TOXIC EXPOSURE:

EXAMINING THE VA'S PRESUMPTIVE

DISABILITY DECISION-MAKING PROCESS

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WEDNESDAY, SEPTEMBER 25, 2019

United States Senate,

Committee on Veterans' Affairs,

Washington, D.C.

The Committee met, pursuant to notice, at 10:00 a.m., in Room 418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

Present: Senators Isakson, Moran, Boozman, Cassidy, Rounds, Tillis, Sullivan, Blackburn, Tester, Brown, Blumenthal, Hirono, Manchin, and Sinema.

OPENING STATEMENT OF CHAIRMAN ISAKSON

Chairman Isakson. Good morning. We are glad to have you here at the Veterans' Affairs Committee for this hearing today, which is a very important hearing. It has been scheduled twice before and was postponed for other problems. One was the principal author could not be here for the hearing, on his bill, and we did not want to do that. And the other, we have got conflicts--problems with our whole calendar on the day and we had to pull it off the calendar because of other votes that preceded it.

But today we do not have any competition. We have competition but it is not any good competition, so we are going to have our hearing and hopefully we are going to have good attendance. This is a very important hearing issue that is bubbling up from time to time in our military, and it is an issue that is not covered greatly, because it is an issue of more modern warfare than some of the old stuff. I think it is important that we hear everything that is going on and what the agency is doing, what those actives are doing, what people who have been conflicted with problems arriving from toxic waste and toxic fire pits and all those things.

And let's get to the fact if we can. We are in the process of beginning the process of gathering facts, and I want to point this out today, which I have never said before. It never occurred to me until we dealt with the Blue Water Navy thing. As you know, we passed Blue Water Navy, what, a month ago, Jon?

Senator Tester. Yeah.

Chairman Isakson. And we have had people working on us for, I guess, ever since you have been Ranking Member and I have been Chairman--four years anyway--to include Blue Water Navy benefits for those who did not serve on land but served at sea, and were in the Vietnam War. And that opened it up to a lot more payments for presumed

illness because of Agent Orange. This would be injury that would ultimately end up in a presumed illness and presumed cause. It might be from Agent Orange but it would be from something else.

So we have to be very careful when we start gathering facts that we gather facts, number one, and they deal with the subject, number two, and we do not try and create hints, if you will, or secondhand information or indirect cause and effect. We want to find out exactly what is causing things, or is not causing things, exactly where the problems may or may not be, and hear from the agency exactly what it would take us to do the research and get the findings in. And then if we did have a cause of action, how long it would take us and how far we would have to go in substantiating that cause of action for veterans.

So we have got a long way to go before we have any legislation or anything else, but it is time to start looking at that. In Iraq and Afghanistan, we have done a lot of incidences of fire pits and other things, which, in that terrain and that atmosphere and that country are tough as it is. I have had, in my own district, we had one incident involving Iraq that took place near a fire pit and ended up in the fire pit, the old fire pit, by the time the investigation took place. So you had the

waste that had come from a previous burn pit, affecting soldiers who were fighting today, and that is something that causes a big problem too.

So we are going to get all the facts we can, we will make sure our soldiers get what they are entitled to get and what they earn, representing our country, and I want to see to it that we get all the facts on the table so we don't have a rush to justice without something we think is true. We have a rush to do what is right because we know it is, and that is what plan on doing at this hearing today.

Before I go to introduce our guests I want to introduce Ranking Member Jon Tester from Montana for his comments.

OPENING STATEMENT OF SENATOR TESTER

Senator Tester. Well, thank you, Mr. Chairman, and I want to thank the folks on both panels who are going to be testifying today. I appreciate you taking time out of your schedules to be here to testify before us on a very critically important issue.

Before we get to business I also want to take a moment and recognize Bobby Daniels, a Blue Water Navy veteran from Missouri. Bobby, it is good to have you in the crowd. I know this is an issue that you have been working on for some time, and we appreciate your service,

so thank you, sir.

[Applause.]

Senator Tester. I also want to say a few things about the fellow to my left, who said he would be returning back home to Georgia at the end of this year. There are going to be a lot of things said about Johnny Isakson over the next three to four months, but the fact is that serving with Johnny on this Committee has been an honor of a lifetime for me. He is an example of what the United States Senate should be--civility, bipartisanship, and decency--and one that we should all try to emulate.

Johnny is everything that you could ask for in a colleague, in a friend, and he has been the best damn advocate for veterans in this country that they could ever ask for. And we have accomplished a lot under Johnny's chairmanship, from the MISSION Act to the Forever GI bill, to the Appeals Modernization, and, yes, to the Blue Water Navy Veterans Act. And that is why we are here today, not just to talk about the process but to talk about fulfilling this nation's promises to our veterans.

When folks sign up for the military, there are promises made, and the cost of fulfilling those promises are the costs of war. In terms of Agent Orange exposure we are talking about an aging Vietnam veterans'

population, a population that often returned home to protests in angry and divided communities. They did not return home to parades or other appreciation from a grateful nation. This population has suffered for far too long from health conditions caused by service to a government, and far too frequently that government refused to acknowledge the true extent of their sacrifice.

So now is the time. The time has passed to wait for these veterans' families to wait for three medical conditions--hypothyroidism, bladder cancer, Parkinson's type syndromes or Parkinsonism. The National Academy suggests that those are associated with Agent Orange. And in the case of the fourth condition, hypertension, their view of the studies have shown there is a positive association between that and Agent Orange.

Yet, in all four of these cases, Vietnam veterans continue to wait for VA bureaucracy to unravel itself from the red tape and issue a decision on whether to extend presumptive exposure. There is absolutely nothing stopping the Secretary from making a decision on these four conditions right now.

Meanwhile, those Vietnam veterans who served offshore, their wait continues. Despite the court ordering the Department to finally acknowledge Blue Water

Navy veterans' exposure to Agent Orange and other herbicides, the VA continues to slow-walk processing claims for these veterans, and the VA must do right by these Blue Water Navy veterans, quite frankly, lift the stay and begin processing their claims today and the wait, because the fact is the VA is outliving these veterans and that is simply not right.

We are at a point where our newest generation of veterans is losing faith in this government because the VA bureaucracy has not prioritized or appropriately addressed the health outcomes of veterans exposed to harmful toxins while in service. For the Gulf War veterans, their health has worsened in comparison to their non-deployed counterparts, and the VA must work harder to figure out why this is.

While I understand the National Academy is undertaking a comprehensive review of the health effects of airborne hazards from burn pits, veterans are understandably frustrated with the pace of progress in examining their exposures. Moving forward, we must develop a better process for recognizing health outcomes caused by toxic and environmental exposures. Veterans and their families cannot wait decades for determinations that their military exposures caused their illness. We need a simpler, quicker process.

At Secretary Wilkie's confirmation, he said that a veteran should not have to employ a team of lawyers to get their benefits to the care that they are entitled, and I know he sincerely believes that, and I agree with him. But it is my opinion that the VA could make this progress much less adversarial if it stopped employing armies of lawyers to find ways to deny care or benefits to veterans and start hiring additional docs and claims processors to provide more timely care to their veterans.

But the VA is not the only government agency that bears fault here. The Department of Defense must do a better job mitigating the damage done by environmental hazards, by working to prevent them in the first place. It needs to more accurately record the exposure our troops come in contact with and make sure our troops' medical records document these exposures.

I have worked closely with Senators Blackburn and Blumenthal on the OATH Act, which would require such documentation. It would help veterans establish that contact with toxic occurred so that they have more easily fileable claims for exposure, just as it helps the VA with diagnosis and treatment.

The Joint Economic Council exists to improve coordination between the DoD and the VA and ultimately improve outcomes for servicemembers and veterans. Why is

common-sense legislation like the OATH Act even necessary when the highest levels of the DoD and VA are supposed to be looking into these issues routinely?

To that end, I would like to see the JEC take a harder look at how the DoD and VA can work collaboratively to ensure that the VA has the information that it needs to substantiate the claims so that veterans do not have to hire a team of lawyers, referenced by the Secretary.

Making a decision on science should not take more than three years. Following a court decision should not take nine months. And not learning from decades of mistakes and allowing our newest generation of veterans to experience the same hold-ups as the Vietnam veterans have is a failure in and of itself.

Mr. Chairman, I cannot thank you enough for calling this hearing today. It is one of the most important hearings I think we are going to have this year in the VA Committee. Thank you.

Chairman Isakson. Well, thank you, Jon, and thank you for your kind remarks about me, but I want to tell everybody, one fact to keep in mind. In the past two years, all the legislation we have passed, making changes, all of them that have been made--new GI bill, everything--there was one dissenting vote from one

Committee member on one vote. So we have 100 percent votes for everything we did, except for one time we had one no vote and we had 14 yes votes on that bill. So we are a team, we are not an individual up here, and we are ready to work on problems and get them solved. And I appreciate your help along the way. We had a good committee all the way through.

Now for our panel today. Our first panel is Dr. Patricia Hastings, Chief Consultant, Post-Deployment Health, VA, accompanied by Dr. Drew Helmer, Director of War-Related Illness and Injury Study Center, and Dr. Terry Rauch, Acting Deputy Assistant Secretary of Defense for Health Readiness, Policy, and Oversight.

Dr. Hastings, you are first.

STATEMENT OF PATRICIA HASTINGS, MD, CHIEF CONSULTANT, POST-DEPLOYMENT HEALTH (VA); ACCOMPANIED BY DREW HELMER, MD, DIRECTOR, WAR RELATED ILLNESS AND INJURY STUDY CENTER (WRIISC)

Dr. Hastings. Thank you very much.

Chairman Isakson. And I will interrupt for one second. You have got up to five minutes. You are so pretty, if you take a little longer I will not say anything. If you take a lot longer I will say a lot.

Dr. Hastings. Okay. Chairman Isakson, Ranking Member Tester, and members of the Committee, I really want to thank you for having this meeting. I want to thank you for allowing the VA to talk about what we do in regard to military environmental exposures and how we take care of veterans.

I am a 30-year veteran at retirement. I decided that I would come to the VA to continue to serve veterans. I am joined today by Dr. Drew Helmer. He is the previous Director of the War-Related Illness and Injury Study Center at East Orange, New Jersey, and last month he was selected to be the Deputy Director at the Center for Quality Innovations, Effectiveness, and Safety at the Houston Medical Center in Houston, Texas.

I am a board and emergency medicine physician with a degree in public health, and I am very happy to continue

serving.

Post Deployment Health Services (PDHS) is the oversight for military environmental exposures, and we know how critical this is for veterans. Exposures are the reason that my office exists. We have four programs in Post Deployment Health Services. These are the Pre-9/11 programs, the Post-9/11 Era Programs, and here we have subject matter experts that look at how to develop policy that is effective and works for the veterans.

Epidemiology looks at the science, does some original research, and informs policy for the VA. The War-Related Illness and Injury Study Center, that I just spoke about, does research, education, very extensive education, and also sees the most difficult cases in the VA, those veterans that are hard to diagnose and hard to make a treatment plan for.

At the War Related Illness and Injury Study Center in New Jersey there is the Airborne Hazards Open Burn Pit Center of Excellence, and I think you know about that because you have supported it vigorously. Your support has accelerated research for veterans and care for veterans, and I would like to sincerely say thank you.

VA does recognize that environmental exposures during deployment may be associated with immediate and delayed adverse outcomes, and the greatest challenge

there is getting the work done. VA cares for 9.6 million veterans. A third of these veterans report that they may have had an exposure to an environmental hazard, and a quarter of those veterans are concerned that they may have an adverse health outcome.

We have teams that are addressing this. We have epidemiologists. We have physiologists. We have internists. We have pulmonologists. We work with the other Federal agencies. We work very closely with the DoD. We work with the National Academy of Medicine. We work with CDC, VBA, all of these in support of veterans.

When a disability is determined to be due to an in-service exposure, whether it is through a presumption or direct proof of exposure, VBA is there to help veterans with compensation.

In certain circumstances, VA does presume that a disability was caused by military service, and presumption can take the place of some other forms of proof. They are established by Congress or by the Secretary after review of the science by the subject matter experts, and in the VA we use external agencies as well as the internal subject matter experts. One of the greatest challenges with the presumption process is that good science does take time, and we are working very hard to get things done.

In the absence of a presumption, however, we do encourage the veteran to turn in a claim which can be looked at on an individual basis if they believe that their service has harmed their health.

A central question that does remain unanswered, in many cases, is what aspect of the deployment is causing the ill health? We see that right now with airborne hazards. Is it the dust? Is it the burn pits? Is it an infectious process? Is it blast over pressure or a combination of all those things? And VA is working with DoD and our other partners to find the answers.

An exciting new opportunity to improve understanding is ILER. I think most of you know about the Individual Longitudinal Exposure Record. If you match ILER with the electronic health record, and we have the ability to do big data, we have a very powerful tool that can look at large or small cohorts very quickly and get you the answers that you seek for care of veterans. We hold scientific exchanges with the DoD. We have the airborne Hazards Symposium, toxic-embedded fragments studies, the July Environmental Health Conference. All of these have taken place in the last six months. We publish our research findings in peer-reviewed journals.

In conclusion, sir, VA is committed to the health and well-being of veterans. My office is dedicated to

that specifically. To this end, your continued support, as has been, is essential. And, Mr. Chairman, this concludes my testimony. My colleague and I are prepared to answer your questions.

[The prepared statement of Dr. Hastings follows:]

Chairman Isakson. Thank you very much for your testimony.

Our next witness is Dr. Helmer of Veterans Affairs. Dr. Helmer. Oh, you're the--

Mr. Rauch. I am the second.

Chairman Isakson. You are the second?

Mr. Rauch. Dr. Rauch, for the DoD.

Chairman Isakson. Okay, Dr. Rauch. I am sorry. We will take your expert testimony, and then he can correct it after I introduce him.

Mr. Rauch. My pleasure.

STATEMENT OF TERRY RAUCH, PHD, ACTING DEPUTY ASSISTANT SECRETARY OF DEFENSE FOR HEALTH READINESS POLICY AND OVERSIGHT, DEPARTMENT OF DEFENSE

Mr. Rauch. Chairman Isakson, Ranking Member Tester, and members of the Committee, thank you for the opportunity to discuss the Department's process for exposure monitoring, identifying illnesses that are potentially associated with exposures during military service, and our collaboration with the VA.

I spent 27 years on active duty in the Army, some of that time working on this topic in the deployed and garrison environment. The Department has a longstanding collaborative relationship with the VA, focused on a continuum of care for servicemembers and veterans. We collaborate extensively on occupational and environmental exposures, including the exchange of individual exposure information, health effects research to determine possible linkage of exposures to illnesses, exposure-related registries, and outreach and education to our servicemembers, veterans, and their health care providers.

The Department's current process for assessing garrison- and deployment-related health hazards informs our commanders of the health risk to their personnel, so

that they, along with their public health and safety professionals, can make necessary operational decisions to mitigate the health risk and protect the health of the force.

The health risk assessment process also informs health care provided to individuals and provides information to the VA to support the determination of claims for veterans. The Department and VA have several processes in place to share exposure-related information on servicemembers and veterans. These processes include, but are not limited to, the service treatment record, the newly developed electronic Individual Longitudinal Exposure Record, known as ILER, establishment of specific exposure registries, and collaborative meetings, sharing research findings on the health effects of environmental exposures in military environments.

The DoD and VA have collaborated on the establishment of several exposure-related registries as a means to provide event-related exposure information to the servicemember and veteran, health care providers, researchers, claims adjudicators, and others. Existing exposure registries include Agent Orange, Gulf War Illness, Ionizing Radiation, Depleted Uranium, Toxic Embedded Fragments, Operation Tomodachi, and the Airborne Hazards and Open Burn Pit Registry.

Moreover, past, current, and emerging exposures of concern are deliberated with the intent of developing recommendations to inform policy decisions, updating of exposure and health effects knowledge, supporting joint project development, critical information-sharing, and health risk communication.

The Department has, and will continue to, collaborate with the VA and other Federal agencies, academia, and others on epidemiological and health-related research to gain a better understanding of the potential long-term health outcomes associated with exposures and to translate our research findings to improve the health care of our servicemembers and veterans.

The Department is grateful for the unwavering congressional support that has enabled collaborative actions, focused on the health and readiness of servicemembers, the health of veterans, and the provision of high-quality care to servicemembers, veterans, and their families.

Thank you again for the opportunity to be here with my VA colleagues. I look forward to your questions.

[The prepared statement of Mr. Rauch follows:]

Chairman Isakson. Thank you very much, Doctor. We are glad to have you here today. I will ask the first questions and then go to Jon, and then we will go to Mr. Rounds and other members as they come here today.

On the identification of illnesses, the work that you have to finally determine whether there is a presumption of association or not, how long a process is that, or is that a process to which there is a discipline and a rule of order that you take place, or does it depend on what the accusation is or what the illness is?

Dr. Rauch, do you have anything on that?

Mr. Rauch. Well, our process starts from the ground up, where we have preventive medicine units in the deployed and garrison environment that routinely collect surveillance data, environmental health, occupational health data. That data is then captured into databases. It is evaluated. It is reported to the commander. The commander has the ultimate decision to mitigate risk, which he or she sees from those environmental and occupational health assessments.

So those are done routinely, and as a matter of fact, in some environments they are done routinely daily.

Chairman Isakson. More of the things that you investigate are things that you initiate in the Department itself rather than things that are brought to

you by a veteran. Is that right? Would that be a correct assumption?

Mr. Rauch. Yes, that would be correct.

Chairman Isakson. Very good. Dr. Helmer, I had a call two weeks ago from a veteran, whom I know very well, so I know his credibility. In fact, he was an elected official after his service in Vietnam and a very successful person in our community. He has terminal liver cancer, and he called me and said that it is a liver cancer that is not covered by--I do not remember what the name of the cancer is. This is just a what-if question. It is a liver cancer for which there is no benefit paid from the Veterans Administration. There is some caregiver money but there is not any direct benefit paid.

Is every benefit that is paid for an illness or a condition or a situation like cancer, is that determined broadly or is that determined individual in the Department by the disease?

Dr. Helmer. So I think the answer is that it is a combination, and that for the presumed service-connected conditions they are defined more explicitly and often have limits, in terms of what is covered, depending on the language that is used, either in the Secretary's language or in the congressional language.

As Dr. Hastings mentioned, every veteran can file a claim for service connection on an individual basis, and so that determination is made on a case-by-case basis, weighing both the evidence of the actual connection, the nexus to the military service, as well as the evidence supporting the association between perhaps an exposure and that health condition.

Chairman Isakson. Do you know if there is a process in the Veterans Administration whereby someone can bring a request for a benefit for something that is not covered and is handled on an individual basis?

Dr. Helmer. And it is handled on an individual basis?

Chairman Isakson. Is there a process for that? I am not looking for one. I just want to know if there was one.

Dr. Helmer. I will refer to Dr. Hastings.

Dr. Hastings. Sir, that would be the claims process, and if any veteran has a condition that has caused a disability which they believe is related to their military service, it will be evaluated on an individual basis. In fact, that is how most VA claims are handled. It does not require a presumption.

Chairman Isakson. If a condition is determined for one individual veteran and the Department pays benefits,

and another veteran comes in with the same condition, do they automatically get the benefit or do they have to go through the same process as the first one did?

Dr. Hastings. They would be going through the same process.

Chairman Isakson. Does that happen very often?

Dr. Hastings. I can ask the VBA how often it happens, and I would be very happy to get the information for you and brief you back on it.

Chairman Isakson. I want you to be very careful when you answer this question. This is the last one I am going to ask. There is a process whereby you could get a piece of legislation passed in the Congress on citizenship or on legality or on immigration, and handle a single case with one bill, if somebody wants it done. Would that be the case--do you know of any case within the Veterans Administration where a Senator or a Representative has introduced a bill that directed the VA to cover one individual incident or disease?

Dr. Hastings. I do not know of any but I will go to VBA and ask if there have been any.

Chairman Isakson. That was a good answer. Thank you. I appreciate it.

Dr. Rauch? No, you have already--who is next? Dr. Helmer, right? I am trying to avoid you.

Dr. Helmer. Well, if I can just tag onto what Dr. Rauch said about the VHA, and you were asking do we ever go to the DoD and ask about service-connected conditions, or conditions of concern. I would say we do. As a matter of fact, on a clinical level, at the War-Related Illness and Injury Study Center, we have very close collaborations with our counterparts over in the DoD, and we will routinely ask them about an exposure that a veteran brings to us. And so on a one-on-one basis we certainly have that opportunity, as well as the more formal arrangements that were mentioned.

Chairman Isakson. Thank you very much. Okay, next is Senator Tester.

Senator Tester. Thank you, Mr. Chairman.

Dr. Hastings, thank you for being here. Thank you all for being here. As I said in my opening remarks, I think it is time to end the way veterans, Blue Water Navy veterans have, and for the VA to start making sure these guys and gals get the benefits that they have earned. I recognized Bobby Daniels in my opening statement. Bobby Daniels has just applied for a--recently applied for a second mortgage on his house to pay for his medical bills. It is my belief that these medical bills would be paid for if the blanket stay was lifted.

Do you believe that the VA will reverse course on

its blanket stay? I think they say it is going to be stayed until January of 2020. Do you think there is any potential that it could lift its blanket earlier than that, and start processing claims?

Dr. Hastings. I know that right now VBA is getting ready for the increased claims, doing the training. I do not know that they would be able to do it any earlier. But they have hired more people, they are training them, and veterans certainly can put in a claim at this time, and the adjudication process will take place as quickly as possible.

Senator Tester. So it is not an issue of recognizing that things like hypertension or bladder cancer are now to be covered, but it is more an issue of infrastructure within the VA?

Dr. Hastings. It is the preparation in the VBA to make sure that they can process all the claims that will be coming on.

Senator Tester. Okay. So I--and you just have to help me with this. This is just a straight-up, honest question that I do not get. Isn't it the VBA's business to allocate benefits? I mean, isn't that what they are set up for?

Dr. Hastings. That is what VBA is set up for, to make sure that they take care of the veterans with

regards to claims.

Senator Tester. I got you. So why--I understand it is more numbers, but it looks to me like the process is already set up, ready to go. You just add the four presumptives on and you are rocking and rolling.

Dr. Hastings. The presumptives are a separate issue, and those are with leadership and in coordination, right now, for the decisions to be made.

With regards to Blue Water Navy, one of the things that they also are doing, since it is within 12 miles, there is a process by which they are taking the ships' logs from the archives, they are having them scanned in and put into a computer program. Ships used to make sure where they were in the ocean three time a day.

Senator Tester. I got you. So--and this may not be in your bailiwick, but it would appear to me that they know already where some of those ships were. Why not lift the stay on those, at least? I mean, I am not sure that you need to know 100 percent to be able to start giving out benefits.

Dr. Hastings. With regards to the ships, I would have to ask VBA if they have any ships that they have already delineated, but I know they are scanning in 65 million pages of the ships' logs, in order to--

Senator Tester. Yeah. I--I got that. I question

whether 65 million pages of ship logs, in relation to the Vietnam War, but maybe there is. And I just--I think they are making it more complicated than it needs to be.

As far as these presumptives go, is the research done on these presumptives now done because of the court cases and because of our actions here in Congress, or is there still work being done on those presumptives as applied to Agent Orange exposure?

Dr. Hastings. There is still work that is being done on the presumptives. We are still researching the issues that face the Vietnam veterans.

Senator Tester. Okay. Is that going to have any impact upon benefits, that research?

Dr. Hastings. I believe that it may. We are still looking at the issues that face veterans. We are looking at intergenerational effects. We are looking at other disease processes, not simply the bladder cancer--

Senator Tester. I got you. All right. So over and beyond what the court decision said, you are looking at potential impact, generational impacts and others.

Dr. Hastings. We have veterans that have many concerns that they expressed to us, and we do look at those individually--

Senator Tester. Okay.

Dr. Hastings. --and on a population basis.

Senator Tester. Because it appears to me, with the court case and with the action that Congress has taken, that it is pretty much as soon as you get the infrastructure built, the benefits should go out. Am I misreading that?

Dr. Hastings. I do not believe so, sir.

Senator Tester. Okay. Good. I am out of time but hopefully we will have another round of questions. Thank you, Johnny.

Chairman Isakson. Senator Rounds.

Senator Rounds. Thank you, Mr. Chairman, and let me begin by just adding my thoughts with regard to having the privilege of serving with you, Mr. Chairman. I think the Ranking Member, Mr. Tester, has done a very nice job of indicating how strongly we feel about your service to our country and your service within the United States Senate, and as Chairman of this Committee, and the work that you have done for veterans. And we have been honored to be a part of this process with you.

It would seem to me that there is a concept here that perhaps the VA, this Committee has tried to put together, with regard to the issue of disability and the issue of whether or not there is a connection between service-related injuries, disabilities, and so forth, and a simplified process of taking care of those veterans. I

can't count the number of times that I have stood in front of groups and said "thank you for your service," or the number of times that we have said we want to make sure that everything which you are entitled to, as a member, or as a former member, that you receive.

And yet when we get down to the paperwork of it, the legalese of it, it seems like we continue to find these reasons why we cannot get it done on a timely basis, and in some cases, there are reasons why we do not get it done at all, whether it be making payments for emergency room visits to veterans, which clearly should have been taken care of, and it all comes back down to money, and it comes back down to where the money is going to go, inside the VA or outside the VA.

Right now we are talking about what the DoD does and what the VA does, and are they consistent and are they focused on with a culture of finding a way to take care of an injured veteran long-term.

It starts with whether or not--and this may seem unusual, but we put men and women in harm's way, and yet we should find a way to take care of their health, if possible, to do everything we can to protect them. That means more than simply issuing the appropriate equipment, whether it be jackets, whether it be the right type of clothing, whether it be the right type of armaments. It

also means protecting them from environmental issues as well, wherever possible.

Dr. Rauch, what alternatives has DoD taken to reduce the likelihood of servicemembers being exposed to toxic materials, and is this integrated into logistical planning or, if not, is there an initiative to do so?

Mr. Rauch. Thank you for the question, Senator. We, in the Department, have initiated an aggressive research agenda to do just that, research and develop technologies for the servicemember in the deployed environment, to sense and characterize the environment and potential exposures that he or she will be subject to, to sense, record, document, and analyze. Now that is a vision. It is a research program to research technologies. We are putting money against it, and we have an initiative to pursue that.

Senator Rounds. Okay. But have we deployed any qualified medical service officers, or have any of them been assigned to pre-deployment or post-deployment planning cells, perhaps with an eye towards citing infrastructure, to reduce exposure to toxic elements? It seems to me that we have known about these issues for more than 20 years now, and it would seem that there would be something in the works besides just the research.

Is any action being taken today to try to--with regard to burn pits, or with regard to exposures to chemicals, to where there are actual medical personnel who have been assigned to any of these facilities or any locations around the world today?

Mr. Rauch. Every deployed force has some organic medical element to support that deployed unit, and that medical element will consist of medical professionals, to include a preventive medicine team.

Senator Rounds. Do they have the ability to make recommendations, to limit exposure to those areas where they feel there is a risk involved?

Mr. Rauch. So the preventive medicine unit or team will make recommendations to the commander on the group, to identify health hazards and recommend mitigation of those health hazards. At the end of the day, the commander on the group is going to make a decision based upon the mission he or she has to do.

Senator Rounds. Thank you.

Thank you, Mr. Chairman. My time has expired.

Chairman Isakson. Thank you, Senator Rounds. Senator Hirono.

Senator Hirono. Thank you, Mr. Chairman. Dr. Hastings, I think I heard you say that most of the veterans who file claims to have coverage for their

medical conditions are decided on an individual basis. On this there is a presumption that applies for their medical condition. Is that correct?

Dr. Hastings. Right.

Senator Hirono. So I want to know, since most of the veterans have to come to you on a case-by-case basis and no presumption, what is the burden of proof on them to show that there is a connection between service and illness?

Dr. Hastings. I would vary by the illness, but I would be very happy to get the information from VBA or arrange for them to give you a briefing.

Senator Hirono. Well, give me an example. What is--because I think that it is quite a high burden for the veteran to show the connection, is it not?

Dr. Hastings. We would want medical records that could be reviewed. In many cases it will talk about their medical condition, and if it does have a relation to an exposure, that will be adjudicated. It is very easy to look at someone who has a back injury and say here is an x-ray. It is harder to look at these things with toxic exposures, but there is literature that we use. We--

Senator Hirono. I am not talking about the existence of a symptom or the injury, but it is the

connection that is a barrier that the veteran faces, isn't it, that it is service-related?

Dr. Hastings. That is one of the things they would need to show that they were near--in the example of airborne hazards, that they were in a certain location that had burn pits.

Senator Hirono. So, yeah, but who--and what the burden of proof is is often very--it is an indicator of what the result will be. So I am very concerned that there is requirement that the veterans produce a whole slew of evidence to support their claim, and that this makes it really hard for them. So I would like to know, this review process I realize all the claims are different, but, you know, what is the average length of time for a veteran to come and ask for a decision regarding their claim and their decision?

Dr. Hastings. I do not know the length of time from VBA. I am very happy to take that back. But I do agree with you. One of the things that is a game-changer, as we talked about, is ILER. It will take some of the burden of proof--

Senator Hirono. What is that?

Dr. Hastings. The Individual Longitudinal Exposure Record.

Senator Hirono. Uh-huh.

Dr. Hastings. This will take some of the burden of proof off the veteran, it will make research easier, it will make VBA and the claims process easier, and it will improve medical care.

Senator Hirono. And so when was this process instituted?

Dr. Hastings. Well, it actually is going to go live 1 October, and we have already had some of the physicians and the researchers look at it already and use it, what we have had. It has been very well accepted. It will be able to match a servicemember with a location, a time and date, and the monitoring that went on there. And as I was saying before, in my testimony, if you can link this to the electronic health record and we can manipulate big data, it will make a huge difference for research claims and care.

Senator Hirono. Is this available for Vietnam veterans, for example, or is it a time frame that goes back not so long?

Dr. Hastings. No. The time frame is really from when we had the computerized records, so it is 2000 forward. But even though it--

Senator Hirono. 2000?

Dr. Hastings. --is going forward, it will help us inform some of our decisions from the past.

Senator Hirono. So my point is that we should do everything we can to enable the veteran to meet his or her burden without making that burden so hard that their claims are routinely denied. And I think there are so many barriers to them, having their claims sustained. So I am glad that you have something in place. I am sorry that it took this long.

Regarding--he already asked about the four new illnesses or conditions connected to Agent Orange, and you said you are still reviewing it. I mean, what is the time frame for the VA to say, okay, that is going to be a presumption for these four new illnesses?

Dr. Hastings. The review of the National Academy report was given to the leadership in mid-summer, and it is with the leadership right now and undergoing the coordination with the other Federal agencies.

Senator Hirono. You are supposed to do it within--this is also supposed to happen within 60 days of the report from the National Academy of Medicine, isn't it?

Dr. Hastings. We do have a directive, which is called 0215, which does describe how we will review the external reports from the National Academy, and we did follow that. If anyone would like a copy of that I can certainly provide it.

Senator Hirono. Well, we know that there are years-

long delays in the VA attending to these situations.

I have a question about PFAs as it relates to the testing that you are doing. So it is a class of chemicals, as you know, used in firefighting, et cetera, very toxic. And my understanding is that the DoD has been testing drinking or ground water on or around hundreds of military sites for PFA contamination.

Dr. Rauch, has the DoD tested the water at military sites in Hawaii for this chemical?

Mr. Rauch. Senator, I know that we have tested numerous military installations. I will get back to you with regard to a specific installation in Hawaii.

Senator Hirono. Okay. And if you did do such testing, of course you will tell me what locations and if any contamination was found, and if there was not any testing on any of the military sites in Hawaii, why not. Okay. Because we have a lot of military sites in Hawaii.

Mr. Rauch. I will provide a detailed answer.

Senator Hirono. Thank you. Thank you, Mr. Chairman.

Chairman Isakson. Senator Boozman.

Senator Boozman. Thank you, Mr. Chairman, and we certainly appreciate you. You are not going anywhere, though, for a while. We need you around here to keep Senator Tester under control.

[Laughter.]

Senator Boozman. That is a big job.

But thank you for holding the hearing, both of you all. This is an area that I believe that everybody on the Committee is working on some project or working in unison. As most of you know, Senator Tester and I sponsored a bill in the last two Congresses to provide a way for veterans who served in Thailand to get benefits and health care. I believe that they would be left behind by the current limitations on the presumption of toxic exposure to Agent Orange. It was an Arkansas veteran, Bill Rhodes, who first brought this policy inequity to my attention. Mr. Rhodes served in Thailand and was exposed to toxic chemicals, and now suffers from an Agent Orange-related illness and cannot get the VA to consider his claim for benefits.

The VA currently limits service-connected benefits to veterans whose duties placed them on or near the perimeters of military bases. The VA says that only those veterans might have been exposed to the harmful effects of toxic chemicals.

The current policy further limits the possibility of exposure to veterans who served in security-related military occupational specialties. This limitation arbitrarily, I believe, disqualifies veterans who may

have otherwise been exposed to toxic chemicals during their service in Thailand by transiting through the perimeter or by the toxin moving through air or water to other parts of the base. With the Thailand Toxic Exposure bill, S. 1381, Senator Tester and I seek to eliminate the barrier for veterans.

For my colleagues on the Committee, most of you probably received letters in the bright orange envelopes like these. Mr. Rhodes and his fellow Thailand veterans and their families have started a letter-writing campaign to make sure that we keep them at the top our minds as we make policy. I appreciate their support. I understand their urgencies and hope that we can fix this soon.

So, Dr. Hastings, within the VA's Post-Deployment Health Services, the environmental health program makes policy recommendations for health outcomes related to military exposure for Agent Orange, among other things. Let me ask you two or three things, you know, altogether, and then you can think about it.

How often do you all look at your current policy to recommend updates, like to those currently limiting benefits for Thailand service? Is there any process to review claims data from claims approved, denied, and pending, to identify trends that may warrant a review of presumption policy?

For example, let's say there were a number of claims from veterans who had served in the interior of a Thailand-based location not covered by the VA's current presumption. If those claims contain medical diagnosis of something like amyloidosis, you know, one of these things that seems to be directly related to Agent Orange, are you aware of a process that would identify that trend and trigger a view policy?

And then, finally, when you recommend policy changes, who in the Department ultimately determines whether to implement your recommendations?

Dr. Hastings. Yes, sir. Thank you very much. I would like to just comment on the Agent Orange locations, if I might. GAO asked for a report to be done by DoD and VA. DoD went to the archives and to the original manifest, et cetera. We do have a new Agent Orange list that we have just received from the DoD and we are looking at it right now. It is with my office and with VBA, and we hope to post that soon.

You asked about looking at current policy and benefits review. We review it every two years. It has been with the National Academy of Medicine reports. So we have 11 reports that they have given us, so we have had a review every two years. My office also looks at trends in between times with the registry. We look at

some of the health outcomes. Recently, we were concerned about cholangiocarcinoma. There have been questions about brain cancers before. So we do look at it in the interim, also.

With regards to claims pending, we do look at those, for example, with the Airborne Hazards Registry. We look at the top 10 items that go in, and I routinely screen those and see if there are any things that we might be missing or that we need to look at further.

Further, we do take our registry, the Airborne Hazards Registry, and if people want to go online and see what the top complaints are, what the issues are, we have datamined that registry and it is available for people to look at. We want to be as open and transparent as possible.

With regards to policy changes, those are submitted to the leadership of VA. They do recognize that my office has the subject matter experts, and if they have further questions they will work with us. But our policies have mainly been in the area of the examines for the veterans and how to document those for the VA, and some care.

Senator Boozman. We appreciate it, appreciate your hard work, and look forward to working with you. But I would be interested in following up, and maybe we can get

together, as to if there are trends that you have identified in regard to, you know, just the military police that worked in the area. It is very restrictive right now. And so this is not asking that we do everybody, but it is asking that those that can build a case, that have a disease directly related to, you know, to Agent Orange, that they are able to prosecute that.

So thank you very much. Thank you, Mr. Chairman.

Chairman Isakson. Thank you, Senator Boozman.

Before we go to Senator Sinema I want to interrupt to make a statement, if I can, for the record, and for all of you that are here. And it is because Senator Manchin is here and he may leave before I get to him, and if he does I wanted him to hear it.

You know, we had a lot of problems at the Veterans Administration with the timeliness of their follow-through on problems. I mean, they were quick to tell us about things they were doing good but they weren't quick to tell us about where they had problems, and we all of a sudden read about them on the front page of the newspaper. And that got a lot of us upset and we started working on ways to get that information out. And I want to commend the VA on how forthright they have been in almost all cases, about bringing the bad news as well as the good news to us in a timely fashion. Because it is

important if we have a problem that we address the problem so it does not happen again.

The reason I bring this up when Senator Manchin is in line to talk, Senator Manchin brought a problem in West Virginia to our attention, as well as the other Senator from West Virginia, which we jumped on when we got it, but when we got it was a lot later than we should have gotten it. And I want to commend the Senators from West Virginia for their bringing it to our attention.

Senator Manchin called me at home. I was almost in bed when he called me. I did not mind to get out of bed for Senator Manchin at all, but it is--at my age, that's tough. And we got to respond to it, and we are responding now, and it is a situation that is going to probably include criminal charges as well as other things. So whatever it is, it is going to take a while, but it has already been too long as far as the people affected by the charge or concern.

So we jumped on that late. We are jumping on it with both feet now and we are going to get to it as quick as we can. I am working with the West Virginia Senators to see to it we do.

At the same time, I made a statement two weeks ago, on the floor of the Senate, about how proud I was of the VA for sending us the good news and the bad news

contemporaneously, so that we were not having problems anymore with people finding out things after the fact. And lo and behold, I got home to Atlanta the same day, and there was a big story about ants on the body of a man who died in the VA's care, at a senior facility in Atlanta. So I just felt like my statement would have been considered wrong to have made it, because it was the same day that was uncovered and happened.

So I wanted to say we got the VA on that as well, and because of the accountability law that we passed in this Committee, people on the--not on the West Virginia case, because that is potential criminal case, but on the Atlanta case, for violations of the care, the standard of care, we have eight people that are gone. And we are going to see that that accountability takes places.

I want to you to know it is not just the good things we talk about, but it is also when we have a problem we jump on it. And the VA is jumping on it now. We are making sure people are held accountable, and I just wanted to make sure that got in before Joe had to leave, or something else. So that is all I have. We are bragging about the good things but we are also bringing the bad things to attention, and we are going after them just as fast as the headlines for the good things.

Now Senator Sinema. Senator, your turn.

Senator Sinema. Well, first, Mr. Chairman, let me thank you for the work of this Committee and for your leadership. You know, as we all know I live in Arizona, and before coming to the Senate I served in Congressional District 9, which is home to the Phoenix VA, where we know many of the previous scandals came to light, unfortunately well after many of the individuals did not receive the care that they deserved and that they needed.

So I want to thank you for your leadership on this Committee and ensuring that we are taking care of our veterans all around the country. Thanks.

And I want to thank our witnesses for being here today. You know, my team of military and veteran case workers support Arizona veterans every day on a range of needs, including support with disability compensation claims. And I can tell you that based on those calls and their work, the issue of presumptive conditions and the frustration with how slow the process can be to recognize presumptive conditions impacts veterans and their families every day.

And while it is important to consider the process, I wanted to remind us about the people who depend on the process to work for them. Mr. Grau is a Vietnam veteran who served in the United States Navy from 1967 to 1971,

and deployed to Vietnam. He came home from Vietnam 50 years ago, and to this day eh still dreams about his experiences in Vietnam. For 40 years after returning home, he did not pursue his VA benefits because he felt that no one wanted to hear about his nightmares and the trauma that he brought back with him from his service in Vietnam.

He now has an 80 percent disability rating, which includes PTSD and Parkinson's disease. He was recently diagnosed with precancerous cells in his prostate and will soon be applying again to recognize service-connected diabetes as a presumptive condition. He began the disability compensation process 10 years ago, and it has taken 10 years, including the help of my office, for VA to recognize his service-connected disabilities. And his work continues as VA adds additional presumptive conditions to recognize his already obvious illnesses.

As new presumptive conditions arise, he goes through the formal process of telling VA what he has known for years, that many of his health problems are connected to his service and that the country owes him care and compensation for those injuries and illnesses.

So in sharing this story, Mr. Grau told my staff that he was willing to risk his life for this country, but he did not realize he would also have to fight for

his right to treatment, and he said with the U.S. called upon him and his compatriots to serve, they stepped up without pause. They did not wait 10 years to serve, but he is still waiting for much of his benefits and care.

The men and women who served and continue to serve this country do so with an understanding that we will take care of them in return, and we cannot forget all that they and their families have given in service to our country. So our priority must be about fulfilling our promise to care for them.

So for Doctors Rauch and Hastings, throughout our military history, the U.S. servicemembers have been exposed to chemicals and hazards that have had a negative impact on their health, and they have faced unreasonable obstacles in receiving care for the injuries and illnesses that have resulted from those exposures.

While I understand the need for research to inform the process, one cannot cast aside the suffering that servicemembers and veterans who are waiting for the U.S. Government to fulfill its promise to care for those who have borne the battle.

So what lessons have been learned in navigating Agent Orange and other exposures to inform the process moving forward for current and future generations of our servicemembers and veterans?

Dr. Hastings. Thank you very much. I agree with you that many things have taken too long, and ILER--I go back to the Individual Longitudinal Exposure Record--is one of the lessons learned. We need to be able to match a person with a location, a time, and the exposure.

We have also learned, from the Agent Orange experience, that we need to constantly, during conflict, look at what are those exposures people may have and start studying them right away, and we have done that with airborne hazards. We appreciate the support that this Committee has given us with the Airborne Hazards Open Burn Pit Center of Excellence, that will be able to look at research much more quickly. The electronic health record will make a huge difference because of the transmission of data between the two groups, but we do have the ability to transfer now. This will make it more seamless.

One of the things we need to get good with, in the VA and in my office, in particular, is the manipulation of big data, so we can look at the groups, whether they be a small group, like the Sulphur fires at Al-Mishraq, or a much larger issue like the burn pits. We have learned a lot with the Vietnam experience. We are carrying it over into the burn pits experience.

Mr. Rauch. I will just add to Dr. Hastings'

comment. I agree with you also. We have a duty in the Department of Defense, when we put servicemembers in harm's way, and we do, in some pretty tough environments, we have an obligation to take care of them. We have an obligation to protect them. And we have an obligation to sponsor research and technologies to put into our force that deploys to be able to protect them, and at least capture the environment and the exposures that they are deployed into, for a matter of record, and for a matter of care.

Senator Sinema. In 2008, the National Academy of Sciences published a report that reviewed the presumptive disability decision-making process for veterans, and they offered 19 recommendations on the topic, and 12 were specifically addressed to VA and DoD. A number of these recommendations are geared towards developing and executing improved surveillance strategies, exposure monitoring, medical treatment, tracking, all of which would allow for a more proactive monitoring of exposures and health status of veterans.

So how have the DoD and VA effectively addressed the need to keep better record and proactively monitor this data so that servicemembers and veterans who are showing health impacts from these exposures do not have to wait decades for the research to catch up?

Dr. Hastings. Senator, I do have a copy of that book, and I agree with you. It had some excellent points in it. And that was probably the nidus for a number of things in the DoD and the VA, but most notably the Individual Longitudinal Exposure Record. It also made it apparent that we needed to do coordination, so we meet with the deployment health working group every month, and, in fact, I meet with them tomorrow afternoon. And we talk about research, we talk about trends.

Two years ago we were at--actually, two and a half years ago we were talking about the perfluorinated compounds and the importance of studying that, so we have been working with EPA since that time.

But I absolutely agree with you. The ability to share the data, the ability to manipulate the data, is going to be critical, and that is going to improve care, research, and the claims process for veterans.

Senator Sinema. Thank you. Mr. Chairman, I have exceeded my time. Thank you.

Chairman Isakson. Thank you. Senator Cassidy.

Senator Cassidy. Thank you. Mr. Rauch, a lot of my questions were set up by Senator Sinema. But if DoD is not collecting the data, nothing the VA does is going to be of scientific worth. It will be presumptions, and presumptions are based upon assumptions, and assumptions

can be manipulated.

So can you go into detail how, if somebody is in Iraq, and I saw a picture in the New York Times once of them around something which was clearly chemical weapons, and they were not known to be there but they found them. How would you then document something which was not a planned exposure, like a burn pit, but rather an incidental exposure, and how would that be filed in a way in which subsequent investigators would be able to use the information?

Mr. Rauch. Thank you for the question, Senator. The documentation really begins with the assessment, occupational health, and environmental assessment that is really done by the preventive medicine units that are deployed with--

Senator Cassidy. So I am thinking of a forward--I have limited time so I do not mean to interrupt. So am on the front lines. I am ahead of the support personnel in pursuit of an enemy. And we come upon something which could be a toxic exposure. The enlisted man may not know--or woman--may not know that it is, but nonetheless it is. And later on it is discovered by people coming behind that, indeed it is.

I guess I am not quite sure, in that dynamic situation, how this is being captured.

Mr. Rauch. Well, it is being captured because even in the forward deployed units you still have organic medical preventive medicine detachments with those forward--

Senator Cassidy. I do not mean to be incredulous, but we are going to have an MPH--and I do not mean to be rude, but I truly do find that we are going to have somebody with master's of public health adjoining somebody with--going after bad guys, who are moving forward very quickly. And we can imagine, in that situation, that they would come up on multiple situations which would require an assessment. So you would have to have redundancy in terms of your ability to track and trace, if you will.

Because that does not seem logistically feasible to me, but is that the current plan?

Mr. Rauch. Well, our ability to capture exposure information to far forward forces is really dependent upon our preventive medicine units that are in support of those far forward forces, and they move right along with those far forward forces.

Senator Cassidy. I do not see--in all fairness, I do not see how, in the battle zone, that is going to be practical, because you would have to have a fair number of folks, presuming that the squad may end up being

dispersed--I keep on think of what if in Fallujah, in Fallujah a firefight every street, with snipers all around, but you stumble upon chemical weapons. And again, I do not mean to challenge you. I know this sounds rude, and I apologize for that. But I do find this--I am not quite sure how it works.

And I think Dr. Hastings just gave you a note, so Dr. Hastings, if you have something, again, I am just trying to understand this.

Dr. Hastings. Like passing notes in school, it is bad.

Senator Cassidy. No, no, no. I am okay with that, because I just want answers.

Dr. Hastings. Absolutely. Some of it is done after the fact, and I have two examples, if I might. One is Qarmat Ali, the water treatment plant outside Basra, that had the hexavalent chromium, and if anyone remembers that was the chemical in the Erin Brockovich movie. There were about 800 servicemembers that were exposed to that. It was noted during the time that they were there. We have their names. We are following up with them with letters and chest x-rays.

Senator Cassidy. So let me ask you, when the soldier is on the battlefield, is their GPS location tracked so that if, at a later point, you can see that

there was exposure to something, such as that?

Dr. Hastings. They do track the location of the units.

Senator Cassidy. And of the--and would you be confident that the members of the unit would stay sufficiently together that if the unit were in a location, all would be in that location?

Dr. Hastings. Some individuals may leave, and this is speaking from my time in the military, when I was deployed to Iraq. And so some of it would be self-reporting. But we also have a chemical weapons agents. There were some servicemembers exposed to chemical weapons agents. We looked at their medical records, and, in fact, Dr. Helmer has put a note in all of their medical records in the VA, so that we can track them. And this was a combination between the DoD and the VA.

Senator Cassidy. One more thing, because I am out of time. That would go to location but not to intensity of exposure. Correct?

Dr. Hastings. The intensity of exposure was examined not only were they seen at the time of the occurrence but they were looked at later at Walter Reed Army Medical Center, actually, Walter Reed National Military Medical Center now, and did get a screening exam, an exam which was transmitted to the VA, and we are

now caring for those individuals.

Senator Cassidy. No. I mean, there can be a threshold effect of exposure. A little bit of sunlight is not bad, but too much sunlight gives you melanoma. And so--but I am over time and I will stop there. Thank you very much.

Chairman Isakson. Senator Manchin.

Senator Manchin. Thank you, Mr. Chairman, and I am going to follow up on what you had mentioned. I want to thank you and Senator Tester for being so attentive to a horrible situation, and I can report what I know, that has been publicly made, and I think you all know a little bit about it, in Clarksburg, West Virginia. We know that we had at least two of our veterans who were murdered, and maybe more. It is a horrible, horrible situation.

Let me tell you something that is even more disturbing. The people in charge--the people in charge at that VA hospital--and the VA hospital has had a good record of doing great jobs and doing good work--they did not know--did not know, and this is the head doctor in charge, and the head of nursing--so they didn't know, but the inspector general was able to find, in an investigation that was done very quickly, that almost nine months before they even said they knew, and the inspector general found very shortly that somebody knew

something, and there were some concerns nine months prior to that.

Nothing adds up here. Nothing makes any sense. And we are in a--it is a homicide, and it is going to be horrible when we find out the final. We do not know if it is one person of interest or more. We do not know.

What I also did not know is how the VA controls its medication on the floors, I mean, who has control of that, who has access to it. But then I also did not know this. I did not know that basically insulin--this is hypoglycemia, in all these cases--that insulin can be purchased in any pharmacy, without any prescription, and you can get a syringe to administer it. There are so many fallacies in all of this.

So we are going to need all hands on deck. Our veterans deserve better than this, and to have this horrible, horrible atrocity on these veterans is something that is unexplainable. And you can imagine the fear that we have. Operations are being cancelled. They are afraid of getting services, and things on and on and on.

So hopefully--and I want to thank you again, both of you, for being attentive to this, and we need to get to the bottom as quick as possible. The inspector general--it has been over a year now, this has been under

investigation--I mean, the northern prosecuting attorney, U.S. attorney is on top of this, and I have all the confidence in him, because his father is a veteran and also uses the hospitals and clinics.

So I just want you all to be aware, and I hope you are looking through all your operations, all the operations, throughout the hospitals and clinics throughout this country.

But on another note here, I know we were talking. I know Senator Cassidy was talking about, and I am, about the veterans who served in Iraq and Afghanistan after 9/11. They were exposed to large-scale use of open-air pits to dispose of waste during combat operations. The burn pits exposed our servicemembers to toxic chemicals, like benzene, arsenic, Freon, sulfuric acid, which have had all sorts of impact on otherwise healthy veterans. That is why many are calling burn pits this generation's Agent Orange.

So that is why I am working on a bill with Senator Sullivan to provide presumption of exposure, not presumption of benefits, for veterans who served in area with burn pits. Our bill would make it easier for veterans to prove their exposure to toxic burn pits.

My question would be, we cannot take as long on burn pits as we did on Agent Orange to take care of our

veterans. What are the VA and DoD doing in accelerating research into the health impacts of these chemicals?

Dr. Hastings. Sir, I will go ahead and start, and them I am sure that Dr. Rauch would probably have something to add.

We work with the DoD very closely on research. We also work with our academic institutions. We have Airborne Hazard Symposium that takes place each year. DoD ran it last year and we will be running it this year. We do invite the VSOs to that. We have over 50 research projects right now with the DoD in regard to the toxic substances. We have SME exchanges. We do conferences together. We publish our information in the peer-reviewed journals. And this is not only beneficial to the veterans and the active duty servicemembers but also to the civilian community that are also affected by toxic hazards at other--

Senator Manchin. Let me just, if I may, interrupt real quick.

Dr. Hastings. Certainly.

Senator Manchin. You know, we know about Agent Orange. We did not know until well after, many, many years after the exposure that Agent Orange even, not a direct but incidental exposure. So we know what effects it is having now. The burn pits we know because it has

been reported and all the different types of toxic material that is being disposed of.

Are we looking at other ways our servicemembers are being exposed to toxic chemicals that could have an effect? Are we doing that in a proactive way or are we just waiting until we have these devastating effects to their health?

Dr. Hastings. We are looking very proactively. We learned a lot from Agent Orange. That is the unfortunate reality. We are looking at burn pits proactively. We are actually looking at the health effects right now with the National Academy. They are doing a report that we will have next October. We know that intergenerational effects are of concern to veterans also, and we just had an intergenerational effects report that came to us from the National Academy.

We want the answers to come more quickly. We are datamining the registry. We are actively pursuing the electronic health record and the Individual Longitudinal Exposure Record, because that really will make a difference with looking at exposures, and even in some of the very small exposures.

Dr. Helmer. Could I just add to that?

Senator Manchin. Please.

Dr. Helmer. So I was the Director at the War-

Related Illness and Injury Study Center and I would like to just say that the Burn Pit Center of Excellence that is based there is really doing exactly what Dr. Hastings said. We are taking advantage of some of the data that have already been gathered, and ILER is going to make that even better.

But as of right now we have 185,000 veterans and servicemembers who have participated in the Burn Pit Registry, and because it is the modern registry where the data are online, it is pretty instantaneous that we get access to the information, from the veteran themselves, and then we can link it to the electronic medical record and actually do this cross-batch through the big data activities, to see what is going on.

So we generate reports on a quarterly basis and more often.

Senator Manchin. I know about the reports. I am asking, are we being proactive in looking at other exposure, exposures that our servicemembers might have that we do not--we are not even looking at at this point in time? We have only seen, you know, post, if you will, what happened with Agent Orange, now what happens with burn pits. It there something else besides Agent Orange and burn pits we should be looking at, that we are exposing our servicemembers to?

Dr. Helmer. On the VA side, certainly as a clinician I get that information, and as the War-Related Illness and Injury Study Center, people are referred to us, we take that information and we share it with our colleagues in Central Office, and it is shared with the DoD through the Defense Health Working Group. But we are not able to do the assessments in real time, in terms of the exposures.

Chairman Isakson. Thank you, Senator Manchin. Senator Sullivan.

Senator Sullivan. Thank you, Mr. Chairman, and I want to thank Senator Manchin. We have--

Senator Brown. [Off microphone.]

Senator Sullivan. Yeah, I think we go--thank you. So I want to thank Senator Manchin for the work. His questions are going to be similar to mine, because what we are trying to do with our bill is get this right, get this right in terms of how we do it, but we are going to need your help. And there are lessons learned, right, from previous examples of toxic exposure.

I also want to just thank the Chairman here. And, you know, in light of his announcement that he is going to retire at the end of year, I just want to thank him, in this Committee, on the great leadership that he has provided all of us, all of our veterans. A true champion

of our veterans. I think when you see how much impactful legislation this Committee gets done, it is, in large measure, due to the distinguished Senator from Georgia. So I am honored to serve with him. Thank you, Mr. Chairman.

Let me follow up. Again, it's more process. We are always talking process, and I think it is important on legislation. But we have got to remember that there are people at the end of the process chain, and I know you guys all know that.

But let me just ask a couple of questions that are going to help us refine this kind of legislation and work with all of you to get it right. How does DoD assist a servicemember who is deployed at a site with a known burn pit but does not have it in their health records? So that is kind of a big gap, in how can we or the Department of Defense or VA try to address that gap?

Mr. Rauch. Well, thank you, Senator, for the question. At the deployed site, as I explained in some previous remarks, there are preventative medicine assessment teams that do health hazard and occupational health assessments. If a servicemember presents a complaint while they are deployed, to the medical unit, that is documented. It is in their medical record. And then as we explained a little while ago, now that medical

record is going to be linked to ILER, which is a long-term environmental health exposure record.

Senator Sullivan. But if you have a soldier, a Marine who is like, "Well, wait. I was in Bagram. I know there is--and my medical record does not indicate this." Is there a way to fix that?

Mr. Rauch. Certainly. I mean, the servicemember can present to their provider, and the provider can so indicate those symptoms in the servicemember's record, and also the provider, if it is primary care, can refer that servicemember in to occupational health.

Senator Sullivan. Okay. Let me ask Dr. Hastings, according to the VA, from 2007 through 2018, there were 11,500 burn pit claims lodged with the VA. Out of those, over 9,000, or 80 percent, were denied. My staff has been working with your staff on trying to get a little granularity on why the majority of these claims were denied. But can you go into a little bit more detail from your perspective? I know it is individual ones, but that is a pretty high number. And maybe you could submit, for the record, to the Committee here, in a little bit more detail than you have, with a minute left and my questioning on why you think that pretty high majority of claims is denied, at least at this juncture.

Dr. Hastings. Sir, I would be very happy to go ahead and get that information for you on the number of claims that are covered and not covered. If it would not be inappropriate, I would also like to just answer your other question just a little bit--

Senator Sullivan. Sure.

Dr. Hastings. --in regard to--

Senator Sullivan. But do you have an answer to my first question?

Dr. Hastings. Your first question--

Senator Sullivan. Eighty percent--

Dr. Hastings. I do not. I would have to look at what the reasons were. I know that in the top 10 reasons that people put in a burn pit claim, some of them do not seem like they would be related to burn pits--

Senator Sullivan. Okay.

Dr. Hastings. --but I do not have the medical records and review. Some are complaining of irritable bowel syndrome. Some people are complaining of migraines. The sinusitis and the breathing problems, those are pretty easy to connect. Some of the others that would be harder to connect would be things that were not associated with the respiratory system. But I would be very happy to talk to VBA and get that information for you.

Senator Sullivan. Good. That would be helpful. On the other one?

Dr. Hastings. On the other one, everyone goes through a post-deployment health assessment when they come back. I have gone through several of those. I did them for my co-servicemembers as their physician, and I also had someone else do them for me. And we also do have the feed from the Defense Manpower Data Center, so we know where people were.

Now there are times that they would be sent out of area, but for the most part we know where people were. And, frankly, in most cases, we do believe the servicemember or the veteran, and, in fact, I know of stories where there were no records of the person being in Vietnam because they flew from Korea. All we asked for was a picture of them in front of their aircraft at the Osan Air Base. And so in the majority of cases, we do believe the information that is given to us by the veteran.

Senator Sullivan. Great. Thank you. Thank you, Mr. Chairman.

Chairman Isakson. Thanks, Senator Sullivan. Before I do Senator Brown I want to say that while he was a little bit late, there is something we need to take care of. Senator Brown is the reason this hearing is taking

place today. He and Senator Tester and a few others have insisted on us dealing with toxic information, and getting that information for us. So even though he was a little bit late he did not need to apologize for that. He told me yesterday he would be. But he is appropriately here now and I want to introduce him with the appropriate credit for what he did.

Senator Brown. Thank you, Senator Isakson, and thanks to you and Senator Tester for this, and your Staff--Pat, Leslie, Adam, Simon, J.C., and Tony, and my staff, Anne and Drew. This is such an important hearing and I appreciate all of you being here.

Senator Tester and Senator Isakson and I--Senator Moran came a little bit later--we have been on this Committee for 13 years now. I have known Johnny longer, but Jon and I with him for 13 years. And the question is always, "Why isn't the VA taking better care of these awful illnesses and diseases?" The question never seems to be, "Why do we pursue stupid wars in Vietnam and Iraq?" And now I worry, with Iran, and the tough talk and the escalation on both sides, where this leads.

Sitting on this Committee really makes you, I think, understand the cost of war, and what Senator Sinema said about this constituent of hers waking up and still thinking about Vietnam five decades later ought to be a

lesson to our policymakers and President on making some of the decisions they have had on if we go to war with Iran, three big, stupid wars in a row.

Dr. Hastings, on March 26th, not you but VA officials told this Committee that within 90 days the Department would make a decision on expanding the list of Agent Orange presumptive diseases to include bladder cancer, hypothyroidism, Parkinson's-like symptoms, and hypertension. March 26th--April, May--June 26th was the 90 days. Now it has been 183 days. You just told the Committee the decision is within leadership. It might be a commentary on your leadership. But when is this going to be made?

Dr. Hastings. It is in leadership and it is in coordination with other Federal agencies. So I am as hopeful for a decision soon as you are.

Senator Brown. Can you do anything about more than hope? Can you accelerate this? I mean, it has been twice the 90 days that your superiors came in here and promised. I assume they are your superiors.

Dr. Hastings. Pretty much everybody is my superior.

Senator Brown. I do not think so, but--

Dr. Hastings. I can absolutely find out where it is in the process with the external coordination, and I would be very happy to get that information and give you

that brief.

Senator Brown. Okay. I mean, every day we wait on presumptive eligibility is more people fighting with the VA, more of your resources, processing these, with less certitude, and probably more men and women dying from one of these illnesses.

A shift to burn pits. Since forces deployed to Afghanistan and Iraq, DoD has known that burn pits, similar to Dow Chemical and probably DoD knowing about Agent Orange, DoD has known that burn pits released toxic blooms into the air. There are memos, one dating back to 2006, near the beginning of the Iraq war or soon after, containing phrases like "an acute health hazard for individuals," another phrase, "possibility for chronic health hazards associated with smoke," another, "the known carcinogens and respiratory sensitizers released from the atmosphere present both an acute and a chronic health hazard to our troops and our local population."

But the burn pits continued, the size of football fields, is my understanding. Air quality testing in Bagram airfield found that air samples were considered, quote, "unhealthy by EPA standards."

So Dr. Rauch, walk me through the Department's thinking here. If we have weekly air sample data from burn pits that routinely show particulate matter

exceeding EPA health standards, DoD shared that raw data with VA or outside experts to build a comprehensive picture of what our servicemembers, civilians, contractors in the local populations were exposed to. So walk me through this. What is the problem?

Mr. Rauch. Well, the Department's position is in response, really, to, I believe it was on the House side that requested a report from the Department, which is due February, on alternatives to burn pit--technology alternatives to burn pits in the deployed environment.

So that report is still ongoing, in terms of the analysis and the proposed solutions, but the Department is moving away from open burn pits--

Senator Brown. As they should have. But let me boil it down. So DoD shared that information with VA years and years ago. Correct?

Mr. Rauch. Well, I--we share information with the VA all the time. I can't say it was years and years ago.

Senator Brown. okay. I would really like to know some of those comments made, that I quoted, and other data from DoD, I would like to know when, in fact, that was shared with the VA, first point, and if you would get that to us--

Mr. Rauch. I will.

Senator Brown. --at some point. You know, I would

like to know what local population were exposed to. That is really important. We go into these war zones. We leave behind lots of things, some toxic, sometimes a better life for people. But sometimes--you get it.

And last, Dr. Hastings, has VA established a presumption of eligibility of service connection and list of diseases associated with exposure? Senator Manchin asked about, you know, it took us a long time but we learned something from Agent Orange. We were too slow. Elected officials were too slow. VA, we were all too slow. DoD knew more than they told us, all those things.

But we know that burn pits--exposure to burn pits is a very serious thing, resulting in illness and sometimes death. So are we going to do a presumption of service connection and list diseases on burn pits? If we are, when, and why not yet?

Dr. Hastings. I do not know if we will be required to do a presumption for burn pits. We are getting a lot more information--

Senator Brown. What do you mean, required?

Dr. Hastings. I do not know if a presumption will be necessary. We may be able to do it on an individual basis. If we do have a presumption that comes out, I believe we would look at it after the National Academy

Report that we will get in October of next year.

I would like to ask my colleague, Dr. Helmer, who was previously at the War-Related Illness and Injury Study Center at the Airborne Hazard and Open Burn Pit Center of Excellence if he has any comments in regard to that.

Dr. Helmer. So I think you are seeing a real flourishing of information and scientific, high-quality research that is coming out about what might be associated with, let's start with the unexplained shortness of breath and decreased exercise tolerance that many of our veterans have reported since their deployment to Iraq or Afghanistan.

I think at this point there are multiple potential causes, the burn pit smoke being one of them. The ambient air quality was actually highlighted by the National Academy's report in 2011 as maybe the most likely source of the problem for those servicemembers. And our own work, more recently, has actually highlighted the possibility of blast over pressure as being a contributing factor, at least in some individuals experiencing shortness of breath.

So I think there is a lot of good science that is being done, and we are getting a better understanding of what the causal factors might be. And so I would just--

you know, if--were a presumption is determined, perhaps, we should understand a little better about why.

Senator Brown. Thank you. I see that. My time is way over, but I want to make three real quick comments.

First of all, there seems to be a lack of urgency in all of this, as people get sick and die, in far too many cases, and every time we wait to add names to the presumption, to the list, to the Agent Orange presumptive eligibility list, every time we talk about this with burn pits, another day goes by in people's lives. That is one point.

Dr. Hastings, you used the word "requirement." Well, there is no requirement. Congress should pass a requirement, but you can move on a requirement of beginning to compile which diseases should, in fact, be on this list.

And third, that you made a statement--and you do not need to respond now. It is just that I am over time--but you made a statement that the VA--that we do not know if we need presumptive eligibility, that we can handle each one--and that is the whole point. If we handle each one it just slows everything down. That is what we tried to do with Agent Orange for, I don't know, two decades, or whatever, until Congress and the VA and the public and the DAV and the VFW and the American Legion and Polish

American Vets had all figured this out, that we need presumptive eligibility.

So those are just my three assertions that I hope you take into account. Thank you, Mr. Chairman.

Chairman Isakson. Thank you, Senator Brown. Senator Moran.

Senator Moran. Mr. Chairman, thank you. It is a pleasing thing to me that it is not Senator Tester who is departing the Committee but you, because I could not find anything nice to say about Senator Tester.

[Laughter.]

Senator Moran. But if you say that, I will believe it. But I would take this moment to thank you for your leadership on this Committee and your love, care, and compassion for the United States Senate, for the citizens of Georgia, and, most particularly in this instance, for the veterans of America.

I have been in a number of settings where you have received accolades and toasts and cheers on back, pats on the back and cheers, a lot about who you are as a person, a man who was interested in bipartisanship, a person who cares about this institution for its well-being and the well-being of America, your willingness to, in addition to working across the aisle, trying to find right answers and treating people with respect. Those are things that

ought to be able to be said about every person in public life, and, unfortunately, it is more rare than it should be.

So for you and the way you treat people and the role model that you provide for those of us who serve in public service, I thank you for that. I cannot imagine that one would want to be known more than being a good person, but I would add to that there is not a veteran in this country who has not benefitted by what you have done on their behalf. And I commend you for that and I respect you for that. And should Senator Tester retire or be defeated, I will work on something to say about him as well.

I appreciate you having this hearing and the leadership that many around the table have led on toxic exposure. My particular interest was piqued in 2014, when I attended a conference in Wichita, Kansas, hosted by the Vietnam Veterans of American, on toxic exposure. And I visited with veterans who certainly experienced the consequences of that exposure themselves.

But what captured my attention even more than that was the realization, the belief, the recognition that there are those who are the children and grandchildren of those veterans who, it is believed, are experiencing consequences from their mother, father, their

grandparents' exposure to toxic substances. And we set out to try to do something to find out what the nature of the relationship is between toxic exposure for a veteran, for a military man or woman, and those who follow them, their children and grandchildren.

And my guess is that most every service man or woman recognizes that they are creating risks for themselves, but what a tremendous burden it must be to recognize that something you did, in service to your country, has a consequence to those in your family who are yet to be born.

And so I will save my questions for the second panel. I am interested in the scientific nature of the study that has been completed.

Senator Blumenthal and I teamed up on this issue. We introduced legislation that would require a scientific study, review and assessment conducted by the National Academy of Sciences, regarding the toxicological and epidemiological research on descendants of individuals with toxic exposure. And I am interested in hearing more about what the results from the National Academy of Sciences is, so that we can set the stage to care for those who, through no actions of their own, now may be suffering from the actions of the patriotic service of their parents and grandparents.

And Senator Tester and I, we teamed up to try to get legislation passed, which we were successful, that declassifies records of veterans exposed to toxins, so they can better pursue their claims. One of the things we learned, I learned in those conversations with those veterans that day in Wichita was that we cannot often prove our case to the Department of Veterans Affairs because of the places that we served, the circumstances we served under, the records simply are not available.

And so that bill is part of NDAA, which a year or so ago became law, and I needed to follow up and make certain that there is a consequence to the law changing and that veterans have greater access to those records.

And I would suggest to this panel that we are spending a lot of money on information services. The DoD, in my view, ought to be able to collect--it is a bit of what Senator Sullivan was talking about--ought to be able to collect information when that military man or woman returns and enters into the care of the VA. That is the moment--as you tell your personal history and your medical history, that is the point at which that service man and woman ought to be able to tell their story.

But I also would say that with the new electronic health records that we have underway, that could be the place to capture the exposure information and track

conditions, not only of that military man or woman, and soon to be veteran, but also their family members as well.

And so I would recommend to the VA, if you are not specifically looking electronic medical records, that ought to be an awfully good place to start as we presumably are on a path that puts the Department of Defense and the Department of Veterans Affairs in the same system.

Mr. Chairman, thank you for the opportunity to make those remarks, and I will save my questions for Panel 2.

Chairman Isakson. Thank you, Senator Moran. Senator Blumenthal.

Senator Blumenthal. Thank you, Mr. Chairman. I want to thank both you and the Ranking member for holding this year. I apologize that I was at other hearings and so missed the first panel, but I just want to--I am sorry--I missed the beginning of the testimony from the first panel.

But I want to really second, as strongly as possible, the point made by Senator Tester, that the VA seems to be needless staying and delaying the Blue Water Navy veteran Vietnam claims. The date is now January 1, 2020. The VA had been issuing claims decision since April of 2019.

I do not need to go over the history of the Blue Water Navy veterans, but I am proud of the work that we have done, on a bipartisan basis, over the past several years, to pass the Blue Water Navy Act. And I am deeply disappointed--in fact, I am angry, like a number of my colleagues, that the VA chose to stay all these claims until the last possible minute, rather than work to grant them as soon as possible.

So I hope that the VA can address this issue and move forward without hiding behind the lawyers. I have nothing against lawyers. I am one myself. But the VA has no excuse for failing to move forward on these claims.

I am also concerned, and I have been very proud to team with my colleague, Senator Moran, on the issue of burn pits and airborne hazards and other toxics and poisons on the battlefield. Many of us have a personal stake in this issue, having family members who have served there. I am concerned that the DoD continues to use open burn pits when we know there are serious medical consequences for our troops. We have got millions of servicemembers deployed to areas in which the DoD's own tests show the air is not safe to breathe, and we are, in effect, repeating mistakes that we made in the past, with our Agent Orange veterans.

I know Senator Sullivan asked you, Dr. Rauch, about this topic, but can you specify what DoD reporting requirements are for exposure to burn pits? Does the DoD keep records of detailed information, that would allow the VA and veterans to establish a claim for disability?

Mr. Rauch. Thank you, Senator, for the question. First of all, the Department's position is to move away from burn pits and replace them with alternative technologies. The documentation of ambient air quality surrounding burn pits and the deployed environment is collected by area air monitoring, which is done daily by the preventive medicine that is organic to the unit attached to that area. So the ambient air quality is assessed 24/7, as well as other environmental hazards in that area.

Senator Blumenthal. So a veteran could establish the connection between the disability and that service connection?

Mr. Rauch. Well, the veteran--so I am talking about air monitoring in an area, so now we are talking about individual in that area, and once again, determining what the rate or degree of exposure is, is difficult. I can just tell you that the Department is not there on--

Could the DoD establish better measures?

Mr. Rauch. Absolutely. Absolutely.

Senator Blumenthal. Do you think that it will?

Mr. Rauch. We will. We have a research effort to develop technologies--it is probably going to be wearable--for the individual, that would characterize and capture the exposures at a point in time to that individual servicemember. This is research, so it is not going to happen tomorrow, but it is an active research effort that we are spending money on.

Senator Blumenthal. Dr. Hastings, can you explain why the VA has stayed every single claim under the Blue Water Navy Act?

Dr. Hastings. I know that the VBA is getting ready for January, but I cannot tell you why there is a stay.

Senator Blumenthal. You cannot tell us why?

Dr. Hastings. I do not know.

Senator Blumenthal. Well, I would like to ask you to respond in writing.

Dr. Hastings. I absolutely will, sir.

Senator Blumenthal. Thank you. My time has expired. Thank you, Mr. Chairman.

Chairman Isakson. Thank you. Senator Tillis.

Senator Tillis. Thank you, Mr. Chairman. I want to associate myself with the comments made by Senator Moran about you and your role model behavior. I will only take one exception to something that Senator Moran said.

Senator Tester, I like your hair.

[Laughter.]

Senator Tillis. That is a place to build on.

Thank you all for being here. I wanted to go back. It was not a question I had intended to ask but I think it is very important, since we have the DoD and the VA represented here. One thing that I am very interested in, and excited about, is having more compatible electronic health records going forward.

Dr. Rauch, as we move forward and we collect more information, I think we need to understand the situation that we find ourselves in sometimes when burn pits are used today. These are very dangerous situations where they are trying to do the best to get out of a dangerous situation. It is clearly not a preferred technique, and I know we are looking for other ones. So while we still have these practices in place, we have to capture more information, have more insight into how individual were exposed.

I am particularly interested in making sure that once we capture that data it becomes a part of the lifetime record for that soldier when they move into veteran status, so that, over time, we may be able to predict a risk before any symptoms manifest themselves. So that is the idea future state of fully interactive,

integrated electronic health records, and I think the research that you say that you are working on may be an indicator that we need to make sure ultimately finds itself into the man or woman who is serving at the time of exposure.

Ms. Hastings, I had a question for you on the family member program, specifically around some of the toxic substances that you may know that we worked a fair amount on the toxic substances issue down at Camp Lejeune. And I believe the number is right, that we have about 300 family members who may have been exposed to toxic substances that seem to be linked in utero, but they are having a difficult time getting care.

So what do we need to do, if it is not within the VA's authorities, to step up that family member care? What should we be looking at, as a matter of policies that we should consider for congressional action?

Dr. Hastings. Sir, I am very active in the Camp Lejeune Community Assistance panel meetings, and, in fact, they had one here in D.C. the 13th and 14th, and I did attend that. They are run by the Agency for Toxic Substance Diseases Registry. If there was a child in utero, and had a specified relationship with the veteran on Camp Lejeune--

Senator Tillis. In the time period in question?

Dr. Hastings. --in the time period in question, they are covered for those 15 covered conditions. And the community program, the Community Care Program, run out of Denver, I routinely talk with them if there are problems. Whether they are financial or medical review, we help them with them. If you have a specific case, I am very happy to take that forward to the Community Care group, because I do also get individual requests from people. I had one yesterday. And I am very welling to run the traps and help people.

Senator Tillis. And it may very well be that once they go through the traps they are in a good place. Some of it seems to be getting them to the point to where I guess they present a sufficient case. We will go back--I do not do casework in committee hearings, but we will go back to any specific cases. But the main thing, much the same way that we went through with some of the presumptions, you know, we got to, I think, a much better place in terms of the presumptions a couple of years ago. But it sort of giving them the benefit of the doubt, if a significant part of the information that they present looks like they should be qualified for support. So we will deal with that outside of the Committee.

The other question that I did have for you, though, was this idea--and I saw this when we were going through

the Camp Lejeune discussion, about some of the additional presumptions. Do you think that there is a value in us having, as more information is available, more scientific data is available, that we have more frequent review of presumptions and update these? It took a lot of time and effort for us to get where we ultimately got, under the Ensminger Act and some of the other VA decisions. But what more could we do to just make this a recurring, iterative process, not episodic?

Dr. Hastings. I just agreed, at this last Community Assistance panel meeting, to talk with the Agency for Toxic Substance Disease Registry and have another meeting to review the new scientific literature. I did review much of the research that they have just completed. I have my epidemiologists working on that right now.

Senator Tillis. Thank you very much. Thank you, Mr. Chair.

Chairman Isakson. Thank you, Senator. Before I introduce Panel 2 I want to turn the gavel over to Senator Tester, who has agreed to finish the balance of the hearing, which I appreciate very much. I have a previous commitment that I have to finish with.

I want to say, though, that this is the best participation for any meeting we have had. Almost every member of the Committee, at one time or another, was in

asking questions, and our panel did an excellent job and I want to thank both of you for your time.

I will ask Panel 2 to move forward and Panel 1 may move out.

Senator Tester. Can I just say one thing?

Chairman Isakson. Before that, Senator Tester has a comment.

Senator Tester. I appreciate you guys' testimony and I really appreciate your work, when you talk about the studies that you are doing. But ultimately, decisions have to be made.

I think Senator Brown touched on this. I often think that there is an adversarial relationship between the VA and the veterans, and I don't think that is you guys' intent. But the truth is we have got folks out there that are dying, that were put in positions that they got them that way.

I am a farmer. I could get hit by a tractor and get killed any time. That is my choice. These folks were put in positions--and you folks; you are probably all military, right, at one time or another--were put in positions that you had no control over. We have an obligation to deal with these folks in a timely manner.

You do good work. We need to make sure that your work results in decisions, not just reports. And I just

want to thank you for being here today.

Dr. Hastings. Thank you, sir.

Dr. Helmer. Thank you.

Chairman Isakson. Panel Number 2, please come forward.

[Pause.]

Senator Tester. [Presiding.] First of all, I want to welcome the second panel. This is going to be a very, very brief introduction, and forgive me for that. You all deserve a longer one.

But I want to first introduce Dr. David Butler, Director of the Office of Military and Veterans Health, the National Academies of Sciences, Engineering, and Medicine. Thank you for being here, David. We have got Mr. Shane L. Liermann, who is familiar to all of us. He is DAV Deputy National Legislative Director for Benefits. Thank you for being here, Shane. And we have Dr. Robert Miller, from Vanderbilt University Medical Center. We appreciate you making the trek up, Robert. Thank you.

We will let you start, Dr. Butler. You have got five minutes, and the remainder of your testimony will be put in the record.

STATEMENT OF DAVID BUTLER, PHD, DIRECTOR, OFFICE OF MILITARY AND VETERANS HEALTH, THE NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE

Mr. Butler. Thank you, Ranking Member Tester, and members of the Committee, for the opportunity to testify today. As you mentioned, my name is Dr. David Butler. I serve as a Scholar in the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine, and director of its Office of Military and Veterans Health.

The National Academies have a long history of advising the Federal Government on the health effects of military service in general, and on the effects of in-theater exposures resulting from military activities, in particular. We have also, when requested, offered perspectives on the decision-making processes used by the Department of Veterans Affairs in their determination of whether a particular health problem in a veteran may be associated with their military service.

The most recent report addressing this issue as it relates to toxic exposures is entitled "Improving the Presumptive Disability Decision-Making Process for Veterans," and that was released in 2008. The study committee formed to research and write that report was charged with describing the process for how presumptive

decisions are made for veterans who have health conditions arising from military service and proposing a scientific framework for making such presumptive decisions in the future.

To address its charge, the study committee conducted a thorough review of relative research and met with a full range of involved stakeholders, including Congress, the VA, veteran service organizations, and individual veterans. It attempted to capture how VA's presumptive disability determination approach works and completed a set of case studies to identify lessons learned that would be useful in proposing new approaches.

The study committee also considered how information obtain on the health of veterans and how exposures during military service can be linked to health consequences via scientific investigation. Substantial attention was paid to how information can best be synthesized to determine if a particular exposure is associated with a risk to health.

This assessment led the study committee to recommend an approach to assure that the presumptive disability decision-making process is based on the best possible scientific evidence.

That approach comprised the following components: an open process for nominating exposures and health

conditions for review, involving all stakeholders in the process; a revised process for evaluating scientific information on whether a given exposure causes a health condition in veterans, including a revised set of categories to assess the strength of evidence for an association, and estimate the number of exposed veterans whose health condition might be attributed to their military exposure; a consistent and transparent presumptive disability determination process by the VA, a system for tracking exposures of military personnel and for monitoring the health conditions of all military personnel while in service and after separation; and an organizational structure to support this process.

To support the implementation of the study's recommendations, it suggested the creation of two panels. One was an advisory committee to the VA that would assemble, consider, and give priority to exposures and health conditions proposed for possible presumptive evaluation. Nominations for presumptions could come from veterans or other stakeholders, as well as from health tracking, surveillance, and research.

The second panel was a scientific review board, an independent body that would evaluate the strength of evidence that links a health condition to a military exposure, and then estimates the fraction of exposed

veterans whose health condition could be attributed to their military exposure. The scientific review board's reports and recommendations would then go to VA for its consideration.

The VA would use explicit criteria to render a decision with regard to whether a presumption would be established. In addition, the scientific review board would monitor information on the health of veterans as it accumulates, over time, in DoD and VA tracking systems, and nominate new exposures for health conditions for evaluation, as appropriate.

The report suggested that this framework be considered as a model to guide the evolution of the current process. It observed that the ability to implement changes would be improved by the provision of appropriate resources for all the participants in the presumptive disability decision-making process.

The study committee recognized that action by Congress would be needed to implement all of the components of its proposed approach, but noted that some changes could be carried out without legislative action. They concluded that veterans deserve to have an improved system where decisions about disability compensation and related benefits are based on the best possible documentation and evidence.

Thank you.

[The prepared statement of Mr. Butler follows:]

Senator Tester. Thank you. Shane?

STATEMENT OF SHANE L. LIERMANN, DAV DEPUTY NATIONAL LEGISLATIVE DIRECTOR FOR BENEFITS

Mr. Liermann. Ranking Member Tester, members of the Committee, thank you for inviting DAV to testify at today's hearing on toxic exposures and the presumptive decision-making process.

At the outset, I want to thank Mr. Bobby Daniels, a Blue Water Navy veteran, and Mrs. Claudia Holt, wife of Frank Holt, a Blue Water Navy veteran who passed away this May. They proudly stood with us and others yesterday, in front of the Capitol, to call on the President to lift the stay and put an end to their wait.

Bobby Daniels, who is with us today, has terminal prostate cancer. He is fearful and angry that his wife of 56 years, Judy, may not receive survivor benefits after he is gone. Claudia Holt, who has applied for survivor benefits, is worried about how she will pay her bills and whether or not she will lose her home. But because of the blanket stay, both of them are forced to continue waiting.

And that is why today's hearing on the future of presumptive decision-making process is so important, so we can prevent these types of injustices from ever happening again.

You have my full written testimony, but in my oral

remarks I will highlight three of our key recommendations. First, we recommend to statutorily require future studies on all toxic exposures. Not all of the established presumptive processes have requirements for future studies for reviewing and potentially adding new diseases to each presumptive disease list. Only Persian Gulf water illnesses and Agent Orange exposures have required continued studies. Therefore, in order to ensure we utilize all scientific analysis and research for toxic exposures, we recommend that any new presumptive process have a requirement for new studies every two years.

Second, we recommend to add time requirements for decisions and actions by the Secretary. The statutory provisions for Agent Orange and Persian Gulf illnesses that require timely decisions and actions by the Secretary, on the recommendations from the National Academies, have expired.

The lack of statutory mandate unfortunately has resulted in no action by the VA, on the National Academies recommendations on three presumptive diseases from 2016--bladder cancer, hypothyroidism, and Parkinson's-like syndromes, as well as one from 2018, hypertension. All of these diseases are associated with Agent Orange exposure, and in our view all four should be

added.

Veterans with terminal diseases such as bladder cancer do not have the time to wait for the Secretary to decide. Regardless of whether the Secretary decides to add the diseases or not, veterans deserve timely action.

Third, we recommend to establish a concession of exposure for burn pits. The common denominator for all presumptive processes is something called the concession of exposure to a specific toxin or environmental hazard. There are requirements that must be met to concede the toxic exposure prior to establishing if a presumptive process applies to that veteran.

For example, the presumptive processes for mustard gas, radiation, Persian Gulf illnesses, Agent Orange, and Camp Lejeune contaminated water all have a concession of exposure built into the presumptions.

We are proposing to concede the exposure without establishing a presumptive process for burn pits. A concession of exposure would still require a veteran to provide a diagnosis of a current illness. However, by conceding veterans who served in areas of active burn pits, were exposed to chemicals and toxins, to include those already recognized in VA's adjudication manual, the veteran would not have to provide proof of their personal evidence of that exposure.

This would still require veterans to have a medical opinion linking the condition to the exposure. However, by conceding their exposure to the known toxins, a physician, VA or private, will now be able to provide a medical opinion, with the scientific rationale, as the toxins of exposure are now known. To be clear, this proposal would not create a list of diseases for burn pit exposures.

We are currently working with Senator Sullivan and Senator Manchin to draft legislation that would address the need for a concession of exposure for burn pits. They are both committed to providing an avenue for burn pit veterans to establish entitlement to benefits and VA health care. We look forward to their introduction of the bill in the near future.

This concludes my testimony. I would be pleased to answer any questions you or members of the Committee may have.

[The prepared statement of Mr. Liermann follows:]

Senator Tester. Thank you, Shane. Robert?

STATEMENT OF ROBERT MILLER, MD, VANDERBILT UNIVERSITY MEDICAL CENTER

Dr. Miller. Chairman Isakson, Ranking Member Tester, and Committee, thank you for allowing me to present today.

I began seeing soldiers with unexplained shortness of breath in 2004, following their deployments in support of Operation Iraqi Freedom. All were physically fit at the time of deployment but were quite short of breath on return. They were incapable of completing their two-mile runs within regulation time, which meant that they no longer met Army physical fitness standards. Ft. Campbell referred dozens of similarly affected soldiers to Vanderbilt University Medical Center, and as a result we became leaders in evaluating and understanding this condition.

The soldiers referred underwent standard testing, including chest radiographs, pulmonary function testing, and exercise studies, all of which were normal, and therefore failed to explain their exercise limitation. This led us to perform surgical lung biopsies, which consistently exhibited characteristics of toxic inhalation. Most of the biopsies demonstrated a condition known as constrictive bronchiolitis affecting the small airways, but there were other multiple other

pathologic features demonstrating toxic inhalation.

You may wonder why the earlier studies failed to detect these changes, and the answer is that diseases affecting the small airways are frequently missed with non-invasive tests and are diagnosed only with biopsy, something that has been known for over 40 years.

Performing surgical biopsies in patients with normal preexisting testing was unconventional, but the stories of these deployers were striking. All of them faced dismissal from the military with a label of "unexplained shortness of breath," which does not qualify as a diagnosis and therefore does not meet the standard for disability. The biopsies established a connection between the exposers of deployment, and their symptoms, as a result. The results of our initial 80 patients were published in the New England Journal of Medicine in August 2011.

Vanderbilt University has now evaluated over 250 deployers with unexplained shortness of breath. Approximately 100 of them have had surgical lung biopsies, all of which are abnormal. Other major academic centers have reported similar biopsy results. The DoD STAMPEDE trial reported that standard clinical evaluations fail to explain respiratory complaints over 40 percent of patients presenting with shortness of

breath. These patients were similar to the patients that we saw at Vanderbilt, but they did not under biopsy.

A large number of deployers report respiratory symptoms associated with deployment. Some of them are easily assessed and meet criteria for straightforward diagnoses, such as asthma, sinusitis, allergic rhinitis. But the patients referred to Vanderbilt were more complicated, and they had been dismissed by clinicians who had limited experience with this presentation, and they misinterpreted their normal preoperative evaluations. The absence of a diagnosis was unsettling to those veterans who were affected.

This brings us to the two issues that I would like to raise related to unexplained respiratory symptoms following deployment. The first is how to best medically evaluate those with this presentation. While surgical biopsies may explain symptoms, performing them on a routine basis is not practical. They are invasive and expensive. They may, however, provide clarity for veterans whose symptoms are unrelenting and severe enough to end their military service and whose symptoms may have been dismissed by previous providers.

The DoD and VA should consider designating Centers of Excellence to evaluate deployers with unexplained shortness of breath. These centers would establish

standard protocols for evaluating these respiratory symptoms, and determine who may need surgical lung biopsy and who may be eligible for a presumptive diagnosis of deployment-related lung injury.

The second issue relates to disability benefits for deployers who have been diagnosed with a deployment-related lung disease. As noted earlier, Vanderbilt has performed surgical lung biopsies in over 100 deployers. Those who were actively serving were medically boarded out of the military with inconsistent ratings. Those who applied for VA benefits were usually denied a rating, due to their normal pulmonary function tests. The current VA standard does not allow a disability rating for veterans with biopsies showing inhalation lung injury when pulmonary function tests are normal. This is inconsistent with the report from the U.S. Defense Health Board, which states that pulmonary function testing usually fails to detect small airways disease.

Patients with deployment-related airways disease represent a unique group of veterans. While this injury may not be as noticeable as loss of limb, respiratory disorders are associated with lifetime limitation.

It has been 10 years since I first presented our preliminary data to this committee. I hope that it is evident that this issue is not a transient one for our

veterans and that too many of them with this disorder feel that they are not receiving proper health care or appropriate disability benefits.

Thank you, and I would be glad to answer any questions.

[The prepared statement of Dr. Miller follows:]

Senator Tester. Thank you, Dr. Miller. Senator Moran.

Senator Moran. Mr. Chairman, or Mr. Ranking Member, thank you. Thank you for your service on this Committee.

Dr. Butler, I have questions for you, but I thank all of you for being here, and I took seriously the testimony that you presented.

Dr. Butler, in November of last year, the National Academy of Sciences published the Gulf War and Health, Volume 11, Generational Health Effects of Serving in the Gulf War. This report concluded that there is, quote, "a substantial dearth of information," unquote, on the generational effects of toxic exposure. Also within that report, the National Academy prioritized the collection, storage, and maintenance of a comprehensive baseline and longitudinal data, and biospecimens from veterans, their partners, and their descendants, in order to develop an effective, successful health monitoring and research program.

The Department of Defense, and the Department of Veterans Affairs continued to develop that, an Individual Longitudinal Exposure Record, and my questions to you-- well, first of all, I learned in our efforts to have research completed that would demonstrate whether or not there is a medical-scientific connection between

generations, that before that was possible we had to demonstrate that there was not sufficient evidence in that regard existing. And so your study, Dr. Butler, at the National Academy of Sciences, was very important as a step in determining that connection.

And so my question is, I just want you to expand upon that report, your findings, and if you have any sense of whether the cooperation between the Department of Defense and Veterans Affairs is on its path towards getting the necessary data about the necessary facts about the occurrences.

Mr. Butler. Thank you for the question. The Gulf War and Update 11 Report not only looked at the existing evidence regarding possible reproductive effects of exposures but also put together a comprehensive research plan that could be followed that would allow VA to make more informed decisions about this in the future. The report is still a relatively new one. As Dr. Hastings mentioned, and Dr. Rauch, the ILAR system that is about to come on line is going to provide an important new source of information on exposures and getting a handle on exposure assessment, which is typically the poorest part of the information set that is available for making decisions like this. It is going to be really important in the future in getting a better handle on outcomes that

might be related, not only to reproductive and generational effects but all the other effects.

Senator Moran. And do you have a sense--you know, I have heard and read the testimony of the Department--do you have a sense that that process is--which is soon to be completed and available, utilized--is it the right process? You are comfortable with the direction they are going, or have you not analyzed that?

Mr. Butler. The National Academies has not yet analyzed it. The extensive research plan that was put forward as part of the Gulf War and Health Report does provide a roadmap in the future for getting information specific to reproductive and generational effects.

Senator Moran. Do you have the sense your roadmap is being followed?

Mr. Butler. We do not have specific information on what is being done at the moment.

Senator Moran. Thank you, Doctor. Thank you.

Senator Tester. Senator Brown?

Senator Brown. Thank you, Senator Tester. Before I start I would like to acknowledge my constituents, Susan Zeier, who has joined us. She has been a driving force behind this hearing. Senator Isakson and Senator Tester commented earlier this hearing was done because of a push from people in Ohio and elsewhere. She has made

countless visits with Burn Pits 360. And we are also joined by Paul McMillan, who is an activist in Ohio. Thank you for joining us. To ensure--they have done these visits to ensure that we acknowledge what has been done for our servicemembers in finding an approach that provides the kind of help that all of them have earned.

And I would like to submit a statement for the record that she prepared, with information we gathered from Ohio veterans.

Senator Tester. Without objection.

[The letter follows:]

/ COMMITTEE INSERT

Senator Tester. Thank you. And also Ms. Zeier is training a service dog for someone, so thank you for that.

Dr. Miller--thank you for your testimony, all three of you--you have treated servicemembers exposed to sulfur mine fire burn pits, other environmental exposures. Walk me through examples of what you have seen while treating patients, and in your clinical opinion, do you think DoD and VA have the protocols in place to correctly diagnose these respiratory illnesses?

Dr. Miller. There are probably two phases to what we have seen. Early on, in 2004, we saw a free flow of patients from Fort Campbell who returned from one year of service in Iraq with unexplained shortness of breath. And there was good cooperation at that time. That is when we made our original find of constrictive bronchiolitis.

Over time, these servicemembers have become more complicated. They are farther out from service. We are not seeing as many direct referrals from Fort Campbell as we used to. A lot of them have seen other providers who are not familiar with this, or--

Senator Brown. They stopped referring veterans to specialists?

Dr. Miller. They stopped referring to Vanderbilt

and other academic institutions and chose to refer to DoD facilities.

Senator Brown. Are they getting the care they should?

Dr. Miller. I think that if you were to go one of the centers that they were referring to you would get a different evaluation than you might get with us or with other academic medical centers. We felt like that we were able to characterize those patients who were ultimately diagnosed with deployment-related lung disease. They had a consistent pattern of exercise limitation, and despite their pulmonary function tests and exercise studies being normal, we were willing to take this a step further and get them a diagnosis with lung biopsies. I would say that except in rare circumstances, the DoD facilities did not do that.

Senator Brown. Thank you. Mr. Liermann, thank you for being in front of this Committee again. The first panel I asked a similar question, why do you think, given what we know about air quality tests and DoD recordkeeping, DoD and VA, have not been more forward-leaning to develop a process, a presumptive or otherwise to provide health care and disability for servicemembers and veterans exposed to burn pits?

You ended by suggesting that one step Congress

should take to apply pressure would be to reinstate the timeline by which VA needs to act after receiving a National Academies report. Senator Hill and I introduced a bill last year, which obviously did not pass.

Why is it important to reinstate that requirement?

Mr. Liermann. Thank you, Senator. Without that requirement we are in the situation we are right now where we have three additional diseases that have not been added for almost three years but yet were recommended. That requirement that there be some sort of action within the time frame, good, better, indifferent is going to get a decision, and at the very least veterans need to have a decision. That way we know other avenues to proceed for service connection if it is not going to be as a presumptive disease.

Senator Brown. Okay. Thank you. Thank you, Mr. Chairman.

Senator Tester. Thank you, Senator Brown. Senator Tillis?

Senator Tillis. Thank you, Senator Tester, and thank you all for being here. You know, one question I wanted to ask Dr. Miller, you alluded to the idea of centers of excellence in your opening statement, and it really relates somewhat to the discussion you just had with Senator Brown on some of the referrals going to

facilities that may or may not have the same level of expertise.

So in your mind, waving a wand, what would a good network of centers of excellence look like? And I would assume that that would be in and out of the DoD or VA.

Dr. Miller. I think it could be in or out of DoD and VA, but I think that for patients with unexplained shortness of breath, which are the large number of patients with respiratory disorders, there is an unfamiliarity that you can be ill, that you can have toxic inhalation with a normal x-ray and pulmonary function test.

There is also an unwillingness to take it to the next level, to either do a lung biopsy or to say, "You have the characteristics of people who have been diagnosed with deployment-related lung disease, and we think that you meet those criteria."

So you need the expertise but you also need the willingness to take it to that level.

Senator Tillis. So some of that may require us to do a better job of educating servicemembers who were in potential at-risk situations to understand what they may be going through and getting advice or engaging experts in the area. That is more a matter of increasing awareness and engagement on the part of the

servicemember?

Dr. Miller. It is more increasing the awareness among providers. The typical person that I am seeing now is somebody who has seen multiple providers, some of them in the private world, some of them through DoD, some of them through VA. The DoD and VA providers frequently are aware of what we have done at Vanderbilt or has been done in National Jewish in Colorado, but they do not take it to the level that we do. And the servicemembers leave with a diagnosis that, "We are sorry that you are short of breath. Your x-rays and pulmonary function tests are normal."

Senator Tillis. You mentioned that the referrals reduced to Vanderbilt in favor of, I guess, DoD Health. Do you know why that happened? Is there any speculation on why that happened?

Dr. Miller. I think you would have to ask them.

Senator Tillis. We will.

Dr. Miller. I think that they were uncomfortable with the idea that we would do lung biopsies on somebody who had normal x-rays and pulmonary function tests. And I will tell you that that is a leap for me, as a clinician, to have made that diagnosis, and it is one that when I see patients I tell them that it is unconventional. But in this group of patients, it has a

very high yield.

Senator Tillis. Thank you. Mr. Butler, I want to go back and follow up on a question I asked of Dr. Hastings on the first panel, and that has to do with what the National Academies specifically can do to review some of the more conditions affecting dependents and family members. I referred to some of the exposures in utero. What more do you think we can do there?

Mr. Butler. Well, as I mentioned, the Gulf War and Health 11 Report put forward a comprehensive research protocol that could be followed to get more information in this area, that National Academies is an institution and does not conduct primary research, which is to say we do not research data on individual veterans or groups of veterans directly, but we do review the literature. It is a challenging area to do research in, but it is one that is very important and that the committee who wrote the Gulf War and Health 11 Report thought deserved greater attention.

Senator Tillis. Mr. Liermann, it is good to see you back. Just a real quick question, that also relates to a question I asked of the prior panel, and it has to do with--I think you are familiar with the fact that Senator Burr co-introduced the Janey Ensminger Act, and we have worked hard to make sure the VA is changing some of their

presumptions. We have made some progress over time.

But what do you think that we need to do, either what the VA can do or what more we need to do to make sure that we are constantly reassessing the data, constantly challenging the presumptions and making sure we are giving the care to as many people as we can?

Mr. Liermann. Thank you, Senator. I believe one of the big things we can do is require additional studies, have additional research, because as things change and more information is gathered we are going to know more commonalities between different diseases and different disabilities.

And so by providing that research every two years, and having that available for the scientific community to go through and glean and find that key information, is really a key part of this. Because if we do not continue to do those types of things, for example, for Agent Orange-exposed veterans, we would not continue to find these additional diseases that are associated with their exposure. So studies and research, and I would say, at the minimum of two years, would go a long way.

Senator Tillis. Thank you very much. Thank you, Senator Tester.

Senator Tester. Yes. Senator Blackburn.

Senator Blackburn. Thank you. Dr. Miller, I

appreciate so much that you are here, and, of course, representing our great state of Tennessee. I have heard a bit about your work at Vanderbilt, and the fact that I have two military retirees and veterans that are a part of our team and they have been deployed in the Gulf. And I have heard many stories, as I have talked with those Fort Campbell families, about the crud that they bring back with them from those early days in Iraq and Afghanistan.

We will be following up with you on some more specifics. I know the lung biopsies are painful. It is not a simple procedure. But we want to make certain that the best treatment possible is available for our men and women in uniform. And indeed, we have heard so many stories about the shortness of breath issue, which seems to be unexplainable in an otherwise completely healthy individual. And, Mr. Liermann, you spoke to the toxins and the inhalation of those.

So it does concern us, and as someone who, in 2003, a group of women went in to visit the 101st. There were six female Members of the House that went in, and I was in that group. And we saw firsthand some of the particulate that seemed to be floating through the air and ever-present. So living in that and inhaling that is something that does leave that residual effect, and we

want to make certain that things are well cared for.

We have just had votes called and we are going to need to scoot to the floor, but, Dr. Miller--and I think I am going to ask you to do this as a written response, just in the interest of time. But what I would like to have from you is a little bit of a deeper dive, when you talk about the differences in the DoD testing and the differences in what Vanderbilt has done. And it is only so curious to me when there is research work that is being done with the VA located on Vandy's campus. It seems as if more would be available for these veterans, and we appreciate that you have targeted this area.

So if you would talk a little bit about these exams, the center of excellence type concept, what DoD does, and where they end the process but how that is not the fullness of what ought to be the process, to get to the bottom of this. I would appreciate that.

And with that, Mr. Chairman, I am going to yield back, and I thank each of you for your attention to the issue. And, Dr. Miller, I especially thank you for your willingness to come and speak before us today.

I yield back.

Senator Tester. Yeah, thank you, Senator Blackburn, and I want to also thank Dr. Hastings and Dr. Helmer for sticking around here for the second panel. I appreciate

you wanting to hear what these folks had to say. And I don't know if Dr. Rauch--I did not pick him out in the crowd--if he is here I thank him also.

I am going to start with you, Dr. Butler. As requested by the VA, the National Academies have convened a committee to review, evaluate, and summarize available scientific and medical literature regarding respiratory health effects and exposure to airborne hazards. Can you summarize the process for performing this study?

Mr. Butler. Yes. This is a study that is ongoing. We have assembled an expert panel of--

Senator Tester. When did it start?

Mr. Butler. It started at the beginning of this year. We are going to be holding a meeting next Thursday and Friday, a workshop, where we will be gathering information for the committee's consideration. That is a public event and one that will be broadcast over the Web.

We are also in the middle of a large-scale literature review of all of the information that has been published on this topic. We will be assembling that literature review, the additional information, including one of Dr. Miller's colleagues from Vanderbilt who will be giving us a presentation. And we will be preparing a report that will be completed in last spring of next year.

Senator Tester. Late spring of next year? Okay. And that report will go to the VA, correct?

Mr. Butler. It will, and it will also be made public and will be capable of being downloaded for free from the internet.

Senator Tester. Yeah, and typically--and I do not know if you can answer this question, and if you cannot you do not have to--but typically how long does it take the VA to make a decision after you have forwarded information to them?

Mr. Butler. That would depend on the particular report that we are doing.

Senator Tester. I am assuming these reports are pretty comprehensive?

Mr. Butler. We try to make them as comprehensive as possible, yes.

Senator Tester. Okay. Are there any ongoing studies right now that have been requested of the National Academies over and above this?

Mr. Butler. Aside from this study, we are competing a study on the effect of exposure to anti-malarial agents--

Senator Tester. Okay.

Mr. Butler. --and that will be--that will also come out in 2020.

Senator Tester. Okay. All right.

Dr. Miller, you have seen a number of servicemen. There is a study you did, and it may be a number of years ago now, where you conducted research on 100 veterans who had, I believe, shortness of breath, and you performed biopsies on those. Were all 100 percent abnormal?

First of all, did all 100 percent--did all 100 veterans have shortness of breath?

Dr. Miller. All of them did. Our original study was 80 patients. We have now seen 250 with shortness of breath, and we have done biopsies on a little over 100. All of the biopsies are abnormal.

Senator Tester. Okay.

Dr. Miller. And all of them are patterns of toxic inhalation.

Senator Tester. I got you. And how do you choose the 100? Was it random or was it the worst-case scenarios?

Dr. Miller. Some of them had other explanations for their shortness of breath. They might have asthma. Some of them had too many comorbid conditions to undergo biopsy, and some of them did not want biopsies.

Senator Tester. Okay. So as I am sitting here listening to your testimony and you do a biopsy on the 100 veterans who have shortness of breath and it all

comes back bad news, and then the VA does not use you anymore, it tends to put red flags up for me, because potentially it makes me think they do not want to hear the bad news. Do you look at it the same way?

Dr. Miller. I--between 2004 and 2009, we worked very closely with the DoD, and we had people come down and define the protocol that we used with Fort Campbell, and I felt like that we were working well together.

Senator Tester. Yeah, to supplant DoD. Yeah, keep going.

Dr. Miller. And then--and then it changed, and it changed when our data became more nationally known. There was a large consensus conference in Denver where we presented our data, and it was the first time that a lot of them had seen our data, and that is when things changed.

Over time, many VA facilities have been willing to take the same approach that we do. For example, the VA in Nashville, the VA in Denver do a lot of biopsies. The big problem with the VA has been in the disability rating--

Senator Tester. Oh yeah.

Dr. Miller. --and that has been--I guess there were two issues. One is their willingness to say that someone's unexplained shortness of breath was deployment-

related, or to do a biopsy, and the other is that for those that were diagnosed they would not give them a disability rating, despite significant exercise limitations.

Senator Tester. Okay. Really quick, going back to Dr. Butler, you are gleaning information from a lot of different sources, including places like Vanderbilt. Correct?

Mr. Butler. That is correct. As I mentioned, one of Dr. Miller's colleagues will be giving us a presentation.

Senator Tester. Right. And when is the last time you did any research that the DoD requested?

Mr. Butler. The DoD has not requested any from us. We get a few patients--

Senator Tester. In how many years--10?

Mr. Butler. It has probably been 10.

Senator Tester. Okay. The information that you are gleaning, Dr. Butler, is it 10-year-old information, or are you getting all your information from the DoD over the last 5 years?

Mr. Butler. We try to get the most recent information available from all sources.

Senator Tester. I got you, but is that information only available from the DoD now?

Mr. Butler. No. It is also available from academic researchers. We also ask the service organizations and veterans.

Senator Tester. Okay. Sounds good, and thank you.

Shane, do you believe the VA is capable of rewarding claims of some Blue Water veterans right now?

Mr. Liermann. Absolutely.

Senator Tester. And so why is it important that at least they take a look at some of them? In your testimony that we heard yesterday you actually listed off some that they should be considering. Why is that important?

Mr. Liermann. When you take a look at veterans like Bobby, who is here with us today, who is terminal and dying from his condition, but yet they will not take any action on his care, that is one of the very important reasons why they should at least look at those cases now. And then--this was touched on earlier, Senator, and I just wanted to expand on it a little bit--

Senator Tester. Yeah. Go ahead.

Mr. Liermann. --there are certain pieces where the VA already knows where the ship was. They do not have to reconstruct hundreds of thousands of millions of pages of documents to prove it.

Senator Tester. Bingo.

Mr. Liermann. For example, Da Nang Harbor. For years, if a veteran served on a ship in Da Nang Harbor but never went ashore, they were not considered in country. They already have all of that information on those veterans. There is enough information for them right now to make decisions on cases. Will a lot of them have to be developed more? Absolutely. But do they have enough now they can make decisions on? Yes.

Senator Tester. Gotcha.

I want to thank all three of you for your testimony and your work that you do. I very much appreciate it, and keep up the good work.

I would just say that members have five days to submit additional statements or questions for the record, and with that we will adjourn this hearing. Thank you all.

[Whereupon, at 12:32 p.m., the Committee was adjourned.]