

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

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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

1 Reserve.

2 CSM DeJONG: Good morning.
3 Command Sergeant Major Steve
4 DeJong, representing the National Guard
5 Bureau.

6 MS. MALEBRANCHE: Good morning.
7 Karen Malebranche. I'm
8 representing the VA.

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

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

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

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

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

22 DR. PHILLIPS: Steve Phillips,

1 representing NIH, a Vietnam veteran.

2 CO-CHAIR CROCKETT-JONES: Very
3 good.

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

6 I am going to turn it over to you.

7 CO-CHAIR NATHAN: All right.

8 Well, welcome back, everybody, and welcome to
9 our newest members.

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

15 CSM DeJONG: Go big or go home.

16 CO-CHAIR NATHAN: Go big or go
17 home.

18 (Laughter.)

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

21 (Laughter.)

22 Over the next two days we will

1 review our members' consolidated observations
2 to assist in the development and the
3 discussion of possible recommendations for the
4 2014, and I might add final, report.

5 To date, we have provided a total
6 of 77 recommendations to the Secretary of
7 Defense. This fiscal year we have conducted
8 14 installation visits and four information-
9 gathering business meetings, which will
10 provide the majority of the substance behind
11 the 2014 recs.

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

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

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

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

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

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

22 In addition to the IDES

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

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

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

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

19 CAPT SANDERS: Thank you.

20 Good morning.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 CO-CHAIR CROCKETT-JONES: And the

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

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

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

21 CO-CHAIR CROCKETT-JONES: Yes.

22 MR. DRACH: I would like to think

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

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

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

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

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

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

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

22 How do we find some balance in

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

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

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

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

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

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

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

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

1 We're going to process you for disability."

2 That's what this is.

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

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

14 There are two issues here, I
15 think.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 CO-CHAIR CROCKETT-JONES: Well, I

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 back together?

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

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

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

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

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

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

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

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

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

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

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

18 Suzanne, you were going to say
19 something?

20 CO-CHAIR CROCKETT-JONES: No.

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

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

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

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

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

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

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

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

1 obviously not coming back to service.

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

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

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

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

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

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

1 just huge.

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

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

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

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

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

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

1 both seem to be at critical mass.

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

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

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

22 So much depends on semantics and

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

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

1 then let's just get you into that system.

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

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

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

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

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

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

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

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

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

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

18 Once again, I will defer to the
19 larger group.

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

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

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

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

15 The DoDI, on the private sector
16 internship thing, come on. You know,
17 Operation Warfighter has been around since
18 '05-06, something like that. If that had been
19 opened up to the private sector five years
20 ago, how many people would have taken
21 advantage of it, because federal opportunities
22 are too limited? And if you are in an MTF

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

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

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

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

1 the compensation. It is a whole different
2 issue.

3 So, anyway, I don't know.

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

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

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

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

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

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

1 there's a lot of lessons learned in there.

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

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

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

22 But, anyway, just some thoughts.

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

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

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

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

1 same rock over and over again.

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

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

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

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

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

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

1 their fair due.

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

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

1 better. You still got paid.

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

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

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

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

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

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

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

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

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

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

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

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

1 the philosophical viewpoint?

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

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

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

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

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

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

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

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

3 (Laughter.)

4 So, to kind of get traction on all
5 of this, I am hearing more of an interest in
6 going towards Recommendation 2, the group of
7 2, with some twists and turns to it, than 1.
8 Okay. So, I think we have got that. Okay?

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

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

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

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

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

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

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

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

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

1 for this first sort of very difficult topic.

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

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

8 (Laughter.)

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

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

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

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

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

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

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

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

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

1 draft.

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

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

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

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

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

4 So, Karen, your initial thoughts?

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

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

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

1 signed this coming week here.

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

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

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

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

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

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

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

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

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

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

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

19 MS. DAILEY: Yes.

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

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

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

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

22 Are there comments on that?

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

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

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

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

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

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

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

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

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

14 This is just a bit sideways, but
15 let me throw out a suggestion that might
16 actually come to a recommendation and let me
17 just preface it by saying next month I'll be
18 74 years old. I have the best access and the
19 best delivery of care possible. I have
20 TRICARE; I have Medicare. I can go to any
21 military hospital. I can go to any VA
22 hospital. I can go to any civilian clinic and

1 be cared for.

2 Why sort of at the tail-end of my
3 existence do I have better care than, say, a
4 23-year-old who had both legs blown off or was
5 blinded, and so forth? And so, again, this is
6 a little sideways, but in my mind I'm saying,
7 if I am eligible for DoD care, if I am
8 eligible for VA care, why can't I be
9 immediately automatically eligible for
10 Medicare? I guess I don't have to go into
11 those details about the benefits of doing that
12 related to remote locations and waiting lists,
13 and so forth.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 system being enrolled in this.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 taken over that.

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

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

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

22 You know, I come from a place --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 opportunities for them.

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

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

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

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

1 recommendation?

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

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

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

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

22 CO-CHAIR NATHAN: Command Sergeant

1 Major?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 including the VSOs.

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

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

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

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

22 I have been kind of silent this

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

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

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

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

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

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

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

11 CO-CHAIR NATHAN: Other thoughts?

12 (No response.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 added thought.

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

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

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

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

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

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

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

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

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

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

1 University of Southern Florida.

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

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

22 Right now, there is no requirement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 happen.

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

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

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

1 contemplating.

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

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

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

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

9 Any other thoughts?

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

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

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

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

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

1 going to be templated.

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

8 Going once --

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

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

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

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

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

8 MS. DAILEY: Should I or not?

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

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

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

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

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

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

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

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

1 using in other places."

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

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

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

1 paradigm. So, it is a subtle difference.

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

7 Once, twice, sold. Okay.

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

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

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

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

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

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

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

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

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

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

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

22 As we review items 1a through 1b,

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

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

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

10 DR. PHILLIPS: Thank you.

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

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

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

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

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

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

1 involved from the get-go.

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

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

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

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

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

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

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

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

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

22 What they are advocating is that,

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

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

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

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

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

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

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

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

1 a team supporting them?

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

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

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

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

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

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

5 CAPT SANDERS: If you take a look
6 at the wording of that last bullet under 2 and
7 3d, and work along the lines that you're
8 discussing, sir, and think about that in
9 relation to the Spouse Protection Act issues,
10 you can't sign away your SBP without the
11 spouse being notified, if you were able to
12 bundle that up in a package which makes the
13 Service member and the family all come
14 together at a certain point in time, the
15 Service has opt-out ability, but he can't opt-
16 out in the dark. It has to be in the light
17 where others can see.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 and communities.

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

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

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

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

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

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

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

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

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

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

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

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

11 Concerns? Comments on that?

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

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

22 CO-CHAIR NATHAN: And just so we

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

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

6 CO-CHAIR NATHAN: Okay.

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

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

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

21 CSM DeJONG: Absolutely.

22 LT COL KEANE: Yes.

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

7 (Laughter.)

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

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

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

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

22 So, I am not hard over on it being

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

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

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

22 Then, the second part that we

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

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

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

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

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

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

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

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

1 initial appointments from the get-go.

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

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

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

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

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

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

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

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

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

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

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

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

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

4 DR. PHILLIPS: I would like to add
5 that I strongly support that. I retired in
6 1993 and I am still filling out my VA forms.
7 I mean, I haven't -- sort of tongue in cheek,
8 but I see no downside for this automatic
9 appointment and referral. I mean, it is part
10 of the warm handoff.

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

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

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

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

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

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

22 And having transparency for the

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

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

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

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

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

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

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

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

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

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

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

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

1 sure. Some of you may have eyes on that.

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

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

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

22 Then, teasing out potential other

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 CO-CHAIR NATHAN: Oh, okay.

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

20 CO-CHAIR NATHAN: Okay. Okay.

21 Thank you for the clarification.

22 Because this would be germane to

1 all exiting Service members.

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

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

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

15 CO-CHAIR NATHAN: Right.

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

22 CO-CHAIR NATHAN: Right. Couldn't

1 help.

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

5 CO-CHAIR NATHAN: Yes. Yes.

6 LT COL WONG: -- to initiate a
7 claim.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 But is there a consensus for this

1 to be a recommendation or a possible
2 recommendation?

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

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

9 CO-CHAIR NATHAN: Uh-hum.

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

13 CO-CHAIR NATHAN: Okay.

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

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

22 We have plowed some of the EHR

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

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

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

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

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

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

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

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

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

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

8 (Laughter.)

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

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

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

1 CAPT SANDERS: So, the first
2 bullet -- excuse me -- the second bullet under
3 2 and No. 1, which is "promoting interagency
4 healthcare collaboration," I am assuming that
5 we already said that before, or we haven't?
6 Under No. 1 on this page 4?

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

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

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

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

22 I think that we one doesn't stand

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

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

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

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

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

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

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

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

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

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

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

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

1 39, 50, whatever, recommendations have been
2 not addressed?

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

5 MR. DRACH: Okay.

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

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

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

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

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

11 CO-CHAIR NATHAN: Any comment on
12 that?

13 (No response.)

14 Going once, going twice.

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

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

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

22 (Laughter.)

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

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

5 (Laughter.)

6 So, thank you all for the topical
7 discussion.

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

12 MS. DAILEY: An hour or would
13 you --

14 CO-CHAIR NATHAN: Yes.

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

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

20 Anybody want to meet earlier than
21 that?

22 (No response.)

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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.)

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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

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

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

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

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

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

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

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

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

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

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

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

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

22 MS. MALEBRANCHE: They are, and I

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 CSM DeJONG: Got it.

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

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

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

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

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

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

1 have talked about.

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

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

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

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

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

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

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

22 The concept of taking a year to

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

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

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

22 And the best thing that we could

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 we can't pursue that.

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

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

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

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

22 LT COL KEANE: As we have done in

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

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

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

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

22 But there are some differences,

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

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

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

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

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

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

3 MS. DAILEY: Okay. We have --

4 DR. PHILLIPS: -- if those work.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 bureaucracy of MOUs and agreements between
2 Services.

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

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

8 (No response.)

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

13 Anything else in this area?

14 (No response.)

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

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

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

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

3 MS. DAILEY: Oh, okay.

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

6 MS. DAILEY: The gossip around the
7 street is --

8 CO-CHAIR NATHAN: Right, right.

9 MS. DAILEY: Okay.

10 CO-CHAIR NATHAN: But when you
11 hear Ms. Malebranche's comments and you heard
12 Command Sergeant Major DeJong's and Ms.
13 Crockett-Jones -- I just sort of called for
14 the question and just said the recommendation
15 generically is to find common policy in the
16 interagency, especially DoD and VA, that deals
17 with a myriad of issues, not the least of
18 which is transitional handoff from one system
19 to the other.

20 MS. DAILEY: Right.

21 CO-CHAIR NATHAN: But I don't know
22 if you wanted to put a finer point on it or if

1 you had additions.

2 CO-CHAIR CROCKETT-JONES: I think
3 the research team probably has the kernel of
4 what we are saying for the language when they
5 craft it.

6 But it is really not that we are
7 looking for common policy. We want them to be
8 able to have joint policy --

9 MS. DAILEY: We don't want them to
10 have joint policy.

11 CO-CHAIR CROCKETT-JONES:
12 Interagency policy. Excuse me. We want them
13 to have interagency policy issues coming
14 forth, not common policy on each side. We
15 want them to have --

16 CO-CHAIR NATHAN: One policy?

17 CO-CHAIR CROCKETT-JONES: One
18 policy, yes.

19 CO-CHAIR NATHAN: One policy.
20 That's what I meant by common, one policy
21 common to the various interagencies, the
22 various agencies that are inter with each

1 other.

2 (Laughter.)

3 CO-CHAIR CROCKETT-JONES: Exactly.

4 CO-CHAIR NATHAN: That's how I see
5 it, as opposed to the outer agencies.

6 (Laughter.)

7 Those agencies of whom we will not
8 speak, as in Harry Potter.

9 (Laughter.)

10 MS. DAILEY: Okay. And from the
11 discussion, sir -- and I will answer your
12 question, and I do want to clear up some
13 points -- from the discussion, this is not a
14 request for legislation. Or is it a request
15 for legislation? What is the legislative role
16 here? Is there a legislative role?

17 CO-CHAIR CROCKETT-JONES: If it
18 takes legislation.

19 MS. MALEBRANCHE: If there is no
20 mechanism for interagency policy right now --
21 I mean, this has to be researched a little bit
22 -- then, I think it may take legislation. It

1 is not just going to be a series of MOUs and
2 joint local agreements. If it takes
3 legislation to have interagency policy, which
4 because in looking for what we used to call a
5 joint policy in IC3, and we can ask our
6 attorney here, they said, "Well, if the
7 General Counsel said there is no mechanism for
8 policy, then it might be legislation." I
9 don't know.

10 CO-CHAIR NATHAN: Where are we
11 when we have deliverables from the HEC, the
12 JEC, and the BEC? Because the HEC and the JEC
13 -- are DoD and VA sitting down, are the heavy-
14 hitters sitting down with their counterparts
15 and deciding on a way ahead, and is that
16 memorialized in that policy? Is that
17 memorialized in an MOU? Is that memorialized
18 in goodwill and the moral persuasion of both
19 people will do it?

20 I don't know technically how
21 that --

22 CO-CHAIR CROCKETT-JONES: My

1 impression was that it is all based on
2 memorandums, MOUs.

3 MS. MALEBRANCHE: Or each side
4 writes their own policy. There is not a
5 single policy, not a single overarching
6 policy.

7 CAPT SANDERS: Well, a mechanism
8 to get to an overarching policy is for the
9 Secretary to ask the President to issue a
10 Presidential Directive. And you get a DoD
11 Directive that does overarch all the policies
12 of the Executive Branch agencies.

13 I am not sure if that is the
14 direction anybody wants to head. But if you
15 are trying to link it all together and get the
16 Executive to push all the agencies in one way,
17 that is a way.

18 CO-CHAIR CROCKETT-JONES: I think
19 that we are hoping to find a simpler solution
20 that is a framework that all the interagency
21 -- I mean, Presidential Directive, to have to
22 go to a Presidential Directive every time

1 there is an interagency program that needs a
2 policy, that seems unlikely.

3 MS. DAILEY: Well, I have to tell
4 you I think, actually, in one category the
5 environment is ripe for that, particularly
6 from the presidential level.

7 MR. STONE: Before we get to that,
8 I think Admiral Nathan's question is correct.
9 We need to go back and research what is the
10 power of the HEC. The decisions that are made
11 at that level, are they strictly agreements
12 based on the position of the Chairs or do they
13 carry additional weight, based on some sort of
14 existing structure or law?

15 MS. DAILEY: Ladies and gentlemen,
16 the JEC is established in law, established in
17 2002 as the integrating agency for DoD and VA
18 for healthcare and benefits. That is its
19 legislative mandate.

20 According to its lawyers, it
21 cannot make interagency policy. The way they
22 manage is through DoDIs, MOUs, CPGs, the

1 promulgation of those types of products in
2 each agency.

3 To move this question a little bit
4 for a recommendation, one recommendation would
5 be the JEC needs a structure and format for
6 interagency policy. That is some language for
7 a recommendation. So, it could sound like
8 that, too. I mean, Ms. Malebranche, those
9 words came out of her mouth, which is
10 directing this to the JEC to get the JEC needs
11 a structure for format and interagency policy.
12 Excuse me. The JEC needs a structure and
13 format for interagency policy. That is one
14 direction to go.

15 The other language of the
16 recommendation would be, which we have heard,
17 which is interagency policy needs to be
18 established to address the disability,
19 Recovering Warriors, credentialing, and the
20 handoff.

21 And then, the third option on this
22 one is tell Congress or ask for a

1 Presidential. Like I said, I think the
2 environment might even get that some traction.
3 The problem with Presidential Executive
4 Orders, they go away when the President goes
5 away.

6 CAPT SANDERS: I have a question.
7 Now is the JEC membership -- who are the
8 members and what is their status?

9 MS. DAILEY: I would have to go
10 through the legislation. Right off the top of
11 my head, I don't remember.

12 The Secretary, the Deputy
13 Secretary -- the Secretary?

14 MS. MALEBRANCHE: It is the Deputy
15 Secretary of VA and --

16 MS. DAILEY: And the P&R.

17 MS. MALEBRANCHE: -- the P&R for
18 DoD.

19 MS. DAILEY: Are the Chairs.

20 MS. MALEBRANCHE: And then, the
21 membership is specifically listed. I mean, we
22 can pull that. I don't know the titles now.

1 CAPT SANDERS: So, it is
2 essentially a Deputies' committee, the same
3 structure that you have in a national security
4 environment? We have a Deputies' committee,
5 and a Deputies' committee puts together policy
6 recommendations for their Directors and for
7 the President to sign off on.

8 And so, the issue now is to give
9 them enough power or for somebody to say that
10 they have the power to come up with a policy
11 to move forward.

12 MS. DAILEY: It's, yes --

13 CAPT SANDERS: As a fourth
14 alternative to your list of three.

15 MS. DAILEY: Well, I'm not sure
16 the JEC works exactly that way. They have to
17 push it back to Health Affairs if they want a
18 legislative proposal or P&R. VA's can
19 implement and suggest VA legislative
20 proposals.

21 CO-CHAIR NATHAN: So, might I
22 suggest, then, Ms. Dailey, your team, your

1 very accomplished team, maybe we take the
2 generic phrasing that we left with a little
3 while ago on the recommendation, and then, we
4 season it with some of the research they are
5 going to do, looking at the language of the
6 HEC and what the mechanisms are and how
7 binding they are in law and where that comes
8 from. And that will be ready for us at our
9 next meeting when we go to determine how we
10 are going to tee this up for a recommendation,
11 if we are going to tee this up and how we
12 would tee it up for a recommendation.

13 MS. DAILEY: Okay.

14 CO-CHAIR NATHAN: It is the HEC
15 Liaison and the JEC Liaison; in other words,
16 the HECL and the JECL.

17 (Laughter.)

18 Okay.

19 MS. DAILEY: All right. So, we
20 are going to pull out of there -- so, if we
21 want to keep this in the interagency policy
22 lane, we are going to stick with "a" and "b",

1 really "a" and "b" and "c"; "d", "e", and "f"
2 we would take out because we wanted to stick
3 with an interagency policy or an
4 interagency --

5 LT COL KEANE: I have one more
6 thing to add, Ms. Dailey.

7 MS. DAILEY: Yes?

8 LT COL KEANE: For your team, I
9 found a website, Assistant General Counsel for
10 the Department of Veterans Affairs, Mr. Walter
11 A. Hall, he has a PowerPoint out there, and he
12 addresses topics covered: legislation
13 requiring joint activities, and he references
14 Public Law 110-181. And in this Public Law,
15 there are seven or eight different
16 requirements in the Section 1600xxx. That
17 mandates joint development and implementation
18 of policies regarding the care and transition
19 of Recovering Service members, and then, it
20 gets into more specific things.

21 I would just kind of draw your
22 attention to that. Maybe there's something

1 that is already out there.

2 MS. DAILEY: We got all of that.

3 CO-CHAIR NATHAN: All right.

4 That's good.

5 MS. MALEBRANCHE: We might have to
6 find you a new point of contact. Mr. Hall
7 retired, but --

8 MS. DAILEY: Yes. Say it again.
9 I'm not sure what's going on here. Pull that
10 site up again. Is it still up? Say it again.
11 Say it slowly.

12 CO-CHAIR NATHAN: Because anytime
13 you bring up law 110-181, that is going to
14 draw some interest.

15 LT COL KEANE: I will do it. Let
16 me pull it up. I don't have to waste
17 everybody's time to pull it back up.

18 MS. DAILEY: And you all also
19 broadened this to talk about Recovering
20 Warrior families, comp and pen credentialing,
21 the warm handoff, the disability evaluation
22 system.

1 Do you want it to go that broad or
2 do you want it to cover transition?

3 CSM DeJONG: I think those were
4 just examples of what are currently -- and
5 correct me I am wrong -- MOUs that would be
6 affected or removed by an interagency policy.

7 MS. MALEBRANCHE: Correct.

8 CO-CHAIR NATHAN: So, remember,
9 the aegis of this was as the first sentence.
10 Remember, the aegis of this was you all are
11 buying into the goodness of somehow
12 strengthening the interagency system, and you
13 are going to do it with a more common
14 operating picture, a more uni -- uni-
15 whatever -- system, a uniform system of policy
16 between the agencies that specifically applies
17 to the transfer of Service members from DoD to
18 VA. But are you widening that aperture?

19 MS. MALEBRANCHE: No. What I gave
20 you were examples of where we don't have
21 interagency policy, that have been working on
22 MOUs, that have taken inordinate amounts of

1 time --

2 CO-CHAIR NATHAN: Okay.

3 MS. MALEBRANCHE: -- especially
4 IDES, et cetera, because they have been
5 working on MOUs for every site that this type
6 of thing could be used for. So, it is not
7 just one place that it would be beneficial.
8 It wasn't suggesting that you should go back,
9 but I am sure everybody will jump on.

10 CO-CHAIR NATHAN: Okay.

11 MS. DAILEY: My concern is we have
12 centered this discussion a lot around how much
13 time we think this would save. I am not sure
14 we are time-saving here.

15 I'll just kind of throw this out:
16 I think the effort here would eliminate, would
17 be more successful in eliminating seams, gaps,
18 eliminating silos between the two agencies.
19 I am not sure you can even hang your hat on
20 time-savings, but --

21 CO-CHAIR CROCKETT-JONES: Yes, it
22 might not be quicker. Yes, I agree, it might

1 not be a quicker process, but it might also
2 eliminate in that right now we have regional
3 MOUs which, then, don't meet a standard. And
4 then, that goes through a review process.

5 Some of that sort of sausage-
6 making to get everyone on the same page
7 through all these many MOUs will be
8 eliminated. If there is a policy, they won't
9 need to have a local MOU. And that is
10 probably really more where time-saving will
11 occur, not necessarily when joint policy is
12 issued.

13 CSM DeJONG: And I also believe
14 the time-saving on this is that they won't
15 have to be redone under new leadership. So,
16 once it's established, it's established. So,
17 it may be an arduous process to get it done,
18 but once it is one, it is established and it
19 stays.

20 MS. DAILEY: Okay, okay.

21 CO-CHAIR NATHAN: Anything else?

22 (No response.)

1 Going once, going twice. Okay, we
2 got it. Great.

3 CO-CHAIR CROCKETT-JONES: Do we
4 need a break or can we move on to --

5 CO-CHAIR NATHAN: We have one more
6 section left.

7 CO-CHAIR CROCKETT-JONES: --
8 family caregivers?

9 CO-CHAIR NATHAN: So, we can
10 either take a break or we can power through
11 and you can take breaks as needed
12 individually. Keep driving?

13 CO-CHAIR CROCKETT-JONES: Keep
14 driving? Okay.

15 The next observations for review
16 are related to family caregivers. These
17 observations come from our visit to the WCP
18 office and installation visits.

19 The language here requires a DoDI
20 policy to be written. Additionally, this
21 entails a high degree of detail that needs to
22 be included in the policy statement. During

1 discussion with WCP in January, they requested
2 for this detail to be included. This level of
3 detail has been gathered from family members
4 over the past four years.

5 The observation about enhancing
6 SCAADL addresses broadening the legislative
7 policy about eligibility. These observations
8 include additions highlighted in red, provided
9 through feedback from me and from Lieutenant
10 Colonel Keane.

11 As we review items 1a through 1o
12 and 2a through 2b, I ask that you select those
13 ideas that are most important to you.

14 I will start off this discussion,
15 though I expect that Tech Sergeant Eudy and
16 Command Sergeant Major DeJong will be jumping
17 in.

18 This is a lot to digest. One of
19 the standardization features is a definition
20 of the term "family member". We need that to
21 be more uniform. We want it to really include
22 people whom the Service member who is going

1 through the recovery process designates. As
2 a family member, we want them to have the
3 option. I mean, it is heartbreaking to hear
4 that a fiancée isn't included because they
5 weren't technically a family member. You
6 know, it doesn't often happen anymore, but if
7 everyone had an agreed-upon definition, we
8 know we would eliminate those kinds of cracks
9 through which people fall.

10 You can look at all of these.

11 In terms of SCAADL, because it is
12 something for family members, it falls under
13 here, but, really, I want to relate that to
14 also looking at what are the activities of
15 daily living that are significant.

16 We do need them to be able to
17 review how SCAADL is applied and what
18 qualifies you. Right now, it is using
19 language and lists of activities that the VA
20 has already begun to rethink. With the large
21 number of TBI and PTSD diagnoses, the VA is
22 seeing that -- and the development of

1 effective prosthetics -- they are seeing that
2 getting dressed may not be the signature need
3 for those who are really struggling, that it
4 might be remembering to take your meds and get
5 to your appointments, because of memory issues
6 from TBI.

7 So, they have been reworking some
8 of the ways they assess their caregiver
9 program. And I don't see any move to update
10 SCAADL in a similar way.

11 And the training that the VA uses,
12 the Easter Seals training, touches on both the
13 physical activities and, then, training on
14 recognizing how to interact with people who
15 have cognition issues. And so, they have
16 really been progressing and modifying, and
17 there has been this evolution of an
18 understanding on the VA side. It is
19 beginning; I wouldn't say it is the perfect
20 model, but it is definitely evolving.

21 I would like to see SCAADL and
22 comprehension evolve in a similar manner on

1 the DoD side. So, I am throwing that out to
2 you as an area where we might want to make a
3 recommendation. It may be too fine a point.
4 So, I would love to have a discussion about
5 that.

6 LT COL KEANE: The first things
7 -- you can stand by -- the first things I
8 would like to pull out our "g" and "l". Those
9 would fall underneath what I would define as
10 the bedside information, clarifying the types
11 of outreach services, making sure that the
12 family, spouses, caregivers are at the
13 bedside, that they know what is going on from
14 the get-go.

15 MS. DAILEY: Okay. Hang on.
16 "Pull out" means what? Eliminate or --

17 LT COL KEANE: Pull them out and
18 discuss them.

19 MS. DAILEY: And discuss them?
20 Okay. So, when you said "Pull out," I just
21 had my staff erase them. So, they aren't
22 going anywhere?

1 LT COL KEANE: Exactly. Okay.

2 So, those two support what I am echoing as the
3 No. 1 priority of a recommendation.

4 MS. DAILEY: Okay.

5 LT COL KEANE: The second thing,
6 and to address SCAADL, is to have a
7 discussion. And I would argue that SCAADL is
8 better than the VA caregiver. At least SCAADL
9 includes illness. The VA caregiver would be
10 the one I would suggest that would need to be
11 modified to come in line with SCAADL.

12 CO-CHAIR CROCKETT-JONES: It's
13 almost like they both have voids. And really,
14 it is almost as if there was a joint policy
15 for caregiver compensation that took care of
16 both of those issues; we would see a
17 progression and SCAADL might evolve to include
18 more timely activities, and caregiver would
19 then include illnesses. This is one of those
20 areas where these two programs could be better
21 if they were each broadened to a joint level.

22 LT COL KEANE: There would be a

1 cost-savings, too. One of the big "nut rolls"
2 I did monthly was rectifying our marines who
3 were getting SCAADL who were now eligible for
4 caregiver, and make sure that that SCAADL was
5 turned off, even though DoD has allowed for an
6 overlap to ensure that there was no drop in
7 coverage. If there was one, I agree if there
8 was caregiver thing, we would save money.

9 CSM DeJONG: The way I see this is
10 to continue down where you were is also
11 interagency policy. I see three different
12 things and one that is possibly missing that
13 we might want to throw in.

14 We have the training along with
15 what Colonel Keane was talking about. We have
16 got the training aspect of it along with the
17 interagency policy of it to make the two
18 equal. The one that I don't see in here that
19 we did do some discussion on our last meeting
20 was -- and I don't remember which one is which
21 -- a tax-free benefit, and that is not here.
22 I looked ahead for tomorrow, and I don't see

1 it there. So, we might want to throw that in
2 here and look at it as three separate issues
3 under this category.

4 CO-CHAIR CROCKETT-JONES: SCAADL
5 is the one that is not a tax-free benefit.

6 MS. DAILEY: And that was last
7 year's recommendation.

8 So, this, the first thing I think
9 you all might help your discussion is this is
10 recommending a DoDI, a family policy that
11 addresses families in the Department of
12 Defense. That's where this starts, because
13 there isn't even a DoDI on families.

14 And then, underneath it are all
15 the things that Warrior Care Policy asked us
16 to include. Some of those things, we have
17 made recommendations on. We are just listing
18 them here to hold Warrior Care Policy
19 accountable and to also allow them one-stop
20 shop for what that DoDI should look like.

21 CO-CHAIR NATHAN: Right. I think
22 you have said that very well, Ms. Dailey. The

1 genesis for this is that there is an
2 impression that families and caregivers are
3 not getting the information, the support, and
4 the wherewithal needed to meet the needs of
5 the Recovering Warrior or themselves. That is
6 the premise.

7 And what happened was, when the
8 Warrior Care Policy people came before us,
9 they said, "Help. Here's what we need." And
10 that is where we got 1a through o.

11 And so, the first question, the
12 first call of the question is what Ms. Dailey
13 is saying: do we believe that, one, a DoDI is
14 what is necessary to do this, a DoDI being
15 sort of the hammer that basically says, "You
16 do this or else." Usually, it is fairly
17 effective at changing. So, there is no
18 guarantee that DoD will take us up on it, but
19 if they do, DoDIs usually equal action. Do
20 you believe it needs that level of impetus?
21 We will talk about SCAADL in a second.

22 And then, secondly, if you do want

1 a DoDI, do you believe that it should contain
2 the types of things that Ms. Crockett-Jones
3 and Command Sergeant Major DeJong were talking
4 about, including Colonel Keane, that basically
5 talks about do you limit it from the list of
6 these roughly 20 items that would be in the
7 DoDI.

8 So, first DoDI, because that is
9 what the first sentence say, right? No. 1, it
10 says, "DoD should publish a DoDI for
11 addressing the needs of Recovering Warrior
12 family members and caregivers."

13 Anybody really for it? Anybody
14 really against it? Anybody see an alternative
15 way to do it? Anybody think that it is not a
16 problem, that this has since dissipated, and
17 war is cranking down and families are getting
18 better, and we have got it all wired?

19 CAPT SANDERS: Is this another
20 case where we are trying to find uniformity
21 among the differing practices of Services on
22 how they treat Wounded Warriors and family

1 members?

2 CO-CHAIR NATHAN: I would think it
3 is more than uniformity. It is making sure it
4 happens. We are not sure it happens in all
5 cases. In other words, each Service has the
6 way of approaching it, but the WCP people came
7 to us basically saying, "We've got some lost
8 lambs out there."

9 CAPT SANDERS: Well, I think they
10 have identified to us a need, then, right?

11 CO-CHAIR NATHAN: From their
12 perspective, yes.

13 CAPT SANDERS: From their
14 perspective.

15 LT COL WONG: I think development
16 of a DoDI will create that transparency for
17 the caregivers and the family person that we
18 are looking for. It will also create that
19 enduring mission that we are looking for as
20 well if we address it in a DoDI. So, I think
21 that would be a good, strong recommendation.

22 LT COL KEANE: I agree, sir, that

1 a DoDI would be a great way to tee it up.

2 CO-CHAIR NATHAN: Wow, normally
3 the contrarian, and now he's with us. Let's
4 quit. Mission accomplished sign; hang it up
5 on the conning tower.

6 (Laughter.)

7 "But I haven't finished yet, sir.
8 I want to whack all of them except 'g'."

9 (Laughter.)

10 Okay. So, it sounds like we have
11 a DoDI.

12 LT COL KEANE: Sir, to clarify,
13 you're not impersonating me in the room?

14 CO-CHAIR NATHAN: No, no, no. I
15 couldn't, and imitation is the highest form of
16 flattery, anyway, Colonel.

17 (Laughter.)

18 So, I see general consensus that a
19 DoDI is needed. You would agree with the
20 premise?

21 Okay. Now we need to work on what
22 you think a DoDI should or should not include

1 from either pick or lose or use these "a"
2 through "o" or add some of your own.

3 TSGT EUDY: In regards to
4 broaching "g", sir, we have addressed that
5 slightly earlier. I don't want to hit it in
6 two separate areas and end up with policy that
7 does not go forward in the same manner.

8 Just the same as when we make
9 recommendations and everything is clearly
10 defined in our findings, and the Services come
11 back and say, "We already do that." And then,
12 one Service meets the need versus the other
13 goes, "Well, you know, we interpret it in such
14 a manner." As long as there are specifics
15 based on each of these items, how do meet
16 those needs in the DoDI, then they can't say,
17 "We already do that."

18 Because if the Services were
19 briefing us on a lot of these items already,
20 they would say clearly, "We meet this need."
21 We need to demonstrate how that is not met in
22 regards to perfecting this DoDI. I would hate

1 for the Services to come back and say, "Well,
2 thank you. Now we've got the DoDI, we are
3 following it." And then, at the next war,
4 they end up coming with this exact same list.

5 CO-CHAIR NATHAN: I think that is
6 a very good point. If this is going to have
7 teeth, it needs to have teeth where it makes
8 sense to the Services as well.

9 CO-CHAIR CROCKETT-JONES: Well,
10 number or letter "d" talks about identifying
11 Service member reporting metrics. We might
12 link the metrics to the list. You know,
13 metrics really might want to be linked to the
14 rest of the list. The metrics, that might be
15 the last letter on this list, to say the
16 metrics should reflect the priorities of this
17 list.

18 CO-CHAIR NATHAN: Right. Well,
19 the genesis of the metrics I think would be,
20 if you are going to go to the trouble to
21 create a DoDI that is going to theoretically
22 improve the process and improve the quality,

1 how do you measure that? How do you, then,
2 come back and say?

3 Because, theoretically, right, if
4 we get this right, a DoDI, the world before
5 the DoDI and the world after the DoDI, we
6 should be able to, we would hope, aside from
7 just asking people, "How are you doing?", and
8 they say, "Oh, so much better," we would hope
9 to have something that would show you that
10 your DoDI has given you traction and improved
11 the process.

12 CO-CHAIR CROCKETT-JONES: Yes,
13 exactly. I would just say that, if one of the
14 things we are saying is address optimal
15 caregiver use of the Family Medical Leave Act,
16 we don't want them to say, "But we don't
17 measure that. We don't know how many people
18 take it."

19 If the metrics are one of the last
20 things listed and we say the metrics should
21 align with this list, hopefully, we would be
22 able to say how many people used FMLA because

1 the DoDI addressed metrics in alignment with
2 this list. That would make more sense to me
3 than just leaving the option of metrics open.

4 I don't want them to say, "Well,
5 we do keep metrics. We know this is how many
6 family members we have. That is just not a
7 sufficient metrics to measure if the DoDI is
8 effective and where its gaps are.

9 MR. DRACH: While you are
10 mentioning FMLA, and I don't want to get too
11 far ahead, I am not sure that the FMLA in its
12 current authority really covers caregivers, I
13 think as we are discussing caregivers, which
14 are, from my experience, a lot of them have
15 already quit their job other than left their
16 job temporarily. And I think FMLA only covers
17 like 30 days, but don't quote me on that. I
18 don't know what FMLA is.

19 CO-CHAIR CROCKETT-JONES: FMLA
20 covers six weeks, and sometimes people go to
21 bedside for that short of a time, or even if
22 it is four months, they have to be bedside,

1 not necessarily the extended caregivers. This
2 is a separate sort of look at family members
3 who don't realize they can ask for FMLA to be
4 bedside during the most critical recovery
5 time.

6 MR. DRACH: Should we be thinking
7 beyond on that and possibly suggesting an
8 amendment to FMLA that would be more than six
9 weeks?

10 CO-CHAIR NATHAN: You mean
11 specifically just for the Recovering Warrior
12 families as opposed to the general federal
13 employee?

14 MR. DRACH: Just this population.

15 CO-CHAIR CROCKETT-JONES: Here I
16 am going to sound like a stingy taxpayer. I
17 actually don't think that it is necessary
18 because I think, if someone winds up being
19 needed for that extended period of time, they
20 should apply for SCAADL and fall into the
21 compensation from the military for what they
22 are doing, and then, maybe eventually, in the

1 VA Caregiver Program.

2 I think if it is going to be more
3 than six weeks --

4 MR. DRACH: Yes, I hear what you
5 are saying, but SCAADL doesn't replace a
6 career. So, if somebody interrupts their
7 career, they lose 401, they lose pension, they
8 lose Social Security, they lose tenure, they
9 lose self-respect, they lose a lot of things,
10 tangible and intangible.

11 I am not hung up on this, but I
12 just don't know that six weeks is enough time.
13 When somebody is spending three years post-
14 injury in the system -- and I am not
15 suggesting three years would be the ideal,
16 and, of course, that is a legislative DOL
17 issue, not a legislative DoD or VA issue. So,
18 I don't know if we are going down a wrong lane
19 there or not.

20 CO-CHAIR CROCKETT-JONES: I am not
21 sure we have the power to ask for FMLA to
22 be --

1 TSGT EUDY: And correction, it
2 says "26 workweeks of unpaid job-protective
3 leave during a single 12-month period". And
4 there are currently revisions going on
5 amongst --

6 CO-CHAIR CROCKETT-JONES: So, it
7 is six full months. That is a significant
8 amount of time.

9 CO-CHAIR NATHAN: Okay. Why don't
10 we take it by the numbers? Because I think we
11 have had some of the conversations ahead,
12 which will save some time.

13 So, under 1, is there agreement,
14 based on what you think intrinsically or based
15 on what you heard from the WCP, that a DoDI
16 actually needs to define what a Recovering
17 Warrior family member is?

18 DR. PHILLIPS: I have a little
19 trouble with that. You know, I will just
20 throw this out.

21 I am wondering if we shouldn't
22 define what that person is, designated

1 caregiver, because they may not be family
2 members, as we discussed. And over a period
3 of time, they may change. Someone at Walter
4 Reed may have a girlfriend or a mom, and when
5 they move back to Idaho, it might be somebody
6 else.

7 So, I am just wondering if it
8 wouldn't be better for us to simply say the
9 designated caregiver and not leave it open for
10 a definition.

11 CO-CHAIR CROCKETT-JONES: There is
12 a problem. Caregivers are specific family
13 members. Not everyone who goes to the bedside
14 is considered a caregiver.

15 For instance, someone wants both
16 parents at bedside; only one of them is going
17 to be considered the caregiver or NMA even.
18 And both are family members in terms of
19 looking at programs for informing them.

20 So, the only thing I would say
21 that is missing from this list is including
22 non-relative family members if the Service

1 member designates one. They should be able to
2 designate a fiancée as the family member if
3 that is who is going to be bedside.

4 DR. PHILLIPS: Yes, I was thinking
5 more broadly. Because if we are having
6 trouble defining it, whoever is supposed to
7 define it may have, you know, more trouble.

8 Again, it is just a suggestion,
9 but I would feel more comfortable if we can
10 come up with the terminology and present it,
11 rather than waiting for them to do something.

12 MR. STONE: So, within the SCAADL
13 law, how is it defined? I remember when
14 SCAADL came out, and we were working with it
15 early on, there is a definition there that I
16 think if you pull out, this may just require
17 some tweaking of the SCAADL definition to
18 include non-family members as designated.

19 MS. DAILEY: Yes, the SCAADL
20 defines the injury, the level of injury. And
21 then, the Service member gets to identify that
22 he has a caregiver, regardless. And then, he

1 gets paid or she gets paid the benefit.

2 MR. STONE: And so, how is that
3 definition, why should it be restricted in any
4 way?

5 CO-CHAIR CROCKETT-JONES: I don't
6 think it should be. I think, though, what we
7 don't want to do is call family members the
8 only caregivers, since sometimes they don't
9 fall under that category. They are just the
10 family member at bedside. Caregiver is
11 assuming a specific role. The VA has a
12 definition for caregiver. Not all of these
13 family members that are part of the process
14 will be SCAADL recipients.

15 So, in having a DoDI, I would just
16 want the Service member to be the one who
17 designates who their family members are.

18 MR. STONE: I am not speaking
19 against the DoDI creation.

20 CO-CHAIR CROCKETT-JONES: Right.

21 MR. STONE: What I am saying is,
22 take the wording that is in the SCAADL law and

1 import it into the DoDI, and you have answered
2 this question.

3 CO-CHAIR CROCKETT-JONES: I think
4 you're right because the SCAADL law allows the
5 Service member to designate who their family
6 member is.

7 LT COL WONG: And I know we are
8 talking specifically fiancées, but there is an
9 expansion of family members law. There's
10 domestic partners, there's other personnel
11 that are out there that potentially the
12 Service member may want by their bedside that
13 they are currently excluded until this is
14 expanded.

15 CO-CHAIR NATHAN: So, what I am
16 hearing is everybody is onboard with "a" and
17 the sub-bullets, but you would like to expand
18 the definition to be caregivers.

19 CO-CHAIR CROCKETT-JONES: No, I
20 think we want the designation to be made by
21 the Service member.

22 CO-CHAIR NATHAN: Okay.

1 MR. DRACH: On double "i" under
2 that, should we add "FRC" after "RCC"?
3 Somebody that has been assigned a Federal
4 Recovery Coordinator? They are the more
5 severely --

6 MS. MALEBRANCHE: I don't think so
7 for that, adding the FRC, because that
8 terminology may change. So, that would limit
9 us here.

10 CAPT SANDERS: Before we leave the
11 family member piece, I just want to ask a
12 question. So, is family members a term of art
13 within this legislation, so that the way it is
14 structured right now you can designate a
15 family member, and once you designate a family
16 member, you, then, become eligible to be the
17 caregiver? And the Service member can
18 designate anyone he or she chooses to be a
19 family member, whether or not they are a
20 relative by blood or not?

21 MS. DAILEY: Correct.

22 CO-CHAIR CROCKETT-JONES: Correct,

1 but you can't name -- you are only really
2 getting --

3 CAPT SANDERS: One caregiver.

4 CO-CHAIR CROCKETT-JONES: One
5 caregiver.

6 CAPT SANDERS: Right. But the
7 caregiver has to come from that distinct group
8 of family members that are identified by the
9 member as well?

10 CO-CHAIR CROCKETT-JONES: Yes,
11 that seems --

12 CAPT SANDERS: And they don't have
13 to be a blood member of the family?

14 CO-CHAIR CROCKETT-JONES: No.

15 CAPT SANDERS: The family member
16 is whoever decides this family is or she
17 decides who the family is? Okay.

18 LT COL WONG: There is one
19 exclusion under the SCAADL. The caregiver
20 cannot be a DoD member or paid DoD member.

21 MS. DAILEY: Okay. Every DoDI
22 requires a definition of terms. I realize

1 this definition of terms is best implemented
2 when the Services agree on the definitions.
3 Your DoDIs are more effective not necessarily
4 when they agree, but at least when they have
5 all been asked to collaborate on the
6 definition of family member, the definition of
7 caregiver. There are several terms in there,
8 out there, that this first bullet is designed
9 to clarify for all the Services. What's a
10 caregiver? What's a family member?

11 And then, once those definitions
12 are established, then they can get benefits.
13 The caregiver gets benefits; the family member
14 does not. The caregiver gets this
15 information; the family member does not get
16 this information. Once you have defined these
17 categories, you can then allot resources and
18 information that is appropriate for those
19 categories.

20 It is best done by the Services in
21 their process, so that there is buy-in and
22 support because they have had input to it.

1 CAPT SANDERS: I just want to make
2 a point. There's other law out there that
3 defines family members under DoD that is not
4 related to this?

5 MS. DAILEY: No.

6 CAPT SANDERS: None at all?

7 MS. DAILEY: The SCAADL law --

8 CAPT SANDERS: No, no, not --

9 MS. DAILEY: -- addresses the
10 Service member only.

11 CAPT SANDERS: Okay, not related
12 to Wounded Warriors or Recovering Warriors,
13 but the Department of Defense has been
14 directed in other ways to define family
15 members for other circumstances, and whether
16 or not that bleeds into this could be an
17 issue, if the definition somehow doesn't fit.

18 MS. DAILEY: Because that
19 statement is not correct, I can't address it.
20 I don't know if Department of Homeland
21 Security -- excuse me -- DDS has defined
22 caregiver if --

1 CAPT SANDERS: I wasn't talking
2 about caregiver; I was talking about family
3 member.

4 MS. DAILEY: Family member. In
5 general, family member is a Department of
6 Defense culture. There are very few other
7 agencies that have the culture that we have
8 for taking care of families. So, I would not
9 expect family member to be defined in the
10 Transportation Department.

11 CO-CHAIR CROCKETT-JONES: No, he
12 was saying DoD. He was saying DoD may have
13 other regulations that define family member.
14 But I believe that they rely on the term
15 "dependence" --

16 MS. DAILEY: Yes.

17 CO-CHAIR CROCKETT-JONES: -- in
18 their definitions.

19 MS. DAILEY: I see what you are
20 saying, a DEERS.

21 CO-CHAIR CROCKETT-JONES: A DEERS
22 and all that.

1 MS. DAILEY: A beneficiary.

2 CO-CHAIR CROCKETT-JONES: They are
3 beneficiaries.

4 MS. DAILEY: Yes.

5 CO-CHAIR CROCKETT-JONES: They are
6 dependents. They have other terms. I don't
7 think that, in general, they use the term
8 family member, specifically because they are
9 defining something very specifically.

10 MS. DAILEY: So, if you want to
11 give DoD -- first of all, you are only making
12 a recommendation. So, if you want to make a
13 recommendation to DoD that caregiver be
14 defined this way and family member be defined
15 this way, it is only a recommendation. And it
16 is the product of your collective knowledge
17 and not their collective knowledge.

18 CO-CHAIR CROCKETT-JONES: Like I
19 said, the only thing on this list of 1 through
20 4 under "a" is in the way that SCAADL leaves
21 it open to be the person a Service member
22 designates as a single family member to be

1 bedside.

2 I don't want that to go sight
3 unseen and wind up excluding people because
4 they defined it based on this list, which does
5 not include non-blood relatives. So, the
6 fiancée gets included, the partner gets
7 included, the foster brother winds up getting
8 included as the family member that is going to
9 be designated to receive the information and
10 to help them through the recovery process if
11 that is who the best person is.

12 MS. DAILEY: Okay. Yes. Team,
13 was it intentional on every one of those, 1,
14 2, 3, and 4, we use "family member includes
15 family"? For the Army, it includes family and
16 for any family member. Did we do that
17 intentionally to not have non-blood relatives
18 in there? Okay. So, we were just
19 overabundant and enthusiastic about family.
20 Okay. We will broaden that.

21 CO-CHAIR CROCKETT-JONES: Persons.

22 CO-CHAIR NATHAN: Yes, I think if

1 you just broaden it to include non-blood
2 relatives or non-blood persons, people without
3 blood -- (laughter) -- then it will be fine.

4 Okay, let's move on to require the
5 Services -- do you feel strongly that the DoDI
6 should require the Services to identify the
7 Service-specific office within both the active
8 and Reserve components tasked with supporting
9 Recovering Warrior families? Is this
10 something that is not being done now and the
11 DoDI should require the Services early on --
12 remember, the guiding principle from sentence
13 one is, "early in the recovery process to
14 identify the Service-specific office".

15 Army, you have got to tell Army
16 families where the office is that supports
17 them, where the people are who support them.
18 Maybe you've got to do the same.

19 Is there anything to be lost? I
20 mean, is there anything to lose? Do you have
21 everything to gain with this and nothing to
22 lose? Or is there any potential blowback on

1 it?

2 Going once.

3 This came from the WCP. This is
4 their wish list.

5 CO-CHAIR CROCKETT-JONES: Yes,
6 this is the WCP.

7 TSGT EUDY: Correct, and where was
8 their shortfall in seeing this, because this
9 is one of those statements, again, where I
10 will see the Services saying, "We do this."

11 CO-CHAIR CROCKETT-JONES: No.
12 Some Services have done this, but not all
13 Services have designated an office or a role
14 responsible.

15 CO-CHAIR NATHAN: And remember, it
16 doesn't say create the office; it says
17 identify the office.

18 TSGT EUDY: So, then, we will be
19 leaving it up to the DoDI and, then, the
20 Services then to choose whether they use,
21 let's say, a cadre member versus a Lead
22 Coordinator versus --

1 CSM DeJONG: No, this is more
2 level of WCP building the algorithm as to who
3 is their go-to person and/or office in the
4 next level at each Service.

5 TSGT EUDY: Connecting directly,
6 then, with that family member?

7 CSM DeJONG: Then, it goes down
8 from there.

9 TSGT EUDY: Just making sure,
10 then, it is the same commensurate. Okay.

11 MR. STONE: Do we really need to
12 get to this level of telling the Services how
13 to execute this?

14 CO-CHAIR CROCKETT-JONES: This is
15 what WCP has said prevents them from telling
16 the Services how to do this.

17 MS. DAILEY: They ask for a list
18 of things that we have seen over the years
19 that would be helpful that they should include
20 in the DoDI.

21 MR. STONE: Since they are a
22 policy office, it seems to me that generating

1 DoD-level policy is something the Department
2 does pretty well at. Are they having trouble
3 deciding who to send their policy to? Is that
4 the problem? Or nobody pays attention to
5 them?

6 MS. DAILEY: Well, I think their
7 intent here was that in each Service they had
8 a reciprocal policy office for promulgation
9 and that they are not confident that that is
10 what is out there for families.

11 CO-CHAIR NATHAN: And what we are
12 doing, I think, is brokering their wish list
13 against our intuition, based on what we have
14 seen as a Task Force, and as we have talked to
15 families and as we have observed the processes
16 across the dynamic over the years. You should
17 be asking yourself exactly what General Stone
18 did, which is, okay, is this something that
19 they already do and we don't need to tell them
20 how to do it or (b) we do need to tell them to
21 do it because we agree with WCP this isn't
22 really well-established and would be a

1 goodness?

2 So, do I hear any objections to
3 Services required early in the process to
4 identify the office to the WCP that is tasked
5 with supporting the RW families? No?

6 Okay. Remember, you can cogitate
7 on these over the next eight, six weeks. When
8 we get back together in July and we have the
9 Mad Max from Thunderdome 12 recommendations
10 enter; one recommendation leaves.

11 "C, delineate the role" -- if you
12 liked "b", you will love "c".

13 (Laughter.)

14 Delineate the role of the Service-
15 specific office tasked with supporting...."
16 That now, if you like telling people how to
17 suck the egg, Rich, you've got it in spades
18 there in "c".

19 MR. STONE: Could we go back to
20 the no-blood comment?

21 (Laughter.)

22 CO-CHAIR NATHAN: I do worry that

1 "c" is getting a little weedy, but --

2 CSM DeJONG: I don't see why we
3 would have to go that far into it. I think if
4 they need help identifying, they need help,
5 and I agree with you, sir, I don't know why
6 they need our help to identify a Service-
7 specific office.

8 MR. STONE: Sergeant Major, I am
9 struggling with it because it seems like we
10 need to give them the address of who to send
11 it to or?

12 (Laughter.)

13 CSM DeJONG: I'm with you.

14 MR. STONE: I'm not sure. This is
15 a very well-developed Department. Certainly,
16 we understand that this office is in a state
17 of evolution. There are some great people
18 there. They are working hard to develop it.
19 So, I am not sure we really need to tell them
20 how to do their business.

21 I think we can put some things in.
22 If they asked for it, I understand. I am

1 still not sure we need to give it to them.

2 CSM DeJONG: I would entertain
3 "b"; I would hesitate to entertain "c".

4 CO-CHAIR NATHAN: Okay. I didn't
5 really hear any objections to "b", but I'm
6 hearing the vocal minority so far concerned
7 about "c".

8 Is there anybody who believes
9 strongly enough in "c" that we need to leave
10 that teed-up?

11 MR. STONE: Sir, I don't mean to
12 belabor this. Could we pull the enabling
13 document that says how the WCP stood up and
14 what their roles are? Do we have the enabling
15 document?

16 CO-CHAIR NATHAN: Their charter?

17 MR. STONE: Yes.

18 MS. DAILEY: All right, sir. I
19 was there when it was stood up.

20 We have attempted to put it in --
21 we put it in a recommendation to establish
22 this office in law. DoD non-concurred.

1 They have done a number of
2 documents over the years to create their
3 mission. There isn't anything in law. There
4 is one line in the P&R DoDD, Department of
5 Defense Directives, that says P&R will manage
6 Recovering Warrior care. They call it a
7 different name. There is no DoDI that covers
8 this office.

9 I can give you all sorts of emails
10 from Mr. --

11 CO-CHAIR CROCKETT-JONES: Yes, I
12 think what we are struggling with right now,
13 Denise, is that the office has, in responding
14 to us, implied that they don't actually have
15 the force, the power to enforce that Services
16 comply. Now they can only make policy
17 suggestions. And at this point now they seem
18 to be saying they can't make the policy
19 suggestion for the DoDI; they need us to do
20 that.

21 I am a little frustrated because I
22 thought I was understanding the role of WCP,

1 in that even though they had no teeth or
2 manner of enforcement, they made policy
3 recommendations for this population.

4 MS. DAILEY: They do. They wrote
5 the IDES policy. They wrote, okay, so they
6 wrote the RCC policy. They wrote the
7 Operation Warfighter policy. They write
8 policy all the time.

9 We have kicked this topic of
10 asking them, telling them, making a
11 recommendation to do a family policy, we have
12 discussed this almost every year. You've not
13 gone down this road. So, you don't have to go
14 down it again, but it is one of the areas from
15 their office that they have never written
16 policy for, and they said, "We'll do it. Tell
17 us what you want in there."

18 The Services have been asking us.
19 Army has come to us and said, "You want us to
20 do that? Put it in a policy."

21 You can just put a one-liner,
22 "Write a DoDI family policy." That will help

1 them move down the road.

2 When you make a recommendation,
3 whether it be small or detailed, big or
4 detailed, you give them leverage; you give
5 them something to point to. So, your voice
6 gives them something to go back to when it
7 comes to leveraging compliance from the
8 Services.

9 CO-CHAIR CROCKETT-JONES: So, if
10 our recommendation was that a DoDI needs to be
11 written to address the needs and the processes
12 that touch family caregivers early on in the
13 process, some more basic recommendation, could
14 these topics that we have repeatedly said are
15 significant be included not necessarily in
16 that recommendation, but, instead, in an
17 explanation? So that our recommendation isn't
18 as granular as all these sub-topics?

19 Yes, I think it would be more
20 clear. And rather than have a recommendation
21 be non-concurred because they don't go along
22 with "d" or "f" or "k", or because it doesn't

1 apply, rather than being non-concurred, the
2 broad recommendation that DoDI needs a policy,
3 I don't know how anyone could -- do you see
4 what I'm saying? I think that would have more
5 buy-in.

6 CO-CHAIR NATHAN: Less is more.

7 CO-CHAIR CROCKETT-JONES: Less is
8 more. Thank you.

9 MS. DAILEY: We can put what you
10 have, what is here, in the findings. So, we
11 can put what we have in here in the findings.
12 That's fine. That is your call, definitely.

13 CO-CHAIR NATHAN: Okay. So, that
14 is an interesting dynamic that has been
15 brought up here, and I think we need, before
16 we keep going down the list, Ms. Crockett-
17 Jones brings up a good point, which do we not
18 even get into the weeds of this? Do we do as
19 Ms. Dailey suggested is a possibility, put
20 these kinds of things in the findings that we
21 heard? And those findings -- and there's no
22 question they were findings because they were

1 presented to us sort of in evidence from the
2 WCP that came before us, and we have seen some
3 of these things in our own personal travails
4 through the system. If we put those in the
5 findings and we use those findings to generate
6 a much more general one impact statement that
7 says: you publish a DoDI that addresses the
8 needs of Recovering Warrior family members and
9 caregivers early in the process, identifying
10 the baseline services to be delivered by each
11 Service branch.

12 And we can finetune that in July,
13 but that would be the concept we would leave
14 here with, and we would not go through and
15 decide if we are going to add, subtract, or
16 change each individual thing from "a" through
17 "o", unless you feel there is one in there --
18 and I hate even saying this -- unless you feel
19 there is one in there that is so heinous --
20 I like that word, "heinous". "Man, I thought
21 you said something else for a second."

22 (Laughter.)

1 That is so heinous that it has to
2 be demarcated with the general statement.

3 CAPT SANDERS: Just one point.
4 Earlier Denise made a comment about this is
5 incorrect; it doesn't apply. My point was
6 that federal law defines a family member. And
7 how we ask them to address federal law, I
8 would like the researchers to go look at
9 those, considering the Family Leave Act, 5 USC
10 8701, and the OPM definition. If we define it
11 differently than those definitions, we are
12 problematic.

13 CO-CHAIR NATHAN: Say that again,
14 please?

15 CAPT SANDERS: There was a point I
16 made earlier about defining family members.
17 And apparently, we have a definition that we
18 have adopted from someplace.

19 Well, in "a" we are clarifying a
20 family member, and there are federal statutes
21 right now which define family member. We need
22 to be consistent.

1 CO-CHAIR CROCKETT-JONES: We were
2 telling DoD to define it. There isn't a
3 definition yet.

4 CAPT SANDERS: Well, there is a
5 definition. I just looked up --

6 CO-CHAIR CROCKETT-JONES: But
7 there is a federal definition. I think what
8 was more appropriate than this list would just
9 be to indicate that a Service member who is
10 wounded, ill, or injured should be able to
11 designate a family member.

12 CAPT SANDERS: If it is consistent
13 with the existing laws; it doesn't violate
14 their definition; it doesn't violate the laws
15 that exist, that's perfect.

16 CO-CHAIR CROCKETT-JONES: As long
17 as it doesn't, yes --

18 CAPT SANDERS: So, we need to find
19 out what those laws say and make sure the
20 definition that we want them to be able to use
21 fits.

22 MS. MALEBRANCHE: Isn't the

1 definition in law of a family member, not of
2 a Recovering Warrior family member?

3 CAPT SANDERS: Correct. So, that
4 is a key definition. That is a good point.

5 CO-CHAIR CROCKETT-JONES: Yes.

6 CAPT SANDERS: We need to make
7 sure we stay in that box.

8 CO-CHAIR CROCKETT-JONES: Yes.

9 MS. DAILEY: I got it. We are
10 going to look up the family member definition
11 under the Family Leave Act. And you also
12 mentioned OPM. The Family Leave Act falls
13 under OPM, right?

14 CAPT SANDERS: There are three
15 separate statutes that defines it. I just did
16 a quick search, and three came up with it.

17 MS. DAILEY: Okay.

18 CO-CHAIR CROCKETT-JONES: And
19 we're safer if we say they need to define a
20 Recovering Warrior family member because,
21 then, it is separating that from the federal
22 term "family member".

1 CAPT SANDERS: Right, and we are
2 creating a definition, the one that we want to
3 be out there.

4 MS. DAILEY: Okay. I got it.

5 CO-CHAIR NATHAN: And then,
6 sentence one, the nice thing is it talks about
7 the needs of the Recovering Warrior family
8 members and caregivers, because any family
9 member could be a caregiver, but any caregiver
10 cannot necessarily be a family member.
11 They're not. And as you say, you can only
12 have one person at a time identified as a non-
13 medical attendant.

14 So, any other questions on that?
15 Concerns?

16 CSM DeJONG: The last comment, I
17 think this, again, adds to, going back to --
18 what is it? -- interagency policy, when we
19 start talking about -- I didn't want a book
20 thrown at me from behind.

21 (Laughter.)

22 So, when we start talking about

1 coordinating and equalizing in "h" the type of
2 training, then we go into 2 and, again,
3 redefining at an interagency level of what are
4 activities of daily living that we want to
5 address, I think if that is done at that
6 level, it will help and we can possibly use
7 some of this to caveat and strengthen that
8 recommendation.

9 TSGT EUDY: Something in addition
10 there, too. We had discussed the uniform
11 application of SCAADL. I don't know if -- if
12 I missed it while I was at the restroom, I'm
13 sorry, but that uniform application to make
14 sure that everyone that was applicable was
15 receiving. Because I know we talked about
16 Service members that were by some Services a
17 certain category, and all were being
18 approached. And then, there were discrepancies
19 regarding the number of individuals that were
20 actually on it versus not. So, making sure
21 that each and every one applies that in the
22 same manner.

1 CO-CHAIR CROCKETT-JONES: Yes, I
2 would say for now the DoDI really should
3 address a uniform policy for SCAADL
4 application. And in the long-term, we need an
5 interagency policy on caregiver training and
6 compensation to include SCAADL or caregiver
7 compensation and the definitions.

8 So, it can be included in the
9 findings for this, but it can also be a matter
10 for findings under the joint interagency
11 policy recommendation.

12 CO-CHAIR NATHAN: Well, to the
13 spirit of the first sentence, I know that from
14 watching Commander Sergeant Major DeJong
15 fairly consistently ask groups, when we would
16 meet with focus groups, about SCAADL, there is
17 a woeful lack of knowledge in many pockets of
18 that. Some places had it teed-up pretty well;
19 others just didn't understand the benefit.
20 And I wasn't confident necessarily that the
21 organization was getting it to them.

22 And again, it applies to a certain

1 subset of the Recovering Warriors, but,
2 nonetheless, I think the DoDI could help with
3 that. Whether you want to actually include
4 that as part of the recommendation, because
5 SCAADL is broken out here, or not? What are
6 your thoughts?

7 CSM DeJONG: No, I concur, sir.

8 MS. DAILEY: We did a
9 recommendation last year on better marketing
10 of SCAADL.

11 CO-CHAIR NATHAN: See, I knew I
12 was a genius. Okay.

13 (Laughter.)

14 Yes, I remembered we addressed in
15 the past. I had forgotten we had recommended
16 it. Okay.

17 MS. DAILEY: So, you want in the
18 findings the possibility of future interagency
19 training between both agencies for caregivers
20 and --

21 CO-CHAIR CROCKETT-JONES: I think
22 that right now there is no training required

1 for SCAADL. I would like to see in the
2 findings, either here or under the interagency
3 policy recommendation, an example would be to
4 align those two programs so that they have
5 consistent training, consistent definitions,
6 consistent lists of activities of daily
7 living.

8 CSM DeJONG: And that would also
9 ease, that policy would also ease the handoff
10 from one to the other.

11 LT COL KEANE: If I could put my
12 two cents in?

13 MS. DAILEY: There is a -- I'm
14 sorry -- there is a SCAADL policy. So, what
15 is the recommendation? Well, I will include
16 it in the findings. You don't want another
17 recommendation on this? Okay. Okay, we'll
18 talk about it in the findings.

19 LT COL KEANE: I guess I don't
20 agree that -- I viewed 1, No. 1, DoD should
21 publish a DoD instruction as one item. And
22 then, I looked at 2 as another item. In

1 reading this, I didn't envision them being one
2 recommendation.

3 CSM DeJONG: No, sir, it is not --
4 there is just one recommendation. Not within
5 the recommendation is 2 or "h", but I think 2
6 and "h" could be used to help caveat a policy,
7 an interagency policy, because it helps
8 standardize definitions of what are activities
9 of daily living. It helps standardize
10 training for the two, and it helps a handoff
11 from one to the other, as you transition from
12 DoD to VA.

13 I think an interagency policy on
14 that, and I was just going back to help caveat
15 the interagency policy recommendation that we
16 had talked about prior to lunch.

17 LT COL KEANE: But I don't
18 envision a discussion of SCAADL being in the
19 DoDI that we are recommending. Okay, okay.

20 CO-CHAIR CROCKETT-JONES: No,
21 except for as it is listed under "h", which is
22 to say that caregiving training and, 2,

1 attendance mandatory for SCAADL recipients,
2 that caregiving training is optional, but it
3 is mandatory if you are receiving SCAADL,
4 should be part of the DoDI as the findings,
5 not as a part of the recommendation.

6 CO-CHAIR NATHAN: Any further
7 discussion on that topic?

8 (No response.)

9 Denise, do your folks have any
10 questions or concerns about the distillation
11 of this conversation?

12 MS. DAILEY: No, sir. We have most
13 of it here. From what I understand, it is in
14 "a" through "o", and we are going to discuss
15 training for SCAADL. We are not going to make
16 a recommendation for expansion under
17 legislation for SCAADL, but we want to see
18 them align SCAADL training with VA caregiver
19 training, and that needs to be in the DoDI or
20 we will put it in the findings to highlight
21 it.

22 CO-CHAIR CROCKETT-JONES: Put it

1 in the findings to highlight it under the
2 joint policy, because it is not just the
3 training. We are not going to do a separate
4 No. 2 recommendation. But we are saying they
5 should share the same list of activities of
6 daily living. They should share the
7 definition of caregiver. They should share
8 the training.

9 And the reason why it would make a
10 perfect program to fall under joint policy,
11 because of sharing all of those aspects. And
12 that way, each has a deficit that would be
13 fixed by those two programs being in
14 alignment.

15 MS. DAILEY: Okay. And so, we
16 would allude to this making a good joint
17 policy when they have defined a structure and
18 format for joint policy?

19 CO-CHAIR CROCKETT-JONES: Exactly.

20 MS. DAILEY: Okay.

21 CO-CHAIR NATHAN: Anything else?

22 (No response.)

1 Okay. There being no further
2 discussion, I think that wraps us for today.

3 MS. DAILEY: Unless you all wanted
4 to work on tomorrow's first topic item.

5 CO-CHAIR CROCKETT-JONES: Do we
6 want to work on Reserve component IDES or are
7 we --

8 (Laughter.)

9 LT COL KEANE: I thought we were
10 going to discuss this. Is this in here for a
11 reason?

12 MS. DAILEY: It is. I mean, it is
13 for your information, if you want to discuss
14 it.

15 LT COL KEANE: I have some
16 suggestions.

17 Tab C, I assume it is the proposed
18 cover?

19 The focus is, I believe, wounded,
20 ill, or injured Service members. When I look
21 at the second picture, I guess the two
22 pictures of the airmen, doctors or whatever

1 they are, my focus is on the provider as
2 opposed to the wound, ill, and injured person.
3 So, when I look at those two pictures of the
4 airmen that are doctors, or whatever they are
5 doing, my focus is on the Service member
6 providing the service. I think we need to
7 have like a hospital bed picture to represent
8 someone ill and some other person maybe a
9 prosthetic. I know we must have a bunch of
10 pictures.

11 I would just suggest that those
12 two pictures be replaced with focusing more on
13 the wounded, ill, and injured, like the other
14 pictures do.

15 MS. DAILEY: Okay.

16 CAPT SANDERS: I would also suggest
17 maybe some pictures that align with the
18 individual we met the last time we were here.
19 So, these young men and women who were out on
20 a bike ride who were demonstrating recovery
21 might be another way to take a look at it.

22 MS. DAILEY: Okay.

1 MS. MALEBRANCHE: We have got some
2 good pictures, Denise, at the VA from the
3 Warrior Games and things, likewise, that show
4 Recovering Warriors on the way to recovery
5 that I think might be pretty inspirational
6 actually.

7 MS. DAILEY: Okay.

8 CO-CHAIR NATHAN: We have got two
9 months, just about.

10 (Laughter.)

11 CO-CHAIR CROCKETT-JONES: I just
12 want to make sure nobody wants to spend the
13 time to cover one of our topic areas from
14 tomorrow this afternoon. Be really sure,
15 because maybe we could handle empowering the
16 Centers of Excellence.

17 I have a long way to drive
18 tomorrow after our meeting.

19 MS. DAILEY: We are not going to
20 have Admiral Nathan with us tomorrow. So,
21 Captain Sanders, you are in the hot seat
22 tomorrow.

1 (Laughter.)

2 Unless you have changed your mind,
3 sir, freed-up your schedule, and --

4 CO-CHAIR NATHAN: I wish I could.
5 I will be sitting in the coach between two
6 Sumo wrestlers on a 14-hour flight over to
7 Guam. But I think I would rather be here with
8 you all. No matter what, I would rather be
9 here with you all, good or what, but
10 especially tomorrow.

11 (Laughter.)

12 So, I think it is fine with me. I
13 mean, I am happy to plow ahead tonight. On
14 the other hand, I have been looking at the
15 agenda for tomorrow. It doesn't look like it
16 is going to be any more arduous or robust than
17 today. I think you are going to move along at
18 a pretty good clip tomorrow.

19 And you have the benefit of --
20 will General Mustion be here tomorrow? Okay.
21 So, you have the benefit of General Stone
22 here. So, I think we are well-covered.

1 As President Kennedy said one time
2 at a dinner he was hosting on behalf of his
3 wife Jacqueline, he was hosting artists and
4 PhDs and Nobel Laureates and famous singers
5 for dinner, and he looked around the table,
6 and he said, "There has never been so much
7 talent and achievement assembled around this
8 table since Thomas Jefferson dined alone."

9 And so, I think we have got
10 several Thomas Jeffersons here. So, I'm not
11 worried.

12 But if you are still going when I
13 get back in a few days, I will certainly jump
14 in.

15 (Laughter.)

16 CO-CHAIR CROCKETT-JONES: All
17 right, then, I am bowing to the pressure from
18 my left. We will close for today and see you
19 again in the morning at 8:00 a.m.

20 (Whereupon, at 2:45 p.m., the
21 meeting was adjourned, to reconvene the
22 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.



Court Reporter

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