SUMMARY OF MINUTES OF THE SEVENTH PUBLIC MEETING OF THE VETERANS' ADVISORY BOARD ON DOSE RECONSTRUCTION

The seventh meeting of the Veterans' Advisory Board on Dose Reconstruction (VBDR or the Board) was held at the Sheraton Mission Valley, 1433 Camino Del Rio South, San Diego, California on April 2-3, 2008.

In accordance with the provisions of the Federal Advisory Committee Act, *Public Law 92-463*, which sets forth standards for the formation and conduct of government advisory committees, the meeting was open to the public.

ATTENDANCE

Board Members Present: Dr. James A. Zimble (Chairman), Dr. Ronald R. Blanck, Dr. Paul K. Blake, Mr. Harold L. Beck, Dr. John D. Boice, Dr. Patricia A. Fleming, Mr. Kenneth L. Groves, Dr. John F. Lathrop, Dr. David E. McCurdy, Mr. Thomas J. Pamperin, Dr. Curt W. Reimann (via telephone on the first day only), Mr. Rudolph J. Ritter, Mr. David P. Ropeik, Dr. Kristin N. Swenson, Mr. George Edwin Taylor (via telephone), Mr. Paul G. Voillequé, and Dr. Gary H. Zeman.
Board Members Absent: None.
Quorum present: Yes.

OPENING REMARKS

Mr. Eric Wright (Alternate Designated Federal Officer) called the meeting to order and welcomed everyone to the seventh meeting of the Board.

Dr. Zimble (Chairman) also welcomed everyone to the seventh meeting of the Board, and invited guests to make use of the available handouts.

SUMMARY OF SEVENTH PUBLIC MEETING OF THE BOARD

The primary topics of the two-day VBDR meeting included briefings on Activities of Atomic-Bomb Survivors (HIBAKUSHA) Health Care Committee Based on HIBAKUSHA Protection Law by **Dr. Yasuhito Sasaki**, and Department of Veterans Affairs Quality Review of the Radiation Claims by **Ms. Edna MacDonald**. Presentations were also given on the current status and activities of the Nuclear Test Personnel Review (NTPR) dose reconstruction program by **Dr. Paul Blake,** and the Department of Veterans Affairs (VA) compensation program by **Mr. Thomas Pamperin**. The activities and accomplishments of the four VBDR subcommittees (Dose Reconstruction, VA Claims, Quality Management, and Communications and Outreach) were also presented.

During the meeting, eight veterans including a family member gave public testimony regarding their cancers and other debilitating illnesses they believe resulted from participation in atmospheric nuclear testing. They also discussed problems with claims decisions made by the Department of Veterans Affairs (VA).

Verbatim transcripts of each presentation, session, and public comment are available on the VBDR Web site at http://vbdr.org.

SUMMARY OF PRESENTATIONS TO VBDR

Dr. Yasuhito Sasaki's presentation:

The purpose of the presentation was to provide information on the population covered under HIBAKUSHA, the Japanese law to support the atomic-bomb survivors, the various allowances for those covered, the special medical care allowance, and procedures for approval.

The term "HIBAKUSHA" officially covers those individuals who possess a HIBAKUSHA health certificate issued by a local government, and which approves individuals who were present in Hiroshima or Nagasaki, or in officially designated vicinities at the time of the atomic bombings; those who entered designated areas within two weeks after the bombings; those who were in other situations that may have caused radiation health effects, or who were unborn babies of pregnant mothers in any of the previously-designated situations.

It was noted that the first thing to know about the HIBAKUSHA is that it literally means those exposed to radiation from the atomic bomb.

Dr. Sasaki explained that a person registered as HIBAKUSHA is eligible to receive an annual health checkup for both general cancer and other specific medical examinations. He also noted that Japan has a national health insurance system under which the patient presently pays 30 percent of medical care costs, with 70 percent being reimbursed by the government. The 30 percent share is not required for HIBAKUSHA.

As of March 2007 there are approximately 250,000 HIBAKUSHA, as opposed to the 100,000 in the life span studies of Hiroshima and Nagasaki survivors and others throughout Japan. The average age of an atomic-bomb survivor is 74.

Addressing the special allowances, Dr. Sasaki noted that the most important is the special medical care allowance, which is handled by a committee. Once a decision is made to recognize a radiogenic disease, which must be treated, the person receives approximately $1,300 for three years in addition to medical benefits. At the end of that period, the medical condition is re-evaluated. If the disease is regarded as cured, the patient's special allowance will be reduced by about two thirds.

There are other allowances such as an atomic-bomb microcephaly allowance, health management allowance, and nursing care or care by family allowance. Furthermore, when the atomic-bomb survivor dies, funeral fees are provided to the bereaved.

The approval process for the special medical allowance includes an application to the Minister of Health, Labor and Welfare through local governments. This application includes the situation of atomic-bomb exposure, age at exposure, distance from ground zero, shielding conditions, medical conditions, opinions of attending physicians and related medical examination data. After consulting with the subcommittee for Medical Care of HIBAKUSHA, the Minister of Health, Labor and Welfare confirms that the disease is caused by exposure to radiation and authorizes the condition's medical treatment.

The HIBAKUSHA Health Care Commission operates as a subcommittee of the Examination Committee of Certification of Sickness and Disability that is established by the Ministry of Health, Labor and Welfare of Japan. The subcommittee reviews each application submitted by HIBAKUSHA in a closed meeting. The review process is based on guidelines that were developed in meetings open to the public. Upon making the decision (approve, decline, or suspended while further information is gathered), the Minister notifies each applicant of the outcome.

The guidelines for assessing whether a disease or condition is caused by radiation include the probability of causation (PC) for cancer, the threshold for radiation-induced cataracts, radiation dose estimates, and medical treatment based on the condition of the claimant.

Difficulties faced by the program were described as how to deal with non-cancer diseases and revising the guideline based on newly-published scientific evidence. Dr. Sasaki noted that is not an easy task and recommended the need to establish an independent advisory committee to discuss the newly-published scientific information and determine whether it should be included in the guidelines.

Other challenges include establishing precise dose estimates based on the actions of an applicant 60 years ago, dealing with the HIBAKUSHA living abroad and dissatisfaction among those whose application has been declined.

In discussing new trends, Dr. Sasaki noted that many of the dissatisfied HIBAKUSHA have taken legal action. Ten lawsuits have taken place in district court; each suit involves from two to 50 plaintiffs.

Dr. Sasaki closed his presentation by announcing that in March 2008 new guidelines will be implemented for the special medical care allowance. This will include the use of the 2002 dosimetry system (DS02) for dose estimations, with a notation that relief of suffering is more important than scientifically-based reasoning. Probability of causation will not be used, which will make the processing of applications faster.

Ms. Edna MacDonald's presentation:

The presentation focused on the Veterans Benefit Administration's national quality assurance program that reviews rating decisions and disability determinations made in the field. One of the program's tasks is to do special focused reviews when needed by the agency, which is how Ms. MacDonald's office came to look at a sampling of radiation claims completed by the Jackson VA Regional Office.

A background on how the Jackson VA Regional Office set things up after they were tasked with consolidation was provided. It was noted that an oversight visit was done at the Jackson VA Regional Office in February of 2008.

In the focused review, 246 radiation claims which had been completed by the Jackson VA Regional Office from October of 2006 through October 2007 were selected; 232 of those cases were reviewed. Review could not be conducted of cases under appeal or if a file was unavailable for other reasons. The focus of the review was on accuracy of the claim, the radiation relevance, and an effort was made to gather information and track the timeliness of processing.

Preliminary findings indicated improved accuracy and improved timeliness by VA and DTRA.

Dr. Zimble's presentation:

The presentation included information on the Board's previous activities, and the number of formal recommendations the Board had made to DTRA and VA between June 2006 and April 2007. Dr. Zimble addressed each recommendation for each agency and then asked VA and DTRA to present an update on their programs.

Dr. Paul Blake's presentation:

The presentation included a program update, documentation status, dose uncertainty initiatives, quality initiative relative to expedited cases and the radiation dose assessment (RDA) double-blind study, the status of the Board's recommendations, and the road ahead.

In reporting on the program, Dr. Blake noted that the program had eliminated its backlog of cases and had achieved a steady state condition. The incoming case load, the time to complete a case, and the pending case load were also discussed.

The expedited dose initiative has provided faster responses to the veterans and VA, enabled a significant increase in favorable outcomes for veterans with skin and cataract claims, eliminated DTRA's backlog of non-presumptive cases, and reduced DTRA program costs.

Turning to documentation status, Dr. Blake explained in detail that the three types of documentations are policy documents, which included the Code of Federal Regulations and the NTPR policy and guidance manual; implementing documents, which included

procedures, technical guidance and training manuals; and the operating documents, which include worksheets and forms.

A progress on the dose uncertainty analysis was also discussed, and the report is expected to be completed with an update in the Standard Operating Procedures and system integration by July of 2008.

Quality initiatives included the double-blind intercomparison studies of NTPR reconstructed dose assessments that are performed independently by the NTPR and two independent consultants, operating on the theory that, if procedures are well written, any competent health physicist should get similar results. Although the results are not identical, Dr. Blake noted that he had yet to see any difference that would have affected a veteran's compensation decision.

Another quality initiative described was the independent review of expedited RDAs. This resulted in a recommendation to develop the decision summary sheet in order to capture the DTRA analyst's justification for expediting an RDA rather than perform detailed dose reconstruction calculations.

Turning to the status of VBDR recommendations as they relate to DTRA, Dr. Blake noted that of 18 formal Board recommendations, 11 have been completed, with the remaining seven in an ongoing status. He addressed each recommendation in more detail, providing completion target dates for those requiring more work.

Looking ahead, Dr. Blake indicated that during the last half of 2008 he hopes to update DTRA dose reconstruction policy in the Code of Federal Regulations and complete work on VBDR recommendations.

Mr. Thomas Pamperin's presentation:

The presentation included an update on the VA's compensation program and status of the Board's recommendations to VA. Mr. Pamperin addressed each recommendation, indicating acceptance or acceptance with limitations.

Accepted with limitations included the recommendation that VA provide outcome of claims adjudication to NTPR. Mr. Pamperin noted that VA does provide summary lists of the outcomes for all medical opinions which because of Privacy Act issues do not include personal identifiers.

Although the recommendation that DTRA and VA agree on a process through which a decision would be made on whether a case required dose reconstruction, the VA is unable to implement it. The legal opinion of VA's Office of General Counsel stated that VA is legally required to submit all claims, even those that are non-radiogenic, for dose estimates.

The recommendation that the VA reinforce its instructions to all regional offices to promptly route radiation claims to its Jackson Office was generally accepted; however, Mr. Pamperin

noted that included in the recommendation is a provision for VBDR's continued advice for the VA to consider developing alternatives to current methodologies, including possible legislative relief and/or modification of regulations for the non-radiogenic claims which the VA cannot accept.

The VA has no plans to seek legislative relief or modification of instructions contained in 38 CFR 3.311. Mr. Pamperin added that instructions and reminders have been provided to the regional offices detailing procedures for handling of non-radiogenic claims and actions required to support the claims prior to referral to the Jackson VA Regional Office.

Recommendations not included in Mr. Pamperin's slide presentation were also noted. One is a recommendation that VA grant service connection without regard to dose for atomic veterans with basal cell cancers and melanomas. This recommendation has become moot because of the expedited processing methods developed by DTRA and that all of those conditions are being granted service connection.

Another recommendation was for retroactive payments of entitlements to the earliest date the disability was first claimed once a presumption is established. That recommendation was not accepted. It is not within the authority of the VA and would require legislation.

Mr. Pamperin mentioned that Dr. Neil Otchin, who was providing the medical opinions on all radiologic claims, has retired. As of this date his position has not been filled, a situation which has created a hold on a number of cases awaiting medical opinions. Some cases are awaiting referral by the Compensation and Pension Service, and there are 118 cases in the Jackson VA Regional Office awaiting medical opinion. Mr. Pamperin commented that Mr. Steve Sloan, Deputy Director of the Environmental Agents Service, is taking on as many of the responsibilities as possible; however, since he is not a physician he cannot render medical opinions.

Other issues include the Dole-Shalala report and other potential changes to benefits. Mr. Pamperin also cited a study by the Center for Naval Analysis last summer, the results of which indicate that the VA rating schedule does a reasonably good job. The only area found to be under-compensated was mental health, and VA is evaluating that.

As a result of the Walter Reed situation there is a pilot program regarding the DoD disability evaluation system. The program requires the VA to assign a disability rating for use by the DoD. The VA rates disability somewhat higher than DoD for most medical conditions and substantially higher for mental illnesses. It is quite likely that the pilot program will become a normal business practice by next year.

Reporting on claims activity as a result of the current conflict, Mr. Pamperin explained that the VA had recently published proposed regulation on traumatic brain injury. The four signature wounds of the current conflict are burns, amputations, traumatic brain injuries and post-traumatic stress disorders. The VA doesn't anticipate much change relative to amputations, but significant changes to the other ratings schedule are expected relatively soon.

Lastly, the VA is in the process of a massive hiring effort. Challenges are expected in terms of training new staff, but Mr. Pamperin noted that the VA has redesigned training programs to make new staff able to contribute to workload reduction more quickly than previously.

VBDR SUBCOMMITTEES

The Board was mandated by Congress to audit dose reconstruction and the VA claims decisions for service connection of radiogenic diseases and improve communication with veterans. The Board's mission is also to address veterans concerns about the possibility of an elevated risk of cancer and other illnesses in veterans who were exposed to radiation or fallout from nuclear weapons testing, and the validity of their dose reconstructions.

To accomplish its task, the Board approved the formation of four subcommittees, their scope of work and their membership. The work of these subcommittees will meet specific requirements of Public Law 108-183.

Subcommittee 1 report presented by Mr. Harold Beck, VBDR Subcommittee 1 Chairman

The task of Subcommittee 1 is to assess the dose reconstruction procedures, and to audit a random sample of NTPR dose reconstructions. Thus, five randomly selected cases had been chosen for assessment from an updated list of RDAs, and one was chosen by DTRA for the double-blind exercise. Several additional cases done under the expedited process were also chosen in order to assure that this was being done correctly in terms of the decision to expedite. Also chosen was an additional case done in-house by DTRA. Those are cases involving Nagasaki and Hiroshima occupation forces.

Subcommittee 1's preliminary audit findings were discussed. The six new audits are not yet complete. A formal draft report summarizing its findings on each case audited will be distributed to Board members when the audit is complete.

Subcommittee 1 met with the NTPR's contractor and interviewed the analyst who prepared an RDA report of each case to be sure the subcommittee understands the reasoning, methodology, and conclusions. This has proved useful to both the subcommittee and the contractor. Various problems which had been identified in a preliminary audit of the cases were also discussed at the meeting.

Mr. Beck also reported that Subcommittee 1 continues to find the contractor is generally assuring benefit of the doubt for the veteran in developing the Scenario of Participation and Radiation Exposure (SPARE) and in doing dose assessments. The majority of cases are being expedited, and there are relatively few full dose reconstructions. Those are more complicated cases and have to be reviewed more carefully.

Good progress has been made with new techniques and software, and methods are improving. However, Subcommittee 1 feels that the dose assessment report of calculations

made and the SPARE still could be improved upon to make it more understandable. Case file documentation continues to improve, although there is a little more work to be done.

A potential problem has to do with the fact that often the particular organ for which a dose should be calculated is not clear, and the PCs have not been developed for certain organs. That requires the selection of an organ surrogate, which must be done carefully to see whether it represents the best choice, and whether the organ for which the dose was analyzed represents the proper organ to calculate dose for the particular medical condition.

It was noted there are two types of Hiroshima/Nagasaki veterans in the category of cases analyzed by DTRA. One is the occupation forces and the second is persons who were prisoners of war (POW) in Japan at the time of the bombing. Those two types of cases were being handled in much the same way by DTRA, and Subcommittee 1 has suggested they might consider changing the policy and having a full dose reconstruction for POWs since their SPARE is more complicated generally, and there are not many of those cases.

Looking at the sample of expedited cases, Subcommittee 1 identified a need for better supporting documents in the file to justify why the case has been expedited.

There have been three attempts at double-blind DRs, and only one has been fully completed. Mr. Beck suggested that this is an issue that will take time to develop before the subcommittee is satisfied that it has been fully implemented.

Subcommittee 1 plans to audit additional cases, though perhaps not six full RDAs since the number of those cases has been reduced, but will concentrate more on expedited cases and double-blind cases. Subcommittee 1 will continue their assessment of established methods, propose new methods, and closely monitor developments with respect to the new uncertainty analysis.

The independent quality assurance (QA) process by Oak Ridge Associated Universities is recognized as beneficial and should be expanded to include expedited cases.

Mr. Beck announced that Subcommittee 1 will not suggest recommendations to be made by the Board at this time. However, this report is intended as information to the Board as to issues Subcommittee 1 considers important for the Board to watch such as upper bound factors; discontinuation of using the same template for Hiroshima/Nagasaki POW cases as for occupation forces; an improved section in the dose reconstruction SOPs relative to surrogate organs; and continued emphasis on consistent clarity in communications to veterans.

Subcommittee 2 report presented by Dr. Ronald Blanck, VBDR Subcommittee 2 Chairman

The presentation included a description of the purposes of Subcommittee 2 and a summary of its activities since the previous Board meeting.

Dr. Blanck reported that two members of Subcommittee 2 visited the Jackson VA Regional Office and that the report of their visit is attached to the Subcommittee 2's report.

He then reported that the Subcommittee's consultant reviewed 12 randomly-selected cases from the Jackson VA Regional Office to see how they're dealing with radiation claims.

Dr. Blanck congratulated the Jackson VA Regional Office for the consolidation effort, commenting that what they're doing is very good in terms of dealing with the radiation claims, not only with integrity and concern for the veteran, but with a degree of efficiency not previously noted.

It was pointed out that Subcommittee 2 is concerned that although there have been successes in the Jackson VA Regional Office, Dr. Otchin's departure has the potential of leading to significant delays. The Subcommittee 2 urges that a replacement be found as quickly as possible.

Subcommittee 2 also expressed concern regarding the observation that the Jackson VA Regional Office had previously received reviews or ratings that were outstanding which led to individual performance bonuses. The consolidation, resulting in twice the number of claims as anticipated, may have adversely affected their ability to realize their performance goals. Therefore, Subcommittee 2 asks VA to look at rewarding the Jackson VA Regional Office for their success with this program, rather than impair their opportunities for future awards.

Subcommittee 2 also continues to ask that the Jackson VA Regional Office have a proper number of dedicated and trained personnel resources to focus on processing radiation exposure claims adjudication, giving these claims a high priority, particularly when the claimant is an aging veteran with multiple compensable conditions.

It was also noted during the visit to the Jackson VA Regional Office that 34 percent of the claims received were returned to the referring regional office because the claims contained no radiation exposure. The Subcommittee 2 recommends that the regional offices and associated service organizations receive further education and training in the proper identification of radiation claims and that a standard protocol be developed for referring such claims to the Jackson VA Regional Office.

Subcommittee 3 report presented by Dr. Kristin Swenson, VBDR Subcommittee 3 Member

Dr. Kristin Swenson delivered the report of Subcommittee 3 in Dr. Reimann's absence. She explained that Subcommittee 3 is responsible for all aspects of the claims process to ensure there is a quality management system to cover its entirety. She also noted that members of Subcommittee 3 attended other subcommittee meetings on dose reconstruction oversight and communication.

Dr. Swenson reported that at this time Subcommittee 3 has no recommendations for DTRA since it has made substantial progress on its quality management system, and that

Subcommittee 3 continues to receive documents from DTRA as they are updated. The main issue at this time is the development of the decision summary sheet, which they have agreed to work on.

Subcommittee 3 looks forward to the progress and results of the double-blind studies, and commends NTPR on its progress in the area of quality.

As for the VA, Subcommittee 3 agrees with Subcommittee 2's statement relative to Dr. Otchin's departure. Subcommittee 3 recommends VA develop standard operating procedures with respect to running the Interactive Radio Epidemiological Program, in interpreting results, and should develop detailed documents to support decisions regarding both radiogenic and non-radiogenic cases.

Subcommittee 3 also looks forward to a final report on the focused radiation quality review as discussed by Ms. MacDonald.

Dr. David McCurdy, as a Subcommittee 3 member, added that the Subcommittee wanted to ensure that a double-blind program be incorporated into the quality assessment SOPs, and that there should be a quantitative basis for deciding what constitutes significant differences between the three reported doses. Subcommittee 3 also expects that the quality assurance plan would be updated to include the decision summary sheets.

Subcommittee 4 report presented by Mr. Kenneth Groves, VBDR Subcommittee 4 Chairman

The presentation included a description of the purposes of Subcommittee 4 and a summary of its activities since the previous Board meeting.

A joint meeting between the Public Affairs staff of VA, DTRA, and a subset of Subcommittee 4 had been a prelude to a recommendation Subcommittee 4 will present to the Board to ensure that DTRA and VA send a consistent message to the atomic veterans. Subcommittee 4 also met in January 2008 and worked on a variety of issues.

Mr. Groves acknowledged with praise Dr. John Lathrop's work in developing the gap analysis document. This is a collection of data about recommendations and responses which proved useful to all four subcommittees in preparing their reports, and will be helpful for additional discussions at the September 2008 meeting regarding the Board's path forward.

Subcommittee 4 recommended that VA proactively communicate with atomic veterans to increase awareness of their potential eligibility for benefits. The VA has the lead on this recommendation with support as needed from DTRA on establishing the most current mailing list for the atomic veterans' community. As part of the recommendation, Subcommittee 4 has provided a draft letter that can be used as part of that outreach effort. A draft of the letter is appended to this report following Addendum A.

It was also noted that the brochure produced through the cooperative hard work of the Board and the sponsoring agencies, and which is available now to the VA for a variety of uses, would make an excellent enclosure to that letter.

Dr. Lathrop added that although Subcommittee 4 tried to avoid micromanagement or giving detailed recommendations for implementation, he wanted the Board to realize that the outreach effort will involve significant effort from VA. He acknowledged that now that VA has the compatible database from DTRA, they will be faced with the management task of combining that with other information they have in house.

BOARD DISCUSSION

With a substantive number of actions having taken place based on the Board's recommendations, Dr. Zimble indicated that he was encouraged by the progress made by VA and DTRA. He then announced that the main purpose of the upcoming discussion was to get the Board's input regarding its future mission, vision and strategy. Remarking that with one more meeting scheduled for 2008 (September in Washington, D.C.), Dr. Zimble expressed a hope that at that time the Board could come forward with a recommendation to the two sponsoring agencies for the Board's future charter.

Referring the Board members to the legislation under which the Board was created, along with its charter outlining its objectives, Dr. Zimble asked that they keep those objectives in mind as they consider what has been done thus far and the results and comments from the public, as they prepare their input for the September meeting.

The following suggestions and issues were raised and discussed.

Several Board members noted that it is time to operate on another plane, which might be directed more to QA, in that the decision summary sheets and double-blind studies still have a way to go before they could be considered operational. In addition, there is a need to develop a constructive, effective and non-burdensome way to set up a QA process across DTRA and VA to list critical decisions and rationales behind them, similar to a decision summary sheet. Thus, there is a need for the Board to continue providing independent oversight for at least another year before determining the Board's future direction. However, the Board could be downsized for a somewhat different oversight role.

Regarding the issue of trust between the served community and the agencies, which has improved, several Board members feel that this still needs work. In addition, the Board has developed an image as a responsive contact point for veterans, and perhaps should continue to serve as a trusted advocate for veterans, although in a more limited or reduced manner.

With respect to communication, several Board members feel that an ongoing role for this Board is to offer its resources and expertise to both agencies. This is an opportunity for the Board to continue supporting an interface between the two agencies to ensure they speak with a single voice relative to the program. In addition, it is important that all surviving

atomic veterans be aware of the program, which may require something more proactive than a letter advising them of their eligibility.

Getting the new VA staff integrated and trained in the next year, and how the regional offices adapt to understanding the process regarding which claims should be sent to the Jackson VA Regional Office, all indicate it is premature to abandon the role of oversight. However, the role of the Board might change to one of facilitator and resolver of issues. And if there is a thought of continuation in a limited fashion, perhaps there should be a reassessment every two years or so to determine whether there is a need to continue.

While auditing will continue to be very important, it doesn't need to be done by the Board.

A few Board members noted that there is a difference between treating issues fairly and treating them equally. One example is having a dual system of presumptive and non-presumptive which has always been a problem. Although the Board does not have the authority to make the following recommendation, there seems to be a need to consider one system, either all presumptive or all non-presumptive, which would be fairer to veterans. Such a system would entirely eliminate the dose reconstruction process, despite the fact that it is a valid scientific tool.

It was also noted that this cannot happen because non-presumptive cases would require dose reconstruction, would require a legislative change and would have significant impact on the budget. However, if dose reconstructions were eliminated, there would still be a need for a medical board to judge the probability of causation of a medical condition by ionizing radiation.

With regard to communication, several Board members argued that the way the veterans know about the activities of the four subcommittees is by reports during the Board meetings. However, this can be handled through newsletters and publications by the various veterans' groups.

Dr. Zimble summarized the discussions by commenting that the Board had started off in a repair and improve mode, looking at processes that had substantive problems which needed to be addressed. It appears that they're now ready to move to a position of maintenance, which may be an ongoing function, to ensure that the improvements remain intact, and that further improvements might be recommended. He also noted that it became clear that this Board, as it is presently constituted, is not ready to go out of business. However, the Board is ready to scale down in order to give the agencies time to implement all accepted recommendations.

Dr. Zimble stressed the point that the Board will continue discussing the future role of VBDR further at the September 2008 meeting. He then asked the Board members to keep the discussion going between now and the September 2008 meeting.

BOARD'S RECOMMENDATIONS

See Addendum A for a full set of the Board's recommendations that was transmitted to VA on April 28, 2008.

PUBLIC COMMENT PERIOD

Prior to opening the meeting for public comments, attendees were reminded that the Board had two objectives. The first is oversight of dose reconstruction and the filing and processing of veterans' claims dealing with ionizing radiation. The second is to assist DTRA, specifically NTPR, and the VA in communicating with veterans and keeping them informed.

The Board is not responsible for reviewing individual dose reconstructions nor does it serve as an appeals board. If the system is not working the Board needs to know, but the Board has no legislative power.

Input from the public was solicited on both days of the meeting and is reported in the meeting transcripts. The following is a list of the members of the public who addressed the Board at the meeting. Verbatim transcripts of the public comments are available on the VBDR Web site at http://vbdr.org.

James Elliott (atomic veteran); **Charles Clark** (Radiated Veterans); **Arthur Templin** (atomic veteran); **David Bryant** (Radiated Veterans, spoke on behalf of his deceased father); **John Chiment**(atomic veteran); **John Argeris** (atomic veteran); **Richard Haight** (atomic veteran); **Billie Ringgold** (atomic veteran).

FUTURE VBDR MEETINGS

Following discussion by the Board, it was agreed to hold the eighth meeting on September 2008 in the Washington, DC area. Details about future meeting dates and locations will be announced in the federal register and on the VBDR Web site.

Dr. Zimble remarked that a reasonable amount of business had been carried out. He thanked the Board and the staff for their efforts, the public for their comments, and called for a motion to adjourn.

The motion was made, seconded and carried.

ADDENDUM A

BOARD'S RECOMMENDATIONS

On the basis of its audits and assessments of Nuclear Test Personnel Review (NTPR) Program radiation dose assessments (RDAs) and Department of Veterans Affairs (VA) claim procedures, the Veterans' Advisory Board on Dose Reconstruction (VBDR) offered a number of recommendations at the April 2008 meeting held in San Diego, California. The Board believes that these recommendations, if implemented, would improve the VA compensation program for atomic veterans.

For the Department of Veterans Affairs (VA):

Recommendation 1: Given the age of atomic veterans, the Board recommends that sufficient staff at the Jackson Regional Office, who are experienced with radiation claims, be dedicated to the processing of ionizing radiation claims to insure expedited processing.

Recommendation 2: Thirty four percent of claims sent to Jackson from other VA regional offices (VAROs) were returned to the referring VAROs because radiation exposure was not part of the claim. Thus, the Board recommends that the staff at the local VAROs and associated service organizations receive further guidance regarding the identification of radiation claims and that a standard protocol be developed for referring claims to the Jackson Regional Office.

Recommendation 3: That the VA central office provide to the Jackson office personnel ongoing focused training on current trends and issues regarding radiation claims.

Recommendation 4: That the VA develop standard operating procedures with respect to running and interpreting the results of the Interactive Radio-Epidemiological Program (IREP) and develop detailed documentation supporting the decisions for processing both non-radiogenic and radiogenic claims.

Recommendation 5: That VA proactively communicate with atomic veterans to increase awareness of their potential eligibility for benefits. The VA has the lead on this recommendation with support as needed from DTRA on establishing the most current mailing list for the atomic veterans' community. A draft suggested letter is attached.

Draft letter to veterans

Dear

Our records indicate you may be an "Atomic Veteran," someone who may have participated in U. S. atmospheric nuclear tests, served with the American occupation forces of Hiroshima and Nagasaki, or were Prisoners of War in Japan at the conclusion of World War II. A brochure with all the details, and a list of specific nuclear tests, is enclosed. Exposure to ionizing radiation from nuclear devices in connection with your service may have caused health problems. Depending on the nature of your illness, and where and when you served, you may be entitled to a range of VA benefits. The surviving spouse and/or children of a veteran may be eligible for these benefits as well. We want to tell you how to begin a claim if you think you may be eligible.

If records confirm that you served at specific locations at specific times, and independent medical evidence confirms that you have any of 21 health problems that might be caused by ionizing radiation, we automatically presume your illness was caused by the radiation exposure and you qualify for benefits. (The list of these presumptive diseases is included in the enclosed brochure.) Any benefits awarded will depend on your specific health circumstances. A claim may be filed for diseases that are not included in this presumptive list; in those cases, the Department of Defense estimates the radiation dose you likely received. With that added information we can then judge whether you qualify. You should know, however, that many Atomic Veterans who file such claims do not meet various criteria related to radiation exposure and are denied.

It is important for you to know that the secrecy oath taken by atomic veterans was rescinded by the Secretary of Defense in 1996; so you are now free to talk about your service in filing a claim.

If you think you may be eligible and want to take the next steps:

- you can call or visit your local VA center, or
- you can call the VA's national toll free line at 1 800 827-1000, or
- you can visit the VA's main website at www.va.gov, or
- you can visit the specific website we have about this program at www.va.gov/irad.

If you speak to anyone by phone, tell them you want information about filing a claim for illnesses that may be caused by radiation exposure.

Atomic Veterans served patriotically; if you are an Atomic Veteran, or the surviving spouse or child of an Atomic Veteran, we want you to get the benefits you deserve. We look forward to serving you.

Sincerely,