UNITED STATES DEPARTMENT OF DEFENSE

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TASK FORCE ON THE CARE, MANAGEMENT AND TRANSITION OF RECOVERING WOUNDED, ILL AND INJURED MEMBERS OF THE ARMED FORCES

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MAY BUSINESS MEETING

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MONDAY
MAY 12, 2014

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The Task Force met in the DoubleTree Hotel Washington, D.C.-Crystal City located at 300 Army Navy Drive, Arlington, Virginia, at 8:00 a.m., Suzanne Crockett-Jones and Matthew L. Nathan, Co-Chairs, presiding.

MEMBERS PRESENT

SUZANNE CROCKETT-JONES, Non-DoD, Co-Chair
VADM MATTHEW L. NATHAN, DoD Co-Chair
CSM STEVEN D. DeJONG
RONALD DRACH
TSGT ALEX J. EUDY
LT COL SEAN KEANE
KAREN MALEBRANCHE
STEVEN PHILLIPS, M.D.
CAPT ROBERT SANDERS
RICHARD STONE, M.D.
LT COL THEODORE WONG

EXECUTIVE DIRECTOR
DENISE DAILEY

C-O-N-T-E-N-T-S

C-O-N-T-E-N-T-S (CONTINUED)

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

8:07 a.m.

CO-CHAIR CROCKETT-JONES: Good morning, everyone.

Thank you for attending our May business meeting. The primary focus of this meeting is to discuss our observations over the 2014 fiscal year and develop recommendations within specific topic areas.

We are going to go around the table and introduce ourselves. Let me start with you, Mr. Drach.

MR. DRACH: Yes, good morning.

Ron Drach, non-DoD member of the Task Force, been on since the beginning. Was wounded in Vietnam in 1967 and have worked in the area of veterans' benefits ever since.

LT COL WONG: Good morning.

Lieutenant Colonel Theodore Wong, United States Marine Corps representative. I am currently the Wounded Warrior rep, the Wounded Warrior Regiment L&L for Marine Corps

Reserve.

CSM DeJONG: Good morning.

Command Sergeant Major Steve DeJong, representing the National Guard Bureau.

MS. MALEBRANCHE: Good morning.

Karen Malebranche. I'm representing the VA.

CO-CHAIR NATHAN: Matt Nathan, Navy SG and the DoD Co-Chair.

CO-CHAIR CROCKETT-JONES: I am Suzanne Crockett-Jones. I'm the spouse of a recovering Army officer and the non-DoD Co-Chair.

LT COL KEANE: Lieutenant Colonel Keane. I'm the Reserve representative.

TSGT EUDY: Technical Sergeant Alex Eudy, representing both the Air Force and Special Operations Command.

CAPT SANDERS: Rob Sanders, U.S. Navy, representing the Navy.

DR. PHILLIPS: Steve Phillips,

representing NIH, a Vietnam veteran.

CO-CHAIR CROCKETT-JONES: Very good.

Mr. Rehbein will not be here with us during this meeting.

I am going to turn it over to you.

CO-CHAIR NATHAN: All right. Well, welcome back, everybody, and welcome to our newest members.

I appreciate teasing Command Sergeant Major DeJong about having to sit on the other side of the room today, and I know it's difficult for the Army to make change, but I think we will march through it.

CSM DeJONG: Go big or go home.

CO-CHAIR NATHAN: Go big or go home.

(Laughter.)

You do more by eight o'clock than everybody else has done all day.

(Laughter.)

Over the next two days we will

review our members' consolidated observations to assist in the development and the discussion of possible recommendations for the 2014, and I might add final, report.

To date, we have provided a total of 77 recommendations to the Secretary of Defense. This fiscal year we have conducted 14 installation visits and four information-gathering business meetings, which will provide the majority of the substance behind the 2014 recs.

Prior to the meeting, everyone was assigned topics from the consolidated observations. Please note that, although members are assigned to a specific topic area, that assignment does not mean the member is in favor of the observation, nor does it restrict anyone from advocating for other topics of interest.

The overall objective of this business meeting is to prioritize and think strategically about this past year, keeping in

mind there may be tactical recommendations you want to make. We want to be judicious on our strategic and tactical recommendations. Mr. Rehbein and Lieutenant Colonel Keane have already mentioned that they have identified large areas for strategic recommendations.

This is the Task Force's opportunity to formulate how we want our last report to look.

CO-CHAIR CROCKETT-JONES: So, we will start our recommendation development discussion with a review of strategic observations related to holistic reform of the Disability Evaluation System.

As briefed by Denise during our last meeting, there have been several committees that have worked this topic area. We have yet to see traction in Congress, DoD, or VA. This does not mean that we cannot add our experience and perspective, based on four years of site visits in this area.

In addition to the IDES

observation we reviewed during the April meeting, Mr. Rehbein included his feedback and alternative version for the Task Force to consider, which is No. 2 on the screen there.

As we review the items included in the two forms of this observation, I ask that you select those ideas that are most important to you.

We don't have Dr. Stone here or General Mustion. So, I am going to say, if you want to start, Captain Sanders, and I am sure all of us, there are many of us who have some opinions on this topic.

And I just want to reiterate, what would be the added weight that would be the tipping point for Congress to get traction on this. So, there is no reason not to delve into this.

CAPT SANDERS: Thank you.

Good morning.

As we can see, there has, obviously, been a lot of discussion about this

for some members who have been using this system or observed it being used on their family members, and it is ripe for change. It is just a matter of what that change should be. And I think we can come up with some very definite ideas and send forward. But I share your concern about whether or not there is going to be traction.

CO-CHAIR CROCKETT-JONES: I think that the first version on this list, it has the advantage of clarity, but I think that in some ways -- this is the difficulty on this topic. There have been many folks pointing out that there is a need for change. There needs to be an enormous amount of change, perhaps a very different system.

In light of the unlikelihood that that is going to happen anytime soon, the problems within the current system are more clearly defined under the second description. And so, I think in some ways that is the choice we have to make here in our

recommendation, is whether we want to make a recommendation about a fundamental change to the entire way the system works or to the most important correction in the current system as it works.

And so, those are the two choices up there, and I would like to hear everyone's opinion who has one on those two, sort of balancing those two possible ways of looking at this.

DR. PHILLIPS: I would like to just make a global statement about the issues and to emphasize how important it is to have this whole system condensed. And it is related to the behavioral health issues.

If one just thinks a little bit out of the box related to post traumatic stress, if you don't have it, you will get it because of these huge delays. And I would like us to think about perhaps developing some language that will emphasize the fact that these long delays and the process, and the

unknown areas that you are in, really aggravate behavioral health issues related to not only the Service member, but their family. And I think perhaps that will get someone's attention.

I mean, the huge effort to treat and manage is one component of it, but just the fact that we have a year or two or three, or even more for some folks, that is not healthy.

CO-CHAIR CROCKETT-JONES: Well, I think that stress is totally aggravated by the lack of transparency in the system. People have a perception -- we hear it all the time -- that they start this process and, then, it is this unknown force that moves them around in ways that they are unaware of, until it finally resolves. And it takes long enough that they have no idea where they are landing.

And that lack of transparency, either you have to resolve the transparency or you have to resolve the amount of time that

people are in that system. As it is, those two things conspire.

Both of these versions highlight and start with the transparency and the amount of time. As a difference between these two forms, the first is a more generalized set of requirements for a system that is reasonable to evaluate the disability and move people through to a medical retirement.

The second has much more specific recommendations and includes the concern that some of our members have regarding getting folks into productive work or preparation for post-DD-214 life and sort of making the most of the time that they are in that status, rather than having that status be a complete limbo.

Does anyone else want to talk about those, about the advantages of one of these versions of looking at it or the other?

MS. MALEBRANCHE: Actually, Suzanne, the thing that I liked about the

second set that isn't in the first set, understanding the first nice and kind of succinct, but I think that the piece about the work atmosphere that you mentioned is probably the most important. Because, right now, looking at the DES system, there is a number of days that each Service is trying to meet. I am not so sure how much effort is being placed on the issue of the work, and meaningful work for these members is a significant issue and/or the families. So, maybe a combination of the two even, maybe taking some pieces from the second and putting it into the first.

I'm not sure I understand the last two bullets from Mr. Rehbein about minimized used of remotely-located services such as legal. And "minimizing use," I am not sure exactly. It sounds like they don't get it, or I'm not sure what that means.

And then, the last one, too, about providing them all the same access to C&P

exams, I thought that was taking place, and I guess I just don't understand those last two bullets very well. But it sounds like the others are -- I mean, you can kind of crosswalk those.

CO-CHAIR CROCKETT-JONES: I can probably, yes -- or do you want to --

MS. DAILEY: The last bullet addresses the National Guard sending their Service members to the VA for the C&Ps instead of going to an installation and going through their C&P process at the installation when it is being set up locally. Generally, they aren't going to VA hospitals. They are getting C&Ps at the MTF, basically, or at facilities located near the MTF. And then, they are getting specialty care or they are getting a specialty consult at the VA hospital. The recommendation is that it be done through the MTFs and not from Joint Headquarters to a VA hospital.

CO-CHAIR CROCKETT-JONES: And the

bullet about minimizing use of remotely-located services, in order to be timely, you know, since we have seen such an advantage to understanding the process when someone goes into Legal early, even before they have the concept of appeal or just from the beginning, if they go in and make themselves a client of Legal, Legal explains the process to them more effectively than anyone else, based on what we have seen.

And if their legal services, if they are in San Antonio and their legal service is in Florida, and they have to do it by Skype maybe or they do it by phone consult, and how available is -- this is not as effective as a sit-down, understand-the-process, especially for some of our TBI and PTSD folks.

MS. MALEBRANCHE: So, remote versus onsite legal? I see it. Got it.

CO-CHAIR CROCKETT-JONES: Yes.

MR. DRACH: I would like to think

a minute for the issue of the timeliness. And I agree with Dr. Phillips about the time delay.

But are we talking about here, in terms of taking less time, are we talking about -- I think there are two issues: the time it takes to get into the IDES system and the time it takes when you're in the IDES system. Are the Service members getting into the IDES system on a timely basis? And once they are in, are they getting processed through on a timely basis?

CO-CHAIR CROCKETT-JONES: I think that this is about the process time within the system. I think that some Services have decreased the amount of time that they take to get someone into the IDES system.

And I almost hesitate to ask for the time to get into it to be shortened, since one of the things that we have seen is that having a pause to see if it is appropriate, having a timeframe to say, is this person

actually going to be medically retired, or are we going to process them and not medically retire them -- we want a more discrete population in the system itself. And so, I don't want them to eliminate some of their pre-screening in an effort to reduce time. I think we should be cautious about that.

MR. DRACH: I don't totally disagree with that, but I do to some extent. Now, if you are talking about behavioral health issues which make take longer to diagnose or get a handle on, somebody with severe, dramatic physical injuries, okay, you have an issue of how long does it take to recover to the point where they can adequately and effectively go through and be aware of what is going on with the IDES process.

Why are we seeing recovering Service members still on active duty, still in the system up to three years post-injury? To me, that is way, way too long.

How do we find some balance in

between where they get into the IDES system more rapidly, but, yet, still equitably? I don't know if there is an answer to this, but I am just concerned that this takes -- you know, what is causing the three-year holding?

CO-CHAIR NATHAN: So, it is a separate issue. The IDES is once the system has been made by the system that you are going to qualify for discharge and disability; you are going to be processed for that.

Your question I think, Ron, is a good one, which is, you know, in the frustration of Service members who linger with definable injuries, and sometimes illnesses, before the decision is made by the medical practitioners you're no longer fit for duty; your injuries or your illness is not compatible with remaining on active service, and so, we are going to forge you into the IDES system.

The only other way to get off active duty, right, is either to just

separate, to just retire, or to be given a disease not considered a disability, a condition not considered to be a disability, sleepwalking, that kind of thing.

And that has to do with the limited-duty status. What you are talking about is people on limited-duty status. We put them on a medical board or a limited-duty medical board. We renew the medical board. There are rules that say, after two medical boards, you either have to be fit for full duty or you have to be put in the disability system.

But other people go, "You know what?" People don't follow policy. "I think if this person had just six more months to heal, they could get it." And so, that is part of the problem, is leading up to it.

So, this is really dealing, though, with the disability evaluation system, which is, once the switch has been toggled by the Service to say, "You're not staying in.

We're going to process you for disability." That's what this is.

And then, you have, by instruction, you have something like 297 days from the time that decision is made to the time your disability dispensation is made.

MR. DRACH: But should we and do we want to separate them, or not talk about the process leading up to, "When do I get into the IDES system? How long does it take?" What can we do to effectively facilitate earlier entry into the IDES system if, in fact, there is a reason to do that?

There are two issues here, I think.

CO-CHAIR NATHAN: My concern would be you can find individual cases that you can make a strong point in their favor; people who have said, "Boy, I wish I had just gotten out two years earlier instead of lingered on." In other cases, there have been people who have been returned to duty because the Services

dragged their feet on folding, and they have been able to heal and return and find programs to return. So, I think that one is a little more nebulous.

And I don't know that we have had the opportunity to really see, evaluate, and talk to people at length about the merits of deciding when to go to the disability system. Where we have put most of our gravitas is once they enter the IDES system and how it is going to work.

So, I think your point is very well-taken. It is just that it becomes more nebulous to try to figure out how the Services should get somebody into IDES as opposed to once they make the decision. Because once they make the decision, now we are on Mr. Toad's Wild Ride. Each Service has different ways of approaching it. They have different administrative procedures. There is very little transparency to the individual, and it is, as you know, the IDES is the sum of its

parts. And the two parts is the DoD part and the VA part. Each one can be the chokepoint for it. So, I think that is sort of what we are trying to wrestle with now.

But if your point is there are some people who they should have made a decision on much earlier and put them in the IDES system earlier, amen, absolutely. But I don't know how we are going to wrestle that one to the ground.

CO-CHAIR CROCKETT-JONES: I have a suggestion for this topic that has just occurred to me. When we looked at the IT issue and we wanted VA and DoD to come together, we recognized that there needed to be a joint answer and it was going to take time. It was down the road.

And we told them, "You need to work on that. But, in the interim, you need steps to improve what is right here and now."

And I am kind of thinking that, when I think about all that we have talked

about as a group and everything we have seen, that is possibly what we need to say here. Although I think Mr. Rehbein captured lots of the topics that concerned us about the current system, that as a group, we generally have said the system itself is what needs to be changed, that the evaluation system needs to be transformed dramatically for many reasons, not just these sub-reasons, but because it does not seem equitable. It is outdated. The rating systems need to be reevaluated.

There are so many aspects to it that need to be changed, that perhaps the entire system needs to be reviewed and altered. And so, perhaps we want to craft language that is very similar to what we did for the IT. And basically, what we need is this needs to be something fully owned by both DoD and VA. The long-term answer needs to be something that is more equitable, that is easier to facilitate changes, especially in the way we rate things, because disabilities

change. And the impact on a person's life of various diseases and injuries changes.

So, the system by which we evaluate them has to be more flexible than the current system, and it needs to be able to fluctuate in its capacity, as we have more and less -- there needs to be some hallmarks for a long-term system, and DoD and VA need to own that and work towards a long-term solution. They need that as a project in the same way they need an integrated information and health record system. But, in the interim, we need them to also look at these things.

CAPT SANDERS: So, would a possibility be forwarding these as benchmarks to go forward, that we would ask them to actually hit those nodes along the way to build this new system?

CO-CHAIR CROCKETT-JONES: I wouldn't say benchmarks. I would say that these are the interim measures we need them to take care of while this evaluation system

stands. But, in the long-term, they need a different evaluation system.

CO-CHAIR NATHAN: Well, you have got to decide a couple of fundamental tactical things first, I think, that we have to decide as a recommendation.

Do we believe that the current system of each Service having an independent way of processing IDES is correct? In other words, each Service has cultivated what they think is best for them in the way they process them, the people they hire to do it, the number of people they hire to do it, and the process they do it. It is a little bit different in every Service.

So, I think that is one of our fundamental questions. Before we improve this, do we believe that one size should fit all? Because it is going to be pretty hard to align it with the VA if we already have the feeding system into it somewhat disparate.

CO-CHAIR CROCKETT-JONES: Well, I

think one of the things that we have seen everywhere we went was an increasingly purple medical health system for military members; disparate systems are painful for Service members and frustrating for family members. And they encourage a sense of unfairness and confrontation.

So, I think that, as much as all the Services are going to not like changing and accepting a DoD-wide avenue, that is the reality of the financial situation. That is the economic reality on the ground.

And so, I think we need to talk about unifying the system, yes, you're right; I can see that. That needs to be part of this discussion.

MS. MALEBRANCHE: I think, also, one of the things that they have been working on in this DES system is coming up with these standardized templates for different conditions, so that everybody who sees the individual, whether it be the Air Force, Navy,

civilian, or VA, you have a standard template for a condition.

And everybody is trained differently. So, they might look at that. But they have been starting to do this, and it is even more and more now. I can't remember the template; there's a name for this. Yes, the DBQs.

And so, that is the first effort to standardize, when a lot of things were noticed. And so, that would seem to say that, yes, you do need a single system and, yes, perhaps this is another area of joint policy.

We have talked about in other areas, but this would seem to be one that certainly would be one of the first and foremost areas that could use that, knowing that your providers come from different backgrounds, as do your Service members. But it should be objective enough that, regardless of where they come from, you should be able to do this physical.

CSM DeJONG: I think we are looking at, I mean, it is a huge recommendation. And I agree wholeheartedly with the conversation that we have had.

I think if we look at it, there are two separate aspects of what we have to look at. One is what we have just talked about with standardizing the actual system, and we have to look at the VA system. Right now, at the VA -- and we have had this discussion -- it really does not foster an environment of healing. Right now, we reward staying broke. As you heal, your benefits will get less, and no one likes to do that.

So, there are two different aspects that we have to look at. One is getting into it, but I think we also have to separate that from the VA and how we review the comp and pension overall.

So, I think if we meld these together right now under one recommendation, we are going to lose visibility on what we are

trying to do for each, for the Services side and the VA side. I think we are going to lose something in the middle of that.

So, as I listen to the conversation, I was considering -- I'll just throw it out there on the floor -- looking at this as two different recommendations, one for the comp and pension side and one for the IDES side. They are going to have to work together to come up with what Ms. Malebranche was just talking about, the standards. But, then, the VA that is now doing all the comp and pension is going to have to handle that on their own.

CO-CHAIR NATHAN: That is a good point. The IDES piece is the travel, is your travels through the system to reach a decision on compensation. That is the tactical, logistical path you navigate to get the decision.

And what you are saying, I think, is that decision needs another look at, as to how that decision is made and how motivational

it is to somebody to encourage health, rather than persistent illness or injury or disease.

You know, this is an elephant and we are all taking a little bite of it at different places as it continues to mow down trees in the jungle.

I think we need to decide firsthand how big you want to go. As you said, Command Sergeant Major, "Go big or go home." How big do you want to go on the IDES system?

Because what I am hearing -- and I am just summarizing what I have been hearing from you all, not offering -- do we need to completely revolutionize and reconstruct a new IDES system? Is the one that we have now, because of some of the things that are listed there, because it is not transparent, because it doesn't reward for motivation, but it rewards for disability, because it is different among the Services, because there are still significant seams because of the

electronic medical record between the DoD and the VA -- does our first recommendation in bold need to be completely renovate, reconstruct, reorganize the IDES system?

That is world hunger, but, then, somebody would say, "Well, that's nice. Thanks. Okay, well, our job is done. You know, we're done. We gave you the recommendation." You know, "Russia and Ukraine, stop messing with each other. Thank you. We're done. That will be 50 bucks, please."

I mean, that is a big thing to say, and then, we have to, I think, go down and give some talking points as to what, some bullets as to what we would do to organize the IDES system.

And, No. 1, thoughts, just thoughts. You know, some people might say the first thing you do is you're going to assemble a functional team, a cross-functional team from the Services and from the VA and from

family members. And you don't want it too big because too big, you will never get anything done; too small, it will be too myopic. But you want to get it just right with the right number of people at the party who you lock in a room, you slide pizza under a door, and you don't unlock the door until they come out with a new IDES system that is applicable to all the Services and that the VA has bought off on, and that either uses the current IMIT system or recommends how they are going to get to one that works.

But that is, I think, the first thing we have to decide, is: are we going to try to wicker the current IDES system and finetune it to make it better, based on our visits and the people we have had in front of us who have told us about it? Or, do we say, if it were us, I would bulldoze the house down and I would rebuild it together, this time with all Services and the VA with a hammer and a saw, looking over the plans, and building it

back together?

CAPT SANDERS: I think we need to go with the latter, frankly. There is a lot of piecemeal work that could be done to try to fix the system as it exists, but, the end-state, we are going to be back where we were, not really addressing all the things that need to be done in a holistic manner.

CO-CHAIR NATHAN: One more comment, and then I will yield to the rest of the crowd.

But I was interested, I pulled a book from the Civil War, Congress and the Civil War, and it was deja vu all over again. Congress was arguing about how they are going to take care of the veterans and how we are going to fund it and what the process should be, and how we pension people.

And I don't know if you all saw in The Wall Street Journal an article. There is one remaining pensioner from the Civil War. It is the daughter of a widow of a Civil War

soldier. She is now 85 years old. She is the last remaining pensioner. She receives $79 a month, which was the pension that the soldier gave to his wife. They had a daughter, and the daughter received it from the wife. The modern equivalent is the -- I'm blanking on when you can elect to give your spouse your retirement. I am forgetting the name of that system. SBP. So, it is sort of the old-fashioned SBP from the Civil War.

So, the tail on this is incredible. I mean, this is the tail. I'm not saying it is right or wrong.

At any rate, I think that we have been wrestling with this, everything, because we have continued to approach it from each Service thinks theirs is best and thinks theirs only works for theirs, and the members get caught in the middle.

The VA and the DoD have been stovepiped, and they still are, by the way. I mean, you can't get either one to really hug

each other over an EHR. They are being brought together by the White House, which is sort of like Tito bringing the Balkans together.

And so, I think that there is merit, whether there is pragmatism in it, whether it will bite and get any traction, and whether Congress will stand up and say, "Holy guacamole, why didn't we think of this? So it is written, so it shall be done."

But, nonetheless, maybe the good thing to do is to just simply say, if we feel this inertly in our visits, the people we hear stand before us, our own personal experiences, that they just need to rebuild this, so that the warrior of 2025 or 2030 won't be encumbered with these challenges.

Suzanne, you were going to say something?

CO-CHAIR CROCKETT-JONES: No.

CAPT SANDERS: I just think one of the things that we are looking for is put the

"uniform" back in this, which is "uniformity" across the board. And every other thing that we think about in the military Services, we think about uniformity. Why would we be looking in a different direction for this when it is the same issue for every Service member, no matter what color your uniform is?

LT COL WONG: If this is going to be our silver bullet, this is going to be our big statement, I think as we frame it also we do have to acknowledge that there have been some improvements from the DES to the IDES within this five-year span. Otherwise, we will lose that silver bullet framing because they will say, "Hey, we've already improved the timing of this."

And so, therefore, we use that as a starting point and emphasize areas that still we really feel heartily that need to be addressed, like a total reform, with giving them the acknowledgment, kind of like padding per se, as you break the news to them.

Talking about adding behavioral health, you know, inclusion of the family members which minutely has been touched within these five years; emphasizing recovery.

And I see we are always putting transparency and time in the same sentence, and I think that maybe needs to be separated because people will say, "Well, we have improved the time. We went from 400 days down to 108. That's almost a 50-percent improvement." And then, you lose the emphasis of transparency.

MS. MALEBRANCHE: I think the days has always been somewhat artificial, you know, the 400 down to the 200. It was trying to get a time and trying to get a measure.

And I am trying to remember when Dole-Shalala first came out there was initially some recommendations put together, and some of those things even looked at other countries and how they do a one-time disability payment for those that are

obviously not coming back to service.

And I believe it is the UK that, for that possibly would come back, they look at the work program and how they can get a meaningful work and go back into life.

And so, those sorts of things were, I think, just skimmed over the top. We did not go into that when we looked at IDES. And so, in thinking what the Admiral is talking about, there I think is some merit to going to looking at that as opposed to putting together all these different things. It would be somewhat uniform, though I am sure folks would not agree with it across the board.

I think there is also this aspect of countries and how they do their care, their national care system. So, when they are in their Service and they are out, they can go to their country and they will always have care, equitable as it is across the board. So, there is a different type of healthcare. It is almost a socialist type of healthcare.

So, those are other things to look at for IDES to try to make it more equitable. And several folks mentioned, too, like the system with VA and coming back. And then, it is kind of perverse incentive: if you get better, you will get things taken away. So, that has to be somehow I think equalized because that is not an incentive to get better and to do work.

So, I am not sure of the answer, but there are ways to look at this. And we didn't delve too much into those pieces. We looked at the current system and tried making it better. So, I think that is an option where we have given some thought to that.

CO-CHAIR CROCKETT-JONES: I would say, yes, we have seen that there is a huge issue for Service members on maintaining healthcare for their family because that number determines whether they get affordable healthcare for their family or not. And everybody wants to hit that number, and it's

just huge.

And that has to do with our current, you know, the healthcare as it exists in this country. But I think that IDES itself is such a huge topic, that they could have a Task Force of this size, doing this much work, just on fixing IDES. And we were given 13 other topics. So, our scope was very limited.

I think I just want to reiterate that in the past when the same issues and sort of depth and breadth of knowledge required to fix them is part of the electronic health record, and what we had recommended in the past is: that's your target and you need to form serious teams getting you to that target, but there is an interim reality for Service members that they can't wait until you get there. You need to look at or fix this set of interim issues while this still exists, but that this is not a sufficient system.

And I don't mind, basically, whether that is one recommendation or two, I

am not as concerned about structure, though I defer to those who are more familiar with understanding the people who receive this, since I really don't understand how they read these.

But I think we need to say both those things. I think that we can't sacrifice one or the other because time and time again this Task Force, as we talk as members and talk with folks on our trips, we see both those situations as being near critical mass. A new system is definitely required. It needs to be uniform. It needs to be transparent. It needs to be flexible. It needs to be more effective and less confrontational. It needs to encourage work.

We see all of those things as being required and this system not being able to adapt to them. But we also know that the current system has some obvious fixes that could happen in the interim. I don't think we can sacrifice one or the other because they

both seem to be at critical mass.

But I think we need to task DoD and VA jointly to come up with a new system, and I think we need to task DoD and VA to have some interim fixes for the problems that are critical right now in the current system. I think we really need both of these things.

Two recommendations, one recommendation, five recommendations, I defer on that, on the structure, but I don't want us to think that we have to sacrifice one of those recommendations for the other. I think it is a legitimate thing to say, "This is your target. It is going to take you years to get there, and in the interim you can't let Service members suffer the way they are suffering now." I think that is completely legitimate.

DR. PHILLIPS: Let me make some suggestions, just listening to the conversation.

So much depends on semantics and

how you say it. I think if we say we recommend a new system, we will get tremendous pushback because will say, "Well, you know, we have been working so hard to establish and fix what we have." But if we say that we would like all the Services to have a single template, I mean, we're not saying it is a new system, but it sort of is. We mandate or we would like the Services all to have a single template for folks to get through the system. And then, we add the bullet points that are appropriate, and these are the endpoints we would like to achieve: transparency, emphasize wellness, the family involvement, et cetera, like that.

And then, perhaps to address what Mr. Drach said, I think it is very important that perhaps there have to be specific criteria for entrance; all the Services have the same criteria for entrance into that system. I mean, it may be as simple as saying that, if you are not going to return to duty,

then let's just get you into that system.

So, rather than saying, "Let's create a new system," let's say what we think needs to be done. I think if we say one template for all the Services, that really is a huge step, if we can get that done.

MR. DRACH: Suzanne, you opened up another box here when you mentioned the IDES system encouraging work. It is mentioned differently in the recommendation.

It is my opinion, only my opinion, going back to my earlier discussion, the IDES system does not encourage or discourage work; it is the time it takes to get to the IDES system. If I am sitting around for 18, 22, 24 months doing nothing, twiddling my thumbs, I become, in my mind, too disabled to do anything because nobody is letting me do anything or nobody is encouraging me to do anything.

If you are talking about compensation as a result of the outcome of the

IDES system, you are talking about changing the rating schedule because the rating schedule is what determines the percentage of disability, not whether or not the person goes to work.

CO-CHAIR CROCKETT-JONES: Mr. Drach, I think when we talk about the IDES system, we include the activities of the person who is in the process. I mean, I think that is, in part, what they are able to do, what they are allowed to do, what they have access to, what the expectations are of that Service member while they are waiting. I think we would like to see that more standardized and taken into account in the system.

But I can see that that is a different part of the process than the actual evaluation system. Under Mr. Rehbein's, we have sort of combined those two, the time that they are spending and what they have access to while they are in the system and the system

itself. That is sort of how it is set up on these two things, because one of the bullets is to allow Service members access to enrollment in education and training programs. Technically, they do have that access.

What we want is the process to account for some of those timelines. We want to standardize things, so that folks don't wind up being pushed into a system, and they have too short of a time to go do a college enrollment or they are too short of a time to do vocational internships, or something like that.

So, we have sort of combined those two issues. And I see what you are saying, Mr. Drach; they are really two different issues.

Once again, I will defer to the larger group.

MR. DRACH: They are two different issues, and that is where my concern comes in. Do we know on average how long it takes to get

through the IDES system? We have a handout here that shows that, overall, DoD in one year there was about a 5,000 reduction in the IDES system.

So, you mentioned time to get enrolled in an education program, or whatever. If you wait until the IDES system to enroll that person, you're right, they are probably not going to have enough time.

That is why this process or this intervention has to start way before the IDES system. As soon as that individual is medically able to do something, he or she should be encouraged.

The DoDI, on the private sector internship thing, come on. You know, Operation Warfighter has been around since '05-06, something like that. If that had been opened up to the private sector five years ago, how many people would have taken advantage of it, because federal opportunities are too limited? And if you are in an MTF

where there is not a lot of federal work, then you are not going to be interested in the Operation Warfighter.

So, we can't go back and change that, but, again, if we wait until I get into the IDES system, am I already lost? Am I already convinced that I can't work because I have convinced myself that I can't work because of my disability, because people won't let me do something?

It is two different issues, and I just don't know, as the Admiral mentioned, how do we fix the first one? I don't know. But we are talking about the IDES system versus the IDES outcomes, and that is where the rating schedule comes in, the outcome, which we can't change by changing the system. We can only recommend a change.

And there is a footnote there about the Dole-Shalala report, and that is a whole other issue in terms of why the Dole-Shalala report didn't go anywhere in terms of

the compensation. It is a whole different issue.

So, anyway, I don't know.

MS. MALEBRANCHE: I think, in light of some of these things we have said -- I was listening, thinking about, Suzanne, what you said about perhaps two recommendations and, also, what Dr. Phillips said, that if we just say, "Well, this is no good," that's probably not going to fly.

But probably there are two pieces to this, to relook at IDES, and the numbers and the things we get I think aren't necessarily an accurate picture of what is occurring because the numbers of disabilities are going down. And so, when you look at total numbers, you're looking at total numbers, the end changes. So, you kind of have to move. It is like a sliding scale.

But, in light of some of the things that we did see in the current system, which you have to have a transition system to

get to a final, that doesn't mean you should stop looking at a different final. And the final piece, and we recognized that early on, and probably one of the things that didn't go because of Dole-Shalala, it is so difficult to look at a system from the 1950s and try to overhaul that from the beginning.

But perhaps to look at some business practice changes in the current one, but in the meantime continue to strive for that one when you do get the electronic health record, and that is, of course, thinking positively we are going to get that.

But I think it will be two recommendations, and the other one in the current system and how to fix that perhaps is going to have a lot of sub-recommendations. Because the other thing is, regardless of what occurs, either one of those, we are always going to have people in a disability system. And it is now changed. The war was 10 years, and it took a lot of stuff in between and

there's a lot of lessons learned in there.

But we should be able to have a system that, regardless, war or peacetime, that it should be able to flex, ebb and tide with whatever occurs, and that we should be able to do this same process and it shouldn't change because of that timing. People should still be evaluated the same. People should be able to go to work the same.

So, I think we are looking at two recommendations somewhat different, but in the meantime to keep this on track, to get there, or to at least get to that end-state, we are going to end up with different, well, two recommendations, not necessarily totally different, but one to get to the bigger one.

The overhaul we talked about early on, and we didn't tackle that one because we didn't think that would be accepted, either, or it was too difficult. There were so many things that were complicated in that.

But, anyway, just some thoughts.

MS. DAILEY: So, ladies and gentlemen, you have made lots of recommendations on IDES for the last few years to fix the current system. Okay? So, you say two recommendations. True, what I am hearing is, and these bullets you see here, these bullets kind of wrap up your years of recommendations. I see some new ones: study it. And I see another one, standardized template, that we would add in there.

So, I see a global recommendation to reform, and then, these bullets to keep everyone focused on the day-to-day activities of fixing these items as we go forward.

CO-CHAIR NATHAN: Denise, I think that is true. I think all these help improve the present system. And so, I would be fine with them.

I guess my concern is -- and I admit that sometimes trying to change the current inertial system, you run up the hill with your sword out breaking it against the

same rock over and over again.

So, right now, if you look at the IDES system, the two Services that are sort of in spec are the Navy and the Air Force, and the Marine Corps to some extent, primarily for two reasons.

Reason No. 1, they have had less demand signal with less people injured and less veterans coming out than the Army. And the other reason that the Army didn't change process, the Army just hired more people to try to stem the tide of the number of things, and the Navy changed process. But, of course, there is also a lot less people to deal with in the Navy. And so, it is easier for us to get in spec.

I am still disheartened by each Service holding onto its own unique system. And I just think as the war, God willing, winds down, and we are able to somewhat take a knee in between this war and the next, we would be remiss if we didn't say -- and you're

right, Karen, there is going to be disability, no matter what. There is going to be motor vehicle accidents. There is going to be illnesses. There is going to be meningitis. There is going to be low back pain.

But I just think that I have to believe that, after World War I, after World War II, after Vietnam, after Korea, people like us sort of sat around and said, "You know, one of these days, they've got to get one system that just works for the soldier, the sailor, the marine, the airman, because we are wrestling with it."

We have had 12 years now of war, which has just taxed our disability system and our VA processing system because the Wounded Warriors have come back, and they have piled up. The good news is now we recognize and we appreciate the emotional issues that go with post traumatic stress and with traumatic brain injury, and that has complicated the stew, because we want to make sure those folks get

their fair due.

And then, balanced against all of this is -- and I think this is why they need to sort of burn it down and rebuild it -- is the fact that I know people who are gainfully employed and working construction sites who are 100 percent disability based on the current system. It is not fraud. They have the diagnoses when they left the Service that allow 90 to 100 percent disability. It could be sleep apnea, plus they had a bad knee, plus they had migraines, plus they had asthma, but, yet, they can go out and work full-time.

And I do worry that the present system does reward disability and does encourage it. I have also heard and I think there is some merit to the one-time payment because you get a lump sum over the first year or something, and then, that's it. And then, it's up to you. If you want to stay sick, you stay sick; you're not getting any more money for it. If you want to get better, you get

better. You still got paid.

But I just think that the one recurrent theme we have had through our meetings has been, boy, it's sure complicated; it takes a long time to get through. It is frustrating to the Service member. It is frustrating to the family. There is still a huge backlog, even today, of people waiting to get into the disability system.

You have heard my joke before, which is when I talk to young kids in grade school about entering medicine in the military, I tell any of them who plan to be enrolled the Service they should start their VA disability now because of the problem with the Service and the VA trying to get people through. And it is the system we have handed them. It's the system we have handed them.

And I don't think we need to just say burn it out down and rebuild it, and rebuild it with a team that will have ownership of all of it, and then, just fold

their arms and go home, because we still have a system which is in effect now that needs some specific recommendations to make it better while they approach a new one. And I don't know if they will burn it and build a new one or not, but I think they should. I think they should.

I think we are doing a disservice to the people, to the Task Force -- when Captain Kirk, the Admiral Kirk is chairing this Board 300 years from now, I think we are doing a disservice if he has to say, "Why is the futuristic Army and futuristic Air Force still doing a different system of processing their Service members out of the military, into the disability system?"

So, I do feel that we can be bold, and I would love to see -- maybe the rest of you wouldn't -- but I would love to see a headline in The Washington Post that says, "DoD Task Force says, `Burn down current IDES system.'" Maybe that would light a fire under

somebody; I don't know. And maybe Congress would go, "Yeah, we've heard that before, but that's not realistic. Let's move on." I don't know.

So, I think that is our challenge. And, Suzanne, as you said, the flagship military medical center of the United States military, Walter Reed-Bethesda, is no longer a Navy hospital; it is no longer an Army hospital. It is a DHA joint hospital. Ft. Belvoir is a joint hospital. We are selecting our graduates, graduate medical education people, in a joint environment. All our medical care in theater now is done under a joint commander, and we are going to get more and more joint.

And I can tell you -- and I am as guilty as anybody else -- the Services on their own volition will never ever get together one day over a beer or a Pepsi and say, "Let's make on system." They won't do it. They are too wedded to their own systems.

And the only way it is ever going to happen is if that change comes from Congress.

Just like the VA and the DoD are never going to on their own say, "Let's throw out each of our own EHR systems and create a new one." They won't do it. The VA is wedded to Vista; the DoD is wedded to Alta. And hopefully, they will do it because there will be a third party pushing them by somebody, "Do it," us perhaps. I mean, we are the ones who have said, you know, "You've got to get a better EHR." So, I do think it has to be a consideration.

So, to call for the question, so we don't keep, you know, beating the horse, do any of you want to sort of synthesize what you think the recommendation should be? We are not voting on them now. We will have a business meeting in July that puts these down. So, what you say now isn't going into print, but for the staff, for Denise's staff, as they sort of capture the discussion here, what is

the philosophical viewpoint?

And it shouldn't be mine and you can take issue with mine or Suzanne's or anybody else's. But what have we heard that we think we should be doing and what are our tactical recommendations?

We know it has to stop -- we know it shouldn't go as far as, "We think you should hire three clerks for every 1,000 people." That is not as granular as we are going to get. And we know it needs to be more tactical than saying, "Get rid of the current one and build a new one." It has to be somewhere in between.

CAPT SANDERS: Well, I think we need to recognize the things that work, so we don't throw out the baby with the bath water, and reach back to the Service and say, "You've done these things. These things are good. They should go forward into a new system. Carry that forward and allow that process to happen." Someone has to identify that, the

things that have been done that are now working from DES to IDES that we want to go forward with.

Second, I do believe that Denise pointed out a couple of things that just in the discussion need to get added to the second recommendation list. And I would say that the second recommendation with some augmentation would be the direction I would favor.

CO-CHAIR CROCKETT-JONES: Okay, and I also want to point out, we do always include best practices as part of our report. So, I don't necessarily want to move them into the recommendation because I like to think less is more in the actual recommendation.

I agree with Colonel Wong about transparency standing on its own. And I totally agree with you. I would be fine even with the language that says, "Burn it down." I'm good with that. So, I'm just throwing that out there, but I know we are not going to be quite that bold.

CO-CHAIR NATHAN: That's her Berkeley roots: free the Chicago Seven.

(Laughter.)

So, to kind of get traction on all of this, I am hearing more of an interest in going towards Recommendation 2, the group of 2, with some twists and turns to it, than 1. Okay. So, I think we have got that. Okay?

And I look at 2 as sort of doing a couple of things. I look at it as, one, talking about how you can take the current system and make it better, the current system as it exists and make it better.

And then, is there room for, or should there be room for, an overarching recommendation ahead of that one that says we need to completely reexamine, rebuild, and reconstruct the IDES system, really the DES system, the Disability Evaluation System? Because, right, we went from DES to IDES to son of IDES, which was going to be rIDES, right? And rIDES sort of fell off the map.

But do we want to put an overarching thing in there at some point that says -- what does Congress say? The "spirit of Congress" or the something of Congress, the intent of Congress is that there be a new system, Disability Evaluation System, created using the best practice, but must be created by a joint group of architects from all the Services, from the VA.

CO-CHAIR CROCKETT-JONES: Yes, I think that first one may say it has to be a single system, you know, that the end result is a single standardized system that all Services use. And I think that if we have that overarching first recommendation, then the second recommendation say, you know, in the interim, while that work is being done, the current system needs to reflect these.

And if that language is clear, I think we can do both of those recommendations and get both intents that we have seen in this Task Force in the recommendations.

CO-CHAIR NATHAN: I just think Nirvana would be the Reserve soldier can walk into Naval Medical Center, San Diego, and get the same help from the same system that the Reserve sailor could get by walking into Ft. Bragg. That's what I think is Nirvana, instead of "Nope, we don't do that in the Navy. We don't use that."

You know, I have argued over this with Wounded Warriors Care as well, that we still -- before the disability system, we treat Wounded Warriors differently, not medically; they all get the same surgeon; they all get the same splint, but, after that, how we support them, how we organize the various systems.

It seems to work now. We have made it work because it has gotten a lot of attention. But, again, that is a different story.

CO-CHAIR CROCKETT-JONES: Okay. So, I think that we have gotten the framework

for this first sort of very difficult topic.

If we take like a 15-minute break, I think we are ready to move on to the next topic.

CO-CHAIR NATHAN: Any further alibis before -- this says "Break for lunch," but --

(Laughter.)

CO-CHAIR CROCKETT-JONES: Yes, no one is getting lunch yet.

CO-CHAIR NATHAN: Yes, we haven't moved that far yet.

Okay. All right. So, we will be back at 9:30.

(Whereupon, the foregoing matter went off the record at 9:14 a.m. and went back on the record at 9:33 a.m.)

CO-CHAIR NATHAN: Okay. So, we are going to now review strategic observations that are related to the harmonizing of Recovering Warrior health and the transition services across the DoD, the VA, and other

federal agencies, and the private sector, the private sector being key I think.

This observation comes from our exposure to Service member-centered metropolitan areas such as San Antonio, San Diego, and Tampa, that are demonstrating high levels of innovation in addressing the needs of the Service members and veterans.

This observation seeks to integrate the many public and private services available into one seamless net for addressing the transition from Service member to veteran. The text of this observation includes additions provided through feedback from Lieutenant Colonel Wong, specifically the new item highlighted in red.

In addition to the new ideas, items from Point 3 through Point 7 pull together some observations from other areas. During our discussion, we will need to consider the best place for these observations if we wish to have them in the non-voted

draft.

As we review Items 1a through 1h, I ask you select those ideas that are most important to you.

Ms. Malebranche will please the discussion. Mr. Drach and I will also support this discussion.

Before I turn it over to Karen, I will just simply add, for those of you who didn't make some of those trips, there are some areas in the country which have really -- they are on a pretty good journey of trying to find a collaborative environment to take care of the veteran or the transitioning Service member across the spectrum of the VA.

And I will use Tampa as an example. So, the James Haley, located on one side of the University of South Florida, SOCOM and Admiral McRaven located on the other side of USF, and they are both intersecting through USF. And USF is trying to build programs that can accommodate the transitioning warriors out

of SOCOM and support the veterans at the Haley VA. And it seems like a pretty synergistic relationship.

So, Karen, your initial thoughts?

MS. MALEBRANCHE: Well, so many of the places we visited I think are different. As the Admiral mentioned, I thought that Florida was probably one of the best examples of how things are working very, very well.

In talking about some of the things like the Lead Coordinator Initiative, that is still a pilot, and it is still part of this Interagency Care and Coordination Committee. And I understand that you had a briefing on that last time.

So far, it appears that that Lead Coordinator Initiative is working very well, and we are getting closer and closer, I think, to some finalization. We just had a meeting last Friday in which the Policy and Oversight Group that Dr. Smith and I chair, we think that we are going to have that joint MOU

signed this coming week here.

And we talked about the charters for the different groups. One is this community of practice, which is probably -- I think Florida is almost the embodiment of that idea, this community of practice that pulls together the civilian, the military, the VA, and all those things together.

And I noticed there were a number of different items under this, too. Each one of those of those I think is somewhat of a separate discussion, such as the Centers of Excellence and the staffing of those.

I guess I want to be a little bit careful when we talk about ratios and things because it seems that there are so many other factors, geographical barriers, those sorts of things. I mean, certainly, we found almost everyplace we have gone there has been some very synergistic sorts of activity when people are placed together, such as the liaison groups. And I think that is still not

happening everywhere. So, I would like to kind of look at those, too.

But I thought the visit in Florida was probably one of the best. The visit in San Antonio, which also has a lot of these different groups, there were some significant issues there that I think we probably ought to talk about again, some of it geography and some of it service-centric.

But the ratios, I am not so sure about. That in our past recommendations was a significant issue. I am not so sure that that is as much now as some of the larger leadership issues.

CO-CHAIR CROCKETT-JONES: I agree. I think that we have discovered that and we have recommended in the past, trying to get fidelity on how to calculate ratios and what some of the other factors are.

I love the language of saying that this is an enduring mission. And I hope that we include that somewhere in this

recommendation under this topic. That has been a concern from the beginning that many of the members have voiced that we want to see some strategy to maintain this as an enduring mission into the future and not lose institutional knowledge, processes, structure.

I am not sure how comfortable I would be talking to the level of ratios and the specifics under "a", but I do think we need to address that there is a call for an enduring mission, and that some of the progressive structure that we are seeing just emerging shouldn't fall off the cliff with the contraction of the services.

MS. MALEBRANCHE: Did you, when you had the briefing from the Interagency folks last time, see the structure of how that fits under the Joint Executive Committee?

MS. DAILEY: Yes.

MS. MALEBRANCHE: Okay. Because that was one of those very things for the enduring piece, and I echo what Ms. Crockett-

Jones says. And then, that is one of the things that our Secretary charged us with, in that he said, as the war waxes and wanes, this system should not be created every time we have a new conflict or something comes up, but it should always be there. So, he wanted process in place, and I think that is key. And processes are what are being looked at now with the Services. So, I think that is absolutely key.

MS. MALEBRANCHE: Okay. So, I am going to pull the red there out. That is too tactical.

Ladies and gentlemen, the essence -- the essence -- of this recommendation is the public/private collaboration, the building of the safety net and the DoD and VA's leadership in that role as people transition to civilian life, and incorporating the many benevolent organizations we have out there. That is the essence of that.

Are there comments on that?

CO-CHAIR CROCKETT-JONES: Yes, I just wanted to say that we have seen models in San Antonio and San Diego and Tampa. I would hope that there could be some guidance, some more formal method of guidance from DoD and VA jointly to those communities that want to coordinate the local benevolent services, the public and private interaction.

Right now, a community starts this, starts the ball rolling, and develops a unique situation in every new location. And I understand that every community is different, has different organizations. They do need to be unique in some ways.

But there should also be some input from DoD and VA to make that comprehensive and best practices and transmit it, rather than every town has to reinvent the wheel, and things get left behind. And best practices aren't learned from one city to another as they grow this community of practice to address those needs.

And so, I would like to see some formalized -- it would be great if the DoD or the VA had an expert to loan those communities in some way to help them create this community of practice and share best practices. I don't know what place within the DoD is the base of knowledge for that, but I am just throwing it out there. I am not wedded to this. I just want to throw this out there as the thing that I avoid.

MS. MALEBRANCHE: One of the things in the IC3 is the Community of Practice Work Group. Currently, Ms. Nancy Weaver on DoD side, Dr. Raj Jain, and two other Co-Chairs are working that sort of issue.

There also is this Office of Community Engagement that the First Lady has brought up that I think both DoD and the VA are actively working.

I think we did see some of this in Florida, of this coalescing of these different things together. That, to me, was one of the

best examples, and certainly they even presented to us all together. I thought that was excellent. I think other folks had the same impression; I'm not sure, but I do think that that was one of the better examples that we saw of community engagement for longevity and how they worked it within the current system that could be even leveraged further.

DR. PHILLIPS: We all agree that San Antonio and Tampa are just wonderful models of public/private cooperation. And we know the world is flat and it is getting flatter.

This is just a bit sideways, but let me throw out a suggestion that might actually come to a recommendation and let me just preface it by saying next month I'll be 74 years old. I have the best access and the best delivery of care possible. I have TRICARE; I have Medicare. I can go to any military hospital. I can go to any VA hospital. I can go to any civilian clinic and

be cared for.

Why sort of at the tail-end of my existence do I have better care than, say, a 23-year-old who had both legs blown off or was blinded, and so forth? And so, again, this is a little sideways, but in my mind I'm saying, if I am eligible for DoD care, if I am eligible for VA care, why can't I be immediately automatically eligible for Medicare? I guess I don't have to go into those details about the benefits of doing that related to remote locations and waiting lists, and so forth.

I know that if you're an injured service member, you have to wait about two years before you can do some of these things. But I just throw that out because I think something like that would cover a lot of the issues we are dealing with. It is the same pot of money, and the number of people that would be accessing perhaps Medicare would be very small compared to the total picture. And

again, I just emphasize, it is the same pot of money through the VA, Medicare, DoD.

So, I don't know what the term would be. I don't know how this would -- you know, Congress would have to do it. But if you're eligible for the two that I mentioned, DoD and VA, why not do the Medicare.

CO-CHAIR CROCKETT-JONES: I want us to hold that thought because I think that this topic focuses more on the non-medical, and that it is a public/private partnership between benevolent organizations and the Services in transition.

But I don't dismiss your point because I agree with you. But I think that this is more about a non-medical support.

MR. DRACH: Well, first of all, I would like to say I like the idea of the enduring mission. Now there was some reference earlier about, once the war is over, everybody is back, we are going to still continue to have injuries, illnesses,

accidents, et cetera, but we are also going to have injuries under combat simulations, training accidents. You're still going to have amputations. You're still going to possibly have TBIs. You still can possibly have PTSD. You know, that could be. But I think the idea of enduring mission helps that.

When you talk about the benevolent organizations -- and I don't know if this has been totally resolved -- but in the early days, when organizations came forward and said, "We want to provide a free meal," and we want to provide this, the $25 gift thing came up, now that has been resolved to a certain extent, maybe totally. I'm not really, really sure.

But what restrictions are there still with regards to benevolent organizations? Looking at the VA system -- and it may have changed -- it used to be that, if a veterans' organization wanted to donate a TV to the VA office, they could do it to the

healthcare system, to the hospital; they couldn't do it to the VBA, the Veterans Benefits Administration. They couldn't donate anything to VBA. They could donate almost anything to the healthcare system.

So, are there still restrictions on what benevolent organizations can and will and do provide? I just don't know what restrictions there might be.

When you look at community of practice, what can we learn or what can we find by going back and looking at Admiral Mullen's Sea of Goodwill? What has he framed, what did he frame, when he was Chairman about the community of practice? I know I haven't read it for quite a while, but there may be something of value in that document that we could call from.

When you talk about cities taking the lead and you talk about collaboration with private/public, et cetera, I don't think I have heard anything about the public health

system being enrolled in this.

I was at the American Public Health Association Conference in November up in Boston. Based on my observations at that, and talking at some of the people that are involved in that system, they are not ready; the healthcare system is not ready for the tsunami, let alone VA and DoD. So, we talk about the tsunami.

So, what can we fold into our recommendation that would pull in the public health system, whether it be the American Public Health Association or something more broad or more specific maybe to the local community?

And then, going just a couple of paragraphs ahead under "b", we talk about "DoD and VA should provide leadership for cities to establish and resource comprehensive interagency solutions, one-stop centers." Who would man these one-stop centers? Would this be established by the city? Would the city

pay for it? Would it come out of city coffers? Would they be willing to do this, because they have to pay for it? Are we recommending any federal support?

And we talk about there the public/private partnerships. Now you can correct me if I am wrong, but I vaguely remember reading something back in the early years following 9/11 when the Craig Institute and Johns Hopkins and a few others came forward and said, "We've got a lot of experience with TBI. We can help you." And the response was, "Don't worry. We've got this. Everything is taken care of." And we found that it is not okay.

So, when we look at the public/private partnerships, I think we ought to look at and maybe even specifically mention public health systems and these rehab hospitals that have extensive experience in dealing with particular TBI and other severe physical injuries.

CO-CHAIR NATHAN: Ron, you bring up a lot of great points. I think we need to understand the genesis of why that different places have done so well.

Florida was orchestrated by the energy and passion of the SOCOM leadership next to a university that said, "Boy, you know, we can't beat them, so let's join them, and let's harvest this relationship." And they happened to proximated to one of the flagship VA hospitals.

So, it was the leadership of the three private -- or "private" is the wrong word -- but the three separate institutions, the VA leadership locally, the USF campus which had sort of a vision and said, "We're sitting right here between these two. We ought to figure out a way to (a) do some things that's good and (b) make some money at the same time and grow our programs."

And SOCOM is saying, "Wow, this is great. You guys at the VA and you guys at the

University want to sort of team up with us and figure out some TBI and PTS stuff for our Special Forces. That's great."

So, that came from the various participants, as opposed to San Diego, across the country, which was generated by the city elders. The city elders said, "Wow, we remember what happened in Vietnam, and it wasn't pretty. This downtown San Diego was laden with homeless vets that basically were a blight on our beautiful city."

And so, for two reasons, No. 1, we don't want people to be homeless; we want to take care of them. And No. 2, we just don't need it for the ambiance of San Diego, and it costs us so much resource-wise to take care of homeless people. Let's figure it out ahead of time.

So, they created, through the Chamber of Commerce, a consortium -- and I can't remember the exact name of it -- but that is the one that now they are the ones who

brought the Navy together with the VA together, with the city together, and they are trying to build a large infrastructure, an actual building that they are going to call the one-stop shopping for the veteran that comes back. And they are going to want to have VA counselors in it, and they are going to want to have DoD counselors. They are going to want to have partial homeless social workers and a homeless shelter. So, they can get these people in.

So, going back to the Denise's point, if this section is really about trying to create more marriages of civic organizations with the private sector, with the academic sector, with the VA and with the DoD, then one recommendation may have to be, since in some places they don't grow it their own -- it naturally occurred in Florida. It occurred with city elders with some prescience in San Diego. In other places it may have to be either federally- or state-mandated.

In other words, is there a practical recommendation that goes back to Congress that Congress has some way of saying to the Services or to the country, to a governor, or at the federal level, "You will create something analogous to what San Diego did. You will create at least a committee or a task force within your major city, or at least at the state level, that forces these organizations to talk to each other and look at how you're going to be synergistic in your approach to healthcare."

Because, otherwise, you know, I don't know what the veteran population is in Cincinnati, but it gets cold there and people tend to migrate down south. Hence, Tampa and Miami are two places where veterans just stack up like cordwood, because if they don't have much to live on, they would rather live in a warmer climate than a colder one.

I am just sort of throwing this out there, just to make sure you understand

the differences, the difference in genesis between the two model cities or model areas of the country.

MS. MALEBRANCHE: Something else that comes to mind is, when we were in Alaska, too, because of their geographic and how they work together, but I think not to be the person that throws out barriers, but some of the things to consider are, like right now the military has got these multi-Service markets. So, that is already forcing three Services to kind of come together. VA is not part of that, but kind of. I mean, it is a little different. That hasn't been part of it.

But, as Dr. Phillips was mentioning, too, the country is divided in TRICARE areas; the country is divided in VISNs by the VA. We now have the MISNs, the multi-Service markets. We also have state. I mean, there is a number. Navy has a way they have divided, the Army has a way, but I think that is kind of taking -- the MISNs I think has

taken over that.

So, those are some things from a national level, when we are suggesting some ways to look at things, that perhaps are starting points to look at where we should do things together.

I know when it first came out with TRICARE in the Colorado area, where I was, it was like the Pike's Peak Commission, and they all got together for those people in that area. So, it seems to be a natural draw, maybe not always, but it does seem like we have a start with this multi-Service market, that the country does have some borders and things to pull together.

CO-CHAIR CROCKETT-JONES: Yes, I would say that we also want to consider that, rather than recommending -- I think that there are many templates, and every place is going to have something that works more effectively with what is the void.

You know, I come from a place --

you know, Baltimore has more healthcare specialty care and it would never need a template that draws on more healthcare, but it does lack coordination on transitional services and all the non-medical things.

As opposed to someplace like Nebraska, you know, Lincoln, Nebraska, which might not have great access to some of those specialty cares that specifically our Service members need, but they have got a lot more community interaction, and non-medical transitional services might be a lot easier to coordinate there.

So, I think that when we looked at this, what we saw was that there are a number of ways to peel this banana, skin the cat, whatever. And we would like to see DoD and VA a little more invested in helping to template that, so that they aren't -- some of the issues that they have more expertise in that don't go sight unseen by these local upgrowing communities. They come up from the

grassroots, and they may not have a grasp of how important psychological healthcare is or they may not have a grasp of the issue is transportation to VA, not VA provision.

So, we have seen some successful templates, more than one. Considering how many people are going to be getting out and still needing these services, we can't let people fall off a cliff.

So, I think that was the genesis of this recommendation, though I think we still are not real clear on how we wanted this to happen or what this recommendation should really look like.

What is the comfort level? I would like to sort of survey you all about what the comfort level is with this recommendation's topic area in general. So, more of you need to talk to me, is what I am saying.

Sergeant, maybe you can -- yes, you'll know; you're on the spot.

MR. STONE: So, if I may -- and I apologize to the Committee for my tardiness this morning -- if my comments are misplaced, then sign it off on my late arrival.

I have a very simplistic view of this, and I would go back to Steve's original comments. Access to these systems is based on ability to pay for it. Therefore, systems that are put in place that allow broad access, and based on Service need or desire, is what is really necessary.

Steve's model of where he is at in his life as far as broad access to healthcare is much different than the Service member leaving active federal service who is restricted as a method of payment.

Now, frankly, that method of payment is somewhat broader for the young veteran in the first few years out. But, once out, when the TRICARE benefits may be lost, he is more restricted or she is more restricted in access. Therefore, I think the

recommendation should be about expanding payment options, allowing, then, various federal and civilian systems to come out and compete for what is best for the veterans' needs.

As far as transition coordination in the various system, the lack of access to various benefit systems is a result of the bureaucracy of the systems, nothing more. There are enough assets out in every county in this nation. There is VBA access. But they are highly-bureaucratic systems that are tough to negotiate through.

CO-CHAIR NATHAN: I think the last part of what you said, Rich, is the key because, to me, they are separate issues. One is simply access to healthcare. I know how to navigate it. I know how to get it. There is a number I can call. Am I eligible for it? This doctor takes Medicare, not TRICARE. This facility takes TRICARE, not Medicare. This facility covers whatever.

And, Denise, stop me before I kill again. But I see the crux of this being how are communities preparing themselves to handle a bolus of veterans in their community and get them to navigate the healthcare, which includes access. Access has got to be a piece of it. But how they have complemented each other with what they do and don't do.

What is available for TBI, for PTS? What innovative programs there are to support veteran-specific issues? And then, the more broader scope of access.

So, in other words, I look at this as these cities have said or these areas of the country have said we're going to have a large footprint of veterans in our community, and many of them are going to suffer from maladies which are different than the general population suffers from. Many of them the same. Many of them are going to have arthritis, heart disease, back pain, asthma, you know, pulmonary disease.

But many of them are going to have traumatic brain issues. They are going to have Post Traumatic Stress. They are going to be trying to figure out their disability and how that affects their employment and their livelihood. They are going to need federal guidelines for that.

We are already seeing in the military that, when we send our patients who have PTS or TBI to the private sector in some cities, it is not a disaster, but it is not goodness because the standard of care is so different and there's no evidence-based medicine, or little evidence-based medicine, being practiced in the private sector when we sent somebody out to the private psychiatrist or psychologist or social worker, emotional health social worker.

And so, these communities are trying to create one standard of care. For instance, in Tampa, on average, the civilian within the lifelines there will be practicing

the same kind of medicine as the person at Haley or at USF.

So, I think that that is the crux of this, is: how do we get these places to work together? Because, first of all, you have to have access. That has to be a given.

But I look at this particular subject being more on the warm handoff from one system to another for people who are in the Service and leaving the Service.

CO-CHAIR CROCKETT-JONES: I am going to throw in another caution, though. These communities that we cite have said -- for instance, at USF, they have said, "We have special opportunities that uniquely work for Service members who are transitioning out. And the way we get that information and get those opportunities to those Service members is through coordinating together and working together."

In San Diego, the town said, "We are going to have a population with unique

needs and there are services, but we need to coordinate their contact."

This is not just about medical care. In fact, I think we need to almost separate it from --

CO-CHAIR NATHAN: No, it's social services as well.

CO-CHAIR CROCKETT-JONES: It's social services as well, and it's educational opportunities and transitional opportunities. And what this recommendation focused on was not so much access, which I think we definitely need to tackle, but not necessarily under this topic. And that is to say, we also hear from benevolent organizations everywhere we go. We have no way -- we don't know how to get in touch. We don't know how to tell those Service members that we want to hire disabled veterans. We don't know how to tell those Service members that this university is willing to give TBI disability extra support through services with editing or their papers

or more opportunities for tutoring. So, they have no idea how to get in touch with Service members, and Service members don't know. There's hundreds of things available, and Service members never hear about them. And they are local, home-grown. They can't tackle going national.

You know, the place that can fund a counselor to do marriage retreats for 20 people can't go national, but they also go empty, for lack of being able to get in touch with the local Service members who are retiring and have needs because they have severe PTSD.

So, communities grown grassroots organizations, and they either focus them around -- we have seen a template where they focused it around the university or we have seen the template in San Diego where the city itself said, it's to our benefit to create this coordinated effort to marry Service members to civilian organizations that have

opportunities for them.

And then, natural best practice has been when DoD and VA are also invested in that. That is what has made the successful templates in San Diego and in Tampa and in San Antonio.

And so, this recommendation is really about saying that we can't mandate necessarily by a purview, although we could always make the recommendation to do so. We can't really mandate that cities or states do this.

But when they do, we can ask DoD and VA to have a coordinated, proactive, ready assistance for those places, so that they aren't creating a system that doesn't work with the DoD transition and doesn't work with the VA opportunities.

CO-CHAIR NATHAN: So, let me just ask real quick, and then, more conversation. So, Suzanne, what would you sort of throw against the wall to see if it sticks for a

recommendation?

CO-CHAIR CROCKETT-JONES: I think the way I would say it is I would like DoD and VA to have a ready office of contact and be willing to supply expertise to those cities and states and communities that want to grow a community of practice for Service members who are coming out post-DD-214.

I would want them to have the resource readily available in an office, so that they don't have to search out necessarily a local representative. So, they are not working just with SOCOM in Tampa.

MS. DAILEY: So, scroll down. Read No. b. Is that in the camp? "DoD and VA should provide leadership for cities to establish and resource comprehensive interagency solutions through public/private partnerships."

CO-CHAIR CROCKETT-JONES: Exactly, "b" and "d" and add in NRD.

CO-CHAIR NATHAN: Command Sergeant

Major?

CSM DeJONG: Listening to the conversation and hearing it, I am just wondering if this isn't more of a best practice with some supporting documentation from the communities that we have talked to versus trying to make a recommendation that may be interpreted 50 different ways.

CO-CHAIR NATHAN: Thoughts on whether this should be a recommendation versus highlighted as a best practice?

MS. MALEBRANCHE: I guess one of the things I am thinking, because "b" talks about leadership for cities, but I wonder if they are looking for a national one place or different areas. I think that is going to be hard to -- I don't know, and I was thinking of NRD, too, when we were talking about that. And that's at a national level. But that would be interesting. I am not sure. And I am not answering your question here about best practice.

CO-CHAIR CROCKETT-JONES: I think there just needs to be a place that a city can go to and have contact and get a positive reception. Right now, for instance, if City X is near Marine Base Whatever, and they go to that local Marine Base and say, "You know what? We are starting, we want to have a community that responds, and we need to know about your folks," maybe the leadership there will have answers for them. Maybe they will say, "Oh, we coordinate well with the VA, and these are the people who we can talk to."

That might happen, but it doesn't necessarily happen. They might get a "Yeah, we're the military and we don't need you." They might, from leadership, because there is no -- yes, there is an office for support of community practice coordination, and it is at the DoD, and this is who you need to call. And if they need us to send you a uniformed task person to help with one issue or another, and the VA has this office and there is a

joint office, that if they had a place to go that had this resident information, then it would not be a matter of maybe it happens, maybe it's supported, maybe it doesn't.

Do you see what I am saying? I think that, right now, the best practices that we are seeing have relied on luck and great people with the right intent.

When I look at this as a possible recommendation, I am saying let's take out luck and leadership qualities out of this and say there is a structure and there is a place for that resident knowledge to be accessed by any community who wants to do this.

MS. MALEBRANCHE: I guess what I am actually saying, where do you see that structure at? At what level?

CO-CHAIR CROCKETT-JONES: I think it would have to be a joint DoD/VA initiative. I think, minimally, it has to be DoD, but I think, really, the best results are when DoD and VA work together in those circumstances.

MR. DRACH: I agree with what you are saying, Suzanne. I think you make some very, very good points.

And again, maybe I am speaking out of turn here, because I am not up on the issue as much as I should be maybe. Historically, anyway, DoD looks and the Service look at benevolent organizations to include TROA, MOAA, and that's pretty much it.

The VSOs have never really stepped forward to indicate that we support the DoD mission. They do support the VA mission, unquestionably. But they have historically, at least the traditional VSOs have pretty much historically stayed away from DoD issues.

So, I think it may be a two-way street here. The Services, the military treatment facilities, the bases, whatever, I think need to be very open, that our doors are open; we want you to come in. We want you to tell us what you can provide, what you can do, who you are, so forth and so on, and maybe

including the VSOs.

There's been -- I've heard different figures -- something like 40,000 new nonprofits established since 9/11. What are they all doing? What can they do? What do they bring to the table?

So, I think perhaps the DoD/VA collaboration again, the leadership going out there, but you don't always have a VA facility where you have a DoD facility or a military service facility. So, you have got to try to pull in somehow or other the players from other geographic locations.

But, again, as you point out, the benevolent organizations I think have a lot to bring to the table, but most people don't know what they are, who they are or what they are.

LT COL KEANE: To answer the Admiral's initial question, I believe I concur with the Sergeant Major; this should probably be a best practice.

I have been kind of silent this

morning because I am trying to take this all in, and this may not be the perfect place to put this. But I believe that we should have minimal amount of recommendations this year. This is our last year. We are not here next year to kind of follow up on anything else.

Discussion of IDES, if you turn to tab B, the last page of tab B, I kind of draft roughly three points, and maybe it is four. Maybe there are one or two that may percolate up.

But I think we really need to kind of think of hitting the home run with each recommendation. What I pull out of this one, what I saw, is anticipation of post-war what can we do in the future. That will be the third bullet, is codify what we have done with the programs that are in place, the Wounded Warrior Regiment, and such.

I throw that out there because there are several other recommendations in here, and I think the more we add, the less it

is going to stand out in importance. And if we start putting in recommendations that really kind of need followup, we won't have that ability next year.

I think we need to kind of, in my background, you know, in the back of my mind, is minimize the amount of recommendations we have. They will have more weight.

So, I would actively add this as a best practice.

CO-CHAIR NATHAN: Other thoughts?

(No response.)

Since nobody else is talking, I will just summarize what I am hearing, and maybe segue on it. If we make this a best practice, which they are. They are. We have looked at them, and we have said they are best practices.

The question is, do we feel that they need to carry the weight of a recommendation because, if you say this is a best practice to Congress, do you think -- and

again, I am sort of ambivalent about it -- but do you think that Congress, anybody will take this for action without a recommendation?

In other words, you have to decide, do you feel that when we highlight something as a best practice, there is somebody in an office somewhere that reads this and goes, "Holy guacamole, this is best practice. This is something I've got to do. I'm going to get right away to my member, to my Senator, to my Chairman, and get them to start doing this in other cities, or I'm going to take this for action in my own state. This is good stuff."?

That's technically why we highlight best practices, so that the readers of this, be it DoD, the VA system, the Congress looks at it and goes, "Yeah, boy, there's some good stuff here. We should be doing this other places."

That is why you send out best practices. We send out our IGs. When they do

an IG visit at various institutions, they always send Headquarters the best practices they saw. And then, Headquarters takes them and says, "You know what? I had no idea this commander was doing this. This is great stuff. I'm going to tell my staff to make this a policy and send it out to my other institutions." So, best practices are alive and well in our Services, I think, from what our IGs find.

So, the question you have to ask yourself -- and I am not hard one way or the other -- but, do you think this deserves enough weight that it becomes a recommendation? Because if somebody doesn't take this for action, passively, from seeing it as a best practice, there will be suffering on it.

And like the Colonel says, we don't have the ability to come back a year from now and say, "Look, you idiots, we told you this was a best practice, and we haven't

seen anything in a year that it's copied anywhere." Or, "We told you this was a recommendation, and you haven't done anything about it."

So, I would offer that as you decide whether this should be a best practice, because it is -- they are -- whether it should migrate to a recommendation. How strongly do you feel about that, balancing the Colonel's very good point that, if you give too many things that you think are important, than nothing becomes important. And if you want impact, we are going to have to tailor our recommendations to those that make impact.

MR. STONE: The problem with implementation on this one is it requires that public/private partnership, but does not guarantee funding. It does not guarantee implementation, and it has the risk of creating a large bureaucracy.

I think that Steve has probably got it right, that this is a best practice

that can be highlighted because it is going to get lost in detail on the implementation side. So, I would speak to this as a best practice rather than a recommendation.

DR. PHILLIPS: Let me throw in a little curve ball, and I apologize for this ahead of time. We look at the DoD and VA should provide. We now have two folks put in a leadership role, and they have to work together; there is no question about that.

The mission of the military is to prepare and fight wars. All these other things are important. The mission of the VA is to take care of veterans.

So, whether this be a best practice or a recommendation -- and I kind of lean toward best practice -- I think we should consider choosing one to take the leadership role, like the VA, with the DoD backing it up. Otherwise, I think we are going to be, again, not coming back next year, be wondering, well, who is supposed to do this? That is just an

added thought.

MS. MALEBRANCHE: I think, also, because we have the active duty that become veterans, and then, they are back active duty, Guard and Reserve being a huge component of what we have talked about, we have to consider that.

I understand about the best practice, but I guess in terms of being able to measure this for the future -- and I don't know a lot about this multi-Service market. But if you look at No. c, where it says, "Plan should build upon existing models of partnerships" here, such as San Antonio, it would seem to me that we ought to look at -- because I would imagine these multi-Service markets are looking at that. I remember General Keenan gave us quite a nice overview of what the Services are doing to come together.

If we had the VA in that mix, because I think public/private folks are in

there, I do agree with Dr. Stone about, you know, it is a lot of funding. Funding is the driver in a lot of these places. But I think they are building on some of these benevolent sorts of things where organizations are coming in. Sometimes they need to be vetted to make sure they are actually appropriate for that.

But perhaps in that sort of structure, that we could put this best practice to be measured in that market without creating a new additional problem in there, because it seems like that would be being looked at anyway.

But, maybe within that structure, to look at what they are already doing and build upon that. I don't know what they are already doing. They are still fairly new.

MS. DAILEY: When we lay out a best practice, ladies and gentlemen, we lay out what is going on currently with those functions. I am not sure I can integrate this with the eMSMs, ma'am. These are --

CO-CHAIR NATHAN: Well, the eMSMs are still in their infancy, and I think they are going to have to get to level flight before we can do too much external to them. But I clearly understand what you're saying, Karen. The inertia of the eMSMs is a good one, and if we can widen the aperture on them, I think we can get more and more joint collective work and efficiencies, remove redundancies.

CO-CHAIR CROCKETT-JONES: I see this being a best practice model is a perfectly legitimate alternative to a recommendation. I am going to argue your point, though, about there being more bureaucracy here.

Generally, where we have seen this stood up, the people who create this find the funding separately and they are the ones motivated to fund it and do it, the towns themselves or an organization within it that sees an opportunity through it, like the

University of Southern Florida.

And so, I don't think that this is a matter of funding. I don't think that's why this should not be a recommendation, but should be, instead, a best practice. It is fine as a best practice. I think that the important message that I glean from this is that we don't want to sort of waste energy and the force that we have in recommendations by including this in recommendations. That is fine as a best practice, but I think that we need clarity in what we are saying is the best practice and why we think DoD and VA should embrace this as a best practice and respond to it.

And if we are going to do that, then we have to be clear. We are not saying that DoD or VA should go out and set these up. We are saying that they should cooperate with those communities that move forward to do that.

Right now, there is no requirement

that they cooperate. Right now, it is completely driven by local leadership. And as a best practice, it's great. If we want to leave it to the local leadership and say this is a best practice for those of you who are interested, that is a legitimate view for the Task Force to take.

As a recommendation, it would only be to say it is in the DoD and VA's interest to make this knowledge available, to embrace that as it grows up in local communities, and to help coordinate those efforts.

Because, right now, if a city like Cincinnati has a benevolent organization say, "You know what? We're having an issue, more and more homeless vets. They are all these young guys, and they all have PTSD and they all have TBI. You know, we know there are services for them, but they never seem to get access to them."

And the VA is over here, and the folks coming out of the nearest post are

pretty far away, and there should be transportation. And some benevolent organization wants to help coordinate that and, say, resolve this, so that the people get to their services.

We want to make sure that they're not an organization that winds up making money off of our veterans or otherwise abusing the veterans or abusing the services. We don't want them to get funneled to, say, for-profit universities at the expense of public universities. It would be in the DoD and VA interest to be part of that and embrace that and not just say "when local leadership does it."

If we don't feel strongly enough to recommend that DoD and VA keep their toe in that water, but just look at this as a best practice, that is a legitimate alternative. But I really want us to be clear on what was the genesis of this recommendation. This wasn't to build a new structure. This was

about our response to local community efforts, as DoD and VA as a group.

CSM DeJONG: I am afraid that, with what Dr. Stone was saying, as soon as you take it outside of a best practice, and you start to formulate a recommendation around it, somebody is going to look at that as something that has to be done. And as soon as something has to be done, it has to be funded. And the benevolents are not going to be benevolent anymore because our leadership is saying that you must do this. So, once you say you must do this, or however it is worded, the hand comes out.

There can be best practices in a corporate world of having a meeting 30 minutes before your day starts. As soon as the CEO of the corporation says, "You will have the meeting 30 minutes before your day starts," it becomes payable.

CAPT SANDERS: Just kind of a story of a practice in the past.

Jacksonville, Florida, has a military liaison, essentially, on the Council in the city government. And that individual tracks the things that the military does in the city to keep them up-to-speed with what is going on.

And at one point in time, the city, the Boys and Girls Clubs there, the National Guard, and the police decided that they needed to attack the issue of children from 3:00 in the afternoon until 5:00 in the afternoon, the worst time of the day for children to be in trouble.

So, they took an old National Guard base, put a Boys and Girls Club in there, put a police stop station in there, made it a charter school and a community center, and had a liaison coordinate around those folks.

I think we are looking for something like that. But it wasn't driven by the feds to do it. It wasn't driven by anybody other than the community decided this

needed to happen because we were having issues with our children, and they reached out to the existing entity, the city/military liaison guy, to say, "Help us coordinate this."

So, I think we are looking for something like that.

CO-CHAIR CROCKETT-JONES: Exactly. If there hadn't been a military liaison on the city's functioning Council or department within that city, where would they have gone? That is my question.

And is there a place that they could call to say, "We need some information. How do we get permission to use this empty armory?"

And if there is a local person who knows, great. But what if there isn't? What if there is no place to call, no contact to be made, no one who knows what permits? And basically, services go uncoordinated and people remain homeless because best intentions weren't quite enough to make a best practice

happen.

And that's my question: is this a best practice that we want to say this is a best practice, but there is a role for DoD and VA? Or do we want to say this is a best practice; you should help this. You know, just say nothing more than this is a best practice, and these models should be considered in places where they are appropriate.

And either is a legitimate for the Task Force to handle this. But this is not a call to say the DoD needs to start a structure to make these things happen.

The question is, is there an entity for that communication to happen? What about places that don't have a liaison? That is really what the question is at the level of recommendation. And if it is not at a level, then the best practices is sufficient. But it is not about a model of new structure. And I just want to make us clear on what we are

contemplating.

CO-CHAIR NATHAN: So, what I hear is this either is going to be a best practice or it is going to be a recommendation. If it is a recommendation, I think Suzanne's point is a good one. It is going to mostly involve, you know, creation of a liaison person or individuals, not necessarily setting up a new building with a new group of people that are staffed with secretaries and administrators and a parking lot, but it is going to represent some augmentation of personnel and/or -- "and/or," and this would be where the funding part comes in, because I have heard this expressed by the group as well -- a central place which would require some funding, not a new building, but of a dedicated group of people from the VA and DoD who a city could call upon to ask for guidance.

Either one of those recommendations may or may not be your cup of

tea, but I think we need to decide if it is going to be a recommendation, if it is going to carry the weight of a recommendation or if it should reside as a best practice.

So far, I have sort of heard Steve say best practice, Colonel Keane say best practice, Dr. Stone say best practice, Command Sergeant Major say best practice.

Any other thoughts?

LT COL WONG: Yes, sir. I think there's a lot of very good points out here about reducing the number of recommendations, adding the weight to it, et cetera.

And if this does become a best practice, which I also concur on, some of the language that we need to emphasize is it is about easing the cooperation with these benevolent organizations or city entities, et cetera, and remove the barriers for them to be able to do it.

Because, anecdotally, there is a large city in California that wanted to do a

program like this, talked to the VA. The VA wanted to do it. But, then, they just couldn't get anyone there because they didn't know who to call. And they reached out to me because I was from that local area, and I put them in contact with other people. And it is still trying to get that traction, but, again, if they don't have a local liaison, it can be very difficult when private industry, VA, and cities want to launch something, but they just don't know how.

CO-CHAIR NATHAN: So, you can certainly make it a best practice and the framework for it in the report as it articulates this is a best practice, is to articulate what the rudiments of it are that we think makes it a best practice. And it could include verbiage such as, you know, this is a great best practice, and it includes people with a working knowledge of how the other systems work, and that must be found either internally or externally, if this is

going to be templated.

You could certainly sort of find a hybrid between a recommendation, and you could have it in the best practice section of the report, but you could sort of couch the recommendation of how you get to that best practice in it.

Going once --

MS. MALEBRANCHE: I think that is the key of how to get there in a best practice. Because I could go with best practice as long as you tell someone where to go to get that, like Office of Community Engagement. I mean, some people have that. We have that at a national level in VA. I don't know how the DoD has got that, but to have a best practice. And so, you have one; then, how do you proliferate that? There has got to be some sort of recommendation in there to where to begin.

So, I could understand that; I could go with that.

CO-CHAIR NATHAN: Ms. Dailey, I'm watching your body language over there. Don't play poker, Ms. Dailey.

MS. DAILEY: No, I'm not. I'm just trying to figure out --

CO-CHAIR NATHAN: No, I just mean you give away your hand.

MS. DAILEY: Should I or not?

So, I am game. It goes in the best practice piece. We include websites. I think the intent of best practices is that people who are interested and do it then contact those organizations and those agencies.

So, where we have a website here, for example, for San Diego Grantmakers .org, "About us," "Who we are," "What we do," "Military family support working group," it is a big website. I mean, the anticipation is that they, then, the interested communities then go to those communities and try to copy their template, use their POCs, follow their

processes for establishing it. Okay. So, I'm game for --

CO-CHAIR NATHAN: So, going once, going twice --

MR. DRACH: I'm sorry, one last comment. If we adopt anything as a best practice, aren't we, in essence, saying we are recommending that you adopt this best practice?

CO-CHAIR CROCKETT-JONES: No. No, you're not even going to vote on it.

MR. DRACH: You don't think the average reader would interpret that?

CO-CHAIR NATHAN: Well, I think we are endorsing it. I think when we say this is a best practice, we are endorsing it and saying this is something we found that works well in the location that we saw it. And we wouldn't bother to mention a best practice if we didn't think that somebody reading the report wouldn't say, "Wow, I hadn't considered that. This is something I think we should be

using in other places."

That's why you put a best practice in. It is not just to reward and say you're "good doobies" out there in San Diego or Tampa, or whatever. It is for the reader, whoever that is, of the report to say, "Hmm, I hadn't considered this. This is something that maybe I should tell with somebody else, because I think this may work well in our location." That's what you're doing with it.

But it is not going as far as to say, we're not being presumptuous and saying, if we don't recommend it, then we're not being presumptuous and saying, "We recommend you do this everywhere," because all we're doing is saying this is a best practice for you to choose or lose.

The recommendation carries more weight. The recommendation says this is not just a best practice. This is something that, if you don't do it in your location, you are missing out; you are not providing the best

paradigm. So, it is a subtle difference.

So, hearing no more, I think we are sort of settled on it is going to be a best practice, and we can finesse the wording of it a little bit as we wrestle with Ms. Dailey and the crew in the future meetings.

Once, twice, sold. Okay.

CO-CHAIR CROCKETT-JONES: We are ahead of schedule, but we can keep plowing on.

CO-CHAIR NATHAN: Keep plowing on, or does anybody need 10 minutes?

CO-CHAIR CROCKETT-JONES: Okay, let's take a quick bio break in order to get our head clear, and then, we will come back for the next topic.

(Whereupon, the foregoing matter went off the record at 10:40 a.m. and went back on the record at 11:02 a.m.)

CO-CHAIR CROCKETT-JONES: Are we ready to move on? We are transitioning into a review of observations related to interagency healthcare collaboration and

harmonization of DoD, VA, and civilian IT systems and PTSD care.

Observation 1a came directly from the Hawaii visit, which included a demonstration of the JANUS Joint Legacy Viewer.

In addition to the observations we reviewed at the April meeting, under No. 1, Mr. Rehbein included his feedback on an alternative version for the Task Force to consider.

No. 2, Observations 3 and 3b address concerns that the quality of PTSD care from network providers may not be as good as care received at the MTFs.

Observation 3c addresses concerns that those efforts are not be proliferated by the MTFs.

Observation 3d addresses greater involvement of family in PTSD treatment, regardless of HIPAA constraints.

As we review items 1a through 1b,

Mr. Rehbein's alternate, and 3a through 3d, I ask that you select those ideas that are most important to you.

I am going to ask Dr. Phillips to lead this discussion, and I expect some input from Lieutenant Colonel Keane and Command Sergeant Major DeJong.

So, I am turning this over to you, Dr. Phillips.

DR. PHILLIPS: Thank you.

Looking at both sets of recommendations, I have a suggestion. Instead of the "or", make that an "and", and then, we work and get rid of the redundancies and the duplications.

And the only question I have -- and I don't think there is an answer -- it is related to the news that I have read recently about the VA looking for a new electronic health record system. I don't know how that enters into anything that we are doing, but I think it would be appropriate if we can

continue to push the integration or the harmonization, or whatever language we want to use. So that we don't have a new system that is totally isolated and not accessible.

I mean, we are making, I think it is a good recommendation as an interim, until they can, hopefully, have a universal system, the Joint Legacy Viewer. We are making a recommendation that that be purchased by the DoD. But if the VA changes its system, I don't know how that would interact.

So, again, perhaps not "or" but "and", and then, we can talk about the specific details.

LT COL KEANE: Of all these bullets and sub-bullets, the one I am most interested in, and I think is the most important that I would bold and capitalize and italicize, would be 3d, and not pertaining just to PTSD or TBI, but for all recovering, wounded, ill, and injured Service members. It is getting that next of kin or caregiver

involved from the get-go.

You all know the benefits that we found when the caregiver or the spouse is involved early on. And that, to me, is the No. 1 important recommendation that I would recommend. If the spouse or caregiver is in the know from the get-go, everything is much easier.

CO-CHAIR CROCKETT-JONES: I think that would be an avenue for our concerns, too, about whether evidence-based treatment was being delivered. Because if a family member or caregiver has an idea of what evidence-based treatment is and what the expectations are, they will know if that is not what is being delivered, if they have the information and if they are brought into the process.

I think we get better fidelity through a caregiver or a family member on how treatment is going, whether treatment is being completed, whether someone is non-compliant, especially once they are at the VA. I think

that non-compliance can be much more difficult for them to enforce or track than they are when they are still pre-DD-214. So, sort of having a knowledgeable family would help in that process. I am wholly with Colonel Keane on that.

LT COL WONG: I would also like to concur with what Colonel Keane was mentioning. You know, I thought about this from our last business meeting and how we could remove those barriers.

I think, at the point of injury or entrance into the DES or initiating at the first limited duty is having that Service member sign a Privacy Act release or a HIPAA release for the family member as part of that process. If we make that within the process, then we remove that barrier of HIPAA, et cetera, and provide an avenue to contact that family member.

CO-CHAIR NATHAN: The devil is in the details on that. There is a family in San

Diego of a National Guard soldier who had multiple deployments, significant PTS. Got out and was followed by the VA. Cycled down, cycled down, cycled down. His parents would call him and say, "How are you doing?" He would say, "I'm doing fine." And he killed himself.

And so, now they are barnstorming the country trying to figure out a way that there would be -- and they recognize that he did not want them to know what was going on at the time he was ill. They get that, and they recognize that it is probably too dramatic to say, "We're going to tell the family anyway." In other words, we are going to just create a program that says, "You're no longer allowed privacy. We're going to tell those who love you, be it your spouse or be it your parents, what's going on with you." They recognize that's probably not right, if the person at the time really objects.

What they are advocating is that,

when you enter service or when you are first deployed, before you are injured or before you have a problem, you sign it then. Because if his parents were here, they would say, "That was when he was reasonable. That's when he would understand the goodness of having us know. But by the time he was already in the throes of his post traumatic stress and his difficulty, he was not reasonable and he did not want us to know what was going on."

The lawyers got a hold of that and said, "Okay, well, here's the challenge. What if he has changed his mind?" You know, his spirit has changed his mind when he's left and he is not incompetent medically. Or, what if this or that?

And so, I agree. And so, the family is saying, "If we had only known what was going on, we might have been able to intervene and help."

And we see that so much, especially in suicides. We see the spouse who

says, "I knew what was going on, but my husband," or my loved one, "was telling me, `Please do not call my command. Please do not tell them I am sitting in the corner crying. I will lose my security clearance,'" or "I will lose this job," or "I will lose this."

And the spouse, then, has this tremendous rush of guilt after the event, thinking "I should have told somebody, but my loved one forbad me to do it."

So, the spouse then goes to the doctor and says, you know, "This is what's going on." It's all HIPAA, HIPAA, HIPAA.

So, this is something that I think is legitimate. I mean, if we are going to make a difference for the people who have the most dramatic consequences from recovering as warriors, the most dramatic consequences, are they not, are the ones, the people who are emotionally impaired, who are emotionally disabled, and who can't recover to the fullest extent because they don't have the family as

a team supporting them?

And who do we normally see who does well when the entire family is into it? And when we were in Alaska, what did we hear from the spouses? You know, "The doctor won't let me in the room to talk with the behavioral issues of my spouse." And then, you talk to the doctor, and they say, "The spouse won't allow it."

This is even for intakes. This is even for the initial intakes where they are just told about here's how the system works.

And if you remember, one of our recommendations from last year was we were going to sort of take that option away from the member and say, "You will make the member come to you and explain why they don't want their spouse in there at the initial intake of the premise."

So, we are sort of dropping anchor here, but I think this one can change and save lives, if we can get it right. But there are

challenges because of the tremendous concern over the privilege of patient privacy.

So, I think the wording of it has to be targeted and efficient to make sense.

CAPT SANDERS: If you take a look at the wording of that last bullet under 2 and 3d, and work along the lines that you're discussing, sir, and think about that in relation to the Spouse Protection Act issues, you can't sign away your SBP without the spouse being notified, if you were able to bundle that up in a package which makes the Service member and the family all come together at a certain point in time, the Service has opt-out ability, but he can't opt-out in the dark. It has to be in the light where others can see.

And there maybe has to also be a periodic retouch. You know, every time I get ready to deploy, I have to requalify with my wife. So, every time he gets ready to do something in the process -- I don't know if

the something should be something medical -- they would have to readjust that.

Every time I change duty stations, I have to do a new page 2 and verify that everybody on that page 2 is eligible for the benefits that they're going to get from my service.

A similar-type process for folks coming through the system, either at the beginning, as this unfortunate young yeoman's parents like, or as they leave the Service and go into the VA program. And that would allow for HIPAA to still be respected, because the member is playing with knowledge and opting-out with knowledge, and the family has knowledge of that situation happening.

So, it doesn't just all happen in the dark. It happens with a sequence and a systematic look at it that is repeated. It is not just a one-time thing.

DR. PHILLIPS: I agree, and have said this before, but in the transplant arena

in the U.S. it was required to request for an organ to be donated. In some countries in Europe it is required to deny it. It is automatic unless you deny it.

So, perhaps we can use language like that, that it is a required denial if you do not want to have the family and the members in there, instead of required request.

LT COL WONG: And we do have that on the page 2. At least on the Marine Corps/Navy side is a "Do not notify." I mean, the intent is a little bit different, a "Do not notify" in case of any injuries, but we could probably look at that and maybe modify that portion.

Because, looking at the majority of my marines I ever look at, you look on that page 2 and "Do not notify," there's no names about not notifying. So, that leaves it open for next of kin to be notified.

MS. DAILEY: Yes, and that is, the language is an opt-out, which means that

everyone is in until they positive opt-out or they decline. They have to decline.

CO-CHAIR NATHAN: This doesn't happen often, but we see that backfire on the page 2 when the member remarries and they don't update their page 2. Because they have to opt-out from the first spouse being the beneficiary, and then, they go through a medical upheavalment where there is a lot of money involved and there's TSI, and all that kind of other stuff, SGLI and all that other stuff, and the second wife says, "You've got to be kidding me. You know, she gets it?" -- or the first husband, whatever. So, it requires a discipline to keep your records up if it is an opt-out system.

MR. STONE: I think the discussion really has to direct itself to the HIPAA privacy laws, and what an inhibitor it is for communities and families to step in, and an acknowledgment of the fact that people get better because of the commitment of families

and communities.

These are at-risk individuals. We all know that. And they do very well when the community is involved and the family is involved.

Therefore, I think the recommendation has to directly go after the inhibition of HIPAA, and our recommendations, as spoken to already by other members, of how you overcome that, and whether it an opt-out system that is recommended, it has to acknowledge the need to engage the broad community in their recovery.

CO-CHAIR CROCKETT-JONES: I think it is a good point. I think in the explanation, not within the recommendation itself, but in the discussion of why we have recommended this, we can point out that creating a deliberate trigger, an opt-out system, we also require some scrutiny that allows non-supportive or dysfunctional family situations to be known and addressed. When a

person has to make that paperwork change and make those choices, if it has scrutiny, if it is done, as you put it, in the light, then higher-risk family situations become known.

You known, when we have discussed this and talked about this in our visits, some of the concerns that people have had is that they have experienced families that, through various forms of dysfunction, are actually detrimental to soldiers recovering or Service members recovering.

But that is sight unseen, unless there is a deliberate point of scrutiny. And I think that to address that concern, this actually does address that concern. Because if someone has taken the time to make a deliberate choice and, then, they go into care, in highlighting the need of that family's cooperation, that family now, the higher risk, the red flags are going to be more likely to be known, rather than, why is this person perpetually cycling back into

substance abuse? If there is family contact and we know that substance abuse is a family issue, then we know.

So, I think we can include that in the discussion to allay some of the concerns that we have heard when we have made our visits. I think narrowing it down to this area of our recommendation, I think I agree with Colonel Keane, this is the very most important part of all that we have discussed here, is focusing on that, overcoming that HIPAA obstacle.

CSM DeJONG: I would almost daresay that the issue we are discussing right now almost needs to be separate from the delivery methods, separate from the electronic health records, so that it does not get lost in other language. Not that healthcare records aren't important, but I would like to see it separate.

CO-CHAIR NATHAN: Okay. So, how would you want to summarize -- first of all,

discussion on that, splitting it out, splitting out the mitigating HIPAA, working through HIPAA, finding a way to do much better, do a more aggressive socialization of the individual's issues with close family members, breaking that out from the EHR.

You're almost looking at possibly, since neither one of these are best practices, so you are looking at these as being two recommendations.

Concerns? Comments on that?

LT COL KEANE: I agree with half of that, Admiral, that 3d would become its own and, in my mind, most important recommendation, about getting the family members involved, which a sub-bullet of that would be the HIPAA issue.

In my mind, at this point, the rest of it is not a recommendation. It doesn't reach Keane's level of make this a recommendation.

CO-CHAIR NATHAN: And just so we

can record this properly, what do you mean "the rest of it"?

LT COL KEANE: The rest of page 5 and 6, the healthcare record, that discussion, sir.

CO-CHAIR NATHAN: Okay.

CSM DeJONG: And as Dr. Phillips said, there are changes already that are happening. So, we don't have the time on our side in order to see where those changes go.

Based off of making recommendations, I am afraid that if we made a recommendation, it might change the change that is happening, if that makes sense.

LT COL KEANE: We have seen that time and time again, where we make a recommendation, a three-point recommendation. The Service or DoD addresses one-third of that, and they misinterpret what we say. That is an easy --

CSM DeJONG: Absolutely.

LT COL KEANE: Yes.

CO-CHAIR NATHAN: Well, sensing sort of how the prevailing sentiment is, I try to align myself with it. As I often tell my people, you have my complete, 100-percent support and I will be behind you until it becomes unpopular to do so.

(Laughter.)

I think one thought I would add into the sort of laissez-faire part of the record is that there's a tremendous amount of pressure coming from organizations that have much higher umpth than us, from the White House, Congress. The heat is on, I think, to find a more common EHR. There's White House programs finding the virtual health record, the integrated health record.

Although, Command Sergeant Major, I would love to think that, if we said go this way, everybody would stop and go that way, instead of the way they are already going, I don't know that they would. We could certainly throw another log on the fire and

say, you know, you've got to keep -- I mean, there is just no question, in my min, that almost everywhere we have been, if you could ask me what is one common lament that we have heard everywhere we go, whether it be the Reserve arm or whether it be in the National Guard, whether it be the behavioral health up in Fairbanks, whether it be in Tampa, it is transparency from an electronic record that people can tap into. That's the one thing everybody wants, whether it be in the MEB system, the PEB system, following the IDES system, trying to get an idea of where somebody is in their medical journey. That would be the one thing.

Now the good news is, I think, that other people besides us get that, and there's a lot of heat from the DoD and the VA to find a way ahead with an EHR, and one that speaks with the private sector in the area as well.

So, I am not hard over on it being

a recommendation, but I think we need to make sure we understand that I think it is one of our top three things that we hear about.

So, everybody is okay with a recommendation that talks about -- and how we would word it and we will vote on it down the road is for tomorrow or is for down the road, not today -- but everyone is okay with the concept of leaving a recommendation, parsing out a recommendation from this section that speaks to a more robust socialization or opportunity for the family and the support systems of the patient, of the warrior, to get information, to be dialed-in, to be read-in, to have the opportunity to be contacted, to make the default to contact the support system unless told not to vis to not contact the support system unless told to do so?

Have I captured that correctly? Everybody is okay with that? Okay. So, we'll close that.

Then, the second part that we

would have to close out in this section is, do we stop there on this section and go to the next one or do we wrestle with another recommendation that has to deal with the largesse of the integrated health record?

CO-CHAIR CROCKETT-JONES: Just before we say anything, there is one other item in this list that doesn't quite fall under the topic of the electronic health record. And that is the automatic enrollment bullet under No. 2. And I am not saying this in support and I am not unsupportive of it. I just want to say that this doesn't fit with the other things that we have said, you know, are so in process and have so much other heat.

"On medical enrollment of the Service member into the VA system upon military discharge to include the scheduling of an initial appointment at the Service member's VAMC of choice."

If we can actually scroll up to another page, we will have it on the viewer.

It is page 6 that I am looking at. Where is it? Page 6? I don't know. Keep going. Keep going one more. No. Yes, the last bullet under No. 2, it starts at the bottom of the lefthand page and goes up.

That doesn't fall under the healthcare record purview. So, if we can discuss whether that also needs to be a recommendation or not, since this doesn't quite fit in with our discussion so far?

LT COL KEANE: If I could put on my old VA, wrinkled liaison hat, this is happening in the Marine Corps. So, the VA liaisons are doing this. They have an appointment before the marine gets out if the marine has a lower acuity. Someone who is on the high end, obviously, you know, is being taken care of.

But what the VA's focus and what our regiment's focus was was getting those stragglers or people who are on the lower end of need, making sure that they had their

initial appointments from the get-go.

That's what the yellow ribbon does with our Reserve marines. Okay. So, I assume -- maybe, Karen, if you know --

MS. DAILEY: And this is more encompassing than the Wounded Warrior. It is that soldier, sailor, airman, marine who is leaving the military after his contract is up. He has two combat experiences, deployments, but he hasn't hit anybody's radar yet. He has not been in a Wounded Warrior Unit. He has not been diagnosed. But he walks out and he decompensates. But he was totally symptomless when he left.

And this is an automatic enrollment in VA, and it is still a first appointment with the VAMC, because, otherwise, he falls into the crack. That is what this one is after.

CAPT SANDERS: Well, I go back to my point a minute ago when I tied these two together, which is we were looking for a way

to identify those people who needed to be identified and help those people who may have a problem and get their family involved. I think this goes in the same direction.

You know, you are identifying somebody who could fall through the cracks upfront by putting them in this system and giving them knowledge of the system, and at the same time maybe educating their family that the system exists and that they will have an opportunity to go and utilize it at a certain point later in time.

So, I don't think it comes out of the -- I think it comes out of the IT, but I think it goes along with 3d, as part and parcel. It is the same end-state we are trying to get to, which is knowledge to people to go forward and utilize the system to help them be better at the end.

MR. STONE: So, as a recent retiree who did not register, in anticipation of this, I decided I would sign up for the VA.

And 45 minutes into the enrollment process, I discovered that I did not possess all the Social Security Numbers of my children, and therefore, had to back out of it, and everything was lost. I have to start over again.

I am really impressed with how difficult this process is. I would like you all to acknowledge the fact that I am firmly committed to the Committee, as I try to work my way through this process, and I am going back in and going to try and be successful.

But I am intrigued with this bullet because it really is difficult. I feel the same way I did when we started to try to correct the eScript's access for mail order pharmacy, and I spent hours on that website trying to negotiate it. It is way better now.

So, please do not accept this as whining on my part. I will go back in and work it, but it is really not an easy system, something that was an automatic opt-out that

would grab my data. And it is really more administrative data than it is healthcare stuff. It is about administrative register.

DR. PHILLIPS: I would like to add that I strongly support that. I retired in 1993 and I am still filling out my VA forms. I mean, I haven't -- sort of tongue in cheek, but I see no downside for this automatic appointment and referral. I mean, it is part of the warm handoff.

Whether it is part of IT record, which I could justify it as part of the electronic record because it is just automatic, or whether it is in some other area, but I think this would be very, very helpful to the population in general, just to do this. It is a no-brainer.

MS. MALEBRANCHE: Yes, I would agree, also, with you. We had tacked this at one point in the Health Executive Committee. At the time there was some discussion about people might choose what they shouldn't. But

I think the opt-out is a good thing, where it would grab it from the IT record. So, I see it affiliated with this IT recommendation.

But there is no reason, with all of the information you put in initially, that it couldn't be grabbed by the next system. And then, it would alleviate this. Because I hear you; I've been there, done that.

And I think that it would be important, but I do see it tied to the IT piece of all this. And I do like the idea of the opting-out. It gives you a choice and you are forced to go in and look at it, and you're not forced, then, to go look for all your Social Security Numbers and things.

LT COL WONG: Again, as we look at this, I don't want to lose sight of any of the other good things that are in here as well. Again, when we look at recommendations, we want them all to be great silver bullets, so they are all taken.

And having transparency for the

families I think really is going to work. The network that is supporting that Service member is important. And maybe everything else may fall into either a lessons learned or best practices.

Like the electronic record, I know the VA has done some great things once they have gone to electronic health records. I mean, they have saved six weeks of time from just being able to send that record now from one email to another person and, then, a doctor do a consult, and then, give them feedback immediately.

But having to take that paper copy, sign it out, send it over to another department maybe three floors down in the same building, getting it transferred all around, and, finally, getting to the doctor, getting to that patient. They make their notation, and then, it routes back up. And it was a six-week process that now they can do instantaneously over email.

The Marine Corps released a MARADMIN three months ago, that now all medical records are copied upon discharge and transferred to the VA automatically. I don't know if the other Services are doing that now, but it is a best practice. So, maybe we roll that up into it.

And then, I don't want to lose evidence-based treatment for PTSD. That is why that is in here. And maybe that is also a best practice, maybe not to the level of a recommendation like the transparency to the network that is going to support this Service member, but I think we still don't want to lose sight of these items as well.

TSGT EUDY: Out of seven items that we have previously talked about with recommendations -- I know the Sergeant Major brought it up -- items that are continuously in the works, we don't want to recommend stuff that has already been talked about and is in the process of being fixed.

Last year we had talked about DCoE conducting a DoDI and having proper reporting chains for how they bring best practices to the field of Fox Eye Shield. And recently, you just see in the newspaper that it is everyone; you know, now the Fox is getting implemented. So, that stuff is coming to fruition.

Looking at items under No. 3, thinking back over the past year and a half, our most recent visits, a lot of emphasis was placed, again, on those completion rates for PTSD programs and the different levels of varying knowledge, based on where you went for treatment and whether that was evidence-based practices or what the Service member was receiving, whether that was MTF, VA, and we knew the big disparity between military and civilian levels of care.

So, again, I agree with Colonel Keane with that HIPAA constraints is something completely different than this. However, I

feel there needs to be some focus onto PTSD because we have discussed it countless times, as the elephant in the room, as something to address, especially now that NICoE satellites are starting to stand up. And for our active-duty Guard members or Reserve members that are being going to those facilities, making sure that they are receiving that same level of care throughout all of the satellites because that's going to be our Centers of Excellence.

You know, we are moving from the Center of Excellence being that corpsman on the battlefield, now taking back and sending our Service member to a concussion care center in theater, to now we are having to do everything, well, soon to be everything is going to be back stateside, and those are going to be our Centers of Excellence back home.

Making sure that the practices are going to continue to be the same in those that may be being done right by the NICoE; I'm not

sure. Some of you may have eyes on that.

But that assures members receive that same level of care and that it is standardized throughout each of the satellites and, then, feeding up through the NICoE. So, it is turning back around.

And then, those items can then be sent out to the civilian community, separate to the MTFs. We don't want to be doing one kind of practice for treatment within the DoD and, then, all of a sudden, sending them to something different within the VA, who is then sending something different out to the civilian community.

CO-CHAIR NATHAN: This is a tough one. So, what I have heard so far is there is general consensus on a recommendation for better understanding, for better socialization with the support with the family or with the significant support people. That is a slam-dunk.

Then, teasing out potential other

recommendations, I heard one clearly about evidence-based treatment for PTSD in conjunction with the electronic health record.

Has that got consensus to be a standalone or something about PTS to be a standalone recommendation?

MS. DAILEY: The standalone recommendations you have there, ladies and gentlemen -- you have made all the other recommendations on PTSD, frankly. You have got eight recommendations over the last three years on PTSD. Standardize it. Provide a DoDI for it. Promulgate the CPGs.

The ones you have here are the gaps, frankly, that are left over from your last three years, that you have touched. Your real question is, do you want to cover those gaps? And they are discrete. I apologize, they are discrete.

Under the PTSD, one is requiring, the first one, "a", is your contractors, let's say at Ft. Hood, who is getting 25 percent of

the PTSD treatment from Ft. Hood to use -- this is the contractors to use the CPGs -- you have not covered that before.

"B", you know, a study between the MTFs, efficacy in CPGs, or their ability to influence versus a network provider's ability to create outcomes, good outcomes -- not addressed.

And then, your last one is the NICoEs imaging. It is a specific technique that they are developing, the imaging techniques coming out of NICoE.

So, these are three discrete. You haven't covered these before, and I assure you, you have covered just about everything else on PTSD.

CO-CHAIR NATHAN: Thank you, Denise. That is very helpful, because that either helps us decide that these are relevant and they are not redundant to what we have talked about before in PTSD, or they help you decide that they are clearly nuances that we

have missed in the past, but on their own don't stand alone to warrant a recommendation.

MR. STONE: So, the difficulty with this, with post-traumatic-stress-related syndromes is that there is not clinical consensus that has been reached. There is a couple of problems with this.

No. 1, DoD does a pretty poor job of managing its research portfolio, and although there has been lots of research done, there's not been consensus developed across the clinical communities or the Services of sort of how to approach this.

In addition, the civilian community has not reached broad consensus. I don't know where the VA system is on reaching consensus.

But to say, "Gee, we want the regional contractor payor of the network to institute a CPG," when the community hasn't done that -- I think this really needs to be reworked. And that is, we need to acknowledge

the infancy of PTSD work. And I can even come back to a recent Marine Corps flag officer's comments on post traumatic stress related to approach as a community.

But we need to come back to, we need to reach consensus first in how best to approach this patient population. Once we reach consensus, then we can have a broader discussion of how you implement that consensus, but the need is for consensus across America of how you approach post traumatic stress disorders, and that affects not only military and veterans, but it also affects the broader civilian community.

MS. DAILEY: And I am happy to revisit that, but the Task Force's previous recommendations have advocated for promulgation of the current CPGs and the current evidence-based treatments.

And whereas the community may not have reached consensus, the Task Force reached consensus that these were the directions that

the Services, DoD, and VA need to go, with the evidence-based treatments, the CPGs, the joint DoD/VA CPG. You have coalesced around that and made recommendations advocating for that.

We can revisit it, but we have to say, "Although in the past we have advocated for the CPGs, the evidence-based treatments, we now want to revisit that by saying we realize the community has not reached consensus on these." That's a lot of work.

CO-CHAIR NATHAN: Well, I think you are both in violent agreement because it is true what Rich Stone is saying; there is still a tremendous amount of controversy and question as to what the right algorithm should be.

That said, the DoD has settled on an algorithm as one of evidence-based practice for their system. So, we pushed that out.

If, because we have decided that at least consistency and following some things which are evidence-based that we are learning

from is better than a hodgepodge of what we were seeing with a soldier getting a different treatment at Brooke than Campbell than Bragg, we are trying to line that up as much as possible.

So, I think they are both right. I think the question comes down to -- so, let me just ask it in these terms. Because I think Ms. Crockett-Jones was showing me the two centers of gravity she has seen is 3d and the last bullet in 2, 3d I am saying that's a winner; that's going to get a recommendation in some form or another.

Let's take the last bullet in 2, automatic enrollment of a Service member. And the options there are to say that is a recommendation, that everybody should get it, unless, as Ms. Dailey says, they opt-out. When you are discharged from the Service, you are going to go to a VA facility and you are going to get an introductory meeting, appointment, orientation -- I don't care what

-- but you are going to establish some sort of link with them for, hopefully, a VA that you would be using, unless you decide to opt-out because you say, "I'm independently wealthy," "I've bought my own doctor," you know, whatever.

Does that meet the group's consensus for a recommendation? Or is it a best practice, because we have heard the Marines do that automatically? And what I am hearing you say is -- and I wasn't aware it was that written in stone -- no marine leaves the Service without seeing the VA before they get their DD-214?

LT COL KEANE: No, wounded, ill, and injured marine.

CO-CHAIR NATHAN: Oh, okay.

LT COL KEANE: Right. Yes, sir, to clarify.

CO-CHAIR NATHAN: Okay. Okay. Thank you for the clarification.

Because this would be germane to

all exiting Service members.

LT COL WONG: The MARADMIN is all marines now. That just got released a couple of months ago. So, any marine that gets discharged, their records go to the VA.

CO-CHAIR NATHAN: Well, those are the STRs. Those are the STRs you are talking about, Service Treatment Records, that have to be within 45 days processed to the VA, and they have to have the diagnoses on them and all that stuff.

LT COL WONG: They are not automatically enrolled, nor is an appointment set up --

CO-CHAIR NATHAN: Right.

LT COL WONG: -- because I think the issue, the reason why the Marine Corps is not doing that is because what initially was happening was, then, they were being referred to the VA that was closest to the base that they were at, and then, they would go home.

CO-CHAIR NATHAN: Right. Couldn't

help.

LT COL WONG: And then, the Marine Corps is getting charged for those appointments that they missed --

CO-CHAIR NATHAN: Yes. Yes.

LT COL WONG: -- to initiate a claim.

CO-CHAIR NATHAN: That's like taking your car to somebody you didn't buy it from; the dealer doesn't really want to see it.

So, I don't know if we can call it best practice yet. So, do you all feel strong enough about the concept that it should be a recommendation or teed up for recommendation?

MR. DRACH: I would just like to comment that I think there is a secondary benefit to the automatic enrollment, and that is the Service member would learn, hopefully, that he or she has five years to receive treatment for any condition at the VA without proving Service connection.

So, if I get enrolled, I get out, I get my first appointment, as part of that first appointment protocol, I am informed that I can come back for the next five years and get treatment for anything.

I don't know that we need to mention that, but just as an observation.

CO-CHAIR NATHAN: I think we do because that is a new on one me.

MS. DAILEY: We will put that, yes, we will put that in the findings. That would be all the evidence that would support something along these lines.

You have made some recommendations in the past about the warm handoff to VA. This would reinforce it. It could bubble up, also, as an overarching followup that Congress should be doing about getting everyone into VA.

LT COL KEANE: I think we also covered it in the past in a broader brush of requiring the Services to make sure everybody

goes to TAMP. I mean, that is covered there.

How does that saying go? You can take a horse to water, but you can't make them drink.

I'm unsure at this point if this should a recommendation. Maybe tee it up and we will discuss it more. I would like to have information, can the VA support it, I mean if we can get that kind of information? But at this point I am unsure whether or not it would be a recommendation.

I think that the reason why it came up here was that, as the development of electronic records happens, that the automatic enrollment would just be a transfer of digital information that initiated an appointment.

So, I am not sure, even though we have made recommendations like this, I think this is a much more clear recommendation that this be part of what happens in an automatic system. But whether we keep it as a recommendation or not, I think that we should

get some good language, so that our voting can be on a clear topic. I think there is enough impetus to say we need good wording on this to be able to vote it up or down as a recommendation.

MS. MALEBRANCHE: I think you're right, Suzanne, this was tied to electronic health record. Because if you do automatic enrollment and you don't have the IT portion of it, you know, well, you can say, "Well, I got out of the Service and I wasn't automatically enrolled, and I went there and I wasn't seen." It was very much tied to the IT piece of it.

I think the PTSD piece of this, I can see cutting that loose from this because understanding there was some of that there, too, but we have addressed it so many other ways, and now we are throwing in some new stuff.

But this was tied to the IT piece, so that you would have -- this record would

already be over there when you went in. We don't have that as automatic enrollment. I am not sure how making sure that that is done would happen.

LT COL WONG: And maybe we should consider -- we talk about boarding. Maybe "enrollment" isn't the right word; maybe it is "registration" because that doesn't require that appointment.

Because the Marine Corps does what we call IRR musters. They have already done their initial required service obligation, but now they are in their inactive ready-reserve time.

And we do approximately eight megamusters a year, and we bring about 400 Service members, you know, veterans back in. And we actually register them with the VA during these megamusters. So, then, they can set appointments if they so desire. But we do make them at least register, so the VA does get their information. Then, the VA can reach

out to them and say, "Hey, you were at this muster. You may have some Service-connected injuries. Can we get you in for an appointment?" It helps facilitate that.

CO-CHAIR NATHAN: Okay. Well, we can sort of work the "happy to glad" at the voting meeting. But, really, now we need to know if you want this teed up as a recommendation. You can vote it down as a recommendation in July as well, but do you want this called out, this last bullet of two called out and teed up as a recommendation? And it is subject to change, meaning it could be orientation; it could be registration; it could be a variety of things.

But the sentiment of it is to automatically somehow connect you initially when you leave the Service. We have heard questions of, could the VA support this? Can you build it? Because if they come, will you be able to build it, that sort of thing?

But is there a consensus for this

to be a recommendation or a possible recommendation?

I am hearing more ayes than nays. Okay. So, we've got that. We've got 3d. And then, there was one other one. I'm having a senior moment here.

CSM DeJONG: Sir, I think you had mentioned the electronic health record.

CO-CHAIR NATHAN: Uh-hum.

CSM DeJONG: I think if we don't add it, we would be remiss to put our support behind it.

CO-CHAIR NATHAN: Okay.

MS. DAILEY: You have done it before. So, these are more discrete recommendations. But if you would like to --

CO-CHAIR NATHAN: Right. I mean, I think we need to shape it a little bit. What sentiment would you like to say about this? Because we don't want it to be just like motherhood, we're for it.

We have plowed some of the EHR

ground before, as we made recommendations. And I don't disagree with you, Command Sergeant Major. I think, like I said in my comments, if I had to pick one thing that seems to bug people most about everything we do, it is this one area.

Any specific bullets there or others that you have seen that you think would shape the conversation on our recommendation about the EHR?

MS. MALEBRANCHE: I was thinking, I was looking, I don't want to say that we should incentivize TRICARE providers, but I think the piece that we have looked at before, we have always said the VA and DoD should have a common record.

One of the things that we have discovered as we have gone around is that both DoD and VA, when they use outside or civilian providers, the private sector, it is not required that they have an electronic record. And so, then, the individual Service member or

family person has to be the person that brings in that record to scan into the system. And therefore, it is not necessarily computable, but it is viewable if they choose to bring it.

So, I think the added piece from my perspective, anyway, for IT is that both DoD and VA need to, when using outside providers, have a requirement somehow to use their IT or be compatible or to send things electronically, so we don't have, again, now we have got DoD and VA on the same system, but everybody they use, which could be a greater number, do not have to have that.

So, we can require that in our agencies through contracts, through whatever, I mean to become a provider, if they choose to have that. And so, that would be my take on this IT piece of enhancing it for this year.

MS. DAILEY: Yes, we have -- excuse me -- we do have that in last year's recommendations, to require them to do that. This year's is to incentivize it. The

language is specific. It is the incentive to be compatible and to utilize that. It is the incentivization.

CO-CHAIR NATHAN: So, we should just put last year's recommendation down again with an asterisk at the bottom that says, "We're not kidding."?

(Laughter.)

MS. MALEBRANCHE: I guess, but it says TRICARE providers. Denise, is that inclusive, then, of VA, because VA is a TRICARE provider and all VA civilian provider, civilian contract support? Is that inclusive of that?

CO-CHAIR CROCKETT-JONES: No, because that would be inappropriate. I think that that is what that word "appropriate incentives" means, is to say -- but that's my reading when I read it.

MS. DAILEY: It is really your network providers, the doc out in Killeen, Texas.

CAPT SANDERS: So, the first bullet -- excuse me -- the second bullet under 2 and No. 1, which is "promoting interagency healthcare collaboration," I am assuming that we already said that before, or we haven't? Under No. 1 on this page 4?

CO-CHAIR CROCKETT-JONES: We have said general things similar to that under No. 1. What we haven't said are the specifics of "a" and "b".

CAPT SANDERS: Is there a distinct reason why those are carved apart and why they couldn't go together as a recommendation?

CO-CHAIR CROCKETT-JONES: I'm just speaking from my assumptions on reading, on all the reading.

That was one of the alternatives for specifics that we hadn't yet tapped in our previous recommendations, was 1a and b, and that under 2 was an alternative way to look at the electronic health record.

I think that we one doesn't stand

alone without "a" and "b" from the standpoint of how this was crafted. So, I would say "a" and "b" seem off the record because we have decide they are too specific and they are too married to an interim solution. That is my take. And if anybody feels differently, they can correct me.

And looking under 2, there doesn't seem to be a whole lot of impetus for the first three bullets, except for possibly that third bullet, if we want to incentivize network providers.

And although you have expressed an interest that you want to get on the map on keeping our force in maintaining the electronic health record, Denise seems to be saying, unless we do it with a very specific way, we are just repeating our recommendation.

CSM DeJONG: No, and I understand that, ma'am, and it is also the same way with the PTS. I don't know how to word it, and I don't know how we would put it in there.

I would hate to not mention those, as much as we have heard from around our site visits as PTS and electronic health records being two of the hot topics that everyone has talked about. I don't think we have to make a whole other recommendation.

I don't know if there is a way to put it in the report of saying, "Here's where we have recommended under PTS and electronic health records for the last three years. We know this is our last year. We still continue to hear that these are hot topics across all Services and VA," and fill in a couple of the gaps without making a specific recommendation to it. I don't know if that's possible.

MS. DAILEY: Yes, we can put it in the introduction, ladies and gentlemen. We can say something along the lines of, "We continue to urge DoD, VA, and Congress to implement electronic health records and to continue their efforts in the PTSD arena," which in language that would address how these

are pernicious and continue to be unresolvable, something along those lines in the introduction, to highlight your emphasis on this area.

CSM DeJONG: I'm okay with that. I think we would be remiss if we didn't at least mention it one last time.

CO-CHAIR CROCKETT-JONES: Okay. Well, I think that we are more comfortable with it being mentioned broadly in the introduction than in the sub-recommendations that get into the jots and tittles there.

MR. DRACH: I agree with that, but it also brings up another thought. And that is the last three years. We have submitted three reports. Some of the recommendations perhaps have been implemented in full and some in part and some not at all.

Could we, should we have an appendix listing all of the previous recommendations with some reference to the Task Force is still concerned that these past

39, 50, whatever, recommendations have been not addressed?

MS. DAILEY: Yes, we have that every year.

MR. DRACH: Okay.

MS. DAILEY: We do lay out what the status of the recommendation is in an appendix right after your recommendations. Actually, the page after your recommendations is the status of the previous recommendations.

And we thought this year we would -- Team, did we not discuss, either in that section or in the introduction, wrapping up what are the big nuggets that still need to be worked and emphasized, and we would encourage Congress to keep their focus on these areas? Okay?

CO-CHAIR NATHAN: All right. So, who wants to sum up where we are on either the one recommendation that deals with EHR and PTS or the two recommendations that deal, one with with the EHR and one with PTS, or no

recommendation, but it is put in the body of the introduction?

CSM DeJONG: Sir, what I think I have taken away in hearing the conversation and looking at the reactions is that we have two separate recommendations, one on the HIPAA constraints, one on the VA enrollment, those being separate recommendations, and then, the introduction, doing an emphasis on electronic health records and PTS.

CO-CHAIR NATHAN: Any comment on that?

(No response.)

Going once, going twice.

Denise, do you or the team need any further guidance or clarification on that?

MS. DAILEY: I am perfectly clear. I have got north-south on all my research guys. So, we are solid. Solid.

CO-CHAIR NATHAN: Okay. As long as they are not lying sideways, we are good.

(Laughter.)

CO-CHAIR CROCKETT-JONES: It's lunchtime.

CO-CHAIR NATHAN: Oh, yes, that's me; it's blue.

(Laughter.)

So, thank you all for the topical discussion.

We will now break for lunch and reconvene at -- this says 1:15. Do we need that long for lunch? I mean, it is noon now, right?

MS. DAILEY: An hour or would you --

CO-CHAIR NATHAN: Yes.

MS. DAILEY: -- 12:45 or an hour or --

CO-CHAIR NATHAN: Well, the sooner we get back, the sooner we get going. I would recommend at least by noon.

Anybody want to meet earlier than that?

(No response.)

One o'clock. Okay.

MS. DAILEY: Okay, one o'clock.

Thank you, ladies and gentlemen. Good job, good job.

(Whereupon, the foregoing matter went off the record for lunch at 12:03 p.m. and went back on the record at 1:03 p.m.)

A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

1:03 p.m.

CO-CHAIR NATHAN: Okay, we will go ahead and get started. We have got a quorum now.

So, we are going to review the observations that now are related to the interagency systems for facilitating the successful transfer of Service members from DoD to the VA healthcare system.

The Task Force has spent a great deal of time addressing the warm handoff, or lack thereof, from DoD to VA. While IC3 has promised continued work on observations 1a through 1c, it is valuable for us to add our experience and perspective based on our four years of site visits.

As we review items numbered 1a through numbered 1f, I ask that you select those ideas that are most important to you and, as we have done earlier today, if you find something in between the seams or you

find something that you think is an offshoot of those, let us know.

Ms. Malebranche, if you would, please lead the discussion with support from Ms. Crockett-Jones.

MS. MALEBRANCHE: Okay. I know I missed the last business meeting, but I do know that you all had a discussion, a briefing from the Interagency Care Coordination Group. And one of the things on that group that I also mentioned earlier that was discussed was that there is no precedent or no prior joint policy. So, the General Counsels for both Department of Defense and VA suggested that we go with an MOU, and then, have supporting Department of Defense instruction and VA directive and/or handbook support.

It is still the intention to continue to pursue joint policy, and we have asked the Chairs of that Committee to go to the Joint Executive Council to look for something joint in terms of policy because we

believe that there are that and several other things that need it.

I think that still is going to be a significant issue to pursue, and I would like for this Committee to consider again, as we did last time, to propose that we look for joint policy, whether that be legislated or whatever the need is or the mechanism to pursue that, because it does hold more than an instruction or a handbook. We have had some discussion on that.

And the other thing about the warm handoffs and the Lead Coordinator concept, which is also part of this effort and this pilot, Lead Coordinator is so far a pilot. It has been successful, but it does need to proliferate through other areas.

We heard about it in San Antonio. Not everybody was familiar with it. But when you have a pilot like this and you have Service members and veterans that are not in one place all the time, you have to be able to

sustain that by having it in other places. So, when they transition or move there, you still have these handoffs. So, that was another piece that I think we talked a lot about when we were at the different installations and how that was working.

Some people had never even heard of the Lead Coordinator concept. It is not a new position. It is a new role for those people that are already in these transition positions to take on that concept of being able to help Service members and veterans.

So, the different issues that are sub-bullets under here about policy, I think those are very important and I would be interested to hear what the other members of the Committee have to say about that as well.

LT COL KEANE: Ms. Malebranche, would it be safe to say that published policy, policy to include policy, isn't the IC3 working on all of those issues?

MS. MALEBRANCHE: They are, and I

think it would help from this Task Force to support those issues, but they are looking at all those different policies within that.

I think specifically there has been some terminology change. And like the OEF, OIF, OND, since things are now changing, they are calling them transition. So, it is not substantive. There have been some name changes. But I guess just the support that this continues on, and that this becomes a permanent part, because, as we mentioned before, this conflict goes away, but the issues don't go away and they always has to be the ability and process to have these.

So, if wanted to put specific things for the policy, you can take a look at the MOU, but the MOU is pretty generic. And so, for specific things to be in policy is a very different type of thing than a Memorandum of Understanding.

CO-CHAIR CROCKETT-JONES: I think it would facilitate future coordination if the

JAC figured out the language and structure and format for joint policy. I think that a lot of these issues wind up taking longer to resolve and getting serious standardization because they pursue the old MOU methodology, which is long and there's of people who can roadblock in the process. So, a joint policy structure, a way to pursue that seems like that something that is almost more important than anything, it seems like something almost more important than any particular policies. At this point because of the time involved in developing MOUs, joint policy seems like, well, I would be very supportive of that as a recommendation.

MS. MALEBRANCHE: Well, right now, in the MOU they are talking specifically about metrics that go, what good does this MOU -- what kind of metrics, what shows? Just as an example, there are 47 policies between the VA, DoD, the Services within DoD that all are mentioning this. So, there are already

policies out there, but there are 47 of them. And then, to come under an MOU, I think it would be much more -- I just think there would be a lot more power or force behind to get into a joint policy.

It is something that is not done -- it doesn't mean that its shouldn't be done -- it just has not been done before. And there are probably things I don't even recognize in terms of legalities of policies versus MOUs, but I do know that MOUs, we have got a lot of them. We don't have a joint policy.

So, that was a great deal of what you were hearing, I think, from the IC3, because we did just present it again last week to the Joint Chairs.

CSM DeJONG: I guess put me back on track if I'm way off, but we had just spent prior to lunch discussing what I believe is a warm handoff by transferring records and an automatic enrollment into the VA once you

leave DoD. So, would this further facilitate that or would this add to that? Would this strengthen that handoff?

If the IC3 is working on this, I guess if we want to make a recommendation for this, I am good, but I would want some more, you know, how can we bolster our support to what they are working on?

CO-CHAIR CROCKETT-JONES: My understanding is that the IC3 was given a series, a range of tasks in the same way this Task Force was. So, one of the things in that Lead Coordinator, the Lead Coordinator resolution will work with any records transfer that is automated and includes an opt-out.

But I think that in the work that the IC3 is doing, one of the roadblocks they have is that the process every time they develop a best practice that they want to test and have a beta for, it requires sort of a Memorandum of Understanding and policies have to be reviewed, and the paperwork trickles

down, and people roadblock it or people pass it on, and then, it trickles back up. And then, it all gets modified. The modified version trickles back.

And there may be similar issues with joint policy, but they will get never get to the framework of that until someone says new process.

CSM DeJONG: Got it.

CO-CHAIR CROCKETT-JONES: And so, that is sort of one of the sub-recommendations. I think it is true that a lot of the recommendations we have have sort of been used and pulled into the knowledge base to create the IC3 work. I mean, they seem to be on the same page with a lot of our experience.

MS. MALEBRANCHE: And you are right, Sergeant Major, a lot of this, these things that they are doing now are from the Recovering Warrior. It is also because just from practice over time you will see that

things -- I mean, everybody can kind of see that it is necessary, but even getting this MOU off the ground, I'll tell you, a year ago we talked about this group. And it has taken a year to get an MOU.

Policy goes in legislation. You have to enact it. Right now, the MOU, there is a lot of different roadblocks along the way, but I think it might be a legislated policy that needs to take place.

This isn't legislative. This is kind of by let's coerce, cajole, talk folks into it. I think this is the part that I believe is part of the problem because people don't all necessarily want to do that.

The other thing that this group is taken into is the National Resource Directory, the whole issue with the Federal Recovery Coordinators, the Recovery Coordination folks, the TAAs. That is all part of this group, and they are creating this community of practice. So, it has bled over into other areas that we

have talked about.

And the IT thing not being insignificant in this, and the metrics being very reliant on some of those issues. So, probably some more specificity; the MOU right now is pretty generic in trying to get it through. And then, when you push it out to the Services, I think you are going to find also it probably becomes more dilute trying to get it through.

And so, for purposes to get something that is more meaningful and workable, to take some of the recommendations from this Committee that we have found and researched, to have it in there.

But the warm handoffs are always to have been taking place. We found that it is not true. So, we need some measures and we need some specifics on how to make that work.

So, I am hoping that this Committee is going to be a long-term sort of thing. And also, this brings into another

piece on this, the Comprehensive Plan. The written Comprehensive Plan does bring in, too, the civilian sector. It is not just DoD and VA. How do we, then, reintegrate the individual back into the community? And that is a part of this. So, it has gone a bit farther, but we are still at the beginnings in a lot of cases.

MR. STONE: I found the presentation last month pretty frustrating. It seemed like the metrics that they were spending years thinking about, or at least a year, were not terribly patient-centric.

And we talked a little bit last time about the World Health Organization definition of what an integrated healthcare system is and how you have to start with patient-centric approaches. And it is not about the bureaucracies that are in every healthcare system. It is about what are the needs of the patient.

The concept of taking a year to

come to agreement on an MOU is a perfect demonstration of why I am so pessimistic about this current effort, not that people aren't well-intended, but the bureaucracy just stops this.

And I think one of the things that needs to go into our recommendation is really a discussion of what an integrated healthcare system is about. And it is really about the needs of the Service member or the veteran or the recipient of whatever service is being tendered.

But it really has to be patient-centric or person-centric. And we need to move this system a lot faster than we are doing. And if it takes a law to be created in order to get two large organizations to get along with each other, that just seems ludicrous to me. And it means that we are going to spend years trying to figure this out.

And the best thing that we could

recommend them is an alternative payor system that would allow people to go out and seek care, whichever they think is the best, and let these organizations then come back and compete for services, which would certainly change the dynamics.

CO-CHAIR NATHAN: So, as we distill the comments that you all have heard, we will start wide and narrow-down. Does everyone believe that this merits one or more recommendations or teeing-up one or more recommendations that deal with strengthening the interagency between DoD and VA healthcare systems from the standpoint of transfer, warm handoff?

Is there anybody who feels this is either old news or not big enough news?

LT COL KEANE: That's me, sir. When I look at this and I look at my big three, of which talking about the caregivers and bringing them in initially to the bedside, talking about fixing the disability evaluation

system, this doesn't rise, doesn't equate to a recommendation in my mind at this time.

I don't know if somebody can pull something out of this to make a recommendation. I think the IC3 is their own thing. They can decide whether or not they want to do policy or publish policy,.

MS. MALEBRANCHE: I think the one thing I would like to see, despite the IC3 or in support of, I would like to see the ability for joint policy. I think, from the different things that we have looked at here, such as the disability system, such as this recovery coordination process, such as the separation health assessments, such as the credentialing and privileging of providers in both systems, that I think there is a definite need for joint policy. And there is not a mechanism or anything in place to do that yet.

It seems to me that there is a number of things that we are looking at in addition to this that, if there is a joint

policy, it wouldn't take a year to get an MOU, and it is now going to take how long to get credentialing and privileging, understanding that that is also some of the civilian things.

But I think there is a need for joint policy ability without having to go through a year of trying to figure out how to do something.

CSM DeJONG: I concur with what Ms. Malebranche is saying, and understanding now what all this was going to, I think the mechanism for a joint policy will help our four years of work that we have done actually come to fruition in a shorter amount of time without going back and forth through MOUs.

So, I think that there is one solid recommendation, and a pretty straightforward recommendation, that could come out of this, with trying to get that authority.

CO-CHAIR CROCKETT-JONES: Yes, I think that, even under the concerns that you

do have for recommendations, like keeping family at the bedside, I think if there was a joint policy, there would be a lot more power at keeping a standard across all these treatment facilities. Whether someone winds up at a polytrauma center while they are still active duty or whether someone, as a veteran, winds up getting sent back to specialty care to an MTF, it seems to me that the consistency on something like that is now reliant upon MOUs and service.

So, I think joint policy, actually, a structure for that, which at this point some of what I hear from the folks at the IC3 is that there not being a current structure is where people are falling to say, "That's why we can't have one. There is no precedent, so we can't go there."

And that just impedes all of the work that this Task Force has been calling for over the years. To my mind, the answer to that create structure for joint policy, not so

we can't pursue that.

And I think that a lot of the concerns we have would have more power if it was an expectation to have family by the side. And I think you might get more support from the VA side on something like that, and if there is joint policy, it pulls along DoD and the military.

Do you see what I am saying, that this is an equalizing force? And the hesitation towards it is disconcerting.

CO-CHAIR NATHAN: Suzanne, what would you add to 1b?

CO-CHAIR CROCKETT-JONES: I would just make it more declarative than worrying about its addressing the transition and warm handoffs. I think that we want the JAC, we would have more effect if the JAC had a structure and format for joint policy, if they resolved that and got it done, and joint policy became a way to move forward.

LT COL KEANE: As we have done in

the past when we have received replies back from the Services and DoD, what comes to mind would be the DoD and VA saying, "We do that. We've done that. The FRC program, this is the joint policy."

CO-CHAIR CROCKETT-JONES: It's not a joint policy. They don't have a joint policy. There is no joint policy. They have a program that they agree to through many MOUs, sometimes regional.

MS. MALEBRANCHE: And as you were talking about the Federal Recovery Coordinator, that is also an MOU. And MOUs, usually the last statement of them, "This MOU may be rescinded by either party with notification within" 30, 60, 90 days. It is not like policy.

Whereas, when you get the NDAA, it said, "The Secretary of Defense shall...," and it might be "The Secretary of Veterans Affairs shall...." It is not "may".

But there are some differences,

definitely. The MOU, you say, "Okay, I am no longer a part of this. I can't do it anymore. It doesn't make business sense. I am going to quit." And policy, that is not quite the same.

DR. PHILLIPS: Question: in the San Diego or the Tampa model, where there is interaction between the institutions, is there any written or language that we might be able to utilize that might help us with perhaps a policy recommendation? I don't know. I am just wondering if we could research that.

CO-CHAIR CROCKETT-JONES: The problem is that those are all based on MOUs, sometimes local ones. And so, I don't know that there is language that can be used.

I think that the language barrier is part of what is preventing people from creating joint policy, is legal language.

DR. PHILLIPS: Well, I understand that these are all MOUs, but I am wondering if we could look at these and maybe extract key

sentences or paragraphs that can be perhaps massaged into an NDAA policy recommendation --

MS. DAILEY: Okay. We have --

DR. PHILLIPS: -- if those work.

MS. DAILEY: Yes, we are looking at other, first of all, we are looking at other interagency -- this is not joint; keep in mind, ladies and gentlemen, "joint" means Army, Air Force, Navy, Marine Corps. So, we need to put language in our permanent record here that says "interagency policy". So, we are talking interagency policy.

We are looking at other interagencies that have established or other agencies that have established interagency policy. That is what the research team is doing. I think we might have one, maybe two, examples of cross-federal agency policies that we can possibly put in the findings for this, as an example.

But there is not going to be anything in our communities that is going to

be useful, Dr. Phillips. We really need to look at other interagency language, what they have used. So, I think that would be our best example if you want to go in that direction.

All right. It is still a little weak. I think I found one maybe good one, and another one would be when the crisis in the financial industry came up, there were a number of interagency, there was one interagency policy published to pull together these agencies that are supposed to be monitoring our fiscal health. So, that might be an example.

And then, I think I might have found one in the security community dealing with security issues and collaboration across agencies for security issues and defense of the homeland.

So, that is what we would use if you are interested in an interagency policy.

MS. MALEBRANCHE: Okay. That's a good point about the interagency piece. But,

again, I would like to make this point about the issue with MOUs: because of fiscal sorts of things and constraints, when a new person comes along in charge and the MOU is written from a previous command or a previous VISN Director, that can be negated because now the priorities change.

When you have a policy, an interagency policy, that, then, supersedes individuals and goes for the issue at hand or the policy at hand. So, I think there is more strength and weight with a policy that addresses veterans and Service members than with MOUs because it doesn't rest on the individual who also has other priorities that might be conflicting.

It keeps, then, the focus or the central figure here of the Service member or veteran and family in that space. So, that was the issue for me.

CO-CHAIR NATHAN: Okay. Well, I think that pretty much says it all. Could I

ask you to sum that up as sort of how you would look at that as a recommendation?

MS. MALEBRANCHE: Without tying this directly to IC3, I think the recommendation should be that interagency policy be considered for a number of issues, and we could perhaps list some of these things in the areas of disability, in the areas of Recovering Warriors and families. There are a number of different areas that policy could be considered, but I think there is more than just one. So, it is not just specifically with this particular issue.

Like I mentioned before, the separation health piece and when they are doing comp and pen exams, that you have this credentialing and -- well, privileging is local, but credentialing issues, that there is some policy that covers the different areas that affect Service members, veterans, and families to expedite processes or current systems that are slowed-down by awaiting the

bureaucracy of MOUs and agreements between Services.

I am not quite doing this well, but I can probably get some help, given a little time.

CO-CHAIR NATHAN: Okay. Other comments, add-ons, whatever?

(No response.)

The gist of that was require more common policy at the interagency across a variety of mediums, not the least of which is transitional handoff.

Anything else in this area?

(No response.)

So, Denise, what have you and your gang heard from this?

MS. DAILEY: What we heard is on the paper here, sir. We, again, are going to look, we are looking for examples --

CO-CHAIR NATHAN: I'm sorry, not before this. I mean, what you have heard on this subject in general is what you

articulated here. But what have you heard from this conversation?

MS. DAILEY: Oh, okay.

CO-CHAIR NATHAN: So that, when we move from this conversation forward --

MS. DAILEY: The gossip around the street is --

CO-CHAIR NATHAN: Right, right.

MS. DAILEY: Okay.

CO-CHAIR NATHAN: But when you hear Ms. Malebranche's comments and you heard Command Sergeant Major DeJong's and Ms. Crockett-Jones -- I just sort of called for the question and just said the recommendation generically is to find common policy in the interagency, especially DoD and VA, that deals with a myriad of issues, not the least of which is transitional handoff from one system to the other.

MS. DAILEY: Right.

CO-CHAIR NATHAN: But I don't know if you wanted to put a finer point on it or if

you had additions.

CO-CHAIR CROCKETT-JONES: I think the research team probably has the kernel of what we are saying for the language when they craft it.

But it is really not that we are looking for common policy. We want them to be able to have joint policy --

MS. DAILEY: We don't want them to have joint policy.

CO-CHAIR CROCKETT-JONES: Interagency policy. Excuse me. We want them to have interagency policy issues coming forth, not common policy on each side. We want them to have --

CO-CHAIR NATHAN: One policy?

CO-CHAIR CROCKETT-JONES: One policy, yes.

CO-CHAIR NATHAN: One policy. That's what I meant by common, one policy common to the various interagencies, the various agencies that are inter with each

other.

(Laughter.)

CO-CHAIR CROCKETT-JONES: Exactly.

CO-CHAIR NATHAN: That's how I see it, as opposed to the outer agencies.

(Laughter.)

Those agencies of whom we will not speak, as in Harry Potter.

(Laughter.)

MS. DAILEY: Okay. And from the discussion, sir -- and I will answer your question, and I do want to clear up some points -- from the discussion, this is not a request for legislation. Or is it a request for legislation? What is the legislative role here? Is there a legislative role?

CO-CHAIR CROCKETT-JONES: If it takes legislation.

MS. MALEBRANCHE: If there is no mechanism for interagency policy right now -- I mean, this has to be researched a little bit -- then, I think it may take legislation. It

is not just going to be a series of MOUs and joint local agreements. If it takes legislation to have interagency policy, which because in looking for what we used to call a joint policy in IC3, and we can ask our attorney here, they said, "Well, if the General Counsel said there is no mechanism for policy, then it might be legislation." I don't know.

CO-CHAIR NATHAN: Where are we when we have deliverables from the HEC, the JEC, and the BEC? Because the HEC and the JEC -- are DoD and VA sitting down, are the heavy-hitters sitting down with their counterparts and deciding on a way ahead, and is that memorialized in that policy? Is that memorialized in an MOU? Is that memorialized in goodwill and the moral persuasion of both people will do it?

I don't know technically how that --

CO-CHAIR CROCKETT-JONES: My

impression was that it is all based on memorandums, MOUs.

MS. MALEBRANCHE: Or each side writes their own policy. There is not a single policy, not a single overarching policy.

CAPT SANDERS: Well, a mechanism to get to an overarching policy is for the Secretary to ask the President to issue a Presidential Directive. And you get a DoD Directive that does overarch all the policies of the Executive Branch agencies.

I am not sure if that is the direction anybody wants to head. But if you are trying to link it all together and get the Executive to push all the agencies in one way, that is a way.

CO-CHAIR CROCKETT-JONES: I think that we are hoping to find a simpler solution that is a framework that all the interagency -- I mean, Presidential Directive, to have to go to a Presidential Directive every time

there is an interagency program that needs a policy, that seems unlikely.

MS. DAILEY: Well, I have to tell you I think, actually, in one category the environment is ripe for that, particularly from the presidential level.

MR. STONE: Before we get to that, I think Admiral Nathan's question is correct. We need to go back and research what is the power of the HEC. The decisions that are made at that level, are they strictly agreements based on the position of the Chairs or do they carry additional weight, based on some sort of existing structure or law?

MS. DAILEY: Ladies and gentlemen, the JEC is established in law, established in 2002 as the integrating agency for DoD and VA for healthcare and benefits. That is its legislative mandate.

According to its lawyers, it cannot make interagency policy. The way they manage is through DoDIs, MOUs, CPGs, the

promulgation of those types of products in each agency.

To move this question a little bit for a recommendation, one recommendation would be the JEC needs a structure and format for interagency policy. That is some language for a recommendation. So, it could sound like that, too. I mean, Ms. Malebranche, those words came out of her mouth, which is directing this to the JEC to get the JEC needs a structure for format and interagency policy. Excuse me. The JEC needs a structure and format for interagency policy. That is one direction to go.

The other language of the recommendation would be, which we have heard, which is interagency policy needs to be established to address the disability, Recovering Warriors, credentialing, and the handoff.

And then, the third option on this one is tell Congress or ask for a

Presidential. Like I said, I think the environment might even get that some traction. The problem with Presidential Executive Orders, they go away when the President goes away.

CAPT SANDERS: I have a question. Now is the JEC membership -- who are the members and what is their status?

MS. DAILEY: I would have to go through the legislation. Right off the top of my head, I don't remember.

The Secretary, the Deputy Secretary -- the Secretary?

MS. MALEBRANCHE: It is the Deputy Secretary of VA and --

MS. DAILEY: And the P&R.

MS. MALEBRANCHE: -- the P&R for DoD.

MS. DAILEY: Are the Chairs.

MS. MALEBRANCHE: And then, the membership is specifically listed. I mean, we can pull that. I don't know the titles now.

CAPT SANDERS: So, it is essentially a Deputies' committee, the same structure that you have in a national security environment? We have a Deputies' committee, and a Deputies' committee puts together policy recommendations for their Directors and for the President to sign off on.

And so, the issue now is to give them enough power or for somebody to say that they have the power to come up with a policy to move forward.

MS. DAILEY: It's, yes --

CAPT SANDERS: As a fourth alternative to your list of three.

MS. DAILEY: Well, I'm not sure the JEC works exactly that way. They have to push it back to Health Affairs if they want a legislative proposal or P&R. VA's can implement and suggest VA legislative proposals.

CO-CHAIR NATHAN: So, might I suggest, then, Ms. Dailey, your team, your

very accomplished team, maybe we take the generic phrasing that we left with a little while ago on the recommendation, and then, we season it with some of the research they are going to do, looking at the language of the HEC and what the mechanisms are and how binding they are in law and where that comes from. And that will be ready for us at our next meeting when we go to determine how we are going to tee this up for a recommendation, if we are going to tee this up and how we would tee it up for a recommendation.

MS. DAILEY: Okay.

CO-CHAIR NATHAN: It is the HEC Liaison and the JEC Liaison; in other words, the HECL and the JECL.

(Laughter.)

Okay.

MS. DAILEY: All right. So, we are going to pull out of there -- so, if we want to keep this in the interagency policy lane, we are going to stick with "a" and "b",

really "a" and "b" and "c"; "d", "e", and "f" we would take out because we wanted to stick with an interagency policy or an interagency --

LT COL KEANE: I have one more thing to add, Ms. Dailey.

MS. DAILEY: Yes?

LT COL KEANE: For your team, I found a website, Assistant General Counsel for the Department of Veterans Affairs, Mr. Walter A. Hall, he has a PowerPoint out there, and he addresses topics covered: legislation requiring joint activities, and he references Public Law 110-181. And in this Public Law, there are seven or eight different requirements in the Section 1600xxx. That mandates joint development and implementation of policies regarding the care and transition of Recovering Service members, and then, it gets into more specific things.

I would just kind of draw your attention to that. Maybe there's something

that is already out there.

MS. DAILEY: We got all of that.

CO-CHAIR NATHAN: All right. That's good.

MS. MALEBRANCHE: We might have to find you a new point of contact. Mr. Hall retired, but --

MS. DAILEY: Yes. Say it again. I'm not sure what's going on here. Pull that site up again. Is it still up? Say it again. Say it slowly.

CO-CHAIR NATHAN: Because anytime you bring up law 110-181, that is going to draw some interest.

LT COL KEANE: I will do it. Let me pull it up. I don't have to waste everybody's time to pull it back up.

MS. DAILEY: And you all also broadened this to talk about Recovering Warrior families, comp and pen credentialing, the warm handoff, the disability evaluation system.

Do you want it to go that broad or do you want it to cover transition?

CSM DeJONG: I think those were just examples of what are currently -- and correct me I am wrong -- MOUs that would be affected or removed by an interagency policy.

MS. MALEBRANCHE: Correct.

CO-CHAIR NATHAN: So, remember, the aegis of this was as the first sentence. Remember, the aegis of this was you all are buying into the goodness of somehow strengthening the interagency system, and you are going to do it with a more common operating picture, a more uni -- uni- whatever -- system, a uniform system of policy between the agencies that specifically applies to the transfer of Service members from DoD to VA. But are you widening that aperture?

MS. MALEBRANCHE: No. What I gave you were examples of where we don't have interagency policy, that have been working on MOUs, that have taken inordinate amounts of

time --

CO-CHAIR NATHAN: Okay.

MS. MALEBRANCHE: -- especially IDES, et cetera, because they have been working on MOUs for every site that this type of thing could be used for. So, it is not just one place that it would be beneficial. It wasn't suggesting that you should go back, but I am sure everybody will jump on.

CO-CHAIR NATHAN: Okay.

MS. DAILEY: My concern is we have centered this discussion a lot around how much time we think this would save. I am not sure we are time-saving here.

I'll just kind of throw this out: I think the effort here would eliminate, would be more successful in eliminating seams, gaps, eliminating silos between the two agencies. I am not sure you can even hang your hat on time-savings, but --

CO-CHAIR CROCKETT-JONES: Yes, it might not be quicker. Yes, I agree, it might

not be a quicker process, but it might also eliminate in that right now we have regional MOUs which, then, don't meet a standard. And then, that goes through a review process.

Some of that sort of sausage-making to get everyone on the same page through all these many MOUs will be eliminated. If there is a policy, they won't need to have a local MOU. And that is probably really more where time-saving will occur, not necessarily when joint policy is issued.

CSM DeJONG: And I also believe the time-saving on this is that they won't have to be redone under new leadership. So, once it's established, it's established. So, it may be an arduous process to get it done, but once it is one, it is established and it stays.

MS. DAILEY: Okay, okay.

CO-CHAIR NATHAN: Anything else?

(No response.)

Going once, going twice. Okay, we got it. Great.

CO-CHAIR CROCKETT-JONES: Do we need a break or can we move on to --

CO-CHAIR NATHAN: We have one more section left.

CO-CHAIR CROCKETT-JONES: -- family caregivers?

CO-CHAIR NATHAN: So, we can either take a break or we can power through and you can take breaks as needed individually. Keep driving?

CO-CHAIR CROCKETT-JONES: Keep driving? Okay.

The next observations for review are related to family caregivers. These observations come from our visit to the WCP office and installation visits.

The language here requires a DoDI policy to be written. Additionally, this entails a high degree of detail that needs to be included in the policy statement. During

discussion with WCP in January, they requested for this detail to be included. This level of detail has been gathered from family members over the past four years.

The observation about enhancing SCAADL addresses broadening the legislative policy about eligibility. These observations include additions highlighted in red, provided through feedback from me and from Lieutenant Colonel Keane.

As we review items 1a through 1o and 2a through 2b, I ask that you select those ideas that are most important to you.

I will start off this discussion, though I expect that Tech Sergeant Eudy and Command Sergeant Major DeJong will be jumping in.

This is a lot to digest. One of the standardization features is a definition of the term "family member". We need that to be more uniform. We want it to really include people whom the Service member who is going

through the recovery process designates. As a family member, we want them to have the option. I mean, it is heartbreaking to hear that a fiancee isn't included because they weren't technically a family member. You know, it doesn't often happen anymore, but if everyone had an agreed-upon definition, we know we would eliminate those kinds of cracks through which people fall.

You can look at all of these.

In terms of SCAADL, because it is something for family members, it falls under here, but, really, I want to relate that to also looking at what are the activities of daily living that are significant.

We do need them to be able to review how SCAADL is applied and what qualifies you. Right now, it is using language and lists of activities that the VA has already begun to rethink. With the large number of TBI and PTSD diagnoses, the VA is seeing that -- and the development of

effective prosthetics -- they are seeing that getting dressed may not be the signature need for those who are really struggling, that it might be remembering to take your meds and get to your appointments, because of memory issues from TBI.

So, they have been reworking some of the ways they assess their caregiver program. And I don't see any move to update SCAADL in a similar way.

And the training that the VA uses, the Easter Seals training, touches on both the physical activities and, then, training on recognizing how to interact with people who have cognition issues. And so, they have really been progressing and modifying, and there has been this evolution of an understanding on the VA side. It is beginning; I wouldn't say it is the perfect model, but it is definitely evolving.

I would like to see SCAADL and comprehension evolve in a similar manner on

the DoD side. So, I am throwing that out to you as an area where we might want to make a recommendation. It may be too fine a point. So, I would love to have a discussion about that.

LT COL KEANE: The first things -- you can stand by -- the first things I would like to pull out our "g" and "l". Those would fall underneath what I would define as the bedside information, clarifying the types of outreach services, making sure that the family, spouses, caregivers are at the bedside, that they know what is going on from the get-go.

MS. DAILEY: Okay. Hang on. "Pull out" means what? Eliminate or --

LT COL KEANE: Pull them out and discuss them.

MS. DAILEY: And discuss them? Okay. So, when you said "Pull out," I just had my staff erase them. So, they aren't going anywhere?

LT COL KEANE: Exactly. Okay. So, those two support what I am echoing as the No. 1 priority of a recommendation.

MS. DAILEY: Okay.

LT COL KEANE: The second thing, and to address SCAADL, is to have a discussion. And I would argue that SCAADL is better than the VA caregiver. At least SCAADL includes illness. The VA caregiver would be the one I would suggest that would need to be modified to come in line with SCAADL.

CO-CHAIR CROCKETT-JONES: It's almost like they both have voids. And really, it is almost as if there was a joint policy for caregiver compensation that took care of both of those issues; we would see a progression and SCAADL might evolve to include more timely activities, and caregiver would then include illnesses. This is one of those areas where these two programs could be better if they were each broadened to a joint level.

LT COL KEANE: There would be a

cost-savings, too. One of the big "nut rolls" I did monthly was rectifying our marines who were getting SCAADL who were now eligible for caregiver, and make sure that that SCAADL was turned off, even though DoD has allowed for an overlap to ensure that there was no drop in coverage. If there was one, I agree if there was caregiver thing, we would save money.

CSM DeJONG: The way I see this is to continue down where you were is also interagency policy. I see three different things and one that is possibly missing that we might want to throw in.

We have the training along with what Colonel Keane was talking about. We have got the training aspect of it along with the interagency policy of it to make the two equal. The one that I don't see in here that we did do some discussion on our last meeting was -- and I don't remember which one is which -- a tax-free benefit, and that is not here. I looked ahead for tomorrow, and I don't see

it there. So, we might want to throw that in here and look at it as three separate issues under this category.

CO-CHAIR CROCKETT-JONES: SCAADL is the one that is not a tax-free benefit.

MS. DAILEY: And that was last year's recommendation.

So, this, the first thing I think you all might help your discussion is this is recommending a DoDI, a family policy that addresses families in the Department of Defense. That's where this starts, because there isn't even a DoDI on families.

And then, underneath it are all the things that Warrior Care Policy asked us to include. Some of those things, we have made recommendations on. We are just listing them here to hold Warrior Care Policy accountable and to also allow them one-stop shop for what that DoDI should look like.

CO-CHAIR NATHAN: Right. I think you have said that very well, Ms. Dailey. The

genesis for this is that there is an impression that families and caregivers are not getting the information, the support, and the wherewithal needed to meet the needs of the Recovering Warrior or themselves. That is the premise.

And what happened was, when the Warrior Care Policy people came before us, they said, "Help. Here's what we need." And that is where we got 1a through o.

And so, the first question, the first call of the question is what Ms. Dailey is saying: do we believe that, one, a DoDI is what is necessary to do this, a DoDI being sort of the hammer that basically says, "You do this or else." Usually, it is fairly effective at changing. So, there is no guarantee that DoD will take us up on it, but if they do, DoDIs usually equal action. Do you believe it needs that level of impetus? We will talk about SCAADL in a second.

And then, secondly, if you do want

a DoDI, do you believe that it should contain the types of things that Ms. Crockett-Jones and Command Sergeant Major DeJong were talking about, including Colonel Keane, that basically talks about do you limit it from the list of these roughly 20 items that would be in the DoDI.

So, first DoDI, because that is what the first sentence say, right? No. 1, it says, "DoD should publish a DoDI for addressing the needs of Recovering Warrior family members and caregivers."

Anybody really for it? Anybody really against it? Anybody see an alternative way to do it? Anybody think that it is not a problem, that this has since dissipated, and war is cranking down and families are getting better, and we have got it all wired?

CAPT SANDERS: Is this another case where we are trying to find uniformity among the differing practices of Services on how they treat Wounded Warriors and family

members?

CO-CHAIR NATHAN: I would think it is more than uniformity. It is making sure it happens. We are not sure it happens in all cases. In other words, each Service has the way of approaching it, but the WCP people came to us basically saying, "We've got some lost lambs out there."

CAPT SANDERS: Well, I think they have identified to us a need, then, right?

CO-CHAIR NATHAN: From their perspective, yes.

CAPT SANDERS: From their perspective.

LT COL WONG: I think development of a DoDI will create that transparency for the caregivers and the family person that we are looking for. It will also create that enduring mission that we are looking for as well if we address it in a DoDI. So, I think that would be a good, strong recommendation.

LT COL KEANE: I agree, sir, that

a DoDI would be a great way to tee it up.

CO-CHAIR NATHAN: Wow, normally the contrarian, and now he's with us. Let's quit. Mission accomplished sign; hang it up on the conning tower.

(Laughter.)

"But I haven't finished yet, sir. I want to whack all of them except `g'."

(Laughter.)

Okay. So, it sounds like we have a DoDI.

LT COL KEANE: Sir, to clarify, you're not impersonating me in the room?

CO-CHAIR NATHAN: No, no, no. I couldn't, and imitation is the highest form of flattery, anyway, Colonel.

(Laughter.)

So, I see general consensus that a DoDI is needed. You would agree with the premise?

Okay. Now we need to work on what you think a DoDI should or should not include

from either pick or lose or use these "a" through "o" or add some of your own.

TSGT EUDY: In regards to broaching "g", sir, we have addressed that slightly earlier. I don't want to hit it in two separate areas and end up with policy that does not go forward in the same manner.

Just the same as when we make recommendations and everything is clearly defined in our findings, and the Services come back and say, "We already do that." And then, one Service meets the need versus the other goes, "Well, you know, we interpret it in such a manner." As long as there are specifics based on each of these items, how do meet those needs in the DoDI, then they can't say, "We already do that."

Because if the Services were briefing us on a lot of these items already, they would say clearly, "We meet this need." We need to demonstrate how that is not met in regards to perfecting this DoDI. I would hate

for the Services to come back and say, "Well, thank you. Now we've got the DoDI, we are following it." And then, at the next war, they end up coming with this exact same list.

CO-CHAIR NATHAN: I think that is a very good point. If this is going to have teeth, it needs to have teeth where it makes sense to the Services as well.

CO-CHAIR CROCKETT-JONES: Well, number or letter "d" talks about identifying Service member reporting metrics. We might link the metrics to the list. You know, metrics really might want to be linked to the rest of the list. The metrics, that might be the last letter on this list, to say the metrics should reflect the priorities of this list.

CO-CHAIR NATHAN: Right. Well, the genesis of the metrics I think would be, if you are going to go to the trouble to create a DoDI that is going to theoretically improve the process and improve the quality,

how do you measure that? How do you, then, come back and say?

Because, theoretically, right, if we get this right, a DoDI, the world before the DoDI and the world after the DoDI, we should be able to, we would hope, aside from just asking people, "How are you doing?", and they say, "Oh, so much better," we would hope to have something that would show you that your DoDI has given you traction and improved the process.

CO-CHAIR CROCKETT-JONES: Yes, exactly. I would just say that, if one of the things we are saying is address optimal caregiver use of the Family Medical Leave Act, we don't want them to say, "But we don't measure that. We don't know how many people take it."

If the metrics are one of the last things listed and we say the metrics should align with this list, hopefully, we would be able to say how many people used FMLA because

the DoDI addressed metrics in alignment with this list. That would make more sense to me than just leaving the option of metrics open.

I don't want them to say, "Well, we do keep metrics. We know this is how many family members we have. That is just not a sufficient metrics to measure if the DoDI is effective and where its gaps are.

MR. DRACH: While you are mentioning FMLA, and I don't want to get too far ahead, I am not sure that the FMLA in its current authority really covers caregivers, I think as we are discussing caregivers, which are, from my experience, a lot of them have already quit their job other than left their job temporarily. And I think FMLA only covers like 30 days, but don't quote me on that. I don't know what FMLA is.

CO-CHAIR CROCKETT-JONES: FMLA covers six weeks, and sometimes people go to bedside for that short of a time, or even if it is four months, they have to be bedside,

not necessarily the extended caregivers. This is a separate sort of look at family members who don't realize they can ask for FMLA to be bedside during the most critical recovery time.

MR. DRACH: Should we be thinking beyond on that and possibly suggesting an amendment to FMLA that would be more than six weeks?

CO-CHAIR NATHAN: You mean specifically just for the Recovering Warrior families as opposed to the general federal employee?

MR. DRACH: Just this population.

CO-CHAIR CROCKETT-JONES: Here I am going to sound like a stingy taxpayer. I actually don't think that it is necessary because I think, if someone winds up being needed for that extended period of time, they should apply for SCAADL and fall into the compensation from the military for what they are doing, and then, maybe eventually, in the

VA Caregiver Program.

I think if it is going to be more than six weeks --

MR. DRACH: Yes, I hear what you are saying, but SCAADL doesn't replace a career. So, if somebody interrupts their career, they lose 401, they lose pension, they lose Social Security, they lose tenure, they lose self-respect, they lose a lot of things, tangible and intangible.

I am not hung up on this, but I just don't know that six weeks is enough time. When somebody is spending three years post-injury in the system -- and I am not suggesting three years would be the ideal, and, of course, that is a legislative DOL issue, not a legislative DoD or VA issue. So, I don't know if we are going down a wrong lane there or not.

CO-CHAIR CROCKETT-JONES: I am not sure we have the power to ask for FMLA to be --

TSGT EUDY: And correction, it says "26 workweeks of unpaid job-protective leave during a single 12-month period". And there are currently revisions going on amongst --

CO-CHAIR CROCKETT-JONES: So, it is six full months. That is a significant amount of time.

CO-CHAIR NATHAN: Okay. Why don't we take it by the numbers? Because I think we have had some of the conversations ahead, which will save some time.

So, under 1, is there agreement, based on what you think intrinsically or based on what you heard from the WCP, that a DoDI actually needs to define what a Recovering Warrior family member is?

DR. PHILLIPS: I have a little trouble with that. You know, I will just throw this out.

I am wondering if we shouldn't define what that person is, designated

caregiver, because they may not be family members, as we discussed. And over a period of time, they may change. Someone at Walter Reed may have a girlfriend or a mom, and when they move back to Idaho, it might be somebody else.

So, I am just wondering if it wouldn't be better for us to simply say the designated caregiver and not leave it open for a definition.

CO-CHAIR CROCKETT-JONES: There is a problem. Caregivers are specific family members. Not everyone who goes to the bedside is considered a caregiver.

For instance, someone wants both parents at bedside; only one of them is going to be considered the caregiver or NMA even. And both are family members in terms of looking at programs for informing them.

So, the only thing I would say that is missing from this list is including non-relative family members if the Service

member designates one. They should be able to designate a fiancee as the family member if that is who is going to be bedside.

DR. PHILLIPS: Yes, I was thinking more broadly. Because if we are having trouble defining it, whoever is supposed to define it may have, you know, more trouble.

Again, it is just a suggestion, but I would feel more comfortable if we can come up with the terminology and present it, rather than waiting for them to do something.

MR. STONE: So, within the SCAADL law, how is it defined? I remember when SCAADL came out, and we were working with it early on, there is a definition there that I think if you pull out, this may just require some tweaking of the SCAADL definition to include non-family members as designated.

MS. DAILEY: Yes, the SCAADL defines the injury, the level of injury. And then, the Service member gets to identify that he has a caregiver, regardless. And then, he

gets paid or she gets paid the benefit.

MR. STONE: And so, how is that definition, why should it be restricted in any way?

CO-CHAIR CROCKETT-JONES: I don't think it should be. I think, though, what we don't want to do is call family members the only caregivers, since sometimes they don't fall under that category. They are just the family member at bedside. Caregiver is assuming a specific role. The VA has a definition for caregiver. Not all of these family members that are part of the process will be SCAADL recipients.

So, in having a DoDI, I would just want the Service member to be the one who designates who their family members are.

MR. STONE: I am not speaking against the DoDI creation.

CO-CHAIR CROCKETT-JONES: Right.

MR. STONE: What I am saying is, take the wording that is in the SCAADL law and

import it into the DoDI, and you have answered this question.

CO-CHAIR CROCKETT-JONES: I think you're right because the SCAADL law allows the Service member to designate who their family member is.

LT COL WONG: And I know we are talking specifically fiancees, but there is an expansion of family members law. There's domestic partners, there's other personnel that are out there that potentially the Service member may want by their bedside that they are currently excluded until this is expanded.

CO-CHAIR NATHAN: So, what I am hearing is everybody is onboard with "a" and the sub-bullets, but you would like to expand the definition to be caregivers.

CO-CHAIR CROCKETT-JONES: No, I think we want the designation to be made by the Service member.

CO-CHAIR NATHAN: Okay.

MR. DRACH: On double "i" under that, should we add "FRC" after "RCC"? Somebody that has been assigned a Federal Recovery Coordinator? They are the more severely --

MS. MALEBRANCHE: I don't think so for that, adding the FRC, because that terminology may change. So, that would limit us here.

CAPT SANDERS: Before we leave the family member piece, I just want to ask a question. So, is family members a term of art within this legislation, so that the way it is structured right now you can designate a family member, and once you designate a family member, you, then, become eligible to be the caregiver? And the Service member can designate anyone he or she chooses to be a family member, whether or not they are a relative by blood or not?

MS. DAILEY: Correct.

CO-CHAIR CROCKETT-JONES: Correct,

but you can't name -- you are only really getting --

CAPT SANDERS: One caregiver.

CO-CHAIR CROCKETT-JONES: One caregiver.

CAPT SANDERS: Right. But the caregiver has to come from that distinct group of family members that are identified by the member as well?

CO-CHAIR CROCKETT-JONES: Yes, that seems --

CAPT SANDERS: And they don't have to be a blood member of the family?

CO-CHAIR CROCKETT-JONES: No.

CAPT SANDERS: The family member is whoever decides this family is or she decides who the family is? Okay.

LT COL WONG: There is one exclusion under the SCAADL. The caregiver cannot be a DoD member or paid DoD member.

MS. DAILEY: Okay. Every DoDI requires a definition of terms. I realize

this definition of terms is best implemented when the Services agree on the definitions. Your DoDIs are more effective not necessarily when they agree, but at least when they have all been asked to collaborate on the definition of family member, the definition of caregiver. There are several terms in there, out there, that this first bullet is designed to clarify for all the Services. What's a caregiver? What's a family member?

And then, once those definitions are established, then they can get benefits. The caregiver gets benefits; the family member does not. The caregiver gets this information; the family member does not get this information. Once you have defined these categories, you can then allot resources and information that is appropriate for those categories.

It is best done by the Services in their process, so that there is buy-in and support because they have had input to it.

CAPT SANDERS: I just want to make a point. There's other law out there that defines family members under DoD that is not related to this?

MS. DAILEY: No.

CAPT SANDERS: None at all?

MS. DAILEY: The SCAADL law --

CAPT SANDERS: No, no, not --

MS. DAILEY: -- addresses the Service member only.

CAPT SANDERS: Okay, not related to Wounded Warriors or Recovering Warriors, but the Department of Defense has been directed in other ways to define family members for other circumstances, and whether or not that bleeds into this could be an issue, if the definition somehow doesn't fit.

MS. DAILEY: Because that statement is not correct, I can't address it. I don't know if Department of Homeland Security -- excuse me -- DDS has defined caregiver if --

CAPT SANDERS: I wasn't talking about caregiver; I was talking about family member.

MS. DAILEY: Family member. In general, family member is a Department of Defense culture. There are very few other agencies that have the culture that we have for taking care of families. So, I would not expect family member to be defined in the Transportation Department.

CO-CHAIR CROCKETT-JONES: No, he was saying DoD. He was saying DoD may have other regulations that define family member. But I believe that they rely on the term "dependence" --

MS. DAILEY: Yes.

CO-CHAIR CROCKETT-JONES: -- in their definitions.

MS. DAILEY: I see what you are saying, a DEERS.

CO-CHAIR CROCKETT-JONES: A DEERS and all that.

MS. DAILEY: A beneficiary.

CO-CHAIR CROCKETT-JONES: They are beneficiaries.

MS. DAILEY: Yes.

CO-CHAIR CROCKETT-JONES: They are dependents. They have other terms. I don't think that, in general, they use the term family member, specifically because they are defining something very specifically.

MS. DAILEY: So, if you want to give DoD -- first of all, you are only making a recommendation. So, if you want to make a recommendation to DoD that caregiver be defined this way and family member be defined this way, it is only a recommendation. And it is the product of your collective knowledge and not their collective knowledge.

CO-CHAIR CROCKETT-JONES: Like I said, the only thing on this list of 1 through 4 under "a" is in the way that SCAADL leaves it open to be the person a Service member designates as a single family member to be

bedside.

I don't want that to go sight unseen and wind up excluding people because they defined it based on this list, which does not include non-blood relatives. So, the fiancee gets included, the partner gets included, the foster brother winds up getting included as the family member that is going to be designated to receive the information and to help them through the recovery process if that is who the best person is.

MS. DAILEY: Okay. Yes. Team, was it intentional on every one of those, 1, 2, 3, and 4, we use "family member includes family"? For the Army, it includes family and for any family member. Did we do that intentionally to not have non-blood relatives in there? Okay. So, we were just overabundant and enthusiastic about family. Okay. We will broaden that.

CO-CHAIR CROCKETT-JONES: Persons.

CO-CHAIR NATHAN: Yes, I think if

you just broaden it to include non-blood relatives or non-blood persons, people without blood -- (laughter) -- then it will be fine.

Okay, let's move on to require the Services -- do you feel strongly that the DoDI should require the Services to identify the Service-specific office within both the active and Reserve components tasked with supporting Recovering Warrior families? Is this something that is not being done now and the DoDI should require the Services early on -- remember, the guiding principle from sentence one is, "early in the recovery process to identify the Service-specific office".

Army, you have got to tell Army families where the office is that supports them, where the people are who support them. Maybe you've got to do the same.

Is there anything to be lost? I mean, is there anything to lose? Do you have everything to gain with this and nothing to lose? Or is there any potential blowback on

it?

Going once.

This came from the WCP. This is their wish list.

CO-CHAIR CROCKETT-JONES: Yes, this is the WCP.

TSGT EUDY: Correct, and where was their shortfall in seeing this, because this is one of those statements, again, where I will see the Services saying, "We do this."

CO-CHAIR CROCKETT-JONES: No. Some Services have done this, but not all Services have designated an office or a role responsible.

CO-CHAIR NATHAN: And remember, it doesn't say create the office; it says identify the office.

TSGT EUDY: So, then, we will be leaving it up to the DoDI and, then, the Services then to choose whether they use, let's say, a cadre member versus a Lead Coordinator versus --

CSM DeJONG: No, this is more level of WCP building the algorithm as to who is their go-to person and/or office in the next level at each Service.

TSGT EUDY: Connecting directly, then, with that family member?

CSM DeJONG: Then, it goes down from there.

TSGT EUDY: Just making sure, then, it is the same commensurate. Okay.

MR. STONE: Do we really need to get to this level of telling the Services how to execute this?

CO-CHAIR CROCKETT-JONES: This is what WCP has said prevents them from telling the Services how to do this.

MS. DAILEY: They ask for a list of things that we have seen over the years that would be helpful that they should include in the DoDI.

MR. STONE: Since they are a policy office, it seems to me that generating

DoD-level policy is something the Department does pretty well at. Are they having trouble deciding who to send their policy to? Is that the problem? Or nobody pays attention to them?

MS. DAILEY: Well, I think their intent here was that in each Service they had a reciprocal policy office for promulgation and that they are not confident that that is what is out there for families.

CO-CHAIR NATHAN: And what we are doing, I think, is brokering their wish list against our intuition, based on what we have seen as a Task Force, and as we have talked to families and as we have observed the processes across the dynamic over the years. You should be asking yourself exactly what General Stone did, which is, okay, is this something that they already do and we don't need to tell them how to do it or (b) we do need to tell them to do it because we agree with WCP this isn't really well-established and would be a

goodness?

So, do I hear any objections to Services required early in the process to identify the office to the WCP that is tasked with supporting the RW families? No?

Okay. Remember, you can cogitate on these over the next eight, six weeks. When we get back together in July and we have the Mad Max from Thunderdome 12 recommendations enter; one recommendation leaves.

"C, delineate the role" -- if you liked "b", you will love "c".

(Laughter.)

Delineate the role of the Service-specific office tasked with supporting...." That now, if you like telling people how to suck the egg, Rich, you've got it in spades there in "c".

MR. STONE: Could we go back to the no-blood comment?

(Laughter.)

CO-CHAIR NATHAN: I do worry that

"c" is getting a little weedy, but --

CSM DeJONG: I don't see why we would have to go that far into it. I think if they need help identifying, they need help, and I agree with you, sir, I don't know why they need our help to identify a Service-specific office.

MR. STONE: Sergeant Major, I am struggling with it because it seems like we need to give them the address of who to send it to or?

(Laughter.)

CSM DeJONG: I'm with you.

MR. STONE: I'm not sure. This is a very well-developed Department. Certainly, we understand that this office is in a state of evolution. There are some great people there. They are working hard to develop it. So, I am not sure we really need to tell them how to do their business.

I think we can put some things in. If they asked for it, I understand. I am

still not sure we need to give it to them.

CSM DeJONG: I would entertain "b"; I would hesitate to entertain "c".

CO-CHAIR NATHAN: Okay. I didn't really hear any objections to "b", but I'm hearing the vocal minority so far concerned about "c".

Is there anybody who believes strongly enough in "c" that we need to leave that teed-up?

MR. STONE: Sir, I don't mean to belabor this. Could we pull the enabling document that says how the WCP stood up and what their roles are? Do we have the enabling document?

CO-CHAIR NATHAN: Their charter?

MR. STONE: Yes.

MS. DAILEY: All right, sir. I was there when it was stood up.

We have attempted to put it in -- we put it in a recommendation to establish this office in law. DoD non-concurred.

They have done a number of documents over the years to create their mission. There isn't anything in law. There is one line in the P&R DoDD, Department of Defense Directives, that says P&R will manage Recovering Warrior care. They call it a different name. There is no DoDI that covers this office.

I can give you all sorts of emails from Mr. --

CO-CHAIR CROCKETT-JONES: Yes, I think what we are struggling with right now, Denise, is that the office has, in responding to us, implied that they don't actually have the force, the power to enforce that Services comply. Now they can only make policy suggestions. And at this point now they seem to be saying they can't make the policy suggestion for the DoDI; they need us to do that.

I am a little frustrated because I thought I was understanding the role of WCP,

in that even though they had no teeth or manner of enforcement, they made policy recommendations for this population.

MS. DAILEY: They do. They wrote the IDES policy. They wrote, okay, so they wrote the RCC policy. They wrote the Operation Warfighter policy. They write policy all the time.

We have kicked this topic of asking them, telling them, making a recommendation to do a family policy, we have discussed this almost every year. You've not gone down this road. So, you don't have to go down it again, but it is one of the areas from their office that they have never written policy for, and they said, "We'll do it. Tell us what you want in there."

The Services have been asking us. Army has come to us and said, "You want us to do that? Put it in a policy."

You can just put a one-liner, "Write a DoDI family policy." That will help

them move down the road.

When you make a recommendation, whether it be small or detailed, big or detailed, you give them leverage; you give them something to point to. So, your voice gives them something to go back to when it comes to leveraging compliance from the Services.

CO-CHAIR CROCKETT-JONES: So, if our recommendation was that a DoDI needs to be written to address the needs and the processes that touch family caregivers early on in the process, some more basic recommendation, could these topics that we have repeatedly said are significant be included not necessarily in that recommendation, but, instead, in an explanation? So that our recommendation isn't as granular as all these sub-topics?

Yes, I think it would be more clear. And rather than have a recommendation be non-concurred because they don't go along with "d" or "f" or "k", or because it doesn't

apply, rather than being non-concurred, the broad recommendation that DoDI needs a policy, I don't know how anyone could -- do you see what I'm saying? I think that would have more buy-in.

CO-CHAIR NATHAN: Less is more.

CO-CHAIR CROCKETT-JONES: Less is more. Thank you.

MS. DAILEY: We can put what you have, what is here, in the findings. So, we can put what we have in here in the findings. That's fine. That is your call, definitely.

CO-CHAIR NATHAN: Okay. So, that is an interesting dynamic that has been brought up here, and I think we need, before we keep going down the list, Ms. Crockett-Jones brings up a good point, which do we not even get into the weeds of this? Do we do as Ms. Dailey suggested is a possibility, put these kinds of things in the findings that we heard? And those findings -- and there's no question they were findings because they were

presented to us sort of in evidence from the WCP that came before us, and we have seen some of these things in our own personal travails through the system. If we put those in the findings and we use those findings to generate a much more general one impact statement that says: you publish a DoDI that addresses the needs of Recovering Warrior family members and caregivers early in the process, identifying the baseline services to be delivered by each Service branch.

And we can finetune that in July, but that would be the concept we would leave here with, and we would not go through and decide if we are going to add, subtract, or change each individual thing from "a" through "o", unless you feel there is one in there -- and I hate even saying this -- unless you feel there is one in there that is so heinous -- I like that word, "heinous". "Man, I thought you said something else for a second."

(Laughter.)

That is so heinous that it has to be demarcated with the general statement.

CAPT SANDERS: Just one point. Earlier Denise made a comment about this is incorrect; it doesn't apply. My point was that federal law defines a family member. And how we ask them to address federal law, I would like the researchers to go look at those, considering the Family Leave Act, 5 USC 8701, and the OPM definition. If we define it differently than those definitions, we are problematic.

CO-CHAIR NATHAN: Say that again, please?

CAPT SANDERS: There was a point I made earlier about defining family members. And apparently, we have a definition that we have adopted from someplace.

Well, in "a" we are clarifying a family member, and there are federal statutes right now which define family member. We need to be consistent.

CO-CHAIR CROCKETT-JONES: We were telling DoD to define it. There isn't a definition yet.

CAPT SANDERS: Well, there is a definition. I just looked up --

CO-CHAIR CROCKETT-JONES: But there is a federal definition. I think what was more appropriate than this list would just be to indicate that a Service member who is wounded, ill, or injured should be able to designate a family member.

CAPT SANDERS: If it is consistent with the existing laws; it doesn't violate their definition; it doesn't violate the laws that exist, that's perfect.

CO-CHAIR CROCKETT-JONES: As long as it doesn't, yes --

CAPT SANDERS: So, we need to find out what those laws say and make sure the definition that we want them to be able to use fits.

MS. MALEBRANCHE: Isn't the

definition in law of a family member, not of a Recovering Warrior family member?

CAPT SANDERS: Correct. So, that is a key definition. That is a good point.

CO-CHAIR CROCKETT-JONES: Yes.

CAPT SANDERS: We need to make sure we stay in that box.

CO-CHAIR CROCKETT-JONES: Yes.

MS. DAILEY: I got it. We are going to look up the family member definition under the Family Leave Act. And you also mentioned OPM. The Family Leave Act falls under OPM, right?

CAPT SANDERS: There are three separate statutes that defines it. I just did a quick search, and three came up with it.

MS. DAILEY: Okay.

CO-CHAIR CROCKETT-JONES: And we're safer if we say they need to define a Recovering Warrior family member because, then, it is separating that from the federal term "family member".

CAPT SANDERS: Right, and we are creating a definition, the one that we want to be out there.

MS. DAILEY: Okay. I got it.

CO-CHAIR NATHAN: And then, sentence one, the nice thing is it talks about the needs of the Recovering Warrior family members and caregivers, because any family member could be a caregiver, but any caregiver cannot necessarily be a family member. They're not. And as you say, you can only have one person at a time identified as a non-medical attendant.

So, any other questions on that? Concerns?

CSM DeJONG: The last comment, I think this, again, adds to, going back to -- what is it? -- interagency policy, when we start talking about -- I didn't want a book thrown at me from behind.

(Laughter.)

So, when we start talking about

coordinating and equalizing in "h" the type of training, then we go into 2 and, again, redefining at an interagency level of what are activities of daily living that we want to address, I think if that is done at that level, it will help and we can possibly use some of this to caveat and strengthen that recommendation.

TSGT EUDY: Something in addition there, too. We had discussed the uniform application of SCAADL. I don't know if -- if I missed it while I was at the restroom, I'm sorry, but that uniform application to make sure that everyone that was applicable was receiving. Because I know we talked about Service members that were by some Services a certain category, and all were being approached. And then, there were discrepancies regarding the number of individuals that were actually on it versus not. So, making sure that each and every one applies that in the same manner.

CO-CHAIR CROCKETT-JONES: Yes, I would say for now the DoDI really should address a uniform policy for SCAADL application. And in the long-term, we need an interagency policy on caregiver training and compensation to include SCAADL or caregiver compensation and the definitions.

So, it can be included in the findings for this, but it can also be a matter for findings under the joint interagency policy recommendation.

CO-CHAIR NATHAN: Well, to the spirit of the first sentence, I know that from watching Commander Sergeant Major DeJong fairly consistently ask groups, when we would meet with focus groups, about SCAADL, there is a woeful lack of knowledge in many pockets of that. Some places had it teed-up pretty well; others just didn't understand the benefit. And I wasn't confident necessarily that the organization was getting it to them.

And again, it applies to a certain

subset of the Recovering Warriors, but, nonetheless, I think the DoDI could help with that. Whether you want to actually include that as part of the recommendation, because SCAADL is broken out here, or not? What are your thoughts?

CSM DeJONG: No, I concur, sir.

MS. DAILEY: We did a recommendation last year on better marketing of SCAADL.

CO-CHAIR NATHAN: See, I knew I was a genius. Okay.

(Laughter.)

Yes, I remembered we addressed in the past. I had forgotten we had recommended it. Okay.

MS. DAILEY: So, you want in the findings the possibility of future interagency training between both agencies for caregivers and --

CO-CHAIR CROCKETT-JONES: I think that right now there is no training required

for SCAADL. I would like to see in the findings, either here or under the interagency policy recommendation, an example would be to align those two programs so that they have consistent training, consistent definitions, consistent lists of activities of daily living.

CSM DeJONG: And that would also ease, that policy would also ease the handoff from one to the other.

LT COL KEANE: If I could put my two cents in?

MS. DAILEY: There is a -- I'm sorry -- there is a SCAADL policy. So, what is the recommendation? Well, I will include it in the findings. You don't want another recommendation on this? Okay. Okay, we'll talk about it in the findings.

LT COL KEANE: I guess I don't agree that -- I viewed 1, No. 1, DoD should publish a DoD instruction as one item. And then, I looked at 2 as another item. In

reading this, I didn't envision them being one recommendation.

CSM DeJONG: No, sir, it is not -- there is just one recommendation. Not within the recommendation is 2 or "h", but I think 2 and "h" could be used to help caveat a policy, an interagency policy, because it helps standardize definitions of what are activities of daily living. It helps standardize training for the two, and it helps a handoff from one to the other, as you transition from DoD to VA.

I think an interagency policy on that, and I was just going back to help caveat the interagency policy recommendation that we had talked about prior to lunch.

LT COL KEANE: But I don't envision a discussion of SCAADL being in the DoDI that we are recommending. Okay, okay.

CO-CHAIR CROCKETT-JONES: No, except for as it is listed under "h", which is to say that caregiving training and, 2,

attendance mandatory for SCAADL recipients, that caregiving training is optional, but it is mandatory if you are receiving SCAADL, should be part of the DoDI as the findings, not as a part of the recommendation.

CO-CHAIR NATHAN: Any further discussion on that topic?

(No response.)

Denise, do your folks have any questions or concerns about the distillation of this conversation?

MS. DAILEY: No, sir. We have most of it here. From what I understand, it is in "a" through "o", and we are going to discuss training for SCAADL. We are not going to make a recommendation for expansion under legislation for SCAADL, but we want to see them align SCAADL training with VA caregiver training, and that needs to be in the DoDI or we will put it in the findings to highlight it.

CO-CHAIR CROCKETT-JONES: Put it

in the findings to highlight it under the joint policy, because it is not just the training. We are not going to do a separate No. 2 recommendation. But we are saying they should share the same list of activities of daily living. They should share the definition of caregiver. They should share the training.

And the reason why it would make a perfect program to fall under joint policy, because of sharing all of those aspects. And that way, each has a deficit that would be fixed by those two programs being in alignment.

MS. DAILEY: Okay. And so, we would allude to this making a good joint policy when they have defined a structure and format for joint policy?

CO-CHAIR CROCKETT-JONES: Exactly.

MS. DAILEY: Okay.

CO-CHAIR NATHAN: Anything else?

(No response.)

Okay. There being no further discussion, I think that wraps us for today.

MS. DAILEY: Unless you all wanted to work on tomorrow's first topic item.

CO-CHAIR CROCKETT-JONES: Do we want to work on Reserve component IDES or are we --

(Laughter.)

LT COL KEANE: I thought we were going to discuss this. Is this in here for a reason?

MS. DAILEY: It is. I mean, it is for your information, if you want to discuss it.

LT COL KEANE: I have some suggestions.

Tab C, I assume it is the proposed cover?

The focus is, I believe, wounded, ill, or injured Service members. When I look at the second picture, I guess the two pictures of the airmen, doctors or whatever

they are, my focus is on the provider as opposed to the wound, ill, and injured person. So, when I look at those two pictures of the airmen that are doctors, or whatever they are doing, my focus is on the Service member providing the service. I think we need to have like a hospital bed picture to represent someone ill and some other person maybe a prosthetic. I know we must have a bunch of pictures.

I would just suggest that those two pictures be replaced with focusing more on the wounded, ill, and injured, like the other pictures do.

MS. DAILEY: Okay.

CAPT SANDERS: I would also suggest maybe some pictures that align with the individual we met the last time we were here. So, these young men and women who were out on a bike ride who were demonstrating recovery might be another way to take a look at it.

MS. DAILEY: Okay.

MS. MALEBRANCHE: We have got some good pictures, Denise, at the VA from the Warrior Games and things, likewise, that show Recovering Warriors on the way to recovery that I think might be pretty inspirational actually.

MS. DAILEY: Okay.

CO-CHAIR NATHAN: We have got two months, just about.

(Laughter.)

CO-CHAIR CROCKETT-JONES: I just want to make sure nobody wants to spend the time to cover one of our topic areas from tomorrow this afternoon. Be really sure, because maybe we could handle empowering the Centers of Excellence.

I have a long way to drive tomorrow after our meeting.

MS. DAILEY: We are not going to have Admiral Nathan with us tomorrow. So, Captain Sanders, you are in the hot seat tomorrow.

(Laughter.)

Unless you have changed your mind, sir, freed-up your schedule, and --

CO-CHAIR NATHAN: I wish I could. I will be sitting in the coach between two Sumo wrestlers on a 14-hour flight over to Guam. But I think I would rather be here with you all. No matter what, I would rather be here with you all, good or what, but especially tomorrow.

(Laughter.)

So, I think it is fine with me. I mean, I am happy to plow ahead tonight. On the other hand, I have been looking at the agenda for tomorrow. It doesn't look like it is going to be any more arduous or robust than today. I think you are going to move along at a pretty good clip tomorrow.

And you have the benefit of -- will General Mustion be here tomorrow? Okay. So, you have the benefit of General Stone here. So, I think we are well-covered.

As President Kennedy said one time at a dinner he was hosting on behalf of his wife Jacqueline, he was hosting artists and PhDs and Nobel Laureates and famous singers for dinner, and he looked around the table, and he said, "There has never been so much talent and achievement assembled around this table since Thomas Jefferson dined alone."

And so, I think we have got several Thomas Jeffersons here. So, I'm not worried.

But if you are still going when I get back in a few days, I will certainly jump in.

(Laughter.)

CO-CHAIR CROCKETT-JONES: All right, then, I am bowing to the pressure from my left. We will close for today and see you again in the morning at 8:00 a.m.

(Whereupon, at 2:45 p.m., the meeting was adjourned, to reconvene the Tuesday, May 13, 2014, at 8:00 a.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Task Force on the Care of Recovering Wounded - May Business Meeting

Before: US DOD

Date: 05-12-14

Place: Arlington, VA

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter