

**Department of Veterans Affairs Advisory Committee on Gulf War Veterans
February 18 – 19, 2009**

**February 18, 2009
Atlanta, VA Medical Center**

Present:

The Honorable Charlie Cragin, Committee Chair

Committee Members (alphabetical order):

Martha Douthit

Dr. Henry Falk

Mark Garner

Rusty Jones

Kirt Love

Dan Ortiz

Dan Pinedo

LTG (USAR, RET) Tom Plewes

Valerie Randall

Randy Reese

Steve Robertson

Not Present:

Dr. Lynn Goldman

Dr. John Hart

Opening Remarks by the Honorable Charlie Cragin

The Chairman opened the meeting by welcoming the Committee members, the public, and those who called in through the teleconference line. Mr. Cragin also welcomed Mr. Gerald Johnson, the new VBA liaison to the Committee. Mr. Johnson replaced Mr. Mike MacDonald who recently received a promotion. The Chairman then thanked Mr. James Clark, the Director of the Atlanta VA Medical Center for hosting the meeting.

Welcome

James Clark, Director Atlanta VA Medical Center

Mr. Clark welcomed the members to Atlanta and began by thanking all those that participated in the planning and the logistics of the meeting. He also thanked the Committee for selecting the Atlanta Medical Center to hold one of its meetings for such an important issue. He explained that the Medical Center sees approximately 72,000 Veterans every year which includes Gulf War Veterans. He told the members that he has an open door policy to Veterans and wants to hear what they have to say. Mr. Clark told the Committee that the Medical Center's logo states there will be quality second to none, patient-centered care, one Veteran at a time.

Atlanta VAMC Gulf War Veteran Landscape Changes

Bruce Rooney, Chief Social Worker, Atlanta VAMC

Mr. Rooney, now the Chief of Social Work for the Atlanta VAMC, has been in a social work capacity at VA for more than four decades. He worked with returning Vietnam Veterans, Gulf War I Veterans and now current era Veterans. Mr. Rooney began by talking about the Persian Gulf Family Support Program which began during 1992. The Program was established to assist Veterans and families readjust after the stress of war. There were originally 32 sites which were solely based on numbers of Veterans returning from Desert Storm who came in for treatment through Primary Care or the Emergency Room. The Atlanta VAMC was the only site in the state of Georgia, and the VISN had a total of three sites. The program consisted of social workers and program support personnel whose primary focus was outreach. Services included family counseling, referrals for services and benefits, enrollment of Guard and Reserve personnel into the Persian Gulf Registry. This was the first time that VA had actually reached out to family members. One of the sites conducted up to 225 physicals in one day. Mr. Rooney's team worked weekends and did whatever was necessary to meet with family members.

Mr. Rooney said the key Veterans/Families' concerns were medical, psychological, family dynamics, and vocational. He said the most noted physical symptoms were unusual chronic fatigue in young Veterans, gastrointestinal problems, issues with sexual intercourse, and headaches. Mr. Rooney also said that some Veterans and family members complained of birth defects which they believed were related to Gulf War service. He went on to say that many of the Veterans psychologically dealt with the stigma of the effects of the Pyridostigmine Bromide (PB) pills on the Veterans as well as their offspring, dealing with the unknowns of chemical exposures, and the rejection experienced by clinicians and others not taking their medical issues seriously. Mr. Rooney stated that the large number of women activated from the Guard and Reserve caused significant family adjustments for family members. He noted family members complained of substance abuse, financial problems, and readjustment issues. He said family members would often come in to speak with VA staff out of concern for their Veteran family members particularly when the Veterans themselves would not come in. Congress funded 32 Persian Gulf Family Support Programs but terminated them after one year. The Atlanta site and a few others continued their programs with local funding for a short time after Congressional funding stopped.

Mr. Rooney told the Committee that the Atlanta VAMC has a very good working relationship with the local civilian hospitals. VA contracts patient beds with several private facilities. He also said the local civilian hospitals almost immediately refer patients with mental health problems who identify themselves as Veterans to the Atlanta VAMC. Mr. Rooney offered the recommendation of more outreach to Gulf War Veterans. He suggested that VA use the VSOs to reach out to these Veterans to see how they are doing.

Registry Exams

Dr. Suzanne Cullins, Chief of Compensation & Pension (C&P) and Specialty Exams

Dr. Cullins presented an overview of the Atlanta Gulf War Registry program which is housed under the Compensation and Pension/Special Exams Unit Section at the Atlanta VA Medical

Center. Her office manages C&P exams, Agent Orange and Gulf War Registry exams, active duty military separation exams, Aid and Attendance exams, and Depleted Uranium exams. She pointed out that the contractor QTC also conducts C&P exams for the Atlanta Regional Office. Dr. Cullins' presentation began with a Gulf War Veteran demographics overview. Using the Environmental Agents Gulf War Registry as her source, she noted there have been 3,272 unique registry exams completed at the Atlanta VAMC since 1990. Of that number, 406 were female Veterans. Nineteen Gulf War I Veteran registry exams have been completed in 2009. Dr. Cullins said that the progressiveness of the Gulf War I Veteran's personal medical situation typically necessitates an additional exam. She also believes recent media reports about Gulf War Illnesses may be another reason Veterans are coming back to VA. Many of them are becoming aware of conditions that they had not recognized previously. Committee Member Steve Robertson added the registry exams originally began to establish a baseline of the Veteran's health condition as of that date. The initial evaluations had nothing to do with obtaining compensation. Subsequent evaluations were based upon new problems the Veterans were encountering or manifesting conditions. Usually by the second or third exam, the Veteran would start looking at compensation.

Dr. Cullins discussed the various exposures Gulf War I Veterans experienced as well as common complaints which are outlined in her presentation. She said that the number one complaint among male Veterans was fatigue. Headaches were the number one complaint for women, followed by fatigue. Dr. Cullins said when Veterans come in for an exam, they are encouraged to see a service representative to file a claim in order to get into the system. Many of the Veterans she has seen are employed and already have healthcare benefits but are still encouraged to get enrolled into the system.

Dr. Cullins said the number of doctors in the Compensation and Pension/Special Exams Unit Section considerably decreased when VA contracted with QTC to do C&P exams. She noted there was a significant no-show rate of fifty percent of Gulf War Veterans who would make appointments but not show up. She suspected there could have been various reasons for them not showing up to include not being able to get off from work. Dr. Cullins responded to the Chairman's question about the overall attitude of the physicians caring for Gulf War Veterans during the time she took over the Section in 2003 by saying it was not very good. She said there was an older doctor at that time who was doing the examinations who did not have a favorable opinion about fatigue related diagnoses and fibromyalgia. He thought Veterans were malingering. This doctor at the time was the person making the professional decision with respect to the C&P exams. Dr. Cullins said that there has been a significant paradigm shift in providing better care to Gulf War Veterans at the Atlanta VAMC. She offered that greater outreach to this population of Veterans must be done to get them back to the VA and continued clinician education is very important. Dr. Cullins' presentation can be found on the Advisory Committee on Gulf War Veterans website.

Primary Care

Dr. Sanjay Ponkshe, Chief Primary Care

Dr. Ponkshe discussed the Atlanta VAMC Primary Care Program. He started with presenting the history of primary care since the 1990s. He said the program began when a group of doctors joined together to form a system of primary care which gives more meaning to the term primary care. He said the goal is to always deliver the highest quality of care. Primary Care serves as the medium by which patients avail themselves of VA care. The Atlanta VAMC Primary Care Program includes several outpatient clinics, specialty care referrals, nutritional care, clinical pharmaceutical therapy, Social Services, and a 24-7 telephone care program. The Primary Care Program has 13 primary care teams distributed among four service lines. The 60 Atlanta VAMC primary care doctors have approximately 60,000 patients assigned and completed 140,000 appointments in fiscal year 2008. Twenty-five percent of the Primary Care patients are Gulf War Veterans. There is currently no backlog.

Patient visits are one hour for initial appointments and 30 minutes for follow-on appointments at the Atlanta VAMC. Appointment lengths vary within the VISN and throughout VA. However, the overall VA average is 20 minutes. VA is currently reviewing the visit times because of the additional checklists that must be completed in addition to the allotment of necessary personal attention required for each Veteran.

Dr. Ponkshe described the demographics of the Primary Care physicians as younger and mostly unfamiliar with some of the illnesses and syndromes related to the Gulf War and prior wars. He advocates top-leadership implementing global education within the VA. He insists that negative feelings are not an issue for caring for Veterans at the Atlanta VAMC but rather it is the lack of education. Dr. Ponkshe said that if the doctors are taught the right way, they will provide the correct care. He went on to say that he is not aware of any Veteran being turned away because the provider did not believe him or her. He said that a medical opinion is based on the doctor's skill sets and knowledge. It is not critical that a patient agree with a diagnosis. However, any patient complaint is valid, and there is value and opportunity in every complaint.

There is not presently a system in place to identify symptom trends seen by the 60 different doctors. Therefore, if Gulf War era Veterans or other Veteran populations are experiencing the same ailments, the illnesses may not be identified statistically. Committee Member Dr. Henry Falk retorted it is really difficult for someone in a clinical setting to be able to detect unusual occurrences or events. It is an investigative unit or surveillance program that collects and investigates that kind of information. He said perhaps that could be a recommendation from the Committee. Another Committee member commented that VA did not respond to some issues in the past until there was public outcry. The process is driving the care rather than the care driving the system. Another Committee member said that Primary Care should be the "point person" for the VA to react.

Dr. Ponkshe said his recommendations for helping Gulf War Veterans are increased outreach and continuous education of medical personnel. Dr. Ponkshe's presentation can be found on the Advisory Committee for Gulf War Veterans website.

VISN 7 Post Deployment Integrated Care Initiative Model (PDICI) Roll-out

Lawrence Biro, VISN 7 Director (VTC from Washington, DC)

Robin Anderson, VISN 7 Representative

Dr. Gordon Schectman, National Director for Primary Care (VTC from Madison, WI)

Robin Anderson spoke with the Committee about the VISN Post Deployment Integrated Care Initiative rollout plan for VISN 7. She was accompanied, via VTC, by VISN 7 Director, Lawrence Biro, and National Director for Primary Care, Dr. Gordon Schectman. She began with an overview of the VISN which spans Georgia, Alabama, and South Carolina and has eight medical centers and over 30 community based outpatient clinics. VISN 7 has the fourth largest Veteran population in the Nation which has approximately 1.5 million Veterans. VISN 7 treats over 350,000 Veterans, has treated more than 1,500 nursing home care patients in the last year, treated approximately about 1,500 Veterans in domiciliaries, and conducted over three million outpatient visits.

Ms. Anderson discussed the efforts of the Seamless Transition Program which began under former Secretary Principi in 2003 with the OIF/OEF Veterans. The program is comprehensive and involves significant collaboration between the tri-state area and military organizations. Although the Seamless Transition is specifically focused on OIF/OEF Veterans, the outreach aspect of the program includes reaching out to all Veterans. VISN 7 hired 14 Veterans Advocates to fulfill this role. Ms. Anderson also explained the timeline and the other elements of the program outlined in her presentation which can be found on the Advisory Committee on Gulf War Veterans website.

Ms. Anderson explained the three care models being utilized throughout VISN 7: the Cohort Model, Consultative Model, and the Post Deployment Clinic Model. Only the Atlanta and Tuscaloosa VAMCs currently have Post Deployment Clinics. The VISN goal is to use existing experience and expertise from VISN 7 and Seattle VAMC staff to facilitate the implementation of the Post Deployment Integrated Care Model at all of the VISN 7 hospitals. Mr. Biro said the model should be fully implemented between six weeks to six months at all hospitals. Ms. Anderson said that the VISN's Post Deployment Model is designed for OIF/OEF combat Veterans who served in country. She said while all OIF/OEF Veterans may have an assessment, the focus is on combat Veterans. There is no formal plan in VISN 7 to include Gulf War I Veterans in the Post Deployment Integrated Care Initiative. Mr. Biro added if including Gulf War Veterans in the program will help the Veteran population, the VISN will move to make it happen referring back to the VISN promise of providing care second to none. A few Committee members commented that it is unfair that Veterans from the same war are not being treated the same. Mr. Mark Gorenflo, Deputy Assistant Secretary for Policy, accentuated that Dr. Stephen Hunt's model from Seattle which is the model being propagated is "era agnostic." He went on to say that one of the reasons for the Committee's visit to Atlanta is to see how the model is being rolled out. Committee Member Randy Reese said he does not agree that it is being rolled out nationally along those lines. The Chairman said that model may be era agnostic if a Veteran walks through the door, but there is no specific outreach to Gulf War I Veterans. The VISN 7 Post Deployment Integrated Care Initiative (PDICI) presentation can be found on the Advisory Committee on Gulf War Veterans website.

Veterans Affairs' Strategic Plan for the Post Deployment Integrated Care Initiative Model (PDICI) Roll-out

Dr. Gordon Schectman, National Director for Primary Care (Via video conferencing (VTC))

Dr. Schectman met with the Committee via VTC. Due to scheduling constraints he was unable to give his entire presentation but was invited to meet with the Committee at a subsequent date. He explained to the members that VA is currently in the national implementation phase of the Post Deployment Care Model. The long term plan is to have the Post Deployment Care, as described by Dr. Stephen Hunt, in place within twenty-four months. VA understands that there needs to be cultural transformation on a variety of levels, and the flexibility of the model is something that will be developed over time. Dr. Schectman said he is certain that Gulf War Veterans with undiagnosed illnesses will receive the care they require under this improved model. Dr. Schectman's full presentation can be found on the Advisory Committee on Gulf War Veterans website.

To War and Back: A Comparison of the Experiences of Gulf War and OIF/OEF Army Reserve Veterans

Colonel Sumathy Reddy, Assistant Army Reserve Surgeon, Fort McPherson, GA

Colonel Reddy, an Army Reserve Soldier who was mobilized in support of Deserts Shield and Storm, Operations Global Eagle, and the Global War on Terrorism, presented a comparison of processes and procedures in place for Army Reserve Soldiers mobilizing and demobilizing for the OIF/OEF as a result of lessons learned from the Gulf War. She began with describing the differences between active duty and reserve personnel. Active duty personnel live in tight military knit communities where they have military support to help their families. Unlike the reserve component, they do not have to worry about having a job when they return from war. Reserve personnel live in a civilian culture with civilian jobs. Often they are called to active duty with very little notice having to pack up and leave their jobs and families. This causes significant stress not only on the military member but also their families. She said that many Reservists down play illnesses or injuries upon their demobilization so that they can reunite with families and reintegrate into their civilian lives. Colonel Reddy said that OIF/OEF Veterans have very similar challenges but it may have been more difficult for Gulf War Veterans because the country had not experienced war for almost 20 years after the Vietnam War.

Colonel Reddy talked about various issues to include premobilization, demobilization, health care and follow-up after release from active duty, healthcare benefits, and disability benefits. She said that during the Gulf War era, the military used pre-deployment checklists and available medical documentation to screen personnel. Because of poor processing procedures at that time, non-physically qualified soldiers reporting to the mobilization processing stations, some in receipt of VA disability compensation for previous injuries or illnesses, were still allowed to deploy.

Colonel Reddy also discussed many of the programs and procedures that are now in place for the Army Reserve and National Guard as a result of lessons learned. In addition, she talked about some of the ongoing initiatives to improve readiness which is a significant problem during the Gulf War. Some of them include online Medically Non-deployable Modules for uniform and

consisting medical profiling, electronic medical records, annual Periodic Health Assessments (PHA) which replaced the previous five year physicals, and expanded healthcare benefits. Colonel Reddy's presentation can be found on the Advisory Committee on Gulf War Veterans website.

Leishmaniasis

Dr. Barbara L. Herwaldt, Centers for Disease Control and Prevention, Division of Parasitic Diseases

Dr. Herwaldt spoke with the Committee members on principles and perspectives of Leishmaniasis in the contexts of the known and the unknowns of the disease. Leishmaniasis is a parasitic disease with multiple forms; the most notable are visceral, cutaneous, and mucosal. She began with the disclaimer that she is not in the military and does not claim to know the official military numbers regarding personnel affected by the disease. The parasites are unicellular, intracellular, and are spread by phlebotomine sandflies. They are not worms as many may think. There are more than 20 species that infect humans. For the sandfly species, there are about 30 that serve as vectors. Overall, Visceral Leishmaniasis is found in approximately 65 countries, but most of the world's cases occur in India, Bangladesh, Nepal, Sudan, and Brazil. Cutaneous Leishmaniasis is found in focal areas of approximately 85 countries, mostly found in Afghanistan, Algeria, Iran, Iraq, Saudi Arabia, Syria, Brazil, and Peru. In some cases Leishmaniasis can be found in the Southern United States and in some cases Texas and Oklahoma. Confirming Leishmaniasis parasitologically is very complex. The kinetoplast must be present in order to make a Leishmaniasis diagnosis.

The Department of Defense identified approximately 20 documented cases of Cutaneous Leishmaniasis and documented 12 cases of Viscerotropic Leishmaniasis in Operations Desert Shield and Desert Storm. Dr. Herwaldt also talked about risk assessment. She said that sandflies are weak flyers and only a portion of them are infected. She stated that there are various factors to consider including the area of the country, personal factors like timing of day, sleeping activities, immunities, and the use of protective measures.

Dr. Herwaldt said treatments goals are to individualize the care for each patient, ideally provide 100 percent effective and safe therapy, aim for one oral dose, target amastigotes or where the parasites are located, and to kill the parasite causing a complete and lasting sterile cure and immunity. The worst thing that can happen to a person with classic Visceral Leishmaniasis is death. Dr. Herwaldt expressed concern that there is a small population Leishmaniasis subject matter experts and that organizations like the Department of Defense, Centers for Disease Control, and Veterans Affairs, should make efforts to retain them. She is also concerned that Veterans and others are getting the benefits and services they need. When asked if physicians can generally recognize Leishmaniasis in a patient, she said no. That is because very little time is spent on the study of parasitic diseases in medical school. Dr. Herwaldt's presentation can be found on the Advisory Committee's website.

Georgia Department of Veterans Service (SDVS)

Tom E. Cook, Assistant Commissioner, Field Operations & Claims

Mr. Cook spoke with the Committee regarding the benefits and services the state of Georgia has for its Veterans. Georgia has more than 765,000 Veterans with over 200,000 Gulf War Veterans. The Georgia SDVS, an independent department, has 150 personnel which includes the 100 for Field Operations and Claims, Central Office, Education and Training, and Cemetery Personnel. Mr. Cook highlighted several of the State's Veterans programs to include the SDVS Supermarket, which has been duplicated in other states. It originated during the Vietnam War in 1965 with the First Cavalry Division in Columbus, GA when Commissioner Wheeler spearheaded the program to take care of returning Veterans. It was considered a "one-stop shop" opportunity to bring together State, Federal, and local agencies to help Veterans and family members. This program has continued until today in various locations across the state. Mr. Cook also highlighted Georgia's State Nursing Homes in Milledgeville and Augusta as well as the state's two Veterans cemeteries in Glennville and Milledgeville, GA. There are five Gulf War Veterans buried in Glennville and fifteen Gulf War Veterans in Milledgeville Veterans Cemetery.

The Georgia SDVS, under the leadership of Commissioner Wheeler, has a joint initiative with the Atlanta VAMC to build a bridge between the Atlanta VAMC and the RO to facilitate ambulatory transit for Veterans who are visiting the VAMC and would like to go to the RO. The steep incline makes it difficult for Veterans to walk to the RO from the hospital. The VAMC presently has a shuttle to take Veterans to the RO. Some of the other Veterans' benefits in Georgia include certain tax exemptions, special license plates, and hunting and fishing license privileges. Mr. Cook expressed that Georgia, like other states, is experiencing budget cuts but is making every effort to not limit benefits and services to the State's Veterans. Mr. Cook also said that the state will look into additional avenues to increase outreach and training for Gulf War Veterans and surviving spouses.

Commissioner Pete Wheeler was unable to meet with the Committee due to family illness. Mr. Cook's presentation can be found on the Advisory Committee on Gulf War Veterans website. Additional information pertaining to the Georgia Department of Veterans Service can also be found at <http://sdvs.georgia.gov/>.

The Alabama Department of Veterans Affairs

Robert Horton, ADVA Public Information Officer

Mr. Horton talked with the Committee about the various benefits and services the Alabama Department of Veterans Affairs offers its Veterans. Alabama has 420,000 Veterans of which close to 90,000 are Gulf War Veterans who are spread out across 67 counties. The Alabama Department of Veterans Affairs is an independent Department which has a board that is comprised of Veterans service organizations which are chartered by Congress. The top leadership of the fifteen member board are The American Legion, the VFW, and the DAV. The Commissioner is appointed by the board and reports to both the board and the Governor. The Alabama Department of Veterans Affairs has 150 Veterans service officers who provide claims assistance. Some of the state's benefits and services Mr. Horton highlighted include the three

State Veterans Homes in Alexander City, Bay Minette and Huntsville that provide long-term care to Alabama Veterans, the Alabama Dependent's G.I. Scholarship Program, certain tax exemptions, and unemployment compensation. Mr. Horton said that in November 2008, the St. Clair County Economic and Development Council deeded 27 acres to the Alabama Department of Veterans Affairs to build a fourth Veterans Home in Shelby County, about thirty miles east of Birmingham. He said that home will have approximately 280 beds. The Department is also focusing efforts on the growing population of female Veterans. Mr. Horton acknowledged that Alabama is concerned about the budget crisis, but it has not currently adversely affected Veterans' benefits and services. He expressed that there is a need for outreach to Gulf War Veterans and all other Veteran populations. He said the way Alabama is trying to address this need is through the Supermarket of Veterans Benefits Program which Commissioner Marsh implemented in Alabama two years ago. Last year the Supermarket was held in one of the large shopping malls in Huntsville, Alabama. Over 1,000 Veterans were served over a five hour span. He mentioned that additional outreach efforts include annual public Veterans information forums and a community based VA public relations campaign.

Commissioner Clyde Marsh was unable to meet with the Committee because he was invited to the Veterans Day at the Legislature. Mr. Marsh has been working on legislation for the past three years that will provide additional benefits to Alabama Veterans.

Mr. Horton's presentation can be found on the Advisory Committee on Gulf War Veterans website. Additional information pertaining to the Alabama Department of Veterans Affairs can be found on its website: <http://www.va.state.al.us/>.

Atlanta Regional Office

Al Bocchicchio, Director, Atlanta Regional Office

Bambi Anderson-Ivers, Assistant Veterans Service Center Manager

Eboni White, Chief Education Claims Processing

Mr. Bocchicchio gave an overview of the Atlanta Regional Office operations which include Disability Compensation and Pension, Education, Loan Guaranty, and Vocational Rehabilitation and Employment. The Atlanta VA Regional Office is the only RO in VA with all four business lines. VA is in the process of consolidating the pension workload to Milwaukee, Philadelphia, and St. Paul. Mr. Bocchicchio said the Atlanta RO has approximately 200 hundred pension claims pending for Veterans in the state of Georgia. After these claims are processed, future claims will automatically go to Philadelphia for processing.

A regional loan center, Atlanta RO services Georgia, Tennessee, North and South Carolina. Mr. Bocchicchio stated that the RO has seen an increased workload due to the depressed economy. 11,642 loans have been guaranteed during fiscal year 2009 which projects out to over 35,000 for this year. The RO processed 31,000 loans in fiscal year 2008 and 27,000 loans in 2007. Mr. Bocchicchio said the loan guaranty division has done a tremendous job in meeting the needs of Veterans using loan guaranty benefits. They have met and exceeded performance goals and are proactive in helping Veterans when they can. He noted there have been instances when Veterans asked for assistance when their loans were too far along in the process and VA was unable to

intervene. However, the loan guaranty division personnel continue to work with lenders and Veterans for favorable results.

Ms. Anderson-Ivers gave an overview of Gulf War undiagnosed illness and environmental hazards exposure and what the VA looks for to award compensation for these claims. She explained that undiagnosed illness is defined as objective indications of chronic disability for six months or longer which became manifest during military service or manifests to a degree of ten percent prior to December 21, 2011, and the disability is not attributable to a known diagnosis. Ms. Anderson-Ivers also explained how claims are processed beginning with the Veteran submitting the claim to the medical examination to the rating decision. Mr. Bocchicchio pointed out Veterans Service Representatives and the Rating Veterans Service Representatives take approximately two years of training to get to the journey level. He said that the Gulf War Veterans' claims are given to the more experienced representatives. Ms. Anderson-Ives pointed out that the chief issue is not receiving the Service Treatment Records (STRs), particularly from the Guard and the Reserve. She stated that another problem is the liquidity of the issues involved with undiagnosed illnesses and chronic fatigue to get the medical evidence to make decisions. Ms. Anderson-Ives said she has seen positive changes in attitude and increased education in medical experts and examiners with regard to Gulf War Veterans claims. Mr. Bocchicchio emphasized that the RO rating specialists are not clinicians. They totally rely on the medical evidence submitted. The objective evidence of the examiner is recorded on the criteria worksheet. The RO will provide a copy of the worksheet to the members.

Ms. Anderson-Ivers also discussed the Disability Evaluation System which opened at Fort Stewart on December 1, 2008 and the Benefits Delivery at Discharge (BDD) Program which are now being utilized at Fort Benning, Fort Gordon, and Fort Stewart. She also went on to talk about the RO's various outreach efforts which include the Supermarket of Benefits Mr. Cook and Mr. Horton discussed earlier in the day. Mr. Bocchicchio said the RO does not turn down any outreach opportunities.

Ms. Eboni White presented a very comprehensive presentation about VA education benefits eligibility requirements for all Veteran eras. She explained in great detail VA's newest GI Bill, the Post 9/11 Veterans Educational Assistance Act of 2008. She pointed out there are Gulf War I Veterans who are eligible for this program. The Atlanta RO is one of four Regional Processing Centers (RPO) for VA educational benefits. The region consists of nine southern states and Puerto Rico. Ms. White's presentation can be found on the Advisory Committee for Gulf War Veterans website.

Public Comments

Public comments were received from Ms. Jani McGee, EdS. LPC, Georgia JFSAP, Military OneSource Consultant.

Gulf War I Veterans Panel

The Veterans Panel consisted of Gulf War I Veterans who served in Theater between 1990 and 1991. Each Veteran talked about his or her experience with either the VA healthcare system or the claims process. Several discussed their health issues related to undiagnosed illnesses. The following Veterans spoke with the Committee:

- Robert Tanner, U.S. Army, along with his father, Robert Tanner Sr. and mother, Mary Tanner; Mrs. Robert Tanner's wife, Jacqueline Tanner, submitted a written letter to the Committee.
- Kathy Davison, U.S. Army Anesthetist
- Jacques Swafford, activated U.S. Army Reservist
- Gail Reid, U.S. Army
- Robert Travis, USMC, and his wife Deidra Travis
- Carol Williams, USN Corpsman
- Lisa Ellis, spouse of Jim Ellis, USMC
- Danny Byse, U.S. Army
- Lyndon Habersham, USMC

Committee Discussion

Mark Gorenflo, Deputy Assistant Secretary for Policy, announced that while Secretary Shinseki is in the process of reviewing all VA Advisory Committees, committee meetings will be held in abeyance. He said he expects the review will be completed within the next few weeks. Mr. Cragin then asked the members to individually consider what their current recommendations would be to the Secretary. The Committee members discussed various ways to write the recommendations to include issues that are measurable. The Chairman asked that the members send their recommendations to the Office of Policy and Planning staff for compilation by March 18, 2009. He said the Committee will deliberate on the recommendations at the next public meeting.