way you pull the number out of?

DR. BLAKE: Right, there's a term in probability of causation where you -- there's an actual category for non-- non-organ -- just a general term, and that's one way we can come in with -- when you can't do anything else,

there's a catch-all term, and basically that's what we can come back with a response in some cases.

VICE ADMIRAL ZIMBLE: Dr. Fleming, do you have anoth-- do you have another question? Okay, no.

DR. LATHROP: Just to -- not to pursue this too hard, but so do I understand correctly that the veteran is given a statement saying given this dose, and your dose must have been less than this dose, there can be no service connection, when in fact the truth of the matter is frankly, for any dose, there wouldn't be a service connection, but the veteran's never told that. I guess that's okay. It's all -- strikes me as a little bit of an Alice in Wonderla-- I just wanted to see, from a risk communication point of view, what's happening. Don't quote me about the Alice thing.

DR. BLAKE: Both Mr. Pamperin and I are jumping on that because certainly the Department of Defense is not going to make any comment about service connection. That -- that's a VA function. All we do is report a dose.

VICE ADMIRAL ZIMBLE: Mr. Pamperin.

MR. PAMPERIN: I -- just a question then. If I submit a claim for my male pattern baldness and you get a maximum dose for that, and I subsequently develop lung cancer and -- is the agency stuck with that dose?

DR. BLAKE: No -- no, it's not, and I think that's one of the things that you're hearing at the discussions about communication, distinguishing an actual dose with an associated uncertainty from an upper bound, and that's difficult to explain to our veterans 'cause they see a dose that's a rem. It's a rem, it's a rem. But one thing that we -- we spent a lot of time in our correspondence is trying to make that explicitly clear, the difference between a -- a value that we say is the absolute top value, we don't say it has any connection to reality except it can't exceed that, by some actual dose that we've gone through and determined with an associated uncertainty with it. And so if they came back with a specific organ dose of that type, then we would -- we would report that and once again try to explain what the difference was to the veteran. But you -- you're hitting on a

significant communication aspect as we try to communicate with the veteran on what's going on.

VICE ADMIRAL ZIMBLE: This is just why we need Elaine Vaughan to review this communication and make sure we've done it in as -- as understandable a method as possible. Mr. Ba-- Mr. Beck.

MR. BECK: Yeah, I just -- in my report I did point this out as one of our findings, but I just want to emphasize we saw this in the same letter where the veteran, in the same letter, received two doses, an expedited dose and a calculated dose. And so that -- that's even more glaring problem than if he gets several different letters over the years. So this really is a communications problem that we've identified and talked to Dr. Blake about, and I think he really needs to get together with Elaine and develop some kind of procedure about how -- what -- how they're going to communicate this 'cause it is very tricky. It's very important.

DR. BLAKE: Harold, if I could just respond, that with -- the reason those cases come up is

a veteran can present with multiple cancers or diseases. We have to report multiple organ doses. Some of them may fall under the expedited category and some aren't applicable, we have to do a full dose calculation, and that's once again why we have to be able to explain to the veteran the difference in what we're actually doing there, and that is the -- the challenge in communication issues.

VICE ADMIRAL ZIMBLE: Dr. Swenson?

DR. SWENSON: This question is for Mr. Pamperin. Is there a chance that when the claims officer, after they've completed your male pattern baldness request and you have the letter from DTRA about that, then you -- that you submit the claim for the lung cancer, could they look at that accidentally and not send it on to DTRA, or do they -- I mean is that a chance?

MR. PAMPERIN: I -- absolutely. I mean it -- I mean my guess is it would happen more often than not and I -- I've made a note to myself that we have to give -- explain this to the field very closely. We have a way of marking in our system the kinds of information that I

think we could have a work around that would be kind of a flash -- hey, you know, get anymore...

VICE ADMIRAL ZIMBLE: I have a question, Mr. Pamperin, and this is just a -- out of the blue, but if the veteran supplies a claim for a particular condition which we know is non-radiogenic, and his personal physician, his health provider, has written a letter for him, which happens a great number of times -- written a letter saying it's a possibility, and -- and we're now in the middle of a process that is very difficult to turn around. Is there a pot-- is there a possibility of the VA sending a letter back to the practitioner advising him of the -- of today's science and of today's findings and the fact that the -- that it is unlikely that -- that -- that his diagnosis is correct and perhaps he ought to relook at that? Again, just a suggestion, so that that same practitioner doesn't keep using that letter over and over again.

MR. PAMPERIN: That would be kind of unique in our process to do that. I think, realistically, particularly treating physicians

are advocates for their patients and sometimes when their patients are really insistent, in order to maintain the relationship they may be willing to sign some very non-definitive document that we have to dia-- that we have to deal with. But I -- I think more -- and I think that would be putting the -- the clinician in an awkward position because we do recognize that, you know, they are confronted with patients who are trying to get disability Social Security or special parking permits or a whole host of other kind of benefits due to disability, and that, you know, it's -- it's just easier, if you're going to maintain the patient relationship, to do something that's innocuous. So I guess our approach -- I think we would be more comfortable with just saying, you know, we've looked at the evidence and he's wrong. You know, and take the -- take the -- the hit ourselves.

VICE ADMIRAL ZIMBLE: Okay. I thought it was just a marvelous opportunity for continuing education.

Dr. Zeman.

DR. ZEMAN: I'd just like to raise one point,

and that is the -- the role of the Decision Summary Sheet is a very important -- important role, and that is one that is still maturing and still evolving. It's -- it's not just the communications to the VA and the vet that need to be clear, but also the file itself, the record in -- in DTRA's hands needs to be clear so that people like myself, when we come to review a case, can try to understand exactly what's been done. The logic tree that leads from arrival of the case down to exactly how it's handled and whether some organs might have an expedited dose and other organs not an expedited dose but a full calculated dose is -- is a complicated logic that needs to be well documented, clearly, so that a year from now, two years, five years from now when somebody comes back to look at that case, they'll be able to understand exactly how the decisions were made to process it the way it was processed.

VICE ADMIRAL ZIMBLE: It would be a great help to the future oversight entity. Mr. Beck.

MR. BECK: I'd just like to follow up on that a little bit, also. These doses they're assigned

go into the NTPR database, NUTRIS*, and again here's a quality assurance issue that if it's not clear when they go in there, what's a calculated dose and what's a non-calculated or expedited dose, there could be big problems down the line with somebody doing an epidemiological study and going through there and picking out a dose, and it turns out it's an expedited dose, extreme upper bound, rather than a real dose. So I -- I think that -- my question is, is there some kind of quality assurance on that input into DT-- into NUTRIS, you know, out -- we've looked at a couple of those and there's little codes there, and if you don't know those codes and somebody puts the wrong code in, could be a problem.

DR. BLAKE: I'll -- I'll answer that in two ways. One, I'll -- I'll take that as an action item to ensure, if it hasn't already occurred, that those appropriate flags are in there on coding. But the second thing is, most of our expedited doses are so much larger than any calculated dose that they do -- you can almost recognize them just from that perspective itself. But we'll take a look at that from a

quality assurance viewpoint and -- and next time I report back, I will address that with you on what we've done and how we're ensuring that that -- that actually occurs. And that's an item that'll come back to both SC-1 and SC-3 on when we put it into our database 'cause perhaps Dr. Boice is -- may be the most knowledgeable one that's spent a -- many hours looking at our database with all the different flags, but we -- we have a lot of flags in there, whether it's a film badge dose, how we calculated that dose, and many fields in that -- and how they track. And certainly we do need to make it very clear whether it's an expedited dose or a calculated dose, or an actual measurement from a film badge and other avenues, too, so I've got that as an action item and I -- when I report back in a month or two on all the results of quality assurance to both subcommittees, I will provide that as -- as an update.

A REPORT FROM SUBCOMMITTEE 2 ON VA CLAIMS ADJUCICATION PROCEDURES

VICE ADMIRAL ZIMBLE: All right, I think we can now move on to Subcommittee 2. I'm very pleased and relieved to see it's a two-page

report and so --

DR. BLANCK: Thank you, Mr. Chairman. I've added a lot since our meeting, however.

(Pause)

VICE ADMIRAL ZIMBLE: I'm sorry, I've been reminded that we need to now ask the Board if they will accept report from Subcommittee Number 1, so all those in favor of accepting Subcommittee 1's report?

(Affirmative responses)

Okay. Opposed?

(No responses)

Hearing none, we'll move on to report number two.

DR. BLANCK: Thank you, Mr. Chairman. Subcommittee 2, in yesterday's meeting, reviewed the response from the VA, a very timely response of 20 May which at least I had not seen previously and congratulate the VA on their timely and positive response to our recommendations from the 2nd and 3rd of April meeting.

Since then we have also asked our consultant to review seven additionally randomly selected cases from the Jackson VA Regional Office.

Obviously since it's consolidated, we need to provide that -- that random audit to see how they are doing. We were not totally pleased to find at least two instances, and I think there were a couple of more, where cases were not processed -- at least as the consultant said -- properly. One was that one was processed under the non-presumptive, should have been presumptive; another valid veteran's claim returned.

Now actually the VA has subsequently looked at these and perhaps there is more to the story. That is, they've gone into greater detail and the consultant may not have been right. The point is that the consultant's review brings up issues that then need to be looked at by the VA. They may be found to be true mistakes corrected, or may be found that the -- the consultant's report is incorrect. So this is a very valuable kind of thing that we intend to continue.

We held a conference call on 16 July to discuss the issues raised in the consultant's report, with Mr. Pamperin and each other, and forwarded copies of the audits to the VA for exactly the

kind of review that I've just described. We continue to ask that the Jackson VA receive the proper number of resources, dedicated personnel, and that ongoing training continues. We mentioned in our April 2008 report that the VA's sole qualified atomic veteran medical expert, Dr. Otchin, retired. You've heard Mr. Pamperin say that Dr. Reeves has provided some coverage, and appreciate DTRA's willingness to provide Dr. Reeves to the VA, and that either a contract or a hire of someone to replace Dr. Otchin is expected in our lifetime -- no, actually within the next -- next month. So all positive steps because we believe that, because of the backlog engendered by that, there were additional Congressional inquiries, some frustration on the part of atomic veterans, and it appears that a lot of the backlog is being cleared, thanks to Dr. Reeves, and then having -- having folks on board soon. That -- that will be very helpful.

We ask -- and -- and this was a recommendation from the last time that was put off -- that once the vacancy of the reviewing health professional in the Veterans Health

Administration is filled, Dr. Otchin's job, then documentation of the requirement supporting decisions for non-presumptive claims should be done. And Mr. Pamperin now recognizes that recommendation and we're working it. Obviously it's not going to be in someone -- until someone is in that job. We also learned that effective August 1, 2008 the consultant we've used, Ms. Jean York, will be rejoining the VA, and so therefore, since we do intend to continue these random audits, another consultant needs to be hired. We would like to review 20 additional cases after this meeting, and we would recommen-- welcome a recommendation from the VA as to that person. We've talked with Mr. Pamperin about that. Subcommittee 2 specifically wants to commend the Jackson VA Regional Office on their efforts and hard work performed in support of this mission. They are dedicated folks and doing a great job. We do note that there seems to be a few areas in the process where perhaps some degree of further streamlining might occur. Perhaps we could be helpful in that. We've talked about another visit of a couple of

subcommittee members, as occurred some months ago, that seemed to show some issues that the VA corrected. So we really are pretty much recommending what we've already recommended, that there be continued ongoing refresher training to the Jackson VA Regional Office staff about processing this, and that's just going -- ongoing kind of thing. And as new people come in, that -- that will need to occur; that the VA continue to ensure proper resources and that there be some response to our recommendation that a -- a documentation of the requirements be done when a new person is in Dr. Otchin's job.

Subcommittee 2 did not specifically address where we go after this, but in our discussions it seems clear to me, and I believe the other members of the subcommittee would agree, that much of the success of how the VA has dealt with this has to do with the consolidation at one office, but that clearly continued auditing needs to be carried out for the foreseeable future, and may well go into -- I believe it was Edna MacDonald's process and -- and she has a STAR report that might take some of the --

the auditing function. Certainly there are measures that could be looked at. One was mentioned this morning as far as the percentage of non-valid -- non-atomic veteran claims sent to that office that had to be returned, those sorts of things. So an audit of what goes on down there just needs to be continued for the foreseeable.

But the big point of the consolidation, I congratulate you and I think all members of the subcommittee do -- or the whole Board -- 'cause that's been monumental. Thank you.

VICE ADMIRAL ZIMBLE: Dr. Blake, I would -- Dr. Blanck, I would gather from -- from this report that -- that you don't -- you're not asking for any new formal recommendation from the Board.

DR. BLANCK: That's actually correct. It's a continuation of what --

VICE ADMIRAL ZIMBLE: Right.

DR. BLANCK: -- we've already recommended.

VICE ADMIRAL ZIMBLE: But in view of the fact that you feel that there is a -- a need for ongoing auditing and for ongoing review of training processes, et cetera, that you would concur with Subcommittee 1 in that there be an

independent entity, preferably non-FACA, that would in fact provide not only auditing and surveillance of the processes of dose reconstruction, but also the auditing of the processes coming out of Jackson, Mississippi --

DR. BLANCK: Right.

VICE ADMIRAL ZIMBLE: Okay.

DR. BLANCK: Yes, exactly. We would support the recommendations of Subcommittee 1.

VICE ADMIRAL ZIMBLE: Okay. All right, any comments? Oh, Mr. Pamperin.

MR. PAMPERIN: Yes, I -- before lunch I had the opportunity to talk to Dr. Blake's predecessor, who is -- currently works for another company that VHA, in addition to hiring a clinician for the dose reconstruction, is also seeking contractor support. And as a result of the recommendation that you had made the last time about an SOP, he informs me that the -- one of the work requirements in the statement of work for this is the development of this SOP.

DR. BLANCK: Excellent.

VICE ADMIRAL ZIMBLE: Any other comments?

(No responses)

Hearing none, do we accept the report of

Subcommittee 2? All those in favor?

(Affirmative responses)

Opposed?

(No responses)

Hearing none, we will accept report number two.

Subcommittee 3.

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

DR. REIMANN: Okay. Subcommittee 3 deals with all aspects of quality management in dose reconstruction and claims adjudication procedures, things that you've heard a fair bit about here in the last little over an hour, and make recommendations in parallel with these other committees, but hopefully reinforcing. And in fact that effort to reinforce is a very important part of getting the integration that is -- is a major purpose of our subcommittee. So we sort of try to do our work via interactive approaches to maintain that integration. And in doing so, for example, Dave McCurdy here to my right has been a regular liaison to SC-1. Others of us have also participated in probably two or three or more of SC-1 meetings. And John Lathrop across

the way, who presented the gap analysis, is also a regular card-carrying member of the Subcommittee 4. So that's how we -- we do our work, so it's highly interactive. And that also, I think, puts the main burden of the case we want to make so that it isn't too repetitious when, by the nature of what we're doing, it will be somewhat repetitious. So we're in the quality management business and so, for example, we're heavily involved in design kinds of issues related to the creation of some kind of a system. And if a -- if a VBDR sunset or a transition means anything, it means that at some point the pro-- the program, the work of the two agencies on behalf of the veterans are so systemic and so built into the way the agencies do their work, with well-defined quality systems, that really at that point minimal outside involvement is needed, and I'll come back to that when we talk about the future of -- of VBDR.

Now I mentioned the design end of the spectrum here in terms of trying to perceive the systems that wrap around the work of the two agencies and the way the two agencies interact. We're

also the people who I think have to be most sensitive to the wiring diagrams of how all these things work when they're up and running. And that up and running part is the last thing that happens, particularly when a program is digging out of past concerns that led to the creation of the Board. So there's a -- a big investment in things that were really design issues maybe 15, 20 or more years ago, but the best we can do now is to put those things on a sound footing.

So on the front end we're supposed to be design-oriented people, and at the back end we're supposed to be the last people to be happy, and -- because it takes time to get an embedded system.

So having given that little brief background of -- of who we are, what we're trying to do is think about the various strategies for eliminating errors and also mechanisms for exposing the errors that are made so that they can be eliminated. So those are two major strategic issues. So some of the dialogue this morning after -- particularly after Tom Pamperin's discussion, were really about that

where we noted that the number of claims being routed incorrectly from the other VAROs, something like 34 percent, but just knowing that is -- is a very, very important and dynamic step. So in a sense, at this stage we're really happy about that because the frustrations of not knowing things like that leave you hanging in terms of where the heck are we. So the fact that this is now on the radar screen as an important metric gives us a step up, as does the report that Ron Blanck's committee just noted that it's -- it's now looking at. So those are the kinds of things that give a philosophical background.

So that will al-- that, plus the comments made by the other two committees, I think will allow for a tighter presentation of the last part. It's already been noted by -- by Harold, who's one of my favorite pen pals now, SC-1 and SC-3 are routinely sharing these kinds of things and -- and many of the insights related to our work I think have properly come from SC-1, because very often the technical knowledge is beyond that of our group in terms of dose reconstruction, and so we have to filter ideas

through their committee to see if something really makes sense. Is that our lack of understanding or is that really what he's seeing, too. And so that has been a very, very valuable discussion. And he's -- he's noted that, through multiple reviews and -- and continued development of the SOPs and the quality documents and policy and guidance, there's been tremendous progress made that I think everyone is -- is really very happy about, the reduction of the backlog and the appearance of metrics and so on, very, very positive steps.

The double-blind -- the problems with that have been noted. Actually that arose out of conversations in our own subcommittee years ago when dose reconstructions were the principal output rather than the expedited cases. But we -- we see now the morphing of that into becoming, in a way, a new quality instrument. That's the positive side of it.

The more negative side of it is that it no longer fulfills narrowly the concepts that gave birth to it, and so we feel we have to push that further. But that shouldn't detract in

any way from the fact that SC-1 has already stated that they see great value in it, and we concur in that because it has already, through an analysis -- a lessons-learned analysis, has already identified a whole lot of things that are going to end up improving the program. So that's again a positive step.

We also have been sort of chipping away at issues, right from the beginning. Actually even our first meeting we were talking about the importance of establishing program metrics that allow managers of the programs and also boards like VBDR, any successor boards or successor groups, to get a snapshot of what's happening in the program. So that, for example, if you have a variety of metrics like through-put and errors of various types, rejected -- reconstructions in review or whatever, one should see on a -- in a program management sense, that over time those things are -- are disappearing. They're -- they're un-- they're under management control. So when we say something's up and running, we say that a manager at any point -- you could wake them up in the middle of the night and they could

show you the metrics that -- that they've been collecting over a period of -- of months and show you that everything is trending in the right direction. Response to the veterans is much more rapid, errors of routing are disappearing, and so on. So that's something that we continue to push.

On the other hand, that's not a new recommendation. What we're trying to do is be clearer about -- about past recommendations. In -- in terms of the VA side, in addition to giving -- giving us I think a very good summary this morning about very positive developments that -- Tom mentioned the expanded, the over-- overview -- quality over-- reviews, twice the number of cases, looking at consistency across VAROs in the larger sense, inter-rater reliability -- those are all things that on the -- on the -- in the quality management sense are really the basic building blocks, the basis for training and so on. So these are mechanisms for reducing errors and also opportunities to get a handle on the errors that are being made because those are the places where time/money are going to be saved

and better -- much better quality and reliability of output is -- is going to be -- is going to be demonstrated. So when we say something is up and running, we say that something ought to be demonstrable and easily shown that it's -- that if it's important to through-put and quality, that the managers know where it stands and can show you how and -- how and -- and probably why it's getting better.

We note also from Tom's presentation that the -- - the Standard Operating Procedure for the -- the so-called Otchin post will be -- will be addressed when -- when that new hire is put in place. So in that, plus the fact that we would -- we, as category two, the claims adjudication people, want to see an ongoing, running account of how things are going with respect to quality-related processing in -- in the claims -- in -- in the VARO and so on. Those are the -- are the principal things that we're concerned with now.

So we're approaching the point on a lot of fronts where we're -- where we're saying the good things are -- are coming together, but it's still a little bit too early to run up the

flag and say it's -- you know, it's -- it's accomplished, but it's certainly in -- in -- it's under development. I don't think anyone here would say that -- that it-- that it's not coming together well and that some of the things, particularly when hundreds or even thousands of pages are involved, it takes a while for the documentation to catch up with the -- with the actual process. And then as the collision occurs between day to day running, there's also a need then to look at the documentation to find out where the problem points are so that that work can be completed in -- in secondary and tertiary reviews and so on.

So if all of that is -- is happening but it's not yet fairly described as up and running with a good scoreboard behind it, so that as a backdrop, our position with respect to the future of VBDR is really quite consistent with what we've heard so far. We see a basic transition that's underway, and I guess maybe opinions might differ a little bit on the timing of how that would -- of how -- how long would it take for this to -- to be up and

running. And for example, in discussing alternatives to VBDR itself, like a smaller board, a -- less frequent meetings and so on, we also expressed or -- or uncovered the concern, maybe some of you knew it right away, but we uncovered that concern that with a much smaller group you run into other problems related to the requirements of FACA, which obviously have to be understood and -- and honored. But it can get in the way of I think the really positive dialogue that operates now quite well within the rules. So we're pleased with that, so maybe there's some -- some way to -- to move into a more -- let's say a less -- less frequent meeting mode while still trying to maintain the role of individual subcommittees to make sure that these individual pieces are coming together, and then perhaps looking at these meetings for more of a display of those -- of the scoreboard that really basically is a demonstration that all of the pieces are coming together and working. So that's the way we're coming at it, so our future activities involve trying to look in on some of the -- the -- the changes that have

taken place in the program via the new design, to see how that double-blind is working, whether -- whether any new recommendations need to be made there; maybe new understandings on the quality system will come out of that.

On the issue of the DSS, which has now gotten a lot of air time, I have the personal concern that it is more of a process or a product. I think of it as a process with a product in the sense that it's -- it -- the -- the documents themselves need to be living in the sense that as we learn and as we change any process, we have to be able to capture the important decisions and communicate those so that quality evaluations can be made, but that the DSSes, at any given flashpoint in the history of the program, will look a lot like a product and then, as time goes on and changes start to diminish, the DSS will look a whole lot like a product and will be -- will basically be a demonstration and a realization that things have -- have settled and that the processes being used by the agencies are -- there's a embedded self-correction.

The other thing I would -- I would note in --

in closing on the future of VBDR, one can be sort of guided in a way by excellent current treatment and -- and caring that we've seen from the agencies, but if you imagine all the people being replaced and new pressures coming up and new people coming in and not being aware of all of the hard work and so on that -- that went into this, there can be some sort of falling off the wagon, which is an extremely common thing in quality systems, that newcomers who are pressured with new issues don't necessarily pay attention to all of the hard work and they start taking down fences before they appreciate why the fences were put up and so on. So we feel that part of what we do as a -- as a group is to try to make the -- the systems that we're recommending so robust that they -- they act like a flywheel to keep the -- keep things going and then, through some advisory channels and so on, and hopefully good communications between current program managers and the people who replace them and any subsequent boards or committees, advisory groups that follow here, would be a device for keeping all that going because it has to be

kept going. But that's sort of philosophically where we -- where we come from, and we look forward to the -- to the discussion about the future.

VICE ADMIRAL ZIMBLE: Thank you very much, Dr. Reimann. Comments? Right, General -- General Manner.

BRIGADIER GENERAL MANNER: My background also is decision sciences and risk assessment, quality assurance and so on. One of the things I'm concerned about -- first of all, everything you said I completely concur with. I am concerned about one of your closing comments, which was making the systems so robust that they will serve as a flywheel to perpetuate themselves. One of the concerns that I have in government -- I won't speak for the Veterans Administration, but certainly in the military our defense is once there are higher priorities, decisions are made to reshift all of the resources around, independent of the history or the -- the value. And as long as a law was not being broken, those resources are shifted fast. So I'd like to just say to the -- I'm not a member of the Board, but I would

just like to encourage the Board to -- some of the suggestions that were made earlier about having some oversight that has, even though perhaps it's a gentleman's hammer, it's still some type of a hammer to oversee the continuation of this, even though the forum -- which I'm gleaning from everyone's comments so far -- would not be in the form it is right now, but certainly something I think would be of great value. So I say that purely independently and as a -- as a comment.

DR. REIMANN: Yeah, just let me comment 'cause -- 'cause you referred to my comments. I've been associated with NIST for 46 years, and very often in the dialogue with external bodies who had no control over us, they were purely advisory, we did much more preparation and had much more direct dialogue about important internal things than we ever had with our own management, regardless of the management. So the -- the managers came and went, but the advisory committees come in and would give us, you know, a -- a good, clear picture of how our technologies compared with the best in industry and where we are serving and where the gaps are

and so on. So this is an extremely valuable thing. But this was all conducted at a time when we didn't have the federal advisory committees, and none -- and none of these groups were subject to that. So many of the -- the best discussions and by far the best discussions were in the context of informal dialogue. And so I can't say enough good about that, and -- and I think that the gentleman we have now would certainly I think operate well within that, but the replacements might not, particularly with new priorities. We can defend against only so much, but if we've created something, including something that has a numerical picture, you've put the next group in the best possible position to figure out where it stands because all they have to do is record the numbers that are showing up on those things, and if the numbers, you know, stop dropping in terms of defects or increasing -- or de-- or time to respond to veterans and so on, if those things start turning around, at least somebody knows it. But you know, I mean we can't play God in this and that -- so this is as -- I think as far as a group can go, but

I think it's already been noted very well that when the -- when the advice is no longer of a -- of a basic change type and it's more of a -- of an ongoing nature, then the advisory nature in a public sense doesn't make really the same kind of sense as it does when you're -- when you're talking about let's say shifting from largely dose reconstructions on everything to expedited cases. That's something that has to take place in a public setting and -- and go through different channels of review, whereas ongoing improvement is much more advisory -- much less costly on everyone. I mean these meetings induce a lot of extra work for the agencies, not just -- it's not just the cost of the Board in the narrow sense. It's what that induces. You're all sitting here talking to us rather than doing other things, so we know that.

VICE ADMIRAL ZIMBLE: Yeah, I -- the picture I take from -- from your comments is that there needs to be -- said there needs to be a full deployment of a quality system, and -- and I would say that the quality system has got to be a very useful tool to the -- to not only

management, but to the people that do the job. And -- and so I can see a role of the -- of the Board or -- or what -- the follow-on to the Board, to be one of mentoring in the institution at the work site to help -- to help build the -- the quality centers, to help establish the metrics that become indispensable and become a part of the normal routine, rather than building a quality system from the top down, which gets big documentation and then which gets filed, and then people go about doing the same thing. It cannot be burdensome to the individuals that are trying to do the work, and the work has to be horizontal across various vertical entities.

Also, if it's a system for this process, that system has to bridge two Departments, and it has to -- it has to be a system that is -- that is transparent in terms of the metrics and the quality issues from -- from VA to DTRA and back to VA. That's -- that -- that needs a lot of training. It needs a lot of mentoring. That's -- that's a -- that's a big full-time job that may -- and may require the -- the agencies take on the role of -- of doing the mentoring with -

- with some oversight by the Board. But it's a big job and certainly your -- if I understand your recommendation, it's more of the same, an independent entity that can provide oversight. But I would add to oversight and auditing some mentoring capacity for that -- for that entity. And I might as well mention it now rather than wait until the fourth report, that non-FACA is very helpful to getting work done. But non-FACA is difficult to achieve when there is no sunset clause in the legislation and it will require -- if I'm not mistaken, it will require some legislation to relieve us from the FACA requirements. And I would ask our -- the -- the Congressional liaison at DTRA and at the VA to at least investigate how -- how readily available such an option would be. It -- it sounds like it's going to go into our recommendations, but the alternative is going to be the -- the Board continues with a restructured mission. And we'll -- we can discuss that further, but I -- I thank you very much for your comments --

DR. REIMANN: The other thing I just wanted to add, Jim, that one of the bonuses, whether it

be -- certainly from VBDR, is acting as a really good bridge between the agencies, where that opportunity to mix and -- and have an informal dialogue is also extremely valuable. So if -- if you move to an advisory structure, I don't think you want to give up that bridging between --

VICE ADMIRAL ZIMBLE: No.

DR. REIMANN: -- the agency 'cause that's extremely healthy.

VICE ADMIRAL ZIMBLE: I also -- I also made a note you -- you see a -- a good reason to keep the committees and -- and I'm starting to get a sense of that because it's the -- the expertise for the oversight is quite varied from one committee to another, so you -- I've got that noted so when we have our discussions to come up with our formal recommendations it'll be -- Dr. Boice?

DR. BOICE: Yes, if I could have just a clarification for my own understanding because I was just a ti-- little bit confused, Admiral, and then General Manner, and I'm -- it's the value of being a FACA committee and a non-FACA committee. Is there a special value by being a

FACA committee that the recommendations and such handle more teeth and there actually is sort of a requirement to meet and to consider the recommendations and to continue on? I -- it was -- it was a little bit -- you know, everyone is very busy, and I know the veterans, and 800,000 processes a year and a war going on, you know, there's a lot of other demands, as the General mentioned on priorities. Does -- and I think we've all in the agreement that we -- we see a need for a continuation in some fashion, and my question is -- it's a simple one, I think -- it's just I don't quite understand, is there an advantage to continuing to being a FACA committee or really not an advantage what -- what's -- at all and being a non-FACA would allow this continuation in a fashion that's being suggested.

VICE ADMIRAL ZIMBLE: General Manner I think would like to answer that.

BRIGADIER GENERAL MANNER: Well, this is always one of those questions that in the military we're trained that if we don't know the answer, we say I'll find out and I'll get back to you, which is exactly why I've been doing hand and

arm signals back there to Mr. Wright 'cause I have not yet gone through my Designated Federal Officer training formally. I've only gotten the orientations. So that's on our agenda to -- as a task to us in that capacity to determine what are the various options and alternatives, and what are the pros and the cons, and we will then -- we'll put that together and then get that back.

VICE ADMIRAL ZIMBLE: Okay. We -- we can hold off on qualifying the entity as FACA or non-FACA. That -- that's a -- that's a very good point. I -- I see the disadvantages. I -- I have yet to see the advantages, so -- so if there are any, I'm looking forward to hearing about them.

Dr. Lathrop.

DR. LATHROP: Just -- just a quick note. I think some of the audience could be forgiven for deciding that a lot of what we're saying here are good intentions and gee, this would be nice if. I think one of my favorite minutes on this Board was, while meeting with -- a meeting that included John Stiver of the SAIC crew doing -- doing the work when he actually said,

and this gladdened my heart -- and Curt, I want you to listen -- these Decision Summary Sheets are really helping my management. Perfect. Couldn't have said it better. And that's what we should be after, not burden, but actually helping the management.

VICE ADMIRAL ZIMBLE: Okay. All right, I would ask now that the Board accept the report from Subcommittee 3.

(Affirmative responses)

Okay. Okay, no objections?

(No responses)

A REPORT FROM SUBCOMMITTEE 4 ON COMMUNICATION AND OUTREACH

We'll move on to Subcommittee 4, Mr. Groves.

MR. GROVES: Thank you, Mr. Chair. I want to preface the remarks that you have in -- in front of you in that there have been some changes made based on the information we received this morning from Mr. Pamperin and the follow-on discussion. And I want to tell you, Tom, we appreciated both the discussion last night and this morning about what some of the options are, and I will discuss with you how we've changed the words accordingly.

We wanted to remind everybody in our minutes

that we had had eight meetings and that they have been in a number of locations around the country, designed specifically to encourage veteran participation. And I think we would have loved to have seen a full house at every location, but I think we -- we did get input from -- from the veterans. I think it certainly demonstrates our willingness to take our meetings out to where at least the option was there for -- for folks in the local vicinities to come visit us.

We have kept a number of records, mainly at the NCRP office that supports us, and the numbers are not as important as the fact that we've had a -- a very active communication with veterans who have called many times directly to the VBDR, and of course we help them where we can. But our main help to them is to get them in touch with the appropriate person, either at the VA or at the NTPR program, to answer their questions. And I think it's fair to say, and I'm looking for Isaf, that no -- no question, either by mail, by phone or e-mail, has gone unanswered. So thank you very much for -- for that support.

Our subcommittee, because of some funding issues, has not been able to meet in person since our last meeting in San Diego, but we have had two very good conference calls, one in July -- one in June and one in July. And I would like to say that after our meeting we are considering publishing an article -- in fact there is one essentially waiting to be published in the Ionizing Radiation Review at its -- at its next printing.

We wanted to revisit the discussion of this proactive outreach by VA and DTRA to the atomic veterans who may be unaware of their eligibility for benefits. And again -- and I will discuss this more in just a moment, we -- we think this is an important effort and -- and I think that we now have our path forward with the information that we got from Tom this morning. We recognize that there is the potential for considerable resources. As we've said all along, we've looked at a -- not having to do this all or none, but rather to even pilot a part of the program to see what the response would be as a way to kind of predict what we might have to do to ramp up. I'm going

to add the fact that we were very encouraged by the options that were offered by the VA and supported by DTRA for a selective and tiered outreach effort, and I think we have defined some of the cohorts that we would, you know, move to the front of the line for this. And I think that that is very satisfying to us on our communication and outreach subcommittee, and I think to the Board as a whole, based on the comments I heard this morning.

We have -- we're continuing in our process to review and advise concerning letters that both the VA and NTPR send to the atomic veteran claimants. SC-4 has made and will continue to provide input for clearly communicating to the veterans his option -- to the veteran his options for making a claim and managing his expectations, which is an important thing that we feel and has been one of the efforts we've made to both organizations and -- and we've discussed it here again this afternoon. We -- we have -- we encourage and we certainly see this coming to fruition that both of the agencies are ensuring, wherever possible when they're talking about the same thing, that we

say it in a consistent manner so as not to con- - confuse the veterans.

We have in the past been actively participating with both DTRA and the VA on communication and outreach-related efforts. We had an excellent meeting yesterday with a representative from the DTRA public affairs office and from the editor of the Ionizing Radiation Review newsletter from VA. And I think we all agreed that the tripartite nature of those two organizations and our Board in reviewing and collaborating all outreach and communication issues will really benefit the process, and we seem to have a commitment from both of the agencies as well as from the -- the subcommittee. And then of course we have the support from Elaine -- you're still there -- right, Elaine? Well, from Elaine Vaughan, who -- those of you that -- some of you may not know, she was originally a member of the committee and, for health reasons, had to drop off, but we've been very fortunate in being able to retrieve her in the form of a consultant to help us with risk communication and other communication-related issues.

So as far as our subcommittee is concerned in, you know, where do we go next, I think that we feel that -- as many of the other subcommittees do -- that a lot of the recommendations have been made and we're not making any new recommendations here. We have a couple, as Tom discussed this morning, that are not complete regarding communications and outreach, but they are being worked jointly and that's -- I think that's where we need to be.

I do see the need for a continued monitoring and support of the outreach effort, and I don't know that that has to be a FACA or a non-FACA, but rather just some mechanism to do that and -- and continue to work together on these outreach efforts.

VICE ADMIRAL ZIMBLE: Okay, any comments?

COLONEL TAYLOR: Ed Taylor, can I make a comment?

VICE ADMIRAL ZIMBLE: There is -- I see some significant similarity in the recommendations from the four com-- four committee chairs regarding ongoing surveillance, et cetera. All of those in favor of accepting the report

COLONEL TAYLOR: Before we -- before we --

VICE ADMIRAL ZIMBLE: Any opposed?

COLONEL TAYLOR: -- (unintelligible) make a comment?

VICE ADMIRAL ZIMBLE: Seeing none, the report is accepted.

MR. WRIGHT: Colonel Taylor is on the -- on the phone line.

VICE ADMIRAL ZIMBLE: I think -- pardon me?

MR. WRIGHT: Colonel Taylor is on the -- on the speaker. I think he's trying to make a comment --

VICE ADMIRAL ZIMBLE: Oh, Colonel Taylor?

COLONEL TAYLOR: Yes.

VICE ADMIRAL ZIMBLE: How are you feeling?

COLONEL TAYLOR: I'm doing fine, I just wanted to make a comment, particularly to Kenneth Groves in that I thought he did a very complete and succinct report on the activities of the committee as I have seen it from several directions -- one, as a member of the Board; and two, as an atomic veteran; and three, as a very interested individual in trying to be fair and open about this process we're doing. And I think it's important that we keep that in mind, and I think he's right on track with that and I

wanted to leave that comment with you. Thank you.

VICE ADMIRAL ZIMBLE: Thank you very much, Ed, and I trust you stay well and healthy.

COLONEL TAYLOR: I'm working on it.

VICE ADMIRAL ZIMBLE: Okay. Thanks again.

COLONEL TAYLOR: All right.

VICE ADMIRAL ZIMBLE: Now I see by the clock that -- and I see some people breaking out in a sweat -- you'd like to take a break. All right? We are now adjourned for a 15-minute break.

(Whereupon, a recess was taken from 3:30 p.m. to 4:04 p.m.)

VICE ADMIRAL ZIMBLE: Ladies and gentlemen, we need to get started. I want to bring up one piece of business that has come before all of us via a letter from a Mr. Cafarelli*. We all received this letter. The letter needs to be put into the record as -- as testimony. It will not be published but it will be filed along with other testimony. This -- I don't know whether you've seen this.

UNIDENTIFIED: I have not, no.

VICE ADMIRAL ZIMBLE: Mr. Cafarelli is angry,

and Mr. Cafarelli writes that he's not been dealt with fairly regarding a -- a radiation-related claim. I -- I've asked Mr. Pamperin -- you've all -- each one of you have gotten a copy -- has anybody not gotten a copy of his letter? Everybody's gotten a copy, okay. I've -- I've -- Dr. -- Mr. Pamperin has volunteered to -- to have VA respond to this letter. He's got a misunderstanding regarding dosages. He's confusing I think rems with millirems or roentgens with millirems. So we'll send a letter back to him. Any comments or questions? Oh, yes.

DR. BLAKE: I -- I'd just like to comment on Mr. Cafarello*'s case, more from a general viewpoint than I think -- specifics aren't appropriate, but this once again deals with the communication issue we discussed between expedited doses and actual doses. He received originally an actual dose estimate that was -- is very small based on what -- and -- and he reports that in his letter. Later on, based on the expedited doses, we provided expedited doses both on skin and cataract. In both cases those would typically be service-connected, so

from our viewpoint at the agency, everything that he's filed for, he's received doses that would be service connected. What the -- but I think he's still frustrated in that he sees values of rem that seem different, and perhaps that's a communication issue. But I -- I will tell you, and I won't speak directly about Mr. Cafarello, but in some of these veterans' cases we've been on the phone with them for ten to 20 separate times over the last few years, there've been Congressional inquiries, there've been many letters back and forth to the agency, we have lots and lots of discussions. In some cases I don't think we're ever going to resolve the problem with the veteran. So -- but in this case, he -- he indicates he -- and if you read the letter, you'll see the actual doses we reported, but the ones that -- for -- he came in for with organs were all under -- eventually became expedited organ doses that were service connected. So I -- I don't think we can do much more from an agency viewpoint.

Yes, Dr. Fleming?

DR. FLEMING: Well, just a clarification. If he's receiving -- if he received a RECA

payment, he had to have had a presumptive cancer. I mean you don't -- you don't get a RECA payment for a non-presumptive. So I just want to sh-- mention that. I don't know where else to go with that except that there's also the fact that we know that a RECA -- that VA payments are offset by RECA, so were he to be eligible, he would not be receiving benefits until that offset was finished.

MR. PAMPERIN: Obviously under the Privacy Act we can't discuss specifically the -- the specific disabilities that an individual has and why they're being compensated. We can -- we can release -- any citizen is entitled to know how much disa-- disability payment is being received from VA; they just don't have a right to know why. In -- in this particular case, since -- since the ent-- any citizen has a right to know the amount, he is service connected at the 70 percent disability level. He -- he has a -- a condition that would qualify for a RECA payment. RECA payments are not always recouped. If the -- if a disability has been granted service connection on a presumptive basis and a RECA payment is also

made, we must recoup the RECA payment. However, if the condition for which a RECA payment is made was granted service connection on a direct basis -- for example, the condition developed while on active duty -- the only real issue we have or care about is one of two. If a person is very, very early in their service -- basic training or something like that -- we will look at whether or not this is a pre-existing condition that merely manifested -- but absent that, the only thing we care about is that the condition was -- was incurred in line of duty; i.e., if you have a broken back becau-- you know, the only reason we would not pay you is if the reason you have a broken -- broken back is because you got in an automobile accident while you were drunk. That's a willful misconduct thing; we wouldn't pay. But as long as it's a line of duty issue and the person develops it during service, we would compensate on a direct basis. Now if -- in another day, under another program -- somebody can qualify under a presumptive basis, then they can get both benefits without offset.

DR. VAUGHAN: If I can make a comment?

VICE ADMIRAL ZIMBLE: Okay, any further com--

MR. WRIGHT: You've got Elaine Vaughan on the -- on the speaker.

VICE ADMIRAL ZIMBLE: Pardon me?

MR. WRIGHT: You've got Dr. Vaughan on the speaker --

VICE ADMIRAL ZIMBLE: Oh, Dr. Vaughan.

DR. VAUGHAN: Yes, just a comment, I -- I think that this case brings up very important principles about the basis of outrage and the specifics of a dose estimate may not be as important as the basis of outrage, which can include the process issues, does this person feel that he has been treated fairly. And if not, there are things you can do in communicating in that final letter, to him or to anyone in this kind of outrage category, that could increase the chances that a person will feel satisfied. But a person has to feel that he or she is being treated fairly, and that's usually one of the main components of outrage, regardless of the decision or the specifics of the case. So I just wanted to throw that in. It's a very important area for effective risk communications.

VICE ADMIRAL ZIMBLE: Yeah, thank you very much, Elaine. We really appreciate that. Outrage from not being treated fairly and outrage from being totally ignored --

DR. VAUGHAN: Yes.

VICE ADMIRAL ZIMBLE: -- are two areas that need to be addressed, so he does deserve an answer to his letter and -- and I'm going to ask Mr. Pamperin to make sure that it's -- it's well-understoo-- as -- as best we can, explain that he was treated fairly.

DR. VAUGHAN: Yes.

VICE ADMIRAL ZIMBLE: Okay. Thank you very much, Elaine. Paul Voillequé?

MR. VOILLEQUÉ: I was just going to comment that -- that what really struck me about this, and it's probably because we had -- we had been discussing this in the context of our subcommittee -- is that he seems not to understand the distinction between the expedited doses and -- and the other doses. I mean he seems -- you know, and it may be the way he presents this information, I don't -- I don't really know, but he seems to be saying, you know, if I shouted long enough, I finally

got them to give me some revised doses, which are much bigger than the doses that were previously assigned. And so it just brought up in my mind the importance of making the distinction that we had talked about earlier.

VICE ADMIRAL ZIMBLE: Absolutely. Okay, I -- I have been given some -- several people have made some recommendations to me, given me some advice, that they would -- they would like to see this meeting adjourned at 4:30, especially since there's -- we still have a half-day that we can devote to formalizing our recommendations to go forward. And I can -- I can -- I can accede to that request, but I would ask, before we adjourn, that we turn to task seven and -- and look at a current charter. I think I would like everybody to refresh their memory as to what's -- what's in the charter and what specifically we have -- we have been mandated to do. We have a fair amount of license since we can carry out other activities. That -- that's helpful, as long as they are -- as -- as long as they are specified jointly by the VA and DTRA. So we can make a recommendation that can modify these -- these

missions accordingly, and if we get the approval of the two agencies, we're -- we're one step ahead of the game.

Yes, Eric?

MR. WRIGHT: Mr. Chairman, if I may, I'd just like the Board to (electronic interference) that in the -- paragraph (b) and (c), those are both -- those are both taken directly out of Public Law 108, so what it says specifically the Board shall do and the Board membership, those two paragraphs are directly out of Public Law 108. And -- this is going to limit what the Board can do, initially -- those are statutes, by the way, so in order to change those, you'd have to change the statute.

VICE ADMIRAL ZIMBLE: Don't have to change them, just -- this -- we can just reinterpret them.

MR. WRIGHT: Well, let me -- let me also say that --

VICE ADMIRAL ZIMBLE: Trust me, it's not a problem.

MR. WRIGHT: Let me also say that -- just for clarification purposes -- paragraph (e) that talks about duration and termination of the

Board, the char-- all this renewal charter does is allows the Board to operate -- to meet. If you don't have a charter, you cannot meet.

VICE ADMIRAL ZIMBLE: Right.

MR. WRIGHT: It doesn't have anything to do with the duration of the Board. The duration of the Board is by statute.

VICE ADMIRAL ZIMBLE: Okay.

MR. WRIGHT: That's all I --

VICE ADMIRAL ZIMBLE: Thank you very much, Eric, appreciate that help.

But any -- we have to -- Dr. Swenson, go ahead. Go ahead.

DR. SWENSON: I wanted to throw another option out there, and this was based on what Dr. Zimble mentioned yesterday from talking to the Veteran Affairs Committee staffer, from what Mr. Beck mentioned yesterday, and also from talking to Eric Wright about benefit of a FACA. This is just another option that we could throw on the table is maybe to downsize the FACA, meet -- still meet the requirements. You could probably have maybe six members, and then you'd have a group of consultants that would really do most of the work.

The benefit I guess would -- of the FACA would be that it is still public and our veterans would feel maybe still part of the process. Whether they attend or not, they are, you know, still part of the process. You would be meeting the statutes of the law. The FACA would -- obviously with six members, would have a very hard time getting together and working on anything. However, if you had let's say a dose reconstruction person on the FACA, which is required, they could then meet with the consultants who are on dose reconstruction and you would not have issues with the FACA rules. So it's just another option, and -- so I just wanted to mention that.

VICE ADMIRAL ZIMBLE: That's good. That's -- and -- and these are the things about which I would like you to ruminate overnight and we can discuss them tomorrow as we try to formulate a -- a formal recommendation. But I think a -- I think it's important to -- to recognize -- you know, six may be way too small, but if you look at what the Board membership is mandated to be, we do have a fair amount of license. And if you'll notice that we can make recommendations

on the modification of the mission and -- and procedures as -- that we consider to be appropriate. So we can -- we can recommend modifications, and we can carry on such other activities and tho-- those two specifics allow us to, I think, go forward with a -- with a -- with some restructuring of the committee. General Manner.

BRIGADIER GENERAL MANNER: I don't mean to put Eric on the spot, but I'm going to do it anyway.

UNIDENTIFIED: But you will.

BRIGADIER GENERAL MANNER: Yes. Eric, is there any chance that overnight, before we convene tomorrow morning at 9:00 o'clock, that you could propose three or four -- not recommendations, but three or four courses of action for the committee to consider tomorrow, with the proviso that -- because we wouldn't have time to do a complete legal review -- that if the committee chose any one of those options, it would be with the full understanding it would be subject to a legal review and verification that that was legitimate? Could you do that?

MR. WRIGHT: I could provide you my best -- my best input. I -- I've gone through the -- the Federal Advisory Committee Act training and that doesn't necessarily make me an expert on everything and there may be some things that the General Counsel will need to -- to review. You know, the intent of -- of the FACA law, from the courses that I've attended, is -- is to really bring the public into these discussions and -- and so the -- there's a desire for greater transparency, that they understand how -- and certainly in this circumstance it affects people who are out there in the public -- their understanding of why some decisions and recommendations are made. So that's -- that's the intent. I can give you the benefit of my experience and -- and provide some recommendations. I don't think there's going to be any great breakthroughs. I think you can operate under the current guides of the charter. One of the things -- I'm a little sensitive about changing the charter because we're right now in a position where there's going to be presidential transition teams that are going to start moving

into the Executive Branch, and trying to get a charter through in November, which is -- the charter has to be renewed by the end of November --

BRIGADIER GENERAL MANNER: Okay, let me -- let me cut you off for a moment. How about if you just do three or four courses of action overnight that the Chairman would permit you to present early on, and using the dragnet approach of just the facts, ma'am -- they're not recommendations; they're just courses of action -- and we would have right on the slide, one single slide perhaps, or even verbal, that this would be subject to a legal review. Even if the committee chose to further pursue it, it would be in full understanding that we'd have to make sure that all the I's were dotted and T's were crossed.

MR. WRIGHT: Yes.

BRIGADIER GENERAL MANNER: So in that way, if there was -- you would be able to -- it's your best educated judgment, but not constituting a General Counsel review.

MR. WRIGHT: Yes, sir, there's a -- unfortunately, this problem can't be bounded

just by FACA. There's also a legislative piece to it, so Legislative Affairs I think is also a part of this process. So you know, I -- we're trying to set a boundary around this, but it's going to involve interactions between different parts.

BRIGADIER GENERAL MANNER: Okay. In that case then, as the DFO, Mr. Chairman, I'd like to suggest that tomorrow morning there be a brief discussion or presentation as a foundation for further discussion, and that we'll just do the best we can overnight with that proviso, that it would take more research to validate whatever course of action you may choose.

VICE ADMIRAL ZIMBLE: I -- that's -- I think that's a -- perfectly acceptable to this Board. I -- I don't see any -- any areas where there'd be any -- any problem with that and I -- I think that is the prudent way to go. Basically all we can do right now is come up with recommendations that go to the two agencies and the two agencies will have lots of opportunity to -- to come back to us with either a yes, a no, or a modification. So I -- but I -- I would appreciate looking at some various

courses of actions that could be taken, and so I think that would be very helpful.

Okay. Thank you. Paul?

MR. VOILLEQUÉ: Yes, on the assumption that -- that you were referring to item four where it says the Board shall make modification -- recommendations on modifications, I think it's necessary to read the whole sentence.

VICE ADMIRAL ZIMBLE: I -- yes, I --

MR. VOILLEQUÉ: On -- on -- to the --

VICE ADMIRAL ZIMBLE: I really hate it when you do that.

MR. VOILLEQUÉ: -- missions -- to the missions and procedures of the dose reconstruction program.

VICE ADMIRAL ZIMBLE: Thank you very much. I -- once I made that statement, I realized that it was referring to something different and -- but -- but I -- as a -- I -- I see that you're probably a card-carrying member of the Word Watcher's Society here in Washington, but thank you.

Dr. Lathrop.

DR. LATHROP: The irritation is beginning to show. Well, I'll take it and run with it. I'm

a decision analyst, so I'm professionally obligated to list the criteria that we might consider -- in my humble opinion, that we might consider in terms of the group. I mean I've just assembled this from the discussions today. There's only six, which is quite a short list for me.

First one, ability to obtain the necessary information from an interaction with the two agencies, and here I can't emphasize too strongly how much we owe to Paul Blake and Tom Pamperin in terms of that. I mean we just talk to them and they get the information for us. Now one of these days Tom or Paul is going to get hit by a truck and we've got to figure out ways to -- you know, I don't wish for that.

VICE ADMIRAL ZIMBLE: Be service connected.

DR. LATHROP: Service connected, right.

MR. GROVES: Maybe they will just retire or something.

DR. LATHROP: No -- okay, a military trial, right, right, right, right.

So yeah, the ability to actually get information from the agencies.

Expertise on Board or via the consultants. As

we've said, you know -- not me, I'm just a decision analyst -- but the expertise here in dose reconstruction and -- and ethics and the agencies and QA and veterans is really -- it takes me aback. And you know, it's non-trivial to have a follow-on group which had that -- that expertise, although could have it in the consultants, there you go.

Organizational will be to pursue VBDR's mission. I have, and maybe a lot of us have, been parts of groups where it's a working group and sometimes there's not a fire in the belly. And I think this sort of thing needs a fire in the belly.

Ability -- this might be the hardest one. Ability to have recommendations be complied with by the two agencies. Complied with -- you know, this is all careful. We're an advisory board; we can't order anybody to open a door. Okay? But we do, in order to fulfill the mission of VBDR and Public Law 108 and so forth and so on, we -- we need to think about a follow-on group that will receive appropriate attention from the two agencies.

Then, by the way, funding.

And then, by the way -- we've mentioned this -- the ability to meet effectively. And Kristen was one of the ones who pointed out, gee, if you cut it down to six and it's FACA, you know, you can't have subcommittees among the six, any -- you can't -- you can't have three of them meet without full FACA sunshine and so forth and so on.

And you know, these are just things to think about: Ability to obtain the information, expertise on Board or with consultants, organizational will to pursue the mission, ability to have recommendations paid attention to at an appropriate level, funding and just the mechanics of meeting. That's all.

VICE ADMIRAL ZIMBLE: Okay. Those are -- those are excellent points and the point specifically about institutional mem-- or Board memory and fire in the belly sort of has an intimation, it's relatively implicit, that you're talking about a continuation of the Board rather than some new entity come in.

DR. LATHROP: I didn't say that.

VICE ADMIRAL ZIMBLE: No, you didn't.

DR. LATHROP: I just laid out the criteria;

that's all I did.

VICE ADMIRAL ZIMBLE: You didn't say it, but it -- but it came through loud and clear, you see. At any rate, that's an -- that's an excellent point. Okay? And -- and although we may -- we -- we can certainly look that within the mandate, within the legislative mandate, within the charter, we can certainly reduce the membership -- okay? -- not to an extreme where we no longer can function as a committee, but we can reduce the membership still so that -- so that the budget can go a little bit further. And I think that -- that's worth considering. But I think -- this is not the time to do that. This is the time to come together and make a recommendation that says what do we do now that we really feel we have no further recommendations to make but we need to see follow-through on the recommendations that have been accepted. Right? Okay.

DR. LATHROP: But let me just point out, I haven't heard a formal vote among the Board to agree with this sentence you just made.

VICE ADMIRAL ZIMBLE: I thought we would hold that off until tomorrow. I want to allow for

some more rumination. Okay?

But do I hear a motion to adjourn?

MR. PAMPERIN: Motion.

DR. LATHROP: That was quick. That was the quickest motion all day. Fastest I've seen Tom move all day.

VICE ADMIRAL ZIMBLE: Do I hear a second?

MR. GROVES: Second.

VICE ADMIRAL ZIMBLE: Okay, we are adjourned. Thank you. Have a good evening.

(Whereupon, the meeting adjourned at 4:30 p.m.)

C E R T I F I C A T E OF COURT REPORTER

STATE OF GEORGIA

COUNTY OF FULTON

I, Steven Ray Green, Certified Merit Court Reporter, do hereby certify that I reported the above and foregoing on the day of Sept. 10, 2008; and it is a true and accurate transcript of the testimony captioned herein.

I further certify that I am neither kin nor counsel to any of the parties herein, nor have any interest in the cause named herein.

WITNESS my hand and official seal this the 10th day of Oct., 2008.

Steven Ray Green, CCR

STEVEN RAY GREEN, CCR, CVR-CM

CERTIFIED MERIT COURT REPORTER

CERTIFICATE NUMBER: A-2102